Northampton
General Hospital
NHS Trust

ANNUAL REPORT AND ACCOUNTS

2017/18

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All NHS organisations are required to publish an annual report and financial statements at the end of each financial year. This report provides an overview of the work of Northampton General Hospital NHS Trust between 1st April 2017 and 31st March 2018.

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SECTION ONE:

PERFORMANCE REPORT

Chairman and Chief Executive's Overview: the year in review

Welcome to our 2017/18 annual report. This report summarises some of our main achievements and challenges over the last year. It covers our finances and other important measures of our overall performance. We recommend reading this report alongside our Quality Account, which looks at the quality of our services over the same time period.

The highlight of our year in review was the result of our inspections by the Care Quality Commission that saw an improvement in our official rating, from *requires improvement* to *good*. Inspectors spoke of an inclusive and supportive staff culture, confidence in leadership at all levels and a clear focus on patient safety. The inspection report painted a picture that everyone working here recognised, the essence of which is a positive team spirit delivering care of a high standard in a clinically-led structure where staff are proud of what they do.

The report echoes the hundreds of emails and letters we receive every month from patients and their loved ones, people who take the time to tell us how much it means to them when we get it right, when we prioritise their experience and safety above everything else. The report confirms that this was a whole team effort and that our direction of travel is the right one. It gives us renewed confidence that if we sustain our current improvements and continue our current approach, we will be able to move from *Good* to *Outstanding.*

The timing of our improved inspection rating, in late autumn, proved motivational as we focused on our preparations for what we predicted correctly would be our most challenging winter period yet. Every winter, as we worry that we are at the limit of our ability to provide safe care, we manage to do just that little bit more to improve things but this winter was exceptional in its pressures.

Those patients who come in are older, sicker and frailer and they stay longer. The number of patients in our beds for over seven days is just about the highest in the country and has been rising. On average this winter, this was the case with 70% of our bed capacity; a smaller bed base makes it even more difficult to admit patients who need our care. This is not safe for the patients who are staying with us too long and becoming debilitated. And it isn't safe for the patients who need to come in acutely because we have a chronic and severe problem with patient flow through the hospital.

Alongside our operational pressures, our financial position has been extremely challenging and we spent much of the year grappling with significant overspends in the main bed holding divisions. Across the organisation, we have an improved understanding that our operational performance is wedded to our financial performance: if we are able to get patients to the right bed quickly then their care will be better and safer, **and** we will incur less excess cost **and** be able to receive payment for the elective work which we can then do.

Our organisation-wide response to these pressures took the form of a comprehensive programme, Fixing the Flow, to improve bed flow across the hospital and address exit block, the situation of patients being unable to leave the hospital despite being medically fit for discharge. Some of the barriers to optimum bed flow are external and we're

working with our health and social care partners to address those issues. However, there are steps we can take that will make a significant difference to how efficiently we operate. The key outcomes we are focusing on are:

- the standardisation across the hospital of operational practices for admissions, ward rounds and discharge
- planning for discharge as soon as a patient is admitted

In delivering Fixing the Flow, we've asked our employees to work differently. Some examples include having additional medical consultants in A&E to increase the range of specialist expertise for patients needing emergency care. In many cases, this means our patients can be treated and be home again without the need for an admission; for other patients, it means identifying their care needs earlier even if they have needed to wait until a bed becomes available on a ward. We've fine-tuned the process of discharging a patient home once they're ready to leave, so that those beds can be made available as quickly as possible for other patients in need. We also piloted, and are now rolling out across our wards, new way of approaching the ward round so we can bring consistency in best practice across our organisation. We've seen changes in ward working arrangements, more seven-day working, lots of clinical and support staff doing extra shifts. We've also seen teams across the hospital embrace the opportunities represented by Fixing the Flow and been heartened by the enthusiasm for meaningful change.

Worthy of particular mention is the multiagency discharge event (MADE) held over three days in the New Year. This was supported by the national Emergency Care Improvement Programme (ECIP) and by partners across the health and social care system. We saw what we can achieve when we work collaboratively, with a significant increase in the number of patients going home. The event reaffirmed that change is needed in the way services are delivered and commissioned and this remains one of the biggest challenges in our local health economy.

Support and recognition for our employees

We continue our determination to provide the best care we can and support our staff in the best way possible. One of the most important ways of doing this is to continue our resolve to nurture an open and honest culture with respect and support for all. In the course of the year, we launched two initiatives to say thank you to our employees and to celebrate when they do great work, when their actions made a difference in the lives of others or helped us to be a better organisation.

We're proud to be one of the first hospitals in the UK to introduce the DAISY Award, an international recognition programme that honours and celebrates the skillful, compassionate care nurses and midwives provide every day. The award gives patients or their families an opportunity to nominate a member of the nursing and midwifery workforce and share their story of how a nurse or midwife made a difference.

We also launched our Winter Heroes award to acknowledge the many ways our employees and volunteers responded to our winter pressures. This initiative was prompted initially by stories of individual acts of selflessness and heroism during heavy snow in December; nominations continued to pour in for months with nominees featuring in our Winter Heroes wall of fame on Hospital Street.

The primary theme of our health and wellbeing strategy during the year was mental health awareness. We held events throughout the year helping staff to recognise the signs and symptoms of stress, anxiety and depression and looking at ways we can do more to tackle stigma and discrimination. These included mental health awareness workshops and talking therapy sessions delivered by the charity MIND and a mental health awareness drop-in event *Mind Your Head* that coinciding with World Mental Health Day.

We also introduced critical incident stress debriefing to support employees who have experience a profound or distressing event in the course of their work. A critical incident could be the sudden death of a patient, a serious injury, or a physical or psychological threat to the safety or wellbeing of a member of staff regardless of the type of incident. We have a core group of staff who are trained to provide debriefing, allows those involved with the incident to process the event and reflect on its impact.

During the year, we were at the spearhead of the Cavell Nurses' Trust new membership programme. Cavell Nurses' Trust is a charity providing support for UK nurses, midwives and healthcare assistants, both working and retired, when they're suffering personal or financial hardship – often because of illness, disability, domestic abuse and the effects of older age.

Our volunteers

We continue to be indebted to each and every one of our volunteers for their support and commitment. The year saw many developments for our volunteer services team, including the growth of the Bedside Book Club and an increased presence in clinical areas.

Following the disbanding of the Friends of NGH charity in August 2017, we were delighted to retain the expertise and knowledge of over 40 of experienced volunteers who chose to join our in-house service. Demand for the buggy service continues to grow with the number of journeys increasing by 25 per cent over the last year. Fundraising is ongoing to allow the buggy service to be self-sufficient.

Relationships have gone from strength to strength with Pets as Therapy charity, with two new dogs introduced into five wards. The dogs visit weekly and offer an alternative therapy to those who are in hospital and missing their own pets.

And this year, the service began developing a programme to support with people with mild learning disabilities and introduce them into voluntary positions such as gardening, guiding and working alongside the Bedside Book Club.

Our buildings, facilities and IT infrastructure

Our most significant development this year has been the construction of our new emergency assessment unit. This will be used to assess acutely unwell patients arriving from the emergency department or referred by their GP. Our staff were asked to name the new building and its wards. The overall structure will be called **The Nye Bevan Building** in honour of the architect of the NHS who 70 years ago established the British

system of a health service funded from general taxation and free at the point of use. The two wards in the building will be named:

- The Esther White Ward, in honour of Northampton General Hospital's first matron, who began working at the hospital in 1743.
- The Walter Tull Ward in honour of the footballer who signed for Northampton Town Football Club from Spurs in 1911. He made 111 first team appearances before serving Britain's war effort in the first world war, becoming the first British Army officer of black heritage.

The building will be staffed by a dedicated team of consultants, nurses, assistant practitioners and healthcare support workers with specialist support from other services across the hospital. It offers exciting opportunities to explore new ways of working, both internally and with our community health partners and GPs.

We also reopened of our chemotherapy suite following huge public response to a fundraising appeal. The refurbishment has increased capacity by four additional treatment bays which will reduce waiting times for patients. With the careful use of design, lighting and colour, the treatment area is a more welcoming and calm environment offering more privacy to patients as well as being a more practical working space for staff. The fundraising campaign was led by the hospital's charity, Northamptonshire Healthcare Charitable Trust and saw £500k donated by individuals and local groups and businesses specifically for the refurbishment.

Another project that benefited from the support of our local community was the creation of a therapeutic sensory garden near our centre for elderly medicine. The garden has particular benefits for our patients with dementia and was created thanks to a donation form local business Michael Jones Jewellers..

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

- The creation of a new urgent care centre, Springfield, opposite our emergency department
- The completion of a second MRI suite
- The relocation of our children's outpatients area
- The refurbishment programme of our paediatric wards to include new sleeping spaces for parents

Another major improvement was the complete transfer of the site electrical infrastructure onto back-up generator electrical supplies. This has had a significant impact on the resilience of the power supplies across the site thus improving the day to day running of the hospital during mains failure creating a safer patient environment.

During the year, we recruited a chief information officer, a key element in our to drive to become an information-led organisation and to drive paperless NHS agenda. Understanding that information helps deliver great care, we have created a new structure for our technology and information department to support our clinical colleagues: the technology team; the clinical support team; the data team; and the informatics team.

Innovation, improvement and awards

Quality improvement is core to the delivery of safe compassionate services at NGH. During the year, our employees continued to embrace opportunities to improve the services they deliver and the experience of our patients.

For the past year, our wards have been supported with a new way of working that introduces a collaborative approach to making improvements at a local level. A number of shared decision-making councils are up and running leading to improvements in patient care, working procedures and the local environment. In a shared decision-making council process, the impetus for change comes from the team and is delivered by the team.

During the year, we became the first district general hospital in the UK to fit the world's smallest pacemaker. The leadless pacemaker can be implanted directly into the patient's heart via a vein in the leg, halving the risk of major complications associated with conventional pacemakers. Conventional pacemakers are placed in the patient's chest with leads running to the heart.

Our cardiac department also introduced a new treatment for patients with severely blocked arteries that cannot be treated with routine surgery, a complex surgical procedure, called rotablation, which uses high-speed drills to blast away hardened calcium.

We introduced a virtual fracture clinic aimed at getting patients seen by the right person at the right time in the right place. For some patients this means a telephone consultation with an orthopaedic nurse rather than a visit to hospital. The overall effect is the release of more on-site appointments for patients who need to be seen in person and a reduction in waiting times. The success of this approach is now being looked at across the hospital to identify suitable services where it might be emulated.

These examples are a microcosm of the improvement and innovation continually taking place in teams, departments and services right across the hospital.

In a year in which we cared for more people than ever before, we had so much to celebrate and the nominations flooded in from members of the public, patients and staff for our 2017 Best Possible Care Awards. We hold these awards to recognise our employees and volunteers who make an exceptional contribution to patient care – and they took place last year thanks to funding from the Northamptonshire Health Charitable Fund

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

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

- We were shortlisted in three categories of the Patient Experience Network's National Awards (PENNA) which aim to highlight outstanding patient experience across the health and social care sector in the UK.

  The *Keep Connected* initiative is a real-time survey of patients while they are in hospital. The results equip the wards to make immediate improvements wherever possible. It was shortlisted in two categories, and received the runner-up accolade in the Measuring, Reporting & Acting category

  Meanwhile, the midwifery service's *Meet the Matrons* project was shortlisted for their work with expectant mothers and fathers when preparing for the arrival of their baby and providing opportunities to parents to reflect on their experience of pregnancy and birth.

- Our campaign that led to the creation of a mobile library for our patients won the Community Initiative Campaign of the Year category at the UK Public Sector Communications Awards. The awards celebrate excellence in communications in the NHS, local and national government, emergency services and not-for-profit bodies from across the UK. The library is run by our volunteers and was created thanks to book donations from the public of Northampton when earlier this year, we asked people living and working in Northampton to donate their favourite book.

- A collaborative working project to develop individualised plans for patients with learning disabilities and complex needs who need to undergo surgery in hospital was shortlisted in the Learning Disabilities Nursing category of the Nursing Times Awards. The initiative sees our lead learning disability nurse work with patients, their carers, their GP or other community health professionals, and members of our surgical team to identify challenges and areas of concern. A bespoke care plan is then produced.

- A second shortlisted entry in the Nursing Times awards, in the Theatres category, was our scheme to deliver in-house speciality training for registered nurses working in a surgical environment. The specialist training focuses on best evidence-based clinical practice and incorporates simulation training to develop clinical, leadership and team-working skills.

- Ophthalmology registrar Dr Sohaib Rufai was awarded a national research prize, the Vernon Prize Trophy, for his clinical research into the diagnosis and management of underdevelopment of the retina in young children

Finally, we extend our unreserved thanks on behalf of the whole trust board to the 5,000 staff and volunteers who make up Team NGH. We are immensely proud to lead an organisation with so many dedicated colleagues strive to do their very best for their patients and colleagues.

Debbie Needham
Deputy Chief Executive Officer

Paul Farenden
Chairman

AN INTRODUCTION TO NORTHAMPTON GENERAL HOSPITAL NHS TRUST

About Us

Here at Northampton General Hospital we are equally proud of our tradition and innovation. We have served the people of Northampton for 275 years and now provide general acute services to a local community of 380,000 people. Our hyper- acute, vascular and renal services are provided to 692,000 people who live in the wider Northamptonshire area.

We are proud of our status as an accredited cancer centre, caring for a wider population of 880,000 people living in Northamptonshire and parts of Buckinghamshire.

With an income of approximately £300 million we provide services from several locations, with our main hospital site situated close to Northampton town centre. We offer a more limited range of acute services at Danetre Hospital in Daventry. Care is also provided for patients awaiting discharge from two wards in the Cliftonville Care Home, while the Angela Grace Care Centre provides more specialist care: both are located adjacent to our main hospital site.

Our Vision, Values and Strategy

Our vision is to provide the best possible care for our patients.

We are constantly seeking to innovate and provide services in the safest and most clinically-effective way. We aspire to align all our efforts around quality improvement. Increasingly , we know that we can't achieve our vision without investing in Team NGH and our view is that this investment needs to include development , support and nurture of our workforce.

Our values underpin all we do and are the behaviours against which we judge ourselves:

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

Our Strategic Aims

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

To support delivery of these organisational priorities during 2017/18 the Board has developed five strategic aims aligned to our vision and values. They are:

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

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

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

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

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

Risks

The current healthcare environment remains very challenging and the constrained financial environment and difficulty in recruiting a substantive workforce are our main strategic risks. In addition, the Northamptonshire Sustainability and Transformation Programme is rated as challenged adding to difficulties in achieving strategic ambition. However we continually focus on:

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

PERFORMANCE ANALYSIS

Overview

The past year has seen increased collaborative working with other service providers within the county to ensure that patients are provided with the best possible care in the timeliest manner.

We have experienced some operational challenges throughout 2017/18.

There has been a 2 per cent increase in A&E attendances but with the introduction of the Springfield urgent treatment centre in November, we have been able to provide quick and effective treatment for patients requiring a GP-type service. This in turn has reduced the burden on our busy emergency department. Self-presenting patients are streamed by a streaming practitioner (paramedic/nurse) to the co-located urgent treatment centre between the hours of 8am and 11pm. Currently 55% of all attendances are seen by a streaming practitioner, of these 20% are seen, treated and discharged through our UTC.

The winter period started earlier than normal and we saw a significant increase in patients over the age of 75 presenting with acute conditions.

While we admitted fewer patients via A&E than many other hospitals, those patients we did admit required longer periods of time in the hospital with many requiring care in the community after their period of acute care was complete. The delays in discharging patients for their ongoing care did increase through the year with significant numbers of patients waiting in the hospital for care in their own homes or in nursing/community beds.

As in previous years, we have worked to review existing processes and practices to improve efficiency in all patient pathways with the aim of ensuring safety and quality of care along with a reduced length of hospital stay and safe discharge, thus improving the outcome and experience for our patients. The quality improvement programme was relaunched in October 2017 and is led by the chief operating officer, medical director and director of nursing. The programme (Fixing the Flow) has a dedicated clinical manager overseeing the individual projects of work.

The aim of Fixing the Flow is to encourage rapid cycles of change which are tested using a quality improvement methodology (PDSA: plan, do, study, act). Some of the changes which have taken place throughout the year are:

- Introduction of the SAFER patient flow bundle
    - Clarity of the plan for all our patients and our staff
    - Increased productivity of twice daily board rounds
    - Red2Green 'bundle' being delivered twice daily
    - Increased percentage of our patients are getting out of bed during the day where appropriate
    - Focus on the actions for tomorrow's discharges from the afternoon board rounds
    - Organised teams, easier to lead, less onerous for medical staff
    - Improved teamwork and morale

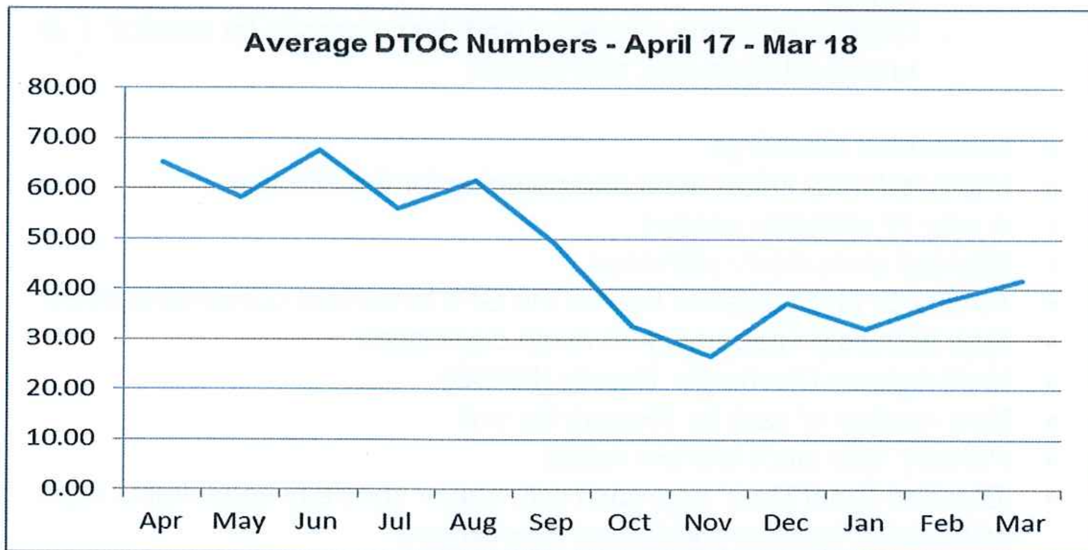
- Criteria-led discharge
- Improved daily information and planning for the site team
- A new IV antibiotic service
- Revised ambulatory pathways
- An advice and guidance line for the GPs to contact consultants direct
- New admission paperwork to avoid duplication
- Multi Agency Discharge Events (MADE)
- New models of care for therapy led unit
- Primary care input into two wards
- 'Blended Front Door' approach with senior specialty consultants supporting ED with senior decision-making as assessment
- Spot purchase of care home beds to supports discharge flow out of the hospital
- Daily tracking meetings during the peak of winter with our external colleagues to confirm and challenge every patient's pathway, identify blockages and free them up
- Additional registrar and consultant medics on duty overnight and at weekends
- Junior doctor allocated to discharge suite to support the rapid production of TTOs (to take out – medicines given to patients on discharge)

Alongside the change programme a winter plan was developed with the clinical divisions during the summer months. Although winter pressure arrived early the plan was put into place and with additional resource we were able to ensure extra medical staff could focus on discharge later in the evenings and at weekends. Additional patient transport was put into place as well as extra discharge nurses. We procured an additional seven beds at Avery Healthcare care home.

All routine elective operating ceased before Christmas and throughout January. While this was reinstated during February, we were forced to cancel many scheduled appointments on the day of their operations in February; therefore, a decision was taken to cease routine operating during March while the urgent care pressures continued. The adverse weather during the winter period also had an effect on our ability to discharge as many patients as required.

Delayed discharges (DTOC)
There has been a focus between NGH and our external partners on reducing the number of delayed transfers of care (DTOCs) this financial year. Numbers decreased dramatically from September through to November but are now starting to increase again. Pressures on social care services in Northamptonshire may result in further increases in the number of DTOCs as there are insufficient facilities in the community/primary care to support their discharge.

On average, 7 per cent of our bed base is being utilised by patients who are clinically fit for discharge. This is a reduction from 16/17 where the average figure was 12 per cent.



ACTIVITY

Activity Comparison	2014-15	2015-16	2016-17	2017-18	Diff	% Diff
Emergency Inpatients	40,349	43,456	47,701	46,061	-1,640	-3%
Elective Inpatients	6,208	5,824	5,634	5,135	-499	-9%
Elective Daycases	38,346	39,610	42,393	41,840	-553	-1%
New outpatient attendances - Consultant led	80,037	83,474	105,790	107,493	1,703	2%
Follow-up outpatient attendances - Consultant led	149,977	155,562	208,420	231,503	23,083	11%
New outpatient attendances - Nurse led	38,571	42,127	27,758	27,746	-12	0%
Follow-up outpatient attendances - Nurse led	114,953	154,412	101,938	83,142	-18,796	-18%
Total number of outpatient DNA's	30,350	34,770	36,708	35,764	-944	-3%
Patients seen in Accident & Emergency (All Types)	109,305	114,179	116,183	122,582	6,399	6%
Number of babies born	4,685	4,726	4,867	4,760	-107	-2%
Average length of stay (in days)	3.55	4.36	4.52	4.88	0.36	8%

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

The accident and emergency figures now include type 3 attendances (minor illnesses and injuries) through our Springfield urgent treatment centre site. This was opened in November 2017 and accounts for 5,679 attendances in the data above.

There has been a 6% increase in attendances between this year and last, largely due to additional patients attending Springfield. Type 1 attendances increased by 2% across the two years. Type 2 attendances remained static.

National Performance Standards

There have been significant challenges with our performance standards, especially with the pressure on urgent care in quarters 3 and 4 of 2017/18. This also impacted on our elective activity and referral-to-treatment time (RTT) performance, as an agreed stepdown of elective care was put in place to manage the winter pressures which in turn generated a backlog that now needs to be addressed.

Although not achieving December 2017 and January 2018 referral-to-treatment time (RTT) performance levels, we did achieve and maintain the diagnostics 6-week wait time performance and made significant progress with our cancer standards since the beginning of quarter 3.

Indicator title	Q1	Q2	Q3	Q4
Cancer waits - 2 weeks wait				
Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	89.3%	81.4%	85.5%	
Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	65.8%	42.1%	62.8%	
Cancer waits - 31 days				
Cancer: Percentage of patients treated within 31 days - from diagnosis to first definitive treatment	95.7%	97.1%	96.8%	
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	93.9%	90.6%	98.2%	
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	97.1%	97%	98.6%	
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	95.8%	96.6%	96.8%	
Cancer waits - 62 days				
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85.0%	77.7%	84.2%	
Cancer: Percentage of patients treated within 62 days of referral from screening	92.0%	92.9%	90.7%	
RTT				
RTT waiting times – Patients on incomplete pathways with a current wait time < 18 weeks	92.1%	92.1%	91.8%	89.0%
Zero tolerance RTT waits over 52 weeks for incomplete pathways	0	0	1	1
A&E				
A&E: Total time in A&E (month)	87.2%	88.3%	84.1%	83.6%
Trolley Waits in A&E > 12 hours	7	0	0	0

4-hour A&E standard

2017/18 has been another challenging year for our urgent and emergency care pathways which has seen increased numbers of high acuity patients presenting throughout the year and peaking in March 2018.

A&E	2017/18											
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Total Patients Seen	9591	10185	10269	10484	9811	9726	10287	10141	11888	12051	11076	12109
> 4 Hour Waits	1205	1494	1152	1202	1039	1271	1383	1756	1932	1886	2124	1805
Trajectory	84%	84%	84%	85%	86%	85%	85%	85%	85%	86%	87%	88%
Actual performance	87.44%	85.33%	88.78%	88.53%	89.41%	86.93%	86.56%	82.68%	83.75%	84.35%	80.82%	85.09%

These issues have contributed to a high bed occupancy rate throughout autumn and winter of 2017/18.

There has been increased collaborative working with partners in health and social care with our new type 3 urgent care centre at Springfield. This service has seen a further 5,000 patients presenting.

Work is also well underway with our new Nye Bevan unit, a 60 bedded acute assessment hub with new models of care to support both the emergency department and the flow of patients through the organisation.

Cancer waiting times standard
We have continued on our cancer improvement journey during 2017/18. Our cancer board and more recently the daily tracking meeting has continued to oversee the operational teams. New pathways for patients on the prostate, lower GI and lung pathways are in place having undergone an extensive review and changes in line with best practice.

Quarter 1 proved challenging from a radiology capacity perspective and significantly affected the time patents remained on a cancer pathway. This has shown radical improvements over the course of the year considering the national recognition of radiology workforce shortages; the focus ongoing is to aspire to all diagnostics requested and reported within seven days.

This year also saw challenges in the breast service; with the two week wait standard not being met for the first time, additional capacity was sourced externally. This target remain challenging going into 2018/19.

Meeting the 62 day standard has still proved challenging for the best part of 2017 and has meant an intense focus and support package being made available by NHSi.

This - coupled with daily PTL meetings introduced in quarter 2 supported and attended by senior managers for all tumour sites and including histopathology, oncology and radiology - has delivered a sustained three-month success at reaching the 62 day performance, with NGH being the most improved in the region during November reaching 90.1 percent.

During December we met all nine cancer waiting times standards, the first time on record in more than five years.

The numbers of patients waiting in excess of 62 days on a cancer pathway have improved hugely during 2017 with 115 at its highest in 2016 and 15 as of 23 February 2018. The impact of this is also the reduction of patients waiting in excess of 104 days.

The results of the 2016 National Cancer Patient Experience Survey published in 2017 shows improvements in patient experience at NGH; 437 patients (68 per cent) responded and for the first time since the survey began six years ago, we are in line with the national average for overall cancer experience

We have worked incredibly hard the past year laying the foundations to make sustainable change; the challenge going forward is to embed that change and to continue to improve in order to deliver the best possible care to all patients on a cancer pathway.

18 week referral-to-treatment time (RTT) standard

We maintained the achievement of the referral-to-treatment time (RTT) target through to November 2017. However due to the urgent care winter pressures we implemented a step down of elective activity as directed by NHS England. This step-down has led to a significant backlog in elective activity which has resulted in the deterioration of performance in elective specialities and in particular within orthopaedics.

We failed to meet the 92 per cent performance level in December 2017 and January 2018 for the first time since the change to RTT reporting in October 2015. RTT performance levels will remain very challenging as we work at clearing the backlog generated by the step-down of the elective work.

Inpatient orthopaedic work continues to be outsourced with a focus on delivering day case activity in-house.

Recovery for the RTT ongoing target is expected in November 2018.

SUSTAINABILITY REPORT

Annual Sustainability Report 2017/18

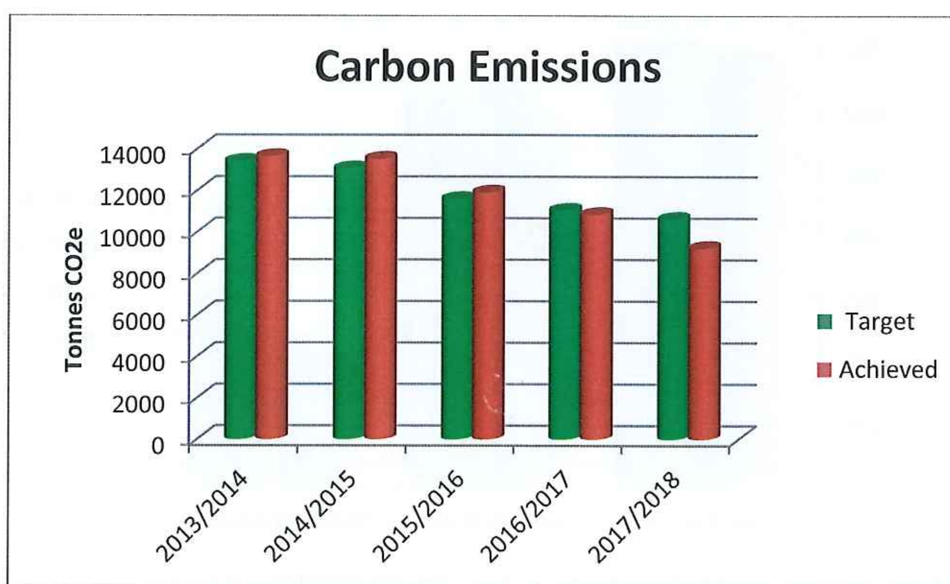
Over the last twelve months NGH has

- Reduced carbon emissions from buildings, travel and anaesthetic gases
- Reduced water consumption
- Increased recycling
- Maintained Investors in the Environment and Food For Life accreditations.

Energy and Carbon Emissions

	2015/2016	2016/2017	2017/2018
Consumption Data			
Gas kWh	22,683,936	18,937,723	17,723,952
Electricity kWh	15,222,263	15,657,244	15,620,993
*Biomass		2,131,484	3,664,301
*Water m^3	136,464	151,982	137,967
Business Travel miles	943,475	894,928	810,214
Financial Data £			
Gas	1,276,017	1,189,156	1,086,173
Electricity	477,196	246,904	289,057
*Biomass		64,456	102,500
*Water	263,063	297,080	290,414
Business Mileage	395,717	364,465	334,109
Carbon Credits	191,202	171,965	188,038
Renewable Heat Incentive		(73,343)	(101,523)

**approximate figures as full data not yet confirmed at time of compiling*



Carbon emissions from fuels, water and business travel against target for the year.

During 2017/18 we reduced carbon emissions from our buildings by a further 1136 tonnes, an 11 per cent reduction, which means we are still on track to achieve our 2020 target of a 34 per cent reduction. This means that over the last five years emissions from the NGH site buildings have reduced by 4841 tonnes or 36 per cent. The majority of this year's reduction has been a result of the decarbonisation of the grid electricity. In addition, we purchased renewable certificates for our grid electricity; a further 815 tonnes.

The biomass boiler using wood sourced from tree clearances from a Northampton firm has reduced carbon emissions by over 500 tonnes (compared with using gas-fired boilers) and brought in a revenue from the Government's Renewable Heat Incentive scheme in excess of £100,000.

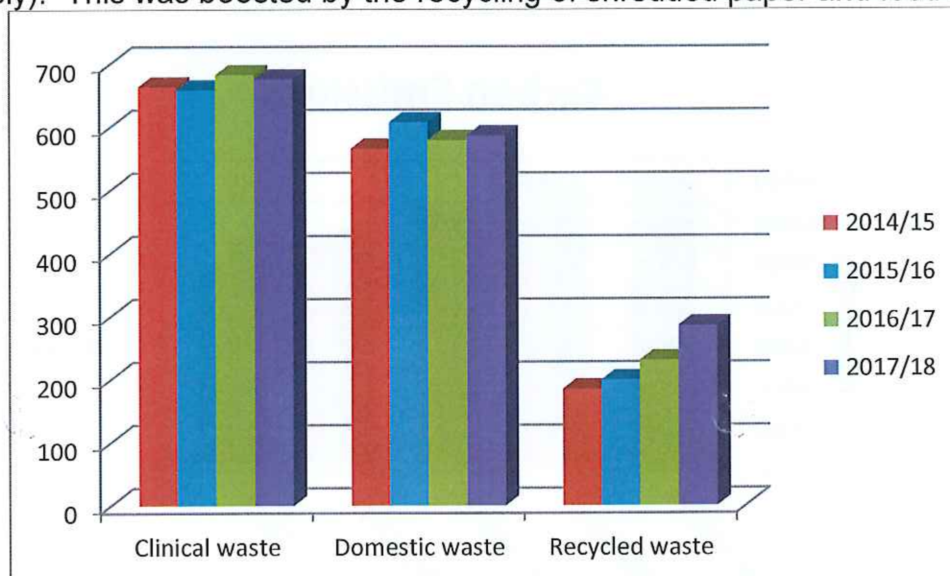
We have continued to invest in energy reduction measures, optimising our building management system and making our lights more efficient. Although we took partial occupancy of the Springfield urgent care centre this year, its effect on our carbon emissions and water consumption is still being calculated and is therefore not included in this year's report.

Water

Despite having had two major underground water leaks in the second half of the year our water consumption was lower than last year. A water strategy and action plan to determine the next steps required to reduce our water usage by our internal KPIs will be created in the first quarter of 2018/19.

Waste

We have worked hard to improve our recycling and reduce our costs in the last year as well as trying to reduce the total amount of waste produced. Our sustainability strategy set a target of a 5 per cent increase in recycling weights each year which we exceeded in both 2016/17 and in 2017/18 (16 per cent and 24 per cent increase in weight respectively). This was boosted by the recycling of shredded paper and food in 2017/18.



(Figures do not include weights from reuse, or from the confidential waste which also goes for recycling.)

We continue to donate unwanted items to a local charity that uses them in hospitals in Ghana and Syria. We have kept the Warp-It platform for reuse of items both internally and with other external organisations in the Warp-It network and now have 124 staff members registered with the site.

We reduced the amount we spend on confidential waste collections by putting a shredder baler into the medical records department which generates approximately half of our confidential waste. This also brings a revenue for the recycled paper.

Our domestic waste and recycling is managed by Cawleys, a local company who helped us run a hazardous waste awareness day. We have also started a new food waste collection. The scraps from our retail outlets are sent for anaerobic digestion to create energy rather than sending the waste down the drains and potentially blocking Anglian Water's sewers.

In conjunction with our infection prevention team, we introduced the Clinismart bag-to-bed system across the wards, reducing the number of bins and improving the patient environment. We also led a collaborative clinical waste tender, working with Kettering General Hospital and Northamptonshire Healthcare Foundation Trust and are now working with our new waste partners to reduce costs.

In the next year we will be looking at the implementation of further recycling streams as well as starting to reduce the amount of single use plastic that we use.

Leadership
We maintained our Investors in the Environment Green Accreditation for 2016/17. Following an audit during 2017 our score increased from 95 to 96 per cent.

We were one of the founding members of the Global Green and Healthy Hospitals group, a worldwide network of healthcare institutions that are actively promoting sustainable healthcare. As part of the group we pledged to reduce our carbon emissions by 2020 and were given a silver award in 2017 for our actions to date.

We also contributed to the SDU's new Natural Resources Footprinting tool and the Sustainable Development Assessment Tool – the replacement of the Good Corporate Citizenship tool. We have nearly finished our first assessment using the new tool and will use this to find the areas we need to concentrate on in the coming year.

Carbon footprint and procurement
One of the major sources of greenhouse gas emissions from acute hospitals is anaesthetic gases, due to their high global warming potential. Our emissions this year were 3.5 per cent lower than last year at 2827 tonnes CO2e. Other measured greenhouse gas emissions come from refrigerants used for cooling both in patient areas and for equipment such as refrigerators in the kitchen. The emissions from these accounted for a further 308 tonnes CO2e – equivalent to the emissions from our business travel. A comparison cannot be made to previous years as the data has not been readily available.

Using the Defra procuring for carbon reduction tool, the embedded carbon emissions from the products and services we buy has been calculated at 87,650 tonnes. This is an increase of 9 per cent. However, this is only an approximate measure and is based on spend. We promote, wherever possible, the use of local suppliers. In 2017/18 7 per cent of our spend was with companies in the NN postcode area while a total of 12 per cent of the spend was with companies registered within 25 miles of NGH.

Sustainability and Quality Improvement
Improving the efficiency and safety of all of our services is a major pillar of both sustainability and quality improvement. Therefore, sustainability metrics are now presented as part of the quality improvement scorecard each month. In addition sustainability measures are also considered for all new QI projects that are undertaken at NGH.

Outdoor spaces
Although we have limited green space, we are trying to make the best of it for staff, patients and wildlife. The recent revamp of the therapies garden, primarily for people with dementia, specified that the plants needed to be good for pollinators. This is a course that will be followed in any changes made to our green spaces. We were also fortunate to have a wild plant list created for the site by a local botany expert. This will hopefully be the start of some biological recording on the site.

Catering
Food is an essential part of both the patient care pathway and our staff wellbeing, but also has a major environmental impact. Our catering team has maintained their Food for Life Bronze Accreditation for both patient meals and the main staff and visitor restaurant. This has increased the environmental and health benefits of the food we serve; increasing the amount of freshly prepared food to over 90 per cent, ensuring ingredients are sourced from suppliers adhering to recognised standards such as MCS (Marine Conservation Society) certified fish and Red Tractor meat and applying government buying standards thus reducing salt, fat and sugar. Further environmental actions include a loyalty card for people buying the vegetarian option on Meat Free Mondays and a discount on hot drinks for anyone bringing their own mugs as well as recycling from the tea rounds on the wards.

Following a successful trial in the elderly wards, the team have introduced smaller food portions as an option on most wards, which has reduced the amount of wasted food.

Staff engagement
All new domestics and healthcare assistants as well as junior doctors entering the anaesthetic department receive bespoke training to highlight the good things they can do in their area. In addition a monthly newsletter is sent out with all the sustainability news and actions that staff can take both at work and at home.
The environment was also firmly on the agenda during Antibiotic Awareness Week when the sustainability manager followed up a talk about antibiotic resistance in the environment at the infection prevention study day with a presence at the events held.

Travel

Business mileage reduced further, as did the carbon emissions for our travel.
NGH hosted two Dr Bike Days arranged in conjunction with Northamptonshire County Council during the summer to encourage staff to get on their bikes. One of these was held on Clean Air Day where also handed out leaflets to visitors and staff highlighting the health problems connected with urban pollution.

SECTION TWO

ACCOUNTABILITY REPORT

Report of the Director of Finance

Economic outlook and impact

The NHS continues to be under significant pressure both financially and operationally. Our response to this is to continue to focus on providing high quality care to our patients through our clinically-led structure. Given these pressures we were unable to improve our financial position in 2017/18 due to the at times extreme pressures on the hospital, particularly due to increasing demand for urgent care services.

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

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

Financial performance

We planned for a deficit of £13.5 million in 2017/18. This compared to the deficit of £15.1 million in 2016/17. The actual deficit was £23.3 million which was adverse to plan by £9.8 million. £4.8m was due to an income and expenditure variance and £5.0 million due to lost Sustainability and Transformation (STP) funding due to not achieving the financial and A&E performance targets

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

Capital expenditure

We invested £13.2 million in 2017/18 improving our estate, medical equipment and information technology (IT) assets. This included further substantial investment in MRI machines and in a new patient administration system. We have almost completed the building of a new assessment hub, the Nye Bevan Unit; this development is due for completion in summer 2018. The development will be financed through a lease with a capital value of approximately £12.4 million.

Charitable Funds

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

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

During the financial year, the charity paid £630k as grants. Of specific note are the following:

- Chemotherapy suite refurbishment completion costs in 2017/18 totalled £92k.
- Initial professional fees associated with the creation of the emergency assessment unit in Talbot Butler £24k.
- Investment in 6 bladder scanners for the wards £44k.
- Staff engagement survey (Questback) software & licences £36k.
- Staff training & course fees £83k.
- 20 reclining treatment chairs in oncology 40k.
- 10 parent wallbeds in child health £28k.
- 586 patient bed panels hospital wide £21k.

Phil Bradley

Interim Director of Finance

Annual Governance Statement 2017/2018

1. Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me.

I am also responsible for ensuring that the NHS rust is administered prudently and economically and that resources are applied efficiently and effectively.

I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*

2. Governance framework of the organisation and its purpose

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

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Northampton General Hospital NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place within the Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Trust Board and committee structure

Northampton General Hospital NHS Trust has a Board of Directors (the Board) which comprises of both Executive and Non-Executive Directors and has met monthly throughout the year.

Voting members comprise the Chair and five non-Executive Directors, one Associate non-Executive Director and five Executive Directors, including the Chief Executive along with four non-voting Directors.

The role of the Board is to govern the organisation effectively and in doing so to build public and stakeholder confidence that their health and healthcare is in safe hands and ensure the Trust is providing safe, high quality patient – centred care.
The Board holds its meetings in public bi monthly and papers are available on the Trust website. The Board regularly reviews performance against national standards and regulatory requirements and a summary of performance against these priorities is available through the Trust's Annual report. The Board places a strong emphasis on quality and safety of patient care and in addition to performance reports, regularly hears directly from patients and carers, including patient stories and ward visits.

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

The Trust Board approved the organisation's Quality Account in June 2017, further to review by the Quality Governance Committee. The accuracy of the Quality Account is assured through internal review and data checking processes as part of the Trust's data quality arrangements.

The Trust's External Auditors also undertook an audit of the 2017/18 Quality Account and their findings are being taken into account for the production of this year's Quality Account which is due to be agreed by the Board in June 2018.

During 2017/18 the Board has continued to review its effectiveness using the Care Quality Commission's Well Led framework and more recently the revised requirements of the NHS Improvement document "Developmental reviews of leadership and governance using the well led framework". Work is underway through a gap analysis process to understand challenges and areas where externally facilitated development review may be of most benefit.

The Board also undertakes a bi-monthly programme of Board development activity. During 2017/18 this has continued to be centred on ensuring the Board understands the changing healthcare landscape and in particular the work in relation to Sustainability and Transformation programmes and how they link with organisational strategic aims related to ensuring safe and sustainable services via clinical collaboration.

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

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

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

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

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

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

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

Board and Subcommittee Attendance

Name	Position	Date of Commencing Appointment	Board Record of Attendance *April 2017 to Mar 2018*	Audit Committee	Quality Governance Committee	Finance Investment & Performance Committee	Workforce Committee	Remuneration and Appointments Committee
Paul Farenden	Non- Executive Director, Chair	1.3.12	10/12		x	x	x	x
Phil Zeidler	Non- Executive Director, Vice Chair	1.12.08	9/12	x		x		x
David Noble	Non- Executive Director	1.1.13	10/12	x	x	x		x
Graham Kershaw *01.12.17	Non- Executive Director	1.3.13	6/8	x	x		x	x
John Archard-Jones	Non- Executive Director	01.01.17	12/12	x	x			
Olivia Clymer *31.10.17	Non- Executive Director	2.11.15	3/7	x	x		x	x
Annette Gill	Non- Executive Director (Associate)	01.01.17	11/12	x			x	x
Sonia Swart	CEO	23.9.13	10/12		x	x	x	
Debbie Needham	Chief Operating Officer/ Deputy CEO	10.4.14	11/12		x	x	x	

Name	Position	Date of Commencing Appointment	Board Record of Attendance *April 2017 to Mar 2018*	Audit Committee	Quality Governance Committee	Finance Investment & Performance Committee	Workforce Committee	Remuneration and Appointments Committee
Catherine Thorne	Director of Corporate Development Governance and Assurance	19.1.15	11/12	Attend	x	x		
Simon Lazarus *01.12.17	Director of Finance	11.3.14	8/8	Attend	x	x		
Philip Bradley	Interim Director of Finance	04.12.17**	3/4	Attend	x	x		
Janine Brennan	Director of Workforce and Transformation	2.4.13	11/12		x	x	x	
Charles Abolins *31.08.17	Director of Facilities	1991	5/5		x	x	x	
Stuart Finn	Interim Director of Estates and Facilities	01.09.17**	3/6		x	x	x	
Chris Pallot	Director of Strategy and Partnerships	11.10.10	12/12		x	x		
Mike Cusack *20.10.17	Medical Director	26.9.14	5/6		x		x	
Matthew Metcalfe	Medical Director	02.10.17**	5/6		x		x	
Carolyn Fox	Director of Nursing	20.7.15	11/12		x	x	x	

Stepped down *
Appointed **

3. The risk and control framework and risk assessment

The Trust board has overall accountability for the Trust's risk management approach through the executive directors. The framework and policy, approved by the Trust Board, supports the development of an organisational style whereby effective risk management is an integral part of providing healthcare and day-to-day decision-making.

Whilst executive directors are full-time employees who manage the daily running of the Trust, the entire Trust board takes collective responsibility for setting out the strategic direction and for holding the executive to account for the Trust's performance. The Trust board is also accountable for upholding high standards of

governance and probity. The chairman and non- executives in particular provide strategic guidance and support.

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

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

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

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

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

- For each of the Trust's Divisions a Divisional Director has lead responsibility for governance and risk issues and is responsible for coordinating risk management processes within the Divisions, including management of the Divisional risk register supported by the Divisional Manager. The Divisional management groups have responsibility for monitoring, managing and where necessary escalating risks on their risk registers and significant risks are reviewed at monthly performance review meeting.

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

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

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

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

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

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

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

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

TIAA have delivered the 2017/18 internal audit plan as agreed at the start of the year through the Audit committee.

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

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

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

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

Patients and the public

- The work of the, the Patient Advice and Liaison Service and specific patient representative groups.
- Patient membership of key Trust committees and groups.
- The work of the local Health and Wellbeing Boards.
- Meetings of the Trust Board held in public which include monthly Patient Stories.
- An extensive volunteering programme across hospital departments including a new group of volunteers specifically dedicated to supporting the Trust's Friends and Family Test (FFT) agenda, handing out postcards for completion and collating data
- Representation on the Patient & Carer Experience and Engagement Group (PCEEG) from a Patient Representative and internal focus groups (such as BME, Dignity, end of life).
- Expert patient involvement in the redesign programmes across Northampton and Kettering hospitals
- Plans for 2017/18 include development of a network of Patient and Family partners launched through a "Quality Conversation" event in early 2017.

Staff

- Strong focus on encouraging staff to raise concerns with a Freedom to Speak Up Guardian and launch of a Respect and Support campaign led by the Human Resources Division to support improvements in the staff survey outcomes.
- Board to Ward and "Beat the Bug" visits by Executive and non-Executive Directors.
- Implementation of a programme of "Question Time comes to NGH" to allow staff greater access to senior staff to inform and provide discussion forum for topical issues.
- Monthly Core Brief to staff by Executive team.
- Partnership forum with staff-side representation.
- Staff Engagement Strategy that includes specific vehicle through which staff views are sought on key matters.

Partners

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

Compliance matters

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

The Trust has Workforce Equality Objectives as part of our Four Year Plan. The two main objectives link to the Equality Delivery System (ED2) outcomes relating to the workforce, with the key actions linked to the Workforce Race Equality Standard (WRES), health and wellbeing, staff survey results, divisional objectives and the leadership and management development programme.

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

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

During 2017/18 the Trust has developed a three year Patient Equality & Diversity Strategy. The strategy sets out the Trusts approach to ensuring patient equality and diversity of service provision for patients and is complementary to our strategy for equality and diversity in the workplace.

The Patient Equality & Diversity Strategy explains the statutory duties placed on the Trust by the Equality Act and Equality Duties and demonstrates the process by which these requirements are responded to. Alongside our Patient Equality & Diversity Strategy we have completed an Annual report for 2016/17. We have also set up the Patient Equality and Diversity Steering Group which monitors the Trust compliance with the Public Sector Equality Duty through our four year Equality Delivery System (EDS2) plan.

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

Northampton General Hospital maintains an Environmental Management System which is externally verified by and accredited to the Investors in the Environment Scheme (Green Level).

The Trust has a Sustainability Strategy that has been approved by the Board with accompanying Sustainable Development Action Plans, progress against which is monitored through the Sustainable Development Committee.

An adaptation policy is in preparation, following a review of the risks to the Trust arising from the changing climate. The Trust has in the past regularly reviewed and published its Good Corporate Citizenship scores. Going forward we will be using the Sustainable Development Assessment Tool to measure progress against ourselves, other trusts and against the UN Sustainable Development Goals.

Progress in carbon reduction, climate change mitigation and adaptation along with other sustainable development initiatives are reported in the annual report and to the Board. Regular updates are also provided in the monthly newsletter that is sent to NGH staff.

The Trust Board receives a monthly update report on compliance with the Care Quality Commission's Essential Standards of Quality and Safety through the Quality Governance committee which scrutiny improvement performance and metrics described in the CQC intelligent monitoring report. Please see section 4 for performance information in respect to CQC compliance.

Information Governance (IG)

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

In 2017/18 the Trust has appointed a Chief Information officer to support organisational oversight and improvement and overhauled governance reporting to improve the management of risks to data security. The Trust is currently implementing changes related to General Data Protection Regulations and this is overseen by the Data Governance Group.

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

Quality Account

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

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

The indicators within this document are subject to external audit scrutiny and the auditors are required to provide an independent assurance opinion to the organisation. The Trust received an unqualified limited assurance opinion for its Quality Account in 2017.

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

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

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

The Head of Internal Audit Opinion for 2017/18 concludes in summary that:

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

This is based on:

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

b) An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the first nine months of the financial year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

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

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

Assurance Assessments	Number of Reviews
Substantial Assurance	1
Reasonable Assurance	8
Limited Assurance	8
No Assurance	0

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

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

- The Board has played a key role in reviewing risks to the delivery of the Trust's performance objectives through monthly monitoring and discussion of the Corporate Performance Report and detailed financial and quality and safety reports, and through Board and committee reporting on progress against other strategic objectives.
- The Audit Committee and Risk and Compliance Group have overseen the effectiveness of the risk management arrangements.
- The Risk and Compliance Group has reviewed the Trust's risk register and monitored key clinical and non-clinical risks highlighted by Trust committees and individual managers.
- Executive Directors have ensured that key risks have been highlighted and monitored within their functional areas and the necessary action taken to address them.
- Both Internal and External Audit have provided scrutiny and assurance in relation to governance and control arrangements across a wide range of the Trust's activities.

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

Northampton General Hospital NHS Trust is registered with the Care Quality Commission (CQC) and following the CQC Chief Inspector of Hospital's Inspection in February and November of 2017 the Trust received an overall rating of 'GOOD'

Data Security
The Trust reported three Information Governance incidents to the Information Commissioner's Office in 2017/18

Details of Incident 1
The Estates department are engaging with a company that provides a bespoke lift share app which is better than currently advertised means available on the Trust Intranet. The data required is staff names, department, NGH email addresses and home postcodes for employees. The Non-disclosure agreement with the company was agreed; however the data was shared before the staff consultation process took place which meant staff were not given the opportunity to opt out before the data was shared

The incident was graded as a level 1 reportable incident and recorded on the IG Toolkit but did not need reporting to the Information Commissioners' Office (ICO).

Details of Incident 2
On searching the word Stress in the search bar of the Trusts intranet page, the first result took you to a spreadsheet from 2011 which gave individual names, where they worked, i.e. NGH, GP etc. and the type of stress they were suffering from, i.e. Occupational or Personal stress. The data was uploaded to the Trusts intranet page as part of a mass upload of documents and a Datix was immediately raised with the spreadsheet being removed from the intranet by ICT

The incident was graded as a level 2 breach and recorded on the IG Toolkit with the ICO being informed. The lessons learnt and actions from this were that the ICT process for mass uploads was put under review

Details of Incident 3
A member of staff requested clinical audit data from the Informatics department. This included the personal data (PAS Number, Patient Full Name, Operation Date, Main Operation description, Outpatient Appointment Date) for 243 patients. The information was sent to the Dr's NGH email address and in subsequent communication it is apparent that the information was sent by the member of staff to unsecured email address. This is a breach of our Data Protection and Confidentiality policy, and Email and Communications policy.

The incident was graded as a level 2 breach and recorded on the IG Toolkit with the ICO being informed. The lessons learnt and actions from this were further trust wide training and communication required on sending information. Asked informatics to look at a 2 step process where justification for PID and then approved by Senior Manager. On the request form an IG statement will be included.

National Performance Standards
There have been significant challenges with our performance standards, especially with the pressure on urgent care during 2017/18. This also impacted on our elective activity and RTT performance as an agreed stepdown of elective care was put in place to manage the winter pressures which in-turn has generated a backlog which requires addressing in 2018/19.

4 hour A&E standard
2017/18 has been another challenging year for the Trust's urgent and emergency care pathways which has seen a 2.4% increase in attendances to the emergency department together with higher acuity of those patients throughout the year, peaking in January 2018.

This has also contributed to a high bed occupancy rate particularly throughout autumn and winter and these issues remain challenging for the Trust which is exacerbated by high numbers of delayed discharges.

The Trust has implemented a "Fixing the Flow" improvement programme during the year aimed at a fast paced approach to testing new solutions in order to improve patient flow and patient experience.

Part of this programme is supporting an increasing collaborative approach in working with partners across health and social care with a new walk-in centre opened in November 2017.This will also provide a primary care streaming facility to reduce the burden on the emergency department. Early indications point to in excess of 5,000 patients presenting there since is opening.

Additional work is completing on a 60 bedded acute assessment hub with new models of care to support flow through the Trust which should ease the burden on our emergency department and reduce bed occupancy levels across the trust.

Cancer Waiting Times standard
The Trust has continued on its cancer improvement journey during 2017/18 with both the internal Cancer Board and countywide Cancer Board supporting and overseeing implementation of pathway improvements, together with the development of a broader strategy to sustain performance.

Nationally, the Cancer Alliance has identified three pathways of lung, prostate and lower gastrointestinal cancers for radical improvement with the Trust being an active participant in this work throughout the year.

In terms of performance against standards the Trust has had several issues affecting consistent attainment of targets. These include radiology capacity due to the nationally recognised workforce shortages together with recruitment difficulties within the breast cancer service.

Meeting the 62 day standard continues to prove challenging for the organisation, however towards the end of 2017/18, there has been a marked improvement in progress with intense leadership scrutiny, to achieve the standard with the Trust being the most improved in performance by November 2017.

18 Week RTT standards

The period up to November 2017 the Trust maintained achievement for RTT, however due to urgent care winter pressures the Trust had to step down some elective activity for a period as directed by NHS England. This step-down led to development of a backlog in elective activity which has resulted in the deterioration of performance in elective specialities and in particular within orthopaedics.

The trust failed the 92% performance level in December 2017 and January 2018 for the first time since the change to RTT reporting in October 2015. RTT performance levels will remain very challenging as the trust works at clearing the backlog generated by the step-down of the elective work.

Inpatient Orthopaedic work continues to be outsourced, with a focus on delivering day case activity in house. Whilst in ENT, virtual clinics have been established to provide further capacity and support the Head and Neck services, whilst a restructure and full review of processes is undertaken.

Data Quality and Accuracy

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

Internal spot check audits across all areas have also played a key part in validating the quality and accuracy of our data and subsequent reporting.

4hr A&E standard

In November 2017 the method of counting Emergency Department activity was changed under the guidance of NHSI, this saw the inclusion of other non-elective walk-in activity, such as that provided by the ambulatory care unit and Paediatric Assessment Unit. The reasoning for this was that this activity historically would have attended the Emergency Department; these areas were introduced to provide care in the right setting for specific patient groups.

Significant validation work has been undertaken in this area to ensure the accurate capture of data and therefore accurate reporting; this is ongoing. Additionally, throughout the year, spot check audits have been undertaken to cross reference activity recorded on the Emergency Department system, correlated with that recorded on the main PAS system with findings reported and cascaded as necessary.

Cancer Waiting Times standard

The Trusts Cancer Services employ an Audit & Data Validation Officer whose role is to validate all Cancer Waiting Times Standards submissions; working alongside the Data Analyst responsible for national uploads. Weekly and monthly audits occur before monthly submission deadlines.

Additionally, a data quality review was conducted for 2017/18 which resulted in a 92% assurance level, with manual data input errors the overarching theme.

Cancer Services are currently exploring working with Somerset Cancer Register to trial their data import features from other hospital systems, which would reduce data input errors and provide one version of a patient's journey.

<u>18 Week RTT standards</u>
The Trust has updated its Access Policy during 2017/18 to include more detailed information in respect to patient pathways and the recording of information.

Additionally there has been an ongoing programme of work, including the use of external validators, to validate our incomplete RTT pathways for confirmation of accuracy as well as undertaking internal "spot checks" on pathways to include "clock stops" as well as the incomplete pathways.

A change in the weekly performance meeting format has removed the previous acknowledgement that poor performance is merely poor data quality, with a need to provide plans to improve performance as recorded and increased focus being put on timely, "right first time" data capture.

In preparation for the migration of data to a new patient administration system (PAS), the Trust's pathway validation team has validated data both from the current system and once migrated to the new system; any issues of data quality have been identified and escalated to areas with a new training programme put in-place to mitigate the risk of incorrect data input.

A team of external validators has been put in place to validate all records on the current PAS system for accuracy and to highlight areas of concern in the recording and managing of patient pathways to ensure that when migrated to the new PAS system, it is as accurate as we can make it. Issues of data quality identified whilst undertaking this validation are also being addressed, irrespective of their effect on performance figures.

Current areas of risk in respect to data quality include:
1. Non adherence to the access policy and timely input of data onto PAS. This is being mitigated by providing training to all key staff on the use of the access policy with more intensive training for individuals as identified through the audit and validation work is, specifically around pathways for Referral to Treatment (RTT) and diagnostics.

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

3. Data Migration to the new PAS may present a number of areas of data quality issues and the recording of pathways, when the trust moves from a referral based system, to a system more aligned with the capture of pathway activity. This is being mitigated by the data quality and pathway validation teams being wholly engaged with the migration

programme and seeking out possible areas of concern to correct and educate as necessary, prior to migration and then time dedicated to the auditing post "go live".

4. External validators will remain on site for two weeks post system "go live" to ensure there are no issues with the data collected and reported on

Never events
There have been three Never Event incident reported by Northampton General Hospital during 2017/18 and as required by national guidelines these have been reported onto STEIS (Strategic Executive Information System)

- Incident 1 - Wrong Site Surgery (Hip)
- Incident 2 - Wrong Site Block (Ear surgery)
- Incident 3 - Wrong strength Ophthalmic Lens Implant
-

Incident 1
This incident pertains to a patient who lacked capacity to consent for surgery for a fractured hip. Despite having a Lasting Power of Attorney for Health and Welfare in place, correct consenting and surgical site marking procedures were not followed, resulting in the patient having surgery commenced on the left hip instead of the fractured right hip.

The investigation determined that wrong site surgery was commenced due a systematic contravention of safety procedures, which are specifically in place to avoid such errors. This included a series of failures commencing on the ward, continuing through to the operating theatre itself, where a final opportunity to recognise the error and halt surgery was not taken.

The error was recognised intra-operatively and the patient went on to have the correct hip operated on, making a recovery and then being discharged from the Trust.

An improvement plan has been implemented following the investigation findings.

Incident 2 and 3
At the time of writing these incidents remain under detailed investigation. However preliminary findings indicate the patients have not come to serious harm as a result of these events.

Since these incidents, changes in various policies and procedures are being made, which include a revision of the Trust Consent Policy, review of the Surgical Site Marking policy, and review of previously agreed actions in relation to ophthalmic lens checking prior to insertion.

The learning from the Incident 1 was shared both locally within the Orthopaedic Governance and Departmental meetings in addition to, organisational learning through the Trust's quarterly Dare to Share Learning Event.

A similar process for dissemination of learning will be used for subsequent incidents

Financial Position
2017/18 was a very difficult year for the Trust from a financial perspective. A deficit plan of £13.5m, inclusive of £8.7m of STF funding, was agreed with NHSI. However the out turn position was a deficit of £23.3m which was £9.8m adverse to plan, of which £4.8m related to I & E and £5.0m to loss of STF, due to not achieving our A & E or financial targets for most of the year.

The Changing Care @ NGH programme which is the route by which the Trust improves quality and efficiency and hence deliver financial savings was only able to achieve £4.9m of its £12.9m target in year. This programme has been re-booted for 2018/19 as efficiency targets and savings do need to be delivered.

For 2018/19 there is now much more of a need to work together across the health and care system, to ensure that we, along with our partners, are financially sustainable and that the Trust delivers it's £18.5m deficit plan (inclusive of £9.2m of Provider Sustainability Funding (PSF) which replaces STF funds).

Nurse Recruitment
The future of Nursing & Midwifery supply and demand is one of the most challenging workforce issues nationally. To mitigate the risks of recruitment the Trust's overarching vision for Nursing & Midwifery has been set out in a three year plan as described in our Nursing & Midwifery Strategy.

The document describes clear priorities to develop a successful and sustainable workforce as part of our recruitment & retention campaign. The Strategy focuses on staff recognition and staff well-being and links with our plans to develop local flexible routes into Nursing, in order to optimise the supply and retention of nursing capacity. These new routes into Nursing will provide a real opportunity for the Trust to develop its own locally-owned flexible routes into Nursing from a Healthcare Support Worker, through to a Registered Nurse.

Our focus on the recruitment and retention of our staff has seen positive results and over the last 2 years there has been a consistent reduction of vacancies for the core in-patient wards and since October 2017, the vacancy rate for Nursing (and Midwifery) has been below the Trust target of 9%.

Trust Estate
A full estate compliance risk assessment paper was presented to the Board in 2017 with further progress update papers, delivered throughout 2017 and early part of 2018.
The update papers presented a detailed plan of risk mitigation and action plans, to reduce the risk with regular review and assessments of these risks by estates senior management.

Additional capital funding has been approved for 2018/19 to deliver the first stage of a site wide ward decant plan to allow essential planned maintenance work to support the building infrastructure estates compliance works.

Conclusion

In respect to Northampton General Hospital's system of internal control, the Trusts programme of internal audit has identified no significant internal control issues. However some weaknesses have been identified in audited elements of sterile services, safeguarding recommendations related to the Lampard report, recruitment of Medical Staffing, Medical records, Health and Safety, timesheet authorisation for Medical staffing, Estates procurement and Clinical Audit.

The improvement recommendations for these audits have either been already actioned or are subject to a wider improvement plan, which is being monitored and overseen through Executive Director Portfolio's with reports on progress to the relevant Board subcommittee with responsibility for overseeing associated risks associated with a gap in control.

With the exception of these internal control issues, my review, supported by a Head of Internal Audit opinion of reasonable assurance, confirms that Northampton General Hospital NHS Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives.

Debbie Needham
Deputy Chief Executive Officer
Northampton General Hospital NHS Trust

Appendix 1

Organisational Principal risks

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

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

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

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

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

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

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

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

9. Risk of action by the ICO for failure of staff to comply with Trust systems and processes which ensure compliance with confidentiality of person identifiable information and a failure to implement the requirements of the General Data Protection Regulations by May 2018.

Statement of the chief executive's responsibilities as the accountable officer of the trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

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

Date 25 May 2018 Debbie Needham, Deputy Chief Executive

Statement of directors' responsibilities in respect of the accounts

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

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts
- assess the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity

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

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

By order of the Board

Date **25 May 2018** **Debbie Needham, Deputy Chief Executive**

Date **25 May 2018** **Phil Bradley, Interim Director of Finance**

STAFF REPORT

Remuneration

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

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

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

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

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

Pay Multiples

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

The banded remuneration of the highest paid director in the Trust in the financial year 2017/18 was £225-230k (2016/17, £225-230k). This was 10.28 times (2016/17, 10.48 times) the median remuneration of the workforce, which was £22,128 (2016/17, £21,909).

In 2017/18 and 2016/17 no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £1k for part-time staff to £178k for the next highest paid director and £228k for the highest paid agency locum (full year effect) (2016/17 £1k - £213k)

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

The ratio has decreased in 2017/18 by 0.2. Nursing staff represent the largest increase in Total Average Staff Numbers. The majority of staff on Agenda for Change terms and conditions received a 1% pay increase. This has contributed to the increase in the overall median remuneration of the workforce.

Salary and Pension Report

Salary and pension entitlements of senior managers

Remuneration

Name and Title	2017-18					
	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100* £	Performance Pay and Bonuses (bands of £5,000) £000	Long term Performance Pay and Bonuses (bands of £5,000) £000	All Pension-related Benefits (bands of £2,500) £000	Total - Salary & Benefits (bands of £5,000) £000
Paul Farenden - Chairman	25 - 30	1,700				30 - 35
Sonia Swart - Chief Executive Officer	225 - 230					225 - 230
Deborah Needham - Chief Operating Officer / Deputy Chief Executive Officer	130 - 135				62.5 -65	195 - 200
Michael Cusack - Medical Director (to 1st October 17)	90 - 95				12.5 - 15	110 - 115
Matthew Metcalfe - Medical Director (2nd October 17 onwards)	85 -90				25 - 27.5	115 - 120
Carolyn Fox - Director of Nursing, Midwifery & Patient Services	110 - 115				17.5 - 20	130 - 135
Simon Lazarus - Director of Finance (to 1st December 17)	80 - 85				15 - 17.5	95 - 100
Philip Bradley - Interim Director of Finance (4th December 17 onwards)	40 - 45				72.5 - 75	115 - 120
Charles Abolins - Director of Facilities & Capital Development (to 31st August 17)	40 -45					40 - 45
Stuart Finn - Interim Director of Facilities & Capital Development (1st September 17 onwards)	55 -60				130 - 132.5	185 - 190
Janine Brennan - Director of Workforce and Transformation	120 - 125				20 - 22.5	145 - 150
Chris Pallot - Director of Strategy & Partnerships	105 - 110				77.5 - 80	185 - 190
Catherine Thorne - Director of Corporate Development, Governance & Assurance	100 - 105				22.5 - 25	125 - 130
Phil Zeidler - Non-Executive Director (Vice Chairman)	5 - 10	400				5 - 10
Graham Kershaw - Non-Executive Director (to 1st December 17)	0 - 5	300				0 - 5
David Noble - Non-Executive Director	5 - 10	500				5 - 10
Olivia Clymer - Non-Executive Director (to 31st October 17)	0 - 5					0 - 5
John Archard-Jones - Non-Executive Director	5 - 10					5 - 10
Annette Gill - Non-Executive Director (2nd November 17 onwards)/Associate Non-Executive Director (to 1st November 17)	5 - 10					5 - 10
Emma Heap - Associate Non-Executive Director (from 25th January 18)	0 - 5					0 - 5
Melanie Henwood - Non-Executive Director (19th January - 16th February 18)	0 - 5					0 - 5

Name and Title	2016-17					
	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100* £	Performance Pay and Bonuses (bands of £5,000) £000	Long term Performance Pay and Bonuses (bands of £5,000) £000	All Pension-related Benefits (bands of £2,500) £000	Total - Salary & Benefits (bands of £5,000) £000
Paul Farenden - Chairman	20 - 25	1,900				20 - 25
Sonia Swart - Chief Executive Officer	225 - 230				0	225 - 230
Deborah Needham - Chief Operating Officer / Deputy Chief Executive Officer	125 - 130				37.5 - 40	165 -170
Michael Cusack - Medical Director (to 1st October 17)	185 - 190				47.5 - 50	235 - 240
Matthew Metcalfe - Medical Director (2nd October 17 onwards)						
Carolyn Fox - Director of Nursing, Midwifery & Patient Services	110 - 115				105 - 107.5	215 - 220
Simon Lazarus - Director of Finance (to 1st December 17)	120 - 125				32.5 - 35	155 - 160
Philip Bradley - Interim Director of Finance (4th December 17 onwards)						
Charles Abolins - Director of Facilities & Capital Development (to 31st August 17)	85 - 90				0	85 - 90
Stuart Finn - Interim Director of Facilities & Capital Development (1st September 17 onwards)						
Janine Brennan - Director of Workforce and Transformation	120 - 125				30 - 32.5	150 - 155
Chris Pallot - Director of Strategy & Partnerships	95 - 100				32.5 - 35	130 - 135
Catherine Thorne - Director of Corporate Development, Governance & Assurance	100 - 105				22.5 - 25	125 - 130
Phil Zeidler - Non-Executive Director (Vice Chairman)	5 - 10	400				5 - 10
Graham Kershaw - Non-Executive Director (to 1st December 17)	5 - 10	600				5 - 10
David Noble - Non-Executive Director	5 - 10	900				5 - 10
Olivia Clymer - Non-Executive Director (to 31st October 17)	5 - 10	500				5 - 10
John Archard-Jones - Non-Executive Director	0 - 5					0 - 5
Annette Gill - Non-Executive Director (2nd November 17 onwards)/Associate Non-Executive Director (to 1st November 17)	0 - 5					0 - 5
Emma Heap - Associate Non-Executive Director (from 25th January 18)						
Melanie Henwood - Non-Executive Director (19th January - 16th February 18)						

Salary Notes

Michael Cusack's 2016-17 salary represents a full year
Simon Lazarus's 2016-17 salary represents a full year
Matthew Metcalfe, Philip Bradley, Stuart Finn, Emma Heap & Melanie Henwood were appointed to the Board in 2017-18. There is therefore no salary information for 2016-17

Charles Abolin's 2016-17 salary represents 11 month's only. 2017-18 salary represents 5 months only
John Archard-Jones & Annette Gill were appointed to the Board in 2016-17. 2016-17 salary represents 3 months only
Olivia Clymer's 2016-17 salary represents a full year

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

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

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

Pension Benefits

Name & Title	Real increase in pension at Pension Age (bands of £2,500)	Real increase in pension lump sum at Pension Age (bands of £2,500)	Total accrued pension at Pension Age at 31 March 2018 (bands of £5,000)	Lump sum at Pension Age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Sonia Swart - Chief Executive Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0
Deborah Needham - Chief Operating Officer / Deputy Chief Executive Officer	2.5 - 5	2.5 - 5	45 - 50	115 - 120	580	89	674	0
Michael Cusack - Medical Director (to 1st October 17)	0 - 2.5	0	45 - 50	120 - 125	801	18	845	0
Matthew Metcalfe - Medical Director (2nd October 17 onwards)	0 - 2.5	0	30 - 35	70 - 75	455	11	482	0
Carolyn Fox - Director of Nursing, Midwifery & Patient Services	0 - 2.5	2.5 - 5	35 - 40	105 - 110	551	62	618	0
Simon Lazarus - Director of Finance (to 1st December 17)	0 - 2.5	0	35 - 40	90 - 95	592	35	650	0
Philip Bradley - Interim Director of Finance (4th December 17 onwards)	0 - 2.5	2.5 - 5	50 -55	150 - 155	923	40	1,056	0
Charles Abolins - Director of Facilities & Capital Development (to 31st August 17)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0
Stuart Finn - Interim Director of Facilities & Capital Development (1st September 17 onwards)	2.5 - 5	7.5 -10	10 - 15	30 - 35	122	53	215	0
Janine Brennan - Director of Workforce and Transformation	0 - 2.5	5 - 7.5	50 - 55	150 - 155	947	62	1,018	0
Chris Pallot - Director of Strategy & Partnerships	2.5 - 5	5 - 7.5	30 - 35	80 - 85	432	70	506	0
Catherine Thorne - Director of Corporate Development, Governance & Assurance	0 - 2.5	0	35 - 40	110 - 115	712	41	761	0

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

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

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

A rate of 1% Consumer Price Index (CPI) annual inflation has been used to calculate the real increases.

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

Off –payroll engagements

Table 1: Off-Payroll Engagements longer than 6 months

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months

Narrative	Number
Number of existing engagements as of 31 March 2018	**11**
Of which, the number that have existed:	
for less than one year at the time of reporting	**5**
for between 1 and 2 years at the time of reporting	**6**
for between 2 and 3 years at the time of reporting	**0**
for between 3 and 4 years at the time of reporting	**0**
for 4 or more years at the time of reporting	**0**

Table 2: New Off-Payroll Engagements

For all new off-payroll engagements, or those that reached six months in duration,between 1 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months

Narrative	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	**77**
Of which:	
No.assessed as caught by IR35	**72**
No.assessed as not caught by IR35	**5**
No.engaged directly (via PSC contracted to department) and are on the departmental payroll	**72**
No.of engagements reassesed for consistency / assurance purposes during the year	**13**
No.of engagements that saw a change to IR35 status following the consistency review	**0**

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

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

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

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

Expenditure on consultancy

Details of our expenditure on consultancy can be found at note 6.1 on page 85 in the annual accounts.

Exit Packages

The Trust has no exit packages in 2017/18.

Staff costs

In line with the HM Treasury requirements, some previous accounts disclosures relating to staff costs are now required to be included in the staff report section of the annual report instead. The following tables link to data contained in the TAC and are included here for ease of formatting for the annual report. They should not be included in the annual accounts and these tables are not a complete list of numerical disclosures for the staff report.

	Permanent	Other	2017/18 Total	2016/17 Total
	£000	£000	£000	£000
Salaries and wages	162,961	1,293	**164,254**	155,250
Social security costs	16,692	0	**16,692**	15,385
Apprenticeship levy	807	0	**807**	0
Employer's contributions to NHS pensions	17,970	0	**17,970**	17,045
Pension cost - other	5	0	**5**	5
Other post employment benefits	0	0	**0**	0
Other employment benefits	0	0	**0**	0
Termination benefits	0	0	**0**	0
Temporary staff	0	12,196	**12,196**	16,079
Total gross staff costs	**198,435**	**13,489**	**211,924**	**203,764**
Recoveries in respect of seconded staff	0	0	**0**	0
Total staff costs	**198,435**	**13,489**	**211,924**	**203,764**
Of which				
Costs capitalised as part of assets	454	0	**454**	0

Average number of employees (WTE basis)

	Permanent	Other	2017/18 Total	2016/17 Total
	Number	Number	Number	Number
Medical and dental	504	52	**556**	557
Ambulance staff	0	0	**0**	0
Administration and estates	970	87	**1,057**	1,036
Healthcare assistants and other support staff	891	196	**1,087**	1,074
Nursing, midwifery and health visiting staff	1,334	182	**1,516**	1,470
Nursing, midwifery and health visiting learners	0	0	**0**	0
Scientific, therapeutic and technical staff	505	46	**551**	520
Healthcare science staff	150	0	**150**	150
Social care staff	0	0	**0**	0
Other	0	0	**0**	0
Total average numbers	**4,354**	**563**	**4,917**	**4,807**
Of which:				
Number of employees (WTE) engaged on capital projects	17	0	**17**	0

Reporting of compensation schemes - exit packages 2017/18

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
<£10,000	0	1	**1**
£10,001 - £25,000	0	0	**0**
£25,001 - 50,000	0	0	**0**
£50,001 - £100,000	0	0	**0**
£100,001 - £150,000	0	0	**0**
£150,001 - £200,000	0	0	**0**
>£200,000	0	0	**0**
Total number of exit packages by type	**0**	**1**	**1**
Total resource cost (£)	£0	£8,000	**£8,000**

Reporting of compensation schemes - exit packages 2016/17

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

Exit packages: other (non-compulsory) departure payments

	2017/18		2016/17	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	1	8	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	**1**	**8**	**0**	**0**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	0	0	0	0

Staff numbers

	2017/2018			2016/2017		
Average Staff Numbers	Total Number	Permanently Employed	Other	Total Number	Permanently Employed	Other
Add Prof Scientific and Technic	143	142	1	135	134	1
Additional Clinical Services	876	866	10	862	851	11
Administrative and Clerical	1067	1045	22	1042	1014	28
Allied Health Professionals	247	243	4	233	228	5
Estates and Ancillary	484	482	2	468	467	1
Healthcare Scientists	128	124	4	128	126	2
Medical and Dental	527	232	295	526	226	300
Nursing and Midwifery Registered	1525	1510	15	1491	1484	7
Other	0	0	0	1	0	1
TOTAL	**4997**	**4644**	**353**	**4886**	**4530**	**356**

Staff sickness absence

Staff Sickness Absence % - from April 2017 to March 2018

Sickness Absence %												
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Short Term Sickness Absence	2.02%	1.96%	1.98%	2.04%	2.14%	2.21%	2.47%	2.55%	2.54%	2.95%	2.56%	1.98%
Long Term Sickness Absence	1.27%	1.55%	1.55%	1.79%	1.95%	1.98%	2.08%	1.80%	2.23%	1.95%	2.09%	1.96%
Total Sickness Absence	3.29%	3.51%	3.53%	3.84%	4.09%	4.18%	4.56%	4.35%	4.77%	4.90%	4.65%	3.95%

Ill Health Retirement

	2017/18	2016/17
	number	number
Number of persons retired on ill health grounds	1	2
	£000s	£000s
Total additional pension liabilities accrued in the year	67	241

Trade union activity

As part of the Trade Union (Facilities Time Publication Requirements) Regulations 2017, we have collated information regarding the facilities time activities of our recognised Trade Union officials during the relevant period of 1 April 2017 to 31 March 2018. We have undertaken the following calculations and the results are detailed in the tables below:

- Number of employees who were relevant union officials during the relevant period
- Full-time equivalent employee number
- Percentage of time spent on facility time
- Percentage of pay bill spent on facility time
- Paid trade union activities

Relevant Union Officials

• Number of Employees Who Were Relevant Union Officials During the Relevant Period	Full-Time Equivalent Employee Number
30	4405.87

Percentage of Time Spent on Facility Time

Percentage of Time	Number of Employees
0%	8
1%-50%	21
51%-99%	1
100%	0

Table 3 – Percentage of Pay Bill Spent on Facility Time

Total Cost of Facility Time	£30,457.61
Total Pay Bill	£197,832,597
Percentage of Total Pay Bill Spent on Facility Time	0.02%

Table 4 – Paid Trade Union Activities

Time Spent on Paid Trade Union Activities as a Percentage of Total Paid Facility Time Hours	100%

EQUALITY

During the year, we continued to work to and review our progress against our equality objectives/four year plan, which is underpinned by our Workforce Equality and Diversity Strategy.
Our equality objectives/four year plan has two main objectives based on the Equality Delivery System (EDS2) outcomes relating to the workforce, with the key actions linked to:

- The Workforce Race Equality Standard (WRES)
- Health and wellbeing
- Staff survey results
- Divisional objectives
- Leadership and management development programmes.

Our objectives are:

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

The detailed action plan and all our other equality and diversity documents can be accessed on our website: http://www.northamptongeneral.nhs.uk/About/Policies-Reports-and-strategies/Equality-and-diversity-information/Equality-Diversity-Human-Rights.aspx

2017 NHS Staff Survey Equality and Diversity Key Findings
The demographics of our workforce who responded to the staff survey were broadly similar to our overall workforce with the exception:

- staff with a disability where 19% of the respondents were disabled compared to the 3% of our workforce
- ethnic background where 14% of the respondents were Black and Minority Ethnic compared to 22% of our workforce.

The percentage of staff reporting they had experienced discrimination at work in the last 12 months has not changed since the 2016 survey and we were benchmarked as worse than average when compared to other acute trusts, indicating an overall improvement for other trusts.

There was also no change in relation to the key finding which relates to the percentage of staff who believe that the organisation provides equal opportunities for career progression and/or promotion. We were benchmarked as above average when compared to other acute trusts, an improvement on the 2016 survey in which case a deterioration is indicated nationally.

The survey has highlighted some areas of concern and we will be working with our teams to analyse the results more deeply in order to continue our work in ensuring all our staff are focused on our values, displaying positive behaviours, delivering high quality care and striving for continuous improvement and meaningful staff engagement to sustainably improve staff satisfaction at work.

Workforce Race Equality Standards

We undertook the data analysis exercise for the National Workforce Race Equality Standard (WRES) in 2017 and compared these results to the previous year to establish if there had been improvements in the experiences or the treatment of white staff and BME staff.

Of the nine WRES indicators we showed improvement in all areas with the exception of one, namely the percentage difference between our Board voting membership and our overall workforce. We were also able to compare our local analysis with the national NHS position and for the majority of the national key findings we compared favourably.

Although we had some positive results there is still work to do to improve the experiences and treatment of our BME workforce and this year we will deliver a *respect and support* campaign to address some of the issues highlighted.

Gender Pay Gap Reporting 2017

As required by the Gender Pay Gap Information Regulations 2017 we compiled and analysed our data in preparation to submitting it to the Government by 31 March 2018. Although we are not legally required to produce a written report we decided this should be done to give context to the data and this was also published on our website. We will be looking at the results more closely in the coming year to see where we can address identified gaps.

Gender Distribution of Staff

Directors and non-executive directors

Gender	Count	%
Female	7	46.67
Male	8	53.33
Grand Total	15	100

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

Gender	Count	%
Female	226	52.31
Male	206	47.69
Grand Total	432	100

Senior managers (Band 8a and above)

Gender	Count	%
Female	151	71.90
Male	59	28.10
Grand Total	210	100

Breakdown by senior manager pay scales

Pay Scale	Count	Female	Male
XN08/XR08	130	100	30
XN09/XR09	40	26	14
XN10/XR10	15	9	6
XN11/XR11	4	4	0
WQ00	21	12	9
Total	210	151	59

Senior medical staff (consultants)

Gender	Count	%
Female	75	33.78
Male	147	66.22
Grand Total	222	100

Breakdown by senior medical staff (consultant) pay scales

Pay Scale	Count	Female	Male
MC21	1	1	0
WQ00	1	1	0
YC53	2	1	1
YC62	1	1	0
YC72	67	27	40
YC73	12	3	9
YM51	3	2	1
YM52	5	0	5
YM53	11	4	7
YM54	6	1	5
YM55	10	1	9
YM56	5	2	3
YM57	10	3	7
YM58	8	3	5
YM59	1	0	1
YM60	3	1	2
YM61	2	0	2
YM62	1	0	1
YM63	1	1	0
YM69	1	0	1
YM72	69	22	47
YM73	2	1	1
Total	222	75	147

All Employees

Gender	**Count**	**%**
Female	**3945**	**78.95**
Male	**1052**	**21.05**
Grand Total	**4997**	**100**

Disability Related Polices

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

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

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

- to raise awareness of the employment of people with disabilities throughout the organisation and ensure employees are aware of our commitment to people with disabilities or someone's association with a disabled person
- to ensure recruitment procedures are reviewed and developed to encourage applications and the employment of people with disabilities or someone associated with a person with disabilities
- to ensure that staff and potential job applicants with a disability, or associated with a disabled person, are treated fairly and receive the same opportunities as other staff to develop within the Trust with appropriate and reasonable support.
- to take all reasonable steps to ensure that the working environment does not prevent disabled people or people associated with a disabled person from taking up positions for which they are suitably qualified.
- to assist staff who become disabled during their employment to adapt to the disability and to continue in post wherever possible, or, if this is not possible, to be redeployed or retrained, where this is practicable.

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

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

The Recruitment, Selection and Retention Policy, together with the associated procedures, provides a framework which promotes a professional approach and the highest possible standards throughout the recruitment and selection process and to ensure a proactive and lawful approach to equality and diversity issues within the process, including the recruitment of disabled people.

We continue to be certified as a Disability Confident Employer and as part of this commitment, we will:

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

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

SECTION THREE:

FINANCIAL STATEMENTS

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

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Northampton General Hospital NHS Trust ("the Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 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 being relevant to NHS Trusts in England and included in the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 2017/18. We have nothing to report in this respect.

KPMG

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2017/18.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 47, the Directors are responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on Page 46 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

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

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Qualified conclusion

Subject to the matters outlined in the basis for qualified conclusion paragraph below we are satisfied that in all significant respects Northampton General Hospital NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

Basis for qualified conclusion

In considering the Trust's arrangements for securing sustainable resource deployment, we identified that the Trust had reported a deficit of £23.3 million in 2017/18 and had failed to deliver a number of operational targets for the year. In particular the Trust failed to meet its Accident and Emergency targets.

KPMG

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement set out on page 46, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

We are required to report to you if we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency;

On 23 May 2018 we referred a matter to the Secretary of State under section 30 (1)(b) of the 2014 Act in relation to the breach of the Trust's breakeven duty due to the reported deficit of £23.3 million in 2017/18, and the cumulative deficit of £66.7 million at 31 March 2018.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

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

CERTIFICATE OF COMPLETION OF THE AUDIT

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

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

28 May 2018

Statement of Comprehensive Income

	Note	2017/18	2016/17
		£000	£000
Operating income from patient care activities	3	276,476	262,949
Other operating income	4	28,284	35,291
Operating expenses	6	(329,173)	(309,603)
Operating surplus/(deficit) from continuing operations		**(24,413)**	**(11,363)**
Finance income	11	31	29
Finance expenses	12	(918)	(813)
PDC dividends payable		(2,391)	(3,290)
Net finance costs		**(3,278)**	**(4,074)**
Other gains / (losses)	13	127	273
Surplus / (deficit) for the year from continuing operations		**(27,564)**	**(15,164)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations		**0**	**0**
Surplus / (deficit) for the year		**(27,564)**	**(15,164)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments		0	0
Revaluations	17	(5,346)	(3,815)
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains / (losses) on available-for-sale financial investments	13	0	0
Recycling gains / (losses) on available-for-sale financial investments	13	0	0
Foreign exchange gains / (losses) recognised directly in OCI	13	0	0
Total comprehensive income / (expense) for the period		**(32,910)**	**(18,979)**
Adjusted financial performance			
Surplus / (deficit) for the period		(27,564)	(15,164)
Add back all I&E impairments / (reversals)	7	4,086	1,732
Adjustments in respect of donated gov't grant asset reserve elimination		139	(415)
Adjusted retained surplus / (deficit)		**(23,339)**	**(13,847)**

The increase in impairment of £4,086k relates to applying the net effect of the quarterly BCIS indices applied to the Buildings and 31 March 2018 desktop revlauation exercise and is excluded from retained deficit and statutory breakeven in accordance with the DHSC Group Accounting Manual (GAM), note 16 refers.

Donated asset adjustment of £139k (consisting of £320k donated depreciation less £181k donated additions) is excluded from retained surplus and statutory breakeven duty in accordance with the DHSC Manual for Accounts.

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	14	1,577	1,204
Property, plant and equipment	15	151,867	158,405
Trade and other receivables	19	192	200
Total non-current assets		**153,636**	**159,809**
Current assets			
Inventories	18	6,272	5,770
Trade and other receivables	19	16,479	23,887
Non-current assets held for sale / assets in disposal groups	20	0	0
Cash and cash equivalents	21	1,547	1,621
Total current assets		**24,298**	**31,278**
Current liabilities			
Trade and other payables	22	(21,475)	(22,316)
Borrowings	24	(20,878)	(20,458)
Provisions	26	(2,744)	(4,808)
Other liabilities	23	(2,073)	(2,546)
Total current liabilities		**(47,170)**	**(50,128)**
Total assets less current liabilities		**130,764**	**140,959**
Non-current liabilities			
Borrowings	24	(53,386)	(31,610)
Provisions	26	(1,001)	(1,055)
Total non-current liabilities		**(54,387)**	**(32,665)**
Total assets employed		**76,377**	**108,294**
Financed by			
Public dividend capital		120,251	119,258
Revaluation reserve		31,782	37,392
Income and expenditure reserve		(75,656)	(48,356)
Total taxpayers' equity		**76,377**	**108,294**

The notes on pages 71 to 112 form part of these accounts.

The financial statements on pages 67 to 70 were approved by the Board on 25 May 2018 and signed on its behalf by

Name	**Debbie Needham**
Position	Deputy Chief Executive
Date	25-May-18

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**119,258**	**37,392**	**(48,356)**	**108,294**
Surplus/(deficit) for the year	0	0	(27,564)	**(27,564)**
Other transfers between reserves	0	(264)	264	**0**
Impairments	0	0	0	**0**
Revaluations	0	(5,346)	0	**(5,346)**
Public dividend capital received	993	0	0	**993**
Taxpayers' equity at 31 March 2018	**120,251**	**31,782**	**(75,656)**	**76,377**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**119,258**	**41,435**	**(33,420)**	**127,273**
Prior period adjustment	0	0	0	**0**
Taxpayers' equity at 1 April 2016 - restated	**119,258**	**41,435**	**(33,420)**	**127,273**
Surplus/(deficit) for the year	0	0	(15,164)	**(15,164)**
Other transfers between reserves	0	(228)	228	**0**
Impairments	0	0	0	**0**
Revaluations	0	(3,815)	0	**(3,815)**
Taxpayers' equity at 31 March 2017	**119,258**	**37,392**	**(48,356)**	**108,294**

Information on reserves

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

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

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

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(24,413)	(11,363)
Non-cash income and expense:			
Depreciation and amortisation	6.1	10,056	9,703
Net impairments	7	4,086	1,732
Income recognised in respect of capital donations	4	(181)	(738)
(Increase) / decrease in receivables and other assets		7,914	(7,506)
(Increase) / decrease in inventories		(502)	(26)
Increase / (decrease) in payables and other liabilties		(907)	1,886
Increase / (decrease) in provisions		(2,124)	2,062
Other movements in operating cash flows		(13)	58
Net cash generated from / (used in) operating activities		**(6,084)**	**(4,192)**
Cash flows from investing activities			
Interest received	11	31	29
Purchase of intangible assets		(756)	(628)
Purchase of property, plant, equipment and investment property		(12,868)	(15,381)
Sales of property, plant, equipment and investment property		153	585
Net cash generated from / (used in) investing activities		**(13,440)**	**(15,395)**
Cash flows from financing activities			
Public dividend capital received		993	0
Movement on loans from the Department of Health and Social Care		22,325	23,992
Movement on other loans		(4)	(155)
Capital element of finance lease rental payments		(124)	(121)
Interest paid on finance lease liabilities		(46)	(50)
Other interest paid		(778)	(673)
PDC dividend (paid) / refunded		(2,916)	(3,387)
Net cash generated from / (used in) financing activities		**19,450**	**19,606**
Increase / (decrease) in cash and cash equivalents		**(74)**	**19**
Cash and cash equivalents at 1 April - brought forward		**1,621**	**1,602**
Prior period adjustments			**0**
Cash and cash equivalents at 1 April - restated		**1,621**	**1,602**
Cash and cash equivalents transferred under absorption accounting		**0**	**0**
Unrealised gains / (losses) on foreign exchange		**0**	**0**
Cash and cash equivalents at 31 March	21	**1,547**	**1,621**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation
The Department of Health and Social Care has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 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.

Note 1.1.2 Going concern
These accounts have been prepared on a going concern basis.

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

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

Continuity of service:
The Trust recorded a deficit of £23.3m which was £9.8m worse than its planned deficit of £13.5m in 2017-18. This position included lost of £5.0m STF funding as the Trust did not meet a number of its STF financial and operational trajectories. Further, the Trust was unable to fully deliver all of the £12.9m challenging CIP programme in a budgetary and recurrent manner.

The Board of Directors are in discussion with NHSI about the revised plan for 2018-19 and expect any outstanding issues to be resolved by 30 April 2018. The clinical income assumptions included in the draft plan are supported by signed contracts with Commissioners. The draft plan also recognises risks to its delivery such as bed capacity, STP associated schemes, challenges to meeting the STF conditions, challenges within the Northamptonshire county, in addition to a stretching CIP programme expected to deliver £14.5m in 2018/19.

In spite of the above, as the Trust has not received any notice of discontinuation or notice of transfer of its services to another entity, it intends to prepare its accounts on a going concern basis.

Financing:
The Board of Directors also has a reasonable expectation that the Trust will have access to adequate resources in the form of financial support from the Department of Health (NHS Act 2006,s42a) to continue to deliver the full range of mandatory services for the foreseeable future. The Trust has been reliant on cash support from the Department of Health in meeting its payment obligations and has drawn down a total of £23.907m at 31 March 2018; made up of £20.296m (revenue support loans) and £3.611m (capital loan).

Of the revenue support loans, £18.85m has been rolled over to be repayable in February 2019 which will be less than 12 months from the reporting date. The Department of Health is yet to advise of further refinancing arrangements regarding this loan however the uncertainty about the refinancing does not of itself affect the Trust's going concern basis.

The Board of Directors has therefore satisfied itself that on the basis that the Trust will continue to provide healthcare services and that its cash requirements will be supported by the Department of Health, it considers it appropriate that the accounts for the year ended 31 March 2018 should be prepared on a Going Concern basis.

Note 1.2 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

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

Note 1.2.1 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

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

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

Note 1.3 Interests in other entities

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

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

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

Note 1.4 Income

Income 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 income for the trust is contracts with commissioners in respect of health care services. At the year end, the trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. Revenue relating to patient care spells that are part-completed at the year-end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay using the financial year's case-mix and tariff rules.

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

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

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

Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

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

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension 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 in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition
Property, plant and equipment is capitalised where:

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

Note 1.7.2 Measurement

Valuation

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

All assets are measured subsequently at valuation.

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

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

The Trust will undertake a desktop revaluation exercise on an annual basis with a full revaluation exercise on a five yearly basis, the next full exercise is due in April 2021.

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

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

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

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

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Subsequent expenditure

Depreciation

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

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.
Assets held under finance leases are depreciated over their estimated useful lives.

Revaluation gains and losses

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

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

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

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

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

Note 1.7.3 Derecognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

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

Note 1.7.4 Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

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

Note 1.7.5 Useful economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful

	Min life Years	**Max life Years**
Buildings, excluding dwellings	15	80
Dwellings	15	80
Plant & machinery	5	15
Transport equipment	7	7
Information technology	3	10
Furniture & fittings	5	5

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term,

Impairment of financial assets
At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

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

Where a bad debt provision is used, the accounting policies should include the criteria for determining when an asset's carrying value is written down directly and when the allowance account is used, and the criteria for writing off amounts charged to the allowance account against the carrying amount of the financial asset.

Note 1.8 Intangible assets

Note 1.8.1 Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

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

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the trust intends to complete the asset and sell or use it
• the trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
• the trust can measure reliably the expenses attributable to the asset during development.

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

Note 1.8.2 Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

Amortisation

Note 1.8.3 Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful

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

Note 1.9 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.

Note 1.10 Cash and cash equivalents

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

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

Note 1.11 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.12 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

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

All other financial assets and financial liabilities are recognised when the trust becomes a party to the contractual provisions of the instrument.

De-recognition

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

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

Classification and measurement

Financial assets are categorised as fair value through income and expenditure, loans and receivables or available-for-sale financial assets.

Financial liabilities are classified as fair value through income and expenditure or as other financial liabilities.

Financial assets and financial liabilities at "fair value through income and expenditure"
Financial assets and financial liabilities at fair value through income and expenditure are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not "closely-related" to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets
Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "finance costs" in the Statement of Comprehensive Income.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices, independent appraisals or discounted cash flow analysis.

Impairment of financial assets
At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

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

Where a bad debt provision is used, the accounting policies should include the criteria for determining when an asset's carrying value is written down directly and when the allowance account is used, and the criteria for writing off amounts charged to the allowance account against the carrying amount of the financial asset.

Note 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.

Note 1.13.1 The trust as lessee
Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

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

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability. is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
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.

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

Note 1.13.2 The trust as lessor
Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trusts' net investment outstanding in respect of the leases.

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

Note 1.14 Provisions

The trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

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

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

Note 1.15 Contingencies
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in **note 27** where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in **note 27**, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

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

Note 1.16 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

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

Note 1.17 Value added tax
Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Foreign exchange
The functional and presentational currency of the trust is sterling.

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

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

• monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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

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

Note 1.19 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.20 Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.21 Gifts
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.22 Transfers of functions to / from other NHS bodies / local government bodies
For functions that have been transferred to the trust from another NHS / local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets/ liabilities transferred is recognised within income / expenses, but not within operating activities.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the trust has transferred to another NHS / local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets/ liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

The Trust has no transfers of function to report.

Note 1.23 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted
The DH GAM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

In preparation for implementation of these standards the following is being considered:-

IFRS 9 Financial Instruments
Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted

• review of recovered levels of income in relation to invoice types is currently being undertaken and this will provide a base line for future assumptions in applying the standard.
• A main area of review will be private patients and overseas visitors

IFRS 15 Revenue for Contracts with Customers
Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted

• The core principle underlying the new model is that an entity should recognise revenue in a manner that depicts the transfer of goods and services to customers, the amount recognised should reflect the amount to which the entity expects to be entitled in exchange for those goods and services.
• For healthcare providers consideration will be required where pricing includes variable amounts, whether goods and services are considered collectable and separation of supply of goods and services.
• A review will be undertaken with Procurement, Finance and Service Leads.

IFRS 16 Leases
Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted

• IFRS 16 will bring most leases on balance sheet for lessees
• All entities that lease assets for use in their business will see an increase in reported assets and liabilities
• Definition of a lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration
• Most complex area in the NHS is likely to be managed service agreements
• A review of contracts with Procurement, Service and Finance Leads will be undertaken to identify any assets being utilised by the Trust.

Note 2 Operating Segments

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

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	**2017/18**	**2016/17**
	£000	**£000**
Acute services		
Elective income	39,033	39,591
Non elective income	104,163	83,768
First outpatient income	10,258	9,418
Follow up outpatient income	29,526	35,098
A & E income	15,454	13,349
High cost drugs income from commissioners (excluding pass-through costs)	23,645	22,113
Other NHS clinical income	52,249	57,239
All services		
Private patient income	845	910
Other clinical income	1,303	1,463
Total income from activities	**276,476**	**262,949**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2017/18**	**2016/17**
	£000	**£000**
NHS England	50,324	44,975
Clinical commissioning groups	222,649	214,485
Department of Health and Social Care	0	0
Other NHS providers	1,051	1,009
NHS other	107	107
Local authorities	0	0
Non-NHS: private patients	845	910
Non-NHS: overseas patients (chargeable to patient)	151	134
NHS injury scheme	1,152	1,329
Non NHS: other	197	0
Total income from activities	**276,476**	**262,949**
Of which:		
Related to continuing operations	276,476	262,949
Related to discontinued operations	0	0

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

	2017/18	2016/17
	£000	£000
Income recognised this year	151	134
Cash payments received in-year	93	112
Amounts added to provision for impairment of receivables	103	167
Amounts written off in-year	49	338

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	231	223
Education and training	9,990	10,434
Receipt of capital grants and donations	181	738
Charitable and other contributions to expenditure	449	399
Non-patient care services to other bodies	1,455	1,481
Sustainability and transformation fund income *	3,691	10,739
Rental revenue from operating leases	54	58
Income in respect of staff costs where accounted on gross basis	3,423	3,132
Other income	8,810	8,087
Total other operating income	**28,284**	**35,291**
Of which:		
Related to continuing operations	28,284	35,291
Related to discontinued operations	0	0

*** Sustainability & Transformation Fund (STF) Income**

- core STF £1,111k (£9,619k)
- incentive STF £0k (£258k)
- bonus STF £0k (£862k)
- incentive STF general distribution £2,580k (£0k)

Other income includes :

Pharmacy Sales £285k (£417k)
Accommodation Charges £543k (£519k)
Clinical Tests £1,023k (£745k)
Car Parking Income £1,259k (£1,56k)
Catering £1,422k (£1,391k)
VAT Audit Claim £507k (£225k)
Sterile Services Sales £454k (£432k)

Note 5 Fees and charges

	2017/18	2016/17
	£000	£000
Income	2,735	2,700
Full cost	(1,405)	(1,350)
Surplus / (deficit)	**1,330**	**1,350**

Note 6.1 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	113	53
Purchase of healthcare from non-NHS and non-DHSC bodies	3,815	2,759
Staff and executive directors costs	211,470	203,764
Remuneration of non-executive directors	65	56
Supplies and services - clinical (excluding drugs costs)	33,175	31,259
Supplies and services - general	3,659	3,514
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	29,885	27,694
Inventories written down	79	126
Consultancy costs	18	239
Establishment	2,315	3,271
Premises	13,401	11,716
Transport (including patient travel)	130	117
Depreciation on property, plant and equipment	9,371	8,923
Amortisation on intangible assets	685	780
Net impairments	4,086	1,732
Increase/(decrease) in provision for impairment of receivables	387	517
Change in provisions discount rate(s)	2	15
Audit fees payable to the external auditor		
audit services- statutory audit	39	45
other auditor remuneration (external auditor only)	10	40
Internal audit costs	151	138
Clinical negligence	11,198	8,005
Legal fees	307	277
Insurance	231	219
Research and development	4	1
Education and training	716	837
Rentals under operating leases	877	675
Car parking & security	343	327
Hospitality	9	12
Losses, ex gratia & special payments	18	26
Other services, eg external payroll	1,379	1,349
Other	1,235	1,117
Total	**329,173**	**309,603**
Of which:		
Related to continuing operations	329,173	309,603
Related to discontinued operations	0	0

Other auditors remuneration includes :
KPMG £10k (£40k)
- Expenses in relation to Salary Sacrifice Schemes £0k (£30k)
- Quality Accounts Audit Fee £10k (£10k)

Other expenditure includes :
Translation Services £118k (£87k)
Home Oxygen Service £130k (£123k)
Professional Subscriptions £319k (£229k)
Professional Fees £629k (£452k)

Note 6.2 Other auditor remuneration

	2017/18	2016/17
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	10	10
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	30
Total	**10**	**40**

Note 6.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2017/18 or 2016/17.

Note 7 Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	0	0
Over specification of assets	0	0
Abandonment of assets in course of construction	0	0
Unforeseen obsolescence	0	0
Loss as a result of catastrophe	0	0
Changes in market price	4,086	1,732
Other	0	0
Total net impairments charged to operating surplus / deficit	**4,086**	**1,732**
Impairments charged to the revaluation reserve	0	0
Total net impairments	**4,086**	**1,732**

The desktop revaluation exercise was undertaken as at 31 March 2018 following an unprecedented increase in the BCIS index and location factor which had been applied on a quarterly basis since the last revaluation exercise in September 2015.

The impact is a reduction in land of £3,366k from £13,200k to £9,834k and buildings of £23,537k from £137,160k to £113,624k as at March 2018.

Note that this is the impact of the revaluation exercise following the application of the quarterly indices throughout the financial year and applied at 31 March 2018.

The land reduction is based on a modern equivalent asset (MEA) basis in providing services from a six storey block with a GIA (Gross Internal Area) of 90,600sqm. Based on Bexley Wing St James Hospital Leeds and comprising ground and 1st floors each of 17,000sqm and 4 upper floors each of 14,150sqm. The existing blocks can fit into this footprint.

Note 8 Employee benefits

	2017/18	2016/17
	Total	Total
	£000	£000
Salaries and wages	164,254	155,250
Social security costs	16,692	15,385
Apprenticeship levy	807	0
Employer's contributions to NHS pensions	17,970	17,045
Pension cost - other	5	5
Other post employment benefits	0	0
Other employment benefits	0	0
Termination benefits	0	0
Temporary staff (including agency)	12,196	16,079
Total gross staff costs	**211,924**	**203,764**
Recoveries in respect of seconded staff	**0**	0
Total staff costs	**211,924**	**203,764**
Of which		
Costs capitalised as part of assets	454	0

Note 8.1 Retirements due to ill-health

During 2017/18 there was 1 early retirement from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £67k (£241k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders

Note 10 Operating leases

Note 10.1 Northampton General Hospital NHS Trust as a lessor

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

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

	2017/18	2016/17
	£000	£000
Operating lease revenue		
Minimum lease receipts	54	58
Contingent rent	0	0
Other	0	0
Total	**54**	**58**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	54	58
- later than one year and not later than five years;	0	0
- later than five years.	0	0
Total	**54**	**58**

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.

Note 10.2 Northampton General Hospital NHS Trust as a lessee

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

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

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	877	675
Contingent rents	0	0
Less sublease payments received	0	0
Total	**877**	**675**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	760	562
- later than one year and not later than five years;	1,774	1,508
- later than five years.	250	454
Total	**2,784**	**2,524**
Future minimum sublease payments to be received	0	0

Note 11 Finance income

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

	2017/18	2016/17
	£000	£000
Interest on bank accounts	31	16
Interest on impaired financial assets	0	0
Interest income on finance leases	0	0
Interest on other investments / financial assets	0	13
Other finance income	0	0
Total	**31**	**29**

Note 12.1 Finance expenditure

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

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	854	749
Other loans	0	0
Overdrafts	0	0
Finance leases	46	50
Interest on late payment of commercial debt	1	0
Main finance costs on PFI and LIFT schemes obligations	0	0
Contingent finance costs on PFI and LIFT scheme obligations	0	0
Total interest expense	**901**	**799**
Unwinding of discount on provisions	6	5
Other finance costs	11	9
Total finance costs	**918**	**813**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	0	0
Amounts included within interest payable arising from claims made under this legislation	1	0
Compensation paid to cover debt recovery costs under this legislation	0	0

Note 13 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	127	273
Losses on disposal of assets	0	0
Total gains / (losses) on disposal of assets	127	273
Gains / (losses) on foreign exchange	0	0
Fair value gains / (losses) on investment properties	0	0
Fair value gains / (losses) on financial assets / investments	0	0
Fair value gains / (losses) on financial liabilities	0	0
Recycling gains / (losses) on disposal of available-for-sale financial investments	0	0
Total other gains / (losses)	**127**	**273**

The Gains on disposal of assets includes £118k from the sale of a CT scanner within our Radiology department which was disposed of in 2016/17, but the sale transaction was in 2017/18.

Note 14.1 Intangible assets - 2017/18

	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	8,704	399	9,103
Transfers by absorption	0	0	0
Additions	771	0	771
Impairments	0	0	0
Reversals of impairments	0	0	0
Revaluations	0	0	0
Reclassifications	287	0	287
Transfers to/ from assets held for sale	0	0	0
Disposals / derecognition	(2,045)	0	(2,045)
Gross cost at 31 March 2018	7,717	399	8,116
Amortisation at 1 April 2017 - brought forward	7,617	282	7,899
Transfers by absorption	0	0	0
Provided during the year	568	117	685
Impairments	0	0	0
Reversals of impairments	0	0	0
Revaluations	0	0	0
Reclassifications	0	0	0
Transfers to / from assets held for sale	0	0	0
Disposals / derecognition	(2,045)	0	(2,045)
Amortisation at 31 March 2018	6,140	399	6,539
Net book value at 31 March 2018	1,577	0	1,577
Net book value at 1 April 2017	1,087	117	1,204

Note 14.2 Intangible assets - 2016/17

	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	8,082	399	8,481
Prior period adjustments	0	0	0
Valuation / gross cost at 1 April 2016 - restated	8,082	399	8,481
Transfers by absorption	0	0	0
Additions	714	0	714
Impairments	0	0	0
Reversals of impairments	0	0	0
Revaluations	0	0	0
Reclassifications	0	0	0
Transfers to/ from assets held for sale	0	0	0
Disposals / derecognition	(92)	0	(92)
Valuation / gross cost at 31 March 2017	8,704	399	9,103
Amortisation at 1 April 2016 - as previously stated	6,931	280	7,211
Prior period adjustments	0	0	0
Amortisation at 1 April 2016 - restated	6,931	280	7,211
Transfers by absorption	0	0	0
Provided during the year	778	2	780
Impairments	0	0	0
Reversals of impairments	0	0	0
Revaluations	0	0	0
Reclassifications	0	0	0
Transfers to/ from assets held for sale	0	0	0
Disposals / derecognition	(92)	0	(92)
Amortisation at 31 March 2017	7,617	282	7,899
Net book value at 31 March 2017	1,087	117	1,204
Net book value at 1 April 2016	1,151	119	1,270

Note 15.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	13,200	121,112	576	2,726	42,628	58	22,433	175	202,908
Additions	0	4,559	0	3,948	2,498	18	1,529	0	12,552
Impairments	0	(4,086)	0	0	0	0	0	0	(4,086)
Reversals of impairments	0	0	0	0	0	0	0	0	0
Revaluations	(3,366)	(8,473)	(60)	0	1,439	2	0	0	(10,458)
Reclassifications	0	2,096	0	(3,118)	673	0	62	0	(287)
Transfers to/ from assets held for sale	0	0	0	0	0	0	0	0	0
Disposals / derecognition	0	0	0	0	(1,924)	(7)	(2,010)	0	(3,941)
Valuation/gross cost at 31 March 2018	9,834	115,208	516	3,556	45,314	71	22,014	175	196,688
Accumulated depreciation at 1 April 2017 - brought forward	0	3,497	39	0	25,799	46	14,951	171	44,503
Provided during the year	0	2,739	21	0	3,647	5	2,956	3	9,371
Impairments	0	0	0	0	0	0	0	0	0
Reversals of impairments	0	0	0	0	0	0	0	0	0
Revaluations	0	(5,911)	(60)	0	857	2	0	0	(5,112)
Reclassifications	0	0	0	0	0	0	0	0	0
Transfers to / from assets held for sale	0	0	0	0	0	0	0	0	0
Disposals / derecognition	0	0	0	0	(1,924)	(7)	(2,010)	0	(3,941)
Accumulated depreciation at 31 March 2018	0	325	0	0	28,379	46	15,897	174	44,821
Net book value at 31 March 2018	9,834	114,883	516	3,556	16,935	25	6,117	1	151,867
Net book value at 1 April 2017	13,200	117,615	537	2,726	16,829	12	7,482	4	158,405

Note 15.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	13,200	122,755	576	3,433	39,329	68	19,075	175	198,611
Prior period adjustments	0	0	0	0	0	0	0	0	0
Valuation / gross cost at 1 April 2016 - restated	13,200	122,755	576	3,433	39,329	68	19,075	175	198,611
Additions	0	3,974	0	4,658	2,650	0	2,672	0	13,954
Impairments	0	(1,732)	0	0	0	0	0	0	(1,732)
Reversals of impairments	0	0	0	0	0	0	0	0	0
Revaluations	0	(3,885)	0	0	217	0	0	0	(3,668)
Reclassifications	0	0	0	(5,365)	4,581	0	784	0	0
Transfers to / from assets held for sale	0	0	0	0	0	0	0	0	0
Disposals / derecognition	0	0	0	0	(4,149)	(10)	(98)	0	(4,257)
Valuation/gross cost at 31 March 2017	13,200	121,112	576	2,726	42,628	58	22,433	175	202,908
Accumulated depreciation at 1 April 2016 - as previously stated	0	1,134	21	0	26,397	51	11,943	144	39,690
Prior period adjustments	0	0	0	0	0	0	0	0	0
Accumulated depreciation at 1 April 2016 - restated	0	1,134	21	0	26,397	51	11,943	144	39,690
Provided during the year	0	2,363	18	0	3,404	5	3,106	27	8,923
Impairments	0	0	0	0	0	0	0	0	0
Reversals of impairments	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	147	0	0	0	147
Reclassifications	0	0	0	0	0	0	0	0	0
Transfers to/ from assets held for sale	0	0	0	0	0	0	0	0	0
Disposals/ derecognition	0	0	0	0	(4,149)	(10)	(98)	0	(4,257)
Accumulated depreciation at 31 March 2017	0	3,497	39	0	25,799	46	14,951	171	44,503
Net book value at 31 March 2017	13,200	117,615	537	2,726	16,829	12	7,482	4	158,405
Net book value at 1 April 2016	13,200	121,621	555	3,433	12,932	17	7,132	31	158,921

Note 15.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	9,834	106,504	516	3,532	16,482	25	6,113	1	143,007
Finance leased	0	1,093	0	0	0	0	0	0	1,093
Owned - donated	0	7,286	0	24	453	0	4	0	7,767
NBV total at 31 March 2018	9,834	114,883	516	3,556	16,935	25	6,117	1	151,867

Note 15.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned - purchased	13,200	109,486	537	2,203	16,267	12	7,470	4	149,179
Finance leased	0	1,234	0	0	0	0	0	0	1,234
Owned - donated	0	6,895	0	523	562	0	12	0	7,992
NBV total at 31 March 2017	13,200	117,615	537	2,726	16,829	12	7,482	4	158,405

Note 16 Donations of property, plant and equipment

The table below details donations of property, plant and equipment received during the year from Northamptonshire Health Charitable Funds

Description	Department	£000
Equipment		
2 x Bladder Scanners	Becket & Rowan Wards	15
Vscan with Dual Probe	Cardiology	5
4 x Bladder Scanners	2 in Urology Centre, 1 in Hawthorne & 1 in Stroke	29
	Total Equipment Capitalised	**49**
Intangible		
Software- Questback Staff engagement survey	Communications	15
	Total IT Capitalised	**15**
Buildings		
Chemotherapy Suite	Oncology	92
	Total Building Capitalised	**92**
Assets Under Construction		
Emergency Assessment Unit	Talbot Butler	24
	Total Building Capitalised	**24**

Note 17 Revaluations of property, plant and equipment

The desktop revaluation exercise was undertaken as at 31 March 2018 following an unprecedented increase in the BCIS index and location factor which had been applied on a quarterly basis since the last revaluation exercise in September 2015.

The impact of the revaluation exercise was a reduction in land of £3,366k from £13,200k to £9,834k and buildings of £23,537k from £137,160k to £113,624k as at March 2018.

Note that this is the impact of the revaluation exercise following the application of the quarterly indices throughout the financial year and applied at 31 March 2018.

The land reduction is based on a modern equivalent asset (MEA) basis in providing services from a six storey block with a GIA (Gross Internal Area) of 90,600sqm. Based on Bexley Wing St James Hospital Leeds and comprising ground and 1st floors each of 17,000sqm and 4 upper floors each of 14,150sqm. The existing blocks can fit into this footprint.

The movement on the revaluation reserve is as follows:-

Asset Category	Indexation £000's	Revaluation £000's	Impairment £000's	Total £000's
Land		-3,366		-3,366
Buildings	11,462	-17,396	3,371	-2,563
Equipment	583			583
Total	**12,045**	-20,762	**3,371**	-5,346

The gross carrying amount of fully depreciated assets still in use for plant & equipment is £28,397k (£25,820k) and for intangible assets is £5,922k (£6,017k)

Note 18 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	1,958	1,815
Work In progress	0	0
Consumables	4,270	3,909
Energy	44	46
Other	0	0
Total inventories	**6,272**	**5,770**
of which:		
Held at fair value less costs to sell	0	0

Inventories recognised in expenses for the year were £56,048k (2016/17: £52,920k). Write-down of inventories recognised as expenses for the year were £79k (2016/17: £126k).

Note 19.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	9,879	16,804
Capital receivables (including accrued capital related income)	3	30
Provision for impaired receivables	(842)	(752)
Prepayments (non-PFI)	2,416	2,909
Finance lease receivables	9	9
PDC dividend receivable	562	37
VAT receivable	669	610
Other receivables	3,783	4,240
Total current trade and other receivables	**16,479**	**23,887**
Non-current		
Finance lease receivables	192	200
Total non-current trade and other receivables	**192**	**200**
Of which receivables from NHS and DHSC group bodies:		
Current	8,489	15,173
Non-current	0	0

Note 19.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	752	834
Prior period adjustments	0	0
At 1 April - restated	752	834
Transfers by absorption	0	0
Increase in provision	567	517
Amounts utilised	(297)	(599)
Unused amounts reversed	(180)	0
At 31 March	842	752

The Trust provides for non recovery of receivables as follows:
All Non-NHS Trade receivables over 60 days old from date of invoice unless known reason for payment delay.
13.50% (13.50 %) (local provision) of recognised Injury Cost Recovery claims are provided for.
All salary overpayments for which no recovery plan is in place, are provided for in full.

Note 19.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	£000	£000	£000	£000
0 - 30 days	5	0	0	0
30-60 Days	1	0	41	0
60-90 days	25	0	30	0
90- 180 days	135	0	92	0
Over 180 days	279	0	350	0
Total	445	0	513	0
Ageing of non-impaired financial assets past their due date				
0 - 30 days	0	0	0	0
30-60 Days	365	0	408	0
60-90 days	341	0	449	0
90- 180 days	344	0	335	0
Over 180 days	357	0	552	0
Total	1,407	0	1,744	0

This includes £238k (£89k) relating to invoices raised to Clinical Commissioning Groups for Non Contracted Activity data.

Note 20 Non-current assets held for sale and assets in disposal groups

	2017/18	2016/17
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**0**	**375**
Prior period adjustment		**0**
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	**0**	**375**
Transfers by absorption	0	**0**
Assets classified as available for sale in the year	0	**0**
Assets sold in year	0	**(375)**
Impairment of assets held for sale	0	**0**
Reversal of impairment of assets held for sale	0	**0**
Assets no longer classified as held for sale, for reasons other than disposal by sale	0	**0**
NBV of non-current assets for sale and assets in disposal groups at 31 March	**0**	**0**

Note 21 Cash and cash equivalents movements

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

	2017/18	2016/17
	£000	£000
At 1 April	**1,621**	**1,602**
Prior period adjustments	0	0
At 1 April (restated)	**1,621**	**1,602**
At start of period for new FTs	**0**	**0**
Transfers by absorption	0	0
Net change in year	(74)	19
Transfer to FT upon authorisation	0	0
At 31 March	**1,547**	**1,621**
Broken down into:		
Cash at commercial banks and in hand	83	76
Cash with the Government Banking Service	1,464	1,545
Deposits with the National Loan Fund	0	0
Other current investments	0	0
Total cash and cash equivalents as in SoFP	**1,547**	**1,621**
Bank overdrafts (GBS and commercial banks)	0	0
Drawdown in committed facility	0	0
Total cash and cash equivalents as in SoCF	**1,547**	**1,621**

Note 22.1 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	3,355	3,816
Capital payables	2,631	3,113
Accruals	6,995	7,730
Receipts in advance (including payments on account)	0	0
Social security costs	4,513	4,028
VAT payables	0	0
Other taxes payable	0	0
PDC dividend payable	0	0
Accrued interest on loans	150	75
Other payables	3,831	3,554
Total current trade and other payables	**21,475**	**22,316**
Non-current		
Trade payables	0	0
Capital payables	0	0
Accruals	0	0
Receipts in advance (including payments on account)	0	0
VAT payables	0	0
Other taxes payable	0	0
Other payables	0	0
Total non-current trade and other payables	**0**	**0**
Of which payables from NHS and DHSC group bodies:		
Current	1,559	855
Non-current	0	0

Note 22.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2018 £000	31 March 2018 Number	31 March 2017 £000	31 March 2017 Number
- to buy out the liability for early retirements over 5 years	0		0	
- number of cases involved		0		0
- outstanding pension contributions	2,474		2,380	

Note 23 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	2,073	2,546
Deferred grants	0	0
PFI deferred income / credits	0	0
Lease incentives	0	0
Total other current liabilities	**2,073**	**2,546**
Non-current		
Deferred income	0	0
Deferred grants	0	0
PFI deferred income / credits	0	0
Lease incentives	0	0
Net pension scheme liability	0	0
Total other non-current liabilities	**0**	**0**

Note 24 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Bank overdrafts	0	0
Drawdown in committed facility	0	0
Loans from the Department of Health and Scoial Care	20,686	20,250
Other loans	62	84
Obligations under finance leases	130	124
PFI lifecycle replacement received in advance	0	0
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	0	0
Total current borrowings	**20,878**	**20,458**
Non-current		
Loans from the Department of Health and Scoial Care	52,295	30,407
Other loans	100	82
Obligations under finance leases	991	1,121
PFI lifecycle replacement received in advance	0	0
Obligations under PFI, LIFT or other service concession contracts	0	0
Total non-current borrowings	**53,386**	**31,610**
Total borrowings (current and non-current)	**74,264**	**52,068**

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

The Trust has agreed thirteen schemes since 2012/13, of which eight have been fully repaid.

Each of these loans are subject to zero interest and are repayable over 4 years in equal instalments although these have been drawn on completion of each scheme.

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

Loan Type	Agreement Date	Loan Facility Amount £000's	Interest Rate	Repayment Date	Analysis of Loan Balance - March 2018						
					Capital Funding £000's	Capital Repay £000's	Capital Balance £000's	Deficit Funding £000's	STF Funding £000's	STF Repay £000's	Total £000's
Capital	Mar-15	7,207	1.60%	10 year period	6,086	-761	5,325				**5,325**
Capital	Mar-16	9,352	1.16%	10 year period	9,352	-822	8,530				**8,530**
Revenue	Feb-16	18,851	1.50%	Feb-19				18,851			**18,851**
Revenue	Feb-17	14,515	1.50%	Jan-20				11,282	3,233		**14,515**
Revenue	Feb-17	2,995	1.50%	Feb-20				2,187	808		**2,995**
Revenue	Mar-17	2,469	1.50%	Mar-20				1,660	809		**2,469**
Revenue	Apr-17	1,127	1.50%	Apr-20				3,116	436	-2,425	**1,127**
Revenue	May-17	404	1.50%	May-20				-32	436		**404**
Revenue	Jun-17	1,414	1.50%	Jun-20				979	435		**1,414**
Revenue	Jul-17	1,104	1.50%	Jul-20				523	581		**1,104**
Revenue	Aug-17	0	1.50%	No Loan Drawn				1,703	581	-2,284	**0**
Revenue	Sep-17	1,516	1.50%	Sep-20				1,076	581	-141	**1,516**
Revenue	Oct-17	0	1.50%	No Loan Drawn				286	872	-1,158	**0**
Revenue	Nov-17	1,024	1.50%	Nov-20				301	872	-149	**1,024**
Revenue	Dec-17	1,477	1.50%	Dec-20				1,914		-437	**1,477**
Revenue	Jan-18	4,697	1.50%	Jan-21				3,680	1,017		**4,697**
Revenue	Feb-18	3,218	1.50%	Feb-21				4,031		-813	**3,218**
Revenue	Mar-18	4,315	1.50%	Mar-21				7,569		-3,254	**4,315**
Total		**75,685**			**15,438**	**-1,583**	**13,855**	**59,126**	**10,661**	**-10,661**	**72,981**

Total - Loan Balance at 31 March 2018	**13,855**	**59,126**	**72,981**

Note 25 Finance leases

Note 25.1 Northampton General Hospital NHS Trust as a lessor

Future lease receipts due under finance lease agreements where Northampton General Hospital NHS Trust is the lessor:

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

	31 March 2018	31 March 2017
	£000	£000
Gross lease receivables	**201**	**209**
of which those receivable:		
- not later than one year;	9	9
- later than one year and not later than five years;	36	36
- later than five years.	156	164
Net lease receivables	**201**	**209**
of which those receivable:		
- not later than one year;	9	9
- later than one year and not later than five years;	36	36
- later than five years.	156	164
The unguaranteed residual value accruing to the lessor	0	0
Contingent rents recognised as income in the period	0	0

Note 25.2 Northampton General Hospital NHS Trust as a lessee

Obligations under finance leases where Northampton General Hospital NHS Trust is the lessee.

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

	31 March 2018	31 March 2017
	£000	£000
Gross lease liabilities	**1,121**	**1,245**
of which liabilities are due:		
- not later than one year;	130	124
- later than one year and not later than five years;	571	550
- later than five years.	420	571
Net lease liabilities	**1,121**	**1,245**
of which payable:		
- not later than one year;	130	124
- later than one year and not later than five years;	571	550
- later than five years.	420	571
Total of future minimum sublease payments to be received at the reporting date	**0**	**0**
Contingent rent recognised as an expense in the period	0	0

Note 26.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Re-structuring	Continuing care	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2017	**0**	**0**	**0**	**0**	**0**	**0**	**5,863**	**5,863**
Transfers by absorption	0	0	0	0	0	0	0	**0**
Change in the discount rate	0	0	0	0	0	0	2	**2**
Arising during the year	0	0	0	0	0	0	2,118	**2,118**
Utilised during the year	0	0	0	0	0	0	(3,534)	**(3,534)**
Reclassified to liabilities held in disposal groups	0	0	0	0	0	0	0	**0**
Reversed unused	0	0	0	0	0	0	(710)	**(710)**
Unwinding of discount	0	0	0	0	0	0	6	**6**
At 31 March 2018	**0**	**0**	**0**	**0**	**0**	**0**	**3,745**	**3,745**
Expected timing of cash flows:								
- not later than one year;	0	0	0	0	0	0	2,744	**2,744**
- later than one year and not later than five years;	0	0	0	0	0	0	890	**890**
- later than five years.	0	0	0	0	0	0	111	**111**
Total	**0**	**0**	**0**	**0**	**0**	**0**	**3,745**	**3,745**

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

Note 26.2 Clinical negligence liabilities

At 31 March 2018, £150,933k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Northampton General Hospital NHS Trust (31 March 2017: £95,245k).

Note 27 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	0	0
Employment tribunal and other employee related litigation	0	0
Redundancy	0	0
Other	0	0
Gross value of contingent liabilities	**0**	**0**
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	**0**	**0**
Net value of contingent assets	0	0

No contingency liabilities or assets have been identified.

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

The Trust has a pre-lease contract with Shawbrook Asset Finance in relation to construction of the Nye Bevan Assessment Unit with a capital value of £12.3m. The works to March 2018 have reached £7.5m and are due to complete in June 2018. At this point a finance lease will be finalised with the Trust.

Note 28 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	729	2,941
Intangible assets	32	0
Total	**761**	**2,941**

Note 29 Financial instruments

Note 29.1 Financial risk management

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

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

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

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

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

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust 's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

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

Note 29.2 Carrying values of financial assets

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity at £000	Available-for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2018					
Trade and other receivables excluding non financial assets	12,530	0	0	0	**12,530**
Other investments / financial assets	201	0	0	0	**201**
Cash and cash equivalents at bank and in hand	1,547	0	0	0	**1,547**
Total at 31 March 2018	**14,278**	**0**	**0**	**0**	**14,278**

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non financial assets	20,578	0	0	0	**20,578**
Other investments / financial assets	209	0	0	0	**209**
Cash and cash equivalents at bank and in hand	1,621	0	0	0	**1,621**
Total at 31 March 2017	**22,408**	**0**	**0**	**0**	**22,408**

Note 29.3 Carrying value of financial liabilities

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total book value £000
Liabilities as per SoFP as at 31 March 2018			
Borrowings excluding finance lease and PFI liabilities	73,143	0	**73,143**
Obligations under finance leases	1,121	0	**1,121**
Trade and other payables excluding non financial liabilities	16,962	0	**16,962**
Total at 31 March 2018	**91,226**	**0**	**91,226**

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	50,823	0	**50,823**
Obligations under finance leases	1,245	0	**1,245**
Trade and other payables excluding non financial liabilities	18,288	0	**18,288**
Total at 31 March 2017	**70,356**	**0**	**70,356**

Note 29.4 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	37,841	58,807
In more than one year but not more than two years	21,996	1,529
In more than two years but not more than five years	26,290	4,616
In more than five years	5,099	5,404
Total	**91,226**	**70,356**

Note 30 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	2	5	512	205
Fruitless payments	0	0	1	14
Bad debts and claims abandoned	193	51	344	232
Stores losses and damage to property	0	0	0	0
Total losses	**195**	**56**	**857**	**452**
Special payments				
Compensation under court order or legally binding arbitration award	0	0	0	0
Extra-contractual payments	0	0	0	0
Ex-gratia payments	47	60	41	110
Special severence payments	0	0	0	0
Extra-statutory and extra-regulatory payments	0	0	0	0
Total special payments	**47**	**60**	**41**	**110**
Total losses and special payments	**242**	**116**	**898**	**561**
Compensation payments received		-		-

Note 31 Related parties

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

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

Revenue Transactions

Health Education England £10.0m (£10.4m)
Nene Clinical Commissioning Group £213.1m (£203.7m)
Corby Clinical Commissioning Group £2.5m (£2.4m)
Milton Keynes Clinical Commissioning Group £2.9m (£2.9m)
East Midlands Specialised Commissioning Hub £41.7m (£38.8m)
Central Midlands Local Office £7.0m (£8.0m)
Northamptonshire Healthcare NHS Foundation Trust £1.4m (£1.3m)
Kettering General Hospital Foundation Trust £1.8m (£1.5m)
University Hospitals of Leicester NHS Trust £0.9m (£1.0m)

Expenditure Transactions

NHS Resolution £11.4m (£8.2m)
Northamptonshire Healthcare NHS Foundation Trust £1.6m (£1.4m)
NHS Blood and Transplant £1.3m (£1.4m)

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Northampton Borough Council (Business Rates £1,039k (£770k)), Northamptonshire County Council (Pathology Services £150k (£149k)) and HM Revenue & Customs (Employers National Insurance contribution £17.5m (£15.4m)), National Health Service Pension Fund Scheme £17.8m (£17.0m) and NHS Business Services Authority £9.2m (£10.4m)

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

Grants totalling £422k (£341k), 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 £208k (£796k) of Building Works & Medical Equipment.

The Charitable Fund produces separate Trustees Report and Accounts which are available from the Finance Department of the Trust or on the Charity Commission website www.charity-commision.gov.uk. Should you wish to learn more about the Charitable Fund's activities and current initiatives visit www.nhcfgreenheart.co.uk or contact the Fundraising Team on 01604 626927 or E-mail greenheart@ngh.nhs.uk

Note 32 Events after the reporting date

There are no material events after the reporting date of 31 March 2018 which effect the financial position.

Note 33 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	81,245	117,439	93,148	111,972
Total non-NHS trade invoices paid within target	79,785	111,089	92,303	109,534
Percentage of non-NHS trade invoices paid within target	**98.20%**	**94.59%**	**99.09%**	**97.82%**
NHS Payables				
Total NHS trade invoices paid in the year	2,114	20,972	2,127	20,938
Total NHS trade invoices paid within target	2,001	20,469	2,085	20,858
Percentage of NHS trade invoices paid within target	**94.65%**	**97.60%**	**98.03%**	**99.62%**

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

Note 34 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	23,264	24,426
Finance leases taken out in year		1,410
Other capital receipts	0	0
External financing requirement	**23,264**	**25,836**
External financing limit (EFL)	23,455	26,297
Under / (over) spend against EFL	191	461

Note 35 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	13,323	14,669
Less: Disposals	0	(375)
Less: Donated and granted capital additions	(181)	(738)
Plus: Loss on disposal of donated/granted assets	0	0
Charge against Capital Resource Limit	13,142	13,556
Capital Resource Limit	13,340	13,561
Under / (over) spend against CRL	198	5

N.B. the £198k under-shoot includes £190k which wasn't adjusted by NHSI relating to £158k reduction in depreciation actual EOY position and £32k additional capital loan principal repayments which reduced the cash backed capital resources available to the Trust, therefore under spend against available resources is £8k

Note 36 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(23,339)
Remove impairments scoring to Departmental Expenditure Limit	0
Add back income for impact of 2016/17 post-accounts STF reallocation	0
Add back non-cash element of On-SoFP pension scheme charges	0
IFRIC 12 breakeven adjustment	0
Breakeven duty financial performance surplus / (deficit)	(23,339)

Note 37 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		2,081	1,109	504	399	197	-16,525	-20,151	-13,847	-23,339
Breakeven duty cumulative position	2,892	4,973	6,082	6,586	6,985	7,182	-9,343	-29,494	-43,341	-66,680
Operating income		227,805	236,260	255,481	271,295	276,894	270,358	273,562	298,240	304,760
Cumulative breakeven position as a percentage of operating income		2.18%	2.57%	2.58%	2.57%	2.59%	-3.46%	-10.78%	-14.53%	-21.88%