Annual Report and Financial Statements

2012 - 2013

Right care, first time, every time

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Chairman and Chief Executive's Introduction

We must begin by thanking all our staff for their hard work, commitment and dedication during a challenging year. Despite seeing unprecedented levels of demand for our urgent care services, which in itself has an impact on all services we provide, our staff maintained their determination to provide high quality patient care. At the same time they welcomed the opportunities presented by Listening into Action, which we launched in the summer of 2012, to work together and look at how they could improve their services even further. We look forward to the second feedback event in July 2013, when we will hear from the second wave teams what they have achieved.

Like other NHS Trusts, we have been faced with financial and activity pressures. Despite this, during the year we were able to achieve £10.5m transformation savings, making a total of more than £29m over the past two years. Credit is due to our staff for all their efforts to help us not only achieve this level of savings, but also to ensure we ended the year with a £0.4m surplus.

We must also pay tribute to the commitment of our shadow governors, who have been actively involved throughout the year. They have helped us look at different aspects of the services we offer, including taking part in ward audits to help us identify areas where we could improve our services. We have also been pleased to welcome our members to the Trust and have held a series of events to help them learn more about the services we provide and how they can become involved.

Our focus remains on patient safety and the quality of the care and services we provide. Our patient safety academy and patient safety strategy have the aims of increasing staff engagement in a range of safety-related quality and improvement projects bringing about changes to clinical processes and practices to improve patient care.

While the Trust has faced tough challenges, including unprecedented levels of activity in our A&E department, we have been able to respond by creating additional capacity and recruiting staff. We have also enjoyed some significant achievements. NGH was awarded a national Top Hospital award by a leading independent provider of healthcare intelligence. CHKS Ltd recognised the hospital as one of the 40 best performing acute trusts across the UK, based on the evaluation of 23 indicators of clinical effectiveness, health outcomes, efficiency, patient experience and quality of care.

Our new haematology unit, funded by the hospital and a charity appeal by Macmillan Cancer Support, provides a state-of-the-art, purpose-built facility to offer our patients a more relaxing, comfortable and appropriate environment. This development has helped to improve working conditions for staff and reduce waiting times for our patients.

We have also been successful in obtaining external and additional funding for projects. Working with the East Midlands Specialised Commissioning Group we secured funding that enabled us to recruit two additional neonatal consultants and additional nurses to support the

development of the neonatal service so that we have a dedicated team covering our neonatal unit at all times.

In early 2013 we were awarded funding to set up a new midwifery-led maternity unit as part of a £25m government drive to improve maternity care. When the unit opens later in the year it will provide a more relaxed environment to give birth and offer further choice to mothers-to-be about where they can give birth.

Many clinicians and senior managers from the Trust have been actively involved in working on the Healthier Together programme, a review of acute hospital services across the South East Midlands. We are now working with our colleagues at Kettering General Hospital NHS Foundation Trust, NHS Nene Clinical Commissioning Group and NHS Corby Clinical Commissioning Group to identify ways in which we could work more closely together to ensure high quality patient services can continue to be provided to people living in the county. Our aim is to ensure this work proceeds at a pace that reflects local issues and ensures service provision meets the needs of the communities served.

The year has also seen leadership change, with the resignation of three non-executive directors and the departure of three executive directors, including our highly respected chief executive, Dr Gerry McSorley, who left the Trust in February 2013. Christine Allen, our chief operating officer and deputy chief executive, was appointed acting chief executive until her departure to take up a new post as chief executive of James Paget NHS Foundation Trust during the summer of 2013. We are grateful to them all for their contribution.

We are confident that NGH will rise to the challenges ahead because no organisation could have a more committed and dedicated workforce. Our thanks go to them, our governors, members and our volunteers too, for all their hard work and commitment to helping us improve the services we provide to our patients.

Paul Farenden
Chairman

Christine Allen
Acting Chief Executive

Directors' Report

All NHS organisations are required to publish an annual report and financial statements at the end of each financial year. This report provides an overview of the work of Northampton General Hospital NHS Trust between 1st April 2012 and 31st March 2013.

The report is made up of two parts. This first part includes information about some of the projects we have been involved in an invested in over the year, as well as the details of our performance and a commentary on wider events that have shaped our business and priorities. The second is a summary of the organisation's financial statements for the financial year 2012-13, including the remuneration report.

Directors during 2012-13

Job title	Name	Comments
Chairman	Mr Paul Farenden	
Chief Executive	Dr Gerry McSorley Mrs Christine Allen (acting)	Resigned from 28.02.2013 From 01.03.2013
Non-Executive Directors	Mrs Neelam Aggarwal Singh Mr Colin Astbury Mr Barry Noble Mr David Noble Mr Graham Kershaw Mr Nicholas Robertson Mrs Elizabeth Searle Mr Phil Zeidler	Resigned from 31.08.2012 Resigned from 31.08.2012 Resigned from 31.08.2012 From 01.01.2013 From 01.01.2013
Medical Director	Dr Sonia Swart	
Chief Operating Officer/ Deputy Chief Executive	Mrs Christine Allen Dr Sonia Swart (acting)	To 28.02.2013 Acting Deputy Chief Executive from 04.03.2013
Director of Nursing, Midwifery and Patient Services	Mrs Fiona Barnes (acting) Ms Suzie Loader	To 15.04.2012 From 16.04.2012
Director of Finance	Mr James Drury Mr Peter Hollinshead (interim) Mr Andrew Foster (acting)	Resigned position from 31.12.2012 From 01.10.2012 to 31.03.2013 From 01.04.2013
Director of Facilities and Capital Development	Mr Charles Abolins	
Director of Strategy and Partnerships	Mr Chris Pallot	
Director of Human Resources	Ms Chanelle Wilkinson	To 03.06.2012
Director of Workforce and Transformation	Mrs Geraldine Opreshko (interim) Mrs Janine Brennan	From 01.06.2012 to 31.03.2013 From 01.04.2013

An introduction to Northampton General Hospital

Who We Are

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

We are a designated cancer centre and the stroke centre for Northamptonshire. From April 2012 Northampton General Hospital became the centre for vascular surgery in Northamptonshire. We have also invested in a number of additional specialist services, including in-patient rental services and interventional cardiology.

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

What We Do

Northampton General Hospital NHS Trust provides general acute services for a population of 380,000 and hyper-acute stroke, vascular and renal services to people living throughout whole of Northamptonshire, a population of 684,000. The Trust is also an accredited Cancer Centre and provides cancer services to a wider population of 880,000 who live in Northamptonshire and parts of Buckinghamshire.

In addition to the main hospital site, which is located close to Northampton town centre, the Trust also provides services at the following sites in the county:

- Danetre Hospital in Daventry: outpatients, day surgery and in-patient rehabilitation
- Isebrook Hospital in Wellingborough: In-patient rehabilitation services
- Corby Community Hospital: In-patient rehabilitation services

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

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

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

We are committed to training, teaching and development. Our training and development department offers a wide range of clinical and non-clinical training courses, accessed in a variety of ways through a range of media including e-learning. The Trust has excellent training facilities which were upgraded during the year.

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

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

Our Vision and Aims

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

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

In order to achieve our vision, the Trust has set out its aims which are summarised below. NGH aims to:

- Be a provider of quality care for all our patients
- Enhance our range of hyper acute services for the wider community
- Provide appropriate care for our patients in the most effective way
- Foster a culture where staff can give their best and thrive
- Ensure we invest wisely to make improvements in care

Review of the Trust's Business

Service developments

During 2012-13 the Trust continued the development of hyper acute services. The Northamptonshire vascular service was centralised to NGH from 1st April 2012, all elective and non-elective vascular surgery for the county now takes place at NGH. An aortic abdominal aneurysm (AAA) screening programme was launched for all men over 65 across the county. The Trust continued to develop the county wide primary stroke centre based at NGH with the development of the early supported discharge (ESD) team and the community services stroke rehabilitation team. The thrombolysis service has been extended and will move to a 24/7 service during 2013.

The Trust extended the specialist radiotherapy service provided to patients across Northamptonshire and Milton Keynes. The Trust has extended both intensity modulated radiotherapy (IMRT) and image guided radiotherapy (IGRT). In December 2012, the Trust introduced stereotactic ablative radiotherapy (SABR) as part of an East Midlands pilot study. This highly accurate treatment delivers very high doses of radiation to a focused area over a much shorter course than traditional radiotherapy treatments.

During the year the Trust redesigned the emergency care pathway and introduced an urgent care programme board to implement and monitor delivery of the emergency care pathway.

A new midwifery-led maternity unit is currently being developed on the site following the award of £480k as part of the government's £25m investment to improve maternity care. The unit will offer a more relaxed environment in which women can give birth, with four birthing rooms (three with pools), as well as kitchenettes, sofas and beds so dads and birthing partners can stay. This means we will be able to offer further choice to women about where they can give birth, whilst at the same time ensuring expert medical support is very close by if the need arises.

The Trust carried out a review with the Central Newborn Network and the East Midlands Specialised Commissioning Group (EMSCG) to develop the NGH neonatal service in order to maintain a local neonatal unit (LNU). During the year, the EMSCG provided additional funding to support the development of the service, two additional neonatal consultants were appointed. This has enabled the Trust to separate the neonatal and general paediatric rotas resulting in a dedicated neonatal team covering the LNU at all times. Additional nurses were appointed to ensure the number of nurses per cot is aligned to the national toolkit for neonatal nursing.

Summary of Quality

Quality has always been an integral component of Trust business. There is an expectation that all staff will apply high quality standards to their work and this is being made more explicit through multiple programmes of work. This will result in the best outcomes for patients and higher levels of satisfaction for the people who help deliver those outcomes.

The Trust recognises the connection between the quality of care that our patients receive and the values, aspirations and skills of our staff. Health organisations whose staff are more involved deliver better care. There is also compelling evidence that staff wellbeing and staff experience at work reflect in patient experience and outcomes.

During the early part of 2013 the Trust launched the patient safety strategy. The overall aim of the patient safety strategy is to increase staff engagement in a programme of quality and improvement projects related to patient safety; thereby bringing changes to clinical processes and practice to improve patient care. This will develop an improved safety culture and a reduction in avoidable harm in hospital.

The core of the Patient Safety Academy was established in the summer of 2012 with the appointment of 5 clinical leads and the introduction of project management support in November 2012. The recruitment of champions from a variety of clinical and non-clinical areas

has commenced and these champions will be part of the safety academy as this matures. The clinical leads and champions report to the patient safety programme director and to the board via the Medical Director. This is outlined in the patient safety strategy which articulates the aims of the Patient Safety Improvement programme and supports the Trust's quality strategy.

Highlights of 2012-13

- A newly refurbished room on the NGH labour ward allows bereaved parents to spend time with their baby in quiet and comfortable surroundings away from the clinical area. The new Snowdrop room was provided through the fundraising efforts of Northamptonshire SANDS - the local branch of the national stillbirth and neonatal death charity.
- Our £2m state of the art haematology unit, funded by the hospital and a charity appeal by Macmillan Cancer Support, was officially opened. The new unit is bigger, purpose-built to offer patients a more relaxing, comfortable and appropriate environment. The extra space has helped to improve working conditions for staff and reduce waiting times for patients.
- A new prostate cancer treatment was introduced, needing just two visits for high dose rate brachytherapy compared with as many as 40 conventional radiotherapy sessions. The new 'monotherapy' treatment means that patients' travel to the hospital is greatly reduced and they can return to normal life more quickly.
- A set of standards was introduced for all our outpatient clinics, to help ensure that all clinics provide a consistently good experience for patients. The ten standards being measured include providing a waiting time of less than 30 minutes, displaying patient feedback in the area, and ensuring that correspondence is back with GPs and patients within 10 days.
- Additional clinical expertise was enlisted to improve waiting times for follow-up outpatient appointments in the ophthalmology department. Extra NHS consultants, supplied by a specialist company at no additional cost to the hospital, are ensuring that patients with long-term eye conditions are checked every six months.
- Work has continued throughout the year to improve care for patients admitted to the hospital for acute treatment who also have dementia diagnoses. Patient profiles help staff learn about the person's interests and background, photographs and memory boxes are used to stimulate recollections from the past. Better signage, plus coloured panels and images to distinguish each bed space have been introduced on Creaton ward, where a high proportion of patients with dementia are cared for.
- NGH was awarded a national Top Hospital award by a leading independent provider of healthcare intelligence. CHKS Ltd recognised the hospital as one of the 40 best performing acute trusts across the UK, based on the evaluation of 23 indicators of clinical effectiveness, health outcomes, efficiency, patient experience and quality of care.
- The findings from the national 2012 Accident and Emergency patient survey showed some encouraging results for NGH. The survey highlighted some improvements on cleanliness, privacy and advice given to patients since the previous survey. Since the survey took place, we have expanded and updated A&E, providing an additional five

cubicles, a larger waiting area, and greater privacy at reception. A new system of working has also been introduced to speed up treatment of seriously ill patients, helping to reduce the time taken for ambulance patients to be handed over to the hospital.

- NGH was selected and accredited as a trauma unit, and the hospital plays an important role in the new national trauma care network system that ensures the most severely injured patients get the best care as quickly as possible. Local patients with the most complex needs are transferred to University Hospital Coventry and Warwickshire for a wider range of specialist services.
- Christopher Head, one of the hospital's healthcare assistants, was presented with a national award for Hand Hygiene Champion of 2012 by the Infection Prevention Society. Chris, who also starred in a 'Gangnam-style' YouTube video to promote hand-washing (which went viral), was awarded the honour for his proactive and enthusiastic teaching of effective hand hygiene - not just to hospital staff, but also to children and adults in his local St John Ambulance group.
- A number of our staff were nominated by patients as part of the national NHS Heroes campaign that ran throughout summer 2012. Certificates were presented to five individuals and three wards who had been put forward for 'going the extra mile' and being a credit to the hospital.
- Staff have continued with their voluntary efforts to support healthcare projects overseas, taking part in ventures such as Operation Hernia, and developing services at our own 'twinned' hospital at Nandom in Ghana. Two midwives fundraised and volunteered at a maternity hospital in Zimbabwe, a country which has one of the highest number of maternal deaths worldwide. Another of our midwives presented to the Royal College of Midwives annual conference about her trips to the Gambia to help train staff in delivering safer care.
- A Northampton man who suffered a heart attack at home made national news headlines following his life-saving treatment at the NGH Heart Centre. Despite being clinically dead for 80 minutes while he was operated upon, John Thomson made a remarkably complete recovery, thanks to the sterling work of our staff and ambulance service paramedics.
- Staff from Cawthorne Ward at Danetre Hospital in Daventry, which is managed by NGH, were presented with a national award recognising their high quality of care for people nearing the end of life. The ward, which has a suite of six palliative care rooms, saving many people from the Daventry area a long journey to receive acute care at NGH or to a hospice, was the first in the country to achieve the Gold Standards Framework Quality Hallmark Award.
- We recognised some more NGH 'stars' at our annual Star Awards ceremony to celebrate staff who go the extra mile for patients. Winners and runners-up in seven categories attended a special lunch where they were presented with their certificates. We also held another recognition lunch for long service employees who achieved 25 years' service with the Trust.

Performance Against Key Targets

During 2012-13 Northampton General Hospital achieved the majority of its key national performance targets, including referral to treatment times.

The Trust achieved 91.46% against the transit time target of 95% during 2012-13. Our emergency care service experienced unprecedented demand and saw increased in A&E attendances (+ 11% on 2011-12 and emergency admissions (+ 3% on 2011-12).

During the year the Trust had one patient breach the standard of no patients waiting more than 6 weeks for a diagnostic test. This was a result of an administration error. A full investigation has been undertaken to ensure there is no recurrence.

The Trust met all of the cancer standards with the exception of the 62 day standard from urgent referral, achieving 83% against the standard of 85%.

There were two cases of MRSA bacteraemia reported during the year against the Trust's target of one. Thirty cases of Clostridium Difficile infections were reported during the year, which was below the target of thirty-six cases.

Risks and Uncertainties

Changes to the structure of the NHS locally were implemented during 2012-13 in readiness for implementation from 1st April 2013. During the year the Trust worked with colleagues in the primary care and the Clinical Commissioning Groups to support a smooth transition.

Clinicians and senior managers from the Trust were actively involved in the Healthier Together programme, which explored potential models of care that outlined how services might be delivered across the five acute general hospitals in the South East Midlands so that they can continue to meet the changing needs of a growing and ageing population, whilst at the same time keeping up to date with national and international best practice.
The next phase of this programme will be taken forward locally and in January 2013 the Boards of Northampton General Hospital and Kettering General Hospital agreed that they would look at ways in which the hospitals could work more closely together to ensure high quality patient services can continue to be provided to people living in the county. This will enable work to proceed at a pace that reflects local issues and ensures service provision meets the needs of the communities served.

The challenges that face our services are:

- A population that is increasing
- People are living longer and their expectations are increasing
- Shortages of skilled and experienced clinicians in key disciplines, including A&E and maternity services
- The NHS – in common with all UK public services – is under financial constraint

Emergency Preparedness

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

In the last 12 months we have:

- Delivered business continuity plans for all areas of the Trust
- Undertaken exercises for all departments' business continuity plans
- Delivered major incident training at all levels of the organisation
- Completed the permanent decontamination facility in the Accident & Emergency department.
- Delivered a live CBRN (chemical, biological, radiological and nuclear defence) exercise
- Managed the preparation and response to strike actions.
- Responded to and implemented lessons from a potential loss of power incident at one of the Trusts of site locations
- Responded to and implemented the lessons from a fire at a local nightclub
- Developed our joint protocols with the fire and rescue and police services
- Delivered an innovative electronic call-out system for major incidents

In the next 12 months we will be working to deliver the resilience planning group's plan for 2013-14 which includes:

- Expanding the major incident alert system across the Trust
- Delivering a Trust-wide training programme for all staff involved in major incidents.
- Supporting local teams to review and update local business continuity management (BCM) and major incident plans
- Develop specific BCM plans for the Trust's very high risk areas

Charges for Information

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

Quality Report

Quality has always been an integral component of Trust business. There is an expectation that all staff will apply high quality standards to their work and this is being made more explicit through various programmes of work. This will result in the best outcomes for patients and higher levels of satisfaction for the people who help deliver those outcomes.

The Trust recognises the connection between the quality of care that our patients receive and the values, aspirations and skills of our staff. Health organisations whose staff are more involved deliver better care. There is also compelling evidence that staff wellbeing and staff experience at work reflect in patient experience and outcomes.

Being recognised as a hospital that delivers safe, clinically effective services focused entirely on the needs of the patient, their relatives and carers means delivering the highest quality standards.

During 2012-13 the Trust launched the patient safety strategy with the aim of increasing staff engagement in a programme of quality and improvement projects related to patient safety. This will bring about changes to clinical processes and practice to improve patient care, thereby developing an improved safety culture and a reduction in avoidable harm.

The revised quality strategy focuses on three core areas:

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

The Trust publishes annual quality accounts. This is a separate statutory report that sits alongside the Trust annual report and financial statements that sets out the Trust's achievements against the year's agreed quality priorities and describes the quality priorities for the year ahead. Setting the priorities for 2012-13 involved a process of consulting individuals through patient and public involvement groups, professional meetings and management meetings on what should be included. This year, it was agreed that we would roll forward the same quality priorities as the previous year, as they remained a priority and there is still a lot of work to do in these areas.

During the financial year the healthcare governance committee on behalf of the Board has received periodic reports on how the Trust is performing against each quality priority. It has challenged progress and requested further action to be taken to support delivery of the

quality priorities, thereby improving standards of care. The final achievements are published in the quality account.

The Trust encourages staff to report all incidents and accidents involving patients, staff, visitors and others. A positive incident reporting culture is desirable and the Trust achieved an increase in reporting during 2012-13. We investigate these incidents thoroughly and analyse in detail information gathered to ensure that the individual team and the Trust as a whole learns from them to reduce the likelihood of their recurring in the future. We seek external advice where it is needed to support us and we keep abreast of best practice to drive quality improvements.

The Trust has systems in place to listen to our patients' views about how they were treated and about their overall experience in hospital, whether they be inpatients or outpatients. In 2012-13, the Trust was also involved in the pilot scheme for the Friends and Family Test, which asks the question 'How likely are you to recommend our ward to friends and family if they needed similar care or treatment?' This scheme will roll out nationally during 2013-014.

The Trust maintains a clear focus on clinically-led safety projects which involve senior and junior doctors working with nurses, often through the Patient Safety Academy, such as:

- Audit of the use of red sepsis boxes across the Trust
- Increased safety training based on clinical simulation scenarios encompassing relevant mandatory training and learning from serious incidents
- A trial of a pictorial fluid balance chart, to assist with fluid intake
- Completion of an audit of ward electronic discharge notifications (EDNs); paediatrics are being consulted on their processes that led to zero unauthorised EDNs on the children's wards.

The Trust, along with the nation, received the Francis report in February 2013. We held listening events with staff to identify what can be learnt here at Northampton General Hospital from the events at Mid-Staffordshire NHS Foundation Trust.

More than 500 people, including governors, were involved in the listening events and the key themes were identified. Actions are being put in place to address these and any remaining gaps in our local processes. These will include:

- a focus on organisational development
- reviewing our culture
- leadership

Quality Priorities

The quality priorities for 2012-13 were:

- Redesigning the emergency pathway
- Caring for vulnerable adults
- Patient safety programme
- Patient experience

For 2013-14, the decision was taken by management in consultation with governors to keep working on the same priorities. This is because whilst the Trust has made some progress, it has not yet achieved all that it aspired to in last year's quality priorities. These priorities remain are as relevant now as they were a year ago and this continuity will help the Trust to make further progress.

Quality Priorities: objectives for 2013/14

Quality Priority	Objectives for 2013/14
1. Redesigning the emergency pathway	Embedding the systems and processes to support staff in delivering quality care first time every time.
2. Caring for vulnerable adults	Improve further the care given to people with dementia and people with learning disabilities by improving recognition of patients with these needs and offering care pathways to meet their needs.
3. Patient safety programme	Continue with the six streams of the 'Safety Academy': which represent high profile patient safety projects and education for all staff groups.
4. Patient experience	Improve the patient experience through focused initiatives. Increase both participation in Friends and Family test and the resulting scores.

Incorporated into this year's quality priority objectives are specific actions aimed at addressing learning from the second Francis report. The quality strategy also outlines three quality goals. The have been chosen to improve each of the three key components of quality. The Trust's quality goals are:

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

Clinical Governance Review Scheme (CGRS)

Since February 2011 the Trust Board has supported the Clinical Governance Review Scheme (CGRS). This is a Trust programme where clinical staff peer review wards to provide assurance that Care Quality Commission (CQC) standards are achieved routinely.

An analysis of Phase 1 and 2 of CGRS showed that most areas had either shown an improvement in the 'concern level' or had remained the same. The themes from the two phases were reported to the Board. These themes bear out some of the findings of the CQC inspection and other intelligence, such as patient surveys.

The three CQC outcomes highlighted by the CGRS scheme were:

CQC outcome	Issues to be addressed	Samples of action taken to improve and process to assure
Outcome 1 Dignity and Involvement	Communication Care rounds	An agenda item to the matrons meeting agenda for monitoring Hospedia patient experience monitoring
Outcome 5 Nutrition	Nutritional assessments Fluid balance and Protected mealtimes	Nutritional nurse specialist involvement in action planning Safety thermometer monitoring Fluid balance chart under review
Outcomes 12, 13 & 14 Staffing and Training	Staffing issues Training Staff ID wearing	Recruitment plan for qualified and unqualified nursing achieved (350 nurses and healthcare assistants employed during 2012-13) Managers have a feedback mechanism within team meetings to include outcomes of incident reporting Lessons Learnt to be fed back into the organisation for a full learning loop. Uniform policy enforced by management teams.

Local Action plans were developed for each area and monitored locally. Phase 3 of the CGRS was being completed at the end of the financial year and provided an opportunity to re-examine the wards. The findings are being collated for reporting to Board.

Patient experience

The Trust remains committed to improving the patient experience, approving the patient experience strategy and implementation plan last year. Since then the patient experience board has been established, chaired by the Director of Nursing Midwifery and Patient Experience, and supported with a non-executive director. The Trust will be looking to appoint a dedicated patient experience lead in the summer of 2013.

The focus remains on implementing the national patient experience measure, the Friends and Family Test: 'How likely are you to recommend our ward/A&E to friends and family if they needed similar care or treatment?' and the national patient reported outcome measures (PROMs) questionnaires. The results are reviewed and fedback to the specific clinical areas.

National Inpatient Survey 2012

The results of the national inpatient survey were published by the Care Quality Commission in April 2013. The results show the Trust response rate (61%) is higher than the overall rate for all Trusts (51%). The majority of scores are similar to most Trusts. In all but 5 cases, the scores remain consistent with the 2011 results, with no statistically significant change to the negative or positive.

Where the scores are lower than the 2011 results, the issues raised have been identified within other surveys and are currently being addressed as part of existing patient experience work. It has been very encouraging to see that there are no areas identified by the survey that are not also being highlighted elsewhere and gives the Trust confidence about their current processes for capturing feedback. There are action plans in place for all of the areas where we would like our performance to improve.

All patients are asked to respond to key questions when they are discharged to enable us to monitor continually. In addition, other work e.g. the noise at night audits is taking place to validate the results of the questionnaire and to involve lay people in the evaluation of the patient experience. Work is also underway to review the current discharge procedures to scope the feasibility of standardising this process.

Actions Planned to improve the patient experience for 2013/14

The Trust's quality strategy identifies the prominence of the patient experience in its vision for quality and includes an identified executive lead for patient experience and a non-executive sponsor.

Work is now underway to implement the patient experience strategy. Central to this is the implementation of the national Friends and Family Test. Northampton General acted as pilot site for this test in 2012 ahead of the national roll out in April 2013. There is a CQUIN (Commissioning for Quality and Innovation) attached to this test with a requirement that the Trust achieves a 15% response rate. The Trust response rates average just over 15% with a 19% response rate recorded in February 2013.

Going forward the CQUIN target is set for a 20% response rate; work is underway to achieve this through a raising awareness of the measure and value amongst staff and patients. This is being achieved through a number of staff meetings and the publication and distribution of patient information materials. Where response rates have been historically lower, work is underway to introduce a kiosk for patients to input their data direct.

Two big interventions planned for 2013-2014 are the recruitment of a patent experience lead within the Trust to drive the agenda and to support the embedding of patient experience in the development and delivery of patient care in the ward environment. Work is underway to recruit patient experience champions within the clinical setting who will be working in a nursing, medical or administrative capacity and can lead on patient experience work and ensure the dissemination of recommendations.

Complaints

The Trust received a total of 538 written complaints that were investigated through the NHS Complaints Procedure from 1st April 2012 to 31st March 2013, which compares with 517 complaints received the previous financial year.

Total no of complaints for the year	538
Total no of complaints responded to within the agreed timescale (including 194 renegotiated timescales)	452 (84%)
Total no of complaints that exceeded the renegotiated timescale	86 (16%)
Complaints that were still open at the time that the information was prepared (1st Week in April 2013)	99
Total patient contacts/episodes (Versus 2011-2012)	483/408 (497/469)
Percentage of complaints versus number of patient contacts/episodes (Versus 2011-2012)	0.11% (0.10%)

The Trust takes pride in the way in which complaints are managed. In line with the Principles for Remedy best practice guidance for complaints handling, which were introduced in 2009, it is important to us that the process, decision making and way we communicate, are as straight forward and effective as possible. We aim to provide various remedies through the issuing of an appropriate apology and a variety of actions which aim to redress the issues identified, where appropriate.

All of the Trust's complaint responses are signed by the Chief Executive or deputy, in order to underpin our approach to complaints handling, and our wish to reassure the public that we take complaints very seriously. We always ensure that organisational learning is clearly identified in the response, and that this is supported internally through evidence being available, to assure stakeholders that we have done what we said that we would do.

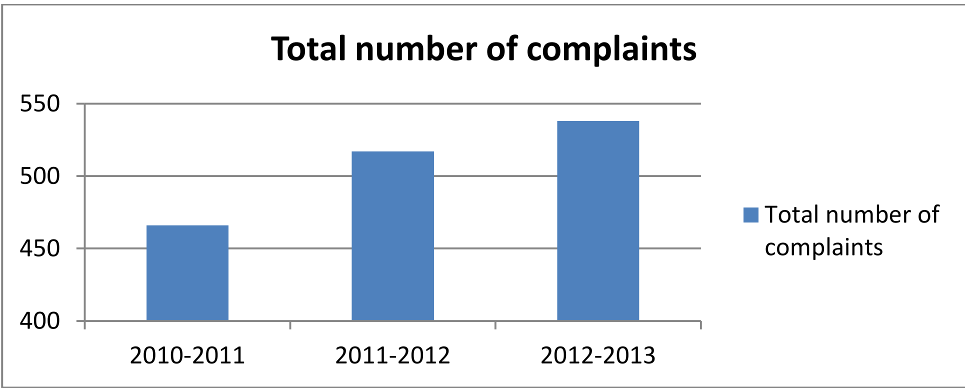
It is important that members of the public are fully aware as to how they may raise concerns or complaints regarding all aspects of their experiences of services that are provided by NGH. The 4 Cs (comments, concerns, complaints and compliments) principles form part of this process as members of the public are provided with a range of options that they may choose from. This involves initial support and advice through front line staff to on-the-spot support from our PALS team, and up to our complaints department.

Our complaints and PALS Teams recognise the value of all feedback whether it is a comment, concern, complaint or compliment (4C's). Our posters and leaflets actively support and encourage patients to tell us about their experience, and we deliver training to staff to help give them the confidence to resolve issues locally wherever possible.

In 2012 the complaints team and our patient advice and liaison service (PALS) received an excellent rating from the CEAC internal audit report regarding the handling arrangements for formal, and informal complaints/concerns, a rating rarely awarded to Trusts, for which staff worked exceptionally hard to achieve.

The Trust reports on the number of complaints to the Board as well as internally through the governance structure, on a monthly and quarterly basis. An annual report is also presented to the healthcare governance committee and Trust Board.

In 2009 the NHS statutory complaints regulations changed, and initially the Trust saw a significant reduction in the number of complaints received. However, over the last 3 years the number of complaints received has steadily increased, which is evidenced in the chart below:



Trend Analysis

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

	2012-2013	% of complaints received
Clinical Care	230	43
Communication	103	19
Delays/Cancellations	102	19
Discharge	53	10
Attitude & Behaviour	45	8
Other	5	1

Learning from Complaints

In line with the Principles for Remedy, the Trust seeks to learn from complaints and, where appropriate, an action plan is prepared and implemented to ensure that any necessary changes are made. Two examples of changes we have made as a result of complaints received during the past year are highlighted below:

Ophthalmology Department
A high number of complaints/concerns were received regarding administration processes within the department. This was escalated through the Trust's quarterly reporting structures to senior management and the executive team. The service was subsequently reviewed, an action plan implemented and a significant number of improvements made to the service. This is evidenced by a significant reduction in the number of issues now reported about this area.

Orthopaedics
A patient was referred in to the A&E department by their GP as an orthopaedic expected patient. However, following review it was agreed that the patient did not require admission to the hospital and was discharged home. The patient raised concerns as their GP did not subsequently receive any information about the review/tests/investigations carried out, and the patient was also unsure of the care plan. On investigation it was found that it was usual practice for discharge notes to be sent to the GP within 48 hours if a patient self-presented at the A&E department. However, this practice did not extend to patients who were not admitted, but had been referred to the A&E department by their GP.

To ensure a consistent approach and improve communication the directorate have now issued the on-call orthopaedic time with an 'on-call dictaphone'. This enables the on-call clinicians to immediately prepare a letter detailing all investigations and planned follow-up. The letter is sent to the GP, with a copy to the patient and the on-call consultant for that day. Other clinical areas are now considering adopting this process.

Serious Incidents

Numbers and themes of Serious Incidents over the last year

The Trust Board receives monthly reports on serious incidents and there are quarterly reports internally through the governance structure. An annual report is presented to the clinical quality & effectiveness group (CQEG) and the healthcare governance committee (HGC).

During 2012-13 the number of serious incidents (SIs) rose to 78. This represents an increase of 42% over the 55 serious incidents reported the previous year. More than 60% relate to pressure ulcers or falls which result in harm. It should be noted that the total number of reported incidents has increased this year (in line with good practise) and the proportion of incidents which are classed as a serious incident has remained almost the same as last year.

Leadership of the serious incident management process is provided jointly by the Medical Director and Director of Nursing, Midwifery & Patient Services, supported by the risk management team. Every serious incident is reviewed in detail and agreed for investigation. If appropriate, incidents are reported to our Commissioners via the National Reporting and Learning System (NRLS) as serious. The culture of incident reporting at the Trust is continually embedded to ensure that lessons are learnt if something goes wrong.

Breakdown of the number and themes of serious incidents during 2012-13:

Incident Category	Number
Pressure ulcers	30
Slip, trip, falls	19
Deteriorating patients	8
Infections (including MRSA)	5
Diagnosis incidents	2
Surgical incidents	2
Test results	1
Maternal death	2
Accident	1
Screening	1
Delay	3
Drug incident	1
Premature discharge	1
Never Event (wrong site surgery)	1
Other	1
Total	78

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

- Early Warning Score (EWS) charts in NGH are monitored continually to ensure patients that become acutely unwell are seen quickly by a doctor. Feedback is provided to wards to enable them to maintain and improve their performance.
- Nursing documentation is under review to enable a consistent standard in clinical observations and record keeping.
- The radiology ‘communicator’ system is being rolled out to assist with the reporting and escalation of patient scan results.
- Patients and relatives are encouraged to attend ‘being open’ meetings with NGH to discuss serious incident investigations and their outcome.
- Ward round reviews will ensure that where possible patients are seen by a specialist senior consultant within 12 hours of hospital admission.
- The Trust is moving towards 24/7 availability of bariatric equipment in 2013.
- Our patient safety academy has increased the number of patient safety champions. These are staff based on the ward or in clinical departments who are the ‘eyes and ears’ for patient safety in their area and are tasked with acting on any issues identified. There are a number of safety projects being taken forward via this Trust initiative.

Numbers and themes of Never Events over the last year

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

During the 2012-13 reporting period, the Trust investigated one ‘never event’ which related to wrong site vascular surgery. Following this event, a number of actions have been implemented to reduce the risk of recurrence and included: a full review of our practice and processes relating to completion of the WHO (World Health Organisation) surgical check list in theatres and provision of additional training.
A ‘surgical never event’ meeting has been held to take forward recommendations from this review and embed leaning from this incident. The findings have helped to inform the patient safety strategy.

Trust Strategic Objectives

NGH is committed to providing the very best care for all our patients. Our overall aims are to:

- Be a provider of quality care for all our patients
- Enhance our range of hyper acute services to the wider community
- Provide appropriate care for our patients in the most effective way
- Foster a culture where staff can give their best and thrive
- Ensure we invest wisely to make improvements in care

To deliver these aims, the Trust developed its quality priorities through an involvement and consultation process which included the shadow governors, staff, public (via publication on the internet and intranet), public partnership forums and other external stakeholders.
As a result of the consultation and after reflecting on progress against national and local priorities, the Board agreed the following priorities for the year 2012-13:

- To redesign the emergency pathway
- Caring for vulnerable adults
- To establish a Patient Safety Programme
- To enhance our focus on patient experience

In recognition of the fact that the future landscape for healthcare provision will change to reflect the forecast economic outlook, the trust boards of Northampton General Hospital and Kettering General Hospital agreed that both hospitals should work together during 2013/14 to look at ways in which they can work more closely together to ensure high quality patient services are provided to people living in the county. A full range of options, up to and including a full merger of the Trusts, will be explored with any recommendations made being subject to a formal approval process.

During the coming year we will be working in partnership with colleagues at Kettering General Hospital NHS Foundation Trust (KGH), NHS Nene Clinical Commissioning Group and NHS Corby Clinical Commissioning Group to progress the commissioner-led work on the configuration of acute services and take forward the provider-led work in relation to partnership working.

The partnership has agreed to take this work forward through a single Programme Management Office (PMO) working on behalf of the four organisations. The PMO will be jointly led by two Programme Directors, one on behalf of Clinical Commissioning Groups and the second on behalf of the acute providers. The commissioned PMO will be required to deliver three over-arching workstreams:

1. Programme Governance: to develop and deliver the role of the PMO and associated governance framework.
2. Commissioner work-stream: to develop an acute clinical commissioning strategy that enables the delivery of transformational change to acute care for Northamptonshire;

thereby providing the county with sustainable and financially viable clinical services that offer high quality and improving health outcomes.

3. Provider work-stream: to determine options for any future partnerships and integration between NGH and KGH.

Performance against strategic objectives

During 2012-13 we have made progress against each of our strategic objectives.

1. Be a provider of quality care for all our patients

We have:

- Demonstrated improved clinical effectiveness through NICE compliance and effective use of clinical audit.
- Introduced Listening into Action to support teams making improvements in the services they provide.
- Reduced carbon emissions by 4% since the start of the carbon management strategy in 2010/11.
- Approved a patient experience strategy and implementation plan.
- Reviewed our governance structures, investing in a revised enhanced structure which supports the Care Groups whilst providing additional support to the corporate functions in order to meet growing compliance requirements.
- Introduced night audits to monitor noise at night, recommend improvements to the ward environment and improve the patient experience.
- Recruited to 1176 posts during 2012-13; of these 329 positions were within nursing and midwifery. In addition the Trust's volunteer service was expanded with the recruitment of just over 100 volunteers.

2. Enhance our range of hyper acute services for the wider community

We have:

- Provided a county-wide vascular service at NGH from 1 April 2012, treating 269 patients in its first year
- Established the county-wide abdominal aortic aneurysm (AAA) screening programme, screening 3597 men aged 65 years
- Introduced new specialist radiotherapy services for head and neck and lung cancer patients
- Continued to develop relationships with GP commissioning groups
- Agreed partnership working with Kettering General Hospital NHS Foundation Trust

3. Provide appropriate care for our patients in the most effective way

We have:

- Established the urgent care programme board focussed on five work streams: medical workforce; A&E assessment units; patient flow/length of stay; discharge planning and community beds and rehabilitation
- Amended the protocol for troponin testing on patients at admission to aid faster diagnosis
- Introduced new patient progress charts on our stroke unit
- Implemented specialty and group score cards for care group boards

4. Foster a culture where staff can give their best and thrive

We have:

- Reduced long-term sickness absence to 2.17%
- Introduced Listening into Action with 25 teams now actively involved in working together to identify and implement service changes to improve staff morale, efficiency and the patient experience
- Launched a job shadowing initiative
- Introduced a monthly core brief
- Recruited 350 nurses and healthcare assistant to the general wards during the year, reducing vacancy rates in these areas to 1%.

In fostering a culture where staff can give their best and thrive we will develop a new approach to leadership and will develop our leaders so that they, together with our staff, will work to make NGH a great place to work, learn and develop.

5. Ensure we invest wisely to make improvements in care

We have:

- Delivered an income and expenditure surplus of £0.4m for the financial year 2012-13
- Delivered £10.5m savings against a plan of £11.1 m for 2012-13

Shadow Governors’ Council

Introduction

At April 2013 we had 4,550 public members and 3,994 staff members. From this membership we have developed a strong and engaged council of governors who have supported us in our vision to provide the safest care that we can for our patients with the the highest clinical outcomes and the best patient experience possible.

We set up a series of focus groups chaired by members of the council of governors looking at different aspects of the services that we offer, such as infection prevention, hotel services and trauma and orthopaedics. These groups have all continued to meet, reporting to the patient and public Involvement strategic steering group which is also chaired by a member of the council of governors and feeds into the patient experience board and the Trust Board.

In 2011 we began a series of ward audits looking at specific areas: preventable noise at night and protected mealtimes. The audits groups, made up of members volunteers are facilitated by members of the council of governors. The results of these audits are helping us to understand what we are doing to improve patient care by identifying areas for improvement.

Governors' Council composition

Since 2006, when our governors' council was established, we have seen some members of the council stand down, leaving a core of governors who have continued to work closely with us.

During the year we have identified and invited members to join the council as interim shadow governors, and have now increased the size of our council. The current composition of the council is shown below:

Constituency	Number
Public	19
Northampton	12
Daventry and South Northants	6
East Northants and the rest of the UK	1
Staff	4
Medical and Dental	0
Nursing and Midwifery	1
Allied Health Professionals	1
Non-Clinical	2
Appointed	2
University of Northampton	1
Northants County Council	1
PCT or CCG	0

The council continues to meet on a bi-monthly basis. As well as chairing various focus groups and audit teams, governors have an active communications and membership group which oversees membership recruitment and engagement activity.

Developing the role of the governor

The new members of the council are being provided with appropriate induction and training to enable them to carry out their role effectively with the support of the relevant knowledge.

A training framework and code of conduct was developed to develop the governor role. This has been developed to form the basis for the governor training and on-going development programme, and is reviewed at both the council of governors meeting and the meetings of the communications and membership subcommittee.

The council of governors meeting agendas include the most recent performance, finance and patient quality and safety reports. They are also updated on the following:

- Workforce strategy and current status,
- Transformation project updates
- Listening into Action initiative.

Governors are given the opportunity to request specific training sessions at the council meeting, along with updates on aspects of the Trusts' strategies. These have included

- Finance within the NHS
- Infection prevention
- Sustainability
- Feedback from both patient surveys and the staff survey
- Updates on the Acute Services Review in the South East Midlands (Healthier Together)
- Governors have been consulted on the Trust's quality priorities

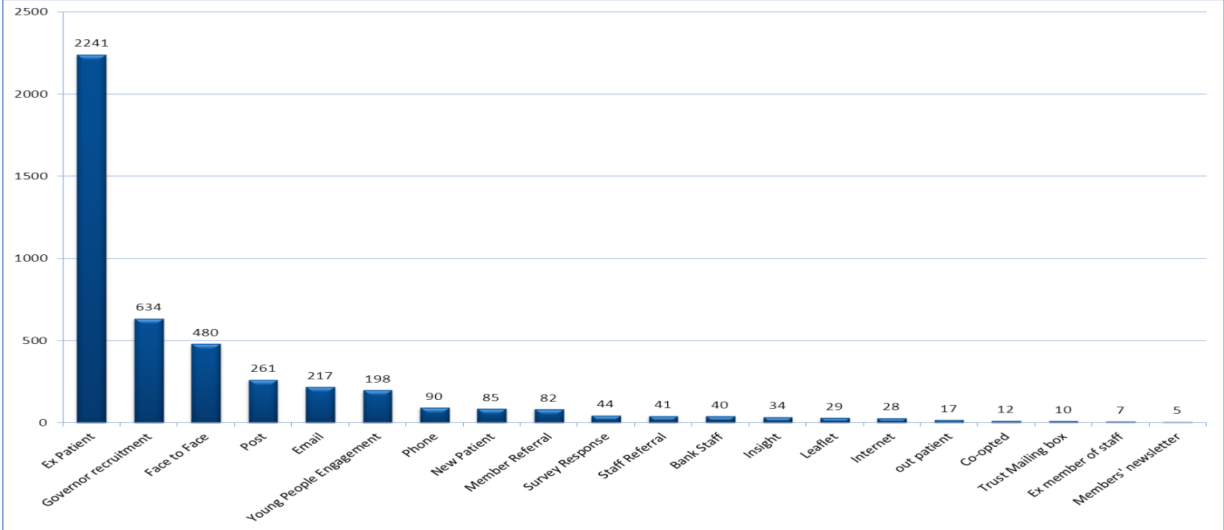
Governors are given the opportunity to raise questions of the executive team at the council of governors meetings, through the Lead Governor or through the Chairman.

The council of governors have the opportunity for open discussion with both the Chairman and the non-executive directors at meetings outside the auspices of the Trust Board.

Membership Report

Membership

The Trust currently has 4,500 public members and 4248 staff members. These have been recruited through the following methods:



The membership database is regularly cleansed to ensure that the information stored is as current as possible, and members are given the opportunity to step down either through unsubscribing when they are contacted by email, or when they are invite to attend the AGM if they do not share their email details.

When members join the Trust, they are sent a questionnaire which includes a section on age, gender and ethnicity. This information is then used to give us a profile of our membership which we can compare to the figures for our region so that we can monitor whether our membership is representative of the community that we serve.

Informing and engaging with members

During the year the Trust has held a series of events to enable members to learn more about its services. These have included an event taking the audience through the journey of a stroke patient, from the ambulance to rehabilitation, an opportunity to learn of the benefits that patients experience through enhanced recovery techniques, an evening celebrating the work of our nursing staff, and an evening to raise awareness of bowel cancer.

Further events included an opportunity to take part in Heart Start training by members of the East Midlands Ambulance Service, learning more about becoming a ward audit volunteer, and finding out about the experience of living with dementia. Our AGM included a very informative talk by one of our consultant cardiologists on the innovations being seen in the heart care centre, and was followed by an open and frank question and answer session, members were given the opportunity to submit questions prior to the meeting and these were either responded to at the meeting, or a written reply was sent to the questioner.
We developed a series of ward audits with the Practice Development team which looked at specific aspects of patient care: preventable noise at night and protected mealtimes. We recruited teams of ward audit volunteers from our membership to help us with these audits, and following an induction have set up timetables of regular audits facilitated by the governor leaders of the group, with support from the membership manager and practice development facilitator. The protected mealtime audits are now run independently by the audit teams, who schedule the audit dates and carry out the audits on a monthly basis. The results are reported back to the Patient and Public Involvement Strategic Steering Group, the council of governors and the Patient Experience Board. They are fed into the Nursing Dashboard which tracks the performance of Patient and Nursing Services across the Trust, and fed through this to the Trust Board.

The work of these ward audit volunteers offers our members a very valuable insight into how we are doing with regard to these measures, and we are very grateful for their time and support

Plans for the Future

We are planning to hold a the NGH Festival after the AGM in September 2013 when members and the public will be able to see for themselves some of the new developments within the Trust for themselves, such as the new Haematology Unit and other specialist care that we offer.

We are also planning an event which will help to give our members an insight into how our A & E department works and how we interact with the ambulance services.

We will continue to engage with our members through the quarterly newsletter and through member events. We will also build on our relationships with our partner organisations to share knowledge and resources.

We are working towards our target membership of 5,000 public members, and will resume mailing our discharged patients from April 2013 as this is the most effective method that we have employed to develop a membership of engaged and active members.

Operating and Financial Review

Our Vision

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

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

Trust Performance

During 2012-13 Northampton General Hospital achieved the majority of its key national performance targets, including referral to treatment times.

The Trust achieved 91.46% against the transit time target of 95% during 2012-13. Our emergency care service experienced unprecedented demand and saw increased in A&E attendances (+ 11% on 2011/12 and emergency admissions (+ 3% on 2011/12).

During the year the Trust had one patient breach the standard of no patients waiting more than 6 weeks for a diagnostic test. This was a result of an administration error. A full investigation has been undertaken to ensure there is no recurrence.

The Trust met all of the cancer standards with the exception of the 62 day standard from urgent referral, achieving 83% against the standard of 85%.

There were two cases of MRSA bacteraemia reported during the year against the Trust's target of one. Thirty cases of C.Difficile infections were reported during the year, which was below the target of thirty-six cases.

Patient Activity

During the year we treated the following number of patients:

Point of delivery	2010/11	2011/12	2012-13
Elective inpatients	7,829	7,091	6,702
Day cases	39,975	38,769	38,224
Non-elective admissions	40,689	43,620	44,875
First outpatient attendances	91,784	91,065	89,433
Follow-up outpatient attendances	174,389	185,009	180,100
Outpatient procedures	27,209	38,942	40,513
A&E attendances (excluding MIaMI*)	83,136	86,868	96,180
GP referrals	54,353	51,097	50,987

* Minor Injuries and Minor Illnesses Unit

18 weeks

During 2012-13 the Trust continued to maintain delivery of the national 18 week journey time for the fifth consecutive year. This meant that 95% of admitted patients and 90% of non-admitted patients received their first definitive treatment within 18 weeks.

Accident & Emergency

2012-13 saw unprecedented levels of demand placed on our emergency services and there was a significant increase in both A&E attendances and emergency admissions. 91.46% of patients were seen, treated, admitted or discharge within 4 hours against the 95% target.

A recovery plan and urgent care programme has been implemented to improve flow through the emergency pathway and improve performance. Progress is monitored through the urgent care programme board and also reported to the Trust Board.

Diagnostics

Due to an administration error one patient did not achieve the standard of no patients waiting more than six weeks for a diagnostic test. A full investigation has been undertaken.

Cancer Waiting Times

During 2012-13 the Trust delivered the majority of the national cancer targets, with the exception of 62 days urgent referral to treatment of all cancers where the Trust achieved 83% against the national standard of 85%.

The reasons for not achieving the target have been investigated and relate to patient choice to defer appointments or diagnostic tests and complex diagnostic pathways. A recovery plan has been implemented and an additional weekly performance meeting is held that is dedicated to delivery of the cancer standards.

Cancer wait times 2012-13	Target	2012-13
2 week GP referral to first outpatient	93%	96.8%
2 week GP referral to first outpatient – breast symptoms	93%	99.4%
31 day diagnosis to first treatment	96%	98.2%
31 day second or subsequent treatment – surgery	94%	98.3%
31 day second or subsequent treatment – drug	98%	98.0%
31 day second or subsequent treatment – radiotherapy	94%	98.5%
62 day referral to treatment from screening	85%	96.2%
62 day referral to treatment from hospital specialist	85%	89.1%
62 days urgent referral to treatment of all cancers	85%	82.9%

The Trust's Estate

The 2012-13 Estates capital plan continued to focus on reducing the impact of the growing backlog maintenance, ensuring our statutory obligations were met, minimising our carbon footprint and continually improving the patient environment.

The condition of Trust's estate is directly linked to patient safety and the ability to deliver quality healthcare. The Estates capital plan therefore prioritises high risk backlog maintenance to ensure the best use of the capital budget. Alongside the rolling programme of clinical area refurbishments and infection prevention works, significant schemes this year included replacement of ageing air handling plant to Sturtridge Ward, replacement of Pathology's chilled water plant, refurbishment of critical patient passenger lifts, upgrading of the building management system and essential electrical infrastructure works to improve resilience.

As in previous years, there has been continued investment ensuring that the estate remains compliant with our statutory requirements. Upgrading of the fire detection system continued with obsolete control panels and devices being replaced with newer more effective versions and additional devices being installed where risk assessments and inspections have highlighted risk. A supplementary water treatment system was installed to improve the quality of water across site and further works to improve the resilience of the medical vacuum systems were completed.

We have continued to improve energy efficiency within the Trust. Schemes included LED replacement of all external street lighting, replacement double glazed windows, cavity wall insulation and replacement of high energy internal lighting.

Improvement works to the environment and access for staff, patients and visitors with a disability were also completed. Works carried out during 2012-2013 comprised of, new reception desks, mirrors to all lifts to assist persons on mobility scooters reversing out, fire alarm beacons to public WCs and corridor areas to indicate to persons who are hard of hearing that there is a fire, further hearing aid loops installed to non-patient receptions, additional automatic doors and external path modifications to enhance pedestrian routes.

New developments on site over the past 12 months have included our new Cancer Information Centre. The new centre is located within the Oncology department and gives our cancer patients a quite area where they can access information and support. Histopathology has also seen changes with new offices and additional refrigerated storage facilities which have helped them manage increased demand on their services.

Work has also started on improved the birthing facilities on Sturtridge Ward and the development of a midwifery-led unit on Balmoral Ward which will be completed in the summer of 2013.

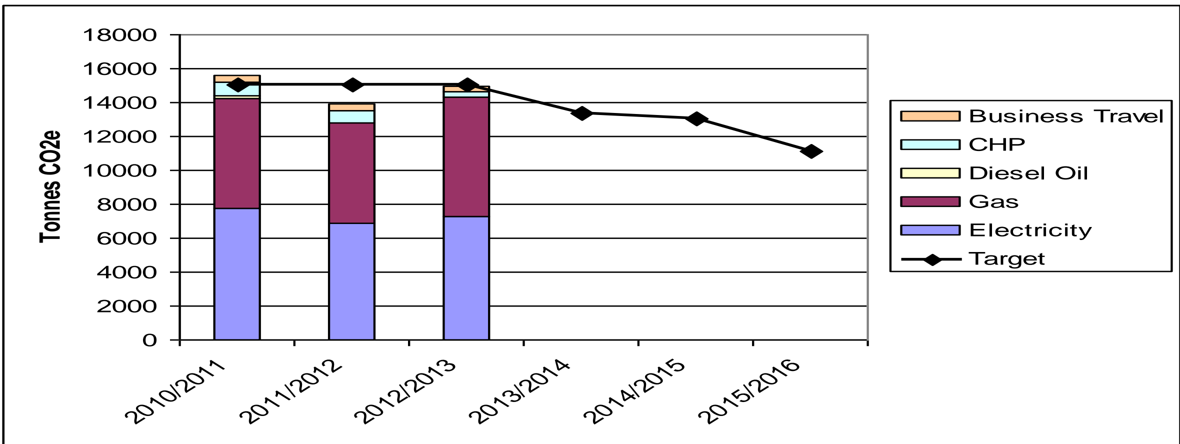
Embedding Sustainability

In order to deliver the Sustainable Development Action Plan the Trust appointed a full time Energy and Sustainability Manager reporting into the Executive Director lead on Sustainability. Sustainability is now included as part of the Trust Induction program for all new starters, and sustainability presentations are being given to individual departments.

Carbon Management Plan

Having already achieved the government target of a 10% reduction in carbon emissions by 2015, NGH was accepted onto the Carbon Trust programme and developed a plan to reduce emissions by 25% by 2015 relative to the 2010 baseline.

Emissions from buildings have shown an increase over the last twelve months. This is due in part to the colder than average year and the reduced running of the Combined Heat and Power (CHP) plants which combined to give an increase in emissions for 2012-2013 of 510 tonnes of CO2e compared to the previous year. Despite this and the increased activity there has been a reduction of 4% since the start of the carbon management plan and we remain within the planned trajectory reaching the target of 15075 tonnes CO2e. in 2012-13.



Investment

During 2012-13 NGH invested a total of £458,000 in carbon reduction initiatives. These included a pool cover for the Cripps recreation centre, replacement of inefficient lighting, incorporating some occupancy sensors, improved insulation of steam mains, cavity wall and double glazing in some of the older buildings and the replacement of all the external lights with lower energy LEDs.

Alongside these investments a significant amount of capital has been invested in the installation of sub meters to allow reporting of electricity consumption at a building and ward level. Upgrades have also been made to the Trust's Building Energy Management System (BEMS). These investments will start to pay back in the next 12 months through improved control and better monitoring, targeting and reporting of energy consumption.
In the next 12 months we will continue to improve the BEMS and have applied for further funding to continue its implementation of the carbon management plan.

Water, Waste and Recycling

NGH has started a series of projects with Anglian Water to map the water use across the site and use this to target areas for water saving devices and water reduction strategies.

Recycling levels have remained static at NGH, a position that we will be working hard to address in 2013-14. In 2012-13 we introduced metal recycling, started to auction our unwanted medical equipment and were also the first trust in the NHS to recycle the wrap used for instrument trays from its sterile services division. In 2013-14 we will be increasing the number of recycling bins around the site, particularly in public areas, in addition to creating some new recycling streams.

Travel

A new travel plan was written aimed at decreasing the number of single occupant car journeys to the hospital.

A staff survey is planned for 2013 to determine the mode of transport and staff attitudes towards more sustainable forms of travel.

NGH has worked with the council and local bus company and from the end of March an additional service has been stopping close to the A&E department of the hospital.

A Bicycle User Group has been formed from cyclists and members of the Facilities Department with the aim of increasing the number of employees cycling to work. NGH will be providing more cycle storage facilities on site, has introduced a cycle to work scheme and has agreed a discount at a local bicycle store.

At the end of March a Dr Bike Day was held in conjunction with SusTrans to give NGH employees' bikes a safety check and repair. This coincided with a police registration day on site and the NHS Sustainability Day.

Our Staff

Learning and development

Learning and development is part of the human resources directorate and supports all staff in their continued professional development at work. The main areas of activity are mandatory training, covering everything specified to comply with Care Quality Commission requirements and professional training which delivers a wide range of skills and learning.

The Trust has strengthened delivery of mandatory training by offering a variety of formats to suit individual learning needs, including workbooks, DVDs and e-learning. All mandatory training is now effectively recorded on completion to ensure staff are demonstrably compliant with guidelines. All new staff are required to attend a corporate Trust induction programme which delivers mandatory training topics in the first three days of employment with patient-facing staff then expected to attend additional training.

Other learning & development activities over the past year include two cohorts of specifically tailored leadership & management programmes for Bands 3-4 & 6-7 which were delivered to Trust staff alongside colleagues from NHS Northamptonshire, when all participants were required to develop a service-improvement project.

Staff are encouraged to access on-going development across all levels; this includes apprenticeship frameworks, NVQs & foundation degrees. Registered staff are also able to access modules from Universities at post-graduate degree and Masters level.

NGH is also an employer of apprentices across most directorates and a variety of roles, many of whom are full time employment by the Trust on completing their apprenticeship.

NGH has a very long history of successful involvement in postgraduate medical education and over the last decade has established a similarly good reputation for the education of undergraduates from both the Universities of Oxford and Leicester. We aim to be a provider of choice for medical training. The organisation currently has an income of approximately £8m a year for the work we undertake in these areas.

Medical education

Doctors employed and funded through the medical and dental education levy deliver a significant proportion of our clinical care.

In order to maintain this level of income (and the students and doctors who go with it) we are required to provide training of a standard that satisfies the national quality assurance standards laid down by the Universities (for undergraduate work) and the General Medical Council (GMC) for postgraduates. There are regular quality management assessments of the Trust's training standards undertaken by the East Midlands Deanery as part of the overarching GMC quality assurance process with input from the results of this inputting to the CQC and

NHSLA (NHS Litigation Authority) processes for the organisation as a whole. There are three broad elements to being successful in these assessments:

- The consultants and other full time staff supervising the training must be demonstrated to be suitably trained for the tasks they perform (as defined by the GMC) and have adequate time in their job plans to deliver the requirements. Such staff must meet the requirements for clinical and educational supervisory roles.
- The training environment must facilitate learning for the trainees: they need appropriate access to clinical experience (which may slow down service delivery at times) clinical supervision, provision of teaching, time to attend training and mentoring and support if in difficulty. At all times that environment must be safe for patients, the trainees and the organization.
- The Trust has developed a Trust wide training infrastructure that includes departmental training leads (college tutors and undergraduate leads) with input to regional teams (planning, recruitment, assessment and pastoral care), undergraduate, foundation level, staff and associate specialist doctors (SAS) and specialty training leads and a director of medical education with an overarching responsibility for medical training at all levels and full involvement in the senior management of the organisation.

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

In 2012-13 we introduced a new educational governance structure to support the delivery of these requirements. Regular faculty group meetings now feed reports into the restructured medical education committee with that group reporting to the Medical Director and strategic management board. There is an increased emphasis on safety as well as continued review of trainee progress within the new processes. We expect in future to be able to identify any training issues within departments more rapidly than before as well as provide more timely support to trainees who may be struggling.

GMC revalidation for trainees also began during 2012-13. This system requires more detailed reporting of non-training issues such as trainee involvement in patient complaints and serious incidents. New processes have been set up to provide this, with central recording of all such issues. Inevitably both of these new initiatives have an impact on the time required from consultants involved in training which needs to be recognized in their job plans.

Finally, the Trust has been approached by the University of Leicester to develop and provide patient safety and leadership training to of their medical undergraduates. This is on the background of existing highly rated programmes that we already provide to a minority of them. This will be fully funded and provides a fantastic opportunity to enhance training and the reputation of the Trust.

Transformation

In 2011 the NHS in England was set a £20bn central efficiency target, which required NGH to make recurrent savings of £30m over 2 years from 2011-2013. The Trust embarked on a large-scale transformation programme in 2011-12 and during the year identified and achieved £19.1m savings.

The transformation programme continued throughout 2012-13. Through the programme we are endeavouring to ensure we are as efficient as possible, and have reviewed opportunities to reduce spending through procurement schemes which have been successful in reducing the cost of products that the Trust uses.

We have introduced an outpatient reminder system to reduce the number of 'no-shows'. This in turn led to a decrease in the number of patients who either missed or failed to attend their appointment.

We have also introduced staff benefits/salary sacrifice schemes such as green cars and buy-back of annual leave.

During 2012-13 we experienced a significant increase in the number of patients requiring A&E and emergency care. The increased activity meant we had to revise our plans to reduce overall bed numbers and theatre capacity, which in turn had an impact on our ability to achieve the savings we had anticipated as part of the transformation programme. However, the Trust is clear that the impact of any transformation scheme must be assessed against our ability to meet the needs of our patients and continue to provide safe, effective care.

Safety and quality is key component of the transformation programme. All ideas and schemes are assessed against a set of criteria to ensure that financial savings do not compromise the quality of care offered to our patients. Quality metrics are tracked throughout the life of the workstream to monitor this.

Whilst 2012-13 was a challenging year for transformation for the reasons described, we achieved an additional £10.5m savings, which means we have delivered £29.6m savings over the past two years.

Transformation requires the Trust seek to continuously improve the quality of services we provide to our local population. We are now developing plans to transform our services for the next 2 years.

Equality and Human Rights

The Trust believes in the dignity of all people and their right to respect and equality of opportunity. The Trust values the strength that comes with difference and the positive contribution that diversity brings to the hospital. The Trust operates within a national framework of equality legislation, however, the Trust aims beyond simple compliance with the law. Equality is central to all that we do.

The Trust sees equality of opportunity and access as a vital part of its approach to delivering quality patient care and becoming a model employer. It is committed to providing services which respect and respond to the diversity of the local population. It is also committed to ensuring staff are recruited fairly and are provided with a positive and valuing work environment which supports them to achieve their maximum potential.

Northampton General Hospital NHS Trust is committed to ensuring equality of opportunity for all employees including prospective and existing employees with a disability. It is the intention

of the Trust to ensure that every effort is made to explore ways of accommodating people with disabilities to make a valuable contribution to the work of the Trust.

The Trust will not tolerate discrimination against disabled applicants or staff and aims to promote a working environment that encourages equal opportunities for all to work towards achieving a diverse workforce. The Trust has a policy for the employment of people with a disability which provides guidance on the 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 is covered within the policy.

Northampton General Hospital has adopted the Equality Delivery System (EDS), a Department of Health initiative designed to support NHS organisations deliver better outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse. The EDS is all about making positive differences to healthy living and working lives so that everyone counts.

At the heart of the EDS is a set of 18 outcomes grouped into four goals. These outcomes focus on the issues of most concern to patients, carers, communities, NHS staff and Boards. It is against these outcomes that performance is analysed, graded and action determined. The goals are:

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

The outcomes have shaped and been mapped onto the actions planned within this equality and human rights strategy.
During 2012 and 2013 we agreed a four year plan with reference to public sector and other duties and to equality target groups. The objectives set encourage an outcome-focussed approach to setting challenging but measurable targets to improve service outcomes and the way we employ our staff.

The objectives address the biggest and most pressing issues facing the protected groups that we provide services for and employ, prioritising the most significant issues for the protected characteristics.

In summary our four year plan is outlined below:

Goal	Objective
1. Better Health outcomes for all	We will develop a programme of data collection and analysis to understand areas where there are health inequalities amongst protected groups. This will be completed in line with the Trust's quality programme and in conjunction with NHS Northamptonshire
2. Improved access and experience	The Trust will increase the engagement and involvement with representatives from protected groups. In 2 years we will aim to achieve representation from 100% of the protected groups.

Goal	Objective
3. Empowered, engaged and well supported staff	We will aim by 2014 to improve our staff satisfaction rates as reported in the annual staff survey so that we are in the top 25% of Trust's for response to the question regarding whether staff would recommend the Trust as place to work.
4. Inclusive leadership at all levels	To develop a management and leadership strategy and programme for all staff based on the standards set out in the NHS leadership framework and its supporting frameworks.

The detailed action plan of the Trust's equality objectives which are updated on a six monthly basis can be access via the Trust's internet via:
www.northamptongeneral.nhs.uk/WorkforUs/Downloads/Equality-Objectives-2012-to-2016.pdf

NHS Staff Survey 2012

Whilst the response rate from staff for the 2012 staff survey was below the acute Trust average, 385 individuals did respond, and we are grateful to all those who took part.

The Trust takes the staff survey results very seriously as it provides us with an indication of what is important to our staff and the aspects of their working lives which we need to collectively improve upon.

The results were disappointing this year, however, this will provide us with an added impetus to fully engage with our staff to make those improvements that are important to them.

A presentation event, prepared by Capita Health Service Partners, was delivered to both management and staff side in April 2013. A reference group has been set up to review the results and determine the approach we will take to ensure our staff are engaged in the process and have the opportunity to feedback their suggestions, which will inform the actions we need to take to make the necessary improvements.

On a positive note the Trust continues to be above the average for staff having equality and diversity training and saying that hand washing materials are always available.
In June 2012 the Trust introduced Listening into Action (LiA), a proven approach which looks at how to fundamentally shift the way we work and lead, putting staff at the centre of change. This approach supports our Trust's vision of providing the very best care for all of our patients by asking our staff and patients how best we can achieve this.

We began in the summer of 2012 by holding conversations with staff across the Trust to understand what day to day issues get in the way of staff delivering their service. Our staff wanted the Trust to look at various corporate themes: communication, patient experience, documentation, car parking, IT, staffing and documentation. From these themes we have delivered actions that are helping our staff improve the service to our patients and visitors, including:

- Introducing a monthly core brief
- Developing proposals to increase car parking provision on site
- Appointing a patient experience lead
- Improving IT service desk support

Eleven Trust teams introduced LiA as a new way of working in September 2012 and held their own team conversations to find out what there day to day issues are and have achieved fantastic results some examples are below.

In February 2013 a further ten teams began using LiA and we have four corporate themes we will be taking forward: communication, respect, accountability/responsibility/roles and 'In Your Shoes'.

'In Your Shoes' was launched in March 2013 and is an exciting initiative for staff to visit other departments in the Trust to finds out more about what they do, the services they provide and how they impact on patient care.

Ward/Dept	**What staff said …**	**Together we did …**
Pathology	We would like to work closer with other teams in the Trust to assist with quicker diagnosis of patients, for example A&E	Teamed up with cardiology and A&E to change the protocol for troponin testing on patients at admission. As a result we have saved £250k of bed days in the hospital.
Theatres	Communication needs improvement	'Group huddle' held in main and Manfield theatres every morning for all staff, providing an overview of the day ahead and any relevant news. Monthly theatre newsletter to keep staff informed of theatre and Trust related news.
Holcot Ward (Stroke Unit)	We would like improved communication between all members of our MDT (multi-disciplinary team). Improved written and verbal handover.	New blue signs now in use so nursing staff can quickly identify those patients due for physiotherapy the next morning. New yellow patient progress charts have been developed to aid improved communication between therapists and nursing staff.

Sickness Absence

Year on year the management of sickness absence remains a high priority for the Trust and during 2012-13 a task and finish group was set up to look at ways of reducing sickness absence across the Trust.

A number of initiatives were introduced in this campaign and were aimed at providing managers and staff with understanding the difficulties the Trust is faced with when sickness absence is high. These included:

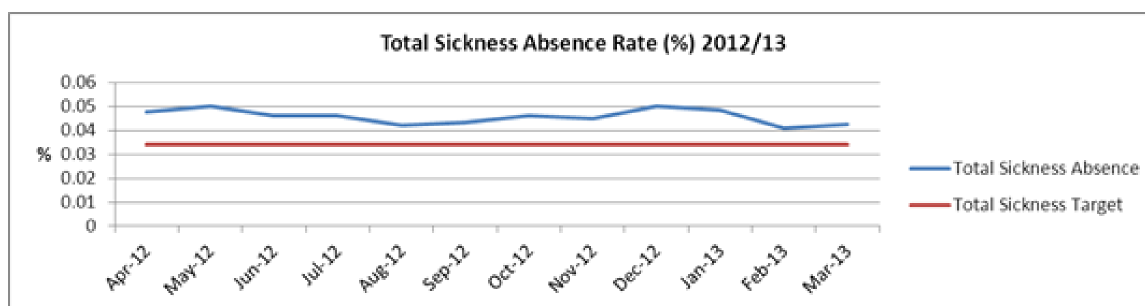
- the distribution of posters across all areas of the Trust given clear instructions on how individuals should notify their manager's when off sick
- a facts and figures bulletin distributed to all areas providing the simple message of the cost of sickness absence to the Trust.

With the introduction of HR advisor roles in 2012 the HR department has been able to provide managers with the support required to manage both short term and long term sickness

absence and we have identified a clear correlation where sickness reduces if return to work interviews are carried out.

Towards the latter end of the year a successful training programme on sickness absence was delivered in conjunction with our union colleagues to many managers in the Trust. However, more work is required as the sickness absence rate has remained above the Trust target of 3.4%, with the Trust's total sickness absence average for the financial year 2012-13 at 4.58%.

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Short Term Sickness Absence (%)	2.22%	2.30%	2.18%	2.42%	1.89%	2.46%	2.90%	2.45%	2.21%	2.41%	1.88%	2.08%
Long Term Sickness Absence (%)	2.56%	2.70%	2.46%	2.22%	2.34%	1.88%	1.73%	2.05%	2.79%	2.44%	2.20%	2.17%
Total Sickness Absence (%)	4.78%	5.00%	4.63%	4.63%	4.23%	4.34%	4.62%	4.50%	5.00%	4.85%	4.08%	4.25%



Information Technology

As part of the Trust's transformation programme the executive team stated the following vision for information technology…….

'It is the vision of the Trust to move to a paperless hospital in 5 years. The development of an electronic patient record will make information more accessible to clinicians to allow for more efficient treatment of patient. We are committed to invest in easy access to good quality clinical information. Our first priority is to invest in the current infrastructure to ensure that access to the systems is quick, easy and reliable.'

……and our electronic patient record (EPR) strategy was written and given Board approval in October 2012.

It was agreed that the Trust would continue with its 'best of breed' strategy, linking information from specialist systems within the Trust and increasing the amount and quality of information sent electronically to a patient's GP following an inpatient stay or a visit to an outpatient clinic. Tools to facilitate timeliness of transmission have been implemented, including voice recognition and hybrid mail, which have been integrated with the core patient

content store (PCS) and this will provide the platform for the further development of clinical assessments and ward workspace functionality over the coming period.

Major improvements which have taken place this year to our medical document scanning IT system will, in time, allow a move to the digitisation of all medical records supporting the national drive towards a paperless NHS by 2018.

Provision of new and ground breaking clinical IT systems must be underpinned by a robust infrastructure and our Infrastructure Improvement Programme began with the installation of a brand new network and extensive work to improve the environment in our main data centre. Next financial year the focus turns to resilience and disaster recovery and further roll out of mobile computing devices to enable ease of data capture at patients' bedsides.

Report from the Director of Finance

I am pleased to report that the Trust has delivered a surplus position of £0.4m after adding back impairments of non-current assets of £0.9m and adjusting for donated asset eliminations of £0.3m. For the purposes of calculating the break even duty referred to below impairments are excluded.

Economic Outlook and Impact on the Trust

As an NHS provider organisation the Trust continues to face downward pressure on the tariffs and income it receives with all the signs being that this will continue to be the case for the foreseeable future. Throughout the financial year the Trust has continued to face increasing demand for emergency services which required the opening of additional wards during the year. These two factors combined result in a very challenging financial environment which has required both additional investment from the local commissioners and the delivery of £10.5m of cost improvement programmes.

Financial Duties

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

Breakeven on income and expenditure (see Note 40.1 to the financial statements)
The Trust reported an in-year surplus of £0.4m, giving a cumulative breakeven position of £7m and therefore meeting its five year breakeven duty. The cumulative breakeven position is 2.6% of 2012-13 turnover.

Capital costs absorption rate (see Note 40.2 to the financial statements)
NHS Trusts are targeted to absorb the cost of capital at a rate of 3.5% of average relevant net assets as reflected in their opening and closing balance sheets for the financial year. The Trust has achieved this target in 2012-13.

External Financing Limit (see Note 40.3 to the financial statements)
The Trust was set an External Financing Limit of £1m for 2012-13. The Trust reports that it has achieved its External Financing Limit undershooting by £0.8m thereby increasing its cash at bank and in hand to £4.3m.

Capital Expenditure

The Trust has invested a total of £10.2m in capital expenditure in 2012-13 which includes £0.3m donated through the Charitable Funds. This expenditure included investment of £3.2m in IT infrastructure including systems to deliver digital dictation and voice recognition. Investment in the NGH estate has continued with capital expenditure of £3.5m in year including £0.4m of externally funded energy efficiency projects through the SALIX scheme.

The cost of replacing medical equipment amounted to £1.4m during the year with an additional £0.7m of additional funding being received from the Radiotherapy Innovation Fund to support upgrades to the existing Linear Accelerators. Further, the Trust invested £0.3m in endoscopic ultrasound capacity and has spent £0.2m to house a new pharmacy robot.

The Trust has been successful in attracting an additional £0.5m of Department of Health investment to refurbish the maternity unit and preliminary work started on this scheme during the year.

Charitable Funds

The Charitable Fund has continued to make significant contributions to the Trust during 2012-13, which has included £0.2m for staff and patient benefit and £0.3m for building projects and medical equipment.

Of specific note during the year has been the completion of the physiotherapy garden project and the refurbishment of the urology suite, which were both fully funded by charitable donations.

The Trust Board

Introduction

The Trust Board is led by the Chairman, Paul Farenden, and comprises both executive and non-executive directors. Its 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
- Deliver the Board's responsibility for ensuring compliance with Department of Health guidance, relevant statutory requirements and contractual obligations.

The current composition of the Board is:

- Chairman
- Five non-executive directors
- Five executive directors with voting rights
- Three executive directors with non-voting rights

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

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

Table of Attendance 2012-2013

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

	Board Meetings 9 Meetings		Audit Committee 5 Meetings		Healthcare Governance Committee 11 Meetings		Finance and Performance Committee 12 Meetings		Remuneration Committee 2 meetings		Nomination Committee 0 Meetings	
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	8	9	-	-	7	11	7	11	2	2	-	-
Chief Executive	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Dr Gerry McSorley	7	8	-	-	7	10	7	10	1	1	-	-
Christine Allen	1	1	-	-	1	1	1	1	1	1	-	-
Non-Executive Directors	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Neelam Aggarwal Singh	2	3	2	2	3	5	3	5	1	1	-	-
Colin Astbury	3	3	2	2	4	5	4	5	1	1	-	-
Barry Noble	3	3	-	-	2	5	2	5	1	1	-	-
David Noble	3	3	0	1	3	3	3	3	1	1	-	-
Graham Kershaw	9	9	4	5	11	11	11	11	2	2	-	-
Nicholas Robertson	8	9	5	5	9	11	9	11	2	2	-	-
Elizabeth Searle	3	3	-	-	2	3	2	3	1	1	-	-
Phil Zeidler	7	9	5	5	7	11	7	11	2	2	-	-
Executive Directors	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Christine Allen	8	8	-	-	10	10	10	10	-	-	-	-
Dr Sonia Swart	9	9	-	-	10	11	10	11	-	-	-	-
Suzie Loader	9	9	-	-	9	11	9	11	-	-	-	-
James Drury	1	3	0	3	0	5	0	5	-	-	-	-
Peter Hollinshead	6	6	2	2	6	6	6	6	-	-	-	-
Charles Abolins	8	9	-	-	11	11	11	11	-	-	-	-
Chris Pallot	8	9	-	-	11	11	11	11	-	-	-	-
Chanelle Wilkinson	1	1	-	-	0	2	0	2	-	-	-	-
Geraldine Opreshko	8	8	-	-	8	9	8	9	2	2	-	-

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.

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.

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

Nicholas Robertson, MA, FCA
Non-executive director
Nick left Royal Dutch Shell in 2009 after 32 years, in which he worked in many countries, mainly in finance roles but also in general management and HR. From 2000 he was Vice President, Group Risk Management and Insurance. He is now acting as a consultant; on risk management for industrial companies and on finance for smaller oil and gas companies. He is a trustee director of Mental Health Matters, a charity. Nick has a degree in engineering and economics and is a chartered accountant. Nick chairs the audit committee.

Elizabeth Searle
Non-executive director
After qualifying as a nurse and working in cancer and palliative care, Liz 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.

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

Christine Allen, PG Diploma in Management Studies
Acting Chief Executive
Christine was appointed Acting Chief Executive in March 2013. She previously held the post of Chief Operating Officer and Deputy Chief Executive, where she was responsible for the day to day management of the Trust. Christine has worked for the NHS for over 25 years, for both the Health Authority and acute Trust. As director of planning and performance she was instrumental in establishing the Trust's formal planning process, performance framework and effective contact management. Following the completion of a postgraduate DMS, Christine led several high profile improvement programmes, including the national booking programme implementation and the hospital improvement partnership.

Dr Sonia Swart, MA, MB, BCh, MD, FRCP, FRCPath
Medical Director and Deputy Chief Executive
Sonia is responsible for providing medical advice to the Board, medical manpower and training, clinical audit, research and development and developing clinical driven issues with both the consultant and junior medical staff. She also shares responsibility for clinical governance. Sonia qualified from the University of Cambridge and went on to train in general medicine and clinical haematology. She worked as a consultant haematologist in North Warwickshire before taking up her post at Northampton General Hospital in 1994. She has combined an active clinical role with a number of managerial activities including head of pathology, clinical director for diagnostics, and clinical lead for the foundation trust application before becoming medical director in September 2007. Sonia was appointed Deputy Chief Executive in March 2013.

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

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

Andrew Foster
Acting Director of Finance (from April 2013)
Andrew is a qualified accountant who has worked for 25 years in the NHS in a range of finance roles and joined NGH in 2006 as Deputy Director of Finance. Prior to this he held senior positions at the Strategic Health Authority and Birmingham Women's Hospital.

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) (from April 2013)
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. Janine 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. Her special interest is in developing staff commitment & engagement in ways which 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 came to work for the Trust in January 2010, initially on secondment from NHS Northamptonshire, before being appointed as the Trust's director of planning and performance in September 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 positions at Kettering General Hospital, the NHS Modernisation Agency and NHS Northamptonshire. In previous roles he has been responsible for operational management, service improvement and commissioning & contracting. As Director of Strategy and Partnerships, he has responsibility for contracting, market development, clinical coding and medical records, information management, and service improvement provision.

Remuneration Report

Salary and Pension Entitlements of Senior Managers

Salary

Name and Title	2012-13			20111-12		
	Salary (bands of £5000) £000	Other remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100
Paul Farenden - Chairman	20-25		2,000	0-5		0
Gerry McSorley (April 2012-Feb 2013)	175-180			150-155		
Sonia Swart – Medical Director (full year)/Acting Chief Executive/ Deputy Chief Executive (March 2013)	110-115	95-100		80-85	140-145	
Fiona Barnes - Acting Director of Nursing, Midwifery & Patient Services (1-15 April 2012)	5-10			80-85		
Suzie Loader - Director of Nursing, Midwifery & Patient Services (16 April 12 - March 13)	105-110			0		
James Drury - Director of Finance (April - July 2012)	35-40			110-115		
Peter Hollinshead - Interim Director of Finance (Oct 2012 – March 2013)	120-125			0		
Christine Allen - Deputy Chief Executive/Chief Operating Officer (April 2012 - Feb 2013) / Acting Chief Executive (March 2013)	125-130			0		
Charles Abolins, Director of Facilities & Capital Development	85-90			100-105		
Chris Pallot, Director of Strategy & Partnerships	90-95			85-90		
Chanelle Wilkinson - Director of Human Resources (April 2012 – 3 June 2012)	265-270			95-100		
Geraldine Opreshko - Interim Director of Workforce & Transformation (June 2012 - March 2013)	170-175			0		
Neelam Aggarwal-Singh - Non-Executive Director (April-Aug 2012)	0-5			5-10		0
Colin Astbury - Non-Executive Director (April - Dec 2012)	0-5		1,800	5-10		400
Barry Noble – Non-Executive Director (April-Aug 2012)	0-5		2,000	5-10		1,800
Nicholas Robertson - Non-Executive Director	5-10		500	5-10		500
Phil Zeidler – Non-Executive Director	5-10		200	5-10		200
Graham Kershaw – Non-Executive Director (Associate Non-Executive Director April-Dec 2012)	5-10		1,200	5-10		500
David Noble – Non-Executive Director (January 2013 onwards)	0-5			0		
Elizabeth Searle – Non-Executive Director (January 2013 onwards)	0-5			0		

Salary Notes

1. Paul Farenden 2011-12 salary represents March 2012 only
2. Gerry McSorley 2011-12 salary represents June 2011 – March 2012
3. Sonia Swart's 'Other Remuneration' includes clinical work
4. Fiona Barnes, James Drury and Chanelle Wilkinson 2011-12 salary represents a full year
5. Suzie Loader, Geraldine Opreshko and Peter Hollinshead 2012-13 salary only as appointed to the Trust Board during the financial year.
   No director salary paid in 2011-12
6. Peter Hollinshead had a service contract with NGH whilst Interim Director of Finance
7. Chanelle Wilkinson – Position ceased on 3rd June 2013. Salary includes redundancy payment made in line with terms set out in Agenda for Change
8. Geraldine Opreshko had a service contract with NGH whilst Interim Director of Workforce and Transformation – salary represents fees net of VAT charged to the Trust in 2012-13
9. Neelam Aggarwal-Singh, Colin Astbury and Barry Noble – 2011-12 salary represents a full year
10. The benefits paid to Non-Executives and the Chairman relate to travel and subsistence between home and office

Pension Benefits

Name and Title	Real increase/ decrease in pension at age 60 (bands of £2,500)	Real increase/ decrease in lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase/ decrease in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Gerry McSorley (April 2012-Feb 2013)	10-12.5	32.5-35	85-90	255-260	1,822	1,436	286	0
Sonia Swart – Medical Director (full year)/Acting Chief Executive/ Deputy Chief Executive (March 2013)	(12.5) -(10)	(12.5)-(10)	90-95	295-300	N/A	2,262	(2379)	0
Fiona Barnes - Acting Director of Nursing, Midwifery & Patient Services (1-15 April 2012)	(2.5)-0	(2.5)-0	25-30	75-80	416	475	(3)	0
Suzie Loader - Director of Nursing, Midwifery & Patient Services (16 April 12 - March 13)	2.5-5	12.5-15	30-35	100-105	598	486	83	0
James Drury - Director of Finance (April - July 2012)	0-2.5	0-2.5	5-10	25-30	130	109	5	0
Peter Hollinshead - Interim Director of Finance (Oct 2012 – March 2013)								
Christine Allen - Deputy Chief Executive/Chief Operating Officer (April 2012 - Feb 2013) / Acting Chief Executive (March 2013)	2.5-5	7.5-10	40-45	120-125	702	601	69	0
Charles Abolins, Director of Facilities & Capital Development	(2..5)-0	(5) –(2.5)	45-50	135-140	N/A	N/A	N/A	0
Chris Pallot, Director of Strategy & Partnerships	0-2.5	2.5.5	20-25	60-65	285	247	26	0
Chanelle Wilkinson - Director of Human Resources (April 2012 – 3 June 2012)	(2.5)-0	(5)-(2.5)	25-30	80-85	N/A	592	(208)	0
Geraldine Opreshko - Interim Director of Workforce & Transformation (June 2012 - March 2013)								

Pension Notes

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 pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV – This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

No CETV is shown for pensioners, members over 60 (1995 Section) or members over 65 (2008 Section).

Pay Multiples

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

The banded remuneration of the highest paid director in the Trust in the financial year 2012-13 was £205-£210k (2011-12, £225-£230k). This was 8.77 times (2011-12, 9.11 times) the median remuneration of the workforce, which was £24k (2011-12, £25k).

In 2012-13 and 2011-12 no employees received remuneration in excess of the highest-paid director.

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

Off-Payroll Engagements

The Trust is required to report on the number of individuals who are engaged off the Trust's payroll. These are individuals who are either self-employed or acting through a personal service company and are paid gross by the Trust as employer. The details are set out in the tables below.

Table 1 – For off-payroll engagements at a cost of over £58,200 per annum that were in place as at 31st January 2012

Number in place on 31st January 2012	**5**
Number who have since come onto the NGH payroll	0
Number who have since been renegotiated/re-engaged to include contractual clauses allowing NGH to seek assurance as to their tax obligations	0
Number that have not been successfully renegotiated and, therefore, continue without contractual clauses allowing NGH to seek assurance as to their tax obligations	4
Number that have come to an end	1
Total	**5**

The Trust has received assurance as to their tax obligations and terms will be included in any contract relating to subsequent use of their service to affirm this.

Table 2 – For all new off-payroll engagements between 23rd August and 31st March 2013, for more than £220 per day and more than six months

Number of new engagements	**1**
Number who have since come onto the NGH payroll	0
Number who have since been renegotiated/re-engaged to include contractual clauses allowing NGH to seek assurance as to their tax obligations	0
Number that have not been successfully renegotiated and, therefore, continue without contractual clauses allowing NGH to seek assurance as to their tax obligations	0
Number that have come to an end	0
Total	**1**

Annual Accounts

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

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

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

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

Signed
Christine Allen, Acting Chief Executive

Date 3 June 2013

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

3 June 2013 Date Christine Allen Acting Chief Executive

3 June 2013 Date Andrew Foster Acting Director of Finance

Annual Governance Statement 2012-13

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

2. The Governance Framework of Northampton General Hospital NHS Trust
Northampton General Hospital NHS Trust has a Board of Directors (the Board), which comprises both executive and non-executive directors. The Board's function is to:

- Ensure all stakeholders have an understanding of Northampton General Hospital NHS Trust's purpose
- Set the values for the Trust including its strategic direction
- Hold management to account for the success and safety of the Trust
- Shape the organisational culture that supports its vision and values and encourages openness, honesty and integrity

Through its strategic vision, values and aims, the Board is committed to delivering a strong, financially viable and sustainable organisation with quality of service at the heart of its business.

To discharge its duties effectively, the Board has a number of formally constituted board committees with delegated responsibilities as set out within the Trust's scheme of reservation and delegation.

The Trust's committee structure is based on a rationale that the committees' purpose is to receive assurance and hold the executive team to account. The key features of the committee structure include:

- All are chaired by a non-executive member of the Board
- All committees work closely with others to ensure that all governance issues relating to quality, finance, risk management and internal control are considered in a holistic and integrated way
- Streamlined and effective administration of the Board sub-committees with structured reports, forward planning, schemes of delegation and escalation processes
- All committees report regularly the findings, issues and assurances discussed at each of their meeting to the Board

Throughout the whole of 2012/13, the Board and its committees have met whilst quorate, with a minimum of 75% attendance by standing members.

The Board is actively participating in a structured programme of development, including a detailed appraisal of its performance and effectiveness. The conclusions from this exercise will inform the Board's development programme for 2013/14.

As Accountable Officer, I am aware that effective corporate governance is a fundamental cornerstone for the success of the Trust. The challenges placed on the Trust by the journey to become a foundation trust, the reform of healthcare, the Trust's public service purpose, the drive to improve quality and experience and the fact that NHS trusts are entrusted with public funds demand that their boards operate according to the highest corporate standards. To this end, the Board formally signed up to the Code of Conduct and Code of Accountability for NHS Boards.

3. Risk Assessment

As Chief Executive I have overall responsibility for risk management. Specific responsibilities are delegated to senior managers throughout the organisation. The Board oversees risks, establishes a risk appetite for high level risks on a risk by risk basis and encourages proactive identification and mitigation of risks.

The joint healthcare governance committee and audit committee approved risk management strategy clearly outlines the leadership, responsibility and accountability arrangements. The assessment and management of risk policy ensures that the Trust approaches the control of risk in a strategic and organised manner.

Leadership and co-ordination of risk management activities is provided by the Director of Nursing, Midwifery & Patient Services with support from all members of the executive team. Operational responsibility rests with all staff aligned to their individual roles. Risk management training is part of induction; training updates for existing staff are also provided.

Risk identification, prioritisation, mitigation or elimination occurs through assessment and grading using a nationally-recognised matrix of impact and likelihood. Incident reporting is a factor in the ongoing assessment of risk and results in the instigation of changes in practice. Complaints and other feedback from users and stakeholders are also used and reported to the Board. Risk management is incorporated in objective setting and appraisals.

The top risks identified through the risk management process having a significant impact on the Trust's ability to deliver its strategic goals are documented on the Board assurance framework. During 2012/13 a significant amount of work was undertaken to manage, rationalise and ensure consistency of risks identified through the risk management process.

The key strategic risks which have been identified through business planning processes and approved at the Board are:

- Due to underdeveloped governance systems and processes and workforce pressures, there is a risk that the Trust will fail to continue improvements in line with Care Quality Commission (CQC) standards, other regulatory bodies and to learn from incidents and complaints, ultimately failing to deliver its quality strategy, impacting on the safety and experience of patients.
- Risk of failure to investigate and instigate improvement plans for any area that has concerns regarding HSMR (hospital standardised mortality ratio).

- Risk of failure to follow up patients with serious eye disease.
- Risk of failure to adequately address recommendations of external reports.
- Failure of the estate infrastructure due to the age profile of the estate and limited capital funding for statutory maintenance, replacement infrastructure, patient environment improvements and infection control which would adversely impact on health and safety, patient experience and quality of care.
- The Trust's inability to effectively develop and implement its workforce plans due to the changing workforce profile. The Trust is unable to recruit to a safe establishment which will impact on the safety of care provided and reduce staff satisfaction. This has a knock on effect on education commissioning.
- Continue to have high use of bank and agency staff - high sickness absence and failure to recruit to establishment.
- Inability to develop revised business strategy due to Healthier Together local partnership work, external environment and commissioning intentions.
- Failure to deliver a successful foundation trust (FT) application leading to loss of strategic direction and organisational stability.
- Failure to develop strategic relationships with commissioners constrains our ability to redesign services to provide innovative patient pathway and a decline in reputation with local commissioners.
- Non elective activity levels exceeding plan leading to inability to safely manage urgent care patients and urgent care standards. This in turn increases pressure on the workforce due to insufficient physical and staffing resources available.
- Failure to meet contractual requirements or breach of targets leading to financial penalties.
- Inability to meet the Trust target of 100% mandatory training due to the demands and pressures on clinical and non-clinical areas and the inability to release staff.
- Risk of failing to retain talent/leaders as knowledge is invaluable to developing expertise to run a high performing organisation.
- Instability within the senior management team due to high turnover impacts on the continuity of leadership of the Trust. This could adversely affect staff satisfaction and morale, the ability to recruit and retain staff, the momentum of partnership working and the culture of the Trust.
- Current financial position and projections fail to deliver Monitor requirements for authorisation as a FT and the obligations set out in the Tripartite Formal Agreement (TFA) with the NHS Trust Development Authority (TDA) and Department of Health (DH). Requirement to deliver net surplus of 1% of turnover.
- Failure to generate cash balance of circa £10m to cover 15 days operating expenditure.
- Failure of transformation programme to deliver £16.1m of cost reduction in 2012/13 and £14.3m in 2013/14.
- Inability to find safe sustainable savings in the new commissioning environment through negotiating a fair and just financial envelope. If a fair financial envelope is not agreed, the Trust may not be able to maintain financial stability which will impact on service delivery, patient experience, liquidity and quality.

These risks continue to be managed through the risk management and assurance processes throughout 2013/14. Where appropriate, the Trust will discuss risks which threaten the achievement of its objectives with commissioners, our partners in healthcare and social services, the local authority, voluntary bodies and through involvement of public and patients' representatives in Trust business.

At the time of writing this statement, there were no serious incidents requiring investigation involving personal data were identified this year that are required to be reported to the Information Commissioner, as set out in guidance on serious untoward incidents involving data. The Medical Director is the Trust's Caldicott Guardian.

4. The Risk and Control Framework

The Board takes responsibility for oversight and assurance of risk management throughout the Trust and reviews the Board assurance framework at its meetings.

Delivery of the Trust's strategic aims forms the basis of risk assessment covered by the Board assurance framework. Key risks are linked to strategic aims with internal controls mitigations and assurances recorded and monitored for each risk. The control mechanisms in place minimise the risk of failure to deliver business objectives supported by robust corporate and performance management frameworks, service level agreements and contract monitoring, policies and procedures.

The Board delegates detailed oversight of the Board assurance framework to the audit committee. This committee assesses the effectiveness of risk management by: managing and monitoring the implementation of the risk management strategy; considering findings from internal and external audit reviews; calling executive directors to account for their risk portfolios and monitoring the Board assurance framework at each of its meetings. The audit committee regularly reviews progress in resolving all high and medium risk internal audit recommendations and any audit with limited assurance. The audit committee has highlighted HR as an area for further attention and the appointment of a new substantive HR director in this area will start to address the issues raised during the 2012-13 internal audit of this area.

An end of year review of the Board assurance framework by the Head of Internal Audit has established that an assurance framework, which was designed and has been operating to meet the requirements of the 2012-13 Annual Governance Statement, had not been fully in place during the year. However sufficiently robust and effective alternative and compensating processes were in place to provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

The Trust has a comprehensive an approved risk management strategy and a policy for assessment and management of risk which is available to all staff on the Trust's intranet site. The purpose of this strategy and policy is to ensure that the Trust manages risks in all areas using a systematic and consistent approach. The objectives of the risk management strategy are stated as follows:

- Ensure understanding at all levels of the organisation of the processes and responsibilities for incident reporting; risk assessment, identification and management;

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

The risk management strategy provides the framework for a robust risk management process throughout the Trust. The document describes the Trust's overall risk management process and the Trust's risk identification, evaluation and control system. Risk appetite is covered in the policy for assessment and management of risk. The Trust's major risks are identified in the Board assurance framework, annual report and Trust corporate risk register.

The Board is committed to a culture of continual learning and quality improvement from risk related issues, incidents, complaints, claims and significant events and these are key to maintaining the risk management culture of Northampton General Hospital NHS Trust.

The healthcare governance committee assures the Board of key areas of learning through the investigating, analysing and learning from incidents, complaints and claims policy. Learning is acquired from a variety of sources, including:

- Analysis of incidents, complaints and claims and acting on root cause analysis reports at directorate level and thematically at organisation level
- External reviews and inspections
- Health and safety issues
- Organisation patient safety incident reports from the National Reporting and Learning System (NRLS) (was NPSA)
- Assurance from internal and external audit reports and monitoring of action plans to address recommendations
- Clinical audit reports
- Directorate and executive team review of risks, risk assessments and action plans to mitigate
- Patient safety learning forum
- Presentations on areas of concern

The healthcare governance committee provides assurance to the Board in relation to meeting quality standards and the management of clinical risks.

Compliance with the Care Quality Commission (CQC) essential standards of quality and safety are a key component of the organisation's risk management process. The Trust is registered with the CQC without conditions. Internal audit completed a CQC Compliance Monitoring Processes review in February 2013 and gave good assurance.

The CQC made an unannounced visit to the main hospital site in July 2012. The resulting report from the CQC outlined two moderate concerns in outcomes 9 (medicine) and 12 (staffing) of the Essential Standards of Quality and Safety. The Trust has action plans in place for each of these, which are monitored through the clinical quality and effectiveness group and the healthcare governance committee.

The Board has been assured through the audit committee and Trust Board that effective arrangements are in place to manage and control risks to information and data. An information governance strategy is in place, progress is reported annually to the Trust Board by the Director of Strategy and Partnerships, the Trust senior information risk owner with overall responsibility for information governance. The Trust has an information governance programme board (IGPB) which is chaired by the Director of Strategy and Partnerships. The IGPB provides the Trust Board, through the audit committee, that effective information governance best practices are in place. Assurance has been gained through the annual information governance toolkit self-assessment, internal audits and the annual payment by results (PbR) assurance audit which is reported to the audit committee and Commissioners.

The audit committee received regular reports from the local counter fraud specialist which identified specific fraud risks and investigated whether there was evidence of those being exploited. No significant risks or classes of transactions or account balances had been identified. However, the committee was alerted to potential under-reporting of fraud and a counter-fraud plan was agreed with a substantial proactive component to promote an anti-fraud culture. Data security risks are managed and monitored within the overall risk management framework overseen by an information team to ensure security threats are followed up and appropriately managed.

Control measures are in place to manage the organisation's obligations under equality, diversity and human rights legislation are now in place.

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

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

- Engagement with the local Health Overview and Scrutiny Committee
- Engagement with the Local Involvement Network (LINk)
- The shadow council of governors is consulted on key issues and risks as part of the annual plan

- Annual members meeting
- Engagement with user groups and support groups

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

5. Review of effectiveness

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

The Head of Internal Audit has provided an opinion of satisfactory assurance that there was generally a sound system of internal control, which was designed to meet the organisation's objectives, and that controls were generally being applied consistently.

Director statements from executive directors and senior managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Board assurance framework, whilst still developing, provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed and addressed.

I have drawn on the content of the quality report within the annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

My review is also informed by:

- Work of the Trust's audit committee, finance and performance committee and healthcare governance committee
- CQC Registration requirements
- Patient and staff surveys
- Patient-led assessments of the care environment (PLACE) inspections
- Internal sources such as clinical audit, performance management reports, benchmarking and self-assessment reports
- Assessment of key findings of external enquiries
- Action plans to address findings of internal audits

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board supported by the audit committee, healthcare governance committee and finance and performance committee.

Processes are in place to maintain and review the effectiveness of the system of internal control by:

- the Board providing overall leadership for the management of risk against the achievement of organisational objectives;
- The Board's receipt of the Board assurance framework at its meetings
- The audit committee, healthcare governance committee and the finance and performance committee providing assurance on the effective operation of the risk management system;
- Each level of management being responsible for the risks in their areas, regularly reviewing them and the controls in place to mitigate them;
- The internal assurance process used to monitor compliance with the Care Quality Commission Essential Standards.

6. Significant Issues

In preparing the Annual Governance Statement for 2012-13 I have considered the following significant issues together with the actions the Board has taken for each as worthy of note.

Significant Issue Description:	Remedial Action Taken and Plans for Mitigation:
Urgent care standards: The Trust will not meet the urgent care standards 2012-13 due to significant increases in volume of both non- elective admission and attendances.	Urgent care programme in place led by senior clinicians. The programme board is Chaired by the CEO to ensure plans are delivered. A revised trajectory has been agreed. Additional capacity opened to manage demand will remain open and fully staffed until a reduction in activity levels in line with the Clinical Commissioning Group (CCG) demand management schemes is seen.
Recurrent financial position: The Trust has submitted a deficit plan to the TDA for 2013-14 of £4.8m. The deficit will require additional cashflow support in the form of DH borrowing. The total cost improvement (CIP) target included in the plan is £13m of which £4.5m are unidentified and pose a risk to delivery of the plan.	The Trust will meet with the TDA in early April to discuss a range of potential mitigations including: • Additional mitigating actions to be considered to close CIP gap. • Bid to CCG to attract investment of readmissions fines (not included in income plan) and support from the CCG 2% strategic reserve. • No account of winter pressures funding has been made in the plan. • Use of contingency reserves.
Meeting CQC recommendations: The CQC identified two moderate concerns following their inspection in July 2012. These related to: • Staffing shortages • Medicines Management	**Staffing shortages:** These were predominantly in nursing on the general wards and were due to a large number of vacancies. A very successful recruitment campaign was commenced and, as a result, the general wards will be up to full establishment (registered nurses and healthcare assistants) by the end of April 2013. In addition, the Board approved a nursing & midwifery staffing strategy (2013-2017) in March 2013. Part of this strategy related to an increase in establishment/ skill mix on some of the general wards and the development of a maternity pool to cover maternity leave. This year's financial plan includes £1.9m of investment to support this strategy.

Significant Issue Description:	Remedial Action Taken and Plans for Mitigation:
/continued	**Medicines management:** An action plan has been developed to enhance medicines management across the trust, specifically in relation to security of medicines and documentation of omissions of medicines. A task and finish group has been established to support improved documentation surrounding medicines omissions – this is audited on a monthly basis by the pharmacy department and improvements are being demonstrated.

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 control that supports the achievement of its goals, vision, values, policies, aims and objectives and that those control issues have been or are being addressed.

Signed…………………..……………………….

Christine Allen, Acting Chief Executive
Date: 19th April 2013

Independent Auditor's Report to the 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 2013 on pages 66 to 107. 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 the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

This report is made solely to the Board of Directors of Northampton General Hospital NHS Trust ('the Trust'), as a body, in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective Responsibilities of Directors and Auditor

As explained more fully in the Statement of Directors' Responsibilities set out on page 52, the Directors are responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the Audit of the Financial Statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Directors; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on Financial Statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Northampton General Hospital NHS Trust as at 31 March 2013 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on Other Matters Prescribed by the Code of Audit Practice 2010 for Local NHS Bodies

In our opinion:

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

Matters on Which We are Required to Report by Exception

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

- in our opinion, the Governance Statement does not reflect compliance with the Department of Health's requirements; or
- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of the audit.

We have made a referral to the Secretary of State under section 19 of the Audit Commission Act 1998 on the grounds that the Trust has breached its cumulative statutory breakeven duty.

Conclusion on the Trust's Arrangements for Securing Economy, Efficiency and Effectiveness in the Use of Resources

Trust's Responsibilities

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's Responsibilities

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

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

Scope of the Review of Arrangements for Securing Economy, Efficiency and Effectiveness in the Use of Resources

We have undertaken our work in accordance with the Code of Audit Practice 2010 for local NHS bodies, having regard to the guidance on the specified criteria, published by the Audit Commission in November 2012, as to whether the Trust has proper arrangements for:

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

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice 2010 for local NHS bodies in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2013.

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

Basis for Qualified Conclusion

- In considering the Trust's arrangements for securing financial resilience we identified that: As a result of slippage in its £16m Cost Improvement Programme (CIP) during 2012/13 the Trust changed its forecast outturn position from a £1m surplus to a potential deficit of £10m. The slippage in the CIP resulted in severe cash flow problems for the Trust which meant that the Trust had to obtain a £4m short-term loan from the Department of Health in order to meet its liabilities during Quarters 2 and 3. By the end 2012/13 the Trust had repaid this £4m loan and achieved a surplus of £0.4m. However, only £10.1m of the CIP had been delivered. The Trust has a forecast budget deficit of £4.8m in 2013/14 after a CIP target of £13m. The Trust does not yet have a financial recovery plan in place to:

    - demonstrate how the £4.8m budget deficit is going to be recovered;
    - ensure the successful delivery of the 2013/14 CIP; and
    - outline how the organisation is going to reduce reliance on one-off and non-recurring measures to achieve financial balance and stability

- In considering the Trust's arrangements for challenging how it secures economy, efficiency and effectiveness we identified that the slippage in the 2012/13 CIP programme was intended, in part, to meet increased levels of demand, particularly in relation to Accident and Emergency services. Despite the additional resources that became available through slippage in the CIP the Trust admitted or discharged 91.46% of patients within 4 hours of them presenting at Accident and Emergency against a National Indicator target of 95%.

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in November 2012, with the exception of the matters reported in the basis for qualified conclusion paragraph above, we are satisfied that in all significant respects Northampton General Hospital NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2013.

Certificate

We cannot issue an audit certificate until we have completed the work necessary to provide assurance over the Trust's annual quality accounts. Completion of our limited assurance work on the annual quality accounts is not expected to give rise to any issues which will have an impact on the statutory financial statements or on our use of resources conclusion.

John Cornett for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
1 Waterloo Way,
Leicester,
LE1 6LP

4 June 2013

Northampton General Hospital NHS Trust - Annual Accounts 2012-13

Statement of Comprehensive Income for year ended 31 March 2013

	NOTE	**2012-13** **£000**	2011-12 £000
Gross employee benefits	10.1	**(175,717)**	(165,950)
Other costs	8	**(92,047)**	(87,207)
Revenue from patient care activities	5	**236,321**	220,501
Other Operating revenue	6	**34,974**	34,980
Operating surplus/(deficit)		**3,531**	2,324
Investment revenue	12	**24**	29
Other gains and (losses)	13	**15**	12
Finance costs	14	**(78)**	(18)
Surplus/(deficit) for the financial year		**3,492**	2,347
Public dividend capital dividends payable		**(4,256)**	(4,264)
Net Gain/(loss) on transfers by absorption		**0**	0
Retained surplus/(deficit) for the year		**(764)**	(1,917)

Other Comprehensive Income	**2012-13** **£000**	2011-12 £000
Impairments and reversals	**(2,839)**	(2,152)
Net gain/(loss) on revaluation of property, plant & equipment	**1,962**	6,674
Net gain/(loss) on revaluation of intangibles	**0**	0
Net gain/(loss) on revaluation of financial assets	**0**	0
Movements in Other Reserves eg. Non NHS Pensions Scheme	**0**	92
Net gain/(loss) on available for sale financial assets	**0**	0
Net Gain / (loss) on Assets Held for Sale	**0**	0
Net actuarial gain/(loss) on pension schemes	**0**	0
Reclassification Adjustments		
On disposal of available for sale financial assets	**0**	0
Total comprehensive income for the year*	**(1,641)**	2,697

Financial performance for the year

	2012-13 **£000**	2011-12 £000
Retained surplus/(deficit) for the year	**(764)**	(1,917)
Prior period adjustment to correct errors	**0**	0
IFRIC 12 adjustment	**0**	0
Impairments	**899**	3,453
Adjustments in respect of donated asset elimination	**264**	(1,032)
Adjusted retained surplus/(deficit)	**399**	504

Impairments of buildings related to a £899k change in the economic value and is excluded from retained surplus and statutory breakeven in accordance with the DH Manual for Accounts, note 17 refers.

Donated asset net benefit of £264k (consisting of £564k donated depreciation and £300k donated additions) is excluded from retained surplus and statutory breakeven duty in accordance with the DH Manual for Accounts.

	2012-13 **£000**
PDC dividend: balance receivable/(payable) at 31 March 2013	**(36)**
PDC dividend: balance receivable/(payable) at 1 April 2012	**56**

Northampton General Hospital NHS Trust - Annual Accounts 2012-13

Statement of Financial Position as at 31 March 2013

	NOTE	31 March 2013 £000s	31 March 2012 £000s
Non-current assets:			
Property, plant and equipment	15	**130,749**	132,254
Intangible assets	16	**2,794**	2,564
Investment property	18	**0**	0
Other financial assets	23	**0**	0
Trade and other receivables	22.1	**246**	257
Total non-current assets		**133,789**	135,075
Current assets:			
Inventories	21	**4,934**	4,723
Trade and other receivables	22.1	**10,149**	10,954
Other financial assets	23	**0**	0
Other current assets	24	**0**	0
Cash and cash equivalents	25	**4,341**	3,944
Total current assets		**19,424**	19,621
Non-current assets held for sale	26	**0**	300
Total current assets		**19,424**	19,921
Total assets		**153,213**	154,996
Current liabilities			
Trade and other payables	27	**(14,071)**	(17,862)
Other liabilities	28	**(786)**	(629)
Provisions	34	**(3,501)**	(1,583)
Borrowings	29	**(285)**	(190)
Other financial liabilities	30	**0**	0
Working capital loan from Department		**0**	0
Capital loan from Department		**0**	0
Total current liabilities		**(18,643)**	(20,264)
Non-current assets plus/less net current assets/liabilities		**134,570**	134,732
Non-current liabilities			
Trade and other payables	27	**0**	0
Other Liabilities	28	**0**	0
Provisions	34	**(1,281)**	(330)
Borrowings	29	**(384)**	(336)
Other financial liabilities	30	**0**	0
Working capital loan from Department		**0**	0
Capital loan from Department		**0**	0
Total non-current liabilities		**(1,665)**	(666)
Total Assets Employed:		**132,905**	134,066
FINANCED BY:			
TAXPAYERS' EQUITY			
Public Dividend Capital		**100,115**	99,635
Retained earnings		**(306)**	(225)
Revaluation reserve		**32,487**	34,047
Other reserves		**609**	609
Total Taxpayers' Equity:		**132,905**	134,066

Notes 1 to 41 which commence on page 70 form part of these accounts

The financial statements on pages 66 to 69 were approved by the Board on 30 May 2013 and signed on its behalf by

Acting Chief Executive: **Date:**

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2013

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	**£000s**	**£000s**	**£000s**	**£000s**
Balance at 1 April 2012	**99,635**	**(225)** 0	**34,047** 00	**609**	**134,066**
Changes in taxpayers' equity for the year ended 31 March 2013					
Retained surplus/(deficit) for the year	0	(764)	0	0	**(764)**
Net gain / (loss) on revaluation of property, plant, equipment	0	0	1,962	0	**1,962**
Net gain / (loss) on revaluation of intangible assets	0	0	0	0	**0**
Net gain / (loss) on revaluation of financial assets	0	0	0	0	**0**
Net gain / (loss) on revaluation of assets held for sale	0	0	0	0	**0**
Impairments and reversals	0	0	(2,839)	0	**(2,839)**
Movements in other reserves	0	0	0	0	**0**
Transfers between reserves	0	683	(683)	0	**0**
Release of reserves to Statement of Comprehensive Income	0	0	0	0	**0**
Reclassification Adjustments					
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0	**0**
Transfers between Revaluation Reserve & Retained Earnings in respect of assets transferred under absorption	0	0	0	0	**0**
On Disposal of Available for Sale financial Assets	0	0	0	0	**0**
Reserves eliminated on dissolution	0	0	0	0	**0**
Originating capital for Trust established in year	0	0	0	0	**0**
New PDC Received	4,480	0	0	0	**4,480**
PDC Repaid In Year	(4,000)	0	0	0	**(4,000)**
PDC Written Off	0	0	0	0	**0**
Transferred to NHS Foundation Trust	0	0	0	0	**0**
Other Movements in PDC In Year	0	0	0	0	**0**
Net Actuarial Gain/(Loss) on Pension	0	0	0	0	**0**
Net recognised revenue/(expense) for the year	**480**	**(81)**	**(1,560)**	**0**	**(1,161)**
Balance at 31 March 2013	**100,115**	**(306)**	**32,487**	**609**	**132,905**

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
Balance at 1 April 2011	**99,635**	**1,239**	**29,978**	**517**	**131,369**
Changes in taxpayers' equity for the year ended 31 March 2012					
Retained surplus/(deficit) for the year	0	(1,917)	0	0	(1,917)
Net gain / (loss) on revaluation of property, plant, equipment	0	0	6,674	0	6,674
Net gain / (loss) on revaluation of intangible assets	0	0	0	0	0
Net gain / (loss) on revaluation of financial assets	0	0	0	0	0
Net gain / (loss) on revaluation of assets held for sale	0	0	0	0	0
Impairments and reversals	0	0	(2,152)	0	(2,152)
Movements in other reserves	0	0	0	92	92
Transfers between reserves	0	453	(453)	0	0
Release of reserves to Statement of Comprehensive Income	0	0	0	0	0
Reclassification Adjustments					
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0	0
On Disposal of Available for Sale financial Assets	0	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0	0
Originating capital for Trust established in year	0	0	0	0	0
New PDC Received	0	0	0	0	0
PDC Repaid In Year	0	0	0	0	0
PDC Written Off	0	0	0	0	0
Transferred to NHS Foundation Trust	0	0	0	0	0
Other Movements in PDC In Year	0	0	0	0	0
Net Actuarial Gain/(Loss) on Pension	0	0	0	0	0
Net recognised revenue/(expense) for the year	0	(1,464)	4,069	92	2,697
Balance at 31 March 2012	**99,635**	**(225)**	**34,047**	**609**	**134,066**

Northampton General Hospital NHS Trust - Annual Accounts 2012-13

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED
31 March 2013

	NOTE	**2012-13 £000s**	2011-12 £000s
Cash Flows from Operating Activities			
Operating Surplus/Deficit		**3,531**	2,324
Depreciation and Amortisation		**9,738**	10,065
Impairments and Reversals		**899**	3,453
Other Gains / (Losses) on foreign exchange		**0**	0
Donated Assets received credited to revenue but non-cash		**(300)**	(1,583)
Government Granted Assets received credited to revenue but non-cash		**0**	0
Interest Paid		**(1)**	0
Dividend (Paid) / Refunded		**(4,164)**	(4,303)
Release of PFI/deferred credit		**0**	0
(Increase)/Decrease in Inventories		**(211)**	(167)
(Increase)/Decrease in Trade and Other Receivables		**786**	(862)
(Increase)/Decrease in Other Current Assets		**0**	0
Increase/(Decrease) in Trade and Other Payables		**(2,826)**	(688)
(Increase)/Decrease in Other Current Liabilities		**157**	(719)
Provisions Utilised		**(1,239)**	(293)
Increase/(Decrease) in Provisions		**4,019**	1,498
Net Cash Inflow/(Outflow) from Operating Activities		**10,389**	8,725
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest Received		**24**	28
(Payments) for Property, Plant and Equipment		**(9,916)**	(7,834)
(Payments) for Intangible Assets		**(1,038)**	(892)
(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)		**315**	12
Proceeds of disposal of assets held for sale (Intangible)		**0**	0
Proceeds from Disposal of Investment with DH		**0**	0
Proceeds from Disposal of Other Financial Assets		**0**	0
Proceeds from the disposal of Financial Assets (LIFT)		**0**	0
Loans Made in Respect of LIFT		**0**	0
Loans Repaid in Respect of LIFT		**0**	0
Rental Revenue		**0**	0
Net Cash Inflow/(Outflow) from Investing Activities		**(10,615)**	(8,686)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING		**(226)**	39
CASH FLOWS FROM FINANCING ACTIVITIES			
Public Dividend Capital Received		**4,480**	0
Public Dividend Capital Repaid		**(4,000)**	0
Loans received from DH - New Capital Investment Loans		**0**	0
Loans received from DH - New Revenue Support Loans		**0**	0
Other Loans Received		**381**	203
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**0**	0
Loans repaid to DH -Revenue Support Loans		**0**	0
Other Loans Repaid		**(238)**	(165)
Cash transferred to NHS Foundation Trusts		**0**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**0**	0
Capital grants and other capital receipts		**0**	0
Net Cash Inflow/(Outflow) from Financing Activities		**623**	38
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**397**	77
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**3,944**	3,867
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		**4,341**	3,944

Northampton General Hospital NHS Trust - Annual Accounts 2012-13

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012-13 NHS Trusts Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.1.1 Basis of accounting – going concern

As described in the Directors' Report of the Annual Report, the current economic environment for all NHS Trusts remains challenging. Whilst the Trust has delivered a surplus of income and expenditure of £0.4m for the year ended 31 March 2013, the recurrent nature of the financial position has led the Board to agree a deficit plan of £4.8m for the 2013/14 financial year. In so doing, the Directors have considered the impact of incurring a deficit in terms of cash flow and have included a requirement for additional cash borrowing of £6m in the annual NHS Trust Development Agency (NTDA) plan submission.

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

● Agreement of the 2013/14 annual plan and key assumptions with the NHS Trust Development Authority.

● The Trust has signed service contracts with CCGs for 2013/14 which demonstrate the continuation of the provision of a service in the future. Importantly the Trust has agreement with its lead Clinical Commissioning Group to the reinvestment of fines and penalties (in accordance with prevailing Payment by Results guidance) that are not currently factored into the planned position for 2013/14.

● The Department of Health and NHS Trust Development Agency will confirm to the Trust arrangements for accessing cash financing for organisations that have submitted a deficit plan for 2013/14. The NTDA's Accountability Framework sets out the process where an NHS Trust will be assisted to develop and agreement of a formal recovery plan to address deficit positions.

● The NTDA have issued guidance to the NHS Trusts stating that the reporting of an actual or planned deficit should not; in themselves trigger difficulties in respect of the concept of going concern. The NTDA has put in place arrangements to ensure that organisations can demonstrate continuity of service through the contract agreement process with NHS England. Where organisations have reported a deficit, an escalation process is in place. Access to cash financing will also be available in certain circumstances, this will also, provide further assurance of the continuing nature of funding available to the organisation.

● Robust arrangements are in place for the delivery of cost improvement plans through a formal Transformation Programme established in the Trust.

● For the period ended 31st March 2013, the Trust has a cumulative surplus of £6.9m (2.45%) for the purposes of calculating the statutory NHS breakeven duty.

In preparing the annual plan for 2013/14 the Directors have considered a range of risks to the financial position, notably the identification of cost improvement plans and mitigation of slippage in CIP delivery. The Board remains reasonably confident that the plan will be delivered, enabling on-going operations to continue. After making enquiries, and considering the uncertainties described above, the Directors have a reasonable expectation that the Trust will have access to adequate resources to continue in operational existence for the foreseeable future.

NOTES TO THE ACCOUNTS

1.2 Acquisitions and discontinued operations

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

1.3 Transforming Community Services (TCS) transactions

Under the TCS initiative, services historically provided by PCTs have transferred to other providers - notably NHS Trusts and NHS Foundation Trusts. Such transfers fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCNE, and is disclosed separately from operating costs.

1.4 Critical accounting judgements and key sources of estimation uncertainty

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

1.4.1 Critical judgements in applying accounting policies

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

It's 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.

1.4.2 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.

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

1.5 Revenue

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

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

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

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

1.6 Employee Benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

1.7 Other expenses

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

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

● it is held for use in delivering services or for administrative purposes;

● it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;

● it is expected to be used for more than one financial year;

● the cost of the item can be measured reliably; and

● the item has cost of at least £5,000; or

● Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

● Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

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

Valuation

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

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

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

As of 1 April 2009 the Trust has adopted HM Treasury standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. To comply with IFRS requirements, that valuations should reflect fair value, land and building valuations have been reviewed to reflect current economic conditions.

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

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

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease 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.

1.9 Intangible assets

Recognition

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

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

● the technical feasibility of completing the intangible asset so that it will be available for use

● the intention to complete the intangible asset and use it

● the ability to sell or use the intangible asset

● how the intangible asset will generate probable future economic benefits or service potential

● the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it

● the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement

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

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

1.10 Depreciation, amortisation and impairments

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

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

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

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

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

1.11 Donated assets

Following the accounting policy change outlined in the Treasury FREM for 2011-12, a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.12 Government grants

Following the accounting policy change outlined in the Treasury FREM for 2011-12, a government grant reserve is no longer maintained. The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.13 Non-current assets held for sale

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

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

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

1.14 Leases

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

The Trust as lessee

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

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

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

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 Trust’s net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the trust’s net investment outstanding in respect of the leases.

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

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

1.15 Inventories

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

1.16 Cash and cash equivalents

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

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

1.17 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms (2.8% for employee early departure obligations).

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

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

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures 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.

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

1.18 Clinical negligence costs

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

1.19 Non-clinical risk pooling

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

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.

1.20 EU Emissions Trading Scheme

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

Carbon Reduction Commitment (CRC) Energy Efficiency Scheme

The CRC Scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is required to register with the CRC Scheme and with effect from 2011-12, to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year based on estimates from metered gas and electricity usage, (the current rate is £12 per tonne). The current liability at 31 March 2013 will therefore reflect the CO2 emissions that are made during 2012-13.

1.21 Contingencies

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

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

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

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

1.22 Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

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

Held to maturity investments

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

Available for sale financial assets

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

1.23 Financial liabilities

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

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

1.24 Value Added Tax

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

1.25 Foreign currencies

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

1.26 Third party assets

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

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

1.27 Public Dividend Capital (PDC) and PDC dividend

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

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and cash balances with the Government Banking Service. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. From 1 April 2009, the dividend payable is based on the actual average relevant net assets for the year instead of forecast amounts.

1.28 Losses and Special Payments

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

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

1.29 Subsidiaries

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust's or where the subsidiary's accounting date is before 1 January or after 30 June.

For 2011-12 and 2012-13 in accordance with the directed accounting policy from the Secretary of State, the Trust does not consolidate the NHS charitable funds for which it is the corporate trustee.

1.30 Joint operations

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

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

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2012-13. The application of the Standards as revised would not have a material impact on the accounts for 2012-13, were they applied in that year:

IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation

2. Pooled budgets

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

3. Operating segments

Northampton General Hospital NHS Trust considers all of its operations to be the provision of Healthcare operated as a single segment.

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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	**2012-13** **£000s**	2011-12 £000s
Income	**2,027**	1,817
Full cost	**965**	819
Surplus/(deficit)	**1,062**	998

5. Revenue from patient care activities	**2012-13** **£000s**	2011-12 £000s
Strategic Health Authorities	**107**	107
NHS Trusts	**0**	0
Primary Care Trusts - tariff	**157,086**	153,019
Primary Care Trusts - non-tariff	**75,999**	63,997
Primary Care Trusts - market forces factor	**0**	0
NHS Foundation Trusts	**255**	581
Local Authorities	**0**	0
Department of Health	**0**	0
NHS other	**0**	0
Non-NHS:		
Private patients	**1,334**	1,362
Overseas patients (non-reciprocal)	**192**	137
Injury costs recovery	**1,348**	1,298
Other	**0**	0
Total Revenue from patient care activities	**236,321**	220,501

6. Other operating revenue	**2012-13** **£000s**	2011-12 £000s
Recoveries in respect of employee benefits	**4,290**	3,516
Patient transport services	**0**	0
Education, training and research	**11,388**	10,985
Charitable and other contributions to revenue expenditure - NHS	**407**	265
Charitable and other contributions to revenue expenditure -non- NHS	**0**	0
Receipt of donations for capital acquisitions - NHS Charity	**300**	1,583
Receipt of Government grants for capital acquisitions	**0**	0
Non-patient care services to other bodies	**1,765**	3,218
Income generation	**2,027**	1,817
Rental revenue from finance leases	**19**	19
Rental revenue from operating leases	**26**	30
Other revenue	**14,752**	13,547
Total Other Operating Revenue	**34,974**	34,980
Total operating revenue	**271,295**	255,481

Other revenue includes :
Pharmacy Sales £6,423k (£6,163k)
Accommodation Charges £458k (£388k)
Provision of Services to private hospitals £320k (£324k)
Transformation Funding £3,000k (£3,871k)
Emergency Care Project £1,000k (£0k)
Radiotherapy Innovation Fund £714k (£0k)

7. Revenue	**2012-13** **£000**	2011-12 £000
From rendering of services	**264,214**	248,723
From sale of goods	**7,081**	6,758

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

8. Operating expenses (excluding employee benefits)	2012-13 £000s	2011-12 £000s
Services from other NHS trusts	**0**	0
Services from PCTs	**5**	132
Services from other NHS bodies	**0**	0
Services from foundation trusts	**1,071**	782
Purchase of healthcare from non NHS bodies	**1,206**	780
Trust Chair and Non-executive Directors	**49**	54
Supplies and services - clinical	**52,245**	47,645
Supplies and services - general	**3,167**	3,202
Consultancy services	**1,211**	2,604
Establishment	**2,910**	2,506
Transport	**175**	136
Premises	**9,160**	8,226
Impairments and Reversals of Receivables	**758**	250
Inventories write down	**168**	94
Depreciation	**8,907**	9,023
Amortisation	**831**	1,042
Impairments and reversals of property, plant and equipment	**899**	3,453
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
Impairments and reversals of investment properties	**0**	0
Audit fees	**84**	123
Other auditor's remuneration	**28**	1
Clinical negligence	**5,604**	5,020
Research and development (excluding staff costs)	**0**	0
Education and Training	**663**	662
Change in discount rate	**21**	2
Other	**2,885**	1,470
Total Operating expenses (excluding employee benefits)	**92,047**	87,207

Supplies & services clinical includes value of drugs including gases of £25,304k (£22,027k)

Other auditors remuneration includes :
KPMG £20k (£0k) - 12/13 consultancy in relation to implementation of Salary Sacrifice Schemes
Audit Commission £8k (£1k) - 11/12 fees and 12/13 National Fraud Initiative

Other expenditure includes :
Insurance £171k (£155k)
Legal Fees £455k (£345k)
Translation Services £76k (£96k)
Internal Audit Fees £135k (£141k)
Claims & Provisions £1,461k (£221k)

Employee benefits		
Employee benefits excluding Board members	**174,312**	164,932
Board members	**1,405**	1,018
Total employee benefits	**175,717**	165,950
Total operating expenses	**267,764**	253,157

9 Operating Leases

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

9.1 Trust as lessee

				2012-13	
	Land	**Buildings**	**Other**	**Total**	2011-12
	£000s	**£000s**	**£000s**	**£000s**	£000s
Payments recognised as an expense					
Minimum lease payments	0	0	558	**558**	546
Contingent rents	0	0	0	**0**	0
Sub-lease payments	0	0	0	**0**	0
Total	**0**	**0**	**558**	**558**	546
Payable:					
No later than one year	0	0	462	**462**	538
Between one and five years	0	0	1,029	**1,029**	1,120
After five years	0	0	0	**0**	107
Total	**0**	**0**	**1,491**	**1,491**	1,765

9.2 Trust as lessor

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

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

	2012-13	2011-12
	£000	£000s
Recognised as income		
Rental revenue	26	30
Contingent rents	0	0
Total	**26**	30
Receivable:		
No later than one year	26	33
Between one and five years	0	0
After five years	0	0
Total	**26**	33

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.

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10 Employee benefits and staff numbers

10.1 Employee benefits

	2012-13		
	Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	**149,393**	138,168	11,225
Social security costs	**10,502**	10,502	0
Employer Contributions to NHS BSA - Pensions Division	**15,010**	15,010	0
Other pension costs	**0**	0	0
Other post-employment benefits	**0**	0	0
Other employment benefits	**0**	0	0
Termination benefits	**916**	916	0
TOTAL - including capitalised costs	**175,821**	**164,596**	**11,225**
Less recoveries in respect of employee benefits (table below)	**(4,290)**	(4,290)	0
Total - Net Employee Benefits including capitalised costs	**171,531**	**160,306**	**11,225**
Recognised as			
Employee costs capitalised	**104**	104	0
Gross Employee Benefits excluding capitalised costs	**175,717**	**164,492**	**11,225**

Employee Benefits 2012-13 - income			
Salaries and wages	**3,584**	3,584	0
Social Security costs	**298**	298	0
Employer Contributions to NHS BSA - Pensions Division	**408**	408	0
Other pension costs	**0**	0	0
Other Post Employment Benefits	**0**	0	0
Other Employment Benefits	**0**	0	0
Termination Benefits	**0**	0	0
TOTAL excluding capitalised costs	**4,290**	**4,290**	**0**

	2011/12		
	Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	**139,603**	127,110	12,493
Social security costs	**11,014**	10,599	415
Employer Contributions to NHS BSA - Pensions Division	**14,664**	14,627	37
Other pension costs	**0**	0	0
Other post-employment benefits	**0**	0	0
Other employment benefits	**0**	0	0
Termination benefits	**866**	866	0
TOTAL - including capitalised costs	**166,147**	**153,202**	**12,945**
Less recoveries in respect of employee benefits	**(3,516)**	(3,516)	0
Total - Net Employee Benefits including capitalised costs	**162,631**	**149,686**	**12,945**
Recognised as			
Employee costs capitalised	**197**	**197**	**0**
Gross Employee Benefits excluding capitalised costs	**165,950**	**153,005**	**12,945**

10.2 Staff Numbers

	2012-13			2011-12
	Total Number	Permanently employed Number	Other Number	Total Number
Average Staff Numbers				
Medical and dental	**484**	461	23	469
Ambulance staff	**0**	0	0	0
Administration and estates	**639**	608	31	616
Healthcare assistants and other support staff	**1,316**	1,231	85	1,320
Nursing, midwifery and health visiting staff	**1,305**	1,255	50	1,293
Nursing, midwifery and health visiting learners	**0**	0	0	0
Scientific, therapeutic and technical staff	**448**	437	11	432
Social Care Staff	**0**	0	0	0
Other	**8**	8	0	9
TOTAL	**4,200**	**4,000**	**200**	4,139
Included above - staff engaged on capital projects	**2**	2	0	8

10.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	39,370	34,305
Total Staff Years	3,845	3,790
Average working Days Lost	10.24	9.05

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	**4**	4
	£000s	£000s
Total additional pensions liabilities accrued in the year	**155**	74

10.4 Exit Packages agreed in 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Less than £10,000	1	14	15	0	0	0
£10,001-£25,000	0	16	16	2	0	2
£25,001-£50,000	0	3	3	2	0	2
£50,001-£100,000	3	0	3	3	0	3
£100,001 - £150,000	0	0	0	3	0	3
£150,001 - £200,000	1	0	1	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost	**5**	**33**	**38**	10	0	10
Total resource cost (£000s)	**435**	**480**	**915**	790	0	790

This note provides an analysis of Exit Packages agreed during the year. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill health retirement costs are met by the NHS pensions scheme and are not included in the table.

The Trust offered a voluntary severance scheme (VSS) in 2012/13. Total costs of the VSS amounted to £480k.

10.5 Pension costs

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

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

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013, is based on the valuation data as 31 March 2012, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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 scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

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

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

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

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

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

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

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

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

11 Better Payment Practice Code

11.1 Measure of compliance

	2012-13 Number	**2012-13 £000s**	2011-12 Number	2011-12 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**77,253**	**86,299**	60,734	76,473
Total Non-NHS Trade Invoices Paid Within Target	**66,146**	**56,341**	54,424	46,529
Percentage of NHS Trade Invoices Paid Within Target	**85.62%**	**65.29%**	89.61%	60.84%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,137**	**17,700**	2,322	**15,854**
Total NHS Trade Invoices Paid Within Target	**1,245**	**3,353**	1,583	**2,016**
Percentage of NHS Trade Invoices Paid Within Target	**58.26%**	**18.94%**	68.17%	12.72%

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

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

	2012-13 £000s	2011-12 £000s
Amounts included in finance costs from claims made under this legislation	**1**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**1**	0

12 Investment Income

	2012-13 £000s	2011-12 £000s
Rental Income		
PFI finance lease revenue (planned)	**0**	0
PFI finance lease revenue (contingent)	**0**	0
Other finance lease revenue	**0**	0
Subtotal	**0**	0
Interest Income		
LIFT: equity dividends receivable	**0**	0
LIFT: loan interest receivable	**0**	0
Bank interest	**24**	29
Other loans and receivables	**0**	0
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Subtotal	**24**	29
Total investment income	**24**	29

13 Other Gains and Losses

	2012-13 £000s	2011-12 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**15**	12
Gain/(Loss) on disposal of assets other than by sale (intangibles)	**0**	0
Gain/(Loss) on disposal of Financial Assets other then held for sale	**0**	0
Gain (Loss) on disposal of assets held for sale	**0**	0
Gain/(loss) on foreign exchange	**0**	0
Change in fair value of financial assets carried at fair value through the SoCI	**0**	0
Change in fair value of financial liabilities carried at fair value through the SoCI	**0**	0
Change in fair value of investment property	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	0
Total	**15**	12

14 Finance Costs

	2012-13 £000s	2011-12 £000s
Interest		
Interest on loans and overdrafts	**0**	0
Interest on obligations under finance leases	**0**	0
Interest on obligations under PFI contracts:		
- main finance cost	**0**	0
- contingent finance cost	**0**	0
Interest on obligations under LIFT contracts:		
- main finance cost	**0**	0
- contingent finance cost	**0**	0
Interest on late payment of commercial debt	**1**	0
Other interest expense	**0**	0
Total interest expense	**1**	0
Other finance costs	**9**	2
Provisions - unwinding of discount	**68**	16
Total	**78**	18

15.1 Property, plant and equipment

2012-13	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 2012	**20,100**	**94,365**	**556**	**525**	**35,766**	**83**	**11,992**	**716**	**164,103**
Additions of Assets Under Construction	**0**	**0**	**0**	**663**	**0**	**0**	**0**	**0**	**663**
Additions Purchased	0	4,303	3	**0**	2,283	0	1,649	0	**8,238**
Additions Donated	0	31	0	83	174	0	0	12	**300**
Additions Government Granted	0	0	0	0	0	0	0	0	**0**
Additions Leased	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	543	0	(725)	0	0	159	0	**(23)**
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(1,194)	0	(73)	(219)	**(1,486)**
Upward revaluation/positive indexation	0	1,526	15	0	1,188	4	0	0	**2,733**
Impairments/negative indexation	0	(2,818)	(21)	0	0	0	0	0	**(2,839)**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Transfers to NHS Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies	0	0	0	0	0	0	0	0	**0**
At 31 March 2013	**20,100**	**97,950**	**553**	**546**	**38,217**	**87**	**13,727**	**509**	**171,689**
Depreciation									
At 1 April 2012	**0**	**0**	**0**	**0**	**23,390**	**45**	**7,827**	**587**	**31,849**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(1,194)	0	(73)	(219)	**(1,486)**
Upward revaluation/positive indexation	0	0	0	0	769	2	0	0	**771**
Impairments	0	892	7	0	0	0	0	0	**899**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	3,816	33	0	3,488	9	1,532	29	**8,907**
Transfers to NHS Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies	0	0	0	0	0	0	0	0	**0**
At 31 March 2013	**0**	**4,708**	**40**	**0**	**26,453**	**56**	**9,286**	**397**	**40,940**
Net Book Value at 31 March 2013	**20,100**	**93,242**	**513**	**546**	**11,764**	**31**	**4,441**	**112**	**130,749**
Purchased	20,100	86,477	513	546	11,062	16	4,419	15	**123,148**
Donated	0	6,765	0	0	702	15	22	97	**7,601**
Government Granted	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2013	**20,100**	**93,242**	**513**	**546**	**11,764**	**31**	**4,441**	**112**	**130,749**
Asset financing:									
Owned	20,100	93,242	513	546	11,764	31	4,441	112	**130,749**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2013	**20,100**	**93,242**	**513**	**546**	**11,764**	**31**	**4,441**	**112**	**130,749**

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 2012	11,241	21,315	0	0	1,290	1	0	3	**33,850**
Movements (specify)	0	(1,298)	0	0	(65)	0	0	0	**(1,363)**
At 31 March 2013	**11,241**	**20,017**	**0**	**0**	**1,225**	**1**	**0**	**3**	**32,487**

Additions to Assets Under Construction in 2012-13

	£000's
Land	0
Buildings excl Dwellings	254
Dwellings	0
Plant & Machinery	409
Balance as at YTD	**663**

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15.2 Property, plant and equipment prior-year

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:									
At 1 April 2011	21,924	103,186	689	2,989	33,560	78	9,925	988	173,339
Additions - purchased	0	3,801	0	1,680	1,746	0	968	0	8,195
Additions - donated	0	22	0	1,321	124	0	8	108	1,583
Additions - government granted	0	0	0	0	0	0	0	0	0
Reclassifications	0	3,782	0	(5,465)	218	0	1,190	0	(275)
Reclassifications as Held for Sale and reversals	0	(300)	0	0	0	0	0	0	(300)
Disposals other than by sale	0	0	0	0	(1,641)	0	(99)	(380)	(2,120)
Revaluation & indexation gains	0	5,998	0	0	1,759	5	0	0	7,762
Impairments	(1,824)	(310)	(18)	0	0	0	0	0	(2,152)
Reversals of impairments	0	0	0	0	0	0	0	0	0
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	0
Transfer to NHS Foundation Trust	0	0	0	0	0	0	0	0	0
Cumulative dep netted off cost following revaluation	0	(21,814)	(115)	0	0	0	0	0	(21,929)
At 31 March 2012	20,100	94,365	556	525	35,766	83	11,992	716	164,103
Depreciation									
At 1 April 2011	0	14,441	75	0	20,335	32	6,543	908	42,334
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	0	(1,641)	0	(99)	(380)	(2,120)
Upward revaluation/positive indexation	0	0	0	0	1,086	2	0	0	1,088
Impairments	0	5,162	0	0	0	0	0	0	5,162
Reversal of Impairments	0	(1,709)	0	0	0	0	0	0	(1,709)
Charged During the Year	0	3,920	40	0	3,610	11	1,383	59	9,023
Transfers to NHS Bodies	0	0	0	0	0	0	0	0	0
Transfer to NHS Foundation Trust	0	0	0	0	0	0	0	0	0
Cumulative dep netted off cost following revaluation	0	(21,814)	(115)	0	0	0	0	0	(21,929)
At 31 March 2012	0	0	0	0	23,390	45	7,827	587	31,849
Net book value at 31 March 2012	20,100	94,365	556	525	12,376	38	4,165	129	132,254
Purchased	20,100	87,283	556	525	11,609	18	4,135	21	124,247
Donated	0	7,082	0	0	767	20	30	108	8,007
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2012	20,100	94,365	556	525	12,376	38	4,165	129	132,254
Asset financing:									
Owned	20,100	94,365	556	525	12,376	38	4,165	129	132,254
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2012	20,100	94,365	556	525	12,376	38	4,165	129	132,254

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	**Total**
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	**£000's**
At 1 April 2011 restated	13,065	15,940	99	1,068	0	0	3	**30,175**
Movements (specify)	(1,824)	5,572	(99)	222	1	0	0	**3,872**
At 31 March 2012	11,241	21,512	0	1,290	1	0	3	**34,047**

15.3. Property, plant and equipment

Donated equipment to the value of £174k & other minor building work to the value of £126k were funded by NGH Charitable Fund.

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

A site revaluation exercise was undertaken in the 2011-12 financial year with an effective date of 1 April 2012 for land and buildings and this valuation, the next revaluation exercise is due in April 2015.

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 £24,398k.

16.1 Intangible non-current assets

2012-13	Software internally generated	Software purchased	Licences & trademarks	Patents	Development expenditure	Total
	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	**395**	**6,274**	**0**	**0**	**0**	**6,669**
Additions - purchased	0	1,038	0	0	0	**1,038**
Additions - internally generated	0	0	0	0	0	**0**
Additions - donated	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	**0**
Additions - leased	0	0	0	0	0	**0**
Reclassifications	0	23	0	0	0	**23**
Reclassified as Held for Sale and Reversals	0	0	0	0	0	**0**
Disposals other than by sale	0	(45)	0	0	0	**(45)**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments charged to reserves	0	0	0	0	0	**0**
Reversal of impairments charged to reserves	0	0	0	0	0	**0**
Transfer to NHS Foundation Trust	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies	0	0	0	0	0	**0**
At 31 March 2013	**395**	**7,290**	**0**	**0**	**0**	**7,685**
Amortisation						
At 1 April 2012	**124**	**3,981**	**0**	**0**	**0**	**4,105**
Reclassifications	0	0	0	0	0	**0**
Reclassified as Held for Sale and Reversals	0	0	0	0	0	**0**
Disposals other than by sale	0	(45)	0	0	0	**(45)**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	0	831	0	0	0	**831**
Transfer to NHS Foundation Trust	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies	0	0	0	0	0	**0**
At 31 March 2013	**124**	**4,767**	**0**	**0**	**0**	**4,891**
Net Book Value at 31 March 2013	**271**	**2,523**	**0**	**0**	**0**	**2,794**
Net book value at 31 March 2013 comprises:						
Purchased	271	2,523	0	0	0	**2,794**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2013	**271**	**2,523**	**0**	**0**	**0**	**2,794**

Revaluation reserve balance for intangible non-current assets

	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	0	0	0	0	0	**0**
Movements (specify)	0	0	0	0	0	**0**
At 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**

16.2 Intangible non-current assets prior year

2011-12	Software internally generated	Software purchased	Licences & trademarks	Patents	Development expenditure	Total
	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:						
At 1 April 2011	342	5,160	0	0	0	5,502
Additions - purchased	0	839	0	0	0	839
Additions - internally generated	53	0	0	0	0	53
Additions - donated	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0
Reclassifications	0	275	0	0	0	275
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation & indexation gains	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Transfer to NHS Foundation Trust	0	0	0	0	0	0
Less cumulative depreciation written down on revaluation	0	0	0	0	0	0
At 31 March 2012	395	6,274	0	0	0	6,669
Amortisation						
At 1 April 2011	53	3,010	0	0	0	3,063
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation or indexation gains	0	0	0	0	0	0
Impairments charged to operating expenses	0	0	0	0	0	0
Reversal of impairments charged to operating expenses	0	0	0	0	0	0
Charged during the year	71	971	0	0	0	1,042
Transfer to NHS Foundation Trust	0	0	0	0	0	0
Less cumulative depreciation written down on revaluation	0	0	0	0	0	
At 31 March 2012	124	3,981	0	0	0	4,105
Net book value at 31 March 2012	271	2,293	0	0	0	2,564
Net book value at 31 March 2012 comprises:						
Purchased	271	2,293	0	0	0	2,564
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Total at 31 March 2012	271	2,293	0	0	0	2,564

16.3 Intangible non-current assets

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

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

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

Intangible Assets are depreciated on current cost evenly over the estimated life of the asset, which is determined on a case by case basis between 2 and 5 years.

17 Analysis of impairments and reversals recognised in 2012-13

	2012-13 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	899
Total charged to Annually Managed Expenditure	**899**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve	
Loss or damage resulting from normal operations	0
Over Specification of Assets	0
Abandonment of assets in the course of construction	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	2,839
Total impairments for PPE charged to reserves	**2,839**
Total Impairments of Property, Plant and Equipment	**3,738**
Intangible assets impairments and reversals charged to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	**0**
Intangible Assets impairments and reversals charged to the Revaluation Reserve	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total impairments for Intangible Assets charged to Reserves	**0**
Total Impairments of Intangibles	**0**

Financial Assets charged to SoCI	
Loss or damage resulting from normal operations	0
Total charged to Departmental Expenditure Limit	**0**
Loss as a result of catastrophe	0
Other	0
Total charged to Annually Managed Expenditure	**0**

17 Analysis of impairments and reversals recognised in 2012-13 (cont'd)

	2012-13 Total £000s
Financial Assets impairments and reversals charged to the Revaluation Reserve	
Loss or damage resulting from normal operations	0
Loss as a result of catastrophe	0
Other	0
TOTAL impairments for Financial Assets charged to reserves	**0**
Total Impairments of Financial Assets	**0**
Non-current assets held for sale - impairments and reversals charged to SoCI.	
Loss or damage resulting from normal operations	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	**0**
Total impairments of non-current assets held for sale	**0**
Inventories - impairments and reversals charged to SoCI.	
Loss or damage resulting from normal operations	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 Inventories	**0**
Investment Property impairments charged to SoCI	
Loss or damage resulting from normal operations	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 Investment Property impairments charged to SoCI	**0**
Investment Property impairments and reversals charged to the revaluation reserve	
Loss or damage resulting from normal operations	0
Over Specification of Assets	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total impairments for Investment Property charged to reserves	**0**
Total Impairments of Investment Property	**0**
Total Impairments charged to Revaluation Reserve	**2,839**
Total Impairments charged to SoCI - DEL	**0**
Total Impairments charged to SoCI - AME	**899**
Overall Total Impairments	**3,738**
Of which:	
Impairment on revaluation to "modern equivalent asset" basis	0
Donated and Gov Granted Assets, included above	
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	351
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0

18 Investment property

	31 March 2013	31 March 2012
	£000s	£000s
At fair value		
Balance at 1 April 2012	**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
Gain from Fair Value Adjustments - Reversal of Impairments	**0**	0
Gain from Fair Value Adjustments	**0**	0
Transfer to other NHS Foundation Trust	**0**	0
Transfers (to) / from Other Public Sector Bodies	**0**	0
Other Changes	**0**	0
Balance at 31 March 2013	**0**	0
Investment property transactions in 2012-13		
Capital expenditure	**0**	0
Capital income	**0**	0
	0	0

19 Commitments

19.1 Capital commitments

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

	31 March 2013	31 March 2012
	£000s	£000s
Property, plant and equipment	**1,189**	668
Intangible assets	**282**	5
Total	**1,471**	673

19.2 Other financial commitments

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

	31 March 2013	31 March 2012
	£000s	£000s
Not later than one year	**0**	0
Later than one year and not later than five year	**0**	0
Later than five years	**0**	0
Total	**0**	**0**

20 Intra-Government and other balances

	Current receivables	**Non-current receivables**	**Current payables**	**Non-current payables**
	£000s	**£000s**	**£000s**	**£000s**
Balances with other Central Government Bodies	4,234	0	3,011	0
Balances with Local Authorities	1	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	164	0
Balances with NHS Trusts and Foundation Trusts	795	0	400	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	5,119	246	10,496	0
At 31 March 2013	**10,149**	**246**	**14,071**	**0**
prior period:				
Balances with other Central Government Bodies	4,615	0	5,663	0
Balances with Local Authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	1,351	0	707	0
Balances with Public Corporations and Trading Funds	0	0	35	0
Balances with bodies external to government	4,988	257	11,457	0
At 31 March 2012	**10,954**	**257**	**17,862**	**0**

21 Inventories

	Drugs £000s	Consumables £000s	Energy £000s	Work in progress £000s	Total £000s
Balance at 1 April 2012	1,876	2,775	72	0	**4,723**
Additions	25,434	22,581	0	0	**48,015**
Inventories recognised as an expense in the period	(25,090)	(22,546)	0	0	**(47,636)**
Write-down of inventories (including losses)	(168)	0	0	0	**(168)**
Reversal of write-down previously taken to SoCI	0	0	0	0	**0**
Transfers (to) Foundation Trusts	0	0	0	0	**0**
Transfers (to) / from other Public Sector Bodies	0	0	0	0	**0**
Balance at 31 March 2013	2,052	2,810	72	0	**4,934**

22.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000s	31 March 2012 £000s	**31 March 2013 £000s**	31 March 2012 £000s
NHS receivables - revenue	**4,103**	5,730	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**0**	0	**0**	0
Non-NHS receivables - revenue	**2,295**	985	**0**	0
Non-NHS receivables - capital	**0**	30	**0**	0
Non-NHS prepayments and accrued income	**1,388**	1,458	**0**	0
Provision for the impairment of receivables	**(958)**	(432)	**0**	0
VAT	**196**	236	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**0**	2	**0**	0
Finance lease receivables	**0**	0	**246**	257
Operating lease receivables	**0**	0	**0**	0
Other receivables	**3,125**	2,945	**0**	0
Total	**10,149**	10,954	**246**	257
Total current and non current	**10,395**	11,211		
Included in NHS receivables are prepaid pension contributions:	**0**	0		

NHS receivables - revenue
- Estimated value of partially completed spells £1,031k (£1,002k)

Other receivables include:
- Injury Cost Recovery claims (ICR) £2,514k (£2,554k)
- Salary overpayments/other recoverable pay £433k (£310k)

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

22.2 Receivables past their due date but not impaired

	31 March 2013 £000s	31 March 2012 £000s
By up to three months	**365**	19
By three to six months	**192**	0
By more than six months	**0**	82
Total	**557**	101

22.3 Provision for impairment of receivables

	2012-13 £000s	2011-12 £000s
Balance at 1 April 2012	**(432)**	(420)
Amount written off during the year	**232**	238
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**(758)**	(250)
Transfer to NHS Foundation Trust	**0**	
Balance at 31 March 2013	**(958)**	**(432)**

The Trust provides for non recovery of receivables as follows:
All Non-NHS Trade receivables over 3 months old from date of invoice unless known reason for payment delay.
12.6% of recognised Injury Cost Recovery claims are provided for as per DH guidance.
All salary overpayments that occurred prior to 31 March 2012, for which no recovery plan is in place, are provided for in full.

23 Other Financial Assets - Current

	31 March 2013 £000s	31 March 2012 £000s
Opening balance 1 April	0	0
Transfers (to)/from Other Public Sector Bodies in year	0	0
Other Movements	0	0
Closing balance 31 March	**0**	0

24 Other current assets

	31 March 2013 £000s	31 March 2012 £000s
EU Emissions Trading Scheme Allowance	**0**	0
Other Assets	**0**	0
Total	**0**	0

25 Cash and Cash Equivalents

	31 March 2013 £000s	31 March 2012 £000s
Opening balance	**3,944**	3,867
Net change in year	**397**	77
Closing balance	**4,341**	3,944
Made up of		
Cash with Government Banking Service	**4,253**	3,808
Commercial banks	**80**	128
Cash in hand	**8**	8
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**4,341**	3,944
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**4,341**	3,944
Patients' money held by the Trust, not included above	**3**	3

26 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2012	0	300	0	0	0	0	0	0	0	**300**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	0	(300)	0	0	0	0	0	0	0	**(300)**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	**0**
Transfers to Foundation Trust	0	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from other public sector bodies	0	0	0	0	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Balance at 1 April 2011	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	300	0	0	0	0	0	0	0	**300**
Less assets sold in the year	0	0	0	0	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2012	**0**	**300**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**300**
Liabilities associated with assets held for sale at 31 March 2012	0	0	0	0	0	0	0	0	0	0

The above relates to the sale of Sunnyside, which was a free standing property located on a corner of the hospital site, which has ceased to be used since the transfer of the CAMH service to Northamptonshire Healthcare NHS Foundation Trust. The property was sold for £300k on 13th December 2012 to an unrelated third party.

27 Trade and other payables

	Current		Non-current	
	31 March 2013 £000s	31 March 2012 £000s	**31 March 2013 £000s**	31 March 2012 £000s
Interest payable	**0**	0	**0**	0
NHS payables - revenue	**628**	1,158	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**0**	0	**0**	0
Non-NHS payables - revenue	**1,256**	4,170	**0**	0
Non-NHS payables - capital	**1,744**	2,759	**0**	0
Non-NHS accruals and deferred income	**6,132**	4,018	**0**	0
Social security costs	**1,769**	3,423	**0**	0
VAT	**0**	0	**0**	0
Tax	**0**	0	**0**	0
Payments received on account	**0**	0	**0**	0
Other	**2,542**	2,334	**0**	0
Total	**14,071**	17,862	**0**	0
Total payables (current and non-current)	**14,071**	**17,862**		
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	2,011	1,826		

28 Other liabilities

	Current		Non-current	
	31 March 2013 £000s	31 March 2012 £000s	**31 March 2013 £000s**	31 March 2012 £000s
PFI/LIFT deferred credit	**0**	0	**0**	0
Lease incentives	**0**	0	**0**	0
Other - Employee Benefits	**786**	629	**0**	0
Total	**786**	629	**0**	0
Total other liabilities (current and non-current)	**786**	**629**		

29 Borrowings

	Current		Non-current	
	31 March 2013 £000s	31 March 2012 £000s	**31 March 2013 £000s**	31 March 2012 £000s
Bank overdraft - Government Banking Service	**0**	0	**0**	0
Bank overdraft - commercial banks	**0**	0	**0**	0
Loans from Department of Health	**0**	0	**0**	0
Loans from other entities	**285**	190	**384**	336
PFI liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0	**0**	0
Other (describe)	**0**	0	**0**	0
Total	**285**	**190**	**384**	**336**
Total other liabilities (current and non-current)	**669**	**526**		

Loans - repayment of principal falling due in:

	31 March 2013		
	DH £000s	**Other £000s**	**Total £000s**
0-1 years	0	285	**285**
1 - 2 Years	0	216	**216**
2 - 5 Years	0	168	**168**
Over 5 Years	0	0	**0**
TOTAL	**0**	**669**	**669**

The Trust has taken advantage of participating in the Energy Efficiency Loan Scheme operated by Salix Finance Ltd.
The loan is subject to zero interest and is repayable over 4 years in equal instalments.

30 Other financial liabilities

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000s	£000s	**£000s**	£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 liabilities (current and non-current)	**0**	**0**		

31 Deferred income

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000s	£000s	**£000s**	£000s
Opening balance at 1 April 2012	45	160	0	0
Deferred income addition	33	44	0	0
Transfer of deferred income	(27)	(159)	**0**	0
Current deferred Income at 31 March 2013	**51**	45	**0**	0
Total deferred income (current and non-current)	**51**	**45**		

32 Finance lease obligations as lessee

The Trust has no finance lease obligations as a lessee.

33 Finance lease receivables as lessor

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

Amounts receivable under finance leases (buildings)	**Gross investments in leases**		**Present value of minimum lease payments**	
Of minimum lease payments	**31 March 2013**	31 March 2012	**31 March 2013**	31 March 2012
	£000s	£000s	**£000s**	£000s
Within one year	**10**	10	**10**	10
Between one and five years	**40**	40	**40**	40
After five years	**196**	207	**196**	207
Less future finance charges	0	0		
Present value of minimum lease payments	**246**	257	**246**	257
Less allowance for uncollectible lease payments:	0	0	0	0
Total finance lease receivable recognised in the statement of financial position	**246**	**257**	246	**257**
Included in:				
Current finance lease receivables			**0**	0
Non-current finance lease receivables			246	257
			246	257

Rental Income	**31 March 2013**	31 March 2012
Contingent rent	**19**	19
Other	**0**	0
Total rental income	**19**	19
Finance lease commitments	0	0

34 Provisions

Comprising:

	Total	Pensions to Former Directors	Pensions Relating to Other Staff	Legal Claims	Restructuring	Continuing Care	Equal Pay	Agenda for Change	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2012	**1,913**	0	119	0	0	0	0	0	1,231	563
Arising During the Year	**4,086**	0	0	0	0	0	0	0	3,992	94
Utilised During the Year	**(1,239)**	0	(129)	0	0	0	0	0	(547)	(563)
Reversed Unused	**(67)**	0	(66)	0	0	0	0	0	(1)	0
Unwinding of Discount	**68**	0	63	0	0	0	0	0	5	0
Change in Discount Rate	**21**	0	13	0	0	0	0	0	8	0
Transfers to NHS Foundation Trusts (for Trusts becoming FTs only)	**0**	0	0	0	0	0	0	0	0	0
Transferred (to)/from other public sector bodies	**0**	0	0	0	0	0	0	0	0	0
Balance at 31 March 2013	**4,782**	**0**	**0**	**0**	**0**	**0**	**0**	0	**4,688**	**94**
Expected Timing of Cash Flows:										
No Later than One Year	**3,501**	0	0	0	0	0	0	0	3,407	94
Later than One Year and not later than Five Years	**1,181**	0	0	0	0	0	0	0	1,181	0
Later than Five Years	**100**	0	0	0	0	0	0	0	100	0

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

	£000s
As at 31 March 2013	35,221
As at 31 March 2012	32,179

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

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

Redundancy and severance costs relate to active transformation initiatives.

35 Contingencies

	31 March 2013	31 March 2012
	£000s	£000s
Contingent liabilities		
Equal Pay	**0**	0
Other	**0**	0
Amounts Recoverable Against Contingent Liabilities	**0**	0
Net Value of Contingent Liabilities	**0**	0
Contingent Assets		
Contingent Assets	**0**	0
Net Value of Contingent Assets	**0**	0

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36 Financial Instruments

36.1 Financial risk management

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

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

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

Interest rate risk

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

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2013 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with primary care trusts, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

36.2 Financial Assets	**At 'fair value through profit and loss'**	**Loans and receivables**	**Available for sale**	**Total**
	£000s	**£000s**	**£000s**	**£000s**
Embedded derivatives	0	0	0	**0**
Receivables - NHS	0	4,103	0	**4,103**
Receivables - non-NHS	0	5,850	0	**5,850**
Cash at bank and in hand	0	4,341	0	**4,341**
Other financial assets	0	246	0	**246**
Total at 31 March 2013	**0**	**14,540**	**0**	**14,540**
Embedded derivatives	0	0	0	0
Receivables - NHS	0	5,725	0	5,725
Receivables - non-NHS	0	3,547	0	3,547
Cash at bank and in hand	0	3,944	0	3,944
Other financial assets	0	257	0	257
Total at 31 March 2012	0	13,473	0	13,473

36.3 Financial Liabilities	**At 'fair value through profit and loss'**	**Other**	**Total**
	£000s	**£000s**	**£000s**
Embedded derivatives	0	0	**0**
NHS payables	0	628	**628**
Non-NHS payables	0	11,674	**11,674**
Other borrowings	0	669	**669**
PFI & finance lease obligations	0	0	**0**
Other financial liabilities	0	786	**786**
Total at 31 March 2013	**0**	**13,757**	**13,757**
Embedded derivatives	0	0	0
NHS payables	0	1,674	1,674
Non-NHS payables	0	12,776	12,776
Other borrowings	0	526	526
PFI & finance lease obligations	0	0	0
Other financial liabilities	0	706	706
Total at 31 March 2012	0	15,682	15,682

37 Events after the end of the reporting period

There are no material events after the reporting date of 31 March 2013 which effect the financial position.

38 Related party transactions

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

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

Revenue Transactions
East Midlands SHA £9.8m (£9.5m)
Northamptonshire Teaching Primary Care Trust £208.0m (£201.8m)
Leicestershire County & Rutland Primary Care Trust £22.4m (£14.7m)
Milton Keynes PCT £6.7m (£6.6m)
Northamptonshire Healthcare NHS Foundation Trust £6.6m (£6.3m)

Expenditure Transactions
NHS Litigation Authority £5.8m (£ 5.0m)
Northamptonshire Healthcare NHS Foundation Trust £2.2m (£1.9m)
NHS Blood and Transplant £1.7m (£1.5m)

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 £588k (£648k)), Northamptonshire County Council (Pathology Services £151k (£151k)) and HM Revenue & Customs (Employers National Insurance contribution £11.4m (£11.0m)), VAT refunds received £2.3m (£2.6m).

The Trust has also received revenue and capital payments from Northampton General Hospital Charitable fund. The corporate trustee of the NGH Charitable Fund is the Trust Board.
Charitable Fund. The Corporate Trustee is the NGH Trust Board.

Grants totalling £378k (£264k), 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 £287k (£373k) of Building Works & Medical Equipment.

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

39 Losses and special payments

The total number of losses cases in 2012-13 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	247,665	355
Special payments	187,685	58
Total losses and special payments	435,350	413

The total number of losses cases in 2011-12 and their total value was as follows:

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

40. Financial performance targets

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

40.1 Breakeven performance	**2005-06 £000s**	**2006-07 £000s**	**2007-08 £000s**	**2008-09 £000s**	**2009-10 £000s**	**2010-11 £000s**	**2011-12 £000s**	**2012-13 £000s**
Turnover	164,673	174,041	187,379	206,926	227,805	236,260	255,481	**271,295**
Retained surplus/(deficit) for the year	(2,907)	156	1,834	2,100	(4,958)	1,109	(1,917)	**(764)**
Adjustment for:								
Timing/non-cash impacting distortions:								
Use of pre - 1.4.97 surpluses [FDL(97)24 Agreements]	0	0	0	0	0	0	0	**0**
2006/07 PPA (relating to 1997/98 to 2005/06)	0							
2007/08 PPA (relating to 1997/98 to 2006/07)	0	0						
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	0					
Adjustments for Impairments				729	7,039	0	3,453	**899**
Adjustments for impact of policy change re donated/government grants assets							(1,032)	**264**
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*					0	0	0	**0**
Adsorption Accounting Adjustment								**0**
Other agreed adjustments	0	0	0	0	0	0	0	**0**
Break-even in-year position	**(2,907)**	**156**	**1,834**	**2,829**	**2,081**	**1,109**	**504**	**399**
Break-even cumulative position	**(1,927)**	**(1,771)**	**63**	**2,892**	**4,973**	**6,082**	**6,586**	**6,985**

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

	2005-06 %	**2006-07 %**	**2007-08 %**	**2008-09 %**	**2009-10 %**	**2010-11 %**	**2011-12 %**	**2012-13 %**
Materiality test (I.e. is it equal to or less than 0.5%):								
Break-even in-year position as a percentage of turnover	-1.77	0.09	0.98	1.37	0.91	0.47	0.20	**0.15**
Break-even cumulative position as a percentage of turnover	-1.17	-1.02	0.03	1.40	2.18	2.57	2.58	**2.57**

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

40.2 Capital cost absorption rate

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

40.3 External financing

The trust is given an external financing limit, it is not permitted to overshoot but which it is permitted to undershoot.

		2012-13	2011-12
	£000s	**£000s**	£000s
External financing limit		**1,000**	62
Cash flow financing	**226**		(39)
Finance leases taken out in the year	**0**		0
Other capital receipts	**0**		0
External financing requirement		**226**	(39)
Undershoot/(overshoot)		**774**	101

40.4 Capital resource limit

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

	2012-13	2011-12
	£000s	£000s
Gross capital expenditure	**10,239**	10,670
Less: book value of assets disposed of	**(300)**	0
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(300)**	(1,583)
Charge against the capital resource limit	**9,639**	9,087
Capital resource limit	**9,795**	10,543
(Over)/underspend against the capital resource limit	**156**	1,456

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 2013	31 March 2012
	£000s	£000s
Third party assets held by the Trust	**3**	3