NHS
Northampton General Hospital
NHS Trust

Proud to be a part of

University Hospitals of Northamptonshire
NHS Group

Annual Report and Accounts 2021/22

Dedicated to excellence


Welcome

Contents

All NHS organisations are required to publish an annual report and financial statements following the end of each financial year. This report provides an overview of the work of Northampton General Hospital NHS Trust between 1 April 2021 and 31 March 2022 (2021/22).

The report is made up of three parts:

Section 1: Performance Report (Pages 3-41)

Section 2: Accountability Report (pages 42-74)

Section 3: Financial Statements (page 75)

Section 1: Performance Report

Trust Chair and Group Chief Executive's Introduction

On 1 July 2021 we announced that Northampton ('the Trust') and Kettering Hospitals (KGH) had come together to form a hospital group. We also announced that we had achieved University Hospital status, and we would now be known as the University Hospitals of Northamptonshire (UHN) Group. This was the culmination of a long-held ambition and marked the beginning of a new chapter in Northamptonshire healthcare provision. Whilst both trusts remain separate legal organisations and each will produce an annual report, we are pleased to present the first group overview this year. Our opening words are followed by more details about each Trust's performance over the past 12 months, with the analysis in this document presented by our Hospital Chief Executive (CEO), Heidi Smoult.

As we began the new financial year in April 2021, the COVID pandemic was still at large across the country, so managing healthcare in a pandemic has provided a relentless backdrop to the past 12 months. The Hospital CEO will further cover COVID and its impacts on our work in her update later in this report, although we wanted to use this opportunity to note the exemplary commitment from colleagues that has been evident during the past year. Colleagues working across the Trusts, in all disciplines, have worked extremely hard, frequently going above and beyond their roles and responsibilities to care for our communities within a framework of exceptional professionalism and compassion. We are extremely proud to be the Chairman and Group Chief Executive of these hospital Trusts.

The pandemic, however, was not the only area of focus for the hospitals during 2021/22, and amongst other areas where we directed dedicated focus and resources, extensive progress was made on reducing our elective surgery waiting lists to ensure those in need of surgery received their treatments in a timely manner. This has resulted in there being very few patients under the care of the UHN Group waiting more than 52 weeks for surgery, putting Northamptonshire amongst the top healthcare systems in the Midlands region. There has been considerable hard work from teams across both hospitals to achieve this and it should be celebrated.

To ensure the new hospital group delivers improved patient care for Northamptonshire, work is underway to deliver new strategic approaches. In February 2022, we published a clinical ambition that outlines our aim for closer clinical collaboration within the UHN Group, followed by a Group Clinical Strategy in May 2022.

There are four core elements to the clinical ambition;

1. Work with our partners to prevent ill-health and reduce hospitalisation
2. Develop Northamptonshire Cardiology and Cancer Centres of Excellence
3. Protect elective beds to reduce cancelled operations, reduce long waiting times and increase efficiency and
4. Build on our University Hospital status to become a hub for innovation.

During the last quarter of 2021/22, we have hosted a number of engagement events with colleagues and the wider community. These will continue during 2022 as we are keen to hear from those who will use or support our services as we move to a more collaborative model.

Feedback we have received is mostly positive with patients, colleagues and partners supporting a model that will result in improved patient care.

The impact of the ongoing pandemic over the last year has meant that both hospitals have been under sustained and significant pressure. To manage the impact of COVID, the UHN Group had to change the way we managed our bed base to comply with infection prevention guidance, ensuring that our patients and staff were kept safe. This has been a real challenge for our teams to manage and has impacted on the flow and discharge of patients across both organisations. COVID also had an impact on our system partners' capacity and ability to take patients out of hospital when they no longer needed our care, causing long and protracted lengths of stay for some of our patients.

Over the past year, both hospitals have seen attendance to the Accident and Emergency departments increase up to, and beyond pre pandemic levels as communities return to a normal way of life. This, along with the impact of COVID and an increase in the number of patients with a length of stay over 21 days, has meant both hospitals have had a bed occupancy of over 98%. This has meant that flow across the organisations has been slow and has resulted in more patients having to wait over 12 hours for admission into a bed.

Nationally there has been a real concern around ambulance handovers which exceeded 60 minutes or more and, whilst we have had some breaches of this standard, the Group remains committed to timely handovers to ensure that crews can be released back into the community as quickly as possible to care for those most in need.

Both trusts are part of the National "Hospital Only Discharge Programme", which is a great opportunity for us to improve our processes across the organisations and more importantly, the experiences of our patients. The programme commenced in January 2022, and we are already seeing a reduction in length of stay for our over 65-year-olds and we hope to improve this further over the next 12 months.

Despite the pressures described, in March 2022 both hospitals worked hard to reduce length of stay to enable elective care wards to be ring fenced for patients requiring elective surgery; this is essential as we embark on our elective recovery programme.

With the formation of the UNH Group, work is underway to establish a new corporate governance structure to support its ambitions, alongside the requirements of the individual Trusts. We have developed committees in common, with membership from both the KGH and Northampton boards, including People, Finance and Collaboration. These committees bring a cohesive and consistent approach to the complexities of a governance structure that sits over two sovereign hospitals. Ensuring these committees, which are at the heart of how our hospitals operate, run efficiently is a significant challenge, as it involves bringing together the work of two individual organisations that have sometimes functioned as two competing, separate entities in the past. Work is progressing to establish and embed these committees, and we are grateful to the Chairs of these committees and fellow non-executive directors (Neds) for the effort and commitment they have shown to ensure they support the Trusts with the appropriate degree of oversight.

The coming year will see significant 'once in a generation' change in healthcare, with the introduction of the Integrated Care System (ICS) to replace the Clinical Commissioning Groups (CCG). The UHN Group is working closely with the ICS to ensure that it becomes fully functioning in 2022, and that it is supported and effective. We are all committed to addressing

the areas of concern that have arisen in the Northamptonshire Healthcare system, primary of which is developing a sustainable financial framework, with the intention of ensuring the communities of Northamptonshire receive exemplary care throughout their lives.

There were some changes in the compositions of our sovereign boards during the year, which saw us say goodbye to Non-Executive Directors Anne Gill (NGH) and Janet Gray (KGH), welcoming Professor Andre Ng, Elena Lokteva (NGH) and Professor Edmund Burke (KGH). There were some departures from our Executive Teams also, and we extend our thanks to Director of Nursing and Quality Sheran Oke and Chief Operating Officer Jo Fawcus (both NGH), wishing them both well in their future careers.

The past 12 months have marked a turning point for healthcare provision in Northamptonshire, particularly in the acute Trusts. Much hard work has been undertaken to bring the hospitals to this position, and that this has been achieved against the backdrop of an unprecedented pandemic is remarkable. We want to thank everyone at the UHN Group for their continuing hard work and commitment, they have achieved much in the past 12 months.

Alan Burns,

Group Chair

Simon Weldon,

Group Chief Executive

Who we are and what we do

NGH provides general acute services for a population of 380,000 and hyper-acute stroke, vascular and renal services to people living throughout the whole of Northamptonshire, a population of 692,000. The Trust is also an accredited cancer centre and provides cancer services to a wider population of 880,000 who live in Northamptonshire and parts of Buckinghamshire. In addition to the main hospital site, which is located close to Northampton town centre, the trust also provides outpatient and day surgery services at Danetre Hospital in Daventry.

The principal activity of the trust is the provision of free healthcare to eligible patients. They 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 their services from many district general hospitals. They also provide a very small amount of healthcare to private patients. The trust is constantly seeking to expand the portfolio of hyper-acute specialties and to provide services in the most clinically effective way. Examples are developments in both urological cancer surgery and laparoscopic colorectal surgery placing the trust at the forefront of regional provision for these treatments.

The Trust trains a wide range of clinical staff, including doctors, nurses, therapists, scientists and other professionals. The training and development department offers a wide range of clinical and non-clinical training courses, accessed in a variety of ways 6 through a range of media including e-learning. The trust has excellent training facilities which were recently upgraded. Their services may be delivered from their acute hospital site in Northampton or by their staff in the community.

Our Board of Directors

Northampton General Hospital NHS Trust is governed by a Board of Directors. The Board is made up of Executive Directors, appointed to specific roles within the organisation, and Non-Executive Directors, who bring a range of external expertise with them.

CHAIR AND NON-EXECUTIVE DIRECTORS

Alan Burns, Chairman

Alan was appointed as Chairman in December 2018. He has many years' experience as a strategic health authority Chief Executive and is currently Chair of Kettering General Hospital NHS Foundation Trust. Alan was previously Chair of Hinchingbrooke Hospital and Princess Alexandra Hospital in Harlow. He has also been involved in national work on public sector reform and research and development, and was Vice-Chairman of the NHS Confederation.

Rachel Parker

Rachel Parker was appointed as a non-executive director in January 2020. She has several years' board level experience of managing operations and improving performance through a combination of leadership and strategic planning.

Rachel chairs the Finance and Performance Committee and Co-chairs the Collaboration Programme Committee with Kettering General Hospital

Jill Houghton

Jill was appointed as a non-executive director in May 2018. She is currently a registered nurse and has worked as a midwife and health visitor. Jill has had experience in all sectors of healthcare, clinically and managerially within primary and secondary care. As a board member she has been responsible for patient services, quality, medicines optimisation and children, young people and maternity commissioning. Jill was most recently Chief Nurse for Cambridgeshire and Peterborough CCG and is now a Maternity Clinical Lead within the national Maternal and Neonatal Health Safety Collaborative. Jill is the Trust's Non-Executive Maternity champion.

Denise Kirkham

Denise joined the NGH Board in February 2020. As an Executive Resourcing and Organisational Development professional, Denise is highly experienced at working with Boards and Executive teams in an advisory and developmental capacity. Qualified to Level A and B in Occupational Testing, Myers Briggs and ILM 7 Executive coaching studies, Denise has held posts at Director level across sectors. Throughout her consultancy career, Denise has led and delivered on executive and Ned recruitment, major Culture Change projects, organisational structure reviews and Executive coaching. Through her earlier career in the private sector, Denise developed strong business development and commercial skills, and a clear understanding of Customer Focus.

David Moore

David was appointed as a non-executive director of the Trust in August 2018 following six years on the board of Milton Keynes University Hospital NHS Foundation Trust. He spent most of his career in banking with Citibank in a variety of roles, for the most part working internationally. He has significant board experience not only in the private sector but also as a Public Member of Network Rail and as a Lay Member of the Council and Treasurer of the University of Leicester. David is currently a Trustee of the Leicester Students' Union and also sits on the University's Investment Committee. He lives in Daventry.

David is the Trust's Senior Independent Director and Chairs the Audit Committee.

Elena Lokteva

Elena's executive career was in the private equity. Focusing on investments in complex, turnaround situations she managed international teams handling acquisitions and exits across Europe and the Middle East and led restructuring of business in Russia and Finland.

Elena has more than twenty years of board level experience in executive, and non-executive capacities. Her current Ned portfolio includes another two organisations in healthcare sector - North Middlesex University Hospital NHS Trust and St Andrews Healthcare. Elena is a qualified accountant and a Fellow at the Chartered Institute of Management Accountants. Elena is a member of the Trust's Audit and Group People Committees.

Professor G. Andre Ng (Associate, Non-Voting)

André was appointed as an Associate Non-Executive Director in December 2021. He is a consultant cardiologist and electrophysiologist based at Leicester with specialist interest in heart rhythm management. He is a clinical academic and is currently Head of Department of Cardiovascular Sciences at the University of Leicester, with research interests in sudden cardiac death and atrial fibrillation. He is Vice President (Education and Research) of the British Cardiovascular Society and recently appointed as Deputy Chair of the East Midlands Cardiac Network as well as clinical pathway lead for heart rhythm. Andre chairs the Trust's Quality Governance Committee and co-chairs the Group Clinical Quality, Safety and Performance Committee.

EXECUTIVE DIRECTORS

Simon Weldon, Group Chief Executive (Voting)

Simon was appointed as Group Chief Executive for Northampton General Hospital NHS Trust and Kettering General Hospital NHS Foundation Trust in July 2020. Simon was appointed as chief executive of Kettering General Hospital in July 2018, prior to which he was director of operations and delivery within NHS England. As regional chief operating officer for NHS England in London, Simon's responsibilities included public health, primary care and specialised commissioning. He has extensive experience of acute contracting and performance.

Heidi Smoult, Hospital CEO (Voting)

Heidi joined the Trust as Hospital Chief Executive in August 2021. Prior to this, Heidi was at the Care Quality Commission (CQC) where she held the role of Deputy Chief Inspector for seven years. Heidi began her career as a Midwife and has worked in a number of operational roles in NHS Trusts, before leading work at a regional and national level in the CQC.

Jon Evans, Group Chief Finance Officer (Voting)

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

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

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

Matt Metcalfe, Medical Director (Voting)

Matt joined the Trust as Medical Director in the autumn of 2017 having been deputy medical director at University Hospitals of Leicester NHS trust and previously medical lead for the cancer centre there. He is a liver and pancreas surgeon by background and was motivated to join us by our vision to deliver best possible care for all our patients

Debra Shanahan, Interim Director of Nursing and Quality (Voting)

Debra took up this role on an Interim Basis in February 2022, having previously held the post of Deputy Director of Nursing and Quality.

Mark Smith, Chief People Officer (Non-Voting)

In September 2019 Mark was appointed as Chief People Officer across both Kettering and Northampton General Hospitals. Mark has the responsibility for creating systems and processes that engage all staff in living the values of the organisation.

Mark has held a number of roles in Human Resources within the NHS since 2004 and prior to this has held roles within the private sector. Mark joined the Trust from his position as Director of People Development at Barking, Havering and Redbridge University Hospitals NHS Trust, where he led a cultural change campaign which resulted in consistently improving staff engagement outcomes throughout the organisation.

Andy Callow, Group Chief Digital Information Officer (Non-Voting)

Andy was appointed as Group Chief Digital Information Officer across both Northampton General Hospital and Kettering General Hospital in December 2020. He has responsibility for delivery of the digital strategy across both hospitals. For Andy, digital is not a rebadged IT but about a different way of working and across the Group he is striving to apply the culture, processes, business models and technologies of the internet era to respond to people's raised expectations.

Andy is also the Chief Digital Information Officer at Kettering Hospital and brings a wealth of digital experience to the role from a career spanning the public and private sector. Andy was previously Programme Director for the innovative NHS App at NHS Digital and took the app from inception to availability in the app stores in a little over 12 months. Prior to that he was the Head of Technology Delivery for the national NHS website NHS.UK, which receives c40m visits each month.

Stuart Finn, Group Director of Estates and Facilities (Non-Voting)

Stuart's career began in electrical engineering. He has worked in both technical and senior management roles in several industries including airports, automotive manufacturing, semi-conductor manufacturing and facilities management. He joined the Trust in December 2006 and prior to his current role he was the

Head of Estates and Deputy Director of Facilities. Stuart has responsibility for both hard and soft services facilities management as well as our procurement and sterile services departments.

Becky Taylor, Group Director of Transformation and Quality Improvement (Non-Voting)

Becky fulfilled this role on an Interim basis during the year and was appointed to the role on a substantive basis in March 2022.

Palmer Winstanley, Chief Operating Officer (Non-Voting)

Palmer joined the Trust in early 2022 having previously worked in senior operational roles at King's College Hospital, East and North Hertfordshire and Norfolk and Norwich Hospitals.

Our Vision, Values and Group Objectives

We announced our intention to form a hospital group with Kettering General Hospital NHS Foundation Trust in 2020 and appointed Simon Weldon as Group Chief Executive of our hospital, and of Kettering General Hospital NHS Foundation Trust. This is not an organisational merger but sees both Trusts working collaboratively to improve the quality of the care we provide, enable more equitable access to services across the county, and make better use of our valuable resources.

During 2020-2021, we developed plans and arrangements for the new Group, adopting in January 2021 (with Kettering General Hospital) a 'Dedicated to Excellence' Strategy which we officially launched with a public and staff stakeholder event in July 2021, articulating the group's common vision and mission, supported by shared priorities and values. From the outset we were committed to involving staff, volunteers, patient representatives, healthcare partners and other stakeholders in this activity.

We engaged extensively to develop our Group ambition, holding many facilitated discussions within open forums, regular meetings and committees, and with targeted groups using on-line engagement tools. The COVID pandemic provided a challenging backdrop for the engagement programme, and most activities were undertaken virtually owing to the travel restrictions and social distancing measures in place.

More than 1,000 people were directly involved in discussions, with staff across both organisations also receiving regular updates about the emerging vision, mission and values. Staff and members of the public were invited to attend open events and share information via the #LetsTalkNow email, through social media and activities which were also publicised within the local media.

Our Group vision:

Dedicated to outstanding patient care and staff experience by becoming a university hospital group and a leader in clinical excellence, inclusivity and collaborative healthcare.

Our Group mission:

Provide safe, compassionate and clinically excellent patient care by being an outstanding employer for our people, creating opportunity and supporting innovation, and working in partnership to improve local health and care services.

Our Group values:

The Group's core values directly reflect the most common themes shared by staff, patient representatives and other stakeholders during the engagement programme. The top aspirational values we need to nurture have been woven into the vision and mission statements and will form an important part of our Group organisational development plans.

Compassion

We care about our patients and each other. We consistently show kindness and empathy and take the time to imagine ourselves in other people's shoes.

Integrity

We are consistently open, honest and trustworthy. We can be relied upon, we stand by our values and we always strive to do the right thing.

Respect

We value each other, embrace diversity and make sure everyone feels included. We take the time to listen to, appreciate and understand the thoughts, beliefs and feelings of others.

Courage

We dare to take on difficult challenges and try out new things. We find the strength to speak up when it matters and we see potential failure as an opportunity to learn and improve.

Accountability

We take responsibility for our decisions, our actions and our behaviours. We do what we say we will do, when we say we will do it. We acknowledge our mistakes and we learn from them.

Dedicated to Excellence: Review of Progress

The UHN Boards received a progress report on the delivery of the Group strategy at their November 2021 meetings, which celebrated good progress in a number of areas including:

- Achieving University Hospital status in partnership with the University of Leicester and University of Northampton;
- Adoption of enabling strategies for People, Nursing, Midwifery and Allied Health Professional, Academic and Digital;
- Embedding values through Group briefings;
- Launch of a new ENT service model (Ears, Nose and Throat), moving emergency weekend services to Northampton; and
- Appointments to shared leadership posts in finance, transformation, communications and engagement.

Our Group Academic Strategy

The Academic Strategy was adopted in November 2020. It sets out our ambition to achieve international recognition as an academic centre that provides and delivers better health service and outcomes for our patients. The Trusts obtained University Hospital Group status in July 2021 with the Universities of Leicester and Northampton, with the University of Leicester appointing representatives to our Boards of Directors: Professors edmund Burke (KGH) and Andre Ng (NGH). We have grown the numbers of Honorary posts with the University of Leicester and, in recruiting over 3,000 patients into research projects, exceededed our baseline target by 16%. We are looking to develop our partnership with the University of Northampton as we continue to implement a strategy which will generate significant benefits for our:

- Patients, for example through access to new treatments through clinical trials;
- Workforce, for example through the creation of new academic careers, and
- Group, for example through increased income from clinical trials.

Our Group Digital Strategy

The Trusts adopted a Group Digital Strategy in March 2021, setting out the Group's ambition to be the most digital hospital group in England by July 2023. By March 2022, we have made significant progress against each of the eight themes set out in the strategy, with 10 targets complete to a point where:

- 25% of outpatient appointments are virtual.
- End user hardware is more fit for purpose and there is greater ability to collaborate across organisations.
- There were no cyber security incidents during 2021/22
- The Group is a market leader in the automation of coding.
- Clinicians have access to frail patients' data and system-wide complex geriatric assessment, which improved clinical decision making, and
- Phase 1 of the move to a Group Digital function is complete.

Over the next 12 months, key deliverables include the implementation and embedding of new services funded by the Targeted Investment Fund (over £10 million), commencing the implementation of the Electronic Patient Record Programme at Northampton and resolution to technical issues to enable to successful 'go live' of a shared care record for the county.

Our Strategy for Nurses, Midwives and Allied Health Professionals

Nurses, Midwives and Allied Health Professionals (AHPs) form the largest professional groups across both hospitals. As part of our journey to becoming a Group, our Directors of Nursing articulated their joint ambition to work together and to 'ignite the voice' of Nurses, Midwives and Allied Health Professionals. The strategy speaks to being equal partners in the clinically-led group, excel in patient care and be the employer of choice in Northamptonshire. They also wanted to underpin this by aiming to become the first Group of hospitals to be Pathway to Excellence® accredited (NGH is proud to have already obtained this accreditation).

To fulfil this ambition, both Trusts have aligned their Nursing, Midwifery and Allied Health Professional (AHP) workforces by sharing a common voice through the launch of the inaugural Nursing, Midwifery and AHP Strategy.

This Strategy has been developed following engagement with over one thousand members of staff spanning the three professional groups using a range of methods. Following a thematic analysis, five key priorities emerged. These five key Priorities also align with the Pathway to Excellence® Standards which reflect the direction of the Group and our commitment to be Dedicated to Excellence through the creation of a positive practice environment.

The Five Themes which emerged were:

- Provide Safe and Quality Care
- Strengthen Leadership
- Value our People
- Develop our Workforce, and
- Empower and Innovate

Within these themes, the document presents a series of commitments, measures of success and how we will achieve these. These will form the basis of our annual work plans for each organisation encompassing the three professional groups.

Our Group People Plan

In March 2021, both Trusts adopted a Group People Plan to deliver the Group's vision for people in the development of "An inclusive place to work where people are empowered to be the difference".

In September 2021, we provided a progress update on delivery against that plan and set out our priorities for the remainder of the year.

The winter period challenged us more than we had anticipated particularly due to;

- the COVID booster jab roll out,

- the Omicron wave of COVID and;

- new legislation being introduced regarding vaccination as a condition of deployment (VCOD).

The Omicron wave provided significant challenges with regards to resourcing our Trusts and contributed to high absence and unavailability rates in both Trusts.

VCOD, again recognised nationally, resulted in a redirection of resources to sensitively manage the messages and process for implementation with over 2,500 contacts made to support colleagues across Trusts.

Wellbeing has therefore remained at the forefront, and psychological support for staff including the 'Open Office' service and Supporting Our Staff teams including the county-wide 'Stronger Together' programme. We also reintroduced free meals in both Trusts between January to March 2022.

This period has affected our People Plan ambitions, for example our ability to provide education and development and this will need to be addressed as we move forward into 2022/23.

In spite of these challenges, we have secured some key achievements. We have worked with colleagues to address capacity concerns in supporting collaborative change and transformation, which will now enable us to take forward this area of work over the coming months.

We exceededed the overall Group response rate to our regular People Pulse surveys in September 2021 (17%) and January 2022 (15%); these surveys enable us to maintain regular oversight of staff views and allow us to react quickly to embed feedback into our performance frameworks.

We have also continued to on-board and grow our volunteering numbers with 546 active volunteers across the Group and a further 160 in the recruitment pipeline, therefore reaching our goal set out in our people plan for 600 volunteers before 31st March 2022.

Our Group Clinical Strategy

In February 2022, we launched a Group Clinical Ambition (leading to a Group Clinical Strategy, adopted in May 2022), outlining how the Trust would be working together across the Group and system to deliver excellent patient care and improve services for its patients.

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

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

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

Performance Management Framework

During 2021/22, the Group developed a revised suite of 86 key performance metrics to monitor its performance, with the first consolidated report to the Board of Directors submitted in January 2022.

NGH has embedded its Board Assurance Framework (BAF) and Corporate Risk Register, allowing for the alignment and escalation of risks from ward through Directorate and Divisional risk registers up to the corporate risk register. BAF reviews are overseen by the Audit Committee.

Assurance and escalation of the Trust's performance on quality, risk, operational performance and finance is achieved through management action and accountabilities through the Hospital Management Team. Further details are set out in the Accountability Report below

Links to the Integrated Governance Reports, considered by the Board of Directors during the year, are available on our public website: https://www.northamptongeneral.nhs.uk/About/Our-Trust-Board/Meeting-and-papers/Meeting-papers.aspx

Trust Performance analysis

Hospital Chief Executive's Introduction

The past year has been a time of change for Northampton General Hospital. The past year has bought with it new challenges which colleagues have worked to manage in incredible ways, and new opportunities for us to think in different ways than we have before. Firstly, I would like to formally introduce myself as the new Hospital Chief Executive and start by saying how proud I am to be a part of the team at the Trust. I started this role in August 2021, and it has been a real privilege to come into the hospital as CEO, particularly at such a pivotal time for the Trust and the wider NHS.

My first few months have moved at pace, and I have spent a lot of time getting to know as many teams and individuals as I can so I can understand what it's like to provide and receive care here, and how it feels to work here. In the time I have been here, I have had the pleasure of meeting some incredibly dedicated and caring people who are very proud to work for the Trust and the NHS.

Celebrating how we adapted

Teams have continued to work tirelessly to manage the COVID pandemic while ensuring our normal care services resumed. As guidance and restrictions changed, teams showed huge strength and perseverance to adapt and continue to provide the standard of care our local community deserves. The subsequent waves of COVID have each bought with them new challenges and changes to how we have worked as a team. People often describe to me how throughout COVID they have felt as though we were all in it together and shared a common purpose, this shared purpose is one of the things we want to keep. We have worked hard to protect those who needed us and I'm proud of how teams worked to continue with cancer care and support keeping as many routine appointments as possible.

We have also seen a greater demand for our services, especially during the latter half of the year, as the government restrictions were lifted and work began on tackling the backlog of electives, which were put on hold due to the COVID emergency. Where services needed to be paused teams have worked diligently to ensure appointments were caught up. I'm proud that we have also been able to reinstate electives and we hope to support our local community to receive access to the care they need in a timely way.

The pandemic has bought with it so much change and I am so proud by the adaptability and dedication from colleagues at the Trust. Colleagues pulled together to ensure that our patients received the best care and experience in emotionally and physically challenging circumstances. I would like to extend a huge thank you to every member of the our whole team, our volunteers and charity supporters for everything they have done this year.

Investing in our future

Despite the challenges of the COVID pandemic, our passion for innovation and improving care has continued. Patient experience is at the heart of everything we do, and we have worked to improve our site and the facilities available to support patients, visitors and colleagues. In July 2021, we were delighted to open the first of our three new major developments, our new South Entrance. The new entrance provides a more welcoming space when entering the hospital and the addition of new retail units to provide food, drinks and clothing for patients, visitors, and colleagues.

In September 2021 we started treating patients in our new Paediatric Emergency Department. The new £2.9m facility was built in seven months and will provide a separate emergency care space for children in the county. We were thrilled to welcome Her Royal Highness the Princess Royal to the hospital to visit the new unit and officially open the department with a commemorative plaque.

The third of our new buildings, our new Critical Care Unit is due to open in 2022 and will provide a new innovative space to care for our most unwell patients. We also secured funding from the NHSE/I Targeted Investment Fund to purchase a Da Vinci Surgical robot to treat patients with cancer locally.

This new robot is supporting us to reduce length of stay, increase surgical dexterity and improve outcomes for our patients.

Throughout these improvements we are also committing to a greener future and making positive changes to improve our impact on the environment. The first EV charging points have been installed on site and we have installed the first solar panels onto our new Critical Care Unit. As well as this, we have also seen some new residents move into the Trust site as we have installed wildflower meadows to encourage more bees, insects, and butterflies to live at the Trust and improve our biodiversity. You can read more about our sustainability work on pages 36-41 below.

Making the Trust a great place to work

While the past year has changed a lot about how we work we also know that the pandemic has had a huge impact on our people. We know that to provide great care we need great people, and we need them to be feeling their best. I am personally determined and committed to improve the experiences of teams by driving the necessary changes for people to truly be united in making the Trust the best it can be – a place where people feel valued, respected, and empowered. I want to work to make sure we keep the amazing staff we have and support them to implement change and feel valued at work.

Valuing and supporting colleagues' wellbeing has always been a priority, but now more than ever we need to ensure health and wellbeing of our workforce is at the heart of everyday working life. I have been proud to see our Supporting Our Staff (SoS) service progress and develop to support colleagues during the past year. The service provides a space for colleagues to de-brief after challenging incidents, speak about their experiences and gives a safe space to take time away from work and discuss the emotional impact of their roles.

I am also committed to encouraging our teams to think differently and explore ideas with them on how we can make the Trust the best place to work and receive care. We have established a number of staff networks to ensure that we celebrate and embrace the diversity of teams. Our REACH (Race, Ethnicity and Cultural Heritage), DAWN (Disability and Wellbeing Network), PRIDE (LGBTQ+) and VOICE (the Trust Women in Medicine) networks all support colleagues to have their voices heard and provide a space for us to all learn and improve how we do things here.

The people who work here are the experts in knowing what we can do to improve experiences for patients. Often the smaller changes are the ones that have a big impact and I know that teams and colleagues have some amazing ideas to share. Throughout this report you will see many examples of innovation from colleagues, and I hope we will see many more throughout the next 12 months too.

Every single day the Trust teams achieve extraordinary things for our patients, and for each other. Whilst we remain under a large amount of operational pressure, each moment there are extraordinary things happening. I am proud to see colleagues working together as a team and I am delighted to share this annual report with you to share just some of the milestones we have achieved over the past year.

Heidi Smoult, Hospital CEO

Our highlights of 2021/22

March 2021

The Trust was crowned Health and Wellbeing Employer of the Year, at the Skills for Health 'Our Health Heroes Awards', for its staff wellbeing services to support the workforce, both physically and mentally, during COVID and beyond.

The numerous initiatives offered by the Health and Wellbeing Services focus on maximising the emotional, physical, and practical resources available to care for all staff, at every stage of their journeys.

The Trust was also Highly Commended for the Environmental Sustainability Award at the 40th HSJ Awards. The entry was based on the hospital-wide actions that have been taken to reduce our environmental impact.

April 2021

We opened our on-site lateral flow testing unit to support visiting to maternity appointment. The on-site facility supported birth partners to take a free lateral flow test before visiting their partners appointment.

May 2021

We celebrated International Day of the Midwife on 5 May and International Nurse's Day on 12 May, across both the UHN Group. Our volunteer led hospital buggy service resumed their service after a pause due to COVID.

June 2021

We celebrated Volunteers week and took the opportunity to thank our army of volunteers who support our hospital.

The first journey was completed in the volunteer discharge car. The discharge car supports our patients to get home from the hospital safely after an inpatient stay with us.

July 2021

We opened our new hospital entrance to provide staff, patients, and visitors with a more welcoming and contemporary reception area.

The entrance brings a modern new look as well as first-class facilities for staff, patients, and visitors. As well as familiar high-street brands providing healthy, and popular food options as well as a grab-and-go dining and a convenient shopping offer.

We officially launched our new Hospital Group in partnership with Kettering General Hospital and celebrated being awarded University Hospital Status from the University of Northampton. To mark this day in our history, Madam Mayor Councillor Rufia Ashraf, Simon Weldon and volunteers Gabriela Bolohan and Howard Wood sealed the contents of a time capsule containing memories from both our hospitals, to be opened again in 20 years!

Another group of daredevils braved abseiling down the Northampton Lift Tower to raise money for the Northamptonshire Health Charity.

August 2021

We welcomed a new cohort of junior doctors to Northampton General Hospital and said farewell to those doctors who left us for their next placement.

September 2021

Her Royal Highness The Princess Royal officially opened Northampton General Hospital's new Paediatric Emergency Department.

The £2.9m new facility will improve care for the 28,000 children who require hospital emergency department support each year.

The Princess Royal arrived at the hospital and was received by the Lord-Lieutenant of Northamptonshire, James Saunders Watson.

Her Royal Highness then met senior hospital leaders, clinicians, volunteers, and key NHS partners involved in the county's response to the COVID pandemic.

She then had a tour of the new building and met the clinicians and staff that run the department before unveiling a plaque to officially open it.

October 2021

Four midwives from the Trust scooped Royal College of Midwives (RCM) awards, recognising their contribution to maternity services.

Fatima Ghaouch and Samukeliso Sibanda received the first ever RCM Race Matters award for their work in supporting pregnant Black, Asian and minority ethnic patients during the pandemic. As well as providing additional support to these women, they have also been working hard to raise awareness of racial inequalities that exist in the NHS.

Picking up the Excellence in Maternity Care During a Global Pandemic award, Anne Richley and Claire Dale were recognised for their work in keeping community maternity services running during the pandemic. In just a few days Anne, Claire, and their colleagues, set up alternative locations for patients to receive their midwifery support when local services had to be relocated from GP surgeries.

November 2021

The UHN Group held the first Excellence Awards ceremonies to mark the achievements of staff after a year of coping with the global pandemic.

Among Northampton General's 12 winners were an audiology team member whose outstanding support may have saved a 16-year-old's hearing, a doctor whose extra tests found and treated a cancer, and teams and individuals who have gone beyond the call of duty to support patients and colleagues during the pandemic.

December 2021

Specialists at the Trust launched a new treatment for patients with common skin cancers which can help patients to recover faster and without the need for surgery.

The hospital has introduced Skin Brachytherapy - a highly targeted radiotherapy technique used to treat certain types of basal cell or squamous cell skin cancers. It will be available to suitable patients from across the whole of Northamptonshire.

The Northamptonshire Health Charity hosted their annual Light Up A Life event to remember and celebrate life in a positive way.

January 2022

National Plan B Lockdown restrictions were eased across the country. In our hospital restrictions remained in place to help to stop the spread of COVID. Our colleagues supported with our Protect and Respect campaign to remind patients, visitors, and colleagues to wash or gel their hands, wear a face mask and social distance.

February 2022

The Army was thanked by for the valuable support they provided for front-line staff during the Omicron wave of the COVID pandemic. From 18 January – 10 February, 14 soldiers from 3rd Battalion Royal Regiment of Scotland (SCOTS 3 The Black Watch) and The Royal Scots Dragoon Guards (SCOTS DG) worked across the UHN Group.

They provided a much appreciated helping hand to hospital staff at the UHN Group who have been under significant pressure over the last few months coping with the impact of the Omicron variant.

The Trust also introduced a new procedure to help diagnose bowel problems involving a patient swallowing a tiny pill-sized capsule containing a video camera.

March 2022

A state-of-the-art Surgical Robot was used in Northamptonshire for the first time to help improve care for patients and tackle waiting lists impacted by the COVID pandemic.

The University Hospitals of Northamptonshire NHS Group – which runs Northampton and Kettering general hospitals – has invested in the £1.7m Surgical Robot, which is held at Northampton, as part of its clinical strategy.

Performance Analysis: Patient and Quality

This year we have prioritised improving our mortality (a measured by the Standardised Hospital Mortality Index or SHMI) and on reducing harm through work to provide better care for deteriorating patients.

These work programmes have been directed towards the UHN Group quality priorities of best in peer group mortality rates and zero avoidable harms.

The various approaches deployed to reduce mortality for our patients include some disease specific work, including to improve the quality of care for patients with heart failure, and some more generally applicable work. The latter includes the “working diagnosis” project with a real emphasis on supporting our clinical teams to crystallise their clinical plans. Elements of this have been picked up by the board round project, with multiple wards being allocated executive team sponsors to support board rounds, with a view to improving the quality of care and also expediting it where possible.

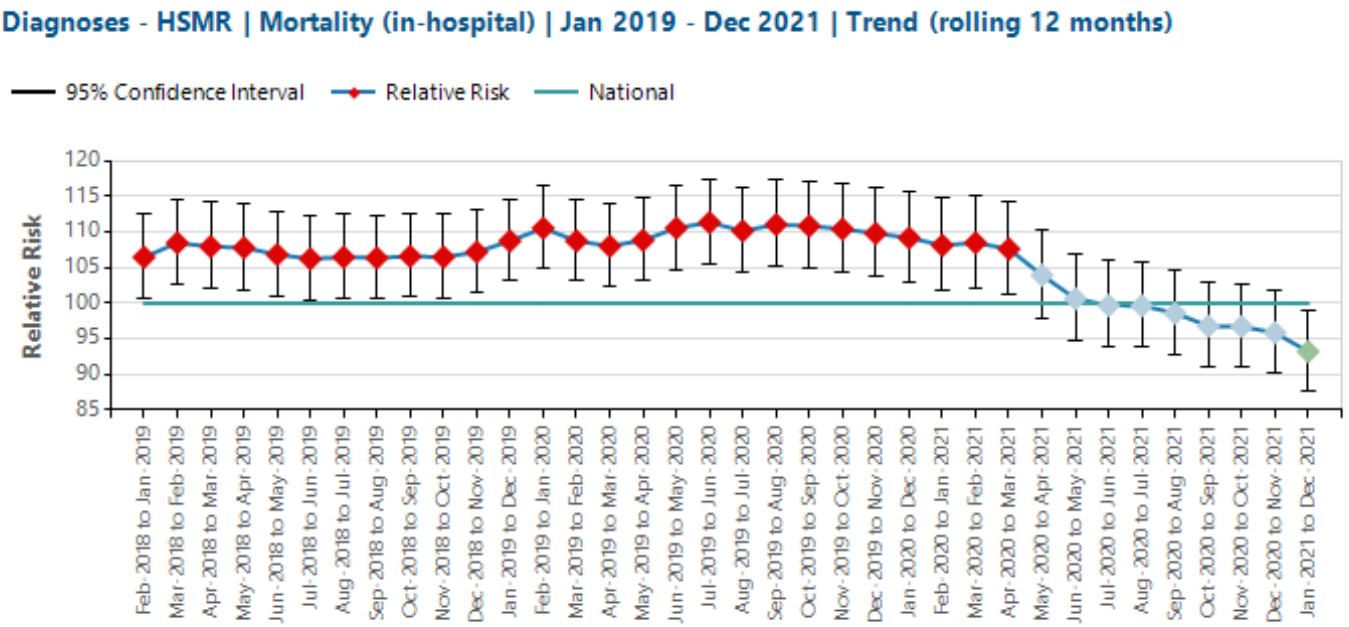
Other work to improve mortality has included providing respiratory specialist care in addition to general internal medicine for patients presenting urgently to our hospital. We have also increased the numbers of doctors working in our hospitals out of hours.

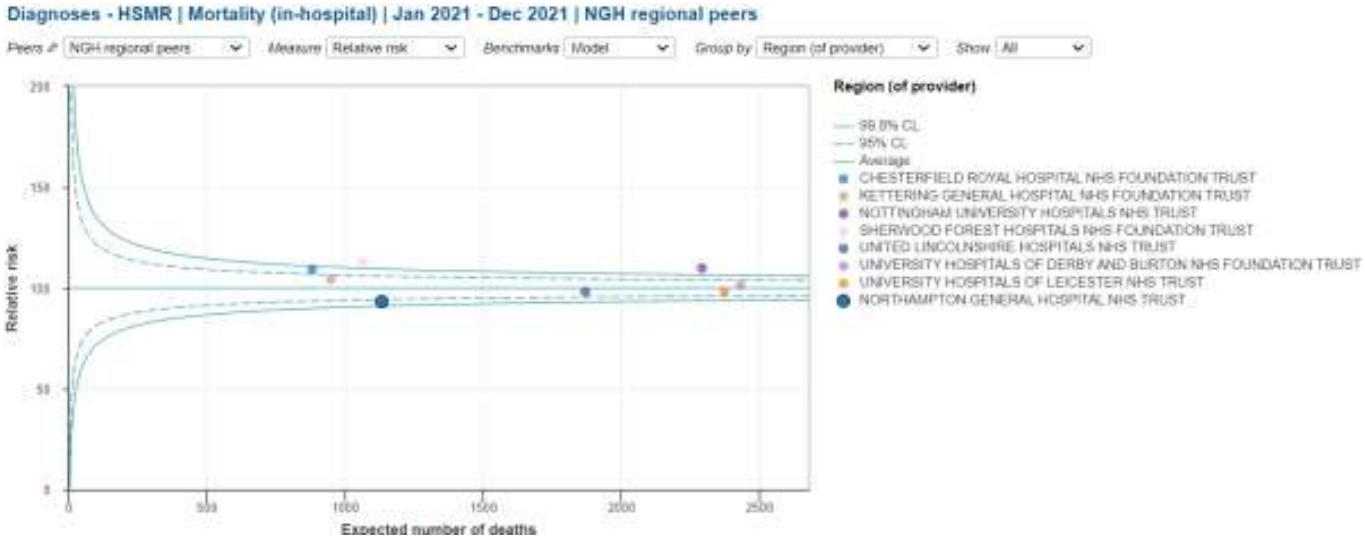
Finally, and linked also with the work to reduce avoidable harms, our work to recognise rapidly and respond holistically to deteriorating patients has gone digital. The patient safety and outreach teams have been able to coordinate their support for our clinical teams through central oversight of patients with high “early warning” (NEWS2) scores and these also trigger a “task list” which guides the clinical teams to ensure all appropriate treatments are considered and acted upon in a timely way.

The net result of these interventions is a substantial improvement in the SHMI at the Trust. A score of 100 is the national average, and during the year our SHMI has reduced from 102.8 to 91.3.

This substantial and sustained reduction is a great credit to all who have worked toward it. Currently an analysis is in progress to ascertain the relative contributions of the various interventions outlined above to the improved position to support future decision making around areas for investment.

The other commonly referenced index of mortality is the Hospital Standardised Mortality Ratio (HSMR). This has also improved substantially over the same time course, from a maximum during the year of 108 to the current 93.2. The current HSMR is statistically better than expected and is currently the best of peer comparator trusts.





The key intervention in reducing avoidable harms has been through the deteriorating patient work programme as described above. The numbers of harms resulting from unrecognised or inadequately responded to deterioration have fallen substantially.

The overall level of harms classified as of “moderate” or above severity have recently increased in line with the increase in level of operational pressure: the hospital operated at OPEL 4, the highest level of operational pressure, for majority of the time during 2021/22 due to the combination of COVID and non-COVID demand, with the additional complexities of keeping patients “COVID safe”, i.e. physically segregating COVID from non-COVID patients. This has in turn been compounded by the frequency of outbreaks of COVID due to the extraordinary infectiousness of the more recent variants. The impact in terms of incidents has been felt in the areas experiencing the consequences of the operational pressure, primarily in the emergency department. There has also been a relatively high rate of harms recorded in the maternity service where levels of midwifery staffing are particularly challenged.

Both of these clinical areas are recipients of internal (e.g. patient safety team) and external (e.g. regional midwifery team) support.

Additional work programmes which will bring down rates of avoidable harm include the deployment of the electronic prescribing system (with built in venous thromboembolism screening and protection), work on junior doctor handovers and prioritisation of systems for work out of hours.

We are confident that these will be bearing fruit in a way that will be demonstrable at the time of the next annual report.

Patient experience

Supporting patients and families during the ongoing pandemic

The ongoing pandemic posed a number of challenges in terms of patient experience and ensuring that patients received the support that they required whilst visiting was suspended. During the pandemic, several initiatives were set up by the Patient Experience Team, the Volunteers Service and the PALS (Patient Advice and Liaison Service) and Complaints teams. These initiatives helped to ensure patients were kept connected with their loved ones, received the essentials and home comforts that they would need during their stay, and were also provided with entertainment to alleviate boredom and isolation. This report will outline these and the impacts that they have had on our patients and their families.

Electronic Tablets on the wards

Letters to Loved Ones

I just want to say a huge, heartfelt thank you, as this service meant more to me than you will ever know.'

Virtual Visiting

In addition to the ward-based tablets, the Volunteers established a Virtual Visiting facilitated service that enabled families and patients to book a facilitated call.

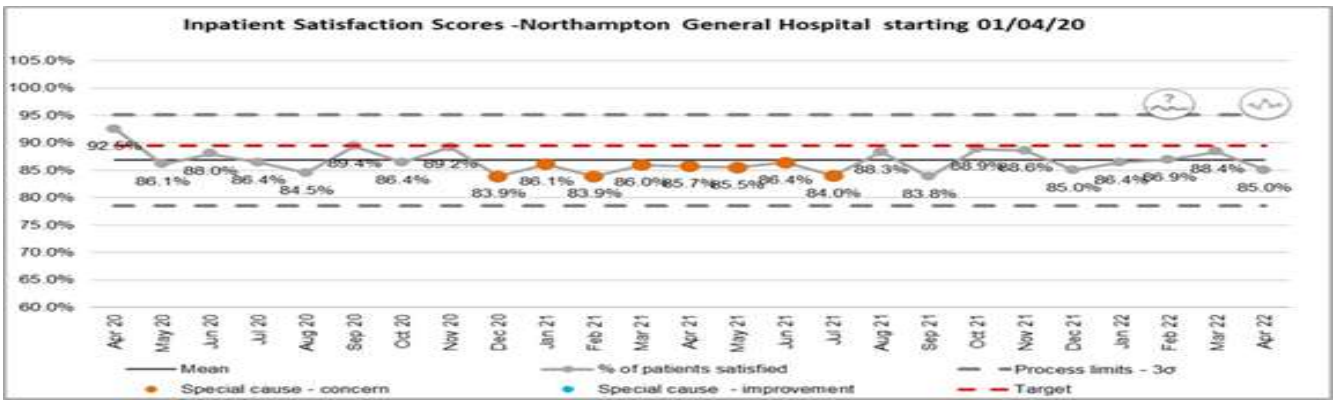
Patient Property Drop off Services

When visiting stopped it became evident that we would need to establish a way for patients to be given their belongings, particularly those that were rushed in as an emergency. The volunteers established a drop off service which ran throughout the pandemic. Belongings which are dropped off are then delivered to the wards the same day.

Supporting patients to give their feedback during the pandemic

Hearing from patients during the pandemic has been important and the hospital continued to do so through text messages and automated calls and now non electronic collection. This has proven extremely valuable, both in providing assurance that patients have had as good an experience as possible, but also to provide the staff with the many thank-you's and messages of appreciation. All negative feedback has continued to be collated, analysed and passed onto the services.

Satisfaction scores have remained between 83% - 88.9%. Since April 2021, satisfaction scores average 84%.



Moving forward

The pandemic has proven to us that technology can be our friend and there is no reason that we should go backwards and lose everything that we have created. The intention is to continue harnessing digital methods to collect feedback. Communication continues to be a theme of dissatisfaction for the hospital and, as part of the work to improve this, an overhaul of the current Developing Patient Information policy and procedure will be undertaken to ensure patient information developed is of high quality and is accessible to all. This will further harness the power of technology through creating leaflets that are on the website and can be translated into multiple languages.

Complaints

The Trust received 455 Complaints in the year 2021/22 which was 126 or 38% more than the previous year:

	2021/22	2020/21
Total no of complaints for the year	455	329
Average response rate within target timeframes	93%	99%
Total no of complaints that required a renegotiated timescale, agreed by the complainant	166	72
Total no of complaints that exceededed the renegotiated timescale	36	1
Complaints that were still open at the time that the information was prepared (8th April 2022[2])	151	32
Total patient contacts/episodes*	710,480	599,080
Percentage of complaints versus number of patient contacts/episodes	0.06%	0.05%

*emergency inpatients elective inpatients, elective day cases, new outpatient attendances, follow-up outpatient attendances, patients seen in Accident and Emergency, number of babies born

Across three months (October, November, December) our response rate dropped below our target of 90%. This followed another COVID increase and coincided with the build-up of winter pressures. Clinical staff were exceptionally busy providing patient care, thus reducing the time available to undertake other duties. In December, the Trust made the decision to instigate an internal pause to support staff which was approximately four weeks. Following this pause, the response rate has improved.

Other Initiatives: Cancer Care

The Trust has undertaken many pieces of work in the past year to improve our patient experience, some of these are shown below.

The results of the 2020 *Cancer Patient Experience survey* were published in November 2021. Participation was voluntary due to the pandemic, therefore no national comparison was available. The Trust maintained the overall satisfactory rating of 8.6. Considering the survey was conducted in the middle of a pandemic, staff should be congratulated for all their hard work during a very difficult time.

The Trust continues to focus on implementing the key elements of the *national personalised care agenda*, including holistic Needs Assessment/Care Planning, End of Treatment Summaries and Health and Wellbeing

Evidence continues to grow about the benefits of *prehabilitation before surgery* and other oncological treatment for cancer. Prehabilitation prior to colorectal surgery has been launched at the Trust. Patients are given written information about the benefits of prehabilitation during their first consultation, and directed to the cancer webinar platform where information is available to help them prepare physically and emotionally for surgery. Due to the success of the initial pilot, a business case has been developed for a dedicated prehab/rehab service to provide specialist holistic assessment and treatment for those diagnosed with cancer across Northamptonshire from the point of diagnosis and throughout the treatment pathway. The benefits of prehab/rehab are well documented with providers seeing reductions in length of stay and improved patient outcomes.

The Trust is hosts monthly *'walk and talk'* sessions for anyone affected by cancer. Patients have the opportunity to walk with other people living with cancer, share their experiences whilst getting support from the Macmillan Information and Support Lead.

The Northants Cancer Information *You Tube channel* was launched in December 2021. This will enable anyone affected by cancer to have access to information and support to guide them through their cancer journey.

The *Macmillan Information Centre* has developed a quarterly newsletter to promote the service and the activities available for patients, this ensuring patients have access to events to support their needs. The newsletter promotes the monthly national cancer awareness campaigns and how the Trust is responding locally.

The Trust is working with the East Midlands Cancer Alliance to stratify *pathways for people living with cancer.* The Trust is one of two hospitals within the region who have all the elements in place for prostate, colorectal and breast cancer pathways.

The work led by the Urology Cancer Clinical Nurse Specialists, supported by Rachael Lovesy and the Macmillan Cancer Recovery Package Team as part of the cancer improvement collaborative was shortlisted for the Patient Experience Network (PEN) award. There were seven hospitals shortlisted in the CPES category and following the presentation on 15th September, the Trust was announced as the winner. The Trust was approached by NHS England to share its experience, working with patients at a national forum called "Shining the Light" . This is held four times a year where hospitals who can demonstrate true partnership working with those with lived experience are invited to show case their work and the Trust participated in November 2021.

The Trust underwent its *'Getting it Right First Time' Lung Cancer assessment*; overall, the Trust received positive feedback on its achievements including being identified as an exemplary site for information and support for patients at the beginning of the pathway. It also highlighted areas that the Trust is aware of that need improvement relating to respiratory medicine and diagnostic capacity.

The Trust participated in the *GRAIL trial* in February 2022. The study relates to a blood test that could detect approximately fifty types of cancer early, supporting the national drive to detect and treat cancer earlier. Northamptonshire was the second area to take part in the study. People between the ages 50 and 75 were invited to take a blood test which would go to the United States, where the samples would be studied with the results returning to Kings College. Patients with a relevant signal in the blood were contacted and referred to the Trust on the 2-week pathway. Patients received additional support from the Macmillan Information Centre whilst on the pathway. Cancers have been detected for trust patients during this trial, which could change the screening programme for cancer in the future and presents an exciting opportunity.

Performance Analysis: Operations

Despite challenging circumstances and continued emergency and operational pressures, this year has concentrated on restoration and recovery and a 94% reduction in the backlog of patient waiting over 52 weeks for treatment was achieved.

Winter and COVID were challenging across the health and social care economy again this year and a Level 4 National Incident was declared with routine Elective activity cancelled from 16th December 2021 recommencing in February 2022. Subsequent cancellations and prioritisation of P1's/Cancers resulted in a marginally increased position in respect of waits over 52 weeks.

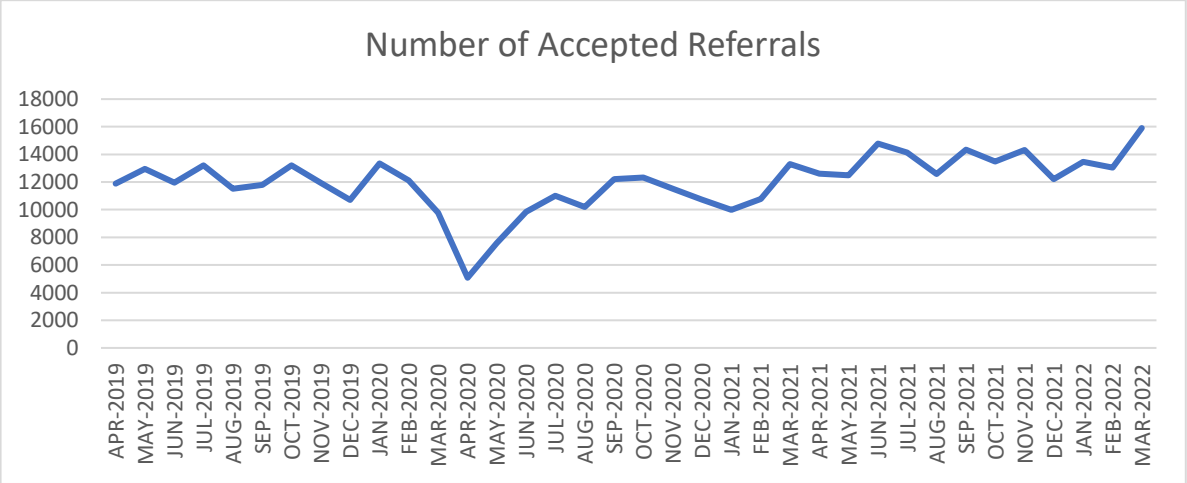
Whilst Regionally and Nationally, the 52-week wait has been significantly challenged, the Trust throughout the year has had the lowest backlogs in the region being one of the lowest regionally and retains this position.

Whilst the 6-week performance for diagnostics was not achieved this year, there has been significant improvement in performance from 79.5% in March 2021 to 91% in March 2022 and many modalities are delivering activity over 100% above baseline which is comparative regionally.

National Performance Standards

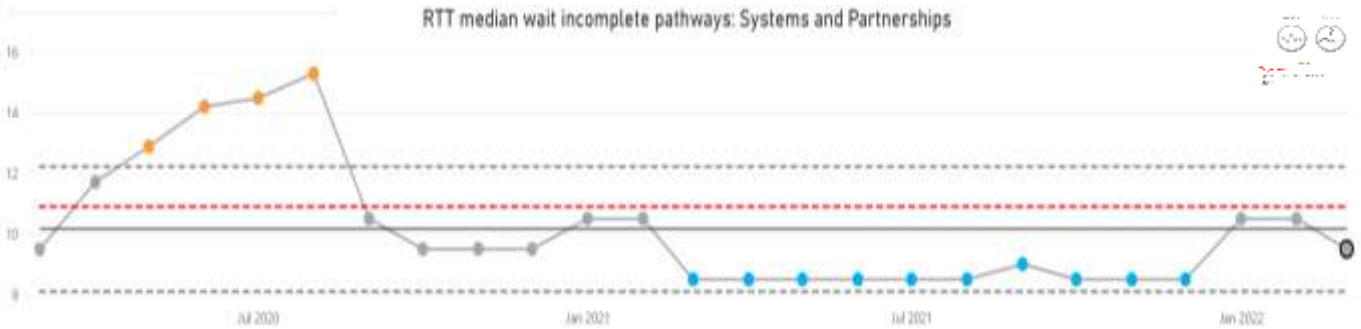
The COVID pandemic required significant pathway changes in hospital to ensure our patients and our staff remained safe.

Referrals



The chart above provides a three-year trajectory for this indicator. During 2021/22, we have seen a 31% average increase in accepted referrals compared to the previous year. This has contributed to an increased waiting list size. The Trust is working with the system on demand management and triage methodologies to mitigate.

Median Waits



The Trust continues to be a pilot site for the reporting on the new national standard for elective care. The pilot, which began in July 2019, remains in place, and notes the average time to treatment. The Trust has delivered against the target during the whole year and continues to achieve.

Waits of over 52 weeks

Due to COVID, the previous year had seen pressure on the Intensive Care Unit intensifying, resulting in the main theatre complex being used to create capacity to support intensive care. Elective capacity in the remaining theatre areas was used to treat cancer and urgent patients and to ensure there were suitable theatre areas to treat COVID and non-COVID patients. This, combined with additional operational pressures resulted, in the backlog at the start of the year.

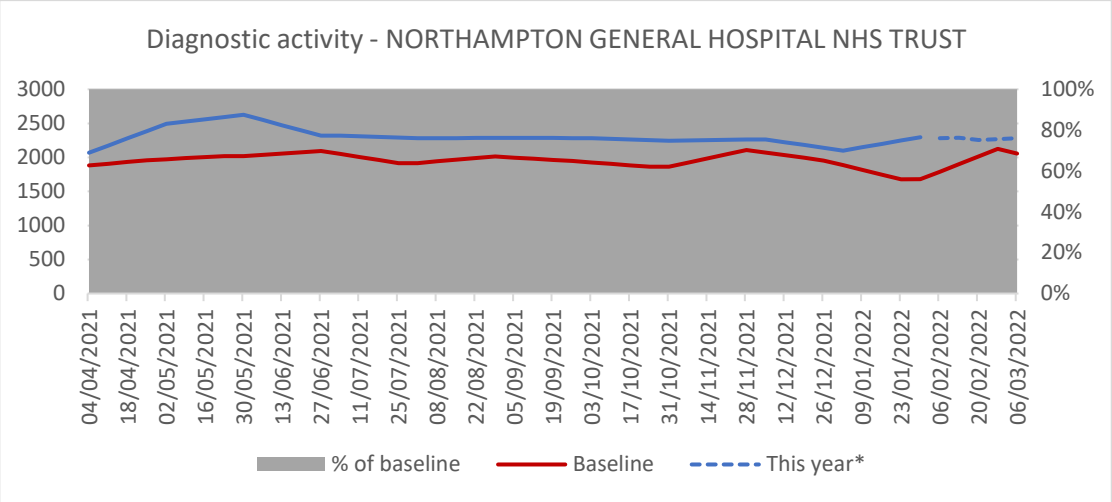
Divisions focused on plans to support restoration and recovery of the position to include insourcing, Waiting List Initiatives and restoration of base capacity using a phased approach to re-open theatres and Compton ward for Trauma and Orthopaedic . Use of the independent sector was also undertaken where possible.

This has seen the Trust's 52-week wait backlog reduced from 723 patients waiting over 52 weeks at the end of March 2021 to 40 patients waiting over 52 weeks at the end of November 2021 and a year end March 2022 position of 84 patients waiting over 52 weeks. A 94% reduction in the backlog was achieved.

Regionally and nationally, the 52-week wait has been significantly challenged; however, the Trust throughout the year has had the lowest backlogs in the region and retains this position.

6-week diagnostic target

Whilst the 6-week performance for diagnostics was not achieved this year there has been significant improvement in performance from 79.5% in March 2021 to 91% in March 2022.
This has not been without challenges as, once activity was able to be restored following the first wave, the Trust has seen reduced capacity due to Infection Prevention and Control guidelines, increased Inpatient demand across all imaging modalities and Increased emergency attendances.



Urgent Care

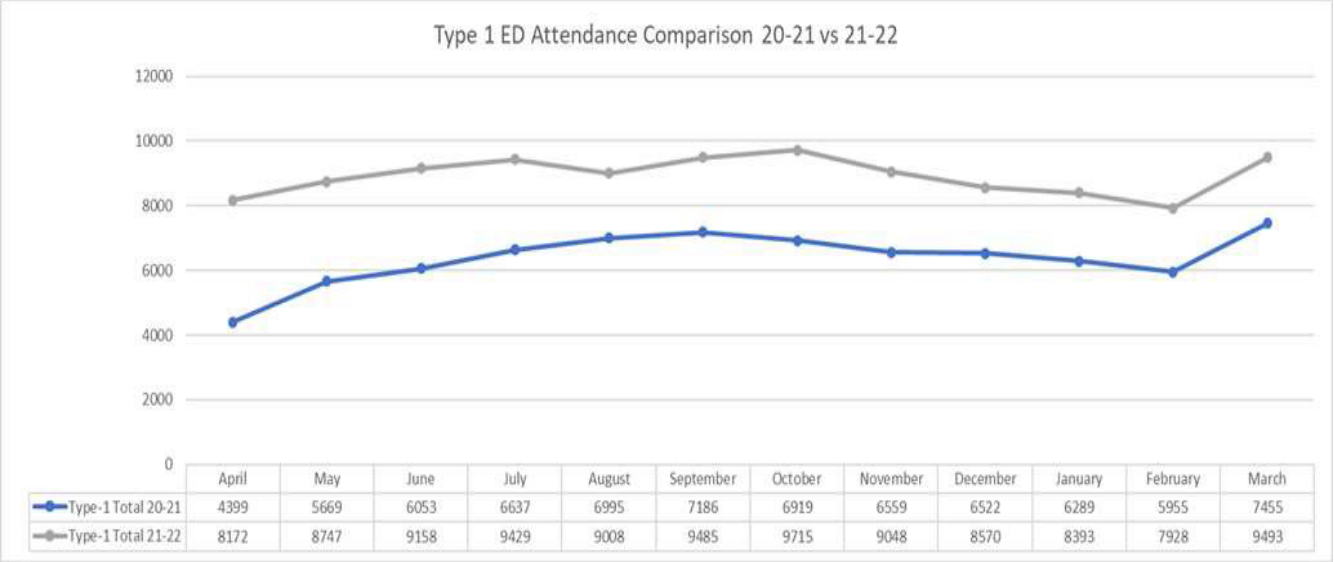
With the increase in attendances at A&E, we have experienced significant challenges in meeting some of the national performance standards. The COVID pandemic required significant pathway changes in hospital to ensure our patients and our staff remained safe.

This was most notably observed in the ability to move patients out of A&E in a timely way with many delays related to COVID screening required, the ability to offload ambulances due to sheer volume of COVID presentations and lack of physical space. The ability to fully access our bed base with large numbers of beds 'trapped' due to COVID exposure was also a factor. There were also significant ward moves due to the need to contain COVID exposure, all of which have contributed to put significant and sustained pressure on bed base and flow out of A&E.

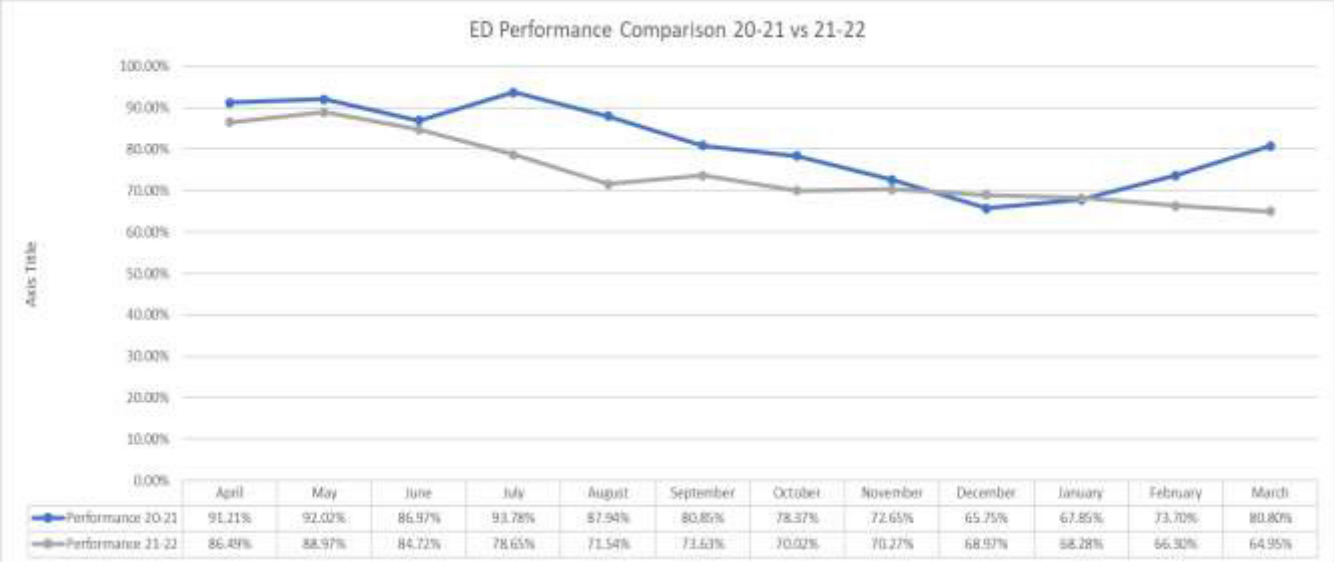
A&E was frequently 'gridlocked' in terms of having no outflow into the bed base, and a change was made to place patients into beds based on clinical priority, clinical need for space in that particular area of ed, and patient needs. This has increased the number of patients waiting on trolleys for 12 hours or more.

We have also reduced our non-elective bed base by having a ring-fenced bed base to support elective activity.

A&E	Target	Q1	Q2	Q3	Q4
Percentage of patients waiting < 4 hours	95%	86.70%	74.65%	69.77%	66.44%
Trolley Waits in ed > 12 hours	0	0	0	205	1077



	April	May	June	July	August	September	October	November	December	January	February	March
Type-1 Total 20-21	4399	5669	6053	6637	6995	7186	6919	6559	6522	6289	5955	7455
Type-1 Total 21-22	8172	8747	9158	9429	9008	9485	9715	9048	8570	8393	7928	9493



	April	May	June	July	August	September	October	November	December	January	February	March
Performance 20-21	91.21%	92.02%	86.97%	93.78%	87.94%	80.85%	78.37%	72.65%	65.75%	67.85%	73.70%	80.80%
Performance 21-22	86.49%	88.97%	84.72%	78.65%	71.54%	73.63%	70.02%	70.27%	68.97%	68.28%	66.30%	64.95%

Cancer waiting times standard

During 2021/22 the continued recovery of cancer services remained a priority for the Trust, with a commitment to reducing our long waiters, ensuring the best possible outcome and experience for our patients.

Whilst performance overall was variable, the Trust performed well in comparison to the other trusts in the East Midlands, and against the national average performance.

The Trust was placed third in the region for the year for its performance against the 62-day standard, achieving 71.4%; no trust in the region met the standard overall in 2021/22, showing how challenging recovery has been following COVID.

As the Trust participated in the 28-day faster diagnosis pilot, it has not been performance -managed against the 2-week wait standard; however, we recognise patients attending their first outpatient appointment or straight to test diagnostic in less than 14 days accelerates their pathways to treatment. The Trust was placed first in the region for 2-week waits, exceededing the standard at 93.6%, and was the only trust in the region to meet this standard for the whole year.

The Trust was placed second in the region for its performance against the 28-day faster diagnosis standard, surpassing the 75% standard at 80.3%.

The Cancer Strategy Group has continued to meet throughout the year overseeing our performance and strategic goals for cancer.

Performance for 2021/22 by quarter

April 2021 to March 2022

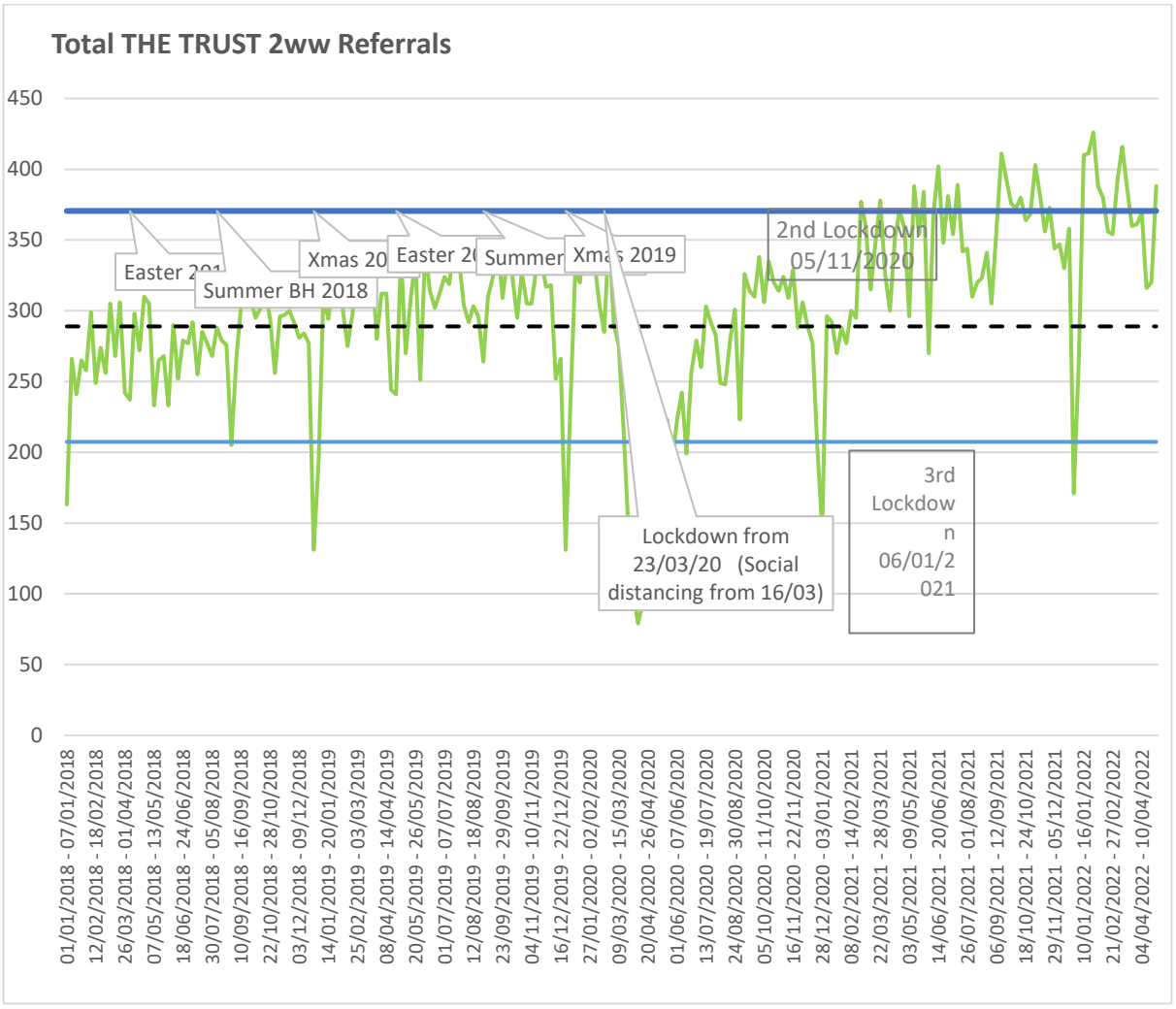
Indicator Title					
Cancer Waits 31 Day	**Target**	**Q1**	**Q2**	**Q3**	**Q4**
31 Day First Treatment Standard - Target = 96% (Operational Standard)	96%	95.4%	95.2%	95.7%	93.4%
31 Day Subsequent Treatment Standards DRUGS	98%	98.2%	98.3%	96.6%	100.0%
31 Day Subsequent Treatment Standards RADIOTHERAPY	94%	95.0%	95.4%	96.9%	95.9%
31 Day Subsequent Treatment Standards SURGERY	94%	93.1%	90.9%	77.3%	92.0%
Cancer Waits 62 Day	**Target**	**Q1**	**Q2**	**Q3**	**Q4**
62 Day First Treatment Standard - Target = 85% (Operational Standard)	85%	77.5%	72.7%	69.1%	67.5%
62 Day Screening Standard - Target = 90% (Operational Standard)	90%	93.4%	88.0%	88.9%	90.1%
Cancer Faster Diagnosis Standard	**Target**	**Q1**	**Q2**	**Q3**	**Q4**
Cancer Faster Diagnosis Standard - Target = 75% (Operational Standard)	75%	83.1%	79.0%	78.8%	79.9%

Performance against our strategic goals

Receipt of 2-week wait referrals

A 'Two Week Wait' referral follows a request from a General Practitioner (GP) to ask the hospital for an urgent appointment for a patient who has symptoms that might indicate that they have cancer.

The year before COVID the Trust received 15,621 referrals. During 2021/22, 18,609 rereferrals were received which is an increase of 19%, this is illustrated below:



This increase in referrals has added pressure to all elements of our clinical pathways, from initial outpatient capacity, diagnostics, histopathology, multi-disciplinary team discussion and treatment planning. To be recognised regionally and nationally against the increase in demand is a real achievement by all teams supporting the cancer pathways.

Clinical Pathway Improvements

The Trust has been at the forefront of innovation delivering cancer treatment this year, supported by national transformation funds.

This culminated in the arrival and implementation of the Da Vinci Robot; initially introduced to support the delivery of robotic urology surgery for patients who previously travelled to Leicester, often experiencing long waits, the robot will also support all patients in the UHN Group and beyond.

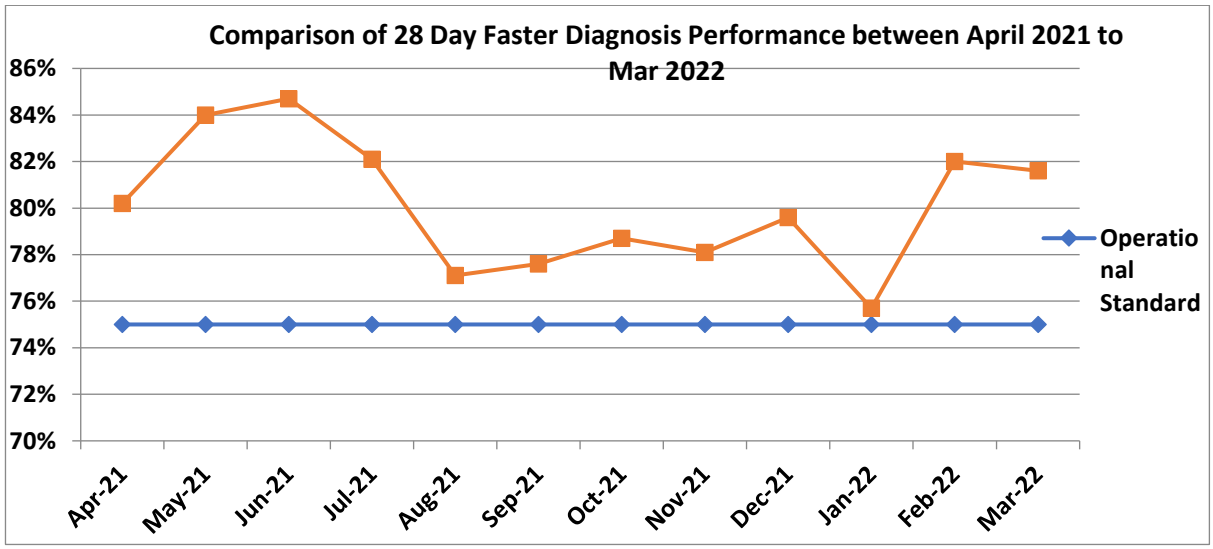
Some examples of pathway changes are shown below which have improved patient experience, outcomes as well as improving our overall performance:

- Clinical triage and straight to test for the colorectal pathway
- Introduction of Capsule Endoscopy- THE TRUST recognised nationally as a best practice trust
- Introduction of a pilot for teledermatology for the skin pathway,
- One stop pathway for gynaecology and breast
- Local Anaesthetic template biopsies for the prostate pathway
- Pathology is currently looking at making available rapid genomic testing for oncogene variants to support cancer pathways. Currently specimens are referred to Genomic Hubs for full DNA/RNA panels using next-generation sequencing. This is a time-consuming test and hubs can struggle to meet the required turnaround times.

28 Day Faster Diagnosis Standard

Once parliament approves the removal of the 2-week wait standard, the 28-Day Faster Diagnosis will be the first measure for patients on a cancer pathway. During 2021/22 the Trust met the standard and often exceededed it every month, illustrated below.

With a conversion rate of 7% in 2021 delivering the message a patient does not have cancer in a timely manner is imperative for our patients' wellbeing, and in turn frees up trust capacity to treat those with cancer quickly to ensure the best possible outcomes.



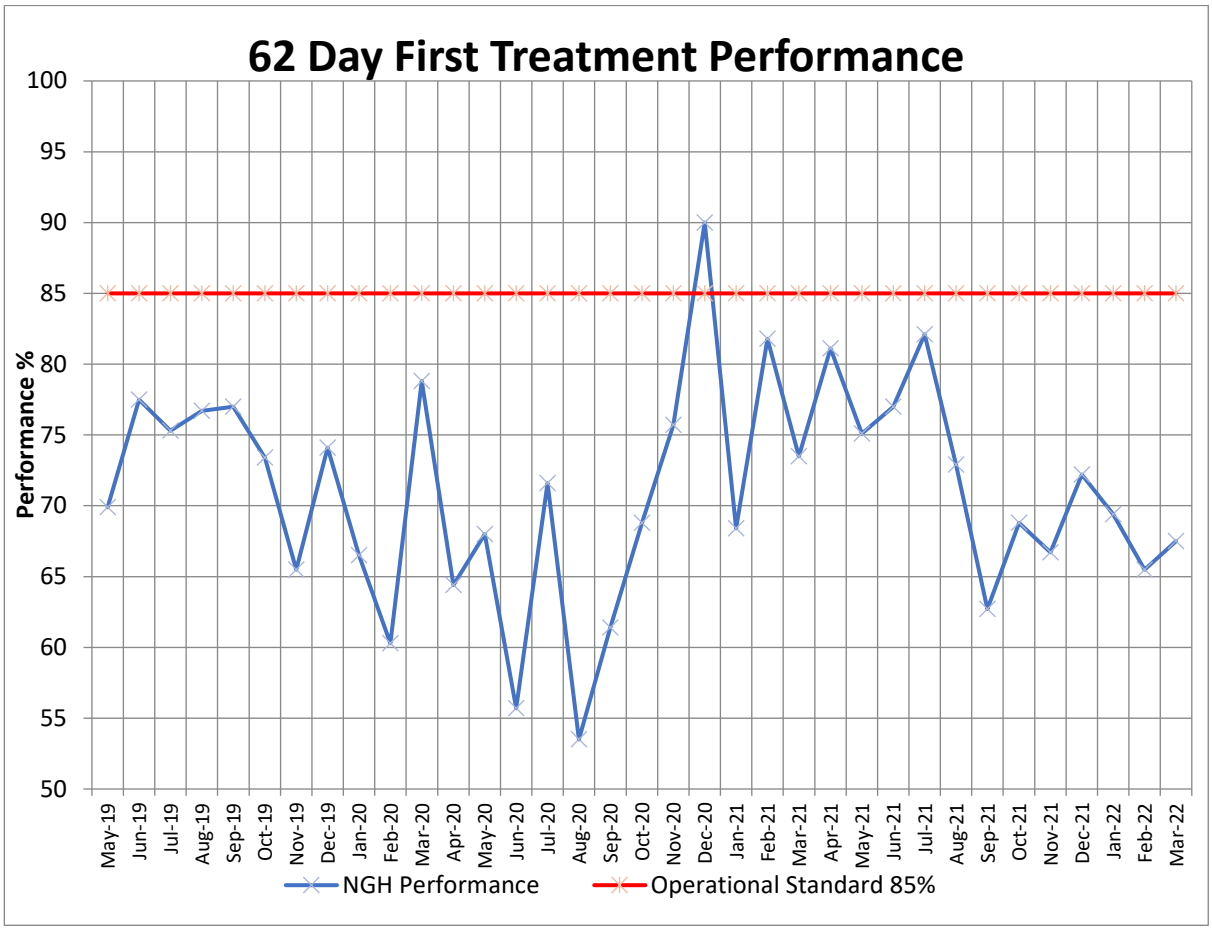
62 Day First Treatment

It is recognised nationally meeting the 62-day standard is challenging. Trusts were asked to provide a trajectory to NHSE/I for 2022/23 showing how they would reduce their legacy patients rather than when they expect to meet this standard, recognising recovery of this standard starts with the reduction in long waiters.

Monthly 62-day performance against the 85% standard is shown in the table below. Quarterly performance was as follows:

2021/22

- Quarter 1- 77.5%
- Quarter 2- 72.7%
- Quarter 3- 69.1%
- Quarter 4 - 67.5%



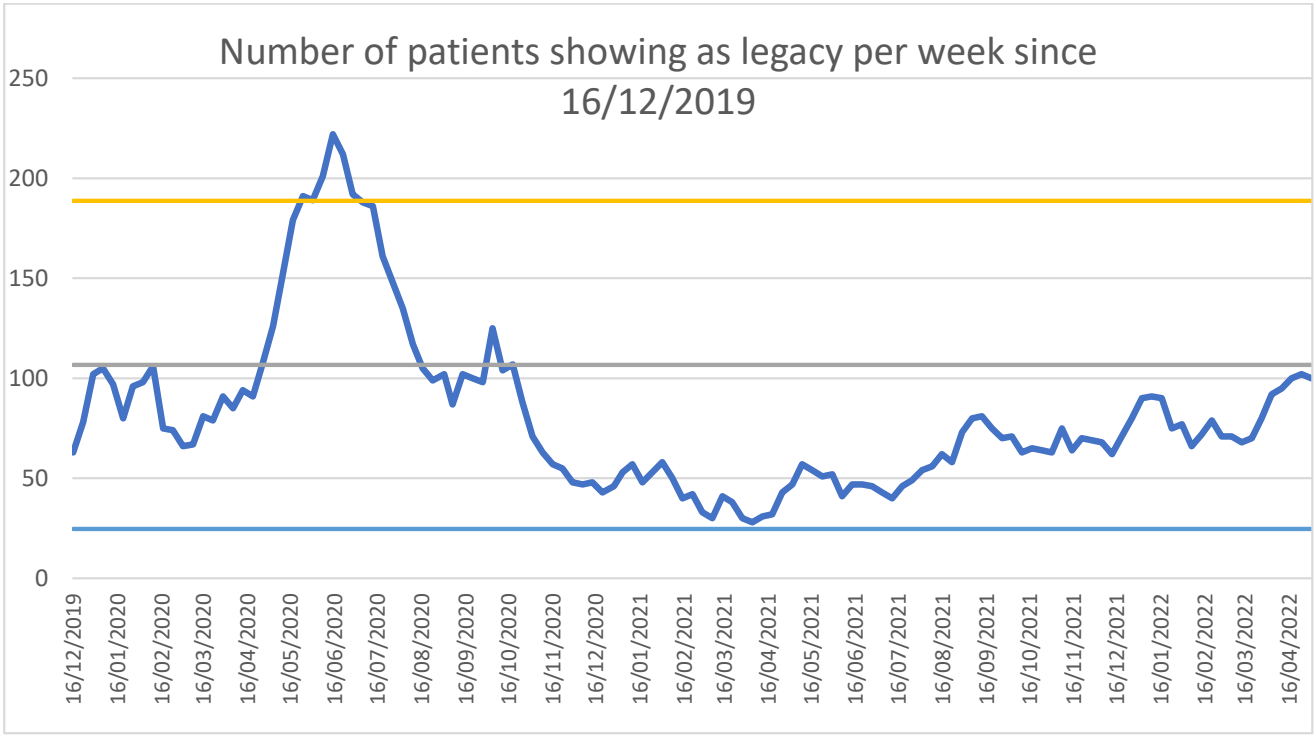
Reducing Patients on pathways beyond 62 days

The Trust has been committed in the past year to reducing patients on their pathway beyond 62 days. The management of patients is overseen by site teams, and the corporate patient tracking list meetings, with 'deep dive' meetings as required with the Deputy Chief Operating Officer, Clinical Director for Cancer, Directorate Manager for Cancer and Divisional Manager for Surgery.

The Trust escalation policy identifies patients not meeting key milestones for clinical teams to flex capacity if able.

As a cancer centre, we continue to receive referrals for treatment of patients: 88% of these in 2021/22 were received after day 38 on the pathway, leaving the Trust 24 days to treat, which has been very challenging due to surgical capacity and oncological planning and capacity.

Whilst our legacy position has had peaks and troughs in the past year, it has never exceededed pre-COVID levels. Northamptonshire as a local care system has been identified as being in the top 25% performing areas.


Number of patients showing as legacy per week since 16/12/2019
250
200
150
100
50
0
16/12/2019
16/01/2020
16/02/2020
16/03/2020
16/04/2020
16/05/2020
16/06/2020
16/07/2020
16/08/2020
16/09/2020
16/10/2020
16/11/2020
16/12/2020
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16/05/2021
16/06/2021
16/07/2021
16/08/2021
16/09/2021
16/10/2021
16/11/2021
16/12/2021
16/01/2022
16/02/2022
16/03/2022
16/04/2022

Workforce

Vacancy

Vacancies have been stable over the year with focused activity to recruit internationally educated nurses and Health Care Assistants (HCAs) as well as ongoing recruitment in all professional groups. We have recruited 103 nurses from overseas, reducing our ward nursing vacancies with the overall Trust vacancy position for nurses being 7% at year end. A particular focus on recruiting new HCA into the Trust has been undertaken, including the use of an apprentice pathway. Apprenticeship pathways have also been developed for a number of professional groups including Radiographers and Operating Department Practitioners. International recruitment of medical staff has been successful this year, contributing to reducing the medical staff vacancies to a rate consistently beneath the 9% target.

Turnover

Turnover has been stable over the course of the year and consistently beneath the 10% target; however, during the latter part of the year, levels began to rise compared to pre-pandemic levels. During the pandemic, the labour market slowed as people did not leave employment – now we are seeing turnover increasing as people are enacting decisions delayed by the pandemic (retirement and career progression and the buoyancy in the labour market is creating competition for the lower skilled and more mobile workforce). Where turnover has increased, this is being addressed through comprehensive recruitment and retention plans ensuring staff experience and career development opportunities are attractive and fulfilling. At 31 March 2022, turnover was 9.47%.

Sickness absence

Sickness absence has steadily risen throughout the year as the cumulative effects of the pandemic are felt. Absence rates were above the 3.8% target all year and ended the year at 6.65%. Colleague attendance at work has been impacted particularly by absence due to COVID infection, anxiety and depression. The Trust has put in place several mitigations to support colleagues to remain well and at work, including an enhanced wellbeing offer, mental health support and access to Stronger Together, our county-wide psychological support service. In addition, we help managers to support their staff by ensuring access to timely information, promoting a companionate dialogue and ensuring managers know what assistance they can offer.

Appraisal

The ongoing impact of further waves of the pandemic in summer 2021 and early winter 2022, have made it extremely challenging for the Trust to achieve its target appraisal completion rates, which were at 73.71% against a target of 85% at 31 March 2022. We continue to promote ‘Appraisal Light’ as an alternative means of completing appraisal, allowing managers to focus on short-term objectives and wellbeing. During 2022/23, we will be revising our appraisal process to ensure it meets the needs of the Group workforce and is aligned to our Excellence values.

Mandatory training

Mandatory training completion rates have been above 85% target throughout the first half of the year with a gradual decline experienced during the second half ending with a compliance rate of 84.26% in March 2022. Information is available about completion rates, enabling managers to target support and also offering a range of ways to complete mandatory training, including videos and workbooks as well as the usual on-line provision. Some of the mandatory training that was previously face to face has now moved online and this has further improved accessibility. Our next target will be to align our mandatory training requirements across the University of Northamptonshire Hospitals Group to enable our staff to work at either Trust.

Sustainability 2021-2022

In November 2021, the Board approved an ambitious Green Plan that aims to reduce our carbon emissions, improve our resource efficiency, reduce air pollution, educate our staff, and adapt our estate and services using innovation and digital technologies. The Green Plan was created by the multi-disciplinary Sustainable Development Committee which includes staff from clinical and non-clinical departments.

Over the last twelve months:

- Carbon emissions from heat and power have remained approximately the same as the previous year
- All purchased electricity is from renewable sources
- The Trust has been awarded a £20.6 million government grant to reduce the carbon emissions from our buildings in a two-year programme of works.
- Water consumption has increased
- Carbon emissions from inhaled anaesthetic gases have reduced beyond NHS targets
- The first electric vehicle charging points were installed for visitors in car park 1 and staff in the admin block car park
- Investors in the Environment Green Accreditation has been maintained at the highest accreditation rating
- The first NHS Net Zero Apprentice has been employed and will commence their employment in May 2022.
- The first solar panels for the Trust have been installed on the new ICU building
- Diversion of clinical waste from infectious orange bags to the offensive waste stream has increased, and
- We have installed outdoor air pollution monitors at strategic points across the site

Net Zero 2040

THE TRUST is committed to Net Zero 2040 as defined by the Greener NHS Strategy. A summary of the contribution to this target from the different sources, and the change from 2021/22 is illustrated below. Increases seen over the previous year are as a result of increased clinical activity carried out on the site. From April 2021, all of the electricity that the Trust purchased from the grid was from renewable sources, thus reducing the carbon emissions by 586 tonnes CO2:

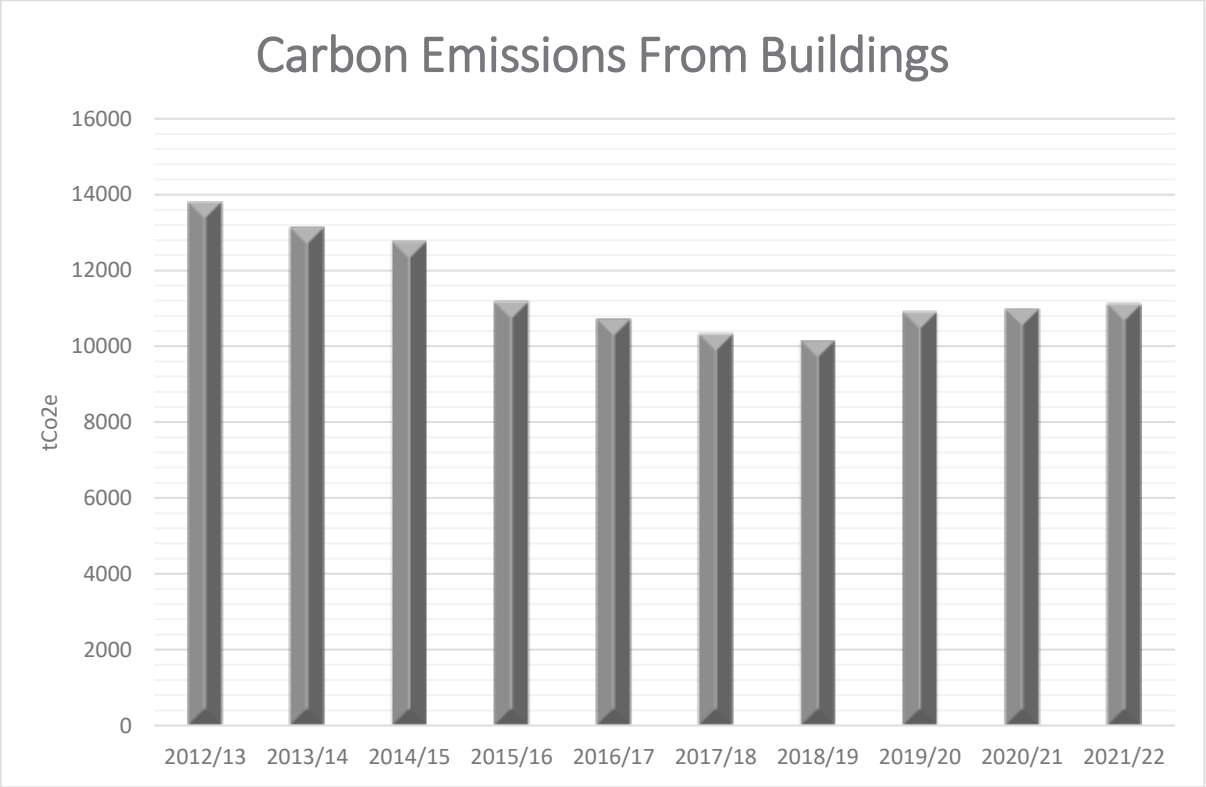
	2020/21	2021/22
Energy (gas, electricity and renewables)	10,972 (10,389 excluding grid electricity offset with a REGO)	(excluding grid electricity from renewable sources)
Anaesthetic gases including nitrous and Entonox	1330	1539
f-gases	232	131
Business mileage	147	186
Water	58	66
Waste	29	39
Metered Dose Inhalers	99 (13.6 kg per inhaler*)	67 (8.27kg per inhaler*)
SF6	Not measured in 2020/21 but	Not measured in 2021/22

Financial and usage data for the main utilities are shown below. Increased activity and ventilation requirements for COVID prevention measures, as well as the addition of the new retail units at the South Entrance are the cause of this slight increase in utility consumption and costs.

	2019/20	2020/21	2021/22
Consumption Data			
**Gas kWh	53,404,918	56,298825	56,550,091
***Electricity kWh	16,149,232	16,097,978	16,603,105
Biomass	2,311,903	2,409,394	2,932,205
Water m^3	145,610	137,930	156,935
Business Travel miles	864,579	533,787	692,304
Financial Data £			
Gas	1,214,892	1,252,413	1,300,780
Electricity	617,927	436,061	537,580
Biomass	204,646	176,301	176,300
Water	382,926	342,673	379,610
Business Mileage	375,389	212,749	296,993
Renewable Heat Incentive	(91,048)	(114,000)	(98,773)

** includes gas to the CHP

*** includes electricity generated from the CHP and imported from the grid

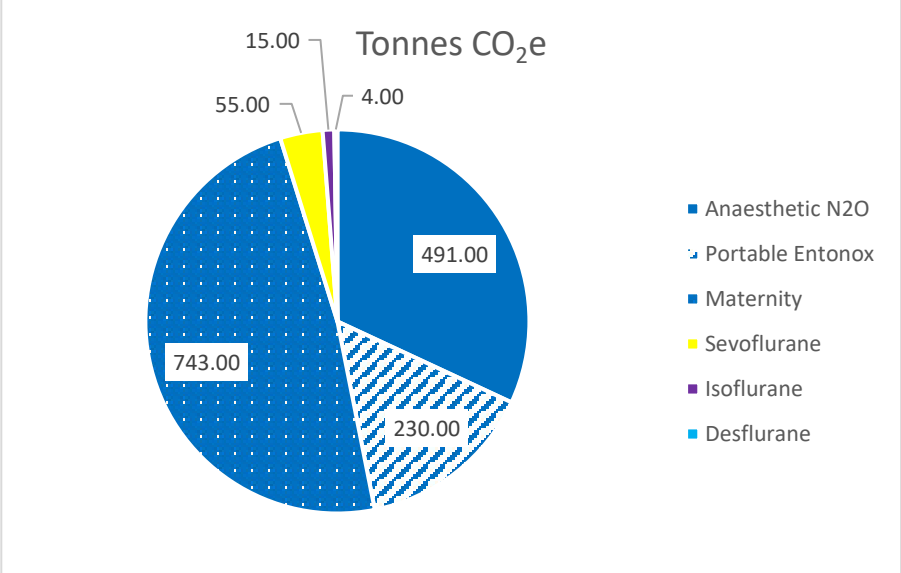


Carbon emissions from buildings have increased, which is a result of ventilation measures to reduce COVID infection and additional buildings on the site; however, in March 2022, the Trust was awarded a £20.6 million government grant to reduce the carbon emissions from buildings. This is an ambitious two-year programme of works which will see the site partially move from steam generation for heating and hot water, currently provided in part by three 50-year-old boilers, replacing one of the boilers with an air source heat pump. It will also allow us to install more efficient motors and lights and start the process of adding more solar panels to the roofs. This will reduce our carbon emissions by approximately 30% and utility costs by around £500,000 per annum, with some offset against increased maintenance costs.

A major source of carbon emissions in hospitals is the use of anaesthetic gases. The NHS has included a reduction in the use of the volatile agent desflurane to less than 10% by volume in the standard contract for 2021/22. In the coming year this target is reduced to below 5%. The anaesthetists at the Trust reduced this to less than 1% in 2021/22, with the majority of operations now being carried out using less environmentally harmful agents. In addition to the environmental benefits, this has generated a £40,000 financial saving.

	Sevoflurane	Isoflurane	Desflurane
2018/19	62%	4%	34%
2019/20	74%	5%	24%
2020/21	85%	7%	8%
2021/22	92.9%	6.7%	0.4%

Nitrous oxide use as an anaesthetic and in maternity areas is also a source of carbon emissions in hospitals. At the Trust, the carbon emissions have increased to previous levels as theatre activity has increased. In 2022, a team of anaesthetists will work with Pharmacy and Estates to determine whether some of this is due to leaks in the system and therefore can be reduced to much lower levels. The total changes in CO2e emissions from all anaesthetic gases is shown below, illustrating the improvements seen since this area was targeted in December 2019.



	2018/19	2019/20	2020/2021	2021/22
Isoflurane	16	16	9	15
Sevoflurane	67	58	31	55
Desflurane	695	366	58	4
Total Volatiles	**778**	**440**	**98**	**74**
Anaesthetic N_2O	507	503	293	491
Portable Cylinders N_2O	410	316	264	230
Maternity Entonox	826	704	675	743
TOTAL CO2e (Tonnes)	**2521**	**1963**	**1330**	**1539**

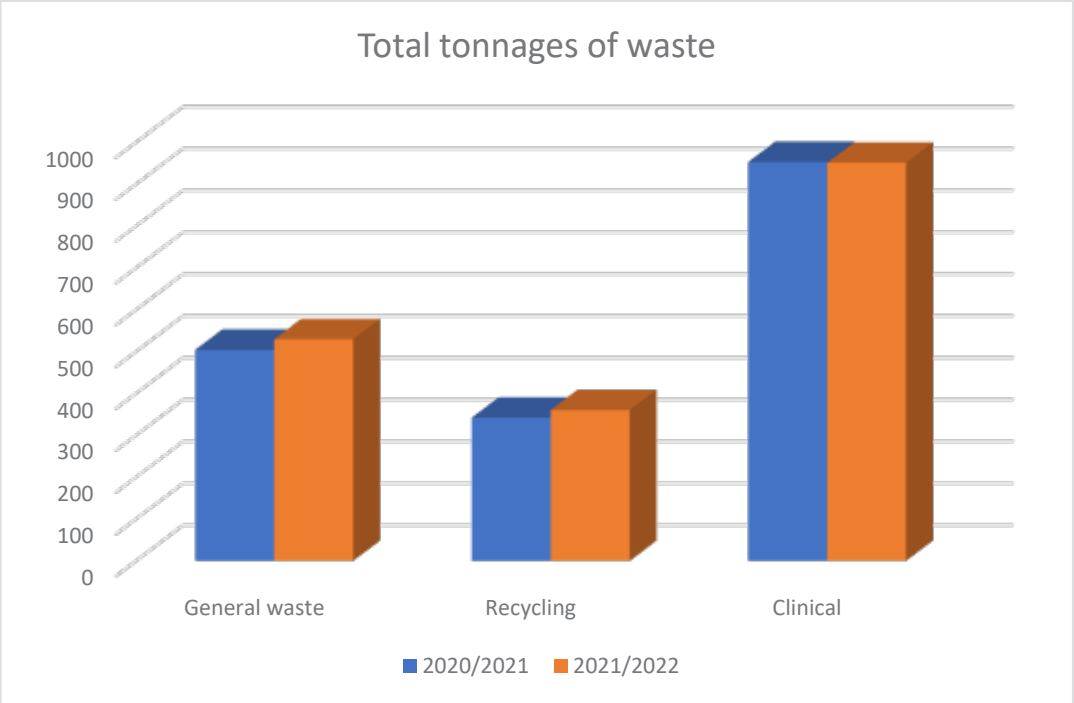
NB the previous years, calculations have been updated to reflect the change in global warming potential of Nitrous oxide in the 5th IPCC report published 2022.

Water

Water consumption has increased above levels seen in the last two years. The reasons for this are as yet unclear. A new contract with Wave Utilities includes the installation of loggers on the meters to tackle some of this uncertainty. A project to review the areas of high consumption will also be carried out next year to allow the installation of fixed water meters on areas of high consumption. In addition, we will trial some more efficient sanitary ware.

Waste

Total tonnages of waste were similar to 2020/21 levels despite increased activity on site, with a slight increase in both general waste and recycling of around 20 tons.



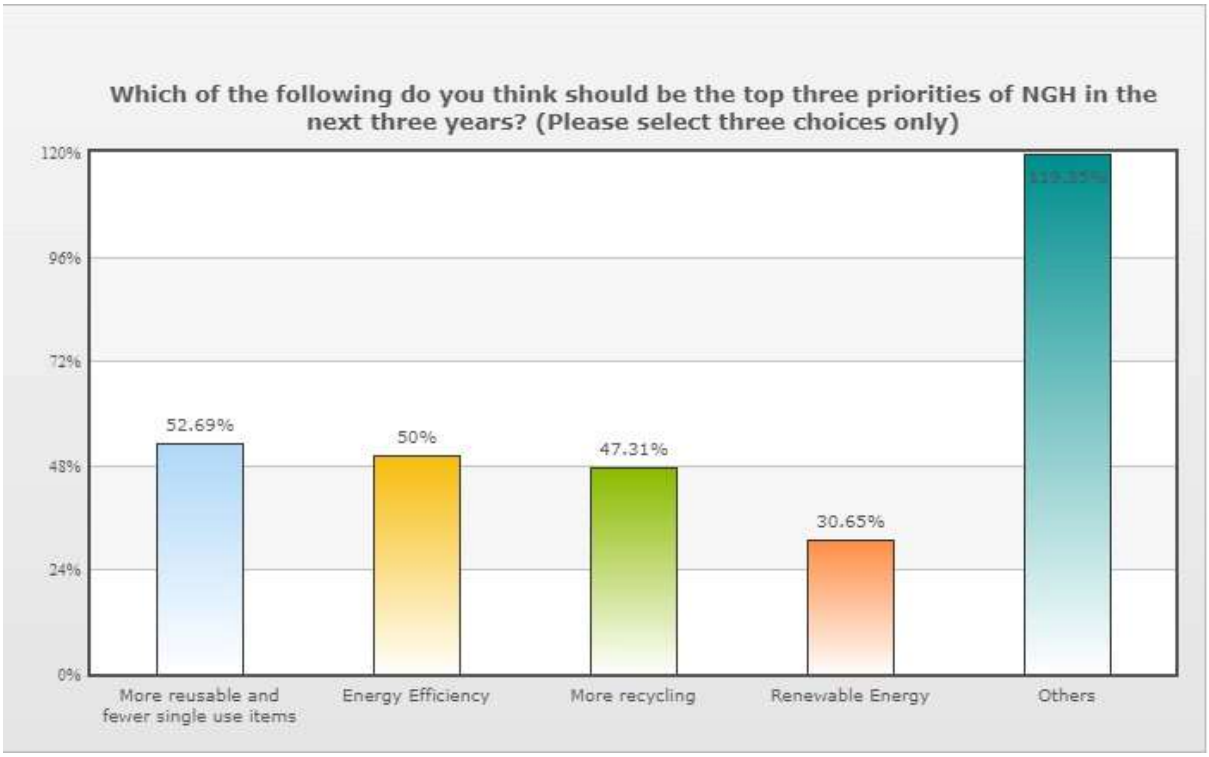
Although clinical waste volumes remained the same, the composition changed as more waste was moved into offensive (non-infectious) waste streams which has a lower disposal cost. This is also in line with the NHS Strategic plan to change segregation, including targets for the treatment of clinical waste streams relating to High Temperature Incineration (HTI), Alternative Treatment (AT) and Offensive Waste (OW). The desired volumes follow a 20:20:60 ratio (20 HTI:20 AT:60 OW). To achieve the desired ratio the Trust will have to divert more clinical orange bagged waste into offensive waste wherever permissible to do so, whilst also reducing the volume of recycling and domestic waste that enters the clinical waste stream.

20:20:60 ratio	2020/21	2021/22	Target
Offensive waste	30	42	60
Alternative treatment	61	47	20
High temperature incineration	9	11	20

The Trust has also joined the Health Plastics Recycling Council, advising manufacturers in order to reduce the amount of non-recyclable plastics in use in the NHS, a major source of clinical waste.

Sustainability Survey

The Trust carried out a sustainability survey of staff early in 2022. There were 185 respondents out of which over 25% were interested in becoming more active in reducing the environmental impact of the Trust. The top priorities for the coming year were as shown below:



These are being incorporated into the Trust's Action Plans for the next year and results will be communicated via intranet pages and newsletters.

Other Sustainability Initiatives

The Northamptonshire Healthcare Charity has generously supported the running of a Green Team competition by the Centre for Sustainable Healthcare across the county. This will allow teams within the Trust to have support to carry out a green project in their area, with the financial, environmental and social impacts assessed and, where possible quantified. The projects will be run in the spring and summer of 2022.

Sustainable Healthcare, considering the impacts of climate change on health and the impact of healthcare on the environment has been included within the teaching curriculum for doctors in training. It also forms part of the innovation module of the Trust's MSc in Patient Safety and Quality Improvement.

The Trust also started to look at ways to improve its biodiversity on site and the first areas were left unmown to encourage pollinators.

A sustainability group has been set up in theatres, with representatives from Procurement and Infection Prevention also attending.

The catering team almost eliminated food waste from one of the children's wards through better stock rotation and a switch to boxed meals.

New cycle racks were added for visitors outside the new entrance and the first EV charging points were added for visitors.

The Trust continued to play an active role in the West Northamptonshire Sustainable Food Places accreditation.

Actions for 2022/23

- Install more EV charging points for staff
- Install more efficient kitchen equipment for cooking patient meals
- Replace the majority of lights with Led
- Start the installation of the heat decarbonisation scheme.
- Complete the installation of pollution monitors
- Install further data loggers on the water systems
- Review the items used in theatres to reduce the number of unnecessary items
- Create a Green Shared Decision-Making Council
- Run the workshops and projects for the Trust Green Team Competition
- Create intranet pages to keep staff up to date with our Green Plan progress
- Reduce general waste volumes entering the clinical waste stream
- Create an online waste segregation training resource for all staff members
- Increase reuse of furniture through Warp-It
- Investigate innovative ways to reduce plastic use in collaboration with HPRC
- Create more wildlife friendly areas
- Promote ebikes to staff including free trials in partnership with the local council.

Simon Weldon

Group Chief Executive Officer

21 June 2022

Section 2: Accountability Report

Corporate Governance Report

(prepared in accordance with guidance issued by NHS England and Improvement in compliance with sections 3.57-3.59 of the Group Accounting Manual 2021/22.)

Group Chief Executive's governance statement

1. Scope of responsibility

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

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Northampton General Hospital NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control is in place and has been maintained in Northampton General Hospital NHS Trust for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Governance arrangements for risk management are as follows:

- **Group risk management:** The Trust and Kettering General Hospital (KGH) Foundation Trust are working together under a Group Management Model to strengthen acute care service provision across Northamptonshire, under the leadership of a jointly appointed Chair and CEO for both Trust Boards.

  A common approach of working across both organisations with emphasis on acute pathway transformation and quality improvement is recognised as a priority. Working in a Group Model across both organisations maintains the statutory duties and responsibilities of two separate Trust Boards.

  As part of the collaboration planning work, and to facilitate the seamless implementation of Group Priorities following approval by Boards in January 2021, both Trusts have established Finance and Performance, Quality, Digital, Strategic Development and People Committees in Common. Committee in Common meetings are a recognised governance approach that enables collaboration between organisations to take decisions together on projects that

cross boundaries without compromising the integrity of their own statutory requirements. These committees are responsible for reviewing and monitoring any strategic risks to both organisations but will retain separate Board Assurance Frameworks and Corporate Risk Registers.

- **The Group Chief Executive**: takes Board-level responsibility for governance, including risk management, and has overall responsibility for maintaining an effective risk management system and for meeting all statutory requirements. Executive directors and clinical directors have delegated responsibility for governance and risk management arrangements within their areas of control.

- **Board of Directors:** The Board of Directors and Group Chief Executive ensure that the risk management arrangements are implemented, monitored and reviewed, and meet all legal and regulatory requirements. The Board receives reports from its Committees on the Trust's risk control measures.

- **Audit Committee:** The Audit committee has overall responsibility for independently monitoring, reviewing and reporting to the Trust Board on all aspects of governance, risk management and internal control. It is supported in this role by all Board Committees.

- **Finance and Performance Committee:** The Finance and Performance committee undertakes on behalf of the Trust Board objective scrutiny of the Trust's financial plans and major investment decisions. Additionally, it is responsible for overseeing the delivery of all key performance metrics and is also responsible for the oversight of the Trust's Operational Estates and procurement functions.

- **Quality Governance Committee:** The Quality Governance committee monitors, reviews and reports on the quality and safety of services provided by the Trust. This includes the review of governance, risk management and internal control systems to ensure the delivery of safe, high quality, patient centred care.

- **Group People Committee:** The People Committee monitors, reviews and reports on the organisational development and workforce performance of the Trust. This includes the achievement of associated key performance indicators and advising the Trust Board on key strategic organisational and workforce initiatives. In 2021, the People Committee has been revised to a joint Committee in common meeting with KGH.

- **Group Digital Hospital Committee:** The Digital Hospital Committee oversees strategic aspects of the NGH and KGH Group's digital, technology and information agenda.

- **Assurance, Compliance and Risk Group (ARC):** The ARC Group is chaired by the Deputy Director of Governance, Quality and Assurance providing executive oversight of risk management issues. The group is responsible for ensuring the development and implementation of effective systems and processes for risk management at each level of the Trust.

- The Trust has a Governance team with a focus on integrated risk management. The team supports the process of identification, assessment, analysis and management of risks and incidents at every level of the organisation and aggregation of results at a corporate level.

- In each of the Trust's Divisions the Divisional Director has lead responsibility for governance and risk issues and is responsible for coordinating risk management processes, including management of the Divisional risk register supported by the Divisional manager. The Divisional management

groups have responsibility for monitoring, managing and where necessary escalating risks on their risk registers and significant risks are reviewed at monthly performance review meeting.

- Data Governance Group: The purpose of the group is to set a clear direction of travel in respect of Data and Information Governance and to provide the Trust Board with the assurance that effective governance for data quality and protection is in place. The Data Governance Group is attended by key stakeholders across the Trust which includes clinical and operational leaders.

  The Trust's Senior Information Risk Owner (SIRO) is the Digital Director and is responsible for taking ownership of information risk and advising the Group Chief Executive accordingly. The SIRO works closely with the Medical Director as Caldicott Guardian and the Data Protection Officer.

- Risk management training is delivered to staff in accordance with the Trust's risk management training needs analysis. This begins at corporate induction which all staff are required to attend.

3. The risk and control framework

The Trust has adopted an integrated framework for risk management supported by policies and procedures. This provides a comprehensive framework for the management of principal risks and is mapped to the Trust's principal and strategic objectives. These are in turn mapped to the risk register to assess the potential risks that threaten the achievement of the Trust's objectives, the existing control measures, and assurance in place.
There is an established governance framework for risk management which includes high level committees, Trust Board and Quality Governance Committee and their sub committees including the Assurance, Risk and Compliance Group (a sub-group of the Quality Governance Committee) to divisional governance committees and department level risk groups

The Risk Management Strategy 2019-2022 was reviewed in November 2020 and updates against the actions are presented to the Assurance Risk and Compliance Group. The Trust policy for the Assessment and Management of Risk was approved in December 2019. A six-month extension to the policy has been agreed whilst the Group's risk management arrangements are reviewed. The policy sets out the approved Trust framework and procedures for risk assessments, risk scoring and management of risks.

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

The policy details the agreed definition of risk appetite, which is consistent with the Risk Management Strategy.

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

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

Communication and consultation is undertaken with internal and external stakeholders when appropriate. The Trust has continued to develop communication channels with its partners, and

within the Trust. Regular reports are prepared for directorates and divisions, the Quality Governance Committee and the Trust Board on the incidents reported, both clinical and non-clinical.

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

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

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

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

The Group People Committee regularly receives assurance reports in respect to safer staffing to ensure adherence to the National Quality Board requirements 2018. This assurance includes the provision of monthly safe staffing review and six-monthly Safe Staffing Review of Inpatient Staffing Levels. Assurance against the requirements of the NHSI 'Developing Workforce Safeguards' guidance is reported and monitored through the People Committee.

The Trust uses a range of workforce-planning methods:

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

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

Clinical teams have access to key performance data. Data sources for dashboard indicators include staff HR metrics (e.g., staffing levels, sickness levels and bank staff usage), patient feedback, numbers of complaints, audit outcomes, numbers of incidents reported and CQC self-assessment rating (NB this list is not exhaustive).

The Trust's Board and its committees receive triangulated data in a number of key documents including the corporate dashboard, Board Assurance Framework and as part of Patient Safety,

Safer Staffing, Workforce and Financial reports. The Trust utilises the information in a number of ways, including to:

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

The Group People Committee, a Joint committee in common of the Trust and KGH Boards, has delegated responsibility for ensuring that any workforce/staffing changes are undertaken with the associated findings reviewed and discussed. The NHSI Developing Workforce Standards offer a framework for this to be undertaken.

The Trust was rated "Requires Improvement" by the Care Quality Commission (CQC) in 2019 and remains fully compliant with the registration requirements of the CQC. The Trust put in place an Improvement Plan in response to the findings which was monitored via the Quality Governance Committee and Trust Board. The plan was last subject to an Internal Audit review, for which the Trust received a 'Reasonable Assurance' opinion, in April 2020. The Action plan was completed and closed in October 2020.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality.

A digital solution has been introduced to encompass all decision-making staff (defined at the Trust as Consultants and staff on Agenda for Change Band 8D and above), as required by the Managing Conflicts of Interest in the NHS guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

The Trust has undertaken risk assessments included in its Adaptation Policy and has a sustainable development management plan in place which is currently being reviewed to take account of UK Climate Projections 2018 (UKCP18) and the Carbon Net Zero by 2040 NHS commitments. The Trust complies with its obligations under the Climate Change Act and Adaptation Reporting guidelines through its annual report.

Risk assessment

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

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

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

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

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

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

At 31 March 2022, the BAF contained the following risks:

- Risk of not meeting regulators minimum standards, local and national performance standards
- Risk of avoidable harm
- Risk of failures related to failing infrastructure due to aging estate leading to poor patient environment, poor infection control and potential health and safety failures
- Risk of failure in ICT infrastructure and/or a successful cyber security attack may lead to loss of service with a significant patient care and reputational impact
- Risk that the Trust is unable to respond appropriately to further pandemic waves; provide sufficient elective care and other clinical services, including non-elective and possible delays to treatment
- Risk that the Trust fails to promote a culture that puts patients first
- Risk that the Trust fails to have financial control measures in place to deliver its 2021/22 financial plan *(this risk did not materialise)*
- Risk that the Trust fails to fully deliver the financial efficiency programme.
- Risk that the Trust fails to manage its Capital programme within Capital Resource limit or fails to secure sufficient funding for infrastructure and equipment improvements

Each risk and its actions are owned by an Executive Director and they are held to account for progress at respective Board Committees and the Board.

The Trust has received a 'Reasonable Assurance' opinion from internal audit on the Board Assurance Framework and Risk Management in March 2022, with the final report issued in June 2022.

The Board last completed a self- review of governance arrangements against the NHSI Well-led Framework in January 2020. The output of that review identified where improvements could be made but identified knowledge gaps and learning opportunities for further Board development.

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

The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NHSE/I oversight framework; and a commitment to comply with all known targets going forward.

The Board ensures that the Trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the Board of Directors; and that all Board positions are filled, or plans are in place to fill any vacancies.

The Board is satisfied that all executive and Non-Executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability. All Board members complete a “Fit and Proper persons” declaration.

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

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

Internal Audit has carried out a review of the Trust’s financial systems during the year and, based on the work undertaken, have concluded that reasonable assurance can be taken, and the system of internal controls is generally adequate and operating effectively.

Whilst the unusual financial landscape continued into 2021/22, because of the pandemic, the Trust continued to maintain appropriate controls to support the use of public money and performed better than a break-even financial position.

The Trust will be carrying out more work on its transformation plans to drive efficiencies and delivery of excellent patient care, with particular focus on Elective recovery, Outpatient transformation and benefits from working with System partners as part of the Integrated Care Board. Also, through the work of the UHN Group, the Trust is continuing to actively work to improve both the quality and financial viability of acute services, by realising benefits of scale and reduced duplication.

5. Information governance

The Data Security and Protection Toolkit deadline is 30th June 2022; the Trust has currently met 84 of the 110 mandatory evidence items required. It is expected that the Trust will be able to complete all assertions for the 2022 submission.

In 2021/22, the Trust reported four Information Governance incidents to the Information Commissioners Office (ICO) that met the NHSD reporting criteria. Three cases have been closed by the ICO with no further action; one incident remains open and is under investigation with the ICO. No action has been taken by the ICO against the Trust regarding incidents reported to date.

6. Data quality and governance

The Data Governance Group meets monthly to ensure the Trust has adequate controls in place to manage Data Quality. Reports are presented each month by Clinical Coding, Data, Data Quality, Informatics, Knowledge Improvement and Data Security and Protection which are scrutinised regularly.

The Data Quality report includes 3 key themes to provide relevant assurance which include the Data Quality Kitemark, The Data Quality Maturity Index (DQMI) and Data Quality Alerts summaries. The DQMI compares its data quality against national peers in order to identify and prioritise necessary improvements. The Data Quality Kitemark is an internal auditing tool which assesses key data sets against a marking structure to give assurance for a Star rating; Sign off, Validation, Timely and Complete, Audit and Accuracy, Robust Systems and Data Capture. The Data Quality Team then provide recommendations for improvements to any areas of concern.

7. Going Concern

The Audit Committee, at its meeting on 25 April 2022, confirmed its agreement with the positive going concern assessment supporting the conclusion that the Trust is a going concern, and formally approved Going Concern status for the completion of the accounts.

8. Review of effectiveness

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

All relevant Board Committee Terms of Reference have been updated.

Board Reporting

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

Board effectiveness

The Board has processes in place to review the effectiveness with which it operates annually. Governance arrangements are also subject to review by Internal Audit annually.

The Board has been assured that there are robust mechanisms to ensure that the evidence to support compliance is in place and available and is routinely monitored and reported upon within the Trusts governance and performance framework. The process that has been applied to maintain the effectiveness of a system of internal control was as follows:

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

Each Board Committee has reviewed its Terms of Reference for Board approval.

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

The Internal Audit's review of the organisation's overall arrangements for gaining assurance has concluded that:

“Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation’s objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.”

Internal audit carried out ten reviews during the years, which were designed to ascertain the extent to which the internal controls in the systems were adequate to ensure that activities and procedures were operating to achieve the Trust’s objectives. All gave rise to findings of ‘reasonable’ assurance. The Head of Internal Audit indicated his satisfaction that, for the areas reviewed during the year, the Trust had reasonable and effective risk management, control and governance processes in place.

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

The Audit Committee received a report to its April 2022 meeting setting out the results of the annual self-assessment against the national Counter Fraud Function Standard Return, indicating full compliance against 11 components and partial compliance against two: fraud, bribery and corruption risk assessment, and anti-bribery and corruption training. The report identified work in progress to achieve full compliance in these areas.

One anti-crime investigation was opened during the year, and one was ongoing at 31 March 2022: no cases have been charged by the Crown Prosecution Service.

The Trust places patient safety at the heart of what we do, we constantly strive to learn from incidents to deliver Best Possible Care. Incidents are discussed at a number of forums, including the Review of Harm Group, Clinical Quality and Effectiveness Group and the Quality Governance Committee.

The Trust has recorded 82 serious incidents in 2021/22 which is an increase from 2020/21. It is important to acknowledge that the COVID pandemic changed profile of clinical work undertaken at the Trust, and so direct comparison of themes is not possible.

Each patient safety incident graded as moderate or serious harm has been reviewed. Those which meet the threshold for more detailed investigation as a Serious Incident have undergone this, using Root Cause Analysis (RCA) methodology, seeking to determine the Root Cause of any preventable harm.

Actions plans are developed based on the investigation findings and changes put in place to reduce the likelihood of re-occurrence. Lessons learnt are shared in a variety of ways, this sharing has been changed during the reporting year due to COVID restrictions and more reliance has had to be places on use of digital meeting technology, and written briefings for staff.

The Care Quality Commission (CQC) and NHS Resolution (NHSR) consider trusts who are high reporters of incidents to have a better and a more effective safety culture. In 2021/22, a total of 13,034 patient safety incidents were reported, which shows an increase in the previous reporting year. The Trust aim to share learning from incidents across the Trust and also wider through a Countywide patient Safety Group.

Despite the pandemic the Trust has met its obligations of Duty of Candour with patients/relatives where harm has been caused.

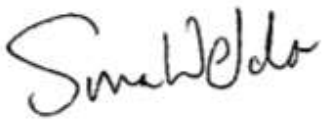
All patient safety incidents graded as moderate or above have continued to be discussed at the weekly 'Review of Harm Group (RoHG)' This multi-disciplinary group, chaired by the Medical Director or his representative, provides challenge in a non-threatening manner. The group reports into the Clinical Quality and Effectiveness Group. To ensure all patient safety incidents are investigated appropriately and proportionately incidents graded. Other incidents of clinical concern (including some complaints, claims or inquests) are also discussed at this meeting.

The Trust process of monitoring of action plans arising from Serious and Moderate graded Incidents continues to be strengthened. This is supported by the directorate governance meetings, and departmental meetings to ensure that actions are implemented. This is currently externally assured by our Commissioners through Serious Incident Action Meetings as well as internally within the Compliance Governance team. The Governance Department continue to provide key support to the local governance meetings in the clinical areas to implement and close action plans ensuring the support of robust governance throughout the Trust.

9. Conclusion

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

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



Simon Weldon

Group Chief Executive and Accountable Officer

21 June 2022

Report from the Group Chief Finance Officer

Economic outlook and impact

2021/22 continued to be an unusual year for the Trust, with the residual effects of a global pandemic dovetailed with the need for Elective Services to be restored over and above pre-COVID levels and a challenging winter period. The impact on staff and patients has been considerable, with thanks to our staff who have worked tirelessly throughout this period and continue to do their best under very challenging circumstances for the benefit of our patients.

Nationally, as in previous financial year, the NHS has received financial support, through a combination of block contracts, COVID funding and top-up arrangements, as well as other non-recurrent funding arrangements.

Looking ahead in 2022/23, the financial landscape will be different, with local health systems working closer together as part of the newly formed Integrated Care Board (ICB) to manage funding and resources in a collaborative manner. As well as the removal of the majority of financial support put in place over the past two years to support the response to the pandemic, national planning expectations are for a notable tightening of funding and financial controls. There is a clear re-focus on the efficient and productive use of resources, in order to create the necessary capacity to deliver improved operational performance and reduced backlog of elective activity. This will be done in the context of System based budgeting, reporting and regulatory oversight. Following two six monthly Plans in 2021/22, a full 12-month Planning Process was re-introduced in 2022/23. The 2022/23 planning round has yet to be concluded at the time of writing.

Financial performance

The continued impact of the pandemic meant that 2021/22 contained two distinct Financial Plans for the first and second halves of the year. The combination of Actuals for the first half and Plan for the second meant the Trust had a year-end target of a break-even position. We delivered an adjusted financial performance surplus of £0.4m as monitored by regulators, largely due to the receipt of non-recurrent funding.

Our capital expenditure programme continues to be considerably larger than pre-pandemic levels, and for 2021/22 was £27.5m. This included a number of key schemes like the Intensive Care Unit, Emergency Electrical upgrade works, which continued from 2020/21, plus significant investment from new Funding sources on Digital Hardware and Software. Despite the challenges of Funding awards being made in second half of the financial year, the capital plan was delivered in full in 2021/22.

We met our other financial duties to manage our borrowing within our external finance limit and to pay our suppliers within 30 days for more than 95% of invoices paid (by value and volume).

Charitable funds

We are supported by the Northamptonshire Health Charity. Its primary purpose is to support our work by providing grant funding, making use of the many generous donations and legacies they receive from the public and from fund raising activities.

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

During the financial year the charity paid £615k as grants, of specific note:

- Hospital Street Staff Changing Rooms £142k
- Cheyne Walk Refurbishment Works £62k

- Various items of medical equipment for Trust-wide use, including a Liver Probe £16k, Cardiovascular Imaging £16k, Urology Mini Dual Laser and Cart £11k and Cardiology Pathfinder Laptop and Dual Screen £23k
- Larger Scale Fixtures, Furnishing and Fittings improvements including Pathology, Breast Screening, Paediatric Emergency Department and Intensive Care Unit, £38k
- Volunteer Services Support and Coordination £73k
- Staff Training and Course Fees £29k
- On Call Rooms Improvement £23k
- PALS Office Support £20k
- Lockers for Domestic Staff £12k
- Staff Awards Event £15k

Jon Evans

Group Chief Finance Officer

21 June 2022

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

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust.

The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

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

As far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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.

Simon Weldon

Group Chief Executive Officer

21 June 2022

Statement of Directors' responsibilities in respect of the accounts

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

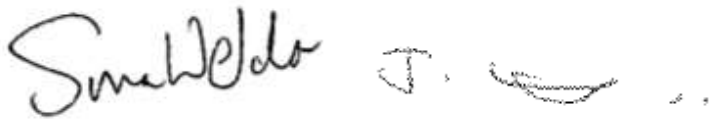
- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and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

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

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

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

By order of the Board



Simon Weldon	Jon Evans
Group Chief Executive Officer	Group Chief Finance Officer
21 June 2022	21 June 2022

Remuneration and Staff Reports

Remuneration report

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

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

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

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

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

Pay multiples – Has been subject to audit

Pay ratio information

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director in their organisation against the 25th percentile, median and 75th percentile of total remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director in Northampton General Hospital NHS Trust in the financial year 2021-22 was £245 – 250k (2020-21, £230 – 235k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table. For clarity, a ratio of 11.97 means that the director receives 11.97 times the relevant salary/remuneration of employees.

2021-22	25th percentile	Median	75th percentile
Total remuneration (£)	20,675	29,224	43,688
Pay ratio information	11.97	8.47	5.67
2020-21			
Total remuneration (£)	19,973	27,227	41,723
Pay ratio information	11.64	8.54	5.57
2021-22			
Salary component of total remuneration (£)	20,330	27,780	39,467
Pay ratio information	12.17	8.91	6.27
2020-21			
Salary component of total remuneration (£)	19,337	26,970	37,890
Pay ratio information	12.02	8.62	6.14

Changes in ratio between current and prior years are as a result of the change from the Medical Director being the highest paid director in 2020-21 to the Hospital Chief Executive Officer (April to August) in 2021-22, when remuneration is annualised. All ratios also reflect the increase in both the total remuneration, and the salary component of total remuneration paid to the organisation's workforce. The Trust believes the median pay ratio for the relevant financial year is consistent with the pay, reward and progression policies for the entity's employees taken as a whole. Ratios would have reduced if the highest paid director's salary had remained the same, reflecting the increase in remuneration of the workforce following pay awards.

Percentage change in remuneration of highest paid director

The percentage change from the previous financial year in respect of the highest paid director was 6%.

Calculation is based on the mid-point of the band of the highest paid director's salary.

The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole, was 6%

Calculation is based on the total for all employees on an annualised basis, excluding the highest paid director, divided by the FTE number of employees (also excluding the highest paid director).

No director or employee received performance pay or bonuses.

Medical staff and Nursing and Midwifery staff represent the largest increase in total average staff numbers. The majority of staff on Agenda for Change terms and conditions and Medical staff received a 3% pay increase as a result of the Pay Review Bodies' recommendations.

In 2021-22, seven (2020-21, four) employees received remuneration in excess of the highest-paid director.

The range of staff remuneration in 2021-22 was from £11 to £350,778 per annum. In 2020/21 this was 2020-21 £10 to £341,250.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.
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Salary and Pension Entitlements of Senior Managers Remuneration – Has been subject to audit

Name and Title	2021/22					
	Salary (bands of	Expense payments (taxable) to nearest £100*	Performance Pay and Bonuses (bands of	Long term Performance Pay and Bonuses (bands of £5,000)	All Pension-related Benefits (bands of	Total - Salary and Benefits (bands of
Alan Burns – Chairman	35 - 40					35 - 40
Simon Weldon - Group Chief Executive	110-115				55-57.5	165-170
Eileen Doyle, Hospital Chief Executive Officer (to 15th August 21)	90-95					90-95
Heidi Smoult, Hospital Chief Executive Officer (from 16th August 2021)	100-105				145-150	245-250
Joanna Fawcus - Chief Operating Officer (to 7th November 21)	75-80				65-67.5	145-150
Palmer Winstanley – Chief Operating Officer (from 31st January 2022)	20-25				45-47.5	65-70
Matthew Metcalfe - Medical Director (whole period) and Chief Operating Officer (8th November 2021 to 30th January 2022)	185-190				245-247.5	430-435
Sheran Oke - Director of Nursing, Midwifery and Patient Services (to 14th February 2022)	110-115				22.5-25	135 - 140
Debra Shanahan - Director of Nursing, Midwifery and Patient Services (from 15th February 2022)	10-15				5-7.5	20 - 25
Jon Evans – Group Chief Finance Officer (from 7 June 2021)	65-70				55-57.5	120-125
Bola Agboola - Director of Finance (to 6th June 2021)	20-25				27.5-30	50-55
Andy Callow – Group Chief Digital Information Officer	70-75				17.5 - 20	90 - 95
Stuart Finn - Director of Facilities and Capital Development (to 31st August 2021) / Group Director of Operational Estates (from 1st September 2021)	75-80				27.5-30	105-110
Karen Spellman - Director of Integration and Partnerships	100-105				85-87.5	185-190
Richard Apps – Group Director of Governance (from 15th January 2022)	5-10				20-22.5	30-35
Claire Campbell - Director of Corporate Development, Governance and Assurance (to 18th January 2022)	85-90				20-22.5	110 - 115
Mark Smith – Group Chief People Officer	80-85					80-85
Rebecca Taylor – Group Director of Transformation and Quality Improvement (from 27th September 2021)	30-35				5-7.5	35-40
John Archard-Jones - Non-Executive Director (to 23rd April 2021)	0-5					0-5
Annette Gill - Non-Executive Director (to 1st November 2021)	5-10					5-10
Jill Houghton - Non-Executive Director	10 - 15					10 - 15
David Moore - Non-Executive Director	10 - 15					10 - 15
Thompson Robinson - Non-Executive Director (to 31st August 2021)	5-10					5-10
Rachel Parker - Non-Executive Director	10 - 15					10 - 15
Denise Kirkham - Non-Executive Director	10 – 15					10 - 15
Elena Lokteva – Non-Executive Director (from 1st January 2022)	0-5					0-5
Andre Ng – Associate Non-Executive Director (from 1st December 2021)	0-5					0-5

Salary Notes 2021-2022

Heidi Smoult, Palmer Winstanley, Debra Shanahan, Jon Evans, Richard Apps, Rebecca Taylor, Elena Lokteva and Andre Ng were appointed to the Board in 2021/22. There is therefore no salary information for 2020-21.

Simon Weldon, Joanna Fawcus, Jon Evans, Andy Callow, Richards Apps, Mark Smith and Rebecca Taylor are employed by KGH.

KGH has recharged 50% of total salaries for the respective months for the 'Group' appointments of Chief Executive (total salary £220 - 225k), Chief Finance Officer (total salary £130 -135k), Chief Digital Information Officer (total salary £145 -150k), Director of Governance (total salary £15-20k), Chief People Officer (total salary £165 - 170k) and Director of Transformation and Quality Improvement (total salary £60 -65k).

The salary for Joanna Fawcus was recharged in full.

50% of the salary for Stuart Finn has been recharged to KGH from 1st September 2021 (total salary £110 -115k)

Philip Bradley received a redundancy payment during 2021/22 of £35-40k. This was subject to the appropriate HMRC regulations for PAYE and National Insurance. The anticipated cost was provided for and reported as an Exit package in 2020/21.

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

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

All pension-related benefits include the cash value of payments (whether in cash or otherwise) in lieu of retirement benefits, and all benefits in year from participating in pension schemes. These are the aggregate input amounts, calculated using the method set out in section 229 of the Finance Act 2004.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Factors determining the variation in the values recorded between individuals include but is not limited to:

A change in role with a resulting change in pay and impact on pension benefits

Changes in the contribution rates

Changes in the wider remuneration package of an individual.

	2020-21					
Name and Title	Salary (bands of	Expense payments (taxable) to nearest £100*	Performance Pay and Bonuses (bands of	Long term Performance Pay and Bonuses (bands of £5,000)	All Pension-related Benefits (bands of	Total - Salary and Benefits (bands of
Alan Burns – Chairman	35 - 40					35 - 40
Simon Weldon - Group Chief Executive (from 1st July 2020)	90-95					90-95
Eileen Doyle, Hospital Chief Executive Officer (from 1st March 2021)	10-15				22.5-25	35-40
Deborah Needham – Hospital Chief Executive (from 1st August 2020 to 28 February 2021) / Chief Operating Officer / Deputy Chief Executive Officer (from 1st April 2020 to 31st July 2020)	145-150				32.5-35	175-180
Sonia Swart - Chief Executive Officer (to 31st July 20)	75 - 80				0	75 - 80
Joanna Fawcus - Chief Operating Officer (from 1st March 21)	10 - 15				30 - 32.5	40 - 45
Carl Holland - Chief Operating Officer (from 1st August 20 to 28th Feb 21)	70 - 75				147.5 - 150	215 - 220
Matthew Metcalfe - Medical Director	230 - 235				82.5 - 85	315 - 320
Sheran Oke - Director of Nursing, Midwifery and Patient Services	125 - 130				12.5 - 15	135 - 140
Bola Agboola - Director of Finance (from 30th November 20)	40 - 45				25 - 27.5	70 - 75
Philip Bradley - Director of Finance (to 29th November 20)	95 - 100				0	95 - 100
Andy Callow – Group Chief Digital Information Officer (from 1st November 20)	25 – 30				15 – 17.5	40 - 45
Stuart Finn - Director of Facilities and Capital Development	100 - 105				25 - 27.5	125 - 130
Karen Spellman - Director of Strategy and Partnerships (from 7th December 20)	30 - 35				55 - 57.5	90 - 95
Chris Pallot - Director of Strategy and Partnerships (to 6th December 20)	75 - 80				30 - 32.5	105 - 110
Claire Campbell - Director of Corporate Development, Governance and	105 -110				0 - 2.5	110 - 115
Mark Smith - Chief People Officer	70 - 75				2.5 - 5	70 - 75
John Archard-Jones - Non-Executive Director	10 - 15					10 - 15
Annette Gill - Non-Executive Director	10 - 15					10 - 15
Jill Houghton - Non-Executive Director	10 - 15					10 - 15
David Moore - Non-Executive Director	10 - 15					10 - 15
Thomson Robinson - Non-Executive Director	10 - 15					10 - 15
Rachel Parker - Non-Executive Director	10 - 15					10 - 15
Denise Kirkham - Non-Executive Director	10 - 15					10 - 15
Tremaine Richard-Noel - Trainee Shadow Non-Executive (NExT Scheme)	N/A					N/A

Salary Notes 2020/21

Simon Weldon, Eileen Doyle, Joanna Fawcus and Mark Smith are employed by Kettering General Hospital NHS Foundation Trust.

KGH has recharged 50% of total salaries for the respective months for the 'Group' appointments of Chief Executive, Chief Digital Information Officer and Chief People Officer.

The salary for Joanna Fawcus was recharged in full. Tremaine Richard-Noel was on a placement through the NExT Director Scheme and did not receive a salary from NGH

Sonia Swart received a redundancy payment during 2020/21 of £53k. This was subject to the appropriate HMRC regulations for PAYE and National Insurance. The anticipated cost was provided for and reported as an Exit package in 2019/20.

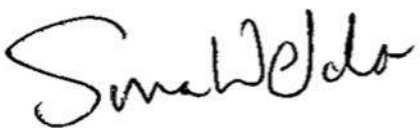
Pension benefit report – Has been subject to audit

Name and Title	Real increase in pension at Pension Age (bands of	Real increase in pension lump sum at Pension Age (bands of £2,500)	Total accrued pension at Pension Age at 31 March 2022 (bands of £5,000)	Lump sum at Pension Age related to accrued pension at 31 March 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2021	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2022	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Simon Weldon – Group Chief Executive	2.5-5	2.5-5	25-30	55-60	506	53	577	N/A
Heidi Smoult, Hospital Chief Executive Officer (from 16th August 2021)	2.5-5	7.5-10	30-35	45-50	315	58	432	N/A
Eileen Doyle, Hospital Chief Executive Officer (to 15th August 21)	N/A	N/A	N/A	N/A	248	N/A	N/A	N/A
Palmer Winstanley – Chief Operating Officer (from 31st January 2022)	0 – 2.5	0	10-15	0	103	1	128	N/A
Joanna Fawcus - Chief Operating Officer (to 7th November 21)	0 - 2.5	0 - 2.5	35 - 40	70 - 75	603	29	672	N/A
Matthew Metcalfe - Medical Director (whole period) and Chief Operating Officer (8th November 2021 to 30th January 2022)	10-12.5	25-27.5	50-55	125-130	759	220	1,009	N/A
Sheran Oke - Director of Nursing, Midwifery and Patient Services (to 14t February 2022)	0 - 2.5	2.5 - 5	55 - 60	170-175	1,298	49	1,381	N/A
Debra Shanahan - Director of Nursing, Midwifery and Patient Services (from 15th February 2022)	0-2.5	0-2.5	35-40	105-110	778	0	816	N/A
Jon Evans – Group Chief Finance Officer (from 7 June 2021)	2.5-5	2.5-5	15-20	25-30	193	27	238	N/A
Bola Agboola - Director of Finance (to 6th June 2021)	0 - 2.5	0	10-15	0	106	0	135	N/A
Andy Callow - Group Chief Digital Information Officer	0 - 2.5	0	5-10	0	72	0	91	N/A
Stuart Finn - Director of Facilities and Capital Development (to 31st August 2021) / Group Director of Operational Estates (from 1st September 2021)	0 - 2.5	0-2.5	15-20	20-25	237	21	270	N/A
Karen Spellman - Director of Integration and Partnerships	2.5-5	7.5-10	30 - 35	65-70	581	84	683	N/A
Richard Apps – Group Director of Governance (from 15th January 2022)	0 - 2.5	0 - 2.5	10-15	20-25	163	0	185	N/A
Claire Campbell - Director of Corporate Development, Governance and Assurance (to 18th January 2022)	0 - 2.5	0 - 2.5	50 - 55	160-165	1,275	33	1,337	N/A
Mark Smith – Group Chief People Officer	N/A	N/A	N/A	N/A	61	0	N/A	N/A
Rebecca Taylor – Group Director of Transformation and Quality Improvement (from 27th September 2021)	0-2.5	0	0-5	0	0	0	5	N/A

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members of the Board. In 2021/22 Simon Weldon, Jon Evans, Andy Callow, Richard Apps, Mark Smith and Rebecca Taylor were fully remunerated by KGH as their primary employer. The Trust reimbursed KGH for 50% of their costs for the period that they held a group role and as such NGH show only 50% of pay and pension details for the relevant period with KGH disclosing the remaining 50%. Stuart Finn was appointed to the role of Group Estates Operational Director on 1st September 2021. Stuart was fully remuneration by NGH as his primary employer. 50% of his costs for the period September 2021 - March 2022 have been recharged to KGH and as such KGH only show 50% of pay and pension details for this period, with KGH disclosing the remaining 50%.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period. The inflation applied to the accrued pension, lump sum (if applicable) and CETV is the percentage (if any) by which the Consumer Prices Index (CPI) for the September before the start of the tax year is higher than it was for the previous September. The Consumer Prices Index up to September 2020 was 0.5%. Therefore for pensions and CETV calculation purposes CPI is 0.5%. No lump sum is shown for senior managers who only have membership in the 2015 Scheme or 2008 Section (unless they chose to move their 1995 Section benefits to the 2008 Section under the Choice exercise). No CETV is shown for pensioners or senior managers over NPA. Age 60 in the 1995 Section, age 65 in the 2008 Section or SPA or age 65, whichever is the later, in the 2015 scheme. No values are shown for senior managers that have opted out of the NHS Pension scheme.



Simon Weldon, Group Chief Executive Officer
21 June 2022

Jon Evans, Group Chief Finance Officer
21 June 2022

Off Payroll Report

Table 1: Off-Payroll Engagements longer than 6 months

For all off-payroll engagements as of 31 March 2022, for more than £245 per day* and that last longer than six months:

Narrative	Number
Number of existing engagements as of 31 March 2022	2
Of which, the number that have existed:	
for less than one year at the time of reporting	2
for between 1 and 2 years at the time of reporting	
for between 2 and 3 years at the time of reporting	
for between 3 and 4 years at the time of reporting	
for 4 or more years at the time of reporting	

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2021 and 31 March 2022, for more than £245* per day:

Narrative	Number
Number of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022	2
Of which, the number	
not subject to off-payroll legislation**	0
subject to off-payroll legislation and determined as in-scope of IR35**	2
subject to off-payroll legislation and determined as out of scope of IR35**	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which : number of engagements that saw a change to IR35 status following review	0

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

**A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes

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

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022

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

Total number of individuals on payroll and off-payroll that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure must include both on payroll and off-payroll engagements	**18**

STAFF REPORT

Staff costs and numbers

			2021/22	2020/21
	Permanent	**Other**	**Total**	**Total**
	£000	**£000**	**£000**	**£000**
Salaries and wages	232,503	1,556	**234,059**	216,563
Social security costs	24,685	0	**24,685**	22,242
Apprenticeship levy	1,165	0	**1,165**	1,063
Employer's contributions to NHS pension scheme	34,908	0	**34,908**	32,881
Pension cost – other	94	0	**94**	58
Other post-employment benefits	0	0	**0**	0
Other employment benefits	0	0	**0**	0
Termination benefits	0	0	**0**	67
Temporary staff	0	23,220	**23,220**	19,114
Total gross staff costs	**293,355**	**24,776**	**318,131**	**291,988**
Recoveries in respect of seconded staff	0	0	**0**	0
Total staff costs	**293,355**	**24,776**	**318,131**	**291,988**
Of which				
Costs capitalised as part of assets	746	103	**849**	762

STAFFING NUMBERS			2021/22	2020/21
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	640	137	**777**	693
Ambulance staff	0	0	**0**	0
Administration and estates	1,109	191	**1,300**	1,215
Healthcare assistants and other support staff	1,098	258	**1,356**	1,352
Nursing, midwifery and health visiting	1,576	248	**1,824**	1,748
Nursing, midwifery and health visiting learners	0	0	**0**	0
Scientific, therapeutic and technical	604	37	**641**	617
Healthcare science staff	152	0	**152**	160
Social care staff	0	0	**0**	0
Other	0	0	**0**	0
Total average numbers	**5,179**	**871**	**6,050**	**5,785**
Of which:				
Number of employees (WTE) engaged on capital projects	11	2	**13**	16

Exit packages

Reporting of compensation schemes - exit packages 2021/22

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	0	0	**0**
£10,000 - £25,000	0	1	**1**
£25,001 - 50,000	1	0	**1**
£50,001 - £100,000	0	0	**0**
£100,001 - £150,000	0	0	**0**
£150,001 - £200,000	0	0	**0**
>£200,000	0	0	**0**
Total number of exit packages by type	**1**	**1**	**2**
Total cost (£)	42,779	19,500	**61,779**

Exit packages: other (non-compulsory) departure payments

	2021/22		2020/21	
	Payments agreed		Payments agreed	
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	1	20	0	0
Total	**1**	**20**	**0**	**0**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	0	0	0	0

Staff sickness absence

Staff sickness absence data is published nationally. Information can be obtained via the NHS Digital publication series on NHS Sickness Absence Rates.

Average FTE 2021	Adjusted FTE days lost to Cabinet Office definitions	Average sick days per FTE	FTE days available	FTE days recorded sickness absence
5,157	67,019	13.0	1,882,243	108,719

Source: NHS Digital - Sickness Absence Publication - based on data from the ESR Data Warehouse
Period covered: January to December 2021
ESR (staff record) does not hold details of normal number of days worked by each employee. Data on days available and days recorded sick are based on a 365-day year.
Average Annual Sick Days per FTE has been estimated by dividing the estimated number of FTE-days sick by the average FTE, and multiplying by 225 (the typical number of working days per year).

Early retirements due to ill health

	2021/22	2021/22	2020/21	2020/21
	£000	Number	£000	Number
No of early retirements on the grounds of ill-health	225	2	73	1

Our Trade Union activity

The Trust provides the following Trade Union Facility Time:

- GMB 1 FTE (Staff Side Chair)
- Unison 1 FTE (Staff Side Secretary)

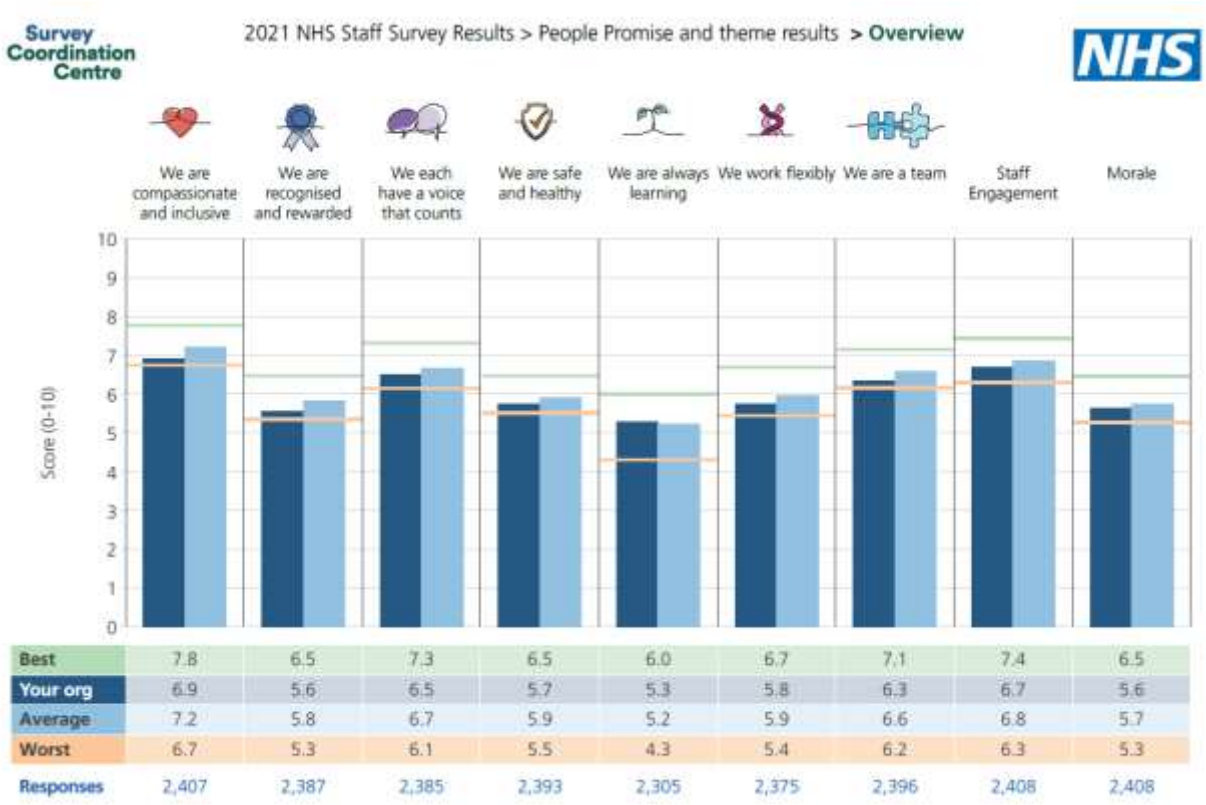
Other ad-hoc time is provided dependent on the exigencies of the service.

In March 2022, for a 12-month period, it was agreed to provide the Staff Side Committee with 1 FTE and Unison with a further 6 days release per week to provide additional support.

Further information regarding Facilities Time can be found on the internet.

Staff Survey Results

NHS National staff survey is a key piece of intelligence which ran at the Trust from the 4 October 2021 to 26 November 2021 with 2,414 colleagues taking part representing 42% of the Trust workforce. This compares with the national median average of 45%.



For 2021 the reporting structure of the survey has changed, and the results are now 'themed' in line with the national People Promise. Our focus will now be working with our Departments and Directorate management teams to help them to understand their results and the areas where our colleagues are reporting things working well and where they are not. This will include a special focus on the People Promises of:

- We are recognised and rewarded
- We are safe and healthy
- We work flexibly
- Morale
- We are always learning

The Trust performance was below the national average in all but one element, with 'team' our lowest performing area.

The survey has been analysed, acknowledging the number of areas for improvement, four main themes have been identified for the Trust which have an consistent and underlying impact on the survey results:

- Team Working
- Respect

- Leadership and Management
- Reward and Recognition

Full survey results are available here: NHS Staff Survey 2021 Benchmark Reports (nhsstaffsurveys.com).

Improvement themes are being developed into a specific and measurable action plan following analysis, further engagement and review, including via Hospital Management Team and Board workshops in April and June 2022.

Equality, Diversity and Inclusion

During 2020/21 we continued to work to and review our progress against our Equality, Diversity and Inclusion Strategy 2021-2024. The key areas of work and actions are linked to and driven by:

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

Our key achievements included:

- The expansion of our REACH (Race, Equality and Cultural Heritage) Network and the introduction of DAWN (Disability and Wellbeing), Pride (LGBTQ+) Network and VOICE (Women in Medicine) Network
- Celebration and promotion of key dates and events, including a permanent rainbow crossing art installation - #CrossWithPride
- Trained Champions in inclusive recruitment on all senior recruitment panels
- The introduction of a reverse mentoring programme with Trust Board members, starting with REACH Network
- Continuing the BAME Clinical Fellow role to support our work with International Medical Graduates
- Recruitment of a Director of Nursing Fellow, specialising in Inclusive Leadership driving forward cultural projects for internationally educated Nurses
- 140 colleagues trained in Unconscious Bias
- Introduction of monthly Inclusion Newsletter showcasing all edI training, celebration and learning opportunities
- Two REACH midwives won the RCM's Race Matters Award for their work in additional support to REACH women during the pandemic and successfully changed pregnancy outcomes
- Creation of Library of Diversity and Inclusion highlighting tools and resources encompassing all 9 protected characteristics

- The development of a joint approach with Kettering General Hospital and agreement, in July 2021, of a Group edI Strategy by Boards.

2021 NHS Staff Survey Equality and Diversity Key Findings

The demographics of our workforce who responded to the staff survey were broadly similar to our overall workforce with the exception of disabled staff where 25.83% of the respondents indicated they had a disability compared to the 4% of the workforce recorded on our systems.

For 2021 the reporting structure of the survey changed and the results are now 'themed' in line with the national People Promise. Equality, Diversity and Inclusion sits within the 'We are Compassionate and Inclusive; theme for which we scored 6.9 out of 10. We are below the national average of 7.2

Underpinning this theme there are four questions from the Staff Survey that contribute to the overall 'theme' result, in relation to Diversity and Equality:

Question 15 – *Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?* There has been a deterioration of 2.3% since 2020 and we are below national average by 4%. The national average has deteriorated by 0.5% since the 2020 survey.

Question 16a – *In the last 12 months have you personally experienced discrimination at work from patients/service users, their relatives or other members of the public?* There has been a deterioration 0.6% since 2020 and we are below the national average by 1.7%. The national average has deteriorated by 0.6% since the 2020 survey.

Question 16b –*In the last 12 months have you personally experienced discrimination at work from managers/team leaders or other colleagues?* There has been a deterioration of 2.1% since 2020 and we are below the national average by 4.1%. The national average has deteriorated by 0.8% since the 2020 survey.

Question 18 – *I think my organization respects individual differences (e.g. cultures, working styles, backgrounds, ideas etc.)* As a new question for 2021 there is no historical comparative data. We scored 63.4%, which was 5.4% below the national average.

The survey has highlighted some areas of concern and we will be working with our colleagues, trades unions and Inclusion Networks to understand the specific issues behind the results so that we can work together to create an inclusive environment where all colleagues are respected and valued.

Workforce Race Equality Standard

We undertook the data analysis exercise for the National Workforce Race Equality Standard (WRES) in 2021 and compared these results to those of 2020 to establish if there had been improvements or deteriorations in the experiences or the treatment of BME staff when compared to our White staff.

We showed improvement in key metrics including:

- The likelihood of BME applicants being shortlisted when compared to White applicants (0.8 to 0.93)
- BME staff experiencing bullying, harassment or abuse from patients, relatives or the public (30%, reduced from 36%)
- BME staff experiencing bullying, harassment or abuse from other colleagues in the last 12 months (34%, reduced from 38%)
- BME staff believing career progression/promotion is fair when compared to White staff (64%, compared to 60%)

Deteriorations were seen in:

- The likelihood of BME staff entering the formal disciplinary process, when compared to White staff (1.52, a deterioration of 0.22)
- The likelihood of BME staff accessing non-mandatory training/Continuous Professional Development when compared to White Staff (1.8, a deterioration of 0.79)
- BME staff experiencing discrimination form managers / team leaders / colleagues (22%, rising from 21%)

We acknowledge there is still work to do to improve the experiences and treatment of our BME workforce and we will be working closely with our REACH (Race, Ethnicity and Cultural Heritage) Inclusion Network Group to address the issues highlighted.

The National WRES Report was released in March 2021 and ,when comparing our results to the national results, we better the national findings in two areas and are below them for the remaining nine indicators.

Our WRES report can be accessed via our website.

Workforce Disability Equality Standard

We undertook the data analysis exercise for the National Workforce Disability Equality Standard (WDES) in 2021 and compared these results to those of 2020 to establish if there had been improvements or deteriorations in the experiences or the treatment of disabled staff when compared to our non-disabled staff.

We showed improvement in:

- The number of disabled staff we employ (276)
- Disabled staff experiencing bullying, harassment or abuse from patients, relatives or the public (35%)
- Disabled staff experiencing bullying, harassment or abuse from managers in the last 12 months (21%)
- Disabled staff or their colleagues reporting bullying, harassment or abuse (50%)
- Staff Engagement score for disabled staff (6.7) compared to non-disabled staff (7.2) and the overall engagement score for the organization

Deteriorations were seen in:

- The likelihood of disabled staff entering the formal capability process, when compared to non-disabled staff (5.85)
- Disabled staff experiencing bullying, harassment or abuse from other colleagues in the last 12 months (31%)
- Disabled staff believing career progression/promotion is fair (77%) when compared to non-disabled staff (84%)
- Disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties (35%)
- Disabled staff (36%) compared to non-disabled staff (49%) saying that they are satisfied with the extent to which their organisation values their work.

One area was unchanged from 2020, namely:

- The total number of disabled staff at a very senior manager level

We acknowledge there is still work to do to improve the experiences and treatment of our disabled workforce and we will be working closely with our DAWN (Disability and Wellbeing Network) Inclusion Group to address the issues highlighted.

Our WDES report can be accessed via our website.

Gender Pay Gap Reporting 2021

As per the Gender Pay Gap Information Regulations 2017, we compiled and analysed our data and submitted it to the Government in March 2022, as part of the requirements under the Regulations. Although we are not legally required to produce a written report, it was agreed this should be done to give context to the data and this will be published on our website.

There has been a deterioration in the gap since 2020. Resulting in female employees earning 88p for every £1 that a male employee earns.

Mean Hourly Rates, the difference and percentage pay gap, from 2020 to 2021

	Mean Hourly Rate 2020	Mean Hourly Rate 2021	Mean Hourly Rate 2020/21 Variation
Male	£22.79	£24.95	+£2.16
Female	£16.42	£16.96	+£0.54
Difference	£6.37	£7.99	£1.62
Pay Gap	27.9%	32.0%	-4.1%

Median Hourly Rates, the difference and percentage pay gap, from 2020 to 2021

	Median Hourly Rate 2020	Median Hourly Rate 2021	Median Hourly Rate 2020/21 Variation
Male	£16.23	£17.24	£1.01
Female	£14.37	£15.10	£0.73
Difference	£1.86	£2.14	£0.28
Pay Gap	11.5%	12.5%	-1.0%

We acknowledge there is a difference in the average pay of our male and female staff that needs to be addressed, which includes a greater female representation in our senior clinical roles.

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

Gender Distribution of Staff

	Agenda for Change Bands 1-7		Agenda for Change Bands 8a – 9		Other Medical and Dental		Consultants		Very Senior Managers		Total
Male	787	63.4%	57	4.6%	220	17.7%	167	13.4%	11	0.9%	1242
Female	4067	88.9%	203	4.5%	194	4.2%	92	2.0%	17	0.4%	4573
Total	4854	83.5%	260	4.5%	414	7.1%	259	4.4%	28	0.5%	5815

Disability Related Polices

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

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

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

- To raise awareness of the employment of people with disabilities throughout the organisation and ensure employees are aware of the Trusts commitment towards disabled people or someone's association with a disabled person

- To ensure recruitment procedures are reviewed and developed to encourage applications and the employment of people with disabilities or someone associated with a disabled person

- To ensure that staff and potential job applicants with a disability, or associated with a disabled person, are treated fairly and receive the same opportunities as other staff to develop within the Trust with appropriate and reasonable support.

- To take all reasonable steps to ensure that the working environment does not prevent disabled people or people associated with a disabled person from taking up positions for which they are suitably qualified.

- To assist staff who become disabled during their employment to adapt to the disability and to continue in post wherever possible, or, if this is not possible, to be redeployed or retrained, where this is practicable.

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

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

The Recruitment, Selection and Retention Policy, together with the associated procedures, provides a framework which promotes a professional approach and the highest possible standards throughout the recruitment and selection process and to

ensure a proactive and lawful approach to equality and diversity issues within the process, including the recruitment of disabled people. We continue to be certified as a Disability Confident Employer (Level 2) and as part of this commitment, we will:

1. Get the right people for our organisation - which includes providing fully inclusive and accessible recruitment processes, offering interviews to disabled people who meet the minimum criteria for the job and making reasonable adjustments as required.

2. Keep and develop our staff - which includes supporting employees to manage their disabilities and health conditions

We will continue to work with our DAWN Inclusion Group to look at how we can better support our disabled staff.

Modern slavery statement

This statement is made in pursuant to section 54 of the Modern Slavery Act 2015 and sets out the steps that Northampton General Hospital NHS Trust has taken and continues to take to ensure that modern slavery or human trafficking is not taking place within our business or supply chain.

Northampton General Hospital NHS Trust provides general acute services for a population of 380,000 and hyper-acute stroke, vascular and renal services to people living throughout whole of Northamptonshire, a population of 692,000.

The organisation is also an accredited cancer centre and provides cancer services to a wider population of 880,000 who live in Northamptonshire and parts of Buckinghamshire.

The principal activity of the organisation is the provision of free healthcare to eligible patients.

Northampton General Hospital NHS Trust's position on modern slavery is to:

- Comply with legislation and regulatory requirements
- Make suppliers and service providers aware that we promote the requirements of the legislation
- Develop an awareness of human trafficking and modern slavery within our workforce
- Consider human trafficking and modern slavery issues when making procurement decisions in accordance with the Trust's Policies on Modern Slavery

The Trust fully supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play in both combatting it and supporting victims.

We are committed to ensuring that there is no modern slavery or human trafficking in any part of our business and in so far as is possible, to requiring our supplies hold a corresponding ethos.

To identify and mitigate the risks of modern slavery and human trafficking in our own business, Northampton General Hospital has established robust recruitment procedures, details of which are found in its Recruitment, Selection and Retention Policy.

The policy supports compliance with national NHS Employment Checks and CQC standards. In addition all other external agencies providing staff have been approved through Government Procurement Suppliers (GPS). Modern slavery is incorporated within Northampton General's Safeguarding Children and Safeguarding Adults policies. In addition, modern slavery is reference within the Safeguarding Children and Adult mandatory training from levels 1 -3, which applies to all staff employed by Northampton General Hospital as per the Safeguarding Training Strategy.

Staff must:

- Confirm their identities as new employees and their right to work in the United Kingdom
- Undertake safeguarding training appropriate to their roles and responsibilities to identify those who are victims of modern slavery and human trafficking
- Raise any concerns about working or clinical practice
- Work with the Procurement Department when looking to work with new suppliers so appropriate checks relating to modern slavery can be undertaken

Working with Suppliers

The Trust's Procurement Department will ensure its supplier base and associated supply chain, which provides goods and / or services to Northampton General Hospital have taken the necessary steps to ensure modern slavery is not taking place.

The Procurement Department have committed to ensuring that this is monitored and reviewed with its supplier base via the Trust's 3 Year Procurement Strategy. The Trust follows good practice, ensuring all reasonable steps are taken to prevent slavery and human trafficking and will continue to support the requirements of the Modern Slavery Act 2015 and any future legislation.

Group Chief Executive Officer – 21 June 2022

Section 3: Financial Statements

Independent auditors report

Annual accounts

Independent auditor's report to the Directors of Northampton General Hospital NHS Trust

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of Northampton General Hospital NHS Trust (the 'Trust') for the year ended 31 March 2022, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2022 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Directors' use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the Directors' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group accounting manual 2021 to 2022 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the Directors with respect to going concern are described in the 'Responsibilities of the Directors and Those Charged with Governance for the financial statements' section of this report.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 16 June 2022 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to Northampton General Hospital NHS Trust' ongoing breach of its statutory break even duty for the three years ended 31 March 2022.

Responsibilities of the Directors and Those Charged with Governance for the financial statements

As explained in the Statement of directors' responsibilities in respect of the accounts set out on page 55, the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

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

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

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022).
- We enquired of management and the Audit Committee, concerning the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management,internal audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.

- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and presumed risk of fraud in revenue and expenditure recognition. We determined that the principal risks were in relation to:
    - journal entries posted by senior members of the finance team
    - unbalanced journal entries
    - journals that altered the Trust's financial performance for the year
    - potential management bias in determining accounting estimates, especially in relation to:
      - the valuation of the Trust's land and buildings
      - accruals of income and expenditure at the end of the financial year
- Our audit procedures involved:
    - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
    - journal entry testing, with a focus on journal entries posted by senior members of the finance team, unbalanced journal entries, and significant journal entries at the end of the financial year which impacted on the Trust's financial performance;
    - challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and buildings valuations and accruals of income and expenditure at the end of the financial year;
    - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to the valuation of the Trust's land and buildings and accruals of income and expenditure at the end of the financial year.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's.
    - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
    - knowledge of the health sector and economy in which the Trust operates
    - understanding of the legal and regulatory requirements specific to the Trust including:
        - the provisions of the applicable legislation
        - NHS England's rules and related guidance
        - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
    - The Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
    - The Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

Our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the Trust's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, they will be reported by exception in a further auditor's report. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2022.

Responsibilities of the Accountable Officer

As explained in the Statement of the chief executive's responsibilities as the accountable officer of the Trust set out on page 54, the Chief Executive, as Accountable Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for Northampton General Hospital NHS Trust for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

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

M C Stocks

Mark Stocks, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham

Date:21 June 2022

Independent auditor's report to the Directors of Northampton General Hospital NHS Trust

In our auditor's report issued on 21st June 2022, we explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2022, in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice, until we had completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2022 issued on 21st June 2022 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2022 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave this opinion.

Report on other legal and regulatory requirements - the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

The Chief Executive, as Accountable Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and

- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of Northampton General Hospital NHS Trust for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

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

M C Stocks

Mark Stocks, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham

14th September 2022

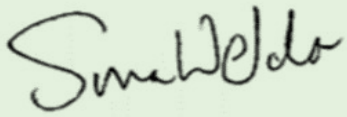
Statement of Comprehensive Income

	Note	2021/22 £000	2020/21 £000
Operating income from patient care activities	3	410,813	363,708
Other operating income	4	51,020	67,078
Operating expenses	7, 9	(458,554)	(427,184)
Operating surplus from continuing operations		**3,279**	**3,602**
Finance income	12	14	4
Finance expenses	13	(341)	(393)
PDC dividends payable		(5,416)	(4,085)
Net finance costs		**(5,743)**	**(4,474)**
Other gains / (losses)	14	4	13
Deficit for the year from continuing operations		**(2,460)**	**(859)**
Deficit for the year	38	**(2,460)**	**(859)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(54)	(2,248)
Revaluations	18	5,843	11,216
Total comprehensive income for the period		**3,329**	**8,109**

Statement of Financial Position

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets	15	7,649	2,907
Property, plant and equipment	16	200,704	185,714
Receivables	20	1,103	1,096
Total non-current assets		**209,456**	**189,717**
Current assets			
Inventories	19	6,663	6,309
Receivables	20	17,773	16,087
Cash and cash equivalents	21	10,063	25,428
Total current assets		**34,499**	**47,824**
Current liabilities			
Trade and other payables	22	(26,534)	(30,327)
Borrowings	24	(1,516)	(1,453)
Provisions	26	(2,342)	(2,477)
Other liabilities	23	(3,562)	(4,466)
Total current liabilities		**(33,954)**	**(38,723)**
Total assets less current liabilities		**210,001**	**198,818**
Non-current liabilities			
Borrowings	24	(7,779)	(9,086)
Provisions	26	(1,866)	(1,585)
Total non-current liabilities		**(9,645)**	**(10,671)**
Total assets employed		**200,356**	**188,147**
Financed by			
Public dividend capital		268,468	259,588
Revaluation reserve		47,799	42,145
Income and expenditure reserve		(115,911)	(113,586)
Total taxpayers' equity		**200,356**	**188,147**

The notes on pages 89 to 137 form part of these accounts.



Name **Simon Weldon**
Position Group Chief Executive Officer
Date 21 June 2022

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**259,588**	**42,145**	**(113,586)**	**188,147**
Surplus/(deficit) for the year	0	0	(2,460)	**(2,460)**
Other transfers between reserves	0	(135)	135	**0**
Impairments	0	(54)	0	**(54)**
Revaluations	0	5,843	0	**5,843**
Public dividend capital received	8,880	0	0	**8,880**
Taxpayers' and others' equity at 31 March 2022	**268,468**	**47,799**	**(115,911)**	**200,356**

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**120,588**	**33,342**	**(112,892)**	**41,038**
Surplus/(deficit) for the year	0	0	(859)	**(859)**
Other transfers between reserves	0	(165)	165	**0**
Impairments	0	(2,248)	0	**(2,248)**
Revaluations	0	11,216	0	**11,216**
Public dividend capital received	139,000	0	0	**139,000**
Taxpayers' and others' equity at 31 March 2021	**259,588**	**42,145**	**(113,586)**	**188,147**

Information on reserves

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

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

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

Statement of Cash Flows

	Note	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Operating surplus / (deficit)		3,279	3,602
Non-cash income and expense:			
Depreciation and amortisation	7.1	12,022	12,291
Net impairments	8	2,096	4,351
Income recognised in respect of capital donations	4	(641)	(813)
(Increase) / decrease in receivables and other assets		(1,693)	3,197
(Increase) / decrease in inventories		(354)	(835)
Increase / (decrease) in payables and other liabilities		1,204	3,209
Increase / (decrease) in provisions		142	1,986
Other movements in operating cash flows		(10)	(11)
Net cash flows from / (used in) operating activities		**16,045**	**26,977**
Cash flows from investing activities			
Interest received		14	4
Purchase of intangible assets		(5,603)	(2,111)
Sales of intangible assets		0	0
Purchase of PPE and investment property		(27,810)	(26,473)
Sales of PPE and investment property		4	64
Net cash flows from / (used in) investing activities		**(33,395)**	**(28,516)**
Cash flows from financing activities			
Public dividend capital received		8,880	139,000
Movement on loans from DHSC		0	(107,969)
Movement on other loans		(38)	146
Capital element of finance lease rental payments		(1,206)	(1,157)
Interest on loans		0	(284)
Other interest		(1)	0
Interest paid on finance lease liabilities		(326)	(374)
PDC dividend (paid) / refunded		(5,324)	(3,971)
Net cash flows from / (used in) financing activities		**1,985**	**25,391**
Increase / (decrease) in cash and cash equivalents		**(15,365)**	**23,852**
Cash and cash equivalents at 1 April - brought forward		**25,428**	**1,576**
Prior period adjustments			0
Cash and cash equivalents at 1 April - restated		**25,428**	**1,576**
Cash and cash equivalents at 31 March	21.1	**10,063**	**25,428**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2021/22 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

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

Payment terms are standard reflecting cross government principles.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at a Sustainability and Transformation Partnership level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

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

Note 1.4 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

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

Measurement

Valuation

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

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

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

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

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

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

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

Depreciation

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

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

Revaluation gains and losses

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

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

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

Impairments

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

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

Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.
Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

Donated and grant funded assets

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

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

This includes assets donated to the trust by the Department of Health and Social Care or NHS England as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Buildings, excluding dwellings	8	55
Dwellings	34	34
Plant & machinery	5	15
Transport equipment	7	7
Information technology	3	10
Furniture & fittings	5	5

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

Note 1.8 Intangible assets

Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

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

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	Max life Years
Information technology	3	5
Software licences	1	8

Note 1.9 Inventories

The cost of inventories is measured using the first in, first out (FIFO) method.

In 2020/21 and 2021/22, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.10 Cash and cash equivalents

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

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

Note 1.11 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

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

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense.

Impairment of financial assets

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

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

A full review has been undertaken by invoice type which includes general, private patient, overseas visitors, salary overpayments and NHS organisations. This has been analysed by levels of aged debt to determine a level of anticipated loss in relation to these. The overseas visitors assumes an average recovery level on an overall rate of 12%. This does not include outstanding debt with other NHS organisations.

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

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

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

Derecognition

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

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

Note 1.12 Leases

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

The trust as a lessee

Finance leases

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

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

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

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

The trust as a lessor

Finance leases

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

Operating leases

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

Note 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2022:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	0.47%	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.70%	0.18%
Long-term	After 10 years up to 40 years	0.95%	1.99%
Very long-term	Exceeding 40 years	0.66%	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2022:

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 26.2 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

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

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity’s control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity’s control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public dividend capital

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

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

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

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

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

Note 1.16 Value added tax

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

Note 1.17 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.18 Foreign exchange

The functional and presentational currency of the trust is sterling.

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

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

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

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

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

Note 1.19 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

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

Note 1.21 Gifts

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

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

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

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	8,700
Additional lease obligations recognised for existing operating leases	(10,011)
Net impact on net assets on 1 April 2022	**(1,311)**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(2,109)
Additional finance costs on lease liabilities	(109)
Lease rentals no longer charged to operating expenditure	2,092
Estimated impact on surplus / deficit in 2022/23	**(126)**
Estimated increase in capital additions for new leases commencing in 2022/23	**2,273**

Note 1.24 Critical judgements in applying accounting policies

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

- determining the appropriate asset lives for the Trust's buildings following a professional review undertaken by professionally qualified chartered surveyors
- determining the appropriate method of valuation of the Trust's property assets and in particular when and how to apply the Modern Equivalent Asset method of valuation. The key assumptions applied in using this approach are set out in note 18

Note 1.25 Sources of estimation uncertainty

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

As detailed in Accounting Policy note 1.7, Revaluations of property plant and equipment, Valuation company Gerald Eve provided the trust with a valuation of the land and building assets (estimated fair value and remaining useful life). The significant estimation being the depreciated replacement value (using modern equivalent methodology) of the Trust's Land and Buildings. The underlying space being valued is based on an assessment of Gross Internal Area (GIA) which is undertaken by the Trust's estates department, and that this assessment is updated on a regular basis. Further revaluations of the Trust's property may result in further material change to the carrying value of these assets.

For a material change to occur a BCIS cost indices or location factor movement of 2.8% for buildings with a current carrying amount of £165.2m would be required for Northamptonshire.

Note 2 Operating Segments

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

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3

Note 3.1 Income from patient care activities (by nature)	**2021/22**	**2020/21**
	£000	**£000**
Block contract / system envelope income	364,166	320,936
High cost drugs income from commissioners (excluding pass-through costs)	28,425	24,622
Other NHS clinical income	1,051	1,688
All services		
Private patient income	643	402
Elective recovery fund	4,886	0
Additional pension contribution central funding*	10,640	9,973
Other clinical income	1,002	6,087
Total income from activities	**410,813**	**363,708**

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

	2021/22	**2020/21**
Income from patient care activities received from:	**£000**	**£000**
NHS England	62,331	62,236
Clinical commissioning groups	345,979	298,546
Other NHS providers	858	627
NHS other	0	107
Non-NHS: private patients	643	402
Non-NHS: overseas patients (chargeable to patient)	267	753
Injury cost recovery scheme	735	1,037
Total income from activities	**410,813**	**363,708**
Of which:		
Related to continuing operations	410,813	363,708
Related to discontinued operations	0	0

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

	2021/22	2020/21
	£000	£000
Income recognised this year	267	753
Cash payments received in-year	136	117
Amounts added to provision for impairment of receivables	330	45
Amounts written off in-year	422	124

Note 4 Other operating income

	2021/22			2020/21		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	133	0	**133**	241	0	**241**
Education and training	13,094	641	**13,735**	12,835	375	**13,210**
Non-patient care services to other bodies	1,336		**1,336**	1,322		**1,322**
Reimbursement and top up funding	3,394		**3,394**	36,203		**36,203**
Income in respect of employee benefits accounted on a gross basis	3,855		**3,855**	3,372		**3,372**
Receipt of capital grants and donations		641	**641**		813	**813**
Charitable and other contributions to expenditure		1,501	**1,501**		6,165	**6,165**
Support from the Department of Health and Social Care for mergers		0	**0**		0	**0**
Rental revenue from finance leases		0	**0**		0	**0**
Rental revenue from operating leases		41	**41**		30	**30**
Amortisation of PFI deferred income / credits		0	**0**		0	**0**
Other income	26,384	0	**26,384**	5,722	0	**5,722**
Total other operating income	**48,196**	**2,824**	**51,020**	**59,695**	**7,383**	**67,078**
Of which:						
Related to continuing operations			51,020			67,078
Related to discontinued operations			0			0

	2021/22	2020/21
	£000	£000
Other contract income includes :		
Development and project related funding income	10,057	813
Non Recurrent System Funding	9,102	76
Clinical Tests	843	521
Catering	743	906
Inter-hospital recharges	728	338
Car Parking Income	711	35
Training support funding	663	0
Pharmacy Sales	652	354
Accommodation Charges	379	386
VAT Audit Claim	405	79
Sterile Services Sales	39	72
Covid Antibody Tests	230	807
Non-Contract Income:		
Receipt of capital grants and donations		
Northamptonshire Health Charity	238	280
DHSC for Covid Response	403	533
Charitable and other contributions to expenditure		
Northamptonshire Health Charity	376	464
DHSC for Covid Response - Equipment	3	35
DHSC for Covid Response - Consumables (PPE)	1,122	5,666

Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

	2021/22	2020/21
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	3,085	1,814
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	0	0

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 6 Fees and charges

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

	2021/22	2020/21
	£000	£000
Income	1,504	962
Full cost	(1,185)	(1,282)
Surplus / (deficit)	**319**	**(320)**

Services include Catering and Car Parking.

Note 16.1 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**7,337**	**129,801**	**464**	**1,229**	**45,703**	**103**	**20,234**	**157**	**205,028**
Additions	0	7,043	0	19,846	4,113	39	2,804	0	**33,845**
Impairments	0	(8,533)	0	0	0	0	(1,651)	0	**(10,184)**
Reversals of impairments	1,361	2,224	0	0	0	0	0	0	**3,585**
Revaluations	0	3,507	(28)	0	0	0	0	0	**3,479**
Reclassifications	0	9,910	0	(9,230)	(680)	0	0	0	**0**
Disposals / derecognition	0	0	0	0	(1,378)	0	(755)	0	**(2,133)**
Valuation/gross cost at 31 March 2021	**8,698**	**143,952**	**436**	**11,845**	**47,758**	**142**	**20,632**	**157**	**233,620**
Accumulated depreciation at 1 April 2020 - brought forward	**0**	**2,354**	**0**	**0**	**31,222**	**59**	**12,637**	**157**	**46,429**
Provided during the year	0	5,403	28	0	3,296	13	2,607	0	**11,347**
Impairments	0	0	0	0	0	0	0	0	**0**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
Revaluations	0	(7,709)	(28)	0	0	0	0	0	**(7,737)**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Disposals / derecognition	0	0	0	0	(1,378)	0	(755)	0	**(2,133)**
Accumulated depreciation at 31 March 2021	**0**	**48**	**0**	**0**	**33,140**	**72**	**14,489**	**157**	**47,906**
Net book value at 31 March 2021	**8,698**	**143,904**	**436**	**11,845**	**14,618**	**70**	**6,143**	**0**	**185,714**
Net book value at 1 April 2020	**7,337**	**127,447**	**464**	**1,229**	**14,481**	**44**	**7,597**	**0**	**158,599**

Note 16.2 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	**9,834**	**126,366**	**495**	**650**	**46,313**	**83**	**22,211**	**157**	**206,109**
Prior period adjustments	0	0	0	0	0	0	0	0	**0**
Valuation / gross cost at 1 April 2019 - restated	**9,834**	**126,366**	**495**	**650**	**46,313**	**83**	**22,211**	**157**	**206,109**
Additions	0	5,196	0	1,208	1,794	20	2,189	0	**10,407**
Impairments	(1,090)	(2,830)	0	(54)	0	0	0	0	**(3,974)**
Reversals of impairments	0	6,233	0	0	0	0	0	0	**6,233**
Revaluations	(1,407)	(5,164)	(31)	0	0	0	0	0	**(6,602)**
Reclassifications	0	0	0	(575)	369	0	206	0	**0**
Transfers to / from assets held for sale	0	0	0	0	0	0	0	0	**0**
Disposals / derecognition	0	0	0	0	(2,773)	0	(4,372)	0	**(7,145)**
Valuation/gross cost at 31 March 2020	**7,337**	**129,801**	**464**	**1,229**	**45,703**	**103**	**20,234**	**157**	**205,028**
Accumulated depreciation at 1 April 2019 - as previously stated	**0**	**1,056**	**0**	**0**	**30,536**	**53**	**14,316**	**157**	**46,118**
Prior period adjustments	0	0	0	0	0	0	0	0	**0**
Accumulated depreciation at 1 April 2019 - restated	**0**	**1,056**	**0**	**0**	**30,536**	**53**	**14,316**	**157**	**46,118**
Provided during the year	0	4,920	31	0	3,459	6	2,693	0	**11,109**
Impairments	1,407	4,509	0	0	0	0	0	0	**5,916**
Reversals of impairments	0	(2,967)	0	0	0	0	0	0	**(2,967)**
Revaluations	(1,407)	(5,164)	(31)	0	0	0	0	0	**(6,602)**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Disposals / derecognition	0	0	0	0	(2,773)	0	(4,372)	0	**(7,145)**
Accumulated depreciation at 31 March 2020	**0**	**2,354**	**0**	**0**	**31,222**	**59**	**12,637**	**157**	**46,429**
Net book value at 31 March 2020	**7,337**	**127,447**	**464**	**1,229**	**14,481**	**44**	**7,597**	**0**	**158,599**
Net book value at 1 April 2019	**9,834**	**125,310**	**495**	**650**	**15,777**	**30**	**7,895**	**0**	**159,991**

Note 7.2 Other auditor remuneration

	2021/22	2020/21
	£000	£000
Total auditor remuneration paid to the external auditor	**0**	**0**

Note 7.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2020/21: £1 million).

Note 8 Impairment of assets

	2021/22	2020/21
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	(594)	1,651
Changes in market price	2,690	2,700
Total net impairments charged to operating surplus / deficit	**2,096**	**4,351**
Impairments charged to the revaluation reserve	54	2,248
Total net impairments	**2,150**	**6,599**

The Trust has reassessed the impairment value arising from a a revised use of the Electronic Patient Record System and on that basis made a write back adjustment of £594k, in relation to last year's impairment charge of £1,651k.

The annual desktop revaluation exercise was completed by the valuation company, Gerald Eve, as at 31 March 2022. This resulted in a net increase in site valuation of £3,099k, split as:
- £5,789k increase to Revaluation Reserve
- £2,690k charge to Impairment Reserve

There has been no significant movements in the land valuation as land values have stayed flat and the value remains broadly around £500k per acre within the Northamptonshire area.

There has been a moderate increase in the existing buildings due to a build cost price inflation. Gerald Eve refer to the BCIS for the build costs and in general many costs have risen by what would be Tender Price Indices inflation which is calculated at +5.4% since last year taking in to account the location factor.

The major impairment this financial year has been the completion of the new Critical Care Unit which resulted in a £2.9m valuation adjustment.

Note 9 Employee benefits

	2021/22 Total £000	2020/21 Total £000
Salaries and wages	234,059	216,563
Social security costs	24,685	22,242
Apprenticeship levy	1,165	1,063
Employer's contributions to NHS pensions*	34,908	32,881
Pension cost - other	94	58
Termination benefits	0	67
Temporary staff (including agency)	23,220	19,114
Total gross staff costs	**318,131**	**291,988**
Recoveries in respect of seconded staff	0	0
Total staff costs	**318,131**	**291,988**
Of which		
Costs capitalised as part of assets	849	762

* Included in the above is £10,640k (£9,973k in 2020/21) relating to the recent revaluation of public sector pensions schemes amounting to 6.3% (increase from 14.38% to 20.68%) in the employer contribution rate. In line with DHSC guidance, the Trust contributed 14.38% and the balance of 6.3% was paid on its behalf by DHSC. However the full cost of 20.68% is included on a gross basis in the accounts as entities are required to account for this as notional funding.

Note 9.1 Retirements due to ill-health

During 2021/22 there were 2 early retirements from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £225k (£73k in 2020/21).

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

Note 10 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

Note 11 Operating leases

Note 11.1 Northampton General Hospital NHS Trust as a lessor

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

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

	2021/22 £000	2020/21 £000
Operating lease revenue		
Minimum lease receipts	41	30
Contingent rent	0	0
Other	0	0
Total	**41**	**30**

	31 March 2022 £000	31 March 2021 £000
Future minimum lease receipts due:		
- not later than one year;	41	30
- later than one year and not later than five years;	0	0
- later than five years.	0	0
Total	**41**	**30**

Note 11.2 Northampton General Hospital NHS Trust as a lessee

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

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

	2021/22 £000	2020/21 £000
Operating lease expense		
Minimum lease payments	1,347	1,340
Contingent rents	0	0
Less sublease payments received	0	0
Total	**1,347**	**1,340**

	31 March 2022 £000	31 March 2021 £000
Future minimum lease payments due:		
- not later than one year;	1,174	1,280
- later than one year and not later than five years;	2,743	3,925
- later than five years.	4,838	3,713
Total	**8,755**	**8,918**
Future minimum sublease payments to be received	0	0

Note 12 Finance income

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

	2021/22	2020/21
	£000	£000
Interest on bank accounts	14	4
Total finance income	**14**	**4**

Note 13.1 Finance expenditure

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

	2021/22	2020/21
	£000	£000
Interest expense:		
Finance leases	326	375
Interest on late payment of commercial debt	1	0
Total interest expense	**327**	**375**
Unwinding of discount on provisions	4	7
Other finance costs	10	11
Total finance costs	**341**	**393**

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

	2021/22	2020/21
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	1	0
Amounts included within interest payable arising from claims made under this legislation	1	0
Compensation paid to cover debt recovery costs under this legislation	0	0

Note 14 Other gains / (losses)

	2021/22	2020/21
	£000	£000
Gains on disposal of assets	4	64
Losses on disposal of assets	0	(51)
Total gains / (losses) on disposal of assets	**4**	**13**

Note 15.1 Intangible assets - 2021/22

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2021 - brought forward	**10,493**	**345**	**845**	**11,683**
Additions	1,846	0	3,896	**5,742**
Reclassifications	918	0	(918)	**0**
Transfers to / from assets held for sale	0	0	0	**0**
Disposals / derecognition	(559)	0	0	**(559)**
Valuation / gross cost at 31 March 2022	**12,698**	**345**	**3,823**	**16,866**
Amortisation at 1 April 2021 - brought forward	**8,431**	**345**	**0**	**8,776**
Provided during the year	1,000	0	0	**1,000**
Disposals / derecognition	(559)	0	0	**(559)**
Amortisation at 31 March 2022	**8,872**	**345**	**0**	**9,217**
Net book value at 31 March 2022	**3,826**	**0**	**3,823**	**7,649**
Net book value at 1 April 2021	**2,062**	**0**	**845**	**2,907**

Note 15.2 Intangible assets - 2020/21

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**9,243**	**345**	**215**	**9,803**
Prior period adjustments	0	0	0	**0**
Valuation / gross cost at 1 April 2020 - restated	**9,243**	**345**	**215**	**9,803**
Additions	1,483	0	657	**2,140**
Reclassifications	27	0	(27)	**0**
Transfers to / from assets held for sale	0	0	0	**0**
Disposals / derecognition	(260)	0	0	**(260)**
Valuation / gross cost at 31 March 2021	**10,493**	**345**	**845**	**11,683**
Amortisation at 1 April 2020 - as previously stated	**7,696**	**345**	**0**	**8,041**
Prior period adjustments	0	0	0	**0**
Amortisation at 1 April 2020 - restated	**7,696**	**345**	**0**	**8,041**
Provided during the year	944	0	0	**944**
Disposals / derecognition	(209)	0	0	**(209)**
Amortisation at 31 March 2021	**8,431**	**345**	**0**	**8,776**
Net book value at 31 March 2021	**2,062**	**0**	**845**	**2,907**
Net book value at 1 April 2020	**1,547**	**0**	**215**	**1,762**

Note 16.1 Property, plant and equipment - 2021/22

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021 - brought forward	**8,698**	**143,952**	**436**	**11,845**	**47,758**	**142**	**20,632**	**157**	**233,620**
Additions	0	4,227	0	7,313	5,707	0	5,072	0	**22,319**
Impairments	0	(4,298)	0	0	0	0	0	0	**(4,298)**
Reversals of impairments	40	1,514	0	0	0	0	594	0	**2,148**
Revaluations	0	909	(36)	0	0	0	0	0	**873**
Reclassifications	0	18,532	0	(19,078)	546	0	0	0	**0**
Disposals / derecognition	0	0	0	0	(1,064)	0	(1,692)	0	**(2,756)**
Valuation/gross cost at 31 March 2022	**8,738**	**164,836**	**400**	**80**	**52,947**	**142**	**24,606**	**157**	**251,906**
Accumulated depreciation at 1 April 2021 - brought forward	**0**	**48**	**0**	**0**	**33,140**	**72**	**14,489**	**157**	**47,906**
Provided during the year	0	4,941	36	0	3,474	14	2,557	0	**11,022**
Impairments	0	0	0	0	0	0	0	0	**0**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
Revaluations	0	(4,934)	(36)	0	0	0	0	0	**(4,970)**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Disposals / derecognition	0	0	0	0	(1,064)	0	(1,692)	0	**(2,756)**
Accumulated depreciation at 31 March 2022	**0**	**55**	**0**	**0**	**35,550**	**86**	**15,354**	**157**	**51,202**
Net book value at 31 March 2022	**8,738**	**164,781**	**400**	**80**	**17,397**	**56**	**9,252**	**0**	**200,704**
Net book value at 1 April 2021	**8,698**	**143,904**	**436**	**11,845**	**14,618**	**70**	**6,143**	**0**	**185,714**

Note 16.2 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**7,337**	**129,801**	**464**	**1,229**	**45,703**	**103**	**20,234**	**157**	**205,028**
Prior period adjustments	0	0	0	0	0	0	0	0	**0**
restated	**7,337**	**129,801**	**464**	**1,229**	**45,703**	**103**	**20,234**	**157**	**205,028**
Additions	0	7,043	0	19,846	4,113	39	2,804	0	**33,845**
Impairments	0	(8,533)	0	0	0	0	(1,651)	0	**(10,184)**
Reversals of impairments	1,361	2,224	0	0	0	0	0	0	**3,585**
Revaluations	0	3,507	(28)	0	0	0	0	0	**3,479**
Reclassifications	0	9,910	0	(9,230)	(680)	0	0	0	**0**
Disposals / derecognition	0	0	0	0	(1,378)	0	(755)	0	**(2,133)**
Valuation/gross cost at 31 March 2021	**8,698**	**143,952**	**436**	**11,845**	**47,758**	**142**	**20,632**	**157**	**233,620**
Accumulated depreciation at 1 April 2020 - as previously stated	**0**	**2,354**	**0**	**0**	**31,222**	**59**	**12,637**	**157**	**46,429**
Prior period adjustments	0	0	0	0	0	0	0	0	**0**
restated	**0**	**2,354**	**0**	**0**	**31,222**	**59**	**12,637**	**157**	**46,429**
Transfers by absorption	0	0	0	0	0	0	0	0	**0**
Provided during the year	0	5,403	28	0	3,296	13	2,607	0	**11,347**
Impairments	0	0	0	0	0	0	0	0	**0**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
Revaluations	0	(7,709)	(28)	0	0	0	0	0	**(7,737)**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Disposals / derecognition	0	0	0	0	(1,378)	0	(755)	0	**(2,133)**
Accumulated depreciation at 31 March 2021	**0**	**48**	**0**	**0**	**33,140**	**72**	**14,489**	**157**	**47,906**
Net book value at 31 March 2021	**8,698**	**143,904**	**436**	**11,845**	**14,618**	**70**	**6,143**	**0**	**185,714**
Net book value at 1 April 2020	**7,337**	**127,447**	**464**	**1,229**	**14,481**	**44**	**7,597**	**0**	**158,599**

Note 16.3 Property, plant and equipment financing - 2021/22

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022									
Owned - purchased	8,738	145,502	400	75	16,375	43	9,231	0	**180,364**
Finance leased	0	12,371	0	0	0	0	0	0	**12,371**
Owned - donated/granted	0	6,908	0	5	1,022	13	21	0	**7,969**
NBV total at 31 March 2022	**8,738**	**164,781**	**400**	**80**	**17,397**	**56**	**9,252**	**0**	**200,704**

Note 16.4 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021									
Owned - purchased	8,698	124,950	436	11,840	13,734	54	6,138	0	**165,850**
Finance leased	0	12,069	0	0	0	0	0	0	**12,069**
Owned - donated/granted	0	6,885	0	5	884	16	5	0	**7,795**
NBV total at 31 March 2021	**8,698**	**143,904**	**436**	**11,845**	**14,618**	**70**	**6,143**	**0**	**185,714**

Note 17 Donations of property, plant and equipment

The table below details donations of property, plant and equipment received during 21/22 from Northamptonshire Health Charitable Funds. It also includes donations of equipment from DHSC as part of the coronavirus pandemic response.

Description	Department	2021/22 £000
Equipment		
Mini Dual Laser & Cart	Urology	11
Pathfiner Laptop & dual screen	Cardiology	23
		34
Buildings		
Staff Changing Rooms		142
Cheyne Walk works		62
		204
DHSC Donated Equipment		
3 x Ultrasounds	Critical Care	51
25 x GE Monitors	Trustwide	160
30 x Mindray Monitors	Trustwide	192
		403
Total Donated Assets		**641**

Note 18 Revaluations of property, plant and equipment

Valuation company Gerald Eve carried out an updated valuation as at 31st March 2022, to the 5 yearly valuation that they carried out at 31st March 2020. The valuations have been prepared to comply with IFRS, specifically with regard to IAS 16 Property Plant and Equipment, IAS40 Investment Properties.

As per the definitions in the current standard the Trust's property is identified as 'specialised property' and therefore valued on a Depreciated Replacement Cost (DRC) method.

Land values remained fairly static at £500k per acre.

Buildings increased by £3,059k , therefore an overall increase in site value of £3,099k. This includes the new Critical Care build impairment of £2.9m.

This has been funded by a £5,789k charge to the Revaluation Reserve and a £2,690k charge to the Impairment reserve.

Asset Type	Total Adjustment £000s	Revaluation Adjustment £000s	Impairment Adjustment £000s
Land	40	0	40
Building	3,059	5,789	(2,730)
Total Revaluation	**3,099**	**5,789**	**(2,690)**
Equipment Historic Cost adjustment	(135)	(135)	0
Total Adjustment	**2,964**	**5,654**	**(2,690)**

There is also a historic cost charge of £135k taken to the Revaluation Reserve for equipment, this is the adjustment made to write down the indexation that has been applied to equipment in previous years.

The Gross carrying amount of fully depreciated assets still in use for plant and equipment is £32,572k (£29,141k in 20/21) and for intangible assets it is £7,568k (£7,562k in 20/21).

Note 19 Inventories

	31 March 2022 £000	31 March 2021 £000
Drugs	2,078	2,218
Consumables*	4,557	4,072
Energy	28	19
Total inventories	**6,663**	**6,309**
of which:		
Held at fair value less costs to sell	0	0

* includes £50k (2020/21: £301k) Department of Health and Social Care centrally procured personal protective equipment

Inventories recognised in expenses for the year were £61,331k (2020/21: £58,674k). Write-down of inventories recognised as expenses for the year were £100k (2020/21: £123k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2021/22 the Trust received £1,122k of items purchased by DHSC (2020/21: £5,666k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 20.1 Receivables

	31 March 2022 £000	31 March 2021 £000
Current		
Contract receivables	11,261	11,328
Allowance for impaired contract receivables / assets	(1,304)	(1,204)
Prepayments (non-PFI)	5,571	4,991
Finance lease receivables	9	9
VAT receivable	2,192	924
Other receivables*	44	39
Total current receivables	**17,773**	**16,087**
Non-current		
Finance lease receivables	162	169
Other receivables*	941	927
Total non-current receivables	**1,103**	**1,096**
Of which receivable from NHS and DHSC group bodies:		
Current	5,287	4,520
Non-current	941	927

*Other receivables - Clinician pension tax provision reimbursement funding from NHS England

Note 20.2 Allowances for credit losses

	2021/22		2020/21	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**1,204**	**0**	**1,091**	**0**
Prior period adjustments	0	0	0	0
Allowances as at 1 April - restated	**1,204**	**0**	**1,091**	**0**
New allowances arising	661	0	813	0
Utilisation of allowances (write offs)	(561)	0	(700)	0
Allowances as at 31 Mar 2022	**1,304**	**0**	**1,204**	**0**

Note 21.1 Cash and cash equivalents movements

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

	2021/22	2020/21
	£000	£000
At 1 April	**25,428**	**1,576**
Prior period adjustments	0	0
At 1 April (restated)	**25,428**	**1,576**
Net change in year	(15,365)	23,852
At 31 March	**10,063**	**25,428**
Broken down into:		
Cash at commercial banks and in hand	20	35
Cash with the Government Banking Service	10,043	25,393
Total cash and cash equivalents as in SoFP	**10,063**	**25,428**
Bank overdrafts (GBS and commercial banks)	0	0
Drawdown in committed facility	0	0
Total cash and cash equivalents as in SoCF	**10,063**	**25,428**

Note 21.2 Third party assets held by the trust

Northampton General Hospital NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2022	31 March 2021
	£000	£000
Bank balances	0	0
Monies on deposit	0	0
Total third party assets	**0**	**0**

Note 22.1 Trade and other payables

	31 March 2022 £000	31 March 2021 £000
Current		
Trade payables	2,792	1,899
Capital payables	2,514	8,507
Accruals	16,456	17,923
Social security costs	928	869
PDC dividend payable	156	64
Other payables	3,688	1,065
Total current trade and other payables	**26,534**	**30,327**
Non-current		
Trade payables	0	0
Capital payables	0	0
Accruals	0	0
Other payables	0	0
Total non-current trade and other payables	**0**	**0**
Of which payables from NHS and DHSC group bodies:		
Current	1,306	1,062
Non-current	0	0

Note 22.2 Early retirements in NHS payables above

There was no early retirements included in the payables note above (2020/21 - Nil)

Note 23 Other liabilities

	31 March 2022 £000	31 March 2021 £000
Current		
Deferred income: contract liabilities	3,562	4,466
Total other current liabilities	**3,562**	**4,466**
Non-current		
Deferred income: contract liabilities	0	0
Total other non-current liabilities	**0**	**0**

Note 24.1 Borrowings

	31 March 2022 £000	31 March 2021 £000
Current		
Other loans - Salix	262	247
Obligations under finance leases	1,254	1,206
Total current borrowings	**1,516**	**1,453**
Non-current		
Other loans - Salix	710	763
Obligations under finance leases	7,069	8,323
Total non-current borrowings	**7,779**	**9,086**

Other Loans - Salix

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

The Trust has agreed 13 schemes since 2013/14, of which 7 have been fully repaid.

Each of the loans are subject to zero interest and the remaining outstanding loans are repayable over 5 years in equal instalments. Repayment commences 6 months after completion of the scheme.

Note 24.2 Reconciliation of liabilities arising from financing activities - 2021/22

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2021	**0**	**1,010**	**9,529**	**0**	**10,539**
Cash movements:					
Financing cash flows - payments and receipts of principal	0	(38)	(1,206)	0	**(1,244)**
Financing cash flows - payments of interest	0	0	(326)	0	**(326)**
Non-cash movements:					
Application of effective interest rate	0	0	326	0	**326**
Carrying value at 31 March 2022	**0**	**972**	**8,323**	**0**	**9,295**

Note 24.3 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2020	**108,253**	**864**	**10,685**	**0**	**119,802**
Prior period adjustment	0	0	0	0	**0**
Carrying value at 1 April 2020 - restated	**108,253**	**864**	**10,685**	**0**	**119,802**
Cash movements:					
Financing cash flows - payments and receipts of principal	(107,969)	146	(1,157)	0	**(108,980)**
Financing cash flows - payments of interest	(284)	0	(374)	0	**(658)**
Non-cash movements:					
Application of effective interest rate	0	0	375	0	**375**
Carrying value at 31 March 2021	**0**	**1,010**	**9,529**	**0**	**10,539**

Note 25 Finance leases

Note 25.1 Northampton General Hospital NHS Trust as a lessor

Future lease receipts due under finance lease agreements where the trust is the lessor:

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

	31 March 2022	31 March 2021
	£000	£000
Gross lease receivables	**171**	**178**
of which those receivable:		
- not later than one year;	9	9
- later than one year and not later than five years;	36	36
- later than five years.	126	133
Net lease receivables	**171**	**178**
of which those receivable:		
- not later than one year;	9	9
- later than one year and not later than five years;	36	36
- later than five years.	126	133
The unguaranteed residual value accruing to the lessor	0	0
Contingent rents recognised as income in the period	0	0

Note 25.2 Northampton General Hospital NHS Trust as a lessee

Obligations under finance leases where the trust is the lessee.

The Trust car park decking and Nye Bevan block were both completed under a Finance Lease arrangement. Each lease has a 10 year term; the car park is due to end in 2025/26 and the Nye Bevan block in 2028/29.

	31 March 2022	31 March 2021
	£000	£000
Gross lease liabilities	**8,323**	**9,529**
of which liabilities are due:		
- not later than one year;	1,254	1,206
- later than one year and not later than five years;	5,265	5,244
- later than five years.	1,804	3,079
Finance charges allocated to future periods	0	0
Net lease liabilities	**8,323**	**9,529**
of which payable:		
- not later than one year;	1,254	1,206
- later than one year and not later than five years;	5,265	5,244
- later than five years.	1,804	3,079
Total of future minimum sublease payments to be received at the reporting date	0	0
Contingent rent recognised as expense in the period	0	0

Note 26 Provisions for liabilities and charges

Note 26.1 Provisions for liabilities and charges analysis

	Pensions: injury benefits	Redundancy	2019/20 Clinicians' Pension Re-imbursement	Other	Total
	£000	£000	0	£000	£000
At 1 April 2021	**175**	**71**	**966**	**2,850**	**4,062**
Change in the discount rate	3	0	0	0	**3**
Arising during the year	0	0	19	2,347	**2,366**
Utilised during the year	(15)	(41)	0	(391)	**(447)**
Reversed unused	0	(30)	0	(1,750)	**(1,780)**
Unwinding of discount	4	0	0	0	**4**
At 31 March 2022	**167**	**0**	**985**	**3,056**	**4,208**
Expected timing of cash flows:					
- not later than one year;	15	0	44	2,283	**2,342**
- later than one year and not later than five years;	59	0	54	773	**886**
- later than five years.	93	0	887	0	**980**
Total	**167**	**0**	**985**	**3,056**	**4,208**

Pensions: injury benefits provisions are based on expected lives and current levels of payment.

Clinician pension tax reimbursement

Clinicians who are members of the NHS Pension Scheme and face an annual allowance tax charge for work undertaken in 2019/20 can elect to have this charge paid by the NHS Pension Scheme. The employing trust will make a contractually binding commitment to pay a corresponding compensated amount on retirement, therefore the provider has a future obligation upon the individual's retirement.

NHS England have provided Trust's with an updated calculation for provision liabilities arising from the 2019/20 clinicians' pensions compensation scheme based on the latest available information on actual uptake of the scheme. The values are derived from combining information on applications to join the 2019/20 scheme under the policy, together with information in the scheme pays election form where present, and with averages assumed where these forms are absent or clearly an estimate (values less than £100). Future liabilities based on individual member data and scheme rules are then discounted to give totals for each Trust.

This payment will be nationally funded therefore the provision recognised is matched with a receivable from NHS England (Note 20.1).

Other Provisions

Other Provisions relate to employment claims and asbestos management and removal costs.

Note 26.2 Clinical negligence liabilities

At 31 March 2022, £301,652k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Northampton General Hospital NHS Trust (31 March 2021: £189,248k).

Note 27 Financial Guarantee

During 2021/22 the Trust entered into a Financial Arrangement with Novinti and Compass for the Front Entrance and Retail Development. Under this Arrangement Compass has a 15 Year Lease with Novinti to occupy this Footprint. The Trust has step in rights under this arrangement should Compass default to the value of £283k per annum. This is considered a guarantee which would be accounted for under IFRS9 Financial Instruments. It is Trust Management's Assessment of Risk that the likelihood of this happening in the foreseeable future is minimal therefore the guarantee value disclosed is £nil.

Note 28 Contractual capital commitments

	31 March 2022	31 March 2021
	£000	£000
Property, plant and equipment	783	8,833
Intangible assets	974	875
Total	**1,757**	**9,708**

Note 29 Financial instruments

Note 29.1 Financial risk management

Note Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Group are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

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

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

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust 's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2020 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust 's operating costs are incurred under contracts with primary care, Clinical Commissioning Groups, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 29.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	10,001	**10,001**
Other investments / financial assets	0	**0**
Cash and cash equivalents	10,063	**10,063**
Total at 31 March 2022	**20,064**	**20,064**

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	10,163	**10,163**
Other investments / financial assets	0	**0**
Cash and cash equivalents	25,428	**25,428**
Total at 31 March 2021	**35,591**	**35,591**

Note 29.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	0	**0**
Obligations under finance leases	8,323	**8,323**
Other borrowings	972	**972**
Trade and other payables excluding non financial liabilities	25,450	**25,450**
Total at 31 March 2022	**34,745**	**34,745**

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	0	**0**
Obligations under finance leases	9,529	**9,529**
Other borrowings	1,010	**1,010**
Trade and other payables excluding non financial liabilities	29,394	**29,394**
Total at 31 March 2021	**39,933**	**39,933**

Note 29.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2022	31 March 2021
	£000	£000
In one year or less	26,966	30,847
In more than one year but not more than five years	5,975	6,007
In more than five years	1,804	3,079
Total	**34,745**	**39,933**

Note 29.5 Fair values of financial assets and liabilities

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

Note 30 Losses and special payments

	2021/22 Total number of cases Number	2021/22 Total value of cases £000	2020/21 Total number of cases Number	2020/21 Total value of cases £000
Losses				
Cash losses	9	6	0	0
Bad debts and claims abandoned	242	437	308	183
Total losses	**251**	**443**	**308**	**183**
Special payments				
Ex-gratia payments	48	484	34	71
Special severance payments	1	20	0	0
Total special payments	**49**	**504**	**34**	**71**
Total losses and special payments	**300**	**947**	**342**	**254**
Compensation payments received		0		0

Ex-gratia payments in 2021/22 include overtime corrective payments made by the Trust in respect of the “Flowers” case of £337k. This is counted as a single case in the disclosure.

Note 31 Related parties

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

The Department of Health & Social Care 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 include :

Health Education England, NHS England, Northamptonshire & Milton Keynes Clinical Commissioning Groups, East Midlands Specialised Commissioning Hub, Central Midlands Local Office, Northamptonshire Healthcare NHS Foundation Trust, Kettering General Hospital Foundation Trust, University Hospitals of Leicester NHS Trust, Oxford University Hospitals Foundation Trust, NHS Resolution and NHS Blood and Transplant.

Group Transactions with Kettering General Hospital Foundation Trust were £2,922k for Total Income and £2,043 for Total Expenditure.

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), Northamptonshire County Council (Pathology Services) and HM Revenue & Customs (Employers National Insurance contribution), National Health Service Pension Fund Scheme and NHS Business Services Authority.

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

Grants 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 Building Works & Medical Equipment.

The Charity owns Springfield House, part of which is being leased to the Trust. The facility is being utilised to provide a GP streaming service. The Trust pays an annual lease charge and also facilities costs.

Note 32 Events after the reporting date

There are no material events after the reporting date of 31 March 2022 which effect the financial position.

Note 33 Better Payment Practice code

Non-NHS Payables	2021/22 Number	2021/22 £000	2020/21 Number	2020/21 £000
Total non-NHS trade invoices paid in the year	69,524	164,992	64,800	146,350
Total non-NHS trade invoices paid within target	68,307	162,600	63,937	144,396
Percentage of non-NHS trade invoices paid within target	98.2%	98.6%	98.7%	98.7%
NHS Payables				
Total NHS trade invoices paid in the year	1,640	25,176	1,604	21,839
Total NHS trade invoices paid within target	1,614	25,072	1,553	21,652
Percentage of NHS trade invoices paid within target	98.4%	99.6%	96.8%	99.1%

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

Note 34 External financing limit

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

	2021/22 £000	2020/21 £000
Cash flow financing	23,001	6,168
Finance leases taken out in year	0	0
Other capital receipts	0	0
External financing requirement	**23,001**	**6,168**
External financing limit (EFL)	23,001	37,059
Under / (over) spend against EFL	**0**	**30,891**

Note 35 Capital Resource Limit

	2021/22 £000	2020/21 £000
Gross capital expenditure	28,061	35,985
Less: Disposals	0	(51)
Less: Donated and granted capital additions	(641)	(813)
Plus: Loss on disposal from capital grants in kind	0	0
Charge against Capital Resource Limit	**27,420**	**35,121**
Capital Resource Limit	27,420	42,262
Under / (over) spend against CRL	**0**	**7,141**

Note 36 Breakeven duty financial performance

	2021/22 £000
Adjusted financial performance surplus / (deficit) (control total basis)	377
Remove impairments scoring to Departmental Expenditure Limit	(594)
Add back non-cash element of On-SoFP pension scheme charges	0
IFRIC 12 breakeven adjustment	0
Breakeven duty financial performance surplus / (deficit)	**(217)**

Note 37 Breakeven duty rolling assessment

The application of breakeven duty means that if a cumulative surplus or deficit is reported (greater than a materiality threshold of 0.5% of operating income), it should be recovered within the subsequent four financial years.

	2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000
Breakeven duty in-year financial performance		2,081	1,109	504	399	197	(16,525)
Breakeven duty cumulative position	2,892	4,973	6,082	6,586	6,985	7,182	(9,343)
Operating income		227,805	236,260	255,481	271,295	276,894	270,358
Cumulative breakeven position as a percentage of operating income		2.2%	2.6%	2.6%	2.6%	2.6%	(3.5%)

	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000
Breakeven duty in-year financial performance	(20,151)	(13,847)	(23,339)	(14,432)	(19,055)	2,789	(217)
Breakeven duty cumulative position	(29,494)	(43,341)	(66,680)	(81,112)	(100,167)	(97,378)	(97,595)
Operating income	273,562	298,240	304,760	326,571	359,129	430,786	461,833
Cumulative breakeven position as a percentage of operating income	(10.8%)	(14.5%)	(21.9%)	(24.8%)	(27.9%)	(22.6%)	(21.1%)

Note 38 Adjusted Financial Performance

	2021/22	2020/21
Adjusted financial performance (control total basis):	**£000**	**£000**
Deficit for the period	(2,460)	(859)
Remove net impairments not scoring to the Departmental expenditure limit	2,690	2,700
Remove (gains) / losses on transfers by absorption	0	0
Remove I&E impact of capital grants and donations	(104)	(402)
Prior period adjustments	0	0
Remove non-cash element of on-SoFP pension costs	0	0
Remove net impact of inventories received from DHSC group bodies for COVID response	251	(301)
Remove loss recognised on return of donated COVID assets to DHSC	0	
Adjusted financial performance Surplus	**377**	**1,138**

The increase in impairment of £2,600k relates to a revaluation exercise applied to the Trust's building as at 31 March 2021 and is excluded from retained deficit and statutory breakeven in accordance with the DHSC Group Accounting Manual (GAM), note 16 refers.

Donated asset adjustment of £104k (consisting of £537k donated depreciation less £641k donated additions) is excluded from retained surplus and statutory breakeven duty in accordance with the DHSC Group Accounting Manual.

NHS

Northampton General Hospital

NHS Trust

Proud to be a part of

University Hospitals of Northamptonshire

NHS Group

September 2022