Annual Report & Financial Statements 2011 - 2012

'Right care, first time, every time'

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Chairman and Chief Executive's introduction

In one very positive respect the past year has been no different from any other, in that the many things that Northampton General Hospital has achieved for its patients and itself across the county have been delivered through the outstanding performance and accomplishments of the people who make up its staff. You will find many examples throughout this annual report.

Some 4,000 of us work either at the Northampton site or in the community-based centres we operate at Daventry, Wellingborough and Corby. Every individual makes his or her contribution to providing our patients with safe, high quality care day or night throughout the year. Each can rightly take a great deal of pride in what they do.

We recognise that in common with the rest of the NHS, NGH is experiencing financial challenges greater than at any time in NHS history and acute healthcare providers like us are required to review how we work so as to ensure we provide quality care within the resources made available to us. At the same time, external factors - including rising healthcare demand from an ageing population and increasing pharmaceutical and medical technology costs – create another set of pressures.

During 2011/12, NGH staff have demonstrated an additional dimension of dedication through their participation in the hospital's Transformation Programme. In 2011/12 the programme delivered £19.1m of savings against a projection of £18.6m. In 2012/13 the challenge will be £19m.

A particularly pleasing highlight of the past year was the outcome of an unannounced visit to the hospital by Care Quality Commission inspectors. Patients gave positive feedback about their care and treatment and the subsequent quality and safety report published by the CQC recognised many areas of good practice, with doctors and nursing staff described as kind and caring.

The 75th anniversary of the opening of the Barratt Maternity Home, a gift to the town in 1936 and now part of the main hospital was commemorated in July. Our very first baby, William Barratt Cannell, returned to help us celebrate and to meet one of the babies born earlier in the day of the anniversary.

There were some changes at the Board in the course of the year. We saw the departure of Dr John Hickey from his role as Trust Board chairman on 29 February following an extremely successful 4-year term built on hard work, commitment and clinical insight. The Trust Board is now led by Paul who was appointed on 1 March. Paul was interim chief executive at NGH for five months during 2011 so makes a welcome return. Gerry joined as Chief Executive from the beginning of June 2011.

As we look forward, we continue to carry the sense of excitement and challenge that has helped deliver the Trust's achievements during 2011/12. Working with our partners, we are continuing to develop the long term stability that will allow the further improvement of the quality and safety of the care we provide for our community and to build on the progress already realised.

Paul Farenden. Chairman
Northampton General Hospital NHS Trust

Dr Gerry McSorley. Chief Executive
Northampton General Hospital NHS Trust

Directors' Report

All NHS organisations are required to publish an annual report and financial statements at the end of each financial year. This report provides an overview of the work of Northampton General Hospital NHS Trust between 1 April 2011 and 31 March 2012.
The report is made up of two parts. This first part includes information about some of the projects we have been involved in and invested in over the year, as well as the details of our performance and commentary on wider events which have shaped our business and priorities.
The second part is a summary of the organisation's financial statements for the financial year 2010/11 including the remuneration report.

Directors during 2011/2012

Job title	Name	Comments
Chairman*	Dr John Hickey Mr Paul Farenden	Dr John Hickey resigned his position as Chairman on 29 February 2012
Chief Executive	Mr Paul Farenden (interim) Mrs Christine Allen (acting) Dr Gerry McSorley	From 4 January to 16 May 2011 From 17 to 30 May 2011 From 1 June 2011
Non-Executive Directors	Mrs Neelam Aggarwal-Singh Mr Colin Astbury Mr Barry Noble Mr Nicholas Robertson Mr Phil Zeidler	
Associate Non-Executive Director	Mr Graham Kershaw	
Medical Director	Dr Sonia Swart	
Chief Operating Officer/Deputy Chief Executive**	Mrs Christine Allen	
Interim Director of Nursing, Midwifery and Patient Services	Mrs Fiona Barnes***	From 5 April 2011
Director of Finance	Mr James Drury	
Director of Facilities and Capital Development	Mr Charles Abolins	
Director of Strategy & Partnerships	Mr Chris Pallot	
Director of Human Resources	Ms Chanelle Wilkinson	

* *Mr Paul Farenden was appointed Chairman on 1st March 2012*
** *Mrs Christine Allen was appointed Deputy Chief Executive from 1st October 2011*
*** *Ms Suzie Loader joined the Trust on 16th April 2012 as Director of Nursing, Midwifery and Patient Services*

An introduction to Northampton General Hospital

Who we are

First established in 1744, Northampton General Hospital moved to its present site in 1793, and from there the hospital has grown in line with the local population.

We are a designated cancer centre; in 2010 we became the stroke centre for Northamptonshire and in 2011 were appointed as the centre for Vascular Surgery in Northamptonshire with effect from 1 April 2012. We have also invested in a number of additional specialist services, including in-patient renal services and interventional cardiology.

As part of our work to improve clinical outcomes we have taken part in a national patient safety programme and invested in systems to capture patients' views on our services. We are committed to providing the very best care for all our patients, which forms the centre of our strategy for the future.

What we do

Northampton General Hospital provides general acute services for a population of 380,000 and hyper acute stroke, vascular and renal services to the whole of Northamptonshire, a population of 684,000. The Trust is also an accredited Cancer Centre delivering cancer services to a wider population of 880,000 to the whole of Northamptonshire, and parts of Buckinghamshire.

- Danetre Hospital in Daventry: Outpatients, day surgery and inpatient rehabilitation and palliative care
- Isebrook Hospital in Wellingborough: Inpatient rehabilitation services
- Corby Community Hospital: Inpatient rehabilitation services

The principal activity of the Trust is the provision of free healthcare to eligible patients. We are a hospital that provides the 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.

We are constantly seeking to expand our portfolio of hyper acute specialties and to provide services in the most clinically effective manner. Examples are developments in both urological cancer surgery and laparoscopic colorectal surgery placing the Trust at the forefront of regional provision for these treatments.

We also train a wide range of clinical staff, including doctors, nurses, therapists, scientists and other professionals.

We are committed to training, teaching and development and 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. The Trust has excellent training facilities which are currently being further upgraded.

Please see the 'Our Staff' section from page 33 for details of activities during the year.

We have focussed our recent service developments on expanding the range of tertiary and specialist services that we offer. This includes a range of cancer, vascular, renal, stroke and enhanced cardiology services. This has broadened the portfolio of the services that the Trust offers and we are now engaged in the process of integrating these services with the existing operations with a view to maximising service potential.

Our Vision and Values

Our Vision is that NGH is committed to providing the very best care for all our patients. The Values that we work by to deliver our Vision are:

- To put our patients first to ensure they receive the care they need
- To treat all patients with respect, dignity and compassion
- To value and support the contribution of staff, volunteers, Governors and other partners in working together to provide the very best care for all our patients
- To effectively manage our resources
- To seize every opportunity to offer improved and innovative care
- To value learning and continuous improvement

There is more about the Trust's Vision and Strategic Objectives on page 21

Review of the Trust's business

Highlights of 2011-12

- Macmillan Cancer Support launched an appeal to help raise £1.55 million towards the building of a new haematology unit, with the hospital paying the remainder of the £2.2m cost. The new unit opened in February 2012 providing a much enhanced environment in which staff can more effectively treat patients with blood cancers.
- A new state-of-the-art training suite which is helping to prepare the doctors and nurses of the future opened at NGH. The simulation centre can replicate any clinical area within the hospital and allows all grades of staff to practise their skills in simulated settings using realistic and responsive patient manikins.
- NGH embarked on a Transformation Programme in January 2011 to achieve £18 million of savings in 2011/12 and £12m in 2012/13 by focusing on the areas such as theatres, back office, patient flow, medical productivity, outpatients, diagnostics and pharmacy.
- The accident and emergency department is being refurbished and extended to provide more cubicles in which to treat increasing numbers of patients, and allow the Minor Illness and Minor Injury (MIaMI) unit to be incorporated back into the main hospital. Upgrades were also carried out on several wards including Talbot Butler and Sturtridge labour ward.
- The hospital's new £1.2 million interventional radiology suite opened, providing quicker, more effective treatment for patients. The suite is used for procedures such as the insertion of balloons, catheters, micro-catheters and stents into the body using x-ray images to guide them.

- The Trust continued with its commitment to sustainability throughout the year, and received a national recycling award for its achievements. Despite producing 1,400 tonnes of rubbish in the past year, none of the hospital's waste now goes to landfill. New lighting is also helping us save £50,000 per year in electricity and reduce our carbon emissions by 220 tonnes per year.
- The number of wasted outpatient appointments at NGH has reduced by a quarter since a new telephone reminder service was introduced at the end of May. The reminders are helping to reduce those not attending, allowing those appointment slots to be offered to other patients.
- Maternity services at NGH achieved a high score in the NHS Litigation Authority's clinical negligence scheme for Trusts (CNST) assessment in March 2011, with the award of a Level 2 rating - just one level below the maximum. Services were commended for the clinical care standard, for which they achieved 100% compliance with 43 out of 50 assessed criteria passed.
- The radiotherapy department introduced a new technology called image guide radiation therapy (IGRT), which delivers even more accurate treatment to benefit patients with certain types of cancers. On its introduction NGH was one of only five centres in the UK with this state-of-the-art technology.
- A new form of internal radiotherapy known as high-dose brachytherapy was introduced to help treat prostate cancer patients with more advanced tumours. The new service is carried out in a day, compared with a seven-week course of radiotherapy normally used.
- NGH was one of the first hospitals to fully digitise its breast screening service. Images are now captured direct to a computer rather than on x-ray film - giving a superior quality and resulting in less need to recall patients for further screening.
- The 'stars' of NGH were recognised at a special awards ceremony to celebrate the staff who go the extra mile for patients. The Star Awards 2012 saw 'Positive about people' awards being given out to nominated staff, and more long service awards to those with 25 years of service to the hospital.
- Protected mealtimes were introduced on all wards to provide patients with a calm, relaxed atmosphere free from interruption in which to eat their meals. Visiting times changed to support the initiative, which allows staff and volunteers to provide whatever assistance and support is needed to patients at mealtimes.
- Many patients needing major surgery are now more involved in their own care as part of a programme known as enhanced recovery. Greater focus on less invasive surgical techniques, pain relief and the management of fluids and diet helps patients to get better faster after their operation.
- Care rounds were introduced on all wards to ensure that patients are as happy and comfortable as possible. Every hour patients are asked whether they need any help or support, providing a structured approach to basic care and evidence that patients' needs are being met.
- Our home birth team was given an award by the All-Party Parliamentary Group on Maternity to add to their award from the Royal College of Midwives. The team delivered 7.5 per cent of our babies at home, one of the highest rates in the country.
- Patients gave positive feedback about their care and treatment when Care Quality Commission inspectors made an unannounced visit to the hospital. A quality and safety report published by the CQC recognised many areas of good practice, and doctors and nursing staff were described as kind and caring.

- A new way of treating elderly patients was introduced at NGH in September, resulting in the length of stay in hospital being halved. Instead of being admitted to a medical ward for treatment, and afterwards transferred to rehabilitation ward, both stages of care are now combined in a 'short-stay' specialist elderly care ward.
- A new medical kit designed by junior doctors at NGH is helping to combat life-threatening blood poisoning. The innovation pulls together all the equipment in one box that staff need to treat septicaemia as soon as signs of the problem are spotted.
- A new specialist 14-bed ward for head and neck patients was opened, including a new treatment room where minor procedures can be carried out. The re-design has improved the environment, streamlined treatment, and enabled staff to provide specialist care for these patients.
- The 75th anniversary of the opening of the Barratt Maternity Home, a gift to the town in 1936 and now part of the main hospital, was commemorated in July. Our very first baby, William Barratt Cannell returned to help us celebrate and to meet up with one of the babies born earlier that day.
- Inpatient rehabilitation beds at Danetre Hospital in Daventry, Corby Community Hospital, and Isebrook Hospital in Wellingborough are now being managed by NGH, having previously been run by NHS Northamptonshire.
- A number of events were held for members of the Trust and the public, providing an opportunity for people to meet the hospital's staff and find out more about the services they provide.

Performance against key targets

During 2011/12 Northampton General Hospital achieved all but one of its key national performance targets including those for maximum waiting times, cancer waiting and treatment times and reducing MRSA and C Difficile infections.

The Trust did not achieve the transit time target of 95% in 2011/12, our emergency care service experienced significant pressure and saw an increases in both A&E attendances (+8.3% vs.2010-11) and Emergency admissions (+4% vs.2010-11).

The number of hospital acquired infections was below the centrally determined target trajectory, with just 2 MRSA bacteraemia reported during the year against a target of 3 and 52 clostridium difficile infections reported against a target of 54

Risks and uncertainties

The Trust operates in an uncertain and changing environment. The NHS is changing rapidly and the Trust has to be ready to adapt and respond to the opportunities and risks this change presents.

The table below demonstrates how we have assessed each of our strategic aims and aligned them to our goals. We have looked at outcome measures for each objective so we know when we have achieved, assessed the risks to achievement and agreed on the enabling strategies for which objective actions are in place, which are monitored through the Trust's governance structures.

Aim	Service Priorities	Outcome Measure	Key Risks	Timeline	Enabling Strategy
Be a provider of quality care for all our patients	Invest in enhanced quality including improvement in the environment in which we deliver	• Clinical Quality Scorecard • CQC Scores • Patient & Staff Surveys • PEAT Scores • Estate KPIs	• Increase in demand • Financial situation • Availability of Capital	Ongoing with capital enhancements 2013 onwards	• Marketing Strategy • Quality Strategy • Estates Strategy
Enhance our range of hyper acute services for the wider community	Develop strategic approaches to relationships with other health provider and stakeholder organisations	• Expansion of current services provided by NGH • Integrated LHE strategic plan • Regular interaction at key LHE forums • Consolidation of existing specialist services	• LHE objectives not aligned • Staff engagement • Protectionism of LHE organisation • Aggressive marketing strategies from other providers • Insufficient resource, capacity and finances to deliver • Acute Services Review	April 2012 and ongoing	• Marketing and PR strategies • Commissioner Strategy • Directorate plans • SHA Strategy • Cancer Strategy
Provide appropriate care for our patients in the most effective way	Enhance all urgent care pathways, including critical care Use information on quality, finance & demand to determine service priorities	• Integrated LHE demand / capacity plan • Target delivery • Increased critical care and level 1 capacity • Reduced outliers and DTOC • Bed occupancy • Integrated LHE demand plan • Outcome of ASR • Convergence with GPCG intentions • EPR implementation • Service rationalisation • Financial sustainability • Delivery of transformation	• Increase in demand • Finance • ASR • Pace of external organisational change • ASR Delivery • Bed Providers plans	April 2013 – 2015 April 2013 - 2015	• Urgent Care Strategy • Marketing Strategy • HR Strategy • Estates Strategy
Foster a culture where staff can give their best and thrive	Enhance all urgent care pathways, including critical care	• Improved Staff Survey • Improved Patient Survey • Nurses Dashboard • Staff turnover • Bank / agency use • Mandatory Training Scores • Development of exemplar leadership programme	• Transformation Agenda • Organisational Change Agenda • Demand & Capacity • Ability to recruit	April 2012 & ongoing	• HR Strategy • Quality Strategy • Estates Strategy • EPR
Ensure we invest wisely to make improvements in care	Invest in enhanced quality including improvements in the environment in which we deliver care Use Information on quality, finance & demand to determine Service priorities	• Backlog maintenance • PEAT scores • CQC rating • Bed occupancy • LTFM • EBITDA • Service rationalisation	• Age of estate • LHE plan not aligned • Financial environment • Commissioning intentions • Demand Management	April 2012 & ongoing April 2012 & ongoing	• LTFM • Estates Strategy • Marketing Strategy

Equality and Diversity

Our commitment to ensuring all our staff have appropriate equality and diversity training is borne out in the results of the Staff Survey which demonstrates we compare most favourably with other acute Trusts in this area.

Equality and Diversity remains high on the Trust’s agenda and much work is underway to implement its Equality Delivery System.

This work is overseen by the Equality and Human Rights Steering Group and the Chief Executive has been actively involved in the development of its key objectives and action plans which were published in April 2012 and will be implemented during 2012/13.

Emergency preparedness

The Trust has a major incident plan that is tested on a regular basis. Our emergency response plans are developed in collaboration with other agencies involved in emergency planning, including the police, fire service, ambulance service, local primary care Trust and commissioners and the county emergency planning office to ensure we provide a cohesive response.

- In the last 12 months we have:
- Undertaken a Trust-wide exercise for all departments' major incident plans
- Delivered Major Incident training at all levels of the organisation
- Finalised the Trust's chemical, biological, radiological, and nuclear (CBRN) procedures including the inclusion of a permanent decontamination facility in the Accident & Emergency department refurbishment programme.
- Delivered a programme of business continuity management (BCM) exercises for all departments within the Trust. BCM is designed to allow continued operations in the event of a disruption, whether due to a major disaster or a minor incident.
- Managed the preparation and response to strike actions.
- Responded to and implemented lessons from a loss of back-up power for key areas of the site
- Developed the Trust's Fuel Shortage Plan

In the next 12 months we will be working to deliver the Resilience Planning Groups plan for 2012-13 which includes:

- Undertaking a live chemical, biological, radiological, and nuclear (CBRN) /Hazardous Materials exercise to commission the new facilities and test plans
- Expanding the Major Incident Alert system across the Trust
- Finalising the Trust Evacuation Plan
- Reviewing and updating existing Major Incident Plans in light of the Trust's organisational restructure
- Delivering training for Major Incident Loggists and CBRN responders across the Trust
- Supporting the internal development training programme by delivering regular training for this group
- Supporting the County response to the Olympic Torch relay

Charges for information

Northampton General Hospital has complied with HM Treasury's guidance on setting charges for information, as outlined in Appendix 6.3, to 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.

Our Quality story so far

For a number of years, the Trust has described quality under the three domains defined in 'High Quality Health for All' (Department of Health, 2008).

- Patient Safety
- Patient Experience
- Clinical Effectiveness and outcomes

The Trust publishes annual Quality Accounts, separately from the annual report and financial accounts, which set out the Trust's Quality Priorities for the year ahead and describe what has been achieved during the previous 12 months. The Trust Board receives quarterly updates on each of the priorities throughout the year and the final achievements are published in the Quality Accounts. The Quality Accounts also include the Trust's Quality Strategy which sets out the vision for quality, the roles and responsibilities of each staff member, working both clinically and in non-clinical settings, and how the Board will gain assurance that the Trust is achieving its aims.

The Trust's Quality Strategy develops the three domains and identifies the organisation's Quality Goals which are also outlined in the Quality Accounts. Patients, staff, shadow Governors and members of the public have the opportunity to participate in defining the Trust's Quality Priorities each year to ensure that they reflect local and national priorities.

This involves a process of consulting through Patient and Public Involvement Groups, professional meetings and management meetings. The Board receives regular reports on how the Trust is performing against each priority and challenges the progress and action being taken to raise standards and deliver the best possible care.

We have systems in place to make sure we collect patients' views about how they were treated and their overall experience whilst they stay in hospital. This year we have led specific projects to improve the patient's experience on admission, at mealtimes and by reducing noise at night.

We analyse in detail information gathered from patient safety incidents; we regularly seek advice from other acute hospitals who are performing well and external leaders; we keep abreast of best practice, comparing our performance with similar sized hospitals and together this drives quality improvements.

Our governance arrangements must ensure that every safety incident and patient complaint is picked up, thoroughly investigated and any lessons to be learnt are widely communicated.

In 2008, the Trust developed its first Patient Safety Strategy, and since then the Trust has achieved some impressive clinically-led safety projects which have involved senior and junior doctors working with nurses. Some recent examples include a focus on surviving sepsis which puts a process in place for doctors and nurses to follow if a patient develops a serious infection; and the re-launching of the Early Warning Score observation chart which helps nurses and doctors to identify when a patient's condition deteriorates.

A Patient Safety Board has been established and provides a forum for sharing improvement and a Junior Doctor Safety Board has also strengthened awareness about patient safety throughout the organisation.

Quality Priorities

In 2011/12 the Trust's Quality priorities were:

- Making sure that patients receive the right care, in the right place, at the right time;
- Improving the patient experience for vulnerable adults (incorporating essential elements of nursing care);
- Improving patient safety through junior doctor engagement;
- Improving patient outcomes and speeding up a patient's recovery after surgery through the enhanced recovery programme.

Quality measure	Target for 2011/12	Key actions taken	Performance in 2011/12
Right care, in the right place, at the right time	Reduce number of patients who are not cared for in the appropriate ward: 21 patients (14%)	Reconfigured bed base Urgent Care Group met regularly Introduced new Short Stay Elderly Ward County wide urgent care action plan	19 patients (target 21)
Improving the patient experience for vulnerable adults	20% reduction in grade 3 and 4 hospital acquired pressure ulcers (N=13)	Training programme New electronic profiling beds introduced Care bundle introduced New RCA template introduced Wound Formulary introduced	22 (target 13)
	20% reduction in falls causing serious harm or death	Care bundle introduced Training programme reviewed and re-launched Falls Champion role introduced Chair alarms piloted	16 falls (target 9)
	Improve patient experience from 72.97 to 74.10	Introduced 3 patient experience care bundles Monthly monitoring of patient experience	Dept. of Health national inpatient survey questions (5) on or above target
Improving patient safety through junior doctor engagement	Bi-monthly Junior Doctor Safety Board meetings (N=6)	Junior Doctor Safety Board held bi-monthly	6 meetings
	Junior Doctor representation on Patient Safety Board (N=6)	Junior Doctors form part of membership of the Trust Patient Safety Board	6 meetings attended
	Participation by junior doctors in patient safety audits (N=15)	Monthly Patient Safety Audit	15 audits completed
	Include patient stories as part of Junior Doctor Safety Board (N=4)	Patient Stories form agenda item on Junior Doctor Safety Board	4 patient stories
Improving patient outcomes through the enhanced recovery programme	Admission on the day of operation (70%)	Admission process streamlined Training implemented	87%
	Reduce length of stay (5 days)	Enhanced recovery pathway introduced in 3 out of 4 specialities	4.74 days length of stay

Quality Objectives: priorities for 2012/13

- Patient Experience – focus on implementing the Patient Experience Strategy and improve the Net Promoter Score by 10% throughout the year;
- Vulnerable Adults – build on last year's achievements by improving the care given to people with dementia and people with learning disabilities
- Emergency Pathway – redesigning emergency pathways to ensure that the systems and processes are in place to support staff to deliver quality care first time every time;
- Patient Safety – forming a 'Safety Academy' to roll out projects and education to all staff groups with regard to patient safety and deliver a high profile portfolio of key projects that link the operational delivery of services with the need to improve quality. This priority will also include the roll out of the NHS Safety Thermometer, an easy to use measurement tool incorporated into everyday clinical practice.

Our Quality Goals again reflect the three domains of quality and encompass the following:

The Trust has identified three Quality Goals within its 3 year Quality Strategy. The Quality Goals have been chosen to improve each of the three key components of Quality.

The Trust's Quality Goals are:

1. Reduce all avoidable harm and save every life we can
2. Improve the Net Promoter Score by 10 points each year
3. Patients will receive high quality evidenced based care

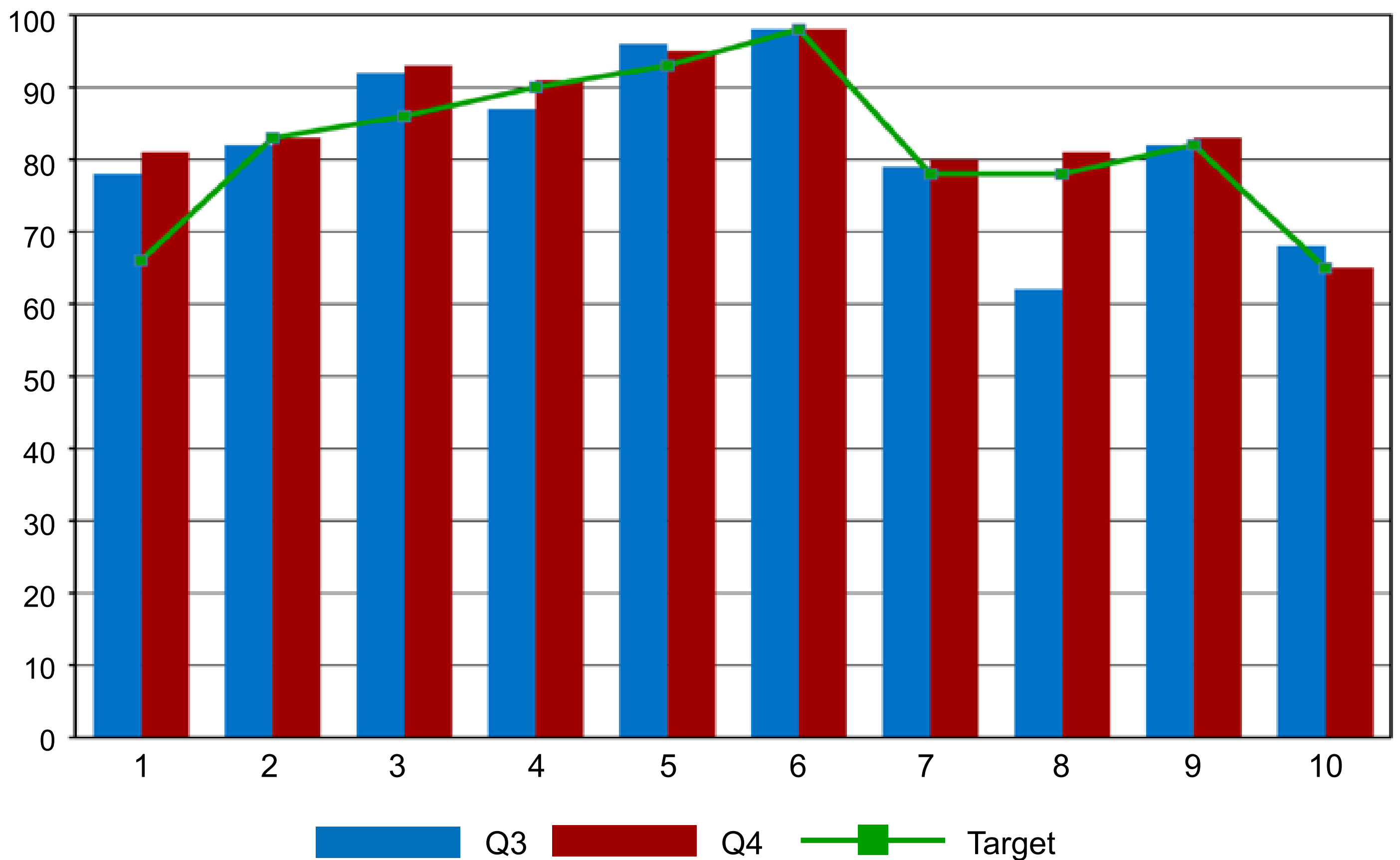
Linked to the Quality Goals are the quality priorities that are reported in the Trust's Quality Accounts. They have been chosen specifically to support the achievement of the higher level Quality Goals.

Patient experience – national survey results and local survey work

National Inpatient Survey 2010

The Trust is demonstrating improvement in all areas and as at the end of 2011/12 is either on or above the target in ten areas identified as 'underperforming' by Quarter Four. These areas included noise at night, sharing sleeping area with the opposite sex and getting enough help with eating meals.

The latest performance figures can be seen in the chart on the next page:



The labels 1-10 on the x axis are the questions as detailed in the table below:

Q1	After you used the call button, how long did it usually take before you got help?
Q2	As far as you know, did doctors wash or clean their hands between touching patients?
Q3	Did nurses talk in front of you as if you weren't there?
Q4	Did the doctors talk in front of you as if you weren't there?
Q5	Did you ever share a sleeping area with patients of the opposite sex?
Q6	Did you feel threatened during your stay in hospital by other patients or visitors?
Q7	Did you get enough help from staff to eat your meals?
Q8	In your opinion, were there enough nurses on duty to care for you in hospital?
Q9	Were you ever bothered by noise at night from hospital staff?
Q10	Were you ever bothered by noise at night from other patients?

National Inpatient Survey 2011

The results of the national inpatient survey are yet to be published by the Care Quality Commission (April 2012), however the Trust has its own results. The results show a marginal improvement on the 2010 survey of 1.2% and the response rate improved by 1%.

The following table compares the bottom 10 performing areas for 2010 (which formed the basis of the local patient experience monitoring questions) vs. the relevant score in 2011:

Question	2010 (%)	2011 (%)
Shared a sleeping area with patients of the opposite sex	19	7
Bothered by noise at night from other patients	54	50
Bothered by noise at night from hospital staff	27	28
Feel threatened during your stay	5	4
Not getting enough help with eating your meals	22	5
Doctors talking in front of you as if you weren't there	9	5
Doctors not washing/cleaning their hands between touching patients	5	4
Nurses talking in front of you as if you weren't there	6	5
Enough nurses on duty to care for you in hospital	52	54
More than 5 minutes for your call button to be answered	21	12

Clinical Governance Review Scheme (CGRS)

Since February 2011 the Trust Board has supported the development of the Clinical Governance Review Scheme (CGRS) as a process to provide assurance that Care Quality Commission (CQC) standards are routinely achieved. Phase 1 of this process was completed July 2011. Phase 2 is currently underway reviewing whether recommendations identified in Phase 1 have been implemented as well as assurance the CQC outcomes continue to be achieved and improved upon. An analysis of the themes coming out of the CGRS across the Trust will be undertaken and a full report made to the Trust Board when Phase 2 visits are complete.

National Outpatient Survey

The results of the national outpatient survey were published by the Care Quality Commission in February 2012. The Trust maintained its position when compared to other trusts nationally and performed extremely well in informing patients of test results and explaining these results in a way that patients can understand. A report was made to the Executive Team and the Board detailing our results and areas for improvement.

The two main areas for improvement were advising patients of how long they would have to wait in the outpatient area to be seen. Since then a local quality target for 2012/13 has been set that patients must be seen within 30 minutes of their appointment time.

The other area for improvement was advising patients of any medication side effects to watch out for; an action plan is currently being developed to improve on this.

Actions Planned to improve the patient experience for 2012/13

The Trust Board has recently approved the Quality Strategy which identifies the prominence of the patient experience in its vision for quality. This includes an identified executive lead for patient experience and identifying a non-executive sponsor.

A Patient Experience Board will be developed chair by the Director of Nursing and A Patient Experience Strategy will also be presented to Board in June 2012. This will identify the work streams that will be put in place to respond not only to the National In-patient Survey, but also to improve the patient experience through the Patient Experience Friends and Family Test score. A suite of patient experience metrics will also be identified to enhance the information that Board receives for assurance on the patient experience.

Complaints

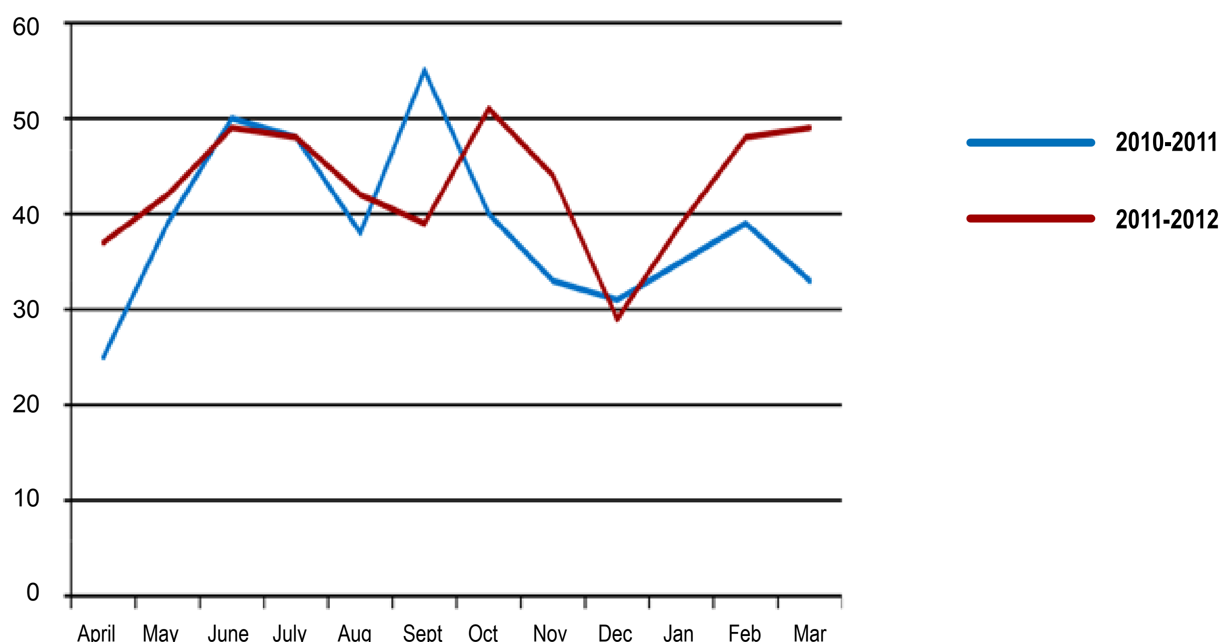
In line with the Principles for Remedy best practice guidance for complaints handling, we investigate complaints in an open and honest way, and with a willingness to learn and make service improvements where indicated. All complainants receive a full written response from the chief executive, and meetings are offered to patients and relatives as required to give them the opportunity to talk directly to senior managers and clinical staff within the Trust.

The Principles for Remedy were introduced in early 2009 and is information that has been issued by the Parliamentary & Health Service Ombudsman (PHSO) and provides the PHSO view on the principles that should guide how public bodies provide remedies for injustice or hardship resulting from maladministration or poor service. The Principles for Remedy set out for complainants and bodies within the PHSO's jurisdiction how public bodies should put things right when they have gone wrong.

It is the Trust's aim to provide suitable and proportionate remedies for complainants whose complaints are upheld and, where appropriate, for others who have suffered injustice or hardship as a result of maladministration or poor service. We want to ensure that we are fair and take responsibility, acknowledging when things have not gone well and apologising for them, to make amends, and to use the opportunity to improve our services.

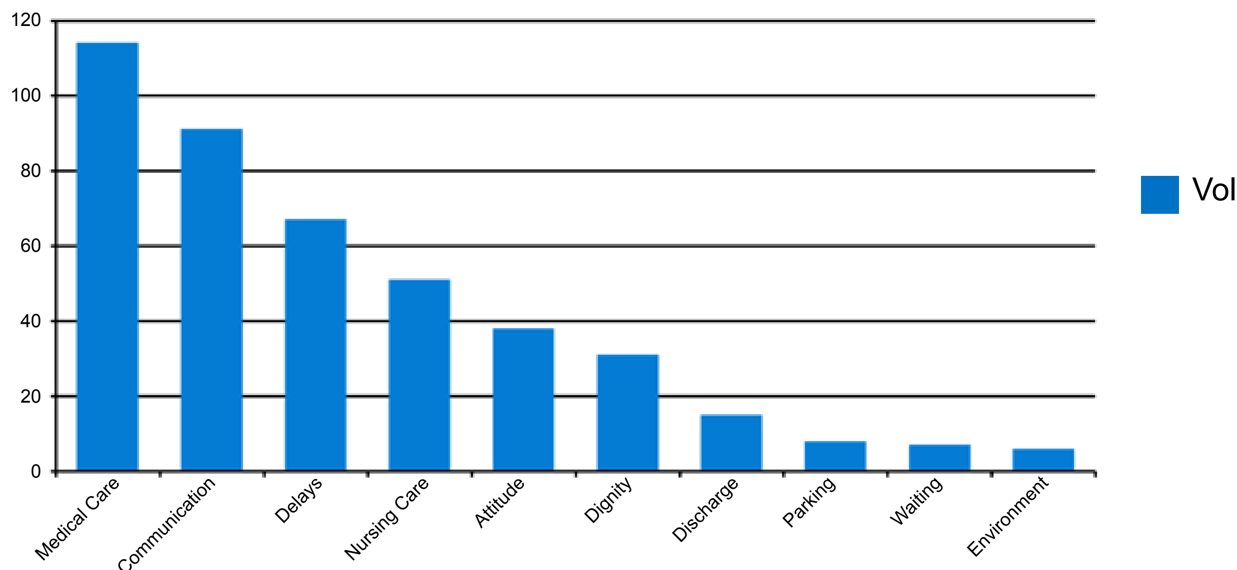
In line with the Principles for Remedy and recommendations from the Ombudsman, the Trust has had one case upheld by through this independent stage of the complaints procedure. Whilst the Ombudsman made recommendations in the case, these did not include financial remedy and therefore no compensation payment was issued. This case relates to a complaint received within the financial year 2009-2010.

The Trust reports on its Complaints to Board each quarter as well as internally through the governance structure on a quarterly basis. An annual report is also presented to the Healthcare Governance Committee (HGC) and Trust Board. Following the introduction of the revised statutory complaints regulations (in April 2009), the Trust initially saw a significant reduction in the number of complaints received. However, over the last 2 years this has gradually increased, which is evidenced in the chart detailed below.



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2010-2011	25	39	50	48	38	55	40	33	31	35	39	33	466
2011-2012	37	42	49	48	42	39	51	44	29	39	48	49	517

The graph detailed below shows the main (primary) theme of each complaint received.



The following actions are being taken across the organisation over the coming year to learn specifically from these complaints to use those findings to improve quality and safety:

Primary theme	Action being taken
Medical care	All complaints are discussed at directorate governance meetings to highlight (clinical) issues raised and to share learning. Some of the organisation wide actions that are being taken to improve medical care include: • A review of the Stoke care pathway Improvements in the consent process as led through the Consent Committee A number of Patient Safety projects that specifically relate to complaints received over the last year are being led by clinicians through the Patient Safety Strategy include: • Weekend Ward handover project • Sepsis project • Pneumonia work stream • Code red – resuscitation and processes • Implementation of the Early Warning Score (EWS) • Implementation of the Safety Thermometer
Communication	Bespoke and ad hoc training sessions delivered by the Head of Patient Experience and Complaints Manager. These sessions include all aspects of communication, attitude and behaviour and how to respond and act upon issues as and when they arise. Complaints handling training is included on the mandatory training prospectus and includes communication, attitude and behaviour. A training plan for the next 12 months has been devised. Communication skills training programmes are now available across the Trust focusing on telephone, verbal and other skills required for effective communication (including body language)
Delays	These mainly relate to ongoing issues that have been experienced in the Eye Department, predominately from an administrative perspective. This has been reported upon through quarterly reporting schedules and a review of the service has been instigated.

Nursing care	The Trust is focusing on reducing pressure ulcers to zero by March 2013 and reducing falls by 20%. In addition, the Trust seeks to build on their success in improving the patient experience. This will include Trust Governors, lay members, volunteers and LINKs members who will monitor the following areas monthly: • Noise at night, on the wards • Protected mealtimes • Patient information on the wards
Attitude & Behaviour	This forms part of the communication activity noted above.

Numbers and themes of Serious Incidents over the last year

The Trust reports on its Serious Incidents to Board each month and internally through the governance structure on a quarterly basis. An annual report is also presented to Clinical Quality & Effectiveness Group (CQEG) and escalated to Healthcare Governance Committee (HGC).

During the previous year (2010/11) the Trust reported 27 Serious Incidents. In 2011/12, that number rose to 55. The increase in the total is as a result of strong leadership of the process by the Medical Director and Director of Nursing and support by the Risk Management Team. This has ensured a robust incident reporting culture which is being embedded across the Trust.

Over the last year the numbers and themes of Serious Incidents are broken down as follows:

Category	Number
Slip, trip, falls	14
Incidents resulting in death	7
Pressure Ulcers	9
Diagnosis incidents	3
Surgical incidents	2
Deteriorating patients	2
Infections	4
Self-inflicted injury	1
Suicide	1
Accident	0
Safeguarding Vulnerable Adults	1
Intrapartum (childbirth) death	2
Child death	1
Maternal death	2
Test results	1
Screening	1
Delay	2
Chemotherapy	1
Patient monitoring	1
Total	55

The systematic investigation of Serious Incidents results in important lessons being learned and improvements identified and implemented. These improvements support the embedding of an effective safety culture thus allowing the delivery of high quality, safe patient care. Examples include:

- The Trust's enhanced observational policy is currently being reviewed and assurance sought that the policy is in line with best practice, with appropriate supporting guidance for the completion of risk assessments and provision of clear instructions relating to the documentation of patient observations.
- A review of the medical documentation and development of a standardised 'check list' to be completed following ward rounds to ensure that investigations and charts have been reviewed, detailing a diagnosis and management plan.
- Development and implementation of a 'site marking policy' to assist in the delivery of correct site surgery and associated procedures.
- A review of the Early Warning Score is currently being undertaken to incorporate the new national approach into the Trust's guidelines; this will be accompanied by an appropriate educational programme and audits to ensure appropriate use of the escalation process in a timely manner resulting in prompt and early assessment of deteriorating patients.
- All patients with Learning Disabilities attending the Accident & Emergency Department and subsequently admitted to a ward are supported by the implementation of "reasonable adjustments" and have a "Patient Passport" to ensure that all staff deliver holistic care to the patient. The Learning Disability nurse is contacted to inform her of the patient's admission so appropriate advice, support and guidance can be determined.
- The development of an information pack to support the verbal information given to pregnant women who are deemed to be at high risk of thromboembolism (formation in a blood vessel of a clot that breaks loose and is carried by the blood stream to plug another vessel) and require thromboprophylaxis (clot prevention therapy) during pregnancy and in the period immediately after childbirth.

Numbers and themes of Never Events over the last year

The National Patient Safety Agency (NPSA) definition of a Never Event is: *A serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers.*

Over the last year, the Trust has had two Never Events, both pertaining to wrong site surgery, despite the World Health Organisation (WHO) checklist having been undertaken before surgery in both occasions. The specific plans to improve clinical quality and safety for 2012/13 in relation to the WHO checklist are:

- A WHO training video, which includes guidance on how to undertake a pre-operative briefing and post-operative debriefing, will be placed on the hospital intranet site to assist in staff training.

- A safety culture questionnaire will be undertaken bi-annually to obtain a greater understanding about safety culture within NGH.

- A two year project which is being run as part of the Junior Doctor Safety Board will

focus on WHO Surgical Safety Checklist compliance.

- A Pre-operative marking policy will be formally launched and implemented.
- An audit of usage of the WHO checklist will be undertaken and an improvement plan developed as part of the process.

Trust Vision and Strategic Objectives

Our strategic objectives

We have focused our recent service developments on expanding the tertiary and specialist services that we offer. This includes a range of cancer, vascular, renal, stroke and enhanced cardiology services. This has broadened the portfolio of the services that the Trust offers and we are now engaged in the process of integrating these services with the existing operations with a view to maximising service potential from a clinical and income perspective.

Our strategic intent can be summarised as follows. We will:

- Consolidate and enhance our position as one of the hyper-acute hospitals in the South-East Midlands network.
- Enhance our focus on providing the highest standards of clinical quality and safety.
- Foster a culture where staff can thrive, delivering excellent patient care in an environment in which they are proud.
- Work alongside our commissioners to redesign the emergency care pathway.
- Develop an exemplar leadership development programme to ensure we attract, recruit and retain the highest quality staff

The Trust recognises that the future landscape for healthcare provision will change to reflect the forecast economic outlook. Unprecedented levels of public sector debt must be reduced. The NHS predicts efficiency savings of £15-20 billion will be required by 2015. Therefore the Trust strategy must be set in the context of reduced spending by healthcare Commissioners (primary care Trust and GP clinical commissioning groups), lower payment levels to hospitals and other providers, restrictions on the Payment by Results scheme which governs how some payments are delivered to hospitals for services. In addition, there is a continuing pressure for greater internal efficiency requirements.

Already the Trust has demonstrated a robust approach to cost reduction through the development and delivery of a transformation programme that has involved the whole Trust. In 2011/12 the programme has delivered £19.1m savings against a projection of £18.6m. In 2012/13 the challenge will be £19m based on a forecast that includes tariff deflation, QIPP schemes and cost inflation.

We are aware that we will have to function with a reduced workforce but this reduction must not diminish the quality of services that we provide. In 2011/12 our workforce reduced by 57 following the successful implementation of Transformation programme measures across the Trust. This focus will continue in the years to come.

We are also cognisant of the changes in Commissioning arising from the Health & Social Care Act 2012. The impact of patient choice and Any Qualified Provider will increase competition for health services as patients become more aware of the rights and options available to them. To ensure we remain competitive in this new environment we are developing our relationships with GPs, improving our booking systems to ensure that they are easier to use and increasing the numbers of outreach services that we provide. We also recognise that we will increasingly need to work in collaboration with other NHS Trusts.

Performance against strategic objectives

During 2011/12 we have made progress against each of our strategic objectives.

To improve the clinical quality of patient care focusing on safe, effective treatment that is patient centred.

We have:

- Undertaken a programme of work to reduce our Hospital Standardised Mortality Ratio
- Introduced new medical models of care to manage emergency admissions
- Developed a short stay elderly ward which has increased patient flow and reduced length of stay
- Improved our patient experience surveys
- Delivered our Clinical Quality Improvement Schemes required our acute services contract

To develop an effective, efficient and flexible workforce to support the changing environment.

We have:

- Reformed the organisational structure to ensure a stronger focus on clinical accountability and service delivery
- Reduced our staff turnover

Develop a revised Business Strategy, reflected in our Integrated Business Plan to obtain Secretary of State approval for NGH to become a Foundation Trust by July 2012.

We agreed our key priorities will be to:

- Invest in enhanced quality including improvement in the environment in which we deliver care
- Develop strategic approaches to relationships with other health provider and stakeholder organisations
- Enhance all urgent care pathways, including critical care
- Use information on quality, finance & demand to determine service priorities
- Enhance staff, patient and public engagement

To develop a strategic partnership with Nene Commissioning and other Commissioners and enhanced working relationships with all local GPs

We have:

- Worked as partners on a number of service developments, many of which as part of the Northamptonshire Integrated Care Partnership
- Jointly developed new patient pathways in a number of specialities
- Developed our GP liaison service
- Invited Commissioner representation for all key developments, especially the development of our strategy

Develop critical clinical care pathways to deliver effective integrated care as part of the Acute Services Review

We have:

- Enabled two senior clinicians to lead the Planned Care and Oncology work-streams of the acute services review
- Worked with partners from across the region to develop the Acute Services Review
- Ensured that local service planning is aligned to the timescales of the Acute Services Review
- Ensured that our long term strategy is aligned to the principles of the Acute Services Review

To agree a revised Estate Strategy in the context of the Trust's Service Strategy, Transformation Programme and the Acute Services Review which explores alternative funding mechanisms and is completed in line with the FT Application timetable.

We have:

- Agreed a medium to long term Estate Strategy that reflects Service Plans and Strategic Priorities
- Developed a 5 Year Capital Investment Plan that is affordable
- A fit for purpose and appropriately sized estate to deliver Trust activity
- A revised strategy, approved by Trust Board and incorporated into the Integrated Business Plan

To develop, implement and sustain transformation in the way we deliver our services in order to maintain quality and deliver c£18million reduction in cost base by the end of 2011/12

We have:

- Delivered £19.1m cost improvement programme and exceeded our plan while managing increases in demand for our services and maintaining service quality

- Set up a Programme Management Office and defined project management approach to cost reduction and organisational change to put Trust in strong position to make year-on-year progress
- Acquired skills within Trust to deliver Transformation Programme through transfer from partner organisations
- Moved towards development of rolling transformation programme with planning well advanced for further significant savings required in 2012/13

To implement effective service line management across the organisation by 31 December 2011 and to develop underpinning business processes that deliver increased managerial control

We have:

- Implemented service line reporting system to allow production of service line reports.
- Tested the system output through engagement with clinical teams to ensure that cost drivers are correctly identified
- Developed a set of reports to provide improved management information to service line teams.
- 2010/11 reference costs submitted using service line reporting

Shadow Governors' Council

Introduction

Northampton General Hospital made the commitment to become a member led organisation as part of the process of applying to achieving authorisation as a Foundation Trust. We began recruiting members in August 2006 and have steadily built our membership from members of the community that is served by the Trust.

At March 2012 we had 4,201 public members and 3,994 staff members. We have developed a strong body of committed shadow Governors from our membership who are actively engaged with the Trust.

The Governor's Council was established in shadow form in April 2006 and has allowed the tailoring of our governance arrangements to the individual circumstances of our community through consultation.

The Shadow Governors' Council continues to meet bi-monthly and has formed a Communications subcommittee which reports regularly on its activities. This subcommittee has worked on the development of the membership strategy, and has shaped the engagement plan for the coming year

Governor Initiatives

The role of the Governor has developed over the year, and although the Council of Governors still operates in shadow form, their views have been sought in the appointment of key executive and non-executive personnel, such as the Director of Nursing & Midwifery, the Chief Executive and the Chairman. The Governors were asked to judge the “unsung hero” category of the staff star awards nominations.

Developing the role

- A framework document which defines the role of the Governor has been developed with the help of the Council of Governors. This will be distributed to members who have expressed an interest in becoming a Governor
- The Governors have also assisted in developing a training and induction framework which will be put into place once the Council of Governors is elected so that the Trust is able to equip the Governors with the tools to discharge their duties immediately we are authorised as a Foundation Trust.
- Development of a rolling agenda at the Governors’ Council meetings to cover key strategic topics presented by members of the Trust’s executive team
- Development of the communications and membership sub-committee which is attended by the head of communications
- Shadow Governor CEO question and answer session at each Council meeting

Governors’ Council composition

Following public consultation on the composition of the proposed Governors’ Council in November 2010, the elected Council will comprise

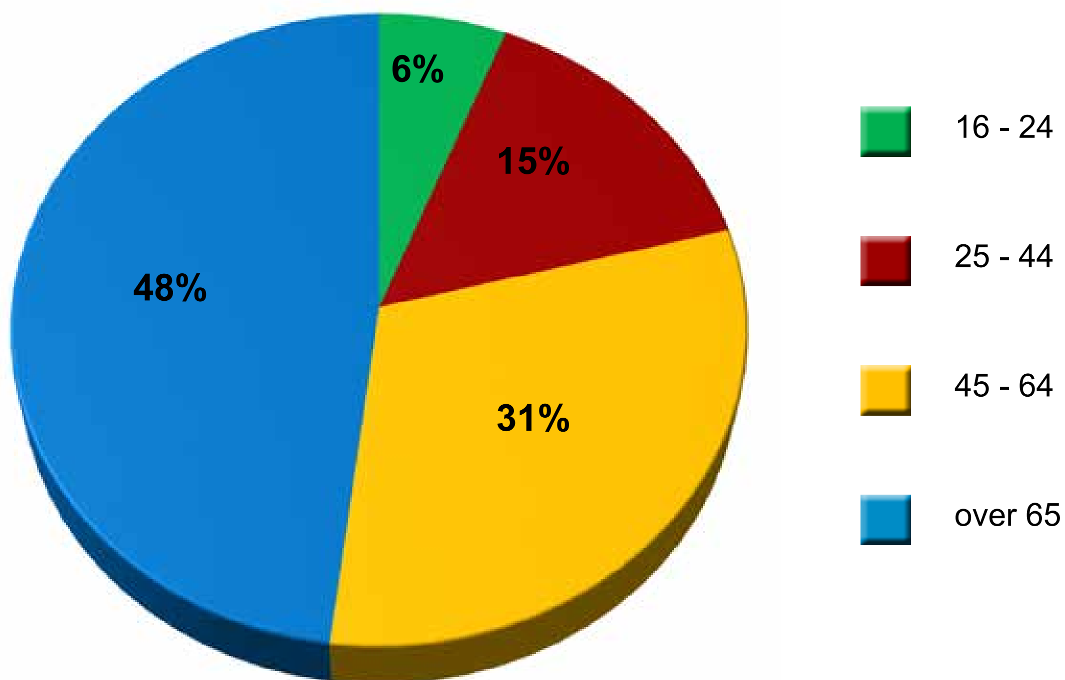
- Public Governors (14):
    - Northampton (6)
    - Daventry and South Northamptonshire (6)
    - East Northamptonshire and the rest of the UK (2)
- Staff Governors (4):
    - Medical and dental staff (1)
    - Nursing staff (1)
    - Other health professional staff (1)
    - Non-clinical staff (1)
- Appointed Governors (2):
    - NHS Northamptonshire (1)
    - Northamptonshire County Council (1)

Member Recruitment and Development

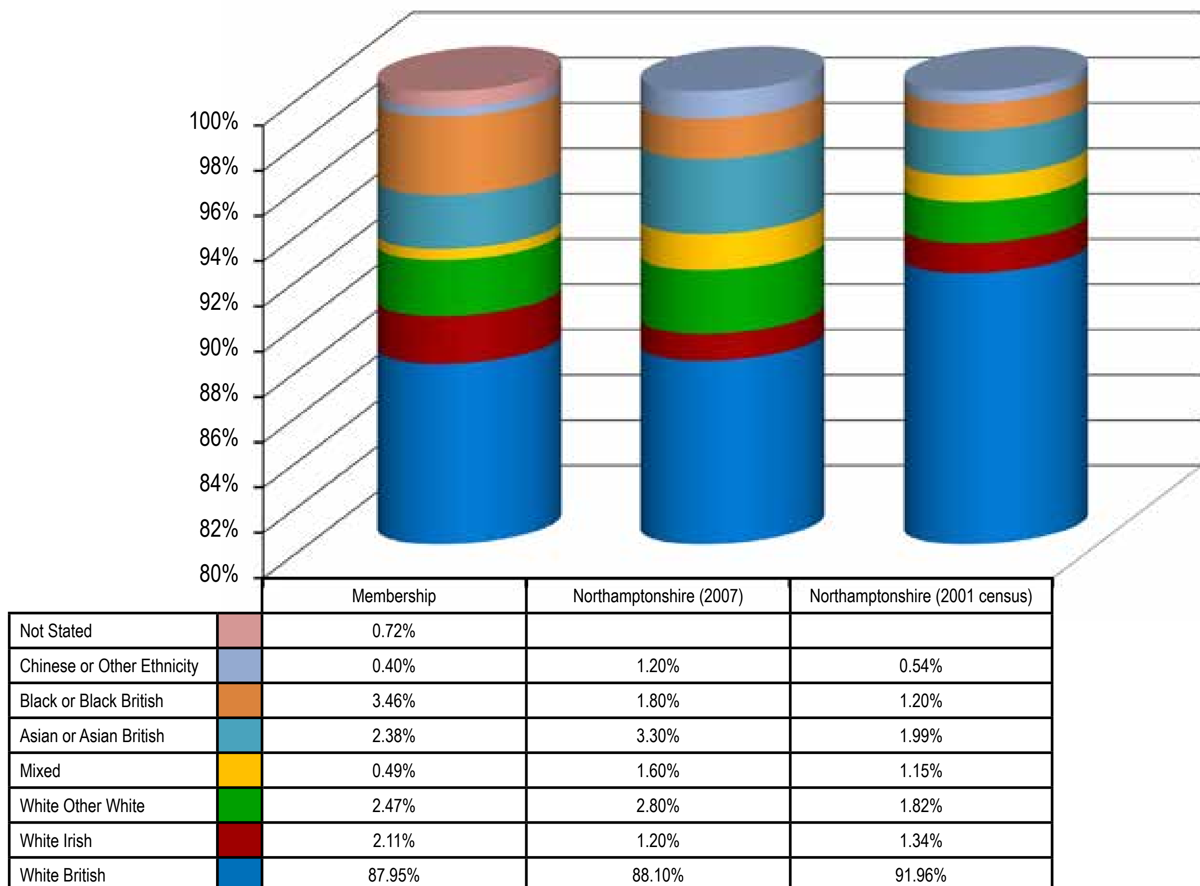
The Trust began recruiting members in the summer of 2006 in conjunction with the first public consultation on our application for NHS Foundation Trust status.

We have set ourselves a target to recruit 5,000 public members by authorisation. We have worked closely with healthcare providers in the area, jointly recruiting members and sharing the facilitation of members' events. This has proved to be an effective way of recruiting and engaging with members, and will form a large part of our on-going membership development.

Membership profile and numbers



Comparison of the ethnicity profile of public membership against northamptonshire profiles 2001 and 2007



	Membership	Northamptonshire (2007)	Northamptonshire (2001 census)
Not Stated	0.72%		
Chinese or Other Ethnicity	0.40%	1.20%	0.54%
Black or Black British	3.46%	1.80%	1.20%
Asian or Asian British	2.38%	3.30%	1.99%
Mixed	0.49%	1.60%	1.15%
White Other White	2.47%	2.80%	1.82%
White Irish	2.11%	1.20%	1.34%
White British	87.95%	88.10%	91.96%

Informing and engaging with members

- The development of a members' newsletter
- Members' events focusing on services delivered at the Trust
- Consultations and surveys by e-mail and post on specific issues
- Chairing focus groups as part of our public and patient involvement strategy

Members' involvement

As we recruit members they are sent a questionnaire asking them key questions, for example the level of involvement they wish to have with the Trust, whether they would be interested in taking part in polls and consultations or attending meetings, and also what their communication preferences are. This has given us a cohort of members that are on hand to support us in the following different ways;

- Being kept informed by receiving regular copies of our newsletter specifically for members
- Linking with a particular service or directorate
- Voting in elections for Governors – to represent them in working with our Board of Directors to determine the future direction of the hospital
- Standing for election as a Governor on the Shadow Governors' Council if they wish
- Attending special events and meetings
- Being consulted on any future developments of the hospital

- Giving their views and opinions about how the hospital should be developed
- Our Shadow Governor's Council comprises people elected from and by the membership. This ensures that the interests of the local community are represented at a strategic level within the Trust.

Strategic partnerships

We have reviewed our Public and Patient Involvement (PPI) Strategy and strengthened our potential to fully engage with members through a 'forum' based approach. Our Shadow Governors are given the opportunity to chair a service based focus group with the aim of providing a conduit for member engagement into our strategic planning. This allows a robust approach to evidence member and public engagement in strategic planning.

Each of the focus group chairs report to the patient and public involvement strategic steering group, which in turn reports to the Trust Board. The six groups set up so far are for surgery, medicine, pain management, infection prevention, trauma and orthopaedics, and hotel services.

Within their first six months the focus groups organised several activities including food tasting, hand hygiene surveys, and ward cleaning inspection visits. The groups have also been able to bring some issues that they have identified through the Shadow Governors' Council to the Board of Directors; so they are having a real influence.

Plans for the future

The first membership event showcasing a service offered by the Trust took place in April 2011, and focused on our then new role as the county's primary stroke centre. The event gave members and the general public the opportunity to learn more about the identification, treatment and prevention of stroke. We held further events throughout the summer of 2011 including a look at developments in nursing care and at the innovative treatment of colo-rectal cancer through enhanced recovery techniques; as well as a tour of the Heart Care Centre following last year's AGM.

We are developing a schedule of events for the coming year that will:

- highlight further areas of the hospital's services
- give our members the opportunity to meet their representative Shadow Governors; and
- increase insight into Healthier Together - the current Acute Services Review in the South East Midlands.

A county network has been set up with other NHS healthcare providers to share knowledge and resources. This will help to ensure that all the organisations work together to include the community in helping to healthcare for the county that fits the population that they serve.

We attended the Wellness Event in June 2011 which is organised by Northamptonshire Healthcare NHS Foundation Trust, and worked together with other health economy partners to recruit and engage with young people through presentations at the local colleges. Introduction

This section of this annual report describes our vision for the services that we offer, illustrates the progress that we have made towards delivering our objectives in 2011/12 as well as our performance against the high-level national targets.

Operating & Financial Review

Our Vision

Our vision is to provide the very best care for all of our patients. This requires Northampton General Hospital NHS Trust to be recognised as a hospital that delivers safe, clinically effective acute services focussed entirely on the needs of the patient and their relatives and carers. These services may be delivered from one of our acute or community hospital sites or by our staff in the community.

We recognise that the financial climate in which the NHS operates has become much more challenging over recent years. It is highly likely that with reduced growth from central funds and changes to national policy, competition between providers will accelerate and that models of care will change with greater horizontal and vertical integration.

The Trust's prime focus is to provide excellent care to our patients, regardless of the setting where this is undertaken.

Trust performance

During 2011/12 Northampton General Hospital achieved all but one of its key national performance targets including those for maximum waiting times, cancer waiting and treatment times and MRSA and C Difficile infections.

The Trust did not achieve the Accident and Emergency transit time target of 95% in 2011/12, our emergency care service experienced significant pressure and saw overall increases in both A&E attendances (4.5% vs.2010-11) and Emergency admissions (4% vs.2010-11). Type 1 A&E attendances – those of the most serious nature – increased by 8.3% compared to 2010-11.

The number of hospital acquired infections was below the centrally determined target trajectory, with just two MRSA bacteraemia reported during the year against a target of three and 52 clostridium difficile infections reported against a target of 54

Patient activity

During the year we treated the following number of patients:

Point of Delivery	2009/10	2010/11	2011/12
Elective inpatients	8,700	7,829	7,091
Day cases	41,351	39,975	38,769
Non-elective admissions	38,178	40,689	43,620
First out-patient attendances	97,277	91,784	91,065
Follow-up out-patient attendances	193,297	174,389	185,009
Outpatient procedures	2,938	27,209	38,942
A&E attendances (excluding MIaMI)	80,808	83,136	86,868
GP referrals	52,199	54,353	51,097

18 weeks

In 2011/12, the Trust maintained delivery of the national 18 week journey time for the fourth year running. This required that 95% of admitted patients and 90% of non-admitted patients receive their first definitive treatment within 18 weeks.

The Trust has proactively worked with commissioners to reduce the number of patients on an incomplete pathway with wait times extended beyond 18 weeks in line with new standards for 2012-13

Accident & Emergency

Both Accident & Emergency attendances and emergency admissions increased significantly in 2011-12 against previous years but the Trust still managed to treat nearly 93% of these patients with in the 4 hour standard. The re-design of our urgent Care pathways will be a priority for the coming year to both improve care for patients and achieve the transit time target.

Diagnostics

Throughout 2011/12 we have continued to deliver the target for a maximum 6-week wait for diagnostic tests and delivered the locally agreed stretch target of diagnostic wait times being no greater than four weeks.

Cancer waiting times

During 2011/12 we have delivered all the national cancer targets.

Patients treated at NGH have continued to receive treatment within the following standards:

Cancer Wait Times 2011-12	Target	2011-12
2 week GP referral to first outpatient	93.0%	96.1%
2 week GP referral to first outpatient - breast symptoms	93.0%	98.1%
31 Day diagnosis to first treatment	96.0%	98.8%
31 day second or subsequent treatment - surgery	94.0%	98.2%
31 day second or subsequent treatment - drug	98.0%	99.2%
31 day second or subsequent treatment - radiotherapy	94.0%	98.1%
62 day referral to treatment from screening	90.0%	96.8%
62 day referral to treatment from hospital specialist	85.0%	94.0%
62 days urgent referral to treatment of all cancers	85.0%	86.2%

The Trust's estate

During 2011/12 there has been continued investment in the Trust's estate in response to the growing backlog maintenance and our strategy to constantly improve the patient environment.

The year's rolling programme included an upgrade to the main theatres, maternity ward and outpatient areas. In addition, work commenced to upgrade and increase capacity to the Accident and Emergency department, which is due for completion in June 2012.

The backlog maintenance programme has been prioritised to address those elements with the highest risk; significant schemes are summarised below.

The year's backlog maintenance programme also included replacement of the main sterilisers within the Sterile Services Department, continued upgrading of the fire alarm system and phased replacement of older lifts.

A programme of work has also commenced this year to replace and upgrade the hospital's ageing electrical infrastructure. This will include replacement of distribution systems and emergency generators and is likely to be phased over 4 or 5 years.

The work to upgrade the hospital's main oxygen supply and distribution system was completed and now provides significant improvement in both capacity and resilience for this essential service.

There have been continued improvements in equality of access this year and this has included the provision of two further disabled accessible toilets, additional motorised entrance doors and inductive loops in reception and clinical areas to provide hearing assistance to hearing-aid users. In addition the construction of a 'changing place' facility has commenced. This is a specialist toilet and changing facility for those with serious physical impairments/learning disabilities and is fitted with motorised hoist and changing table; this facility will be completed in May 2012.

New developments

A £2.2m upgrade and extension to the Haematology Unit, funded in partnership with Macmillan Cancer Care was completed in January 2012. The new unit provides significantly improved outpatient facilities within a modern high quality building, which has been accredited for its environmental performance.

The Trust has already received many compliments from patients being treated in the new unit.

Embedding sustainability

The Trust launched its Sustainability Strategy in December 2010 with an action plan for embedding sustainability issues in to the way the Trust did business. A key element of this work was to take the message out to staff and so during 2011/12 we have run a number of awareness days incorporating themes such as Waste, Energy and Travel.

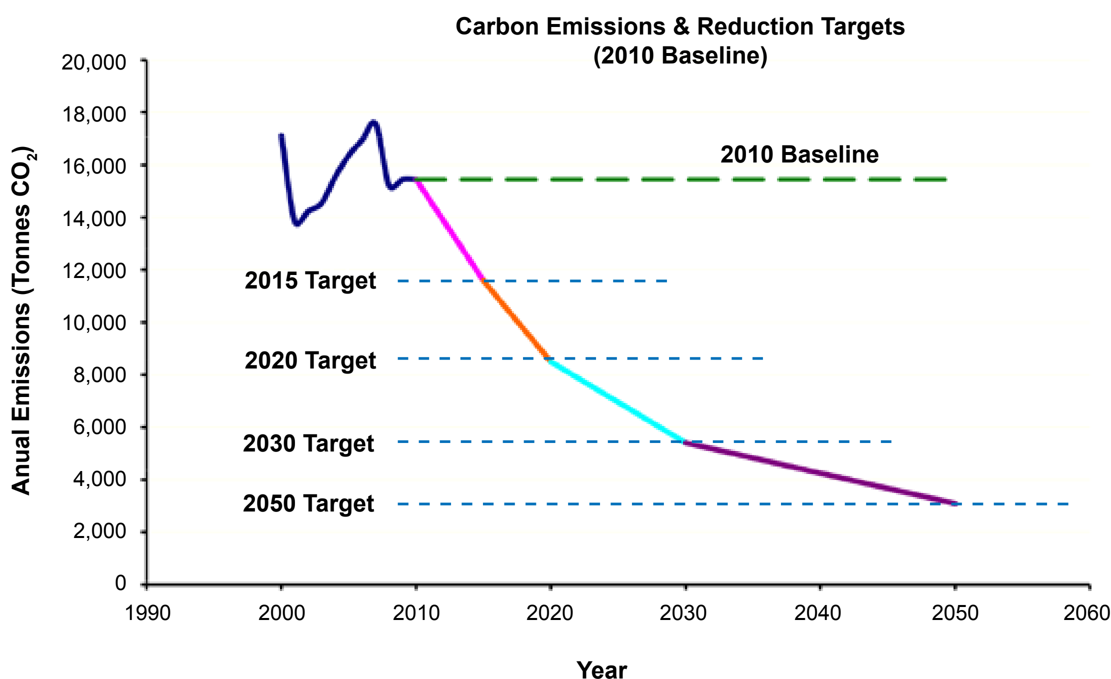
Carbon footprint

The Trust continues to invest in reducing the costs of energy through carbon emissions reduction and energy efficiency. Our compliance with the new Carbon Reduction Commitment Energy Efficiency Scheme (CRC Scheme) requires the mandatory reporting of certain emissions against a 2010/11 baseline. These factors have led us to set our baseline year as 1st April 2010 to 31st March 2011 and this also represents the last full year of emissions. Our 2010/11 carbon footprint was 15,442 tonnes CO2.

Carbon management plan

As reported in the 2010/11 Annual Report, the Carbon Trust announced in December 2010 that it had selected Northampton General Hospital Trust to be one of the organisations it would partner with during 2011/12 to develop a five year carbon reduction strategy – a Carbon Management Plan (CMP).

The Carbon Management Plan Project launched with the Carbon Trust in May 2011 and this formally began the structured development process that has culminated in the 2010-2015 CMP. The CMP sets out an investment and staff engagement approach to deliver a 25% reduction in carbon emissions by the end of 2015/16 against the 2010/11 emissions baseline and proposes a set of new targets in line with the national commitments. The CMP identifies over 60 carbon reduction projects, reducing emissions by around 5,500 tonnes. The full CMP has an overall payback of less than 5 years which means that it will provide a net positive return on investment within this period.



Recycling

In June 2011 the Trust won a Gold National Recycling Star Award which recognises all the work that has been undertaken to increase recycling targets and achieving 100% diversion from landfill on domestic waste. The National Recycling Stars scheme recognises UK organisations that are committed to increasing the amount of waste they recycle and improving the environmental awareness of their staff.

Investment

During 2011, the Trust was successful in applying for just over £200,000 of Salix funding to invest in energy conservation measures including expansion of the Building Management System, heating controls and low energy lighting.

Salix is an independent company funded by the Carbon Trust to help improve energy efficiency in public sector buildings. The Salix fund is an interest free loan fund made up of 50% finance

from the Carbon Trust and 50% from the participating organisation. The funding provides an interest free loan over four years with the loan paid back from the energy savings achieved.

In addition we have also successfully bid for a further £470,000 which will be utilised during the coming year.

The Trust has already made a significant impact on carbon reduction/sustainability issues during the last two years and this will continue into 2011/12 and subsequent years in order to meet the strict carbon reduction targets. The Trust will publish its carbon performance annually so that progress can be monitored.

Our staff

Training, teaching and development

Training and Development is part of the Human Resources Directorate and supports all staff in engaging in continued professional development at work.

There are two main areas of activity; mandatory training, covering everything specified to comply with Care Quality Commission requirements and other Professional Training which delivers a wide range of skills and learning.

The Trust has strengthened delivery of mandatory training by offering a variety of formats to suit individual learning needs, including e-learning.

All mandatory training is now effectively recorded on completion to ensure staff are demonstrably compliant with guidelines. For new staff the revised Trust induction programme delivers all ten Mandatory Training topics in the first three days of employment.

Other Training and Development activities in the past year include the annual awards event where over sixty staff celebrated obtaining their NVQ in a variety of work based activities including Health Care, Theatre Support, Housekeeping Services and Business Administration, all delivered by the Trust's own NVQ centre.

This centre successfully sells its services across and beyond the East Midlands and is widely recognised as a centre of excellence.

A feature of the Transformation process (see page 38) is to ensure all staff work to their highest skill level. The NVQ centre has enabled this, supporting staff to train as Assistant Practitioners through to their Foundation Degree.

Training and Development has also been instrumental in recruiting and supporting apprentices. Many have been offered full time employment by the Trust on completing their apprenticeship.

A number of staff in Pharmacy and Pathology are being supported to complete qualifications becoming valuable team members.

The year also saw the launch of a specifically tailored Leadership and Management qualification for bands 6/7 delivered to Trust staff alongside colleagues from the PCT. The

course concentrates on two specific skill areas for development; Communication and Resource Management, both vital skills for the future of the organisation.

Medical Education

NGH has a very long history of successful involvement in postgraduate medical education and over the last decade has established a similarly good reputation for the education of undergraduates from both the Universities of Oxford and Leicester. It aims to be a provider of choice for medical training. The organisation currently has an income of nearly £8 million a year for the work it undertakes in these areas.

Doctors employed and funded through the Medical and Dental Education Levy deliver a significant proportion of our clinical care.

In order to maintain this level of income (and the students and doctors who go with it) we are required to provide training of a standard that satisfies the national Quality Assurance Standards laid down by the Universities (for undergraduate work) and the General Medical Council (GMC) for postgraduates. There are regular quality management assessments of the Trust's training standards undertaken by the East Midlands Deanery as part of the overarching GMC quality Assurance Process with input from the results of this inputting to the CQC and NHSLA processes for the organisation as a whole. There are 3 broad elements to being successful in these assessments:

- The Consultants and other full time staff supervising the training must be demonstrated to be suitably trained for the tasks they perform (as defined by the GMC) and have adequate time in their job plans to deliver the requirements. Such staff must meet the requirements for Clinical and Educational Supervisory roles.
- The training environment must facilitate learning for the trainees: they need appropriate access to clinical experience (which may slow down service delivery at times) clinical supervision, provision of teaching, time to attend training and mentoring and support if in difficulty.
- The Trust has developed a Trust wide training infrastructure that includes departmental training leads (College tutors and undergraduate leads) with input to regional teams (planning, recruitment, assessment and pastoral care), Undergraduate, Foundation level, Staff and Associate Specialist doctors (SAS) and specialty training leads and a Director of Medical Education with an overarching responsibility for medical training at all levels and full involvement in the senior management of the organisation.

The time required to deliver these elements will vary between roles, specialties, levels of experience of trainees and individual trainee needs.

E-Rostering

To bring greater efficiency to the deployment of expensive staff resources, while at the same time supporting an overriding objective to improve the quality and safety of patient care, the HR information team are implementing an e-rostering solution across the Trust.

The project commenced in November 2010 with an expectation that e-rostering will be Trust-wide within two years. Phase One has involved rolling out e-rostering to a number of wards as well as in two support functions – HR and Finance. Phase Two has already commenced and

will bring completion of the roll out to ward areas by early 2012. Our intention is to implement e-rostering fully and thereby introduce a paperless pay system and implement electronic timesheets for all staff groups working in the Trust.

Our e-rostering plans will see the introduction of a centralised reporting system, which will enable manager to identify any adverse rostering trends and respond to problematic hotspots in a timely way. The key benefits of e-rostering are set out below:

- Releasing senior nursing staff to concentrate on quality of patient care by reducing time spent on manual rostering
- Improving nursing workforce productivity by eliminating working hours that are lost through inefficient manual rostering
- Improving the ability to monitor and manage all leave including sickness absence on a current time basis thereby reducing expenditure on temporary staff
- Developing the capacity to roster and deploy appropriately qualified nurses to match patient acuity
- Improve workforce planning
- Monitoring of Junior Doctors' Hours
- Tracking and managing medical Leave in a balanced and effective way

Equality and Human Rights

During 2011 and 2012 the Trust has made progress in working on the Government's revised Equality agenda for NHS organisations which for the NHS is the development of the Equality Delivery System (EDS). This is aimed at improving the equality performance of the NHS and embedding equality into mainstream business. By using the EDS, the Trust will be able to meet the requirements of the Equality Act 2010 and we will be better placed to meet the registration requirements of the Care Quality Commission (CQC).

The Trust's Equality and Human Rights Steering Group has revised its terms of reference to reflect the work that is in progress and its purpose is to champion and steer the work of the hospital so that it is in full and positive compliance with equality and human rights legislation, regulations and codes of practice including NHS and DoH standards. The group leads, advises and inform on all aspects of policy making, service delivery and employment including various engagements related to equality and inclusion legislation and policy direction. In addition, the Groups aim is to lead and monitor progress on the development of the action plan required in accordance with the NHS Equality Delivery System. (EDS)

In April 2011, the Trust developed an Equality and Human Rights Strategy and questionnaire, which was distributed to 20 community and voluntary sector organisations within Northamptonshire, to LINk representatives and other key stakeholders across the county with a purpose to understand the needs of the diverse community.

In addition, senior managers in the Trust carried out a self-assessment on the four EDS goals:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and included staff
- Inclusive leadership at all levels.

A summary of evidence was identified and in October 2011 the self-assessment was examined with our Staff Side colleagues and comments were provided. This, together with the validation of the self-assessment by a Northamptonshire and Milton Keynes Health Equality Panel, which is a partnership between the community sector and local NHS organisations, will review grading actions and provide recommendations for the Trust in order to develop and finalise the EDS Action Plan.

NHS Staff Survey

The Trust is grateful to all staff members who took part in the 2011 Staff Survey. We believe the national staff survey is a key tool in understanding what matters most to our staff and the aspects of working life we need to collectively improve upon to bring about a culture where our staff can thrive and give their best.

The 2011 NHS staff survey results contain a mixture of scores for NGH and there are clearly areas where we need to improve.

Staff motivation is still one of our best scores, and there has been an increase in the number of staff being appraised and having personal development plans. The percentage of staff experiencing harassment, bullying, abuse or physical violence has shown a decrease – and so too has the incidence of staff witnessing potentially harmful errors.

While there has been some improvement in areas such as appraisal and personal development planning over the past year, we recognise this is not enough. We are committed to making a significant change to the way in which we involve, communicate and engage with our staff.

2012 will see the introduction of a systematic Trust wide programme of communication and staff engagement designed to empower staff at every level of the workplace. This will not only allow staff a genuine opportunity to understand our future plans, but to have a say and share their ideas on how we can improve quality and efficiency in the way we do things at Northampton General Hospital.

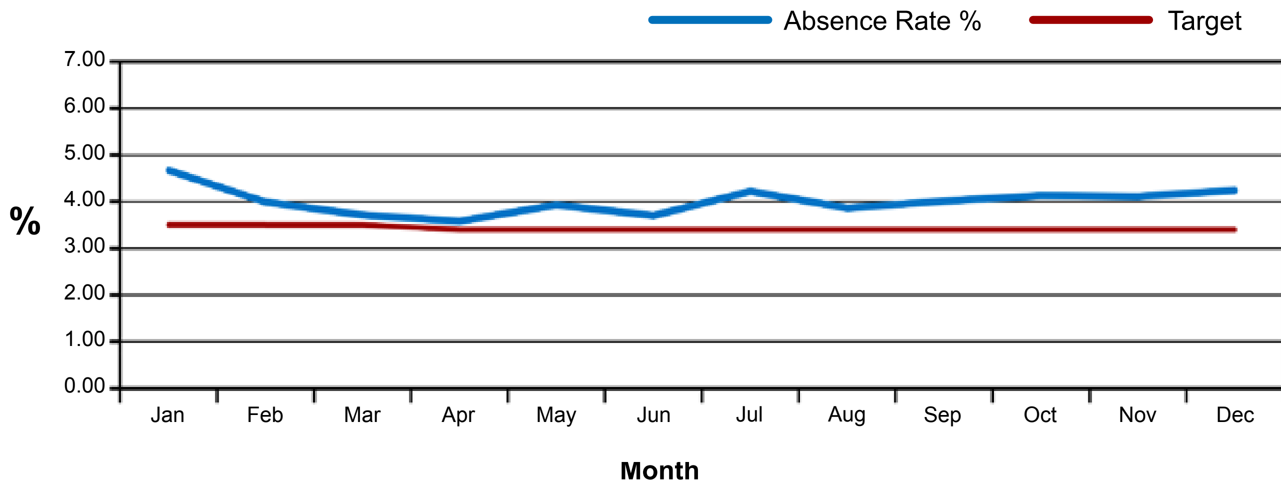
Sickness absence

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

The sickness absence rate, for the Trust, has been significantly reducing over the past 2 years due to a number of initiatives which have been undertaken by the HR Directorate and cascaded through the HR Business Partner model in relation to managing sickness absence more effectively in the Trust including:

- Ensuring sickness absence records are accurately maintained
- Closing long term sickness absence cases within contractual sick pay period
- Raising awareness of sickness absence notification procedures
- Increasing/monitoring the number of Return to Work Interviews
- Tackling high levels of short term sickness in the formal stages of the policy.

Total sickness absence has remained above the Trust target of 3.4%. At the start of the year there was a decrease in total sickness absence falling from 4.83% in January 2011 to 3.50% in April 2011. The Trust total sickness absence average of 12 months (2011 Calendar Year) was 4%.



Information Technology

As a key support service in the delivery of improved patient care and business information provision, the Trust's dedicated IT team have worked hard to meet the challenges of delivering the IT Capital Plan and projects brought about by the Transformation Programme, together with the day to day refresh and support activities of both systems and hardware.

"Best of breed" systems have already been procured and implemented to mitigate the risk caused by delays to the National Programme for IT and in line with the revised NHS Operating Framework; the Trust's current IT strategy is to "connect all, not replace all".

In 2011/12 many of these systems, including A&E, Electronic Discharges (eDN), Integrated Clinical Environment (ICE) Order Communications and the Medway maternity system have been developed and integrated further, in a move towards a full electronic patient record (EPR) and "paper light" working.

Some of the IT enablers to the Transformation Programme, include the implementation of digital dictation, voice recognition and hybrid mail, which will be fully integrated with the Teleologic EPR functionality in 2012.

The automated patient reminders service, implemented earlier in the year, is already providing benefits for both patients and the Trust by reducing the number of missed outpatient appointments.

Substantial investment has been made by the Trust in the replacement of its IT infrastructure. Projects are underway to replace the existing local area network and to provide new PCs and wireless devices.

Report from the Director of Finance

I am pleased to report that for the fifth successive year the Trust has delivered a surplus with the financial statements showing a surplus for the year of £0.5m after adding back impairments of £3.4m (2010/11: £1.1m). For the purposes of calculating the break even duty referred to below impairments are excluded.

Economic outlook and impact on the Trust

In 2010/11 the Trust initiated its Transformation Programme as set out in last year's annual report. This programme was launched in response to the expected impact of an ageing population, advances in medical technology and the pressures on NHS funding. I am pleased to report that the Trust has successfully delivered the first year of the programme and has delivered cost improvements of £19.1m versus a plan of £18.6m. The 2011/12 financial year has confirmed that the pressures identified will continue and through the successful development of the Transformation Programme and the Programme Management Office the Trust has put itself in a strong position to meet the expected challenges

Financial duties

The Trust's performance measured against its statutory duties is summarised as follows.

Breakeven on income and expenditure (see Note 43.1 to the financial statements)

The Trust reported an in year surplus of £0.5m giving a cumulative breakeven position of £6.6m and therefore meeting its five year breakeven duty. The cumulative breakeven position is 2.6% of 2011/12 turnover.

Capital costs absorption rate (see Note 43.2 to the financial statements)

NHS Trusts are targeted to absorb the cost of capital at a rate of 3.5% of average relevant net assets as reflected in their opening and closing balance sheets for the financial year. The Trust has achieved this target in 2011/12

External Financing Limit (see Note 43.3 to the financial statements)

The Trust was set an External Financing Limit of £62k for 2011/12. The Trust reports that it has achieved its External Financing Limit undershooting by £101k thereby increasing its cash at bank and in hand by £0.1m.

Capital Expenditure

The Trust has invested £10.7m in capital expenditure in 2011/12 of which £1.6m relates to the Haematology unit. The total cost of this facility amounts to £2.2m of which £1.6m was funded by Macmillan Cancer Support, £0.4m by NGH and £0.2m by the NGH Charitable Fund. Of the expenditure in 2011/12 £1.0m was funded by Macmillan Cancer Support and £0.6m by NGH and the NGH Charitable Fund.

In addition the Trust has invested £0.7m in refurbishing the A&E department and has invested

a further £0.5m in digital equipment for the Breast Screening Service. This completes the replacement of all Breast Screening equipment. The Trust has continued to invest in new and /or replacement medical equipment with £1.4m invested in year.

The Trust has continued to invest in Information Technology with £2.0m of investment in this financial year. This expenditure included investment of £1.2m in infrastructure to improve robustness and resilience of network and to provide platform for the enhancement of clinical IT systems going forwards.

Investment in the NGH estate has continued with capital expenditure of £3.1m in year. Of this £1.3m related to site infrastructure and £0.6m to refurbishment of clinical areas.

Charitable Funds

The Charitable Fund has continued to make significant contributions to the Trust during 2011/12, which has included £0.3m for staff and patient benefit and £0.4m for capital projects and medical equipment. The Trust would like to take the opportunity to thank all those involved with the work of the Charitable Fund over the last year.

Further we would like to thank the fundraisers, donors and supporters of Macmillan Cancer Support for their contribution of £1.6m over the last two years to the development of the Haematology Unit.

The Trust Board

Introduction

The Trust Board is led by the Chairman, Paul Farenden who was appointed on 1 March 2012, following a 4-year term held by Dr John Hickey. Dr Gerry McSorley, Chief Executive, was appointed on 1 June 2011. Mr Paul Farenden was interim Chief Executive between 4 January 2011 to 16 May 2011, and Mrs Christine Allen held the post of Interim Chief Executive from 17 May 2011 to 30 May 2011. Apart from the Chairman and the Chief Executive, there are four Executive Directors, together with five Non-Executive Directors and one Associate Non-Executive Director.

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.

Table of Attendance 2011 – 2012

	Board Meetings 10		Audit Committee 5		Healthcare Governance Committee 11**		Finance & Performance Committee 7		Remuneration Committee 4		Nomination Committee 1	
Director	A	B	A	B	A	B	A	B	A	B	A	B
Chairman John Hickey[1]	9	7	-	-	10*	9	7	4	3	3	1	1
Paul Farenden[2]	1	1	-	-	-	-	1	1	1	1	-	-
Chief Executive Paul Farenden[3]	1	1	-	-	1	1	-	-	-	-	-	-
Christine Allen[4]	1	1	-	-	1	1	-	-	-	-	-	-
Dr Gerry McSorley[5]	8	8	-	-	8	7	7	5	-	-	-	-
Executive Directors												
	A	B	A	B	A	B	A	B	A	B	A	B
Charles Abolins	10	8	-	-	4	2	7	7	-	-	-	-
Christine Allen	9	8	-	-	4	2	7	7	-	-	-	-
Fiona Barnes[6]	10	10	-	-	11	9	7	6	-	-	-	-
James Drury	10	9	-	-	4	2	7	7	-	-	-	-
Chris Pallot	10	8	-	-	4	3	7	5	-	-	-	-
Dr Sonia Swart	10	9	-	-	11	8	7	6	-	-	-	-
Chanelle Wilkinson	10	8	-	-	4	2	7	3	-	-	-	-
Executive Directors												
	A	B	A	B	A	B	A	B	A	B	A	B
Neelam Aggarwal-Singh	10	8	5	5	4	2	7	6	4	4	1	0
Colin Astbury	10	8	5	4	11*	7	7	5	4	2	1	0
Graham Kershaw[7]	10	7	5	4	4	4	7	4	4	4	1	1
Barry Noble	10	9	5	4	4	1	7	6	4	3	1	1
Nicholas Robertson	10	9	5*	5	4	4	7	4	4	3	1	1
Phil Zeidler	10	8	5	5	4	3	7*	7	4	3	1	1

A = Maximum number of meetings the Director could have attended
B = Number of meetings the Director actually attended
* Committee Chairman
** Membership of the Healthcare Governance Committee was expanded to include all Executive and Non-executive Directors from December 2011

1. John Hickey resigned his position as Chairman on 29 February 2012
2. Paul Farenden was appointed Chair from 1 March 2012
3. Paul Farenden was Interim CEO from 4 January 2011 to 16 May 2011
4. Christine Allen was acting Chief Executive between 16 May and 31 May 2011
5. Dr Gerry McSorley was appointed as Chief Executive on 1 June 2011
6. Fiona Barnes was appointed as interim Director of Nursing, Midwifery and Patient Services from 5 April 2011
7. Graham Kershaw is an Associate Non-executive Director

Board members

Mr Paul Farenden, CIPFA, MBA

Chairman

Paul was appointed as Chairman on 1st March 2012. Paul is a local man who was previously chief executive at the Dudley Group of Hospitals NHS Foundation Trust. He has some 40 years of 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. His experience has provided him with an in-depth understanding of both the NHS and the wider healthcare system.

Neelam Aggarwal-Singh, BA

Non-executive Director

Neelam is a self-employed consultant, who manages and facilitates various projects and delivers training for the local authority. Starting out in retail, she worked for Northampton College between 1991 and 2004; and afterwards for the Northampton Excellence Cluster. She has extensive experience of the local health economy, having previously been a non-executive director of Northampton Community Health Care Trust (1998-2000), Northamptonshire Health Authority (2000-2002), and Northampton Primary Care Trust (2002-2006) for which she was also vice chair.

Colin Astbury, BA, FCILT, MCMI

Non-executive Director

Colin holds an economics degree from the Open University and is a graduate industrial engineer and chartered fellow of the Institute of Logistics and transport. Currently running a supply chain consultancy business, Colin spent many years operating at board level with retail companies including Laura Ashley, Debenhams and Mothercare. Colin chairs the healthcare governance committee. Colin is our senior independent director.

Barry Noble, FCCA, AIA

Non-executive Director

Barry comes from a professional background in finance at senior level in automotive, farming, furniture, and food, with particular concentration on business control, performance, efficiency, strategy and quality. In recent positions underperformance and turnaround have been of particular interest.

Nicholas Robertson, MA, FCA

Non-executive Director

Nick spent 32 years in Royal Dutch Shell working in many countries, mainly in finance roles but also in general management and HR. For his last 9 years in Shell he was Vice President, Group Risk Management and Insurance. He is now acting as a consultant; on risk management for industrial companies and on finance for smaller oil and gas companies. He is a Governor of the University of Northampton and a Trustee director of Mental Health Matters, a charity.

Nick has a degree in Engineering and Economics and is a Chartered Accountant. Nick chairs the Audit committee.

Phil Zeidler, BSc (Hons)

Non-executive Director

Phil had a successful career as an entrepreneur in financial services, building three businesses', the most recent becoming the largest independent outsourced distributor of general insurance in the UK. He is currently Chairman of an insurance business, a music fund and board member of the charity Pilotlight. His core skills lie in strategic planning, innovation and developing strategic relationships. He is married to a consultant paediatrician. Phil chairs the Finance & Performance Committee.

Graham Kershaw, MBA, BA (Hons), FICSA, FCIPD, DipM

Associate Non-executive Director

Graham holds a first class honours degree in business from Leeds Metropolitan University and also has an MBA. He is a fellow of the Chartered Institute of Secretaries and Administrators and a fellow of 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.

Gerry McSorley, BA, MBA, Pg Diploma in Management Studies, Pg Diploma in Consultancy, DipHSM

Chief Executive

Responsible for the overall management of the Trust, and the Trust's accountable officer, Gerry was appointed as the Trust's chief executive from 1st June 2011, prior to which he was interim chief executive at Hinchingbrooke Health Care NHS Trust. He is a very experienced chief executive in the acute hospital sector, having previously held such posts in Derby, Leicester and Nottingham. Gerry has spent time with the National Leadership Council and the NHS Institute for Innovation and Improvement concentrating on senior leader development. He has also held a senior academic appointment at the University of Lincoln specialising in health management and leadership, where he retains a Visiting Professorship. Gerry holds a Doctorate in Business Administration from Brunel University/ Henley Management College, and was Honorary President of the Institute of Healthcare Management from 2005-2007and was elected Companion of the Institute in 2009 for his services to health service management.

Christine Allen, Pg Diploma in Management Studies

Deputy Chief Executive/Chief Operating Officer

Christine was appointed director of operations in January 2010, and Deputy CEO and Chief Operating Officer in October 2011; she is responsible for the day to day management of the Trust. Christine has worked for the NHS for over 25 years, for both the health authority and acute Trust, and previously held the post of director of planning and performance, where she was instrumental in establishing the Trust formal planning process, performance framework and effective contact management.

Christine led several high profile improvement programmes, including the Trust's Transformation programme delivering a significant level of savings and transformational change.

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

Medical Director

Sonia is responsible for providing professional medical advice to the Board on a range of issues including medical manpower and training, clinical audit, research and development and clinical strategy. She is the responsible officer for medical revalidation and shares responsibility for clinical governance with the Director of Nursing. She has a particular interest in improvement work related to patient safety. 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 taking up her post at Northampton General Hospital in 1994. She has 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 before becoming medical director in September 2007.

Suzie Loader, RN, DipM, MSc

Director of Nursing, Midwifery & Patient Services

Suzie is responsible for providing professional nursing & midwifery advice to the Board and for the facilitation of quality management issues, patient and public involvement, and ensuring effective complaints systems are in place. Suzie is also the Director of Infection Prevention and Control and provides the Board with regular updates in this area. She also shares responsibility for clinical governance.

Suzie joined the Trust in April 2012 from the United Lincolnshire Hospitals NHS Trust where she was interim Nurse Advisor leading the turnaround in the quality of nursing care following recent regulator inspections. Previously she has been Head of Case Management at the Nursing and Midwifery Council relating to fitness to practice, Joint lead in support of the Prime Ministers Commission on the Future of Nursing and Midwifery, Project Director for Modernising Nursing Careers at the DH, and Director of Nursing at Heatherwood and Wexham Park NHS Foundation Trust.

James Drury, BA, ACA

Director of Finance

James is the financial advisor for the Board, responsible for the application of statutory financial regulations to the conduct of all Trust activities and financial performance. James trained as a chartered accountant with KPMG. He audited UK listed companies for 10 years prior to specialising in transaction services for private equity houses in 2001. From 2004 he was global executive for chemicals with responsibility for business development, marketing and thought leadership. From January 2006 he worked for Monitor, the independent regulator of NHS foundation Trusts, as a senior assessment manager.

Charles Abolins, FBIFM, MHCIMA

Director of Facilities and Capital Development (non-voting)

Responsible for the Trust's estates and facilities, procurement and capital development,

purchasing and supply. After graduating in hospitality management from Birmingham College of Food and Tourism, Charles has held a number of facilities management posts in the NHS. Since joining NGH, Charles has been responsible for leading and implementing a number of major capital building programmes and is the Trust's lead for sustainability.

Chris Pallot, MSc, BA (Hons), DipHSM, DipM

Director of Strategy & Partnerships (non-voting)

As Director of Strategy and Partnerships Chris has responsibility for service planning, contracting, market development, clinical coding, medical records, information management and information governance. He came to work for the Trust in January 2010, initially on secondment and was appointed substantively in September 2010. Chris joined the NHS Management Training Scheme in 1995 after graduating from University and since then has gained Postgraduate Diplomas in Marketing and Health Service Management and an MSc in Management. During his career, Chris has held positions at Kettering General Hospital, the NHS Modernisation Agency and NHS Northamptonshire. In previous roles he has been responsible for operational management, service improvement and commissioning & contracting.

Chanelle Wilkinson, MBA, MCIPD

Director of Human Resources (non-voting)

Chanelle is responsible for all human resources, including education and training and leadership/management development and occupational health services. Chanelle has gained 20 years' experience of HR in the NHS working in a variety of Healthcare settings. She has worked for many years at Associate Director level and for the past 5 years as an Executive Director of HR and IT at Milton Keynes Hospital Foundation Trust. Chanelle has extensive experience of dealing with complex employment issues and extensive knowledge of developing and managing successful people strategies within the NHS. Chanelle is a member of the Chartered Institute of Personnel and Development holds a post graduate diploma qualification in HR management and an MBA from University of Warwick. She also has a strong interest in employment legislation and is currently completing a postgraduate law degree in Employment Law at University of Leicester.

Name and Title	2011-12			2010-11		
	Salary	Other Remuneration	Benefits in Kind	Salary	Other Remuneration	Benefits in Kind
	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100
John Hickey - Chairman (April 2011 - Feb 2012)	20-25		1,500	20-25		1,500
Paul Farenden - Chairman (March 2012 onwards)	0-5		0			
Paul Farenden - Interim Chief Executive (April - May 2011)	25-30			40-45		
Gerry McSorley Chief Executive (June 2011 onwards)	150-155					
Sonia Swart - Medical Director	80-85	140-145		70-75	150-155	
Susan Hardy - Director of Patient & Nursing Services (up to 4/4/11)	0-5			100-105		
Fiona Barnes - Interim Director of Patient & Nursing Services (5/4/11 onwards)	80-85					
James Drury - Director of Finance	110-115			110-115		
Christine Allen - Director of Operations (April - Oct 2011) / Deputy Chief Executive /Chief Operating Officer (Oct 2011 onwards)	100-105			100-105		
Charles Abolins - Director of Facilities & Capital Development	85-90			85-90		
Chris Pallot - Director of Strategy & Partnerships	85-90			85-90		
Chanelle Wilkinson - Director of Human Resources	95-100			95-100		
Neelam Aggawal-Singh - Non-Executive Director	5-10		0	5-10		0
Colin Astbury - Non-Executive Director	5-10		400	5-10		900
Barry Noble - Non-Executive Director	5-10		1,800	5-10		4,000
Nicholas Robertson - Non-Executive Director	5-10		500	5-10		900
Phil Zeidler - Non-Executive Director	5-10		200	5-10		600
Graham Kershaw - Associate Non-Executive Director	5-10		500	5-10		500

Salary Notes

1. Sonia Swart's 'Other Remuneration' includes Clinical Work.
2. Paul Farenden had a service contract with NGH whilst Interim Chief Executive - 2010-11 represents 3 months' salary
3. Susan Hardy - 2010-11 salary represents a full year.
4. The benefits paid to Non-Executives and Chairman above relate to travel and subsistence between home & office.

Name & Title	Real increase/ decrease in pension at age 60 (bands of £2,500)	Real increase/ decrease in Lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2012 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2012	Cash Equivalent Transfer Value at 31 March 2011	Real increase/ decrease in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Paul Farenden - Interim Chief Executive (April - May)								
Gerry McSorley Chief Executive (June 2011 onwards)	5 - 7.5	15 - 17.5	65 - 70	205 - 210	1,436	1,208	159	0
Sonia Swart - Medical Director	-2.5 - 0	-5 - -2.5	95 - 100	295 - 300	2,262	2,180	38	0
Susan Hardy - Director of Patient & Nursing Services (up to 4/4/11)	0 - 2.5	0 - 2.5	30 - 35	90 - 95	552	453	1	0
Fiona Barnes - Interim Director of Patient & Nursing Services (5/4/11 onwards)	5 - 7.5	17.5 - 20	25 - 30	85 - 90	475	312	152	
James Drury - Director of Finance	0 - 2.5	2.5 - 5	5 - 10	20 - 25	109	68	38	0
Christine Allen - Director of Operations (April - Oct 2011) / Deputy Chief Executive/Chief Operating Officer (Oct 2011 onwards)	0 - 2.5	0 - 2.5	35 - 40	110 - 115	601	503	83	0
Charles Abolins - Director of Facilities & Capital Development	-2.5 - 0	-2.5 - 0	40 - 45	130 - 135	-	1,016	-	0
Chris Pallot - Director of Strategy & Partnerships	2.5 - 5	7.5 -10	15 - 20	55 - 60	247	157	85	0
Chanelle Wilkinson - Director of Human Resources	0 - 2.5	0 -2.5	25 - 30	80 - 85	592	533	42	0

Pension benefits notes

1. As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.
2. A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme,

not just their service in a senior capacity to which the disclosure applies. The CETV figures and 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 within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

3. 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.
4. 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.
5. The value of the CETVs for some members have fallen since 31/3/2011 due to the announcement in 2010 that the uprating (annual increase) of public sector pensions would change from the Retail Price Index (RPI) to the Consumer Prices Index (CPI), with the change expected from April 2011. The new CETV factors have been used in these calculations and they are lower than previous factors. A rate of 4% CPI annual inflation has been used to calculate the real increases/decreases
6. No CETV is shown for pensioners, members over 60 (1995 Section) or members over 65 (2008 Section)

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 2011-12 was £225-230k (2010-11, £225-230k). This was 9.11 times (2010-11, 9.54 times) the median remuneration of the workforce, which was £25k (2010-11, £24k).

In 2011-12 and 2010-11 no employees received remuneration in excess of the highest-paid director.

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

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

The Chief Executive of the NHS 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 Department of Health. 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:.. Chief Executive

Date: ....

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

.... Date .... Chief Executive

.... Date .... Finance Director

Northampton General Hospital NHS Trust

Annual Governance Statement 2011/12

1. Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the Accountable Officer Memorandum.

The Board of Directors, through its Audit Committee, agreed the Trust's 11/12 Internal Audit Plan with its Internal Auditors. The results of these audits culminated in the Head of Internal Audit's opinion on the system of internal control. This Annual Governance Statement is consistent with findings of the Head of Internal Audit's opinion.

The Audit Committee is responsible for seeking evidence and obtaining independent assurance, on behalf of the Board, that there is an effective framework for internal control and corporate governance in place.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Northampton General Hospital NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Northampton General Hospital NHS Trust for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

3.1 The Trust Board is responsible for the overall governance of the Trust. The Board is responsible for reviewing the effectiveness of the system of internal control, including systems and resources for managing all types of risk. The Trust Board approved Risk Management Strategy clearly outlines the leadership, responsibility and accountability arrangements. The Policy for Assessment of Risk ensures that the Trust approaches the control of risk in a strategic and organised manner.

3.2 A comprehensive risk management training needs analysis has been completed across the organisation and there are programmes in place to deliver the identified training needs to all staff. The Trust's Risk Management team deliver risk management training at all levels across the Trust including the Trust Board.

3.3 Assurance on the adequacy of the Trust's governance arrangements has been gained through the work of Internal Audit.

3.4 The Board is committed to a culture of continual learning and quality improvement from risk related issues, incidents, complaints, claims and significant events and these are key to maintaining the risk management culture of Northampton General Hospital NHS Trust. The Healthcare Governance Committee (HGC) assures the Board of key areas of learning through the Investigating, Analysing and Learning from Incidents, Complaints and Claims policy. Learning is acquired from a variety of sources, including:

- Analysis of incidents, complaints and claims and acting on root cause analysis reports at directorate level and thematically at organisation level
- External inspections
- Health and Safety issues
- National Patient Safety Agency data
- Assurance from Internal and External audit reports and monitoring of action plans to address recommendations
- Clinical Audit reports
- Directorate and executive team review of risks, risk assessments and action plans to mitigate
- Patient Safety Learning Forum
- External reviews

3.5 The Healthcare Governance Committee provides assurance to the Board in relation to meeting quality standards and the management of clinical risks.

3.6 The Trust also has a Counter Fraud Work Plan and Local Counter Fraud Specialist which assists in managing risk. In addition the Trust has a Local Security Management Specialist in place.

4. The risk and control framework

The system of internal control is based on an on-going risk management process that is embedded in the organisation and combines the following elements:

4.1 The Trust has a comprehensive Risk Management Strategy and a Policy for Assessment of Risk that has been approved by the Trust Board and is available to all staff on the Trust's intranet site. The purpose of this strategy and policy is to ensure that the Trust manages risks in all areas using a systematic and consistent approach. The objectives of the Risk Management Strategy are stated as follows:

- Ensure understanding at all levels of the organisation of the processes and responsibilities for incident reporting; risk assessment, identification and management;
- Cultivate and foster an 'open culture' in which risk management is identified as part of continuous improvement of patient care and staff wellbeing;
- Integrate risk management into all our business decision making, planning, performance reporting and delivery processes to achieve a confident and rigorous basis for decision-making;
- Ensure a systematic approach to the identification, assessment and analysis of risk and the allocation of resources to eliminate, reduce and/or control them in order that the Board of Directors can meet its objectives;
- Encourage learning (individual and organisational) from all incidents, mistakes, accidents and 'near misses' be they related to clinical, financial, environmental or organisational events;
- Minimise damage and financial losses that arise from avoidable, unplanned events;
- Ensure the Trust complies with relevant statutory, mandatory and professional requirements.

The Risk Management Strategy provides the framework for a robust risk management process throughout the Trust. The document describes the Trust's overall risk management process and the Trust's risk identification, evaluation and control system. Risk appetite is covered in the Assessment of Risk policy. The Trust's major risks are identified in the Business Assurance Framework, Annual Report and Trust risk register.

4.2 The Board has been assured through the Audit Committee and Trust Board that effective arrangements are in place to manage and control risks to information and data. An Information Governance Strategy is in place. The Trust has an Information Governance Programme Board (IGPB) which is chaired by the Director of Strategy and Partnerships, the Trust Senior Information Risk Owner with overall responsibility for Information Governance. The IGPB provides the Trust Board, through the Audit Committee, that effective information governance best practices are in place. Assurance has been gained through the annual Information Governance Toolkit self-assessment. No serious incidents requiring investigation involving personal data were identified this year that are required to be reported to the Information Commissioner, as set out in guidance on serious untoward incidents involving data. The Medical Director is the Trust's Caldicott Guardian.

4.3 The Board has in place a Board Assurance Framework (BAF). It contains the principal risks to the achievement of the organisation's objectives as identified by the Trust Board. The BAF enables the Trust Board to monitor the effectiveness of the controls required to minimise the principal risks that threaten the achievement of Trust objectives and therefore provides the evidence to support this Annual Governance Statement. The BAF sets out assurances that are available against a specific risk. Actions within the BAF address how assurances will be provided; or, where assurances have identified inadequate controls, how controls will be improved. The BAF is reviewed each quarter by the Audit Committee. The Audit Committee has instigated a rolling programme of review of all risk registers for support directorates. HGC, a subcommittee of the Trust Board, chaired by a Non-Executive Director (NED) ensures that clinical risks to the Trust are discussed in detail. The risk register and BAF are cross referenced. The Trust Board reviews the BAF quarterly to ensure the principal risks have been identified. No significant gaps in control have been identified.

4.4 Internal audit undertook a Board Assurance Framework review in April 2012 and the draft report provide satisfactory assurance that the Trust has in place adequate and appropriate arrangements for gaining assurances about the effectiveness of the organisation's system of internal control.

4.5 All staff are responsible for managing risks within the scope of their role and responsibilities as employees of the Trust. There are structured processes in place for incident reporting, and the investigation of Serious Incidents. The Trust Board, through the Risk Management Strategy, Policy for Assessment and Management of Risks and Management of Incidents (including Serious Incidents) Policy, promotes open and honest reporting of incidents, risks and hazards. The Trust has a positive culture of reporting incidents enhanced by accessible online reporting systems available across the Trust. The Board also receives reports where there has been an investigating panel for a Serious Incident.

4.6 The responsibility for risk management is understood by all staff, the Trust Board, NEDs and Executive Directors, department heads, managers and senior clinicians, clinical governance & quality leads, and Health & Safety. Risks are identified reactively and proactively.

4.7 The Trust's Risk Assessment Tool ensures that a consistent approach is taken to the evaluation and monitoring of risk in terms of the assessment of likelihood and impact. Risks are monitored through a formal reporting process. High level corporate risks are reported to and reviewed by the Trust Board quarterly. The monitoring of risks and action plans have been undertaken by the following Board/Committees during 11/12:

- The Trust Board
- The Audit Committee
- The Healthcare Governance Committee

These committees are supported by the Directorate Governance Groups.

4.8 The Trust's commitment to quality and quality governance is based on a clearly defined clinical quality strategy, a system of quality performance management, and a clear risk management process. There is a dashboard presented to the Board which identifies key threats and risks to quality with more detail being reviewed by the Healthcare Governance Committee.

All business cases for investments and cost improvements are subject to a quality impact assessment. Monitoring of the impact on quality of investments and cost improvements is undertaken through Finance & Performance Committee and Healthcare Governance Committee.

4.9 Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Equality impact assessments (EIA) are integrated into core Trust business e.g. they are carried out as standard procedure for all Trust's policies.

4.10 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 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.

4.11 Compliance with the Care Quality Commission (CQC) essential standards of quality and safety are one of the elements of the organisation's risk management process. The Trust is registered with the CQC without conditions. Internal audit reviewed a sample of provider compliance assessments and methodology of CQC compliance monitoring and gave good assurance in December 2010. A further internal audit review has provided good assurance on the control environment and control procedures, including guidelines, policies and procedures adopted by the Trust, to ensure the effective and efficient management of compliance with the Care Quality Commission Essential Standards of Quality and Safety.

The CQC paid an unannounced visit to the main hospital site in June 2011. The resulting report from the CQC outlined one minor concern in Outcome 4 of the essential standards of quality and safety. The CQC paid an unannounced visit to the Hazelwood ward at Isebrook Hospital in February 2012 and the resulting report outlined one minor concern in Outcome 10 of the essential standards of quality and safety.

4.12 The Trust involves its key public stakeholders with managing the risks that affect them through the following mechanisms:

- Engagement with the local Health Overview and Scrutiny Committee
- Engagement with the Local Involvement Network
- The Shadow Council of Governors are consulted on key issues and risks as part of the annual plan
- Annual members meeting
- Engagement with User Groups and Support Groups

4.13 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.

4.14 During 2011/12, the Trust's BAF and governance processes identified the following gaps in control with the risk mitigation/controls plans to be implemented:

Principal Risks to Strategic Objectives	Risk mitigation/control plans
Failure to provide high quality care as reflected in high SHMI and HSMR relating to failure to maintain clinical quality and increasing demand for services and data quality issues	Continued focus on quality outcomes with robust processes and audits in place Urgent Care recovery plan and project manager in place with support from IST Monitor and proactively manage the standards of care across the Trust to improve quality of care experienced by patients, carers and relatives Strengthen the knowledge, skills and competencies of the workforce to reflect the changing needs of our services Improvements in coding of primary diagnosis and significant clinical engagement in data issues. Coding audits undertaken regularly and compliance with action plans monitored through the HSMR & Coding review group.

Difficulty in recruiting and retaining key staff or key groups of staff due to failure to develop a culture and environment where staff can thrive and deliver excellent patient care	Map of key posts under development Workforce templates based on service and financial plans developed for each Directorate area Recruitment procedures streamlined and recruitment timeline reduced. Exit interview questionnaire re-designed. Agreed KPIs for recruitment process Improved sickness absence controls in place Launch of Staff Engagement strategy
Outcome of ASR/Healthier Together is inconsistent with our strategic intent	Full involvement of PCT and GP commissioners in the annual planning process and convergence with activity and financial assumptions Senior Clinical and Director engagement by the Trust in each of the ASR/Healthier Together work streams being developed
Failure to generate cash balance of circa £10m to cover 15 days operating expenditure	Develop capital approval process to allow detailed monthly cash flow projections 2012/13 to include specific clauses in respect of payment for over performance
Failure of Transformation Programme to deliver £18m of cost reduction in 2011/12 and £18m in 2012/13	Identification and work up of plans for closing 2012/13. Monitoring through Finance and Performance Committee
Insufficient capital funding identified for statutory maintenance, replacement infrastructure, patient environment improvements and infection control which would adversely impact on health and safety, patient experience and quality of care	Agreed Estates Strategy Annual capital programme in place to meet requirements Business Continuity plans in place to manage risks from infrastructure failures
Failure to develop a partnership with Commissioners will constrain our ability to redesign services to provide innovative patient pathways and to deliver a robust commissioning process	GP engagement strategy; open and transparent approach to pathway redesign; active involvement in all Commissioner-led programmes Robust Contract Management process

The Trust Board and its sub committees have reviewed these risks and their risk mitigations/ control plans during the year and have received assurance that risk is adequately managed and mitigated.

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

5.1 The following key processes are in place to ensure that resources are used economically, efficiently and effectively:

- Scheme of Delegation and Reservation of Powers approved by the Board
- Standing Financial Instructions including robust competitive processes used for procuring non-staff expenditure items. Above £25k, procurement involves competitive tendering. The Trust Procurement department has formal contracts in place for circa 38% of 2011/12 non pay expenditure. Medicines expenditure amounting to £21.8m in 2011/12 is procured through national contracting arrangements but is not included in

the spend covered by the procurement department. Adding Medicines expenditure to the procurement department's coverage of 38% would result in coverage of circa 65%.

- Use of materials management, rolling procurement plan investment in e-procurement systems to obtain value for money from Trust expenditure and to minimise potential wastage
- Strict controls on vacancy management and recruitment

5.2 The Trust Board receives reports from the Finance and Performance Committee in respect of financial and budgetary management across the organisation and the Audit Committee reviews statements setting out Losses and Compensations, Waivers and Going Concern. Contingent liabilities are discussed at Audit Committee and Trust Board.

5.3 There are a range of internal and external audits that provide further assurance on economy, efficiency and effectiveness, including internal audit reports on creditors, financial reporting and budgetary control, payment by results, cash management, and cost improvement programmes. All Internal Audit reports for 2011/12 for core financial systems have reported satisfactory assurance. For the community ward at Danetre the internal auditors issued a limited assurance report. Action plans are in place to address the recommendations.

6. Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Trusts Boards on the form and content of Annual Quality Reports which incorporate the above legal requirements in the NHS Annual Reporting Manual.

6.1 The Directors of Northampton General Hospital NHS Trust are required to satisfy themselves that the Trust's annual Quality Accounts are fairly stated. In doing so we are required to put in place a system of internal control to ensure that proper arrangements are in place. An internal audit of the 2010/11 quality account was undertaken to assess the control environment and control procedures and provided good assurance.

6.2 The formulation of the Trust's Quality Account has been led by the Medical Director with the full support of the Trust Board. Discussion and consultation with the Board, Directors, staff, patients, shadow governors and stakeholder groups has taken place to determine the Trust's priorities and areas for improvement. The Trust recognises quality as embracing patient safety, clinical effectiveness and patient experience. The Trust's priorities for 2011/12 were:

- Right care, right place, right time
- Improving the experience of people who are vulnerable
- Improving patient safety through junior doctor engagement
- Improving patient outcomes and speeding up a patient's recovery after surgery through the Enhanced Recovery Programme.

6.3 All proposed efficiency/cost savings initiatives are clinically and quality impact assessed to ensure that implementation of proposed schemes will not directly impact on

patient safety and quality. The quality impact assessments are reported to the Finance and Performance Committee.

6.4 The Chief Executive is ultimately accountable for the clinical governance processes in the Trust. This responsibility is jointly delegated to the Medical Director and the Director of Patient and Nursing Services.

6.5 The Board monitors quality through the following processes:

- The quarterly Patient Safety, Clinical Quality and Governance report which is received by the Board;
- Directorate Clinical Governance meetings which report to the Clinical Quality and Effectiveness Group; in turn escalates issues/risks to HGC.
- Quarterly Directorate Performance meetings which include performance against the quality indicators from the Trust dashboard;
- Healthcare Governance Committee, which is a subcommittee of the Board and is chaired by a non-executive director and membership comprised Executive and Non-Executive Directors;
- Board Assurance Framework which identifies the key risks to the delivery of the Trust's business and strategic objectives monitored by the Board on a quarterly basis

6.6 The Trust has a comprehensive clinical audit work plan covering both national and local audits. Regular updates on clinical audit are reported to HGC.

6.7 A framework exists for the management and accountability of data quality, is subject to internal and external challenge and is monitored through weekly performance meetings, the mortality group and HSMR coding review group. The Audit Committee commissions an annual programme of internal audit to ensure the robustness of information provided to the Board which uses Performance Management and Patient Administration System (PAS) Data Quality, however the Audit Committee recognises that this needs to be extended to include other types of data reported to give the Board assurance.

An internal audit regarding data accuracy was conducted in 2011/12 and it identified the following:

- Primary diagnosis correct 87%
- Secondary diagnosis correct 80%
- Primary procedures correct 84%

This indicates data inaccuracy therefore the Board are not assured of the quality of data. The Trust's coding auditor continues to monitor this on a monthly basis and ensures that appropriate action is taken immediately. Actions are being monitored and reported to the Mortality and Coding Group, which in turns reports to the Clinical Quality and Effectiveness Group (CQEG). CQEG escalates issues as appropriate to HGC.

7 Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is

informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report within the Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Healthcare Governance Committee and the Finance and Performance Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the internal audit work. The BAF itself provides me with evidence that the effectiveness of controls that manage risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:

- Work of the Trust's Audit Committee, Finance & Performance Committee and Healthcare Governance Committee
- CQC Registration requirements
- Assessment against the NHSLA Risk Management standard
- Patient and staff surveys
- PEAT inspections
- Internal sources such as clinical audit, performance management reports, benchmarking and self-assessment reports
- Assessment of key findings of external enquiries

The Audit Committee has sought assurance from the Trust's internal and external auditor's from the agreed audit programmes which have been developed through consideration of the gaps in assurance as identified by the Board Assurance Framework. The Healthcare Governance Committee and Finance and Performance Committee have ensured that programmes of work, and the development of policy and strategy, address identified risk areas. These committees have also considered the sources of assurance and incorporate the findings of these assurances in future work programmes.

I therefore conclude that that the Board has conducted a review of the effectiveness of the Trust's system on internal controls and found them to be sufficient.

Conclusion

My review confirms that Northampton General Hospital NHS Trust has no significant internal control issues and a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Signed ....

Dr Gerry McSorley

Chief Executive Date: 30 May 2012

Independent Auditor’s Report To The Directors Of Northampton General Hospital Nhs Trust

I have audited the financial statements of Northampton General Hospital NHS Trust for the year ended 31 March 2012 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers’ Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

I have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes on page 45;
- the table of pension benefits of senior managers and related narrative notes on pages 46 to 47; and
- the pay multiples note on page 47.

This report is made solely to the Board of Directors of Northampton General Hospital NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Respective responsibilities of Directors and auditor

As explained more fully in the Statement of Directors’ Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My 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 me 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 Trust; and the overall presentation of the financial statements. In addition, I read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view of the financial position of Northampton General Hospital NHS Trust as at 31 March 2012 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I report to you if:

- in my opinion the governance statement does not reflect compliance with the Department of Health's Guidance;
- I refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because I have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- I issue a report in the public interest under section 8 of the Audit Commission Act 1998

I have nothing to report in these respects.

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.

I am required under Section 5 of the Audit Commission Act 1998 to satisfy myself that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires me to report to you my conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

I report if significant matters have come to my attention which prevent me from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and

effectiveness in its use of resources. I am not required to consider, nor have I 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

I have undertaken my audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2011, 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 me to consider under the Code of Audit Practice in satisfying myself 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 2012.

I planned my work in accordance with the Code of Audit Practice. Based on my risk assessment, I undertook such work as I considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Conclusion

On the basis of my work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2011, I am satisfied that, in all significant 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 2012.

Delay in certification of completion of the audit

I cannot formally conclude the audit and issue an audit certificate until I have completed the work necessary to provide assurance over the Trust's annual quality accounts. I am satisfied that this work does not have a material effect on the financial statements or on my value for money conclusion.

John Cornett

District Auditor

Unit 10 Whitwick Business Centre

Whitwick Business Park

Stenson Road

Coalville

LE67 4JP

7 June 2012

Statement of Comprehensive Income for year ended 31 March 2012

	NOTE	**2011-12** £000	2010-11 £000 (restated)
Employee benefits	10.1	**(165,950)**	(158,131)
Other costs	8	**(87,207)**	(76,416)
Revenue from patient care activities	5	**220,501**	211,233
Other Operating revenue	6	**34,980**	28,564
Operating surplus/(deficit)		**2,324**	5,250
Investment revenue	12	**29**	36
Other gains and (losses)	13	**12**	24
Finance costs	14	**(18)**	(17)
Surplus/(deficit) for the financial year		**2,347**	5,293
Public dividend capital dividends payable		**(4,264)**	(4,236)
Retained surplus/(deficit) for the year		**(1,917)**	1,057
Other Comprehensive Income			
Impairments and reversals on Revaluation Reserve		**(2,152)**	(678)
Net gain/(loss) on revaluation of property, plant & equipment		**6,674**	581
Net gain/(loss) on revaluation of intangibles		**0**	0
Net gain/(loss) on revaluation of financial assets		**0**	0
Net gain/(loss) on other reserves		**92**	0
Net gain/(loss) on available for sale financial assets		**0**	0
Net actuarial gain/(loss) on pension schemes		**0**	0
Reclassification adjustment on disposal of available for sale financial assets		**0**	0
Total comprehensive income for the year		**2,697**	9 60
Financial performance for the year			
Retained surplus/(deficit) for the year		**(1,917)**	
Prior period adjustment to correct errors		**0**	
IFRIC 12 adjustment		**0**	
Impairments		**3,453**	
Donated Asset Income		**(1,032)**	
Adjusted retained surplus (deficit)		**504**	

Impairments of land and buildings related to change in the economic value and is excluded from retained surplus and statutory breakeven in accordance with the DH Manual for Accounts.
Donated asset income of £1.032m is excluded from retained surplus and statutory breakeven duty in accordance with the DH Manual for Accounts.

PDC dividend: balance receivable/(payable) at 31 March 2012	**56**

Statement of Financial Position as at 31 March 2012

	NOTE	**31 March 2012 £000**	1 April 2011 (restated) £000	Merger adjustments £000	31 March 2011 (restated) £000	31 March 2010 (restated) £000
Non-current assets:						
Property, plant and equipment	15	**132,254**	131,005	650	130,355	130,044
Intangible assets	16	**2,564**	2,439	0	2,439	2,010
investment property		**0**	0	0	0	0
Other financial assets	23	**0**	0	0	0	0
Trade and other receivables	22.1	**257**	267	0	267	276
Total non-current assets		**135,075**	133,711	650	133,061	132,330
Current assets:						
Inventories	21	**4,723**	4,556	0	4,556	3,992
Trade and other receivables	22.1	**10,954**	10,136	0	10,136	10,628
Other financial assets	23	**0**	0	0	0	0
Other current assets	24	**0**	0	0	0	0
Cash and cash equivalents		**3,944**	3,867	0	3,867	2,352
Total current assets		**19,621**	18,559	0	18,559	16,972
Non-current assets held for sale	26	**300**	0	0	0	0
Total current assets		**19,921**	18,559	0	18,559	16,972
Total assets		**154,996**	152,270	650	151,620	149,302
Current liabilities						
Trade and other payables	27	**(17,862)**	(18,284)	(92)	(18,192)	(17,397)
Other liabilities	28	**(629)**	(1,440)	0	(1,440)	(1,234)
Provisions	34	**(1,583)**	(380)	0	(380)	(484)
Borrowings	29	**(190)**	(139)	0	(139)	0
Other financial liabilities		**0**	0	0	0	0
Working capital loan from Department		**0**	0	0	0	0
Capital loan from Department		**0**	0	0	0	0
Total current liabilities		**(20,264)**	(20,243)	(92)	(20,151)	(19,115)
Non-current assets plus/less net current assets/liabilities		**134,732**	132,027	558	131,469	130,187
Non-current liabilities						
Trade and other payables	27	**0**	0	0	0	0
Other Liabilities	28	**0**	0	0	0	0
Provisions	34	**(330)**	(310)	0	(310)	(336)
Borrowings	29	**(336)**	(348)	0	(348)	0
Other financial liabilities		**0**	0	0	0	0
Working capital loan from Department		**0**	0	0	0	0
Capital loan from Department		**0**	0	0	0	0
Total non-current liabilities		**(666)**	(658)	0	(658)	(336)
Total Assets Employed:		**134,066**	131,369	558	130,811	129,851
FINANCED BY:						
TAXPAYERS' EQUITY						
Public Dividend Capital		**99,635**	99,635	0	99,635	99,635
Retained earnings		**(225)**	1,239	0	1,239	(329)
Revaluation reserve		**34,047**	29,978	41	29,937	30,545
Other reserves		**609**	517	517	0	0
Total Taxpayers' Equity:		**134,066**	131,369	558	130,811	129,851

Notes 1 to 41 which commence on page 66 form part of these accounts

The financial statements on pages 62 to 65 were approved by the Board on 30 May 2012 and signed on its behalf by

Chief Executive: Date: 30th May 2012

Statement of Changes in Taxpayers' Equity for year ended 31 March 2012

	Public Dividend capital £000	Retained earnings £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Balance at 1 April 2011	99,635	1,239	29,937	0	130,811
Opening balance adjustments	0	0	0	0	0
Adjustments for Transforming Community Services transactions	0	0	41	517	558
Restated balance at 1 April 2011	99,635	1,239	29,978	517	131,369
Changes in taxpayers' equity for 2011-12					
Retained surplus/(deficit) for the year	0	(1,917)	0	0	(1,917)
Net gain / (loss) on revaluation of property, plant, equipment	0	0	6,674	0	6,674
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	(2,152)	0	(2,152)
Movements in other reserves	0	0	0	92	92
Transfers between reserves	0	453	(453)	0	0
Release of reserves to SOCI	0	0	0	0	0
Transfers to/(from) other bodies within the Resource Account boundary	0	0	0	0	0
Reclassification adjustment 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 PDC Received	0	0	0	0	0
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 in PDC In Year	0	0	0	0	0
Net Actuarial Gain/(Loss) on Pension	0	0	0	0	0
Net recognised revenue/(expense) for the year	0	(1,464)	4,069	92	2,697
Balance at 31 March 2012	99,635	(225)	34,047	609	134,066
Changes in taxpayers' equity for 2010-11					
Balance at 1 April 2010	99,635	(329)	30,545	0	129,851
Retained surplus/(deficit) for the year	0	1,057	0	0	1,057
Net gain / (loss) on revaluation of property, plant, equipment	0	0	581	0	581
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	(678)	0	(678)
Movements in other reserves	0	0	0	0	0
Transfers between reserves	0	511	(511)	0	0
Reclassification adjustment 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 PDC Received	0	0	0	0	0
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 in PDC In Year	0	0	0	0	0
Net Actuarial Gain/(Loss) on Pension	0	0	0	0	0
Net recognised revenue/(expense) for the year	0	1,568	(608)	0	960
Balance at 31 March 2011	99,635	1,239	29,937	0	130,811

Statement Of Cash Flows for year ended 31 March 2012

	NOTE	2011-12 £000	2010-11 £000
Cash Flows from Operating Activities			
Operating Surplus/Deficit		**2,324**	5,250
Depreciation and Amortisation		**10,065**	9,420
Impairments and Reversals		**3,453**	0
Other Gains / (Losses) on foreign exchange		**0**	0
Donated Assets received credited to revenue but non-cash		**(1,583)**	(599)
Government Granted Assets received credited to revenue but non-cash		**0**	0
Interest Paid		**0**	0
Dividend paid		**(4,303)**	(4,253)
Release of PFI/deferred credit		**0**	0
(Increase)/Decrease in Inventories		**(167)**	(564)
(Increase)/Decrease in Trade and Other Receivables		**(862)**	636
(Increase)/Decrease in Other Current Assets		**0**	0
Increase/(Decrease) in Trade and Other Payables		**(688)**	29
(Increase)/Decrease in Other Current Liabilities		**(719)**	206
Provisions Utilised		**(293)**	(348)
Increase/(Decrease) in Provisions		**1,498**	217
Net Cash Inflow/(Outflow) from Operating Activities		**8,725**	9,994
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest Received		**28**	36
(Payments) for Property, Plant and Equipment		**(7,834)**	(8,693)
(Payments) for Intangible Assets		**(892)**	(798)
(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)		**12**	8
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		**(8,686)**	(9,447)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING		**39**	547
CASH FLOWS FROM FINANCING ACTIVITIES			
Public Dividend Capital Received		**0**	0
Public Dividend Capital Repaid		**0**	0
Loans received from DH - New Capital Investment Loans		**0**	0
Loans received from DH - New Working Capital Loans		**0**	0
Other Loans Received		**203**	557
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**0**	0
Loans repaid to DH - Working Capital Loans Repayment of Principal		**0**	0
Other Loans Repaid		**(165)**	(70)
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		**0**	481
Net Cash Inflow/(Outflow) from Financing Activities		**38**	968
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**77**	1,515
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**3,867**	2,352
Opening balance adjustment - TCS transactions		**0**	0
Restated Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**3,867**	2,352
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		**3,944**	3,867

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 NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2011-12 NHS Trusts Manual for Accounts 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 NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circu stances 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

1.2 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 Transforming Community Services (TCS) transactions

Under the TCS initiative, services historically provided by PCTs have transferred to other providers - notably NHS Trusts and NHS FTs. Such transfers fall to be accounted for by use of merger accounting. The Treasury FREM provides that where a transfer takes place in 2011-12, the recipient of the transfer will account for transferred activity in full for the period (and the original provider for none) to reflect the position had the transfer always applied.

For TCS transactions specifically, it is impracticable to adjust the prior period's revenue account in each body and so restatement is effected by an adjustment to 1 April 2011 opening balances rather than by full restatement of comparators.

The following services transferred to the Trust from NHS Northamptonshire during 2011-12.

From 1 April 2011

Inpatient services provided at Danetre Hospital, Daventry.
Minor Injuries and Minor Illnesses Unit (MiAMi) provided at Cliftonville, Northampton.
The agreed annual contract value for these services amounted to £3.725m.

From 1 July 2011

Inpatient Ward at Isebrook Hospital, Wellingborough.
Inpatient Ward at Corby Community Hospital.
The agreed contract value for these services was £3.50m for the part year (£4.45m equivalent for a full financial year).

There were £92k of current liabilities, made up of trade creditors, transferred as part of the above service transfers and no current assets. Non-Current asset transfers amounted to £558k and were made up of equipment and other inventory items agreed with NHS Northamptonshire. There were no PDC transfers in respect of these non-current assets and the Trust has accounted for the non-current asset transfers through reserves in line with the DH manual for accounts.

The application of merger accounting has been applied to the services transferred on 1st July from Corby and Wellingborough only.

1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the 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.

1.4.1 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 Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

- its 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.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.4.2 Key sources of estimation uncertainty

The following are subject to estimation uncertainty at the end of the reporting period, and have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- Partially completed spells;
- Employee Benefits;
- Injury Cost Recovery Scheme Income Debtor.

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

1.5 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 project that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The 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.

1.6 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.

1.7 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.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.8 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 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

As of 1 April 2009 the Trust has adopted HM Treasury 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. To comply with IFRS requirements, that valuations should reflect fair value, land and building valuations have been reviewed to reflect current economic conditions.

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 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 are taken to expenditure. This is a change in accounting policy from previous years where all impairments were taken to the revaluation reserve to the extent that the balance was held for that asset and thereafter 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.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.9 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. All IT assets, both licences and internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.10 Depreciation, amortisation and impairments
Freehold land and properties under construction 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 Trust expects to obtain economic benefits or service potential from the asset. This is specific to the 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 Trust considers 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. This is a change in accounting policy from previous years where all impairments were taken to the revaluation reserve to the extent that a balance was held for that asset and thereafter 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.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.11 Donated assets

Following the accounting policy change outlined in the Treasury FREM for 2011-12, a donated asset reserve is no longer maintained. 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.

This accounting policy change has been applied retrospectively and consequently the 2010-11 results were restated.

1.12 Government grants

Following the accounting policy change outlined in the Treasury FREM for 2011-12, a government grant reserve is no longer maintained. 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.

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been restated.

1.13 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.

1.14 Leases

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

The Trust as 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.

Land and buildings are considered separately when classifying lease arrangements.

The Trust as lessor

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

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.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.15 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.

1.16 Cash and cash equivalents

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

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

1.17 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 discount rate of 2.2% in real terms.

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.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

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 arsing from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.18 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 Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 34.

1.19 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to 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.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.20 EU Emissions Trading Scheme

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

Carbon Reduction Commitment (CRC) Energy Efficiency Scheme

The CRC Scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is required to register with the CRC Scheme and with effect from 2011-12, to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year based on estimates from metered gas and electricity usage, (the current rate is £12 per tonne). The current liability at 31 March 2012 will therefore reflect the CO2 emissions that are made during 2011-12.

1.21 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 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.

1.22 Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

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.

1.23 Financial liabilities

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

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

1.24 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.

1.25 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.

1.26 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.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.27 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. From 1 April 2009, the dividend payable is based on the actual average relevant net assets for the year instead of forecast amounts.

1.28 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.

1.29 Subsidiaries

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows 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 Trust's or where the subsidiary's accounting date is before 1 January or after 30 June.

For 2011-12, in accordance with the DH Manual for Accounts, the Trust does not consolidate the NHS charitable funds for which it is the corporate trustee.

1.30 Joint operations

Joint operations are activities undertaken by the Trust in conjunction with one or more other parties but which are not performed through a separate entity. The Trust records its share of the income and expenditure; gains and losses; assets and liabilities; and cashflows.

1.31 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 2011-12. The application of the Standards as revised would not have a material impact on the accounts for 2011-12, were they applied in that year:

IAS 1 Presentation of financial statements (Other Comprehensive Income) - subject to consultation
IAS12 - Income Taxes (amendment) - subject to consultation
IAS 19 Post-employment benefits (pensions) - subject to consultation
IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 7 - Financial Instruments: Disclosures (annual improvements) - effective 2012-13
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation

2. Pooled budgets

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

3. Operating segments

Northampton General Hospital NHS Trust 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	**2011-12 £000**	2010-11 £000
Income	**1817**	1732
Full cost	**819**	980
Surplus/(deficit)	**998**	752

5. Revenue from patient care activities

	2011-12 £000	2010-11 £000
Strategic health authorities	**107**	107
NHS trusts	**0**	0
Primary care trusts - tariff	**153,019**	139,649
Primary care trusts - non-tariff	**63,997**	58,832
Primary care trusts - market forces factor	**0**	9,453
Foundation trusts	**581**	453
Local authorities	**0**	0
Department of Health	**0**	0
NHS other	**0**	0
Non-NHS:		
Private patients	**1,362**	1,379
Overseas patients (non-reciprocal)	**137**	155
Injury costs recovery	**1,298**	1,158
Other	**0**	47
	220,501	211,233

6. Other operating revenue

	2011-12 £000	2010-11 £000
Recoveries in respect of employee benefits	**3,516**	3,589
Patient transport services	**0**	0
Education, training and research	**10,985**	11,218
Charitable and other contributions to expenditure	**265**	479
Receipt of donations for capital acquisitions	**1,583**	599
Receipt of Government grants for capital acquisitions	**0**	0
Non-patient care services to other bodies	**3,218**	1,988
Income generation	**1,817**	1,732
Rental revenue from finance leases	**19**	19
Rental revenue from operating leases	**30**	39
Other revenue	**13,547**	8,901
	34,980	28,564
Total operating revenue	**255,481**	239,797

Other revenue includes :
Pharmacy Sales £6,163k (£5,485k)
Accommodation Charges £388k (£339k)
Provision of Services to private hospitals £324k (£477k)
Transformation Funding £3,871k (£0)

7. Revenue

	2011-12 £000	2010-11 £000
From rendering of services	**248,723**	234,145
From sale of goods	**6,758**	5,652

Pharmacy sales and drugs recharges to other organisations are treated as sale of goods.

8. Operating expenses (excluding employee benefits)

	2011-12 £000	2010-11 £000
Services from other NHS Trusts	**0**	0
Services from PCTs	**132**	1,171
Services from other NHS bodies	**0**	0
Services from Foundation Trusts	**782**	290
Purchase of healthcare from non NHS bodies	**780**	0
Trust chair and non executive directors	**54**	57
Supplies and services - clinical	**47,645**	44,545
Supplies and services - general	**3,202**	3,017
Consultancy services	**2,604**	1,076
Establishment	**2,506**	2,362
Transport	**136**	142
Premises	**8,226**	6,906
Impairments and Reversals of Receivables	**250**	233
Inventories write down	**94**	96
Depreciation	**9,023**	8,544
Amortisation	**1,042**	876
Impairments and reversals of property, plant and equipment	**3,453**	0
Impairments and reversals of intangible assets	**0**	0
Impairments and reversals of financial assets	**0**	0
Impairments and reversals of non current assets held for sale	**0**	0
Impairments and reversals of investment properties	**0**	0
Audit fees	**123**	125
Other auditor's remuneration	**1**	1
Clinical negligence	**5,020**	4,966
Research and development	**0**	0
Education and Training	**662**	654
Other	**1,472**	1,355
	87,207	76,416

Other auditor's remuneration relates to National Fraud Initiative

Other expenditure includes :
Insurance £155k (£157k)
Legal Fees £345k (271k)
Translation Services 96k (96k)
Internal Audit Fees £141k (131k)

Employee benefits

Employee benefits excluding Board members	**164,933**	157,090
Board members	**1,018**	1,041
Total employee benefits	**165,951**	158,131
Total operating expenses	**253,158**	234,547

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	Buildings	Other	Total	2010-11
	£000	**£000**	**£000**	**£000**	£000
Payments recognised as an expense					
Minimum lease payments				**546**	781
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**546**	781
Payable:					
No later than one year	**0**	**0**	**538**	**538**	523
Between one and five years	**0**	**0**	**1,120**	**1,120**	1,181
After five years	**0**	**0**	**107**	**107**	430
Total	**0**	**0**	**1,765**	**1,765**	2,134

9.2 Trust as lessor

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

Catering provision provided in the Cripps Post Graduate Centre is also under terms of an operating lease.

	2011-12	2010-11
	£000	£000
Recognised as income		
Rents	**30**	39
Contingent rents	**0**	0
Total	**30**	39
Receivable:		
No later than one year	**33**	39
Between one and five years	**0**	40
After five years	**0**	0
Total	**33**	79

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.

10. Employee benefits and staff numbers

10.1 Employee benefits

	Total	Permanently employed	Other
	£000	£000	£000
Employee Benefits 2011-12 - gross expenditure			
Salaries and wages	139,603	127,110	12,493
Social security costs	11,014	10,599	415
Employer contributions to NHS Pensions scheme	14,664	14,627	37
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	866	866	0
Total employee benefits	166,147	153,202	12,945
Less recoveries in respect of employee benefits (table below)	(3,516)	(3,516)	0
Total - Net Employee Benefits including capitalised costs	162,631	149,686	12,945
Employee costs capitalised	197	197	0
Net Employee Benefits excluding capitalised costs	165,950	153,005	12,945
Employee Benefits 2011-12 - income			
Salaries and wages	2,931	2,931	0
Social Security costs	246	246	0
Employer Contributions to NHS BSA - Pensions Division	339	339	0
Other pension costs	0	0	0
Other Post Employment Benefits	0	0	0
Other Employment Benefits	0	0	0
Termination Benefits	0	0	0
TOTAL excluding capitalised costs	3,516	3,516	0

	Total	Permanently employed	Other
	£000	£000	£000
Net expenditure - 2010-11			
Salaries and wages	133,913	121,030	12,883
Social security costs	10,374	9,927	447
Employer contributions to NHS Pensions scheme	14,000	13,971	29
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	125	125	0
Total employee benefits	158,412	145,053	13,359
Employee costs capitalised	281		
Net Employee Benefits excluding capitalised costs	158,131		

10.2 Staff Numbers

	2011-12			2010-11
	Total	**Permanently employed**	**Other**	Total
	Number	**Number**	**Number**	Number
Average Staff Numbers				
Medical and dental	469	450	20	454
Ambulance staff	0	0	0	0
Administration and estates	616	543	72	848
Healthcare assistants and other support staff	1,320	1,198	121	993
Nursing, midwifery and health visiting staff	1,293	1,212	81	1,221
Nursing, midwifery and health visiting learners	0	0	0	0
Scientific, therapeutic and technical staff	432	421	11	424
Social Care Staff	0	0	0	0
Other	9	9	0	13
TOTAL	4,139	3,833	306	3,953
Of the above - staff engaged on capital projects	8	8	0	11

10.3 Staff Sickness absence and ill health retirements

	2011-12	2010-11
	Number	Number
Total Days Lost	**34,305**	35,438
Total Staff Years	**3,790**	3,640
Average working Days Lost	**9.05**	9.74

	2011-12	2010-11
	Number	Number
Number of persons retired early on ill health grounds	**4**	10
	£000s	£000s
Total additional pensions liabilities accrued in the year	**74**	545

10.4 Exit Packages agreed in 2011-12

	2011-12			2010-11		
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Less than £10,000	**0**	0	**0**	3	0	3
£10,001-£25,000	**2**	0	**2**	0	0	0
£25,001-£50,000	**2**	0	**2**	0	0	0
£50,001-£100,000	**3**	0	**3**	0	0	0
£100,001 - £150,000	**3**	0	**3**	1	0	1
£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	**10**	0	**10**	4	0	4
Total resource cost (£000s)	**790**	0	**790**	125	0	125

This note provides an analysis of Exit Packages agreed during the year. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. 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.

10.5 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 formal actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes have been suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision. Employer and employee contribution rates are currently being determined under the new scheme design.

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. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data are accepted as providing suitably robust figures for financial reporting purposes. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at 31 March 2012, is based on detailed membership data as at 31 March 2010 updated to 31 March 2012 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) will be used to replace 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	2011-12 Number	2011-12 £000	2010-11 Number	2010-11 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**60,734**	**76,473**	62,296	72,554
Total Non-NHS Trade Invoices Paid Within Target	**54,424**	**46,529**	48,667	44,877
Percentage of NHS Trade Invoices Paid Within Target	**89.61%**	**60.84%**	78.12%	61.85%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,322**	**15,854**	2,140	13,714
Total NHS Trade Invoices Paid Within Target	**1,583**	**2,016**	1,410	2,613
Percentage of NHS Trade Invoices Paid Within Target	**68.17%**	**12.72%**	65.89%	19.05%

The Better Payment Practice Code requires the Trust 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	2011-12 £000	2010-11 £000
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

12 Investment Income	2011-12 £000	2010-11 £000
Rental Income		
PFI finance lease revenue (planned)	**0**	0
PFI finance lease revenue (contingent)	**0**	0
Other finance lease revenue	**0**	0
Subtotal	**0**	0
Interest Income		
LIFT: equity dividends receivable	**0**	0
LIFT: loan interest receivable	**0**	0
Bank interest	**29**	36
Other loans and receivables	**0**	0
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Subtotal	**29**	36
Total investment income	**29**	36

13 Other Gains and Losses	2011-12 £000	2010-11 £000
Gain/(loss) on disposal of property, plant and equipment	**12**	8
Gain/(loss) on disposal of intangible assets	**0**	0
Gain/(loss) on disposal of financial assets	**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**	16
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	**12**	24

14 Finance Costs

	2011-12	2010-11
	£000	£000
Interest		
Interest on loans and overdrafts	**0**	0
Interest on obligations under finance leases	**0**	0
Provisions - unwinding of discount	**16**	17
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
Other interest expense	**0**	0
Total interest expense	**16**	17
Other finance costs	**2**	0
Total	**18**	17

15.1 Property, plant and equipment

2011-12

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	**Total**
	£000	£000	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:									
At 31 March 2011	21,924	103,186	689	2,989	32,963	78	9,925	935	**172,689**
Prior period adjustments	0	0	0	0	0	0	0	0	**0**
Merger adjustments	0	0	0	0	597	0	0	53	**650**
At 1 April 2011 restated	21,924	103,186	689	2,989	33,560	78	9,925	988	**173,339**
Additions Purchased	0	3,801	0	1,680	1,746	0	968	0	**8,195**
Additions Donated	0	22	0	1,321	124	0	8	108	**1,583**
Additions Government Granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	3,782	0	(5,465)	218	0	1,190	0	**(275)**
Reclassifications as Held for Sale	0	(300)	0	0	0	0	0	0	**(300)**
Disposals other than for sale	0	0	0	0	(1,641)	0	(99)	(380)	**(2,120)**
Upward revaluation/positive indexation	0	5,998	0	0	1,759	5	0	0	**7,762**
Impairments/negative indexation	(1,824)	(310)	(18)	0	0	0	0	0	**(2,152)**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from NHS Bodies	0	0	0	0	0	0	0	0	**0**
Transfers to Foundation Trusts	0	0	0	0	0	0	0	0	**0**
Cumulative dep'n adjustment following revaluation	0	(21,814)	(115)	0	0	0	0	0	**(21,929)**
At 31 March 2012	20,100	94,365	556	525	35,766	83	11,992	716	**164,103**
Depreciation									
At 31 March 2011	0	14,441	75	0	20,335	32	6,543	908	**42,334**
Prior period adjustments	0	0	0	0	0	0	0	0	**0**
Merger adjustments	0	0	0	0	0	0	0	0	**0**
At 1 April 2011 restated	0	14,441	75	0	20,335	32	6,543	908	**42,334**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(1,641)	0	(99)	(380)	**(2,120)**
Upward revaluation/positive indexation	0	0	0	0	1,086	2	0	0	**1,088**
Impairments	0	5,162	0	0	0	0	0	0	**5,162**
Reversal of Impairments	0	(1,709)	0	0	0	0	0	0	**(1,709)**
Charged During the Year	0	3,920	40	0	3,610	11	1,383	59	**9,023**
Transfers to NHS Bodies	0	0	0	0	0	0	0	0	**0**
Transfers to Foundation Trusts	0	0	0	0	0	0	0	0	**0**
Cumulative dep'n adjustment following revaluation	0	(21,814)	(115)	0	0	0	0	0	**(21,929)**
At 31 March 2012	**0**	**0**	**0**	**0**	**23,390**	**45**	**7,827**	**587**	**31,849**
Net book value at 31 March 2012	20,100	94,365	556	525	12,376	38	4,165	129	**132,254**
Purchased	20,100	87,283	556	525	11,609	18	4,135	21	**124,247**
Donated	0	7,082	0	0	767	20	30	108	**8,007**
Government Granted	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2012	**20,100**	**94,365**	**556**	**525**	**12,376**	**38**	**4,165**	**129**	**132,254**
Asset financing:									
Owned	20,100	94,365	556	525	12,376	38	4,165	129	**132,254**
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	**20,100**	**94,365**	**556**	**525**	**12,376**	**38**	**4,165**	**129**	**132,254**

Revaluation Reserve Balance for Property, Plant & Equipment

2011-12

	Land	Buildings excluding dwellings	Dwellings	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	**Total**
	£000	£000	£000	£000	£000	£000	£000	**£000**
At 31 March 2011	13,065	15,743	99	1,030	0	0	0	**29,937**
Prior period adjustments	0	0	0	0	0	0	0	**0**
Merger adjustments	0	0	0	38	0	0	3	**41**
At 1 April 2011 restated	13,065	15,743	99	1,068	0	0	3	**29,978**
Movements	(1,824)	5,572	(99)	222	1	0	0	**3,872**
At 31 March 2012	11,241	21,315	0	1,290	1	0	3	**33,850**

15.2 Property, plant and equipment

2010-11

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	**Total**
	£000	£000	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:									
At 1 April 2010	22,602	98,808	645	2,553	30,451	56	8,871	922	**164,908**
Additions - purchased	0	3,993	44	1,080	2,483	19	1,129	13	**8,761**
Additions - donated	0	74	0	358	136	0	31	0	**599**
Additions - government granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	311	0	(1,006)	182	0	91	0	**(422)**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	(1,801)	0	(197)	0	**(1,998)**
Revaluation & indexation gains	0	0	0	4	1,512	3	0	0	**1,519**
Impairments	(678)	0	0	0	0	0	0	0	**(678)**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Transfers to Foundation Trusts	0	0	0	0	0	0	0	0	**0**
At 31 March 2011	**21,924**	**103,186**	**689**	**2,989**	**32,963**	**78**	**9,925**	**935**	**172,689**
Depreciation									
At 1 April 2010	0	10,779	37	0	17,819	23	5,417	789	**34,864**
Reclassifications	0	0	0	0	0	0	(14)	0	**(14)**
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(1,801)	0	(197)	0	**(1,998)**
Upward revaluation/positive indexation	0	0	0	0	937	1	0	0	**938**
Impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	3,662	38	0	3,380	8	1,337	119	**8,544**
Transfers to NHS Bodies	0	0	0	0	0	0	0	0	**0**
Transfers to Foundation Trusts	0	0	0	0	0	0	0	0	**0**
At 31 March 2011	0	14,441	75	0	20,335	32	6,543	908	**42,334**
Net book value	21,924	88,745	614	2,989	12,628	46	3,382	27	**130,355**
Purchased	21,924	83,745	614	2,649	11,692	21	3,352	27	**124,024**
Donated	0	5,000	0	340	936	25	30	0	**6,331**
Government Granted	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2011	21,924	88,745	614	2,989	12,628	46	3,382	27	**130,355**
Asset financing:									
Owned	21,924	88,745	614	2,989	12,628	46	3,382	27	**130,355**
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**
	21,924	88,745	614	2,989	12,628	46	3,382	27	**130,355**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings excluding dwellings	Dwellings	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**
At 1 April 2010 restated	13,672	15,469	95	778	0	0	0	**30,014**
Movements	(607)	274	4	252	0	0	0	**(77)**
At 31 March 2011	13,065	15,743	99	1,030	0	0	0	**29,937**

15.3 (cont). Property, plant and equipment

In total £1,583k of property and equipment assets were donated to the Trust in the financial year.
Donated equipment to the value of £132k has been provided by NGH Charitable Fund.
A project to redevelop the Haematology Unit commenced in January 2011, as a result the unit has been extended and reopened during the year. In addition to funding of £340k received in 2010-11, funding in 2011-12 amounted to:

Macmillan	£1,210k.
NGH Charitable Funds	£187k

Other minor building work to the value of £54k was also funded by NGH Charitable Fund.

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 has been undertaken in the 2011-12 financial year with an effective date of 1 April 2012 for land and buildings and this valuation has been applied in year.

Sunnyside (Block 62) has been declared as a surplus asset and valued at Open Market Value.

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 £19,830k

16.1 Intangible non-current assets

2011-12	**Software internally generated**	**Software purchased**	**Licences & trademarks**	**Patents**	**Development expenditure**	**Total**
	£000	£000	£000	£000	£000	**£000**
Cost or valuation:						
At 31 March 2011	342	5,160	0	0	0	**5,502**
Prior period adjustments	0	0	0	0	0	**0**
Merger adjustments	0	0	0	0	0	**0**
At 1 April 2011 restated	342	5,160	0	0	0	**5,502**
Additions - purchased	0	839	0	0	0	**839**
Additions - internally generated	53	0	0	0	0	**53**
Additions - donated	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	**0**
Reclassifications	0	275	0	0	0	**275**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
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**
Transfers to Foundation Trusts	0	0	0	0	0	**0**
Cumulative amortisation adjustment following revaluation	0	0	0	0	0	**0**
At 31 March 2012	395	6,274	0	0	0	**6,669**

2011-12	Software internally generated	Software purchased	Licences & trademarks	Patents	Development expenditure	Total
Amortisation	£000	£000	£000	£000	£000	**£000**
At 31 March 2011	53	3,010	0	0	0	**3,063**
Prior period adjustments	0	0	0	0	0	**0**
Merger adjustments	0	0	0	0	0	**0**
At 1 April 2010	53	3,010	0	0	0	**3,063**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
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	71	971	0	0	0	**1,042**
Transfers to Foundation Trusts	0	0	0	0	0	**0**
Cumulative amortisation adjustment following revaluation	0	0	0	0	0	**0**
At 31 March 2012	124	3,981	0	0	0	**4,105**
NBV at 31 March 2012	271	2,293	0	0	0	**2,564**
Net book value at 31 March 2012 comprises:						
Purchased	271	2,293	0	0	0	**2,564**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2012	271	2,293	0	0	0	**2,564**

Revaluation reserve balance for intangible non-current assets

	£000's	£000's	£000's	£000's	£000's	**£000's**
At 31 March 2011	0	0	0	0	0	**0**
Prior period adjustments	0	0	0	0	0	**0**
Merger adjustments	0	0	0	0	0	**0**
At 1 April 2011 restated	0	0	0	0	0	**0**
Movements	0	0	0	0	0	**0**
At 31 March 2012	0	0	0	0	0	**0**

16.2 Intangible non-current assets

2010-11	Software internally generated	Software purchased	Licences & trademarks	Patents	Development expenditure	Total
	£000	£000	£000	£000	£000	**£000**
Cost or valuation:						
At 1 April 2010	75	4,115	0	0	0	**4,190**
Additions - purchased	61	836	0	0	0	**897**
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**
Reclassifications	206	216	0	0	0	**422**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	(7)	0	0	0	**(7)**
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**
Transferred to Foundation Trusts	0	0	0	0	0	**0**
At 31 March 2011	342	5,160	0	0	0	**5,502**
Amortisation						
At 1 April 2010	12	2,168	0	0	0	**2,180**
Reclassifications	0	14	0	0	0	**14**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	(7)	0	0	0	**(7)**
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	41	835	0	0	0	**876**
Transfers to Foundation Trusts	0	0	0	0	0	**0**
At 31 March 2011	53	3,010	0	0	0	**3,063**
Net book value at 31 March 2010	289	2,150	0	0	0	**2,439**
Net book value at 31 March 2010 comprises:						
Purchased	289	2,150	0	0	0	**2,439**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2011	289	2,150	0	0	0	**2,439**

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 2 and 5 years.

17 Analysis of impairments and reversals recognised in 2011-12	**2011-12 Total £000**
Property, Plant and Equipment impairments and reversals taken 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	3,453
Total charged to Annually Managed Expenditure	3,453
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve	
Loss or damage resulting from normal operations	0
Over Specification of Assets	0
Abandonment of assets in the course of construction	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	2,152
Total impairments for PPE charged to reserves	2,152
Total Impairments of Property, Plant and Equipment	5,605
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
Intangible Assets impairments and reversals charged to the Revaluation Reserve	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0

17 Analysis of impairments and reversals recognised in 2011-12 (cont)	2011-12 Total £000
Changes in market price	0
Total impairments for Intangible Assets charged to Reserves	0
Total Impairments of Intangibles	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
Financial Assets impairments and reversals charged to the Revaluation Reserve	
Loss or damage resulting from normal operations	0
Loss as a result of catastrophe	0
Other	0
TOTAL impairments for Financial Assets charged to reserves	0
Total Impairments of Financial Assets	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	0
Investment Property impairments charged to SoCI	
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	0
Total Investment Property impairments charged to SoCI	0
Total Impairments charged to Revaluation Reserve	2,152
Total Impairments charged to SoCI - DEL	0
Total Impairments charged to SoCI - AME	3,453
Overall Total Impairments	5,605
Of which:	
Impairment on revaluation to "modern equivalent asset" basis	0
Donated and Gov Granted Assets, included above	
Donated Asset Impairments: amount charged to SOCI - DEL	0
Donated Asset Impairments: amount charged to SOCI - AME	0
Donated Asset Impairments: amount charged to revaluation reserve	748
Total Donated Asset Impairments	748
Government Granted Asset Impairments: amount charged to SoCI - DEL	0
Government Granted Asset Impairments: amount charged to SoCI - AME	0
Government Granted Asset Impairments: amount charged to revaluation reserve	0
Total Gov Granted asset Impairments.	0
TOTAL DONATED/GOVERNMENT GRANTED ASSET IMPAIRMENTS	748

18 Investment property

	31 March 2012 £000	31 March 2011 £000
At fair value		
Balance at 31 March 2011	**0**	0
Prior period adjustment	**0**	0
Merger adjustment	**0**	
Restated at 1 April 2010	**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	**0**	0
Gain from Fair Value Adjustments	**0**	0
Transferred to Foundation trusts	**0**	0
Other Changes	**0**	0
Balance at 31 March 2012	**0**	0

19 Capital Commitments

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

	31 March 2012 £000	31 March 2011 £000
Property, plant and equipment	**668**	2,420
Intangible assets	**5**	145
Total	**673**	2,565

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	4,615	0	5,663	0
Balances with Local Authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	1,351	0	707	0
Balances with Public Corporations and Trading Funds	0	0	35	0
Balances with bodies external to government	4,988	257	11,457	0
At 31 March 2012	**10,954**	**257**	**17,862**	**0**
prior period:				
Balances with other Central Government Bodies	4,514	0	8,477	0
Balances with Local Authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	666	0	551	0
Balances with Public Corporations and Trading Funds	0	0	247	0
Balances with bodies external to government	4,956	267	8,917	0
At 31 March 2011	**10,136**	**267**	**18,192**	**0**

21 Inventories

	Drugs £000	Consumables £000	Energy £000	Total £000
Balance at 1 April 2011	1,743	2,741	72	**4,556**
Prior period adjustment	0	0	0	**0**
Merger adjustment	0	0	0	**0**
Restated at 1 April 2011	1,743	2,741	72	**4,556**
Additions	22,066	22,660	0	**44,726**
Inventories recognised as an expense in the period	(21,839)	(22,626)	0	**(44,465)**
Write-down of inventories (including losses)	(94)	0	0	**(94)**
Reversal of write-down previously taken to SoCI	0	0	0	**0**
Transfers (to)/from other bodies	0	0	0	**0**
Transfers (to) Foundation Trusts	0	0	0	**0**
Balance at 31 March 2012	1,876	2,775	72	**4,723**

22.1 Trade and other receivables

	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
NHS receivables - revenue	**5,730**	4,812	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**0**	119	**0**	0
Non-NHS receivables - revenue	**985**	1,295	**0**	0
Non-NHS receivables - capital	**30**	118	**0**	0
Non-NHS prepayments and accrued income	**1,458**	720	**0**	0
Provision for the impairment of receivables	**(432)**	(420)	**0**	0
VAT	**236**	368	**0**	0
Current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**2**	1	**0**	0
Finance lease receivables	**0**	0	**257**	267
Operating lease receivables	**0**	0	**0**	0
Other receivables	**2,945**	3,123	**0**	0
Total	**10,954**	10,136	**257**	267
Total current and non current	**11,211**	10,403		
Included in NHS receivables are prepaid pension contributions:	**0**	0		

NHS receivables-revenue
- Estimated value of partially completed spells £1,002k (£2,125k)

Other receivables include:
- Injury Cost Recovery claims (ICR) £2,554k (£2,483k)
- Salary overpayments/other recoverable pay £310k (£291k)

The great majority of trade is with Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts 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 2012 £000	31 March 2011 £000
By up to three months	**19**	183
By three to six months	**0**	28
By more than six months	**82**	126
Total	**101**	337

22.3 Provision for impairment of receivables

	2011-12 £000	2010-11 £000
Balance at 1 April 2011	**(420)**	(446)
Adjustments	**0**	0
Restated balance at 1 April 2011	**(420)**	(446)
Amount written off during the year	**238**	259
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**(250)**	(233)
Transfer to NHS Foundation Trust	**0**	0
Balance at 31 March	**(432)**	(420)

The Trust provides for receivables as follows:
All Non-NHS Trade receivables over 3 months old from date of invoice unless known reason for payment delay.

7.8% of recognised Injury Cost Recovery claims are provided for.

All salary overpayments that occurred prior to 31 March 2010, for which no recovery plan is in place, are provided for in full.

23 Other financial assets

	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
Financial assets carried at fair value through SoCI				
Embedded Derivatives at Fair Value through SoCI	**0**	0	**0**	0
Financial assets carried at fair value through SoCI	**0**	0	**0**	0
Subtotal	**0**	0	**0**	0
Held to maturity investments at amortised cost	**0**	0	**0**	0
Available for sale financial assets carried at fair value	**0**	0	**0**	0
Loans carried at amortised cost	**0**	0	**0**	0
Total	**0**	0	**0**	0
Total other financial assets (current and non-current)	**0**	0		

24 Other current assets

	31 March 2012 £000	31 March 2011 £000
EU Emissions Trading Scheme Allowance	**0**	0
Other Assets	**0**	0
Total	**0**	0

25 Cash and Cash Equivalents

	31 March 2012 £000	31 March 2011 £000
Opening balance at 1 April	**3,867**	2,352
Opening balance adjustment	**0**	0
Merger adjustments	**0**	0
Restated	**3,867**	2,352
Net change in year	**77**	1,515
Closing balance at 31 March	**3,944**	3,867
Made up of		
Cash with Government Banking Service	**3,808**	3,746
Commercial banks	**128**	121
Cash in hand	**8**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**3,944**	3,867
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**3,944**	3,867
Patients' money held by the Trust, not included above	**3**	0

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	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2011	0	0	0	0	0	0	0	0	0	0
Merger adjustments	0	0	0	0	0	0	0	0	0	0
Restated at 1 April 2011	0	0	0	0	0	0	0	0	0	0
Plus assets classified as held for sale in the year	0	300	0	0	0	0	0	0	0	300
Less assets sold in the year	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
Plus reversal of impairment of assets held for sale	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
Transfers (to)/from other bodies	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2012	0	300	0	0	0	0	0	0	0	300
Liabilities associated with assets held for sale at 31 March 2012	0	0	0	0	0	0	0	0	0	0
Balance at 1 April 2010	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
Less assets sold in the year	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
Plus reversal of impairment of assets held for sale	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
Balance at 31 March 2011	0	0	0	0	0	0	0	0	0	0
Liabilities associated with assets held for sale at 31 March 2011	0	0	0	0	0	0	0	0	0	0

Sunnyside (Block 62) :-

Sunnyside, is a free standing property located on a corner of the hospital site which has ceased to be used since the transfer of the CAMH service to Northamptonshire Healthcare Foundation Trust
The property is being offered for sale and it is anticipated the disposal will occur in the next 12 to 18 months subject to finding a suitable purchaser.

27 Trade and other payables

	Current		Non-current	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
Interest payable	**0**	0	**0**	0
NHS payables - revenue	**1,158**	4,177	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**0**	150	**0**	0
Family Health Services (FHS) payables	**0**	0	**0**	0
Non-NHS payables - revenue	**4,170**	3,528	**0**	0
Non-NHS payables - capital	**2,759**	2,401	**0**	0
Non-NHS accruals and deferred income	**4,018**	2,529	**0**	0
Social security costs	**3,423**	3,245	**0**	0
VAT	**0**	0	**0**	0
Tax	**0**	0	**0**	0
Payments received on account	**0**	0	**0**	0
Other	**2,334**	2,162	**0**	0
Total	**17,862**	18,192	**0**	0
Total payables (current and non-current)	**17,862**	18,192		
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	1,826	1,817		

28 Other liabilities

	Current		Non-current	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
PFI/LIFT deferred credit	**0**	0	**0**	0
Lease incentives	**0**	0	**0**	0
Other - employee benefits	**629**	1,440	**0**	0
Total	**629**	1,440	**0**	0
Total other liabilities (current and non-current)	**629**	1,440		

29 Borrowings

	Current		Non-current	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
Bank overdraft - Government Banking Service	**0**	0	**0**	0
Bank overdraft - commercial banks	**0**	0	**0**	0
Loans from Department of Health	**0**	0	**0**	0
Loans from other entities	**190**	139	**336**	348
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	**190**	139	**336**	348
Total other liabilities (current and non-current)	**526**	487		

Loans - repayment of principal falling due in:

	31 March 2012 DH £000	Other £000	Total £000
0-1 years	**0**	190	190
1 - 2 Years	**0**	190	190
2 - 5 Years	**0**	146	146
Over 5 Years	**0**	0	0
TOTAL	**0**	526	526

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 installments.

30 Other financial liabilities

	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
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 liabilities (current and non-current)	**0**	0		

31 Deferred Income

	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
Opening balance at 1 April 2011	**160**	353	**0**	0
Deferred income addition	**44**	160	**0**	0
Transfer of deferred income	**(159)**	(353)	**0**	0
Current deferred income at 31 March 2012	**45**	160	**0**	0

32 Finance lease obligations as lessee
The Trust has no finance lease obligations.

33 Finance lease receivables as lessor
NHS Northamptonshire 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 2012 £000**	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
Within one year	**10**	10	**10**	10
Between one and five years	**40**	40	**40**	40
After five years	**207**	217	**207**	217
Less future finance charges	**0**	0		
Present value of minimum lease payments	**257**	267	**257**	267
Less allowance for uncollectible lease payments:	**0**	0	**0**	0
Total finance lease receivable recognised in the statement of financial position	**257**	267	**257**	267
Included in:				
Current finance lease receivables			**0**	0
Non-current finance lease receivables			**257**	267
			257	267

Rental Income	**31 March 2012 £000**	31 March 2011 **£000**
Contingent rent	**19**	19
Other	**0**	0
Total rental income	**19**	19
Finance lease commitments	**0**	0

34 Provisions

	Total	Comprising: Pensions to Former Directors	Pensions Relating to Other Staff	Legal Claims	Restructuring	Continuing Care	Equal Pay	Agenda for Change	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2011	690	0	118	0	0	0	0	0	572	0
Prior period adjustment	0	0	0	0	0	0	0	0	0	0
Merger adjustments	0	0	0	0	0	0	0	0	0	0
Restated Balance 1 April 2011	690	0	118	0	0	0	0	0	572	0
Arising During the Year	1,498	0	1	0	0	0	0	0	934	563
Utilised During the Year	(293)	0	(12)	0	0	0	0	0	(281)	0
Reversed Unused	0	0	0	0	0	0	0	0	0	0
Unwinding of Discount	16	0	11	0	0	0	0	0	5	0
Change in Discount Rate	2	0	1	0	0	0	0	0	1	0
Transfers to NHS Foundation Trusts	0	0	0	0	0	0	0	0	0	0
Balance as at 31 March 2012	1,913	0	119	0	0	0	0	0	1,231	563
Expected Timing of Cash Flows:										
No Later than One Year	1,583	0	12	0	0	0	0	0	1,008	563
Later than One Year and not later than Five Years	176	0	50	0	0	0	0	0	126	0
Later than Five Years	154	0	57	0	0	0	0	0	97	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

	£000s
As at 31 March 2012	32,179
As at 31 March 2011	30,661

Pension provisions are based on expected lives and current levels of payment.

Provisions arising in year relate to service level agreements associated with the TCS transfer, payments in respect of notice period on protected earnings, injury retirement, commercial and legal staff claims.

Redundancy costs relate to active transformation initiatives.

35 Contingencies

	31 March 2012	31 March 2011
	£000	**£000**
Contingent liabilities		
Equal Pay	**0**	0
Other	**0**	0
Amounts Recoverable Against Contingent Liabilities	**0**	0
Net Value of Contingent Liabilities	**0**	0
Contingent Assets		
Contingent Assets	**0**	0
Net value of contingent assets/(liabilities)	**0**	0

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 primary care trusts and the way those primary care trusts 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 may borrow 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 income comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 March 2012 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 trusts, which are financed from resources voted annually by Parliament . The trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The trust is not, therefore, exposed to significant liquidity risks.

36.2 Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000	£000	£000	£000
Embedded derivatives	**0**	0	**0**	0
Receivables - NHS	**0**	5,725	**0**	5,725
Receivables - non-NHS	**0**	3,547	**0**	3,547
Cash at bank and in hand	**0**	3,944	**0**	3,944
Other financial assets	**0**	257	**0**	257
Total at 31 March 2012	**0**	13,473	**0**	13,473
Embedded derivatives	**0**	0	**0**	0
Receivables - NHS	**0**	4,812	**0**	4,812
Receivables - non-NHS	**0**	4,384	**0**	4,384
Cash at bank and in hand	**0**	3,867	**0**	3,867
Other financial assets	**0**	0	**0**	0
Total at 31 March 2011	**0**	13,063	**0**	13,063

36.3 Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
	£000	£000	£000
Embedded derivatives	**0**	0	**0**
NHS payables	**0**	1,674	**1,674**
Non-NHS payables	**0**	12,776	**12,776**
Other borrowings	**0**	526	**526**
PFI & finance lease obligations	**0**	0	**0**
Other financial liabilities	**0**	706	**706**
Total at 31 March 2012	**0**	15,682	**15,682**
Embedded derivatives	**0**	0	**0**
NHS payables	**0**	4,177	**4,177**
Non-NHS payables	**0**	10,770	**10,770**
Other borrowings	**0**	487	**487**
PFI & finance lease obligations	**0**	0	**0**
Other financial liabilities	**0**	1,440	**1,440**
Total at 31 March 2011	**0**	16,874	**16,874**

37 Events after the end of the reporting period

There are no material events after the reporting date of 31 March 2012 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. These entities are:

Revenue Transactions

East Midlands SHA £9.5m (£9.1m)
Northamptonshire Teaching Primary Care Trust £201.8m (£187.4m)
Leicestershire County & Rutland Primary Care Trust £14.7m (£14.9m)
Milton Keynes PCT £6.6m (£7.0m)
Northamptonshire Healthcare NHS Foundation Trust £6.3m (£5.5m)

Expenditure Transactions
NHS Litigation Authority £ 5.0m (£5.1m)
NHS Blood and Transplant £1.5m (£1.6m)

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 £648k (£676k)), Northamptonshire County Council (Pathology Services £151k (£152k)) and HM Revenue & Customs (Employers National Insurance contribution £11.0m (£10.4m), VAT refunds received £2.6m (£2.3m)).
The Trust has also received revenue and capital payments from Northampton General Hospital Charitable fund. The corporate trustee of the NGH Charitable Fund is the Trust Board.
Grants totalling £264k (£478k), 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 £373k (£258k) 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 2011-12 and their total value was as follows:

	Total Value of Cases £s	Total Number **of Cases**
Losses	130,911	286
Special payments	248,598	57
Total losses and special payments	379,509	343

The total number of losses cases in 2010-11and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	136,742	248
Special payments	97,863	70
Total losses and special payments	234,605	318

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 £000	**2006-07 £000**	**2007-08 £000**	**2008-09 £000**	**2009-10 £000**	**2010-11 £000**	**2011-12 £000**
Turnover	164,673	174,041	187,379	206,926	227,805	236,260	255,481
Retained surplus/(deficit) for the year	(2,907)	156	1,834	2,100	(4,958)	1,109	(1,917)
Adjustment for:							
Timing/non-cash impacting distortions:							
Use of pre 1 April 1997 surpluses [FDL(97)24 Agreements]	0	0	0	0	0	0	0
2006-07 PPA (relating to 1997-98 to 2005-06)	0	0	0	0	0	0	0
2007-08 PPA (relating to 1997-98 to 2006-07)	0	0	0	0	0	0	0
2008-09 PPA (relating to 1997-98 to 2007-08)	0	0	0	0	0	0	0
Adjustments for Impairments	0	0	0	729	7,039	0	3,453
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*	0	0	0	0	0	0	0
Adjustments for impact of policy change re donated/ government grants assets	0	0	0	0	0	0	(1,032)
Other agreed adjustments	0	0	0	0	0	0	0
Break-even in-year position	(2,907)	156	1,834	2,829	2,081	1,109	504
Break-even cumulative position	(1,927)	(1,771)	63	2,892	4,973	6,082	6,586

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust'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
	%	%	%	%	%	%	%
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
Break-even cumulative position as a percentage of turnover	(1.17)	(1.02)	0.03	1.40	2.18	2.57	2.58

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

Until 2008-09 the trust was required to absorb the cost of capital at a rate of 3.5% of forecast average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital bears to the actual average relevant net assets.

From 2009-10 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.

		2011-12	2010-11
	£000	£000	£000
External financing limit		**62**	**(972)**
Cash flow financing	**(39)**		(547)
Finance leases taken out in the year	**0**		0
Other capital receipts	**0**		(481)
External financing requirement		**(39)**	**(1,028)**
Undershoot/(overshoot)		**101**	**56**

40.4 Capital resource limit

The trust is given a capital resource limit which it is not permitted to exceed.

	2011-12	2010-11
	£000	£000
Gross capital expenditure	**10,670**	**10,257**
Less: book value of assets disposed of	**0**	0
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(1,583)**	(599)
Charge against the capital resource limit	**9,087**	**9,658**
Capital resource limit	**10,543**	10,420
(Over)/underspend against the capital resource limit	**1,456**	**762**

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 2012	31 March 2011
	£000s	£000s
Third party assets held by the Trust	3	0