Northampton General Hospital NHS
NHS Trust

Annual report 2010/11

CONTENTS

	Page number
Chairman and chief executive's introduction	**4**
An introduction to Northampton General Hospital	
Who we are	**6**
What we do	**6**
Our vision and mission statement	**6**
Directors' report	
Directors during 2010/11	**7**
Northampton General Hospital's strategy	**8**
Operational performance	**8**
Patient activity	**9**
Performance against key national targets	**9**
Performance against strategic objectives	**10**
Highlights of the year	**11**
Patient care	**11**
Improving the patient experience	**12**
Listening to our patients	**12**
Comments, concerns, complaints and compliments	**13**
A better patient environment	**14**
Quality	**15**
Research and development	**16**
Information governance	**16**
Emergency preparedness	**16**
Sustainability and climate change	**17**
Our staff	
Consultation and involvement	**19**
Staff survey	**19**
Sickness absence	**19**
Training, teaching and developing our staff	**21**
Members and Governors	
Governor initiatives	**24**
Public consultation	**25**
Members involvement	**26**
Membership recruitment and development	**26**

Membership profile	**27**
Strategic partnerships	**27**
Plans for the future	**28**
Risks and uncertainties	**29**
Looking ahead	**31**
Transformation programme	**32**
The Trust Board	
Introduction	**34**
Table of attendance	**34**
Board members	**35**
Changes in board membership	**37**
Remuneration report	**38**
Finance report	**40**
Annual accounts	
Statements from the chief executive and directors	**41**
Statement on internal control	**43**
Independent Auditor's report	**49**
Financial summary	
Notes to the accounts	

INTRODUCTION

CHAIRMAN AND CHIEF EXECUTIVE'S INTRODUCTION

This has been yet another year of progress at Northampton General Hospital, but not without its challenges. With the hard work and support of all our staff, volunteers and members we have sustained our performance and built on the progress made in previous years.

In the fast-moving world of healthcare we must keep pace with the latest improvements and innovations for the benefit of the community we serve. During the past year we have created a strong platform on which to move forward. We know that we face significant challenges in the coming year as we begin to see the impact of a transformation programme that will secure long term stability for NGH and support our NHS foundation trust application.

This year saw an unprecedented demand for acute services, with adverse winter weather and the outbreak of swine flu. Despite this, for the second year running Northampton General Hospital achieved all its key targets, and for the fifth year delivered a financial surplus.

Throughout the year we have continued to meet the overall target to treat all our patients within 18 weeks of referral. This has been achieved in parallel to delivering a range of other key performance targets, notably the work undertaken to drive down healthcare associated infections, which remains a key focus for us all. As a direct result, the number of hospital acquired infections also reduced significantly, with just 2 MRSA bacteraemia reports during the year, and clostridium difficile infections were down by more than half to 48. We are also extremely proud to have met all of the targets associated with our cancer services which we provide across Northamptonshire and Milton Keynes.

Although we have already achieved a great deal in improving the patient experience, our patients tell us there is still more we can do. The information we are collecting in real-time through our patient experience trackers gives us valuable feedback that tells us where we need to do more.

Delivering a better patient experience and achieving high levels of performance depends on our staff, and it is important that we don't forget the impact staff experience in the workplace can have on the way services are delivered. Our annual STAR (staff achievement and recognition) awards provide us with an opportunity to celebrate staff achievements during the year.

We recognise that we are in a period of greater financial pressures and uncertainty which requires the Trust to reduce its cost base by £30m over the next two financial years. We must meet this target whilst at the same time maintaining and enhancing our clinical services and providing high quality patient care, against a background where the demand for our services continues to grow. To achieve this we will have to be flexible, innovative and creative.

We began work on our trust-wide transformation programme during the early part of 2010. This programme will deliver £30m of savings over the next two years. A challenge of this magnitude requires us to have robust processes in place to support the work needed, which will involve us in looking at every aspect of our services. Our aim continues to be to deliver services in the most efficient and cost-effective way, whilst at the same time ensuring we provide the quality and safe services our community rightly expects from us.

There have been some changes to the Board during the year. Paul Forden, chief executive, left the Trust in December 2010 and Sue Hardy, our director of nursing, midwifery and patient Services, departed in April 2011. On behalf of the Board we would like to thank both Paul and Sue for all their efforts during their time at the Trust and wish them both well for the future.

We would like to thank Paul Farenden who served as interim chief executive between January and May 2011. Dr Gerry McSorley will join us at the start of June 2011 as our new chief executive.

Christine Allen, our director of operations, was acting chief executive for the period between Paul Farenden's departure in mid-May and Gerry joining us in June.

Chris Pallot, director of planning and performance was appointed substantively to the Trust in September and Fiona Barnes, formerly deputy director of nursing, was appointed interim director of nursing, midwifery and patient services, pending a substantive appointment being made.

Our Shadow Governors have continued to have significant involvement during the year. They have attended a number of events where we have been able to meet and talk to our members and the wider public about issues that are important to them. Our governors have also been actively involved in many aspects of the Trust's business and we would like to take this opportunity to thank them for their continued commitment.

Much has been achieved by the trust over the past year, but there is still much to do if we are to secure longer term stability and to continue improving the quality and safety of care that we provide. The trust is building a strong platform going forward and, by maintaining our momentum and working with our local partners in healthcare, we are confident we will continue to provide healthcare services that meet the needs of our community. On behalf of the Board we would like to thank everyone for their continued commitment.

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.

Our aim is to deliver the safest, most clinically effective acute services in the country, focused on the needs of the patient.

We are a designated cancer centre and in 2010 became the stroke centre for Northamptonshire. We have also invested in a number of additional specialist services, including in-patient renal services and interventional cardiology. As part of our work to improve clinical outcomes we have taken part in a national patient safety programme and invested in systems to capture patients' views on our services. We understand that sometimes a small change can make a big difference for patients.

What we do

Northampton General Hospital provides acute and emergency hospital services to a local population of 370,000 and cancer services to a wider population of 880,000. We also see and treat patients at Danetre Hospital in Daventry, to ensure that people can receive their care as close to home as possible.

The principal activity of the Trust is the provision of free healthcare to eligible patients. We also provide a very small amount of healthcare to private patients. We also train a wide range of clinical staff, including doctors, nurses, therapists, scientists and other professionals.

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

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

Our vision and mission statement

Our vision is to be the best UK healthcare provider offering outstanding patient care.
This translates into our mission which is for Northampton General Hospital NHS Trust to be recognised as a hospital that delivers the safest, most clinically effective acute services in the country focused on the needs of the patient. These services may be delivered from hospital or by our staff in the community.

DIRECTORS' REPORT

For 2010/11, Northampton General Hospital developed a number of corporate objectives to help prioritise our efforts and to address a range of local, regional and national challenges. These objectives covered the following key themes:

- Developing and embedding measures for quality and clinical outcomes to achieve the highest standards
- Providing a clearly defined, embedded, effective governance regime
- Ensuring facilities are fit for purpose from a patient's perspective and for safe, effective and efficient delivery of services
- Developing a skilled, productive and flexible workforce able to deliver services today and tomorrow
- Developing a strategic approach to our relationships with other healthcare providers and other relevant organisations
- Developing and embedding measures for patient satisfaction
- Planning and delivering/growing and developing services in the most appropriate location
- Ensuring the most efficient, effective and productive use of our resources
- Creating a culture of innovation, continuous improvement, learning and evidence-based practice/sharing

The directors' report, together with the quality report at section 3, includes many examples of the progress we have made against our objectives.

Directors during 2010/11

Job title	Name	Comments
Chairman	John Hickey	
Chief executive	Paul Forden Paul Farenden Dr Gerry McSorley	Until 31 December 2010 From 4 January to 31 May 2011 From 1 June 2011
Non-executive directors	Neelam Aggarwal-Singh Colin Astbury Barry Noble Nicholas Robertson Phil Zeidler	
Associate non-executive director	Graham Kershaw	
Medical director	Dr Sonia Swart	
Director of operations/Acting chief executive*	Christine Allen	
Director of nursing, midwifery and patient services	Sue Hardy Fiona Barnes**	Until 4 April 2011 From 5 April 2011
Director of finance	James Drury	
Director of facilities and capital development	Charles Abolins	
Director of planning and performance	Chris Pallot	
Director of human resources	Chanelle Wilkinson	

* Between 16-31 May 2011, Christine Allen undertook the role of acting chief executive

** Fiona Barnes was appointed interim director of nursing, midwifery and patient services

Northampton General Hospital's strategy

During 2010/11 we developed our five year strategy. In developing the strategy we sought to identify ways to address a number of important issues, in particular:

- Maintaining and enhancing our position as the local provider of choice through patient-centered services.
- Increasing specialist and tertiary services
- Providing services closer to home
- Improving the patient environment
- Ensuring long-term viability through increased efficiency and target delivery

We recognise that the financial climate that the NHS operates in has become much more challenging in recent years and that the years from 2011 to 2014 will see reduced growth from central funds, increased competition between providers and changes in models of care with greater horizontal and vertical integration.

The landscape for healthcare provision will change to reflect the forecast economic outlook. Forecasters have predicted required efficiency savings of £15-20 billion by 2015 and thus the Trust's strategy must be set in the context of reduced PCT allocations, lower tariff prices, payment by results restrictions and greater efficiency requirements.

Our prime focus is to provide excellent care to our patients, regardless of the setting where this is undertaken.

During 2010/11 we continued work on our trust-wide transformation programme. The aim of the programme is to secure the long term stability of Northampton General Hospital, and support the trust's application for foundation trust status.

The transformation programme covers every aspect of clinical and non-clinical services at NGH and differs in its approach to what the trust has done previously. Through provision of dedicated project management support the aim is to deliver a planned and sustainable transformation that leads to the development of an organisation that offers the services the local community needs, provided by people who are committed to what they do.

Operational performance

During 2010/11 Northampton General Hospital achieved all its key national performance targets for the second consecutive year. This includes those for maximum waiting times, cancer waiting and treatment times, A&E transit times and reducing MRSA and C Difficile infections

Accident and emergency attendances increased to 83,000, but the new target for 95% of patients to be treated or admitted within four hours was still met.

The number of emergency admissions to the hospital rose by 5% to over 47,000 for the year, although the number of elective (planned) admissions was down by roughly the same percentage to just over 40,000. The national waiting time targets (18 weeks from referral to treatment) were achieved for the third consecutive year.

The hospital also delivered all nine national cancer targets, including the 2-week GP referral to first outpatient appointment, and the 31-day referral to treatment.

The number of hospital acquired infections improved significantly, with just 2 MRSA bacteraemia reports during the year, and clostridium difficile infections down by more than half to 48.

All the targets were met despite severe winter weather and an outbreak of swine flu, which saw the hospital coping with unprecedented levels of activity during the latter months of the year.

Patient activity

During the year we treated the following number of patients:

	2009/10	**2010/11**
Elective inpatients	*8,700*	**7,829**
Day cases	*41,351*	**39,975**
Non-elective admissions	*38,178*	**40,689**
First out-patient attendances	*97,277*	**91,784**
Follow-up out-patient attendances	*193,297*	**174,389**
Outpatient procedures	*2,938*	**27,209**
A&E attendances	*80,808*	**83,136**
GP referrals	*52,199*	**54,353**

Performance against key national targets

18 weeks

In 2010/11, the Trust continued to deliver the national 18 week journey time for the third year running. This required that 95% of admitted patients and 90% of non-admitted patients receive their first definitive treatment within 18 weeks. During the course of 2010/11 the target was extended to include delivery on a specialty level rather than at a Trust level. NGH achieved this level of performance.

Accident and emergency

Accident and emergency attendances increased to 83,000, but the new target for 95 per cent of patients to be treated or admitted within 4 hours was still met.

Diagnostics

Throughout 2010/11 we have continued to deliver the target for a maximum 6-week wait for diagnostic tests and delivered the locally agreed target of diagnostic wait times being no greater than four weeks.

Cancer waiting times

During 2010/11 we have delivered against all the national cancer targets.

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

- 96.4% of suspected cancers seen within 2 weeks of a GP referral
- 97.3% of all Breast referrals seen within 2 weeks of a GP referral
- 87.1% of patients treated within 62 days from referral to treatment
- 99.6% of patients being treated within 31 days of a decision to treat
- 99.3% of patients being treated for subsequent cancer treatments within 31 days from decision to treat
- 90% of patients treated within 62 days from a consultant upgrade
- 97.3% of patients treated within 62 days from referral from a screening service

Infection control

The number of hospital acquired infections also improved significantly, with just 2 MRSA bacteraemia reports during the year, and clostridium difficile infections down by more than half to 48.

- There has been a year on year decrease in the number of MRSA bacteraemia in the Trust. The target for this year was no more than 6 (post-48 hour) cases. The Trust was attributed 2 cases in total.
- The 2010 – 2011 target set by NHS Northamptonshire for cases of Clostridium difficile associated diarrhoea (CDAD) was 97, with an internal target of 60 set by the Trust Board. The Trust had 48 CDAD cases (post 3 days) attributed to it during 2010/11.

- The infection prevention and control team (IPCT) identified a range of special measures which were implemented on any ward that had 2 or more incidences of colonised new patients with MRSA or Clostridium difficile in a 28-day period.
- The Trust has adopted a 'zero tolerance' approach to all avoidable infections, which has become the driving force for all staff to be fully engaged with the concept of infection prevention.
- To support the on-going HCAI agenda across the Trust all executive directors and the Trust chairman participate in an infection prevention inspection on a monthly basis.
- The infection prevention and control audit is a vital component of robust infection prevention and control service.
- Monthly cleaning audits are performed in all directorates.

Performance against strategic objectives

During 2010/11 we have made progress against our strategic objectives;
We said we would:

Maintain and enhance our position as the local provider of choice through patient centred services.
We have:

- Produced meaningful quality accounts based on the quarterly clinical quality, safety and governance report to describe the progress made in providing safe, effective, services
- Improved upon our Dr Foster patient experience tracker (PET) results across the wards
- Improved in our quality health and patient experience surveys
- Added 24-ensuite shower facilities across 8 wards to provide extra bathroom facilities to conserve bed space and provide same sex accommodation for patients,
- Launched a new breastfeeding support service

Increase our ability to provide more specialist and tertiary services in Northampton in order to provide more care to the local population as well as increase contribution to the Trust's finances.
We have:

- Implemented the Northamptonshire primary stroke centre. From October 2010 all acute stroke patients from across the county are referred to NGH
- Successfully bid to provide antenatal screening pathology services for the whole of the East Midlands
- Introduced enhanced recovery pathways for colorectal and urology patients, whereby patients stay in hospital less time following major surgery

Enhance secondary care services in excellent facilities beyond the hospital sites and offering services closer to patients' homes, making NGH more attractive to patients who elect to choose their provider of care.
We have:

- Worked with our local commissioners to improve patient pathways for example for diabetes and cardiology
- Introduced an oxygen assessment service in the community
- Extended the services we offer at Danetre hospital in Daventry
- Provided radiology services at Danetre hospital and at Weston Favell

Ensure our long term financial viability through improving the clinical quality, productivity and efficiency of services and target delivery.
We have:

- Delivered a surplus of £1.0m and met statutory breakeven, capital resource limit and external financing limit duties
- Implemented a transformation programme to deliver cost improvement savings to secure long term financial viability of NGH

Highlights of the year

The NGH pathology department won a huge contract for processing all antenatal samples from the East Midlands region, against a number of public and private sector bidders. The laboratory now processes an extra 140,000 blood samples a year to determine blood group, antibody and infectious screening for pregnant women – representing almost a 300 per cent increase in workload.

Staff from the estates and facilities team at NGH scooped a national award for its response to providing same sex accommodation at the hospital. The award, for an innovative project to add extra bathroom facilities on to the outside of existing buildings to conserve bed space, was presented at the Building Better Healthcare Awards in November 2010.

A pioneering scheme which has helped keep hospital stays down in Northamptonshire received the highest praise from a Government minister. MP Paul Burstow visited NGH to hear about 'Think Home First', a multi-agency project that sees representatives from NHS hospitals and the county council becoming involved in the discharge process. The scheme won both a regional and national Health and Social Care Award.

Since opening in February 2010, the new day surgery unit carried out almost 2,500 procedures in its first year, drawing widespread comment from patients, who praised the unit as clean and efficient, the staff as excellent, friendly and helpful. It was described by some as being as good, if not better, than facilities provided by a private hospital.

More local mums than ever before are breastfeeding their newborn babies. In September NGH saw 84% of new mothers start breastfeeding, the highest rate ever recorded in the county. In January the hospital launched a new breastfeeding support service where trained peer supporters contact new mums in hospital and at home to check on their progress and offer advice.

The 'stars' of NGH were recognised at a special awards ceremony to celebrate the staff who go the extra mile for patients. The Star Awards 2011 saw 'Positive about people' awards being given out to nominated staff, and more long service awards to those with 25 years service to the hospital.

A stroke awareness event was held for members of the trust and the public, providing an opportunity for people to meet the hospital's stroke team and find out more about the services they provide during a number of presentations and displays.

The wireless computer network installed in 2009/10 is now up and running and, by the summer of this year, all wards will have wireless computers. Wireless technology will also provide many opportunities for improvement in communication, asset management, and productivity.

The Trust's new fully integrated maternity record system is now operational. It covers the complete obstetric pathway from first booking visit to discharge, including all antenatal care, foetal medicine, all aspects of labour management, and postnatal care. The system is currently being extended for use by midwives in the community.

Requesting and reporting of radiology examinations is now a completely paperless process and it is planned that the same should apply for laboratory test requesting and reporting during 2011.

Patient care

We serve a growing population which is currently around 370,000 inhabitants. In addition we provide cancer services to a wider population of 880,000 from Northamptonshire, North Buckinghamshire and South Leicestershire.

The population in Northamptonshire is forecast to grow by 3-4% per annum over the next 5 years. Based on existing models of healthcare provision this will drive an increase in demand for all acute services of 1% per annum with higher growth specifically in paediatrics and elderly specialties. We are the largest acute provider in our local healthcare economy providing 50% of our host PCT's acute requirements.

We recognise that the landscape for the provision of acute healthcare is changing rapidly. Recent developments have focused on the capacity for tertiary and specialist services as well as providing more care to the local community through the hospital in Daventry.

In 2010 NGH became the primary stroke centre for Northamptonshire, one of five specialist centres set up in the East Midlands. Stroke patients across the whole county can get quick access to the specialist care they need, including clot busting thrombolysis when appropriate.

The first stage of a review of vascular services, involving national and regional clinical experts, recommended NGH be proposed by NHS Northamptonshire as the lead site for the focus of the ongoing review. If adopted, this would mean that the county-wide emergency aspect of the vascular service would be based at Northampton General Hospital.

The hospital's maternity services department underwent an intense 2-day assessment in March 2011 to improve its grading under the NHS Litigation Authority's clinical negligence scheme for trusts (CNST). The Trust was awarded a level 2 grading – just 18 months after having achieved the level 1 assessment. It meant NGH was judged to have high standards and presented a lower risk to women, which is good for both mothers and babies and also good for the hospital's finances in reducing insurance premiums.

Improving the patient experience

Our radiotherapy department introduced a new form of treatment which shapes the x-ray beam to match the shape of the tumour, helping to avoid other organs and reducing side effects for patients. In 2011 we are introducing image guided radiotherapy, which delivers even more accurate treatment to benefit patients with certain types of cancers.

During the year we made a significant investment in state-of-the-art laparoscopic equipment, including high-definition cameras and monitors, and also appointed 3 laparoscopic specialist surgeons to develop keyhole surgery at NGH. Patients are now recovering very quickly from major cancer surgery, and get back to normal activity much sooner.

Patients are benefiting from new and life-saving treatments after the opening of a £1.2 million interventional radiology suite. The new unit incorporates a high-tech imaging system, which produces better quality images more quickly. Procedures such as inserting balloons, catheters, microcatheters and stents into the body are carried out using x-ray images to guide them, and are used to treat a wide range of conditions.

A team of NGH midwives won one of the UK's top midwifery prizes for their work on home births. The home birth team of 12 midwives scooped the Implementing Government Policy Award at the Royal College of Midwives (RCM) annual awards, presented in January 2011.

The quality of food provided to patients was rated as 'excellent' by the Patient & Environment Action Team, and was praised by local and regional media who sampled dishes at a series of tasting sessions.

Direct appointment booking

In addition to phoning the existing appointments line, patients are now able to choose where and when they have their appointment by booking over the internet, or booking at the GP surgery. Most NGH services are now on-line and we are working hard to ensure the remainder are on-line as soon as possible.

Listening to our patients

We are committed to involving patients, carers, staff and the public in the development of our services. Our patient and public involvement work ensures that their voices are heard at every level and that we use their feedback to build a patient focused service.

As part of our patient and public involvement work we:

- Provide an extensive range of information to patients. Our patient information leaflets are assessed by a group of volunteer readers to make sure they are easy to understand before being printed.
- Recruit, inform and engage our members. Members are a vital voice in providing feedback about services and we produce a newsletter to keep them updated on key developments in the Trust.

- Have a shadow Council of Governors representing our public members.
- Keep interested members of the public well informed of developments and news through our website, Insight (the hospital's public magazine), the media and other communication channels.
- Trust members take part in a series of focus groups within the directorates to examine strategic issues and look at ways of influencing the longer term plans of the Trust.
- Regularly involve patients in teams working on the improvement of services.

The views of our patients are vital in developing our services and help us know whether we are getting things right. We have a number of ways in which we obtain these views including taking part in national patient surveys, monitoring comments and complaints, and using electronic patient experience 'trackers' to get instant feedback from patients while they are still in hospital.

Comments, concerns, complaints and compliments

The Trust recognises that the nature of providing healthcare means that unfortunately we sometimes get things wrong. We seek to learn from events that don't go as well as they could by seeking patient feedback through our 4 C's approach. The 4 Cs are: comments, concerns, complaints and compliments. We publicise this approach throughout the Trust and have leaflets available that inform people how to give their feedback.

Patient advice and liaison service (PALS)

Comments, concerns and compliments are handled by our patient advice and liaison service (PALS). People can contact PALS for information about services and advice about problems and the staff will do all they can to resolve issues as quickly as possible.

The team provided information, advice and support to 3,048 patients, relatives, carers and visitors during the year. PALS works in an independent capacity within the Trust, representing the views of the service users and their relatives and carers, and resolving local difficulties and concerns by working in partnership with staff throughout the organisation.

PALS provides a platform to give people a voice in the way services are run and act as a source of intelligence in order to feedback to staff at all levels within the organisation in order to help drive improvements in services based on the needs of the patient.

Complaints

In the period from 1 April 2010 to 31 March 2011, we received 466 written complaints (compared to 430 during the previous year). They were about a variety of issues including clinical care, communication, staff attitude, waiting times, and delays or cancellations.

In line with Principles for Remedy best practice guidance for complaints handling, we investigate complaints in an open and honest way, and with a willingness to learn and make service improvements where indicated.

All complainants receive a full written response from the chief executive, and meetings are offered to patients and relatives to give them the opportunity to talk directly to senior managers and clinical staff within the Trust.

We also have a well developed approach to reviewing any serious incidents that happen in the Trust. This ensures that the right people are involved with reviewing practice and developing and implementing actions that arise through the learning process.

Total no of complaints for the year	466
Total no of complaints responded to within the agreed timescale (including 106 who agreed to an extension of time)	403 (98%)
Total no of complaints that exceeded the renegotiated timescale	10 (2%)
Complaints that were still open on 1 April 2011	53

Top five themes of complaints	
Clinical care	215
Communication	179
Attitude and behaviour	76
Delays/cancellations	46
Discharge	38

Parliamentary & Health Service Ombudsman – Principles for Remedy

The Principles for Remedy were introduced in early 2009 and is information that has been issued by the Parliamentary & Health Service Ombudsman which provides their views on the principles that should guide how public bodies provide remedies for injustice or hardship resulting from maladministration or poor service. It sets out for complainants and bodies within the Parliamentary and Health Service Ombudsman's jurisdiction how they think public bodies should put things right when they have gone wrong, and their approach to recommending different remedies.

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

In line with the Principles for Remedy and recommendations from the Ombudsman, the Trust has issued compensation payments in 2 cases, which have been upheld by the independent stage of the NHS complaints procedure, since the Principles for Remedy were introduced in 2009.

Learning from complaints

Following a number of complaints, comments and concerns that have been raised about the ophthalmology department a full clinic review has been undertaken in order to improve the level of service provided to our patients.

A process has been set up and approved for the clinical pathway and interface between community paediatric services and specialist child and adolescent mental health services (CAMHS) in Northamptonshire, when children present with behavioural difficulties suggestive of developmental or other disorders. The process sets out the common understanding between community paediatric services and specialist mental health services in the management of referrals for children with behavioural difficulties.

A better patient environment

Northampton General Hospital has an ageing estate with 67% of the buildings older than 30 years. This creates a number of challenges with an ongoing requirement to upgrade and replace facilities whilst maintaining current services. Investment in backlog maintenance has been prioritised taking account of the risk to service, and statutory compliance, as well as improving the patient's environment.

During 2010/11 the hospital's fire alarm infrastructure was replaced, and the replacement of the hospital's main oxygen supply commenced. Once completed, this will increase resilience and provide additional capacity during periods of high oxygen demand, and is expected to be complete in July 2011.

During the year, Talbot Butler and children's wards have benefited from the rolling programme of ward upgrades. In addition, the ophthalmic operating theatre and outpatient clinic were also upgraded.

A £2 million upgrade and extension to the haematology department commenced in January 2011, funded in partnership with Macmillan Cancer Care, and is due for completion in January 2012. The public response has been superb, with the appeal topping half a million pounds by April 2011, and work on the new unit is well underway.

Quality

In 2010, the Trust published its first annual quality accounts which set out the 4 quality priorities for 2010/11 and described what had been achieved during the previous 12 months. Since then the Trust has approved its first quality strategy which sets out the vision for quality, the roles and responsibilities of each staff member working both clinically and not in clinical settings and how the Board will gain assurance that the Trust is achieving its aims.

The Trust defines quality as encompassing patient safety, clinical effectiveness and patient experience, and over the last year has made good progress in using national, regional and local quality indicators to engage the organisation in improving quality in each of these areas.

Quality priorities

The quality priorities for 2010/11 were:

- Improving the experience for all patients by focusing on essential care in every ward
- Improving the effectiveness, safety and patient experience for the trust's stroke services
- Improving the prevention of blood clots through implementation of best practice for risk assessment and prescription of clot preventing drugs according to NICE guidance
- Reducing all infections including MRSA, C difficile and surgical site infections

The Trust Board received quarterly updates on each of these priorities throughout the year and the final achievements are published in this year's quality accounts.

Achievements

- A second emergency assessment unit has been created in order that the Trust meets its commitment to ensuring that same sex accommodation is provided throughout the hospital.
- The work in reducing healthcare acquired infections has continued over the last year and we have made good progress in achieving our targets for MRSA and Clostridium difficile.
- Last year we made good progress with improving our approach to risk management across the organisation and have strengthened the assessment and management of risk through the implementation of our new risk management strategy. Every few years all NHS trusts are assessed against a set of standards which create the greatest risk. During 2010/11 our maternity services prepared for and successfully achieved level 2 against these standards, which was a great achievement.

Looking ahead to 2011/12 and beyond

In order to involve and consult with key stakeholders about next year's quality priorities a 'long list' of seven was identified by reviewing the Trust's performance over the last year; national or regional priorities; and/ or from horizon scanning.

The 'long list' was discussed and consulted on extensively with staff, patients and the public, and around 200 responses to the consultation were received. A final list of four quality priorities were identified and were approved by the Board in March 2011.

The quality priorities for 2011/12 are:

- Making sure that patients receive the right care, in the right place, at the right time
- Improving the patient experience for vulnerable adults (incorporating essential elements of nursing care)

- Improving patient safety through junior doctor engagement
- Improving patient outcomes and speeding up a patient's recovery after surgery through the enhanced recovery programme

The Trust looks forward to agreeing how these priorities will be implemented and sharing successes from their implementation.

Research and development

The Trust has shown an increasing level of participation in clinical research, which demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. The number of patients receiving NHS services provided by Northampton General Hospital NHS Trust from April 2010 to March 2011 that were recruited during that period to participate in research approved by a research ethics committee was 1847. There were 198 clinical staff participating in research, and the Trust has been involved in 232 clinical research studies.

Our clinical staff stay abreast of the latest possible treatment possibilities, and active participation in research leads to successful patient outcomes. Our engagement with clinical research also demonstrates the hospital's commitment to testing and offering the latest medical treatments and techniques.

Information governance

There were no serious incidents reported by the information governance (IG) team to the Information Commissioner's Office (ICO) during 2010/11. A number of investigations were undertaken into the potential data breaches as defined by the ICO. The IG team conducted 22 preliminary investigations into potential data breaches during the year, but none of these investigations resulted in a serious incident being declared.

The organisation is committed to meeting all government requirements including for the charging for access and re-use of information. The revised information governance strategy includes a clear commitment to meeting the requirements for licensing information for re-use. Ongoing work to communicate our duties to the public is taking place to ensure there is visibility and accountability within this key information governance process.

Emergency preparedness

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

In the last 12 months we have:

- Completed and ratified major incident plans for A&E, theatres and all directorates.
- Completed and ratified a corporate major incident plan and control room plan
- Undertaken exercises in A&E and theatres
- Delivered training at all levels of the organisation
- Developed the Trust's chemical, biological, radiological, and nuclear (CBRN) response including getting approval for a permanent decontamination facility (due to be completed May 2011)
- Completed business impact analyses in most areas as the first stage of business continuity management (BCM) strategy based on BS2599
- Responded to the flu outbreak
- Supported county wide planning

In the next 12 months we will be:

- Undertaking a Trust-wide exercise for all major incident plans
- Further developing the Trust plans in light of the outcomes of the exercise

- Delivering training for major incident and CBRN across the trust
- Further progressing the trusts BCM plans

Sustainability and climate change

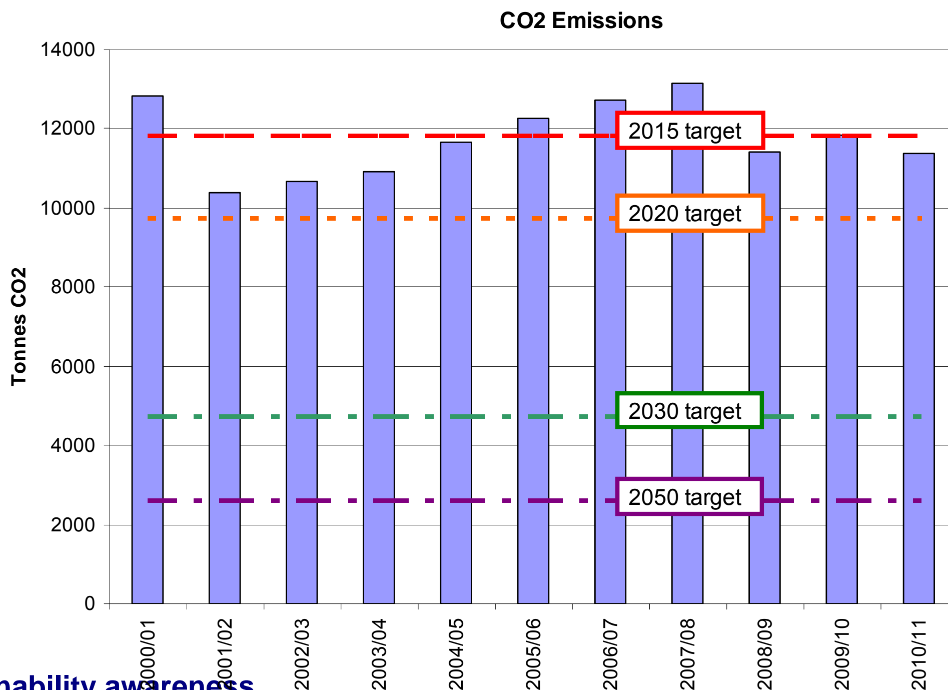
In 2009, the NHS published its carbon reduction strategy that sets targets to reduce its 'carbon footprint' from 2007 levels by 10% in 2015, 26% by 2020 and 80% by 2050. The programme of initiatives will also help NGH save money on its total energy bill of £2.3 million a year.

In response to recommendations within this strategy, Northampton General Hospital:

- Published its Board approved sustainability strategy - April 2010
- Formed a sustainability committee (with representatives from various departments within the Trust as well as patient representatives)
- Developed and published its sustainability action plan – September 2010
- Registered and is using the 'good corporate citizenship' model (to benchmark and monitor progress of carbon reduction and sustainability performance)
- Is raising awareness and reporting on carbon usage within the organisation

Carbon footprint

In 2007/8 the Trust emitted 13,165 tonnes of CO_2 from its buildings (heating, hot water, electrical and process). To meet NHS targets this must be reduced by 10% (to 11,848 tonnes) by 2015. Whilst CO_2 emissions have been increasing as the site expands, energy conservation measures have contained the growth and during 2010/11 reduced the levels by 475 tonnes. There has been significant investment in energy conservation during 2010/11 and this is expected to reduce the CO_2 levels further to below the 2015 target. Despite meeting the 2015 target early, subsequent targets are very challenging. The Trust will therefore continue to invest in carbon reduction activities to meet subsequent targets whilst also mitigating against increases in fuel prices.



Sustainability awareness

The Trust held a very successful sustainability awareness event in December 2010. The event was designed to raise awareness of carbon reduction and sustainability issues for staff and visitors whilst also recruiting 'sustainability champions'. This event will be followed by a series of themed events through 2011/12 aimed at maintaining a high profile of sustainability within the Trust.

Investment

During 2010, the Trust was successful in applying for £560,000 of SALIX funding to invest in energy conservation measures. The funding provides an interest-free loan over 4 years with the

loan paid back from the energy savings achieved. Through this scheme, the Trust has invested in improved insulation, double-glazed windows, new heating and lighting controls and installation of high efficiency light fittings. These actions are forecast to reduce the Trust's CO_2 by 630 tonnes per year and whilst these savings are being achieved, the full effect will not be achieved for 12 months. It is planned to invest further in similar schemes during 2011/12.

Partnerships

The Carbon Trust announced in December 2010 that it had selected Northampton General Hospital to be one of the organisations it will partner during 2011 to help develop and implement its carbon reduction strategies. This will provide invaluable support and will be launched with a Carbon Trust event in May 2011.

New developments

New buildings and refurbishment offer a good opportunity to reduce the Trust's carbon footprint. As an example, the Trust is currently refurbishing the haematology department. This has been designed to be energy efficient and has been designed to BREEAM[1] standard 'very good'.

Capital developments within the Trust's 5-year plan will include schemes designed to reduce carbon emissions and NHS BREEAM will be used for schemes with a capital value greater than £2m.

[1] BREEAM – Building Research Establishment's Environmental Assessment Method for buildings - It sets the standard for best practice in sustainable design and has become the NHS measure used to describe a building's environmental performance.

OUR STAFF

Working with our staff

Consultation and involvement

The Trust is committed to achieving the most effective and efficient way to make a real difference in the lives of its patients, staff and the public. The Trust has a long history of close working relationships with staff, trade union representatives and professional organisations, and believes that effective partnership working between these groups is critical to the success of the organisation from a staff and patient point of view.

The Trust believes that working in partnership with staff through informal and formal mechanisms will enable all parties to work together to achieve the underpinning aims, objectives and outcomes towards all matters relating to terms and conditions of service and good working practices for staff.

We believe that effective partnership working between management, staff and trade unions will:

- Generate solutions to problems
- Provide more information for both management and staff
- Enable staff to make a real contribution through their knowledge and experience
- Contribute to a more effective patient service.

Staff survey

From October 2010 to December 2010, staff at the Trust took part in the eighth annual national NHS staff survey. The results of this survey will be used by the Care Quality Commission as part of an assessment of national priorities within the 2010/11 periodic review and will enable the Department of Health and other national NHS bodies to assess the effectiveness of national workforce policies and strategies.

The Trust will be able to use the survey results to inform improvements in working conditions and practices at local level. As in the past year there will be presentations across the Trust, and focus groups with staff, so that they can discuss what is important to them. Their comments will form directorate action plans to make the hospital a better place for patients and staff.

The Trust response rate was 49%, an increase on the 2009 response rate of 47%.

38 key scores are measured in the survey of which the Trust is in:

- The top 20% of acute trusts for 4 key scores
- The bottom 20% of acute trusts for 20 key scores

The Trust has made significant improvements on 7 key scores since the 2009 survey
The Trust has had significant deteriorations on 2 key scores

Sickness absence

The management of sickness absence remains a high priority for the Trust and much work has already been done this year to ensure that managers have the capability to manage sickness absence effectively. In addition, the payroll team has been working hard to ensure that sickness absence is accurately recorded on payroll and that the number of overpayments in relation to sick leave entitlement is reduced.

Our sickness absence rate has been reducing year on year and the table below demonstrates this across all directorates with the exception of child health. This is due to 5 core initiatives which have been undertaken by the HR directorate and cascaded through the HR business partner model in relation to managing sickness absence more effectively in the Trust:

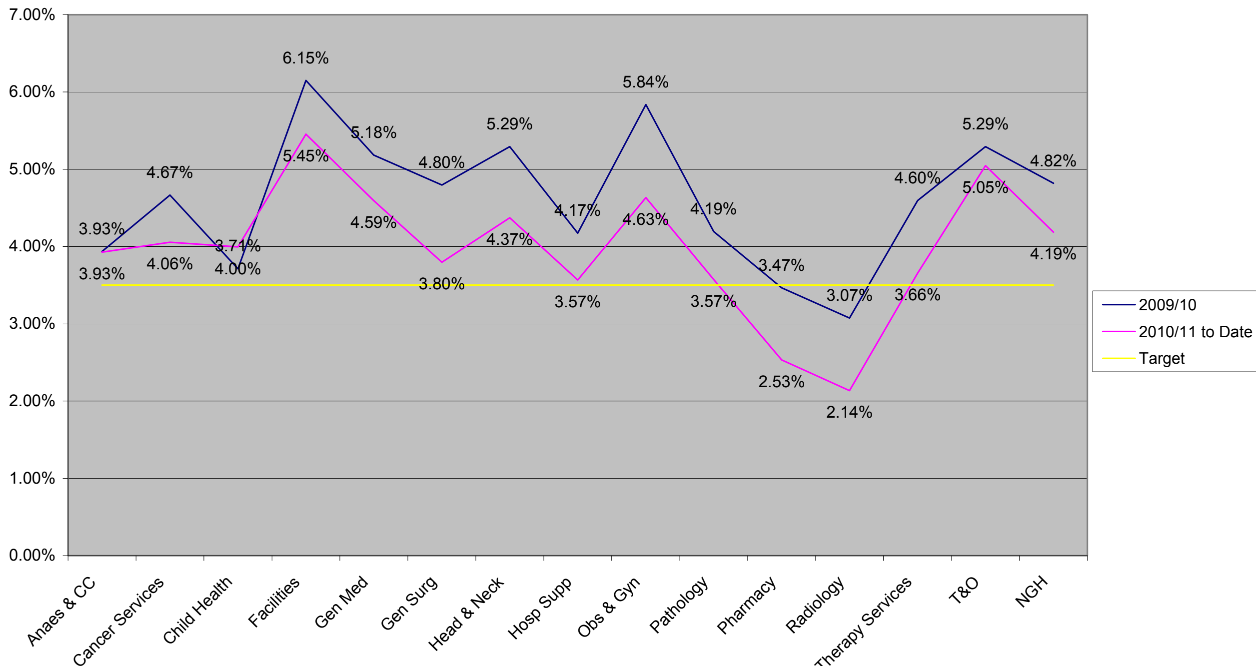
- Ensuring sickness absence records are accurately maintained
- Closing long term sickness absence cases within contractual sick pay period
- Raising awareness of sickness absence notification procedures
- Increasing/monitoring the number of return to work interviews
- Tackling high levels of short term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

In addition, the Trust has agreed and implemented, in conjunction with staff side, a new sickness absence policy with tighter controls to enable short-term sickness to be managed in a more timely and effective way. Training and awareness sessions for staff and staff side have been developed to underpin the implementation of the policy and procedure from October 2010 onwards.

For the foreseeable future, HR business partners will continue to work closely with managers at all levels to ensure that sickness absence is being correctly reported to payroll and managed in accordance with Trust policy and procedures.

Occupational health is now more actively involved with the management of sickness absence and works closely with HR business partners and managers to ensure timely and effective referral management. In addition our occupational health department has been expanded to support the initiatives we are undertaking to underpin the health and wellbeing of our staff.

More focus has been given to sickness absence reporting and regular reports are now provided to managers and HR business partners by the HR information team. These reports enable managers to identify problem cases and to take appropriate action.



Training teaching and developing our staff

The Trust's approach to growing organisational capability and competent staff is based on a philosophy that there needs to be shared commitment to learning between individuals, managers and the organisation. By working in partnership with staff representatives, professional groups and

other stakeholders the Trust aims to create an environment of continuous development for staff who all have the opportunity to participate in annual review and personal development planning.

With these measures in place the Trust will be able to ensure change is achieved to support the transformation of services and improve the experience of patients.

A key objective of the training and development team this year has been to increase the number of staff participating in the appraisal and personal development planning process across the Trust using the NHS knowledge and skills framework. To support this work the appraisal and personal development plan policy and documentation have been revised to provide a more simple and effective way of delivering meaningful appraisal, linked to corporate objectives, whilst at the same time engaging with staff.

Whilst much work is being done to support and implement mandatory training in the Trust it is recognised that there is still much to do to ensure all staff remain up to date with their relevant mandatory training. Pivotal to this has been the development of a comprehensive mandatory training action plan. The plan has been agreed with the key stakeholders and is now being implemented.

The following illustrate the key initiatives being undertaken:

Leadership and management development

Leadership and management development is supported by a framework of programmes for all levels of managers and includes the opportunity for individuals to gain a qualification from the Institute of Leadership and Management. The programmes respond to current and future capability gaps and offer access via more than one delivery method to respect a variety of working patterns and learning styles. All participants are actively encouraged to influence the development of programmes through the evaluation exercise. In addition to this, senior leaders in the Trust have a tailored development programme and the opportunity of bespoke executive coaching. Externally, the Trust supports and sponsors access to management and similar education qualifications.

Post-registration training – non-medical education and training funding

During the year, NGH received around £1.2 million worth of salary support, flexible funding and value of courses through the Learning Beyond Registration contract. Co-ordinated by the head of practice & professional development, this supported education activity for registered and non-registered staff alike and offered significant opportunities for the continuing professional development of registered staff. NGH also operates the 18-month midwifery programme and the nursing degree course run in conjunction with the Open University.

NVQs

The Trust's nationally and regionally recognised NVQ centre offers a broad range of qualifications for all staff. The hospital works in partnership with South Leicestershire College to offer a wide range of national vocational qualifications and is currently involved in facilitating the apprenticeship programmes in health and social care, business administration and customer services. Bi-monthly inductions are open to all staff including bank and temporary staff. IT training for staff ranges from entry level of user to ITQ qualifications and beyond.

Preceptorship programme

To address the transition from student to qualified practitioner, the Nursing and Midwifery Council strongly recommends that all 'new registrants' have a period of 'preceptorship' on commencing employment, and the NGH programme began in March 2010. Feedback from the programme indicates that there are increasing levels of confidence, a positive impact on retention and the overall quality of patient care.

Apprenticeships

Apprenticeships remain high on the Government's agenda and the available funding supports this. Last year saw 19 modern apprentices engaged at NGH and by January alone 13 members of staff (a combination of new and existing) enrolled onto an apprenticeship programme.

External funding for education is reducing, and a focus for 2010/2011 is to identify needs within the Trust that can be serviced by apprenticeships. Recruiting to these temporary posts supports the Trust with staffing, attracts funding to support education and helps address some of the wider challenges around employment within Northamptonshire.

Policy on disabled employees

Northampton General Hospital NHS Trust values the contribution of all individuals irrespective of disability and affirms that all staff should be able to participate in the life and work of the Trust.

As such, the Trust is committed to ensuring that appropriate and reasonable support is offered to members of staff with disabilities. There is a positive duty on directors, managers and supervisors to take into account the needs of staff with disabilities. This includes seeking to establish working conditions which encourage the full participation of employees with disabilities, and obtaining guidance in relation to reasonable and practicable adjustments to work or to the working environment to meet the ascertained needs of staff.

Equality and human rights

The equality and human rights group was established in 2010 with the aim to develop and successfully implement an equality and human rights scheme which will not only enable the hospital to fulfil its legal duties but will support the continued promotion of equality and human rights across the hospital. The group has been making progress against the Trust's action plans and includes the following success:

- Quarterly reporting to the group on employment issues such as recruitment sampling
- The development of the Trust's intranet/internet website which has enabled the publication of equality and human rights information including equality impact assessments
- A revised public patient involvement strategy which includes the formation of six internal focus groups to engage and understand the service delivery of the Trust.
- The revision of the patient information policy and development of a patient carers policy
- The development of appropriate redeployment processes to provide support for staff with short or long term ill health issues and staff with disabilities
- Links to the DisabledGo website (NGH pages) with accessibility directly from the Trust's website
- A review of the mandatory equality and human rights training programme regarding inclusion of public sector duties, human rights and employment regulations
- The monitoring and review of the use of the procurement process to identify that companies and organisations progress in meeting the Trust's equality and human rights expectations
- A completed data validation exercise with staff to improve gaps in employment data which will help to identify any actions that may be required for staff who have a protected characteristic.

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

EDS will be used as a framework for the Trust's 4-year plan and the objectives set will encourage an outcome focused approach to setting challenging but measurable targets to improve service outcomes and the way we employ our staff.

In essence, the Trust will:

- Identify local interests
- Analyse and grade performance
- Identify equality objectives: how they meet the general and public sector duties of the Equality Act as well as the link to corporate goals and other major plans
- Identify priority actions: how progress will be phased with milestones, and how continuous improvement will be maintained
- Carry out an annual review
- Publish, grade and prioritise actions, including which local interest groups were engaged and the outcome

MEMBERS AND GOVERNORS

Introduction

At December 2010 we had 3973 public members and 3,998 staff members. From our membership we have developed a strong body of committed shadow governors who are actively engaged with the Trust. The Trust has been proactive in supporting the Governors in the following ways:

- Help in defining the Governors' role, distinguishing between the staff and public roles
- The appointment of a lead non-executive director, Phil Zeidler, to support and engage with the Governors' Council (Phil is an ex-member of the Governors' Council), holding regular surgeries for members of the Governors' Council
- Facilitation and support for the governor engagement initiatives
- Provided training sessions for shadow governors to gain a greater understanding of the finances of the trust and their role as governors

Governor Initiatives

In order to better inform themselves of the Trust's activities and in turn engage effectively with the member groups, the governors have developed a number of initiatives:

Informing themselves

- Directorate liaisons – Most public governors have chosen a specific directorate within the Trust to form a long term relationship with. This enables them to gain a meaningful understanding of the opportunities and challenges of one area and share these with the governors' council and the membership where appropriate. There is a review process to ensure the liaisons are effective for both the governors and the Trust.
- Development of a rolling agenda at the Governors' Council meetings to cover key strategic topics presented by members of the Trust's executive team
- Development of the communications and membership sub-committee which is attended by the head of communications
- Shadow Governor CEO question and answer session at each Council meeting

Informing and engaging with members

- The development of a members' newsletter
- Governor road show events held within the member community
- Road shows focusing on under represented groups
- Consultations and surveys by e-mail and post on specific issues
- Chairing focus groups as part of our public and patient involvement strategy

Governors' Council composition

Constituency	Sub-Constituency	Following consultation Jul-Oct 06	Current (Actual)	Proposed following consultation Aug - Nov 10
Staff	Medical & Dental	1	1	1
	Nursing & Midwifery	2	1	1
	Allied Professionals	1	1	1
	Non Clinical	2	2	1
Public	Northampton	12	5	6
	Daventry & S Northants	6	3	6
	E Northants and Rest Of UK	2	1	2
Appointed	PCT	1	1	1
	Local authorities and stakeholder organisations	5	5	1
TOTAL		**32**	**20**	**20**

Public consultation

We produced a consultation document in August 2010 which described our vision and outlined our proposed governance arrangements. The consultation document was available in hard copy, electronically and in translated form on request, and was also available to download from the internet.

We asked 8 questions to help us find out if the objectives that we had set ourselves were supported by our community:

- Do our priorities sound right to you?
- Do you agree with the proposed lower age limit of 14 for membership?
- Do you support our proposals for membership of the public constituency?
- Do you agree with the proposed groups of the staff constituency?
- Do you agree with our proposals to reduce the size of the Governors' council from 39 members to 20 members?
- Do you agree with the number and allocation of public seats on the Governors' Council?
- Do you agree with the number and allocation of seats for staff on the Governors' Council?
- Do you agree with the partnership organisations suggested on the Governors' Council?

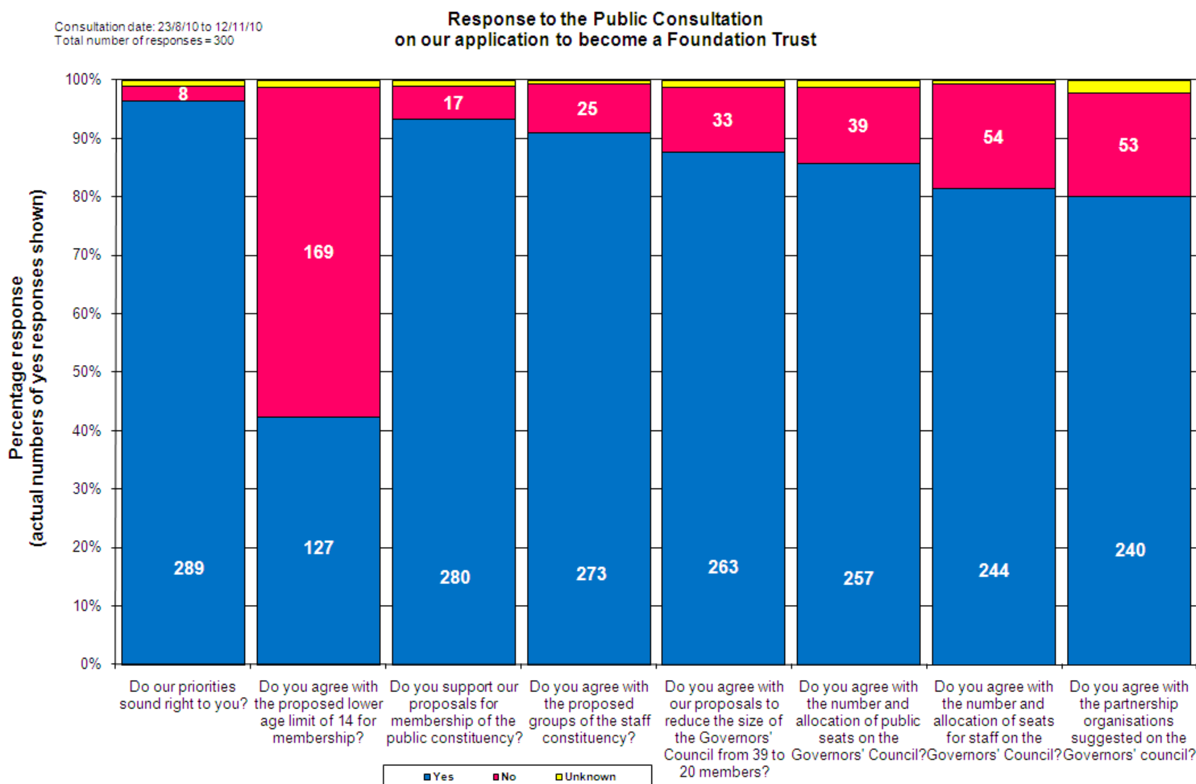
Each of the questions allowed for free text responses in addition to the "yes" or "no" answers. The Foundation Trust project team attended a range of internal and external, staff and public events to promote the consultation and engage with a diverse range of the local population.

We wanted to make it as easy as possible for people to respond to the questions, so we set up an on-line response form, as well as a freepost address and posting boxes around the hospital. We also received responses by email and phone, as well as face to face discussions.

Consultation response

We received 300 responses to our consultation from both the public and members of staff. The table below shows the percentage of responses to each of the eight questions.

Responses from the Public Consultation



Actions taken in response to the public consultation

Following the analysis of responses received through the consultation, we will:

- Maintain the minimum age of 16 for members, but will look at ways to involve younger people, including the option of setting up a youth forum
- Reduce the number of Governors' seats from the current 39 to 20 as set out in the consultation document
- Maintain the constituencies for both staff and public seats

Members' involvement

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

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

Our Governor's Council comprises people elected from and by the membership. This ensures that the interests of the local community are represented at a strategic level within the Trust.
The Governor's Council was established in shadow form in April 2006 and has allowed the tailoring of our governance arrangements to the individual circumstances of our community through consultation.

The Shadow Governors' Council has met many times, and has formed a Membership and Communications subcommittee which reports regularly on its activities to the Governors Council.

Member recruitment and development

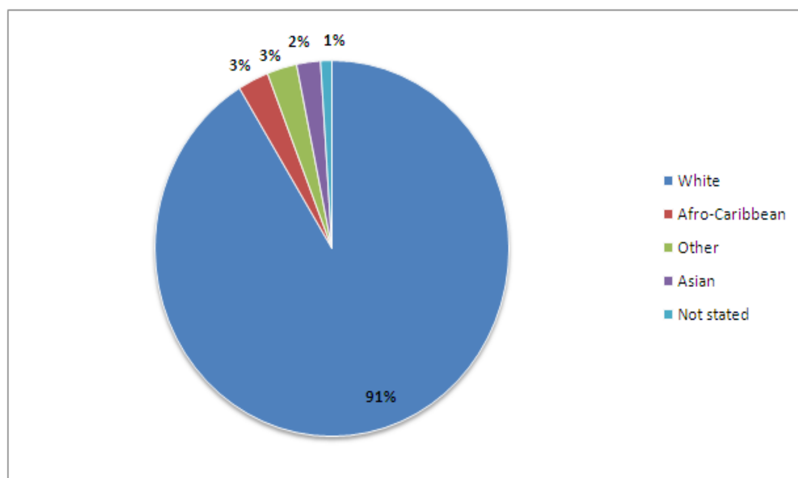
We began recruiting members in the summer of 2006 in conjunction with our first public consultation. We can demonstrate a consistent pattern of recruitment, and by the end of our first year as an authorised Foundation Trust we aim to have a public membership in excess of 5,000. Membership for staff provides a real opportunity for engagement and involvement and therefore staff are automatically opted-in as members, with the opportunity to opt-out if they wish. Staff who leave the Trust are invited to remain members by transferring to public membership.

We regularly compare our membership demographics to that of the local population using the most recent census information to ensure that our membership reflects the diverse population we serve. This enables us to target our recruitment methods to effectively build our representative membership.

Our current methods of recruitment are through existing members and Governors, and writing to previous patients. In writing to previous patients we are able to direct our recruitment efforts in accordance with our membership analysis. For example if our analysis shows that we are lacking in members of a certain age group, we can target letters to ex-patients of that age.

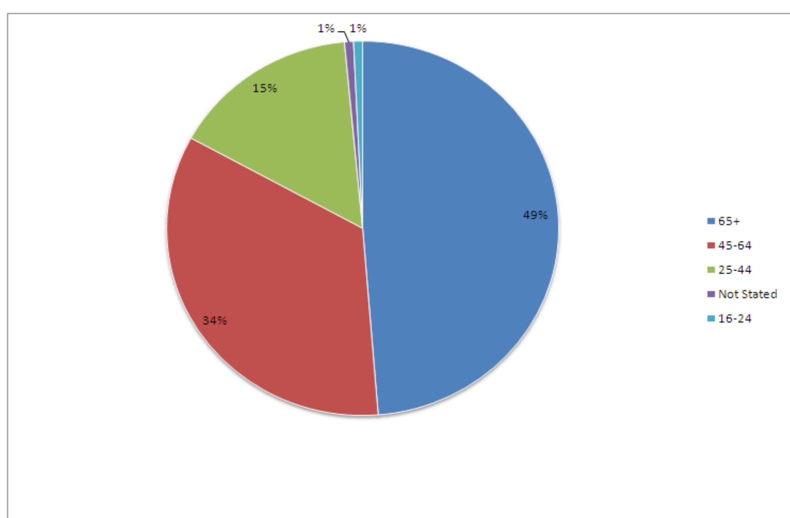
Membership profile and numbers

Public membership by ethnicity



Ethnicity		%
White	1844	91.2
Afro-Caribbean	57	2.8
Other	55	2.7
Asian	44	2.3
Not stated	21	1.0
Total	2021	

Public membership by age



Age		%
65+	985	48.8
45-64	693	34.3
25-44	313	15.5
16-24	15	0.7
Not Stated	15	0.7
Total	2021	

Public membership by gender

Gender		%
Female	863	42.7
Male	642	31.8
Not Stated	516	25.5
Total	2021	

Strategic partnerships

We have reviewed our public and patient involvement (PPI) strategy and strengthened our potential to fully engage with members through a ‘forum’ based approach.

Our Shadow Governors are given the opportunity to chair a service based focus group with the aim of providing a conduit for member engagement into our strategic planning. This allows a robust approach to evidence member and public engagement in strategic planning. Each of the focus

group chairs report to the patient and public involvement strategic steering group, which in turn reports to the Trust Board. The six groups set up so far are for surgery, medicine, pain management, infection prevention, trauma and orthopaedics, and hotel services. Within their first six months the focus groups organised several activities including food tasting, hand hygiene surveys, and ward cleaning inspection visits. The groups have also been able to bring some issues that they have identified directly to the Board of Directors through the Governors' Council, so they are starting to have a real influence.

Plans for the future

The first event showcasing a service offered by the Trust took place in April 2011, and focused on our new role as the county's primary stroke centre. The event gave members as well as the general public the opportunity to learn more about the identification, treatment and prevention of stroke. We plan to hold many similar events in future, along with a series of smaller ones.

A local network has been set up with the other NHS healthcare providers in the county to share knowledge and resource. This will help to ensure that all the organisations work together to educate the wider community and offer them the opportunity to become involved in helping to ensure that the healthcare offered in the county truly fits the population that they serve. We are working together to support the community and offer advice and education to help them lead a healthier lifestyle through combined events.

We will be attending the Wellness Event in June 2011 which is organised by Northamptonshire Healthcare NHS Foundation Trust, and are working together to hold a young person's engagement event in October 2011. A cancer awareness event is being organised, in conjunction with the PCT, to highlight the services we offer.

Risks and uncertainties

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

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

Aim	Goal	Outcome Measure	Risks to Achievement	Timeline	Enabling Strategy
Maintain and enhance position as the local provider of choice	**Develop and embed measures for quality and clinical outcomes to achieve the highest standards.**	• Equivalent performance to other Trusts for: HSMR Patient Survey • Advancing Quality Contract • Reduced numbers of incidents of harm • No 'never' events	• Case mix • Staff engagement • Fit for purpose environment and facilities	Ongoing with quantifiable year on year improvement targets.	• Internal Patient Safety strategy • Contractual Framework • Appraisal System • WHO Surgical Safety checklist • Stakeholder engagement strategy • Patient Safety Learning Forum • Quality Strategy • Clinical Governance Framework • Quality Accounts
	Develop a flexible, productive and efficient workforce to support the delivery of excellent healthcare through the transformation of services in the Trust	• Workforce savings achieved in line with transformation and CIP plans • Paybill optimised and in line with workforce spend predictions • Year on year improvements in staff survey • Management and leadership programme implemented • Increased development of bands 1-4 • Succession planning and talent management strategy implemented	• Increased demand on services and pressures on staffing • Lack of management engagement and workforce controls in practice • Lack of staff and management engagement • Lack of engagement	2011 going forward	• Robust workforce strategy and implementation of supporting HR action plans • Staff survey action plan • Management and leadership action plan • Bands 1-4 action plan • Talent management and succession planning strategy
	Develop and embed measures for enhanced patient satisfaction	• Improved patient satisfaction scores • Increased number of patients recommend Trust as provider of choice • Reduced complaints • Increased number of positive patient feedback	• Lack of patient engagement • Negative press publicity • Staff engagement	Ongoing with quantifiable year on year improvement targets.	• Staff appraisals • Maintain Patient Experience Trackers (PETs) across all wards and FABIO in Paediatrics. • Introduced Patient Care Rounds

Aim	Goal	Outcome Measure	Key Risks	Timeline	Enabling Strategy
Increase Specialist and Tertiary services	**Develop strategic approaches to relationships with other health provider and stakeholder organisations**	• Integrated LHE strategic plan • Regular interaction at key LHE forums • Expansion of current services provided by NGH • Fully engage in the acute services review	• LHE objectives not aligned • Staff engagement • Protectionism of LHE organisation • Aggressive marketing strategies from other providers • Insufficient resource, capacity and finances to deliver • Failure to involve sufficient clinical involvement in the acute services review and QIPPs programme	Ongoing	• Commissioner strategy • Directorate plans • SHA strategy • Transferring of Community services and their integration
Excellent Environment /Close to home	**Fit for purpose facilities and equipment for safe, effective and efficient delivery of services.**	• Improved patient survey results • Increased staff satisfaction • More patients receiving care outside of the main site • Optimal capacity • Optimal equipment usage • Reduced infection rates • Hygiene Code visit and score • PEAT visit and score • Backlog maintenance	• Staff engagement • Financing • Age of estate	Ongoing with capital enhancements 2010 - 2015	• Site development strategy • Capital financing facility • Involvement of governors and members • Safety strategy • Programme to reduce footprint and mothball older capacity • Managed equipment Service for radiology and radiotherapy replacement • Medical Devices Strategy
	Plan, grow, develop and deliver services in the most appropriate location	• More patients receiving care outside of the main site • Improved patient satisfaction • Capacity = demand	• Accessibility of alternative locations • Public perceptions • Competition	2013	• Workforce planning • IT strategy • Governance

Aim	Goal	Outcome Measure	Key Risks	Timeline	Enabling Strategy
Long term financial viability	**Ensure most efficient, effective and productive use of resources through the trusts transformation programme**	• CQC Compliance • Financial statements • Improved performance metrics • Improved liquidity	• Staff engagement • Poor planning of demand and capacity	2012	• Performance management framework • Transformation Programme
	Create a culture of innovation, continuous improvement, learning and evidence based practice driven by effective leaders	• Improved productivity metrics • Improved patient and staff satisfaction • Staff retention • National recognition for improvement work	• Staff engagement • Finance	Ongoing with year on year improvements	• Workforce strategy • Performance management framework • Appraisal system • Staff recognition and awards • Training and development strategy • Patient Safety Learning Forum
	Clearly defined, embedded, effective governance regime	• National targets • Excellent CQC scores • Financial targets achieved • Improved ALE score	• Resources • Finance • Staff engagement • Pandemic	Ongoing with year on year improvements	• Performance management framework • Staff appraisal • Directorate operational plans • Finance strategy • Risk Management Strategy • Clinical Governance Framework • Quality Strategy

Looking ahead

We recognise that strategic partnerships must be developed with other NHS and Foundation Trusts for the long term delivery of certain specialist services or where a critical mass of patients is required for sustainability.

Our relationship with Kettering General Hospital NHS Foundation Trust is vital to the delivery of shared services, and cancer, stroke and PPCI are recent examples. We will continue to foster a partnership approach to the delivery of services on behalf of the population of North Northamptonshire wherever possible.

Outside of the county the most important relationships are with Milton Keynes PCT and Milton Keynes General Hospital NHS Foundation Trust for whom the Trust undertakes radiotherapy and oncology services. As service developments progress, this relationship will become closer.

The Trust will continue to work with healthcare commissioners, providers and key stakeholders across Northamptonshire to review and plan services in line with the acute services review. The QIPPS (Quality, Innovation, Productivity and Patient Safety) board brings together representatives from all health organisations to focus on clinically led projects that concentrate on achieving a seamless patient pathway which is not constrained by traditional commissioning and tariff structures.

We understand that we will have to review the way we operate as the needs of the population change. The continued trend of increasing numbers of elderly patients with long term conditions,

with more outpatient services provided locally are key components of the Trust's strategy for the future delivery of acute care.

The Trust had previously recognised that the current approach to delivering cost improvements would not deliver the level of savings required to secure the continued financial viability of NGH . NGH therefore initiated a major change programme in early 2010 with the intention of transforming how patient care is delivered over the next three years. The challenge was to develop solutions which will deliver real financial and organisational benefits whilst ensuring sustainable high quality patient care remains at the heart of the organisation.

Transformation programme

The Trust's transformation programme is placed at the heart of the organisation, with alignment between the transformation projects and workstreams with Board objectives, foundation trust milestones, external changes and commissioning intentions.

In order to maintain momentum and achieve our targets, we have reviewed and revised the governance arrangements for the transformation programme as well as securing additional external resource to address organisational capacity in order that our plans may be advanced rapidly to implementation. The work we have already done to identify additional productivity-enhancing and cost-reducing initiatives in clinical and non-clinical areas will be taken forward during 2011/12 and into the following year.

The scope of work includes improving both clinical and non-clinical efficiency and effectiveness, reorganisation, turning already completed Independent Business Reviews (IBRs) into action, completing further, accelerated IBRs and building the impact of commissioning intentions into the Trust's transformation programme. :

We are now in phase 2 , which is the major execution phase of the programme. Detailed implementation plans have been developed for key project areas and actual implementation is now underway.

Phase 3 will focus on ensuring action is being taken and progress made in accordance with agreed plans. Progress will be monitored against a balanced scorecard of targets, actions and milestones that will be agreed at the end of Phase 2.

Delivering the required savings

The initiatives to deliver the cost improvement programme requirements are detailed in the table below and work is currently underway ongoing to implement these projects and realise the potential savings.

	11/12 £m	12/13 £m	13/14 £m	14/15 £m	15/16 £m
Reorganisation	0.2	0.8			
Corporate functions	-	0.5			
Other non - clinical	1.0	1.5			
Commissioning intentions	2.0	-			
Independent business reviews	2.0	1.5			
Bed utilisation	2.5	0.5			
Theatres	2.0				

	11/12 £m	12/13 £m	13/14 £m	14/15 £m	15/16 £m
Outpatients	0.5	0.5			
Estates optimisation	0.2	0.6			
Medical productivity	0.3	0.4			
Diagnostics	0.5	0.7			
Bank and agency	1.2	0.3			
Directorate cost improvements	4.0	2.0	2.0	2.0	2.0
Procurement	2.0	1.0	1.0	1.0	1.0
Medicines	1.0	1.5	0.5	0.5	0.5
CNST reduction on achievement of Maternity level 2 / General level 2	0.3	0.2			
Other to be identified	3.1		5.7	5.8	5.6
Total	**22.8**	**11.7**	**9.2**	**9.3**	**8.9**

Cost improvements are presented in detail only for 2011/12 and 2012/13. The size of the cost improvement requirement has increased from 4.0% to 10% of total costs during the contracting process as NHS Northamptonshire has confirmed the size of the financial challenge. The Trust has therefore reviewed its existing programmes and sought to accelerate savings from the later years of the model to meet the delivery target of circa £23m. Once assurance on 2011/12 and 2012/13 cost improvement schemes is obtained the Trust will put steps in place to identify CIP requirements for 2013/14 to 2015/16 using the programme management and methodology skills that will transfer to the Trust.

THE TRUST BOARD

Introduction

The Trust Board is led by the chairman, Dr John Hickey who was appointed for a 4-year term from November 2007. Mr Paul Forden, chief executive, left the Trust on 31 December 2010. An interim chief executive, Mr Paul Farenden, was appointed for the period 4 January 2011 to 31 May 2011. Other than the chairman and chief executive, there are 4 executive directors and 5 non-executive directors and 1 associate non-executive director.

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

Table of attendance 2010-11

	Board Meetings		Audit Committee		Healthcare Governance Committee		Nomination Committee		Remuneration Committee	
Director	**A**	**B**			**A**	**B**	**A**	**B**	**A**	**B**
Chairman										
John Hickey	10	10	-	-	12*	11	4*	4	5*	5
Chief executive										
Paul Forden[1]	7	7	-	-	9	7	3	3	-	-
Paul Farenden[2]	3	2	-	-	3	1	1*	-	-	-
Executive directors										
Charles Abolins	10	10	-	-	-	-	-	-	-	-
Christine Allen	10	8	-	-	-	-	-	-	-	-
James Drury	10	10	-	-	-	-	-	-	-	-
Sue Hardy[3]	10	8	-	-	12	9	-	-	-	-
Chris Pallot	10	9	-	-	-	-	-	-	-	-
Sonia Swart	10	9	-	-	12	9	-	-	-	-
Chanelle Wilkinson	10	9	-	-	-	-	4	4	-	-
Non-executive directors										
Neelam Aggarwal-Singh	10	8	5	4	-	-	4	3	5	3
Colin Astbury	10	10	5	5	12	10	4	4	5	4
Graham Kershaw[4]	10	10	5	5	-	-	4	4	5	5
Barry Noble	10	9	5	5	-	-	4	4	5	5
Nicholas Robertson	10	7	5*	5	-	-	4	4	5	5
Phil Zeidler	10	10	5	5	-	-	4	4	5	5

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

*Committee chairman

[1]Paul Forden left the Trust on 31 December 2010
[2]Paul Farenden joined the Trust as interim chief executive on 4 January 2011
[3]Sue Hardy left the Trust on 4 April 2011
[4]Graham Kershaw is an associate non-executive director

Board members

Dr John Hickey - Chairman

John was appointed as Chairman on 1st November 2007. A registered medical practitioner, he has many years' experience in healthcare and recently retired as chief executive of the Medical Protection Society Ltd. He has a particular interest in patient safety, clinical risk management, medical law and ethics, and has written and lectured on these subjects internationally.

Paul Farenden – Interim chief executive

Paul was appointed as the trust's interim chief executive from 4 January 2011. A local man, he was previously chief executive at the Dudley Group of Hospitals NHS Foundation Trust. He has 40 years of experience in healthcare finance, management and leadership. A qualified accountant, Paul has been chief executive in 3 NHS trusts over the last 20 years, where he has led large scale organisational change. His experience has given him with an in-depth understanding of both the NHS and the wider healthcare system.

Executive Directors

The voting executive directors on the Trust Board are:

Dr Sonia Swart - Medical director

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 with the director of nursing, midwifery and patient services. 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.

Fiona Barnes – Interim director of nursing, midwifery and patient services

As the interim director of nursing Fiona is responsible for the professional leadership of the nursing and midwifery staff, providing professional advice to the Trust Board and organisation. Fiona is also the executive lead for infection prevention, patient experience and in conjunction with the medical director ensures the Trust has a clinical governance framework in place across the Trust. Fiona has worked within the NHS for many years and has extensive experience in operational, managerial & educational roles.

James Drury - Director of finance

James is the financial advisor for the Board, responsible for the application of statutory financial regulations to the conduct of all Trust activities and financial performance, and is also responsible for information management and technology. James trained as a chartered accountant with KPMG. He audited UK listed companies for 10 years prior to specialising in transaction services for private equity houses in 2001. From 2004 he was global executive for chemicals with responsibility for business development, marketing and thought leadership. Prior to joining the Trust in 2007 James worked for Monitor, the independent regulator of NHS foundation trusts, as a senior assessment manager.

Christine Allen - Director of operations

Christine was appointed director of operations in January 2010 and is responsible for the day to day management of the Trust and achievement of all patient access targets. Christine has worked for the NHS for more than 25 years, for both the health authority and acute trust, and previously held the post of director of planning and performance, where she was instrumental in establishing the Trust's formal planning process, performance framework and effective contract management.

Non-executive directors

Non-executive directors are appointed by the Appointments Commission for a term of 4 years and are terminable with 1 month's notice on either side. The non-executive directors are:

Mrs Neelam Aggarwal-Singh

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

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

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

Nicholas Robertson
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.

Phil Zeidler
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.

The non-voting directors who support the Trust Board are:
Charles Abolins - Director of facilities and capital development
Responsible for the Trust's estates and facilities, 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. Charles is the lead director for the trust's 'Shaping the Future' reconfiguration strategy and qualified as a Fellow of the British Institute of Facilities Management (FBIFM) in 1997.

Chris Pallot – Director of planning and performance
Chris came to work for the Trust in January 2010, initially on secondment and was appointed substantively 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 development, and commissioning and contracting. As director of planning and performance he has responsibility for contracting, market development, clinical coding and medical records, information management, and service planning.

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

Graham Kershaw - Associate non-executive director
Graham is a non-voting associate non-executive director who attends Board meetings and the audit committee. He 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.

Changes in Board Membership

During the year there were some changes in the composition of the Trust Board.

Mr Paul Forden, chief executive, left the Trust in December 2010.

Mr Paul Farenden was appointed interim chief executive in January 2011 to May 2011

Mrs Christine Allen was acting chief executive from 16th – 31st May 2011.

Dr Gerry McSorley was appointed chief executive from 1st June 2011

Mrs Sue Hardy, director of nursing, midwifery & patient services left the Trust in April 2011.

Mrs Fiona Barnes was appointed interim director of nursing in April 2011.

Mr Chris Pallot was appointed director of planning and performance in September 2010

Further details of the directors, their remuneration and how they operate are set out in the remuneration report below.

REMUNERATION REPORT

Salary and pension entitlements of senior managers

Name and Title	2010-11			2009-10		
	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
John Hickey - Chairman	20-25		1,500	20-25		1,000
Paul Forden - Chief executive (April-Jan)	135-140		5,400	175-180		6,800
Paul Farenden - Interim chief executive (Jan-March)	40-45					
Sonia Swart - Medical director	70-75	150-155		70-75	155-160	
Sue Hardy - Director of patient & nursing services	100-105			100-105		
James Drury - Director of finance	110-115			110-115		
Christine Allen - Director of planning & service development	100-105			90-95		
Charles Abolins - Director of facilities & capital development	85-90			85-90		
Chanelle Wilkinson - Director of human resources	95-100			60-65		
Chris Pallot - Director of planning & service development	85-90			20-25		
Neelam Aggawal-Singh - Non-executive director	5-10			0-5		
Colin Astbury - Non-executive director	5-10		900	5-10		1,000
Barry Noble - Non-executive director	5-10		4,000	5-10		3,500
Nicholas Robertson - Non-executive director	5-10		900	5-10		700
Phil Zeidler - Non-executive director	5-10		600	5-10		600
Graham Kershaw - Associate non-executive director	5-10		500	5-10		500

Salary Notes

Paul Forden 2009-10 represents a full year, 2010-11 April-Jan only
Sonia Swart's 'Other Remuneration' includes clinical work.
Chanelle Wilkinson 2010-11 represents a full year, 2009-10 Aug-Mar only
Chris Pallot 2010-11 represents a full year, 2009-10 Jan-Mar only
Neelam Aggawal-Singh 2010-11 represents a full year, 2009-10 Mar only
Paul Farenden had a service contract with NGH
Chris Pallot was seconded from NHS Northamptonshire until Oct 2010
The benefits paid to non-executives and chairman above relate to travel and subsistence between home and office
Paul Forden had the provision of a fully leased vehicle

Salary and pension entitlements of senior managers – pension benefits

Name & Title	Real increase/ decrease in pension at age 60 (bands of £2,500)	Real increase/ decrease in Lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2011 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2011 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2011	Cash Equivalent Transfer Value at 31 March 2010	Real increase/ decrease in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Paul Forden - Chief executive (April - Jan)	0-2.5	0-2.5	30-35	95-100	560	590	-41	0
Paul Farenden - Interim chief executive (Jan - March)*								
Sonia Swart - Medical director	-2.5-0	-5-2.5	95-100	290-295	2,180	2,240	-150	0
Susan Hardy - Director of patient & nursing services	0-2.5	0-2.5	25-30	85-90	453	484	-51	0
James Drury - Director of finance	0-2.5	2.5-5	5-10	15-20	68	58	8	0
Christine Allen - Director of planning & service development	5-7.5	15-17.5	35-40	105-110	503	473	11	0
Charles Abolins - Director of facilities & capital development	-2.5-0	-2.5-0	40-45	130-135	1,016	1,048	-74	0
Chanelle Wilkinson - Director of human resources	0-2.5	2.5-5	25-30	75-80	533	542	-31	0
Chris Pallot - Director of planning & performance	0-2.5	2.5-5	10-15	40-45	157	168	-18	0

*Paul Farenden had a service contract with NGH and was not an employee of the Trust

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.

The value of the CETVs for some members have fallen since 31/3/2010 due to the announcement in 2010 that the uprating (annual increase) of public sector pensions would change from the Retail Price Index (RPI) to the Consumer Prices Index (CPI), with the change expected from April 2011. The new CETV factors have been used in these calculations and they are lower than previous factors. A rate of 4% CPI annual inflation has been used to calculate the real increases/decreases.

FINANCE REPORT

Report from the Director of Finance

I am pleased to report that for the fifth successive year the Trust has delivered a surplus with the financial statements showing a surplus for the year of £1.1m (2009/10: £2.1m after adding back impairment charges of £7.0m. For the purposes of calculating the break even duty referred to below impairments are excluded.)

Economic outlook and impact on the Trust

In last year's annual report the Trust set out its approach to the expected forecast downturn through the establishment of the Transformation Programme. This has moved forward significantly and the Trust is making progress in delivering its objective of reducing costs by £30m in 2011/12 and 2012/13. As would be expected with a programme of this size there are risks to the delivery, which the Trust's Board and management team are addressing. Through an extensive communications programme within the Trust the management team have confirmed the importance of the programme to the long term viability of the Trust.

Financial duties

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

Breakeven on income and expenditure (see Note 39.1 to the financial statements)

The Trust reported an in year surplus of £1.1m giving a cumulative breakeven position of £6.1m and therefore meeting its five year breakeven duty.

Capital costs absorption rate (see Note 39.2 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.

External Financing Limit (see Note39.3 to the financial statements)

The Trust was set an External Financing Limit of -£972k for 2010/11. The Trust reports that it has achieved its External Financing Limit undershooting by £56k.

Capital Expenditure

The Trust has incurred capital expenditure £10.3m in 2010/11. This has included investment of £1.5m on replacing general and interventional radiology rooms, £0.6m of enhancements on linear accelerators used for the treatment of cancer and £0.5m on the purchase of digital mammography equipment for the Breast Screening Service. Other purchases of medical equipment amount to £1.0m. Expenditure on estates amounted to £3.9m, which included £0.6m on improving ward facilities and £0.5m on investments to improve the energy efficiency of the Trust real estate. The latter scheme was externally funded by a loan from Salix.

Other expenditure included £2.3m investment on Information Technology including the implementation of a new maternity system (£0.4m) and other clinical systems (£0.3m) and investment in infrastructure (£0.8m)

Charitable Funds

The Charitable Fund has continued to make significant contributions to the Trust during 2010/11, which have included £0.2m in relation to capital projects and a further £0.5m for staff and patient benefit. The Trust would like to take the opportunity to thank the fundraisers, donors and supporters of the Charitable Fund. In addition MacMillan launched their appeal for Haematology in July 2010 and the Trust would similarly like to thank those who have donated to this Appeal.

External Audit Services

So far as the directors are aware, there is no relevant audit information of which the auditors are unaware, and the directors have taken all of the steps required, in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

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..Acting Chief Executive

Date..........................

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

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

- make judgements and estimates which are reasonable and prudent;

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

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

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

By order of the Board

..............................Date...Acting Chief Executive

..............................Date...Finance Director

STATEMENT ON INTERNAL CONTROL

1. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

The Statement on Internal Control for 2010/11 has been prepared against a backdrop of the most significant transformation for the NHS. The planned changes to the NHS, signalled by the publication in July 2010 of the NHS White Paper, *Equity and Excellence: Liberating the NHS,* which includes the creation of new provider, commissioner and public health system for health care.

The opportunities and challenges therefore presented by the NHS White Paper, as well as the level of uncertainty it has generated, have been a significant backdrop for Northampton General Hospital NHS Trust ("NGH") during 2010/11 and will continue to be so during the course of 2011/12.

The key aspects of the arrangements for internal control responsibilities within NGH are:

- The Chief Executive is the Accountable Officer;
- The Board has overall responsibility for governance, whilst the executive leadership of governance, assurance and risk management is delegated in the Integrated Governance Strategy as set out below;
    - Governance and risk management issues to the Director of Nursing, Midwifery & Patient Services;
    - Clinical Governance to the Medical Director and Director of Nursing, Midwifery & Patient Services
    - Financial issues to the Director of Finance.
    - Senior Information Risk Owner to Director of Planning & Performance
- Scrutiny of executive performance on governance matters comes from the Board, the Audit Committee and Healthcare Governance Committee, which are formal committees of the Board. The Audit Committee has met on six occasions during the course of the financial year and the Healthcare Governance Committee on 12 occasions. Both committees have reported through to meetings of the Board;
- The Audit Committee receives independent assurance from internal and external auditors and other bodies, including Local Counter Fraud Services, about the effectiveness of the internal controls within NGH;
- The Audit Committee is established and constituted to provide the Board with an independent and objective review of its financial systems, financial information and compliance with laws, risk and assurance, guidance and regulations governing the NHS;
- The Executive Committee is attended by all Directors of NGH, with a remit covering strategy and planning, risk, governance, performance management and intelligence gathering;
- During the year the Board has reviewed the processes for integrated governance and internal control; endorsing the model and processes for integrated governance that forms the NGH Risk Management Strategy approved by the Board in December 2010;
- NGH works in partnership with local NHS organisations and the Chief Executive of NGH attends the East Midlands Leadership Team (comprising East Midlands Management Board members and the Chief Executives of all NHS trusts in the region), which enables a discussion

of key issues across the region on a collective basis. Further regular meetings are held with NHS Northamptonshire Chief Executive and with Chief executives of other local Trusts through the county QIPPs Board;

- As accountable officer, I am engaged with the East Midlands Strategic Health Authority and other partner organisations through regular meetings to ensure robust monitoring of the Trust's assurance processes and achievement of performance against agreed targets;

2. The purpose of the system of internal control

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

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

The system of internal control has been in place in NGH for the year ended 31 March 2011 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The Trust has successfully raised the profile of risk management in the Trust and developed leadership of the risk management process. A new Risk Management Strategy was developed and approved at a joint meeting of the Audit Committee and Healthcare Governance Committee. The Risk Management Strategy lays out the Risk Management framework which demonstrates leadership at each level of the organisation.

The Audit Committee provides independent assurance of the risk management framework and controls in place on behalf of the Board. It has delegated responsibility for overseeing detailed arrangements for the management of risk and considers reports to gain assurances on key areas of managing of risk. The Audit Committee delegates responsibility for the management of clinical risk and provision of assurance to the Healthcare Governance Committee (HGC).

HGC and the Audit Committee hold bi-annual joint meetings to ensure that systems are integrated between the Committees and across the organisation and to jointly review all corporate risks. The Audit Committee reviews the Board Assurance Framework and seeks assurance on non clinical key risks as part of a rolling programme.

The HGC is a sub-committee of the Board and has delegated responsibility from the Audit Committee for ensuring an effective system of risk management and internal control across the clinical activities of the organisation that support the organisation's objectives. This includes scrutiny of the Patient Safety, Clinical Quality and Governance Progress Report or other clinical reports to ensure that any issues of concern are raised within the Corporate Risk Register as appropriate.

The Risk Management Team co-ordinate and run a training programme for all levels of the organisation. Staff are trained and equipped to manage risk in a way that is appropriate to their authority and duties. During 2010/11 as well as reviewing the Corporate Risk Register quarterly, the Board have received the quarterly report on Safety, Quality and Governance which contains all Directorate level moderate and high risks. This is designed to assure Board members and partly to provide a focus for challenge as well as providing Board members with significant ongoing learning and development. Learning about risk management throughout 2010/11 has been further supplemented through Board Development Days focusing on the Corporate Risk Register and assurance processes.

Directorate Governance Leads supported by Clinical Governance Facilitators have responsibility for risk at Directorate level. Training has been focused on risk assessment; mitigating risk; and reassessment of risks over the last year and this has been supplemented through an increased focus on risk at the monthly Clinical Quality and Effectiveness Group meeting in order to spread learning across directorates. Continued focus on Risk occurs at Directorate's quarterly performance review meetings.

Additionally, the Trust learns from good practice by sharing experiences with other organisations. For example, the Trust has reviewed its risk categories over the last year and has compared the categories with other organisations.
Risk management is an embedded activity which is promoted through training, monthly e-dissemination of a *"Governance Matters"* bulletin, as well as analysis of service user feedback and external reports. Safety is regarded as everyone's business to be achieved by reducing risk exposure to the lowest level possible.

4. The risk and control framework

The Trust's Risk Management Strategy has a number of key elements, these include: the roles and responsibilities of individuals and committees/ groups; the Trust's strategic objectives for risk management; the risk management framework; risk awareness training; and how compliance with the strategy will be monitored.

The previous section describes the role of the two Risk Management Committees within the organisation. Risks are identified, evaluated and controlled using both a top down and bottom up approach. The Board identifies strategic risks on a 6-monthly basis and these are added to the Board Assurance Framework. Each Directorate has their own Risk Register and reviews take place on a monthly basis at Governance Meetings. Risks are assessed using the Trust's risk grading matrix and scope for terminating, treating transferring and/or tolerating risks is evaluated locally and corporately within the organisation taking account of impact, quality of service and best value for money criteria.

All risks graded 16 or over are reviewed monthly by the Head of Governance and the Company Secretary and are subsequently moderated by the Executive Team. All Red Risks are added to the Board Assurance Framework. The 16 and over Risks form the Trust's Corporate Risk Register and are reviewed by the HGC (clinical risks) and Audit Committee (non-clinical risks) quarterly. All moderated risks are also reviewed by the joint meeting.

The risk identification process is both wide-ranging and comprehensive and carried out at all levels of the organisation. Both reactive and proactive sources of information are used to identify risks from sources such as claims, incidents and complaints and audit reports to highlight the risks to which the Trust should react.

Risk registers across the Trust are standardised, which has the advantage of facilitating interrogation of data and population of a Trust-wide risk register. All risks graded 16 and over as a minimum have a detailed action plan embedded in the risk register as well as contingency plans to guard against significant control failure should the risk be realised.

Control measures are based on active consideration of options, which are kept under regular review across the organisation to ensure that they continue to be effective, afford best value for money, and enable the organisation to meet its objectives and targets.

The Risk Management strategy defines the reporting arrangements in place across the Trust to ensure appropriate escalation of risks requiring corporate level management and that the Board receives timely information about key risks, and dependencies between risks. To facilitate this the Trust Board has approved an annual cycle of business and approved the governance framework of the Trust. The governance arrangements aim to improve efficiency, sharing of best practice information, communication and training about risk management. The risk management policy itself sets out the implementation and operational actions.

Control measures are based on active consideration of options, which are kept under regular review across the organisation to ensure that they continue to be effective, afford best value for money, and enable the organisation to meet its objectives and targets

The organisation's Assurance Framework at 31 March 2011, records:

- Risks to achievement of these objectives and targets;
- Systems of internal control in place;
- Review and assurance mechanisms which relate to the effectiveness of the system of internal control;
- Actions taken by the organisation to address control and assurance gaps.

The Assurance Framework is regularly reviewed, discussed and reported to the Audit Committee and the Trust Board to ensure effective and focused management of the principal risks to meeting strategic objectives. The Board and Audit Committee have considered whether any gaps in control and/or assurance exist and have confirmed this, however the Trust continues to assess and develop its Assurance Framework.

All major and potential risks are included in the Trust's Assurance framework and are managed and mitigated through processes set out above.

The Assurance Framework includes all of the Trust's major risks. Potential risks include

- ensuring the Trust has adequate plans to allow it to cope with zero growth in future years and an increased national efficiency target
- harm to patients is not mitigated in all possible circumstances
- the Trust ensures that competition and patient choice does not undermine the stability of services it provides or the financial viability of the Trust
- the Trust ensures that its viability is not usurped through the risk of losing either staff or key group of staff
- the Trust ensures that there is no loss of confidence in services provided by NGH or the NGH brand
- the Trust is assured that the information that it either publishes or has published about it is accurate and reliable

The Trust is fully compliant with CQC essential standards of quality and safety and is registered with no conditions.

Information governance continues to require focus within the organisation. The NHS Information Governance toolkit (version 8) was produced for submission during 2011. This provides an information governance assurance framework for assessment and implementation for the organisation. The toolkit provides the framework for internal risk assessment for the Information Governance team.

This team has produced a strategic vision and associated work programme to deliver on all priority areas for compliance as outlined in the toolkit. This work programme sets quality standards and allows the IG team to monitor progress. Current areas for improvement include extending training to raise competency of information governance for staff and to integrate new information systems and technologies to improve access and retrieval of key business knowledge.

The Trust signs the Connecting for Health Statement of Compliance which has provided during 2011 assurance that the Trust has robust and effective systems in place for handling information securely and confidentiality. It will be renewed as part of the Toolkit version 9 submission in 2012.

In terms of risk, there is a link from the toolkit to improving risk management in terms of the reporting and management of serious incidents relating to data breaches. This is an ongoing project to ensure the excellent practices introduced in relation to risk management are integrated into the management of serious incidents relating to business information.

The Trust recognises that it has a number of public stakeholders who have an on-going interest in the Trust's approach to risk management. Their direct involvement is encouraged through public membership in the development towards Foundation Trust status and is secured through Northamptonshire LINk, the Local Children's Safeguarding Board (LSCB), Safeguarding of Vulnerable Adults Board (SoVA) the Service Users Representation Forum (SURF), Patient Information Group and patient and public involvement focus groups. Support for improvements has also been provided, and gratefully received, from members of the public taking part in fundraising and other charitable activities on behalf of the Trust.

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

The Government Equality & Diversity Council has developed the Equality Delivery System (EDS) aimed at improving the equality performance of the NHS and embedding equality into mainstream business. The Public Duties of the Equality Act require all public bodies to have "equality objectives" which are developed in consultation with the local community, publically published with progress monitored on a regular basis.

The EDS will be used by the Trust in 2011/12 to produce action plans for delivering the equality agenda and thus providing evidence of compliance with the new general duty. The Equality objectives will be developed by October 2011 and at least every four years thereafter.

The aim of the Trust's Equality and Human Rights Group (E&HRG) is to successfully implement and monitor the progress of the new Equality and Human Rights Strategy and the agreed four year plan and objectives. This will not only enable the hospital to fulfil its legal duties but will support the continued promotion of equality and human rights across the hospital.

The Group will develop equality priorities for action and prioritisation and select objectives which will be sent for consultation prior to sign off by the Trust Board and publication.

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

The Trust has undertaken a climate change risk assessment and developed an Adaptation Plan, to support its emergency preparedness and civil contingency requirements, as based on the UK Climate Projections 2009 (UKCP09), to ensure that this organisation's obligations under the Climate Change Act are met. We have relevant plans in place and can demonstrate the measures that we have undertaken to meet the requirements for Climate Change Adaptation under the Climate Change Act 2008.

5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work for 2010/11 satisfactory assurance has been received. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by reports received from the external auditors, the confirm and challenge process to establish full compliance with CQC essential standards, a comprehensive internal audit plan designed to address areas of risk and approved by the Audit Committee.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the relevant internal mechanisms, most notably the Board, Audit Committee, Healthcare Governance Committee and the Executive Team. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board has continued to receive assurances through the regular Board reporting processes. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The risk assurance process provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by the following bodies and processes:

- EMSHA performance reviews;
- NHSLA assessments (including level 1 for acute services and level 1 revised standards for maternity services);
- Internal Audit reports;
- External Audit reports;

- Clinical pathology accreditation processes;
- Data assurance audit;
- Information Governance Toolkit compliance;
- Patient environment action team (PEAT) scores;
- CQC registration without conditions
- Declarations and reports made by Complaints, Local Safeguarding Children Board, Northamptonshire LINk, Overview and Scrutiny Committee (O&SC) and others;
- Local and national clinical and other audit reports;
- Various internal reports, NICE implementation, management of complaints, Trust wide incident trend analysis and the achievement of performance indicators.
- Patient Experience Tracker results

My review confirms that NGH has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

.............................Date...Acting Chief Executive

INDEPENDENT AUDITORS REPORT

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

I have audited the financial statements of Northampton General Hospital NHS Trust for the year ended 31 March 2011 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under the accounting policies set out in the Statement of Accounting Policies. I have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes and
- the table of pension benefits of senior managers and related narrative notes.

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

Respective responsibilities of Directors and auditor

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit the accounting statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view of the state of Northampton General Hospital NHS Trust's affairs as at 31 March 2011 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In my 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 Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the Statement on Internal Control on which I report to you if, in my opinion the Statement on Internal Control does not reflect compliance with the Department of Health's requirements.

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

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

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

Basis of conclusion

I have undertaken my audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2010, as to whether the Trust has proper arrangements for:

■ securing financial resilience; and

■ challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for me to consider under the Code of Audit Practice in satisfying myself whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2011.

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

Conclusion

On the basis of my work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2010, I am satisfied that, in all significant respects, Northampton General Hospital NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2011.

Delay in certification of completion of the audit

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

John Cornett
26 May 2011
Officer of the Audit Commission

Rivermead House, 7 Lewis Court
Grove Park
Enderby
Leicestershire
LE19 1SU

Accounts 2010/11

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2011

	NOTE	**2010-11 £000**	2009-10 £000
Revenue			
Revenue from patient care activities	5	**211,233**	202,864
Other operating revenue	6	**25,027**	24,941
Operating expenses	8	**(230,958)**	(228,081)
Operating surplus/(deficit)		**5,302**	(276)
Finance costs:			
Investment revenue	14	**36**	17
Other gains and losses	15	**24**	(5)
Finance costs	16	**(17)**	(20)
Surplus/(deficit) for the financial year		**5,345**	(284)
Public dividend capital dividends payable		**(4,236)**	(4,674)
Retained surplus/(deficit) for the year		**1,109**	(4,958)
Other comprehensive income			
Impairments and reversals		**(678)**	(20,886)
Gains on revaluations		**581**	331
Receipt of donated/government granted assets		**599**	362
Net gain/(loss) on other reserves		**0**	0
Net gains/(losses) on available for sale financial assets		**0**	0
Reclassification adjustments:			
- Transfers from donated and government grant reserves		**(651)**	(852)
- On disposal of available for sale financial assets		**0**	0
Total comprehensive income for the year		**960**	(26,003)

Notes 1 to 43 which commence on page 58 form part of these accounts.

Reported NHS financial performance position

	2010-11	2009-10
Retained surplus/(deficit) for the year	**1,109**	(4,958)
IFRIC 12 adjustment	**0**	0
Impairments	**0**	7,039
Reported NHS financial performance position	**1,109**	2,081

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2011

	NOTE	**31 March 2011 £000**	31 March 2010 £000
Non-current assets			
Property, plant and equipment	17	**130,355**	130,044
Intangible assets	18	**2,439**	2,010
Other financial assets	23	**0**	0
Trade and other receivables	22	**267**	276
Total non-current assets		**133,061**	132,330
Current assets			
Inventories	21	**4,556**	3,992
Trade and other receivables	22	**10,136**	10,628
Other financial assets	23	**0**	0
Other current assets	24	**0**	0
Cash and cash equivalents	25	**3,867**	2,352
		18,559	16,972
Non-current assets held for sale	26	**0**	0
Total current assets		**18,559**	16,972
Total assets		**151,620**	149,302
Current liabilities			
Trade and other payables	27	**(18,192)**	(17,397)
Other liabilities	29	**(1,440)**	(1,234)
Borrowings	28	**(139)**	0
Other financial liabilities	34	**0**	0
Provisions	35	**(380)**	(484)
Net current assets/(liabilities)		**(1,592)**	(2,143)
Total assets less current liabilities		**131,469**	130,187
Non-current liabilities			
Borrowings	28	**(348)**	0
Trade and other payables	27	**0**	0
Other financial liabilities	34	**0**	0
Provisions	35	**(310)**	(336)
Other liabilities	29	**0**	0
Total assets employed		**130,811**	129,851
Financed by taxpayers' equity:			
Public dividend capital		**99,635**	99,635
Retained earnings		**(3,869)**	(5,384)
Revaluation reserve		**28,714**	29,258
Donated asset reserve		**6,331**	6,342
Government grant reserve		**0**	0
Other reserves		**0**	0
Total taxpayers' equity		**130,811**	129,851

The financial statements on pages 53 to 57 were approved by the Board on 25th May 2011 and signed on its behalf by:

Signed: …………………………………(Acting Chief Executive) Date: ………..

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2010

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Government grant reserve	Other reserves	Total
	£000	£000	£000	£000	£000	£000	£000
Balance at 31 March 2009							
As previously stated	99,661	(756)	48,978	7,997	0	0	155,880
Prior period adjustment	0	0	0	0	0	0	0
Restated balance	99,661	(756)	48,978	7,997	0	0	155,880
Changes in taxpayers' equity for 2009-10							
Total comprehensive income for the year:							
Retained surplus/(deficit) for the year	0	(4,958)	0	0	0	0	(4,958)
Transfers between reserves	0	330	(324)	(6)	0	0	0
Impairments and reversals	0	0	(19,685)	(1,201)	0	0	(20,886)
Net gain on revaluation of property, plant, equipment	0	0	289	42	0	0	331
Net gain on revaluation of intangible assets	0	0	0	0	0	0	0
Net gain on revaluation of financial assets	0	0	0	0	0	0	0
Receipt of donated/government granted assets	0	0	0	362	0	0	362
Net gain/loss on other reserves (e.g. defined benefit pension scheme)	0	0	0	0	0	0	0
Movements in other reserves	0	0	0	0	0	0	0
Reclassification adjustments:							
- transfers from donated asset/government grant reserve	0	0	0	(852)	0	0	(852)
- on disposal of available for sale financial assets	0	0	0	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0	0	0	0
Originating capital for trust establishment in year	0	0	0	0	0	0	0
New PDC received	30	0	0	0	0	0	30
PDC repaid in year	(56)	0	0	0	0	0	(56)
PDC written off	0	0	0	0	0	0	0
Other movements in PDC in year	0	0	0	0	0	0	0
Balance at 31 March 2010	99,635	(5,384)	29,258	6,342	0	0	129,851

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2011

	Public dividend capital (PDC) £000	Retained earnings £000	Revaluation reserve £000	Donated asset reserve £000	Government grant reserve £000	Other reserves £000	Total £000
Changes in taxpayers' equity for 2010-11							
Balance at 1 April 2010	99,635	(5,384)	29,258	6,342	0	0	129,851
Total comprehensive income for the year							
Retained surplus/(deficit) for the year	0	1,109	0	0	0	0	1,109
Transfers between reserves	0	406	(406)	0	0	0	0
Impairments and reversals	0	0	(678)	0	0	0	(678)
Net gain on revaluation of property, plant, equipment	0	0	540	41	0	0	581
Net gain on revaluation of intangible assets	0	0	0	0	0	0	0
Net gain on revaluation of financial assets	0	0	0	0	0	0	0
Receipt of donated/government granted assets	0	0	0	599	0	0	599
Net gain/loss on other reserves (e.g. defined benefit pension scheme)	0	0	0	0	0	0	0
Movements in other reserves	0	0	0	0	0	0	0
Reclassification adjustments:	0	0	0	0	0	0	0
- transfers from donated asset/government grant reserve	0	0	0	(651)	0	0	(651)
- on disposal of available for sale financial assets	0	0	0	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0	0	0	0
Originating capital for trust establishment in year	0	0	0	0	0	0	0
New PDC received	0	0	0	0	0	0	0
PDC repaid in year	0	0	0	0	0	0	0
PDC written off	0	0	0	0	0	0	0
Other movements in PDC in year	0	0	0	0	0	0	0
Balance at 31 March 2011	99,635	(3,869)	28,714	6,331	0	0	130,811

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2011

	NOTE	**2010-11 £000**	2009-10 £000
Cash flows from operating activities			
Operating surplus/(deficit)		**5,302**	(276)
Depreciation and amortisation		**9,420**	9,522
Impairments and reversals		**0**	7,039
Net foreign exchange gains/(losses)		**0**	0
Transfer from donated asset reserve		**(651)**	(852)
Transfer from government grant reserve		**0**	0
Interest paid		**0**	0
Dividends paid		**(4,253)**	(4,674)
(Increase)/decrease in inventories		**(564)**	(170)
(Increase)/decrease in trade and other receivables		**636**	(847)
(Increase)/decrease in other current assets		**0**	0
Increase/(decrease) in trade and other payables		**29**	1,884
Increase/(decrease) in other current liabilities		**206**	(274)
Increase/(decrease) in provisions		**(131)**	185
Net cash inflow/(outflow) from operating activities		**9,994**	11,537
Cash flows from investing activities			
Interest received		**36**	18
(Payments) for property, plant and equipment		**(8,693)**	(10,688)
Proceeds from disposal of plant, property and equipment		**8**	57
(Payments) for intangible assets		**(798)**	(20)
Proceeds from disposal of intangible assets		**0**	0
(Payments) for investments with DH		**0**	0
(Payments) for other investments		**0**	0
Proceeds from disposal of investments with DH		**0**	0
Proceeds from disposal of other financial assets		**0**	0
Revenue rental income		**0**	0
Net cash inflow/(outflow) from investing activities		**(9,447)**	(10,633)
Net cash inflow/(outflow) before financing		**547**	904
Cash flows from financing activities			
Public dividend capital received		**0**	30
Public dividend capital repaid		**0**	(56)
Loans received from the DH		**0**	0
Other loans received		**557**	0
Loans repaid to the DH		**0**	0
Other loans repaid		**(70)**	0
Other capital receipts		**481**	0
Capital element of finance leases and PFI		**0**	0
Net cash inflow/(outflow) from financing		**968**	(26)
Net increase/(decrease) in cash and cash equivalents		**1,515**	878
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year		**2,352**	1,474
Effect of exchange rate changes on the balance of cash held in foreign currencies		**0**	0
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	25	**3,867**	2,352

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 2010/11 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

1.2 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 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.

1.3.1 Critical judgements in applying accounting policies

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

- its ongoing status as a going concern;
- that no major service discontinuation is anticipated;
- selection of indicies for land and building valuations;
- all lease liabilities have been identified through a review of contract documentation

1.3.2 Key sources of estimation uncertainty

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

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

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

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

1.4 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.

In 2010/11 the Trust has recognised critical care as part of its Partially Completed Spells calculation as this is now on a cost per case basis.

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

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

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

1.5 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.

1.6 Other expenses

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

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

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

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

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

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

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. This is a change in accounting policy from previous years where all impairments were taken to the revaluation reserve to the extent that the balance was held for that asset and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

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

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

1.8 Intangible assets

Recognition

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

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

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

Measurement

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

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

1.9 Depreciation, amortisation and impairments

Freehold land and properties under construction are not depreciated.

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

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

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

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

1.10 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to the donated asset reserve. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments are taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to offset the expenditure. On sale of donated assets, the net book value is transferred from the donated asset reserve to retained earnings.

1.11 Government grants

Government grants are grants from government bodies other than revenue from NHS bodies for the provision of services. Revenue grants are treated as deferred income initially and credited to income to match the expenditure to which they relate. Capital grants are credited to the government grant reserve and released to operating revenue over the life of the asset in a manner consistent with the depreciation and impairment charges for that asset. Assets purchased from government grants are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments are taken to the government grant reserve and, each year, an amount equal to the depreciation charge on the asset is released from the government grant reserve to the offset the expenditure.

1.12 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.

1.13 Leases

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

The Trust as lessee

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

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

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

Land and buildings are considered separately when classifying lease arrangements.

The Trust as lessor

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

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

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

1.14 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.

1.15 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.

1.16 Provisions

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

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

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

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

1.17 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 35.

1.18 Non-clinical risk pooling

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

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

1.19 EU Emissions Trading Scheme

EU Emission Trading Scheme does not apply to the Trust until 1 April 2011.

1.20 Contingencies

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

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

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

1.21 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.

1.22 Financial liabilities

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

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

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

1.23 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.

1.24 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.

1.25 Third party assets

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

1.26 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.

1.27 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.

1.28 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 2010/11, 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.

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

1.29 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.

1.30 Accounting standards

The Trust has adopted Accounting Standards as per HM Treasury guidance.

IAS 8 requires that where a new international accounting standard has been issued, but not yet implemented then entities are required to disclose in their financial statements the nature of the standard, and if possible, an estimate of its likely effect on future financial statements. The following standards have been issued but not yet adopted:

•**2011/12**
–IAS 24 related party disclosures
This simplifies the disclosure requirements for government-related entities and clarifies the definition of a related party.
IFRIC 14 amendment
IFRIC 19 Extinguishing financial liabilities with Equity instruments

•**2012/13**
–IFRS 7 financial Instruments: presentation of transfer of Financial Assets
–IFRS 9 financial Instruments: disclosure of Financial Assets and Liabilities
–IAS 12 Income taxes amendment

2. Pooled Budgets

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

3. Operating segments

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

4. Income generation activities

The Trust has no formal registered income generation schemes.

For the purposes of reporting, Catering and Non-Staff Parking are treated as income generation activities. The combined income and costs of these schemes are shown below.

	2010-11	2009-10
	£000	£000
Income	**1,732**	1,737
Full cost	**980**	898
Surplus/(deficit)	**752**	839

5. Revenue from patient care activities	**2010-11**	2009-10
	£000	£000
Strategic health authorities	**107**	0
NHS trusts	**0**	0
Primary care trusts	**207,934**	199,343
Foundation trusts	**453**	2
Local authorities	**0**	0
Department of Health	**0**	129
NHS other	**0**	5
Non-NHS:		
Private patients	**1,379**	2,070
Overseas patients (non-reciprocal)	**155**	87
Injury costs recovery	**1,158**	1,228
Other	**47**	0
	211,233	202,864

Injury cost recovery income is subject to a provision for impairment of receivables of 7.8% to reflect expected rates of collection.

6. Other operating revenue

	2010-11 £000	2009-10 £000
Education, training and research	**11,218**	10,828
Charitable and other contributions to expenditure	**479**	299
Transfers from donated asset reserve	**651**	852
Transfers from government grant reserve	**0**	0
Non-patient care services to other bodies	**1,988**	1,938
Income generation	**1,732**	1,765
Rental revenue from finance leases	**19**	23
Rental revenue from operating leases	**39**	45
Other revenue	**8,901**	9,191
	25,027	24,941

Other revenue includes:
Pharmacy Sales £5,485k (£4,775k)
Accommodation Charges £194k (£144k)
Provision of services to private hospitals £477k (£469k)

7. Revenue

	2010-11 £000	2009-10 £000
From rendering of services	**230,608**	222,990
From sale of goods	**5,652**	4,815

Pharmacy Sales and drugs recharges to other organisations are included as revenue from sales of goods.

8. Operating expenses

	2010-11 £000	2009-10 £000
Services from other NHS trusts	**0**	138
Services from PCTs	**1,171**	1,049
Services from foundation trusts	**290**	103
Purchase of healthcare from non NHS bodies	**0**	2
Trust chair and non executive directors	**57**	49
Employee benefits	**154,542**	146,038
Supplies and services - clinical	**44,545**	42,410
Supplies and services - general	**3,017**	2,972
Consultancy services	**1,076**	1,370
Establishment	**2,362**	2,227
Transport	**142**	732
Premises	**6,906**	7,049
Provision for impairment of receivables	**233**	292
Inventories write down	**96**	71
Depreciation	**8,544**	8,845
Amortisation	**876**	677
Impairments and reversals of property, plant and equipment	**0**	7,039
Audit fees	**125**	127
Other auditor's remuneration	**1**	7
Clinical negligence	**4,966**	4,379
Education and Training	**654**	889
Other	**1,355**	1,616
	230,958	228,081

Other auditor's remuneration relates to National Fraud Initiative & also to IFRS restatement review in 09/10.

Other expenditure includes :
Insurance £157k (£160k)
Legal fees £271k (£612k)
Translation Services £96k (129k)
Internal Audit Fees £131k (88k)

9. Operating leases

9.1 As lessee

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

Payments recognised as an expense	**2010-11**	2009-10
	£000	£000
Minimum lease payments	**781**	735
Contingent rents	**0**	0
Sub-lease payments	**0**	0
	781	735

		2010-11			2009-10
Total future minimum lease payments	**Buildings**	**Land**	**Other**	**Total**	Total
	£000	**£000**	**£000**	**£000**	£000
Payable:					
Not later than one year	**0**	**0**	**523**	**523**	512
Between one and five years	**0**	**0**	**1,181**	**1,181**	916
After 5 years	**0**	**0**	**430**	**430**	118
Total	**0**	**0**	**2,134**	**2,134**	1,546

9.2 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.

Rental revenue	**2010-11**	2009-10
	£000	£000
Contingent rent	**0**	0
Other	**39**	45
Total rental revenue	**39**	45

Total future minimum lease payments	**2010-11**	2009-10
	£000	£000
Receivable:		
Not later than one year	**39**	45
Between one and five years	**40**	96
After 5 years	**0**	0
Total	**79**	141

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

10. Employee costs and numbers

10.1 Employee costs

	2010-11			2009-10		
	Total	**Permanently employed**	**Other**	Total	Permanently employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**130,324**	**117,441**	**12,883**	123,731	107,963	15,768
Social security costs	**10,374**	**9,927**	**447**	9,074	8,502	572
Employer contributions to NHS Pension scheme	**14,000**	**13,971**	**29**	13,234	13,234	0
Other pension costs	**0**	**0**	**0**	0	0	0
Other post-employment benefits	**0**	**0**	**0**	0	0	0
Other employment benefits	**0**	**0**	**0**	0	0	0
Termination benefits	**125**	**125**	**0**	0	0	0
Employee benefits expense	**154,823**	**141,464**	**13,359**	146,039	129,699	16,340

	2010-11	2009-10
Of the total above:		
Charged to capital	**281**	197
Employee benefits charged to revenue	**154,542**	145,842
	154,823	146,039

10.2 Average number of people employed

	2010-11			2009-10		
	Total	**Permanently employed**	**Other**	Total	Permanently employed	Other
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**454**	**434**	**20**	439	419	20
Ambulance staff	**0**	**0**	**0**	0	0	0
Administration and estates	**848**	**767**	**81**	844	756	88
Healthcare assistants and other support staff	**993**	**905**	**88**	1,008	881	127
Nursing, midwifery and health visiting staff	**1,221**	**1,124**	**97**	1,258	1,103	155
Nursing, midwifery and health visiting learners	**0**	**0**	**0**	0	0	0
Scientific, therapeutic and technical staff	**424**	**420**	**4**	405	397	8
Social care staff	**0**	**0**	**0**	0	0	0
Other	**13**	**13**	**0**	4	4	0
Total	**3,953**	**3,663**	**290**	3,958	3,560	**398**

	2010-11	2009-10
Of the above:		
Number of whole time equivalent staff engaged on capital projects	**11**	7

10.3 Staff sickness absence

	2010-11	2009-10
	Number	Number
Total days lost	**35,438**	36,398
Total staff years	**3,640**	3,481
Average working days lost	**10**	10

10.4 Management Costs

	2010-11	2009-10
	£000	£000
Management costs	**10,011**	9,532
Income	**236,260**	227,805

10.5 Exit Packages for staff leaving in 2010-11

Exit package cost band (including any special payment element)	2010-11 *Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	2009-10 *Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
<£20,001	3	0	**3**	0	0	**0**
£20,001 - £40,000	0	0	**0**	0	0	**0**
£40,001 - 100,000	0	0	**0**	0	0	**0**
£100,001 - £150,000	1	0	**1**	0	0	**0**
£150,001 - £200,000	0	0	**0**	0	0	**0**
>£200,000	0	0	**0**	0	0	**0**
Total number of exit packages by type (total cost	**4**	**0**	**4**	**0**	**0**	**0**
Total resource cost (£000s)	125	0	**125**	0	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Agenda for Change/Pension Scheme Terms & Condtions. Exit costs in this note are accounted for in full in the year of departure. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

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

11. 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.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

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

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

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

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

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 statement of comprehensive income at the time the trust commits itself to the retirement, regardless of the method of payment.

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.

12. Retirements due to ill-health

This disclosure is no longer required for NHS Trusts.

13. Better Payment Practice Code

13.1 Better Payment Practice Code - measure of compliance	2010-11		2009-10	
	Number	**£000**	Number	£000
Total Non-NHS trade invoices paid in the year	**62,296**	**72,554**	58,865	68,828
Total Non NHS trade invoices paid within target	**48,667**	**44,877**	43,729	45,577
Percentage of Non-NHS trade invoices paid within target	**78%**	**62%**	74%	66%
Total NHS trade invoices paid in the year	**2,140**	**13,714**	1,700	15,268
Total NHS trade invoices paid within target	**1,410**	**2,613**	1,162	3,427
Percentage of NHS trade invoices paid within target	**66%**	**19%**	68%	22%

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

13.2 The Late Payment of Commercial Debts (Interest) Act 1998	2010-11	2009-10
	£000	£000
Amounts included in finance costs from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	0

14. Investment revenue	**2010-11**	2009-10
	£000	£000
Rental revenue:		
PFI finance lease revenue:		
planned	0	0
contingent	0	0
Other finance lease revenue	19	23
Interest revenue:		
Bank accounts	36	17
Other loans and receivables	0	0
Impaired financial assets	0	0
Other financial assets	0	0
Total	55	40

15. Other gains and losses	**2010-11**	2009-10
	£000	£000
Gain/(loss) on disposal of property, plant and equipment	**8**	(5)
Gain/(loss) on disposal of intangible assets	**0**	0
Gain/(loss) on disposal of financial assets	**0**	0
Gain/(loss) on foreign exchange	**0**	0
Change in fair value of financial assets carried at fair value through profit and loss	**0**	0
Change in fair value of financial liabilities carried at fair value through profit and loss	**16**	0
Total	**24**	(5)

16. Finance costs	**2010-11**	2009-10
	£000	£000
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 late payment of commercial debt	**0**	0
Other interest expense	**0**	0
Total interest expense	**0**	0
Other finance costs	**17**	20
Total	**17**	20

17. Property, plant and equipment

2010-11	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2010	22,602	88,029	608	2,553	30,451	56	8,871	922	154,092
Additions purchased	0	3,993	44	1,080	2,483	19	1,129	13	8,761
Additions donated	0	74	0	358	136	0	31	0	599
Additions government granted	0	0	0	0	0	0	0	0	0
Reclassifications	0	311	0	(1,006)	182	0	91	0	(422)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(1,801)	0	(197)	0	(1,998)
Revaluation/indexation gains	0	0	0	4	1,512	3	0	0	1,519
Impairments	(678)	0	0	0	0	0	0	0	(678)
Reversal of impairments	0	0	0	0	0	0	0	0	0
At 31 March 2011	21,924	92,407	652	2,989	32,963	78	9,925	935	161,873
Depreciation at 1 April 2010	0	0	0	0	17,819	23	5,417	789	24,048
Reclassifications	0	0	0	0	0	0	(14)	0	(14)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(1,801)	0	(197)	0	(1,998)
Revaluation/indexation gains	0	0	0	0	937	1	0	0	938
Impairments	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	3,662	38	0	3,380	8	1,337	119	8,544
Depreciation at 31 March 2011	0	3,662	38	0	20,335	32	6,543	908	31,518
Net book value									
Purchased	21,924	83,745	614	2,649	11,692	21	3,352	27	124,024
Donated	0	5,000	0	340	936	25	30	0	6,331
Government granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2011	21,924	88,745	614	2,989	12,628	46	3,382	27	130,355
Asset financing									
Owned	21,924	88,745	614	2,989	12,628	46	3,382	27	130,355
Finance leased	0	0	0	0	0	0	0	0	0
Private finance initiative	0	0	0	0	0	0	0	0	0
Total 31 March 2011	21,924	88,745	614	2,989	12,628	46	3,382	27	130,355

17.1 Revaluation reserve balance for property, plant & equipment

	Land	Buildings excluding dwellings	Dwellings	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2010	13,672	14,268	95	1,213	0	0	10	29,258
Movements (specify)	(607)	333	4	(264)	0	0	(10)	(544)
At 31 March 2011	13,065	14,601	99	949	0	0	0	28,714

17. Property, plant and equipment continued

2009-10	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2009	24,303	111,259	993	2,978	36,670	266	7,584	945	184,998
Additions purchased	0	4,258	0	3,526	1,967	0	393	18	10,162
Additions donated	0	160	0	39	163	0	0	0	362
Additions government granted	0	0	0	0	0	0	0	0	0
Reclassifications	0	1,703	0	(3,728)	147	0	1,130	0	(748)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(9,383)	(210)	(236)	(41)	(9,870)
Revaluation/indexation gains	0	0	0	3	887	0	0	0	890
Impairments	(1,701)	(18,572)	(348)	(265)	0	0	0	0	(20,886)
Reversal of impairments	0	0	0	0	0	0	0	0	0
At 31 March 2010	22,602	98,808	645	2,553	30,451	56	8,871	922	164,908
Depreciation at 1 April 2009	0	0	0	0	22,859	201	4,501	668	28,229
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(9,359)	(186)	(223)	(40)	(9,808)
Revaluation/indexation gains	0	0	0	0	559	0	0	0	559
Impairments	0	7,039	0	0	0	0	0	0	7,039
Reversal of impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	3,740	37	0	3,760	8	1,139	161	8,845
Depreciation at 31 March 2010	0	10,779	37	0	17,819	23	5,417	789	34,864
Net book value									
Purchased	22,602	82,966	608	2,514	11,425	5	3,449	133	123,702
Donated	0	5,063	0	39	1,207	28	5	0	6,342
Government granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2010	22,602	88,029	608	2,553	12,632	33	3,454	133	130,044
Asset financing									
Owned	22,602	88,029	608	2,553	12,632	33	3,454	133	130,044
Finance leased	0	0	0	0	0	0	0	0	0
Private finance initiative	0	0	0	0	0	0	0	0	0
Total 31 March 2010	22,602	88,029	608	2,553	12,632	33	3,454	133	130,044

17. Property, plant and equipment (cont.)

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. Asset valuations were undertaken in 2008 with an effective date of 1 April 2009 for buildings and this valuation has been applied. Land was revalued as 31 March 2009. To comply with IFRS requirements, valuations have been reviewed in year to ensure that they reflect current economic conditions.

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 £16,549k

All assets leased on an operating basis are buildings

Opening Carrying Value	£276k	(£288k)
In Year Depreciation	£10k	(£12k)
Current Net Book Value	£266k	(£276k)

All donated equipment assets have been provided by NGH Charitable Fund.

A project to redevelop the Haematology Unit commenced in January 2011, as a result block 52 has been identified as a temporarily idle asset. The current Net Book Value is £678k. The project is primarily being funded by Macmillan.

18. Intangible assets

2010-11	Computer software - internally generated	Computer software - Purchased	Licences and trademarks	Patents	Development expenditure (internally generated)	Total
	£000	£000	£000	£000	£000	£000
Gross cost at 1 April 2010	75	4,115	0	0	0	4,190
Additions purchased	61	836	0	0	0	897
Additions internally generated	0	0	0	0	0	0
Additions donated	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0
Reclassifications	206	216	0	0	0	422
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	(7)	0	0	0	(7)
Revaluation/indexation	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversals of impairments	0	0	0	0	0	0
Gross cost at 31 March 2011	342	5,160	0	0	0	5,502
Amortisation at 1 April 2010	12	2,168	0	0	0	2,180
Reclassifications	0	14	0	0	0	14
Reclassifications as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	(7)	0	0	0	(7)
Revaluation	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Charged during the year	41	835	0	0	0	876
Amortisation at 31 March 2011	53	3,010	0	0	0	3,063
Net book value						
Purchased	289	2,150	0	0	0	2,439
Donated	0	0	0	0	0	0
Government granted	0	0	0	0	0	0
Total at 31 March 2011	289	2,150	0	0	0	2,439

18. Intangible assets continued

2009-10	Computer software - internally generated £000	Computer software - Purchased £000	Licences and trademarks £000	Patents £000	Development expenditure (internally generated) £000	Total £000
Gross cost at 1 April 2009	21	3,371	0	0	0	3,392
Additions purchased	0	173	0	0	0	173
Additions internally generated	0	0	0	0	0	0
Additions donated	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0
Reclassifications	54	694	0	0	0	748
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	(123)	0	0	0	(123)
Revaluation / indexation	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversals of impairments	0	0	0	0	0	0
Gross cost at 31 March 2010	75	4,115	0	0	0	4,190
Amortisation at 1 April 2009	5	1,621	0	0	0	1,626
Reclassifications	0	0	0	0	0	0
Reclassifications as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	(123)	0	0	0	(123)
Revaluation	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Charged during the year	7	670	0	0	0	677
Amortisation at 31 March 2010	12	2,168	0	0	0	2,180
Net book value						
Purchased	63	1,947	0	0	0	2,010
Donated	0	0	0	0	0	0
Government granted	0	0	0	0	0	0
Total at 31 March 2010	63	1,947	0	0	0	2,010

18. Intangible assets (cont.)

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.

18.2 Revaluation reserve balance for intangible assets	**2010-11**	2009-10
	£000	£000
At 1 April	**0**	0
Changes	**0**	0
At 31 March	**0**	0

19. Impairments

During the year land valuations have been further reduced in line with market conditions. This reduction is identified as an 'impairment' within the non-current asset analysis.

20. Capital commitments

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

	31 March 2011	31 March 2010
	£000	£000
Property, plant and equipment	**2,420**	1,125
Intangible assets	**145**	8
Total	**2,565**	1,133

21. Inventories

21.1 Inventories	**31 March 2011**	31 March 2010
	£000	£000
Drugs	**1,743**	1,570
Work in progress	**0**	0
Consumables	**2,741**	2,350
Energy	**72**	72
Other	**0**	0
Total	**4,556**	3,992
Of which held at net realisable value:	**4,484**	3,920

21.2 Inventories recognised in expenses	**31 March 2011**	31 March 2010
	£000	£000
Inventories recognised as an expense in the period	**40,744**	38,469
Write-down of inventories (including losses)	**96**	71

22. Trade and other receivables

22.1 Trade and other receivables	**Current**	**Non-current**	Current	Non-current
	31 March 2011	**31 March 2011**	31 March 2010	31 March 2010
	£000	**£000**	£000	£000
NHS receivables-revenue	**4,812**	**0**	6,102	0
NHS receivables-capital	**0**	**0**	0	0
Non-NHS receivables-revenue	**1,295**	**0**	976	0
Non-NHS receivables-capital	**118**	**0**	0	0
Provision for the impairment of receivables	**(420)**	**0**	(446)	0
Prepayments	**839**	**0**	675	0
Finance lease receivables	**0**	**267**	0	276
Operating lease receivables	**0**	**0**	0	0
VAT	**368**	**0**	287	0
Other receivables	**3,124**	**0**	3,034	0
Total	**10,136**	**267**	10,628	276

NHS receivables-revenue
- Estimated value of partially completed spells £2,125k (£1,522k)

Other receivables include:
- Injury Cost Recovery claims (ICR) £2,483k (£2,428k)
- Salary overpayments/other recoverable pay £291k (£426k)

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 2011**	31 March 2010
	£000	£000
By up to three months	**183**	125
By three to six months	**28**	0
By more than six months	**126**	42
Total	**337**	167

22.3 Provision for impairment of receivables	**31 March 2011**	31 March 2010
	£000	£000
Balance at 1 April	**(446)**	(463)
Amount written off during the year	**259**	309
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**(233)**	(292)
Balance at 31 March	**(420)**	(446)

The Trust provides for receivables as follows:

All Non-NHS Trade receivables over 3 months old from date of invoice unless known reason for payment delay.

7.8% of recognised Injury Cost Recovery claims are provided for.
All salary overpayments that occurred prior to 31 March 2010, for which no recovery plan is in place, are provided for in full.

23. Other financial assets	**Current**	**Non-current**	Current	Non-current
	31 March 2011	**31 March 2011**	31 March 2010	31 March 2010
	£000	**£000**	£000	£000
Embedded derivatives carried at fair value through profit and loss	**0**	**0**	0	0
Financial assets carried at fair value through profit and loss	**0**	**0**	0	0
Held to maturity investments at amortised cost	**0**	**0**	0	0
Available for sale financial assets carried at fair value	**0**	**0**	0	0
Loans carried at amortised cost	**0**	**0**	0	0
Total	**0**	**0**	0	0

24. Other current assets	**31 March 2011**	31 March 2010
	£000	£000
EU Emissions trading scheme allowances	**0**	0
Other assets	**0**	0
Total	**0**	0

25. Cash and cash equivalents	**31 March 2011**	31 March 2010
	£000	£000
Balance at 1 April	**2,352**	1,474
Net change in year	**1,515**	878
Balance at 31 March	**3,867**	2,352
Made up of		
Cash with Government banking services	**3,746**	2,128
Commercial banks and cash in hand	**121**	224
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**3,867**	2,352
Bank overdraft - Government banking services	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**3,867**	2,352

26. Non-current assets held for sale

The Trust does not hold any non-current assets for sale.

27. Trade and other payables

	Current 31 March 2011 £000	Non-current 31 March 2011 £000	Current 31 March 2010 £000	Non-current 31 March 2010 £000
Interest payable	**0**	**0**	0	0
NHS payables-revenue	**4,177**	**0**	3,724	0
NHS payables-capital	**0**	**0**	82	0
Non NHS trade payables - revenue	**3,528**	**0**	3,580	0
Non NHS trade payables - capital	**2,401**	**0**	1,553	0
Accruals and deferred income	**2,679**	**0**	3,209	0
Social security costs	**3,245**	**0**	3,088	0
VAT	**0**	**0**	0	0
Tax	**0**	**0**	0	0
Other	**2,162**	**0**	2,161	0
Total	**18,192**	**0**	17,397	0

Other payables include:
£1,817k outstanding pensions contributions at 31 March 2011 (31 March 2010 £1,676k).

28. Borrowings

	Current 31 March 2011 £000	Non-current 31 March 2011 £000	Current 31 March 2010 £000	Non-current 31 March 2010 £000
Bank overdraft - Government banking services	**0**	**0**	0	0
Bank overdraft - Commercial banks	**0**	**0**	0	0
Loans from:				
Department of Health	**0**	**0**	0	0
Other entities	**139**	**348**	0	0
PFI liabilities	**0**	**0**	0	0
LIFT	**0**	**0**	0	0
Finance lease liabilities	**0**	**0**	0	0
Other	**0**	**0**	0	0
Total	**139**	**348**	0	0

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

29. Other liabilities

	Current 31 March 2011 £000	Non-current 31 March 2011 £000	Current 31 March 2010 £000	Non-current 31 March 2010 £000
PFI asset – deferred credit	**0**	**0**	0	0
Lease incentives	**0**	**0**	0	0
Other - employee benefits	**1,440**	**0**	1,234	0
Total	**1,440**	**0**	1,234	0

30. Finance lease obligations

The Trust has no finance lease obligations.

31. Finance lease receivables

NHS Northamptonshire occupies Battle House under a Finance Lease arrangement.

Amounts receivable under finance leases
Of minimum lease payments

	Gross investments in leases	**Present value of minimum lease payments**	**Gross investments in leases**	**Present value of minimum lease payments**
	31 March 2011	**31 March 2011**	31 March 2010	31 March 2010
	£000	**£000**	£000	£000
Within one year	**10**	**10**	12	12
Between one and five years	**40**	**40**	44	44
After five years	**217**	**217**	220	220
Less future finance income	**0**		0	
Present value of minimum lease payments	**267**	**267**	276	276
Less cumulative provision for uncollectable payments:	**0**		0	
Total finance lease receivable recognised in the statement of financial position	**267**	**267**	276	276
Included in:				
Current Finance Lease Receivables		**0**		0
Non-Current Finance Lease Receivables		**267**		276
		267		276

Rental revenue	**2010-11**	2009-10
	£000	£000
Contingent rent	**19**	23
Other	**0**	0
Total rental revenue	**19**	23

32. Finance lease commitments

The Trust has not entered into any finance lease agreement whereby the assets will be made available for use.

33. Private Finance Initiative contracts

The Trust does not have any PFI contracts.

34. Other financial liabilities	**Current 31 March 2011 £000**	**Non-current 31 March 2011 £000**	Current 31 March 2010 £000	Non-current 31 March 2010 £000
Financial liabilities carried at fair value through profit and loss:				
Embedded derivatives	**0**	**0**	0	0
Other financial liabilities	**0**	**0**	0	0
Amortised cost	**0**	**0**	0	0
Total	**0**	**0**	0	0

35. Provisions	**Current 31 March 2011 £000**	**Non-current 31 March 2011 £000**	Current 31 March 2010 £000	Non-current 31 March 2010 £000
Pensions relating to former directors	**0**	**0**	0	0
Pensions relating to other staff	**12**	**106**	11	117
Legal claims	**0**	**0**	0	0
Restructurings	**0**	**0**	0	0
Redundancy	**0**	**0**	0	0
Other	**368**	**204**	473	219
Total	**380**	**310**	484	336

	Pensions relating to former directors £000	**Pensions relating to other staff £000**	**Legal claims £000**	**Restructurings £000**	**Redundancy £000**	**Other £000**	**Total £000**
At 1 April 2010	**0**	**128**	**0**	**0**	**0**	**692**	**820**
Arising during the year	**0**	**2**	**0**	**0**	**0**	**370**	**372**
Used during the year	**0**	**(11)**	**0**	**0**	**0**	**(337)**	**(348)**
Reversed unused	**0**	**0**	**0**	**0**	**0**	**(155)**	**(155)**
Unwinding of discount	**0**	**5**	**0**	**0**	**0**	**12**	**17**
Change of discount rate	**0**	**(6)**	**0**	**0**	**0**	**(10)**	**(16)**
At 31 March 2011	**0**	**118**	**0**	**0**	**0**	**572**	**690**
Expected timing of cash flows:							
Within one year	**0**	**12**	**0**	**0**	**0**	**368**	**380**
Between one and five years	**0**	**50**	**0**	**0**	**0**	**103**	**153**
After five years	**0**	**56**	**0**	**0**	**0**	**101**	**157**

Pension provisions are based on expected lives and current levels of payment. Provisions arising in year relate to ongoing employee and commercial legal claims.

£30,661k is included in the provisions of the NHS Litigation Authority at 31/3/2011 in respect of clinical negligence liabilities of the Trust (31/03/10 £30,607k).

36. Contingencies

36.1 Contingent liabilities

	2010-11	2009-10
	£000	£000
Equal pay cases	**0**	0
Other	**0**	0
Amounts recoverable against contingent liabilities	**0**	0
Total	**0**	0

36.2 Contingent assets

The Trust has not identified any contingent assets.

37. Financial instruments

37.1 Financial assets

	At fair value through profit and loss	**Loans and receivables**	**Available for sale**	**Total**
	£000	**£000**	**£000**	**£000**
Embedded derivatives	**0**	**0**	**0**	**0**
Receivables	**0**	**9,196**	**0**	**9,196**
Cash at bank and in hand	**0**	**3,867**	**0**	**3,867**
Other financial assets	**0**	**0**	**0**	**0**
Total at 31 March 2011	**0**	**13,063**	**0**	**13,063**
Embedded derivatives	0	0	0	0
Receivables	0	10,341	0	10,341
Cash at bank and in hand	0	2,352	0	2,352
Other financial assets	0	0	0	0
Total at 31 March 2010	0	12,693	0	12,693

37.2 Financial liabilities

	At fair value through profit and loss	**Other**	**Total**
	£000	**£000**	**£000**
Embedded derivatives	**0**	**0**	**0**
Payables	**0**	**14,947**	**14,947**
PFI and finance lease obligations	**0**	**0**	**0**
Other borrowings	**0**	**487**	**487**
Other financial liabilities	**0**	**1,440**	**1,440**
Total at 31 March 2011	**0**	**16,874**	**16,874**
Embedded derivatives	0	0	0
Payables	0	14,309	14,309
PFI and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	1,234	1,234
Total at 31 March 2010	0	15,543	15,543

37.3 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 2011 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.

38. Events after the reporting period

There are no material events after the reporting date of 31 March 2011 which effect the Statement of Financial Position.

39. 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.

39.1 Breakeven performance	2005-06 £000	2006-07 £000	2007-08 £000	2008-09 £000	2009-10 £000	2010-11 £000
Turnover	164,673	174,041	187,379	206,926	227,805	236,260
Retained surplus/(deficit) for the year	(2,907)	156	1,834	2,100	(4,958)	1,109
Adjustment for:						
Timing/non-cash impacting distortions:	0	0	0	0	0	0
Use of pre - 1.4.97 surpluses [FDL(97)24 Agreements]	0	0	0	0	0	0
2006/07 PPA (relating to 1997/98 to 2005/06)	0	0	0	0	0	0
2007/08 PPA (relating to 1997/98 to 2006/07)	0	0	0	0	0	0
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	0	0	0	0
Adjustments for Impairments	0	0	0	729	7,039	0
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*	0	0	0	0	0	0
Other agreed adjustments	0	0	0	0	0	0
Break-even in-year position	(2,907)	156	1,834	2,829	2,081	1,109
Break-even cumulative position	(1,927)	(1,771)	63	2,892	4,973	6,082

* 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

	2005-06 %	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %
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%
Break-even cumulative position as a percentage of turnover	(1.17%)	(1.02%)	0.03%	1.40%	2.18%	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.

39.2 Capital cost absorption rate

forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

39.3 External financing

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

		2010-11	2009-10
	£000	**£000**	£000
External financing limit		**(972)**	(888)
Cash flow financing	**(547)**		(904)
Finance leases taken out in the year	**0**		0
Other capital receipts	**(481)**		0
External financing requirement		**(1,028)**	(904)
Undershoot		**56**	16

39.4 Capital resource limit

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

	2010-11	2009-10
	£000	£000
Gross capital expenditure	**10,257**	10,697
Less: book value of assets disposed of	**0**	(62)
Plus: loss on disposal of donated assets	**0**	0
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(599)**	(362)
Charge against the capital resource limit	**9,658**	10,273
Capital resource limit	**10,420**	11,743
Underspend against the capital resource limit	**762**	1,470

The £10,420k notified CRL includes depreciation forecast of £9,831k, whilst actual depreciation in year was £8,769k, i.e. an under spend against plan of £1,062k (internally generated resources that were not realised) and a balance of £645k underspend against actual resources will be reprovided, for schemes on the 2011/12 capital plan.

40. 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 Hopsital 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 Transations

East Midlands SHA £9.1m (£8.2m)
Northamptonshire Teaching Primary Care Trust £187.4m (£177.4m)
Leicestershire County & Rutland Primary Care Trust £14.9m (£16.0m)
Milton Keynes PCT £7.0m (£6.1m)
Northamptonshire Healthcare NHS Foundation Trust £5.5m (£1.3m)

Expenditure Transactions

NHS Litigation Authority £ 5.1m (£4.5m)
NHS Business Services Authority (incl NHS Supply Chain) £7.4m (£6.6m)
NHS Blood and Transplant £1.6m (£2.1m)

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 £676k (£739k)), Northamptonshire County Council (Pathology Services £152k (£151k)) and HM Revenue & Customs (Employers National Insurance contribution £10.4m (£9.2m), VAT refunds received £2.3m (£1.5m)).

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

Grants totalling £478k (£299k), 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 £258k (£362k) 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 545091 or E-mail greenheart@ngh.nhs.uk

41. Third party assets

The Trust held £0.9k cash and cash equivalents at 31 March 2011 (£0.5k - at 31 March 2010) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the Accounts.

42. Intra-Government and other balances	**Current receivables**	**Non-current receivables**	**Current payables**	**Non-current payables**
	£000	**£000**	**£000**	**£000**
Balances with other central government bodies	**4,514**	**0**	**8,477**	**0**
Balances with local authorities	**0**	**0**	**0**	**0**
Balances with NHS trusts and foundation trusts	**666**	**0**	**551**	**0**
Balances with public corporations and trading funds	**0**	**0**	**247**	**0**
Intra government balances	**5,180**	**0**	**9,275**	**0**
Balances with bodies external to government	**4,956**	**267**	**8,917**	**0**
At 31 March 2011	**10,136**	**267**	**18,192**	**0**
Balances with other central government bodies	4,946	276	7,326	0
Balances with local authorities	45	0	0	0
Balances with NHS trusts and foundation trusts	880	0	924	0
Balances with public corporations and trading funds	0	0	321	0
Intra government balances	5,871	276	8,571	0
Balances with bodies external to government	4,757	0	8,826	0
At 31 March 2010	10,628	276	17,397	0

43. Losses and special payments

There were 318 cases of losses and special payments (2009-10: 414 cases) totalling £235k (2009-10: £356k) accrued during 2010-11.