NHS

Northampton General Hospital

NHS Trust

ANNUAL REPORT AND ACCOUNTS 2016/17

CONTENTS

All NHS organisations are required to publish an annual report and financial statements at the end of each financial year. This report provides an overview of the work of Northampton General Hospital NHS Trust between 1st April 2016 and 31st March 2017.

The report is made up of three parts:

SECTION ONE:

PERFORMANCE REPORT

Chairman and Chief Executive's Overview

Welcome to our 2016/17 annual report. This report summarises some of our main achievements and challenges over the last year. It covers our finances and other important measures of our overall performance. We recommend reading this report alongside our Quality Account, which looks at the quality of our services over the same time period.

Our ongoing challenge is to deliver the best possible care for all our patients within our available resources. The recurring theme of the year was pressure on the urgent care system and its impact across the hospital. Against a national backdrop of unprecedented strain on NHS services, our emergency department treated more patients than ever before. The increasingly complex medical and nursing needs of our patients, particularly our older patients, meant we also admitted people in greater numbers than before for assessment or treatment.

There was a relentless focus through the hospital on ensuring our patients were safe and maintaining patient flow so that we could admit those patients in need of our care.

Our urgent care working group introduced significant changes during the year to strengthen our position. The group's main areas of focus during the year were:

- the introduction of the SAFER patient flow bundle – a set of simple rules to improve patient flow and prevent unnecessary waiting for patients
- the Red to Green initiative which sets out standards clarifying the expected time periods in which interventions and procedures should be performed.
- the development of the Dickens Therapy Unit, a therapy-led model of care for providing rehabilitation to help patients to go home, or move onto a suitable place of residence, as independently as possible

The impact of our urgent care pressures reverberated across the hospital, including our financial services. Thanks to the outstanding performance of our finance team, alongside our improving quality and efficiency (IQE) programme and a concerted drive across all departments, we finished the year well within the agreed financial targets. We achieved a year-end position £1.3million better than plan.

Sustainability and transformation plan

Caring for higher numbers presents enormous challenges for a hospital in one of the UK's biggest population growth areas and one of our key priorities is to work with partners locally and the wider NHS economy to look for realistic and sustainable solutions.

During the year Northamptonshire's sustainability and transformation plan (STP) was published outlining how health and social care services in the county will be reshaped to focus on keeping people well – and giving them the right help as close to home as possible.

The STP is designed to ensure that services can meet the needs of local people in the future. To achieve this, there needs to be change. Without change, we will not be

able to deal with the significant challenges we are now facing. The plan is ambitious in scope and will require significant and fundamental changes to the way the health and social care system works.

National events

During the year we were affected by a number of national events and developments, the most significant being the outcome of a referendum in favour of a British withdrawal from the European Union. In the immediate aftermath of the result, we faced much uncertainty about the implications for our international employees. Just over a quarter of our staff were born outside the UK, spanning 91 separate countries or states. It is universally recognised that the entire NHS is dependent on the contribution of non-UK employees but it remains unclear at the time of producing this annual report what the impact of Brexit negotiations will be.

We also started the year with a continuation of the national dispute between junior doctors and the government about the imposition of a new employment contract. A mammoth effort involving teams across the hospital saw us develop plans for dealing with industrial action and we were proud to see that elements of our planning process were adopted as best practice nationally.

Our workforce

With the junior doctors contract dominating the national media agenda, we were approached by Two Four, an award-winning production company commissioned by Channel 4 to produce a documentary series celebrating the work of junior doctors. The four-part series, *Confessions of a Junior Doctor*, was filmed between August and December and when broadcast, it generated overwhelming support from our local community and the wider medical community in the UK.

One of our motivating factors for agreeing to take part in *Confessions of a Junior Doctor* was our pride in the support we give our junior doctors, academically, professionally and pastorally. We recognise that in responding to the sustained pressures across our services, all of our staff have given above and beyond the call of duty every day and so we took steps to bolster the support available to them.

In April 2016, we set a target that at least 10 per cent of our staff should have taken up some of the health and wellbeing initiatives on offer. By the end of the year, 27 per cent of staff had participated in a health and wellbeing initiative - approximately 1,355 staff.

As part of our health and wellbeing strategy, we identified that one of the key areas of employee support that we needed to focus on was mental wellbeing. This year, alongside our physical activity agenda, we will be doing more to tackle stigma and discrimination associated with mental health.

To this end, we have been working with Time to Change, a national campaign run by charities Mind and Rethink Mental Illness. In February, we joined the 473 other organisations which have signed the Time to Change Employer Pledge,

demonstrating our commitment to addressing stigma and discrimination in the workplace. Our pledge is to create a culture where our staff feel they can openly discuss and manage their mental wellbeing. We will raise awareness of the importance of mental health and wellbeing at work and provide the resources and tools our staff need to help them lead healthy lives, cope with the daily pressures, have positive relationships and achieve their full potential.

Our aim is not solely to be a hospital that responds to our patients' needs, but to be a health-promoting organisation making an active contribution to improving the wider health and wellbeing of our staff, our patients and those with whom we come into contact.

The launch of a new nursing and midwifery strategy was a defining moment for those professions at our hospital. Nearly 2,000 nurses, midwives and health care assistants were directly involved in the development of Our Journey to Pathway to Excellence.

It followed a three-month consultation period where nurses and midwives contributed their ideas and suggestions via suggestions boxes, consultation meetings and workshops.

The three-year strategy sets out the principles underpinning the delivery of nursing and midwifery services at the hospital:

- Excellence in patient care
- Building and strengthening leadership at all levels
- Recognising the work of nurses and midwives
- Protecting and promoting wellbeing in a positive practice environment
- Providing opportunities to develop skills and knowledge empowering nursing and midwifery teams to make decisions about clinical practice
- Establishing nursing and midwifery roles that are fit for the future

The strategy followed the announcement earlier this year that we are the first NHS hospital in the UK to sign up to an internationally-recognised programme for nursing and midwifery standards. The Pathway to Excellence programme recognises hospitals for the quality of patient care and professional satisfaction of the nurses and midwives who work in them. The programme is delivered by the American Nurses Credentialing Center (ANCC).

Achieving Pathway to Excellence accreditation mirrors what we're working to achieve here in Northampton, a culture where our nurses and midwives feel inspired and valued and where we aim to deliver the best possible care for our patients. It opens up exciting new opportunities to learn from a global community of healthcare settings, all sharing a common aim of achieving excellent standards of care.

During the year, we welcomed a group of history-making students who are leading the way in shaping the nursing workforce of the future. Thirty eight nursing associate students were recruited to a landmark pilot scheme, and the group began their studies at the University of Northampton in the Spring. The new nursing associate role is a key part of national plans to create a strong, sustainable nursing workforce

for the future. The nursing associates will work alongside existing health care support workers and registered nurses to deliver hands-on care for patients.

We introduced a new student placement model transforming the way student nurses are trained at the hospital following a successful pilot on two of our adult wards. Working with the University of Northampton we designed the programme, known as PL@N (Practice Learning at Northampton General Hospital). It incorporates the principles of supportive collaborative learning and coaching which means that the whole ward team is involved in our student nurses' development and training.

The strength of the support we give our student nurses means we were among the top-performing NHS employers in the country when it comes to mandatory accreditation of overseas nurses and midwives. Although the nurses we recruit from abroad are qualified in their home country, there is another layer of accreditation they have to undertake before they can register to practice here, to demonstrate they have the necessary clinical skills. We are one of only three NHS employers nationally to boast a 100 per cent pass rate among its overseas nurses who sit the OSCE examination, a test of competence that must be passed before a nurse from outside the EEA (European Economic Area) can practice in the UK.

Our patients

A significant amount of the feedback we receive from patients is not directly related to the medical or nursing treatment they received, it's about how we made them feel.

This year, we saw sustained improvement and achieved our highest ever score in the national Friends and Family Test (FFT), a survey recording the percentage of patients who would recommend to friends and family the hospital in which they had received treatment.

A development for 2016 was our inaugural patient listening event in which we posed the question to a group of former patients and their families: "*If you had a magic wand, what changes would you make to improve the experiences of care for other patients and families?*" A random selection of 26 patients who were inpatients in May were invited to attend the event with their families.

The listening event is just one way we used patient feedback to drive improvements. We started real-time patient surveys on our wards in a bid to ensure that feedback to our wards is timely and meaningful.

We're one of only six NHS organisations taking part in a research project to develop a national toolkit for using patient experience data to improve care. The collaborative research project will examine how frontline hospital staff use patient experience data to improve care. The project is led by the University of Oxford's Nuffield Department of Primary Care Health Sciences and Picker Institute Europe and funded by the National Institute for Health Research HS&DR Programme.

The aim of the project is to build an understanding of which types of data or quality improvement approaches are more or less likely to be useful with frontline teams in making health care more person-centred. The two-year project will result in the

production of a practical toolkit for the NHS on strategies for making patient experience data more convincing, credible and useful for frontline teams and Trusts.

During the year, we strengthened our support for patients at risk of domestic abuse with the creation of a new role of Independent Domestic Violence Advisor (IDVA) employed by Northamptonshire Sunflower Centre and based with us to offer advice and guidance to adults who have experienced domestic abuse and are at risk of injury, harm or homicide.

Based initially in the hospital's maternity offices, the role works alongside the hospital's safeguarding midwives. One in six pregnant women will experience domestic violence and around 30 per cent of domestic violence starts or worsens during pregnancy. This means our maternity team is uniquely positioned to identify women who are victims of domestic abuse and to offer support or make a child protection referral where appropriate.

However, we have lots of other departments providing treatment and care to domestic abuse victims, most obviously our various emergencies teams but by no means limited to those. We also know that our ward staff sometimes witness controlling or abusive behaviours towards an individual in-patient from a relative. Those situations can be very difficult for any member of staff to deal with; one of the aims of this new role is to give extra support to our staff in responding to situations where we have concerns that a patient is experiencing abuse.

A considerable amount was achieved during the year for the benefit of our patients who have dementia and their families. We launched *Do It For Dementia* as our primary fundraising campaign.

Over 7,000 people in Northamptonshire have dementia. The Department of Health estimates that only 59 per cent of people with dementia have a formal diagnosis. For patients with memory problems such as those with dementia, a hospital can feel like a chaotic and frightening environment.

With an initial target of £50,000, *Do it for Dementia* is raising money help create dementia-friendly spaces and to buy equipment and resources that will help to reduce confusion, anxiety and distress for patients who have dementia. It also supports our work around preventing depletion in life skills when patients come into hospital.

As part of the *Do It For Dementia* campaign, a 19-metre reminiscence mural of Abington Park was installed in the corridor to our elderly care wards. The spectacular image also triggers memories using the sense of smell and sound. Noises from the park are played through the corridor and the smell of cut grass can be pumped to transport patients away from the reality of the hospital environment to their memories of the park.

Other projects include the refurbishment of a kitchen and therapy area as well as plans for a redesign for dedicated garden area so patients with dementia can spend time outside in the fresh air. As well as those big ticket items, there are lots of resources that we'd like to see on wards across the hospital such as special clocks, memory boxes to encourage soothing reminiscences and calming activities and games.

During the year, nutrition, catering and nursing staff worked together to create a finger food menu for any patient who has difficulty eating a more conventional hot meal and has particular benefits for patients with dementia. The food boxes, providing a selection of finger foods, meet a calorie count of 400 across the required food groups.

Our patients with dementia can often have difficulty eating and drinking in hospital: it's an unsettling and confusing environment and the food we serve might not be familiar to them. As dementia progresses, people often find cutlery difficult to manage and they can lose the ability to identify their own thirst and hunger.

The food isn't wrapped, so it's easier for patients to pick the food up, and to eat when they want, not when we say it's time to eat. It gives them independence to make their own choices around when to eat. It empowers them. It's also good for our nurses because they can be confident that our patients are getting the right nutrition.

We further strengthened the support we give to patients with dementia and their loved ones with to the introduction of John's Campaign on our adult wards.

The aim of John's Campaign is to give relatives of patients with dementia more involvement in their care when they're admitted to hospital and this includes acknowledging the need for more flexible visiting times on wards.

Carers know all the little things about a patient that can make a big difference to the quality of their care. They know the patient best, they know their routines, what they like and dislike. When we involve carers, the patients are more likely to engage better with their treatment so it can reduce the length of stay. That's really good news for our patients because it means they can be back at home sooner.

Our local community

Two events in particular took place during the year that showcase the wonderful support we get from our local community:

- In autumn, we were inundated with donations when we called on local knitters and knitting groups to knit and donate twiddlemuffs to help reduce agitation and restlessness in patients with dementia. A twiddlemuff is a knitted handmuff with bits and bobs like zips and buttons added and incorporating different textures. Dementia can result in restless hands and agitation and twiddlemuffs can provide visual, tactile and sensory stimulation for people with dementia - as well as keeping hands cosy and warm.

- On World Book Day we launched our Bedside Book Club, a mobile library for our adult in-patients. It followed a town-wide campaign where we asked people living and working in Northampton to donate a copy of their favourite book. Thanks to the support of many Northampton businesses and employers, as well as individual donations, we collected an amazing 5,000 books. The library has been extremely well received on the wards taking part and we plan to roll it out to all adult wards before the end of the year.

Our volunteers

The volunteer service aims to support clinical staff to provide the best possible care to our patients.

In April, we appointed a volunteer services manager to oversee the service and increase the presence of volunteers across the hospital. In the course of the year, a new volunteer policy was ratified, confirming our commitment to a robust process ensuring that volunteers are recruited safely and are trained to ensure patient safety.

Following a number of recruitment events and promotions, we recruited an additional 160 volunteers, an increase of 75 per cent on the previous year. We ended the year with a volunteer presence in 23 wards and support services. In addition, 237 volunteers received mandatory training and various other bespoke training packages were created.

We introduced a new volunteer uniform to demonstrate that we value our volunteers as well as making it easier for colleagues, patients and visitors to recognise them.

Our buildings, facilities and IT infrastructure

We now boast the most advanced cancer centre in the UK thanks to a £5.5 million upgrade of our radiotherapy service. Patients receiving radiotherapy treatment now benefit from a greater range of therapies, better accuracy in targeting cancer cells and reduced side effects thanks to the purchase of three new linear accelerator (LINAC) machines, the most sophisticated cancer machines in the UK.

A linear accelerator (LINAC) is the device most commonly used for external beam radiation treatments for patients with cancer. The linear accelerator is used to treat all parts of the body by delivering high-energy x-rays to the region of the patient's tumour.

The upgrade has taken place in tandem with increased collaboration with University Hospitals of Leicester NHS Trust to develop a centre of regional excellence in oncology services for the East Midlands region.

Our partnership with Boots UK enjoyed a successful first year, with the outpatient pharmacy improving services and reducing waiting times for patients. During the first year of operation, over 35,000 patients visited Boots pharmacy. The turnaround on dispensing medicines since the partnership was established in June 2015 increased in speed, with 75 per cent of patients in the area receiving their prescriptions within 15 minutes compared to 29 per cent in 2015. We also saw a significant drop in the average wait time for patients in the same time period from 67 minutes to 41 minutes.

Despite the high levels of activity, we were able to make significant progress in planning, re-developing and improving our clinical areas including:

- The last phase of improvement works within our A&E department was completed. The phased re-development programme, taking place over the past four years, has seen the whole area brought up to latest standards,

capacity increased considerably, additional clinical facilities such as a new ambulatory care centre, a state-of-the-art resuscitation area and clinical observation unit developed – all while maintaining business as usual

- A much-needed expansion to the chemotherapy suite began following a highly successful fundraising campaign. We're seeing increasing numbers of patients receiving cancer treatment and that's largely because treatments are getting better, we have a greater range of options for treating patients and we have longer treatment cycles. That's really good news for our patients - but it means that we've outgrown the facilities for our day patients and we needed to invest in an upgrade of the chemotherapy suite to make their stay more comfortable and improve the working environment for the team.

- A new permanent CT scanning suite was installed, which means we no longer need to utilise a mobile unit which was previously brought to site for two or three days every week.

- During the year, we carried out extensive planning and design work for a new 60-bed assessment hub. The new unit will will be sited on the car park at the front of the A&E department and construction work will commence in the summer of 2017.

- Plans were also developed to provide a GP led streaming unit at the Springfield building adjacent to the A&E department. Its co-location to our emergency department will ensure that patients in need of primary care services can receive these in the most appropriate setting and help alleviate pressure from the increasing attendances in at A&E.

We have continued throughout the year to replace essential services such as heating, ventilation, electrical and water pipework services across the site, as well as ensuring that our public spaces throughout the hospital are kept bright and fresh looking to provide a welcoming environment to our patients and visitors.

Throughout the year, we benefitted from our investment in a robust IT infrastructure, continuously developed to meet the increasing demands of our systems and services. Our previously built-in resilience has reaped huge dividends in zero network downtime and only scheduled server downtime over the course of the year, critical in giving clinicians confidence to move towards "paper-lite" working by 2020 in line with the National Information Board's vision for the NHS. Indeed our emergency department is already working in a paper-lite way. As we produce this annual report, we are in the final stages of procurement to refresh our wireless network, further enabling clinicians to access information on the move.

Excellent progress was made with our *best of breed* approach to electronic patient records:

- electronic prescribing and medicines management is now in use throughout medicine (including the emergency department) and trauma and orthopaedics

- all discharge summaries and clinical correspondence are sent electronically to primary care
- all vital signs and some nursing assessments are recorded electronically
- full electronic order communications for pathology, radiology and a significant number of other services has been in use for quite some time.

Our new core Emis patient administration system is due to go live in June and this will link our suite of Emis products, ED Symphony, Pharmacy, ePMA and PAS in the first instance through a health application portal improving our patient-centric view of clinical information.

As a member of the EMRAD Vanguard consortium since its inception, we worked to improve radiology systems and services across the East Midlands in collaboration with six other hospital trusts. This project made good progress over the year and is enabling sharing of images across the sites, moving towards cross site reporting for the benefit of our patients.

Priorities for the coming year include the PAS go-live and the potential for further integration and clinical noting. We will support greater use of our EMC vendor neutral archive for image storage and further digital records scanning and we will begin the process of replacing our laboratory information management system in collaboration with neighbouring NHS trusts.

Due to the increased focus of cyber-attacks on healthcare, security is paramount on our agenda. In May 2017, a global cyber attack infected many NHS organisations; we were not infected but we took precautionary measures to protect our systems. Thanks to our robust business contingency planning, there was no disruption to scheduled activity. While A&E saw an increase in activity as a result of GP surgeries being affected by the attack, our resilience plans ensured that patient safety remained our top priority.

Our awards

In a year in which we cared for more people than ever before, we had so much to celebrate and the nominations flooded in from members of the public, patients and staff for our 2016 Best Possible Care Awards - which made shortlisting the entries a very difficult task.

We hold these awards to recognise our employees and volunteers who make an exceptional contribution to patient care – and they took place last year thanks to funding from the Northamptonshire Health Charitable Fund and sponsorship from Johnson & Johnson, Avery Healthcare and the BGL Group.

In the midst of all the discussion around pressures on NHS services, our Best Possible Care Awards are an opportunity to take stock of and celebrate the competence and commitment, the professionalism and pride, the exuberance and enthusiasm that we see every day in every ward and every department.

As well as our own awards, we were delighted that a number of our employees were recognised on the national stage for their exceptional achievements:

- Our Chit Chat group was set up as a way of tailoring antenatal education, parenting advice and peer support to women with additional needs including learning disabilities or anxiety. The safeguarding midwives who set up the group won the Enhancing Patient Dignity category of the Nursing Times Awards as well as being finalists in the Royal College of Midwives awards and the Patient Experience Network awards.

- A successful campaign to recruit nurses onto our staff bank won a Public Services Communications gold award celebrating excellence in communications in the public sector. We were the only acute NHS Trust shortlisted for the awards and one of only four organisation nationally to achieve a gold award.

  The nurse bank campaign, entitled "*Join our bank and we'll invest in you*" was also shortlisted in the communications category of the HSJ Value in Healthcare Awards and the staff engagement category of the HSJ Awards.

- Three of our nursing staff were shortlisted for the East Midlands Leadership Academy award. Safeguarding midwife Emma Fathers, ward sister Stacey Cheney and pre-operative assessment sister Sharron Matthews were all finalists in recognition of their outstanding leadership qualities and commitment to improving patient care.

- We were recognised by the NHS for excellence in sustainability reporting, by the Green Organisation with their Golden Apple award for healthcare environmental best practice and we maintained our Investors in the Environment green accreditation, with Best Green Champion (Large Organisations) awarded for the second year.

- Our catering team maintained our bronze Food for Life accreditation for patient meals and extended it to the food served to staff and visitors in the restaurant.

- Our procurement team was highly commended in the sustainable procurement category at the Health Care Supply Association awards. The team have shown how refurbishing condemned furniture such as overbed tables and patient lockers can cut costs in half, which producing environmental and patient experience improvements.

- A quality improvement project which halved the length of time for an emergency gynaecological examination was shortlisted in the HSJ Value in Healthcare awards. Doctors introduced gynaecology emergency assessment bags into the emergency department so that the specialist equipment for a comprehensive gynaecological assessment would be immediately available. As a result, the length of time a patient waits in the department for an examination has been more than halved. It was very simple and inexpensive solution that's significantly reduced waiting times for our patients.

- We scooped a prestigious baby friendly award from children's rights organisation Unicef. The Baby Friendly Initiative, set up by Unicef (United

Nation's Children's Fund) and the World Health Organisation, is a global programme which provides a practical and effective way for health services to improve the care provided for all mothers and babies.

In Northampton, just under 80 per cent of mothers choose to breastfeed their babies. We know that breastfeeding helps protect babies from a range of illnesses like gastroenteritis, chest infections, ear infections. The Baby Friendly award means we have best practice standards in place to strengthen mother-baby relationships and to support mothers who chose to breastfeed.

- We were shortlisted for the Northamptonshire Sports awards in the Active Workplace category. We were recognised for our activity programmes to improve staff health and wellbeing which include nutrition and fitness programme, taking part in local and national fitness challenges and lunchtime dance sessions.

- We won the staff engagement category of the Patient Experience Network Awards in recognition of our work in engaging with staff, collating feedback and using the intelligence gathered

- We won a Patient Experience Network Award for improving the experience of people with a disability. This came hot on the heels of receiving a Getting On Board award from the Northamptonshire Learning Disability Partnership Board in recognition of our work in supporting patients with a learning disability

It's heartening to see individuals, teams and departments across the full spectrum of our services being recognised for their outstanding contribution.

Inspection

As the end of the financial year approached, and still in the grip of our winter pressures, we were inspected by the Care Quality Commission. The inspection results have not been published at the time of producing this annual report but the informal feedback from inspectors was that care for patients was seen to be the priority, A&E felt calm despite the huge pressure we're under, and staff ware positive, confident and proud of their work.

We know we have improved in almost every way since the last inspection three years ago. Our hospital in many ways feels like a very different place and there's a tangible sense of pride in Team NGH.

Debbie Needham
Deputy Chief Executive Officer

Paul Farenden
Chairman

AN INTRODUCTION TO NORTHAMPTON GENERAL HOSPITAL NHS TRUST

Who We Are

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

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

What We Do

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

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

Our Vision and Values

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

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

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

For patients this means they can expect to:

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

Our Strategic Aims
Our Trust Board sets our overall strategic direction, within the context of NHS priorities, and monitors our performance against objectives. It also provides financial stewardship, clinical governance and corporate governance to ensure that we continue to provide high quality care that offers value for money.

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

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

2. To exceed our patients' expectations
We will continuously improve our patient experience and satisfaction by delivering personalised care which is valued by patients

3. To strengthen our local services
Provide a sustainable range of services delivered locally

4. To enable excellence through our people
We will develop, support and value our staff to provide our patients with quality care delivered by a highly trained and motivated workforce.

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

The current healthcare environment remains very challenging and the constrained financial environment and difficulty in recruiting a substantive workforce are our main strategic risks. However we continually focus on

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

Our Strategic Priorities
- Providing and strengthening our core hospital services through partnership working with other primary and secondary care providers
- Continuing to improve urgent care services
- Collaborating with other providers to provide care closer to home
- Developing partnerships with KGH in response to the challenged health economy workstream

- Become the hospital provider of choice for local GPs and patients
- Delivering excellence in patient care
- Developing health and wellbeing campus in partnership with Public Health

At the time of producing our annual report, our clinical strategy is under review.

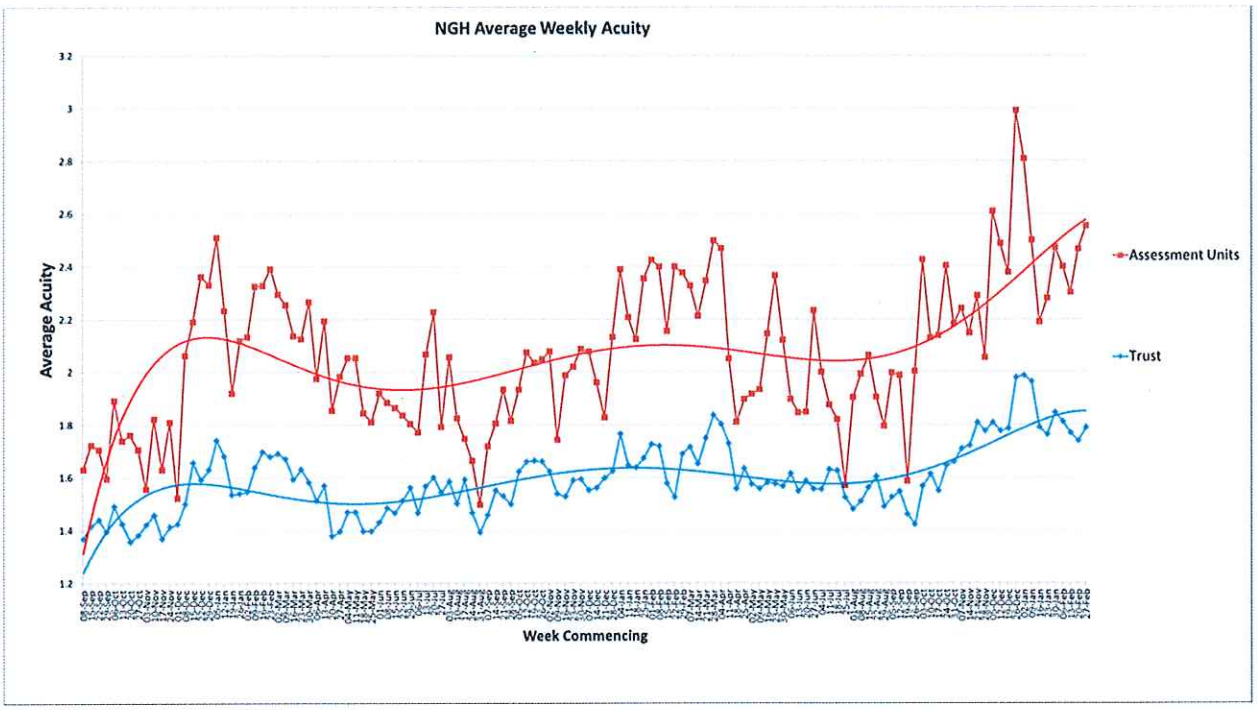
PERFORMANCE ANALYSIS

Overview

The past year has seen increased collaborative working between us and other service providers within the county to ensure that patients are provided with the best quality care in the timeliest manner; quality of care always being at the heart of all service provision.

We experienced some operational challenges throughout 2016/17 with a 2 per cent increase in A&E attendances and a 10 per cent increase on the previous year for emergency admissions, further compounded by high acuity levels of patient presenting especially throughout the winter period. This resulted in increased time in hospital for some patients and in particular longer lengths of stay for those patients who require care or community services after discharge from hospital.

The acuity of our patients in the assessment areas and throughout the rest of the hospital can be seen below with a marked increase during winter.



A number of changes have been put in place over the year to ensure increased efficiency in all patient pathways with the aim of ensuring safety and quality of care along with a reduced length of hospital stay and safe discharge.

1) Perfect weeks – we ran site-wide 'perfect weeks' during the year and especially at Christmas with senior clinical and managerial staff supporting the wards to ensure discharges were optimised. Elective operating for more routine cases was reduced throughout these periods and key clinical staff asked to prioritise working on the ward areas.

2) Proactive management of elective work over the winter period: Winter always places a huge non elective medical demand on us and as such a plan to flex down elective work and to convert Althorp ward from elective orthopaedic surgery to medicine was agreed and planned. Althorp ward was converted to medicine in mid-January and the ward was handed back to orthopaedics during the first week of March. This clearly has had an impact on our elective performance for orthopaedics but during this period we asked other providers to help us with some cases who were clinically urgent while we focussed on day case work.

3) Improved support for frail patients being admitted via the Emergency Department via a dedicated frailty service ensuring patients have a CGA (Comprehensive Geriatric Assessment) within the 24 hours of admission. The frailty service is supported by two full time frailty nurses who work with A&E staff as well as the general wards - this has been and continues to be further developed into a non-bedded area where patients can be assessed with the aim of transfer home unless admission is urgently required.

4) A new rehab model of care utilising capacity at Angela Grace nursing home (Dickens Unit) By October 2017 we had 35 patients being supported with intensive physio and occupational therapy with the aim to ensure a speedy recovery and transition home without the requirement of ongoing care. The effect of this new model of care and therapy has proved successful with many patients now going straight home without the need for community care.

5) Expansion (FIT stop) within emergency department to ensure rapid see and treat. This service opened during the first week of September creating 9 assessment bays and freeing up A&E capacity to increase the footprint to 42 cubicles (including children's ED, resus, majors, minors and FIT stop) This service is consultant-led seven days a week and has been instrumental in ensuring we have the best ambulance handover figures in the region

6) Seven day working: during the year we extended our opening times in the ambulatory care centre. The service now operates across 7 days and into the evenings. The numbers of patients in the unit has continued to increase and is now exceeding the numbers it was originally designed for.

   The weekend discharge team has expanded during the year to include 2 additional senior doctors with the aim of ensuring patients who are ready to leave hospital are reviewed and discharged. At weekends both the on call manager and on call director are also based on site during the day to provide support to the clinical staff.

7) Development of a business case for a new assessment unit. Planning and design work has continued on this large development over the winter period.

8) Additional staff and new ways of working for the emergency department have been invaluable over the past year with the introduction of a social worker, GP, pharmacist and therapy staff based in the A&E to ensure patients are

receiving the most appropriate treatment, medication and can be rapidly seen and discharged home

9) Additional consultants in acute and general medicine were appointed to support the assessment areas and ensure medical teams could manage the increased numbers of medical patients admitted to our wards

10) S.A.F.E.R. patient flow principles were introduced by the end of October 2017 A daily SAFER dashboard is in place and now includes metrics on Red to Green which shows daily if patients' care plans are progressing, with the aim that every patient should be on a green day with something taking place to progress their care and discharge. The communications work on this programme has been recognised nationally and internationally with our SAFER posters being used as far away as New Zealand

11) We run a weekly senior review-and-challenge of all cases where patients are staying in hospital for long periods. At the start of the process we had 40 patients over 100 days stay and the meeting has supported the discharge of many of these patients yielding in excess of 10,000 beds days

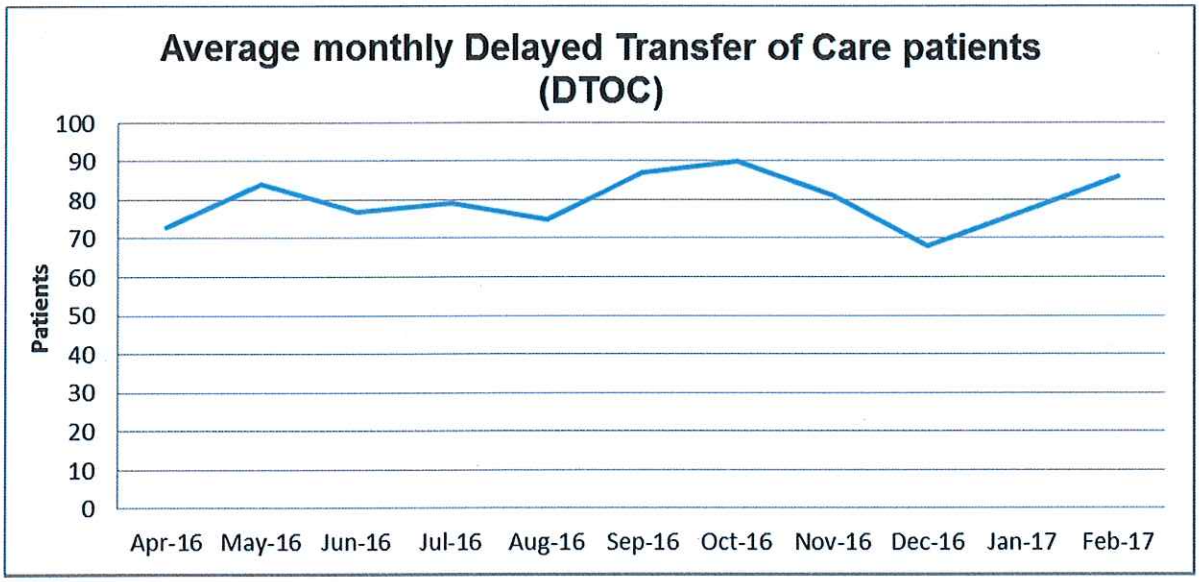
12) The daily safety huddle was reviewed and refined jointly by the operational and nursing teams with a new daily 8.30am huddle that all wards and departments attend to update on patient safety, patient flow and any other concerns. This meeting has been hugely helpful over the winter in monitoring safety as well as galvanising the teams at times of immense pressure

13) The Dementia and Delirium team from NHFT joined our discharge team over the winter period. This small team of therapists have been instrumental in supporting the discharge of some of our most vulnerable patients who can often have longer stays in hospital.

14) Advanced Primary care streaming: The medicine division led a robust plan to divert patients from the front door of ED into more appropriate services within the community as approximately 30 per cent of patients who attend A&E do not require our services. The GP triage staff rapidly assess patients and stream them to
    - ambulatory care
    - gynae assessment unit
    - paediatric assessment unit
    - oncology assessment (EAB)
    - urgent care centre and GP out of hours off site
    - booking them a rapid appointment with their own GP
    - pharmacists
    - home

Delayed Transfer of Care

Delayed transfers of care (DTOC) have been relatively static throughout the year. The figures below identify that, on average, 12 per cent of our bed base is utilised by patients recorded as being clinically fit for discharge but lacking facilities in the community/primary care to support their discharge.



ACTIVITY

The change in outpatient activity between consultant and nurse led is due to a change in the recoding of the activity; taking collectively, first outpatients has increased by 6.3 per cent with little change in the follow up figures.

Activity Comparison	2013-14	2014-15	2015-16	2016-17	Diff	% Diff
Emergency Inpatients	35,907	40,349	43,456	47,701	4,245	10%
Elective Inpatients	7,329	6,208	5,824	5,634	-190	-3%
Elective Daycases	38,052	38,346	39,610	42,393	2,783	7%
New outpatient attendances - Consultant led	77,973	80,037	83,474	105,790	22,316	27%
Follow-up outpatient attendances - Consultant led	152,425	149,977	155,562	208,420	52,858	34%
New outpatient attendances - Nurse led	39,775	38,571	42,127	27,758	-14,369	-34%
Follow-up outpatient attendances - Nurse led	81,535	114,953	154,412	101,938	-52,474	-34%
Total number of outpatient DNA's	26,525	30,350	34,770	36,708	1,938	6%
Patients seen in Accident & Emergency	107,786	109,305	114,179	116,183	2,004	2%
Number of babies born	4,573	4,685	4,726	4,867	141	3%
Average length of stay (in days)	4.60	3.55	4.36	4.52	0.16	4%

The reduction in elective inpatient activity is due to the increased need for emergency inpatients to access our beds which has meant we cancelled operations or on occasions where clinically appropriate we delayed operating in order that we care for those most in need of our services.

During the year we ran transformation programmes across surgery and outpatients with the aim of reducing the numbers of patients who do not attend (DNA), ensuring the numbers of patients in each clinic and on each list are adequate and that time is not wasted - ultimately improving the experience both of patients and our staff. The transformation projects are continuing during 2017/18.

National Performance Standards

Despite the pressures on both the organisation and the health economy in general, both locally and nationally, we fully achieved 9 of the 14 national targets throughout 2016-17 with a further 3 partially achieved, one of which was only missed in the first quarter of the year (cancer: percentage of patients treated within 31 days).

Performance Indicator	Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
A&E: Proportion of patients spending less than 4 hours in A&E	95%	90.80%	90.90%	83.80%	82.40%
A&E: 12 hour trolley waits	0	0	0	0	0
Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	>99%	99.40%	99.80%	99.30%	99.60%
Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	93%	96.30%	96.60%	97.10%	96.90%
Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	93%	97.40%	94.30%	95.10%	95.90%
Cancer: Percentage of patients treated within 62 days of referral from screening	90%	96.10%	97.60%	98.60%	94.00%
Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	85%	79.40%	78.60%	78.40%	91.90%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%	76.50%	76.20%	83.20%	78.40%
Cancer: Percentage of patients treated within 31 days	96%	94.10%	96.70%	97.10%	98.15%
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	94%	94.60%	82.40%	95.30%	90.90%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	98%	99.50%	98.40%	99.40%	97.04%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	94%	94.50%	96.10%	98.30%	96.60%
RTT waiting times incomplete pathways	92%	94.50%	93.80%	92.30%	92.40%
RTT over 52 weeks	0	0	0	0	0

4hr A&E standard

2016/17 has been a challenging year for our urgent and emergency care services. Our emergency department has seen an additional 2,000 patients (two per cent increase) together with 4,000 more admissions than the previous financial year representing a 10 per cent increase.

During the first five months of the year performance exceeded the planned trajectory; however with the challenges of increased attendees to A&E and high acuity of our patients we were unable to sustain the performance throughout the remainder of the year.

A&E												
	A&E Attendance / 4 Hour Breach Performance											
	Baseline	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan 17	Feb 17
Total Patients Seen	9277	9895	10074	10129	10386	9655	9766	10138	9903	9652	9730	9602
> 4 Hour Waits	1823	1143	1612	1519	1350	1352	977	811	1188	1255	1216	1104
Trajectory	80.40%	88.45 %	84.00 %	85.00 %	87.00 %	86.00 %	90.00 %	92.00%	88.00 %	87.00 %	87.5%	88.5%
Actual performance		88.50 %	89.19 %	94.63 %	94.40 %	92.56	89.33 %	84.81 %	83.4%	83.2%	81.4%	78.3%

The external support required to reduce the number of patients who are delayed continues to be a challenge and the constraints within adult social care have impacted on performance within the hospital.

As we enter spring, a marked improvement in performance is identified in March which has continued for the first part of April with 8 of the first 18 days exceeding the 95 per cent target.

Diagnostic waiting times
The six week diagnostic waiting times have been maintained across the year. All specialities have responded well to the increase in activity and have been able to sustain the target by offering additional spaces for our patients.

Cancer waiting times
We had a challenging year with regards to meeting the cancer waiting times standards during 2016-17. This highlighted the need for an intense focus following concerns that the 31 day and 62 day standards in cancer care were not being delivered.

An interim cancer management specialist was recruited in August in order to support the new cancer services management team. A refreshed cancer recovery plan and tumour site action plans were produced with monthly oversight of these by the clinically-led cancer board, underpinned by a newly launched access and operational policy.

Performance prior to this intense focus saw us failing to meet the 62 day standard for 16 months, finally reaching target in December 16 at 86 per cent against the standard of 85 per cent. We sustained the performance against the 31 day standard meeting this each month from July 2016 onwards.

The number of patients exceeding the 62 day wait for a diagnosis/treatment in September 16 was 115, as at March 17 this stands at 48 and has seen a reduction of 58 per cent, however continued focus is required to ensure this is reduced to acceptable levels and does not rise again.

Pressures over the past year included access to medical records for weekly MDT meetings, ability for radiology to sustain access to investigations and reporting within seven days, staffing capacity in oncology and cancer services, availability of histopathology for MDT meetings and timely reporting and winter pressures.

Referral to Treatment

We have successfully maintained the achievement of RTT ongoing target, despite having to stop a significant proportion of elective work over the winter due to the urgent care pressures.

SUSTAINABILITY REPORT

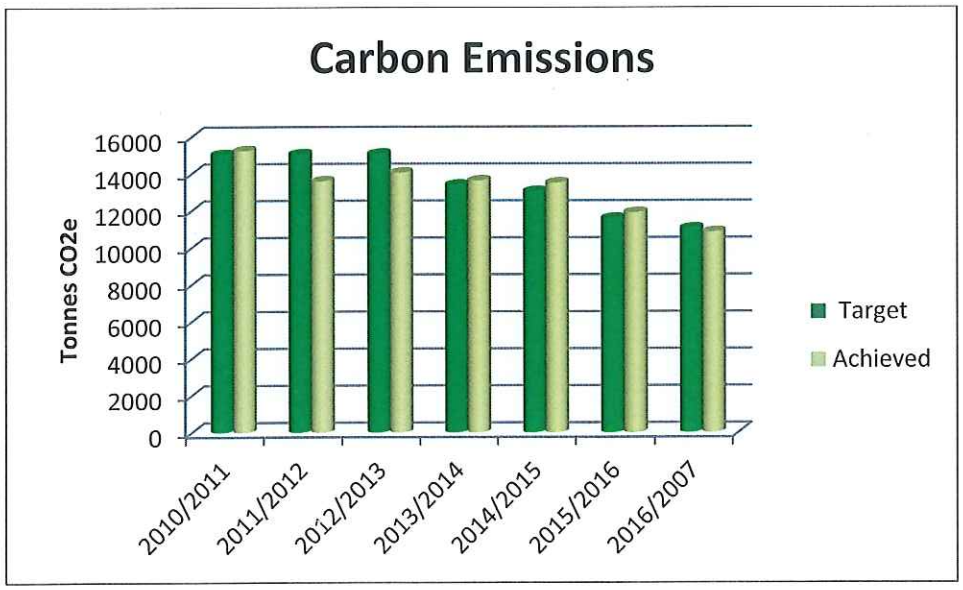
During the year we approved our new sustainability strategy, *Caring for the Future*. While emphasising the continued need to reduce our environmental impact, the strategy moves beyond the traditional areas of energy and waste to the wider sustainability aspects of healthcare delivery. It is aligned with both our clinical strategy and the NHS Sustainability Strategy and includes both quantitative and qualitative goals for the coming five years. All key performance indicators are on target, with the exception of water use.

Carbon Management Plan

We reached the end of the first contracted year of our energy strategy which achieved the guaranteed savings specified in the contract. Carbon emissions from heat and power were down by 11.5 per cent compared to the previous year.

Our biomass boiler became fully operational in December. Woodchip for the boiler is purchased from a local company that conducts tree clearances and tree surgery work around the local area, including our site. Carbon emissions from buildings have reduced by 31 per cent compared to 2010, which puts us close to requirements for the national 2020 target; a major achievement. This is with only a part year of the biomass operation.

Consumption of electricity continues to increase due to increased patient activity, increased data storage requirements and increased cooling requirements. Additional measures are therefore required to stay on target for 2020 and beyond. The potential options will be determined and reviewed in the coming year.



	2014/2015	2015/2016	2016/2017
Consumption Data			
Gas kWh	29,250,909	22,683,936	18,937,723
Electricity kWh	14,611,750	15,222,263	15,657,244
*Biomass			2,131,484
*Water m^3	127,781	136,464	151,982
Business Travel miles	977,976	943,475	894,928
Financial Data £			
Gas	1,148,238	1,276,017	1,189,156
Electricity	1,131,103	477,196	246,904
*Biomass			64,456
*Water	268,190	263,063	297,080
Business Mileage	431,790	395,717	364,465
Carbon Credits	214,397	191,202	171,965
*Renewable Heat Incentive			(73,343)

**approximate figures as full data not yet confirmed*

Investment

Further improvements have been made to our lighting. Inefficient lighting has now been replaced with LEDs in most stairwells, in staff restrooms and along corridors – additional daylight and motion sensors have been added. This work has been funded through an interest free Salix loan.

A review and some retuning of our building energy management system has been undertaken resulting in improved comfort levels and reduced energy spend. Following a successful change to the air handling unit in our pharmacy department, which has reduced spend by approximately £4,000 a year, similar schemes will be incorporated into the 2017 workplan.

Water Use

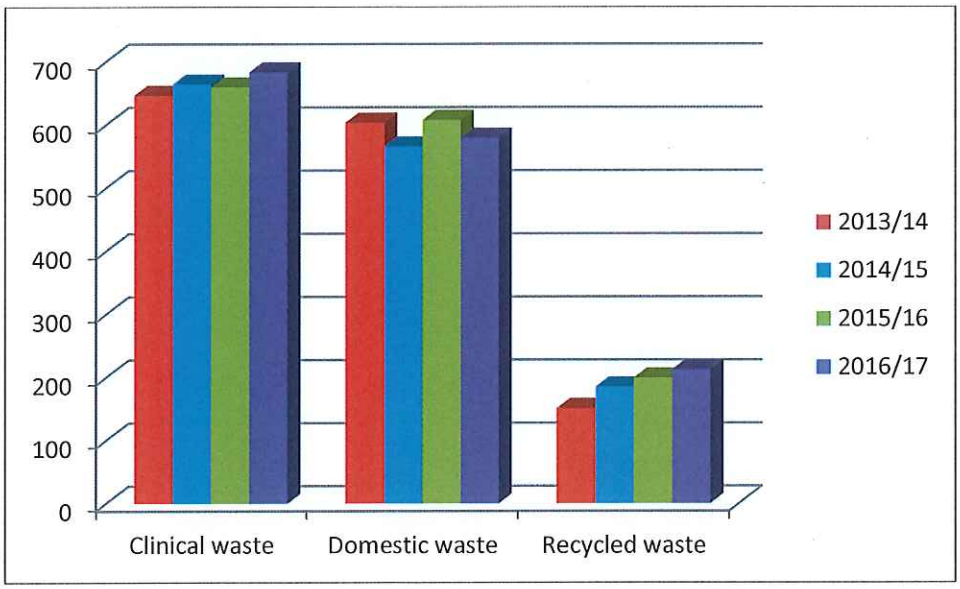
Water use increased significantly in the previous twelve months (11.4 per cent) due to two separate underground water leaks, the first in five years. These have now been repaired and water levels have returned to those of 2015. These water leaks have put us behind our target of a 2 per cent year-on-year decrease, but additional metering will be installed in the coming year to help target the installation of water saving technologies.

In conjunction with Anglian Water we also launched an awareness campaign to highlight the issue and cost of inappropriate items being flushed down toilets both within our hospital and in the wider Northamptonshire area.

Waste and Recycling

2016/17 saw a major push on waste. A multidisciplinary group now meets monthly to set the forward agenda for waste reduction and improved recycling. Joint meetings are held with Kettering General Hospital and our waste management contractor.

Regular waste audits are now conducted in conjunction with the infection prevention team with follow-up training given as appropriate



- Waste production on site has increased; this is a result of increased patient activity. Waste produced per patient decreased by 11.5 per cent compared with 2015/16.
- The level of recycling segregated on site increased by 6.6 per cent to 212 tonnes (almost 27 per cent of non-clinical waste). Additional revenue was also achieved through sale of wooden pallets, and the destruction of a further batch of archived X-Rays. These resulted in a further 97 tonnes of recycling.
- These figures do not include the furniture reused through two reuse initiatives. The WarpIt platform is an online site that allows staff to advertise items no longer required and to obtain items from other organisations. In addition, an innovative project undertaken with our procurement department to refurbish ward furniture has saved over £20,000 and prevented approximately 5 tonnes of waste going to landfill.
- In 2017 we will install a shredder baler which will reduce the confidential waste bill and result in a further revenue. We will continue our work with our waste management companies and improve recycling facilities aiming for a further 5 per cent increase in the amount of waste recycled.

Carbon footprint and procurement
The carbon footprint calculated using the Defra P4CR tool based on spend has been calculated at 80,288 tonnes $CO2_e$, a 6.6 per cent increase on the previous year. This reflects some additional spend categories included in the data set and increasing costs, particularly in construction materials, office equipment, and chemicals and gases.

We have also started to question suppliers about their own sustainability initiatives and have discovered a number of potential waste reduction schemes as a result.

The greenhouse gas emissions from anaesthetic gases are slightly higher than in previous years (2932 tonnes $CO2_e$). This is mainly due to increased use of Entonox, a gas used in A&E and maternity.

Other green initiatives
- Following the annual staff travel survey two further cycle shelters were installed at opposite sides of the site.
- Staff are now offered discounts if they take their own cup to our retail outlets rather than using a disposable cup.
- Over 9,000 Christmas cards were collected and taken to M&S who work with the Woodland Trust to plant more trees in the UK.
- And in more tree-related initiatives, both the emergency department and maternity department have introduced schemes to reduce the amount of paper they use. Between them they are saving around 50 trees a year.

Plans for next year
Next year will see the creation of a carbon management plan to ensure we stay on target to meet government legislation despite increasing energy demands on the site. Part of this will include investigation of further renewable energy schemes alongside the options to participate in capacity market mechanisms. These are schemes run by National Grid whereby high energy users are paid to change their consumption for short periods of time in high use periods, usually during Winter. These are designed to ensure that there is sufficient capacity on the grid reducing the potential of black outs.

We will also participate in Clean Air Day – highlighting the harmful effect of pollution on health, whilst promoting lower carbon forms of transport.

SECTION TWO

ACCOUNTABILITY REPORT

REPORT FROM THE DIRECTOR OF FINANCE

Economic Outlook and Impact on the Trust

The NHS continues to be under significant pressure both financially and operationally. Our response to this is to continue to focus on providing high quality care to our patients through our clinically-led structure. We maintained a stable and improving financial position in 2016/17 despite the at times extreme pressures on the hospital, particularly due to increasing demand for urgent care services.

The challenge going forward is only likely to get even greater as the funding levels for the NHS tighten still further and although we are well prepared to face what lies ahead with detailed plans in place that are agreed with service leaders and regulators, the pressure is continuing unabated so the risk of some non-delivery of targets including financial performance is high.

There is quite considerable uncertainty about future funding levels in the medium and long term but we are nevertheless working hard to establish sustainable plans for the future alongside our partners in the health and social care system.

Financial Performance

We planned for a deficit of £15.1 million in 2016/17. This compared favourably with the deficit of £20.1 million in 2015/16. The actual deficit of £13.8 million was better than plan by £1.3 million.

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

Capital Expenditure

We invested £14.7 million in 2016/17 improving our estate, medical equipment and information technology (IT) assets. This included further substantial investment in radiotherapy treatment machines and high tech diagnostic imaging equipment. There are further plans in 2017/18 and beyond to ensure our estate, equipment and technology is updated to underpin the provision of high quality care for our patients. We are also planning to increase the capacity of the hospital to address the pressures we face through the provision of a new assessment hub; this development will go ahead with building commencing in 2017/18 and due for completion in spring 2018. The development will be financed through a lease with a capital value of approximately £12.4 million.

Charitable Funds

We are supported by the Northamptonshire Health Charitable Fund whose primary purpose is to support our work by providing grant funding, making use of the many generous donations and legacies they receive from the general public and from active fundraising.

During the year, the charity's governing arrangements were amended and the Trustees of the charity are now legally independent of our Trust Board with a brief that continues to ensure the charity contributes to enhancing patient experience.

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 £1.1m as grants. Of specific note is the full funding of chemotherapy suite expansion and refurbishment. Other specific grants contributed towards:

- the acquisition of Springfield House as part of plans to improve urgent care services for our patients.
- provision of new equipment for our neo-natal intensive care unit Gosset ward
- Do It For Dementia (as discussed earlier in this section).
- improvements to patient and staff amenities
- creation of - and improvement to - family rooms
- sponsorship for staff undertaking extended professional development.

Simon Lazarus

Director of Finance

CORPORATE GOVERNANCE: THE TRUST BOARD

NHS Trust Boards are legally required to consist of more non-executive members than executive members. The current composition of the Trust's Board of Directors is:

- Chairman
- Five non-executive directors (one of whom is vice-chairman)
- One Associate Non- Executive Director
- Five executive directors with voting rights
- Four executive directors

The executive directors are full time employees of the Trust and non-executive directors were appointed by NHS Improvement.

Executive directors manage the day-to-day running of the Trust and, together with the Chair and non-executive directors are responsible for determining our strategic direction, agreeing our policy framework, monitoring our performance and systems of internal control and also shaping culture for the organisation.

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

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

. The current composition of the Board is:

- Chairman
- Five non-executive directors (one of whom is vice-chairman)
- One Associate Non- Executive Director
- Five executive directors with voting rights
- Four executive directors

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

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

Directors during 2016 /17
* denotes voting members of the Trust Board.

Job Title	Name	Comments
Chairman*	Paul Farenden	
Chief Executive Officer*	Sonia Swart	
Non-Executive Directors*	Phil Zeidler (vice Chair)	
	Graham Kershaw	
	Elizabeth Searle	Stepped down October 2016
	David Noble	
	Olivia Clymer	Commenced Nov-15
	John Archard Jones	Commenced Jan-17
	Annette Gill (Associate)	Commenced Jan-17
Chief Operating Officer*	Debbie Needham	
Medical Director*	Michael Cusack	
Director of Nursing*	Carolyn Fox	
Director of Finance*	Simon Lazarus	
Director of Facilities and Capital Development	Charles Abolins	
Director of Workforce and Transformation	Janine Brennan	
Director of Strategy and Partnerships	Chris Pallot	
Director of Corporate Development, Governance and Assurance	Catherine Thorne	

Board members

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

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

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

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

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

Olivia Clymer
Non-executive director
Olivia's early career was spent with the Environment Agency, which subsequently led to roles in related areas in both the public and private sector. Her experience of the voluntary and community sector and local authority helped to develop her focus on regeneration and the challenges of social and economic disadvantage. Olivia has served as a member for the Consumer Council for Water and as a housing association board member for nine years. She is currently an associate non-executive director for Dudley and Walsall Mental Health Trust. Her experience in social care and systems transformation has informed her interest in the challenging area of sustainable healthcare provision.

John Archard Jones
Non-executive director
John has 30 years of commercial experience at senior levels in manufacturing, sales management, project management and major bids. He is a former managing director of the African region of ICL, a leading technology company. John now works in business consultancy and is an experienced non-executive director within both the public sector as well as private and listed companies in the UK and overseas. He is a former councillor with the London Borough of Barnet and is the founder and former member of a London-based charity for people with learning disabilities.

Anne Gill
Associate Non-Executive Director
Anne's experience includes a successful career as a senior human resources executive in consumer goods, retail and public sector organisations, with 10 years as HR Board Director for a multi-national fast-moving consumer goods (FMCG) organisation. She has also held leadership roles in supply chain and sales. She is currently a Board Trustee for the charity MedicAlert and works as an independent consultant specialising in leadership coaching and organisation development. She holds an MA in coaching and mentoring practice from Oxford Brookes University and is a Chartered Fellow of the Institute of Personnel and Development.

Dr Sonia Swart, MA, MB, BCh, MD, FRCP, FRCPath
Chief Executive
Sonia was appointed as Chief Executive on 20th September 2013, having been the Trust's Medical Director since September 2007 and acting Chief Executive since July 2013. Sonia qualified from the University of Cambridge and went on to train in general medicine and clinical haematology. She worked as a consultant haematologist in North Warwickshire before joining Northampton General Hospital in 1994. Prior to becoming Medical Director, Sonia combined an active clinical role with a number of managerial activities, including head of pathology, clinical director for diagnostics and clinical lead for the foundation trust application. Sonia has made a commitment to align the trust's aims, values, objectives and corporate governance to support a clinically-led quality agenda.

Deborah Needham
Chief Operating Officer/Deputy Chief Executive
Deborah trained as a Registered General Nurse in Lancashire where she held positions in both respiratory and emergency medicine units, before moving to London in 1998 as a ward manager then general manager. After graduating as a nurse, Deborah gained a diploma in respiratory medicine and nursing care and a BA (Hons) in healthcare management. Deborah moved to NGH in 2004 and has worked as a general manager, Deputy COO and care group director. In 2014 Deborah was substantively appointed to the Chief Operating Officer after a period of acting into the role. Within her portfolio she is responsible for the 4 clinical divisions, national performance standards, emergency planning & resilience, IT and information and the operational day to day running of the entire hospital. Deborah is married and lives in Northampton.

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

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

Carolyn Fox
Director of Nursing
Carolyn began her nursing career in Sheffield and qualified as a Registered Nurse in 1990. She held staff nurse positions and went on to become a Ward Manager in respiratory medicine. Carolyn worked in London as a Clinical Nurse Specialist before relocating to the North West. With an interest in quality, Carolyn worked as a National Programme Manager, NHS Quality Improvement Scotland and Assistant Director of Nursing, Salford Royal Foundation Trust before joining Aintree University Hospital as Deputy Director of Nursing.

Charles Abolins, FBIFM, MHCIMA
Director of Facilities and Capital Development (non-voting)
Responsible for the Trust's estates and facilities, procurement and capital development, purchasing and supply. After graduating in hospitality management from Birmingham College of Food and Tourism, Charles has held a number of facilities management posts in the NHS. Since joining NGH, Charles has been responsible for leading and implementing complex, major capital building programmes and managing a wide range of facilities support services. He is the Trust's lead for sustainability.

Janine Brennan
Director of Workforce and Transformation (non-voting)
Janine was appointed as Director of Workforce & Transformation on 2nd April 2013, having worked previously as Director of Workforce and Organisational Development at Royal Berkshire NHS Foundation Trust. She qualified in law and human resources management and has worked in a number of acute Trusts, as well as the public sector and not for profit

organisations. Janine's special interest is in developing staff commitment and engagement in ways that lead to improvements in the care we give to patients.

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

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

Table of Attendance 2016/17

A = Maximum number of meetings the Director could have attended

B = Number of meetings Director actually attended

	Trust Board / Board of Director Meetings		Audit Committee		Quality Governance Committee		Finance, Investment & Performance Committee		Workforce committee		Remuneration Committee	
Name	A	B	A	B	A	B	A	B	A	B	A	B
Chairman	A	B	A	B	A	B	A	B	A	B	A	B
Paul Farenden	12	10			12	8	12	9	12	6	1	0
Chief executive	A	B	A	B	A	B	A	B	A	B	A	B
Dr Sonia Swart	12	11			12	8	12	10	12	9	1	1
Non-executive Directors	A	B	A	B	A	B	A	B	A	B	A	B
Graham Kershaw	12	10	4	3	12	3			12	11	1	0
David Noble	12	11	4	3			12	9			1	1
Elizabeth Searle	7	4	3	1	7	5					0	0
Phil Zeidler	12	11	4	3			12	9			1	1
Olivia Clymer	12	10	4	0	12	11	12	0	12	9	1	1
John Archard Jones	3	3	1	1	3	3	3	1	3	0	1	1
Anne Gill (Associate)	3	3	1	1	3	2	3	1	3	3	1	1
Executive Directors	A	B	A	B	A	B	A	B	A	B	A	B
Deborah Needham	12	11			12	9	12	11	12	11		
Simon Lazarus	12	11	4	4	12	7	12	11				
Carolyn Fox	12	11			12	11	12	10	12	11		
Dr Michael Cusack	12	11			12	11			12	11		
Chris Pallot	12	9			12	7	12	9				
Janine Brennan	12	10			12	10	12	10	12	11	1	1
Charles Abolins	12	11			12	9	12	9	12	8		
Catherine Thorne	12	12	4	3	12	10	12	10				

Board Meetings

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

Audit committee

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

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

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

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

Declarations of Interest

The Trust has a duty to ensure that all its dealings are conducted to the highest standards of integrity and probity. The statutory obligations are set out in the Code of Conduct and Accountability, published by the Department of Health and to this end we are obliged to compile and maintain a register of interest of directors, which may potentially influence their role.

The register is reviewed regularly and the Board receives a quarterly corporate governance report in which updates are reported. The current register of interest table is shown below.

Directors Interest Declarations:

Paul Farenden	Hon Treasurer of the retirement fellowship
David Noble -	Director, David C Noble Ltd
Phil Zeidler -	Chairman iGO4 Limited
	Chairman iGO4 Partners Limited
	Chairman iGO4 Solutions Limited
	Chairman Curium Solutions Limited
	Chairman Deadhappy Limites
	Non-Executive Director AssureOne Group
	Non-Executive Director Blue Badge Company
	Chairman of Ride High Limited
	Director of Northampton Charitable Funds
	Wife is consultant paediatrician at NGH

Olivia Clymer	Non-Executive Director for Dudley and Walsall Mental Health Trust
John Archard-Jones	Consultant Director First for Wellbeing
	Director and Owner Africa Consulting Ltd.
	Trustee Northants Health Charity
Janine Brennan	Husband is an employee of Oxford University Hospitals – Director of Clinical Services
Chris Pallot	Chairman, Voluntary Impact Northamptonshire

Statement of Chief Executive's Responsibilities as Accountable Officer of the Trust

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the trust;

- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

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

I confirm that, 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 trust's auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Debbie Needham

Deputy Chief Executive

Date 25 May 17

Statement of Directors' Responsibilities in Respect of the Accounts

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

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent;

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

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

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

By order of the Board

Date 25 May 17

Debbie Needham

Deputy Chief Executive

Date 25th May 17

Simon Lazarus

Finance Director

Annual Governance Statement 2016/2017

1. Scope of Responsibility

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

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

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

2. Governance framework of the organisation

The Trust's governance framework and system of internal control is designed to manage risk to a reasonable level rather than eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives and
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically

During 2016 the Trust Board has reviewed its governance arrangements and made some adjustments in reporting that align and embed improved systems of control and risk management to support the organisational operational structure.

In addition in April 2016 the Trust Board approved a three year risk management strategy and implementation plan to support improved risk management and assurance mechanisms across the organisation.

Trust Board and Committee structure

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

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

The Board holds its meetings in public bi monthly and papers are available on the Trust website. The Board regularly reviews performance against national standards and regulatory requirements and a summary of performance against these priorities is available through the Trust's Annual report. The Board places a strong emphasis on quality and safety of patient care and in addition to performance reports, regularly hears directly from patients and carers, including patient stories and ward visits.

With reference to the requirements of the Trust's standing orders, the Director of Corporate Development, Governance and Assurance and Trust secretary has assessed the arrangements for the discharge of statutory functions. No irregularities or gaps in legal compliance have been identified.

The Trust Board approved the organisation's Quality Account in June 2016, further to review by the Quality Governance Committee. The accuracy of the Quality Account is assured through internal review and data checking processes as part of the Trust's data quality arrangements.

The Trust's External Auditors also undertook an audit of the 2016/17 Quality Account and their findings are being taken into account for the production of this year's Quality Account which is due to be agreed by the Board in June 2017.

During 2015/16 the Board reviewed its effectiveness against the Care Quality Commission's Well Led framework where a full gap analysis and action plan was agreed by the Trust Board. This was again reviewed in December 2016 and will be reviewed once again when information from the Care Quality Commission is made available following their latest consultation on their inspection regime.

The Board undertakes a bi-monthly programme of Board development activity. During 2016/17 this has largely centred on ensuring the Board understands the changing healthcare landscape and in particular the work in relation to Sustainability and Transformation programmes and how they link with organisational strategic aims related to ensuring safe and sustainable services via clinical collaboration.

Development activity also includes updates from the work undertaken in the previous year related to the organisational Quality Improvement (QI) agenda. This takes the form of updates and also front line staff presentations in respect to QI projects undertaken from various wards and departments across the organisation. In addition development sessions also include updates to Board member's statutory and mandatory training requirements throughout the year.

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

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

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

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

Workforce Committee
The Workforce committee monitors, reviews and reports on the organisational development and workforce performance of the Trust. This includes the achievement of associated key performance indicators and advising the Trust Board on key strategic organisational and workforce initiatives.

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

Board and Subcommittee Attendance

Name	Position	Date of Commencing Appointment	Board Record of Attendance *April 2016 to Mar 2017*	Audit Committee	Quality Governance Committee	Finance Investment & Performance Committee	Workforce Committee	Remuneration and Appointments Committee
Paul Farenden	Non- Executive Director, Chair	1.3.12	10/12		x	x	x	x
Phil Zeidler	Non- Executive Director, Vice Chair	1.12.08	12/12	x		x		x
David Noble	Non- Executive Director	1.1.13	11/12	x	x	x		x
Elizabeth Searle*	Non- Executive Director	1.1.13	4/4	x	x			x
Graham Kershaw	Non- Executive Director Associate Non-Executive Director	01.01.13 01.12.08	11/12	x	x		x	x
John Archard-Jones	Non- Executive Director	01.01.17	3/3	x	x			
Olivia Clymer	Non- Executive Director	2.11.15	10/12	x	x		x	x
Annette Gill	Non- Executive Director (Associate)	01.01.17	3/3	x			x	x
Sonia Swart	CEO	23.9.13	11/12		x	x	x	
Debbie Needham	Chief Operating Officer/ Deputy CEO	10.4.14	11/12		x	x	x	
Catherine Thorne	Director of Corporate Development Governance and Assurance	19.1.15	12/12	Attend	x	x		
Simon Lazarus	Director of Finance	11.3.14	11/12	Attend	x	x		
Janine Brennan	Director of Workforce and Transformation	2.4.13	10/12		x	x	x	
Charles Abolins	Director of Facilities	1991	11/12		x	x	x	
Chris Pallot	Director of Strategy and Partnerships	11.10.10	9/12		x	x		
Mike Cusack	Medical Director	26.9.14	11/12		x		x	
Carolyn Fox	Director of Nursing	20.7.15	11/12		x	x	x	

**Stepped down – 31/10/16*

3. The risk and control framework and risk assessment

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

Risk Management framework

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

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

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

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

- The Trust has an Assurance Compliance and Risk (ARC) Group which is chaired by the Director of Corporate Development, Governance and Assurance providing executive oversight of risk management issues. The group is responsible for ensuring the development and implementation of effective systems and processes for risk management at each level of the Trust. All new risks with a proposed score of 15 and above ('Significant') are reviewed by a Risk Group who also undertakes a monthly review of corporate directorate and Divisional / Directorate risks with a score of 12 ('High') and above and those risks with high consequence but low likelihood.
  The Risk Group reports to the ARC group and reviews the Trust's corporate risk register on an ongoing basis and this is presented to the Trust Board and its sub committees on a quarterly basis.
- The Trust has a Governance team with a focus on integrated risk management – the team support the process of identification, assessment, analysis and management of risks and incidents at every level of the organisation and aggregation of results at a corporate level.

- The Director of Corporate Development, Governance and Assurance is the Trust's Senior Information Risk Owner (SIRO). Working closely with the Medical Director as Caldicott Guardian, the SIRO is responsible for taking ownership of information risk at Board level and advising the Chief Executive accordingly.

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

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

There is clear policy and guidance on the type of courses that staff need to attend and the frequency of attendance required. Attendance at mandatory risk management training courses is monitored and fed-back to Divisions and corporate directorates via a central monitoring database with Human Resources which allows corrective action to be taken by management teams as required aimed to improve attendance rates throughout the year.

Board Assurance Framework (BAF)

Throughout 2016/17 the organisation continues to review processes for developing the BAF and risk management processes, with the Board approving a revised risk management strategy and implementation plan in 2016.

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

It also 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 monthly by the Executive Director leads with a full review at the end of each quarter which is then presented to the Trust Board. In addition risks to objectives are reported to a Trust Board assurance committee for monitoring and oversight. It is also crossed referenced to the Corporate Risk Register.

The Trust has received a substantial assurance opinion from internal audit on the Board Assurance Framework.

The Trust's principal risks can be found listed in Appendix 1.

Internal Audit

The Trust's internal audit function is provided by TIAA who contribute to assurances available to me as Accountable Officer and to the Board in underpinning the assessment of the effectiveness of the organisation's system of internal control.

TIAA have delivered the 2016/17 internal audit plan as Agreed at the start of the year through the Audit committee.

Counter Fraud

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

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

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

Stakeholder involvement in risk

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

- **Patients and the public**
    - The work of the, the Patient Advice and Liaison Service and specific patient representative groups.
    - Patient membership of key Trust committees and groups.
    - The work of the local Health and Wellbeing Boards.
    - Meetings of the Trust Board held in public which include monthly Patient Stories.
    - An extensive volunteering programme across hospital departments including a new group of volunteers specifically dedicated to supporting the Trust's Friends and Family Test (FFT) agenda, handing out postcards for completion and collating data
    - Development of FFT infograms for each ward with a "You said…We did" focus

- Representation on the Patient & Carer Experience and Engagement Group (PCEEG) from a Patient Representative and internal focus groups (such as BME, Dignity, end of life).
- Expert patient involvement in the redesign of dermatology and rheumatology programmes across Northampton and Kettering hospitals
- Plans for 2017/18 include development of a network of Patient and Family partners launched through a "Quality Conversation" event in early 2017.

- **Staff**
  - Strong focus on encouraging staff to raise concerns
  - Freedom to Speak Up Guardian appointed
  - Board to Ward and "Beat the Bug" visits by Executive and non-Executive Directors.
  - Monthly Core Brief to staff by Executive team.
  - Partnership forum with staff-side representation.
  - Staff Engagement Strategy that includes specific vehicle through which staff views are sought on key matters.
  - Expert patient involvement in the redesign of dermatology and rheumatology programmes across Northampton and Kettering hospitals

- **Partners**
  - Regular performance discussions with commissioners and NHS Improvement.
  - Executive meetings and discussion with Board Members at Kettering General Hospital NHS Foundation Trust and the establishment of a Federation agreement with them.
  - Weekly Operations Executive Meeting comprising the Chief Executive Officers of Health and Social Care partners across the Northamptonshire County.
  - Participation in the Sustainability and Transformation Programme for Northamptonshire.
  - System Resilience Group, A&E Boards, Sustainability and Transformation Board

Compliance matters

The Trust's Workforce Equality and Diversity Strategy was refreshed and reviewed in 2016. It builds on the work already done and progress made on equality and diversity over the years and sets out our co-ordinated and integrated approach in relation to our workforce.

Our Workforce Equality Objectives/Four Year Plan was also reviewed and refreshed in 2016. The two main objectives link to the Equality Delivery System (ED2) outcomes relating to the workforce, with the key actions linked to the Workforce Race Equality Standard (WRES), health and wellbeing, staff survey results, divisional objectives and the leadership and management development programme. Alongside our Trust Equality

Objectives/Four Year Plan each of our Divisions has been asked to produce 2-3 of their own equality objectives based on their specific equality monitoring data.

The Trust has undertaken and published the data required for 2016 in accordance with the NHS England Workforce Race Equality Standard (WRES) and our annual Workforce Equality and Diversity Report and Monitoring Report have also been published on our website along with other key equality and diversity documents.

The Trust has an Equality and Diversity Staff Group that meets on a quarterly basis and it reports into the Trust's Workforce Committee.

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

Northampton General Hospital maintains an Environmental Management System which is externally verified by and accredited to the Investors in the Environment Scheme (Green Level). The Trust has a Sustainability Strategy that has been approved by the Board with accompanying Sustainable Development Action Plans, progress against which is monitored through the Sustainable Development Committee. An adaptation policy is in preparation, following a review of the risks to the Trust arising from the changing climate. The Trust regularly reviews and publishes its Good Corporate Citizenship scores.

Progress in carbon reduction, climate change mitigation and adaptation along with other sustainable development initiatives are reported in the annual report and to the Board. Northampton General Hospital NHS Trust was one of only forty trusts recognised by the SDU, NHSI and HFMA for Excellence in its Reporting of Sustainability for the year 2015/16.

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

Information Governance (IG)

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

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

Quality Account

The Trust produces an annual Quality Account report in respect to its quality priorities and the quality of services by an NHS healthcare provider. This Quality Account is an important way that the Trust reports and demonstrates improvements to the services delivered

In addition to a review of the quality of the services the Quality Account includes specific statements relating to assurance and the Trust's performance against national standards.

The indicators within this document are subject to external audit scrutiny and the auditors are required to provide an independent assurance opinion to the organisation. During 2016/17 the Trust received an unqualified limited assurance opinion for its Quality Account.

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

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

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work.
The Head of Internal Audit Opinion for 2016/17 concludes in summary 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

This is based on:

a) An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and

b) An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the first nine months of the financial year. This

assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

Additional areas of work that may support the opinion will be determined locally but are not required for Department of Health purposes e.g. reliance being placed upon Third Party Assurances.

c) TIAA has carried out 21 assurance reviews to date, which were designed to ascertain the extent to which the internal controls are adequate and to ensure that activities and procedures are operating to achieve the Trust's objectives. For each assurance review an assurance assessment was provided. A summary is set out below:

Assurance Assessments	Number of Reviews
Substantial Assurance	3
Reasonable Assurance	8
Limited Assurance	10
No Assurance	0

TIAA has also undertaken two advisory reviews where an assurance opinion was not provided.

During the course of the period, ten limited/no assurance opinion reports have been issued. A summary of each is provided in the commentary below. Although the ten are a high proportion of the individual opinions for the year, this reflects the targeting of the internal audit plan on areas of risk and opportunity to further improve, and therefore the opinion reflects not just those individual audit results but a wider consideration of the organisational system of internal control

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

- The Board has played a key role in reviewing risks to the delivery of the Trust's performance objectives through monthly monitoring and discussion of the Corporate Performance Report and detailed financial and quality and safety reports, and through Board and committee reporting on progress against other strategic objectives.
- The Audit and Risk Committee has overseen the effectiveness of the risk management arrangements.
- The Risk Management Group has reviewed the Trust's risk register and the Board Assurance Framework and monitored key clinical

and non-clinical risks highlighted by Trust committees and individual managers.
- Executive Directors have ensured that key risks have been highlighted and monitored within their functional areas and the necessary action taken to address them.
- Both Internal and External Audit have provided scrutiny and assurance in relation to governance and control arrangements across a wide range of the Trust's activities.

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

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

Northampton General Hospital NHS Trust is registered with the Care Quality Commission (CQC) and following the CQC Chief Inspector of Hospital's Inspection in January 2014 with a follow up inspection in September 2014 The Trust received an overall rating of 'Requires Improvement'.

The Trust underwent a further CQC inspection in February 2017 and at the time of writing this statement the final report and rating is awaited.

Data Security

The Trust reported one Information Governance incident to the Information Commissioner's Office in 2016/17

Details of the Incident

An anonymised data request was made by an ex-trust doctor for a report on their activity at NGH. A member of staff ran the report and anonymised the data by deleting the 5-6 columns of the report which contain personal identifiable information. This information was sent via an NGH email account to the unsecure email account of the requester.

It was later brought to the Trust's attention that the report was not anonymised but contained sensitive information including personal identifiable data (PID) of 6668 patients at the far right of the data columns within the spreadsheet. Both the member of staff's Line Manager and the Clinical Change Manager, who is the administrator for the IT system, confirmed that PID is usually only contained in the first 5-6 columns of the report. No explanation can be provided as to why the system generated further PID at the end of the report.

The IG serious incident procedure was initiated with a grading report to the Caldicott Guardian and the Senior Information Risk Owner. The incident was graded as a level 3 reportable incident. Based on this grade, the

incident was escalated to the Information Commissioners' Office (ICO) via the Information Governance Incident reporting tool.

The ICO carried out their investigation and the information Governance Team fully cooperated with the ICO providing the necessary documentation and responses to provide assurance to the ICO.

The ICO closed this case and issued a decision notice on the 21st December 2016 of no further action is necessary at this stage. The ICO also stated that it was satisfied that the Trust had the appropriate policies and procedures in place to provide staff with the guidance required in handling such situations.

Lessons Learned

1. All future reports from that system must be sent to and from NHS mail email accounts
2. A procedure/policy will be developed with the specific scope of covering data extraction and sharing from that system.
3. An anonymised report will be programmed into the system for requests where PID is not required.
4. Staff must ensure all attachments or embedded document/reports are scrutinised for PID.
5. Teams or departments that send information out of the Trust regularly must have a process in place where a senior member staff or fellow colleague reviews the information before it is sent.
6. Care must be taken when physically transferring information or documents which contain PID from on location to another, onsite and offsite. All transfers must be carried out in line with Trust policies.

National Performance Standards
We have experienced significant challenges with our performance standards especially with the pressure on urgent care in quarters 3 and 4 of 2016/17. This also impacted on our RTT performance and in particualr some key elective specialties, although we achieved at a Trust level including diagnostics wait time expectations.

4hr A&E standard
2016/17 has been another challenging year for the Trust's urgent and emergency care pathways. Our emergency department has seen an additional 2,080 patients (1.8% increase), patients together with 2,000 more admissions than the previous financial year representing a 7% increase.

After a challenging start to the year, during June, July and August the acuity of patients decreased and performance was sustained above 90% standard however this deteriorated from September onwards with the Trust seeing an increase in both acuity and activity.

These issues contributed to a high bed occupancy rate throughout autumn and winter of 2016/17 and these issues remain challenging for the Trust with additional factors of high numbers of delayed discharges, with often in excess of 10% of acute beds occupied with patients waiting for ongoing care and support outside of an acute hospital setting.

The external support required to reduce the number of patients who are delayed continues to be a challenge and the financial cuts in adult social care have impacted performance within the hospital, therefore along with increased collaborative working with partners in health and social care the plan to put in place a 60 bedded acute assessment hub with new model of care is an absolute necessity.

Cancer waiting times

The Trust had a challenging year with regards to meeting the Cancer Waiting Times Standards during 2016-17. This highlighted the need for an intense focus following concerns that the 31 day and 62 day standards in cancer care were not being delivered.

An interim Cancer management specialist was recruited in August in order to support the new Cancer Services management team. A refreshed Cancer Recovery Plan and tumour site action plans were produced with monthly oversight of these by the Cancer Board, underpinned by a newly launched Access and Operational Policy.

Performance prior to this intense focus saw the Trust failing to meet the 62 day standard for 16 months, finally reaching target in December 16 at 86% against the standard of 85%. The Trust has sustained its performance against the 31 day standard meeting this each month from July 16 onwards.

The number of patients exceeding the 62 day wait for a diagnosis/treatment in September 16 was 115, as at March 17 this stands at 48 and has seen a reduction of 58%, however continued focus is required to ensure this is reduced to acceptable levels and does not rise again.

Pressures over the past year have included access to medical records for weekly MDT meetings, ability for Radiology to sustain access to investigations and reporting within 7 days, staffing capacity in Oncology and Cancer Services, availability of histopathology for MDT meetings and timely reporting and winter pressures.

The Trust continue to attend bi-weekly meetings at the CCG in order to discuss their improvement programme, and provide assurance around patient breaches of the standard, this is now supported by the Trust cancer breach panel established in January 2017.

Improvements continue to be made on building relationships with our tertiary providers.

In order for the Trust to sustain its improvement journey clinicians, divisional management teams and Cancer Services need to continue to work together in order to deliver the best possible care and in a timely manner to all patients on a cancer pathway.

RTT

We have maintained achievement at a trust level of RTT, however due to the urgent care pressures we stopped a significant proportion of elective work over the winter. We outsourced orthopaedic work and focussed on delivering day case activity in house. This led to a deterioration of performance in elective specialities and in particular within orthopaedics.

Re-allocating the specialist elective ward to orthopaedics and continuing with outsourcing will support improvement and attainment of the target during 2017/18.

Quality & accuracy of waiting list data & associated risks

The programme of work throughout 2016/17 has included audits against the accuracy and use of "clock stops" and RTT status codes, the reviewing of data accuracy for SUS returns against both local peers (peers as agreed under the Lord Carter programme) and nationally, as well as responses to internal audit reports as required.

The preparation for data migration to a new patient administration system (PAS) has now required a strong focus on all aspects of data beyond that of waiting lists and performance measurement to ensure that the data migrated is the most accurate it can be; the change in the move to the new PAS system has provided a greater opportunity to further investigate more aspects of data.

A programme of reviewing all national returns has been ongoing throughout the year with a focus on checking national guidance against the criteria used for the reports to generate the figures as well as checks with areas to ensure local criteria is correct; any requirements for change are presented at the Data Quality Steering Group (DQSG) for review and agreement to change with changes documented on the Information department's reporting database.

This group will also ensure that any change to national guidance is identified and implemented in a timely manner with full documentation and sign-off maintained.

Our access policy has been reviewed in light of national recommendations and is currently out for consultation, and training on this and other aspects of data quality will form part of a new role specific mandatory training programme in 2107/18.

Current areas of risk include:

1. Non adherence to the access policy and timely input of data onto PAS. This is being mitigated by providing training to all key staff on the use of the access policy with more intensive training for individuals as identified through the audit and validation work is, specifically around pathways for Referral to Treatment (RTT) and diagnostics. Mandatory role specific annual training is being developed to include data quality, patient pathways and the access policy for 2017/18.

2. Multiple systems being accessed to provide information both internally and externally, which could lead to discrepancies in the information being presented. This is being mitigated by a full assessment of internal and external data returns including information being processed through the data warehouse.

3. Data Migration to the new PAS may present a number of areas of data quality issues and the recording of pathways when the trust moves from a referral based system to a system more aligned with the capture of pathway activity. This is being mitigated by members of the data quality team be wholly engaged with the migration programme and seeking out possible areas of concern to correct and educate as necessary prior to migration and then time dedicated to the auditing post "go live".

Never events

There has been one Never Event incident reported by Northampton General Hospital during 2016/17.

The incident was reported onto STEIS (Strategic Executive Information System) in June 2016 and involved a retained foreign body ("bung") left in place after a laparoscopic hysterectomy.

A "bung", which had been made from sterile surgical theatre gloves filled with sterile swabs, was used on a patient undergoing a hysterectomy and was unintentionally left in situ at the end of the operation.
The patient was discharged home with the "bung" still in place.

The patient returned to the Trust several days later as planned whereby the "bung" was discovered; she was well and there were no complications (bleeding or infection) as a result of the incident. The patient continued to progress well and made an uncomplicated recovery from surgery.

Since the incident, changes in practice have been made which include the inclusion of all swabs used for the "bung" to be included within the swab count, which is checked throughout the procedure and documented.

The learning from the incident was shared both locally within the gynaecology governance and departmental meetings in addition to organisational learning through the Trust's quarterly Dare to Share Learning Event.

Financial Improvement Plan

Northampton General Hospital has an established programme for improving quality and efficiency. This is the Changing Care @ NGH programme which consists of projects led by clinical leaders and executive directors. In 2016/17 the programme delivered £12.2 million of savings.

For 2016/17 the Trust started the year with a planned deficit of £15.1 million. The final deficit reported prior to audit of the accounts was £13.8 million.

The Trust is continuing to work with Health Economy Partners including commissioners, other healthcare providers and local government to identify a medium term sustainability and transformation plan aimed at returning the health system to a more sustainable financial position within five years. NGH does however like many NHS providers currently face a very challenging financial environment and is anticipating a deficit of £13.5 million in 2017/18 based on the latest available information at the time of writing.

Nurse Recruitment

The national shortage of trained nurses continues to pose a significant risk to the organisation. We continue with efforts to mitigate this risk and in addition to an overseas nurses recruitment programme the Trust has moved to a twelve hour shift standardisation within nursing which has seen an improvement in shift fill rates and improved continuity of care for our patients.

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

Trust Estate

During 2016/17 the Trust has undertaken a piece of work to better understand the nature of all risks related to the aging estate of Northampton General Hospital. This has allowed the organisation to prioritise its capital programme and escalate planned maintenance to support the building infrastructure. During the early part of 2017 a full risk assessment paper was resented to the Board and a further plan of mitigation and actions will be produced for 2017/18.

Conclusion

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

Debbie Needham
Deputy Chief Executive Officer
Northampton General Hospital NHS Trust

Appendix 1

Organisational Principal risks

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

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

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

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

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

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

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

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

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

STAFF REPORT

Remuneration

A Remuneration & Appointments Committee meets at least annually and is comprised of non-executive directors. The duties of the Remuneration & Appointments Committee are set out in the Terms of Reference:

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

The Remuneration and Appointments Committee will determine the Remuneration and terms of service for the Chief Executive and executive directors, acting in accordance with the scheme of delegation and reservation of powers to the Board and approve any non-contractual benefits in relation to the termination of employment for executive directors.

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

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

Pay Multiples

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

The banded remuneration of the highest paid director in the Trust in the financial year 2016/17 was £225-230k (2015/16, £225-230k). This was 10.38 times (2015/16, 10.49 times) the median remuneration of the workforce, which was £22k (2015/16, £22k).

In 2016/17 and 2015/16 no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £1k for part-time staff to £182k for the next highest paid director and £213k for the highest paid agency locum (full year effect) (2015/16 £1k - £180k)

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

The ratio has decreased in 2016/17 by 0.11. Nursing staff represent the largest increase in Total Average Staff Numbers. The majority of staff on Agenda for Change terms and conditions received a 1% pay increase. This has contributed to the increase in the overall median remuneration of the workforce.

SALARY AND PENSION REPORT

Salary and pension entitlements of senior managers

Remuneration

Name and Title	2016-17 Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100* £	Performance Pay and Bonuses (bands of £5,000) £000	Long term Performance Pay and Bonuses (bands of £5,000) £000	All Pension-related Benefits (bands of £2,500) £000	Total - Salary & Benefits (bands of £5,000) £000
Paul Farenden - Chairman	20 - 25	1,900				20 - 25
Sonia Swart - Chief Executive Officer	225 - 230				0	225 - 230
Deborah Needham - Chief Operating Officer / Deputy Chief Executive Officer	125 - 130				37.5 - 40	165 -170
Michael Cusack - Medical Director	185 - 190				47.5 - 50	235 - 240
Carolyn Fox - Director of Nursing, Midwifery & Patient Services	110 - 115				105 - 107.5	215 - 220
Simon Lazarus - Director of Finance	120 - 125				32.5 - 35	155 - 160
Charles Abolins - Director of Facilities & Capital Development	85 - 90				0	85 - 90
Janine Brennan - Director of Workforce and Transformation	120 - 125				30 - 32.5	150 - 155
Chris Pallot - Director of Strategy & Partnerships	95 - 100				32.5 - 35	130 - 135
Catherine Thorne - Director of Corporate Development, Governance & Assurance	100 - 105				22.5 - 25	125 - 130
Phil Zeidler - Non-Executive Director (Vice Chairman)	5 - 10	400				5 - 10
Graham Kershaw - Non-Executive Director	5 - 10	600				5 - 10
David Noble - Non-Executive Director	5 - 10	900				5 - 10
Elizabeth Searle - Non-Executive Director (to 31 October 16)	0 - 5					0 - 5
Olivia Clymer - Non-Executive Director	5 - 10	500				5 - 10
John Archard-Jones - Non-Executive Director (1 January 17 onwards)	0 - 5					0 - 5
Annette Gill - Associate Non-Executive Director (1 January 17 onwards)	0 - 5					0 - 5

Name and Title	2015-16 Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100* £	Performance Pay and Bonuses (bands of £5,000) £000	Long term Performance Pay and Bonuses (bands of £5,000) £000	All Pension-related Benefits (bands of £2,500) £000	Total - Salary & Benefits (bands of £5,000) £000
Paul Farenden - Chairman	20 - 25	2,500				20 - 25
Sonia Swart - Chief Executive Officer	225 - 230				0	225 - 230
Deborah Needham - Chief Operating Officer / Deputy Chief Executive Officer	125 - 130				22.5 - 25	150 - 155
Michael Cusack - Medical Director	180 - 185				17.5 - 20	195 - 200
Carolyn Fox - Director of Nursing, Midwifery & Patient Services	75 - 80				200 - 202.5	275 - 280
Simon Lazarus - Director of Finance	120 - 125				17.5 - 20	140 - 145
Charles Abolins - Director of Facilities & Capital Development	95 - 100				0	95 - 100
Janine Brennan - Director of Workforce and Transformation	120 - 125				5 - 7.5	130 - 135
Chris Pallot - Director of Strategy & Partnerships	95 - 100				15 - 17.5	115 - 120
Catherine Thorne - Director of Corporate Development, Governance & Assurance	100 - 105				0	100 - 105
Phil Zeidler - Non-Executive Director (Vice Chairman)	5 - 10	600				5 - 10
Graham Kershaw - Non-Executive Director	5 - 10	1,400				5 - 10
David Noble - Non-Executive Director	5 - 10	700				5 - 10
Elizabeth Searle - Non-Executive Director (to 31 October 16)	5 - 10	500				5 - 10
Olivia Clymer - Non-Executive Director	0 - 5					0 - 5
John Archard-Jones - Non-Executive Director (1 January 17 onwards)						
Annette Gill - Associate Non-Executive Director (1 January 17 onwards)						

Salary Notes

Charles Abolin's 2016-17 salary represents 11 month's only
John Archard-Jones & Annette Gill were appointed to the Board in 2016-17. Therefore no salary values are reported for 2015-16

Carolyn Fox's 2015-16 salary represents a part year (July - March)
Olivia Clymer's 2015-16 salary represents a part year (November - March)
Elizabeth Searle's 2015-16 salary represents a full year

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

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

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

Pension Benefits

Name & Title	Real increase in pension at Pension Age (bands of £2,500)	Real increase in pension lump sum at Pension Age (bands of £2,500)	Total accrued pension at Pension Age at 31 March 2017 (bands of £5,000)	Lump sum at Pension Age related to accrued pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2016	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2017	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Sonia Swart - Chief Executive Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0
Deborah Needham - Chief Operating Officer / Deputy Chief Executive Officer	2.5 - 5	0 - 2.5	40 - 45	110 - 115	538	42	580	0
Michael Cusack - Medical Director	2.5 - 5	0 - 2.5	45 - 50	120 - 125	711	90	801	0
Carolyn Fox - Director of Nursing, Midwifery & Patient Services	5 - 7.5	15 - 17.5	30 - 35	100 - 105	453	98	551	0
Simon Lazarus - Director of Finance	2.5 - 5	0 - 2.5	35 - 40	90 - 95	545	46	592	0
Charles Abolins - Director of Facilities & Capital Development	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0
Janine Brennan - Director of Workforce and Transformation	0 - 2.5	5 - 7.5	45 - 50	140 - 145	859	89	947	0
Chris Pallot - Director of Strategy & Partnerships	0 - 2.5	0 - 2.5	25 - 30	75 - 80	377	55	432	0
Catherine Thorne - Director of Corporate Development, Governance & Assurance	0 - 2.5	2.5 - 5	35 - 40	110 - 115	644	69	712	0

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated in accordance with the Occupational Pensions Schemes (Transfer Values) Regulations 2008.

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.

A rate of 0% Consumer Price Index (CPI) annual inflation has been used to calculate the real increases.

No lump sum is shown for senior managers who only have membership in the 2008 Section of the NHS Pension Scheme, unless they chose to move their 1995 Section benefits under Choice. No CETV is shown for pensioners, senior managers over 60 (1995 Section) or over 65 (2008 Section)

Off-Payroll Engagements Table 1

For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months

Narrative	Number
Number of existing engagements as of 31 March 2017	21
Of which, the number that have existed:	
for less than one year at the time of reporting	11
for between 1 and 2 years at the time of reporting	10
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

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

Off-Payroll Engagements Table 2

For all new off-payroll engagements between 1 April 2016 and 31 March 2017, for more than £220

Narrative	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	11
Number of new engagements which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	10
Number for whom assurance has been requested	1
Of which:	
assurance has been received	0
assurance has not been received	1
engagements terminated as a result of assurance not being received	0

Off-Payroll Engagements Table 3

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	10

Expenditure on consultancy

Details of our expenditure on consultancy can be found at Note 8 on page 95 in the Annual Accounts

Exit packages

The Trust has no exit package costs in 2016/17

OUR STAFF

STAFF NUMBERS

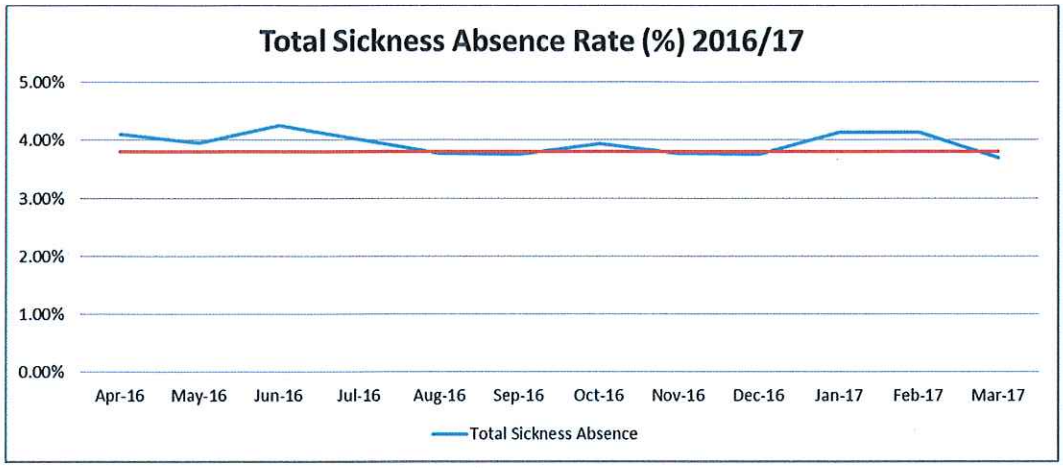
Staff Numbers							
	2016-17			2015-16			2014-15
Average Staff Numbers	**Total Number**	**Permanently Employed Number**	**Other Number**	**Total Number**	**Permanently Employed Number**	**Other Number**	**Total Number**
Medical and dental	558	504	54	529	494	36	534
Administration and Estates*	1036	952	84	983	910	73	984
Healthcare assistants and other support staff	1074	899	175	1065	875	190	1003
Nursing, midwifery and health visiting staff	1469	1303	166	1411	1268	143	1364
Nursing, midwifery and health visiting learners	1	0	1	0	0	0	0
Scientific, therapeutic and technical staff**	519	488	31	515	480	35	509
Healthcare Science Staff	150	150		148	148	0	152
Other	0	0	0	0	0	0	0
TOTAL	**4806**	**4296**	**510**	**4651**	**4174**	**477**	**4546**

* For 2016-7 figures composed of "Administrative & Clerical" and "Estates and Ancillary" staff groups

** For 2016-17 figures composed of "Add Prof Scientific and Technic" and "Allied Health Professionals" staff groups

SICKNESS ABSENCE

Sickness Absence %												
	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Short Term Absence	2.42%	2.23 %	2.37 %	2.31 %	2.04 %	2.04 %	2.56 %	2.12 %	2.40 %	2.89 %	2.73 %	2.52 %
Long Term Absence	1.69%	1.72 %	1.89 %	1.70 %	1.73 %	1.72 %	1.37 %	1.66 %	1.35 %	1.24 %	1.41 %	1.18 %
Total Sickness Absence	4.11%	3.96 %	4.26 %	4.01 %	3.78 %	3.76 %	3.93 %	3.78 %	3.75 %	4.14 %	4.14 %	3.70 %



Staff Sickness absence		
	2016-17	2015-16
	Number	Number
Total Days Lost	40,583	38,400
Total Staff Years	4,277	4,143
Average working Days Lost	9.49	9.27

ILL-HEALTH RETIREMENTS

Retirements due to ill-health

	2016-17	**2015-16**
	Number	**Number**
Number of persons retired early on ill health grounds	2	4
	£000s	**£000s**
Total additional pensions liabilities accrued in the year	241	135

Equality

During 2016/17 we refreshed and reviewed our Workforce Equality and Diversity Strategy. The updated strategy details how we will address requirements of the Public Sector Equality Duty. It builds on the work already done and progress made on equality and diversity over the years and sets out our co-ordinated and integrated approach in relation to our workforce.

Our equality objectives/four year plan was also reviewed and refreshed during 2016/17. The two main objectives link to the Equality Delivery System (EDS2) outcomes relating to the workforce, with the key actions linked to:

- Workforce Race Equality Standard (WRES),
- health and wellbeing,
- staff survey results,
- divisional objectives
- leadership and management development programme.

The objectives are:

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

The detailed action plan can be accessed via our website:

http://www.northamptongeneral.nhs.uk/WorkforUs/Equality,DiversityHumanRights/Equality,DiversityHumanRights.aspx

2016 NHS Staff Survey Equality and Diversity Key Findings

The demographics of our workforce responding to the staff survey were broadly similar to our overall demographic profile were broadly similar with the exception of disabled staff - 15% of respondents were disabled compared to the 4% of our workforce - and ethnic background where 14% of the respondents were Black and Minority Ethnic compared to 79% of our workforce.

The percentage of staff reporting they had experienced discrimination at work in the last 12 months has not changed since the 2015 survey and we were benchmarked as average when compared to acute Trusts.

There was also no change in relation to the key finding which relates to the percentage of staff who believe that the organisation provides equal opportunities for career progression and/or promotion; we were benchmarked as below average when compared to other acute Trusts.

The survey has highlighted some areas of concern and the continuing work the organisational development and improving quality and efficiency teams will work to bring about a shift in culture, where everyone is focused on the values, positive behaviours, quality, continuous improvement and meaningful staff engagement to sustainably improve staff satisfaction at work.

Workforce Race Equality Standards

Following the introduction of the National Workforce Race Equality Standard by NHS England, we produced baseline data for each of the nine indicators in April 2015 and these were published on our website.

We repeated the exercise in 2016 and compared these results to establish if there have been improvements in the experiences or the treatment of White staff and BME staff. Due to a change in two of the indicators in 2016 (1 and 9) no direct comparison could be made with the previous year's results, but of the remaining 7, there were 6 improvements and one deterioration. To address this work is underway to roll out equality training to managers. In addition work has commenced on strengthening the information and support available in relation to bullying and harassment across the organisation.

Gender Distribution of Staff

Directors and non-executive directors

Gender	Count	%
Female	7	43.75
Male	9	56.25
Grand Total	16	100

Senior managers (Band 8a and above) and senior medical staff

Gender	Count	%
Female	217	51.54
Male	204	48.46
Grand Total	421	100

Senior Managers (Band 8a and above)

Gender	Count	%
Female	144	71.29
Male	58	28.71
Grand Total	202	100

Breakdown by senior manager pay scales

Pay Scale	Count	Female	Male
XN08/XR08	129	99	30
XN09/XR09	43	27	16
XN10/XR10	12	7	5
XN11/XR11	5	5	0
WQ00	13	6	7
Total	202	144	58

Senior Medical Staff (Consultants)

Gender	Count	%
Female	73	33.33
Male	146	66.67
Grand Total	219	100

Breakdown by senior medical staff (consultant) pay scales

Pay Scale	Count	Female	Male
MD01	1		1
MC21	1	1	0
YC53	2	1	1
YC62	1	1	0
YC72	64	26	38
YC73	8	0	8
YM51	2	2	0
YM52	6	0	6
YM53	11	4	7
YM54	5	1	4
YM55	10	1	9
YM56	5	2	3
YM57	11	3	8
YM58	8	3	5
YM59	1	0	1
YM60	3	1	2
YM61	6	2	4
YM62	1	0	1
YM63	1	1	0
YM65	1	0	1
YM68	1	1	0
YM69	1	0	1
YM70	1	0	1
YM72	66	22	44
YM73	2	1	1
Total	219	73	146

All Employees

Gender	Count	%
Female	3909	79.19
Male	1027	20.81
Grand Total	4936	100

Disability Related Polices

We have three key policies relating to the recruitment and continuing employment of staff with a disability:

- recruitment, selection and retention policy
- employment of people with a disability policy
- management of sickness absence policy.

The purpose of the recruitment, selection and retention policy, together with the associated procedures, is to provide 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 people with a disability.

The purpose of the management of sickness absence policy is to provide managers with clear guidelines when managing either short term or long term sickness absence and other absence in connection with sickness. It is also designed to ensure compliance with the requirement of any relevant employment legislation including the Equality Act 2010.

Supporting both of these policies is the employment of people with a disability policy. The aim of this policy is:

- To raise awareness of the employment of people with disabilities throughout the organisation and ensure employees are aware of our commitment to people with a disability or someone's association with a person with a disability
- To ensure recruitment procedures are reviewed and developed to encourage applications and the employment of people with disabilities or someone associated with a person with a disability
- To ensure that staff and potential job applicants with a disability, or associated with a person with a disability, are treated fairly and receive the same opportunities as other staff to develop with appropriate and reasonable support.
- To take all reasonable steps to ensure that the working environment does not prevent people with a disability or those associated with a person 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.

We have made a commitment to operate under the Government's Disability Confident Scheme (formally Positive about Disabled People 'Two Ticks' Scheme)

We have been certified as a Disability Confident Employer 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 people

with disabilities who meet the minimum criteria for the job and making reasonable adjustments as required.

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

This policy is underpinned by our workforce equality and diversity strategy.

SECTION THREE:

FINANCIAL STATEMENTS

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

We have audited the financial statements of Northampton General Hospital NHS Trust for the year ended 31 March 2017 on pages 80 to 121 under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

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

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities set out on page 45, the Directors are responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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

Scope of the audit of the financial statements

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

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2016, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for

taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2017 and of the Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England.

Emphasis of Matter – Going Concern

In forming our opinion on the financial statements which is not modified, we have considered the adequacy of disclosures made in note 1.1 in the financial statements concerning the use of going concern basis for the preparation of the accounts. The Trust has a loan of £18.85 million repayable to the Department of Health in February 2018 and the Department of Health has yet to confirm the refinancing arrangements around the repayment of this loan. This matter, along with other matters also explained in note 1.1 in the financial statements, indicate the existence of a material uncertainty which may cast significant doubt on the Trust's ability to continue as a going concern.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England; and
- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the Department of Health Group Accounting Manual 2016/17; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

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

Other matters on which we report by exception – referral to Secretary of State

We have a duty under the Local Audit and Accountability Act 2014 (the 2014 Act) to refer a matter to the Secretary of State if we have reason to believe that the Trust is, taking into account the NHS Finance Manual *Guidance on Breakeven Duty and Provisions*, taking a course of action that, if followed to its conclusion, will lead to a breach of its 'breakeven duty' set out at paragraph 2(1) of Schedule 5 to the National Health Service Act 2006.

On 23 May 2017, we referred a matter to the Secretary of State under section 30 (1)(a) of the 2014 Act in relation to the breach of the Trust's breakeven duty due to the reported deficit of £13.8 million in 2016/17, and a cumulative deficit of £43.3 million at 31 March 2017.

Other matters on which we report by exception - adequacy of arrangements to secure value for money

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

- the Trust has reported a deficit of £13.8 million in 2016/17; and
- the Trust has failed to deliver a number of operational targets for the year. In particular the Trust failed to meet its Accident and Emergency and cancer waiting time targets.

On the basis of our work, with the exception of the matters above, we are satisfied that, in all material respects Northampton General Hospital NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2017.

Certificate

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

Tony Crawley
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
31 Park Row
Nottingham
NG1 6FQ

31 May 2017

Statement of Comprehensive Income for year ended 31 March 2017

	NOTE	2016-17 £000s	2015-16 £000s
Gross employee benefits	10.1	**(203,764)**	(191,283)
Other operating costs	8	**(105,839)**	(94,833)
Revenue from patient care activities	5	**262,949**	248,771
Other operating revenue	6	**35,291**	24,791
Operating surplus/(deficit)		**(11,363)**	(12,554)
Investment revenue	12	**29**	32
Other gains and (losses)	13	**273**	(83)
Finance costs	14	**(813)**	(440)
Surplus/(deficit) for the financial year		**(11,874)**	(13,045)
Public dividend capital dividends payable		**(3,290)**	(4,041)
Transfers by absorption - gains		**0**	0
Transfers by absorption - (losses)		**0**	0
Net Gain/(loss) on transfers by absorption		**0**	0
Retained surplus/(deficit) for the year		**(15,164)**	(17,086)

Other Comprehensive Income

		2016-17 £000s	2015-16 £000s
Impairments and reversals taken to the revaluation reserve		**0**	0
Net gain/(loss) on revaluation of property, plant & equipment	16	**(3,815)**	5,906
Net gain/(loss) on revaluation of intangibles		**0**	0
Net gain/(loss) on revaluation of financial assets		**0**	0
Other gain /(loss) (explain in footnote below)		**0**	0
Net gain/(loss) on revaluation of available for sale financial assets		**0**	0
Net actuarial gain/(loss) on pension schemes		**0**	0
Other pension remeasurements		**0**	0
Reclassification adjustments			
On disposal of available for sale financial assets		**0**	0
Total comprehensive income for the year		**(18,979)**	(11,180)

Financial performance for the year

Retained surplus/(deficit) for the year	**(15,164)**	(17,086)
Prior period adjustment to correct errors and other performance	**0**	0
IFRIC 12 adjustment (including IFRIC 12 impairments)	**0**	0
Impairments (excluding IFRIC 12 impairments)	**1,732**	(3,315)
Adjustments in respect of donated gov't grant asset reserve elimination	**(415)**	250
Adjustment re absorption accounting	**0**	0
Adjusted retained surplus/(deficit)	**(13,847)**	(20,151)

The increase in impairment of £1,732k relates in full to the quarterly BCIS net negative indices applied to the Buildings and is excluded from retained deficit and statutory breakeven in accordance with the DH Group Accounting Manual (GAM), note 16 refers.

Donated asset adjustment of £415k (consisting of £323k donated depreciation less £738k donated additions) is excluded from retained surplus and statutory breakeven duty in accordance with the DH Manual for Accounts.

Statement of Financial Position as at 31 March 2017

	NOTE	31 March 2017 £000s	31 March 2016 £000s
Non-current assets:			
Property, plant and equipment	16	**158,405**	158,921
Intangible assets	17	**1,204**	1,270
Investment property	19	**0**	0
Other financial assets		**0**	0
Trade and other receivables	22.1	**200**	209
Total non-current assets		**159,809**	160,400
Current assets:			
Inventories	21	**5,770**	5,744
Trade and other receivables	22.1	**23,887**	16,340
Other financial assets	23	**0**	0
Other current assets	24	**0**	0
Cash and cash equivalents	25	**1,621**	1,602
Sub-total current assets		**31,278**	23,686
Non-current assets held for sale	26	**0**	375
Total current assets		**31,278**	24,061
Total assets		**191,087**	184,461
Current liabilities			
Trade and other payables	27	**(24,109)**	(24,345)
Other liabilities	28	**(753)**	(710)
Provisions	34	**(4,808)**	(2,802)
Borrowings	29	**(208)**	(276)
Other financial liabilities	30	**0**	0
DH revenue support loan	29	**(18,851)**	0
DH capital loan	29	**(1,399)**	(628)
Total current liabilities		**(50,128)**	(28,761)
Net current assets/(liabilities)		**(18,850)**	(4,700)
Total assets less current liablilities		**140,959**	155,700
Non-current liabilities			
Trade and other payables	27	**0**	0
Other liabilities	28	**0**	0
Provisions	34	**(1,055)**	(979)
Borrowings	29	**(1,203)**	(1,411)
Other financial liabilities	30	**0**	0
DH revenue support loan	29	**(19,979)**	(18,851)
DH capital loan	29	**(10,428)**	(7,186)
Total non-current liabilities		**(32,665)**	(28,427)
Total assets employed:		**108,294**	127,273
FINANCED BY:			
Public Dividend Capital		**119,258**	119,258
Retained earnings		**(48,356)**	(33,420)
Revaluation reserve		**37,392**	41,435
Other reserves		**0**	0
Total Taxpayers' Equity:		**108,294**	127,273

The notes on pages 85 to 121 form part of this account.

The financial statements on pages 80 to 84 were approved by the Board on 25 May 2017 and signed on its behalf by

Deputy Chief Executive: **Date:** 25 May 17

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2017

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**119,258**	**(33,420)**	**41,435**	**0**	**127,273**
Changes in taxpayers' equity for 2016-17					
Retained surplus/(deficit) for the year	0	(15,164)	0	0	**(15,164)**
Net gain / (loss) on revaluation of property, plant, equipment	0	0	(3,815)	0	**(3,815)**
Net gain / (loss) on revaluation of intangible assets	0	0	0	0	**0**
Net gain / (loss) on revaluation of financial assets	0	0	0	0	**0**
Net gain / (loss) on revaluation of available for sale	0	0	0	0	**0**
Impairments and reversals	0	0	0	0	**0**
Other gains/(loss) (provide details below)	0	0	0	0	**0**
Transfers between reserves	0	228	(228)	0	**0**
Reclassification Adjustments					
Transfers between Reserves in respect of assets transferred under absorption	0	0	0	0	**0**
On disposal of available for sale financial assets	0	0	0	0	**0**
Reserves eliminated on dissolution	0	0	0	0	**0**
Originating capital for Trust established in year	0	0	0	0	**0**
Temporary and permanent PDC received - cash	0	0	0	0	**0**
Temporary and permanent PDC repaid in year	0	0	0	0	**0**
PDC written off	0	0	0	0	**0**
Transfer due to change of status from Trust to Foundatio	0	0	0	0	**0**
Other movements	0	0	0	0	**0**
Net actuarial gain/(loss) on pension	0	0	0	0	**0**
Other pensions remeasurement	0	0	0	0	**0**
Net recognised revenue/(expense) for the year	**0**	**(14,936)**	**(4,043)**	**0**	**(18,979)**
Balance at 31 March 2017	**119,258**	**(48,356)**	**37,392**	**0**	**108,294**
Balance at 1 April 2015	**119,240**	**(16,684)**	**35,879**	**0**	**138,435**
Changes in taxpayers' equity for the year ended 31 March 2016					
Retained surplus/(deficit) for the year	0	(17,086)	0	0	(17,086)
Net gain / (loss) on revaluation of property, plant, equipment	0	0	5,906	0	5,906
Net gain / (loss) on revaluation of intangible assets	0	0	0	0	0
Net gain / (loss) on revaluation of financial assets	0	0	0	0	0
Net gain / (loss) on revaluation of assets held for sale	0	0	0	0	0
Impairments and reversals	0	0	0	0	0
Other gains / (loss)	0	0	0	0	0
Transfers between reserves	0	350	(350)	0	0
Reclassification Adjustments					
Transfers between revaluation reserve & retained earnings reserve in respect of assets transferred under	0	0	0	0	0
On disposal of available for sale financial assets	0	0	0	0	0
Originating capital for Trust established in year	0	0	0	0	0
New PDC received - cash	18	0	0	0	18
PDC repaid in year	0	0	0	0	0
Other movements	0	0	0	0	0
Net actuarial gain/(loss) on pension	0	0	0	0	0
Other pension remeasurement	0	0	0	0	0
Net recognised revenue/(expense) for the year	**18**	**(16,736)**	**5,556**	**0**	**(11,162)**
Balance at 31 March 2016	**119,258**	**(33,420)**	**41,435**	**0**	**127,273**

Information on reserves

1 **Public dividend capital**
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities. Additional PDC may also be issued to NHS trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

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

3 **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.

Statement of Cash Flows for the Year ended 31 March 2017

	NOTE	2016-17 £000s	2015-16 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**(11,363)**	(12,554)
Depreciation and amortisation	8	**9,703**	9,941
Impairments and reversals	18	**1,732**	(3,315)
Other gains/(losses) on foreign exchange	13	**0**	0
Donated Assets received credited to revenue but non-cash	6	**(738)**	(7)
Government Granted Assets received credited to revenue but non-cash		**0**	0
Release of PFI/deferred credit		**0**	0
(Increase)/Decrease in Inventories		**(26)**	217
(Increase)/Decrease in Trade and Other Receivables		**(7,506)**	(5,446)
(Increase)/Decrease in Other Current Assets		**0**	0
Increase/(Decrease) in Trade and Other Payables		**1,843**	3,314
(Increase)/Decrease in Other Current Liabilities		**43**	(11)
Provisions utilised		**(1,440)**	(687)
Increase/(Decrease) in movement in non cash provisions		**3,502**	1,978
Net Cash Inflow/(Outflow) from Operating Activities		**(4,250)**	(6,570)
Cash Flows from Investing Activities			
Interest Received		**29**	32
(Payments) for Property, Plant and Equipment		**(15,381)**	(13,298)
(Payments) for Intangible Assets		**(628)**	(398)
(Payments) for Investments with DH		**0**	0
(Payments) for Other Financial Assets		**0**	0
(Payments) for Financial Assets (LIFT)		**0**	0
Proceeds of disposal of assets held for sale (PPE)		**585**	0
Proceeds of disposal of assets held for sale (Intangible)		**0**	0
Proceeds from Disposal of Investment with DH		**0**	0
Proceeds from Disposal of Other Financial Assets		**0**	0
Proceeds from the disposal of Financial Assets (LIFT)		**0**	0
Loans Made in Respect of LIFT		**0**	0
Loans Repaid in Respect of LIFT		**0**	0
Rental Revenue		**58**	0
Net Cash Inflow/(Outflow) from Investing Activities		**(15,337)**	(13,664)
Net Cash Inform / (outflow) before Financing		**(19,587)**	(20,234)
Cash Flows from Financing Activities			
Gross Temporary and Permanent PDC Received		**0**	18
Gross Temporary and Permanent PDC Repaid		**0**	0
Loans received from DH - New Capital Investment Loans		**4,707**	6,651
Loans received from DH - New Revenue Support Loans		**34,852**	35,351
Other Loans Received		**0**	73
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(694)**	(427)
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		**(14,873)**	(16,500)
Other Loans Repaid		**(155)**	(208)
Cash transferred to NHS Foundation Trusts or on dissolution		**0**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(121)**	(44)
Interest paid		**(723)**	(381)
PDC Dividend (paid)/refunded		**(3,387)**	(3,811)
Capital grants and other capital receipts (excluding donated / government granted cash receipts)		**0**	0
Net Cash Inflow/(Outflow) from Financing Activities		**19,606**	20,722
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**19**	488
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**1,602**	1,114
Effect of exchange rate changes in the balance of cash held in foreign currencies		**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	**25**	**1,621**	1,602

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2016-17 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

Going Concern

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

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

Continuity of service:

The Trust recorded a deficit of £13.8m which was £1.3m better than its planned deficit of £15.1m in 2016-17. This improved position included £1.1m of STP incentive and bonus. This was in addition to the core STF funding of £8.6m received as the Trust met most of its STF financial and operational trajectories. Further, the Trust delivered £12.2m of its challenging CIP programme.

The Board of Directors and NHS Improvement approved the Trust's two-year plan of £13.5m deficit in 2017/18 and £10.2m deficit in 2018/19. The income assumptions included in the plan are supported by signed contracts with Commissioners. The plan also recognises risks to its delivery such as bed capacity, appropriate demand management schemes as well as challenges to meeting the STF conditions. Non-recurrent STF funding of £8.7m is included in each of the two years. The plans include expected CIP programme delivery of £12.2m in 2017/18 and £10.7m in 2018/19.

The approved plans, supported by signed commissioner contracts constitute reasonable evidence that the NHS intends that the Trust will continue to provide healthcare services to the people of Northamptonshire.

Financing:

The Board of Directors also has a reasonable expectation that the Trust will have access to adequate resources in the form of financial support from the Department of Health (NHS Act 2006,s42a) to continue to deliver the full range of mandatory services for the foreseeable future. The Trust has been reliant on cash support from the Department of Health in meeting its payment obligations and has drawn down a total of £39.559m at 31 March 2017; made up of £19.979m (revenue support loans), £14.873m (revolving working facility - fully repaid in March 2017) and £4.707m (capital loan).

Of the revenue support loans, £18.85m is repayable in February 2018 which will be less than 12 months from the reporting date. The Department of Health is yet to advise of refinancing arrangements regarding this loan however the uncertainty about the refinancing does not of itself affect the Trust's going concern basis.

The Board of Directors has therefore satisfied itself that on the basis that the Trust will continue to provide healthcare services and that its cash requirements will be supported by the Department of Health, it considers it appropriate that the accounts for the year ended 31 March 2017 should be prepared on a Going Concern basis.

1.2 Acquisitions and discontinued operations

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

1.3 Movement of assets within the DH Group

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

Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

NOTES TO THE ACCOUNTS

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

1.4 Charitable Funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact. The Trust previously decided not to consolidate the charity on the basis of materiality. The Northamptonshire Health Charitable Fund is an independent body from 1 April 2016.

1.5 Critical accounting judgements and key sources of estimation uncertainty

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

1.5.1 Critical judgements in applying accounting policies

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

- Ongoing status as a going concern;
- That no major service discontinuation is anticipated;
- Selection of indices for land and building valuations;
- All lease liabilities have been identified through a review of contract documentation.

1.5.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

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

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

1.6 Revenue

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

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

The NHS trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.7 Employee Benefits

Short-term employee benefits

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

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

NOTES TO THE ACCOUNTS

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

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8 Other expenses

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

1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

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

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

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

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

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

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

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

NOTES TO THE ACCOUNTS

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

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

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

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.11 Depreciation, amortisation and impairments

Freehold land, assets under construction or development, and assets held for sale are not depreciated/amortised.

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

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

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.12 Donated assets
Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.13 Government grants
Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

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

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

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

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.

NOTES TO THE ACCOUNTS

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

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

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

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

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

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

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

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

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

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

1.18 Provisions
Provisions are recognised when the NHS trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.24% (2015-16: positive 1.37%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
- A short term rate of negative 2.70% (2015-16: negative 1.55%) for expected cash flows up to and including 5 years
- A medium term rate of negative 1.95% (2015-16: negative 1.00%) for expected cash flows over 5 years up to and including 10 years
- A long term rate of negative 0.80% (2015-16: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

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

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

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

NOTES TO THE ACCOUNTS

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

1.20 Non-clinical risk pooling

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

1.21 Carbon Reduction Commitment Scheme (CRC)

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

1.22 Contingencies

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

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

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

1.23 Financial assets

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

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

Loans and receivables

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

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the NHS trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset and that have an impact on the estimated future cash flows of the asset.

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

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

1.24 Financial liabilities

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

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

1.25 Value Added Tax

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

NOTES TO THE ACCOUNTS

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

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

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

1.28 Public Dividend Capital (PDC) and PDC dividend
Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

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

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

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the NHS trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

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

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

The Trust has not identified any subsidiaries. Should any of these be identified in the future, further disclosures will be provided.

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

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

The Trust has not identified any associates. Should any of these be identified in the future, further disclosures will be provided.

1.32 Joint arrangements

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

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

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

NOTES TO THE ACCOUNTS

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

Research and Development
Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.33 Accounting Standards that have been issued but have not yet been adopted
The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2016-17. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.34 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.

2. Pooled budgets

The NHS Trust does not have any pooled budget arrangements.

3. Operating segments

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

4. Income generation activities

The Trust has no formal registered income generation schemes.
For the purpose of reporting Catering and Non-staff car parking are treated as income generation activities.
The combined income and costs of these schemes are shown below.

Summary Table - aggregate of all schemes	**2016-17 £000s**	2015-16 £000s
Income	**2,700**	2,585
Full cost	**1,350**	1,239
Surplus/(deficit)	**1,350**	1,346

5. Revenue from patient care activities

	2016-17 £000s	2015-16 £000s
NHS Trusts	**0**	0
NHS England	**44,975**	41,332
Clinical Commissioning Groups	**214,485**	204,058
Foundation Trusts	**1,009**	829
Department of Health	**0**	0
NHS Other (including Public Health England and Prop Co)	**107**	107
Additional income for delivery of healthcare services	**0**	0
Non-NHS:		
Local Authorities	**0**	0
Private patients	**910**	792
Overseas patients (non-reciprocal)	**134**	185
Injury costs recovery	**1,329**	1,468
Other Non-NHS patient care income	**0**	0
Total Revenue from patient care activities	**262,949**	248,771

6. Other operating revenue

	2016-17 £000s	2015-16 £000s
Recoveries in respect of employee benefits	**3,132**	3,021
Patient transport services	**0**	0
Education, training and research	**10,824**	11,306
Charitable and other contributions to revenue expenditure - NHS	**0**	0
Charitable and other contributions to revenue expenditure -non- NHS	**399**	427
Receipt of charitable donations for capital acquisitions	**738**	177
Support from DH for mergers	**0**	0
Receipt of Government grants for capital acquisitions	**0**	0
Non-patient care services to other bodies	**1,481**	1,415
Sustainability & Transformation Fund Income	**10,739**	0
Income generation (Other fees and charges)	**2,700**	2,585
Rental revenue from finance leases	**0**	0
Rental revenue from operating leases	**58**	45
Other revenue	**5,220**	5,815
Total Other Operating Revenue	**35,291**	24,791
Total operating revenue (note 5 + 6)	**298,240**	273,562

Other revenue includes :
Pharmacy Sales £417k (£1,810k)
Accommodation Charges £519k (£483k)
Provision of Services to private hospitals £719k (£482k)
Sustainability & Transformation Fund (STF) Income
- core STF £9,619k
- incentive STF £258k
- bonus STF £862k

7. Overseas Visitors Disclosure

	2016-17 £000s	2015-16 £000s
Income recognised during 2016-17 (invoiced amounts and accruals)	**134**	185
Cash payments received in-year (re receivables at 31 March 2016)	**33**	23
Cash payments received in-year (iro invoices issued 2016-17)	**79**	35
Amounts added to provision for impairment of receivables (re receivables at 31 March 2016)	**138**	11
Amounts added to provision for impairment of receivables (iro invoices issued 2016-17)	**29**	193
Amounts written off in-year (irrespective of year of recognition)	**338**	140

8. Operating expenses

	2016-17 £000s	2015-16 £000s
Services from other NHS Trusts	**53**	234
Services from CCGs/NHS England	**0**	0
Services from other NHS bodies	**0**	0
Services from NHS Foundation Trusts	**1,349**	1,260
Total Services from NHS bodies*	**1,402**	1,494
Purchase of healthcare from non-NHS bodies	**2,759**	2,901
Purchase of Social Care	**0**	**0**
Trust Chair and Non-executive Directors	**56**	54
Supplies and services - clinical	**59,412**	57,614
Supplies and services - general	**3,514**	3,401
Consultancy services	**239**	774
Establishment	**3,399**	2,998
Transport	**205**	139
Service charges - ON-SOFP PFIs and other service concession arrangements	**0**	0
Service charges - On-SOFP LIFT contracts	**0**	0
Total charges - Off-SOFP PFIs and other service concession arrangements	**0**	0
Total charges - Off-SOFP LIFT contracts	**0**	0
Business rates paid to local authorities	**769**	771
Premises	**10,947**	8,913
Hospitality	**12**	8
Insurance	**219**	215
Legal Fees	**277**	296
Impairments and Reversals of Receivables	**517**	790
Inventories write down	**126**	141
Depreciation	**8,923**	9,006
Amortisation	**780**	935
Impairments and reversals of property, plant and equipment	**1,732**	(3,315)
Impairments and reversals of intangible assets	**0**	0
Impairments and reversals of financial assets [by class]	**0**	0
Impairments and reversals of non current assets held for sale	**0**	0
Internal Audit Fees	**138**	141
Audit fees	**45**	54
Other auditor's remuneration	**40**	46
Clinical negligence	**8,005**	5,718
Research and development (excluding staff costs)	**0**	0
Education and Training	**838**	757
Change in Discount Rate	**15**	13
Capital Grants in Kind	**0**	0
Other	**1,470**	969
Total Operating expenses (excluding employee benefits)	**105,839**	94,833

Supplies & services clinical includes value of drugs including gases of £27,698k (£27,757k)

Other auditors remuneration includes :
KPMG £40k (£46k)
- Expenses in relation to Salary Sacrifice Schemes £30k (£34k)
- Quality Accounts Audit Fee £10k (£12k)

Other expenditure includes :
Translation Services £87k (£91k)
Home Oxygen Service £123k (£126k)
Professional Subscriptions £229k (£171k)
Professional Fees £452k (£263k)

Employee Benefits		
Employee benefits excluding Board members	**202,306**	189,809
Board members	**1,458**	1,474
Total Employee Benefits	**203,764**	191,283
Total Operating Expenses	**309,603**	286,116

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

9. Operating Leases

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

9.1. Northampton General Hospital NHS Trust as lessee

	Other £000s	2016-17 Total £000s	2015-16 £000s
Payments recognised as an expense			
Minimum lease payments		**675**	579
Contingent rents		**0**	0
Sub-lease payments		**0**	0
Total		**675**	579
Payable:			
No later than one year	702	**702**	533
Between one and five years	1,990	**1,990**	602
After five years	454	**454**	0
Total	**3,146**	**3,146**	1,135
Total future sublease payments expected to be received:		0	0

9.2. Northampton General Hospital NHS Trust as lessor

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

	2016-17 £000s	2015-16 £000s
Recognised as revenue		
Rental revenue	58	45
Contingent rents	0	0
Total	**58**	45
Receivable:		
No later than one year	58	45
Between one and five years	0	0
After five years	0	0
Total	**58**	45

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

10. Employee benefits

10.1. Employee benefits

	2016-17 Total £000s	2015-16 Total £000s
Employee Benefits - Gross Expenditure		
Salaries and wages	**171,329**	163,187
Social security costs	**15,385**	11,754
Employer Contributions to NHS BSA - Pensions Division	**17,045**	16,333
Other pension costs	**5**	9
Termination benefits	**0**	0
Total employee benefits	**203,764**	191,283
Employee costs capitalised	**0**	0
Gross Employee Benefits excluding capitalised costs	**203,764**	191,283

10.2. Retirements due to ill-health

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	**2**	4
	£000s	£000s
Total additional pensions liabilities accrued in the year	**241**	135

10.3. 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 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 are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. 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 their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

11. Better Payment Practice Code

11.1. Measure of compliance

	2016-17 Number	2016-17 £000s	2015-16 Number	2015-16 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**93,148**	**111,972**	97,099	104,056
Total Non-NHS Trade Invoices Paid Within Target	**92,303**	**109,534**	96,360	103,534
Percentage of NHS Trade Invoices Paid Within Target	**99.09%**	**97.82%**	99.24%	99.50%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,127**	**20,938**	2,154	**19,783**
Total NHS Trade Invoices Paid Within Target	**2,085**	**20,858**	2,132	**19,746**
Percentage of NHS Trade Invoices Paid Within Target	**98.03%**	**99.62%**	98.98%	99.81%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The Trust surpassed the 95% target.

11.2. The Late Payment of Commercial Debts (Interest) Act 1998

	2016-17 £000s	2015-16 £000s
Amounts included in finance costs from claims made under this legislation	**0**	3
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	3

12. Investment Revenue

	2016-17 £000s	2015-16 £000s
Rental revenue		
PFI finance lease revenue (planned)	**0**	0
PFI finance lease revenue (contingent)	**0**	0
Other finance lease revenue	**0**	0
Subtotal	**0**	0
Interest revenue		
LIFT: equity dividends receivable	**0**	0
LIFT: loan interest receivable	**0**	0
Bank interest	**16**	13
Other loans and receivables	**13**	19
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Subtotal	**29**	32
Total investment revenue	**29**	32

13. Other Gains and Losses

	2016-17 £000s	2015-16 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**63**	**(83)**
Gain/(Loss) on disposal of assets other than by sale (intangibles)	**0**	**0**
Gain/(Loss) on disposal of Financial Assets other then held for sale	**0**	**0**
Gain (Loss) on disposal of assets held for sale	**210**	**0**
Gain/(loss) on foreign exchange	**0**	**0**
Change in fair value of financial assets carried at fair value through the SoCI	**0**	**0**
Change in fair value of financial liabilities carried at fair value through the SoCI	**0**	**0**
Change in fair value of investment property	**0**	**0**
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	**0**
Total	**273**	(83)

14. Finance Costs

	2016-17 £000s	2015-16 £000s
Interest		
Interest on loans and overdrafts	749	387
Interest on obligations under finance leases	50	33
Interest on obligations under PFI contracts:		
- main finance cost	0	0
- contingent finance cost	0	0
Interest on obligations under LIFT contracts:		
- main finance cost	0	0
- contingent finance cost	0	0
Interest on late payment of commercial debt	0	3
Total interest expense	799	423
Other finance costs	9	8
Provisions - unwinding of discount	5	9
Total	813	440

15. Auditor Disclosures

15.1. Other auditor remuneration

		2016-17 £000s	2015-16 £000s
Other auditor remuneration paid to the external auditor:			
1. Audit of accounts of any associate of the trust		0	0
2. Audit-related assurance services	Quality A/cts	10	12
3. Taxation compliance services		0	0
4. All taxation advisory services not falling within item 3 above		0	0
5. Internal audit services		0	0
6. All assurance services not falling within items 1 to 5		0	0
7. Corporate finance transaction services not falling within items 1 to 6 above		0	0
8. Other non-audit services not falling within items 2 to 7 above	Salary Sacrifice	30	34
Total		40	46

N.B. These fees exclude VAT

15.2. Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2016/17 or 2015/16.

16.1. Property, plant and equipment

2016-17	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2016	13,200	122,755	576	3,433	39,329	68	19,075	175	**198,611**
Additions of Assets Under Construction	0	0	0	4,140	0	0	0	0	**4,140**
Additions Purchased	0	3,974	0	0	2,430	0	2,672	0	**9,076**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	518	220	0	0	0	**738**
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	0	0	0	0	**0**
Additions Leased (including PFI/LIFT)	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	(5,365)	4,581	0	784	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(4,149)	(10)	(98)	0	**(4,257)**
Revaluation	0	(3,885)	0	0	217	0	0	0	**(3,668)**
Impairments/reversals charged to operating expenses	0	(1,732)	0	0	0	0	0	0	**(1,732)**
Impairments/reversals charged to reserves	0	0	0	0	0	0	0	0	**0**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	**0**
At 31 March 2017	13,200	121,112	576	2,726	42,628	58	22,433	175	202,908
Depreciation									
At 1 April 2016	0	1,134	21	0	26,397	51	11,943	144	**39,690**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(4,149)	(10)	(98)	0	**(4,257)**
Revaluation	0	0	0	0	147	0	0	0	**147**
Impairment/reversals charged to reserves	0	0	0	0	0	0	0	0	**0**
Impairments/reversals charged to operating expenses	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	2,363	18	0	3,404	5	3,106	27	**8,923**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	**0**
At 31 March 2017	0	3,497	39	0	25,799	46	14,951	171	44,503
Net Book Value at 31 March 2017	13,200	117,615	537	2,726	16,829	12	7,482	4	158,405
Asset financing:									
Owned - Purchased	13,200	109,486	537	2,203	16,267	12	7,470	4	**149,179**
Owned - Donated	0	6,895	0	523	562	0	12	0	**7,992**
Owned - Government Granted	0	0	0	0	0	0	0	0	**0**
Held on finance lease	0	1,234	0	0	0	0	0	0	**1,234**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2017	13,200	117,615	537	2,726	16,829	12	7,482	4	158,405

Cost or Valuation: The negative Building Revaluation of £3,885k is the net effect of the BCIS negative indices applied quarterly.
Depreciation: The increase in Building Impairment £1,732k, consists of the net effect of the overall BCIS negative indices applied quarterly.

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2016	4,456	36,506	0	0	472	1	0	0	**41,435**
Movements - indexation	0	(3,890)	0	0	(152)	0	0	0	**(4,042)**
At 31 March 2017	**4,456**	**32,616**	**0**	**0**	**320**	**1**	**0**	**0**	**37,393**

Additions to Assets Under Construction in 2016-17

Land	0
Buildings excl Dwellings	11
Dwellings	0
Plant, Machinery & Equipment (Including IT)	4,129
Balance as at YTD	**4,140**

16.2. Property, plant and equipment prior-year

2015-16	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2015	19,930	101,205	576	2,786	39,083	63	16,867	175	**180,685**
Additions of Assets Under Construction	0	0	0	6,248	0	0	0	0	**6,248**
Additions Purchased	0	4,199	0	0	3,282	5	2,450	0	**9,936**
Additions - Non Cash Donations (i.e. Physical Assets)	0	0	0	0	7	0	0	0	**7**
Additions - Purchases from Cash Donations & Government Grants	0	0	0	5	165	0	0	0	**170**
Additions Leased (including PFI/LIFT)	0	1,410	0	0	0	0	0	0	**1,410**
Reclassifications	0	2,598	0	(5,606)	2,346	0	662	0	**0**
Reclassifications as Held for Sale and Reversals	0	(382)	0	0	0	0	0	0	**(382)**
Disposals other than for sale	0	0	0	0	(5,596)	0	(904)	0	**(6,500)**
Revaluation	(6,730)	10,410	0	0	42	0	0	0	**3,722**
Impairment/reversals charged to reserves	0	3,315	0	0	0	0	0	0	**3,315**
Impairments/reversals charged to operating expenses	0	0	0	0	0	0	0	0	**0**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	**0**
At 31 March 2016	**13,200**	**122,755**	**576**	**3,433**	**39,329**	**68**	**19,075**	**175**	**198,611**
Depreciation									
At 1 April 2015	0	0	0	0	28,666	47	10,435	115	**39,263**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale and Reversals	0	(7)	0	0	0	0	0	0	**(7)**
Disposals other than for sale	0	0	0	0	(5,484)	0	(904)	0	**(6,388)**
Revaluation	0	(2,215)	0	0	31	0	0	0	**(2,184)**
Impairment/reversals charged to reserves	0	0	0	0	0	0	0	0	**0**
Impairments/reversals charged to operating expenses	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	3,356	21	0	3,184	4	2,412	29	**9,006**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	**0**
At 31 March 2016	**0**	**1,134**	**21**	**0**	**26,397**	**51**	**11,943**	**144**	**39,690**
Net Book Value at 31 March 2016	**13,200**	**121,621**	**555**	**3,433**	**12,932**	**17**	**7,132**	**31**	**158,921**
Asset financing:									
Owned - Purchased	13,200	112,892	555	3,428	12,418	17	7,112	7	**149,629**
Owned - Donated	0	7,354	0	5	514	0	20	24	**7,917**
Owned - Government Granted	0	0	0	0	0	0	0	0	**0**
Held on finance lease	0	1,375	0	0	0	0	0	0	**1,375**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2016	**13,200**	**121,621**	**555**	**3,433**	**12,932**	**17**	**7,132**	**31**	**158,921**

16.3. (cont). Property, plant and equipment

The Northamptonshire Health Charitable Fund has extended and refurbished the NGH Chemotherapy Suite, spending £518k in 2016/17, which is due to open end of April 2017. Also, £220k worth of equipment has been donated, including ultrasounds, incubators & ventilators.

BCIS (Building Cost Information Service) indices provided by Cushman & Wakefield have been applied to the Buildings on a quarterly basis. The next site revaluation exercise of NGH's Land & Buildings is due in April 2019.

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

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

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

The gross carrying amount of fully depreciated assets still in use is £25,820k (£23,311k)

17. Intangible non-current assets

17.1. Intangible non-current assets

2016-17	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Intangible Assets Under Construction	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2016	**399**	**8,082**	**0**	**0**	**0**	**0**	**8,481**
Additions of Assets Under Construction	0	0	0	0	0	0	**0**
Additions Purchased	0	714	0	0	0	0	**714**
Additions Internally Generated	0	0	0	0	0	0	**0**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	0	0	**0**
Additions - Purchases from Cash Donations and Government Grants	0	0	0	0	0	0	**0**
Additions Leased (including PFI/LIFT)	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	**0**
Reclassified as Held for Sale and Reversals	0	0	0	0	0	0	**0**
Disposals other than by sale	0	(92)	0	0	0	0	**(92)**
Upward revaluation/positive indexation	0	0	0	0	0	0	**0**
Impairments/reversals charged to operating expenses	0	0	0	0	0	0	**0**
Impairments/reversals charged to reserves	0	0	0	0	0	0	**0**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption	0	0	0	0	0	0	**0**
At 31 March 2017	**399**	**8,704**	**0**	**0**	**0**	**0**	**9,103**
Amortisation							
At 1 April 2016	**280**	**6,931**	**0**	**0**	**0**	**0**	**7,211**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassified as Held for Sale and Reversals	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals other than by sale	**0**	**(92)**	**0**	**0**	**0**	**0**	**(92)**
Upward revaluation/positive indexation	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairment/reversals charged to reserves	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments/reversals charged to operating expenses	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Charged During the Year	**2**	**778**	**0**	**0**	**0**	**0**	**780**
Transfers to NHS Foundation Trust on authorisation as FT	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfer (to)/from Other Public Sector bodies under Absorption	**0**	**0**	**0**	**0**	**0**	**0**	**0**
At 31 March 2017	**282**	**7,617**	**0**	**0**	**0**	**0**	**7,899**
Net Book Value at 31 March 2017	**117**	**1,087**	**0**	**0**	**0**	**0**	**1,204**
Asset Financing: Net book value at 31 March 2017 comprises:							
Purchased	117	1,087	0	0	0	0	**1,204**
Donated	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	**0**
Finance Leased	0	0	0	0	0	0	**0**
On-balance Sheet PFIs	0	0	0	0	0	0	**0**
Total at 31 March 2017	**117**	**1,087**	**0**	**0**	**0**	**0**	**1,204**

Revaluation reserve balance for intangible non-current assets	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2016	0	0	0	0	0	0	**0**
Movements (specify)	0	0	0	0	0	0	**0**
At 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**

17.2. Intangible non-current assets prior year

2015-16	IT - in-house & 3rd party software £000's	Computer Licenses £000's	Licenses and Trademarks £000's	Patents £000's	Development Expenditure - Internally Generated £000's	£000's	Total £000's
Cost or valuation:							
At 1 April 2015	399	7,966	0	0	0	0	**8,365**
Additions - purchased	0	377	0	0	0	0	**377**
Additions - internally generated	0	0	0	0	0	0	**0**
Additions - donated	0	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	0	**0**
Additions Leased (including PFI/LIFT)	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Disposals other than by sale	0	(261)	0	0	0	0	**(261)**
Upward revaluation/positive indexation	0	0	0	0	0	0	**0**
Impairments/reversals charged to operating expenses	0	0	0	0	0	0	**0**
Impairments/reversals charged to reserves	0	0	0	0	0	0	**0**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption	0	0	0	0	0	0	**0**
At 31 March 2016	399	8,082	0	0	0	0	8,481
Amortisation							
At 1 April 2015	262	6,275	0	0	0	0	**6,537**
Reclassifications	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Disposals other than by sale	0	(261)	0	0	0	0	**(261)**
Upward revaluation/positive indexation	0	0	0	0	0	0	**0**
Impairments/reversals charged to operating expenses	0	0	0	0	0	0	**0**
Impairments/reversals charged to reserves	0	0	0	0	0	0	**0**
Charged during the year	18	917	0	0	0	0	**935**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption	0	0	0	0	0	0	**0**
At 31 March 2016	280	6,931	0	0	0	0	7,211
Net book value at 31 March 2016	119	1,151	0	0	0	0	**1,270**
Net book value at 31 March 2016 comprises:							
Purchased	119	1151	0	0	0	0	**1,270**
Donated	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	**0**
Finance Leased	0	0	0	0	0	0	**0**
On-balance Sheet PFIs	0	0	0	0	0	0	**0**
Total at 31 March 2016	119	1,151	0	0	0	0	1,270

17.3. Intangible non-current assets

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

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

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

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

The gross carrying amount of fully depreciated assets still in use is £6,017k (£5,129k)

18. Analysis of impairments and reversals recognised in 2016-17

	2016-17 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	1,732
Total charged to Annually Managed Expenditure	**1,732**
Total Impairments of Property, Plant and Equipment changed to SoCI	**1,732**
Intangible assets impairments and reversals charged to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	**0**
Total Impairments of Intangibles charged to SoCI	**0**
Financial Assets charged to SoCI	
Loss or damage resulting from normal operations	0
Total charged to Departmental Expenditure Limit	**0**
Loss as a result of catastrophe	0
Other	0
Total charged to Annually Managed Expenditure	**0**
Total Impairments of Financial Assets charged to SoCI	**0**
Non-current assets held for sale - impairments and reversals charged to SoCI.	
Loss or damage resulting from normal operations	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	**0**
Total impairments of non-current assets held for sale charged to SoCI	**0**
Total Impairments charged to SoCI - DEL	**0**
Total Impairments charged to SoCI - AME	**1,732**
Overall Total Impairments	**1,732**

Donated and Gov Granted Assets, included above	
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0

18. Analysis of impairments and reversals recognised in 2016-17

	Property Plant and Equipment	Intangible Assets	Financial Assets	Non-Current Assets Held for Sale	Total £000s
Impairments and reversals taken to SoCI					
Loss or damage resulting from normal operations	0	0	0	0	**0**
Over-specification of assets	0	0	0	0	**0**
Abandonment of assets in the course of construction	0	0	0	0	**0**
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**	**0**	**0**
Unforeseen obsolescence	0	0	0	0	**0**
Loss as a result of catastrophe	0	0	0	0	**0**
Other	0	0	0	0	**0**
Changes in market price	1,732	0	0	0	**1,732**
Total charged to Annually Managed Expenditure	**1,732**	**0**	**0**	**0**	**1,732**
Total Impairments of Property, Plant and Equipment changed	**1,732**	**0**	**0**	**0**	**1,732**

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

19. Investment property

	31 March 2017 £000s	31 March 2016 £000s
At fair value		
Balance at 1 April 2016	**0**	0
Additions Through Subsequent Expenditure	**0**	0
Other Acquisitions	**0**	0
Disposals	**0**	0
Property Reclassified as Held for Sale	**0**	0
Loss from Fair Value Adjustments - Impairments	**0**	0
Loss from Fair Value Adjustments - Reversal of Impairments	**0**	0
Gain from Fair Value Adjustments	**0**	0
Transfers to NHS Foundation Trust on authorisation as FT	**0**	0
Transfers (to) / from Other Public Sector Bodies under absorption accounting	**0**	0
Other Changes	**0**	0
Balance at 31 March 2017	**0**	0

20. Commitments

20.1. Capital commitments

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

	31 March 2017 £000s	31 March 2016 £000s
Property, plant and equipment	**2,941**	3,438
Intangible assets	**0**	65
Total	**2,941**	3,503

20.2. Other financial commitments

	31 March 2017 £000s	31 March 2016 £000s
Not later than one year	**0**	0
Later than one year and not later than five year	**0**	0
Later than five years	**0**	0
Total	**0**	0

21. Inventories

	Drugs	Consumables	Work in Progress	Energy	Loan Equipment	Other	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**1,904**	**3,794**	**0**	**46**	**0**	**0**	**5,744**	5,698
Additions	27,736	25,336	0	0	0	0	**53,072**	0
Inventories recognised as an expense in the period	(27,699)	(25,221)	0	0	0	0	**(52,920)**	0
Write-down of inventories (including losses)	(126)	0	0	0	0	0	**(126)**	0
Reversal of write-down previously taken to SOCI	0	0	0	0	0	0	**0**	0
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	**0**	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	**0**	0
Balance at 31 March 2017	**1,815**	**3,909**	**0**	**46**	**0**	**0**	**5,770**	**5,698**

22.1. Trade and other receivables

	Current		Non-current	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**15,136**	9,742	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**0**	0	**0**	0
Non-NHS receivables - revenue	**1,668**	1,250	**0**	0
Non-NHS receivables - capital	**30**	21	**0**	0
Non-NHS prepayments and accrued income	**2,909**	1,923	**0**	0
PDC Dividend prepaid to DH	**37**	0	**0**	0
Provision for the impairment of receivables	**(752)**	(834)	**0**	0
VAT	**610**	473	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income excluding PFI lifecycle	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**9**	9	**200**	209
Operating lease receivables	**0**	0	**0**	0
Other receivables	**4,240**	3,756	**0**	0
Total	**23,887**	16,340	**200**	209
Total current and non current	**24,087**	16,549		
Included in NHS receivables are prepaid pension contributions:	**0**			

NHS receivables - revenue
- Estimated value of partially completed spells £2,625K (£1,436k)

Other receivables include:
- Injury Cost Recovery claims (ICR) £2,653K (£2,582k)
- Salary overpayments/other recoverable pay £347K (£546k)

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

22.2. Receivables past their due date but not impaired

	31 March 2017	31 March 2016
	£000s	£000s
By up to three months	**857**	676
By three to six months	**335**	121
By more than six months	**552**	45
Total	**1,744**	842

This includes £89k (£176k) relating to invoices raised to Clinical Commissioning Groups for Non Contracted Activity data.

22.3. Provision for impairment of receivables

	2016-17 £000s	2015-16 £000s
Balance at 1 April 2016	**(834)**	(1,306)
Amount written off during the year	**599**	1,262
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**(517)**	(790)
Transfers to NHS Foundation Trust on authorisation as FT	**0**	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	0
Balance at 31 March 2017	**(752)**	(834)

The Trust provides for non recovery of receivables as follows:
All Non-NHS Trade receivables over 60 days old from date of invoice unless known reason for payment delay.
17.41% (16.46 %) (local provision) of recognised Injury Cost Recovery claims are provided for.
All salary overpayments for which no recovery plan is in place, are provided for in full.

23. Other Financial Assets - Current

	31 March 2017 £000s	31 March 2016 £000s
Current part of loans repayable transferred from non-current assets	**0**	0
NLF deposits over 3 months	**0**	0
Closing balance 31 March	**0**	0

24. Other current assets

	31 March 2017 £000s	31 March 2016 £000s
EU Emissions Trading Scheme Allowance	0	0
Other Assets	0	0
Total	0	0

25. Cash and Cash Equivalents

	31 March 2017 £000s	31 March 2016 £000s
Opening balance	1,602	1,114
Net change in year	19	488
Closing balance	1,621	1,602
Made up of		
Cash with Government Banking Service	1,545	1,543
Commercial banks	61	50
Cash in hand	15	9
Liquid deposits with NLF	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	1,621	1,602
Bank overdraft - Government Banking Service	0	0
Bank overdraft - Commercial banks	0	0
Cash and cash equivalents as in statement of cash flows	1,621	1,602
Third Party Assets - Bank balance (not included above)	0	0
Third Party Assets - Monies on deposit	0	0

26. Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Financial Assets	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	0	375	0	0	0	0	0	0	0	0	375
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	0	0
Less assets sold in the year	0	(375)	0	0	0	0	0	0	0	0	(375)
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	0
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	0
Transfers to Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2017	0	0	0	0	0	0	0	0	0	0	0
Liabilities associated with assets held for sale at 31 March 2017	0	0	0	0	0	0	0	0	0	0	0
Balance at 1 April 2015	0	0	0	0	0	0	0	0	0	0	0
Plus assets classified as held for sale in the year	0	375	0	0	0	0	0	0	0	0	375
Less assets sold in the year	0	0	0	0	0	0	0	0	0	0	0
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	0
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2016	0	375	0	0	0	0	0	0	0	0	375
Liabilities associated with assets held for sale at 31 March 2016	0	0	0	0	0	0	0	0	0	0	0

The Harborough Lodge Renal Unit located in Kingsthorpe, Northampton was sold in April 2016 for £585k, profit on sale was £210k.

27. Trade and other payables

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
NHS payables - revenue	**855**	978	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**1,167**	1,000	**0**	0
Non-NHS payables - revenue	**2,961**	2,390	**0**	0
Non-NHS payables - capital	**3,113**	5,192	**0**	0
Non-NHS accruals and deferred income	**9,109**	7,966	**0**	0
Social security costs	**4,028**	3,551	**0**	0
PDC Dividend payable to DH	**0**	60	**0**	0
Accrued Interest on DH Loans	**75**	39	**0**	0
VAT	**0**	0	**0**	0
Tax	**0**	0	**0**	0
Payments received on account	**0**	0	**0**	0
Other	**2,801**	3,169	**0**	0
Total	**24,109**	24,345	**0**	0
Total payables (current and non-current)	**24,109**	**24,345**		
Included above:				
to Buy Out the Liability for Early Retirements Over 5 Years	**0**	0		
number of Cases Involved (number)	**0**	0		
outstanding Pension Contributions at the year end	**2,380**	2,347		

28. Other liabilities

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Lease incentives	**0**	0	**0**	0
Other - Employee Benefits	**753**	710	**0**	0
Total	**753**	710	**0**	0
Total other liabilities (current and non-current)	**753**	**710**		

29. Borrowings

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Bank overdraft - Government Banking Service	**0**	0	**0**	0
Bank overdraft - commercial banks	**0**	0	**0**	0
Loans from Department of Health	**20,250**	628	**30,407**	26,037
Loans from other entities - SALIX	**84**	155	**82**	166
PFI liabilities - main liability	**0**	0	**0**	0
LIFT liabilities - main liability	**0**	0	**0**	0
Finance lease liabilities	**124**	121	**1,121**	1,245
Other	**0**	0	**0**	0
Total	**20,458**	**904**	**31,610**	**27,448**
Total other liabilities (current and non-current)	**52,068**	**28,352**		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2017		
	DH £000s	**Other £000s**	**Total £000s**
0-1 Years	20,250	206	**20,456**
1 - 2 Years	1,399	175	**1,574**
2 - 5 Years	24,175	459	**24,634**
Over 5 Years	4,833	571	**5,404**
TOTAL	**50,657**	**1,411**	**52,068**

The Trust has taken advantage of participating in the Energy Efficiency Loan Scheme operated by Salix Finance Ltd.
The Trust has agreed twelve schemes since 2012/13 of which six are fully repaid.
Each of these loans are subject to zero interest and are repayable over 4 years in equal instalments although these have been drawn on completion of each scheme.

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

Loan Type	Agreement Date	Loan Facility Amount £000's	Interest Rate	Repayment Date	Analysis of Loan Balance - March 2017			
					Capital £000's	Deficit £000's	STF £000's	Total £000's
Capital	Mar-15	7,207	1.60%	10 year period	6,086			**6,086**
Capital	Mar-16	9,352	1.16%	10 year period	5,741			**5,741**
Revenue	Feb-16	18,851	1.50%	Feb-18		18,851		**18,851**
Revenue	Feb-17	14,515	1.50%	Jan-20		11,282	3,233	**14,515**
Revenue	Feb-17	2,995	1.50%	Feb-20		2,187	808	**2,995**
Revenue	Mar-17	2,469	1.50%	Mar-20		1,660	809	**2,469**
Total		**55,389**			**11,827**	**33,980**	**4,850**	**50,657**

30. Other financial liabilities

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Embedded derivatives at fair value through SoCI	**0**	0	**0**	0
Financial liabilities carried at fair value through profit and loss	**0**	0	**0**	0
Amortised cost	**0**	0	**0**	0
Total	**0**	0	**0**	0
Total other financial liabilities (current and non-current)	**0**	0		

31. Deferred income

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Opening balance at 1 April 2016	**1,775**	1,777	**0**	0
Deferred revenue addition	**3,660**	849	**0**	0
Transfer of deferred revenue	**(2,889)**	(851)	**0**	0
Current deferred income at 31 March 2017	**2,546**	1,775	**0**	0
Total deferred income (current and non-current)	**2,546**	1,775		

32. Finance lease obligations as lessee

The Trust car park decking was completed under a Finance Lease arrangement.

Amounts payable under finance leases (Buildings)	**Minimum lease payments**		**Present value of minimum**	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Within one year	**124**	121	**124**	121
Between one and five years	**550**	529	**550**	529
After five years	**571**	716	**571**	716
Less future finance charges	**0**	0	**0**	0
Minimum Lease Payments / Present value of minimum lease payments	**1,245**	1,366	**1,245**	1,366
Included in:				
Current borrowings			**124**	121
Non-current borrowings			**1,121**	1,245
			1,245	1,366

	31 March 2017 £000s	31 March 2016 £000s
Finance leases as lessee		
Future Sublease Payments Expected to be received	**0**	0
Contingent Rents Recognised as an Expense	**0**	0

33. Finance lease receivables as lessor

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

Amounts receivable under finance leases (buildings)	**Gross investments in leases**		**Present value of minimum lease payments**	
Of minimum lease payments	**31 March 2017 £000s**	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Within one year	**9**	9	**9**	9
Between one and five years	**36**	36	**36**	36
After five years	**164**	173	**164**	173
Less future finance charges	**0**	0	**0**	0
Gross Investment in Leases / Present Value of Minimum Lease Payments	**209**	218	**209**	218
Less allowance for uncollectible lease payments:	**0**	0	**0**	0
Total finance lease receivable recognised in the statement of financial position	**209**	218	**209**	218
Included in:				
Current finance lease receivables			**9**	9
Non-current finance lease receivables			**200**	209
			209	218

Rental revenue	**31 March 2017**	31 March 2016
Contingent rent	**0**	**0**
Other	**0**	**0**
Total rental revenue	**0**	0

34. Provisions

	Total	Comprising: Early Departure Costs	Legal Claims	Restructuring	Continuing Care	Equal Pay (incl. Agenda for Change	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**3,781**	0	0	0	0	0	3,781	0
Arising during the year	**4,056**	0	0	0	0	0	4,056	0
Utilised during the year	**(1,440)**	0	0	0	0	0	(1,440)	0
Reversed unused	**(554)**	0	0	0	0	0	(554)	0
Unwinding of discount	**5**	0	0	0	0	0	5	0
Change in discount rate	**0**	0	0	0	0	0	0	0
Transfers to NHS Foundation Trusts on being authorised as FT	**0**	0	0	0	0	0	0	0
Transfers (to)/from other public sector bodies under absorption accounting	**0**	0	0	0	0	0	0	0
Balance at 31 March 2017	**5,848**	0	0	0	0	0	5,848	0
Expected Timing of Cash Flows:								
No Later than One Year	**4,808**	0	0	0	0	0	4,808	0
Later than One Year and not later than Five Years	**938**	0	0	0	0	0	938	0
Later than Five Years	**117**	0	0	0	0	0	117	0

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

As at 31 March 2017	95,245
As at 31 March 2016	95,588

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

35. Contingencies

	31 March 2017 £000s	31 March 2016 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	0	0
Employment Tribunal and other employee related litigation	0	0
Redundancy	0	0
Other *[give details]*	0	0
Net value of contingent liabilities	0	0
Contingent assets		
Contingent assets *[give details]*	0	0
Net value of contingent assets	0	0

No contingency liabilities or assets have been identified.

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

36. Financial Instruments

36.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Group are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

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

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

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust 's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2017 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.

36.2. Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Embedded derivatives	0			**0**
Receivables - NHS		15,136		**15,136**
Receivables - non-NHS		8,141		**8,141**
Cash at bank and in hand		1,621		**1,621**
Other financial assets	0	209	0	**209**
Total at 31 March 2017	**0**	**25,107**	**0**	**25,107**
Embedded derivatives	0			0
Receivables - NHS		9,742		9,742
Receivables - non-NHS		6,125		6,125
Cash at bank and in hand		1,602		1,602
Other financial assets	0	218	0	218
Total at 31 March 2016	0	17,687	0	17,687

36.3. Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
Embedded derivatives	0		**0**
NHS payables		855	**855**
Non-NHS payables		19,226	**19,226**
Other borrowings		50,823	**50,823**
PFI & finance lease obligations		1,245	**1,245**
Other financial liabilities	0	753	**753**
Total at 31 March 2017	**0**	**72,902**	**72,902**
Embedded derivatives	0		0
NHS payables		978	978
Non-NHS payables		19,816	19,816
Other borrowings		26,986	26,986
PFI & finance lease obligations		1,366	1,366
Other financial liabilities	0	710	710
Total at 31 March 2016	0	49,856	49,856

37. Events after the end of the reporting period

There are no material events after the reporting date of 31 March 2017 which effect the financial position.

38. Related party transactions

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

The Department of Health is regarded as a related party. During the year Northampton General Hospital NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example :

Revenue Transactions
Health Education England £10.4m (£10.4m)
Nene Clinical Commissioning Group £203.7m (£194.7m)
Corby Clinical Commissioning Group £2.4m (£2.6m)
Milton Keynes Clinical Commissioning Group £2.9m (£2.5m)
East Midlands Specialised Commissioning Hub (previously Central Midlands Commissioning Hub) £38.8m (£32.9m)
Central Midlands Local Office £8.0m (£7.7m)
Northamptonshire Healthcare NHS Foundation Trust £1.3m (£1.3m)
Kettering General Hospital Foundation Trust £1.5m (£1.4m)
University Hospitals of Leicester NHS Trust £1.0m (£1.0m)

Expenditure Transactions
NHS Litigation Authority £8.2m (£5.9m) (NHS Resolution from April 2017)
Northamptonshire Healthcare NHS Foundation Trust £1.4m (£1.3m)
NHS Blood and Transplant £1.4m (£1.4m)

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 £770k (£746k)), Northamptonshire County Council (Pathology Services £149k (£150k)) and HM Revenue & Customs (Employers National Insurance contribution £15.4m (£11.8m)), National Health Service Pension Fund Scheme £17.0m (£16.3m) and NHS Business Services Authority £10.4m (£7.6m)

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

Grants totalling £341k (£372k), 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 £796k (£248k) of Building Works & Medical Equipment.

The Charitable Fund produces separate Trustees Report and Accounts which are available from the Finance Department of the Trust or on the Charity Commission website www.charity-commision.gov.uk. Should you wish to learn more about the Charitable Fund's activities and current initiatives visit www.nhcfgreenheart.co.uk or contact the Fundraising Team on 01604 545857 or E-mail greenheart@ngh.nhs.uk

39. Losses and special payments

The total number of losses cases in 2016-17 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	451,533	857
Special payments	109,768	41
Gifts	0	0
Total losses and special payments and gifts	561,301	898

The total number of losses cases in 2015-16 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	349,951	427
Special payments	53,686	55
Total losses and special payments	403,637	482

40. Financial performance targets

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

40.1. Breakeven performance

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s	2016-17 £000s
Turnover	174,041	187,379	206,926	227,805	236,260	255,481	271,295	276,894	270,358	273,562	298,240
Retained surplus/(deficit) for the year	156	1,834	2,100	(4,958)	1,109	(1,917)	(764)	2,103	(20,111)	(17,086)	(15,164)
Adjustment for:											
Timing/non-cash impacting distortions:											
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	0	0
Prior Period Adjustments	0	0	0	0	0	0	0	0	0	0	0
Adjustments for impairments	0	0	729	7,039	0	3,453	899	(2,257)	3,338	(3,315)	1,732
Adjustments for impact of policy change re donated/government grants assets	0	0	0	0	0	(1,032)	264	351	248	250	(415)
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*	0	0	0	0	0	0	0	0	0	0	0
Absorption accounting adjustment							0	0	0	0	0
Other agreed adjustments	0	0	0	0	0	0	0	0	0	0	0
Break-even in-year position	**156**	**1,834**	**2,829**	**2,081**	**1,109**	**504**	**399**	**197**	**(16,525)**	**(20,151)**	**(13,847)**
Break-even cumulative position	**(1,771)**	**63**	**2,892**	**4,973**	**6,082**	**6,586**	**6,985**	**7,182**	**(9,343)**	**(29,494)**	**(43,341)**

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

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %	2016-17 %
Materiality test (I.e. is it equal to or less than 0.5%):											
Break-even in-year position as a percentage of turnover	0.09	0.98	1.37	0.91	0.47	0.20	0.15	0.07	-6.11	-7.37	-4.64
Break-even cumulative position as a percentage of turnover	-1.02	0.03	1.40	2.18	2.57	2.58	2.57	2.59	-3.46	-10.78	-14.53

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

40.2. Capital cost absorption rate

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

40.3. External financing

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

	2016-17 £000s	2015-16 £000s
External financing limit (EFL)	23,939	26,297
Cash flow financing	23,697	24,426
Finance leases taken out in the year	0	1,410
Other capital receipts	0	0
External financing requirement	**23,697**	25,836
Under/(over) spend against EFL	**242**	461

40.4. Capital resource limit

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

	2016-17 £000s	2015-16 £000s
Gross capital expenditure	14,669	18,149
Less: book value of assets disposed of	(375)	(113)
Less: capital grants	0	0
Less: donations towards the acquisition of non-current assets	(738)	(177)
Charge against the capital resource limit	**13,556**	17,859
Capital resource limit	13,561	17,877
(Over)/underspend against the capital resource limit	**5**	18

41. Third party assets

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

	31 March 2017 £000s	31 March 2016 £000s
Third party assets held by the Trust	**0**	0