



# Annual Report & Accounts 2016/17



Healthcare at its very best - with a personal touch



# **Annual Report & Accounts** 2016/17

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# Chairman's Introduction

It is with great pleasure that I write the Chairman's statement for our review of the year. It is the 11th year I have prepared such a statement and it was not something I expected to do for 2016-17.

I have been the Chairman of The Newcastle upon Tyne Hospitals NHS Foundation Trust almost since its creation and throughout that time it has been a pleasure to lead a Board of Directors and a Council of Governors that are so dedicated to ensuring the continued success of the organisation and its many high quality services.

Having completed my allotted term of office I had expected to hand over the Chairman's role during 2016-17 but the Governors have extended my term of office until September 2017.

In January 2017 Sir Leonard Fenwick, Chief Executive, was placed on a period of extended leave to allow an investigation to be carried out by an independent investigator from outside of the region into a number of serious issues that came to light. This was conducted in line with the Trust's Human Resources processes, which are ongoing.

Since January 2017 the duties of the Chief Executive have been ably shared by Louise Robson, Director of Business & Development and Andy Welch, Medical Director and Angela Dragone, Director of Finance, has taken on the responsibilities of Accounting Officer. I would like to thank them, the rest of the Board, our Council of Governors and all of our employees for their commitment to continuing to provide the best possible services for the people who need our care. Their dedication to the organisation has never wavered and they have continued to focus on the trust's key priority – putting patients at the heart of everything we do.

The Council of Governors will later this year restart the process to recruit a new Chairman for the Trust and whoever takes on that role will have the privilege of leading one of the very best NHS Foundation Trusts in the country. It is one of a handful of trusts rated as outstanding by the Care Quality Commission, a leader in the field of research and development, and it has an enviable track record of consistently delivering on both quality and financial targets.

The Trust's success in 2016-17 is despite increasing demand for the services we provide, tighter financial resources for the whole of England's health and social care system, as well as many new challenges including the development and delivery of Sustainability and Transformation Plans.

I am confident however that the organisation is well placed to meet these challenges – not least because of the excellent staff we have been fortunate to attract and retain, the wonderful volunteers who give so generously of their time, and the strong partnerships we have developed with universities, local authorities, other NHS organisations and the many charities that help to support our services.

Together we have built a strong organisation focused on continuing to deliver the very best care for people who need our services. This review of the year gives just a snap shot of many of those services and their achievements during 2016-17.



**Kingsley W Smith OBE DL**  
Chairman



# Review of the Year - Service Developments



## Tomotherapy technology

As a leading cancer centre we were delighted to take delivery of a second TomoTherapy machine in the radiotherapy department of our Northern Centre for Cancer Care.

This highly specialised system provides extremely precise targeting of cancer cells, and allows even more patients to be treated with the most modern type of radiotherapy, known as Intensity Modulated Radiotherapy. The machine also has an inbuilt CT scanner, which provides detailed images of the patient's anatomy, allowing our cancer experts to closely monitor the progress and effectiveness of the treatment.

This advanced approach helps to effectively treat hard-to-reach and complex tumours and also minimises damage to surrounding healthy tissue during treatment, lowering the risk of side effects for our cancer patients.

As well as the new TomoTherapy machine, the treatment room also had luminous ceiling artwork installed thanks to the Charlie Bear for Cancer Care Fund. The 'SkyCeiling' is a virtual skylight which gives the illusion of real sky views to alleviate stress and help patients relax.

## First in the region to join forces with DisabledGo

We were the first NHS Foundation Trust in the North East to go into partnership with DisabledGo to launch an accessibility checker to help patients, visitors and staff find out more about the accessibility of our buildings and services.

With information including parking, walking distances and toilet facilities this free guide is useful to both able bodied and disabled people. Each place featured on the DisabledGo website has been visited by surveyors employed by the social enterprise to ensure that the detailed information is up-to-date and correct.

Launched in March 2017 the DisabledGo website [www.disabledgo.com](http://www.disabledgo.com) will eventually carry information about the Trust's Dental Hospital, Royal Victoria Infirmary, Great North Children's Hospital, The Freeman Hospital and community services sites across the city.

## North East Children's Transport and Retrieval Service on the move

We saw the move of the North East Children's Transport and Retrieval Service. Still hosted by the Great North Children's Hospital, the service moved into our Campus for Ageing and Vitality and also welcomed two new ambulances.

The services ensures that critically ill children are transported rapidly by an expert team to one of the paediatric intensive care units in the region at the Great North Children's Hospital at the Royal Victoria Infirmary, the Children's Heart Unit at the Freeman Hospital in Newcastle and the James Cook University Hospital in Middlesbrough.

There has been a 50% increase in the number of retrievals since the service began in 1996, but the new base for the ambulances close to the A1 and A69 means the team can reach critically ill children more quickly.

The ambulances, described as 'mobile intensive care units', have been specifically developed to improve the clinical outcome of the critically ill children. They are operated by blue light-trained drivers and allow one parent to travel with their child.

## New technique increases kidney transplant success

Father-of-two Brian Richards was the first patient in the North East to receive a kidney organ involving a pioneering technique at the Institute of Transplantation, based at The Freeman Hospital.

The technique involves taking donor kidneys with a high chance of not working well after transplant and assessing whether they can make urine normally when given blood, oxygen and nutrients on a specialist perfusion machine outside the body. The perfusion process involves warming the kidney to body temperature to assess how well it is working before a decision on transplantation is made.

Currently Addenbrooke's Hospital in Cambridge and The Freeman Hospital are the only two centres in the country offering this process that could increase the number of usable donor kidneys available to people waiting for a transplant.





In other welcome news for kidney disease patients, NHS England chose the Trust and Newcastle University to jointly lead a new national service for atypical haemolytic uraemic syndrome.

The serious inherited kidney disease is caused by a defect in the immune system and can lead to irreversible kidney damage, affecting around 200 people in the UK, with 20 to 30 new diagnoses each year.

The only proven treatment for the condition is Eculizumab - a drug whose use for the condition was pioneered at Newcastle University's Institute of Genetic Medicine.

### Pioneering stroke trial

Leonard McCourt became the first Royal Victoria Infirmary (RVI) patient to take part in the world's first regulated clinical trial of direct stem cell therapy for strokes.

The trial is looking at the effects of stem cell treatment when given to people left with moderate to severe neurological and limb impairments following an ischaemic stroke. Just four days after the pioneering treatment Mr McCourt was able to go home.

The Acute Stroke Unit at the RVI was selected to be part of the trial due to its specialist expertise in treating all types of strokes, as well as having a centre of excellence for complex neurosurgery and stem cell management.

### At the forefront of radiotherapy

Our Northern Centre for Cancer Care at The Freeman Hospital was one of only 16 centres in the UK to be chosen to offer stereotactic radiosurgery.

This highly specialised radiotherapy for patients with certain types of malignant and benign brain tumours, can only be provided by the most advanced cancer centres and The Freeman Hospital is offering this treatment to patients from across the Northern region.

This non-invasive approach offers an excellent treatment option for some patients whose primary cancer is under control but who have developed a small number of secondary brain lesions and whose previous options were extremely limited.

### £16.2m investment in ground-breaking health research

The Trust, in partnership with Newcastle University, welcomed a decision by the National Institute for Health Research (NIHR) to invest £16.2m in the research programmes at the NIHR Newcastle Biomedical Research Centre.

The centre, which is run in partnership by the Trust and University, carries out research to improve the prevention, diagnosis and treatment of major common diseases affecting older people. The five years of funding will support research that will benefit local patients suffering from several chronic diseases, including dementia as well as liver, muscle, joint and skin diseases.

### Wolfson Childhood Cancer Research Centre opened

Two years of hard fund raising paid off with the opening of the centre at Newcastle University.

The £5.5m centre was developed in partnership by the University, Trust and North of England Children's Cancer Research, to bring together clinical and research teams committed to tackling cancers affecting children and young people.

Work at the centre focuses on developing less toxic therapies with fewer side effects, and more effective treatment options for youngsters with advanced cancer and for those whose illness has returned.

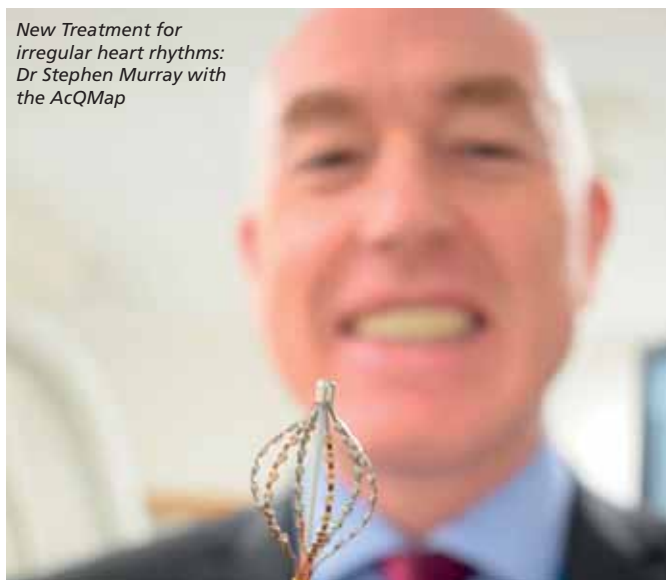
About 1,600 children a year are diagnosed with cancer in the UK and it remains one of the main causes of premature death in children.

### Centre of Excellence for Paget's Disease of Bone

The Newcastle Bone Centre at The Freeman Hospital was awarded Centre of Excellence status by the Paget's Association.

The association recognises hospital and university departments that demonstrate excellence in both the treatment of the disease and research into the condition.

*New Treatment for irregular heart rhythms: Dr Stephen Murray with the AcQMap*



## New treatment for irregular heart rhythms

The trust's Cardiothoracic Centre at The Freeman Hospital began a research study into a new treatment for irregular heart rhythms.

Atrial fibrillation is the leading cause of stroke and heart failure, and the Trust is one of only a handful of centres across Europe to offer a new technique that enables clinicians to better understand a patient's specific irregular heart rhythm and then provide individualised treatment.

The Trust is one of only six centres in the UK to use the 3D mapping system – AcQMap – which provides clinicians with a real time 3D anatomical image of how an abnormal rhythm behaves, and the trust began a research study into the new treatment in November 2016.

## Growing our own nurses

As the national demand for qualified nurses grows the Trust has developed a new partnership with the University of Sunderland to train its own nurses of the future through an adult nursing degree programme.

Throughout the course students will experience a wide range of clinical placements within the Trust, either in its hospitals or community services. Alongside placements students will spend half of their time in the state of the art teaching facilities at the University of Sunderland.

The self-funded three year course, that started in April 2017, is part of a new initiative to help support increasing availability and access to nursing education, and although not NHS funded there are a number of scholarships available to support students.

Students who successfully complete the degree programme will be eligible to register with the Nursing and Midwifery Council as a Registered Nurse (adult). Students will also be guaranteed an interview with the Trust as well as assistance with loan repayments with a one off annual payment of £500 (minus tax and national insurance) for the first five years of employment as a staff nurse.

## Sister transplant centre in Nepal

The Trust's renal and transplant team has been awarded funding by the International Society of Nephrology to establish a Sister Transplant Centre partnership between the Institute of Transplantation at The Freeman Hospital and the Human Organ Transplant Centre in Kathmandu, Nepal.

The global initiative awards funding to create new kidney transplant centres, and develop existing kidney transplant programmes in emerging countries. Funding from the society will help a nephrologist from Kathmandu to travel to Newcastle to study at the transplant unit, and a tissue typing expert to travel from Newcastle to Nepal to help develop their tissue typing service.

*Wolfson Childhood Cancer Research Centre opened: Bill Bryson with Emma*



## World's first mitochondrial licence

Newcastle has been granted the first licence to offer a fertility treatment to mothers affected by mitochondrial disease.

The Human Fertilisation and Embryology Authority (HEFA) granted a treatment licence to the Newcastle Fertility Clinic run by the Trust. This allows a variation to the current clinical licence so that pro-nuclear transfer can be offered to reduce the risk of mothers transferring mitochondrial disease.

From later this year, women will receive this treatment as an NHS service at the Newcastle Fertility Centre and the NHS Highly Specialised Service for Mitochondrial Disease. This licence is for the centre and each separate patient will have to get approval for the procedure.

Experts at the Wellcome Centre for Mitochondrial Research at Newcastle University and the Newcastle Fertility Centre have been at the forefront of the technique, and the team aim to offer treatment for up to 25 women a year affected by mitochondrial disease.

## Memory Café opens

The nurse specialists who form part of the Trust's dementia care team launched a Memory Café to support patients with dementia, their families and loved ones.

The Memory Café, based at the Melville Day Unit in The Freeman Hospital, is aimed at newly diagnosed patients and families. It provides somewhere for them to meet each other in a relaxed environment to share their experiences, as well as help develop future events.

This service development also received the Trust's Annual Nursing and Midwifery Achievement Award, which was presented at the Town's Nursing and Midwifery Conference in May 2017.

## RVI launches rehab hub

In November 2017 the trust launched a new major trauma rehabilitation service at the RVI. Bringing together a multi-disciplinary specialist team, the rehab hub aims to provide early identification of patients rehabilitation needs, co-ordination of care, specialist inpatient rehabilitation after complex trauma, and in-depth discharge planning.

Based on a ten bedded hub on Ward 22 the innovative service works closely with community teams to ensure the seamless transfer of care for patients when they are ready to leave hospital.



World's first mitochondrial licence:  
Professor Mary Herbert

World's first mitochondrial licence:  
Dr Meena Choudhary

Power List: Alice Wort



Pioneering Stroke Trial: Mr McCourt with Michelle Fawcett and Dr Dixit



NHS Sustainability Award: Sustainability Team



Centre of Excellence for Paget's  
Disease of Bone: Dr Terry Aspray  
receiving official plaque



# Review of the Year - Awards

As well as a host of new service developments and innovations, the Trust has also had cause to celebrate the on-going excellent work of many of its teams and individual members of staff being honoured by prestigious external awards over the last year. Here is just a snapshot of some of those awards:

## Newcastle Fertility Centre

The Trust's Fertility Team won the Innovative Technology or Device Category at the 13th annual Bright Ideas in Health Award ceremony, which celebrates the very best innovations developed by healthcare staff in the North East and North Cumbria.

The honour was for the team's development of a device to improve In Vitro Fertilisation (IVF) procedure egg collection. Each year, IVF gives over 60,000 UK couples experiencing problems conceiving, the chance of having a baby. The average success rate of a birth with each procedure is about 25% and research shows that the main factor determining the outcome is the quality of the egg.

To help improve the chances of each egg making a normal embryo experts at the Newcastle Fertility Centre developed the device called the Eggcell - a sealed chamber containing warm fluid that allows the fluid containing the eggs to be passed directly from the needle and tubing into this protected stable environment.

The award will help to fund a clinical trial to determine the recovery rate of eggs taken from the ovary, comparing the use of Eggcell with the current test tube method.

## Award winning research nurse

Helen Hanson, a Senior Research Nurse at the Freeman Hospital's Rheumatology Department, won two awards and was finalist for another, in recognition of her concerted efforts to increase staff and patient awareness, involvement and recruitment into research studies.

Helen won both the Trust's Nursing and Midwifery Research and Audit Prize and the NIHR Clinical Research Network North East and North Cumbria - Research Practitioner of the Year, as well as being a finalist in the Quality Improvement Impact category of the 13th annual Bright Ideas in Health Awards.

Helen explained: "The research was initiated to understand what taking part in research is like for patients and staff. The project is funded by Arthritis Research UK and we are using the results in an ongoing study introducing changes in practice to engage more staff and patients in research. Ultimately, we hope this will raise patient and staff awareness of research, enable more patients to participate in studies and increase our capacity to conduct high quality research."

Helen's NIHR Research Practitioner Award also recognised her efforts in founding and facilitating the patient and public involvement group - Public Involvement in Musculoskeletal Service.

## Emerging Best Practice Award

The Trust's rheumatologists won the British Society of Rheumatology's Emerging Best Practice Award for their work in the development of a clinical database that integrates service, audit and research information.

Honorary Consultant Rheumatologist, Dr Arthur Pratt, who is clinical lead for early arthritis, said: "I am a strong believer that integrating clinical services with high quality research activity creates a virtuous cycle with real benefits for our patients and their carers. Absolutely key to this has been the development of a database, which helps our team to collect relevant information from patients in clinics on a real time basis. As well as providing us with a powerful resource for our research programme, this helps us to monitor how well our services performance against national standards."

## NHS Sustainability Awards

The Trust's sustainability team was shortlisted in two categories at this year's NHS Sustainability Awards, highlighting the innovative work the Trust is undertaking to make its healthcare services more sustainable.



The team was shortlisted in the waste management category for an initiative in the central operating theatres at The Freeman Hospital. It initially focused on the removal of Polyvinyl Chloride (PVC) masks from the clinical waste stream, but quickly expanded to increase the segregation of other recyclables from theatres. The initiative has been a huge success and will increase the amount of waste recycled by over 25 tonnes per year.

The team was also shortlisted in the food category for its campaign to improve the sustainability of the catering department at the Freeman Hospital. This has included working with chefs to create an appropriate menu to encourage the use of local, organic, Fairtrade and meat-free meals.

The department has also introduced two anaerobic digesters, for food preparation and returned plate waste, which have saved over three Olympic sized swimming pools worth of water each year, and their own waste compactor, which reduces the volume of recyclable waste, allowing more to be collected before removal.



## Meritorious Award

Consultant Rachel Hawes has received a prestigious award from Her Majesty's Lord Lieutenant of Tyne & Wear in recognition of her lifesaving 'Blood on Board' work. Eighteen lives were saved in the first year of the project across the North East and Cumbria, which sees medics with the Great North Air Ambulance Service (GNAAS) performing rapid blood transfusions to patients with a life or limb threatening injury at the scene of an incident.

Rachel's ambition to bring the lifesaving service to the region derives from her military experiences in service as an Army Reservist and Lieutenant Colonel with 201 Northern Field Hospital. Specialising in Pre-Hospital Care and Anaesthesia at the RVI, Rachel also works as a GNAAS doctor and has used the 'Blood on Board' service that she introduced to the region on a number of occasions.

## Chiron Medal

Dr Alison Brown, consultant nephrologist at the Freeman Hospital and honorary senior clinical lecturer at Newcastle University, was awarded the prestigious Chiron Medal by The Royal College of Physicians of Edinburgh. The award recognises excellence in teaching and training by a physician with particular focus on recognising exceptional contribution to teaching and innovation in teaching methods.

Dr Brown was previously the nephrology training programme director in the Northern region, and as a member of the Training and Education Committee of the The Renal Association she has contributed to renal training curriculum development.

She is also the secretary of The Renal Association and director of online education for the Royal College of Physicians of Edinburgh. Dr Brown has provided regular support and teaching to the Human Organ Transplant Centre in Bhaktapur, Nepal, and this year successfully applied for International Society of Nephrology Sister Transplant Centre status to support the centre in Nepal from the Institute of Transplantation at the Freeman Hospital.

## Advancing Healthcare Awards

Community nutrition worker, Jen Hopton, was shortlisted for the NHS Employers award which celebrates outstanding achievement by an apprentice, support worker or technician working alongside an allied health professional, scientist or healthcare scientist.

Jen was shortlisted for her role in developing the early years weight management service from a group based intervention to a more personal individual service. She was integral in the redevelopment of the service which now provides holistic family focused interventions at home. The service aims to achieve sustainable lifestyle changes to improve weight prior to the child starting school.

## Accredited Procurement and Supplies team

The Trust's procurement and supplies team is leading the way in NHS procurement in the North East by becoming the first in the region to achieve NHS Standards of Procurement level one accreditation.

Procurement has a key role to play in supporting the delivery of high quality patient care while ensuring value for money. The NHS Standards of Procurement help to support this by providing a clear vision of good procurement, as well as helping organisations identify strength and where improvements can be made.

By achieving level one the team has shown it can meet a number of criteria including demonstrating that a procurement strategy is in place and developed in support of the Trust's strategy. The team is now supporting other trusts in the region to reach their level one accreditation as well as working towards meeting the criteria to achieve their own level two, which includes showing that there are clear plans and structures in place aimed at continuously improving performance.

## Student Nursing Times Award

Lauren McGregor was shortlisted in the Student Nursing Times Awards 2017 for Student Nurse of the Year: Adult.

Lauren was nominated for the involvement and eagerness she demonstrated in helping to develop the Trust's Nursing and Midwifery Strategy. Lauren won the Trust's Student Nurse (Adult) of the year award in 2016, in which she was praised as an excellent role model for other students and for her overall passionate attitude to developing her nursing skills.

## Excellence in Patient Care Awards

The Trust's Liver Unit was shortlisted in the quality improvement category of the Royal College of Physicians' Excellence in Patient Care Awards. The honour was in recognition of the unit's work to develop a care bundle for patients admitted with decompensated cirrhosis – a life threatening condition where the liver does not function properly.

The care bundle provides a simple evidence based checklist to ensure the appropriate investigations and treatments are carried out in a timely manner. Since it was developed the unit has seen significant improvements in patient care and the bundle has also been praised by the British Society of Gastroenterology and British Associate for the Study of the Liver.

*The Newcastle Hospitals' Procurement and Supplies Team: the first to achieve NHS standards of Procurement level one accreditation*





### Power List

Dr Alice Wort, a Specialist Registrar in Microbiology at the Royal Victoria Infirmary, and Clinical Research Fellow at Newcastle University, has joined the illustrious 'Power List' - an annual celebration led by The Pathologist magazine, which highlights key achievements in the laboratory healthcare profession.

Each year the Power List has a different theme with 2016 celebrating the work of some of pathology's rising stars around the world. Chosen by an expert panel of judges, Dr Wort was one of only four UK based pathologists to be included and she was nominated for her ability to represent and advocate for her profession.

### NHS Leadership Award

Teenage Cancer Trust youth support co-ordinators Chris Layfield and Cara Mattok were shortlisted in the Excellence in Patient Experience category of the NHS Leadership Awards.

They were honoured for going above and beyond their roles to support young people who have had a cancer diagnosis. They not only provide support to youngsters in the Trust's hospitals and clinics but also as part of an outreach programme that runs across the North East and Cumbria.

### Sign-up to Safety team

The paediatric sign up to safety team at the Great North Children's Hospital was shortlisted in the Inclusive Leader category of the NHS Leadership Award. They were honoured for exemplary team Leadership in creating a safe environment to recognise and treat children with sepsis.

All staff in the team, along with parents and children, were engaged and empowered to share their views on new systems to identify and treat this potentially life-threatening condition.

### Macmillan one-to-one team

The Trust's Macmillan one-to-one team was shortlisted in the Excellence in Patient Experience Category of the NHS Leadership Awards for their drive to improve care for patients outside of formal pathways.

The team has been extremely proactive in ensuring that patients, often with complex physical, psychological and social needs, can easily access their service when they need help most.

### Clinical Excellence Award

British Heart Foundation Cardiac Genetics Nurse, Julie Goodfellow, was presented with a prestigious Clinical Excellence Award from national charity Cardiomyopathy UK.

The award recognised her involvement with the charity in supporting and informing patients with the heart muscle disease cardiomyopathy, and follows countless nominations put forward by the many patients who have benefitted from her care.

As a Cardiac Genetics Nurse for the North of England Cardiac Family History Service, Julie works as part of a small regional team covering hospitals, which include Sunderland Royal Infirmary, The Freeman Hospital and James Cook Hospital in Middlesbrough.

Julie's role at The Freeman Hospital is to provide assessment and support to families and individuals with suspected inherited cardiac conditions. This includes families who have experienced sudden death syndrome or those with inherited cardiac conditions, providing tailored education advice and support. Outside of her clinical role, Julie also co-facilitates and participates in the local Cardiomyopathy UK support group.

“My consultant and all the doctors and nurses cared for me with respect and kindness. They put my mind at ease at a very difficult and frightening time. I thank them all for that.”

### Sonographers Team of the Year Award

The Trust's Ultrasound Team won the Society and College of Radiographer's Northern Region Team of the Year Award.

The award recognised the can-do attitude of the team in dealing with increasing referrals and staff shortages at the same time as introducing cross site working and developing the skills required to work in specialist transplant centres and oncology services. This approach has allowed ultrasound, radiology and the Trust to maintain exceptionally high standards of care for local people.

### Patients' Choice Awards

Michelle Rutherford, Clinical Nurse Specialist in the Rheumatology Department at The Freeman Hospital, won the Best Care Provided by a Rheumatology Nurse category in the National Ankylosing Spondylitis Society's Patients' Choice Awards.

The awards were voted for by patients who nominated health care professionals that had gone above and beyond the call of duty to help people with this condition.

### Healthcare Champion Award

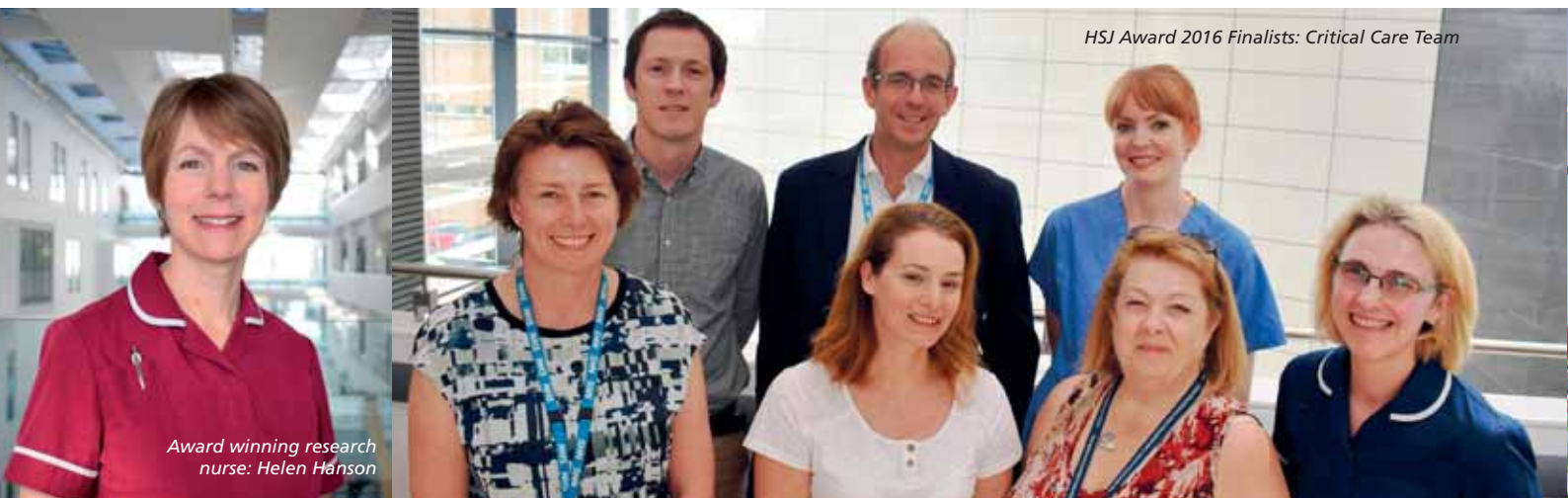
Consultant Rheumatologist Dr Martin Lee and Nurse Specialist Karl Nicholl from The Freeman Hospital won a National Rheumatology Arthritis Society (NRAS) Healthcare Champion Award.

The awards recognise the dedication and professionalism that patients with Rheumatoid Arthritis and Juvenile Idiopathic Arthritis receive from the healthcare professionals in this field, to help them cope with their condition and get the best possible outcomes.

### Team of the Year

The Surgical Nursing Team on Ward 46 at the Royal Victoria Infirmary was shortlisted in the Team of the Year category of the Nursing Times Awards.

The team's nomination recognised the fantastic efforts of all staff on the Ward towards ensuring the delivery of comprehensive "Harm Free Care" for every single patient on their ward.



HSJ Award 2016 Finalists: Critical Care Team

Award winning research nurse: Helen Hanson



Macmillan one-to-one team: Alison McDonald and Kay McAlinden



National Ankylosing Spondylitis Society Patients' Choice Awards: Michelle Rutherford





Royal College of Physicians' Excellence in Patient Care Awards: Dr Stuart McPherson, Elaine Coghill, Dr Mark Hudson, Dr Jess Dyson, Dr Steven Masson



NHS Leadership Award: Chris Layfield and Cara Mattok

Sophie's Award: Mr Kenneth Rankin



Paediatric Sign-up to Safety Team: Matron Jo Mulholland, Dr Matthew Thomas and Dr Emma Lim

## Health Service Journal Awards

The Trust's Critical Care team was shortlisted in the Patient Safety Category of the Health Service Journal Awards. This was in recognition of superb outcomes following a four year quality improvement programme in four adult critical care units across Newcastle's hospitals that has seen an astonishing 63% reduction in pressure ulcers, which affect vulnerable patients

## Sophie's Award

Mr Kenny Rankin, an Honorary Consultant in Orthopaedics at Newcastle's Freeman Hospital, won a national research award.

The "Sophie's Award ideas research grant" was given by the Bone Cancer Research Trust for Mr Rankin's project on the 'Evaluation of a novel MT1-MMP activated ferrous nanoparticle as a theranostic and surgery planning tool in Ewing Sarcoma and Osteosarcoma.'



Meritorius Award: Dr Rachel Hawes who led the Region's Blood on Board Service



Bright Ideas in Health Awards: The winning Newcastle Fertility Centre Team



Clinical Excellence Award from Cardiomyopathy UK: Julie Goodfellow

Advancing Healthcare Awards: Jen Hopton and Gill Steel



Sonographers Team of the Year Award: Winning Ultrasound Team

# 1. Performance Report

## a. Overview of Performance

### Purpose

The purpose of the overview is to provide a summary of The Newcastle upon Tyne Hospitals NHS Foundation Trust, its purpose, the key risks to Trust objectives and how the Trust has performed during the year.



# Chief Executive's Statement

Putting patients at the heart of everything we do is at the core of The Newcastle upon Tyne Hospitals NHS Foundation Trust - it is lived by our staff every day. So despite the many challenges the organisation has faced over the last 12 months we are delighted that we have continued to maintain our focus on providing high quality, safe care for the people who need our services.

We are very grateful to our dedicated staff who have ensured that we have maintained such a high standard of delivery across an organisation that has one of the most comprehensive range of services of any NHS Trust in England.

The Trust, the wider NHS and our social partners have faced - and will continue to face in 2017-18 - some major challenges in maintaining the provision of the high level of care that people deserve and our staff want to deliver day in, day out.

Across the country we are seeing increased demand for services, including from an elderly population with complex needs who require the support of health, social care and voluntary sector organisations. This undoubtedly puts a strain on a national system that is also facing tighter financial resources and workforce shortages in many key areas.

No one organisation can tackle those challenges alone and that is why we have, and will continue, to commit a lot of time and energy to supporting the sustainability and transformation programme for Northumberland, Tyne and Wear, and North Durham. Organisations in this area have a strong track record of successfully working in partnership together and we are confident that despite the challenges facing the local health and social care system, we can make a real positive difference to the long term health and wellbeing of the communities we serve, as well as ensuring that they have access to the high quality health and social care services they need now and in the future. We already have examples of how working together can help to improve services, and you'll see some of those throughout this report.

Along with other local health and social care organisations we have signed a commitment to working towards greater integration of services, and we are already seeing the benefit of that closer working in some areas. For example, in partnership with Gateshead Health NHS Foundation Trust, we have set up a hyper acute stroke unit at the RVI that works closely with a range of specialist community services. Together they have improved not only how quickly patients are treated but also the long term outcomes for local people who suffer a stroke. This unit will be the basis of future leading edge developments in stroke care.

Partnership is important to us not just in terms of delivering current and future services, but also in developing innovative new treatments and services. We have a long track record of fostering innovation, research and development through our work with Newcastle University, Northumbria University, and the Academic Health Science Network. This report contains many examples of how those and other partnerships have led to innovative and often life changing treatments for many of our patients, and it is an area we will continue to focus on and develop in the coming year.

In 2016-17 we were delighted to not only maintain our strong track record of financial performance, but also improve the position slightly on what we had forecast for the year, albeit through the use of non-recurrent resources. That is a situation that the vast majority of NHS organisations would envy, but we are not complacent. We know that 2017-18 is going to be tough financially and we have plans in place to further streamline our operations and improve our efficiency. We will also be working with external partners to maximise our learning from other organisations that have successfully faced similar financial challenges without compromising on the quality of their services.

Over the last year we have seen an increase in demand for many of our services, and that has put a strain on some of our teams, particularly those with recruitment difficulties. This is something challenging Trusts across the country and we are working hard to fill any workforce gaps. We are fortunate that we have such a strong, loyal and dedicated workforce and are experiencing relatively few workforce gaps compared with other organisations.

During 2017-18 we will continue to work with our partners at Newcastle and Northumbria Universities to make our hospitals popular training places for junior doctors, who are the consultants of the future, and we are also working with Sunderland University on a new programme to "grow our own nurses". It is important to the future development of our workforce and services that the Trust is seen as a great place to work and also that our staff are proud of the care we provide, so we were delighted by the results of the latest NHS staff survey, which you can read more about on page 52.





We are very grateful to our dedicated staff who have ensured that we have maintained such a high standard of delivery across an organisation that has one of the most comprehensive range of services of any NHS Trust in England

Staff in our clinical and support services worked hard during 2016-17 to ensure that we continued to achieve nationally and locally set targets for the care we provide. We managed to maintain an excellent performance across the majority of those targets, and even bucked the national trend in meeting access standards for cancer treatment and meeting all 18 week referral for treatment targets throughout the year.

While attendance at our emergency departments was also up on previous years, we did see a drop in the numbers of patients attending our main A&E department at the RVI. Our teams were disappointed to narrowly miss achieving the four hour A&E target for the last two quarters of the year. Across the region other NHS organisations have reported high levels of attendance at A&E departments over the winter, and we have frequently supported neighbouring trusts in taking patients diverted from their emergency departments. We are immensely proud of our staff for the time and effort they have made in delivering, routine emergency care, but also caring for people from across the region with the most complex life threatening injuries and illnesses through our dedicated Major Trauma Centre.

The Chairman's introduction to this report (page 5) has already explained that for the last three months of 2016-17 we have shared the responsibilities of Chief Executive. We always knew that our staff's first commitment was to continue to provide high quality services, but over the last few months we have been humbled by the support we have had from staff throughout the trust. They have helped us maintain that consistent focus on high quality safe services, and we would like to take this opportunity to thank all our staff for the hard work, enthusiasm and commitment they have shown to this organisation during 2016-17.

We are confident that with their continued efforts along with the support of our many partner organisations, volunteers, governors and charity fundraisers, The Newcastle upon Tyne Hospitals NHS Foundation Trust will continue to be a high performing organisation that we can all be proud of.

**Louise Robson**  
*Director of Business and Development*

**Andy Welch**  
*Medical Director*  
*Acting Chief Executives*

# Our Activities

The Newcastle upon Tyne Hospitals NHS Foundation Trusts is one of the most successful teaching NHS trusts in the country. We offer the second highest number of specialist services than any other group of hospitals in the UK, with more than 2,250 beds and more than 1.69 million patient contacts each year. We provide innovative high quality services, including community and primary care services, locally, regionally and nationally.

We deliver services from seven main sites including the:

- Freeman Hospital – including the Institute of Transplantation, the Northern Centre for Cancer Care and Renal Services Centre;
- Royal Victoria Infirmary – including the Great North Children's Hospital and the Great North Trauma and Emergency Centre;
- Campus for Ageing and Vitality (the former Newcastle General Hospital site);
- Newcastle Dental Hospital;
- Newcastle Fertility Centre;
- Northern Genetics Service; and
- Cramlington Manor Walks.

We are proud of all the services we provide to the people who need our care, but our flagship services include:

- The Cardiothoracic Centre at The Freeman Hospital – the only centre in the UK to provide complex cardiopulmonary surgery, including heart and lung transplants for both children and adults.
- The Great North Children's Hospital – caring for infants, children and young people living as far north as Berwick in the borders to Cumbria in the west and down to North Yorkshire to the south.
- The major trauma centre at The Royal Victoria Hospital – serving a population of more than three million people.
- The Newcastle Centre for Cancer Care – providing state-of-the-art cancer care for the people of Newcastle and beyond.
- The Institute of Transplantation – performed the first successful heart transplant for a child, the first single lung and dual lung transplants in Europe, and continues to have exceptional results.
- The Bubble unit at The Royal Victoria Hospital – one of only two units in the country where children with severe immune system problems can be treated in an air-tight isolation ward.

During the last year we were commissioned to provide a range of diagnostic, acute, community and primary care services for a population spanning the North East of England, as well as some supra-regional and national services, such as organ transplantation.

During the last 12 months there were 87,376 inpatient spells, 116,208 day cases, 196,243 attendances at our accident and emergency department and walk in centres, and 872,056 outpatient appointments, as well as 211,598 outpatient procedures.



# The Trust

The Newcastle upon Tyne Hospitals NHS Foundation Trust was formed on 1 June 2006 under the provisions of the Health and Social Care (Community Care and Standards) Act 2003 (consolidated in the National Health Service Act 2006).

The previous organisation – The Newcastle upon Tyne Hospitals NHS Trust – was formed on 1 April 1998 following the merger of the Freeman Group of Hospitals NHS Trust with the Royal Victoria Infirmary & Associated Hospitals NHS Trust.

Our vision is to be “the health service for greater Newcastle” and a leading national healthcare provider.

Our strategic goals are:

- Putting patients first and providing care of the highest standard, focusing on safety and quality.
- Working in partnership to deliver fully integrated care and promoting healthy lifestyles to the people of Newcastle.
- Being a nationally and internationally respected leader in research and development, underpinning our pioneering services.
- Enhancing our reputation as one of the country’s top first class teaching hospitals, promoting a culture of excellence in all that we do.
- Maintaining sound financial management to ensure the ongoing development and success of our organisation.

Our core aim is “putting patients at the heart of everything we do” and our core values are:

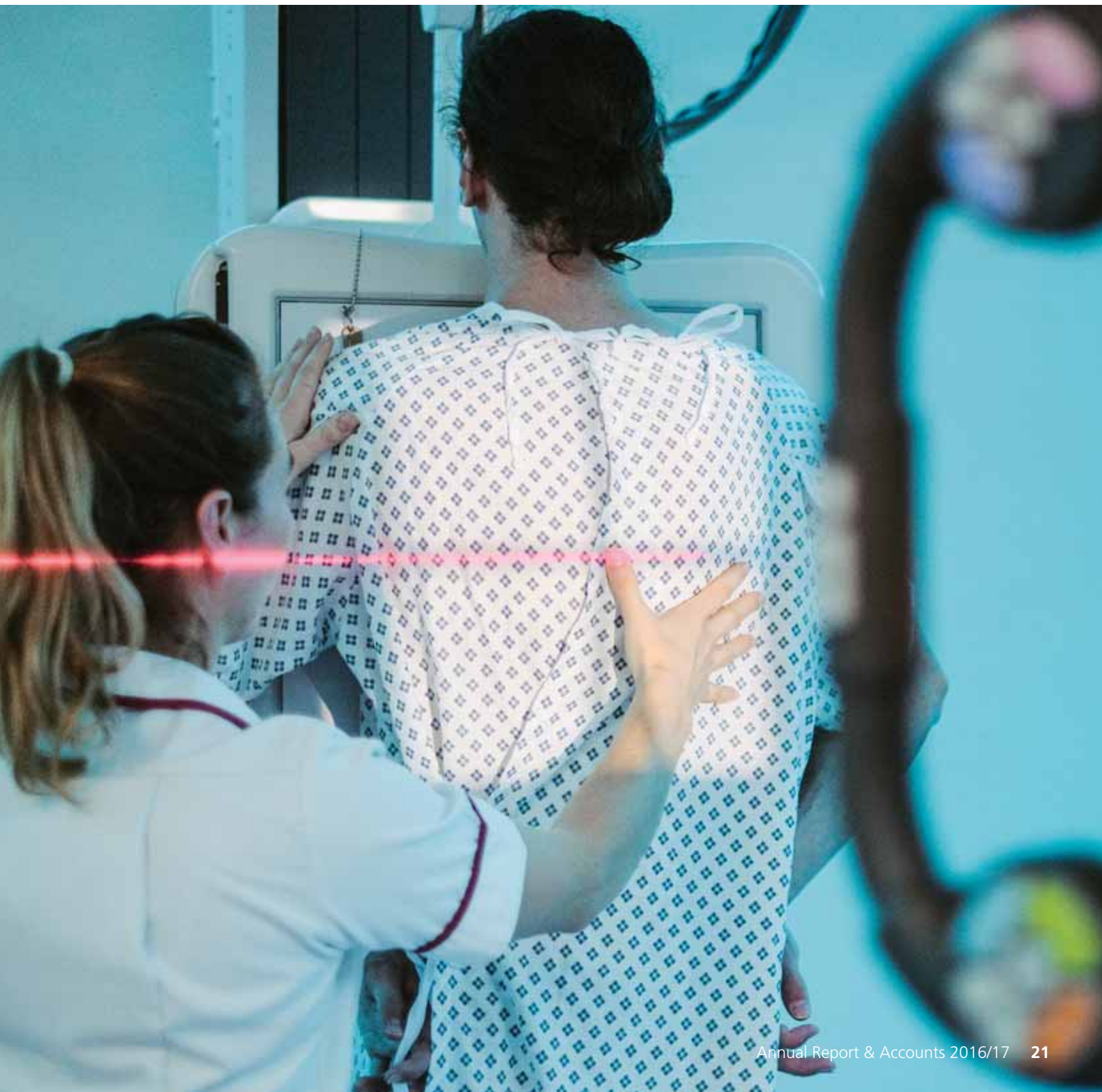
- Patients come first;
- People and partnerships are important;
- Professionalism at all times;
- Pioneering services; and
- Pride in what we do.



# Key risks to delivering our objectives

It is the view of the Board that the key risks faced during the year related to:

- The challenge to deliver the national cost efficiency demanded without compromising quality through achievement of a £33.3m Cost Improvement Programme.
- The impact on services and income streams resulting from New Models of Care, in particular the national focus on establishing Accountable Care Organisations across the North of Tyne and the development of a local Sustainability and Transformation Programme.
- Commissioners' ability to fund the growing demand for clinical services.
- National shortages in nursing staff at specific grades and consultants in certain specialities.
- Achievement of national performance targets, including cancer waiting times, the MRSA bacteraemia zero target, the Clostridium difficile target and associated financial penalties for breaches, and achievement of the 18 weeks referral to treatment target.
- Increasing intensive care capacity to meet the growing demand for this specialist care.



# Going Concern

Throughout the year, and having a mind to the requirement to operate as a going concern, the Board of Directors was advised of the liquidity position, trading activity, compliance with the financial model of the Annual Plan, and achievement of financial targets.

Given the continuing strength of the Trust in terms of liquidity, the trading position, fit with the financial model and achieving the key financial targets, the Board of Directors was content that the Trust was, and is, a going concern, and the Annual Accounts have been prepared on that basis in consequence.

Therefore, after making thorough enquiries, the directors have a reasonable expectation that The Newcastle upon Tyne Hospitals NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, the Trust continues to adopt the going concern basis in preparing the accounts.





# Operating and financial performance

## 1 Financial Performance

The Trust continued to demonstrate financial resilience in the 2016-17 financial year with a surplus of £7.6m (before Sustainability and Transformation Funding (STF) and exceptional items), (2015-16: £2.5m). The Trust received £6.0m STF funding and with adjustments this increased the reported surplus to £13.5m. An overall Financial Risk Rating of 1 was reported, the highest rating possible.

Those results ensure that the Trust remains well placed to address the funding challenge facing all public services. In particular, there remains an underlying strength in the Balance Sheet with the opportunity to progress further innovation and in particular to derive the benefits from leading edge technologies.

## 2 Income

The Trust generated total income of £1,033.4m (2015-16: £988.5m), which exceeded the plan set at the beginning of the year by £7.6m.

There was marginal over-performance against general acute contracts set by commissioners due to growth in the number of patients presenting for emergency and elective care. However, the growth did not materialise at the rate anticipated, in part due to the management of referred activity. The demand for complex and specialist treatment was also lower than expected, though mitigated by over performance in the value of high cost drugs and devices provided by specialist commissioners (NHS England) as well as more distant Clinical Commissioning Groups (CCGs).

It is of note that the international reputation of the Trust has encouraged an increasing number of procedures to be undertaken for overseas patients. There was £3.6m of over performance from complex, specialist treatments provided to non-English patients, primarily overseas Severe Combined Immuno Deficiency patients. This is great credit to the reputation of our clinical workforce.

Growth in the level of income from Research and Development also exceeded expectations by £922,000. Despite the redistribution of training and education funding streams to other healthcare institutions, the Trust generated more income than planned and the research portfolio goes from strength to strength.

2016-17 continued to see increasing levels of emergency presentation over the winter months, exacerbated by reconfigurations of neighbouring Trusts, and the increasing volumes served to constrain elective capacity.

The Trust did secure £1.5m additional funding from CCGs to address and prepare for the consequence of winter pressures and that resource was effectively deployed to ensure the Trust could manage extraordinary increased demand over the winter period.

It is to be noted that the level of private patient income was £3.5m, being 0.4% of total patient care income.

It can also be advised that some 93.2% (2015-16: 94.37% ) of total income was received for the provision of NHS services in England, with the balance received from health service commissioners in Scotland, Wales, Northern Ireland and the Republic of Ireland.

What is most notable is that in this economically constrained environment the Trust has been required to increase reliance on non-recurrent income to sustain the 2016-17 financial position and to deliver to the required NHS Improvement Control Total. This cannot be sustained in the longer term.

## 3 Expenditure

Total expenditure for the year was £989.8m (excluding finance costs and impairments), (2015-16: £955.9m).

The financial position demonstrated sufficient strength to manage the impact of workforce and non-pay cost pressures, which proved to be inflationary for the Trust and placed recurrent pressure on the cost base. Agency costs however, were managed well within the required national limits.

Cost reductions arising from the sustained involvement of healthcare professionals in ensuring the cost effective delivery of services have ensured stability.

## 4 Capital Expenditure Plans

Capital expenditure totalled £31m (2015-16: £24m).

Most notably the Trust proceeded with a significant investment in the addition of Phase 9 of the PFI building project with a value of £11.4 million. The remaining expenditure was primarily in the replacement of medical equipment, including an MRI scanner at the RVI and investment in estate and IT infrastructure.

Following the agreement of the 2016-17 Control Total, the Trust was successful in receiving £3.7m Public Dividend Capital (PDC) funding to support the purchase of two linear accelerators, £0.5m towards the 100,000 Genomes project and £45,000 for a smaller piece of equipment. Also the Trust was awarded £10m that will be received in the coming three years from the Global Digital Exemplar Fund, which will set the Trust apart as a leader in the provision of digital technology.

## 5 Delivering Value for Money in the Public Interest

In 2016-17 the cost efficiency requirement was £33.3m. On closure of the financial year, the efficiency saving delivered by the Trust was £31.8m, with £30m of that saving target recurrent. A shortfall of £3.3m against the recurrent target remains.

For the second year it has not been possible to deliver the recurrent saving requirement. It is a signal of the constant downward financial pressure and unprecedented demands upon the expenditure base.

It is a disappointment that the recurrent saving could not be delivered without compromise to the scope, scale and inherent quality of the service portfolio, but in this period it could not be done without detriment to the interests of the patients.

As we look to the future, the requirement for sustained and demanding efficiencies will continue to challenge all public bodies. Every effort is taken to eliminate waste, to secure savings and deliver productivity gains in areas which do not have a detrimental impact on the direct delivery of patient care and treatment. Savings from on-going tendering and procurement rationalisation, staffing reviews, and a wide range of smaller opportunities delivered at ward and department level continue to be the focus of very detailed attention.

In addition, the Trust continues to review the efficiency of clinical pathways in order to improve the patient experience and the quality of the services provided while at the same time reducing costs.

Given the economic challenge facing the NHS and the anticipation of minimal growth in real terms, the Trust is recognising that transformational change, cost reduction and productivity gains must provide a much higher proportion of the future savings requirement and the Trust has made an investment in 2017-18 to ensure that opportunities are maximised in this regard.



## 6 The Balance Sheet

The assets of the Trust owned estate were valued at £294.2m on 31st March 2017. In addition the Trust has a further £180.8m of PFI assets.

The Trust has valued its land and buildings on a single, optimal site basis and funded through PFI or PF2 arrangements. Such funding is exempt from VAT and the impact of this valuation approach and treatment is an impairment of £92.6m. This can be analysed as below:

- The need for less operational land (a reduction of 41%), and relocation to an area of the city where land is less expensive (c. £25m);
- A 3% reduction in the overall area of hospital buildings, attributed to more effective delivery (c. £10m);
- The removal of VAT from the valuation calculation – previously only 49% of the estate was valued inclusive of VAT (c. £35m); and
- A downward movement in nationally set buildings cost indices (c. £20m).

These impairments have been treated as an exceptional item and disclosed separately on the Statement of Comprehensive Income (SOCl).

The closing year end cash balance at 31st March 2017 was £103m (2015-16: £93m). While this balance provides strength as the leading healthcare provider in the North East, the Trust continues to operate in an increasingly challenged financial environment and changing business delivery landscape.

## 7 Operational Future

As we look to the future, the NHS remains exposed to an unavoidable cost improvement requirement if it is to maintain services in the face of a real term cut in tariff and non-tariff income, as well inevitable inflationary cost pressures. The increased reliance on non-recurrent income to balance the 2016-17 financial position is an indication of pressure on the underlying financial position, and this pressure will exacerbate as the Trust will be required to deliver increasing cost efficiencies if it is to continue to deliver to operational and financial targets and sustain financial stability in an increasingly difficult climate.

Financial instability also presents a challenge to an increasing number of local CCGs. While to date commissioners have met commitments in terms of increasing patient volumes this is a concern for the future.

There is an ongoing focus on encouraging engagement with community and local authority partners and the challenge remains to ensure integration and deliverability of the increasing patient throughput by developing effective schemes to ensure patients are treated in the community setting where appropriate. The opportunity for whole service integration continues to be a goal pursued with enthusiasm.

In relation to education and training funding, there is fundamental concern that the revision of training levies has resulted in material income reductions. The move towards a new training and education funding tariff and the further expectation of central departmental cuts presents a further future challenge to that income stream. Managing the consequence of those reductions without detriment to the delivery of best in class medical and non-medical education and training will prove to be a challenge.

In this environment partnerships are crucial to future stability and the Trust remains well positioned through relationships with Newcastle University to encourage and implement innovation and research and is engaged at national level to ensure the appropriate input to influence changes to future tariff mechanisms.



**“I was made to feel valued as a person. Nothing was too much trouble for the staff, be they doctors, nurses, health care assistants. In my estimation they all worked as a team and did so to the best of their abilities. If a stay in hospital was pleasant – mine was! I cannot praise them highly enough and all are to be commended.”**

## **8 Subsidiaries**

The Trust is a stakeholder in a number of spin-offs and commercial ventures, of which the most important is Freeman Clinics Limited, that operates three health centres in partnership with local GPs at Ponteland Road, Newcastle; Battle Hill, North Tyneside; and Earsdon, North Tyneside.

The Trust also holds shares in and is represented on the Boards of NewGene Limited, which markets novel genetic tests to other NHS bodies; Pulse Diagnostics Limited, which is seeking to commercialise an invention for the non-invasive detection of Peripheral Vascular Disease; and Limbs Alive Limited, which has been involved in developing advanced games software for therapeutic benefits.

Trust Directors who sit on the Boards of spin-off companies are not remunerated for the latter role.

## **9 In Summary**

The Trust continues to deliver to all financial targets without compromise to its national standing as a safe, effective service provider with a comprehensive service portfolio.

Looking to the future, we are determined to steer through the downside of the economic climate by sustaining demonstrable efficiency and effective use of public money, and sustaining the excellent ratings that have been accorded to the Trust year on year.

The Board of Directors is confident of maintaining the long established record of sound financial management and provision of a service portfolio of both national and international esteem.

# 1. Performance Report

## b. Analysis of performance

The Trust prides itself on consistently striving for excellence in healthcare and it monitors performance closely to ensure high levels are achieved and maintained across the organisation. Monitoring also flags up unplanned changes or under performance, which is reviewed and escalated as appropriate. This can sometimes require recovery actions by clinical teams.

The Trust's Performance Management Framework has clear mechanisms for tracking and escalating performance within directorates. The Framework is used by the Board of Directors, senior management, and indeed the whole organisation to drive continuous improvement. While the Trust continually achieves high performance in comparison to local and national peers, there are significant challenges in meeting the nationally mandated performance requirements. This is predominantly due to unprecedented levels of demand often resulting in critical bed occupancy levels, capacity pressures (including national shortages of suitably trained staff), and commissioner affordability constraints. Risks to performance compliance are significant in:

- A&E Clinical Quality 4hrs;
- Referral to Treatment (RTT);
- Cancer 62 days (urgent GP referral); and
- 6 Week Diagnostic Standard.

In addition to this, all clinical directorates, and nominated supporting directorates, are subject to regular risk-based assessment via a rolling programme of performance reviews. The reviews incorporate multi-faceted performance data including finance and Cost Improvement Programme (CIP), activity and income, core operational standards and internal Key Performance Indicators (KPIs), risk register review, human resources, and productivity and efficiency. They ensure that directorates and departments are progressing in line with their strategic aims and objectives, including their contribution to delivery of the Trust's strategy, as well as addressing areas of under performance and acknowledging areas of strong performance. This is further complemented by six monthly directorate quality and patient safety reviews chaired by the Medical Director (as outlined in the Quality Assurance Strategic Plan).

### 2016-17 activity by point of delivery against 2015-16 Outturn

Point of Delivery	15/16 Outturn	16/17 Actual YTD	Number Variance	% Variance
Day Case Spells (DC)	111,542	116,208	4,666	4.18%
Elective Inpatient Spells (EL)	29,179	28,338	-841	-2.88%
Emergency Inpatient Spells (EM)	56,802	54,371	-2,431	-4.28%
Non Elective Inpatient Spells (NEL)	4,683	4,667	-16	-0.34%
New Outpatient Attendances (NOP)	255,442	255,316	-126	-0.05%
Review Outpatient Attendances (FOP)	618,402	616,740	-1,662	-0.27%
Outpatient Procedures (OPPROCS)	192,163	211,598	19,435	10.11%
<b>Admitted Total Spells</b>	<b>202,206</b>	<b>203,584</b>	<b>1,378</b>	<b>0.68%</b>
<b>Outpatient Total Attendances</b>	<b>1,066,007</b>	<b>1,083,654</b>	<b>17,64</b>	<b>1.66%</b>

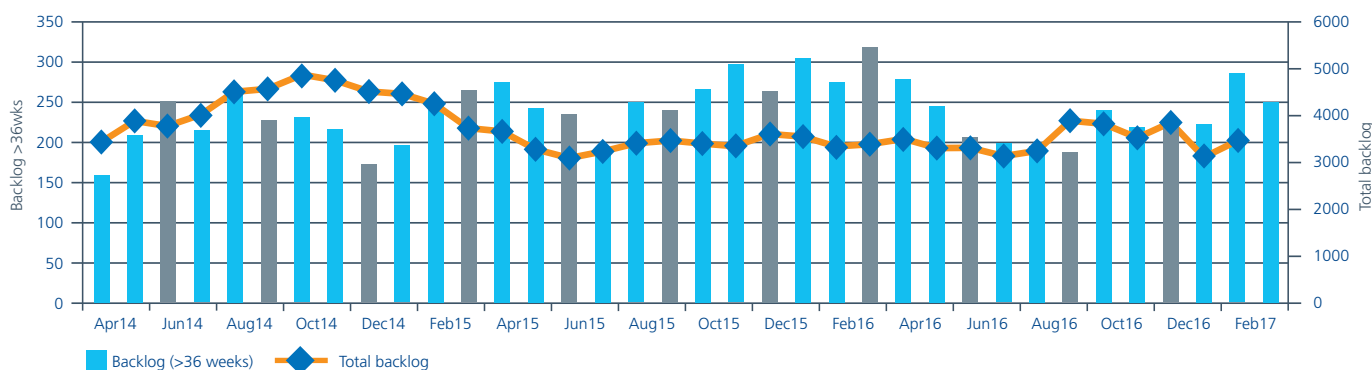
Tolerance: <0% Red, Amber 0-1%, Green >1%

### Waiting times

During 2016-17 the Trust met all referral to treatment 18 week targets, which was contrary the national position that has been consistently breached for some time and shows little real signs of improvement. The organisation also maintained its performance in having no-one waiting 52 weeks for treatment.

Commissioners also required the Trust to achieve a quarterly reduction in over 36 week waiters by specialty (see below).

### Over 36 week waits (All Specialties) Trend



## Diagnostic target

Despite workforce and capacity issues the Trust narrowly achieved the six week diagnostic target of 99% with a performance of 99.2%. Maintaining this performance will remain a challenge for the organisation in 2017-18.

## Cancer Waits

The Trust was on target to achieve all cancer targets at the end of March 2017 (see below). This was despite an increase in referrals in some areas.

The Northern Cancer Alliance has submitted a bid on behalf of the three sustainability and transformational programmes in the region - Northumberland, Tyne and Wear, and North Durham; West, North and East Cumbria, and Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby. The national bid aims to secure funding to implement a transformation programme starting in 2017-18 that would focus on early diagnosis of cancer, the cancer recovery package, and a stratified follow up model.

### Cancer Targets as at March 2017

Cancer	Quarter 1 16/17	Quarter 2 16/17	Quarter 3 16/17	Jan-17	Feb -17
All cancers: 2 week wait (Target 93.0%)	95.9%	95.6%	94.5%	95.3%	94.6%
2 Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected) (Target 93.0%)	96.4%	95.1%	95.5%	95.0%	93.5%
All cancers: 1 month diagnosis to first treatment (Target 96.0%)	97.9%	98.4%	98.3%	97.4%	98.7%
All cancers: 1 month diagnosis to subsequent treatment – surgery (Target 94.0%)	96.8%	95.8%	96.0%	97.8%	97.6%
All cancers: 1 month diagnosis to subsequent treatment – drug (Target 98.0%)	100%	99.2%	98.6%	100.0%	100%
All cancers: 1 month diagnosis to subsequent treatment – radiotherapy (Target 94.0%)	98.7%	98.6%	98.8%	98.1%	98.2%
All cancers: 2 month urgent referral to treatment (Target 85.0%)	85.1%	87.9%	87.9%	85.6%	81.3%

## Accident and emergency activity

The Trust's accident and emergency (A&E) services saw an overall growth of 2.93% compared to 2015-16, which equates to an extra 15 patients per day (see below). This was in line with the reported growth in emergency activity across the North East.

However, the main emergency department at the RVI actually saw a gradual reduction in the number of attendances over the last few months of the year. However, both how acutely ill patients are and at what time of day patients arrive in the department can have a detrimental impact on A&E performance.

### A&E Activity 2015-16 YTD vs 2016-17 YTD

A&E Service	2015/16	2016/17	% Variance	Volume Variance
RVI Emergency Department	121,906	123,341	1.18%	1,435
Molineux St. Walk in Centre	26,450	29,689	12.25%	3,239
Westgate Road Walk in Centre	22,355	22,565	0.94%	210
Eye Casualty	19,952	20,648	3.49%	696
<b>Total</b>	<b>190,663</b>	<b>196,243</b>	<b>2.93%</b>	<b>5,580</b>

The Trust failed to meet the A&E four hour waiting time target in the last two quarters of the year largely due to capacity and patient flow issues. There were also staff issues with both junior and middle grade gaps in the emergency department rota. This meant the organisation narrowly missed meeting the full-year target of 95% (at 94.4%).

As well as national targets for A&E the Trust also works towards a number of targets agreed locally with commissioners, including unplanned re-attendance and patients leaving the department without being seen. During 2016-17 the Trust achieved both the agreed unplanned re-attendance target and leaving the department without being seen rate (see over).

## Local A&E Indicators

Local A&E Indicators		Sept-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Unplanned re-attendance rate (CCG) (Target: <5.0%)	RVI Main ED	3.7%	3.2%	3.6%	3.5%	2.4%	3.0%	3.8%
	Eye Casualty	2.9%	0.6%	0.7%	0.3%	0.0%	0.0%	0.3%
Left department without being seen rate (CCG) (Target: <5.0%)	RVI Main ED	4.2%	3.6%	4.2%	5.4% £2.4k	4.5%	4.2%	4.0%
	Eye Casualty	0.3%	0.5%	0.3%	0.4%	0.4%	0.7%	0.8%

## Delayed Transfers of Care

Nationally, delays to the transfer of patient's care, from hospitals to social care, is a topical issue. In January 2017 the Trust reported a 891 reduction in bed days lost due to delayed transfers of care. However repatriation to other hospitals remained a major cause for concern during the year, and whilst broad principles for addressing the issues in 2017-18 have been agreed this is still to be formalised across the region.

NHS England figures (below) for delayed transfers attributed to social care in the 12 months (up to January 2017) shows a significant gap between the best and worst performing regions and councils (Local Government Chronicle Research). However, attributing fault for a delayed transfer is complicated and not always reflective of the actual reason for delays. While the social care delays in the North East are the lowest in England, the Trust still experienced delays in discharging patients particularly for out of area residents.

### Delayed Transfers of Care (DTOC) by Region

	Region	DTOCs attributable to social care per 1,000 population aged over 65		Council	DTOCs attributable to social care per 1,000 population aged over 65
Regional Variations	West Midlands	112	Best performers	Peterborough City Council	5.6
	North West	93		Rutland CC	6.5
	South West	92		Sunderland City Council	7.2
	South East	83		Newcastle City Council	8.2
	London	70		Darlington BC	8.3
	East of England	69	Worst performers	Southampton City Council	292.0
	Yorkshire & the Humber	48		Trafford MBC	242.2
	East Midlands	39		Cumbria CC	241.6
	North East	30		Manchester City Council	229.9
	England	75		Birmingham City Council	226.0

## Healthcare related infections

In 2016-17 there was a total of nine cases (post successful appeals) of MRSA in the trust. While any cases of MRSA are regrettable - and the trust has a target of zero cases – the organisation has made significant progress in recent years in tackling the rate of this serious infection.

Over the last 12 months the trust reported a total of 57 cases of clostridium difficile against a target of 77. The Trust's target for this infection has remained the same for the last two years.

# Sustainability

Sustainability means spending public money wisely, the efficient use of natural resources, and contributing to building healthy resilient communities.

As an NHS organisation that is responsible for the efficient use of public money we are obliged to work in a way that has a positive impact on the communities we serve. By making the most of the social, environmental and economic assets in our control we can improve the health of local populations.

During 2016 the Trust's sustainability strategy was updated to reflect the national Sustainability Development Unit's (SDU) strategy for the health and social care system. Our strategy sets out our vision for sustainability, which is to: **"deliver outstanding services within the available environmental and social resources, protecting and improving health now and for future generations."**

This means working to:

- reduce carbon emissions
- reduce waste and pollution
- make the best use of scarce resources
- build resilience to a changing climate
- nurturing community strengths and assets.

## Annual sustainability reporting

The SDU has developed guidance for NHS Trusts to ensure good quality annual sustainability reporting is included in Trusts' Annual Reports. Our Annual Sustainability Report for 2015-16 was rated Excellent by the SDU. To build on this success we have produced a larger, more detailed report this year that is available in the latest news section of our Environment and Sustainability pages on the Trust website [www.newcastle-hospitals.org.uk/about-us/environment-and-sustainability\\_latest-news.aspx](http://www.newcastle-hospitals.org.uk/about-us/environment-and-sustainability_latest-news.aspx).

The following sections are an executive summary of our full Annual Sustainability Report 2016-17.

### Good Corporate Citizen (GCC) Assessment Tool

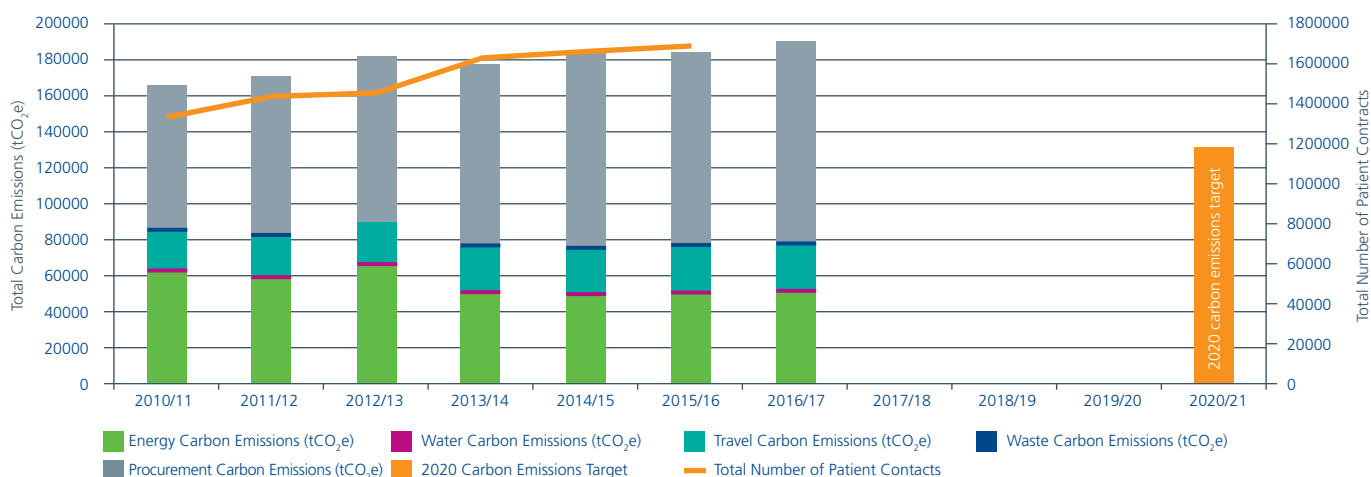
To support NHS organisations with sustainability the SDU developed the GCC Self-Assessment Tool, which helps score Trust's on their performance. The Trust, which has completed the tool every two years since 2012, has seen an improvement in every category and during 2016-17 its score increased from 51% to 58%.

### Carbon footprint

The Trust has a target to reduce its carbon footprint by 28% by 2020. Over the last four years, as our building stock and number of patient contacts have increased, we have managed to reduce our carbon intensity, but achieving the 2020 target still remains a major challenge for the organisation.

As an early adopter of combined heat and power within the NHS, the Trust has benefited from the efficiencies of using waste heat from electricity generated on our sites since the turn of the century (before our baseline year). During the last year the Energy Management Group has developed an energy strategy to help the Trust achieve the carbon emission reductions target in the future.

### Trust Absolute Carbon Emissions (showing 2020 target)



The carbon in the products and services we buy is the largest part of our carbon footprint. We have a well-established sustainable procurement policy that ensures goods and services are bought in a way that achieves value for money, generates benefits for society, and minimises damage to the environment.



## Waste

Over the last four years the Trust has focused on ways of reducing and recycling non-clinical waste. It has a target of re-using or recycling 35% of such waste by 2020, and during 2016-17 it recycled 40.6% of non-clinical waste. Over the next 12 months the Trust plans to increase the recycling rate even further with the expansion of its furniture and equipment portal that will encourage more staff to identify whether other areas have unwanted kit they could use before ordering new products.

## Water usage

During 2016-17 there was a 10% reduction in site water use, bringing usage back down to the levels reported in 2014-15. Part of this reduction was due to proactive water quality management procedures that reduced daily flushing times down from 10 minutes to three minutes. There is also on-going work to improve water metering and response times when potential leaks are identified.

## Buildings and land

James Dixon, the Trust's Head of Environmental Management, set up the Newcastle Sustainability Network, with members drawn from the local universities and landowners in the city. The aim is to work together on green space and biodiversity projects in the future.

Northumbria University students developed a five year site management plan for The Royal Victoria Infirmary Hospital site with the aim of managing new and old trees, creating wildlife corridors, and improving habitats. They are now working on a conservation management plan for The Freeman Hospital site.

## Travel

Travel is one of the main sources of carbon emissions. During 2016-17 the Trust reported a 12% increase in travel CO<sub>2</sub> emissions. This was partly due to increased availability of data as it was the first year the Trust had been able to report emissions from air travel and owned vehicles, although total business travel and fleet only represented 4% of the travel during the last year.

The largest increase in CO<sub>2</sub> emissions, came from the increase in patients visiting our hospitals. Increasing staff numbers increased our staff commute emissions but there are a number of travel initiatives in place to encourage staff to use public transport, including a free cross site shuttle bus as well as walk and cycle to work schemes.

## Staff engagement

Engaging staff is crucial to the success of the many projects that we run to improve our sustainability. A sustainability survey of our staff attracted 1,697 responses and over 98% agreed that it was fairly/very important for the trust to work in a more sustainable way.

During the year we ran a number of sustainability awareness events to give staff and visitors to our hospital more information about the work we are doing, as well as get their ideas for further improvements we could make.

Some 187 of our staff signed up as Green Champions, coming from almost every ward and department in the Trust. They aim to raise awareness of sustainability issues in their areas and encourage staff to get involved in initiatives to reduce waste. The sustainability team produce a quarterly newsletter, which is circulated via the Green Champions, the trust's intranet and website. During 2017-18 the Trust plans to launch Green Impact, which will pit teams of staff against each other to complete pro-environmental actions in a friendly competition.

**Angela Dragone**  
Finance Director



# Health and Safety

The Trust takes the health and safety of its staff, patients and visitors very seriously. It has a dedicated Health and Safety Committee that monitors performance in this area through receiving reports and updates on a range of areas, including:

- staff related incidents e.g. trips, slips, falls, violence and aggression
- quarterly reports on health and safety compliance audits
- quarterly reports on the health and safety inspection programme
- the slips, trips and falls strategy
- needlestick and sharps incidents and training
- work to reduce violence and aggression by patients towards staff
- arrangements to manage and reduce staff stress
- health and safety training

During 2016-17 there were 21 incidents that required reporting nationally compared to 33 in 2015-16.



## 2. Accountability Report



# Board of Directors

During the period 1 April 2016 to 31 March 2017 there were 11 ordinary meetings of the Board of Directors and no extraordinary meetings. In compliance with the requirements of the Health and Social Care Act 2012, the Board meets in public every month (except August) and these meetings are followed by a private business session.

The Board has overall responsibility for the strategic direction of the Trust, taking into account the views of the Council of Governors and in particular their views on the Annual Plan. Executive and Non-Executive Directors have an open invitation to attend all meetings of the Council of Governors. During 2016-17 a number of focused working group meetings of Governors were held with Executive Directors to gain a fuller understanding of the views of Governors.

The Board is also responsible for ensuring that the day-to-day operation of the Trust is as effective, economical and efficient as possible and that all areas of identified risk are managed appropriately.

A detailed Scheme of Reservation and Delegation of Powers is in place and sets out explicitly those decisions which are reserved for the Board, those that may be determined by standing committees, and those that are delegated to managers.

The balance, completeness and appropriateness of the members of the Board is reviewed periodically and when any vacancies arise among Executive or Non-Executive Directors.

## *Detail of board appointments, their backgrounds and attendance at Board meetings*

	Attendance at ordinary meetings
<b>Prof. C Day, Non-Executive Director</b> Appointed 1 April 2008, renewed 1 April 2013 (term of office up to five years, discretion of Newcastle University) Pro-vice Chancellor, Faculty of Medical Sciences, Newcastle University	6 of 11
<b>Dr B C Dobson, Non-Executive Director</b> Appointed 1 October 2013 for three years Re-appointed 1 October 2013 for second term of three years Resigned 30 September 2016 Background in international chemical industries	5 of 5
<b>Mrs A Dragone, Finance Director</b> Appointed 9 March 2009 Career NHS accountant and finance manager	11 of 11
<b>Sir L Fenwick, Chief Executive</b> Appointed June 2006, period of extended leave started 10 January 2017 Career NHS manager	7 of 8
<b>Dr P Kesteven, Non-Executive Director</b> Appointed 1 May 2015 for three years Retired consultant haematologist. Resigned 30 April 2017	4 of 11



<b>Mr J Jowett, Non-Executive Director</b> Appointed 1 November 2016 for three years Company secretary and legal counsel for Greggs PLC	5 of 5
<b>Mrs H Lamont, Nursing and Patient Services Director</b> Appointed 1 April 2009 Career NHS nurse and manager	11 of 11
<b>Prof. K McCourt, Non-Executive Director</b> Appointed 1 December 2015 for three years Former Executive Dean, Faculty of Health & Life Sciences, Northumbria University	10 of 11
<b>Mrs H Parker, Non-Executive Director</b> Appointed 1 June 2006 for two years Appointed 1 June 2008 for three years Appointed 1 June 2011 for three years Appointed 1 June 2014 for final three years Appointment extended until September 2017 Commercial property lawyer	10 of 11
<b>Mrs L Robson, Business and Development Director</b> Appointed 22 October 2012 Career NHS manager	11 of 11
<b>Mr K W Smith, Chairman</b> Appointed 1 September 2006, interim Chairman 1 March 2007 Appointed Chairman 19 September 2007 Term extended to 22 September 2011 Appointed 23 September 2013 for three years Appointment extended until September 2017 Former Treasurer and Chief Executive of County Durham Council, advisor to NSK, global Japanese company	10 of 11
<b>Mr D G Stout, Non-Executive Director and Vice Chairman</b> Appointed 1 August 2013 Appointed 1 August 2015 for three years. Appointed as Vice Chairman 15 September 2016 Career NHS finance manager	10 of 11
<b>Mr E Weir, Non-Executive Director</b> Appointed 1 October 2010 Appointed 1 October 2011 Appointed 1 October 2012 Appointed 1 October 2013 Appointed 1 October 2014 Appointed 1 October 2015 Appointed 1 October 2016 (Term of office annual, discretion of Newcastle City Council) Career Manager	5 of 11
<b>Mr A R Welch, Medical Director</b> Appointed 1 April 2013 Consultant head & neck surgeon	10 of 11

Except where identified above the Non-Executive Directors were appointed with effect from 1 June 2006 under the transitional arrangements pursuant to paragraph 19 of Schedule 1 of the Health and Social Care (Community Health and Standards Act 2003) and for a period of 12 months or the unexpired portion of their original term of appointment, whichever was the longer. The Council of Governors has the power to terminate the appointments of the Chairman and other Non-Executive Directors, subject to the approval of 75% of its membership.

The Board has undertaken a periodic review of its activities in terms of its business agenda and the completeness of processes for arriving at, implementing and monitoring its decisions and those of the standing committees of the Board.

For each individual who was a Director at the time that the Annual Report and Accounts were approved, so far as Directors were aware, there was no relevant audit information of which the Auditors were unaware. The Directors have taken all steps that they ought to have taken to make themselves aware of any relevant audit information and to establish that the Auditors were themselves aware of that information.

The accounts have also been prepared in line with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

The Trust has not made any political donations during 2016-17.

During the year, the following conflicts of interest were declared during Trust Board meetings:

- Mr E Weir declared an interest in any matters pertaining to Newcastle City Council and left the room during Board discussions on contractual matters between the Trust and Newcastle City Council.
- Professor K McCourt declared an interest in matters pertaining to the Junior Doctors Industrial Action and left the room during Board discussions relating to this area.

During 2016-17 members of the Board of Directors claimed a total of £1,914.34 in expenses. This was largely for business travel.

## Audit Committee

The Board of Directors has established a formally constituted Audit Committee, comprising of four Non-Executive Directors and in attendance Trust officers, internal and external auditors.

The quorum is two Non-Executive Directors and during 2016 – 17 the Committee was chaired by Mr Stout.

The key purposes of the Audit Committee are to provide the Board with:

- an independent and objective review of financial and organisational controls, and risk management systems and practice;
- assurance of value for money;
- compliance with relevant and applicable law;
- compliance with all applicable guidance, regulation, codes of conduct and good practice; and
- advice as to the position of the Trust as a “going concern.”

In the course of 2016-17 there were no significant issues that the Committee had to consider in relation to the financial statements. During the year the Committee reviewed the following significant risks:

- Management over-ride of controls;
- Fraud in revenue and expenditure recognition; and
- Valuation of PPE and PFI.

These have been considered through the presentation of the external audit plan and discussions with the Trust’s external auditors, PricewaterhouseCoopers LLP



Five ordinary meetings and one extraordinary meeting was held between 1 April 2016 and 31 March 2016 and attendance was as follows:

	Attendance at ordinary meetings	Attendance at extraordinary meeting
Mr D Stout, Non-Executive Director (Committee Chair)	6 of 6	1 of 1
Mr J Jowett, Non-Executive Director	1 of 2	N/A
Dr M C Dobson, Non-Executive Director	1 of 3	0 of 1
Prof. K McCourt, Non-Executive Director	2 of 2	N/A
Mrs H Parker, Non-Executive Director	4 of 6	1 of 1

To ensure that the independence of the external auditors is not compromised where work outside the scope of the Audit Code has been procured from the external auditors, the Trust has a policy which requires that no member of the team conducting the external audit may be a member of the team carrying out any additional work and their lines of accountability must be separate.

The Council of Governors has the statutory responsibility for the appointment of the external auditors, and this process is led by a sub-group of public Governors supported by Trust officers. On 21 March 2013, following a robust procurement and evaluation

process, the Council of Governors endorsed a recommendation of the sub-group that PricewaterhouseCoopers should be appointed as the Trust’s external auditors for a period of five years subject to satisfactory annual review.

The value of non-audit services provided by PricewaterhouseCoopers in the course of 2016-17 was £35,000, with £10,000 spent on work related to the quality report and £25,000 on work around the Carter Report.

## Internal Audit

The Audit Committee ensured that there was an effective internal audit function established by management that met mandatory Internal Audit Standards and provided appropriate independent assurance.

The Trust receives its internal audit service from AuditOne. Activity each year is conducted in the context of a three year rolling strategy and an annual work plan, with an agreed number of days also set aside for ad hoc work at the request of the Trust. The work plan includes reviews of non-financial and financial systems, governance arrangements and IT systems, including security. Assurance has been achieved by:

- reviewing and approving the Internal Audit Strategy and operational plan and more detailed programme of work, including regular updates of performance against plan;
- consideration of the major findings arising from internal audit work and management's responses;
- receipt of the internal audit Annual Report and Head of Internal Audit Opinion; and
- monitoring progress with implementation of agreed audit recommendations

## Better Payments Practice Code

The Trust is required to pay trade creditors in accordance with the national Better Payments Practice Code and Government Accounting Rules, which require that:

- bills are paid within 30 days, unless covered by other agreed payment terms
- disputes and complaints are handled by a nominated officer
- payment terms are agreed with all traders prior to the commencement of contracts
- payments terms are not varied without prior agreements with traders
- there is a clear policy of paying bills in accordance with contracts.

Any complaints received from traders regarding payments were recorded, investigated and the appropriate action taken, where necessary.

The Trust paid 92% of non-NHS trade invoices within target (2015-16 94%) and 80% of NHS trade invoices were paid within target (2015-16 86%).

Full details of the Trust's performance against the Better Payment Practice Code are included within note 6 of the Annual Accounts.

**"I think that the good things about my stay in hospitals was the skill and compassion of the doctors and nurses involved in my care also I think the food was very good."**

## Quality Governance

The Trust has a Quality Governance Strategy covering the period 2015-18 and key themes of the strategy include:

- drawing the quality governance streams of work together to help the organisation function more effectively;
- embedding quality in everything we do and striving for continual improvement;
- putting patients first and involving them in how their care is delivered and services designed;
- ensuring patients receive treatment that is safe and clinically effective;
- developing our workforce so they have the skills, knowledge and behaviours to contribute fully to high quality patient care;
- developing our leadership capability and capacity, underpinned by the right behaviours and practice, to deliver our strategy; and
- assuring quality governance and management of our risks is subject to rigorous challenge.

The Trust has a robust quality governance reporting structure in place through the established Clinical Governance and Quality Committee, Risk Management and Assurance Committee and other committees and group. They together provide an overarching quality governance framework within which the Trust's services are delivered in line with the Quality Governance Strategy.

The Board of Directors uses NHS Improvement's Quality Governance Framework to evidence that:

- it accurately understands the quality of the care provided by the Trust;
- it is able to assess and mitigate risks to quality; and
- quality is seen as the responsibility of the whole Board.

The Trust is committed to continuous quality improvement and has put in place tools to address any identified areas of under-performance. A detailed Integrated Quality Report, which provides an update on key quality issues, is presented to every public Board meeting and Council of Governors meeting.

Reports on quality are submitted to a number of Board sub-committees related to the priorities agreed in the Quality Account and a six month progress report is also presented to the Board.

The Trust's Assurance Framework is aligned to the organisation's strategic objective and risks. Responsible Executive Directors regularly update the framework, which is a regular agenda item at both the Audit and Risk Management and Assurance Committees and is reported to the Board twice a year.

There are no material inconsistencies between the annual governance statement and the information provided by the Trust to NHS Improvement on an in-year, annual and ad-hoc basis in line with the Single Oversight Framework.

The Directors' approach to quality governance is explained in more detail in the Annual Governance Statement and Quality Report (pages 65 and 66).

## Income disclosures

The Trust has complied with Section 43 (2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) which required that the income from the provision of goods and services for the purposes of the health services in England must be greater than its income from the provision of goods and services for any other purposes.

The impact of other income on the Trust is insignificant. The Trust statutory accounts include a detailed breakdown of other income in note 4 of the Accounts and further information is disclosed in the Operating Review section (page 23).

## Annual statement on remuneration from the Chairman

The Trust has an Appointments and Remuneration Committee, which has been in place since the organisation was established. The Committee advises the Board on appropriate remuneration and terms of service for the Chief Executive, Executive Directors and other senior members of staff. During the year there were no new appointments made to the Executive team.

The Committee met twice during 2016-17 and its work included:

- revising the Committee's terms of reference to make specific reference to the appointment of the Chief Executive and Executive Directors;
- reviewing arrangements for succession planning;
- reviewing very senior managers pay and performance; and
- approving the one per cent pay rise offered to the Chief Executive and Executive Directors, which was in line with the national pay award given to all NHS staff on the Agenda for Change terms and conditions.

### Future policy table

Consideration	Salary/Fees	Taxable benefits	Annual Performance Related Bonus	Long Term Related Bonus	Pension Related Benefits
Support for the short and long term strategic objectives of the Foundation Trust	Ensure the recruitment/retention of directors of sufficient calibre to deliver the Trust's objectives	None disclosed	Not applicable	Not applicable	Ensure the recruitment/retention of directors of sufficient calibre to deliver the Trust's objectives
How the component operates	Monthly remuneration	None disclosed	Not applicable	Not applicable	Contributions are made in accordance with the NHS Pension Scheme
Framework used to assess performance	Trust appraisal system – see also the comments detailed below this table	None disclosed	Not applicable	Not applicable	Contributions are made in accordance with the NHS Pension Scheme
Performance measures	Based on individual objectives agreed with line manager	None disclosed	Not applicable	Not applicable	Not applicable
Performance period	Concurrent with the Trust financial year	None disclosed	Not applicable	Not applicable	Not applicable
Amount paid for minimum level of performance and any further levels of performance	See comments detailed below this table	None disclosed	See comments detailed below this table	Not applicable	Contributions are made in accordance with the NHS Pension Scheme
Explanation of whether there are any provisions for recovery of sums paid to directors, or provision for withholding payment	Any sums paid in error may be recovered	None disclosed	Any sums paid in error may be recovered	None paid	Not applicable

All Executive Directors have substantive contracts of employments with agreed notice periods of between three and six months. No termination payments were made in the course of 2016-17.

In reviewing the annual salary of Directors, the Committee takes into consideration a number of factors including the:

- overall performance of the organisation as an effective and efficient trading entity;
- delivery of agreed corporate objectives for the year; and
- pattern of remuneration amongst NHS Foundation Trusts and the wider NHS.

## Senior managers' remuneration policy

The Appointments and Remuneration Committee oversees the remuneration for, and performance of, Executive Directors. Components of remuneration are:

- Base salary – individual base salaries are reviewed annually and take into account the overall performance of the organisation, any responsibility changes in the context of comparable organisations, and the direction being taken by the NHS overall. For Executive Directors, account is taken of the Department of Health guidance on Very Senior Managers Pay.
- Pensions – some, but not all Executive Directors, participate in the NHS Superannuation Scheme. Service as a Non-Executive Director is not pensionable.

The pay and employment conditions of other employees are also taken into account when determining Directors' remuneration to ensure that levels of responsibility and experience are reflected appropriately. This policy means that there are no components to senior manager salaries other than those disclosed in the single figure total table and the total pension entitlement table on pages 39-40 and there is no component of performance related pay.

The Medical Director's salary is in accordance with the terms and condition of the NHS Consultant Contract plus a responsibility allowance payable for the duration of office.

There are no special contractual compensation issues for the early termination of Executive Director contracts. No awards were made to any past members of the Board of Directors and their immediate deputies.

Those Executive Directors who serve as Non-Executive Directors elsewhere i.e. in spin off companies in which the Trust has an equity interest, are not remunerated for that responsibility and do not retain any earnings related to such appointments.

There is a performance related element to Senior Managers' remuneration for those who are not on the Agenda for Change pay spine. Medical staff are eligible for ACEA pay awards, which are on a scale of one to 12 and then from bronze to platinum. Pay awards between one and nine are funded by the Trust and awards above that point are funded by the Department of Health.

There are no service contract obligations that would give rise to, or impact on, remuneration payments or payments for loss of office. The principle of the Trust's policy on payments for loss of office is to pay only what would be due for the applicable period of notice, plus any sum in compensation for loss of a benefit in kind i.e. use of a lease car. There are no additional components of the remuneration package for senior managers.

The Chairman and Non-Executive Directors received a fee determined by the Council of Governors.

## Annual report on remuneration

The Appointments and Remuneration Committee is responsible for determining all elements of Executive Director remuneration. The Committee has clear terms of reference that are regularly reviewed.

The Committee considers the prevailing market conditions, benchmarks pay and employment conditions against appropriate national and regional comparators and the Trust workforce, and does not routinely apply annual increases. When considered appropriate, the Committee has commissioned independent external advisors to provide days.

The membership of the Committee is made up of the Chairman and four Non-Executive Directors. The Chief Executive and HR Director also attend as appropriate.

The Committee met on two occasions during 2016-17.

	Attendance at ordinary meetings
Mr K W Smith (Chair)	1 of 2
Mr J Jowett, Non-Executive Director	1 of 1
Dr M C Dobson, Non-Executive Director	1 of 1
Mrs H Parker, Non-Executive Director	2 of 2

The Committee has carried two vacant non-executive positions on this Committee for the past year but both meetings were quorate. The original quorum was two non-executive directors but that was increased to three in July 2016 when the Committee's terms of reference were reviewed and approved by the Board of Directors.

None of the Executive Directors has a service contract and there are no special provisions for early termination of contract, instead standard NHS terms apply.

The remuneration for Non-Executive Directors is determined by the Council of Governors, which last reviewed the fees paid to Non-Executive Directors in October 2014. The level of remuneration for Non-Executive Directors is paid for a minimum of two-and-a-half days per month.





## Single Total Figure Table and Total Pension Entitlement Table (this section is subject to audit)

### Single total figure table

Name and title of Senior Manager	2016/17					
	Salary and fees	All taxable benefits	Annual performance-related bonuses	Long-term performance-related bonuses	All pension-related benefits	Total
	(bands of £5,000)	(total to nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
Chairman <b>Mr KW Smith</b>	50-55	-	-	-	-	50-55
Chief Executive <b>Sir LR Fenwick</b>	245-250	-	-	-	-	245-250
Finance Director <b>Mrs A Dragone</b>	155-160	1,400	-	-	72.5-75	230-235
Nursing & Patient Services Director <b>Mrs H Lamont</b>	145-150	-	-	-	-	145-150
Medical Director <b>Mr A Welch</b> (i)	240-245	-	-	-	-	240-245
Business & Development Director <b>Mrs CL Robson</b>	165-170	-	-	-	62.5-65	230-235
Non-Executive Director <b>Professor PH Baylis</b> (ii) (resigned with effect 30th June 2015)	-	-	-	-	-	-
Non-Executive Director <b>Professor CP Day</b>	15-20	-	-	-	-	15-20
Non-Executive Director <b>Dr B Dobson</b> (iii) (resigned with effect 30th September 2016)	5-10	-	-	-	-	5-10
Non-Executive Director <b>Mr J Jowett</b> (iv) (appointed with effect 1st November 2016)	5-10	-	-	-	-	5-10
Non-Executive Director <b>Dr P Kesteven</b> (v) (appointed with effect 1st May 2015)	15-20	-	-	-	-	15-20
Non-Executive Director <b>Professor K McCourt</b> (vi) (appointed with effect 1st December 2015)	15-20	-	-	-	-	15-20
Non-Executive Director <b>Mrs HA Parker</b>	15-20	-	-	-	-	15-20
Non-Executive Director <b>Mr D Stout</b>	20-25	-	-	-	-	20-25
Non-Executive Director <b>Mr E Weir</b>	10-15	-	-	-	-	10-15

Name and title of Senior Manager	2015/16					
	Salary and fees	All taxable benefits	Annual performance-related bonuses	Long-term performance-related bonuses	All pension-related benefits	Total
	(bands of £5,000)	(total to nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
Chairman <b>Mr KW Smith</b>	50-55	-	-	-	-	50-55
Chief Executive <b>Sir LR Fenwick</b>	245-250	-	-	-	-	245-250
Finance Director <b>Mrs A Dragone</b>	155-160	3,900	-	-	40-42.5	200-205
Nursing & Patient Services Director <b>Mrs H Lamont</b>	135-140	-	-	-	5-7.5	145-150
Medical Director <b>Mr A Welch</b> (i)	235-240	-	-	-	-	235-240
Business & Development Director <b>Mrs CL Robson</b>	165-170	-	-	-	37.5-40	205-210
Non-Executive Director <b>Professor PH Baylis</b> (ii) (resigned with effect 30th June 2015)	5-10	-	-	-	-	5-10
Non-Executive Director <b>Professor CP Day</b>	15-20	-	-	-	-	15-20
Non-Executive Director <b>Dr B Dobson</b> (iii) (resigned with effect 30th September 2016)	15-20	-	-	-	-	15-20
Non-Executive Director <b>Mr J Jowett</b> (iv) (appointed with effect 1st November 2016)	-	-	-	-	-	-
Non-Executive Director <b>Dr P Kesteven</b> (v) (appointed with effect 1st May 2015)	10-15	-	-	-	-	10-15
Non-Executive Director <b>Professor K McCourt</b> (vi) (appointed with effect 1st December 2015)	5-10	-	-	-	-	5-10
Non-Executive Director <b>Mrs HA Parker</b>	15-20	-	-	-	-	15-20
Non-Executive Director <b>Mr D Stout</b>	20-25	-	-	-	-	20-25
Non-Executive Director <b>Mr E Weir</b>	10-15	-	-	-	-	10-15

- i) Within the detail reported for Mr A Welch's salary and fees are payments of £116k (2015-16 £115k) made in respect of clinical duties.
- ii) Prof. P H Baylis resigned as a Non-Executive Director with effect from 30 June 2015.
- iii) Dr B Dobson resigned as a Non-Executive Director with effect from 30 September 2016.
- iv) Mr J Jowett was appointed as a Non-Executive Director with effect from 1 November 2016.
- v) Dr P Kesteven was appointed as a Non-Executive Director with effect from 1 May 2015.
- vi) Prof. K McCourt was appointed as a Non-Executive Director with effect from 1 December 2015.

“I had a very friendly, caring and professional experience by all members of staff. I was never made to feel a burden or stupid for asking questions.”

Pension related benefits are calculated as the annual increase in pension entitlement in accordance with the HMRC method. In summary this is as follows:

$$((20 \times PE) + LSE) \times ((20 \times PB) + LSB)$$

PE is the annual rate of pension that would be payable to a director if they became entitled to it at the end of the financial year.

PB is the annual rate of pension adjusted for inflation that would be payable to the director if they became entitled to it at the beginning of the financial year.

LSE is the amount of lump sum that would be payable to the director if they became entitled to it at the end of the financial year.

LSB is the amount of lump sum adjusted for inflation that would be payable to the director if they became entitled to it at the beginning of the financial year.

A significant proportion of the increase in pension related benefits reported for 2015-16 is due to the reduced inflation rate advised by the Treasury for use in the calculation. The inflation rate prescribed for use in 2016-17 is 0% (2015-16 1.2%).

#### Total Pension Entitlement

	Real increase / (decrease) in pension at pension age	Real increase / (decrease) in pension lump sum at pension age	Total accrued pension at pension at 31 March 2017	Lump sum at pension age related to accrued pension at 31 March 2017	Cash Equivalent Transfer Value at 1 April 2016	Real increase / (decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2017
Name and title	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000
Finance Director <b>Mrs A Dragone</b>	2.5-5	7.5-10	55-60	175-180	1,027	89	1,116
Director of Business & Development <b>Mrs CL Robson</b>	2.5-5	7.5-10	60-65	195-200	1,197	125	1,322

Sir LR Fenwick's, Mr A Welch's and Mrs H Lamont's pension sums are no longer shown as these were drawn and taken in a previous year.

The financial information disclosed in the table above is derived from information provided to the NHS Foundation Trust from the NHS Pensions Agency.

Whilst the NHS Foundation Trust accepts responsibility for the values shown, the NHS Foundation Trust is reliant upon the NHS Pensions Agency for the accuracy of the information provided to the NHS Foundation Trust and has no way of auditing these figures. The figures are therefore shown in good faith as an accurate reflection of the directors' pension information.

“Great staff, always kept you well informed and always asking how you were or if you needed anything. Chatted to you while they were on the ward and if you needed any treatment from them they explained exactly what they were going to do.”

#### Fair Pay (this section is subject to audit)

The Trust is required to disclose the relationship between the remuneration for the highest paid director within the organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the Trust in 2016-17 was in band £245,000 - £250,000 (£245,000 - £250,000 in 2015-16). This was 8.76 times (8.61 in 2015-16) the median remuneration of the workforce, which was £28,800 (£28,500 in 2015-16).

This calculation is based on Trust employees as at 31 March 2017. This number includes locum staff, junior doctors on training rotations employed by County Durham and Darlington NHS Foundation Trust as lead employer trust and the Trust's in-house nurse and clerical bank staff, but excludes external agency staff. Any part time employee numbers are pro-rated to provide whole time equivalents.

#### Payments to past senior managers (this section is subject to audit)

The Trust did not make any payments to past senior managers in 2016-17.

#### Payments for loss of office (this section is subject to audit)

The Trust did not make any payments for loss of office in 2016-17.

#### Details of amounts payable to third parties for services of a senior manager

The Board of Directors includes two Non-Executive Directors who are appointed by external bodies and to which the Trust makes the remuneration payment. They are Mr Weir, Non-Executive Director appointed by Newcastle City Council: £11,485, and Professor Day, Non-Executive Director appointed by Newcastle University: £15,000.

<b>Chairman and Non-Executive Directors</b>	
<b>Mr K W Smith</b> Chairman	Chairman of Pulse Diagnostics (part owned by Trust)
<b>Non-Executive Directors</b>	
<b>Professor C P Day</b>	Vice Chancellor (Clinical) and President of University of Newcastle upon Tyne Fellow of the Academy of Medical Sciences Council Member, Medical Research Council Executive, Medical Schools Council Board Member, Northern Health Science Alliance Board Member, North East and North Cumbria Academic Health Science Network Board Member, Helena Biosciences
<b>Dr B C Dobson</b>	Non-Executive Chairman, Revolmer plc Non-Executive Chairman, Applied Graphene Materials plc
<b>Dr P Kesteven</b>	Chair of the Charity Maji Salama
<b>Professor K McCourt</b>	Pro Chancellor at Northumbria University (ambassador role)
<b>Mrs H A Parker</b>	Consultant to Sintons Limited Liability Partnership (Trust Solicitors) Board Member, 4 Housing Group
<b>Mr D Stout</b>	Director and Part Owner of David Stout Consulting Limited
<b>Mr E Weir</b>	Director, Adult and Culture Services, Newcastle City Council
<b>Mr Jonathan Jowett</b>	Director Darlington 1883 Limited and Company Secretary of Greggs PLC Vice Chair of the Percy Hedley Foundation
<b>Executive Directors</b>	
<b>Sir Leonard Fenwick CBE</b> Chief Executive	Chairman and Trustee, St Mary Magdalene & Holy Jesus Trust Chairman and Trustee, Freemen of the City of Newcastle upon Tyne Director, Newcastle NE1 Limited Chairman and Director, NewGene Limited Director, Shelford Group Director, Greystoke Park (No.1) Maintenance Company Limited Vice Chairman & Director, The Academic Health Science Network, North East & North Cumbria Limited
<b>Mrs A Dragone</b> Finance Director	Non-Executive Director, NewGene Limited
<b>Mrs H Lamont</b> Nursing & Patient Services Director	Non-Executive Director, Freeman Clinics Limited (part owned by Trust)
<b>Mrs L Robson</b> Business & Development Director	Director of Changing Health from 9th June 2016 to 22nd August 2016
<b>Mr A R Welch</b> Medical Director	Director, A Welch Limited

**Angela Dragone**  
Finance Director

22 June 2017

# Our Governors

The Trust has a total of 36 Governors – 31 elected by the public and staff and the others appointed by a diverse range of partner organisations. The table on page 43 details the individuals who make up our Council of Governors.

The Council has a number of statutory powers, including the appointment of the Chairman and Non-Executive Directors and the external auditors. During the last year the Council debated a number of key issues for the trust including infection prevention and control, financial performance, and Quality Account. Other topics included:

- Trust fire safety;
- Food and drink strategy;
- Carers support;
- the local Sustainability and Transformation Programme;
- Nursing models of education;
- Safe staffing;
- Operational resilience and winter planning;
- Learning disability services; and
- Congenital heart disease service standards.

The Council of Governors met in alternate months throughout the year and meetings were well attended with wide ranging debate on a number of areas of interest. Debate was facilitated by the presentation of regular reports from each of the Council's Working Groups, each with distinct terms of reference:

- Business Development;
- Community Engagement and Membership; and
- Quality of Patient Experience.

Each of the Working Groups is aligned to specific Directors, reflecting their spheres of interest. In particular, the Business Development Group was given the responsibility to provide input to the annual planning process on behalf of the Council of Governors. Other Governors had an open invitation to take part in the process and some did. Where possible, Governors sought to canvass the views of members of their constituency. None of the appointed Governors took part in the planning process.

Governors were co-opted onto the membership of several standing Trust committees and groups, including the Complaints Panel and Clinical Governance and Quality Committee. Others attended the Infection Prevention and Control Committee and the Patient, Carer and Public Involvement Committee.

Governors also continued a programme of unannounced visits to clinical and support services to learn about how they work and the challenges they face. Governors reported back to the Council on their visits and asked Executive Directors to follow up on any issues highlighted. Some of the areas visited included:

- Dermatology outpatients;
- PUVA clinic;
- Surgical day unit;
- Information technology department; and
- Various wards on all hospital sites.

The Patients Food Tasting Panel continued to visit patient areas in the Trust's hospitals, sampling food at the point of delivery and examining the quality of the overall service. The panel's feedback has helped the Trust to make further improvements to the food it offers patients, how it is presented and delivered.

The Trust holds a register of Governors' interests, which is available on request from the Trust Secretary, Corporate Services, Freeman Hospital, High Heaton, Newcastle upon Tyne, NE7 7DN.

The Board of Directors maintains a close working relationship with the Governors and wider membership in a number of ways. All Directors have an open invitation to attend all Council of Governors meetings and there is Governor engagement in a number of Trust committees and working groups, some chaired by Governors.

On key strategic issues the Board engages with the membership through mass emails or mail shots when required and the Trust also produces a newsletter twice a year to help keep members up-to-date with all the latest developments in the organisation. It holds a series of open members' events each year where members can learn more about the trust's services and different health conditions. These meetings regularly attract around 100 members and subjects covered over the last 12 months include:

- Pathology
- Diabetes
- Stroke
- Parkinson's Disease
- Mitochondrial donation
- Patient experience

As set out in Monitor's Code of Governance for NHS Foundation Trusts, there is a requirement for a mechanism to be in place for the resolution of disagreements between the Board of Directors and Council of Governors. In the first instance, it is the responsibility of the Chairman, as leader of both forums, to attempt to reach a consensus. Failing that the next formal step would be for the Chairman to receive formal representation from the designated Lead Governor to seek to achieve a mutually acceptable position. The Trust did not need to use this resolution mechanism in 2016-17 and there were no conflicts of interest declared by Trust Governors during the year.

During 2016-17 members of the Council of Governors claimed a total of £2,605.28 in expenses. This was largely for business travel.

## Governor elections

In May 2017 there was an election process planned due to a number of Governors reaching the end of their term of office and resignations by both public and staff Governors. However as a result of General Election purdah the Governors' election process was delayed.

There were also changes to the appointed Governors. Mr Ray Venus stepping down in March 2017 as he had completed more than nine years in post and his appointing organisation, Pentagon Partnership, ceased to exist.

Below is a chart setting out Governors' attendance at Council of Governors meetings during 2016-17.

Constituency	Governor	Meeting attendance	Comments
Public - 1	Dr Amit Aggarwal	5 of 6	
Appointed	Mr Derrick Bailey	6 of 6	
Public - 3	Mr John Bedlington	6 of 6	
Public - 2	Mr Graham Blacker	4 of 6	
Public - 2	Mrs Kay Carter	0 of 1	Not re-elected
Public - 1	Mr Adam Chaffer	6 of 6	
Staff	Mrs Elaine Coghill	3 of 6	
Staff	Prof. Paul Corris	1 of 1	Not re-elected
Public - 2	Mrs Carole Errington	5 of 5	
Staff	Mr Richard Fleming	1 of 6	
Public - 2	Mrs Mary Ann Hargreave	1 of 1	Did not stand for re-election in June 2016
Staff	Mrs Eleanor Houlston	4 of 6	
Public - 1	Mr Bill Ions	4 of 5	
Public - 3	Dr Alan Johnson	3 of 6	
Public - 1	Miss Gwyneth Jones	4 of 6	
Public - 2	Mr Brian Keegan	0 of 1	Resigned July 2016
Staff	Dr Phil Laws	4 of 5	
Public - 2	Dr Helen Lucraft	5 of 6	
Public - 1	Mrs Jean McCalman	5 of 6	
Public - 2	Dr Duncan McKinnon	0 of 6	
Staff	Mrs Victoria Mitchinson	1 of 5	
Public - 3	Dr Lakkur Murthy	0 of 1	Resigned July 2016
Public - 1	Mrs Susan Nelson	4 of 5	
Staff	Dr Veronica Oliver-Jenkins	1 of 1	Did not stand for re-election in June 2016
Public - 1	Dr Jim Page	0 of 1	Did not stand for re-election in June 2016
Public - 2	Mr Peter Ramsden	6 of 6	
Staff	Mr Wayne Reed	0 of 6	
Public - 1	Mrs Elsie Richardson	0 of 6	
Public - 2	Mr Paul Richardson	3 of 5	
Public - 3	Dr Michael Saunders	6 of 6	
Public - 2	Mr Adam Shanley	0 of 6	
Staff	Mrs Jacqui Springthorpe	3 of 6	
Public - 1	Mr David Stewart-David	5 of 6	
Appointed	Coun. Jane Streater	3 of 6	
Public - 1	Mr Paul Taylor	0 of 3	Resigned October 2016
Public - 2	Mr Derek Thompson	5 of 6	
Public - 2	Mr Christopher Venables	3 of 6	
Appointed	Mr Raymond Venus	5 of 5	Resigned March 2016
Appointed	Prof. Andrew Wathey	0 of 6	
Public - 2	Mr Fred Wyres	4 of 6	
Appointed	Vacant (Newcastle University)		

### Key:

- 1 Newcastle-upon-Tyne
- 2 Northumberland, Tyne and Wear (excluding Newcastle)
- 3 County Durham, Tees Valley, Cumbria and beyond



## Nominations Committee

The Council of Governors established a formally constituted Nominations Committee to identify, interview and recommend for appointment the Chairman and Non-Executive Directors.

During 2016-17 the Committee's membership was made up of four public governors, the Chief Executive and Director of Finance. They were supported, as appropriate, by Trust officers, the Senior Independent Director, the Chairman and University representative. Attendance of the voting members of the Committee is set out in the table below.

	Number of meetings attended (out of)
Mr P Ramsden (Chair until 19 January 2017)	(10 of 10)
Mr P Taylor (resigned 16 October 2016)	(5 of 6)
Mrs Mary Ann Hargreave (resigned 31 May 2016)	(2 of 2)
Dr Michael Saunders (Chair from 19 January 2017)	(10 of 10)
Mr A Chaffer (joined 28 June 2016 and resigned 19 January 2017)	(7 of 7)
Mr D Stewart-David (joined 17 November 2016)	(3 of 3)
Mr F Wyres (joined 16 March 2017)	(1 of 1)
Mrs A Dragone, Finance Director	(5 of 10)*
Sir Leonard Fenwick, Chief Executive	(2 of 8)**

\* Mrs Dragone declared an interest for 5 of the Committee meetings and therefore did not attend those meetings.

\*\* Sir Leonard Fenwick declared an interest for 5 of the Committee meetings and therefore did not attend those meetings. Sir Leonard Fenwick commenced a period of extended leave on 10th January 2017 and therefore was not present during the 17th January and 14th March 2017 meetings.

There were ten meetings of the Committee in the period 1 April 2016 to 31 March 2017. On two occasions the Committee began processes to appoint a replacement for the Trust Chairman, who reached the end of his nine year term of office in September 2016.

Unfortunately neither process was able to continue and with the advice of NHS Improvement the Committee recommended to the Council of Governors that the Chairman's term of office be extended initially until April 2017 and then until September 2017.

## Membership

The public and Trust staff are invited to become members of the Trust. Membership has a number of benefits including being able to stand for and vote in the elections for Governors. As the Trust continues to develop, members can also expect to be invited to participate more fully in helping to shape services.

The Trust has three public constituencies and anyone over 18 and living in one of the public constituencies can apply to become a member. The public constituencies are:

- Newcastle upon Tyne;
- Northumberland, Tyne and Wear (excluding Newcastle); and
- County Durham, Tees Valley, Cumbria and beyond.

This recommendation was to allow the investigation to be completed into a number of issues raised by different sources against the Chief Executive. The recommendations were endorsed by the Council of Governors.

The Committee expects to re-start the process to appoint a new Chairman in the Autumn of 2017.

The Nominations Committee is responsible for the annual appraisal of all Non-Executive Directors, including the Chairman, using formal objectives that were set and agreed in the previous year.

There are six staff constituencies and they are:

- Admin, clerical, managerial and hospital chaplains;
- Ancillary and estates;
- Health professions council staff;
- Medical and dental;
- Nursing and midwifery; and
- Volunteers.

The target for membership recruitment for the year end was to maintain a total of 9,000 members.

Membership Report, 1st April 2016 to 31st March 2017:

Public Constituencies		Eligible Population	Index
As at 1st April 2016	6,040		
New Members	92		
Members leaving	330		
At year end (31st March 2017)	5,802	1,169,812	
Staff Constituencies			
As at 1st April 2016	2,619		
New Members	95		
Members leaving	8		
At year end (31st March 2017)	2,706		
Patient Constituency		The Trust does not have a separate Patient Constituency	
Public Membership – Age Profile			
0-16	Not applicable – minimum age = 18		
17-21	18	94,325	
22+	5,348	1,075,487	
Not stated	436		
Ethnicity			
White	5,399	1,334,484	
Mixed	30	12,408	
Asian	188	47,904	
Black	35	8,993	
Not stated	150	7,669	
AB	1,606	78,459	
C1	1,636	139,816	
C2	1,168	94,291	
DE	1,300	139,247	
Unspecified (65+)		276,770	
	5,710	728,583*	
Gender Analysis			
Male	2,430	704,142	
Female	3,324	729,002	
Not stated	48		

\*Does not include anyone under the age of 16.

To ensure the membership of the Trust represents the population make-up of the geographic area served by the organisation, a draft membership strategy has been developed to address the identified gaps. This will be considered by the Council of Governor's Community Engagement and Membership Working Group and a plan developed to deliver the strategy in 2017-18.

Since 2009 all new members automatically receive a welcome letter and membership certificate when they sign up. They are then eligible for all the benefits of membership including receiving the regular membership newsletter and the opportunity to attend the regular members' events.

The membership application form is available at public locations across the Trust, and it is included in all outpatient appointment letters, as well as online on the Trust website and at <https://www.nhs-membership.co.uk>.

Members who would like to contact a Governor can do so either via the Trust Secretary, or via the *Contact A Governor page* on the Trust's website. All Governors have a Trust email address and staff members can also email [staff.governors@nuth.nhs.uk](mailto:staff.governors@nuth.nhs.uk) The Trust publishes a *Know Your Governor* leaflet for patients and the public after each annual elections to the Council of Governors.

# Staff Report

## Workforce information

Workforce Demographics	As at March 2016		As at March 2017	
	FTE	% of Total FTE	FTE	% of Total FTE
<b>Staff Group</b>				
Add Prof Scientific and Technic	203.10	1.74%	521.9585	4.37%
Additional Clinical Services	2115.22	17.89%	2197.447	18.20%
Administrative and Clerical	2118.14	17.77%	1966.87	16.03%
Allied Health Professionals	662.70	5.78%	692.7896	5.99%
Estates and Ancillary	857.33	8.16%	1004.757	9.55%
Healthcare Scientists	856.30	6.84%	571.6256	4.40%
Medical and Dental	1120.95	9.03%	1106.246	8.75%
Nursing and Midwifery Registered	3995.02	32.53%	4060.546	32.71%
Grand Total	11928.77		<b>12122.24</b>	
<b>Full Time/Part Time</b>				
Full Time	8942.00	64.80%	9128	64.81%
Part Time	3023.77	35.20%	3085.24	35.19%
<b>Gender</b>				
Female	9160.81	78.36%	9359.537	78.40%
Male	2804.96	21.64%	2853.703	21.60%
<b>Disabled</b>				
No	7447.85	61.16%	8076.636	64.98%
Not recorded	4274.53	36.80%	3853.063	32.72%
Yes	243.39	2.04%	283.5415	2.29%
<b>Ethnic Group</b>				
BME	979.37	7.69%	1028.294	7.94%
Not recorded	296.47	2.51%	262.7275	2.16%
White	10689.93	89.80%	10922.22	89.90%
<b>Age</b>				
15-24	804.25	6.33%	906.3227	6.89%
25-34	2933.98	23.39%	2988.821	23.31%
35-44	2829.32	23.84%	2787.98	23.16%
45-54	3407.91	28.49%	3476.233	28.31%
55-64	1887.40	16.77%	1943.403	17.10%
>65	102.92	1.18%	110.4799	1.24%

Turnover	Apr 15 - Mar 16	Apr 16 - Mar 17
		10.22%





Sickness absence (Trust target is 3%)	2015 -16	2016-17
Total days lost	107,302	111,090
Staff years	11,819	12,119
Average working days lost (per WTE)	9	9

Senior staff gender breakdown	Male	Female
Executive Directors	2	3
Non-Executive Directors	7	2
Other Senior Employees	6	6

Staff numbers (subject to audit)	Total Number	Permanent Number	Other Number
Medical and dental	1,731	1,131	600
Ambulance staff	1	1	
Administration and estates	2,459	2,459	
Healthcare assistants and other support staff	1,953	1,953	
Nursing, midwifery and health visiting staff	4,134	4,134	
Nursing, midwifery and health visiting learners	39	39	
Scientific, therapeutic and technical staff	1,604	1,604	
Healthcare science staff	850	850	
Social care staff	22		22
Agency and contract staff	162		162
Bank staff	310		310
Other	0		
<b>Total average numbers</b>	<b>13,265</b>	<b>12,171</b>	<b>1,094</b>
Of which			
Number of employees (WTE) engaged on capital projects	3	3	

## Human Resources Indicators at March 2017

Directorate	Training >95%	Appraisals >80%	Sickness <3%	Turnover <8%
Cancer Services	92.0%	86.0%	3.2%	9.0%
Cardiothoracic Services	90.3%	70.7%	4.6%	11.3%
Children's Services	87.6%	73.5%	4.7%	10.9%
Community	95.3%	76.3%	5.4%	17.0%
Dental Services	89.0%	78.0%	3.0%	13.0%
ENT	93.1%	83.7%	3.5%	10.6%
Clinical Genetics	98.6%	83.3%	2.8%	8.6%
Lab Medicine	97.7%	83.2%	3.0%	12.2%
Internal Medicine	86.5%	54.6%	5.2%	9.3%
Urgent Care Medicine	86.5%	79.0%	3.6%	9.7%
Musculoskeletal Services	90.0%	74.8%	5.1%	9.6%
Neurosciences	92.9%	90.2%	2.8%	10.2%
Peri-OP FRH	94.6%	89.2%	4.4%	7.9%
Peri-OP RVI	94.0%	91.3%	3.7%	7.9%
Pharmacy	98.7%	80.6%	2.8%	12.1%
POD	89.5%	80.3%	3.8%	9.8%
Radiology	88.7%	77.7%	3.1%	10.9%
Renal Services	93.3%	84.9%	4.0%	8.1%
RMPD	86.5%	87.3%	2.4%	11.3%
Surgical Services	94.2%	83.6%	3.2%	9.6%
Women's Services	94.8%	81.5%	4.9%	7.5%

### Sickness RAG

Green <2.99%, Amber 3%-3.49%, Red >3.5%

The Trust's sickness rate remained static at 4.1%, while the staff turnover rate increased slightly to 10.3%.

## Staff costs

(subject to audit)

	2016/17	2016/17			2016/17	2016/17	2016/17
	Total	Permanently employed			Other		
		Permanently employed total	Business with other WGA bodies	Business with bodies external to Government	Other total	Business with NHS FTs	Business with NHS Trusts
	£000	£000	£000	£000	£000	£000	
Salaries and wages	475,861	408,220		408,220	67,641	969	73
Social security costs	40,068	40,068	40,068		0		
Pension cost - defined contribution plans employer's contributions to NHS pensions	52,690	52,690	52,690		0		
Pension cost - other	32	32		32	0		
Other post employment benefits	0	0			0		
Other employment benefits	0	0			0		
Termination benefits	0	0			0		
Temporary staff - external bank	0				0		
Temporary staff - agency/contract staff	4,613				4,613		
NHS Charitable Funds staff	0	0		0	0		
<b>Total Gross Staff costs</b>	<b>573,264</b>	<b>501,010</b>	<b>92,758</b>	<b>408,252</b>	<b>72,254</b>	<b>969</b>	<b>73</b>
Recoveries from DH Group bodies in respect of staff cost netted off expenditure	(4,026)	(4,026)		(4,026)	0		
Recoveries from other bodies in respect of staff cost netted off expenditure	(2,735)	(2,735)		(2,735)	0		
<b>Total Staff costs</b>	<b>566,503</b>	<b>494,249</b>	<b>92,758</b>	<b>401,491</b>	<b>72,254</b>	<b>969</b>	<b>73</b>



2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17
Other									
Business with DH	Business with Public Health England	Business with Health Education England	Business with CCGs and NHS England	Business with Special Health Authorities	Business with NDPBs	Business with other DH bodies	Business with WGA bodies	Business with Local Authorities	Business with bodies external to Government
£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
			4					646	65,949
									4,613
0	0	0	4	0	0	0	0	646	70,562
<b>0</b>	<b>0</b>	<b>0</b>	<b>4</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>646</b>	<b>70,562</b>

## “Off-Payroll” Engagements (subject to audit)

Table 1: For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last for longer than six months

Number of existing engagements as of 31 Mar 2017	17
Of which:	
Number that have existed for less than one year at the time of reporting	10
Number that have existed for between one and two years at the time of reporting	4
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	3
Confirmation: All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.	

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017, for more than £220 per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration between 01 Apr 2016 and 31 Mar 2017	11
Number of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and national insurance obligations	11
Number for whom assurance has been requested	11
Of which:	
Number for whom assurance has been received	11
Number for whom assurance has not been received	0
Number that have been terminated as a result of assurance not being received	0
There are no cases where the Trust has engaged without including contractual clauses allowing the Trust to seek assurance as to their tax obligations or where assurance has been requested and not received.	
There are no cases where an individual has left after assurance has been requested but before assurance has been received.	
There are no cases of where assurance has been requested by the Trust but not received.	
There are no cases where the Trust is still awaiting information from the individual at the time of reporting.	

Table 3: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed “board members and/or senior officials with significant financial responsibility”. This figure should include both off-payroll and on-payroll engagements.	14

## Exit Packages (subject to audit)

	Number of other departures agreed 2016/17 Number	Cost of other departures agreed 2016/17 £000	Total number of exit packages 2016/17 Number	Total cost of exit packages 2016/17 £000
<b>Exit package cost band</b>				
Less than £10,000	0	0	0	0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
	Number of other departures agreed 2015/16 Number	Cost of other departures agreed 2015/16 £000	Total number of exit packages 2015/16 Number	Total cost of exit packages 2015/16 £000
<b>Exit package cost band</b>				
Less than £10,000	1	4	1	4
<b>Total</b>	<b>1</b>	<b>4</b>	<b>1</b>	<b>4</b>

There were no compulsory redundancies and no special payments were made with regard to the above departures either in the current or prior year.

*Exit packages: other (non-compulsory) departure payments*

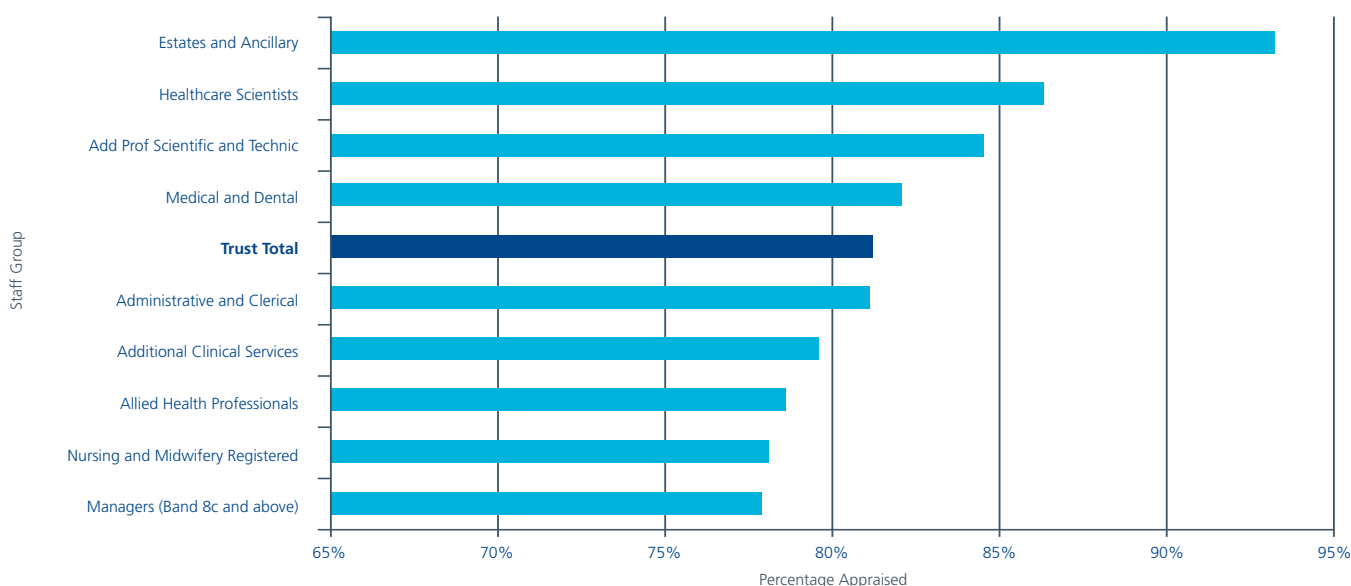
	Payments agreed		Total value of agreements	
	2016/17	2016/17	2015/16	2015/16
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	0	0	1	4
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following employment tribunals or court orders	0	0	0	0
Non contractual payments requiring HMT approval	0	0	0	0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>4</b>

The Trust spent £564,000 on consultancy fees in 2016-17 (£830,000 2015-16).

### Staff Group Appraisal Rates at March 2017

In 1 April 2016 the Trust reset its annual mandatory training modules with all staff required to undertake the annual mandatory training modules from this date. While initial performance was strong, the Trust narrowly missed achieving the 95% standard (92.3%) for the year.

However the Trust did meet its target of at least 80% of staff having an annual appraisal with a performance of 81.3% (see below).



The Trust's sickness rate remained static at 4.1%, while the staff turnover rate increased slightly to 10.3%.

### Staff Engagement and Information

The Trust regularly reviews its HR policies, procedures and systems to ensure they are robust, compliant with current legislation and good practice, and provide equity and opportunity to enable the Trust to appropriately discharge its responsibilities.

The Trust is committed to engaging with all staff at all levels and has various forums and groups, including the Trust Consultative group, the Employees Partnership Forum, Policies and Procedures Group, Medical Advisory Group, and Equality and Diversity network groups, as well as regional networking groups. These groups have management and staff side membership, and discuss strategic and other Trust matters.

The Employees Partnership Forum and Trust Consultative Group are the primary forums through which the Board seeks the views of staff - via their representatives - when making decisions likely to affect their interests and through which the involvement of staff in the performance of the Trust is encouraged. Priorities for improving staff feedback, whether identified through the national staff survey or not, are agreed through the forum, which also monitors implementation of agreed actions.

Following the introduction of the new junior doctor contract last year, a Junior Doctor Forum was established to support engagement and advise the Guardian of Safe Working Hours, and Director of Medical Education in overseeing the working hours and educational opportunities of junior doctors in training, and to facilitate scrutiny of the distribution of income drawn from financial penalties levied on departments by the Guardian where key safe working hours

limits are breached. Those fines will be spent on improvements to the working and training environment of doctors.

There are a number of informal forums which support communication and engagement and which particularly involve Clinical Directors and doctors in training. There is a bi-monthly corporate communications meeting that heads of departments and senior managers are invited to attend. Notes from these meetings are available for all staff and information is shared via the Trust's intranet and cascaded through department heads to enable staff in all directorates and departments to have access to key messages.

The Trust has extensive intranet and internet sites providing information on a range of subjects including all trust policies, procedure and guidelines. A Trust e-bulletin routinely provides updates on news and developments across the organisation, and a number of directorates and departments also produce local news letters to support their communications meetings and engagement arrangements.

The Trust participates in the NHS Staff Survey on an annual basis and the NHS Staff Family and Friends test, which provides a more frequent snapshot of feedback.

The growing use of social media has successfully enabled the Trust to engage more directly with both prospective and current employees. This approach supports the recruitment and retention strategy, and significant success has been noted in response to both clinical and staff success stories that have further enhanced our ability to attract new applicants to the Trust.

Ensuring a focus on staff health and wellbeing, the Trust appointed a 'Better Health at Work' Practitioner who successfully led the organisation to achieve the Silver 'Better Health at Work Award'. The Trust's focus will be on achieving the Gold Award in 2017. As part of this activity, a number of challenges were undertaken over the last year including participation in the "Race to Rio", which saw Trust teams compete with over 200 other NHS organisations to be named 'the most active' trust. This was a great example of engaging with and motivating staff to have fun and improve their own health and wellbeing.

The Trust's employee benefits offering has improved with over 25 new partners being announced that provide a variety of services and products at a discount or with additional benefits to our staff. The new Staff Benefits Website will launch in 2017 giving increased access to our partners and enabling staff to more easily take advantage of discounts. This offer enhances the employment package for staff through providing additional non-financial benefits, and a summary of staff benefits is included on the individual 'Total Rewards Statement' produced annually.

The Trust has comprehensive networks in place to ensure the involvement and engagement of its professional Nursing, Midwifery and Allied Health Professional staff. The Senior Nursing team, led by the Nursing and Patient Services Director has regular monthly meetings with Sisters and Charge Nurses across the organisation to update them on relevant local and national issues, and to provide an opportunity for discussion and engagement.

## 2016 NHS Staff Survey Results

The Trust's Staff Engagement Policy sets out its commitment to build on current practices and to help foster increased levels of staff engagement. It is an integral part of the Workforce Strategy that builds on partnership working arrangements.

The Trust benchmarks its performance in the NHS Staff Survey against regional and Shelford Group NHS organisations. The results of the National Staff Survey 2016 are summarised as follows:

- The volume of responses increased significantly with over 4,400 staff taking the time to respond to the survey.
- The Trust engagement score was 3.97 out of a possible 5. This was an improvement on previous years and ensured the Trust remained in the highest (best) 20% in this sector. This response provides a good proxy for staff on their views about the quality of care.
- 29/32 of the key findings were above the sector average (one was equal to).
- The questions relating to patient care were particularly pleasing with the Trust being the highest ranked non-specialist hospital in the 2016 NHS Staff Survey.

Monthly meetings are also in place for the Trust's Matrons where there are discussions about professional developments, priorities, and the development of nursing and nursing practice. Nurses in Specialist Roles meetings take place on a quarterly basis, ensuring staff that have diverse professional needs are provided with the opportunity to meet and discuss regularly with the Trust's Senior Nursing Team.

Further communication forums have also been sustained including the provision of monthly safety briefing to which all staff are invited. Led by the Senior Nursing and Medical teams across the Trust, these address emerging concerns or priorities to support and ensure organisational learning from incidents and near misses. Schwartz Rounds continue to be well attended and evaluate well as a forum in which multi-disciplinary staff can share and reflect on a range of experiences.

The quarterly Administration and Clerical Forum established last year continues to develop and it provides a platform for a range of speakers from both clinical and non-clinical backgrounds to help inform staff about new developments.

Other forums include the Transformation Group, which shares information about work streams the service improvement teams are undertaking; the Safeguarding Communication Forum and Staff Survey Groups, which enable a wide range of discussion with a cross section of staff.

A number of annual events are well established to both celebrate the contribution of staff, and support sharing of best practice and networking. These include the Nursing and Midwifery Conference, the Medical Education Conference, the Personal Touch Awards Celebrations, Long Service Awards and the Celebration of Success events to mark achievement of educational skills.

The Trust is keen to enable staff to volunteer their time and experience where possible. The Volunteer Services further expanded in 2016-17 and has become a key point of access for people who wish to begin their further educational or NHS careers.

The bi-annual careers events hosted by the Trust are now well established and well attended. They provide the opportunity for staff to share their experience and inspire the next generation to consider employment in the NHS, as well as serve as an additional recruitment tool to meet vacancy requirements.

The careers events continue to form part of our support for the armed forces and our reservists. The armed forces attend both our careers events and staff festivals, while we continue to demonstrate our support to them through an updated Armed Forces Covenant and a dedicated policy for Trust staff who are reservists. The Trust hosts the North East NHS Armed Forces Forum and is an active member of NHS Employers Armed Forces Group.

The Trust's Innovation Strategy continues to positively encourage all staff to identify and submit ideas for improvement and to enhance patient care. Those ideas are celebrated and recognised at an Innovation Recognition event.

Response Rate:				
	2015 (Previous Year)	2016 (Current Year)		Trust Improvement/ Deterioration
	Trust	Trust	Benchmarking group	
Response Rate	27%	32%	Unavailable	Increase by 5% but due to census rather than sample approximately 4,000 extra responses by volume

Top 5 Ranking Scores:				
	2015 (Previous Year)	2016 (Current Year)		Trust Improvement/ Deterioration
	Trust	Trust	Benchmarking group	
KF1. Staff recommendation of the organisation as a place to work or receive treatment	4.06	4.20	3.71	Improvement
KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	28%	23%	29%	Improvement (Lower Better)
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.99	4.12	3.92	Improvement
KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	52%	48%	55%	Improvement (Lower Better)
KF14. Staff satisfaction with resourcing and support	3.38	3.50	3.28	Improvement

Bottom 5 Ranking Scores:				
	2015 (Previous Year)	2016 (Current Year)		Trust Improvement/ Deterioration
	Trust	Trust	Benchmarking group	
KF15. Percentage of staff satisfied with the opportunities for flexible working patterns	41%	42.00%	51.00%	Improvement
KF24. Percentage of staff / colleagues reporting most recent experience of violence	47%	64.00%	67.00%	Improvement
KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	30%	44.00%	45.00%	Improvement
KF16. Percentage of staff working extra hours	75%	71.00%	71.00%	Improvement (Lower Better)
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	85%	91.00%	91.00%	Improvement

A number of key priority areas have been identified which include:

- a project around reporting and speaking up;
- all directorates to receive their own individual survey to create local and relevant action plans;
- improved communications – the Trust has invested in expanding its Communications Team;
- flexible working - local communications and significant work throughout nursing looking at shifts;
- individual leads e.g. Better Health at Work to take forward and develop their own key findings meeting scheduled with Staff-side representatives to discuss findings and any further actions to be taken;
- research and correlation between other surveys being considered e.g. Patient Safety Survey;
- future performance to be measured against the Staff Survey 2017- online census to be completed again allowing for comparable data; and
- the Staff Family and Friends Test is being used as indicator to monitor performance - test monitoring will be established and is currently being completed for Q1 2017.



## Employment of disabled people

As part of our Workforce Strategy, and our ambition to be the NHS Employer of Choice, we are aware of our responsibility to contribute to our local community and to identify how to attract, recruit and retain people to work in the NHS. We also recognise the need to ensure that our workforce becomes more diverse, reflecting the populations we serve.

The Trust remains committed to the employment and career development of disabled people. During 2016-17 we became a Disabled Confident Employer, having given a commitment to offer a guaranteed interview to all disabled applicants who meet the minimum criteria and consider applicants solely on their abilities. Reasonable adjustments are made at each stage of the recruitment and selection process to ensure equality of opportunity for all applicants.

We value the commitment of our staff and make every effort to ensure employees who become disabled during employment are supported and their skills retained, whether through redeployment, retraining or alteration of working arrangements. Our redeployment policy set out these steps. All of our policies and procedures are subject to a thorough equality analysis where the needs of disabled applicant and or staff are considered.

We continue to actively engage with our disabled staff by promoting our Disability Staff Network. Working in partnership we continue to ensure staff develop the appropriate level of disability awareness needed to ensure the achievement of the Trust's commitments, through regular engagement stands, awareness training and sharing of information.

As further evidence of our wish to be acknowledged as the NHS Employer of Choice, the Trust continues to be highly committed to playing a key role in delivering a health service where, equality, diversity and human rights are embraced and communicated in the everyday work of staff.

Through Project Choice, the Trust offers young Newcastle adults with learning difficulties, disabilities or autism, opportunities to support them to become positive role models, and enable them to actively contribute and feel valued for what they achieve. This project equips students with work-based transferable skills enabling them to be work ready after completion of an academic year and also provides a recognised qualification in employability skills.

The Trust continues to recognise that positive action can help remove barriers to employment and pro-actively addresses the under-representation of disabled staff in employment. Now in its fifth year the project has had fantastic results, with 76% of all learners having transitioned into employment, which is exceptional when compared to a national average of just seven per cent of people with a learning disability being in employment. Some 68% of those who have gained employment have secured roles within the Trust. The small minority who have not progressed into work, have transitioned into further education programmes or further supported work experience, with a view to becoming work ready in the near future. The current cohort are due to graduate in July 2017.



**“The Trust remains committed to the employment and career development of disabled people. During 2016–17 we became a Disabled Confident Employer, having given a commitment to offer a guaranteed interview to all disabled applicants who meet the minimum criteria and consider applicants solely on their abilities.”**

The Project is delivered in partnership and supports the Trust as a leading employer in:

- the promotion of equality and diversity;
- challenging discrimination; and
- promoting equality in employment.

Our achievements have been recognised through 13 local and national awards to date and in the last 12 months alone the following honours were picked up:

- June 2016 - A Project Choice apprentice was awarded Learner of the Year by Newcastle City Council.
- July 2016 - A Project Choice intern was awarded The Edge Award by Gateshead College.
- July 2016 - the Trust won the National Employer of people with Learning Disabilities and/or Autism Award.
- September 2016 - A Project Choice employee was awarded the National Learner of the Year award at the National Festival of Learning.

## Occupational health

The Trust’s occupational health service aims to improve staff’s health and wellbeing so they can deliver the best possible health care. For the third year running the service renewed its Safe, Effective, Quality Occupational Health Service (SEQOHS) accreditation in recognition of the high standard of quality services it provides.

Working closely with the Human Resources Department, the service saw referrals increase by 935 to 5,441 in 2016-17. However, waiting times for first appointments remained on average at just ten days.

## Support to speak up

The Public Interest Disclosure Act 1998 protects workers from detrimental treatment or victimisation by their employer if they, in the public interest, “blow the whistle” on wrongdoing.

For a member of staff to be protected they must reasonably believe that their disclosures show that one or more of the following matters is happening, has taken place or is likely to happen in the future:

- a criminal offence
- the breach of a legal obligation
- a miscarriage of justice
- a danger to the health and safety of any individual
- damage to the environment
- deliberate concealment of information tending to show any of the above five matters.

- November 2016- the Trust won the organisations supporting disabled people into employment category of the 2016 North East Equality Awards.
- March 2017 - the Trust’s work on Project Choice was nominated in the outstanding employer category for a Festival of Learning.

The Trust is regularly asked to attend NHS events and other regional employer events to highlight good practice and promote the business impact of the project, which include:

- an increased overall awareness across the organisation of the skills and value that people with learning disabilities, disabilities and autism can offer;
- increasing the diversity of our workforce by creating employment opportunities;
- staff developing specialist mentoring skills and increased staff engagement through involvement in the project, and a sense of pride and achievement; and
- demonstration of an ongoing commitment to promote access to work to those with learning disabilities.

Other key achievements during the last year include:

- Working in partnership with the Human Resources and Health and Safety Teams to develop an interactive stress management website to help direct staff to the most appropriate support.
- Increasing the take-up of flu vaccinations by 23% thanks to a partnership with Lloyds Pharmacy. In the 12 weeks up to Christmas 2016 8,251 vaccinations were given to staff.
- The development of a travel vaccination service that provides tailored advice and inoculations to keep staff safe when travelling abroad.

Under the Act a member of staff will be protected if they:

- make the disclosure in good faith
- reasonably believe that the relevant failure relates to ‘the proper administration of charities and funds given, or held, for charitable purposes’
- reasonably believe that the information disclosed and any allegation contained in it are substantially true.

The Trust takes its responsibilities under the Act very seriously and it was one of the first Trusts in the country to appoint a truly independent Freedom to Speak up Guardian – Sokhjinder Morgan. This independent post demonstrates that the Board of Directors genuinely want to hear about patient safety concerns and any wrongdoing that is in the public interest.

During the year the Guardian worked hard to continue to raise the profile of this independent role and other ways that staff can raise concerns, as well as building strong links with the National Guardian Office, NHS Employers, Health Education England North East and local universities.

# Code of Governance

The Trust applies the main and supporting principles of NHS Improvement's (Monitor) "Code of Governance for NHS Foundation Trusts" on a comply or explain basis. The Code, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issues in 2012.

In the course of the year, the Board reviewed and considered the Code and considered that it has complied with all recommended practice, including the identification of a Senior Independent Director. This role has been filled by Mrs H Parker, Non-Executive Director, since 2015.

The Board conducted a review of the effectiveness of the Trust's system of internal control and the details are set out in the Annual Governance Statement.

The Board of Directors provides effective and proactive leadership within a framework which enables risk to be assessed and managed appropriately (see Annual Governance Statement). The Board ensures compliance with the Terms of Authorisation, the constitution, mandatory guidance, relevant statutory requirements and contractual obligations. It sets the strategic aims of the Trust, taking into account the views of the Council of Governors and ensures that the necessary resources are in place to meet priorities and objectives. There is periodic review of progress and management performance.

Principles and standards of clinical and corporate governance are set and overseen by standing committees of the Board. Directors have overall responsibility for the effective, efficient and economical discharge of the functions of the Trust, taking joint responsibility for every decision of the Board, notwithstanding the particular responsibilities of the Chief Executive as Accounting Officer. Specific mechanisms are in place for the appointment, terms of service and removal of Executive Directors.

Non-Executive Directors are in the majority on the Board and are independent. They challenge and scrutinise the performance of the Executives to satisfy themselves of the integrity of the financial, clinical and other information they receive, and to ensure that risk management and governance arrangements are robust and effective. There is a formal Scheme of Delegation and Reservation of Powers that defines which functions are reserved to the Board and which are delegated to committees and officers. There is a designated Senior Independent Director.

Members of the Board have an open invitation to attend all meetings of the Council of Governors. The constitution sets out the statutory responsibilities of Governors in relation to the appointment and removal of the Chairman and Non-Executive Directors, the appointment and removal of the external auditors, approval of the appointment of the Chief Executive, receiving the Annual Audit Letter, and providing an input to the Annual Plan and its strategies. The Board determines which of its standing committees and panels may have Governors as members or in attendance.

## Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place. Information for the prior year and first two quarters relating to the RAF have not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

## Segmentation

The Newcastle upon Tyne Hospitals NHS Foundation Trust has been placed in segment 1.

This segmentation information is the Trust's position as at 22 May 2017. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

## Finance and use of resources

The finance and use of resources theme is based on the scoring of five of 67 measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2016/17 Q3 score	2016/17 Q4 score
Financial sustainability	Capital service capacity	3	3
	Liquidity	1	1
Financial efficiency	I&E margin	1	1
Financial controls	Distance from financial plan	1	1
	Agency spend	1	1
<b>Overall scoring</b>		<b>2</b>	<b>1</b>

Note: For 31st December 2016 (i.e. cumulative to Q3) the Trust had not at that point agreed a control total and therefore as the Trust had a capital service capacity rating of '3' the maximum score the Trust could achieve was a '2'. If the Trust had agreed a control total in December the score would have been rounded from 1.4 to a '1'.

For the position to 31st March 2017 the Trust had the same metrics as for the position to December but as a control total had been accepted the Trust was able to achieve a '1'.



# Statement of Accounting Officer's Responsibilities

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer include responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, as set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

Under the NHS Act 2006, NHS Improvement has directed the Trust to prepare, for each financial year, a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accrual basis and must give a true and fair view of the state of affairs of the Trust and of its income and expenditure, total recognised gains and losses, and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the HM Treasury Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in HM Treasury Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements.
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance.
- Prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records, which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

It is the responsibility of the Directors to prepare the annual report and accounts. The Directors consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

To the best of my knowledge and believe, I have properly discharged the responsibilities set out in NHS Improvement's NHS Foundation Trust Accounting Officer Memorandum.



**Angela Dragone**  
*Finance Director*

22 June 2017



# Annual Governance Statement

## Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, while 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 Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

## The purpose of the system of internal control

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

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of policies, aims and objectives of the 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 in the Trust for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.



## Capacity to handle risk

### A. Leadership

Overall decisions in relation to the prioritisation of corporate risk issues and resource allocation are taken by the Board of Directors, with delegation of decisions relating to specific risks to sub-committees and panels or the Executive Team, as appropriate.

This decision making process is underpinned by information and advice from the Risk Management and Assurance Committee, regular reports on the Trust's Risk Register and an annual review of progress against the Risk Management Strategy.

The approach to business risks is supported by the work of the Executive Team, which has a specific role in relation to assessment of the financial and corporate risks arising from business cases for specific developments and from the annual business plan.

The remit of the Audit Committee also includes scrutiny of risk management processes. With regard to financial and associated risks, the Investment Committee has a remit to ensure that business cases for significant developments are robust, explicitly address key risks, and deliver a satisfactory rate of return on investment.

The roles and responsibilities of Executive Directors have been developed to cover all aspects of risk. These arrangements are reflected in their job descriptions and performance is monitored through the individual development review process.

Corporate performance is routinely scrutinised by the Performance Management Group, which is comprised of Executive Directors (except the Chief Executive) and supported by specialists in performance review and analysis. The group presents key findings to the Executive Team, when required, and any significant issues are raised with the Board of Directors, as appropriate.

As Accounting Officer I delegate particular aspects of my role to Executive Directors. These arrangements are reflected in job descriptions and performance review mechanisms. The Chief Executive role is directly accountable to the Board of Directors, has overall responsibility and accountability for all aspects of the Risk Management Policy and delegates this responsibility to the senior managers of the Trust, as detailed in the Risk Management Strategy.

Specific responsibilities delegated to members of the Executive Team:

- The Medical Director is responsible for risk management and ensuring that the Risk Management Strategy, structure and systems are in place and working effectively. This includes monitoring of the former Standards for Better Health and oversight of the Care Quality Commission (CQC) registration requirements. The Trust Secretary is the responsible person for CQC registration purposes. In that context, the Medical Director is responsible for the implementation and continuing development of the clinical aspects of the Risk Management Strategy as an integral part of clinical governance.

- The Finance Director is responsible for the management of risk in relation to finance issues.
- The Trust Secretary is responsible for non-clinical governance matters, including information governance in their role as Senior Information Risk Owner.
- The Estates Director, in liaison with the Medical Director, is responsible for the implementation and further development of risk management in relation to business continuity. Fire, security and related operational and organisational issues remain under the direction of the Estates Director, in liaison with the Chief Executive.
- The Quality and Effectiveness Director is responsible for the implementation and further development of the Health and Safety Strategy for the Trust. The Health and Safety Committee is chaired by a Non-Executive Director.
- The Quality and Effectiveness Director is accountable to the Medical Director for supporting the overall co-ordination and integration of risk management activity. This includes the key inputs to the Risk Management and Assurance Committee and overseeing and co-ordinating activities within the risk management working groups.

### B. Training

Training is informed by risk management priorities identified through internal systems and an annual training needs analysis. Training includes:

- Mandatory sessions on the Trust induction programme for all new staff and via departmental induction programmes focused on local key issues, including health and safety.
- Various presentations and workshops through the clinical governance lecture programme.
- External education and training, where appropriate.
- Information on the Trust's intranet.

Wherever possible, opportunities are taken to learn lessons from adverse events and near misses. Communication forums and education sessions are used to share information on lessons learned with staff throughout the organisation. As a result of this focus on risk management training there is an increasing awareness of risk amongst staff, and a more active involvement at all levels of the organisation in the identification and reduction of risk.

## The Risk and Control Framework

### A. Risk Management Strategy

The risk management strategy sets out the structures and processes for the identification, evaluation and control of risk, as well as the system of internal control. Delivery of the strategy is overseen by the Risk Management and Assurance Committee with individual officers having specific delegated responsibilities.

Risk appetite is tested at the Risk Management and Assurance Committee, Audit Committee and Board of Directors as required by the perceived scale and potential impact of any risk. A central risk register is maintained, which records when a risk has been identified, its owners, likelihood of occurrence, potential impact and mitigating action.

Effective risk management requires the involvement of staff at all levels in the organisation. Directorate managements, Clinical Directors and Heads of Department are responsible for ensuring effective risk management in their areas in line with the Trust strategy and policy. This includes primary responsibility for identification, investigation and follow-up of all risk issues as defined in job descriptions and objectives. A key element of this approach is the maintenance of a robust risk register.

Where initial assessment indicates a high level of risk or requires reporting to an external body, Directorate Managers, Clinical Directors and Heads of Department are responsible for reporting the issue to a Director to agree the process for the management of the risk.

The key elements of the risk management strategy are:

- A clear framework for the accountability and delegated responsibility for the management of risk.
- An integrated strategy that sets out the overall purpose and processes, as well as an associated annual plan.
- A clearly defined committee structure that supports robust and timely decision making around key organisational risks.
- Robust systems for the identification, analysis, prioritisation and actions in relation to risks affecting all areas of Trust activity.
- Risk management processes that are integrated and embedded into the day-to-day activities of the Trust.
- A Clinical Governance and Risk Department to support risk control processes
- A tailored training programme to address key risk areas.
- Comprehensive communication processes for governance and risk management policies and procedures, and the dissemination of learning from lessons learned.

Decision making about risk management priorities in the Risk Management and Assurance Committee was informed by:

- Prioritised risk register;
- Reports from incidents, complaints and claims;
- Issues highlighted in directorate and departmental risk reviews, leadership walkabouts and ad hoc feedback;
- Reports from risk management sub-groups and other working groups; and
- Feedback from external stakeholders, the Patient Advice and Liaison Service and patient groups.

Priorities identified by the Committee are included in the corporate risk register and fed into the risk management plan and assurance framework, where appropriate. This helps to support decision making on the prioritisation and allocation of resources. The Committee also communicates directly with the Board of Directors, Audit Committee and Clinical Governance and Quality Committee on specific risk areas.

The Trust is required to make decisions on acceptable and unacceptable levels of risk in relation to specific issues. This is guided by the financial capacity of the organisation, the need to maintain service provision, an assessment of potential harm to patients, staff or the public, coupled with the Trust's obligations in relation to external regulations, standards and targets.

Decision making is supported and informed by the use of objective risk assessment processes. These tools include a standardised risk assessment matrix, the assurance framework and corporate risk register, and they are designed to enable the organisation to adopt a systematic approach to:

- Identifying key risk in all aspects of Trust activity.
- Ensuring clear executive accountability for all key issues.
- Linking and monitoring risk issues related to NHS policy targets.
- Prioritising risks in relation to their likelihood of occurrence and impact.
- Identifying that appropriate management arrangements are in place.
- Ensuring all key topics are subject to the appropriate level of Board scrutiny.
- Informing resource allocation decisions.
- Ensuring appropriate external assurance in relation to all high risk area.

The assurance framework provides a high level analysis of risks in relation to the Trust's key objectives and risks are identified that may affect the organisation's ability to achieve its objectives. For each risk the framework provides an assessment of the controls in place to

ensure the effective management of risks, and the processes and evidence to give the Board assurance that the risk management and control measures are effective. Gaps in control or assurance are identified so that they can be addressed.

Individual members of staff have personal responsibility to take part in risk management processes to identify and address adverse events or potential risks. This includes responsibility for:

- Maintaining awareness of relevant policies and procedures and for ensuring they comply with those and the requirements of their professional body.
- Reporting any incidents, accidents or near misses as set out in the relevant policy.

## B. Quality Governance Arrangements

The Trust has a quality governance framework, which describes how the quality of performance information is accessed and assurance is obtained with regard to compliance with CQC registration requirements. The Board of Directors receives regular reports on these areas.

There is also a patient safety and quality review process in place to act as a quality assurance mechanism by which directorates' performance against patient safety and quality metrics are monitored.

Current patient safety and quality data is routinely available to directors and attendances at a Patient Safety and Quality Review Panel chaired by the Medical Director provides an opportunity to escalate any areas of under-performance. The panel reports to the Clinical Governance and Quality Committee.

## Principal risks to compliance with NHS Foundation Trust governance

The Board of Directors, Audit Committee and Risk Management & Assurance Committee all play a role in ensuring the Trust has robust and effective governance structures. The Constitution and terms of reference for all standing committees of the Board are reviewed periodically and any proposed amendments are subject to Board endorsement. The minutes of all committees are presented to the Board as a standing agenda item.

The responsibilities of Directors and sub-committees are clarified in the Trust's governance structure, which includes reporting lines and accountabilities of committees and individuals.

Systems are in place to ensure the Trust complies with its duty to operate efficiently, effectively and economically, with timely and effective scrutiny and oversight by the Board, including securing compliance with healthcare standards as specified by the Secretary of State for Health, the Care Quality Commission, NHS England, NHS Improvement and statutory regulators of healthcare professions.

## Review of economy, efficiency and effectiveness of the use of resources

During the year the Audit Committee receives a series of internal audit reports in line with an agreed work plan that aims to test the economy, efficiency and effectiveness of an array of Trust systems and processes, including financial management and control. The audit plan is reviewed and agreed by the Committee in April each year.

Any report which offers only limited assurance results in the development of a management action plan with an agreed timescale for improvement and progress is monitored by the Audit Committee. Serious issues are escalated to the Board of Directors.

The external auditors, through their audit of the Annual Report and Accounts, also provide a degree of assurance to the Audit Committee and Board that financial control systems are robust.

Effective financial decision making, management and control includes having appropriate systems and processes in place to ensure the Trust can continue as a going concern. Measures are also in place to





provide accurate, comprehensive, timely and current information for Board and committee decision making, including the identification of material risks.

The Board monitors business plans and their implementation on a monthly basis and this is underpinned by quarterly performance reviews and scrutiny by the Investment Committee.

There is periodic assessment of Board level capability to provide effective organisational leadership on the quality of care, planning and decision making processes. The Board receives monthly reports on quality and other care related issues and takes part in regular walkabouts of services as part of the quality assurance processes.

Patients, staff and other stakeholders are engaged through a number of forums including the Patient, Carer and Public Involvement Committee, Community Advisory Panel and Council of Governors, as well as members' events.

With regard to the annual Governance Statement to NHS Improvement, the Board satisfies itself about compliance through assessment of quarterly returns including the declarations on continuity of service and governance, and through consideration of the annual operational plan and related Board declarations.

## Risks to data security

### A. Implementation of security software

The Trust completed implement of single sign-on software in 2012. This authenticates users and restricts access rights to appropriate software. Encryption software has been installed to ensure that any patient identifiable material carried on transferable media e.g. USBs or CDs, are securely encrypted in line with NHS policy.

### B. Wannacrytor Cyber attack

The Trust IT department was notified of a Cyber-attack at 2pm on 15 May 2017. The initial notification came from colleagues in a neighbouring trust and our IT security team monitored the NHS carecert blogs, and both press and other cyber information portals for any further information.

IT teams (networks, servers and desktop) worked together with IT security to scan local machines and hosts for any sign of infection. The initial information indicated that the attack was dependent on user action, namely responding to an email and clicking a link within the email that would connect with an outside server to download the virus.

Initial scans within the Trust indicated that no machines had been infected.

Cyber Security North East bulletins contained details of the websites hosting the virus. The Trust IT Security team disabled any automatic links from Trust email accounts to the websites highlighted in the bulletin. As information filtered through from other Trusts and NHS Digital it was established that other Trusts in the local area had suffered from the attack.

As a result we decided to cut our external links to all the other Trusts and any third party organisations. This meant that internal systems were fully functional but other Trusts could not, for example, access the foreign film archives held within our radiology libraries. All Trusts in the area took a similar stance and effectively cut direct access between organisations.

On the evening of 15 May the IT security team received details of a Microsoft patch, and the on-call IT service team began the process of rolling out the patch to all Trust machines. The Trust also set up a major incident communications team for the weekend.

Work to roll out the patch continued and networks and servers were continuously monitored over the weekend, but no virus notifications were identified.

From 18 May IT service management oversaw the remedial actions to ensure that all devices were patched appropriately, connections outside the Trust continued to be monitored and Trust firewall rules were reviewed and amended. Internal services were fully functioning throughout the attack and, as other organisations gave assurances about their IT systems, secure connections were re-established.

As a result of prompt actions taken by the Trust the cyber attack had minimal impact on service delivery.

## Information governance

**Information Governance Toolkit** - In 2016 -17 (version 14) the Trust achieved an overall rating of 92%, a five per cent improvement on the position for 2015-16 (Version 13) at 87%. The rating of 92% was a six per cent increase on the target score of 86%. The Trust also maintained its 'Satisfactory' rating, which meets the Monitor requirement of achieving Level 2 ( $\geq 50\%$ ) on all 45 requirements of the toolkit as a minimum.

The focus for 2016-17 was on further building on the work of previous years and to ensure that evidence used was as resilient as possible. Throughout the year, the number of Level 3 requirements rose from 28 to 36. The Information Security Assurance section showed the greatest increase in attainment.

The requirements that relate to the Trust's processes around Smartcard Management and Registration Authority both scored Level 3 compliance, an improvement from previous years. This is thanks to a concerted effort from the Registration Authority team to improve Trust practice and the implementation of a number of audit measures to check compliance.

In addition to this, the requirement concerning Business Continuity also improved its score from a Level 2 to a Level 3. This is in recognition of the efforts of the Business Continuity team to maintain Trust wide processes, the resilience of which was tested in recent exercises.

The Information Governance team is continuing to ensure that the Trust is fully prepared and aware of the changes that will come with the new General Data Protection Regulation, which will replace the

current Data Protection Act when it comes into effect in May 2018. A task and finish group has been established to oversee this and reports directly to the Information Governance Committee.

The Information Governance team also concentrated on the organisation and management of the Trust's corporate records. This has involved liaising with the Tyne and Wear Archives to ensure that the Trust is compliant with its obligations under the 20 year rule and is offering Trust information to them that has historical value.

The Information Governance Toolkit is a performance tool produced by the Department of Health. It draws together the legal rules and central guidance, such as the Data Protection Act and the Common Law Duty of Confidentiality, and presents them in one place as a set of information governance requirements.

Organisations are required to carry out self-assessments of their compliance against these. Submissions are made annually in March, with updated submissions in July and October. The final submission scores reported by organisations are used by the Care Quality Commission to assist with their assessments.

The NHS uses the Information Governance Toolkit to establish and monitor the standards NHS organisations should apply in the management of all of these categories of information. The Trust is required to make an annual submission on its achievement of the standards set out in the Information Governance Toolkit. This information is used by the Care Quality Commission and the NHS Litigation Authority. Compliance with the IG Toolkit is a requirement for ongoing NHSLA Risk Management standards accreditation and Care Quality Commission assessments of Trust performance.

### Summary of Serious Incident Investigations Involving Personal Data as Reported to the Information Commissioners Officer in 2016-17 (Level 2)

One serious incident was reported to the Information Commissioners Office. An unencrypted memory stick containing data relating to two patients was found on public transport by a member of the public. Trust Policy requires encrypted memory sticks to be used. The individual who lost the memory stick has been disciplined and trained in the secure transfer of sensitive data.

#### Summary of Other Personal Data Related Incidents in 2016-17

Category	Breach Type	Total
A	Corruption or inability to recover electronic data	2
B	Disclosed in error	108
C	Lost in transit	8
D	Lost or stolen hardware	2
E	Lost or stolen paperwork	6
F	Non-secure disposal – hardware	0
G	Non-secure disposal – paperwork	8
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	1
J	Unauthorised access/disclosure	1
K	Other (failure to secure information)	7
<b>Total</b>		<b>143</b>

#### Summary of Cyber Breach Incidents in 2016-17

Cyber Breach Incident	Total
Hacking	0
Denial of service	0
Phishing e-mails	0
Social Media Platforms – disclosure by organisation staff through social media channels	0
Web site defacement	0
Malicious internal damage	0
Spoof website	1
Other	0

## Review of effectiveness of the system of internal control

As Accounting Officer I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors, clinical audit, and the executive managers and clinical leads with the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report (page 66) and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, and Risk Management and Assurance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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 the internal audit work. The Head of Internal Audit Opinion for the financial year 2016/17 provided: 'good assurance that there is a sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently'.

One area for improvement highlighted within the Head of Internal Audit Opinion was in relation to completion of outstanding internal audit actions on a timely basis. A new process for follow up was agreed at the April 2017 Audit Committee meeting and therefore this was not identified as a significant issue of concern.

Executive managers within the organisation, who have responsibility for the development and maintenance of the system of internal control, provide me with assurance. The assurance framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by the programme of reviews undertaken by internal and external auditors, monitoring of actions related to previous controls assurance assessments, the clinical audit programme, Care Quality Commission monitoring of clinical governance development, risk management assessments aligned to the standards originally set in the Clinical Negligence Scheme for Trusts, external benchmarking processes, and a range of inspections by professional bodies and agencies.

The effectiveness of the system of internal control has been maintained and reviewed by the Board of Directors via its sub-committees and individual management responsibilities at Director and Senior Manager level. I am satisfied that this annual governance statement describes a system and approach which remained robust for the period from 1 April 2016 to 31 March 2017, and up to the date of approval of the annual report and accounts, that supports preparation of the Annual Accounts on a going concern basis.

Regular reports have been received from sub-committees of individual officers in relation to all key risks. Annual reports have been received by the Board of Directors relation to all important areas of activity as well as ad hoc report as required.

Clinical governance and processes to ensure quality of patient care are overseen by the Clinical Governance and Quality Committee under the leadership of the Medical Director. Minutes of this Committee were received by the Board of Directors together with ad hoc reports as required and an annual report summarises the most significant issues in this area.

The Medical Director has delegated lead responsibility for risk management across the Trust. Practical support and co-ordination is provided by the Clinical Governance and Risk Department. Individual Directors and senior managers are empowered to assess and manage risks within their own areas of responsibility, linking close with wider Trust processes. Significant support was provided via training, advice and guidance documentation to enable senior staff to effectively fulfil its function.

An analysis of controls and assurances in relation to key organisational risks has been undertaken via the assurance framework. Underpinning this, the corporate risk register has been further developed to provide a detailed assessment of specific risks to all departments and key functions. The Risk Management & Assurance Committee scrutinised these processes and advised the Board of Directors in relation to the most significant risk and control issues arising from the assurance framework and risk register. Regular reports from the Committee have highlighted emerging and developing risks.

In addition, the Complaints Panel maintains an overview of the management of complaints, incidents and litigation, and monitors action in response to specific risks. The Risk Management and Assurance Committee provides oversight of incidents to ensure the integration of analysis of incidents and learning lessons from those incidents with other risk assessment and mitigation processes.

The Committee is responsible for the implementation and further development of the risk management strategy, and for ensuring systems are in place to identify and address key risks. This role is complemented by the Audit Committee, which is responsible via internal audit for verifying that the system of internal control was

effective in managing risks in the manner approved by the Board of Directors.

To support further development the Trust has taken advantage of opportunities to benchmark performance against national and international best practice. This included participation in formal and informal external processes, including those supported by the Shelford Group of Trusts, the Department of Health, National Patient Safety Agency, Care Quality Commission and National Audit Office.

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Newcastle upon Tyne Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

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

Control measures are in place to ensure that all the Trust's obligations under equality, diversity and human rights legislation are complied with. Equality Impact Assessments are conducted for each policy as it is reviewed or renewed.

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that the organisation's obligations under the Climate Change Act and the Adaption Reporting requirements are complied with.

## Conclusion

Overall, the organisation has a high level of confidence with regards to the management of key risk issues. The following areas of internal audit work resulted in a limited assurance outcome:

1. Building Management System (BMS) – The internal audit report identified that reliance was placed on the supplier of the system for backups and the location and security of the backups had not been assessed.

Actions have been agreed to mitigate the risks which include that the BMS software will be installed onto a server located in the Trusts two main data centres and backup and restoration arrangements shall be agreed with IT, carried and stored onto the Trust servers and backed up regularly.

2. Transport – The internal audit report identified that the Transport Group terms of reference required review and that a clearly defined policy was required regarding the purchase and use of commercial vehicles. In addition the audit highlighted that more regular transport checks on documentation with the DVLA were recommended.

Actions have been agreed to mitigate the risks which include a review of the terms of reference to be reviewed, development of a clearly defined policy regarding the purchase and use of commercial vehicles and updating of the Trust Driving at Work Policy to specify responsibility for and documentation of Duty of Care checks.

3. WinPak – The internal audit report identified that a number of users could make changes to the system (systems admin), guidance needed to be enhanced, particularly to control Trust-wide access requests and the number of 'generic' cards needed to be reduced.

Actions have been agreed to mitigate the risks which include reviewing Systems admin users and the number of 'generic' cards. Guidance to be developed as outlined within the report and controls for cards with trust-wide access to be reviewed.

For the individual audit reports with an assurance rating of 'limited' / or for internal audits whereby the findings were prioritised as 'high', action plans have been agreed and progress against such plans is being monitored.

The above three areas have been considered and have not been identified as significant control issues for the following reasons:

- None of the issues would prejudice achievement of the Trusts key priorities.
- None of the issues were deemed to undermine the integrity or reputation of the NHS.
- The Audit Committee has reviewed the detailed internal audit reports and is comfortable with the actions outlined within the reports.
- None of the issues could have a material impact on the Trust financial accounts.
- None of the issues could impact on national data security or integrity.

The Trust failed to meet the A&E 4 hour waiting target for the financial year 2016/17, achieving 94.4%. The Trust is part of the regional A&E Improvement Programme Board and actions to improve performance are in place.

I can conclude that no significant control issues have been identified.



**Angela Dragone**  
Finance Director and acting Accountable Officer

22 June 2017

### 3. Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare quality Accounts for each financial year. NHS Improvement issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports, which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

To assure the data used in the Quality Report and Quality Account the Trust has a Digital Governance Steering Group that meets bi-monthly. Chaired by the Chief Information Officer, the group reviews data quality and associated workflows to ensure that NHS data standards are adhered to. This provides assurance to the Board that data is regularly validated and reviewed.

The work of the group is evidenced through regular data quality reports that are shared with directorates and departments for review and data correction. The Information Team continues to support and train system users and suppliers to improve real time data validation.

# Quality Report 2016/17

Unconditionally registered with the CQC since April 2010





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# Statement on quality from the Chief Executive

We are pleased to introduce The Newcastle upon Tyne Hospitals NHS Foundation Trust Quality Account for 2016/2017 which demonstrates our commitment to delivering care of the highest quality. This report focuses on our performance over the past year as well as our key priorities for 2017/2018.

2016/2017 was another very busy year for the Trust – our 11th successful year as an NHS Foundation Trust. More patients than ever were treated with significant increases in surgery and A&E attendances.

This was also the year in which we received the outcome of an inspection by the independent health and social care regulator, the Care Quality Commission (CQC), who rated the Newcastle Hospital's services, and the staff who provide them, as "Outstanding". This Trust is only one of a handful in the country to receive this accolade and indeed is only one of two teaching hospitals to have achieved this.

This is a truly remarkable achievement and testament to each and every one of our 14,500 dedicated and highly professional staff.

In the recent NHS Staff Survey; the Trust was ranked number one for non-specialist acute Trusts. 91% of staff agreed or strongly agreed that "if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation" – a clear testament that they take great pride in the care that they are able to deliver.

As a national leader, with over 16,000 patients enrolled in clinical research studies and trials last year, Newcastle Hospitals, for the fifth consecutive year, topped the NIHRs (National Institute of Health Research) Clinical Research Network's league table for conducting more research than any other NHS provider. This includes participating in the world's first fully regulated clinical trial of direct stem cell therapy for strokes.

The Trust is actively engaged in local Sustainability and Transformation (STP) discussions, the priorities of which include: Prevention, Health and Wellbeing; Out of Hospital Collaboration; and, Optimal Use of the Acute Sector. Integration is a key component of our strategy and an opportunity to accelerate system transformation and further develop integrated pathways of patient care. In partnership with Gateshead Health NHS Foundation Trust, a designated Hyper Acute Stroke Unit has been established at the Royal Victoria Infirmary to improve service response times and deliver the best health outcomes for patients across Newcastle and Gateshead. We continue to collaborate with local GP's with shared learning and educational events allowing exchange of up to date knowledge, ideas and participation in dialogue focussed on clinical issues and streamlined working practices.

As a Trust we continue to develop and facilitate pioneering and innovative procedures to improve patient care. For example, our transplant teams are developing new clinical approaches and

technologies; one example being the assessment and improvement of donor kidneys prior to transplantation. Robotic surgery is performed in more clinical specialties than any other hospital in Europe, and has linked with four other specialist robotic centres to train surgeons across the UK and Europe. There are so many other such examples, of leading edge practice that they are too numerous to mention in this short summary.

Whilst Newcastle Hospitals continues to invest in innovation and world leading technologies we also understand the importance of getting the basics right. The number of patients who suffer a fall during their stay has been successfully reduced; as has the time for patients with sepsis to receive antibiotics. Patient safety and high quality care will, as always remain our number one priority. An open and honest culture has been successfully nurtured; staff feel supported to report incidents and learn from them. Mortality rates remain below the national average and are consistently the lowest in the region.

We are very proud of each and every person who works for the Trust, their dedication and focus on ensuring the very best outcomes for our patients, and whom we know will work tirelessly to continuously improve the quality of care, safety and experience of our patients.

We give our absolute assurance that Newcastle Hospitals will continue to put patients at the heart of everything that we do, will not rest on our laurels and will continue to strive to improve further.

To the best of our knowledge the information contained in this document is an accurate reflection of outcome and achievement.



**Louise Robson**  
Acting Chief Executive



**Andy Welch**  
Acting Chief Executive





Fire exit →

# Review of Quality Performance 2016/17

The information presented in this Quality Account represents information which has been monitored over the last 12 months by the Trust Board, Council of Governors, Clinical Governance and Quality Committee and the Clinical Policy Group. The majority of the Account represents information from all 17 Clinical Directorates presented as total figures for the Trust. The indicators to be presented and monitored were selected following discussions with the Trust Board. They were agreed by the Executive Team and have been developed over the last 12 months following guidance from senior clinical staff. The quality priorities for improvement have been discussed and agreed by the Trust Board and representatives from the Council of Governors.

The Trust has consulted widely with members of the public and local committees in ensuring that the indicators presented in this document are what the public expect to be reported. Comments have been received from Newcastle Health Scrutiny Committee, Newcastle Clinical Commissioning Group (CCGs) and the Newcastle and the Northumberland Healthwatch teams. Amendments have been made in line with this feedback.

## Patient Safety

### Priority 1 - To reduce all forms of healthcare associated infection (HCAI), we will quantify our success in this by:

- Aiming for the annual number of Methicillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia cases to be no more than zero
- Reducing hospital acquired infections related to *Clostridium difficile* (*C. difficile*) to be no more than 77 cases in the next year.

As well as MRSA and *C. difficile*, the Trust monitors rates of Methicillin-Sensitive *Staphylococcus Aureus* (MSSA) and *E.coli* bacteraemia, and we are actively working to reduce these rates.

#### The definition of MRSA is:

*Staphylococcus Aureus* (*S. aureus*) is a bacterium that commonly colonises human skin and mucosa (e.g. inside the nose) without causing any problems. Although most healthy people are unaffected by it, it can cause disease, particularly if the bacteria enters the body, for example through broken skin or a medical procedure. MRSA is a form of *S. aureus* that has developed resistance to more commonly used antibiotics. MRSA bacteraemia is a blood stream infection that can lead to life threatening sepsis which can be fatal if not diagnosed early and treated effectively.

#### The definition of *C. difficile* infection (CDI) is:

*C. difficile* diarrhoea is a type of infectious diarrhoea caused by the bacteria *Clostridium difficile*, a species of gram-positive spore-forming bacteria. While it can be a minor part of normal colonic flora, the bacterium causes disease when competing bacteria in the gut have been reduced by antibiotic treatment.

#### The definition of MSSA is:

As stated above for MSSA the only difference between MRSA and MSSA is their degree of antibiotic resistance: other than that there is no real difference between them.

#### The definition of *E.coli* is:

*Escherichia coli* (*E.coli*) bacteria are frequently found in the intestines of humans and animals. There are many different types of *E.coli*, and while some live in the intestine quite harmlessly, others may cause a variety of diseases.

The bacterium is found in faeces and can survive in the environment. *E.coli* bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. *E.coli* bacteraemia (blood stream infection) may be caused by primary infections spreading to the blood.

During the period April 2016 to March 2017, there have been:-

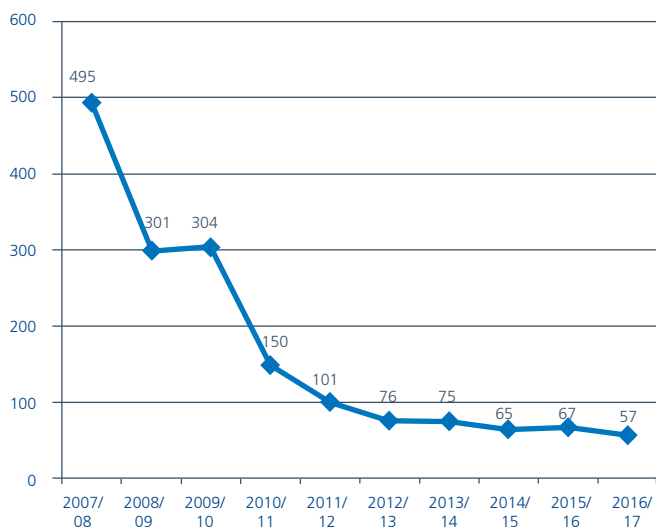
- Nine MRSA bacteraemia cases finally assigned to the Trust. There is a 'zero tolerance' approach to MRSA infections
- 57 cases of hospital acquired *C. difficile*, against an annual target of 77 cases (77 cases were reported but 17 successfully appealed and were therefore not counted towards the target)

- 93 cases of MSSA bacteraemia
- 205 cases of *E.coli* bacteraemia

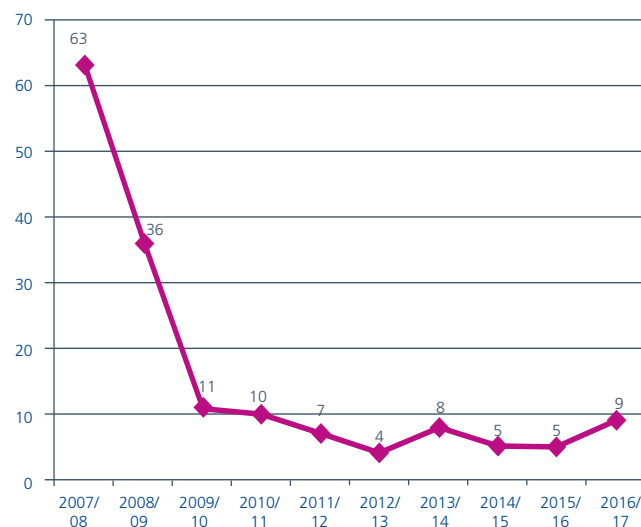
Please note this data is not yet conformed and subject to change.

The graphs below indicate the position of the Trust as at the end of March 2017 and the progress made over time in respect of reducing the incidences of these hospital acquired infections. The figures are reported to the Trust Board and Public Health England (PHE) on a monthly basis.

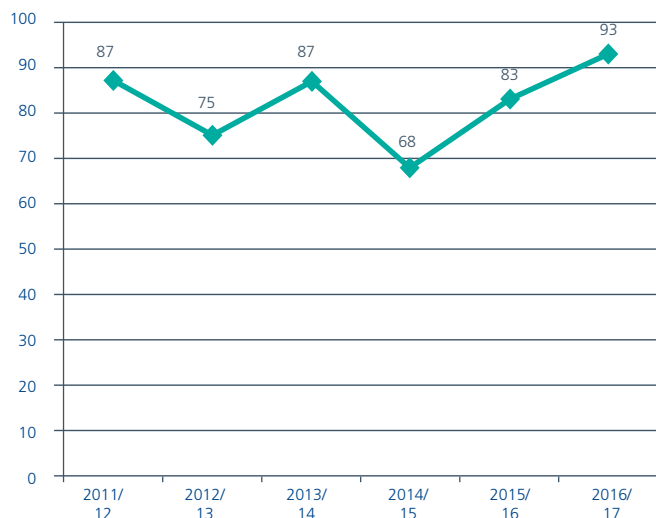
Yearly *C. diff* Rates (minus appeals) 2007/08 to 2016/17



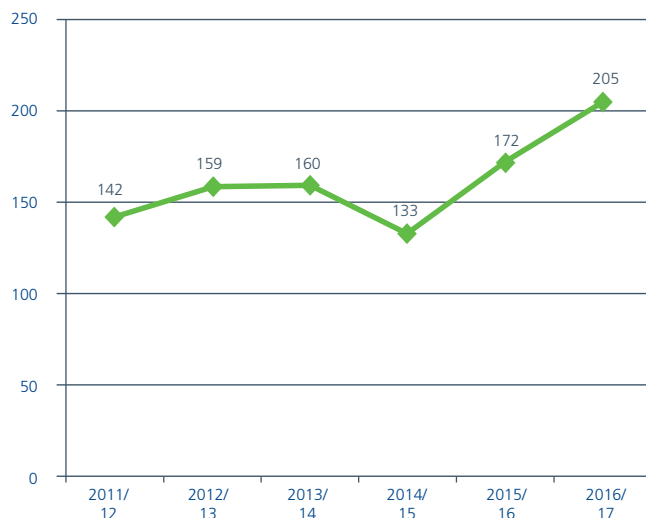
Yearly MRSA Rates 2007/08 to 2016/17



Yearly MSSA Rates 2011/12 to 2016/17



Yearly *E.coli* Numbers (post-48 hours) 2011/12 to Nov 2016



There are a number of strategies that the Trust has implemented to monitor and reduce the number of HCAs, these include:

- Development of an IPC Operational Plan to replace HCAI action plans; progress regularly reviewed by Infection Prevention Control Committee and Operational Group. HCAI is a standing agenda item at the Trust main forums and Directorate level communication and governance meetings. HCAI is a standing agenda item at monthly Site Safety Briefing.
- Following each case of MRSA bacteraemia a rapid review and Post Infection Review (PIR) Toolkit are completed. A Serious Infection Review Meeting (SIRM) is held and lessons learned are discussed and implemented. This information is collated in a quarterly report, which facilitates the sharing of lessons learned and best practice Trust-wide.
- Following each *C. difficile* case attributed to the Trust, a root cause analysis (RCA) form is completed and the results compiled in a database. This information contributes to the production of the quarterly report. A SIRM is held where *C. difficile* is on the death certificate or where there are clear lessons to be learned (such as lapses in care). A period of increased incidence (two or more cases on a ward within 28 days) leads to a MDT review to discuss the cases.

- Since mandatory surveillance of MSSA bacteraemia was introduced in England in 2011, the data from PHE demonstrates an increase in both total number of cases and rates of MSSA bacteraemia. There is a geographical variation in rates, with the North of England reporting higher rates compared to regions in the South and East. The steady increase in reported cases in this Trust has been a significant challenge and reduction strategies remain a key priority. From April 2017, a 10% reduction target will be in place for MSSA bacteraemia occurring 48-hours post admission; this is an internal target agreed at the IPC Operational Group.
- The Trust has focused on areas where patients are identified at a higher risk of MSSA which include the Cardiothoracic and Renal Services Directorates. High risk patients are now identified and treated chlorhexidine washes.
- A new abbreviated RCA to examine the source and contributory factors of MSSA in the Trust is now being used; this has helped identify more accurate data on likely sources of MSSA infection which has assisted in identifying themes and learning to disseminate to all staff. During 2016/17 almost 50% of Trust-apportioned cases were thought to be related to IV devices. This differs from the national picture however provision of data on the source of the bacteraemia is voluntary and information was submitted for only 30% of the cases. There has been a specific focus on promoting best practice in relation to ANTT in all practitioners who perform aseptic procedures, including training and assessment for medical staff ANTT competence. This will continue during the forthcoming year.
- A Task and Finish Group has reviewed the document for recording insertion and ongoing care of peripheral cannula and this is about to be launched Trust wide.
- Peripheral Cannulation Packs have been piloted and the procurement process is in progress to introduce across the Trust.
- An options appraisal paper is in progress to consider the benefits of increasing the current Trust guidelines on antiseptic washes.
- PHE data for total numbers of cases and rates of *E.coli* bacteraemia also demonstrates an increasing trend reported by NHS Trusts in England. The national data for 2015/16 indicates in over 45% of cases the primary source was noted as UTI however this has decreased from previous years. For the forthcoming year, the Microbiologists will review the risk factors for each case to assist in targeting resources where cases are deemed to be potentially avoidable.
- The IPC and Continence Teams continue to work together to promote best practice in relation to urinary catheter care. A new urinary catheter care pathway, which includes the HOUDINI framework, reinforces key elements of practice and actively promotes the review and prompt removal of urinary catheters.
- The SIRM process has changed to focus more on reviewing actions identified at RCA to prevent HCAI, rather than being a forum for reviewing the clinical details of each individual case. Each Directorate now has a slot every few months (at an agreed interval) and will provide a progress update on what has been put in place in response to RCA findings. Individual meetings will still be held for MRSA bacteraemia and *C. difficile* deaths as detailed above.
- Antibiotic stewardship is a standing agenda item at IPCC and a policy underpinning the core principles is now in place. A new phone app for antibiotic guidelines has been introduced across the Trust from August 2016. Antibiotic Leads have been appointed in the majority of medical specialties to lead on audit work. A number of the champions attend the Antimicrobial Steering Group meetings on regular basis to have input into the audit process. Pharmacy undertakes quarterly ward usage audits to demonstrate trends and will implement an annual Trust-wide prevalence audit. As part of a CQUIN, antibiotic review at 72 hours is being audited; there is a focus on reducing total antibiotic usage and use of Tazocin and Carbapenems.

## Priority 2 - Sign up to Safety

In 2015 the Trust signed up to the three year National "Sign up to Safety" Campaign which aims to save 6000 lives and reduce avoidable harm by 50% by 2018. By 'signing up to safety' the Trust has pledged to undertake work in relation to five patient safety priorities. The first year of the project was dedicated to the collection of baseline data, vital in helping to assess the success of improvement interventions; year two has focused on the implementation of interventions and year three will focus on measuring the impact of the changes in practice. During the second 12 months April 2016 to March 2017 progress has been made in each of the priority areas as detailed below.

By signing up to this campaign a number of important Trust developments have been promoted and monitored throughout the Campaign.

## Safety Culture

The promotion of an open learning culture has been a central component of each priority area. Safety culture has been measured through staff safety culture surveys in 2012 and compared to 2016. Significant improvements have been observed in a number of ways. The staff ratings of overall patient safety grade reported as 'very good/excellent' rose from 68% (2012) of staff to 73% (2016) of staff. Of the 42 questions within the survey 28 had improved significantly (statically tested using the Chi-squared test). Some of the survey questions focussed on learning and continuous improvement showing a significant improved position for example more staff were in agreement with the following statements:

- 'We are actively doing things to improve patient safety' from 77% agreement (2012) to 80% (2016)
- 'Staff feel free to question the decisions or actions of those with more authority' from 47% agreement (2012) to 58% (2016)
- 'After changes to improve patient safety, we evaluate their effectiveness' from 56% agreement (2012) to 60% (2016)
- 'We discuss ways to prevent errors from happening again' from 75% (2012) agreement to 80% (2016)
- 'We are given feedback about changes put into place based on incidents' from 52% agreement (2012) to 66% (2016)

One member of staff wrote the following comment on their survey:

**"I feel that reporting all incidents is high on the agenda of all staff to maintain safety and to ensure we learn from any mistakes Patients are always put first".**

Another staff member stated:

**“The reporting culture is generally a positive one. It is better now that feedback is received re Datix reports”**

### Human Factors

The importance of human factors has been promoted throughout the campaign with the development and implementation of an incident investigation tool using a human factor framework, plus training on human factors. Seven members of staff undertook the Human Factors in Healthcare Organisations post graduate level 7 modules provided by Northumbria University; Health Education Northeast provided a 2 day training course on Human Factors which was also accessed by Trust staff.

### Incident Reporting

Many strategies to increase the reporting of incidents have been used, with the aim of learning from incidents and preventing incidents from reoccurring, including:

- Monthly patient safety briefings
- Increased data-sharing, including summaries of incident data and comparisons between directorates
- Workshops for directorate management and clinical leaders focusing on incident investigation quality, learning from incidents, and the importance of considering human factors
- Construction of a medication investigation tool, focussing on identifying all contributory factors and learning, rather than a person-centred model which attributes blame

### Quality Improvement

Quality improvement methods have been promoted and used within all the Sign up to Safety programmes of work. Some staff have participated in the Postgraduate Certificate in Advancing Quality Improvement in Health and Social Care ran by Teesside University.

- Learning from incidents and mistakes promoted to a standing agenda item on many meeting agendas across the Trust
- The 2016 staff survey results showed that the Trust scored well on the questions around errors and incidents; in particular:
- Staff agreeing that preventative action is taken when errors are reported (scores significantly better than other comparable Trusts).
- Staff saying they are given feedback about changes made in response to errors or incidents (scores significantly better than other comparable Trusts).



## 1. DETERIORATING PATIENT:

- To reduce avoidable harm and death associated with missed opportunities to detect/instigate initial management of the deteriorating patient by 50% by 2018 (*Adults*).

- To reduce the number of episodes of avoidable deterioration leading to PICU admission and/or activation of the resuscitation teams and/or death by 50% in the North East North Cumbria Region by 2018 (*Paediatrics*).

### The eRescue project

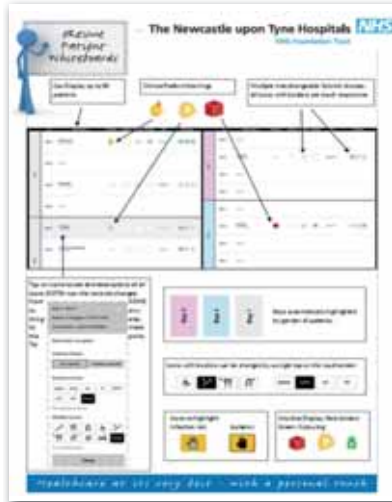
The eRescue project went live on wards 5 RVI (Dermatology) on 28th February 2017 and 20 Freeman (Orthopaedics and Rheumatology) on 28th March 2017 with the first phase of electronic patient whiteboards. These electronic touch screen whiteboards replace the current handwritten whiteboards. It is the first step in a transformative change in inpatient care across the Trust. It uses our existing electronic patient record and displays in real time icons to facilitate patient care. This work has resulted in a real time visually simple and intuitive display that is intended to facilitate patient care at ward level.

Three key clinical patient safety alerts have been included that have a significant impact on patients and high prevalence in the Trust and these are: sugar control, acute kidney injury and sepsis. This is a completely novel approach to improving patient care and aimed at reducing the impact by passively alerting the ward teams with icons that identify in real time risks that will prompt action.

Staff can interact with the touch screen components of the board to update for example mobility, nutrition, discharge transport. The estimated date of discharge has been included as a first step to facilitate the flow of patients across the Trust. These developments have been very positively received by ward staff and a formal evaluation is now underway. The project will be rolled out to the remaining 80 wards, in the scope of the project during May to October 2017.

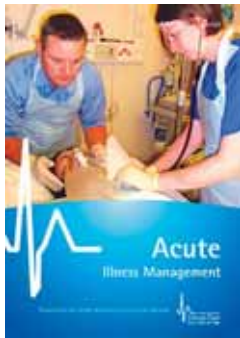
### E Rescue Patient Whiteboard

The development team are into the second phase of the project focussing on electronic observations. Expected implementation of the electronic observation charts is from August 2017 and will include Adult, Paediatric and Obstetric wards. It is anticipated given the scale of the change this roll out will take 18 months.



Example of an E Rescue Patient Whiteboard

### Training on Deteriorating Patient



To improve the quality of Basic Life Support (BLS) training 8 Quality Cardio Pulmonary Resuscitation (QCPR) manikins have been purchased to give real time feedback on this essential skill. It will allow the automation of some BLS training and free up training resource to start to increase the training for staff to care for deteriorating patients. Staff have been trained to deliver the Acute Illness Management Course and will be trialled in June 2017. Once evaluated a decision will be made on the most appropriate way to increase training of the nursing and junior medical staff on the initial assessment and management of an acutely deteriorating patient across the organisation.



QCPR Manikin

**“All staff that worked throughout my stay were excellent in everything they did and were always able to talk if I ever I needed them.”**

### Ward Based Champions

The deteriorating patient champions on each ward have continued to demonstrate through audit, good compliance with observations and early warning scores, running consistently in the 80-90% range. The total number and severity of unplanned intensive care admissions remains static at 68 admissions per month with an average predicted mortality of 20.6% at the RVI and 50 unplanned local admissions per month with an average mortality of 29.2% at the Freeman, reflecting the different case mix of patients in both sites. These metrics will continue to be monitored at ward level as the eRescue project rolls out over 2017 and 2018.

### 0-3 Months

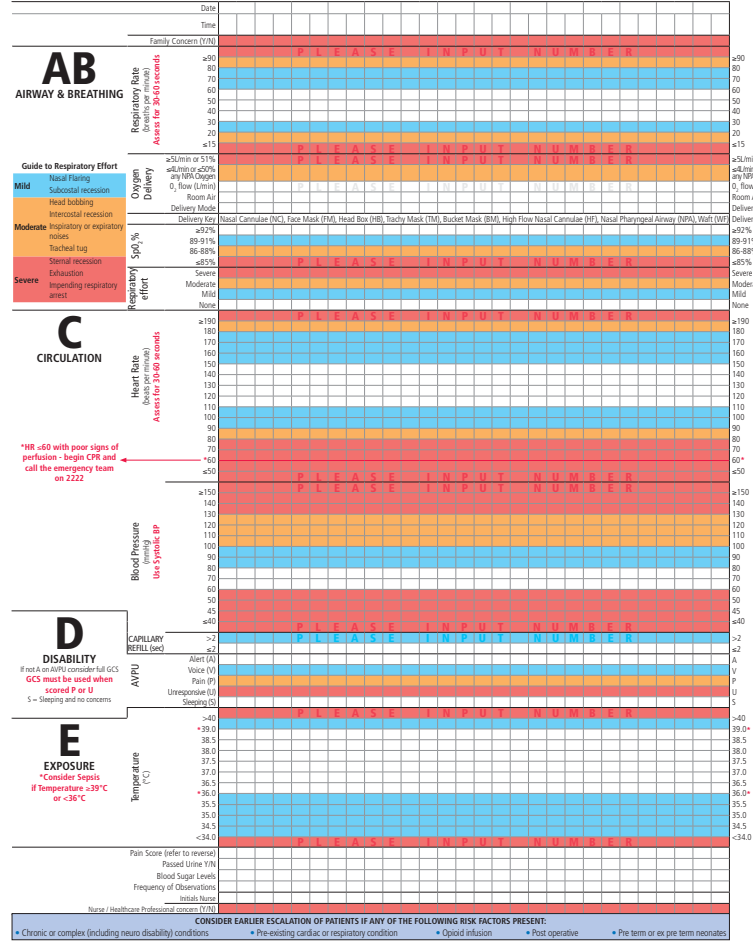
Weight:  Risk Key: LOW MED HIGH

Consultant:

Amendments to PEWS parameters (T = Temporary P = Permanent)			
TP	Clinical Parameters	Acceptable Range	Date / Time

At the patient identification label in box below or complete details

Surname	
Forename	
Address	
Sex	Male / Female
Postcode	



## Paediatric Early Warning system (PEWS)

The new PEWS system has been piloted and was implemented across the Great North Children's Hospital (GNCH) in May 2016. The PEWS system incorporates parental and nursing concern as 'red flags' and this has attracted national interest. The views of young people were taken into account via the Young People's Advisory Group (YPAG). Their concern focused on the availability of an integrated pain scoring system.

The PEWS reflects The Newcastle upon Tyne Hospitals and GNCH values of patient centeredness. Special consideration was given to enabling staff to speak up about their concerns in an ISBARD communication tool (Identification, Situation, Background, Assessment, Recommendation and Decision). The ISBARD tool requires a further Plan Do Study Act (PDSA) cycle to embed in the escalation process. User feedback has revealed it to be too cumbersome and a simpler format is in development.

The use of the charts and communication tool is audited at several levels: bimonthly in collaboration with the Clinical Governance and Risk Department (CGARD), monthly as part of the CAT tool and until end of 2016 during the embedding process also weekly by the ward based PEWS champions. These audits show increasingly engagement with the new system and near universal compliance for most of the items. Special emphasis has been placed on blood pressure monitoring and documenting parental concern. Further work is required to better understand how to have a dialogue about parental concern.

In collaboration with Vocare, Northern Doctors and the regional RESILIENCE project a parental leaflet has been developed, co-designed with parents to pilot noting parental observations about their child and enabling their voice to be heard as part of safety netting.

During winter 2016-2017 all paediatric arrest calls and all unplanned PICU admissions were examined to elicit deeper understanding of the escalation process. This cohort of children consisted mainly of infants with bronchiolitis. The recognition of clinical signs and symptoms requiring escalation to PICU was appropriate, which is reassuring. Further work is underway in the early Spring of 2017 in order to capture children with other diseases.

At the Freeman Hospital site the cardiac specific PEWS has been developed and implemented. The cardiac specific PEWS tool is an innovative development in the identification of the deteriorating child. Specifically it takes into account cyanotic and non-cyanotic heart disease and cardiac specific signs and symptoms.

The description of the PEWS training strategy and package won first prize in the regional Great North Paediatric Conference poster competition.

The SAFE morning ward huddles were piloted on ward 10 (Orthopaedics) and ward 1b (Neuro) in an attempt to customise the Royal College of Paediatrics and Child Health (RCPCH) SAFE (Situation Awareness For Everyone) program to GNCH needs. These safety ward rounds are being evaluated for staff perceived utility and uniquely the paediatric physiotherapists have engaged in a ward compare and contrast evaluation, to better understand what works well. With a change in junior doctor working arrangements, an adaptation is required, which will focus on brief safety board rounds in preparation for electronic boards.

## 2. MEDICATION SAFETY:

- To reduce avoidable harm and death from medication errors by 50% by 2018.

The objectives for medication safety are to:

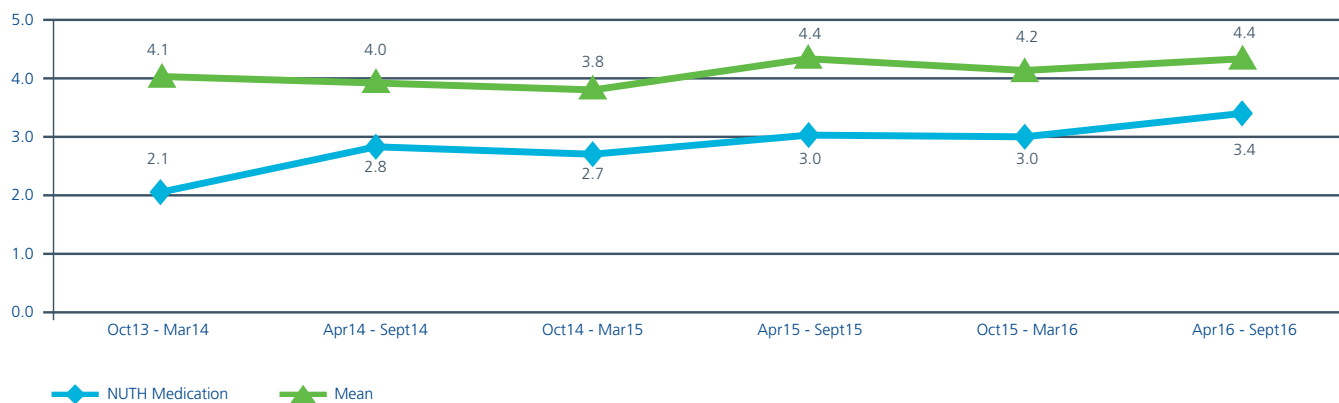
- Increase reporting of medication errors by 10%.
- Increase reporting of medication errors to national average.
- Implement Trust wide robust investigation & learning systems.
- Reduce avoidable harm from high risk medicines.

### To increase reporting of medication errors

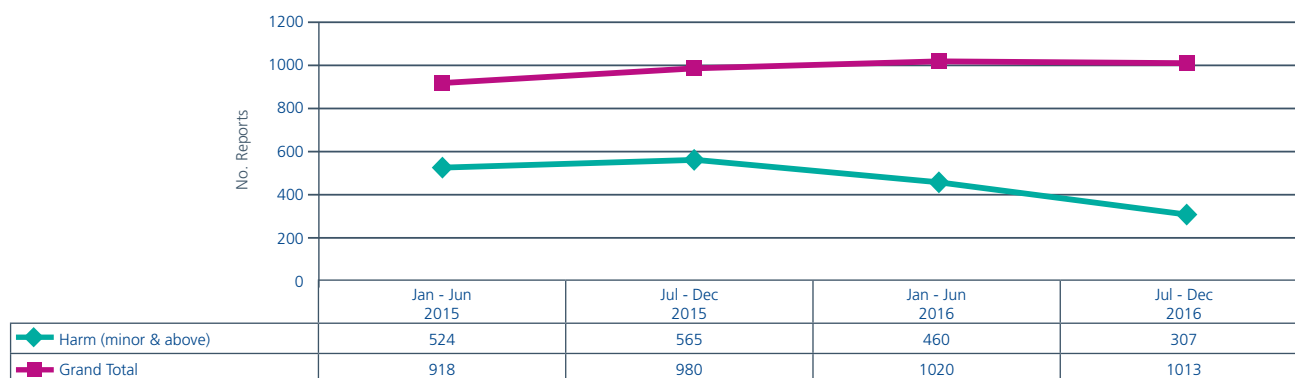
The objective to increase medication incident reporting was set to encourage medication incident reporting by staff who often feel afraid to report. Increased incident reporting increases the opportunities to learn from the situations, with the overall aim of sharing lessons and prevention of reoccurrence in the future.

Medication incident reporting data is published every 6 months by the NHS National Reporting and Learning System. The graphs below show that medication incident reporting rates are continuing to increase and harm is decreasing. Peer group is Acute (non specialist) organisations in England. The green line identifies the mean measurement.

NRLS Medication Reporting Rate / 1000 Bed days NUTH vs Peer Group mean & median (Oct13 - Sept16)



Trend of ALL medication incident reports and harm



### Medication Incident Investigation Tool Development

A tool that aids investigators in the identification of causal factors of medication incidents is now used throughout the Trust. It is recommended that the tool is used for all moderate and above incidents and for all near miss incidents that had the potential to cause significant harm. The tool was evaluated and feedback from users has been very positive (see table below).

	Yes	No	Neither
I found the tool easy to use	92%		8%
I feel that the tool is too detailed	8%	84%	8%
I feel that the tool takes too long to complete	8%	92%	
The tool helps me to identify root causes easily	100%		
The tool helped me to identify more root causes than I may have without it	100%		
Using the tool has improved the incident investigation process	91%		9%
Using the decision tree helped me to decide what action to take next	75%		25%
I would recommend the tool to other investigators	100%		



## Medication Safety Thermometer

The Medication Safety Thermometer is a national measurement tool for improvement. It focuses on medicines reconciliation by a pharmacist, allergy status, medication omission and identifying harm from high risk medicines. Data has been collected for four wards as part of a national pilot for 2 years and work has been carried out within those ward areas to improve results. A focus on omitted doses has led to more appropriate recording of omitted doses within these areas. In order to raise Trust-wide awareness of omitted doses a revised critical medicines list has been produced and published on the internet and a medication safety bulletin circulated to all staff to remind them of the importance of not missing doses.

**“I was treated with respect and a professional care which I feel could not be bettered.”**

## High Risk Medicines

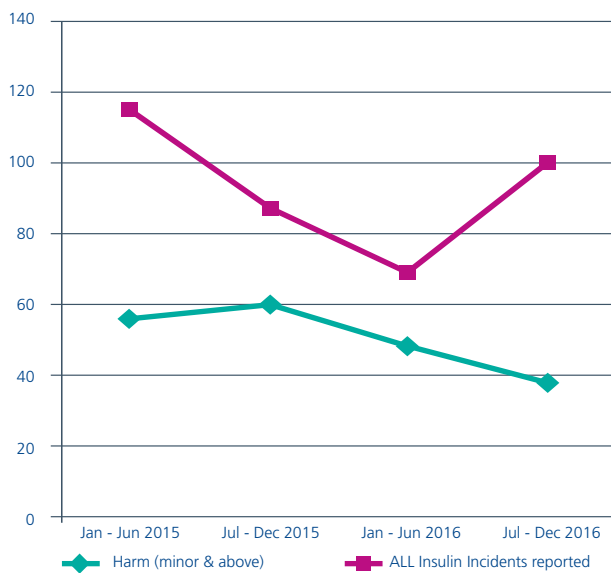
The focus has been on the following high risk medicines: warfarin, insulin, direct acting oral anticoagulant drugs (NOACs) and disease modifying anti-rheumatic drugs (DMARDs).

A number of improvement interventions have taken place and are continuously being refined and developed to reduce harm, these include:

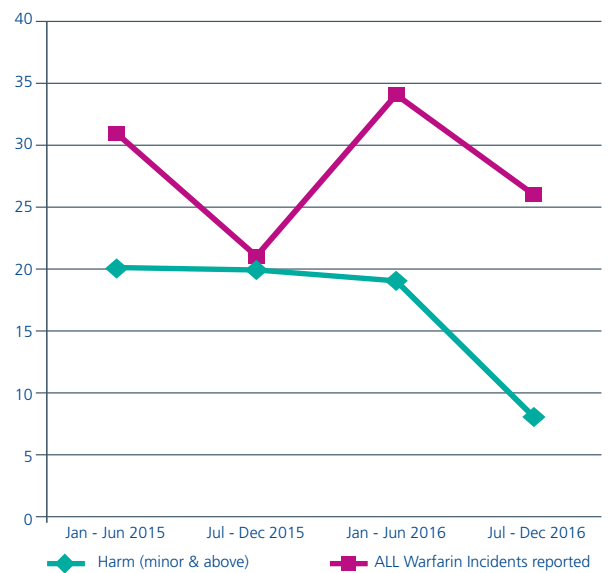
- ‘Establishment and review of insulin e-prescribing
- ‘Continuing education on the use of direct oral anticoagulant drugs (DOACs) for doctors and pharmacists
- ‘Development of new Trust Hyperkalaemia Guidance
- ‘Implementation of an electronic system for monitoring DMARD patients
- ‘Additional DOAC frequently asked questions guidance to the Trust intranet for reference
- ‘Development of an Insulin Always Event as part of a NHS England pilot is currently in the very early stages.

The graphs below show the numbers of incidents reported and the levels of harm associated with the incident. Generally reporting has increased which provides opportunities for learning and improvement and the level of harm for all three has decreased.

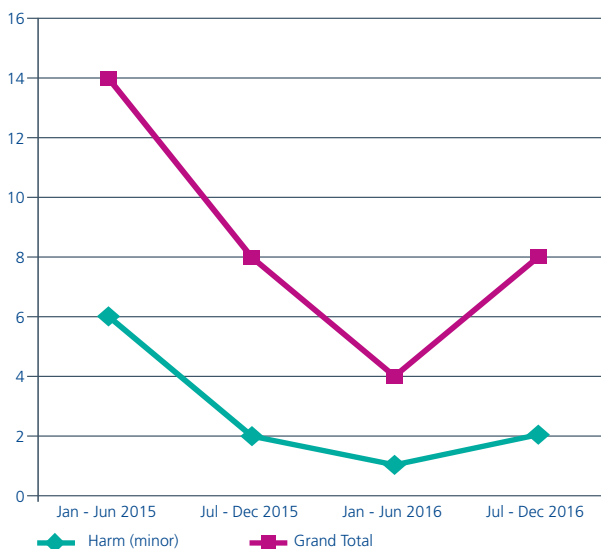
High risk medicine: Insulin incident profile



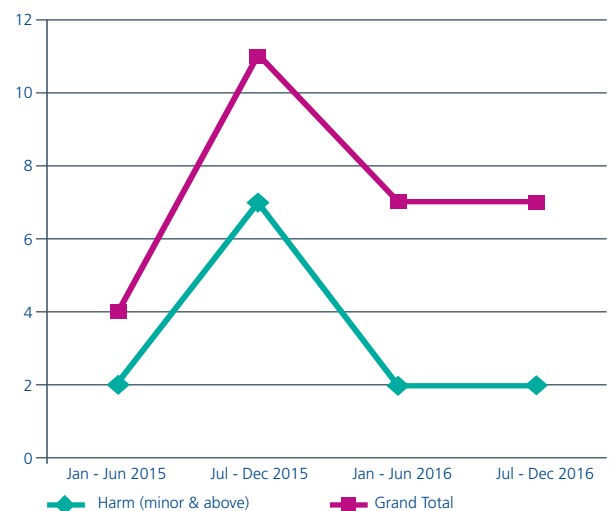
High risk medicine: Warfarin incident profile



High risk medicine: NOAC's incident profile



High risk medicine: DMARD incident profile



## Increasing Awareness of Medication Safety in order to improve reporting

The following improvements have been implemented.

- Development of a 30 minute medication session for preceptee nurses and theatre staff at induction, first delivered October 2016 and to be included in every induction thereafter.
- The establishment of ward medication safety walkabouts. These are in the early stages of development but will give the ward staff the opportunity to discuss their medication safety concerns with the Medication Safety Officer.
- Cleansing of Trust data prior to submission to the National Reporting and Learning System (NRLS) to ensure that it is accurate and appropriately graded.
- Distribution of a monthly Medication Safety Bulletin "Report! Learn! Improve" (please see example below)!

### 3. SEPSIS:

- To improve early detection and initial management of the severely septic/septic shocked patient by 50% by 2018 (*Adults*).
- To reduce the numbers of children treated inappropriately for sepsis by 50% by 2018. (*Paediatrics*).

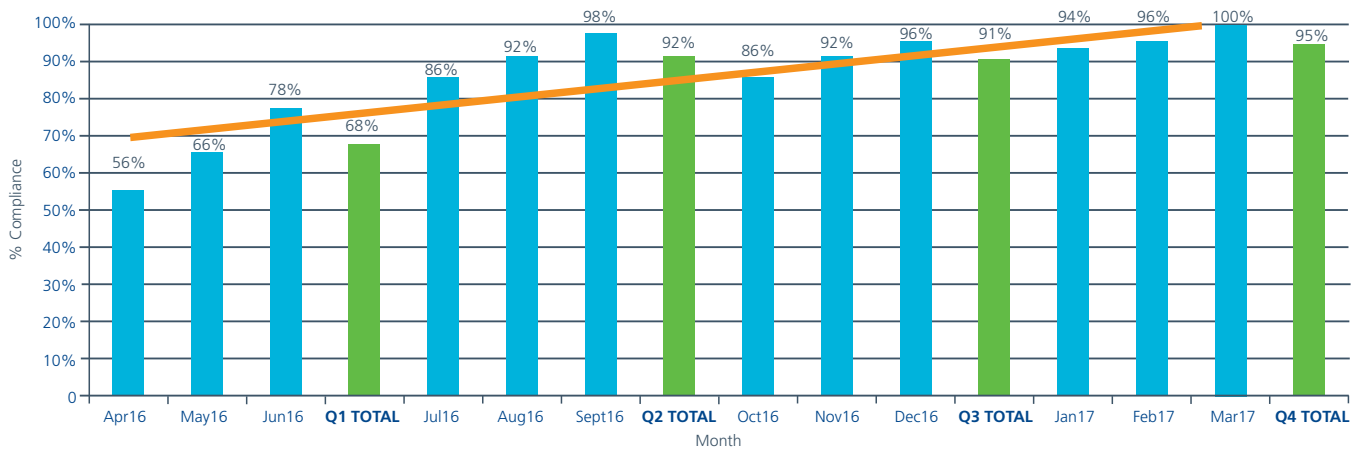
The objectives for Sepsis are to:

- Improve Monitoring
- Improve Recognition
- Improve Communication
- Improve time critical response

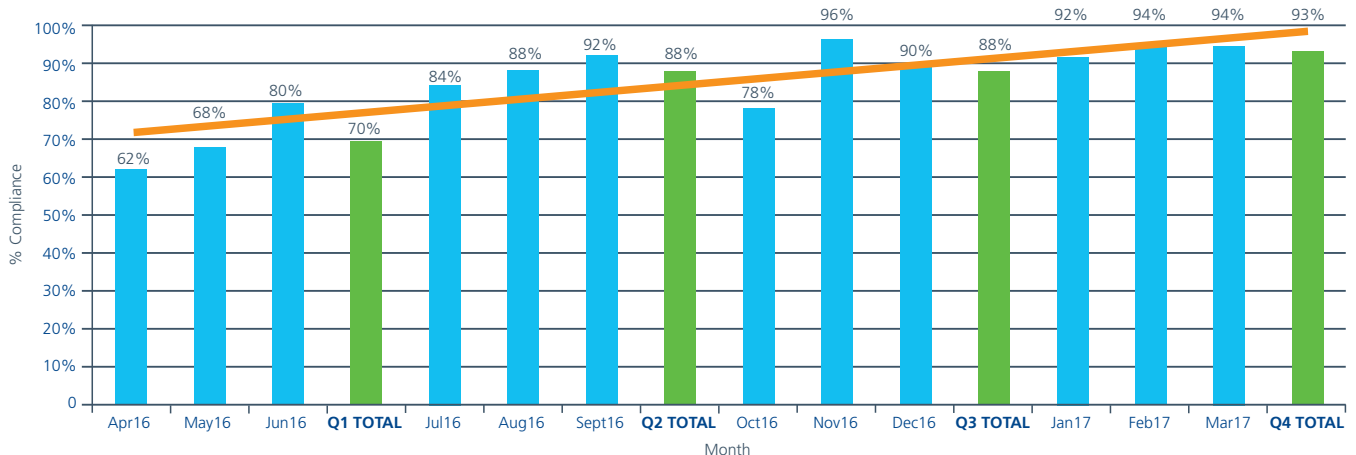
This has been an exciting year for the Trust's Sepsis programme. Significant improvements have been made in the monitoring, recognition and treatment of sepsis. At the start of 2016 an audit undertaken across the Trust showed room for improvement; rates of sepsis screening in A&E were 56% and for all inpatient wards 62%. As demonstrated in the graphs below these rates have improved significantly during 2016/17.



#### Sepsis Screening Compliance in A&E

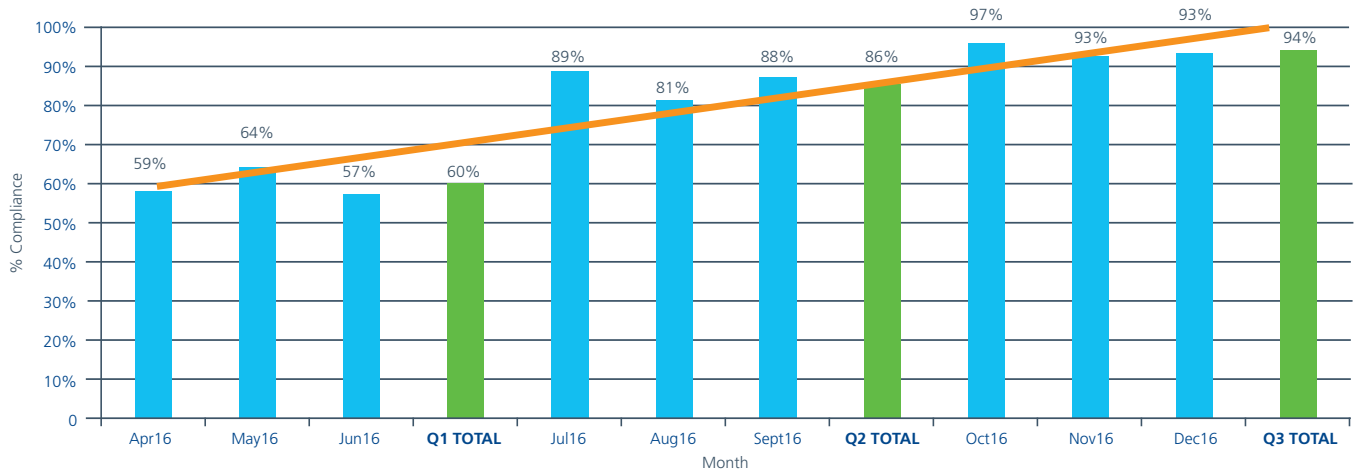


#### Sepsis Screening Compliance - Inpatients

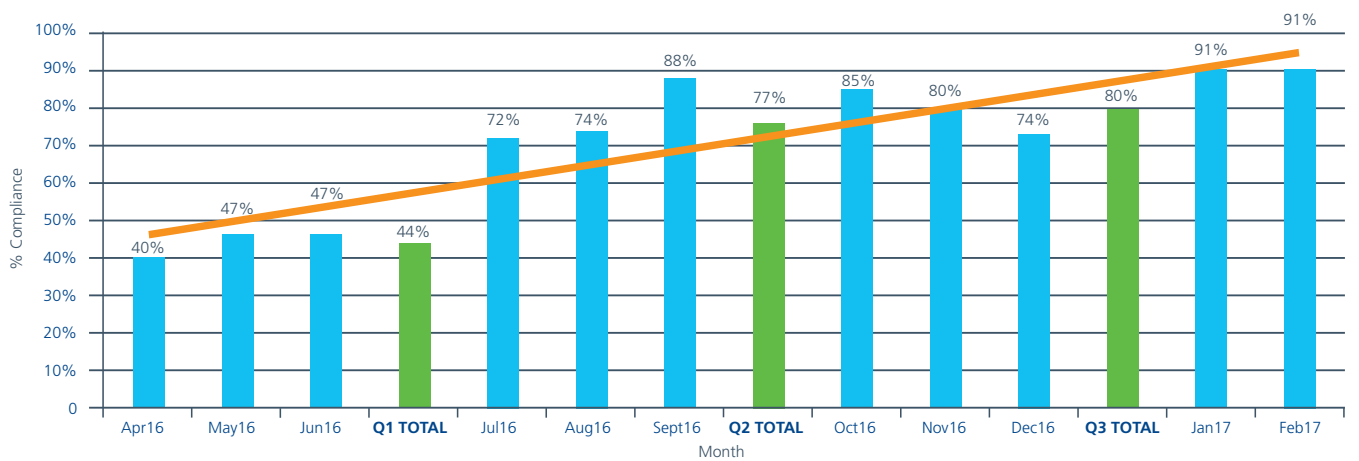


Along with improving screening/recognition we aimed to increase the rates of patients who, once diagnosed with sepsis, received their antibiotics within 60 minutes. Again significant progress has been made in both A&E and inpatient wards.

### Antibiotics in 60 mins (A&E)



### Antibiotics in 60 mins (Inpatients)



These changes have been made possible following the introduction of an online prescribing package helping staff to prescribe antibiotics and other elements of the 'Sepsis 6' quickly and efficiently. A comprehensive training package has also been delivered to all staff; key to this has been a training video that introduces all staff to the importance of sepsis, the recognition of 'Red Flag' sepsis and how to effectively treat sepsis using the 'Sepsis-6'. The film can be accessed by all staff and has been placed on the Trust's YouTube channel – to date there has been over 2000 views. In addition over 4000 prompt cards have been given to staff. These cards can be kept inside their ID badge holders and again are designed to remind staff of the signs, symptoms and treatment options for sepsis.





## Paediatric Sepsis

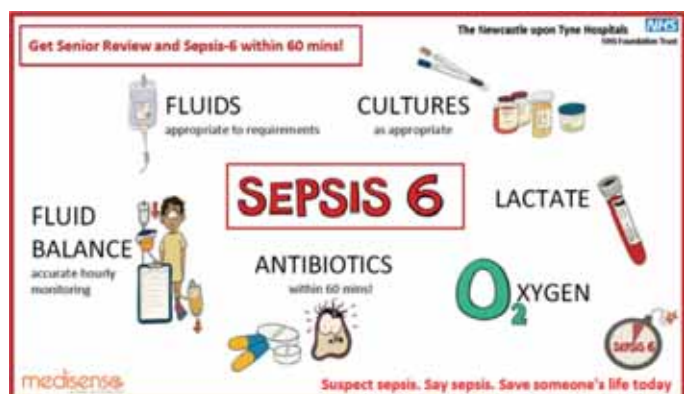
In the wake of the deteriorating child PEWS process, the paediatric sepsis process is well underway. The strategy has been to co-design a sepsis screening and action tool for use in A&E and the Paediatric Evaluation & Assessment Unit. This tool has been piloted and rolled out as of April 2017. This tool incorporates nursing and parental concern as 'red flags' as well as early senior review and decision making. The expectation is that non physiological signs will thus be easier heeded and earlier appropriate action instigated.

Three paediatric sepsis videos have been released for education and awareness in co-design with parents and the Newcastle University Centre for Film and Digital Media and a further two are available for in house learning. The films have been shown at national and regional meetings to great acclaim (October 5, AHSN NENC Patient Safety and Quality Improvement in the North East and North Cumbria, Gateshead; Sepsis unplugged 13-14 October, Brighton).

A paediatric sepsis toolkit has been developed and implemented. This toolkit includes an updated antibiotic policy, lanyard aide memoir card, paediatric sepsis awareness posters, e-record paediatric sepsis bundle, and paediatric sepsis spot teaching and incorporates simulation training.

In collaboration with Northeast Quality Observatory (NEQOS) and the Academic Health Science Network RESILIENCE project a regional definition and data process is in the final stages of development. The expectation is that the uncommon yet potentially devastating paediatric sepsis will be tracked regionally and will enable shared learning and agreed pathways. This region-wide data starting in April 2017.

The ongoing measurement plan includes continued auditing of compliance with PEWS, sepsis tool and 2222 calls and unplanned admissions.



## 4. SURGICAL SAFETY:

- To minimise never events.
- To reduce harm associated with post-operative care of patients undergoing spinal surgery, by 50% by 2018.

During 2016/17 the Surgical Safety Intra-operative group has continued to focus on maintaining compliance with World Health Organisation (WHO) Surgical Checklist in the main operating theatres and the development of Local Safety Standards for Invasive Procedures (LocSSIPs) for non-theatre areas where invasive procedures are carried out.

Audit of the World Health Organisation (WHO) surgical checklist compliance across all Theatre areas consistently achieves between 90-100% in all areas. Good practice and areas for improvement are shared via Theatre Users Group with all theatre staff.

In addition to auditing the WHO checklist compliance, a Surgical Behaviour Observation Tool was developed and tested during January and February 2017 to systematically observe 24 Theatre sessions. This confirmed the findings of the WHO Checklist Audit that most theatre staff were observed to follow best practice. The main area identified for improvements was with the surgical Team Debrief.

- To reduce adverse incidents associated with elective surgery in the diabetic patient by 50% by 2018.
- To reduce spinal surgery infection rates to <1% by 2018.

The purpose of the "Debrief" after a theatre list is for the team to reflect on the day and identify best practice and issues that need to be improved. However, it is acknowledged that on occasions some theatre staff leave before the end of a full list so a Debrief tool was developed and tested whereby feedback is collected throughout the day after each procedure. The completed forms are analysed to identify any themes that need to be addressed. So far this has been well-received and it is therefore being rolled out to all three theatre areas.

Progress has also been achieved with the development of Local Safety Standards for Invasive procedures (LocSSIPs). A LocSSIP for Pleural Procedures has been developed by the Thoracic team and will be shared nationally as an example of good practice. Radiology; Dental and Dermatology are all in the process of drafting their local Standards. These areas were chosen primarily due to high volume of activity and the potential risk of Never Events.

## Never Events

In 2016/2017 Newcastle Hospitals reported 8 Never Events in the following categories. This is an increase of 5 Never Events compared to the 3 reported in 2015/2016.

- 2 retained swabs
- 1 wrong tooth extraction
- 2 wrong side blocks

NHS England defines 'Never Events' as "serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented". According to the NPSA a Never Event must, among others, fulfil the following criteria: there is existing national guidance and/or national safety recommendations on how the event can be prevented and support for implementation, and the event is largely preventable if the guidance is implemented.

The Trust takes its responsibilities extremely seriously in providing high quality care to patients. Never Events are rare but in such circumstances, a thorough and detailed review is undertaken, and acted upon accordingly. Any recommendations and lessons learned are widely shared across the organisation in a timely fashion, and necessary safeguards put in place.

The increase in the number of never events reported in 2016 directly relate to the changes in never event definitions made in 2015, and in particular the removal of the requirement for an outcome of serious harm or death.

A substantial proportion of the never events occurring – as a consequence of the modification of the criteria in 2016 – have resulted in the increase particularly with the inclusion of dental and local anaesthesia blocks, which in isolation do not result in patient

- 2 wrong site surgical interventions
- 1 wrong route drug administration

harm. A number of the Never Events reported by the Trust in 2016 would not have been reported under previous criteria.

Crucially, none of the patients involved in the 8 Never Events that occurred in this Trust died or suffered permanent harm as a result.

The Newcastle upon Tyne Hospitals NHS Foundation Trust performs circa 80,000 surgical procedures annually and includes a Dental Hospital.

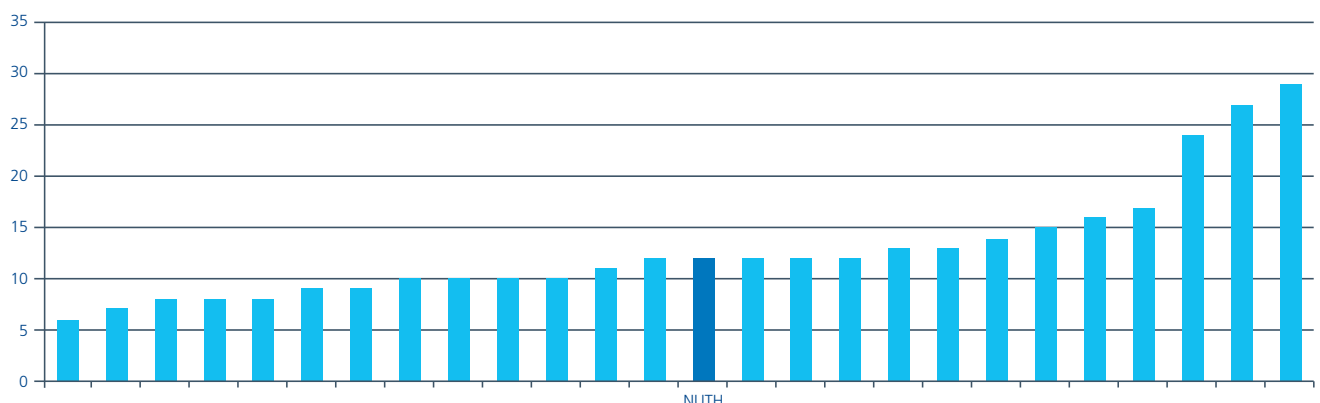
The CQC acknowledged in their inspection of the Trust in January 2016, in which it was rated as "Outstanding", that no other Trust in England performed more surgical procedures.

Never Event data is often reported simply as a crude number; this is a somewhat unique scenario within the NHS given the great lengths taken to risk adjust other key safety indicators - death rates being the obvious comparison.

If this data is examined simply by the total number of Never Events reported, approximately half of those reported over the past three years have occurred in the large acute teaching hospitals (see figure 1) with Newcastle Hospitals falling roughly in the middle of the group with 12 Never Events occurring over the period reported (the average for large teaching hospitals in the UK was 12.8, with 334 reported in total).

Figure 1: Total number of Never Events reported by large, acute teaching Hospitals. April 2014 to February 2017

TOTAL Never Events - Large Acute (2014/15 - 2016/17)



## Expressing Never Events as a Rate

Whilst it is difficult to calculate a denominator to successfully express the number of Never Events as a rate (with surgical activity as a denominator) it is not impossible. Following guidance from the data experts at Healthcare Evaluation Data (HED) based at University Hospital Birmingham we have managed to express the data as a rate using the OPCS Classification of Interventions and Procedures codes. Whilst we acknowledge that this approach is not perfect (minor procedures and scans etc. are included) we believe that it gives a proxy to the level of surgical activity undertaken by a provider.

Again using the large acute teaching hospital group it is clear that rates of Never Events occurring within organisations are extremely small. Rates at NUTH are below the average for the large providers in the UK, although statically within expected limits (see figure 2).

When compared to the Shelford Group (figure 3) and regional providers (figure 4), Newcastle Hospitals are in a similar position; below average and falling approximately within top 30% of providers.

Figure 2: Rates of Never Events reported by Large Acute Teaching Hospitals. Denominator: Total number of activity undertaken including an OPSC code. April 2014 to February 2017

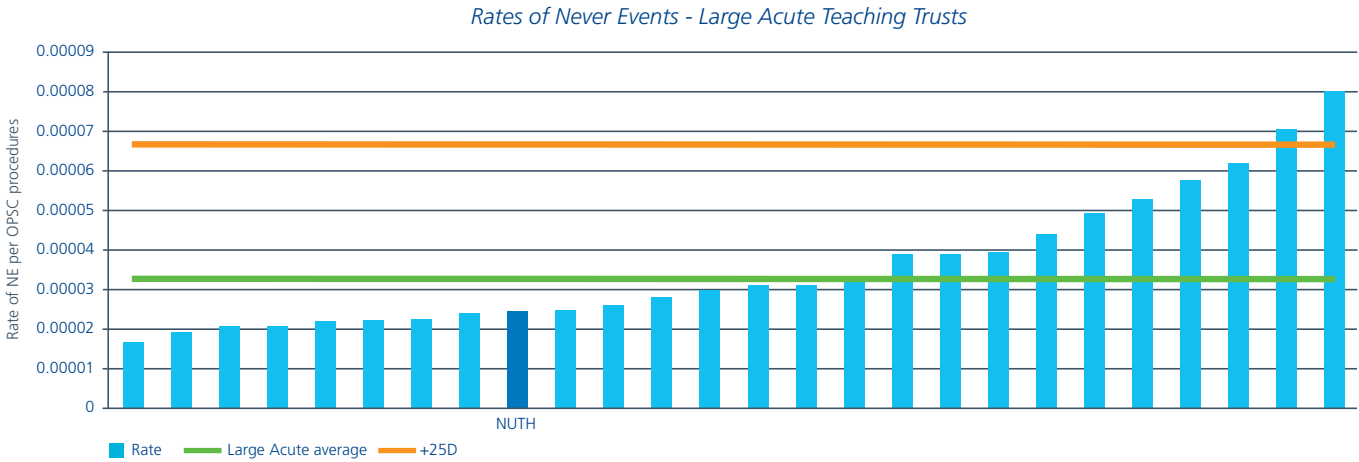


Figure 3: Rates of Never Events reported by Shelford Group Members. Denominator: Total number of activity undertaken including an OPSC code. April 2014 to February 2017

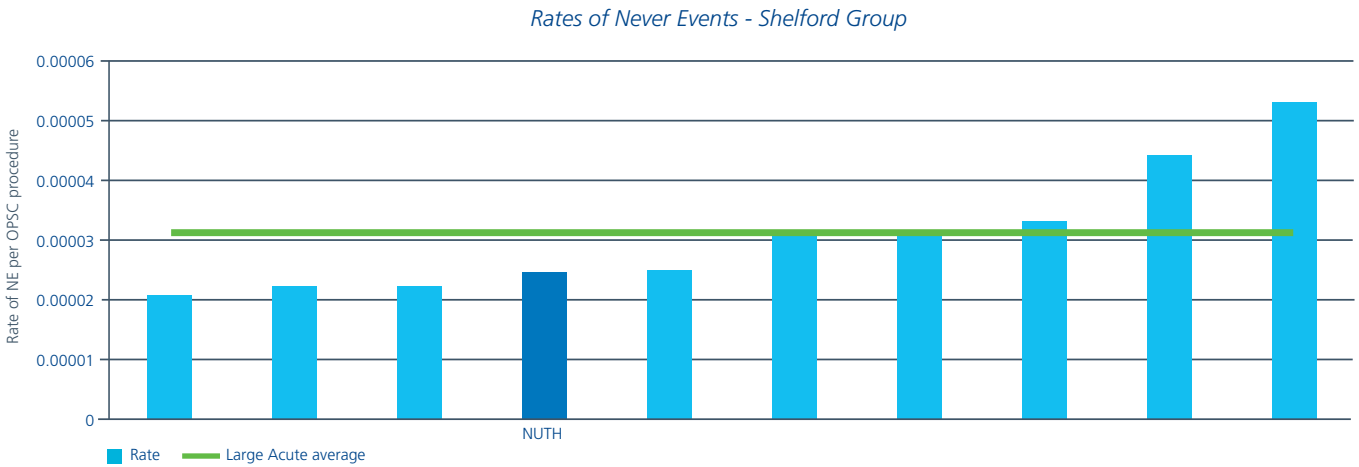
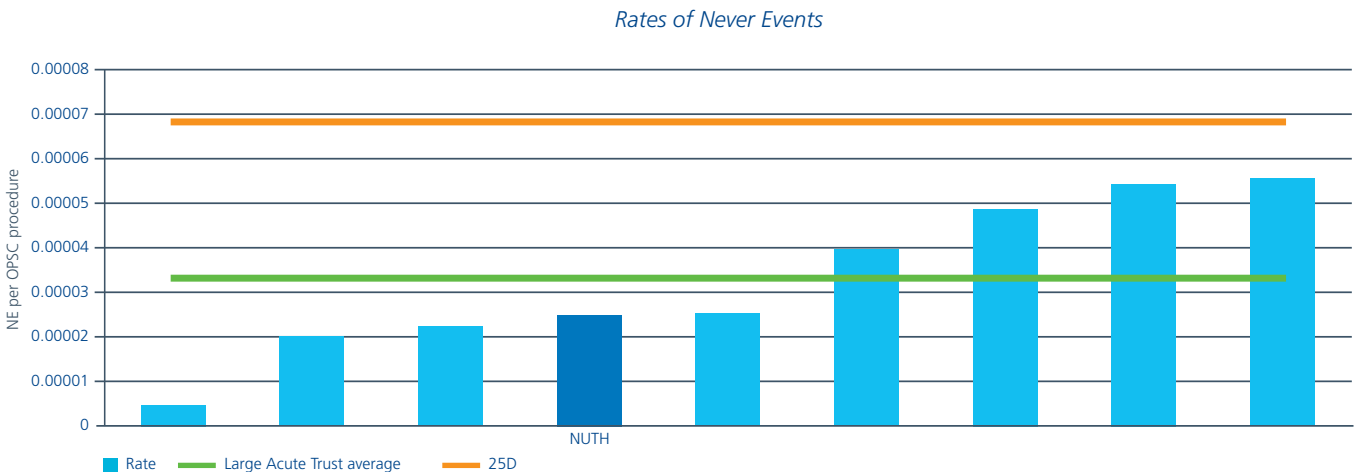


Figure 4: Rates of Never Events reported by North East & Cumbria Providers. Denominator: Total number of activity undertaken including an OPSC code. April 2014 to February 2017



Rates of Never Events at Newcastle Hospitals are within expected levels when compared to peers as either a crude number or when expressed as a rate of procedures undertaken. Irrespective of this, a large research study comparing the number of Never Events reported by provider and a wide variety of patient safety outcomes found that the only factor in predicting the number of Never Events was the size of the organisation (i.e. the number of procedures they had conducted). There was no correlation between high rates of Never Events and poor quality care.

## Surgical Consent

To improve the compliance with surgical consent and in particular to improve the necessary knowledge and behaviours of those obtaining consent, a proposal was developed to gain support to develop two training videos primarily aimed at consultants taking consent for surgical procedures. Other clinicians and junior doctors in training taking consent for treatments and procedures should also find this a helpful resource. The key steps covered in the video are:

- Background, why important, changes due to Montgomery case (the outcome of which states that Informed consent is a fundamental principle of health care: anyone receiving medical treatment must agree to undergo that treatment).
- When and where to consent
- Risks and benefits (discussion, tailoring to individuals, checking understanding)
- Using supporting information
- Documentation

The first video has been designed by three consultant surgeons, an anaesthetist and a junior doctor. The video displays the good practice principles for taking consent and the plan is to develop a second video which will cover taking consent with children and patients without mental capacity.

A one page easy to follow 'flow chart' of key steps in the consent process has been developed and agreed, it summarises important information for staff and it also forms part of Trust Policy for consent.

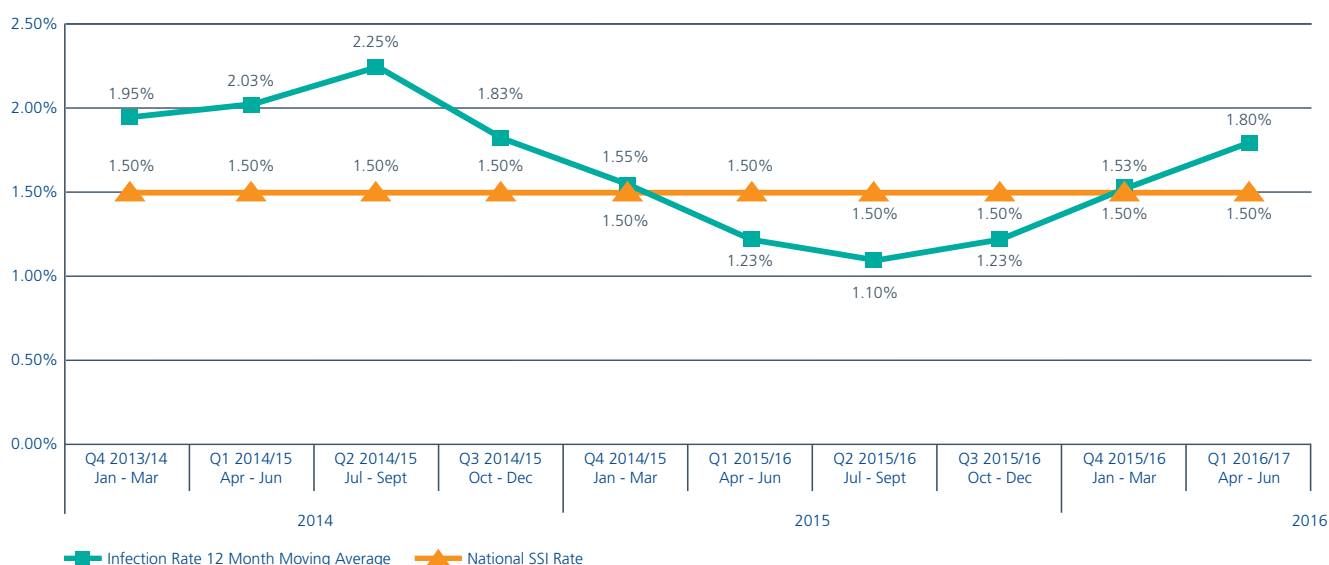
A review of patient information leaflets is underway with the collation of those in use in the Musculoskeletal Directorate. Currently they are being refined to ensure they are available for all surgical operations and in a consistent format with relevant content.

**“We have continued to focus on the trust’s key priority – putting patients at the heart of everything we do.”**

## Spinal Surgical infections

The incidence of spinal surgical infection is externally audited and reported quarterly (see graph below). The Trust incidence is higher than the national average (1.5%) at 1.8-2.8%. The incidence for neurosurgical patients was 2.2% and orthopaedic patients >4%, acknowledging their different caseload mixes. A variety of interventions have been implemented to reduce infections, including: rigorous Root Cause Analysis (RCA) for each infection case and regular feedback to staff of RCA leading to raise awareness of the issues. In addition, a thorough review of the full surgical pathway from pre-assessment to post discharge was undertaken by the multidisciplinary team involving: surgeons, microbiologists and infection prevention and control team. Changes to practice were agreed and implemented (please see diagram below of the bundle of interventions agreed).

Spinal SSI Infection Rates (NuTH and national)





## Spinal Surgery infection prevention bundle

### Pre Operative Infection Preventative Bundle

- Assessment of patients at risk
- Chlorhexidine Back washes pre-operatively
- MRSA eradication treatment for patients
- Patient information re importance of IPC

### Intra Operative Infection Prevention Bundle

- Antibiotics >30 mins prior to incision as per trust guidelines
- Strict adherence to theatre dress code and masks to be worn
- Maintain temperature, glucose levels, oxygen levels
- ANTT
- 4% Chlorhexidine wash prep and draping
- 2% chlorhexidine skin prep
- Skin preparation and hand hygiene
- Application of surgical dressing

### Post Operative Infection Prevention Bundle

- Maintain temperature
- Non disturbance of the surgical dressing for 48 hours
- Hand hygiene
- Antibiotics guidelines for infection

In addition to consistent practice as per these bundles of care, attention has been given to a number of quality improvement interventions:

1. Trust investment to provide a 'Day of Surgery Arrival' area within Ward 42 to facilitate pre-operative skin washes and separation from the main inpatient area to maximise infection prevention and control standards. This will enable the orthopaedic ward standards to match those of neurosurgery.
2. Robust engagement by the whole theatre team with the operating department 'team briefing' at the start of every list and the WHO checklist. This is to enable all members of the team to be fully aware of any issues and improve team working.
3. Strict adherence to theatre dress code, minimisation of theatre traffic and no ward beds to be taken into theatre (unless patient safety issue).
4. Recruitment and retention of theatre staff to provide a stable skilled workforce.
5. Regular bimonthly meeting of the multidisciplinary team to review real time audit of spinal surgical infections cases and audit of the changes along with a continual review of the surgical pathway.
6. Learning from Root Cause Analysis of infections will be themed and communicated to all clinical staff in the department.
7. Behavioural audits of theatre team working will be undertaken on a six monthly basis.



## Making Surgery Safer for Patients with Diabetes

Within this SU2S work stream, a multidisciplinary team including diabetology, surgery and anaesthesia, has implemented documentation to guide the management of all surgical patients with diabetes. These guidelines are for elective and emergency patients to improve their safety and quality of care. A number of other quality improvement interventions have been implemented including: E-prescribing for insulin prescribing and administration, the recruitment and establishment of four Diabetic Specialist Nursing posts to provide backup advice and assistance to wards. In addition an alert page for patients on insulin, anticoagulants, steroids or known allergies is being piloted on four wards. This document is placed at the front of the patient's bedside folder which contains the observation chart and nursing care plans, so staff attending the patient in a crisis has the visual trigger when urgent escalation of care is required. The role of the Diabetic Nurse

Specialist has been vital to this project and has been very patient focussed, especially on the highest risk wards such as vascular and pancreatic surgery. Future work will be to update the diabetes management skills of the permanent ward staff including nurses and doctors, using the established diabetes link nurse structure and the development of an educational project.

Monitoring of this quality improvement has been undertaken by:

- NADIA survey of all in patients with diabetes on one day in September annually
- Snapshot audit of diabetic patients undergoing surgery with the second audit currently being evaluated
- National Confidential Enquiries into Patient Outcome and Death (NCEPOD) audit of surgical patient with diabetes

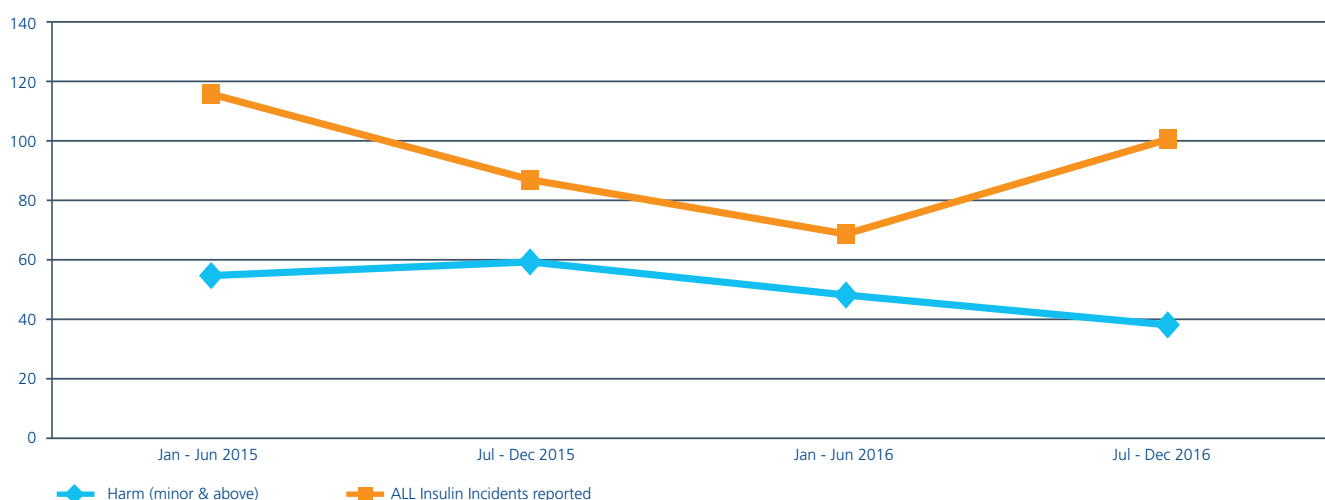
NADIA results in 2016 show increased number of inpatients with diabetes, 235 patients (140 in 2014), 39% on insulin, 9% Type 1. Trust data on surgical patients has been compared to National data (table below).

	NUTH 2015	NUTH 2016	UK
Medication errors	40%	33.1% ↓	37.8%
Prescription errors	10.2%	10.1% ↔	21.1%
Management errors	32.7%	26.1% ↓	24.1%
Insulin errors	30.6%	24.1% ↓	22.7%
Hypoglycaemia errors: Mild BM <4	28.6%	31% ↑	18.5%
Severe BM <3	10.3%	10% ↔	8.3%

The data shows significant improvement in errors but increasing incidence of hypoglycaemia (1:4 patients suffer mild and 1:10 patients suffer severe hypoglycaemia). To address the increased incidence of hypoglycaemia a RED SUGAR CUBE project has been implemented Trust wide. If a patient suffers hypoglycaemia which requires oral/Intravenous treatments a red sugar cube is put on the ward whiteboard to alert all staff and it remains there until action/management change has been taken. An amber sugar cube is used to alert for hyperglycaemia (BM>12). Any incident of harm to a patient due to hypoglycaemia is investigated using Root Cause Analysis.

Monthly meetings of the multidisciplinary team review three monthly datix reports for insulin errors. The below graph shows insulin incident reporting has increased, but patient harm reduced. Themed reports are communicated via Trust groups such as Clinical Risk Group, Clinical Policy Group and Matron's Forum.

High risk medicine: Insulin incident profile



The advice and guideline documentation for the complete surgical pathway is regularly reviewed and compliance is being audited by snapshot audits.

## 5. OBSTETRICS:

- To achieve a 50% reduction in the incidence of avoidable neonatal hypoxic injury sustained during childbirth.

### Improve Provision of Midwifery Practice Support

Three new Practice Support Midwife posts have been funded on the Delivery Suite and successfully recruited to in order to increase practice support from 12 hours/day to 24 hours/day. The Practice Support Team support and develop junior midwives in clinical practice with intrapartum clinical skills and competency development, for example, Cardiotocography (CTG) interpretations and perineal repair. An evaluation was conducted to assess the practice support provision with band 5 midwives. The evaluation highlighted that the practice support allowed midwives to develop their skills, knowledge and confidence in all areas of intrapartum care, with specific situations highlighted in diagram one.

Diagram 1

Main situations where Band 5's reported they would access practice support

Previously Unencountered Clinical Situations

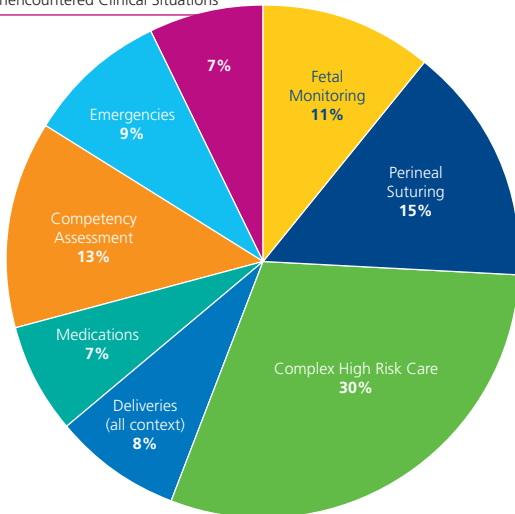
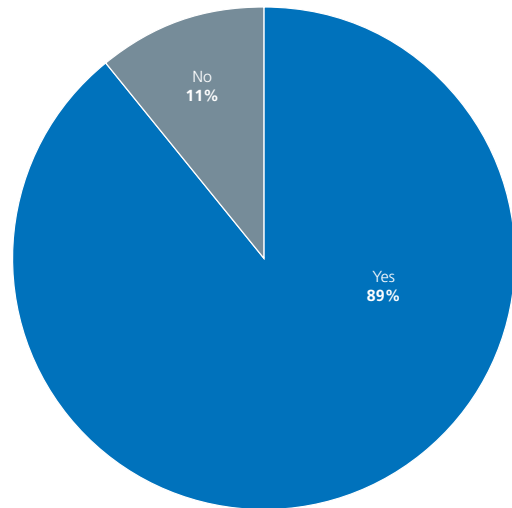


Diagram 2

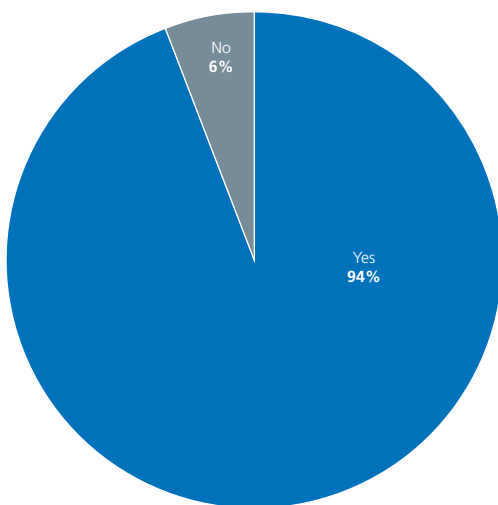
Did you feel the availability of a Practice Support Midwife made it easier to achieve your competencies?



The evaluation also highlighted a strong level of agreement with the contribution the practice support Midwives had made on achieving competencies with new midwives (see diagram 2) and how the Practice Support helped to quicken the time to develop competencies and a band 6 status (diagram 3).

Diagram 3

Do you think it would have taken you longer to achieve a Band 6 status if there were no practice support midwives available?



Some quotes from this group of staff included:

**“Practice support is invaluable in such a busy high risk unit as Delivery Suite at RVI. Much appreciated – I feel it would have been too stressful without such support.”**

**“Overall I feel having practice support is excellent and feel better knowing they are around for help and advice.”**

**“Felt well supported and able to achieve competencies due to the number of PSM and how helpful they are.”**

The practice support team continue to attend all case reviews where HIE (brain injury) is suspected and the baby has required cooling. This enables the team to identify any specific education or practice elements to be addressed on a wider scale within the midwifery or obstetric work force.

## Improve fetal monitoring skills during labour

New CTG monitoring equipment has been purchased and is in full use on the Delivery Suite and Birthing Centre. All fetal monitors in delivery rooms and the induction of labour area on the delivery suite are connected to a central monitoring system, which increases the level of surveillance and allows electronic archiving of the monitor recordings.

Staff continue to complete online fetal monitoring training. There is currently targeted work underway to optimise the skill and documentation of intermittent auscultation for low risk women. This has been in response to action points generated via intrapartum governance structures. In addition a change in national guidance for continuous fetal monitoring has necessitated a change in local guidance which is currently being updated. There will be a formal roll out of an educational programme relating to the new guidance in May 2017.

## Improve availability of cooling equipment for neonatal transfer

The cooling equipment purchased for use with the neonatal transport incubator continues to be used in the retrieval and transfer of babies where HIE is suspected. We continue to monitor achieved temperatures prior to and following transfer and are achieving 100% babies reaching the desired temperature for cooling during transit.

### Priority 3 – The delivery of Harm free care

The delivery of 'Harm Free Care' for all patients is a national and Trust priority. This priority was to continue to build on the work undertaken in 2015/16 to prevent avoidable harm, disability or death from:

- Falls.
- Pressure ulcers.

The Quality Priorities for 2016/17 in relation to Harm Free Care were to:

- Maintain and sustain the 20% reduction achieved in pressure damage.
- Have no deterioration in the falls/1000 bed days rate achieved in 2015/16 despite an increasing at risk population of patients.

Within the Trust incidence of patient harm related to Pressure Damage, Falls and Catheter Associated Infections (CAUTI) are all measured on each inpatient ward using the Safety Thermometer Tool which measures the prevalence of these harms across the Trust and the NHS on a specific day each month. This is published as NHS Safety thermometer data.

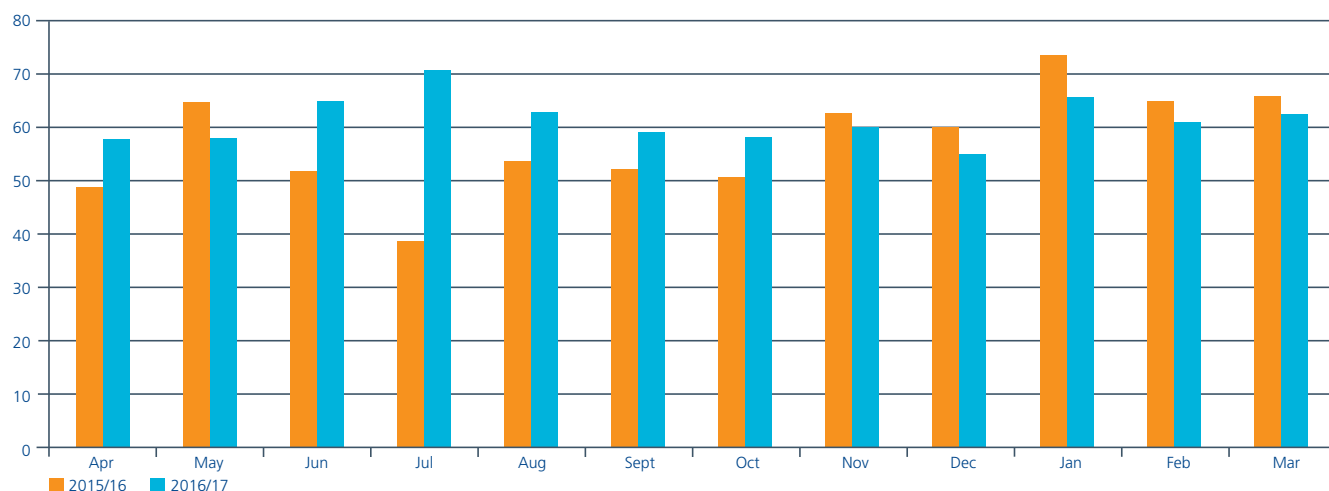
Whilst the Trust performs well, in that it reports less than the national average incidence of harm it has committed to ensuring there is no deterioration and to try and reduce further incidents of harm as measured by Safety Thermometer.

In addition to Safety Thermometer reporting all incidents of falls and pressure damage are reported via the Trust's incident reporting system "Datix". This data is reported regularly internally and externally and assists identify changes or trends in incident patterns and areas that need reviewing, to better understand why some areas have seen less or more incidents. This data is available via the Trust Integrated Quality Report which is presented at the Trust's monthly Board meeting and available on the Trust website.

Each workstream has a multidisciplinary working group who oversee and lead quality improvements, their work is described below. In addition to the monthly Integrated Quality Report, six monthly Harm Free Care reports are presented to Trust Board to update the Board on progress against the commitments, achievements and challenges in this regard, and are available via Trust website. Also available on the Trust website are the monthly Open and Honest care reports.

## Pressure damage

Total Number of Inpatient Acquired Pressure Ulcers



It has been a challenging year, but a year of variation with some areas making excellent progress. An internal target of 20% reduction in pressure ulcers was set. Whilst this was highly ambitious, nonetheless, a number of wards were able to achieve a 20% or better reduction in hospital acquired pressure ulcers. Trust-wide however, an overall increase of 1.2% was noted and this occurred during the first six months of the year, the second part of the year, incidents were less than the previous year. During 2016-2017, no Category IV pressure ulcers (the most severe type of damage) were reported and 96% of all pressure ulcers developed in the Trust were of a superficial nature (Category II).

- 24 wards are on target to achieve 20% or more reduction in pressure ulcers and moisture lesions.
- 6 wards are expected to achieve a reduction <20%.
- 7 wards are expected to not have had an increase in pressure damage.

## Falls

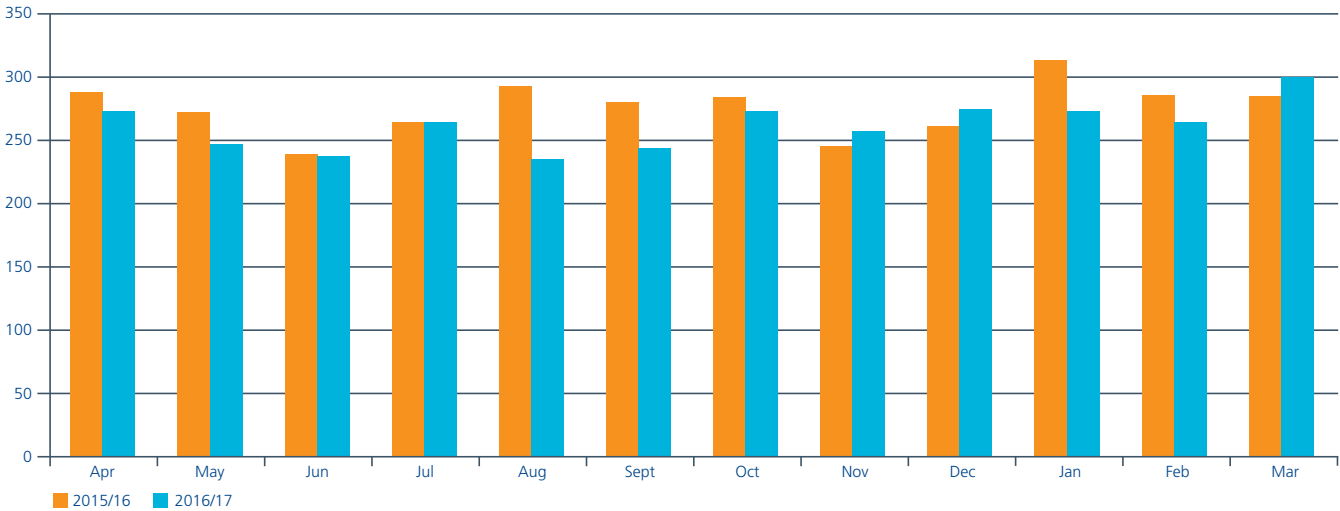
There has been a 5% reduction in the total number of falls in 2016/17 compared to 2015/16. Furthermore there has been a reduction in falls rate (6.0 falls/1000 bed days in 2016/17 compared to 6.2 falls/1000 bed days in 2015/16) and a 17.5% reduction in the number of falls resulting in serious harm (graded moderate and above). This is most notable within the category of falls graded as major in which there has been a 29% reduction. This category is predominantly fractured neck of femurs which have significantly poor outcomes and high rates of morbidity associated with them, therefore this level of reduction is noteworthy. The reduction in falls rate and harm this year is made more significant due to year on year increase in admissions of the highest risk patients (i.e. patients aged 65 and over admitted into the Medicine/Care of the Elderly directorate) over the past 5 years.

This can be attributed to the work streams led by the Falls Task Force Group and Falls Prevention Coordinator which have been embedded in every day practice and implemented by staff across the organisation. Staff have engaged with new initiatives and education to ensure that patients are assessed appropriately for their risk of falling and the relevant falls prevention measures are put in place.

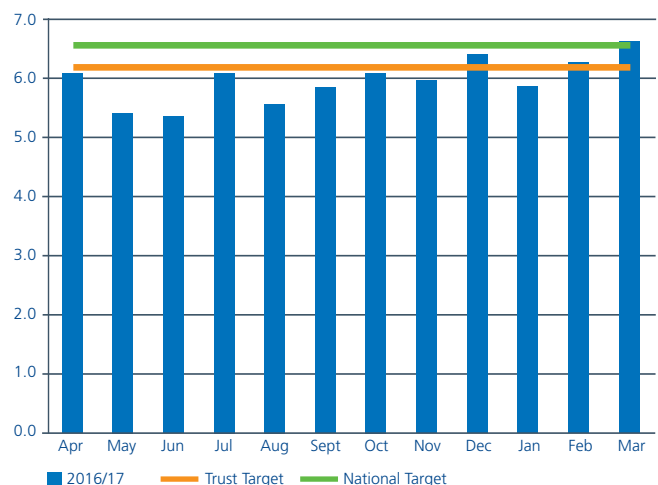


“It has been challenging year, but a year of variation with some areas making excellent progress.”

Patient Falls - total numbers



Patient Falls per 1000 bed days





#### Priority 4 - Safeguarding

The Quality Priorities for 2016/17 related to Safeguarding included:

- The protection of vulnerable adults and children, accessing services across all aspects of the Trust, from all forms of abuse including those at risk of, or subject to, Domestic Violence, Sexual Exploitation, or Female Genital Mutilation (FGM).
- Ensuring the Mental Capacity Act (MCA), and Deprivation of Liberty (DoLS) Safeguards are robustly applied.
- Ensuring that those with Learning Disability are recognised, flagged on Trust systems and appropriate, reasonable adjustments provided to ensure they can access and receive high quality safe care.
- Contribute to city wide work to enhance the protection of vulnerable adults and children through multi-agency working, including case review, education and policy and practice development.
- Ensure Specialist Safeguarding teams are supported to respond to increasing workloads, and that they are supported, and equipped to deal with the complexity and demanding nature of the work they undertake.

Achievements:

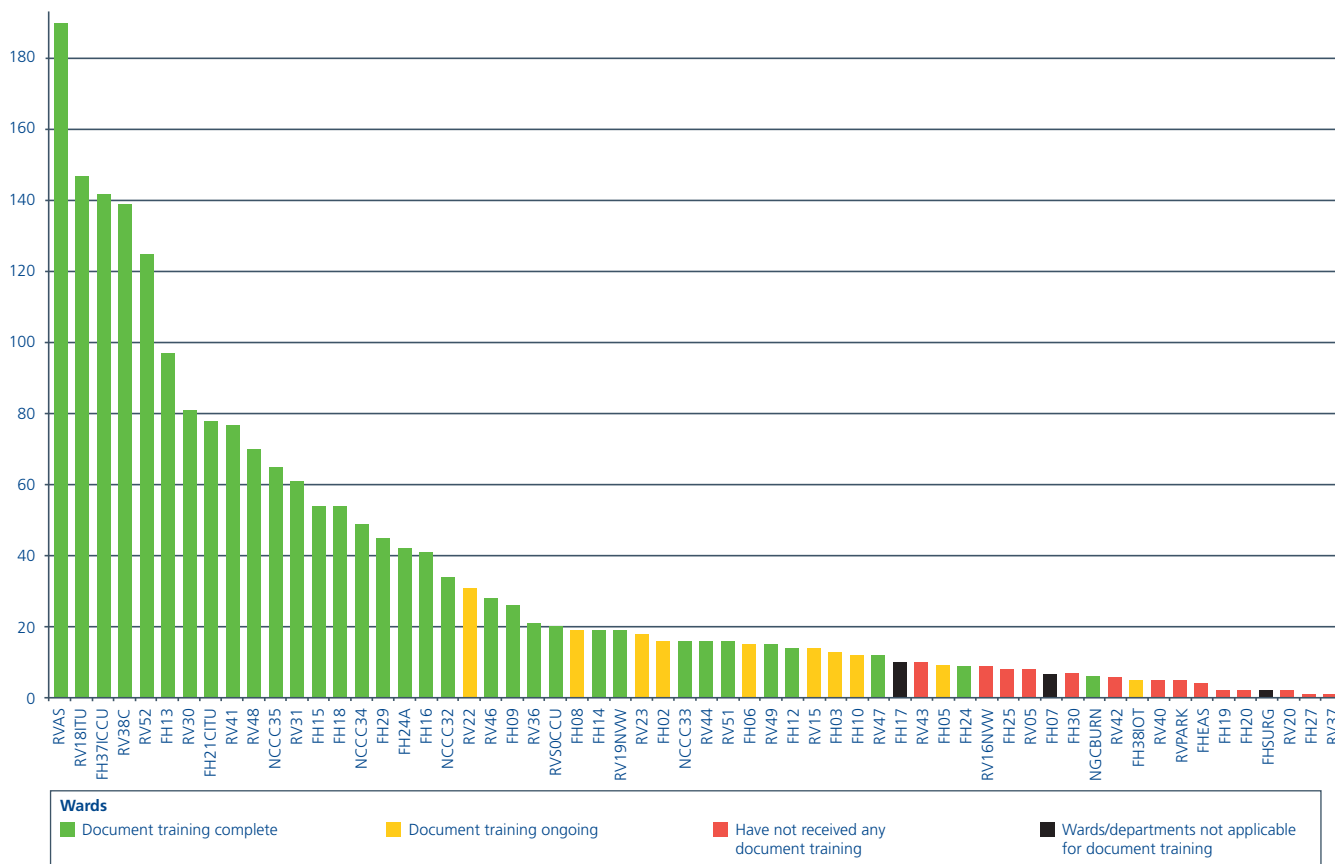
- Dashboards have been implemented for the Learning Disability Team and Deprivation of Liberty safeguards. These are monitored monthly along with dashboards for the Children's' and Adult Safeguarding Teams by the Safeguarding Operational Management Group and are reported quarterly to the Trust Board, Safeguarding Committee and CCG.
- FGM reporting has increased with 64 cases in 2016/17.
- The Named Midwife post has been successfully recruited to.
- There has been a significant improvement in compliance with mandatory training for 2016/17 despite the additional challenge posed by 'resetting the clock' in April 2016.
- Bespoke training has been delivered for Sexual Exploitation, FGM and learning from a Serious Case Review for 'Child J' in Newcastle.
- A training passport has been implemented for Trust staff to capture Level 3 Safeguarding Training and support professional revalidation.
- Service developments include safeguarding supervisor training for the safeguarding adults and safeguarding children's' nurses to implement a nationally recognised framework for the delivery of safeguarding supervision. A range of audits have been completed and policies reviewed including the Child Protection and Safeguarding Children: Policies and Procedures; DNA (Did not Attend) at Hospital Out-Patients Appointment for Children and MAPPA Policy being reviewed. A review of the Mental Capacity Act Policy and Deprivation of Liberty Safeguards Policy is almost complete.
- The Learning Disability Liaison Nurses have continued to support mortality reviews for patients with a diagnosed Learning Disability who died within the Trust. This practice is well embedded and provides useful learning to support improvements in clinical practice. In 2016/2017. The Trust has reviewed all Deaths of people with Learning Disability who died through a formal Learning Disability review process which reflects the principles of National Learning from Deaths Learning Disability Guidance (LeDer). This was 14 deaths (only 11 were between ages of 4-74 and required to be reviewed as defined by LeDer). Good practice and any lessons to learn have been shared across the Trust both through Patient Safety Briefings and formal Clinical Governance processes and used to inform the work of the Learning Disability Team. Examples of good practice include provision of reasonable adjustments and lessons learned e.g. detailed documentation of best interest decisions and involvement of families of carers in those discussions and decisions. The Trust understands that the region will be moving to entering data into the national system within 2017/18 and the Trust will participate in this and regional review processes.
- There has been a significant contribution by the Safeguarding Teams to multi-agency case reviews. There have been a number of Learning Reviews and Serious Case Reviews including a joint review across Newcastle in relation to sexual exploitation of young people and adults.
- The Safeguarding Teams, (Childrens, Maternity, Adults), have developed into a single service with the now well established Head of Safeguarding role providing senior support, leadership, and facilitating service improvements and cohesive working across the teams.

## Priority 5 - Palliative and End of Life Care

High quality palliative and end of life care is a key priority for Newcastle upon Tyne Hospitals NHS Foundation Trust. The Specialist Palliative Care Service and the End of Life team continue to work with staff both in the hospital and community settings to help deliver excellent care, ensuring patients and families receive the information, support and care they require during this difficult time.

### Care of the Dying

- The Macmillan End of Life project commenced in February 2016. One to one support is offered to patients who are dying, and their families, by a band 5 nurse and health care assistants across both hospital sites. In the last year over 360 patients and their families have been supported.
- Comfort packs containing toiletries, neck pillows and blankets, are now routinely offered to families spending long hours at the bedside.
- The charitable fund “A Gift of Kindness” has been established and has already raised funds to provide the comfort packs as well as other small things that make a difference.
- The regional Caring for the Dying Patient documentation supports excellent individualised end of life care in all care settings and promotes good communication between staff. Its use is supported by extensive education and training, with ongoing support and audit. It is currently used in 33 acute wards as well as in Newcastle community compared to 2 in January 2016.
- Patients requiring a continuous subcutaneous infusion for symptom control either at the end of their life, or for complex symptom control are now transferred to care settings across the region with a portable device to ensure good symptom control throughout the journey.
- The introduction in November 2016 of new community chart for administering subcutaneous medications means that this chart can be completed prior to discharge, reducing delays administering medications on arrival home.
- NEAS piloted and then continued a new dedicated End of Life Ambulance which provides transport for patients to enable them to die in their place of choice, be it home, hospice or hospital closer to home.
- Plans are in place to start a 7 day Specialist palliative care service pilot from April 2017.



### Advance Care Planning

Planning care in advance ensures that patients wishes and preferences are met both for the care they receive and where they receive that care.

- Primary Care Palliative Care Standards project.** The Standards facilitation team have worked in partnership with General Practitioners from 16 Newcastle practices and the attached Community nursing teams. This is a supportive process to assist in identifying, reviewing, improving and evidencing the clinical care, communication and co-ordination for palliative patients and their carers. Data from participating practices demonstrates an increased number of palliative patients (cancer and non-cancer diagnoses) identified by practices with a care plan, increased recording of patient’s preferred place of care/death, reduced admission rate to hospital of palliative patients and reduced the number of deaths in hospital.
- Care Homes.** The Palliative Care nurse specialist now works within 20 Care Homes in Newcastle to enable residents to receive the best possible palliative and End of Life Care. It supports person centred holistic assessment enabling residents to discuss preferences and choices for care and place of death by means of a bespoke training programme and structured palliative care register meetings.
- The community Palliative care team have established electronic mobile working. This enables consented sharing of data with District nurses, GPs and the hospices to provide seamless care.

## Staff training

- All clinical staff who care for patients at the end of life have a mandated online module to complete, in the last 12 months 81.5% of eligible staff have completed this.
- We have delivered face to face training to over 5800 staff in the last 12 months including: nurses, junior doctors, health care assistants, Allied Health Professionals. This has included 4 study days/courses.
- We deliver education on the junior doctor and main Trust induction programmes.

## Quality assurance

- Bi-annual audit in the community and hospital settings continues to monitor care. This provides evidence of excellent care and also provides the opportunity for capturing carer and patient views at the time of care delivery to continue to improve the care we deliver.
- The Trust participated in the National End of Life Care Audit – Dying in Hospital in 2015 and the results were published on March 2016. The Trusts results were excellent, with compliance across nearly all of the quality domains well above the national averages.
- Bereavement Survey – a survey undertaken of bereaved relatives was undertaken in November and December 2016. This provided timely feedback on the care delivered in the acute setting. Results indicate that the quality of care has been excellent, on the few occasions where care did not meet a high standard, relatives have appreciated the chance to give their feedback face to face with a real opportunity to improve care for others in the future.
- The Specialist Palliative Care Service is fully compliant with the national recommended Palliative Care Clinical Data Set (PCCDS). This includes patient centred outcome measures that enables monitoring of the impact of interventions at a patient, service and national level.
- A Preferred Place of Death audit was undertaken in December 2016 which demonstrated that when patients are asked about their preferences they are more likely to die at home. Well established systems within the acute setting are helping staff remember to ask and therefore enable, where possible, the patient's wishes.

## Clinical Effectiveness

### Priority 6 - To monitor mortality indicators with the aim of reducing avoidable deaths and look for any lessons that can be learned.

Over the past 12 months the Trust has continued to monitor the number of patients that die within our hospitals and also those who die shortly after being discharged. We carefully monitor our mortality rates comparing the number of patients one would expect to die (given the severity of their condition, their age etc.) by using nationally recognised models against the number of patients who actually die. To help us do this we use both the Summarised Hospital-level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR). Over the last 12 months both the SHMI and HSMR indicators have shown us to have “as expected” mortality rates that are consistently one of the lowest in the region. Despite

consistently achieving “as expected” mortality ratings, the Trust is committed to reducing avoidable deaths and learning from outcomes. This is achieved by undertaking patient level reviews for all patients who were not expected to die. To do this we monitor the 140 different diagnostic groups that make up SHMI. If we notice any patterns or increased numbers of deaths in any areas we ensure that these are fully investigated by senior clinicians with expertise in that field. Within the past 12 months 3 such reviews have been undertaken with no areas of concern identified. The results of all reviews are presented to the Mortality Surveillance Group in order to ensure that any lessons that can be learnt are shared widely.

Table 1 - SHMI vs HSMR for North East Trusts July 2013 to June 2016

SHMI vs HSMR by Trust, July 2013 to June 2016

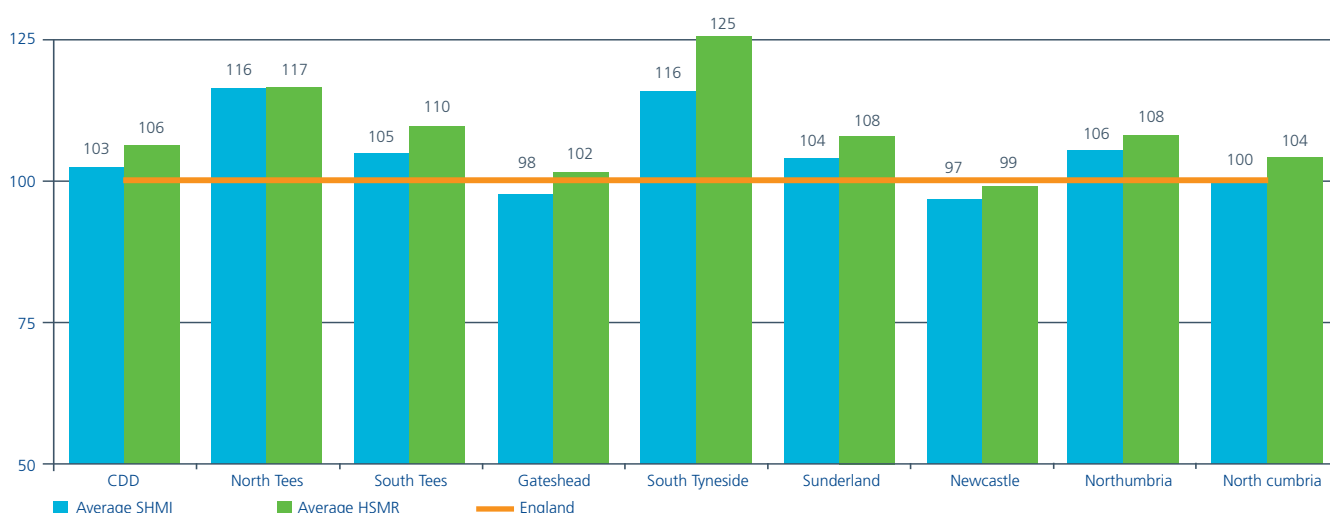


Table 1 shows average SHMI and HSMR by Acute Trust, July 2013 to June 2016.

Source: NEQOS Hospital Mortality Monitoring: Report 31  
Data extracted from HED January 2017

The Mortality Surveillance is a new group that was established during 2016/17 to provide additional oversight and assurance around the Trust's mortality monitoring processes. The group is chaired by the Medical Director and has representation from a wide variety of clinical staff and specialisms. All data and investigations related to mortality will now be discussed at this meeting.

## Priority 7 - National Audits and Confidential Enquiries

During 2016/17, the Trust has continued to participate in the national audits and confidential enquiries which are relevant to its services. A total of 50 national clinical audits and 9 national confidential enquiry reports / review outcome programmes covered NHS services that The Newcastle upon Tyne Foundation Hospitals NHS Foundation Trust provides.

During that period, The Newcastle upon Tyne Hospitals NHS Foundation Trust participated in 49 (98%) national clinical audits and 100% of the national confidential enquiries / review outcome programmes which it was eligible to participate in. The only audit in which the Trust did not participate was the Learning Disability Mortality Review Programme following regional discussion and agreement.

During the last twelve months, the Trust has continued to develop its processes to ensure that the results of all the national audits and confidential enquiries are baseline assessed to determine whether the Trust is compliant and, if not, identify the corrective action which is required to move towards compliance. Baseline assessments were presented to the Trust Board (national audits) on a monthly basis

## Priority 8 - NICE Quality Standards (QSTs)

Major progress has been made during the last twelve months in terms of Trust compliance with the three prioritised National Institute for Health and Clinical Excellence (NICE) QS priorities. The three priority QS's were QS1 Dementia, QS49 Surgical Site Infection and QS66 IV fluids for adults in hospital.

The three had been selected as they were extremely challenging and the following details the progress made:

- **QS1 Dementia** - The Trust is pleased to report that all adult wards and clinical departments in the Trust have a minimum of one nominated Dementia Champion (Nursing and Therapists) and all staff have access to 7 learning modules on dementia awareness via Breeze. A cumulative total of 14,370 staff have received dementia care education/training since the Trust started collecting this data in April 2012.

Bespoke information bags are given out by the Dementia Nurse Specialists including a range of information e.g. on sources of local support is being given out on wards, Signposting and Support (Newcastle Carers Centre, Age UK Newcastle, and Alzheimer's Society). Funding obtained from the Special Trustees to purchase "forget me not" bags which are distributed by the Dementia Nurse Specialist Team specifically tailoring the content of each to suit the individual's needs within an inpatient setting.

Assessments and personalised ongoing care plans are discussed and agreed by ward based multidisciplinary teams as required for all older patients, including those with dementia. In addition, three core care plans relating to the care of people with dementia have been developed and piloted in Older People's Medicine and are to be rolled out across the Trust in May 2017.

All patients registered on the District Nursing Caseload that have a life limiting or palliative diagnosis will receive a holistic assessment of their needs. In respect of dementia care this assessment takes into account Mental Capacity and Best Interest decisions in order to devise a plan of care that is responsive to the individual. These best interest decisions are carried out with other professionals including GPs, Specialist Palliative Care Team, Social Workers and the patients' family and carers.

- **QS49 Surgical site infection** - The requirement regarding the removal of hair from the surgical site area has been incorporated into the Patient Information leaflet "Coming into Hospital – Information for Inpatients and Day Case Patients".

An Antimicrobial Stewardship Working Group (ASWG) was established in May 2016 and meets monthly to review key guidelines. In addition, an Antimicrobial ePrescribing Strategy is in development which will include rollout of task lists for junior doctors and alerts for Microbiology / Infectious Diseases for key areas. Antimicrobial leads have been established in most clinical

and Clinical Governance and Quality Committee (confidential enquiries) as and when new reports are issued.

In addition, the monitoring of national audits and confidential enquiries was incorporated into the Directorate datapacks produced for discussion in the Directorate Patient Safety and Quality Review meeting. This provided the opportunity for Executive Directors and Clinical Directors for Patient Safety and Quality to query the performance of the Directorate in relation to any of the national audit reports and confidential enquiries in which outstanding actions remained.

In order to ensure that the Trust delivers the highest quality of care possible, further enhancement of the process has been established for 2017/18. In particular, the Clinical Effectiveness Audit and Guideline Committee (CEAGC) has incorporated the requirement that the status of all national audits, relevant to that directorate, are included in their Annual Directorate Clinical Effectiveness report including progress on previous actions identified for addressing any gaps in service delivery.

areas with the task of undertaking a Take5 monthly audit. This audit helps monitor appropriateness of antibiotic prescribing. Good antibiotic prescribing contributes to less antibiotic resistance and shorter hospital stay or shortened care in the Community setting, whilst improving patient experience and reducing patient harm. Collecting data for the audit helps prescribers familiarise themselves with the elements of a good antibiotic prescription. This tool must be completed monthly on 5 patients on each inpatient ward. In addition, at its March meeting, the ASWG agreed a new 'Take Five' for surgical prophylaxis.

A significant amount of work has been undertaken in relation to adults having surgery under general or regional anaesthesia have normothermia maintained before, during (unless active cooling is part of the procedure) and after surgery. In particular, theatres have introduced a number of changes in practice / trialed in the directorate. These have included ensuring patients are managed at 21 degrees, tympanic membrane or nasopharyngeal temperature should be undertaken at the commencement of the case and every 30 minutes thereafter (minimum), every patient to have a warm sheet wrapped around them (from warming cupboard) at start of case and again at the end, using the underbody mattress on the trolley for prolonged anaesthetic time and in theatre if available, actively warming patients if surgery is greater than 30 minutes duration and if less than 30 minutes but cold (less than 36.50) then a Bair Hugger should be used and this can continue to be used in recovery.

- **QS66 Intravenous fluid therapy in adults in hospital** - The Trust has an extensive teaching programme in place to ensure that staff are trained in line with the quality standard.

The clinical educators have now attended their train the trainer sessions and have rolled this out in their areas. Feedback received has been very positive although certain issues were experienced in relation to releasing staff to attend training at ward level. Moving forward and in order to overcome some of the difficulties experienced, particularly in terms of new staff it has been added to the preceptorship for all new nurses into the Trust and appears in certain directorate induction days for example critical care. The medical and surgical education teams have also added it to their induction programmes. F1 and F2 doctors all receive training in relation to all elements of the process.

A re-audit of current practice has recently been undertaken and whilst improvements had been made in certain areas there remain certain issues which require further work.

The organisation will continue to monitor the three QS's until all elements are compliant but a major thank you goes out to all staff who have actively engaged in progressing compliance with the standards.



## Quality Standard 1 – Dementia

Standard	Statement	Current Position	Status
1	People with dementia receive care from staff appropriately trained in dementia care	<p>All adult wards and clinical departments in the Trust have a minimum of one nominated Dementia Champion (Nursing and Therapists). This is because patients with dementia can be cared for in any adult wards / department in the Trust. The Champions are responsible for cascading relevant education and information to colleagues in their clinical area and for championing high quality dementia care. Champions meet every two months. All new starters attend a dementia awareness session (30mins) as part of their Induction. All staff have access to 7 learning modules on dementia awareness via Breeze.</p> <p>Three dementia experts working at Band 6 / 7 were identified (nursing and therapies) and undertook a post graduate course in dementia studies which started in September 2014 and was completed in December 2015. A further two members of nursing staff from community services band 5 have been identified to undertake this course alongside two band 6 (nursing and chaplaincy) hospital staff starting in September 2017.</p> <p>A band 7 Dementia Nurse Specialist was recruited in March 2015 who supports and trains clinical staff to care for people with dementia. The CCG's have supported and funded an additional two band 6 Dementia Nurse Specialists who will commence employment in January 2016.</p> <p>A cumulative total of 14,370 staff have received dementia care education/training since the Trust started collecting this data in April 2012.</p>	Compliant
2	People with suspected dementia are referred to a memory assessment service specialising in the diagnosis and initial management of dementia.	Monitored as part of the national contract for emergency admissions over the age of 75yrs.	Compliant
3	People newly diagnosed with dementia and/or their carers receive written and verbal information about their condition, treatment and the support options in their local area.	<p>Information is available on dementia either in the form of a leaflet in ward rack or can be accessed by staff from Alzheimer's Society website via Intranet. Bespoke information bags are given out by the dementia nurse specialists including a range of information e.g. on sources of local support is being given out on wards, Signposting and Support (Newcastle Carers Centre, Age UK Newcastle, and Alzheimer's Society).</p> <p>Questionnaires and focus groups have been undertaken with carers to review information and support. Funding obtained from the Special Trustees to purchase "forget me not" bags which are distributed by the dementia nurse specialist team specifically tailoring the content of each to suit the individual's needs within an inpatient setting.</p> <p>From an outpatient perspective one of the dementia care nurse specialists supports the lead geriatrician weekly at the Melville day unit with cognitive assessments and offers post diagnostic information packs and emotional support for patients and their carers.</p>	Compliant
4	People with dementia have an assessment and an ongoing personalised care plan, agreed across health and social care that identifies a named care coordinator and addresses their individual needs.	Assessments and personalised ongoing care plans are discussed and agreed by ward based multidisciplinary teams as required for all older patients, including those with dementia. In addition, three core care plans relating to the care of people with dementia have been developed and piloted in Older People's Medicine and are to be rolled out across the Trust in May 2017.	Compliant
5	People with dementia, while they have capacity, have the opportunity to discuss and make decisions, together with their carer/s, about the use of: advance statements, advance decisions to refuse treatment, Lasting Power of Attorney, Preferred Priorities of Care.	This aspect of dementia care usually resides with the GP and is carried out using the Deciding Right documentation. Geriatricians currently advise patients and families about LPA at the point of diagnosis.	Compliant

Standard	Statement	Current Position	Status
6	Carers of people with dementia are offered an assessment of emotional, psychological and social needs and, if accepted, receive tailored interventions identified by a care plan to address those needs.	The Trust has a core care plan for signposting and support for carers. This is individualised for each carer.	Compliant
7	People with dementia who develop non-cognitive symptoms that cause them significant distress, or who develop behaviour that challenges, are offered an assessment at an early opportunity to establish generating and aggravating factors. Interventions to improve such behaviour or distress should be recorded in their care plan.	Trust has Guidelines on: Managing Behavioural Problems and Agitation in Dementia and Managing Delirium in Inpatients. Core care plans are available on Managing Behavioural and Psychological Symptoms of Cognitive Impairment and the management of delirium. Core care plans are to be launched Trust wide May 2017. Dementia nurse specialist team offer advice and support to inpatient departments in relation to behaviours that challenge and delirium to all hospital staff.	Compliant
8	People with suspected or known dementia using acute and general hospital inpatient services or emergency departments have access to a liaison service that specialises in the diagnosis and management of dementia and older peoples mental health.	Liaison Psychiatry well established throughout the Trust. The Trust also employs a geriatrician with specialist skills in old age psychiatry, who is the Trust Clinical Lead for Dementia.	Compliant
9	People in the later stages of dementia are assessed by primary care teams to identify and plan their palliative care needs.	All patients registered on the District Nursing Caseload that have a life limiting or palliative diagnosis will receive a holistic assessment of their needs. In respect of dementia care this assessment takes into account Mental Capacity and Best Interest decisions in order to devise a plan of care that is responsive to the individual. These best interest decisions are carried out with other professionals including GP's, Specialist Palliative Care Team, Social Workers and the patients' family and carers.	Compliant
10	Carers of people with dementia have access to a comprehensive range of respite/short-break services that meet the needs of both the carer and the person with dementia.	Respite services not provided by Trust	N/A



## Quality Standard 49 – Surgical Site Infection

The responses below have been provided from the following surgical Directorates: Peri-Op, Plastics and Ophthalmology, ENT, Urology, Cardiothoracic, Neurosciences, Surgery and Women's services.

Standard	Statement	Current Position	Status
1	People having surgery are advised not to remove hair from the surgical site and are advised to have (or are helped to have) a shower, bath or bed bath the day before or on the day of surgery.	The requirement regarding the removal of hair from the surgical site area has been incorporated into the Patient Information leaflet "Coming into Hospital – Information for Inpatients and Day Case Patients".  In their admission letters, all patients who are to have an operation or investigation are advised to have a bath or shower before coming into hospital as it is indicated that this will help prevent infection. Patients are also advised that if they are unable to bathe or shower before coming into hospital to inform a nurse on admission.	Compliant
2	People having surgery for which antibiotic prophylaxis is indicated receive this in accordance with the local antibiotic formulary.	An Antimicrobial Stewardship Working Group (ASWG) was established in May 2016 and meets monthly to review key guidelines. In addition, an Antimicrobial ePrescribing Strategy is in development which will include rollout of task lists for junior doctors and alerts for Microbiology / Infectious Diseases for key areas. Antimicrobial leads have been established in most clinical areas with the task of undertaking a Take5 monthly audit. This audit helps monitor appropriateness of antibiotic prescribing. Good antibiotic prescribing contributes to less antibiotic resistance and shorter hospital stay or shortened care in the Community setting, whilst improving patient experience and reducing patient harm. Collecting data for the audit helps prescribers familiarise themselves with the elements of a good antibiotic prescription. This tool must be completed monthly on 5 patients on each inpatient ward.  At its March meeting, the AMMSG agreed a new 'Take Five' for surgical prophylaxis and this will capture all aspects of Statement 2.	Compliant
3	Adults having surgery under general or regional anaesthesia have normothermia maintained before, during (unless active cooling is part of the procedure) and after surgery.	A significant amount of work has been undertaken in relation to this statement. In particular, theatres have introduced a number of changes in practice / trialled in the directorate. These have included ensuring patients are managed at 21 degrees, tympanic membrane or nasopharyngeal temperature should be undertaken at the commencement of the case and every 30 minutes thereafter (minimum), every patient to have a warm sheet wrapped around them (from warming cupboard) at start of case and again at the end, using the underbody mattress on the trolley for prolonged anaesthetic time and in theatre if available, actively warming patients if surgery is greater than 30 minutes duration and if less than 30 minutes but cold (less than 36.50) then a Bair Hugger should be used and this can continue to be used in recovery.  Continuous audit has indicated that despite significant improvement in audit results, neither the Freeman nor RVI are fully compliant. If applied fully, it is unlikely that 100% compliance will ever be achieved. Nevertheless, the Trust's hypothermia figures remain low thanks to a continuous quality improvement programme (SQIP) which has individualised feedback to all consultants in anaesthesia at the RVI and FRH.	Mostly Met

**"We are very grateful to our dedicated staff who have ensured that we have maintained such a high standard of delivery across an organisation that has one of the most comprehensive range of services of any NHS Trust in England."**

Standard	Statement	Current Position	Status
4	People having surgery are cared for by an operating team that minimises the transfer of microorganisms during the procedure by following best practice in hand hygiene and theatre wear, and by not moving in and out of the operating area unnecessarily	<p>A Trustwide audit programme has been put in place whereby each Theatre is to be audited once per year. The audit evaluates behaviour of staff in the Operating Theatre to ensure best practice is being followed. Awareness is constantly raised with all members of the theatre teams with regards to theatre attire and bare below the elbows. This is monitored closely by the Band 7s and Matron.</p> <p>Training has been provided for staff to ensure that all patients are appropriately prepared for theatre including all patients to have back washed immediately prior to surgery with 4% chlorhexidine aqueous/ hibiscrub using sponge on back of theatre scrub brush – done by surgeon or theatre nurse. Contact time 1 minute, rinse, dry skin. In terms of skin preparation, 2% chlorhexidine in alcohol – chloraprep stick to be used unless surgeon judges 2% chlorhex solution (alcohol) with mop for application would be better for the patient and states the reason (unlicensed). New bottle of chlorhex prep to be used each time. 5 staff members are checked relating to hand hygiene and ensuring that they scrub for the appropriate amount of time, and 3 staff members are checked relating to wearing appropriate theatre attire both inside and outside the theatre environment. For the period 1 April 2016 to 31 January 2017, the compliance rates were 99.7% for staff wearing correct attire in theatre and hand washing was 99.1%.</p> <p>An audit of theatre traffic / etiquette has been undertaken and following the audit, a meeting is to be arranged with groups of staff to discuss Do's and Don'ts and draw up guidance. Washable clogs for parents walking down the corridor have also been suggested.</p>	Compliant
5	People having surgery and their carers receive information and advice on wound and dressing care, including how to recognise problems with the wound and who to contact if they are concerned	In addition, to verbal advice given to patients each directorate produces written information for patients covering the varying procedures undertaken in their areas. Within each leaflet about a treatment, the Trust's Patient Information Panel use a checklist to ensure that the leaflet contains information about after-care, follow-up, risks and contact details for further advice.	Compliant
6	People with a surgical site infection are offered treatment with an antibiotic that covers the likely causative organisms and is selected based on local resistance patterns and the results of microbiological tests.	Statement 6 will be captured by Take Five but not in a manner in which specific data on SSI could be extracted. Numerous departmental audits that have been conducted over the years – but there is currently no formal rolling programme. However, this will be resolved following the annual Point Prevalence Survey in November which will enable this data to be captured. The IPCT also collate surveillance data from orthopaedics/spinal	Mostly Met
7	People having surgery are cared for by healthcare providers that monitor surgical site infection rates (including post-discharge infections) and provide feedback to relevant staff and stakeholders for continuous improvement through adjustment of clinical practice.	Once infections are identified they are discussed at Directorate clinical governance and audit meetings so that the lessons learnt can be shared by all clinical staff. Certain audits have shown that sometimes primary care classifies cases as wound infections and commence patients on antibiotics when in fact they are not. Consequently, patients are now encouraged to re-attend dressing clinics where infections can be picked up, treated and monitored accordingly.	Compliant

**“We will continue to work with our partners at Newcastle and Northumbria Universities to make our hospitals popular training places for junior doctors, who are the consultants of the future, and we are also working with Sunderland University on a new programme to ‘grow our own nurses’.”**

## Quality Standard 66 – Intravenous fluid therapy in adults in hospital

Standard	Statement	Current Position	Status
1	Hospitals have an intravenous (IV) fluids lead who has overall responsibility for training, clinical governance, audit and review of IV fluid prescribing, and patient outcomes.	Overall responsibility lies with Dr Alistair Gascoigne.	Met
2	Adults receiving intravenous (IV) fluid therapy in hospital are cared for by healthcare professionals competent in assessing patients' fluid and electrolyte needs, prescribing and administering IV fluids, and monitoring patient response.	The Trust has an extensive teaching programme in place to ensure that staff are trained in line with the quality standard. As the Trust Education Group decided not to support making IV fluid training a mandatory training requirement, other avenues were explored to ensure staff have the appropriate levels of knowledge and skills. The clinical educators have now attended their train the trainer sessions and have rolled this out in their areas. Feedback received has been very positive although certain issues were experienced in relation to releasing staff to attend training at ward level. Moving forward and in order to overcome some of the difficulties experienced, particularly in terms of new staff it has been added to the preceptorship for all new nurses into the Trust and appears in certain directorate induction days for example critical care. The medical and surgical education teams have also added it to their induction programmes. F1 and F2 doctors all receive training in relation to all elements of the process.	Met
3	Adults receiving intravenous (IV) fluid therapy in hospital have an IV fluid management plan, determined by and reviewed by an expert, which includes the fluid and electrolyte prescription over the next 24 hours and arrangements for assessing patients and monitoring their plan.	This standard is subject to intermittent audit. Although improvements have been made in the percentage of IV plans which contain details of fluid and electrolyte prescription over the next 24 hours and IV plans containing details of assessment there has been a reduction in the overall percentage of patients with an IV management plan, details of IV monitoring plan and plans meeting all elements of the standard. Further education and training to be provided prior to re-audit.	Partly Met
4	For adults who receive intravenous (IV) fluid therapy in hospital, clear incidents of fluid mismanagement are reported as critical incidents.	Staff are encouraged to record all incidents relating to IV fluid therapy regardless of severity. There have been no critical incidents recorded.	Compliant



## Patient Experience

### Priority 9 – Patient Experience

The Trust continues to perform well in measures of Patient Experience as reported to Trust Board and the public on a monthly basis through Board reports and Open and Honest Care reports. Work related to Equality Diversity and Involvement that has progressed and is summarised below.

### Meeting the NHS and Social Care Accessible Information Standard

The Accessible Information Standard came into effect as of 1st August 2016. The directive requires health and social care providers to meet five essential criteria when managing communication with disabled patients / customers; asking about communication needs, recording these, creating alerts, sharing the information and meeting these needs. The Trust is able to meet the core requirements of the standard and work is on-going to develop the required IT infrastructure to embed this information on every patient's electronic record. The Trust have worked collaboratively with charities, 3rd sector organisations and other service providers to understand the needs of disabled service users and ensure the solutions created to meet the standard will improve communication for these patients in a meaningful and sustainable way.

Sessions at clinical forums and on hospital wards have been undertaken to raise awareness of the standard, an educational infographic video has been produced to raise awareness and posters and literature have been produced and distributed to further enhance this understanding.

### Completing the new work with carers

A Carers pack and welcome poster have been developed and distributed to all adult clinical wards. The pack outlines the Trust's commitments to Carers, provides information about Carers Assessments and where Carers can find support in the community. Practical support for Carers has also been put in place, including; flexible visiting, the provision of meals by the Catering Department if the Carer is staying for a longer period of time and fold-out beds have been ordered to support Carers who wish to stay overnight. The Trust has made a pledge to support the principles of John's Campaign which is focused on ensuring that Carers of people with dementia should be able to support their loved ones at whatever time is most helpful to the patient and whatever time is do-able for the carer.

Awareness of the changes has been raised through face to face training, an animated video, written guidance for staff, clinical forums and information on the Trust intranet. Work is on-going to embed support for Carers and an audit is underway to assess the progress with this work. Mapping of work across the Trust has been undertaken to look for areas of common work and prevent duplication; the work is now linked with the work that the Dementia Team are undertaking with Carers. Case studies relating to Carers have been used in 'open and honest' reports and training for staff.

### Launch Accessibility Guides for disabled patients and visitors

The Trust have worked in partnership with 'Disabled Go', a not for profit organisation, to develop a suite of detailed, online accessibility guides which provide information to anyone visiting any Newcastle Hospitals site. We understand the challenges and anxiety that accessing unfamiliar environments can create for patients and visitors and hope that this initiative will go some way to offering peace of mind and reassurance to those visiting the Trust. The Trust is the first in the region to offer such information to visitors.

### Improving communication with Deaf/deaf or hard of hearing patients

The Trust has now launched a 12 month pilot providing 24 hour, 7 day access to British Sign Language (BSL) interpreters online to either enable immediate face-to-face communication with patients attending the Trust or enable such patients to contact Trust staff by phone. The Trust will gather service user and staff feedback to evaluate the impact and quality of the service development. The Trust is the first to offer such a service in the region.

This system will support BSL Users to communicate when a face to face interpreter is not available utilising a remote, fully qualified sign language interpreter. It will be particularly useful in emergency and out of hours situations and is not seen as a replacement for face-to-face interpreting provision.

The system has been demonstrated in a number of forums, team meetings and ward visits. Guidance on how to use the equipment has been drafted and circulated within awareness sessions. The launch date is planned for late April 2017.

To further improve the accessibility of services to deaf or hard of hearing patients, digital listening devices have been purchased for inpatient, outpatient and community services. Full demonstrations have been undertaken with staff and the equipment is now available for use to enhance communication where necessary.

### Partnership across the Trust, Local Authority and 3rd Sector so that the Trust can contribute to reducing social isolation and loneliness

This work now comes under the banner of 'Connected People, Connected Communities'. A conference was held in June 2016 bringing together Public Sector, Third Sector and Voluntary organisations together to build on, and add value to, existing developments including; introducing asset based approaches, health and care integration and developing social prescribing models. A subgroup of the Trust's Equality, Diversity and Human Rights Group developed a poster presentation for the event and has started to consider how we can use waiting areas as a place for people to find information about connecting with others in the community and when they are in hospital.

### Complaints

The Trust remains committed to listening to feedback from patients, their families and carers in order to continuously improve the services we provide. Complaints are an essential source of this feedback and efforts have been made to make the complaints process as accessible and straightforward as possible. The Trust have instigated a number of service improvements in relations to complaints to ensure that:

- Complainants are signposted to the appropriate feedback service
- New 'Raising concerns and providing feedback' posters advising how informal or formal complaints can be made have been produced and displayed in all patient and visitor areas throughout the Trust.
- Feedback is received and acted upon swiftly
- An educational video was produced and distributed to all staff in the Trust highlighting the various channels available to patients / carers / visitors wishing to provide formal or informal feedback on their experience so that they are signposted to the appropriate service.

- Thorough investigations are undertaken
  - The Trust have offered Early Intervention Meetings (EIMs) to complainants where appropriate over the past 12 months with excellent feedback from staff and complainants. EIMs have been described as a 'surprisingly positive experience' and 'an excellent way of discussing concerns' by complainants.
- Quality responses provided in a timely manner
  - The Trust Quality Assurance process has been expanded to provide Directorates with constructive, detailed feedback on the quality of the responses and action plans provided in response to their complaints.
- Learning from complaints is shared across all Trust staff
  - A monthly mailer is produced and cascaded to all staff following the Complaint Review Panel which details themes in complaints and provides recommendations for best practice to avoid repetition in other areas
- Complainants are informed of the service changes resulting from complaints
  - 'You Said... We Did' boards are now installed in all main entrances throughout the Trust illustrating changes made as a result of patient feedback or complaints to illustrate the Trust's commitment to listening and responding to feedback.

## Is it Working?

The number of formal complaints received by the Trust over the past 12 months has significantly fallen in comparison to previous years. This is particularly encouraging as activity is increasing and efforts have been made to publicise the various ways complaints can be made through videos and posters. In 2016/17 the Trust received 552 formal complaints, 14% fewer than in 2015/16. This equates to an average of 1 complaint for each 3,470 patient contacts in 2016/17. The CQC and Parliamentary and Health Service Ombudsman have also reviewed and commended the processes in place and commitment shown by the organisation to listening and acting on complaints.

## Duty of Candour (DoC)

Promoting a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. It involves explaining and apologising for what happened to patients who have been harmed or involved in an incident as a result of their healthcare treatment. It ensures communication is open, honest and occurs as soon as possible following an incident. It encompasses communication between healthcare organisations, healthcare teams and patients and/or their carers.

A contractual requirement to implement the Being Open guidance, called the Duty of Candour was introduced on the 1st April 2013. A statutory requirement to implement Duty of Candour was also introduced in October 2014 as part of CQC registration requirements.

Progress continues to be made with regard to consistent implementation of Duty of Candour, particularly following a serious incident. DoC implementation is discussed every month at the Serious Incident Panel to ensure verbal and written apologies have been given. A twice yearly audit of compliance with the legislation is undertaken and the results shared via Senior Clinical staff.

Awareness raising particularly amongst the medical staff continues to take place with presentations delivered at Directorate Audit meetings by one of the Clinical Directors for Patient Safety and Risk. Key priorities for this year are to develop an e-learning package and to update the policy to make it more user-friendly.

## Quality Priorities for Improvement 2017/18

Following discussion with the Board of Directors, the Council of Governors, patient representatives, staff and public the following priorities for 2017/18 have been agreed. A public consultation event was held in January 2017 and presentations have been provided at various staff meetings across the Trust. In addition staff have also been given the opportunity to help shape the priorities for next year by completing an online survey sent to all members of staff.



## Patient Safety

### Priority 1 - To reduce all forms of healthcare associated infection (HCAI), we will quantify our success in this by:

- Aiming for the annual number of Methicillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia cases to be no more than zero.
- Reducing hospital acquired infections related to *Clostridium difficile* (*C. difficile*) to be no more than 77 cases in 2017/18.
- Reducing the number of hospital acquired infections related to Methicillin-Sensitive *Staphylococcus Aureus* (MSSA) by 10% based on the 2016/17 reported figure.

The Trust will continue to monitor rates of *Escherichia coli* (*E.coli*) and implement strategies to try to reduce the number of patients acquiring this infection.

This indicator will continue to be reported to the Trust Board, the Infection Prevention and Control Committee and other relevant forums.

### Priority 2 - Sign up to Safety (Su2S)

The Trust have signed up to the three year National "Sign up to Safety" Campaign which aims to save 6000 lives and reduce avoidable harm by 50%. In this third year of the Su2S project the Trust will continue to undertake improvement work into five patient safety priorities.

#### 1. DETERIORATING PATIENT:

- To reduce avoidable harm and death, associated with missed opportunities to detect/instigate initial management of the deteriorating patient, by 50% by 2018 (*Adults*).
- To reduce the number of episodes of avoidable deterioration leading to Paediatric Intensive Care Unit (PICU) admission and/or activation of the resuscitation teams and/or death by 50% in the North East North Cumbria Region by 2018 (*Paediatrics*).

#### 2. MEDICATION SAFETY:

- To reduce avoidable harm and death from medication errors by 50% by 2018.

#### 3. SEPSIS:

- To improve early detection and initial management of the severely septic/septic shocked patient by 50% by 2018 (*Adults*).
- To reduce the numbers of children treated inappropriately for sepsis by 50% by 2018. (*Paediatrics*).

#### 4. SURGICAL SAFETY:

- To minimise surgical never events, through learning and sharing.
- To reduce harm associated with post-operative care of patients undergoing spinal surgery, by 50% by 2018.
- To reduce adverse incidents associated with elective surgery in the diabetic patient by 50% by 2018.
- To reduce spinal surgery infection rates to alignment to the national average by 2018.

#### 5. OBSTETRICS:

- To achieve a 50% reduction in the incidence of avoidable neonatal hypoxic injury sustained during childbirth.

By signing up to this campaign The Trust is aiming to promote an open learning culture and promote the importance of human factors, incident reporting, staff morale and quality improvement skills across the workforce. This indicator will be monitored in various ways including incident reporting, investigation outcomes and patient and carer feedback. This will be reported quarterly to the Trust Board via the Clinical Governance and Quality Committee.

**"Partnership is important to us not just in terms of delivering current and future services, but also in developing innovative new treatments and services."**

### Priority 3 – The delivery of 'Harm Free Care' for all patients is a national and Trust priority.

This priority aims to continue to build on the work undertaken in 2016/17 to prevent avoidable harm, disability or death from:

- Falls.
- Pressure ulcers.

And for 2017/18 there will be an enhanced focus on:

- Catheter Associated Urinary Tract Infections (CAUTI).

The Quality Priorities for 2017/18 in relation to Harm Free Care are:

- To sustain the reduction already achieved in falls per 1000 occupied bed days rate, despite an increase in the at risk population of patients.
- To sustain the reduction in serious harm from falls per 1000 occupied bed days rate, despite an increase in the acuity and frailty of patients.
- To reduce the incidence of pressure ulcers and moisture lesions by 5%.
- To work with directorate's Local Task Force to achieve above target.
- To ensure urinary catheters are used appropriately and removed when no longer clinically indicated: patient review to be at least daily.
- Sustain the reduction in serious harm from urinary catheters – such as Catheter Associated Urinary Tract Infections (CAUTI) by reducing infections by 30% and ensuring that catheters are only inserted and remain in situ when clinically indicated.
- To improve health care practice relating to Urinary Tract Infections e.g. antibiotic prescribing/catheter review and stewardship, appropriate urine sampling.





## Falls

Inpatient falls prevention continues to be a priority for staff across the organisation. In the coming year the plan includes:

- The Falls Prevention Coordinator and Falls Taskforce Group will continue to lead the Trust 'No Falls On My Patch' campaign to drive improvement of practice through education, analysis of data and the dissemination of learning from best practice.
- Provide evidence based advice to clinical teams on the individual management of patients with high risk/ clinical needs and overall best practice measures.
- Progress work in relation to providing excellent post fall care. This will expand on work already underway within the Medicine Directorate in 2016/17. This will aim to embed the Post Fall Assessment Checklist using a Plan-Do-Study-Act methodology across all adult in-patient wards.
- In 2015/16 and 2016/17 the Trust led a falls prevention project funded through the North East and North Cumbria Academic Health Science Network (NENC AHSN) which aimed to embed Royal College of Physicians Best Practice Guidelines. In 2017/18 the priority will be to embed this successful work across the organisation without further funding from NENC AHSN.
- The Falls Prevention Coordinator will continue to review all falls graded moderate and above using an established Root Cause Analysis (RCA) investigation process. These will then be reviewed every 6 months to identify common themes and actions to enable this information to be disseminated across the Trust.

## Pressure Damage

The Tissue Viability Team will continue to work with all Trust staff to achieve "zero tolerance" to Trust acquired pressure damage. Plans include:

- The corporate Pressure Ulcer Task Force will continue to monitor incident rates.
- The Tissue Viability team will continue to support clinical areas with Time2Turn campaigns, the most recent one being "React to Red".
- Strengthening leadership within the Trust with regards to our quality improvement programme by participating in the Regional Pressure Ulcer Collaboration project.
- Collaborate with NHS Improvement and the national "Stop the Pressure" campaign.
- Collaborate with the Northern Tissue Viability Forum in organising the Regional STOP the Pressure Conference in November 2017.
- Provide evidence based advice to clinical teams on the individual management of patients with high risk/ clinical needs and overall best practice measures.
- Tissue Viability will continue to review all Trust acquired pressure ulcers and moisture lesion and assist the Deputy Directors of Nursing with the established Root Cause Analysis investigation process. Common themes will be identified and presented at the Trust Patient Safety Briefings and other appropriate forums.
- Support the wards which have had an increase in the incidence of pressure ulcers and moisture lesions to ensure best practice and minimise risk.

## Catheter Associated Urinary Tract Infections (CAUTI) and Urinary Tract Infections (UTI)

- The Nurse Consultant and the Catheter Care Sub Group will continue to improve care and maintain standards through the campaign No Catheter No CAUTI.
- Implement evidence based guidelines to help to achieve harm free care for CAUTI/UTI.
- Provide evidence based clinical advice to clinical areas for urinary catheter insertion, care and removal through active clinical engagement.
- Using a systematic approach to seek and respond to health care guidelines and professional views for CAUTI/UTI prevention and antibiotic stewardship.
- The Nurse Consultant will continue to undertake surveillance of CAUTI/UTI through the Patient Safety Thermometer. A review mechanism is in place to identify new CAUTI.
- Progress with work generated through national and local projects – Health and Innovation network, Unplanned Admissions Consensus Committee ( National Committee looking at best practice in catheter care), Infection Prevention and Control Health Care Associated Infection Action Plan.
- Implement audit work to monitor and improve practice for CAUTI/UTI prevention and embed successful work across the organisation.
- Support clinical areas who have had an increase in the incidence of CAUTI/UTI.

Each work stream has a multidisciplinary working group who oversee and lead on the quality improvements. In addition to the monthly data, detailed Harm Free Care reports are presented to Trust Board to update the Board on progress against the commitments, achievements and challenges in this regard, and are available via Trust website.



#### Priority 4 – Safeguarding

Safeguarding vulnerable patients remains a high priority for the Trust and the safeguarding teams will continue to deliver a high quality service that is accessible and responsive to staff. This includes providing advice, guidance, education and support, alongside implementing service developments to ensure safeguarding processes are robust, quality assured, and meet the increasing challenges faced by Trust staff in acute and community settings. The Trust will continue to be a significant partner in multi-agency working arrangements that are so vital to safeguarding vulnerable individuals.

2017 / 2018 Priorities:

- To promote safeguarding as everyone's responsibility by increasing knowledge and awareness of safeguarding with all Trust staff, service users and visitors.
- Domestic abuse, sexual exploitation and Female Genital Mutilation (FGM) will continue to be a high priority for the safeguarding teams.
- To implement an evidence based Safeguarding Supervision framework that defines a new model of safeguarding supervision that can be used across all Trust services.
- To further develop the provision of Safeguarding Training to meet mandatory requirements in line with national frameworks.
- Audit and assurance frameworks will be strengthened further.
- To continue work that promotes safe, effective and high quality care for those with a Learning Disability and ensure that reasonable adjustments are made.
- The Mental Capacity and Deprivation of Liberty Safeguards will be promoted to further embed these principles in clinical practice, and reflect changes in national guidance or case law.
- To ensure the voice and views of vulnerable children, young people and adults are listened to.
- To ensure the sustainability and resilience of the Safeguarding Teams in the context of demanding roles and workloads.

2017 /2018 commitments:

- The Safeguarding Teams will continue to provide responsive advice and guidance to staff across the organisation, sharing information, as required to protect vulnerable individuals of all ages utilising Trust Services.
- The Safeguarding Teams will continue to work in partnership with other agencies and contribute to the work of the Newcastle Safeguarding Children's Board and Safeguarding Adult's Board including attendance at sub-groups.
- The Safeguarding Teams will support multi-agency working by actively participating in Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews and Appreciative Inquiries. This will include dissemination of learning to support practice improvements.
- The framework for Safeguarding Training will be reviewed and a programme of training will be developed to provide Learning from Practice Events and bespoke training packages to promote Continuing Professional Development for Trust staff.
- The Safeguarding Teams will support multi-agency training and learning events.
- The Named Midwife will develop further work to promote the pathway for FGM which is now a strategic sub-group of the Newcastle Safeguarding Children's Board.
- The implementation of CP-IS (Child Protection Information Sharing) project will be progressed within the Trust. This is a national requirement to have an electronic notification system for children or young people who attend unscheduled care setting such as Emergency Department, Walk in Centres and Maternity Assessment Units.
- The new framework for Safeguarding Supervision will be further implemented across a wider range of services including adult services and district nursing.
- A devolved model of Deprivation of Liberty (DoLS) retaining a "Single Point of Contact" (SPOC) via the Adult Safeguarding Team will be trialled in two areas to support the increased number of applications. This will be evaluated by the Mental Capacity Steering Group before any further recommendations for change are made to the Safeguarding Committee.
- The Childrens Safeguarding Team continues to provide a full-time nurse into the Multi-Agency Safeguarding Hub (MASH) that sits within Children's Social Care. They have also supported a nurse advisors secondment into the Sexual Exploitation Hub.

This indicator will be monitored through the Trust safeguarding management structure using results of audit, assurance work and case reviews which will be examined and challenged and progress against agreed actions monitored and reviewed. Regular reports will go to Trust Board.



## Clinical Effectiveness

### Priority 5 - Mortality

The Trust will continue to monitor mortality rates with the aim of reducing avoidable deaths and build on developments achieved in 2016/17. This will be achieved by scrutinising national mortality indicators such as Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) with an aim to achieving a mortality rate within the 'as expected' category as a minimum.

The Trust will monitor and discuss mortality findings at a new quarterly Mortality Surveillance Group; representatives attend this group from multiple specialities and will monitor Trust mortality data to ensure local learning and quality improvement. This group complements the departmental mortality and morbidity (M&M) meetings within each Directorate.

Like all providers in 2017/18 the Trust will work towards compliance with the new national mortality review process (Structured Judgement Reviews), amending our data capture systems accordingly and closely monitoring progress at the Mortality Surveillance Group.

This indicator will be monitored and reported to the Trust Board and the Clinical Risk Group.

### Priority 6 - Antimicrobial Stewardship

Antibiotic resistance is one of the most significant threats to patients' safety in the UK. It is driven by overusing antibiotics and prescribing them inappropriately. To slow down the development of antibiotic resistance, it is important to use antibiotics in the right way – to use the right drug, at the right dose, at the right time, for the right duration.

Therefore during 2017/18 we will monitor the rates of antibiotic prescribing with the aim of reducing clinically inappropriate antibiotic prescription and consumption. We will continue to educate staff around the importance of antimicrobial stewardship and conduct a regular audit to assess current practice and encourage improvement.

This indicator will be monitored and reported to the Trust Board, the Infection Prevention and Control Committee and other relevant forums.

### Priority 7 - Ill-Health Prevention

The Quality Priorities for 2017/18 related to Ill-Health Prevention include:

- To develop the infrastructure to support staff to make every contact count and document activity.
- To progress to "Gold Award" standard for Better Health at Work.
- To develop a Health and Wellbeing Strategy to define the Trust's vision and strategic ambition for its contribution to the Health and Wellbeing agenda.
- To progress in line with staff health and wellbeing Commissioning for Quality and Innovation (CQUIN) payment scheme.

In order to achieve these targets we will:

- Develop a Making Every Contact Count action plan and Task and Finish Working Group(s) to support implementation and recording of Making Every Contact Count.
- To develop Trust recording systems to capture health improvement conversations and facilitate information sharing.
- To develop/refresh educational packages in relation to delivering brief advice for smoking, alcohol, weight and physical activity.
- To engage with staff to promote and facilitate Making Every Contact Count.
- To work towards "Gold Award" standards of Better Health at Work Award including continuing to develop and support Health Champion network, delivery of co-ordinated health and wellbeing campaigns to Trust workforce.
- Provide Mental Health First Aid Training to line managers.
- Reduce sales of high sugar, high fat drinks and snacks across Trust controlled food outlets.
- Provide an effective flu vaccination programme for staff.
- Develop and publish a Trust Health and Wellbeing Strategy.

This indicator will be monitored and reported to the Trust Board.

## Priority 8 – Palliative & End of Life Care

High quality palliative and end of life care continues to be a key priority for the Trust. Using the recommendations of One Chance to Get It Right (LACDP 2014, <https://www.gov.uk/government/news/new-approach-to-care-for-the-dying-published>) The Ambitions for Palliative and End of Life Care (2015, <http://endoflifecareambitions.org.uk/>) and NICE Guidelines CG31 (2015, <https://www.nice.org.uk/guidance/ng31>) our commitment is that patients and those important to them should receive attentive, high quality, compassionate care, during the last 6-12 months of life, in the last days and hours and in bereavement.

We have a responsibility to give patients and those important to them sensitive, timely and evidence based holistic care whether in hospital or the community, enabling a choice of care setting at the end of life.

To help achieve this we need staff delivering this care to be trained and supported in all care settings. This will be done through continued education and training including a refreshed mandatory training module and through support services such as the Specialist Palliative Care Service and the End of Life Team. The Trust uses the regional 'Caring for the Dying Patient' document to guide staff in

their care planning and delivery for the last days and hours of life in all care settings. The Macmillan End of Life Project continues to further enhance the care and experience for patients and their carers through dedicated one to one time in the hospital setting. Projects such as the Primary Care Palliative Care Standards Project and the Care Homes Palliative Care Nurse Specialist will continue to support and educate staff to enable high quality care planning and delivery in the community.

Monitoring of care delivered within the Trust for patients at the end of life will be achieved by bi-annual audit that also captures patient and carer views, findings will be used to improve patient care. In addition, continued participation in the National End of Life Care Audit: Dying in Hospital compares end of life care within the Trust to that of other providers nationally. Experience of care will also be sought through patient and carer surveys and a bereavement survey. The Specialist Palliative Care and End of Life teams will continue to engage with community services, wards and departments to monitor and support the care delivered within the Trust.

This indicator will be monitored and reported to the Trust Board.

## Priority 9 - Safe & Effective Discharge

Admission avoidance and early, safe discharge from hospital to the patient's own home is a key priority not only for the Trust but also for our patients. The Trust will continue to focus work around pathways that improve the patient experience and achieve a safe and timely discharge. This will include:

**Eden Court Development** A one year pilot of 20 community beds will be supported by a comprehensive multi-disciplinary team including Nurse Practitioners, Nurse Specialists, Occupational Therapists, Physiotherapists, Social Workers and medical staff.

This new enhanced care facility will provide an opportunity for patients to:

- Recuperate – following a period of illness
- Recover – following a functional decline in their health and/or well being
- Rehabilitate – with planned programmes of re-ablement and rehabilitation.

**“The Trust prides itself in consistently striving for excellence in healthcare and it monitors performance closely to ensure high levels are achieved and maintained across the organisation.”**

## Repatriation of patients to their local health authority area following specialist treatment

A regional agreement at executive level will ensure that any patient who is fit for transfer will be accepted back to the referring hospital within 48hrs of a request to transfer being clinically accepted.

## Introduction of the Expected Date of Discharge (EDD)

Effective hospital discharge planning can only be achieved when there is cohesive joint working between the patient, family/carers and all relevant organisations and professional disciplines.

The setting and regular review of Estimated Date of Discharge (EDD) based upon the patients' clinical need helps clinical teams to proactively plan a patient's discharge, enabling the patient and their family/carer(s) to be fully informed about when they will be able to leave hospital.

Clinical teams will continue to work with patients and their families and carers to establish early discharge planning as integral to the patient's clinical management plan.

## Discharge to care homes

The Trust is progressing a collaborative piece of work with Newcastle "Care Home Managers" to adopt an agreed set of principles in relation to the safe transfer of patients moving between hospital and care home and vice versa.

Standards include:

- Patients with a hospital stay of less than 72 hours being discharged back to existing care home could either have a telephone assessment or the opportunity to assess patient but if coming into assess the patient this needs to be within 48 hours (including weekend days).
- If the patient has been in hospital <72 hours we would always expect the assessment to be via telephone unless particular issues have been raised
- Care home to identify staff to undertake assessment and to have the authority to accept the patient in the absence of the manager.

## Continuing healthcare (CHC)

NHS continuing healthcare is the name given to a package of care that is arranged and funded solely by the NHS for individuals who are not in hospital and have been assessed as having a “primary health need”.

Newcastle and Gateshead Clinical Commissioning group are the responsible body in Newcastle for ensuring that patient’s eligibility is assessed in a timely and appropriate manner.

- New national CHC guidelines, due to be launched in July 2017 will include the following standards:
- Less than 15% of CHC assessments occur whilst the patient is in an acute hospital setting;
- Once the initial CHC checklist has been submitted, the assessment team will have to complete the full decision support tool assessment within 28 days.

The Trust will continue to work with “Commissioners” to ensure systems of referral are comprehensive and timely.

This indicator will be monitored and reported to the Trust Board and the Emergency Admissions Steering Group.

### Priority 10 – Enhancing the quality of care through participation in research

Clinical research is a national and Trust priority. The Trust hosts the Clinical Research Network North East and North Cumbria (CRN NENC) and other NIHR research platforms. In addition, the Trust works closely with local Universities, co-funding a Joint Research Office (JRO) in partnership with Newcastle University and co-ordinating a joint research strategy through the Newcastle Academic Health Partnership and Joint Research Executive committees. Through this infrastructure, the Trust continues to lead the way in sponsoring and delivering clinical research. We are one of the highest performing research active NHS organisations, both within the region and at a national level, and regularly top the Guardian Clinical Research League Table.

There is a clear link between research activity, clinical effectiveness and improved patient experience. A recent large-scale study demonstrated that patients cared for in NHS Hospitals that have a high level of participation in clinical research have lower mortality rates and improved clinical outcomes. This effect was not just limited to those people who took part in the trials, but was significant across the entire patient population. It is therefore important that the Trust continually develop clinical research, bringing new therapies and new treatments to the people of the North East and North Cumbria.

The Quality Priorities for 2017/18 in relation to clinical research are to:

- Maintain or improve the number of research trials available for patients to participate in and improve the number of patients participating in clinical research trials. Both of these are target driven; the JRO, in collaboration with local investigators, sets annual targets with the CRN NENC against NIHR portfolio studies. A Local Performance Management System (LPMS) monitors performance against these priorities. The JRO and CRN NENC upload performance data to the NIHR weekly and will report progress to the Trust Board every 6 months.
- Maintain and improve performance in initiating clinical trials and studies. The JRO use the CRN NENC LPMS to measure Trust performance against national benchmarks and NIHR high-level objectives. These data are uploaded quarterly to the NIHR Central Commissioning Facility. In addition, the JRO and CRN NENC will report this performance data to the Trust Board every 6 months.

This indicator will be monitored and reported to the Trust Board.

## Patient Experience

### Priority 11 - Patient participation in research

Patients are at the centre of everything we do. For research, we have an active Patient and Public Involvement and Engagement (PPIE) program to ensure that patients have their say in the design, planning, and delivery of our clinical trials. The Trust also leads the way in developing a national CRN Research Patient Satisfaction Survey.

As part of this program, the JRO and CRN NENC provide a wide range of opportunities throughout The Newcastle upon Tyne Hospitals NHS Foundation Trust and across other Partner Organisations for people to be involved in clinical research. This includes a highly successful Patient Research Ambassador scheme, which places the patient voice at a very senior level within the partner organisations. The Trust successfully appointed its first Non Executive Director Research Champion in April 2016. The JRO and CRN NENC also support a network of over 100 lay representatives from a variety of patient groups and voluntary organisations.

The Quality Priorities for 2017/18 in relation to Patient satisfaction in clinical research are to:

- Collect regular feedback from patients who have experienced care as part of a research study through patient satisfaction surveys, friends and family initiatives and regular public engagement events. The Trust’s Patient Carer and Public Involvement Manager, in collaboration with the CRN NENC PPIE Team, will collate data from these surveys, reporting results nationally and to the Trust Board every 6 months to help shape future service provision in clinical research.

This indicator will be monitored and reported to the Trust Board.

### Priority 12 – Accessibility for Service Users/Carers

Accessibility for Service Users/carers is about making services easier to use for all people. Our aim is to improve accessibility for our service users, we will achieve this by:

- Continuing work towards the full implementation of the Accessibility Information standard.
- Roll out and expand the detail of online accessibility guides for disabled patients and visitors in collaboration with Disabled Go.
- Complete a pilot of 24/7 British Sign Language provision for unplanned admission or where a face-to-face interpreter is unavailable with service user and staff evaluations to inform long-term provision options.
- Complete a pilot and evaluate the use of Video Relay Services enabling deaf patients to contact staff in the Trust from home via a third party interpreter relay.
- Continually review the quality and provision of language interpreting across the Trust.

This indicator will be monitored and reported to the Trust Board, the Patient Experience Steering Group and the Health Wellbeing and Equality Steering Group.

## Priority 13 - Dementia

The Trust has previously implemented a number of new initiatives and strategies to improve the care patients receive with dementia and continue to strive to make further improvements. We aim to work in partnership with carers and families of patients who are living with dementia in line with the Trust's Dementia Strategy 2015 – 2020. We will work towards embedding a positive culture of patient and carer involvement in all decision making. In order to do this we will:

- Sustain and improve use of "Forget Me Not" cards across the Trust.
- Re-launch a core care plan specifically focusing on support, signposting and information for carers and families.
- Introduce a new "Forget me Not" assessment which has a specific section on information for carers.
- Reinforce and extend flexible visiting in line with John's Campaign. (John's Campaign was founded in November 2014 by Nicci Gerrard and Julia Jones. Behind its simple statement of purpose lies the belief that carers should not just be allowed but should be welcomed, and that collaboration between the patients and all connected with them is crucial to their health and their well-being. John's Campaign applies to all hospital settings: acute, community, mental health and its principles could extend to all other caring institutions where people are living away from those closest to them). Further details can be found on <http://johnscampaign.org.uk/#/>.

- Pilot a new questionnaire for carers to complete when attending the Emergency Department with their relative. This questionnaire will provide information about the person attending hospital and their care needs.
- Continue to promote and encourage carer representation on the Trust Dementia Care Steering Group.
- Promote and enable carer involvement in the delivery of in-house dementia care training.

The Dementia Care Team will continue to: -

- Support the patients and carers who receive a diagnosis of dementia at the Melville Day Unit.
- Lead a "memory Café" on a Friday afternoon, once a month at the Melville Day Unit.
- Provide a bespoke "Forget Ne Not" information bags (containing a number of information resources) to carers of patients with dementia throughout the Trust.
- Seek regular feedback from carers using questionnaires; piloting a new system of 'carer feedback days' and acting on feedback to achieve constant quality improvement.

This indicator will be monitored and reported to the Trust Board.

## Commissioning for Quality and Innovation (CQUIN) Indicators

The Commissioning for Quality and Innovation (CQUIN) payment framework is designed to support the cultural shift to put quality at the heart of the NHS. Local CQUIN schemes contain goals for quality and innovation that have been agreed between the Trust and various Commissioning groups. Listed below are the quality and/or innovation projects which have been agreed with the Commissioners for 2017/2018.

<p><b>CQUIN Indicators - Acute Hospital - (NHS England)</b></p> <ul style="list-style-type: none"> <li>• Shared Decision Making</li> <li>• SACT (Dose banding for intravenous anticancer therapy)</li> <li>• Optimising palliative chemo decision making</li> <li>• Enhanced supportive care</li> <li>• Cystic fibrosis patient adherence</li> <li>• Auto-immune management</li> <li>• Paediatric networked care</li> <li>• Neonatal community outreach</li> <li>• Improving HCV treatment pathways</li> <li>• TECS Project</li> </ul>	<p><b>CQUIN Indicators - Acute Hospital - (CCG)</b></p> <ul style="list-style-type: none"> <li>• Improving staff health and wellbeing</li> <li>• Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)</li> <li>• Improving services for people with mental health needs who present to A&amp;E</li> <li>• Offering advice and guidance</li> <li>• NHS e-Referrals – 1 year scheme</li> <li>• Supporting proactive and safe discharge</li> </ul>
<p><b>CQUIN Indicators - Acute Hospital - (Public Health/Dental/other)</b></p> <ul style="list-style-type: none"> <li>• Dental Quality Dashboards</li> <li>• Breast screening</li> <li>• Stereotactic Radiosurgery</li> <li>• Armed Forces Covenant</li> </ul>	<p><b>CQUIN Indicators - Community</b></p> <ul style="list-style-type: none"> <li>• Improving staff health and wellbeing</li> <li>• Improving the assessment of wounds</li> <li>• Supporting proactive and safe discharge</li> <li>• Personalised care and support</li> <li>• End of Life Audit</li> <li>• Healthy Conversations</li> </ul>

**"The staff are very busy and I attend hospital as inpatient on a regular basis, the staff are very good and always have a smile and listen to your concerns."**



## Statement of assurance from the Board

During 2016/17 The Newcastle upon Tyne Hospitals NHS Foundation Trust provided and/or sub-contracted 17 relevant health services.

The Newcastle upon Tyne Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 17 of these relevant health services.

The income generated by the relevant health services reviewed in 2016/17 represents 100 per cent of the total income generated from the provision of relevant health services by the Newcastle upon Tyne Hospitals NHS Foundation Trust for 2016/17.

The Newcastle upon Tyne Hospitals NHS Foundation Trust aims to put quality at the heart of everything we do and to constantly strive for improvement by monitoring effectiveness. High level parameters of quality and safety have been reported monthly to the Board and Council of Governors. Activity is monitored in respect to quality priorities and safety indicators by exception in the Integrated Quality Report, reported monthly to Trust Board and performance is compared with local and national standards.

Leadership walkabouts, coordinated by the Integrated Governance Manager involving Executive and Non-Executive Directors and members of the Senior Trust management team have been regularly conducted in a variety of departments across the Trust. These are reported to the Clinical Governance and Quality Committee, a standing committee of the Trust Board, and any actions reported on acted upon and followed up.

The Trust Complaints Panel is chaired by a Non-Executive Director of the Trust and reports directly to the Trust Board, picking up any areas of concern with individual Directorates as necessary.

The monthly Clinical Assurance Tool (CAT) continues to provide clinical assurance to the Trust Board as an overview of performance against a wide range of clinical and environmental measures for each ward and Directorate. The aim of the CAT is to measure and demonstrate compliance with the published documents and national drivers such as High Impact Actions, Saving Lives as well as providing useful data to support, verify and offer assurance for external inspectorates.

Feedback and, where necessary, reports on improvement actions are provided to the Trust Board via the monthly Integrated Quality Report.

**Kingsley W Smith OBE**  
Chairman

## Information on participation in National Clinical Audits and National Confidential Enquiries

During 2016/17, 50 national clinical audits and 9 national confidential enquiry reports covered NHS services that The Newcastle upon Tyne Foundation Hospitals NHS Foundation Trust provides.

During that period, The Newcastle upon Tyne Hospitals NHS Foundation Trust participated in 98% national clinical audits and 100% of the national confidential enquiries which it was eligible to participate in. The only audit in which the Trust did not participate was the Learning Disability Mortality Review Programme.

The national clinical audits and national confidential enquiries that The Newcastle upon Tyne Hospitals NHS Foundation Trust was eligible to participate in during 2016/17 are as follows:

National Clinical Audits			National Confidential Enquiries
Acute Coronary syndrome or Acute Myocardial Infarction (MINAP)	Learning Disability Mortality Review Programme	National Vascular Registry	Maternal, Newborn and Infant Clinical Outcome Review Programme <ul style="list-style-type: none"> <li>• Maternity Surveillance</li> <li>• Perinatal Mortality Surveillance</li> </ul>
Adult Asthma	Major Trauma Audit	Neonatal Intensive and Special Care (NNAP)	Medical and Surgical Outcome Review Programme: <ul style="list-style-type: none"> <li>• Mental Health</li> <li>• Acute Pancreatitis</li> <li>• Sepsis</li> <li>• Acute Non-invasive Ventilation</li> <li>• Gastrointestinal Haemorrhage</li> </ul>
Adult Cardiac Surgery	National Audit of Dementia	Nephrectomy Audit	Child Health Outcome Review Programme <ul style="list-style-type: none"> <li>• Chronic Neurodisability</li> <li>• Adolescent Mental Health</li> </ul>
Asthma (paediatric and adult) care in Emergency Department	National Audit of Pulmonary Hypertension	Oesophago-gastric Cancer	
Bowel cancer (NBOCAP)	National Cardiac Arrest Audit	Paediatric Intensive care (PICANet)	
Cardiac Rhythm Management	National Chronic Obstructive Pulmonary Disease Audit programme	Paediatric pneumonia	
Case Mix Programme	National Comparative Audit of Blood Transfusion	Percutaneous Nephrolithotomy	
Congenital Heart Disease	National Diabetes Audit - Adults	Radical Prostatectomy Audit	
Coronary Angioplasty / National Audit of Percutaneous Coronary Interventions	National Emergency Laparotomy Audit	Renal Replacement Therapy	
Diabetes (Paediatrics)	National Heart Failure Audit	Rheumatoid and Early Arthritis	
Elective Surgery (National PROMs Programme)	National Joint Registry	Sentinel Stroke National Audit programme	
Endocrine and Thyroid National Audit	National Lung Cancer Audit	Severe sepsis and Septic Shock - care in Emergency Department	
Falls and Fragility fractures Audit Programme (Fracture Liaison Database, Inpatient Falls and National Hip Fracture database)	National Neurosurgery Audit Programme	Specialist rehabilitation for patients with complex needs	
Head and neck cancer audit (HANA)	National Ophthalmology Audit	Stress Urinary Incontinence Audit	
Inflammatory Bowel Disease programme	National Prostate Cancer Audit	UK Cystic Fibrosis Registry	

The national clinical audits and national confidential enquiries that The Newcastle upon Tyne Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2016/17, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.



National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2016/17	Percentage Data completion	Outcome
Acute Myocardial Infarction	National Institute for Cardiovascular Outcomes Research (NICOR)	The Myocardial Ischaemia National Audit Project (MINAP) was established in 1999 in response to the National Service Framework (NSF) for Coronary Heart Disease, to examine the quality of management of heart attacks (Myocardial Infarction) in hospitals in England and Wales.	✓	100%	Action plan developed
Adult Asthma	British Thoracic Society	This audit looks at hospital admissions due to asthma and builds on the information from similar audits in previous years	✓	100%	As yet no date has been identified for publication.
Adult Cardiac Surgery	NICOR	This audit looks at heart operations. Details of who undertakes the operations, the general health of the patients, the nature and outcome of the operation, particularly mortality rates in relation to preoperative risk and major complications.	✓	Ongoing	As data runs for entire 2016/17 report date as yet unknown
Asthma (paediatric and adult) care in Emergency Department	Royal College of Emergency Medicine	The audit includes Adults (16 years and over) presenting to the ED with moderate or acute severe asthma and Children (2-15 years) presenting to the ED with moderate or acute severe asthma	✓	100%	Report not due to be published until May 2017
Bowel Cancer (NBOCA)	Health & Social Care Information Centre	Colorectal (large bowel) cancer is the most common cancer in non-smokers and second most common cause of death from cancer in England and Wales. Each year over 30,000 new cases are diagnosed, and bowel cancer is registered as the underlying cause of death in half of this number.	✓	93%	Action plan developed
Cardiac Rhythm Management	NICOR	The audit aims to monitor the use of implantable devices and interventional procedures for management of cardiac rhythm disorders in UK hospitals.	✓	100%	Compliant
Case Mix Programme (Adult Critical Care)	Intensive Care National Audit and Research Centre (ICNARC)	The aim of the audit is to improve resuscitation care and patient outcomes for the UK and Ireland.	✓	100%	Compliant
Child Health Clinical Outcome Review Programme – Chronic NeuroDisability	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	The programme uses both data linkage and case note review to build on the work of previous child health confidential enquiries which have highlighted a number of issues, in particular that children with chronic conditions, principally neurological comprise the majority of deaths in children over 1 year.	✓	Ongoing	Report due to be published in November 2017
Child Health Clinical Outcome Review Programme – Adolescent Psychiatry			✓	Ongoing	Report due to be published in November 2017
Congenital Heart Disease (Paediatric Cardiac Surgery)	NICOR	The congenital heart disease website profiles every congenital heart disease centre in the UK, including the number and range of procedures they carry out and survival rates for the most common types of treatment.	✓	Ongoing	Date of report release unknown.
Coronary Angioplasty / National Audit of PCI	NICOR	This project looks at percutaneous coronary intervention (PCI) procedures performed in the UK. The audit collects and analyses data on the nature and outcome of PCI procedures, who performs them and the general health of patients. The audit utilises the Central Cardiac Audit Database (CCAD) which has developed secure data collection, analysis and monitoring tools and provides a common infrastructure for all the coronary heart disease audits.	✓	100%	Action plan developed
Diabetes (Paediatric)	Royal College of Child Health and Paediatrics (RCPH)	The audit covers registrations, complications, care process and treatment targets.	✓	90%	Report due to be published in May 2017

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2016/17	Percentage Data completion	Outcome
Elective Surgery (National PROMS Programme)	Health & Social Care Information Centre	The audit looks at the change in patients' self-reported health status for groin hernia surgery, hip replacement, knee replacement and varicose vein surgery.	✓	100%	Compliant
Endocrine and Thyroid National Audit	British Association of Endocrine and Thyroid Surgeons (BAETS)	BAETS owns and manages the UK Registry of Endocrine and Thyroid Surgery (UKRETS) which is an electronic audit of endocrine operations performed in the UK.	✓	Ongoing	Date for publication as yet unknown
Falls and Fragility Fractures Audit Programme – Fracture Liaison Service Database	RCPH	The Falls and Fragility Fracture Audit Programme (FFFAP) is a national clinical audit run by the Royal College of Physicians designed to audit the care that patients with fragility fractures and inpatient falls receive in hospital and to facilitate quality improvement initiatives.	✓	100%	Report due to be published in April 2017
Falls and Fragility Fractures Audit Programme including National Hip Fracture database	RCPH	The Falls and Fragility Fracture Audit Programme (FFFAP) is a national clinical audit run by the Royal College of Physicians designed to audit the care that patients with fragility fractures and inpatient falls receive in hospital and to facilitate quality improvement initiatives.	✓	100%	Action plan developed
Falls and Fragility Fractures Audit Programme – Falls Audit	RCPH	The Falls and Fragility Fracture Audit Programme (FFFAP) is a national clinical audit run by the Royal College of Physicians designed to audit the care that patients with fragility fractures and inpatient falls receive in hospital and to facilitate quality improvement initiatives.	✓	100%	Report due to be published in March 2017 but has been delayed
Head and Neck Cancer Audit	The Facial Surgery Research Foundation (Saving Faces)	The National Head and Neck Cancer Audit focuses on cancer sites within the head and neck (excluding tumours of the brain and thyroid cancers). The most common of which being the larynx and in the oral cavity.	✓	100%	Date of report release unknown
Inflammatory Bowel Disease - Biologics	RCP	The purpose of this audit is to measure the efficacy, safety and appropriate use of biological therapies in patients with inflammatory bowel disease in the UK.	✓	100%	Action plan developed
Learning Disability Mortality Review Programme	University of Bristol	The Learning Disabilities Mortality Review (LeDeR) Programme aims to make improvements to the lives of people with learning disabilities. It clarifies any potentially modifiable factors associated with a person's death, and works to ensure that these are not repeated elsewhere.	✗	N/A	The Trust does not participate in national LD mortality review because the region as a whole has not agreed to do so. The Trust will work with other local partners to agree further developments and participation in 2017/18
Major Trauma: Trauma Audit & Research Network	Trauma Audit Research Network (TARN)	TARN is working towards improving emergency health care systems by collating and analysing trauma care	✓	Completeness 92% Accreditation 95%	Action plan developed
National Audit of Dementia	Royal College of Psychiatrists	The National Audit of Dementia is working with hospitals providing general acute inpatient services to measure criteria relating to care delivery which are known to impact on people with dementia admitted to hospital.	✓	100%	Report due to be published in May 2017
National Audit of Pulmonary Hypertension	Health and Social Care information Centre	The Pulmonary Hypertension Audit measures the quality of care, activity levels, access rates and patient outcomes of pulmonary hypertension services in centres designated by the National Commissioning Group.	✓	100%	Date of report release unknown

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2016/17	Percentage Data completion	Outcome
National Cardiac Arrest Audit	Intensive Care national Audit and research	The Resuscitation Council (UK) and the Intensive Care National Audit & Research Centre (ICNARC) have established a nationwide database of cardiac arrests that take place in hospital. The aim is to enable analysis of all in-hospital cardiac arrests and to compare the frequency of, and outcome from, cardiac arrest between hospitals.	✓	RVI Adults - 98% RVI Paediatrics - 96% FH Adults - 96% FH Paediatrics - 100%	Action plan developed
National Chronic obstructive Pulmonary Disease	Royal College of Physicians	The core aim of the programme is to drive improvements in the quality of care and services provided for COPD patients. Through collecting and linking patient journey data it will enable the comparison of performance and practice, highlight variations in patient care and outcomes, and seek to innovatively drive up standards of patient care.	✓	100%	Action plan developed
National Comparative Audit of Blood Transfusion – Blood Use in Elective Surgery	NHS Blood and Transplant	Audit of Patient Blood Management in adults undergoing elective, scheduled surgery.	✓	100%	Report was due to be published in January 2017 but as yet no report has been released
National Diabetes Footcare Audit	Health & Social Care Information Centre	National Diabetes Foot Care Audit enables all diabetes foot care services to measure their performance against NICE clinical guidelines and peer units, and to monitor adverse outcomes for people with diabetes who develop diabetic foot disease.	✓	100%	Action plan developed
National Pregnancy in Diabetes	Health & Social Care Information Centre	The National Pregnancy in Diabetes (NPID) Audit aims to support clinical teams to deliver better care and outcomes for women with diabetes who become pregnant.	✓	100%	Action plan developed
Diabetes (Inpatient Adult)	Health & Social Care Information Centre	The National Diabetes Audit is considered to be the largest annual clinical audit in the world, providing an infrastructure for the collation, analysis, benchmarking and feedback of local data across the NHS.	✓	100%	Lead Clinician identified and action plan to be developed
National Emergency Laparotomy	Royal College of Anaesthetists	NELA aims to look at structure, process and outcome measures for the quality of care received by patients undergoing emergency laparotomy.	✓	100%	Action plan developed
National Heart Failure	NICOR	The aim of this project is to improve the quality of care for patients with heart failure through continual audit and to support the implementation of the national service framework for coronary heart disease.	✓	100%	Date of report release unknown
National Joint Registry	National Joint Registry Centre	The audit covers clinical audit during the previous calendar year and outcomes including survivorship, mortality and length of stay.	✓	100%	Compliant
Lung Cancer (NLCA)	Health & Social Care Information Centre	Lung cancer has the highest mortality rate of all forms of cancer in the western world and there is evidence that the UK's survival rates compare poorly with those in the rest of Europe. There is also evidence that, in the UK, standards of care differ widely. The audit was set up in response to The NHS Cancer Plan, to monitor the introduction and effectiveness of cancer services.	✓	100%	Action plan developed
National Neurosurgery Audit programme	Society of British Neurological Surgeons	The aim of this programme is to engage units in a comprehensive audit programme that reflects the full spectrum of elective and emergency neurosurgical activity, and to provide a consistent and meaningful approach to reporting on national clinical audit and outcomes data.	✓	100%	Compliant

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2016/17	Percentage Data completion	Outcome
National Ophthalmology Audit	Royal College of Ophthalmologists	The project aims to prospectively collect, collate and analyse a standardised, nationally agreed cataract surgery dataset from all centres providing NHS cataract surgery in England & Wales to update benchmark standards of care and provide a powerful quality improvement tool. In addition to cataract surgery, electronic ophthalmology feasibility audits will be undertaken for glaucoma, retinal detachment surgery and age-related macular degeneration (AMD).	✓	100%	Action plan developed
National Prostate Cancer	Clinical Effectiveness Unit, Royal College of Surgeons	This first audit covers organizational elements of the service and whether key diagnostic, staging and therapeutic facilities are available on site for each provider of prostate cancer services.	✓	100%	Action plan developed
National Vascular Registry including CIA and elements of NVD	RCS	The audit addresses the outcome of surgery for patients who underwent two types of vascular procedure. The first is an elective repair of an infra-renal abdominal aortic aneurysm (AAA). The second is a carotid endarterectomy (CEA).	✓	100%	Action plan developed
Neonatal Intensive and Special Care	BTS	To assess whether babies requiring specialist neonatal care receive consistent high quality care and identify areas for improvement in relation to service delivery and the outcomes of care.	✓	100%	Action plan developed
Nephrectomy	BAUS	In 2015, PCNL data was published for the first time.	✓	100%	Compliant
Oesophago-gastric Cancer	Health & Social Care Information Centre	The oesophago-gastric (stomach) cancer audit aims to examine the quality of care given to patients and thereby help services to improve. The audit evaluates the process of care and the outcomes of treatment for all O-G cancer patients, both curative and palliative.	✓	100%	Action plan developed
Paediatric Intensive Care	University of Leeds	PICANet was established in 2002 and aims to continually support the improvement of paediatric intensive care provision throughout the UK by providing detailed information on paediatric intensive care activity and outcomes.	✓	100%	Compliant
Paediatric Pneumonia	British Thoracic Society	The British Thoracic Society (BTS) guidelines for the management of community-acquired pneumonia in children are used as the audit standard for the annual BTS Paediatric Pneumonia Audit.	✓	Ongoing	Report due to be published in August 2017
Percutaneous Nephrolithotomy (PCNL)	BAUS	In 2015, PCNL data was published for the first time.	✓	100%	Compliant
Radical Prostatectomy	BAUS	In 2015, Radical Prostatectomy data was published for the first time.	✓	100%	Compliant
Renal Replacement Registry	UK Renal Registry	The Registry contains analyses of data submitted via clinical information systems relating to direct clinical care and laboratory permit analyses.	✓	100%	Report due to be published in May 2017
Rheumatoid and Early Inflammatory Arthritis	British Society of Rheumatology	The overall aim of the audit is to improve the quality of care provided by specialist rheumatology services in the management of early inflammatory arthritis.	✓	100%	Action plan developed
Sentinel Stroke National Audit Programme	Health & Social Care Information Centre	The audit collects information about care provided to stroke patients in first three days of hospital. Data is continuous.	✓	100%	Action plan developed

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2016/17	Percentage Data completion	Outcome
Severe Sepsis and Septic Shock – Care in Emergency Department	Royal College of Emergency Medicine	The audit will identify current performance in EDs against RCEM clinical standards, show the results in comparison with other departments, and also across time if there was previous participation in 2011 or 2013.	✓	100%	Report due to be published in May 2017
Specialist rehabilitation for patients with complex needs	London North West Healthcare NHS Trust	The audit provides a comparative assessment of services provided in this area in relation to specialist injuries caused by events such as road accidents and falls etc.	✓	100%	Action plan developed
Stress Urinary Incontinence (SUI) in Women	BAUS	In 2015, SUI data was published for the first time.	✓	100%	Compliant
UK Cystic Fibrosis Registry (Paediatrics)	Cystic Fibrosis Trust	The audit aims to examine both life expectancy and quality of life for children with Cystic Fibrosis.	✓	100%	Compliant
UK Cystic Fibrosis Registry (Adults)	Cystic Fibrosis Trust	The audit aims to examine both life expectancy and quality of life for adults with Cystic Fibrosis.	✓	100%	Action plan developed
Maternal Infant and Newborn Clinical Outcome review Programme – Maternity Surveillance	Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries across the UK	The programme investigates the deaths of women and their babies during or after childbirth, and also cases where women and their babies survive serious illness during pregnancy or after childbirth.	✓	100%	Action plan currently being developed
Maternal Infant and Newborn Clinical Outcome review Programme – Perinatal mortality surveillance			✓	100%	Report due to be published in May 2017
NCEPOD –Mental Health in General Hospitals study	NCEPOD	To explore the overall quality of mental health and physical health care provided to patients with a significant mental disorder (listed in study population criteria) who are admitted to a general hospital.	✓	100%	Lead Clinician identified and action plan to be developed.
NCEPOD – Acute Pancreatitis	NCEPOD	To explore remediable factors in the processes of care of patients, aged 16 or over, who are admitted to hospital with a diagnosis of Acute Pancreatitis.	✓	82%	Action plan developed
NCEPOD – Sepsis	NCEPOD	The aim of the study was to identify and explore remediable factors in the process of care for patients with sepsis.	✓	100%	Action plan developed
NCEPOD – Acute non-invasive ventilation	NCEPOD	To identify and explore avoidable and remediable factors in the process of care for patients treated with non-invasive ventilation	✓	100%	Report due to be published in June 2017
NCEPOD – Gastrointestinal Haemorrhage	NCEPOD	To identify the remediable factors in the quality of care provided to patients treated for a GI bleed who received 4 or more units of blood.	✓	100%	Action plan developed

An additional 13 audits have been added to the list for inclusion in 2017/18 Quality Accounts and all 10 audits are relevant to services provided by the Trust. The eight audits include:

- BAUS Urology Audits: Cystectomy
- BAUS Urology Audits: Urethroplasty
- BAUS Urology Audits: Female stress urinary incontinence
- National audit of Anxiety and Depression
- National Bariatric Surgery
- National End of Life Care Audit
- National Maternity and Perinatal Audit
- Non-invasive ventilation Audit
- Pain in Children – Care in Emergency Departments
- Pleural Procedures
- Procedural Sedation in Adults – Care in Emergency Departments
- Serious Hazards of Transfusion: UK National Haemovigilance scheme
- Smoking Cessation.

Lead clinicians for each of the national audits included in the Quality Account provide the Clinical Governance and Risk Department with six monthly status positions on the implementation of each reports finding and this is discussed at the Clinical Effectiveness, Audit and Guidelines Committee.

The reports of all national clinical audits were reviewed by the provider in 2016/17 and The Newcastle upon Tyne Hospitals NHS Foundation Trust has taken the following actions to improve the quality of healthcare provided:

- The Trust has now firmly embedded monitoring arrangements for national clinical audits with the identified the lead clinician asked to complete an action plan and present this to the Clinical Effectiveness, Audit and Guidelines Committee
- On an annual basis the Committee receives a report on the projects in which the Trust participates and requires the lead clinician of each audit programme to identify any potential risk, where there are concerns action plans will be monitored on a three monthly basis
- In addition, each Directorate is required to present an Annual Clinical Audit Report to the Clinical Effectiveness, Audit and Guidelines Committee detailing all audit activity undertaken both national and local. Clinicians are required to report all audit activity using the Trust's Clinical Effectiveness Register

- Involvement in National audits is monitored at the Patient Safety and Quality Reviews where a data pack is provided that contains audit compliance
- Compliance with National Confidential Enquiries is reported to the Clinical Governance and Quality Committee and exceptions subject to detailed scrutiny and where compliance cannot be achieved this is evidenced onto the Trust Risk Register and monitored accordingly
- Non-compliance with recommendations from National Clinical Audit and National Confidential Enquiries are considered in the Annual Business Planning process.

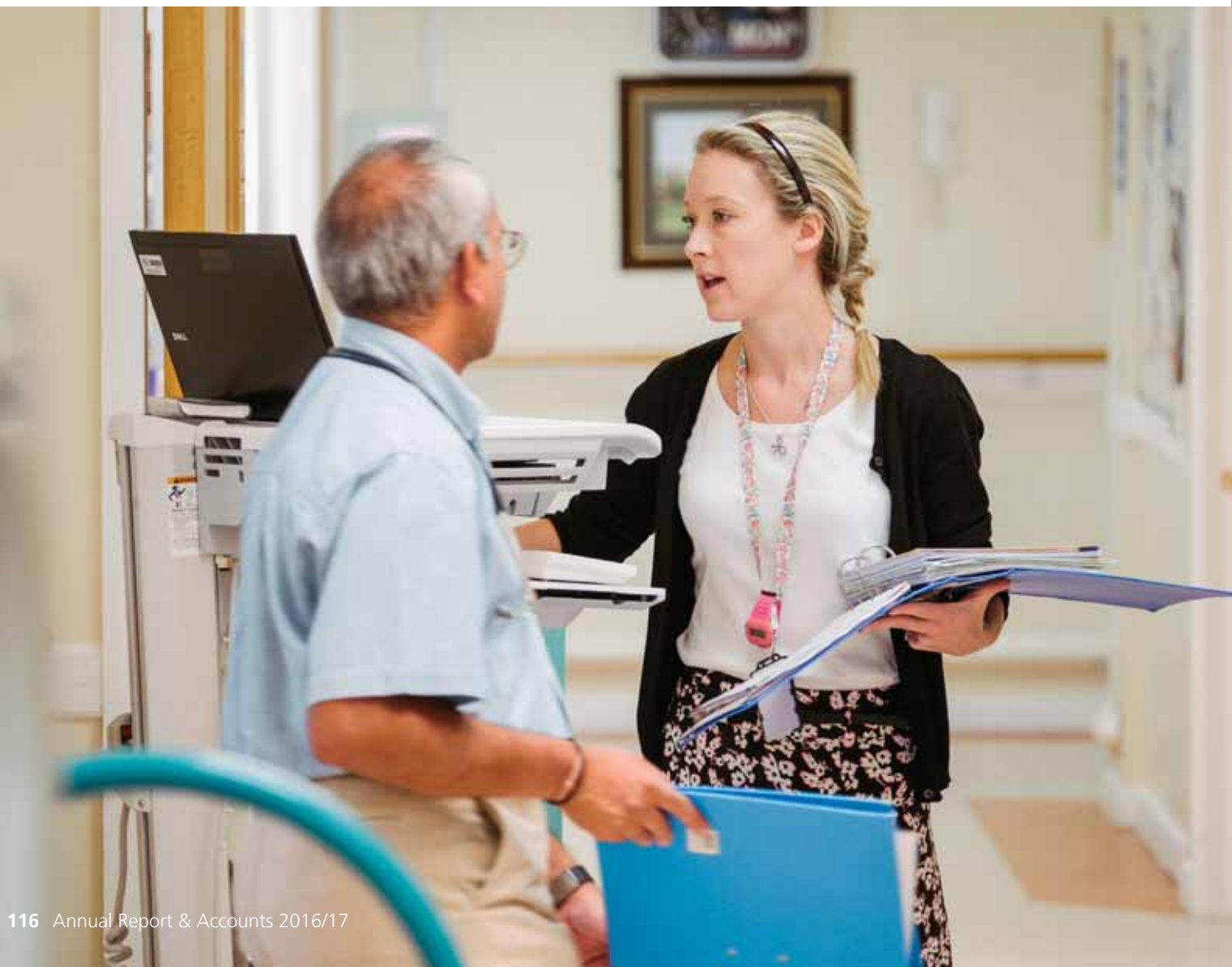
All the above have been actioned and are in place.

The reports of 558 local audits were reviewed by the provider in 2016/17 and The Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following action to improve the quality of health care provided:

- Each Clinical Directorate is required to present an Annual Clinical Audit Report to the Clinical Effectiveness, Audit and Guidelines Committee detailing all audit activity undertaken both national and local.

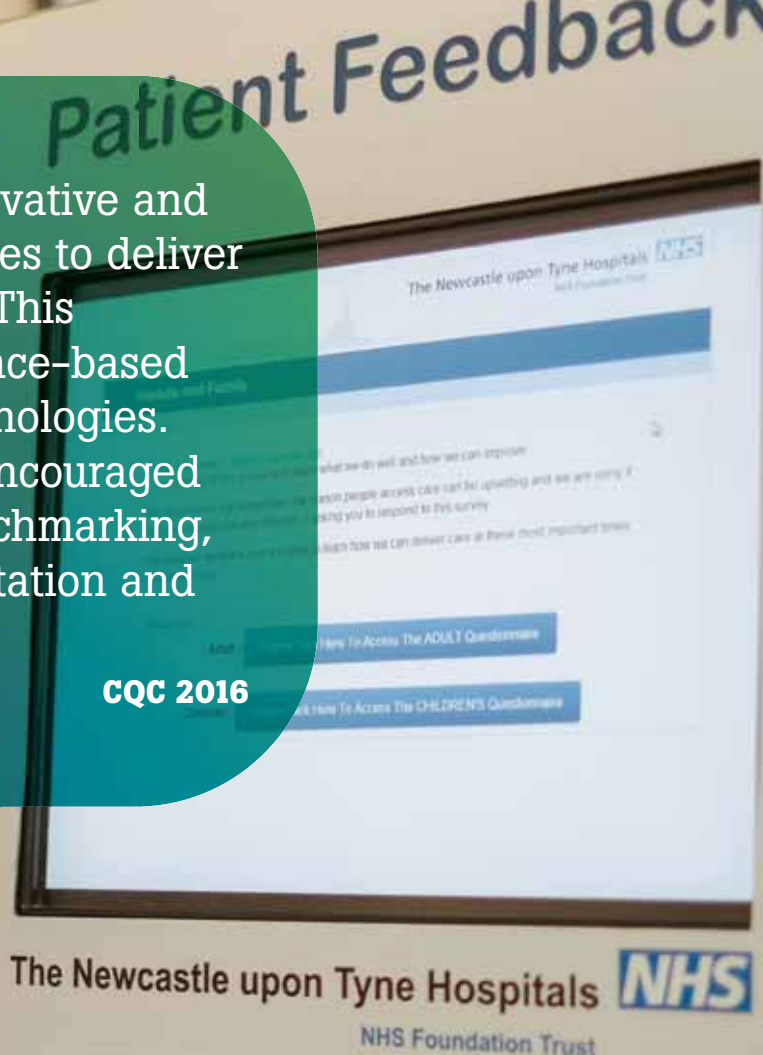
## Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by The Newcastle upon Tyne Hospitals NHS Foundation Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 14,972 of which 12,541 were UKCRN National Portfolio studies which equates to 39% of all patients recruited to National Portfolio studies in the region. The Newcastle Upon Tyne Hospitals NHS Trust is the country's top performing trust for volume of clinical research for five years running.



“The Trust used innovative and pioneering approaches to deliver care and treatment. This included new evidence-based techniques and technologies. Staff were actively encouraged to participate in benchmarking, peer review, accreditation and research”

CQC 2016



### Information on the use of the CQUIN framework

A proportion of The Newcastle upon Tyne Hospital NHS Foundation Trust income in 2016/2017 was conditional upon achieving quality improvement and innovation goals agreed between The Newcastle upon Tyne Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement for the provision of relevant health services, through Commissioning for Quality Innovation (CQUIN) payment framework.

The monetary total for the amount of income in 2016/17 conditional upon achieving quality improvement and innovation goals is £17.7 million. For 2015/16 due to the national payment tariff selected by the Trust we were not eligible to participate in the CQUIN scheme therefore received no CQUIN payments.

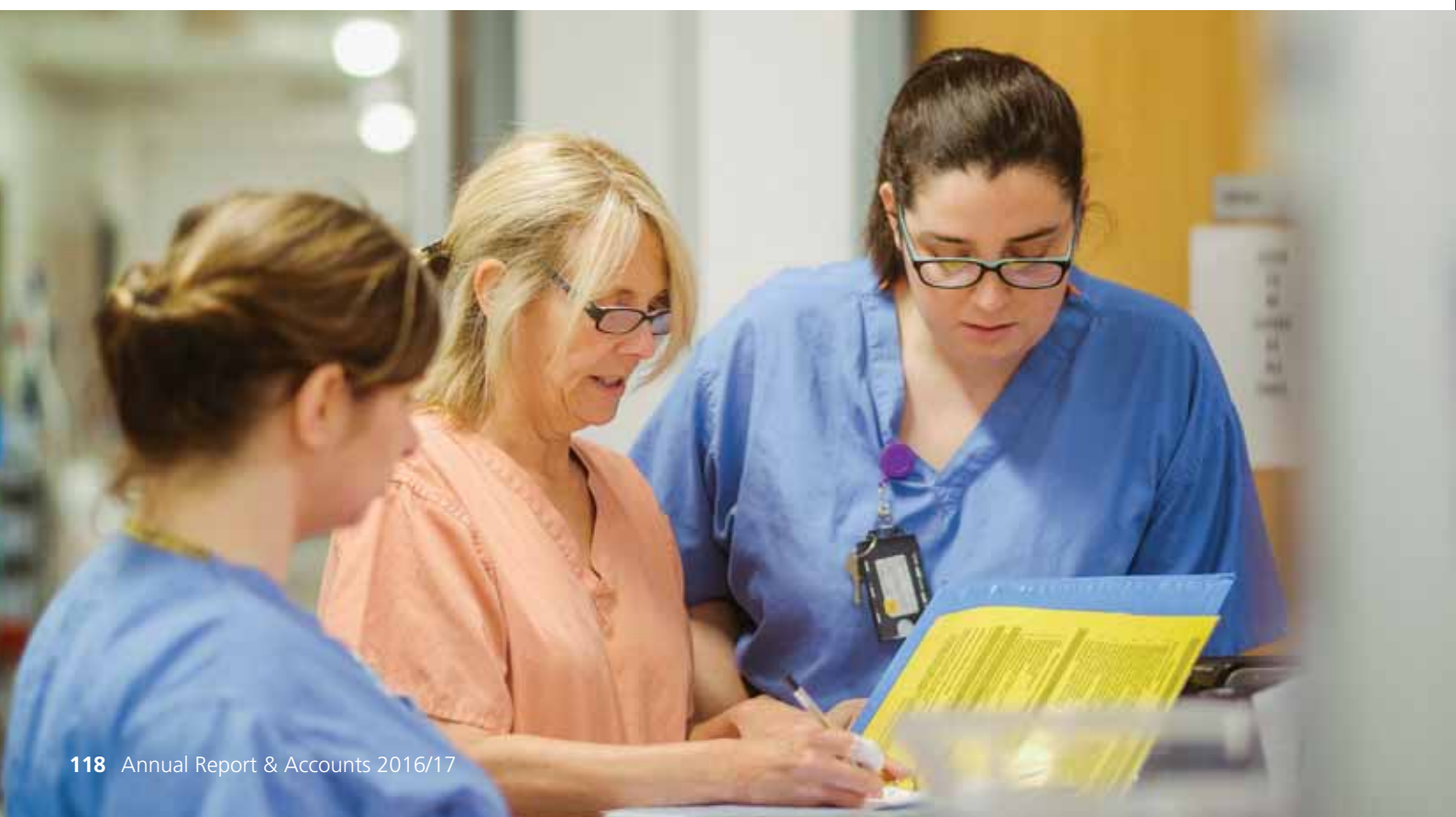
CQUIN Indicators CCG 2016/2017	Origin	Service	Status
<b>Staff Health &amp; Well-being</b> <ul style="list-style-type: none"> <li>• Introduction of health and well-being initiatives</li> <li>• Healthy food for NHS staff, visitors and patients</li> <li>• Improving the uptake of vaccinations for front line staff within providers</li> </ul>	National	Acute & community	
<b>Sepsis Screening</b> <ul style="list-style-type: none"> <li>• Timely identification and treatment for sepsis in ED</li> <li>• Timely identification and treatment for sepsis in Acute inpatient settings</li> </ul>	National	Acute	
<b>Antimicrobial resistance and antimicrobial stewardship</b> <ul style="list-style-type: none"> <li>• Reduction in antibiotic consumption per 1000 admissions</li> <li>• Empiric review of antibiotic prescribing</li> </ul>	National	Acute	
<b>Transformation</b> <ul style="list-style-type: none"> <li>• Individual funding requests</li> <li>• Virtual fracture clinic</li> <li>• CATS for Neurology</li> <li>• Dermatology Referral triage</li> <li>• TECS</li> <li>• Urgent Clinic Promotion</li> <li>• Advice and guidance – Service for immunology and allergy</li> </ul>	National	Acute	

CQUIN Indicators COMMUNITY 2016/2017	Origin	Service	Status
<b>Staff Health and Well-being</b> <ul style="list-style-type: none"> <li>• Introduction of health and well-being initiatives</li> <li>• Healthy food for NHS staff, visitors and patients</li> <li>• Improving the uptake of vaccinations for front line staff within providers</li> </ul>	National	Community	
<b>End of Life Care</b>	Local	Community	
<b>Every Contact Counts</b>	Local	Community	

CQUIN Indicators SPECIALISED 2016/2017	Origin	Service	Status
<b>Optimal Devices (cardiac)</b> <ul style="list-style-type: none"> <li>• Use of the right specification of device appropriate to patients clinical needs</li> </ul>	National	Acute	
<b>Enhanced Supportive Care access for Advanced Cancer Patients</b> <ul style="list-style-type: none"> <li>• To improve access to Enhanced Supportive Care for patients with a diagnosis, of incurable cancer.</li> </ul>	National	Acute	
<b>Adult Critical Care Timely Discharge</b> <ul style="list-style-type: none"> <li>• Discharge from Adult Critical Care within 4h/24h of clinical decision to discharge</li> </ul>	National	Acute	
<b>CAMHS Screening for Paediatric Patients with Long Term Conditions</b> <ul style="list-style-type: none"> <li>• Improve screening for children with relevant long term conditions</li> </ul>	National	Acute	
<b>Hepatitis Virus Improving Treatment Pathways through Operational Delivery</b>	National	Acute	
<b>TEC (telemedicine)</b>	National	Acute	
<b>Stereotactic Radiosurgery</b>	National	Acute	

CQUIN Indicators DENTAL & SCREENING 2016/2017	Origin	Service	Status
<b>Dental Dashboard and audit</b> <ul style="list-style-type: none"> <li>• Compliance with dental dashboard</li> </ul>	National	Acute	
<b>Dental Networks</b> <ul style="list-style-type: none"> <li>• Payable for attendance at networks</li> </ul>	National	Acute	
<b>Breast Screening</b> <ul style="list-style-type: none"> <li>• Identifying geographical areas with low uptake and planning to improve.</li> </ul>	National	Acute	

Further details of the agreed goals for 2016/17 and for the following 12 month period are available electronically at:  
<https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-16-17/>





## Information relating to registration with the Care Quality Commission (CQC)

Inspected and rated

Outstanding 



The Newcastle upon Tyne Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'Registered Without Conditions'. The Newcastle upon Tyne Hospital NHS Foundation Trust is registered with the CQC to deliver care from five separate locations and for eleven regulated activities.

The Care Quality Commission has not taken enforcement action against The Newcastle upon Tyne Hospitals NHS Foundation Trust during 2016/17.

The Newcastle upon Tyne Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the 2016/17.

The Newcastle upon Tyne Hospitals NHS Foundation Trust received a full inspection of all services during January 2016. Following this inspection Newcastle Hospitals was graded as 'Outstanding'.

“Outstanding work! This is a world class hospital”

“Nothing was too much trouble and I could not have been more satisfied”

“Every single person I met introduced themselves to me by their name which helped to put me at ease”

“I just can't commend the staff highly enough for the excellent service they provided”

Overall rating for this Trust	Outstanding	☆
Are services at this Trust safe?	Good	●
Are services at this Trust effective?	Outstanding	☆
Are services at this Trust caring?	Outstanding	☆
Are services at this Trust responsive?	Outstanding	☆
Are services at this Trust well-led?	Outstanding	☆

#### Royal Victoria Infirmary Ratings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Services	Requires improvement	Good	Good	Good	Good	Good
Medical Care	Good	Outstanding	Good	Good	Good	Good
Surgery	Good	Good	Outstanding	Outstanding	Outstanding	Outstanding
Critical Care	Outstanding	Outstanding	Outstanding	Good	Outstanding	Outstanding
Maternity and Gynaecology	Good	Outstanding	Outstanding	Good	Outstanding	Outstanding
Services for children and young people	Requires improvement	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
End of Life care	Good	Good	Good	Good	Requires improvement	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
<b>Overall</b>	Requires improvement	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding

#### Freeman Hospital Ratings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical Care	Good	Outstanding	Outstanding	Good	Good	Outstanding
Surgery	Good	Good	Outstanding	Outstanding	Outstanding	Outstanding
Critical Care	Outstanding	Outstanding	Outstanding	Good	Outstanding	Outstanding
Services for children and young people	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
End of Life care	Good	Good	Good	Good	Requires improvement	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
<b>Overall</b>	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding

#### Dental Hospital Ratings

	Safe	Effective	Caring	Responsive	Well-led	Overall
<b>Overall</b>	Good	Outstanding	Good	Good	Outstanding	Outstanding

#### Community Services Ratings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community Health Services for adults	Good	Good	Good	Good	Good	Good
Community Health Services for children, young people and families	Good	Good	Good	Good	Good	Good
Community End of Life Care Services	Good	Good	Good	Good	Good	Good
Community Health Dental Services	Good	Good	Good	Good	Good	Good
<b>Overall</b>	Good	Good	Good	Good	Good	Good

#### Overall Trust Rating - OUTSTANDING

	Safe	Effective	Caring	Responsive	Well-led	Overall
<b>Overall</b>	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding

## Action Plan

Service	Domain	Action Required	Action Taken	Time Frame
Urgent & Emergency Services	Safe	Ensure that care documentation in the Emergency Care Department and on some wards are fully completed to reflect accurately the treatment, care and support given to patients, and is subject to clinical audit.	Medical and nursing record keeping audit process reviewed and improved. Care documentation in ED enhanced including the introduction of electronic risk assessments . Electronic records and introduction of e-documentation went live on November 9th 2016. Electronic documentation of patients nursing assessment is now active.	Action complete
		Ensure that all housekeeping staff who undertake mattress decontamination audits are aware of the Trust policy relating to mattress cleanliness and the criteria for when to condemn a mattress.	Trolleys are now included in the Trust Mattress Audit. An initial audit of the new system has been undertaken.	Action complete
Services for Children and Young People	Safe	Continue to develop plans to ensure that staffing levels in the Neonatal Unit meet the British Association of Perinatal Medicine guidelines.	The original business case for NIC staffing was supported in principle but funding not secured. It has been revised and resubmitted for further consideration. In recognition of the staffing situation, 2 IC and 6 SC cots on the whole remain closed. The Executive Team agreed to over recruit to 10wte band 5's, supported by slippage in the Directorate. The Unit is extending Practice Support to move new recruits swiftly through the competencies to work in IC and have set out a plan to open cots dependant on securing funds. Last year, we recruited 36 nurses and have recruited 10 to date in 2017. This has enabled us to fill posts in the newly funded Transport service as well as the unit.	Action complete
End of Life care	Well led	Ensure that the departmental risk register in the End of Life Care accurately reflects the current clinical and non-clinical risks faced by the Directorate.	Risks added to the appropriate Trust and/or Directorate risk registers.	Action complete
		Ensure that the Care For The Dying Patient documentation is fully implemented and embedded across acute hospital sites.	The roll out of the Caring for the Dying Patient Document continues as planned and on target. All acute areas with more than 12 deaths per year are using the document-with ongoing support from the End of Life Team. The remaining 8/39 areas are currently receiving in-depth training. All areas are receiving input from the newly appointed Clinical Educator for End of Life Care as and when patients are identified to be in last days/hours of life (Mon-Fri).	All wards with >12 deaths per year are using the document with training from EOL Team .

“We will continue, to commit a lot of time and energy to supporting the sustainability and transformation programme for Northumberland, Tyne and Wear, and North Durham. Organisations in this area have a strong track record of successfully working in partnership together and we are confident that despite the challenges facing the local health and social care system, we can make a real positive difference to the long term health and wellbeing of the communities we serve.”

# A Trust to be proud of



“Staff were proud to work in the organisation and spoke highly of the quality of care provided”

“There was a deep ethos amongst the medical and nursing team about *‘going the extra mile’*”

“There was a very strong, visible patient centred approach to holistic care delivery from all clinical staff across all disciplines. This ethos and spirit permeated throughout the service with patients consistently describing the care they received as *‘excellent’*. Staff put patients first and were determined to meet all elements of their care needs. This desire to deliver exceptional care was not limited to clinicians and we observed examples of true compassion and kindness”

“Managers and staff created a strong, visible, person-centred culture and were highly motivated and inspired to offer the best possible care”

“We found a positive open culture with confident, knowledgeable staff at all levels”

“Every member of staff contributed to the overall care and well-being of patients and families, from domestic staff to clinical leads”

“Overwhelmingly we received feedback that care was excellent and compassionate”



Healthcare at its very best – with a personal touch

## Information on the Quality of Data

The Newcastle upon Tyne Hospitals NHS Foundation submitted records during 2016/17 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data (April 2016 – January 2017). The percentage of records in the published data:

- which included the patients valid NHS number was:

- 98.9% for admitted patient care;
- 99.2% for outpatient care;
- 97.6% for accident and emergency care.

- which included the patients valid General Medical Practice Code was:

- 100% for admitted patient care;
- 100% for outpatient care;
- 100% for accident and emergency care.

The Newcastle upon Tyne Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2016/17 was 92% and was graded Green.

## Clinical Coding Information

### Score for 2016/17 for Information Quality and Records Management, assessed using the Information Governance Toolkit

The Newcastle upon Tyne Hospitals NHS Foundation Trust annual Information Governance Audit 2016/17 for diagnoses and treatment coding of inpatient activity achieved IGT level 3 in three of the four indicators recommended by NHS digital. This is the highest level of attainment. However the Trust's accuracy of primary diagnoses was marginally below at level 2 making the overall IGT level of achievement level 2. Please see tables below detailing IGT attainment requirements (Table 1) and the Trust overall results (Table 2):

The Newcastle upon Tyne Hospitals NHS Foundation Trust was subject to Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnosis and treatment coding are detailed in table 1.

Table 1: Table of Attainment Requirements

Area	Levels of Attainment	
	Level Two	Level Three
Primary diagnosis	>=90%	>=95%
Secondary diagnosis	>=80%	>=90%
Primary procedure	>=90%	>=95%
Secondary procedure	>=80%	>=90%

Table 2: % Trust Coding Accuracy Levels of Attainment

Area	% Correct	Level of Attainment
Primary diagnosis	93.5%	Level Two
Secondary diagnosis	90.3%	Level Three
Primary procedure	95.0%	Level Three
Secondary procedure	95.0%	Level Three

The Newcastle upon Tyne Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

- Ensure the full case note is made available to the coder to ensure capture of co-morbidities and other relevant conditions.
- Feedback all errors highlighted throughout the audit to the clinical coders reiterating the importance of assigning all mandatory and relevant co-morbidities.
- Undertake specialty specific training in coding Gynaecology ensuring standards relating to female prolapse and miscarriage and abortion are accurately applied.
- Reiterate to coders the importance of re-visiting histology reports and updating the coded information as necessary.
- Feedback to Clinicians the importance of dating all care pathways.

The performance of the Trust compared with the national average error rate, measured against the proportion of episodes changing payment, 2.3%, places it in the top 25% of best performing Trusts.

**“The Trust, the wider NHS and our social partners have faced – and will continue to face in 2017-18 – some major challenges in maintaining the provision of the high level of care that people deserve and our staff want to deliver day in, day out.”**



## Core set of Quality Indicators

(Data is compared nationally when available from the NHS Digital Indicator portal). Where national data is not available the Trust has reviewed our own internal data. Any and all updated data is presented.

Measure	Data Source	Target	Value	2016/17			
				Oct 15-Sept 16 NUTH Value: <b>0.97</b>	July 15-June 16 NUTH Value: <b>0.98</b>	April 15-Mar16 NUTH Value: <b>0.98</b>	Jan 15-Dec 15 NUTH Value: <b>0.98</b>
1. The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust	NHS Digital Indicator Portal <a href="https://indicators.ic.nhs.uk/webview/">https://indicators.ic.nhs.uk/webview/</a>	Band 2 "as expected"		<b>NUTH: Band 2</b>	<b>NUTH: Band 2</b>	<b>NUTH: Band 2</b>	<b>NUTH: Band 2</b>
			National average	1.0	1.0	1.0	1.0
			Highest national	1.16	1.17	1.18	1.17
			Lowest national	0.69	0.69	0.68	0.67
2. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust	NHS Digital Indicator Portal <a href="https://indicators.ic.nhs.uk/webview/">https://indicators.ic.nhs.uk/webview/</a>	N/A		<b>22.6%</b>	<b>21.8%</b>	<b>23.0%</b>	<b>22.9%</b>
			National average	Not available	Not available	Not available	Not available
			Highest national	48.9%	44.5%	54.6%	54.7%
			Lowest national	0.4%	0.6%	18.2%	17.7%

### Measure 1. The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust.

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The Trust continues to perform well on mortality indicators. Mortality reports are regularly presented to the Trust Board. The Newcastle upon Tyne Hospitals NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services by closely monitoring mortality rates and conducting detailed investigations when rates increase. We will monitor and discuss mortality findings at a new quarterly Mortality Surveillance Group; representatives attend this group from multiple specialities and will scrutinise Trust mortality data to ensure local learning and quality improvement. This group complements the departmental mortality and morbidity (M&M) meetings within each Directorate.

### Measure 2. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust.

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The use of palliative care codes in the Trust has remained static and aligned to the national average percentage over recent years. The Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by involving the Coding team in routine mortality reviews to ensure accuracy and consistency of palliative care coding.

Measure	Data Source	Value	April 2016/ Sept 2016	April 2015/ Mar 2016	2013/ 14	2012/ 13	2011/ 12
3. The patient reported outcome measures scores (PROMS) for groin hernia surgery (average health gain score)	NHS Digital information portal <a href="http://content.digital.nhs.uk/proms">http://content.digital.nhs.uk/proms</a>	NUTH	Not stated	0.08	0.07	0.10	0.10
		National average:	0.08	0.08	0.08	0.09	0.09
		Highest national:	0.13	0.15	0.14	0.15	0.14
		Lowest national:	0.02	0.03	0.01	0.01	0.03
4. The patient reported outcome measures scores (PROMS) for varicose vein surgery (average health gain)	NHS Digital information portal <a href="http://content.digital.nhs.uk/proms">http://content.digital.nhs.uk/proms</a>	Trust score:	0.13	0.10	0.11	0.10	0.10
		National average:	0.09	0.09	0.09	0.09	0.10
		Highest national:	0.15	0.15	0.16	0.18	0.17
		Lowest national:	0.16	0.02	- 0.02	0.01	0.05
5. The patient reported outcome measures scores (PROMS) for primary hip replacement surgery (average health gain)	NHS Digital information portal <a href="http://content.digital.nhs.uk/prom">http://content.digital.nhs.uk/prom</a>	Trust Score	0.49	0.42	0.43	0.43	0.42
		National average:	0.44	0.43	0.44	0.44	0.42
		Highest national:	0.49	0.50	0.54	0.54	0.47
		Lowest national:	0.33	0.39	0.31	0.32	0.32
6. The patient reported outcome measures scores (PROMS) for primary knee replacement surgery (average health gain)	NHS Digital information portal <a href="http://content.digital.nhs.uk/proms">http://content.digital.nhs.uk/proms</a>	Trust Score	0.36	0.31	0.33	0.32	0.31
		National average:	0.33	0.32	0.32	0.32	0.30
		Highest national:	0.43	0.38	0.42	0.42	0.37
		Lowest national:	0.29	0.23	0.21	0.21	0.18



	2015/16				2014/15			
	Oct 14-Sept 15 NUTH Value: 0.98	July 14-June 15 NUTH Value: 0.99	April 14-Mar 15 NUTH Value: 0.99	Jan 14-Dec 14 NUTH Value: 0.98	Oct 13-Sept 14 NUTH Value: 0.96	July 13-Jun 14 NUTH Value: 0.95	April 13-Mar14 NUTH Value: 0.94	Jan 13-Dec 13 NUTH Value: 0.90
	NUTH: Band 2	NUTH: Band 2	NUTH: Band 2	NUTH: Band 2	NUTH: Band 2	NUTH: Band 2	NUTH: Band 2	NUTH: Band 2
	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
	1.77	1.21	1.21	1.24	1.20	1.20	1.20	1.18
	0.65	0.66	0.67	0.66	0.61	0.54	0.54	0.62
	<b>23.0%</b>	<b>24.3%</b>	<b>24.2%</b>	<b>24.4%</b>	<b>24.16%</b>	<b>23.9%</b>	<b>23.9%</b>	<b>22.9%</b>
	26%	25.7%	25.7%	25.7%	25.3%	24.6%	23.6%	22.0%
	53.5%	48%	51%	48%	49.4%	49%	48.5%	46.9%
	0.2%	0%	0%	0%	0%	0%	0%	1.3%



### Measure 3. The patient reported outcome measures scores (PROMS) for groin hernia surgery.

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The Trust continues to report a similar score as the National average. It is felt that this is because of the low day case rate for this particular surgery. The Newcastle upon Tyne Hospitals NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, by continuing to review the patient pathway. There is no national data available on NHS Digital information portal after September 2016.

### Measure 4. The patient reported outcome measures scores (PROMS) for varicose vein surgery.

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The Trust is above the National average because it offers all modalities of patient treatment in relation to varicose veins. The Newcastle upon Tyne Hospitals NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, by continuing to review the patient pathway. There is no national data available on NHS Digital information portal after September 2016.

### Measure 5. The patient reported outcome measures scores (PROMS) for hip replacement surgery.

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The data shows PROMS score remains static over the 12 month period. The Newcastle upon Tyne Hospitals NHS Trust has an average outcome for hip replacement surgery as many of the simpler cases are outsourced to another provider due to current capacity pressures. This results in more complicated cases being performed by the Trust and therefore the health gain increase could be expected to be less. If the simpler patients were included the Trust believes that the increase would be more significant, however it is important to note that even with a more complex casemix the Trust still provides an 'expected' level of improvement. The Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by working with the Specialist Orthopaedic Alliance in benchmarking best practice for both hip and knee replacement surgery to identify areas for potential future improvement. There is no national data available on NHS Digital information portal after September 2016.

### Measure 6. The patient reported outcome measures scores (PROMS) for knee replacement surgery.

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The data shows an increase in PROMS scores to 0.31 from 0.36 over the 12 month period. The Newcastle upon Tyne Hospitals NHS Foundation Trust provides a statistically significant (2SD) higher outcome for knee replacement surgery than the local average. The Trust believes this signifies the high level of care that the Trust provides and this is also the case when work is outsourced to other providers due to capacity issues. The Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by working with the Specialist Orthopaedic Alliance in benchmarking best practice for both hip and knee replacement surgery to identify areas for potential future improvement. There is no national data available on NHS Digital information portal after September 2016.

### Measure 7. The percentage of patients aged - (i) 0 to 15; and (ii) 16 or over readmitted.

This indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review.

Therefore the Trust have reviewed their own internal data and used their own methodology of reporting readmissions within 28 days (without PbR exclusions).

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The Trust has a robust reporting system in place and adopts a systematic approach to data quality improvement. The Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by continuing with the use of an electronic system.

#### 7a. Emergency readmissions to hospital within 28 days of discharge from hospital: Children of ages 0-15

Year	Total number of admissions/spells	Number of readmissions (all)	Emergency readmission rate (all)
20/11/12	31,548	2,500	7.9
2012/13	31,841	2,454	7.7
2013/14	32,242	2,648	8.2
2014/15	34,561	3,570	10.3
2015/16	38,769	2,875	7.4
2016/17	35,259	1,983	5.6

#### 7b. Emergency readmissions to hospital within 28 days of being discharged aged 16+

Year	Total number of admissions/spells	Number of readmissions (all)	Emergency readmission rate (all)
20/11/12	175,836	9,435	5.4
2012/13	173,270	8,788	5.1
2013/14	177,867	9,052	5.1
2014/15	180,380	9,446	5.2
2015/16	182,668	10,076	5.5
2016/17	186,999	10,219	5.5

**“The staff were all fantastic and I felt like I was in expert hands at all times.”**



Measure	Data Source	Value	2015/16	2014/15	2013/14	2012/13	2011/12	2010/11
8. The trust's responsiveness to the personal needs of its patients	NHS Information Centre Portal <a href="https://indicators.ic.nhs.uk/">https://indicators.ic.nhs.uk/</a>	Trust percentage:	<b>76.1%</b>	<b>76.8%</b>	<b>77.3%</b>	<b>74.2%</b>	<b>72.2%</b>	<b>70.5%</b>
		National average:	<b>69.6%</b>	68.9%	68.7%	68.1%	67.4%	67.3%
		Highest national:	<b>86.2%</b>	86.1%	84.2%	84.4%	85%	82.6%
		Lowest national:	<b>54.4%</b>	59.1%	54.4%	57.4%	56.5%	56.7%
Measure	Data Source	Value	2016	2015	2014	2013	2012	2011
9. The percentage of staff employed by, or under contract to, the trust who would recommend the trust as a provider of care to their family or friends	<a href="http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/Results/">http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/Results/</a>	Trust percentage:	<b>91%</b>	<b>89%</b>	<b>85%</b>	<b>87%</b>	<b>86%</b>	<b>79%</b>
		National average:	<b>72%</b>	69%	65%	64%	62%	62%
		Highest national:	<b>95%</b>	89%	89%	89%	86%	89%
		Lowest national:	<b>48%</b>	46%	38%	40%	35%	33%

#### Measure 8. The Trust's responsiveness to the personal needs of its patients.

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The data shows that the Trust scores above the national average. The Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by continuing to implement processes to capture patient experience and improve its services. Data for 2016/2017 has not yet been released.

#### Measure 9. The percentage of staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends.

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: the Trust has improved on last year's score and is well above the National average. The Newcastle upon Tyne Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by continuing to listen to and act on all sources of staff feedback. Data for 2016/2017 will not be available until the next financial year. 2015/2016 data has just been released in March 2017.

Measure	Data Source	Target	2016/17			
10. The percentage of patients that were admitted to hospital who were risk assessed for Venous thromboembolism (VTE)	<a href="https://www.england.nhs.uk/statistics/statistical-work-areas/vte/">https://www.england.nhs.uk/statistics/statistical-work-areas/vte/</a>	Trust (CQUIN Target - 95%)	<b>Q1 91.7%</b>	<b>Q2 95.8%</b>	<b>Q3 95.6%</b>	<b>Q4 Not available</b>
		National average	95.7%	95.5%	95.6%	Not available
		Highest national	100%	100%	100%	100%
		Lowest national	80.6%	72.1%	76.4%	Not available

#### Measure 10. The percentage of patients that were admitted to hospital who were risk assessed for Venous thromboembolism (VTE)

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The Trust has a robust reporting system in place and adopts a systematic approach to data quality improvement. The Newcastle upon Tyne Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by completion of assessment being electronic to allowing capture of compliance rates and the implementation of the Safety Thermometer. The Trust has continued with use of the practice of undertaking root cause analysis (RCA) on patients who develop a hospital acquired VTE.

Measure	Data Source	Target	2016/17
11. The number and rate per 100,000 bed days of cases of <i>C. difficile</i> infection reported within the trust amongst patients aged 2 or over	NHS Information Centre Portal <a href="http://www.hpa.org.uk/web/HPAweb&amp;Page&amp;HPAwebAutoListName/Page/1179745282408">http://www.hpa.org.uk/web/HPAweb&amp;Page&amp;HPAwebAutoListName/Page/1179745282408</a>	Trust number	<b>74 National figure 57 Local figure</b>
		Trust Rate	<b>14.04 (internal)</b>
		National average	Not available
		Highest national	Not available
		Lowest national	Not available

Measure	Data Source	Target	2016/17
12. The number and rate per 100 admissions of patient safety incidents reported NB: Changed to rate per 1000 bed days April 2014	NHS Information Centre Portal <a href="http://www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports/">http://www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports/</a>	Trust number	April 2016 - Sept 2016 <b>6501</b>
		Trust Rate	<b>27.15</b>
		National average	40.76
		Highest national	71.8
		Lowest national	21.15

Measure	Data Source	Target	2016/17	
13. The number and percentage of patient safety incidents that resulted in severe harm or death	NHS Information Centre Portal <a href="http://www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports/">http://www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports/</a>	Trust number	April 2016 - Sept 2016 <b>Severe Harm 18</b>	April 2016 - Sept 2016 <b>Death 3</b>
		Trust %	0.3%	0%
		National average	0.3%	0.1%
		Highest national	1.4%	0.5%
		Lowest national	0%	0%

**Measure 12. The number and rate of patient safety incidents reported:** The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The Trust take the reporting of incidents very seriously and have an electronic reporting system (Datix) to support this. The Newcastle upon Tyne Hospitals NHS Foundation Trust has taken the following actions to improve this number and rate, and so the quality of its services, by undertaking a campaign to increase awareness of incident/near miss reporting. Incidents are graded, analysed and, where required, undergo a root cause analysis investigation to inform actions, recommendations and learning. Incident data are reported on a monthly basis to the Trust Board Analysis of this data is reported to the Clinical Risk Group to inform our organisational learning themes which are reported to the Board. The number and rate per 100 admissions of patient safety incidents reported changed to rate per 1000 bed days April 2014. The reason for the reduction in the number and rate of patient incidents uploaded to the NRLS in the last year is that we no longer upload non-trust acquired pressure ulcers. This decision was taken following receipt of new guidance from NRLS and accounts for 3162 incidents a year. The number of incidents reported via the DATIX system has continued to increase over this period. No further information after September 2016 is currently available.

	2015/16				2014/15				2013/14			
	Q1 95.9%	Q2 96.4%	Q3 96.2%	Q4 95.8%	Q1 96.4%	Q2 95.8%	Q3 95.5%	Q4 95.7%	Q1 95.8%	Q2 96.3%	Q3 97.4%	Q4 97%
	96%	95.8%	95.4%	95.2%	96.2%	96.2%	96%	95.9%	95.5%	95.8%	95.7%	96%
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	86.1%	75%	100%	78%	87.2%	90.5%	81.2%	70%	78.8%	81.7%	74.1%	78.9%

**Measure 11. The rate per 100,000 bed days of cases of *C. difficile* infection reported within the trust amongst patients aged 2 or over**

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The Trust has a robust reporting system in place and adopts a systematic approach to data quality improvement. The Newcastle upon Tyne Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by having a robust strategy that includes the review of all Trust-apportioned cases to ensure no avoidable cases occur: completion of root cause analysis (RCA) forms for all such cases, including a multidisciplinary meeting to discuss the case; Quarterly HCAI Report to share lessons learned and best practice from the RCAs and Serious Infection Review Meetings. *C. difficile* awareness campaigns took place with staff, alongside regular ongoing hand hygiene and cleanliness audits. Clinical Directorates have also produced HCAI Action Plans to demonstrate how lessons learned are shared with all staff in order to encourage best practice. There is a differential between local and National data for this indicator. The Nationally reported figure is 74, locally it is 58 – this figure reflects successful appeals (16) whereas the National data does not take appeals into consideration.

	2015/16	2014/15	2013/14	2012/13	2011/12	2010/11
	<b>94 National figure 67 Local figure</b>	<b>89 National figure 73 Local figure</b>	<b>75</b>	<b>76</b>	<b>101</b>	<b>150</b>
	<b>19.3</b>	<b>18.5</b>	<b>18.2</b>	<b>15.4</b>	<b>21.4</b>	<b>32.2</b>
	14.9	12.1	14.7	17.4	22.2	29.7
	Not available	Not available	37.1	31.2	58.2	71.2
	Not available	Not available	0	0	0	0

	2015/16		2014/15		2013/14		2012/13	
	Oct 2015 - Mar 2016	April 2015 - Sept 2015	Oct 2014 - Mar 2015	April 2014 - Sept 2014	Oct 2013 - Mar 2014	April 2013 - Sept 2013	Oct 2012 - Mar 2013	April 2012 - Sept 2012
	<b>7015</b>	<b>7741</b>	<b>7313</b>	<b>7084</b>	<b>6619</b>	<b>5727</b>	<b>5138</b>	<b>4573</b>
	<b>28.88</b>	<b>32.34</b>	<b>29.66</b>	<b>28.4</b>	<b>5.3</b>	<b>5.4</b>	<b>4.8</b>	<b>4.3</b>
	39.6	39.2	35.3	35.1	8.7	8.0	7.7	7.0
	75.9	74.7	82.2	74.9	14.9	12.8	13.7	12.12
	14.8	18.1	3.6	0.24	4.6	4.9	3.2	2.77

	2015/16				2014/15				2013/14			
	Oct 2015 - Mar 2016 <b>Severe Harm</b>	Oct 2015 - Mar 2016 <b>Death</b>	Apr 2015 - Sept 2015 <b>Severe Harm</b>	Apr 2015 - Sept 2015 <b>Death</b>	Oct 2014 - Mar 2015 <b>Severe Harm</b>	Oct 2014 - Mar 2015 <b>Death</b>	Apr 2014 - Sept 2014 <b>Severe Harm</b>	Apr 2014 - Sept 2014 <b>Death</b>	Oct 2013 - Mar 2014 <b>Severe Harm</b>	Oct 2013 - Mar 2014 <b>Death</b>	Apr 2013 - Sept 2013 <b>Severe Harm</b>	Apr 2013 - Sept 2013 <b>Death</b>
	26	5	32	4	27	2	30	0	18	0	18	0
	0.4%	0.1%	0.4%	0%	0.4%	0%	0.4%	0%	0.3%	0%	0.31%	0%
	0.3%	0.1%	0.3%	0.1%	0.4%	0.1%	0.4%	0.1%	0.3%	0.1%	0.2%	0.1%
	1.7%	0.4%	2.9%	0.7%	5.2%	1.1%	74.3%	8.6%	0.9%	0.3%	0.8%	0.3%
	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

**Measure 13. The number and percentage of patient safety incidents that resulted in severe harm or death:** The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The Trust takes incidents resulting in severe harm or death very seriously. The rate of incidents resulting in severe harm or death is consistent with the national average. This reflects a culture of reporting incidents which lead to, or have the potential to, cause serious harm or death. The Newcastle upon Tyne Hospitals NHS Foundation Trust has taken the following actions to reduce this number and rate, and so the quality of its services, by the Board receiving monthly reports of incidents resulting in severe harm or death. (The Trust would classify major and catastrophic as permanent harm or death. This would include a fracture following a fall if the patient did not fully recover their normal level of independence. No further information available after September 2016.

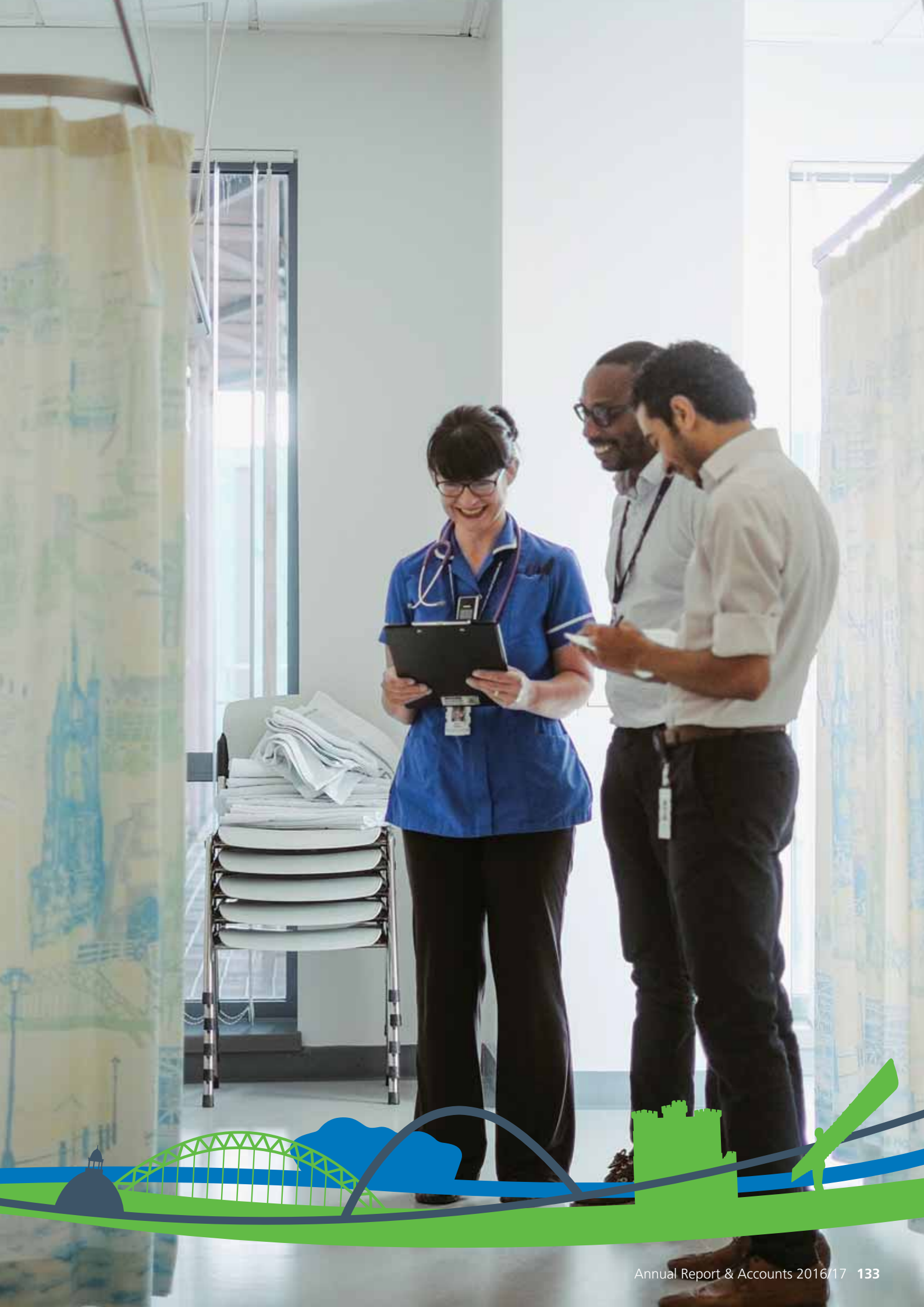
## Part 3

# Other Information

## Overview of monthly Board assurance 2016/17

This is a representation of the Quality Report data presented to the Trust Board on a monthly basis in consultation with relevant stakeholders for the year 2016/17. The indicators were selected because of the adverse implications for patient safety and quality of care should there be any reduction in compliance with the individual elements.

Patient Safety	Data source	Standard	Actual 2015/16	Target 2016/17	Monthly Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2016/17
Screening MRSA: electives	Internal	National definition (2009)	100%	100%	100%	100%	100%	100%	100%	100%
Screening MRSA: emergency	Internal	National definition (2009)	100%	100%	100%	100%	100%	100%	100%	100%
Hand Hygiene audits (opportunity)	Internal	Local CAT tool	99.61%	98%	98%	99.18%	99.47%	98.87%	99.39%	99.23%
Hand Hygiene audits (technique)	Internal	Local CAT tool	99.24%	98%	98%	98.77%	98.95%	98.33%	99.11%	98.79%
Total number of patient incidents reported (Datix)	Internal Datix Incident reporting system	Local Incident Policy	17274*	Not defined	Not defined	4323	4273	4332	4474	17402
Rate per 1000 occupied bed days of patient incidents reported (Datix)	Internal Datix Incident reporting system	National definition	32.2	Not defined	Not defined	32.3	33.6	33.1	33.5	33.1
Slip, trip and fall - patient (Datix) **	Internal Datix Incident reporting system	N/A	3310*	Not defined	Not defined	762	744	811	840	3157
Slip, trip and fall - patient (Datix) per 1,000 bed days	Internal Datix Incident reporting system	National definition	6.2	6.6	6.6	5.7	5.9	6.2	6.3	6.0
Slip, trip and fall - patient (Datix) per 1,000 bed days	Internal Datix Incident reporting system	Local (agreed by Trust Board)	6.2	6.2	6.2	5.7	5.9	6.2	6.3	6.0
Total number of CNST claims	Internal Legal Services Department	National NHSLA definition	240	Not defined	Not defined	50	61	56	69	236
Number of radiation incidents reported to HSE and CQC	Internal Datix Incident reporting system	National IRMER definition	40	Not defined	Not defined	14	7	12	5	38
Never Event	Internal Datix Incident reporting system	National definition	3	Not defined	Not defined	1	1	5	1	8



Patient Safety	Data source	Standard	Actual 2015/16	Target 2016/17	Monthly Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2016/17
Inpatients acquiring pressure damage	Internal Datix Incident reporting system	National	690*	Not defined	Not defined	181	193	173	190	737
Community patients acquiring pressure damage	Internal Datix Incident reporting system	National	3	Not defined	Not defined	0	1	0	0	1
Medication incidents	Internal Datix Incident reporting system	Local	1943	Not defined	Not defined	527	510	488	485	2010
General SIs	Internal Datix Incident reporting system	Local SUI Policy	77*	Not defined	Not defined	14	18	18	16	66
HCAI	Internal Datix Incident reporting system	Local SUI Policy	9	Not defined	Not defined	1	1	4	2	8
Information Governance	Internal Datix Incident reporting system	Local SUI Policy	2*	Not defined	Not defined	1	1	0	1	3
Percentage of patient incidents that resulted in severe harm or death	Internal Datix Incident reporting system	Local	0.8%	Not defined	Not defined	0.37%	0.33%	0.55%	0.43%	0.42%

There have been some slight variations in the reported 2015/2016 data – this is due to the fact that the Trust Incident reporting system is a live database which results in fluctuations in actual numbers of incidents reported as investigations are processed through the system. These areas are denoted by \*.

\*\* The indicator data has been restated following external audit procedures. Changes are Q1 757 to 762, Q2 742 to 744 and Q3 805 to 811.

Clinical Effectiveness	Data source	Standard	Actual 2015/16	Target 2016/17	Monthly Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2016/17
Breast feeding initiation (Cumulative)	Integrated Performance Measures Return (IPMR)	No National Target	69.80%	Not defined	Not defined	69.5%	68.9%	71.2%	68.7%	69.6%
Breast Feeding 6-8 weeks	Integrated Performance Measures Return (PMR)	National Standard	46.40%	45.8%	No monthly target - quarterly 45.8%	48.6%	45.7%	50.6%	43.3%	47.1%
Breaches of standard (previously entitled Cancelled operations rescheduled within 28 days)	Quarterly Monitoring Cancelled Operations Data Set (QMCO)	National Standard	23	Not defined	Not defined	1	1	1	9	12
Number of last minute cancellations in the quarter (previously called Those not admitted within 28 days)	Quarterly Monitoring Cancelled Operations Data Set (QMCO)	National Standard	551	Not defined	Not defined	96	127	145	160	528
Percentage high risk TIA cases treated within 24 hours	Best Practice Tariff	National Standard	99%	60%	60%	100%	100%	100%	100%	100%
Stroke - 80% of people with stroke to spend at least 90% of their time on a stroke unit	Locally Collected	National Standard	84%	80%	80%	80.6%	71.6%	82.4%	Jan 17: 87.2%	YTD 79.9%
eReferral: Slot issues	C&B National Systems & Reports	National Standard	25.60%	Not defined	Not defined	23.5%	21.8%	16.0%	19.2%	20.0%

Please note that national a change was made to title and methods of data collection for Breaches of standard (previously entitled Cancelled operations rescheduled within 28 days) and Number of last minute cancellations in the quarter (previously called Those not admitted within 28 days).

Patient Experience	Data source	Standard	Actual 2015/16	Target 2016/17	Monthly Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2016/17
Number of complaints received	Internal Datix Incident reporting system	Local Complaints Policy	627	Not defined	Not defined	136	138	126	152	552
Friends and Family response rates (inpatients and A&E)	Locally collected reported	National standard	N/A	Not defined	Not defined	15% 3%	13% 3%	15% 3%	16% 2%	15.4% 3.3%



## Workforce factors

**Wellbeing** – the tables below provide data on the loss of work days. Table 15 reports on the Trust and Regional position rate (data taken from the NHS Information Centre) and Table 16 provides an update on the Trust number of staff sick days lost to industrial injury or illness caused by work. No further information after December 2016.

Table below: loss of work days (rate)

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
The Newcastle upon Tyne Hospitals	3.67	3.69	3.86	3.85	3.61	3.90	4.22	4.44	4.63
City Hospitals Sunderland	4.48	4.44	4.48	4.48	4	4.49	4.74	4.86	4.91
County Durham and Darlington	4.35	4.08	4.17	4.05	3.95	4.08	4.37	4.75	4.74
Gateshead Health	4.56	4.61	4.5	4.68	4.64	4.24	4.59	4.74	4.63
North Tees and Hartlepool	4.52	4.61	5.02	5.02	4.54	4.55	4.58	5	5.21
Northumbria Healthcare	4.01	4.01	3.96	4.12	3.97	4.13	4.35	4.53	4.73
South Tees Hospitals	4.42	4.36	4.31	4.41	4.39	4.31	4.4	4.46	4.59
South Tyneside NHS	5.83	5.82	5.71	5.56	5.13	4.57	5.63	5.92	5.63
England	4.1	3.94	4.06	4.17	4.06	4.14	4.45	4.61	4.69

Table below: The number of shift staff sick days lost to industrial injury or illness caused by work

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year Total
2009/2010 no. of days	251	414	581	298	1544
2010/2011 no. of days	118	254	267	366	1005
2011/2012 no. of days	253	299	247	153	952
2012/2013 no. of days	154	138	174	209	675
2013/2014 no. of days	489	331	785	147	1752
2014/2015 no. of days	333	284	178	206	1001
2015/2016 no. of days	360	194	365	219	1138
2016/2017 no. of days	230	387	136	84	837

## 2016 NHS Staff Survey Results Summary

A standard survey was sent directly via Trust staffs internal email address to a census of all staff in October 2016. In 2016 it had been agreed with the Executive Team to increase the sample size across the Trust to enable all staff to participate. It was also agreed to move to an on line survey only. This has resulted in both an increase in the sample size.

### Trust Response Rates

Year	Sample Size	Returned	%
2016	13,700	4,415	32%
2015	1500	401	27%
2014	850	452	47%

The results of the NHS Staff Survey are structured under seven headings as follows:

- The four staff pledges from the NHS Constitution:
  - To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities
  - To provide all staff with personal development, access to appropriate education and training for their jobs and line management support to enable them to fulfil their potential
  - To provide support and opportunities for staff to maintain their health, wellbeing and safety.
  - To engage staff in decisions that affect them and the services they provide individually, through representative organisations, and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

Plus three additional themes of Staff Satisfaction, Equality and Diversity and Patient Experience

A number of the questions asked are either new or have been amended, and therefore, year on year comparisons are not a straightforward as would have been liked. However, where possible, these will be commented upon.

## Overall Staff Engagement

The overall indicator of staff engagement is calculated using the response to three Key Findings (KF) questions: (1) staffs' perceived ability to contribute towards improvements at work, (2) willingness to recommend the Trust as a place to work or receive treatment, and (3) the extent to which they feel engaged and motivated with their work.

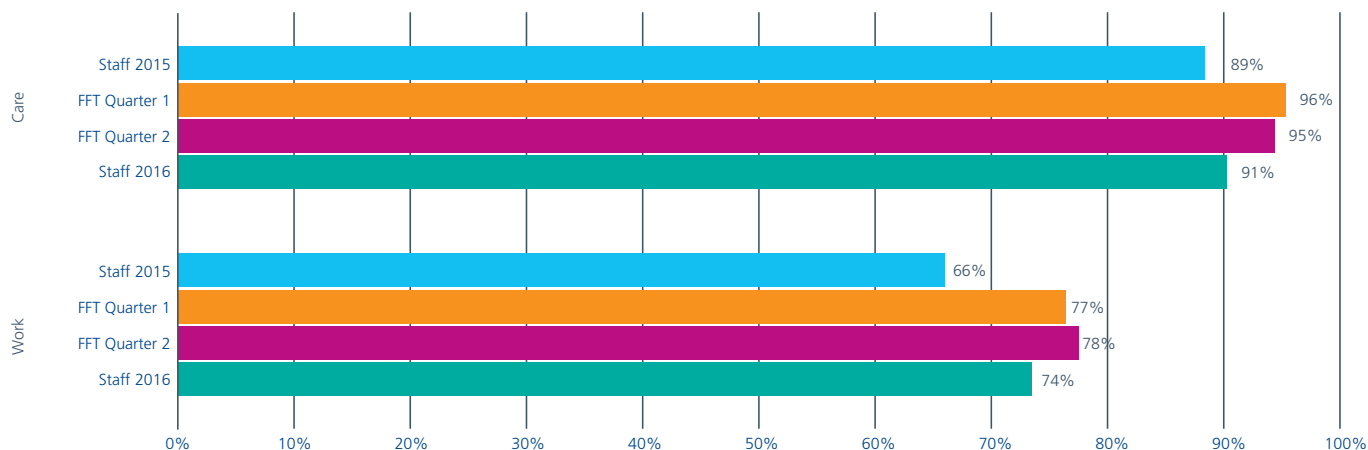
The Trust score was 3.97 (out of possible 5) an improvement from 2015 (3.90).

The response to the questions which feed into KF1 'staff recommendation of the organisation as a place to work or receive treatment' are mixed. Encouragingly, the score is better than average for staff agreeing that the care of patients is the organisation's top priority.

Staff Engagement	Trust 2016	Sector 206
<b>OVERALL STAFF ENGAGEMENT (+) (KF1, KF4, KF7)</b>	<b>3.97</b>	<b>3.85</b>
Base Size (Respondents)	4,401	
Recommend - KF1: Staff recommendation of the organisation as a place to work or receive treatment (+) (Q21a, 21c, 21d)	4.19	3.85
Engage - KF4: Staff motivation at work (+) (Q2a, 2b, 2c)	3.94	3.95
Improve - KF7: able to contribute towards improvements at work (+) (Q4a, 4b, 4d)	3.81	3.76

When compared to the most recent Staff Friends and Family Test, the Staff Survey demonstrates a slightly lower performance for both recommending the Trust as a place for treatment and for work.

### Quarterly FFT vs National Staff Results



## Additional Themes

### Your Job

Overall the Trust's scores are better than average in this section. There is just one score that is significantly worse than the sector score and this relates to staff being satisfied with the opportunities for flexible working (42% compared to 51%).

There have been a number of significant improvements in scores since the previous survey and the results indicate that many staff remain very enthusiastic about their job.

For example, staff saying they are satisfied with the extent to which the organisation values their work has seen a 5% improvement (47%, up from 42% last year); staff agreeing with the quality of care they give has also improved by 5% (89%, up from 84% last year).

Staff motivation at work has seen no change year on year, but remains above average against the Shelford group at 3.97 and average regionally.

### Your Managers

The Trust scores are mixed in this section. The scores around immediate managers are all around average and have shown just small movements since last year. However, all the scores for senior managers are significantly higher than the sector scores and show positive improvements. The results seem to show that staff feel better valued.

For example, on questions about immediate managers, the score for immediate managers encouraging staff to work as a team is the same as the sector score (75%) and the score for immediate managers giving clear feedback is just above the sector score (64%, compared to 61%).

91% of staff say that they know who senior managers are, which is higher than the sector score of 83%. Scores around senior manager communication are all significantly higher than the sector average but, like the rest of the sector are still relatively low. Only 49% of staff say that communication between senior management and staff is effective. Only 40% say that senior managers involve them in important decisions. And only 38% say that senior managers act on their feedback.

## Your Health and Well-being

Overall the Trust scores slightly or significantly better than the sector on questions within this section. Most scores have slightly or significantly improved since last year. The percentage of staff saying that they have felt unwell due to work related stress has decreased from 32% last year, to 30% this year. This is consistent nationally. It suggests that managers are invested in their health and wellbeing, and that broadly, positive action on health is taken.

Staff who said they experienced harassment, bullying and abuse (HBA) from the public is static since last year, and scores better than the sector. The scores for staff experiencing HBA from managers or other colleagues have decreased; from managers 9% this year, compared to 13% last year. However, despite improvement, staff reporting incidents of HBA is below the sector score - 46% reported these, compared to the sector score of 49%.

The Trust scores well on the questions around errors and incidents; in particular staff agreeing that preventative action is taken when errors are reported, and staff saying they are given feedback about changes made in response to errors or incidents. Both have scores that are significantly better than the sector.

## Personal Development

When compared to the rest of the sector, most scores are just above average, and have stayed largely static since last year. The percentage of staff who responded, saying that they have received training in the last 12 months is 75%, which is 1% higher than the sector score. The numbers of staff agreeing that the training they received helped them do their job more effectively is also static, at 87%.

The coverage of appraisals is above average for the sector, but has dropped slightly from 91% last year to 89% this year. 72% of staff said that their appraisal helped them do their job more effectively, which is exactly the same as the sector score. Staff saying their appraisal identified training, learning or development needs is slightly below the sector score (65%, compared to 68%).

## Your Organisation

All scores have shown improvement since last year, over half significantly, and are better than the sector. 91% of Trust staff say that patient/service user care is the Trust's top priority which is 12% higher than the sector score of 79% and an improvement on last year.

The Trust scores on the two NHS Staff Friends and Family Test questions have improved and are both significantly higher than the sector scores. 74% of staff say that they would recommend the Trust as a place to work (compared to 66% last year), and 91% of staff would be happy with the standard of care if a friend or relative were treated at the Trust (compared to 89% last year). These remain hugely positive results in motivation and engagement, particularly given some of the challenges the NHS continues to face.

## Patient Experience

The Trust scores significantly higher than the sector on nearly all questions, but there have been just small movements since last year.

Staff involving patients/service users in decisions about their care and treatment has increased slightly (89% up from 88% last year). However, in response to patients/service users are treated with respect and dignity by staff has fallen slightly (95% down from 96% last year).

## Overall Summary of Key Findings

There is more detailed information in the main survey report which illustrates, in particular, the difference in response from different workforce/occupational groups. Of note, 28% of respondents were Registered Nurses and Midwives; medical and dental staff comprised 11%, AHP's 25%, HCA's 5% with 31% coming from the wider Trust Workforce population. As required by the Quality Account reporting arrangements we are reporting KF26 AND KF21.

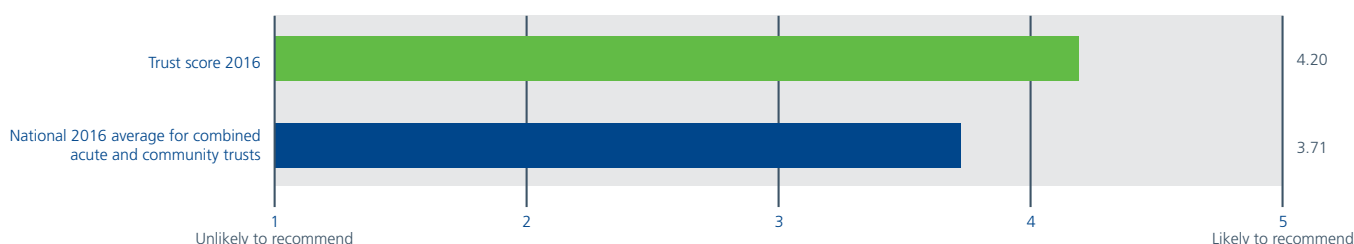
KF26 - Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months – 21%

KF21 - Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion – 92%

### Top five ranking scores: KF1. Staff recommendation of the organisation as a place to work or receive treatment

(the higher the score the better)

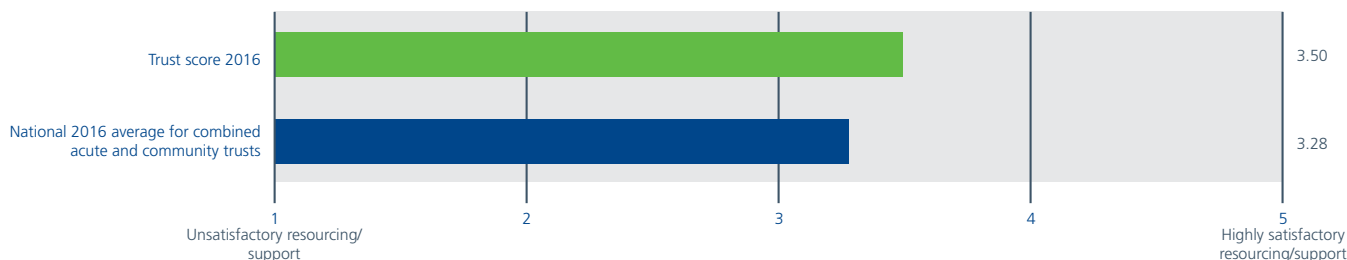
#### Scale summary score



### Top five ranking scores: KF14. Staff satisfaction with resourcing and support

(the higher the score the better)

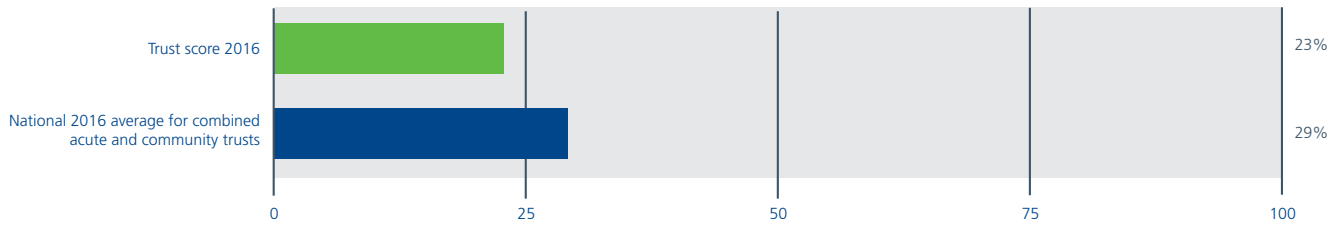
#### Scale summary score



**Top five ranking scores: KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month**

(the lower the score the better)

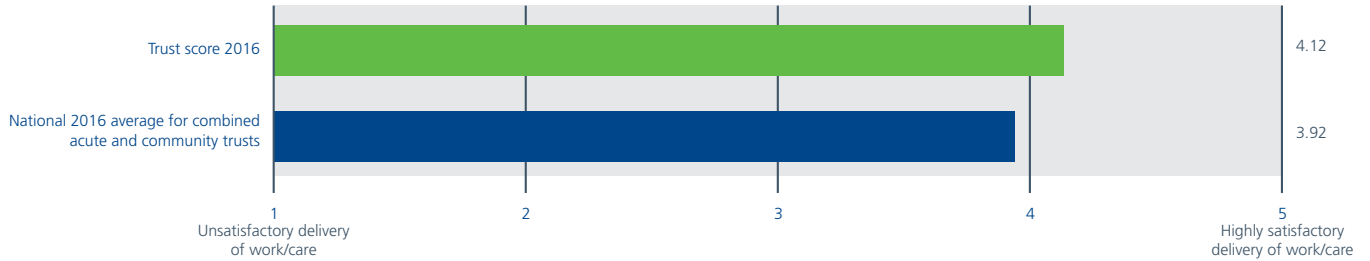
Percentage score



**Top five ranking scores: KF2. Staff satisfaction with the quality of work and care they are able to deliver**

(the higher the score the better)

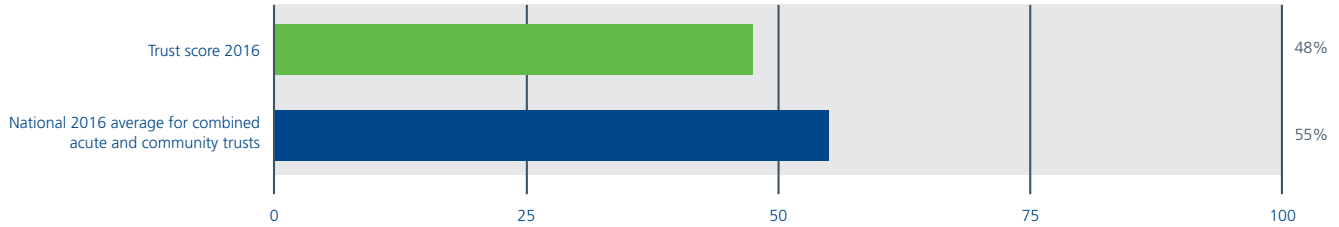
Scale summary score



**Top five ranking scores: KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves**

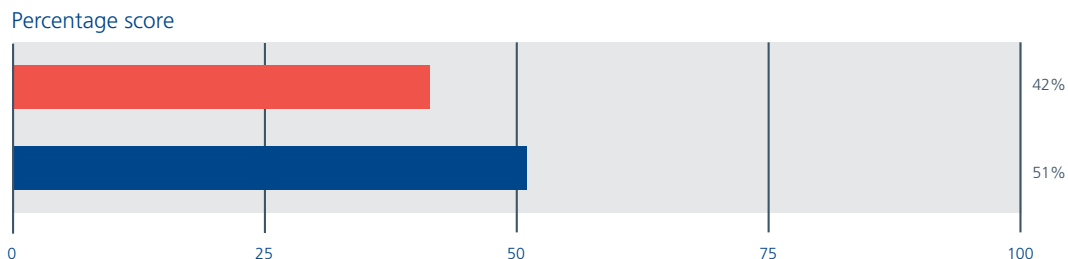
(the lower the score the better)

Percentage score



**Bottom five ranking scores: KF15. Percentage of staff satisfied with the opportunities for flexible working patterns**

(the higher the score the better)



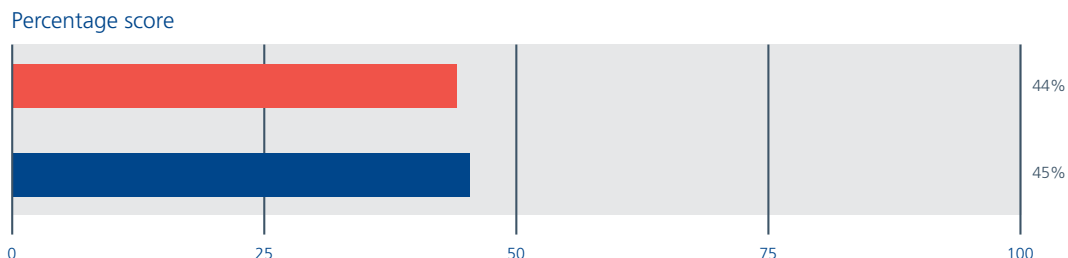
**Bottom five ranking scores: KF24. Percentage of staff/colleagues reporting most recent experience of violence**

(the higher the score the better)



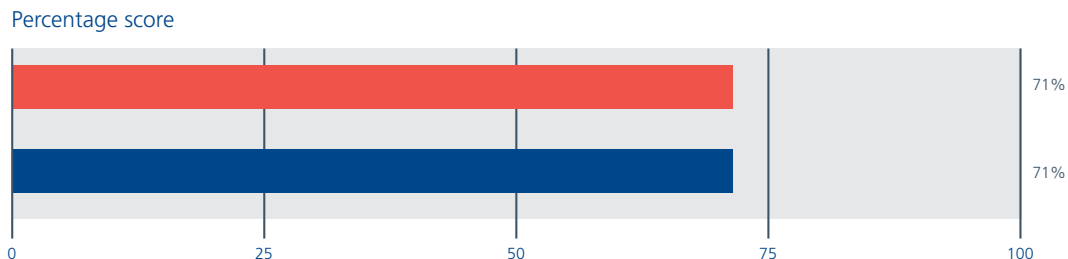
**Bottom five ranking scores: KF27. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse**

(the higher the score the better)



**Bottom five ranking scores: KF16. Percentage of staff working extra hours**

(the lower the score the better)



**Bottom five ranking scores: KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month**

(the higher the score the better)



**“The staff were sympathetic, efficient and responsive. This gave me confidence in all areas of my care.”**

## Regional and Shelford Group Comparison

Newcastle upon Tyne Hospitals NHS Foundation Trust compares very favourably to all other Shelford Trusts, with all key findings for Newcastle upon Tyne Hospitals NHS Foundation Trust ranked either first or second comparable to the Shelford Group Trusts. This is a significant improvement on Staff Survey 2015. Guys and St. Thomas are the only other Shelford Trust with comparable results (4.03 Staff Engagement)

Regionally the Trust is the highest ranked for Staff Engagement (3.97/5) and as a place to work or receive treatment (4.19/5). (Northumbria is second 3.96 Staff Engagement and 4.05 to work or receive treatment)

## Involvement and engagement 2016-17

The Newcastle upon Tyne Hospitals NHS Foundation Trust is committed to patient, carer and public involvement and engagement at all levels to ensure our services are planned around the needs of patients and that continuing improvements in the patient experience are achieved.

Involvement and Engagement activity is monitored in the Trust via the Patient Experience Steering Group and the Health Equality and Wellbeing Committee. Reporting to these forums, we have the Patient, Carer and Public Involvement Group and the Equality, Diversity and Human Rights Working Group. These groups bring together representatives from community and voluntary sector organisations and Trust staff to ensure that patients and the public have equal access to services and that we listen and respond to patient feedback. There is also robust engagement within the trust research activities with dedicated Patient and Career involvement leads in place.

## CQC Report commended the Freeman Hospital for its patient engagement in every day practice

Parents told us that staff understood the impact that the condition and treatment had on their children and provided emotional support. One parent told us that staff constantly offered reassurances and support throughout the treatment process. Parents felt empowered to ask questions and were very confident their children were receiving the best care possible. In recognition of the emotional toll a child's illness has on parents, staff had also recently arranged an evening offering holistic therapy treatments, including massage and aromatherapy. Children, young people and families could access support from psychologists at clinics and on the ward. A senior nurse told us they were also hoping to introduce pet therapy on the ward, recognising the benefits of such a service in meeting the emotional needs of children and families.

## Key National Priorities 2016/17

The key national priorities are performance targets for the NHS which are determined by the Department of Health and form part of the CQC Intelligent Monitoring Report. A wide range of measures are included and the Trust's performance against the key national priorities for 2016/17 are detailed in the table below.

Table - Trust Key National Priorities

Operating and Compliance Framework Target	Target	Annual Performance 2016/17
Incidence of <i>Clostridium difficile</i>	No more than 77	74 (17 appealed, 57 against target)
Incidence of MRSA Bacteraemia	No more than Zero	9 (subject to change, decisions pending on 2 cases - final figure will be between 8 and 10)
All Cancer Two Week Wait	93%	95.2%
Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	93%	95.6%
31-Day (Diagnosis To Treatment) Wait For First Treatment	96%	98.1%
31-Day Wait For Second Or Subsequent Treatment: Surgery	94%	96.1%
31-Day Wait For Second Or Subsequent Treatment: Drug treatment	98%	99.3%
31-Day Wait For Second Or Subsequent Treatment: Radiotherapy	94%	98.7%
62-Day (Urgent GP Referral To Treatment) Wait For First Treatment	85%	86.6%
62-Day Wait For First Treatment from Consultant Upgrade Late referrals Excluded in Local Target	Not defined	73.8%
62-Day Wait For First Treatment From Screening Service	90%	94.1%
RTT – Referral to Treatment - Admitted Compliance	90.0%	90.7%
RTT – Referral to Treatment - Non-Admitted Compliance	95.0%	95.4%
RTT – Referral to Treatment - Incomplete Compliance *	92.0%	94.0% (A)
Maximum waiting time of 4 hours in A&E **	95%	94.5% (A)
Delayed Transfers	<2.5%	under 1%

Operating and Compliance Framework Target	Target	Annual Performance 2016/17
Breaches of standard (previously named Cancelled operations - those not admitted within 28 days)	Not defined	12
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways	92%	94%
Maternity bookings within 12 weeks and 6 days	TBC	89.8%
Data completeness: Community Services comprising: Referral to treatment information	>50%	99.3%
Data completeness: Community Services comprising: Referral information	>50%	95.0%
Data completeness: Community Services comprising: Treatment activity information	>50%	96.1%
Certification against compliance with requirements regarding access to health care for people with learning disabilities	Compliant	Achieved

\* The indicator percentage has been restated following external audit procedures from 94.7% to 95%.

\*\* The indicator percentage has been restated following external audit procedures from 94.4% to 94.5%

## A Mandatory Indicator

1. Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period ("incomplete pathways indicator")

The Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report:

- The indicator is expressed as a percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period;
- The indicator is calculated as the arithmetic average for the monthly reported performance indicators for April 2016 to March 2017;
- The clock start date is defined as the date that the referral is received by the Foundation Trust, meeting the criteria set out by the Department of Health guidance; and

The indicator includes only referrals for consultant-led service, and meeting the definition of the service whereby a consultant retains overall clinical responsibility for the service, team or treatment.

2. Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge ("4 hour A&E waiting times indicator")

The Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report:

- The indicator is defined within the technical definitions that accompany *Everyone counts: planning for patients 2014/15 - 2018/19* and can be found at [www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf](http://www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf)
- Detailed rules and guidance for measuring A&E attendances and emergency admissions can be found at <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/03/AE-Attendances-Emergency-Definitions-v2.0-Final.pdf> with the exception of the following:

For ambulance arrivals, arrival time is always the point at which the Trust first becomes aware of the patient being in the A&E department rather than when hand over occurs or 15 minutes after the ambulance arrives at A&E per the above guidance.



# Statement on behalf of the Health Scrutiny Committee



Ms Anne Marie Troy-Smith  
Quality Development Manager  
Newcastle upon Tyne Hospitals NHS  
Foundation Trust  
Royal Victoria Infirmary  
Queen Victoria Road  
Newcastle upon Tyne  
NE1 4LP

18 May 2017

Our ref: FM/KC17

Dear Anne Marie

**Newcastle upon Tyne Hospitals NHS Foundation Trust, Quality Account 2016/17  
Response of Health Scrutiny Committee, Newcastle City Council**

As Vice-Chair of the Health Scrutiny Committee, I welcome the opportunity to comment on your draft Quality Account for 2016/17. Members discussed the draft at their meeting in May 2017 and this letter provides a summary of the committee's response.

In considering the draft, we would particularly like to highlight our support for the volunteer network which has been established to provide companions for patients who may feel socially isolated while in hospital. We recognise that they can play a vital role in helping to reduce the impact that social isolation can have on health and wellbeing.

We welcome the recent CQC inspection rating of 'outstanding', which is an acknowledgment of the hard work and dedication of all staff.

In relation to progress against the 2016/17 priorities:

- We note the deterioration during the year in relation to priority 1, to reduce all forms of healthcare associated infection. We received assurance from you on actions the trust is taking to respond to this and we would like a further update on the position next year.
- We are pleased to note the actions the trust has taken during the year that has led to a significant increase in Sepsis screening.
- We welcome the 14% reduction in formal complaints received by the trust during the year. However, we are particularly interested in how complaint intelligence is used to understand the quality of healthcare provided and to encourage improvement; and we would like to review complaint information in six months time.

**Councillor Felicity Mendelson  
South Jesmond Ward**

37 Queens Road  
Newcastle upon Tyne, NE2 2PR

Home phone: 0191 281 8255

Mobile: 07946 412 015

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Members' Services Unit

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- We are concerned about the increase in 'never events' during the year and although we understand that the figure is small when taken as a percentage of all surgical procedures completed; it remains that they are 'never events' and as such an increase in numbers is a worrying trend. We would like a further update on the position in six months time.
- We welcome the significant reduction in falls and action the trust is taking to ensure appropriate care is provided and to reduce complications should a fall occur.
- We note the challenge the trust faces in trying to reduce incidents of pressure ulcers, taking into account the frailty of patients; and we welcome the ongoing activity proposed including the introduction of local action plans and visual prompts in wards.
- We are pleased to note progress made over the last year in respect of improvements to support for carers and information available for disabled patients.
- We note that orthopedic waiting times for spinal surgery is a concern for the trust and we have requested information on this and would welcome a further update in six months time.

Overall we found that the Quality Account document helped to provide a clear and informative picture on progress being made against the priorities identified for 2016/17. We would like to echo the comments of Healthwatch Newcastle in welcoming the changes that have been made in response to feedback provided last year.

In relation to the proposed 2017/18 priorities, we recognise all proposed priorities as being of high importance to local residents.

Finally, I would like to welcome the ongoing open dialogue that the trust has established with us during the year and hope that this will continue.

Yours sincerely

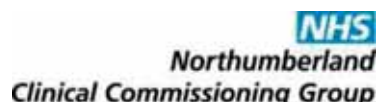


CLr Felicity Mendelson  
Vice-Chair, Health Scrutiny Committee

**If you need this information in another format or language, please contact the writer.**

## Annex 1:

# Statement on behalf of the Newcastle & Gateshead Clinical Commissioning Group Alliance



### **Corroborative statement from Newcastle Gateshead, Northumberland and North Tyneside Clinical Commissioning Groups (CCGs) for Newcastle Upon Tyne Hospitals NHS Foundation Trust Quality Accounts 2016/17**

The CCGs welcome the opportunity to review and comment on Newcastle Upon Tyne Hospitals NHS Foundation Trust's Quality Account for 2016/17 and would like to provide the following commentary.

As commissioners, Newcastle Gateshead, Northumberland and North Tyneside Commissioning Groups (CCGs) are committed to commissioning high quality services from Newcastle Upon Tyne Hospitals NHS Foundation Trust's and take seriously their responsibility to ensure that patients' needs are met by the provision of safe, high quality services and that the views and expectations of patients and the public are listened to and acted upon.

Throughout 2016/17, the CCGs have continued to hold bi-monthly Quality Review Group meetings with the Trust. These meetings provide the opportunity for CCGs to gain assurance that the systems and processes in place to promote the delivery of safe, effective and high quality care are effective. Newcastle Gateshead CCG has continued throughout 2016/17 to conduct a programme of clinical quality assurance visits to the Trust. Their purpose is to gain further insight and assurance into the quality of care and experience provided for patients. This has resulted in valuable partnership working with the Trust and has provided the CCG with an opportunity to make recommendations for suggested areas of improvement. A programme of CCG visits has been planned for 2017/18.

The report provides a comprehensive description of the quality improvement work undertaken within the Trust and an open account of where improvements in priorities have been made. The CCGs recognise the work the Trust has achieved to date in the delivery of the 2016/17 priorities and in the ongoing delivery of the quality measures. We are happy to see that quality remains the Trust's number one priority for 2017/18 and it is reassuring to see that these are also reflective of the CCGs priorities.

The CCGs are pleased to note that the Trust continues to be committed to the national 'Sign Up to Safety Campaign' and recognise the achievements made across these areas. In particular the CCG would like to congratulate the Trust on the significant improvements made in the monitoring, recognition and treatment of Sepsis.

Never Events are serious incidents which are preventable with appropriate procedures in place. It is noted that during 2016/17 the Trust reported eight never events however the CCGs acknowledge the Trust continues to improve surgical safety, including maintaining a focus on achieving compliance with the World Health Organisation (WHO) surgical checklist, the testing of a Surgical Behaviour Tool and achieving progress with Local Safety Standards for Invasive Procedures. The CCGs welcome the Trust's continued commitment to improving surgical safety during 2017/18 and note that an external review of never events will be commissioned by the Trust.

The CCGs are very pleased to see a positive focus on Health Care Associated Infection (HCAI) in the report and the continuation of HCAI as a priority patient safety focus is welcomed. We would like to acknowledge that the Trust was below the national trajectory for Clostridium Difficile following the appeals process agreed with the CCGs. However, it is disappointing that the Trust did not achieve the zero tolerance target for MRSA, despite their best efforts. The collaborative HCAI partnership group will continue its positive contribution to this agenda and remain sighted on the issues.

It is pleasing to note that the Trust has achieved a 5% reduction in the total number of falls in 2016/17 compared to 2015/16 and a reduction in the falls rate per 1000 bed days. The CCGs would like to commend the Trust for the significant progress made in reducing falls with harm and in particular those graded 'major' where there has been a notable 29% reduction. The CCGs welcome the continued work on sustaining this reduction as a 2017/18 quality priority.

There has been an overall 1.2% increase of hospital acquired pressure ulcers and moisture lesions. However it is noted that 96% of these were superficial in nature and no Category Grade IV pressure ulcers (most severe type of damage) were reported. The CCGs acknowledge that excellent progress has been made in some areas and would like to congratulate the 24 wards who achieved the Trust's internal target of 20% (or more) reduction in pressure ulcers and moisture lesions. The CCGs fully support the ongoing initiatives the Trust has in place to achieve 'zero tolerance' to hospital acquired pressure damage.

The Trust is commended on its comprehensive approach to measuring patient experience and the excellent initiatives which have been implemented during 2016/17, including improving communication with deaf/hard of hearing patients, launch of the accessibility guides for disabled patients and visitors, ongoing work with carers. The Trust's approach to learning from complaints and taking action is comprehensive and demonstrates a real commitment to improving patient experience and outcomes. The CCGs acknowledge the work carried out by the Trust to increase the Friends and Family Test response rates, although they remain below the national averages.

The emphasis that the Trust gives to national clinical audits and NICE Quality Standards demonstrates that the Trust is focussed on delivering evidence-based best practice.

The CCGs would also like to congratulate the Trust on the excellent results achieved in the 2016 NHS Staff Survey. The survey results were extremely positive and placed Newcastle upon Tyne Hospitals NHS Foundation Trust in the top 10 best performing acute trusts by staff as a place to work or receive treatment.

Most significantly, the CCGs would like to congratulate the Trust on the excellent results of their Care Quality Commission inspection, which rated Newcastle Hospital's services as 'Outstanding'. This is a fantastic achievement as there are only a small number of NHS organisations to have achieved this rating and only one of two teaching hospitals.

The CCGs welcome the specific priorities for 2017/18 which are highlighted within the report and consider that these are appropriate areas to target for continued improvement. The CCGs note the overview of quality improvements which have been implemented throughout the year and would like to congratulate the Trust on these excellent achievements.

It is felt overall that the report is well written and is reflective of quality activity and aspirations across the organisation for the forthcoming year. The CCGs look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned in 2017/18.



**Dr Neil Morris**  
Medical Director



**Chris Piercy**  
Executive Director of Nursing, Patient Safety & Quality

For and on behalf of NHS Newcastle Gateshead Clinical Commissioning Group  
NHS Northumberland Clinical Commissioning Group  
NHS North Tyneside Clinical Commissioning Group

# Statement on behalf of Healthwatch Gateshead and Healthwatch Newcastle



## **Healthwatch Newcastle and Healthwatch Gateshead combined statement for the Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH) Quality Account 2016-17**

Firstly we would again like to congratulate the Trust on receiving an 'Outstanding' rating by the recent Care Quality Commission's inspection this year.

We also very much welcome that the Trust took on board our suggestion to expand the public consultation for the development of the Quality Account. The engagement event run by the Trust in January 2017 was well prepared and in our view a success. We do hope this will become an annual fixture, and the Trust will continue to build on this initiative to further engage with the public with this important quality improvements work.

We are pleased this year's Quality Account contains less jargon and is therefore easier to read. However the increase from 100 to 130 pages is less welcome, as many will find this off-putting.

### **Results from 2016-17 priorities**

#### ***Priority 1: Reduce hospital associated infections***

We are pleased to read that the Trust has achieved a reduction in *Clostridium difficile* infections (from 67 cases last year, to 57 this year), continuing a strong year-on-year reduction. However it is disappointing to read that there have been significant increases in MRSA (5 to 9 cases), MSSA (83 to 93 cases) and E. coli (170 to 205 cases) during the last year. We hope this trend can be reversed in the coming year.

#### ***Priority 2: Sign up to Safety***

We note that all five areas of this priority (deteriorating patient, medication safety, sepsis, surgical safety and obstetrics) have targets to reduce incidents by 50%; however the results to this specific target are not presented in the report, which make it difficult for the reader to clearly understand the progress made.

From the data provided, we are encouraged by the results from the staff survey related to the safety culture and initiating the implementation of the eRescue project for electronic white boards.

We are very encouraged by the increase in incident reporting, and the consequent drop in harm caused by these incidents.

We are also very encouraged by the major progress in compliance to guidance with sepsis in Accident and Emergency. We would have liked to hear about paediatric compliance rates; we recognise that the new initiatives began in April 2017 but assume that the Trust will be measuring improvement against a baseline rate.

We are pleased to learn that the 'Never Events' rate remains low, and that there have been no deaths caused by Never Events this year. We recognise that the Trust accredits the increase in Never Events to the widening of the criteria to include dentistry and less serious events. However, by definition, these are preventable and we hope that they will reduce in the coming year.

We are concerned that figures show a significant increase in spinal infection rates over the last three reporting quarters (increased from 1.1% to 1.8%), and has gone above the national average figure.

We welcome the progress made with surgery for Diabetes, but note that diabetes management errors, insulin errors and hypoglycaemia errors rates remain above the national average.

***Priority 3: Harm free care***

We are pleased to see the reduction of the rate of falls over the last 12 months (6.0 fall/1000 beds, down from 6.2/1000), with a 17.5% reduction in falls resulting in serious harm.

However it's disappointing to see the pressure ulcers rate increase by 1.2%, when the aim was to reduce by 20%. In the previous quality account the rate of pressure ulcers also increased. However we note that in recent months the trend is improving and hope that you can achieve a reduction for the coming year.

***Priority 5: Palliative and End of Life care***

We are pleased to read about the pilot of the seven-day specialist palliative care service.

***Priority 6: Reducing avoidable deaths***

It is disappointing that both locally collected mortality rates measures of the Summarised Hospital-level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) shows a small increase over the last twelve months. SHMI has increased from 96 to 97 and HSMR from 96 to 99. We request that you make it clear in this report that this is an increase, albeit small. We recognise these figures remain below the national averages, and the best in the North East; however the Trust has aimed to achieve a reduction. We hope that every effort is made to return to reducing mortality rates for the coming year.

***Priority 8: NICE Quality Standards***

We welcome the introduction of Dementia champions in all wards across the Trust.

***Priority 9: Patient Experience***

We very much welcome steps towards compliance to the Accessible Information Standard (AIS) such as the pilot for online British Sign Language (BSL) interpreter services. However the AIS came into effect in August 2016 and should have been fully implemented by that date. The full compliance will have an important positive impact for some of the most vulnerable service users, and we expect that for 2017-18 that the Trust ensures full compliance.

We are also very pleased to read about the improved and strong staff survey results this year. We are especially happy that all staff were invited to take part in this.

## Annex 1:

# Statement on behalf of Healthwatch Gateshead and Healthwatch Newcastle (continued)

### ***2017-18 priorities***

We welcome the ambition with the number of priorities this year, increased from 9 to 13, but hope that having such a large number won't risk reducing the chances of success of each one.

### ***Priority 3: Harm free care***

We are disappointed that there isn't more ambition with falls and pressure ulcers. You aim only to sustain the present reductions in fall, and have a modest 5% reduction target for ulcers. Pressure ulcer rates have increased over the last two years and we would hope for increased focus and ambition with this target.

### ***Priority 5: Mortality***

We would welcome putting a specific target for reducing mortality, especially in regards to the increases reported in mortality rates this year.

### ***Priority 6: Antimicrobial Stewardship***

With the global concerns about microbial resistance we welcome this stewardship initiative.

### ***Priority 7: Ill-health prevention***

We very much welcome this priority and hope this is planned as a multi-year priority to enable substantial gains to take effect.

### ***Priority 12: Accessibility for service-users***

As the Accessible Information Standard came into effect in August 2016 we suggest that you set a more ambitious target to achieve full compliance in 2017-18.

We wish the Trust continued success in the coming year and in achieving the priorities set. We will continue to work together in the coming year, and look forward to supporting the Quality Account engagement event.



Steph Edusei  
Chief Executive

Annex 1:

# Statement on behalf of Northumberland Healthwatch

Healthwatch Northumberland  
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Anne Marie Troy-Smith  
Quality Development Manager  
The Newcastle upon Tyne Hospitals NHS Foundation Trust  
Freeman Hospital,  
Freeman Road,  
High Heaton,  
Newcastle-upon-Tyne,  
Tyne and Wear,  
NE7 7DN

23rd May 2017

Dear Anne Marie

## **Draft Quality Account for year ending 31 March 2017**

We welcome the opportunity to respond to the draft quality account of Newcastle upon Tyne Hospitals NHS Foundation Trust and would like to congratulate the Trust on some good results. Healthwatch Northumberland is looking forward to working further in collaboration with the Trust.

The Trust is to be highly commended for achieving the Outstanding rating from the CQC. This judgement confirms that the Trust is performing very well and it is to be congratulated for such an achievement.

The Trust is to be commended on its achievements regarding Quality Standards and National Clinical Audits. Similarly, the range and quality of Quality and Improvement Initiatives were impressive.

We have identified below areas where we believe the Trust has performed well.

- Progress using the Sign Up to Safety campaign and the improved scores for the staff safety culture surveys.
- The fall in reported radiation incidents (highlighted in 2016 response).
- The improvements to Sepsis screening compliance.
- The reduction in falls and the improving trend (with some way to go) in acquired pressure ulcers. This was highlighted in our response last year.
- The staff training and developments in safeguarding for vulnerable patients.



## Annex 1:

# Statement on behalf of Northumberland Healthwatch (continued)

- The focus on professional, compassionate care for patients living with dementia and their Carers, notably Memory Café and engagement with “John’s Campaign”.

We have identified below areas for improvements.

- We note again this year the disappointing increase in the number of ‘Never’ incidents, notwithstanding the explanatory information given.
- A positive outcome for C. Difficile, but the zero tolerance of MRSA was not achieved and reports the highest figure for 5 years. Similarly, the rising trends in MSSA and E.coli is also disappointing.
- The Staff Survey results were generally positive although the response rate was disappointing and therefore tended to diminish the findings.
- Patient Experience, the indication is that the Trust is ‘performing well’. It would be helpful for data to be provided to substantiate this statement.

Regarding the Trust’s priorities for 2017/18 in our view -

- The plans to improve performance appear positive and achievable with priorities that align with areas highlighted for improvement.
- The identified Patient Survey Priorities are appropriate, clearly articulated with objective Key Performance Indicators. They quite rightly focus on safety, including important areas such as safeguarding and prevention.

Overall the report has commendable detail on what has been done to achieve the targets. Yet it is not always clear whether or not the precise targets have actually been met e.g. Deteriorating Patients, Medication Safety.

The Quality Account would benefit from clearer and consistent presentation of whether or not targets were met and a narrative for where targets have not been met which highlights the lessons have been learned.

Overall we considered that the report does give a fair reflection of the service provided by the Trust.

We look forward to working with the Trust in the coming year and continuing to build on the positive working relationship we have established.

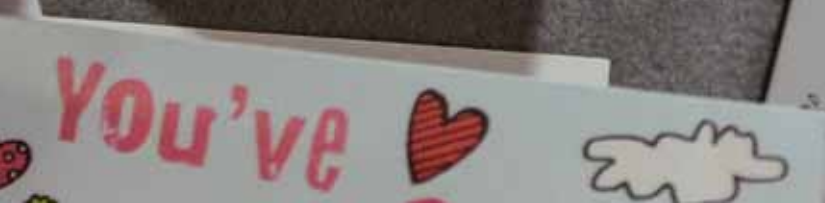
Yours sincerely



Derry Nugent  
Project Coordinator Healthwatch Northumberland







## Annex 2:

# Statement of Directors' responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
- board minutes and papers for the period April 2016-April 2017
- papers relating to quality reported to the Board over the period April 2016-April 2017
- feedback from the commissioners dated 17/05/2017
- feedback from governors dated 15/03/2017
- feedback from Local Healthwatch organisations dated 19/05/2017
- feedback from Local Overview and Scrutiny Committee dated 18/05/2017
- the Trust's latest complaints report included in the Trust's March 2017 Integrated Quality Report, presented to the Trust Board of Directors on 27/04/17

- the national patient survey dated 01/01/2017
- the national staff survey dated 07/03/2017
- the Head of Internal Audit's annual opinion over the trust's control environment dated 23/05/2017
- CQC Inspection report dated 06/06/2016
- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the Board



**Louise Robson**  
Acting Chief Executive

30 May 2017



**Andy Welch**  
Acting Chief Executive

30 May 2017



**Mr. Kingsley W. Smith OBE**  
Chairman

30 May 2017

# Independent Auditors' Limited Assurance Report

to the Board of Governors of The Newcastle upon Tyne Hospitals NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Board of Governors of The Newcastle upon Tyne Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of The Newcastle upon Tyne Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the 'Quality Report') and specified performance indicators contained therein.

## Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance (the "specified indicators") marked with the symbol (A) in the Quality Report, consist of the following national priority indicators as mandated by Monitor:

Specified Indicators	Specified indicators criteria (exact page number where criteria can be found)
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.	Detailed on pages 140 and 141 of the Annual Report
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge	Detailed on pages 140 and 141 of the Annual Report

## Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports for foundation trusts 2016/17" issued by Monitor (operating as NHS Improvement) ("NHSI").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2016/17".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17"; and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- Board minutes for the financial year, April 2016 and up to April 2017 (the period);
- Papers relating to quality report reported to the Board over the period April 2016 to April 2017;
- Feedback from the Newcastle & Gateshead Clinical Commissioning Group Alliance 17/05/17
- Feedback from Governors dated 15/03/17;
- Feedback from Healthwatch Gateshead (dated 19/05/2017) Healthwatch Newcastle (dated 19/05/2017) and Healthwatch Northumberland (dated 23/05/17);
- Feedback from Overview and Scrutiny Committee dated 18/05/17
- The Trust's latest complaint report included in the Trust's March 2017 'Integrated Quality Report' prepared in April 2017
- The national and local patient survey dated 01/01/17;
- The national and local staff survey dated 07/03/17;
- Care Quality Commission inspection, dated 06/06/16; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 23/05/17.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

## Our Independence and Quality Control

We applied the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour. We apply International Standard on Quality Control (UK & Ireland) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

## Use and distribution of the report

This report, including the conclusion, has been prepared solely for the Board of Governors of The Newcastle upon Tyne Hospitals NHS Foundation Trust as a body, to assist the Board of Governors in reporting The Newcastle upon Tyne Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Board of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors as a body and The Newcastle upon Tyne Hospitals NHS Foundation Trust as a body, to assist the Board of Governors in reporting The Newcastle upon Tyne NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

## Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000 (Revised)'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

## Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and "Detailed requirements for quality reports for foundation trusts 2016/17" and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by NHSI. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by The Newcastle upon Tyne Hospitals NHS Foundation Trust as a body, to assist the Board of Governors in reporting The Newcastle upon NHS Foundation Trust.

## Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2017:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17";
- The Quality Report is not consistent in all material respects with the documents specified above; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2016/17".



**PricewaterhouseCoopers LLP**

Newcastle upon Tyne

30 May 2017

The maintenance and integrity of the The Newcastle upon Tyne Hospitals NHS Foundation Trust as a body, to assist the Board of Governors in reporting The Newcastle upon Tyne's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

## Annex 3:

# Abbreviations

Abbreviations	
A&E	Accident & Emergency
ASWG	Antimicrobial Stewardship Working Group
BAUS	British Association of Urological Surgeons
BLS	Basic Life Support
BSL	British Sign Language
BTS	British Thoracic Society
CAT	Clinical Assurance Tool
CAUTI	Catheter Associated Urinary Tract Infection
CCGs	Clinical Commissioning Group
CCT	Care Co-ordination Team
CEAG	Clinical Effectiveness Audit and Guideline Committee
C.diff (CDI)	Clostridium difficile
CGARD	Clinical Governance and Risk Department
CP-IS	Child Protection Information Sharing
CRN NEC	Clinical Research Network North East and Cumbria
CPR	Cardiopulmonary Resuscitation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation (CQUIN) payment framework
CTG	Cardiotocography
DMARDs	Disease Modifying Anti-Rheumatic Drugs
DNA	Did Not Attend
DOACs	Direct Oral Anticoagulant Drugs
DoC	Duty of Candour
DOH	Department of Health
DoLS	Deprivation of Liberty
DVT	Deep Vein Thrombosis
E.coli	Escherichia coli
ED	Emergency Department
EoL	End of Life
FFT	Friends and Family Test
FGM	Female Genital Mutilation
GP	General Practitioner
GNCH	Great North Children's Hospital
HCAI	Healthcare Associated Infection
HES	Hospital Episode Statistics
HSMR	Hospital Standardised Mortality Ratio
ICNARC	Intensive Care National Audit and Research Centre
IPC	Infection Prevention and Control
IPCC	Infection Prevention and Control Committee
ISBARD	Identification,Situation,Background,Assessment, Recommendation & Decision
IV	Intravenous
IVF	In Vitro Fertilisation
JRO	Joint Research Office
KF	Key Finding
Loc SSIPs	Local Safety Standards for Invasive Procedures
LPMS	Local Performance Management System

Abbreviations	
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MDT	Multi-Disciplinary Team
MINAP	Myocardial Ischaemia National Audit Project
M&M	Morbidity & Mortality
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin Sensitive Staphylococcus Aureus
N/A	Not Applicable
NBOCA	National Bowel Cancer Audit
NCEPOD	National Confidential Enquiries into Patient Outcome & Death
NENCAHSN	North East and North Cumbria Academic Health Science Network
NEQOS	North East Quality Observatory
NEWS	National Early Warning Score
NHS	National Health Service
NICE	National Institute for health and clinical excellence
NICOR	National institute for clinical outcome research
NIHR	National Institute of Health Research
NOACs	Novel Oral Anticoagulants
NRLS	National Reporting & Learning System
NUTH	Newcastle upon Tyne NHS Foundation Trust
PCCDS	Palliative Care Clinical Data Set
PCNL	Percutaneous Nephrolithotomy
PDSA	Plan,Do,Study,Act
PEWS	Paediatric Early Warning system
PHE	Public Health England
PICU	Paediatric Intensive Care Unit
PIR	Post Infection Review
PROMs	Patient Reported Outcome Measures
QSTs	Quality Standards
RCA	Root Cause Analysis
RCS	Royal College of Surgeons
RCP	Royal College of Physicians
RCPH	Royal College of Paediatric Health
RCPC	Royal College of Paediatrics and Child Health
RCS	Royal College of Surgeons
RTT	Referral to Treatment Time
RVI	Royal Victoria Infirmary
SAFE	Situation Awareness for Everyone
SHMI	Summary Hospital-level Mortality Indicator
SIRM	Serious Infection Review Meeting
SIs	Serious Incidents
SPOC	Single Point of Contact
SUS	Secondary Users Service
Su2S	Sign up to Safety
STP	Sustainability and Transformation Plans
TARN	Trauma Audit Research Network
UK	United Kingdom
UTI	Urinary Tract Infection
VTE	Venous thromboembolism
WHO	World Health Organisation
YPAG	Young Peoples Advisory Group

# Glossary of Terms

## 1. CQC

The Care Quality Commission (CQC) is the independent regulator of all health and adult social care in England. The aim being to make sure better care is provided for everyone, whether that's in hospital, in care homes, in people's own homes, or elsewhere.

## 2. CQUIN – Commissioning for Quality and Innovation

The CQUIN framework was introduced in April 2009 as a national framework for locally agreed quality improvement schemes. It enables commissioners to reward excellence by linking a proportion of English healthcare provider's income to the achievement of local quality improvement goals.

## 3. DATIX

DATIX is an electronic risk management software system which promotes the reporting of incidents by allowing anyone with access to the Trust Intranet to report directly into the software on easy-to-use-web pages. The system allows incident forms to be completed electronically by all staff.

## 4. HSMR

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than would be expected.

## 5. Near Miss

An unplanned or uncontrolled event, which did not cause injury to persons or damage to property, but had the potential to do so.

## 6. NHS Safety Thermometer

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and "harm free" care. This tool measures four high-volume patient safety issues (pressure ulcers, falls in care, urinary infection (in patients with a catheter) and treatment for venousthromboembolism (Pulmonary embolus or deep vein thrombosis DVT).





# Audit and Controls

## Investment Manager

CCLA & Newton Investment Management Ltd

## Banker

Barclays, Yorkshire

## External Auditor

PricewaterhouseCoopers LLP

## Payroll

NHS Payroll Services

## Internal Auditor

Audit One

## Legal Advisers

Samuel Phillips Law Firm

Bond Dickinson Law Firm

Ward Hadaway

Sintons LLP

Berwin Leighton Paisner LLP

Addleshaw Goddard LLP



The principal objective of the Independent Auditor was to carry out an audit in accordance with paragraph 24(s) of Schedule 7 of the National Health Service Act 2006 and the requirements of the Audit Code issued by Monitor – the Independent Regulator of NHS Foundation Trusts – which by necessity ensures compliance with International Standards for Audit (UK & Ireland) issues by the Auditing Practice Board. This required an opinion on the Annual Accounts and a review of arrangements for legality; financial standing; internal financial control; and standards of financial conduct, including fraud and corruption.



The Audit Committee met on a regular basis to assess a range of studies and work programmes including detailed value for money scrutinies. The internal and external auditors attended all meetings of the Audit Committee and on each occasion there was the opportunity to meet privately with the Non-Executive Director membership. The auditors also had unrestricted access to the Audit Committee, its Chairman and individual members.

Sound corporate governance and all that entails was an overriding priority. This included review and audit of established counter-fraud and corruption policies, reported to the Audit Committee by the Internal Auditors in the context of the national Fraud Awareness Review.



Annual Accounts  
**The Newcastle upon Tyne  
Hospitals NHS Foundation Trust**  
2016/17



# Foreword to the Accounts

The Newcastle upon Tyne Hospitals NHS Foundation Trust

**The accounts for the year ended 31 March 2017 are set out on the following pages and comprise the Consolidated Statement of Comprehensive Income, the NHS Foundation Trust Statement of Comprehensive Income, the Consolidated Statement of Financial Position, the NHS Foundation Trust Statement of Financial Position, the Consolidated Statement of Changes in Taxpayers' and Others' Equity, the NHS Foundation Trust Statement of Changes in Taxpayers' Equity, the Statements of Cash Flows and the Notes to the Accounts.**

The accounts have been prepared by The Newcastle upon Tyne Hospitals NHS Foundation Trust in accordance with Schedule 7, Paragraphs 24 and 25, of the National Health Services Act 2006, in the form which Monitor, the independent regulator of NHS Foundation Trusts has, with the approval of HM Treasury, directed.

The Consolidated Statement of Comprehensive Income has been presented in four columns for consistency with the prior year and to more clearly present the Income & Expenditure of the NHS Foundation Trust (as shown in column 1), before the financial impact of asset revaluation exercises which have taken place during the year (column 2) and the impact of the Charitable Fund consolidation (column 3). The consolidated final result for the year is as presented in column 4. A similar format has been followed for the NHS Foundation Trust's Statement of Comprehensive Income.



Angela Dragone  
*Accounting Officer*

22 June 2017

# Independent Auditors' Report

to the Council of Governors of The Newcastle upon Tyne Hospitals NHS Foundation Trust

## Report on the financial statements

### Our opinion

In our opinion, The Newcastle upon Tyne Hospitals NHS Foundation Trust's Group and Trust financial statements (the "financial statements"):

- give a true and fair view of the state of the Group's and of the Trust's affairs as at 31 March 2017 and of the Group's and of the Trust's income and expenditure and of the Group's and of the Trust's cash flows for the year then ended 31 March 2017; and
- have been properly prepared in accordance with the Department of Health Group Accounting Manual 2016/17.

### What we have audited

The financial statements comprise:

- the Consolidated and Trust's Statements of Financial Position as at 31 March 2017;
- the Consolidated and Trust's Statement of Comprehensive Income for the year then ended;
- the Group and Trust's Statement of Cash Flows for the year then ended;
- the Consolidated and Trust's Statements of Changes in Taxpayers' and Others' Equity for the year then ended; and
- the notes to the accounts, which include a summary of significant accounting policies and other explanatory information.

Certain required disclosures have been presented elsewhere in the Annual Report and Accounts 2016-2017 (the "Annual Report"), rather than in the notes to the financial statements. These are cross-referenced from the financial statements and are identified as audited.

The financial reporting framework that has been applied in the preparation of the financial statements is the Department of Health Group Accounting Manual 2016/17.

### Our audit approach

#### Context

Our audit for the year ended 31 March 2017 was planned and executed having regard to the fact that the Trust's operations and financial stability were largely unchanged in nature from the previous year. In light of this, our approach to the audit in terms of scoping and areas of focus was largely unchanged. However, due to the additional factors in relation to the valuation of property plant and equipment, we have included this as a significant risk (in the prior year we considered this to be an elevated risk).



#### Overview

- Overall materiality: £20,667k which represents 2% of total revenue.
- The audit was conducted at the Trust's Regent Point site where the Finance function is based. The Freeman Hospital and the Royal Victoria Infirmary were also visited during the audit.
- In establishing our overall approach, we assessed the risks of material misstatement and applied our professional judgement to determine the extent of testing required over each balance in the financial statements.
- Management override of control.
- Risk of fraud in revenue and expenditure recognition.
- Valuation of Property, Plant and Equipment and Private Finance Initiative ('PFI') accounting.

## The scope of our audit and our areas of focus

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") and, International Standards on Auditing (UK and Ireland) ("ISAs (UK & Ireland)").

We designed our audit by determining materiality and assessing the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain. As in all of our audits, we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

The risks of material misstatement that had the greatest effect on our audit, including the allocation of our resources and effort, are identified as "areas of focus" in the table below. We have also set out how we tailored our audit to address these specific areas in order to provide an opinion on the financial statements as a whole, and any comments we make on the results of our procedures should be read in this context. This is not a complete list of all risks identified by our audit.

### Area of focus

#### Risk of fraud in revenue and expenditure recognition

See notes 1.3 to 1.4 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to the recognition of income and expenditure and notes 3 to 5 for further information.

We focused on this area because there is a heightened risk due to:

- The Trust agreeing a control total of £7.5m with NHS improvement on the 20th January 2017. This has presented an incentive for management to maximise revenue and reduce costs, which could be achieved through manipulation of the timing of recognition of both revenue and expenditure.
- The uncertainty at month 11 around the ability of the Trust to achieve the control total agreed in January 2017.

#### Revenue

The trust's principal source of income is from the Clinical Commissioning Groups ("CCGs") and NHS England, accounting for 82% of income during the year. The most significant of these is with Newcastle Gateshead CCG. The contracts are renegotiated annually, with variations to the contract made for additional funding that becomes available throughout the year.

Our work has also focused on the appropriateness of the ongoing deferral of income and the expected release profile in line with the associated conditions.

#### Expenditure

We focused our work on the elements of expenditure that are most susceptible to manipulation, being operating expenses excluding payroll costs and depreciation. Our testing included non-standard journal transactions which would impact the completeness of expenditure.

#### Assertions

We considered the risk to be income being accelerated into 2016/17 and expenditure deferred from the current financial year into 2017/18. Our work therefore focused on the existence of income, completeness of expenditure and the cut-off of both income and expenditure.

### How our audit addressed the area of focus

#### Income

We evaluated and tested the accounting policies for income recognition to ensure that it is consistent with the requirements of the Department of Health group reporting manual.

We reconciled a sample of income received from the CCGs to the signed contracts and traced significant contract variations received in year to correspondence from the CCGs. We traced all material invoices and a sample of immaterial invoices raised to cash receipt.

#### Intra-NHS balances

We obtained the Trust's mismatch reports received from Monitor, which identified balances (debtor, creditor, income and expenditure balances) that were disputed by the counterparty. We investigated individual differences above a threshold of £250,000, discussed these with management and corroborated the reasons provided. We have considered the impact, if any, that the remaining disputed amounts would have on the Trust's financial statements and determined that there is no material impact.

#### Deferred Income

We considered both releases to the Statement of Comprehensive Income from deferred income and the remaining year-end balance. We verified releases were appropriate and agreed deferred income balances to source documentation, agreeing both the amount of the balance and the conditional nature of the balance.

#### Expenditure

Operating expenditure includes staff costs (55%), drugs costs (15%), and depreciation and impairment of property, plant and equipment (7%), which we do not consider to be higher risks.

For a sample of operating expenses excluding staff, drugs and depreciation/impairment costs recognised during the year and around the year end (both before and after), we confirmed that the expenditure had been recognised in line with the accounting policies and in the correct accounting period by agreeing the transactions, including the date of delivery of the goods or services, to the supporting invoice to ensure that the service/receipt of goods had occurred in the period in which the expense/liability was recorded.

We have selected a sample of payments made from the Trust's bank statements and traced back to supporting documentation to ensure the completeness of expenditure.

We have performed a high level analytical review of payroll costs, as well as testing a sample of monthly payments from payroll records to bank clearance, tested the year end payroll reconciliation and a number of payroll controls to gain evidence over the standing data on the ESR system.



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## Areas of focus

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### Management override of control including key estimates and judgments

See note 1 to the financial statements for the directors' disclosures of the related accounting policies requiring their judgement.

We focused on this area because there is a heightened risk that the Group's results will be materially misstated due to:

- Agreement of the £7.5m control total and the uncertainty of its achievement
- the number of significant judgemental areas including provisions for legal claims and doubtful debts, and accruals at year end;
- the inherent complexities in a number of contractual arrangements entered into by the Trust; and
- the timing and complexity of the intra-NHS balance reconciliation process.

In the main we would expect misstatement to be through the processing of journals or through bias in exercising of judgement when calculating any significant estimates.

### Valuation of Property, Plant and Equipment and PFI

See note 12.1 to the financial statements for the disclosure of the valuation of land and buildings.

We focused on this area because Property, Plant and Equipment ("PPE") represents the largest balance in the Trust's statement of financial position. PPE is valued at £474.4m of which 87% relates to land and buildings that have been subject to revaluation in year.

Land and buildings are measured initially at cost and subsequently measured at fair value. The valuations are carried out by the District Valuer, using the Modern Equivalent Asset Method of valuation, which involves a range of assumptions being used. The District Valuer is an external independent valuer of the trust who is a professionally qualified member of the Royal Institute of Chartered Surveyors.

Valuations are required to be performed with sufficient regularity to ensure that the carrying value is not materially different from fair value at the reporting date.

A full revaluation of the Trust's portfolio of land and buildings was undertaken during 2016/17 by the Trust's valuation experts, resulting in a decrease in the value of the Trust's estate of £94.2m. This has been driven from management's decision to value its estate on a single site basis, exclusive of VAT, based on its intention to provide services that are currently split two sites onto one new site. Management have determined that any new site would be funded through PFI or PF2.

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## How our audit addressed the area of focus

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### Journals

We have used data analysis techniques in order to identify journals with higher risk characteristics for detailed review,

Our sample of journal transactions selected, focused in particular, on those with the following characteristics:

- Unusual account combinations;
- Postings on non-working days;
- Postings at the end of the financial year that influence the Trust's financial performance;
- Journals containing certain key words in the journal description that, in our experience, are more indicative of manipulation and
- Postings by senior management.

We traced these journal entries to supporting documentation (for example invoices, cash receipts and payments) and confirmed they were recognised appropriately.

### Management estimates

We considered management estimates and did not identify any evidence of management bias, and the approach taken was appropriate and consistent with the prior year. Key areas of estimation considered included:

- Accrued income
- Deferred income;
- Provisions; and
- Valuations;

### Valuations

We have reviewed management's business case for providing the Trust's services on a single site. We have considered the viability of funding the site through PFI and note 49% of the existing site is PFI funded, evidencing previous intent and ability to access such funding. Management have also included commentaries in the annual report and financial statements outlining the basis for the valuation, and represented to us that valuing on an alternative site basis, exclusive of VAT, is the most appropriate method.

We obtained the District Valuer's valuation. We have read the relevant sections of the full valuation performed and have used our in-house valuations expert to confirm that the methodology and the assumptions used by the Trust's valuation experts were consistent with our expectations, based on our experience of similar valuations.

We confirmed the accuracy of the information provided by the Trust to the valuation expert by:

- By checking a sample of the portfolio of properties included in the valuation was consistent with the Trust's fixed asset register, which we had audited; and
- verifying that the input data used by the valuer as the basis of the valuation was consistent with the underlying estates and property asset information held within the Trust's Estates Department.

We tested a sample of assets covering both increases and decreases in valuation, by checking that adjustments had been correctly posted to the Fixed Asset Register and consequently, that the accounting treatment had been recorded appropriately in the Trust's financial statements.

## Areas of focus

Specific areas of risk include:

- the accuracy and completeness of detailed information on assets;
- whether the Trust's assumptions underlying the classification of properties are appropriate; and
- the valuers' methodology, assumptions and underlying data, and our access to these.

### PFI

The above also impacts on the Trust's PFI scheme. As well as the valuation of the PFI assets, the Trust needs to consider the accounting implications for the PFI scheme including the impact of the Unitary Payment and appropriate management of costs and cash flows. Further details of the Trust's PFI scheme can be found in note 21 to the accounts.

The dispute over Phase 9 of the PFI scheme has been settled in the current financial year. The accounting implications of this have been considered.

## How our audit addressed the area of focus

Our testing did not identify any issues. We found:

- the valuation to have been based on appropriate and up to date floor space data;
- the estates and property asset information held on which the valuation was based to be accurate;
- the assumptions and methodology applied to be consistent with our expectations; and the output from the valuation to have been correctly recorded in the financial statements.

### PFI

We have reviewed the settlement agreement with Healthcare Support, Laing O'Rourke Construction Limited and Interserve (Facilities Management) Limited dated 11/08/16.

We considered the treatment of the compensation that had been deferred, and the adjustment to recognise the compensation in full within the Statement of Comprehensive Income.

We tested management's accounting for its PFI assets and found no issues to report.

## How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the structure of the Group, the accounting processes and controls, and the environment in which the Group operates.

The Group includes the parent, The Newcastle upon Tyne Hospitals NHS Foundation Trust, and The Newcastle upon Tyne Hospitals NHS Charity, which is consolidated as a subsidiary. The Trust also holds investments in six additional companies, only two of which traded in the year, with two not having commenced trading and two currently being dormant. The transactions for the six companies in 2016/17 are of such an immaterial level that these organisations have not been consolidated within the Group.

## Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

<b>Overall Group materiality</b>	£20,667k (2016: £9,886k).
<b>How we determined it</b>	2% of revenue (2016: 1% of revenue)
<b>Rationale for benchmark applied</b>	Consistent with last year, we have applied this benchmark, a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate. The rule of thumb deviates from prior year approach. This is due to the introduction of the EU PIE definition which has been adapted, and for which the Trust does not meet.

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £250k (2016: £250k) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

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## Other reporting

### Opinions on other matters prescribed by the Code of Audit Practice

In our opinion:

- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the parts of the Remuneration and Staff Reports to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2016/17.

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### Arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report, by exception, if we conclude we are not satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017; We have nothing to report as a result of this requirement.

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### Other matters on which we report by exception

We are required to report to you if:

- information in the Annual Report is:
  - materially inconsistent with the information in the audited financial statements; or
  - apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Group and Trust acquired in the course of performing our audit; or
  - otherwise misleading.
- the statement given by the directors, within the Statement of Accounting Officer's Responsibilities on page 58, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable and provides the information necessary for members to assess the Group and Trust's performance, business model and strategy is materially inconsistent with our knowledge of the Trust acquired in the course of performing our audit.
- the section of the Annual Report on pages 35 and 36, as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.
- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 or is misleading or inconsistent with our knowledge acquired in the course of performing our audit. We have not considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.
- we have referred a matter to Monitor under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.
- we have issued a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006.

We have no matters to report in relation to these responsibilities.

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## Respective responsibilities of the Directors and the Auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, as set out in the Accountability Report, the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with the Department of Health Group Accounting Manual 2016 /17.

Our responsibility is to audit and express an opinion on the financial statements in accordance with the National Health Service Act 2006, the Code of Audit Practice, and ISAs (UK & Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. We are required under Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report to you where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our work in accordance with the Code of Audit Practice, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has 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. Based on our risk assessment, we undertook such work as we considered necessary.

This report, including the opinions, has been prepared for and only for the Council of Governors of The Newcastle upon Tyne Hospitals NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

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## What an audit of financial statements involves

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Group's and Trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the directors; and
- the overall presentation of the financial statements.

We primarily focus our work in these areas by assessing the directors' judgements against available evidence, forming our own judgements, and evaluating the disclosures in the financial statements.

We test and examine information, using sampling and other auditing techniques, to the extent we consider necessary to provide a reasonable basis for us to draw conclusions. We obtain audit evidence through testing the effectiveness of controls, substantive procedures or a combination of both. In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

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## Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code of Audit Practice.



**Greg Wilson (Senior Statutory Auditor)**

for and on behalf of PricewaterhouseCoopers LLP  
Chartered Accountants and Statutory Auditors  
Newcastle upon Tyne  
22 June 2017

- a) The maintenance and integrity of The Newcastle upon Tyne Hospitals NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.
- b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

# Consolidated Statement of Comprehensive Income

## for the year ended 31 March 2017

	2016/17 Before Exceptional Items and Charitable fund *	2016/17 Exceptional Items *	2016/17 Charitable fund	2016/17 Total	2015/16 Before Exceptional Items and Charitable fund *	2015/16 Exceptional Items *	2015/16 Charitable fund	2015/16 Total	
Note	£000	£000	£000	£000	£000 Restated	£000	£000 Restated	£000	
<b>OPERATING INCOME</b>									
Income from activities	3	880,864	0	0	880,864	849,174	0	0	849,174
Other operating income	4	151,960	0	19,285	171,245	139,144	0	2,843	141,987
<b>TOTAL OPERATING INCOME</b>		<b>1,032,824</b>	<b>0</b>	<b>19,285</b>	<b>1,052,109</b>	988,318	0	2,843	991,161
Operating expenses	5	(989,789)	(50,240)	(2,292)	(1,042,321)	(955,860)	(14,346)	(950)	(971,156)
<b>OPERATING SURPLUS/(DEFICIT)</b>		<b>43,035</b>	<b>(50,240)</b>	<b>16,993</b>	<b>9,788</b>	32,458	(14,346)	1,893	20,005
<b>FINANCE INCOME AND COSTS</b>									
Finance income	7	302	0	801	1,103	516	0	313	829
Finance expense - financial liabilities	8	(22,509)	0	0	(22,509)	(21,653)	0	0	(21,653)
Finance (expense)/income - unwinding of discount on provisions	22	(74)	0	0	(74)	85	0	0	85
PDC dividends payable	9	(7,691)	0	0	(7,691)	(9,083)	0	0	(9,083)
<b>Net finance (costs)/income</b>		<b>(29,972)</b>	<b>0</b>	<b>801</b>	<b>(29,171)</b>	(30,135)	0	313	(29,822)
Losses on disposal of assets		(104)	0	0	(104)	(26)	0	0	(26)
<b>SURPLUS/(DEFICIT) FOR THE YEAR</b>		<b>12,959</b>	<b>(50,240)</b>	<b>17,974</b>	<b>(19,487)</b>	2,297	(14,346)	2,206	(9,843)
<b>SURPLUS/(DEFICIT) FOR THE YEAR</b>		<b>12,959</b>	<b>(50,240)</b>	<b>17,974</b>	<b>(19,487)</b>	2,297	(14,346)	2,206	(9,843)
<b>Other Comprehensive Income/(expense)</b>									
<b>Will not be reclassified to income and expenditure:</b>									
Impairments		0	(47,625)	0	(47,625)	0	0	0	0
Revaluation gains on property, plant and equipment		0	0	0	0	0	2,339	0	2,339
Other movements on reserves		(2)	0	0	(2)	2	0	0	2
<b>May be reclassified to income and expenditure when certain conditions are met:</b>									
Fair value gains/(losses) on available-for-sale financial investments		0	0	2,825	2,825	0	0	(314)	(314)
<b>Total Other Comprehensive (Expense)/Income</b>		<b>(2)</b>	<b>(47,625)</b>	<b>2,825</b>	<b>(44,802)</b>	2	2,339	(314)	2,027
<b>TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR</b>		<b>12,957</b>	<b>(97,865)</b>	<b>20,619</b>	<b>(64,289)</b>	2,299	(12,007)	1,892	(7,816)
<b>ALLOCATION OF PROFITS FOR THE YEAR</b>									
<b>(a) Surplus/(Deficit) for the year attributable to:</b>									
(i) non controlling interest; and		0	0	0	0	0	0	0	0
(ii) owners of the parent.		12,959	(50,240)	17,794	(19,487)	2,297	(14,346)	2,206	(9,843)
<b>TOTAL</b>		<b>12,959</b>	<b>(50,240)</b>	<b>17,794</b>	<b>(19,487)</b>	2,297	(14,346)	2,206	(9,843)
<b>(b) Total comprehensive income/(expense) for the year attributable to:</b>									
(i) non controlling interest; and		0	0	0	0	0	0	0	0
(ii) owners of the parent.		12,957	(97,865)	20,619	(64,289)	2,299	(12,007)	1,892	(7,816)
<b>TOTAL</b>		<b>12,957</b>	<b>(97,865)</b>	<b>20,619</b>	<b>(64,289)</b>	2,299	(12,007)	1,892	(7,816)

The overall Income & Expenditure (I&E) position of the NHS Foundation Trust for the year ended 31 March 2017, before impairments and the consolidation of the Charitable fund, is a surplus of £12,959k. (2015/16 a surplus of £2,297k restated).

\* Exceptional items detail can be found in Note 1.28.

# NHS Foundation Trust Statement of Comprehensive Income

for the year ended 31 March 2017

	2016/17	2016/17	2016/17	2015/16	2015/16	2015/16	
	Before	Exceptional	Total	Before	Exceptional	Total	
Note	Exceptional	Items *	£000	Exceptional	Items *	£000	
	£000	£000	£000	£000	£000	£000	
<b>OPERATING INCOME</b>							
Income from activities	3	<b>880,864</b>	<b>0</b>	<b>880,864</b>	849,174	0	849,174
Other operating income	4	<b>152,490</b>	<b>0</b>	<b>152,490</b>	139,342	0	139,342
<b>TOTAL OPERATING INCOME</b>		<b>1,033,354</b>	<b>0</b>	<b>1,033,354</b>	988,516	0	988,516
Operating expenses	5	<b>(989,789)</b>	<b>(50,240)</b>	<b>(1,040,029)</b>	(955,860)	(14,346)	(970,206)
<b>OPERATING SURPLUS/(DEFICIT)</b>		<b>43,565</b>	<b>(50,240)</b>	<b>(6,675)</b>	32,656	(14,346)	18,310
<b>FINANCE INCOME AND COSTS</b>							
Finance income	7	<b>302</b>	<b>0</b>	<b>302</b>	516	0	516
Finance expense - financial liabilities	8	<b>(22,509)</b>	<b>0</b>	<b>(22,509)</b>	(21,653)	0	(21,653)
Finance (expense)/income - unwinding of discount on provisions	22	<b>(74)</b>	<b>0</b>	<b>(74)</b>	85	0	85
PDC dividends payable	9	<b>(7,691)</b>	<b>0</b>	<b>(7,691)</b>	(9,083)	0	(9,083)
<b>Net finance costs</b>		<b>(29,972)</b>	<b>0</b>	<b>(29,972)</b>	(30,135)	0	(30,135)
Losses on disposal of assets		<b>(104)</b>	<b>0</b>	<b>(104)</b>	(26)	0	(26)
<b>SURPLUS/(DEFICIT) FOR THE YEAR</b>		<b>13,489</b>	<b>(50,240)</b>	<b>(36,751)</b>	2,495	(14,346)	(11,851)
<b>SURPLUS/(DEFICIT) FOR THE YEAR</b>		<b>13,489</b>	<b>(50,240)</b>	<b>(36,751)</b>	2,495	(14,346)	(11,851)
<b>Other Comprehensive (Expense)/Income</b>							
<b>Will not be reclassified to income and expenditure:</b>							
Impairments		<b>0</b>	<b>(47,625)</b>	<b>(47,625)</b>	0	0	0
Revaluation gains on property, plant and equipment		<b>0</b>	<b>0</b>	<b>0</b>	0	2,339	2,339
Other movements on reserves		<b>(2)</b>	<b>0</b>	<b>(2)</b>	2	0	2
<b>Total Other Comprehensive (Expense)/Income</b>		<b>(2)</b>	<b>(47,625)</b>	<b>(47,627)</b>	2	2,339	2,341
<b>TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR</b>		<b>13,487</b>	<b>(97,865)</b>	<b>(84,378)</b>	2,497	(12,007)	(9,510)

\* Exceptional items detail can be found in Note 1.28.

# Consolidated Statement of Financial Position

as at 31 March 2017

	GROUP		
	31 March 2017	31 March 2016	
Note	£000	£000	
<b>NON-CURRENT ASSETS</b>			
Intangible assets	11 2,756	3,033	
Property, plant and equipment	12 474,965	569,247	
Investments in subsidiaries and joint ventures	13 0	193	
Other investments	14 24,900	7,309	
Trade and other receivables	16 11,424	10,373	
<b>TOTAL NON-CURRENT ASSETS</b>	<b>514,045</b>	590,155	
<b>CURRENT ASSETS</b>			
Inventories	15 14,725	18,533	
Trade and other receivables	16 71,248	72,267	
Non current assets held for sale	17 895	0	
Cash and cash equivalents	18 114,682	102,593	
<b>TOTAL CURRENT ASSETS</b>	<b>201,550</b>	193,393	
<b>CURRENT LIABILITIES</b>			
Trade and other payables	19 (98,582)	(94,555)	
Other liabilities	20 (7,965)	(11,162)	
Borrowings	21 (8,583)	(8,540)	
Provisions	22 (1,547)	(6,662)	
<b>TOTAL CURRENT LIABILITIES</b>	<b>(116,677)</b>	(120,919)	
<b>NON-CURRENT LIABILITIES</b>			
Other liabilities	20 0	(5,103)	
Borrowings	21 (244,336)	(243,268)	
Provisions	22 (5,818)	(5,487)	
<b>TOTAL NON-CURRENT LIABILITIES</b>	<b>(250,154)</b>	(253,858)	
<b>TOTAL ASSETS EMPLOYED</b>	<b>348,764</b>	408,771	
<b>TAXPAYERS' EQUITY</b>			
Public dividend capital *	230,581	226,299	
Revaluation reserve *	79,903	128,298	
Income and expenditure reserve *	1,225	37,208	
<b>TOTAL TAXPAYERS' EQUITY</b>	<b>311,709</b>	391,805	
<b>OTHERS' EQUITY</b>			
Charitable reserves *	37,055	16,966	
<b>TOTAL TAXPAYERS' AND OTHERS' EQUITY</b>	<b>348,764</b>	408,771	

\* Reserves:

- Public dividend capital represents the Secretary of State for Health's 'equity' investment in the NHS Foundation Trust.
- The revaluation reserve is used to record revaluation gains and losses on property, plant and equipment.
- The NHS Foundation Trust's surplus for the year is recognised in the Income and Expenditure reserve.
- Charitable reserves relate to those held by the Newcastle upon Tyne Hospitals NHS Charity. Further analysis can be found in Note 33.

The accounts on pages 171 to 216 were approved by the Board on 25 May 2017 and signed on its behalf by:

**Angela Dragone**  
Accounting Officer

22 June 2017

# NHS Foundation Trust

## Statement of Financial Position

as at 31 March 2017

NHS FOUNDATION TRUST			
	31 March 2017	31 March 2016	
	£000	£000	Note
<b>NON-CURRENT ASSETS</b>			
Intangible assets	11	2,756	3,033
Property, plant and equipment	12	474,432	569,247
Investments in subsidiaries and joint ventures	13	0	193
Trade and other receivables	16	11,424	10,373
<b>TOTAL NON-CURRENT ASSETS</b>		<b>488,612</b>	582,846
<b>CURRENT ASSETS</b>			
Inventories	15	14,697	18,506
Trade and other receivables	16	71,483	72,070
Non current assets held for sale	17	895	0
Cash and cash equivalents	18	102,813	93,076
<b>TOTAL CURRENT ASSETS</b>		<b>189,888</b>	183,652
<b>CURRENT LIABILITIES</b>			
Trade and other payables	19	(98,542)	(94,471)
Other liabilities	20	(7,965)	(11,162)
Borrowings	21	(8,583)	(8,540)
Provisions	22	(1,547)	(6,662)
<b>TOTAL CURRENT LIABILITIES</b>		<b>(116,637)</b>	(120,835)
<b>NON-CURRENT LIABILITIES</b>			
Other liabilities	20	0	(5,103)
Borrowings	21	(244,336)	(243,268)
Provisions	22	(5,818)	(5,487)
<b>TOTAL NON-CURRENT LIABILITIES</b>		<b>(250,154)</b>	(253,858)
<b>TOTAL ASSETS EMPLOYED</b>		<b>311,709</b>	391,805
<b>TAXPAYERS' EQUITY</b>			
Public dividend capital *		230,581	226,299
Revaluation reserve *		79,903	128,298
Income and expenditure reserve *		1,225	37,208
<b>TOTAL TAXPAYERS' EQUITY</b>		<b>311,709</b>	391,805

\* Reserves:

- Public dividend capital represents the Secretary of State for Health's 'equity' investment in the NHS Foundation Trust.
- The revaluation reserve is used to record revaluation gains and losses on property, plant and equipment.
- The NHS Foundation Trust's surplus for the year is recognised in the Income and Expenditure reserve.

The accounts on pages 171 to 216 were approved by the Board on 25 May 2017 and signed on its behalf by:



**Angela Dragone**  
Accounting Officer

22 June 2017



# Consolidated Statement of Changes in Taxpayers' and Others' Equity

for the year ended 31 March 2017

## GROUP 2016/17

	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Charitable reserves £000	Total taxpayers' and others' equity £000
<b>Taxpayers' and others' equity at 1 April 2016</b>		226,299	128,298	37,208	16,966	<b>408,771</b>
<b>Total comprehensive (expense)/income for 2016/17</b>						
(Deficit)/Surplus for the year	SOCI	0	0	(37,281)	17,794	<b>(19,487)</b>
Impairments		0	(47,625)	0	0	<b>(47,625)</b>
Fair value gains on available for sale financial investments		0	0	0	2,825	<b>2,825</b>
Transfer from revaluation reserve to I&E reserve for impairments arising from consumption of economic benefits		0	(770)	770	0	<b>0</b>
Other reserve movements		0	0	(2)	0	<b>(2)</b>
Other reserve movements - Charitable funds consolidation movements		0	0	530	(530)	<b>0</b>
<b>Total comprehensive (expense)/income for 2016/17</b>		<b>0</b>	<b>(48,395)</b>	<b>(35,983)</b>	<b>20,089</b>	<b>(64,289)</b>
Public dividend capital received		4,282	0	0	0	<b>4,282</b>
<b>Total reserve movements for 2016/17</b>		<b>4,282</b>	<b>(48,395)</b>	<b>(35,983)</b>	<b>20,089</b>	<b>(60,007)</b>
<b>Taxpayers' and others' equity at 31 March 2017</b>		<b>230,581</b>	<b>79,903</b>	<b>1,225</b>	<b>37,055</b>	<b>348,764</b>

## GROUP 2015/16

	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Charitable reserves £000	Total taxpayers' and others' equity £000
<b>Taxpayers' and others' equity at 1 April 2015</b>		225,052	127,148	47,868	15,272	<b>415,340</b>
<b>Total comprehensive income for 2015/16</b>						
(Deficit)/surplus for the year	SOCI	0	0	(12,049)	2,206	<b>(9,843)</b>
Revaluation gains - property, plant and equipment	12.1	0	2,339	0	0	<b>2,339</b>
Fair value losses on available for sale financial investments		0	0	0	(314)	<b>(314)</b>
Transfer from revaluation reserve to I&E reserve for impairments arising from consumption of economic benefits		0	(1,190)	1,190	0	<b>0</b>
Other reserve movements		0	1	1	0	<b>2</b>
Other reserve movements - Charitable funds consolidation movement		0	0	198	(198)	<b>0</b>
<b>Total comprehensive income/(expense) for 2015/16</b>		<b>0</b>	<b>1,150</b>	<b>(10,660)</b>	<b>1,694</b>	<b>(7,816)</b>
Public dividend capital received		1,247	0	0	0	<b>1,247</b>
<b>Total reserve movements for 2015/16</b>		<b>1,247</b>	<b>1,150</b>	<b>(10,660)</b>	<b>1,694</b>	<b>(6,569)</b>
<b>Taxpayers' and others' equity at 31 March 2016</b>		<b>226,299</b>	<b>128,298</b>	<b>37,208</b>	<b>16,966</b>	<b>408,771</b>

# NHS Foundation Trust Statement of Changes in Taxpayers' Equity

for the year ended 31 March 2017

## NHS FOUNDATION TRUST 2016/17

	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total taxpayers' equity £000
<b>Taxpayers' equity at 1 April 2016</b>		226,299	128,298	37,208	<b>391,805</b>
<b>Total comprehensive income/(expense) for 2016/17</b>					
Deficit for the year	SOCI	0	0	(36,751)	<b>(36,751)</b>
Impairments		0	(47,625)	0	<b>(47,625)</b>
Transfer from revaluation reserve to I&E reserve for impairments arising from consumption of economic benefits		0	(770)	770	<b>0</b>
Other reserve movements		0	0	(2)	<b>(2)</b>
<b>Total comprehensive expense for 2016/17</b>		<b>0</b>	<b>(48,395)</b>	<b>(35,983)</b>	<b>(84,378)</b>
Public dividend capital received		4,282	0	0	<b>4,282</b>
<b>Total reserve movements for 2016/17</b>		<b>4,282</b>	<b>(48,395)</b>	<b>(35,983)</b>	<b>(80,096)</b>
<b>Taxpayers' equity at 31 March 2017</b>		<b>230,581</b>	<b>79,903</b>	<b>1,225</b>	<b>311,709</b>

## NHS FOUNDATION TRUST 2015/16

	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total taxpayers' equity £000
<b>Taxpayers' equity at 1 April 2015</b>		225,052	127,148	47,868	<b>400,068</b>
<b>Total comprehensive income/(expense) for 2015/16</b>					
Deficit for the year	SOCI	0	0	(11,851)	<b>(11,851)</b>
Revaluation gains - property, plant and equipment	12.1	0	2,339	0	<b>2,339</b>
Other reserve movements		0	(1,189)	1,191	<b>2</b>
<b>Total comprehensive income/(expense) for 2015/16</b>		<b>0</b>	<b>1,150</b>	<b>(10,660)</b>	<b>(9,510)</b>
Public dividend capital received		1,247	0	0	<b>1,247</b>
<b>Total reserve movements for 2015/16</b>		<b>1,247</b>	<b>1,150</b>	<b>(10,660)</b>	<b>(8,263)</b>
<b>Taxpayers' equity at 31 March 2016</b>		<b>226,299</b>	<b>128,298</b>	<b>37,208</b>	<b>391,805</b>

# Statements of Cash Flows

for the year ended 31 March 2017

	Note	GROUP		NHS FOUNDATION TRUST	
		2016/17 £000	2015/16 £000	2016/17 £000	2015/16 £000
<b>Cash flows from operating activities</b>					
Net cash generated from operating activities	23	<b>82,554</b>	61,497	<b>65,151</b>	59,890
<b>Cash flows from investing activities</b>					
Interest received		<b>307</b>	508	<b>307</b>	508
Purchase of intangible assets		<b>(728)</b>	(1,185)	<b>(728)</b>	(1,185)
Purchase of property, plant and equipment		<b>(18,510)</b>	(26,196)	<b>(18,510)</b>	(26,196)
Sales of property, plant and equipment		<b>62</b>	62	<b>62</b>	62
Receipt of cash donations to purchase capital assets		<b>363</b>	1,123	<b>893</b>	1,321
NHS Charitable funds - net cash flows from investing activities		<b>(14,521)</b>	313	<b>0</b>	0
<b>Net cash used in investing activities</b>		<b>(33,027)</b>	(25,375)	<b>(17,976)</b>	(25,490)
<b>Cash flows from financing activities</b>					
Public dividend capital received		<b>4,282</b>	1,247	<b>4,282</b>	1,247
Loans repaid to the Department of Health	21	<b>(3,500)</b>	(3,500)	<b>(3,500)</b>	(3,500)
Capital element of private finance initiative obligations		<b>(6,785)</b>	(6,621)	<b>(6,785)</b>	(6,621)
Interest paid		<b>(333)</b>	(434)	<b>(333)</b>	(434)
Interest element of private finance initiative obligations		<b>(22,207)</b>	(21,247)	<b>(22,207)</b>	(21,247)
Public dividend capital dividend paid		<b>(8,895)</b>	(8,662)	<b>(8,895)</b>	(8,662)
<b>Net cash used in financing activities</b>		<b>(37,438)</b>	(39,217)	<b>(37,438)</b>	(39,217)
<b>Increase/(Decrease) in cash and cash equivalents</b>		<b>12,089</b>	(3,095)	<b>9,737</b>	(4,817)
Cash and cash equivalents at 1 April		<b>102,593</b>	105,688	<b>93,076</b>	97,893
<b>Cash and cash equivalents at 31 March</b>	18	<b>114,682</b>	102,593	<b>102,813</b>	93,076

# Notes to the Accounts

## 1 Accounting policies and other information

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS Foundation Trusts under the NHS Act 2006. NHS Improvement has directed that the annual report and accounts of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following accounts have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FRoM) to the extent that they are meaningful and appropriate to NHS Foundation Trusts.

### Change in accounting policies

The NHS Foundation Trust's accounting policies have been applied consistently in the current and prior year in relation to items considered material in relation to the accounts.

### Going concern

Following enquiries the Directors have an expectation the NHS Foundation Trust has adequate resources to continue in operation for the foreseeable future. The accounts therefore continue to be prepared on a going concern basis.

### 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 and the investments held within the charitable fund. NHS Foundation Trusts, in compliance with the DH GAM, are not required to comply with IAS 16 regarding the disclosure of historical cost carrying amounts.

### Critical accounting judgements and key sources of estimation in applying the NHS Foundation Trust's accounting policies

The preparation of the annual report and accounts requires the use of certain critical accounting estimates and also requires the NHS Foundation Trust's directors and senior managers to exercise their judgement in the process of applying the NHS Foundation Trust's accounting policies.

The directors and senior managers make estimates and assumptions concerning the future. As a result the accounting estimates may not equal the related actual results. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year are discussed below:

a) Incomplete patient spells at the year end:

The NHS Foundation Trust prepares an estimate of income generated for incomplete in-patient spells at the year end. This estimate is based on an equivalent month end date occurring earlier in the year to provide a basis for calculation.

b) Legal claims:

Legal claims are based upon professional assessments, which are uncertain to the extent that they are an estimate of the likely outcome of individual cases.

c) Indices:

The valuation of land and buildings is based on building cost indices provided by and used by the District Valuer in his valuation work. These indices are based on an indication of trend of accepted tender prices within the local construction industry as applied to the Public Sector.

d) Private Finance Initiative (PFI) schemes:

As part of the Transforming Newcastle Hospitals (TNH) PFI scheme, the NHS Foundation Trust is required to pay the operator for lifecycle replacement assets. A judgement has been made that payment for these assets is accounted for in equal annual instalments over the period of the scheme, rather than when payments are made. This results in a prepayment for assets being established in the early years of the scheme, which is used in later years when the asset replacement occurs.

As part of a negotiated settlement with the PFI provider the final stage of the TNH scheme has now been excluded from the agreement with regard to completion, service charge and lifecycle payments. The capital element continues to be repayable over the remaining life of the agreement.

e) Valuation of land and buildings:

The directors have made the assumption that the NHS Foundation Trust's PFI and relevant exchequer buildings should be valued exclusive of VAT. This is based on the assumption that any new provision of these buildings would be procured via a special purpose vehicle or via a PFI/PF2 route attracting VAT exemption. The directors have also assumed that the NHS Foundation Trust would provide services from a single site if the opportunity arose as a single site would provide advantages for patient care. Therefore the district valuer was instructed to prepare a valuation of the NHS Foundation Trust's land and buildings at 31 March 2017 which excludes VAT on relevant buildings and uses a single site approach.

### 1.2 Consolidation and investments in subsidiaries and joint ventures

#### 1.2.1 Charitable Fund

The NHS Foundation Trust is the corporate trustee to the Newcastle Upon Tyne Hospitals NHS charitable fund. The NHS Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the NHS Foundation Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the NHS Foundation Trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

# Notes to the Accounts (continued)

## 1 Accounting policies and other information (continued)

### 1.2.1 Charitable Fund (continued)

With effect from 1 April 2016 the NHS Foundation Trust was appointed as Trustee of charitable funds formerly held on behalf of the NHS Foundation Trust by Newcastle Healthcare Charity (Reg. 502473) under a scheme formally approved by the Charity Commission for England & Wales on 21 March 2016. The funds were subsequently merged under the umbrella of the Trust's appointed charitable body, Newcastle upon Tyne Hospitals NHS Charity (Reg. 1057213) and form part of that Charity's and therefore also the NHS Foundation Trust Group accounts for the year ended 31 March 2017.

### 1.2.2 Other investments in subsidiaries and joint ventures

Subsidiary entities are those over which the NHS Foundation Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. Joint ventures are arrangements in which the NHS Foundation Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement.

The NHS Foundation Trust consolidates the results of investments in subsidiaries and joint ventures where results are material to the NHS Foundation Trust's financial position. The consolidated accounts do not incorporate the results of the additional subsidiaries and joint ventures detailed in Note 13 on the grounds of immateriality to the Group. As a consequence the investments in subsidiaries and joint ventures are stated at cost less impairment losses.

### 1.3 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 NHS Foundation Trust is contracts with commissioners in respect of healthcare services.

The NHS Foundation Trust follows the Department of Health's Payment by Results (PbR) methodology in the form of its main contracts with NHS commissioners. Other contracts particularly those with local authorities in respect of Public Health services and CCGs in respect of Community services are agreed predominantly on a block (fixed price) basis.

For partially completed patient spells, which commenced prior to the financial year end and for which the date of discharge is not known, the income relating to the activity is accrued. The accrued income is estimated based on the length of stay in the financial year multiplied by a standard income per day differentiated by speciality.

For patient income where the spell has been completed at the year end but not invoiced, an accrual is calculated based on the relevant price by activity.

Where income is received for a specific activity which is to be delivered in a subsequent financial 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.

Income in respect of the NHS Injury Compensation Scheme is recognised in accordance with standard guidance, when the NHS Foundation Trust receives confirmation from the Compensation Recovery Unit that a patient has lodged a claim.

Research and development income is recognised when the conditions attached to the grant or payment are met.

Education and training income is recognised either in equal instalments over the financial year or if the income can be identified with specific expenditure, in line with this expenditure.

### 1.4 Expenditure on 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.

### 1.5 Intangible assets

#### Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the NHS Foundation 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 NHS Foundation Trust and where the cost of the asset can be measured reliably.

#### Internally generated intangible assets

Expenditure on research is not capitalised, it is written off to the Statement of Comprehensive Income in the period to which it relates.

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 NHS Foundation Trust intends to complete the asset and sell or use it;
- The NHS Foundation Trust has the ability to sell or use the asset;
- How the intangible asset will generate probable future economic or service delivery benefits e.g. 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 NHS Foundation Trust to complete the development and sell or use the asset; and
- The NHS Foundation Trust can measure reliably the expenses attributable to the asset during development.

# Notes to the Accounts (continued)

## 1 Accounting policies and other information (continued)

### Software

Software which is integral to the operation of hardware e.g. 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 e.g. application software and software licences, is capitalised as an intangible asset when expenditure of at least £5,000 is incurred.

### 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. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. (See 1.6 below). An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS13, if it does not meet the requirement of IAS 40 or IFRS 5.

### Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery, normally between 5-10 years.

Intangible assets under development are not amortised.

## 1.6 Property, plant and equipment

### Recognition

Property, plant and equipment is capitalised if it is capable of being used for a period which exceeds one financial year, it is probable that future economic benefits will flow to, or service potential be supplied to the NHS Foundation Trust, the cost of the item can be measured reliably and it is held for use in delivering services or for administrative purposes.

Also the assets:

- a) individually have a cost of at least £5,000; or
- b) form a group of assets which collectively have a cost of at least £5,000, and individually have a cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- c) form part of the initial setting-up cost of a new building, or refurbishment of a ward or unit, and their individual cost exceeds £250.

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

### Measurement

#### Valuation

All property, plant and equipment is 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. Property assets are measured subsequently at valuation, plant and equipment is not revalued.

Property, plant and equipment (excluding specialised land and buildings) - On initial recognition these items are measured at cost, including any costs, such as installation, directly attributable to bringing them into working condition. Subsequently they are measured at fair value which is the lower of replacement cost and recoverable amount. Any costs arising from financing the construction of the property, plant and equipment are not capitalised but are charged to the Statement of Comprehensive Income in the year to which they relate. Non-specialised operational buildings are valued on a current value in existing use basis.

Specialised land and buildings - Specialised operational buildings are measured on a modern equivalent asset basis. The NHS Foundation Trust has over several years assumed an 'optimal build' valuation and in the current year has also applied a 'single site approach'. These approaches recognise any efficiencies that could be obtained if the buildings were to be rebuilt on a single site, whilst allowing for the current level of service provision to be maintained. The valuation of all specialised buildings now excludes VAT. The moves to a single site approach and the exclusion of VAT from exchequer building valuations have been adopted in the current year, the prior year comparatives have not been restated. For non-operational buildings, including surplus land, the valuations are carried out at open market value.

All land and buildings are valued on a frequent basis to ensure that the fair value is not materially misstated. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) *Appraisal and Valuation Manual*. The latest asset valuation exercise concluded as at 31 March 2017 when the District Valuer prepared an updated valuation.

Property in the course of construction is carried at cost. Cost includes professional fees but not borrowing costs, which are recognised as an expense immediately, as allowed by IAS 23 for assets held at fair value. Property in the course of construction once brought into use is valued by professional valuers as part of the standard valuation process.

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 IFRS13, if it does not meet the requirements of IAS 40 or IFRS 5.

# Notes to the Accounts (continued)

## 1 Accounting policies and other information (continued)

### 1.6 Property, plant and equipment (continued)

#### *Subsequent expenditure*

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

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

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

#### *De-recognition*

Assets intended for disposal are reclassified as 'Held for sale' if 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; and
- the sale must be highly probable i.e.:
  - 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, assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

#### *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 which is normally on a straight line basis. The useful economic lives and hence depreciation rates for equipment assets are determined by staff within the Medical Electronics department. Freehold land is considered to have an infinite life and is not depreciated.

Property in the course of construction and payments on account are not depreciated until the property is brought into use. Property, plant and equipment reclassified as 'Held for sale' ceases to be depreciated upon reclassification.

Buildings, installations and fittings are depreciated on their modern equivalent asset value over the estimated remaining life of the asset as assessed by the NHS Foundation Trust's professional valuers.

# Notes to the Accounts (continued)

## 1 Accounting policies and other information (continued)

### 1.6 Property, plant and equipment (continued)

#### Depreciation (continued)

Equipment is depreciated on fair value evenly over the estimated life of the asset. Remaining asset lives fall into the following ranges:

- Land - Not depreciated
- Buildings excluding dwellings - 23 to 74 years
- Dwellings - 31 to 39 years
- Assets under construction - Not depreciated
- Plant and machinery - 1 to 10 years
- Transport equipment - 3 to 7 years
- Information technology - 1 to 10 years
- Furniture and fittings - 2 to 10 years

#### Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation or grant is credited to income at the same time, unless the donor imposes 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 or 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.

### 1.7 Revenue government and other grants

Government grants are grants from government bodies, other than income from Clinical Commissioning Groups or NHS Trusts for the provision of services. Where a government grant is used to fund revenue expenditure the grant is taken to the Statement of Comprehensive Income to match that expenditure.

### 1.8 Private Finance Initiative (PFI) transactions

HM Treasury has determined that the NHS Foundation Trust shall account for infrastructure PFI schemes where the NHS Foundation Trust controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12, Service Concession Agreements. The NHS Foundation Trust therefore recognises PFI assets as items of property, plant and equipment together with the liability to pay for them. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- a) payment for the fair value of services received;
- b) payment for the PFI asset, including finance costs;
- c) payment for the replacement of components of the asset during the contract (lifecycle replacement).

#### Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'. Finance interest and contingent rent in relation to services received are recorded under 'Finance expense - financial liabilities' in the Statement of Comprehensive Income.

#### PFI asset

The PFI assets are recognised as property, plant and equipment when the unitary payment becomes payable. The assets are measured at fair value which is kept up to date in accordance with the NHS Foundation Trust's approach for each relevant class of asset in accordance with the principles of IAS 16, Property, Plant and Equipment.

#### PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17, *Leases*.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the lease liability for the year, and is charged to 'Finance costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase which is due to inflation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as contingent finance cost within the Statement of Comprehensive Income.



# Notes to the Accounts (continued)

## 1 Accounting policies and other information (continued)

### 1.8 Private Finance Initiative (PFI) transactions (continued)

#### Lifecycle replacement

An amount is set aside from the unitary payment each year into a lifecycle replacement prepayment to reflect the fact that the NHS Foundation Trust is effectively pre-funding some elements of future lifecycle replacement by the PFI operator.

When the operator replaces a capital asset, the fair value of this replacement item is recognised as property, plant and equipment.

Where the item was planned for replacement and therefore its value is being funded through the unitary payment, the lifecycle prepayment is reduced by the amount of the fair value.

The prepayment is reviewed annually to ensure that its carrying amount will be realised through future lifecycle components to be provided by the operator. Any unrecoverable balance is written out of the prepayment and charged to operating expenses.

Where the lifecycle item was not planned for replacement during the contract it is effectively being provided free of charge to the NHS Foundation Trust. A deferred income balance is therefore recognised instead and this is released to operating income over the life of the replacement component.

#### Other assets contributed by the NHS Foundation Trust to the operator

Assets contributed (e.g. cash payments) by the NHS Foundation Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS Foundation Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

### 1.9 Non-current assets held for sale

The NHS Foundation Trust has placed on the open market land and buildings which are surplus to requirements known as Grainger Park Road and Westville. The assets are disclosed as non current assets and are valued at fair value, being the offer value less estimated costs to complete the sale.

### 1.10 The NHS Foundation Trust as a lessee

#### Finance leases

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

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as 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

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

#### Leases of land and buildings

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

### 1.11 The NHS Foundation Trust as a lessor

#### Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Assets leased to others are accounted for in accordance with the accounting policy for property, plant and equipment.

### 1.12 Inventories

Inventories are valued at the lower of cost and net realisable value, by reference to supplier information on a first-in first-out basis. This is considered to be a reasonable approximation to fair value due to the high turnover of inventory. The de minimis level for inventory items is £100.

Provision is made for obsolete and defective stock whenever evidence exists that a provision is required.

### 1.13 Cash and cash equivalents

Cash and cash equivalents include cash in hand, deposits held at call with banks and other short term highly liquid investments with original maturities of three months or less. Cash and bank balances are recorded at the current values of these balances in the NHS Foundation Trust's cash book. Interest earned on bank accounts is recorded as 'finance income' in the year to which it relates. Bank charges are recorded as operating expenditure in the years to which they relate.

As the NHS Foundation Trust has no bank overdrafts there is no difference between the amount disclosed as cash and cash equivalents in the Statement of Financial Position and in the Statement of Cash Flows.

# Notes to the Accounts (continued)

## 1 Accounting policies and other information (continued)

### 1.14 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal obligation 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 where a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's short term discount rate of minus 2.7% (2015/16 minus 1.55%) in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 0.24% (2015/16 1.37%) in real terms.

#### Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed in Note 22 but is not recognised in the NHS Foundation Trust's accounts.

Annual premiums under the scheme are charged to operating expenses and provision is made for the 'excess' payable on a case when the liability arises.

#### Non-clinical risk pooling

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

#### Other provisions

Other provisions relate predominantly to building works resulting from on-going developments. The provision and amount is recognised and determined following professional advice from independent qualified property surveyors. The timing of payments is dependent on work programme estimates.

### 1.15 Contingencies

Contingent liabilities are not recognised in the accounts but are disclosed in Note 26, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- a) 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 NHS Foundation Trust's control; or
- b) 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.

The NHS Foundation Trust has no contingent assets to disclose.

### 1.16 Expenditure on employee benefits

#### Short term employee benefits

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

#### Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme (the 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. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore the scheme is accounted for as if it were a defined contribution scheme.

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 operating expenses at the time the NHS Foundation Trust commits itself to the retirement, regardless of the method of payment.

### 1.17 Value Added Tax (VAT)

Most of the activities of the NHS Foundation 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 non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

### 1.18 Corporation tax

NHS Foundation Trusts are exempt from corporation tax on their principal health care income under section 519A Income and Corporation Taxes Act 1988. In determining whether other income may be taxable, a three-stage test must be employed which asks whether the activity is an authorised activity related to the provision of core healthcare, whether the activity is actually or potentially in competition with the private sector, and whether the annual profits of the activity are in excess of £50,000 per trading activity. The NHS Foundation Trust does not have any corporation tax liability in the current or prior year.

# Notes to the Accounts (continued)

## 1 Accounting policies and other information (continued)

### 1.19 Foreign exchange

The functional and presentational currency of the NHS Foundation 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.

The NHS Foundation Trust has no monetary assets or liabilities denominated in a foreign currency at the Statement of Financial Position date.

### 1.20 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in Note 30 to the accounts in accordance with the requirements of the HM Treasury Financial Reporting Manual.

### 1.21 Public Dividend Capital (PDC) and PDC Dividend

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 Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge reflecting the cost of capital utilised by the NHS Foundation 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 NHS Foundation 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, (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 (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 adjustments to net assets occur as a result of the audit of the annual accounts. However any movement in net assets would be reflected in the calculation for the following year.

### 1.22 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 general 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, (excluding any provisions in relation to such payments), including losses which would have been made good through insurance cover had NHS Foundation Trusts 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 accruals basis with the exception of provisions for future losses.

### 1.23 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 NHS Foundation Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. 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 above.

All other financial assets and financial liabilities are recognised when the NHS Foundation 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 NHS Foundation 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 loans and receivables and available for sale financial assets. Financial liabilities are classified as other financial liabilities.

#### Loans and receivables

The NHS Foundation Trust's loans and receivables comprise cash and cash equivalents and trade and other receivables.

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. Loans from the Department of Health are not held for trading and are measured at historic cost with any unpaid interest accrued separately. They are included in non-current and current assets.

# Notes to the Accounts (continued)

## 1 Accounting policies and other information (continued)

### 1.23 Financial instruments and financial liabilities (continued)

#### *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 NHS Foundation 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*

The NHS Foundation Trust's other financial liabilities comprise trade and other payables, other liabilities, PFI obligations, other borrowings and provisions under contract.

All other financial liabilities are recognised initially at cost, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest rate 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 non-current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest rate 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*

The NHS Foundation Trust considers that all of its financial assets which are designated as 'loans and receivables' and all of its financial liabilities are included at cost. The fair value of these financial assets and liabilities is considered to be approximately the same as the carrying value. The 'available for sale financial assets' are included at market value, the value of which are determined by the portfolio manager by reference to relevant share prices at the year end date.

#### *Impairment of financial assets*

At the Statement of Financial Position date, the NHS Foundation Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses are recognised 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.

An asset's carrying value is either written down or a provision made on a judgement basis, based upon past experience. Once it has been established that an amount provided for will not be recovered, this amount is written off against the carrying amount of the financial asset.

### 1.24 Trade payables

Trade payables are initially recognised at fair value and subsequently at amortised cost using the effective interest rate method.

### 1.25 Trade receivables

Trade receivables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest method, less provision for impairment. A provision for impairment of trade receivables is established when there is objective evidence that the NHS Foundation Trust will not be able to collect all amounts due according to the original terms of the receivables. Significant financial difficulties of the debtor, probability that the debtor will enter bankruptcy or financial reorganisation, and default or delay in payments (more than 90 days overdue) are considered indicators that the trade receivable is impaired. The amount of the provision is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted at the original effective interest rate. The carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the Statement of Comprehensive Income within operating expenses. When a trade receivable is uncollectable, it is written off against the allowance account for trade receivables. Subsequent recoveries of amounts previously written off are credited against operating expenses in the Statement of Comprehensive Income.

### 1.26 Carbon Reduction Commitment (CRC) scheme

The NHS Foundation Trust remains in the CRC scheme. Participation in this scheme is mandatory based on the consumption of electricity by the NHS Foundation Trust in the 2010/11 footprint year. The cost of the CRC scheme for 2016/17 is £184k (2015/16 £96k).

### 1.27 Accounting standards that have been issued but have not yet been adopted

The DH GAM does not require the following Standards and Interpretations to be applied in 2016/17. 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 still subject to HM Treasury consideration.

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

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

# Notes to the Accounts (continued)

## 1 Accounting policies and other information (continued)

### 1.27 Accounting standards that have been issued but have not yet been adopted (continued)

*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.

*IFRIC 22* Foreign Currency Transactions and Advance Consideration - Application required for accounting periods beginning on or after 1 January 2018.

### 1.28 Exceptional items

Exceptional items are those items which are considered to be both material and for which separate disclosure in the accounts provides further understanding of the NHS Foundation Trust's results.

Exceptional items reported relate to i) movements on property, plant and equipment as a result of revaluations due to market price changes and impairments due to a reduction in anticipated economic benefit when buildings are declared surplus, ii) impairment of non current assets held for sale to their fair value and iii) impairment of financial assets which are not supported by the underlying net assets of the investment.

### 1.29 Sustainability and transformation fund

The NHS Foundation Trust receives contributions from the sustainability and transformation fund subject to the delivery of agreed financial and operational performance. These amounts are credited to income in the year in which they are earned. In the current year the NHS Foundation Trust earned £6,623k (2015/16 £Nil).

## 2 Segmental Analysis

The NHS Foundation Trust has determined that the Chief Operating Decision Maker is the Board of Directors, on the basis that all strategic decisions are made by the Board. Segmental information is not provided to the Board of Directors and therefore it has been determined that there is only one business segment, that of Healthcare.

The NHS Foundation Trust conducts the majority of its business with Health Bodies in England. Transactions with entities in Scotland, Ireland and Wales are conducted in the same manner as those within England. The NHS Foundation Trust generates its income predominantly from the provision of secondary care services.

Organisations that contributed 5% or more of the NHS Foundation Trust's operating income in either year are set out in the table below. Further information can be found in Note 27, Related Party Transactions. Operating income used in the calculation is before exceptional items and consolidation.

	2016/17	2015/16
	%	%
NHS England - Cumbria, Northumbria and Tyne and Wear Area Team	39	39
NHS Newcastle Gateshead CCG	24	24
NHS Northumberland CCG	6	7
NHS North Tyneside CCG	6	6
Health Education England	6	6

The following is an analysis of the financial information provided to the Board of Directors in relation to the years ended 31 March 2017 and 31 March 2016.

	2016/17	2015/16
	£000	£000
Operating income (within EBITDA)	1,032,461	987,195
Operating expenses (within EBITDA)	(961,989)	(926,879)
<b>Earnings before interest, tax, depreciation and amortisation (EBITDA)</b>	<b>70,472</b>	<b>60,316</b>
Operating expenses (outside EBITDA)	(27,363)	(29,002)
Non-operating income	1,195	1,837
Non-operating expenditure	(30,815)	(30,656)
<b>Surplus for the year excluding (impairments)/reversal of impairments</b>	<b>13,489</b>	<b>2,495</b>
Net impairments	(50,240)	(14,346)
<b>Deficit for the year after impairments</b>	<b>(36,751)</b>	<b>(11,851)</b>

Differences between the amounts presented to the Board in May 2017 and those included within these accounts are purely presentational.

The figures presented to the Board of Directors do not include those of the Newcastle upon Tyne Hospitals NHS Charity.

# Notes to the Accounts (continued)

## 3 Operating income

### 3.1 Income from activities by class

<b>GROUP and NHS FOUNDATION TRUST</b>	<b>2016/17</b>	<b>2015/16</b>
	<b>£000</b>	<b>£000</b>
<b>Acute Trusts</b>		
Elective income	<b>169,747</b>	171,913
Non elective income	<b>150,602</b>	148,237
Outpatient income	<b>128,111</b>	121,358
A & E income	<b>14,765</b>	13,097
Other NHS clinical income *	<b>364,152</b>	339,930
	<b>827,377</b>	794,535
<b>Community Trusts</b>		
Income from CCGs and NHS England	<b>34,390</b>	34,895
Income from other sources	<b>11,980</b>	11,906
	<b>46,370</b>	46,801
<b>All Trusts</b>		
Private patient income	<b>3,498</b>	3,992
Other clinical income **	<b>3,619</b>	3,846
	<b>7,117</b>	7,838
	<b>880,864</b>	849,174
Of which:		
Income from Commissioner Requested services	<b>865,230</b>	833,270
Income from Non-Commissioner Requested services ***	<b>15,634</b>	15,904
	<b>880,864</b>	849,174

The NHS Foundation Trust's Terms of Authorisation set out the mandatory goods and services that the NHS Foundation Trust is required to provide. All of the income from activities shown above, excluding private patient income and other clinical income, is derived from the provision of mandatory services.

\* Other NHS clinical income consists primarily of income received outside of the 'Payment by Results' payment mechanism, e.g., specialised services activity, services unbundled from tariff and income for drugs and devices.

\*\* Other clinical income comprises non-protected clinical income and relates to the NHS Injury Compensation Scheme and overseas patients.

\*\*\* Non-Commissioner Requested services includes overseas patient income, private patient income, income from Scottish, Welsh and Irish Health bodies and NHS Injury Scheme income.

### 3.2 Income from activities by source

<b>GROUP and NHS FOUNDATION TRUST</b>	<b>2016/17</b>	<b>2015/16</b>
	<b>£000</b>	<b>£000</b>
NHS Foundation Trusts	<b>4,166</b>	3,909
NHS Trusts	<b>154</b>	157
CCGs and NHS England	<b>843,309</b>	813,060
Local Authorities	<b>12,933</b>	11,906
Department of Health Other	<b>28</b>	53
NHS Other	<b>4,640</b>	4,185
Non NHS (including non-English NHS):		
- Private patients	<b>3,498</b>	3,992
- Overseas patients (chargeable to patient)	<b>287</b>	216
- NHS Injury Scheme (formerly RTA) *	<b>3,332</b>	3,630
- Other **	<b>8,517</b>	8,066
	<b>880,864</b>	849,174

All income relates to continuing operations.

\* NHS Injury Compensation Scheme income is subject to a provision for impaired receivables to reflect expected rates of collection. The provision is based on the value of receivables not recovered in previous years which is assessed at 22.94% (2015/16 21.99%). Any movement in year is adjusted against the receivable balance in the Statement of Financial Position.

\*\* Non-NHS other income relates primarily to healthcare activity income from Scottish, Welsh and Irish health bodies.

# Notes to the Accounts (continued)

## 3 Operating income (continued)

### 3.3 Income from overseas visitors

	2016/17 £000	2015/16 £000
Income recognised in the year	<b>287</b>	216
Cash payments received in-year (relating to invoices raised in the current and previous years)	<b>62</b>	81
Amounts added to the provision for impairment of receivables (relating to invoices raised in the current and prior years)	<b>279</b>	167
Amounts written off in-year (relating to invoices raised in the current and previous years)	<b>81</b>	138

## 4 Other operating income

	GROUP		NHS FOUNDATION TRUST	
	2016/17 £000	2015/16 £000	2016/17 £000	2015/16 £000
Research and development	<b>35,297</b>	34,896	<b>35,297</b>	34,896
Education and training	<b>58,018</b>	60,039	<b>58,018</b>	60,039
Charitable and other contributions to expenditure	<b>0</b>	0	<b>893</b>	1,321
Received from other bodies - cash donations for capital expenditure	<b>363</b>	1,123	<b>0</b>	0
Non-patient care services to other bodies *	<b>13,019</b>	13,271	<b>13,019</b>	13,271
Sustainability and Transformation Fund income	<b>6,623</b>	0	<b>6,623</b>	0
Rental income from operating leases	<b>832</b>	828	<b>832</b>	828
Income in respect of staff costs where accounted on gross basis	<b>25</b>	27	<b>25</b>	27
Other income **	<b>37,783</b>	28,960	<b>37,783</b>	28,960
NHS Charitable funds income	<b>19,285</b>	2,843	<b>0</b>	0
	<b>171,245</b>	141,987	<b>152,490</b>	139,342

\* Non-patient care services to other bodies includes the hosting of Northern Medical Physics and Clinical Engineering (NMPCE) (formerly known as Regional Medical Physics Department (RMPD) Services) and Regional Drugs and Therapeutics Services.

\*\* Other income includes Department of Health funding for clinical excellence awards, clinical test income, property utilities income and catering and nursery income.

### 4.1 Operating lease income

GROUP and NHS FOUNDATION TRUST	2016/17 £000	2015/16 £000
Building rental recognised in other income	<b>832</b>	828
<b>Future minimum lease payments due</b>		
- not later than one year	<b>817</b>	831
- later than one year and not later than five years	<b>1,441</b>	1,668
- later than five years	<b>181</b>	423
	<b>2,439</b>	2,922

The NHS Foundation Trust acts as lessor of certain buildings and office accommodation, principally for healthcare purposes.

# Notes to the Accounts (continued)

## 5 Operating Expenses

### 5.1 Operating expenses comprise:

	GROUP		NHS FOUNDATION TRUST	
	2016/17 £000	2015/16 £000 Restated	2016/17 £000	2015/16 £000 Restated
Services from NHS Foundation Trusts	4,560	4,866	4,560	4,866
Services from NHS Trusts	2,023	1,612	2,023	1,612
Services from CCGs and NHS England	30	0	30	0
Services from other NHS bodies	1,797	1,584	1,797	1,584
Purchase of healthcare from non NHS bodies	12,352	11,642	12,352	11,642
Employee expenses - executive directors	1,010	1,001	1,010	1,001
Employee expenses - non-executive directors	178	168	178	168
Employee expenses - staff	565,379	542,578	565,379	542,578
Supplies and services - clinical (excluding drugs costs)	120,309	120,510	120,309	120,510
Supplies and services - general	12,396	11,940	12,396	11,940
Establishment	5,451	5,389	5,451	5,389
Research and development - (not included in employee expenses)	2,504	2,489	2,504	2,489
Transport - other	4,273	4,306	4,273	4,306
Transport - business	1,871	1,747	1,871	1,747
Premises - business rates payable to Local Authorities	6,059	5,571	6,059	5,571
Premises - other	44,597	29,009	44,597	29,009
Increase in provision for impairment of receivables	3,734	7,336	3,734	7,336
(Decrease)/Increase in other provisions	(4,199)	4,331	(4,199)	4,331
Change in provisions - discount rate	437	(21)	437	(21)
Inventories written down (net, including inventory drugs)	251	272	251	272
Drugs costs (non-inventory drugs only)	1,212	691	1,212	691
Drugs inventories consumed	155,875	150,634	155,875	150,634
Rentals under operating leases - minimum lease payments	2,738	2,797	2,738	2,797
Depreciation on property, plant and equipment (Note 12)	26,491	28,297	26,491	28,297
Amortisation on intangible assets (Note 11)	873	704	873	704
NHS charitable funds: Depreciation and amortisation on charitable fund assets	22	0	0	0
Net impairments of property, plant and equipment *(Note 12)	49,914	14,346	49,914	14,346
Net impairment of financial assets *	193	0	193	0
Net impairment of assets held for sale *	133	0	133	0
External audit fees - Statutory audit	63	63	63	63
External audit fees - Other auditors' remuneration	35	24	35	24
External audit fees - Charitable Fund accounts	14	5	0	0
NHSLA insurance premium	9,671	8,266	9,671	8,266
Internal audit costs not included within employee expenses	217	221	217	221
Legal fees	1,305	1,604	1,305	1,604
Consultancy costs	564	830	564	830
Training costs and conferences	1,964	1,712	1,964	1,712
Patient travel	243	221	243	221
Hospitality	16	17	16	17
Publishing	75	65	75	65
Insurance	560	574	560	574
Losses ex-gratia and special payments	35	18	35	18
NHS Charitable fund - other resources expended	2,256	945	0	0
Other	2,840	2,792	2,840	2,792
	<b>1,042,321</b>	<b>971,156</b>	<b>1,040,029</b>	<b>970,206</b>

\*Net impairments are disclosed as exceptional items within the statement of comprehensive income. Net impairments total £50,240k (2015/16 £14,346k). Non exceptional operating expenses total £992,081k (2015/16 £ 956,810k).



# Notes to the Accounts (continued)

## 5 Operating Expenses (continued)

### 5.2 Auditors' remuneration

To comply with technical advice, the amounts paid by the Newcastle Upon Tyne Hospitals NHS Foundation Trust for auditors' remuneration are disclosed excluding non recoverable VAT.

'Statutory audit' remuneration excludes the charge for the audit of the NHS Foundation Trust's Quality Report which is included within 'Other auditor remuneration'.

'Other auditors' remuneration' of £35k (2015/16 £24k) was paid in the year for the audit of the NHS Foundation Trust's Quality Report and additional technical advice.

The NHS Foundation Trust approved the principal terms of engagement with its auditors, PricewaterhouseCoopers LLP, on 15 March 2017, covering the period of PricewaterhouseCoopers LLP's engagement as auditors. The terms include a limitation on their liability to pay damages for losses arising as a direct result of breach of contract or negligence, of £1m.

### 5.3 Arrangements containing an operating lease:

<b>GROUP and NHS FOUNDATION TRUST</b>	<b>2016/17</b>	<b>2015/16</b>						
	<b>£000</b>	<b>£000</b>						
Minimum lease rentals	<b>2,738</b>	2,797						
			<b>2016/17</b>	<b>2016/17</b>	<b>2016/17</b>	2015/16	2015/16	2015/16
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
	<b>Buildings</b>	<b>Plant and machinery</b>	<b>Total</b>	<b>Buildings</b>	<b>Plant and machinery</b>	<b>Total</b>	<b>Buildings</b>	<b>Total</b>
<b>Future minimum lease payments due:</b>								
- not later than one year	<b>644</b>	<b>1,782</b>	<b>2,426</b>	631	1,924	2,555		
- later than one year and not later than five years	<b>527</b>	<b>4,197</b>	<b>4,724</b>	994	5,131	6,125		
- later than five years	<b>0</b>	<b>3,883</b>	<b>3,883</b>	0	3,290	3,290		
<b>Total</b>	<b>1,171</b>	<b>9,862</b>	<b>11,033</b>	1,625	10,345	11,970		

The NHS Foundation Trust leases certain buildings and equipment under operating leases where financial assessment has provided evidence that leasing provides better value for money than outright purchase. Operating leases for buildings are predominantly for residential and office space. Significant equipment operating leases relate to managed service contracts, as detailed below:

#### **Picture Archiving and Communication System (PACS)**

The NHS Foundation Trust entered into a 10 year PACS contract with Carestream during 2015/16. The contract expires on 31 January 2026

#### **Laboratory managed equipment services contract**

The NHS Foundation Trust entered into a managed services contract with Roche Diagnostics Limited from 1 April 2010 for a period of 10 years for laboratory services. The provision of the equipment under this contract has been assessed as an operating lease under the requirements of IAS 17, Leases.

#### **Print managed service contract**

The NHS Foundation Trust entered into a seven year print managed service contract with Xerox on 31 August 2012. The provision of the equipment under this contract has been assessed as an operating lease under the requirements of IAS 17, Leases.

# Notes to the Accounts (continued)

## 5 Operating Expenses (continued)

### 5.4 Directors' remuneration and other benefits

The single total figure table, the total pension entitlement disclosures and the fair pay multiple are included within the remuneration report.

	2016/17 £000	2015/16 £000
Executive directors' remuneration	851	839
Employer's contribution to pension	46	54
	<b>897</b>	893
Non-executive director's remuneration *	164	156
Total	<b>1,061</b>	1,049

The remuneration costs disclosed above exclude employer's national insurance contributions.

<b>The total number of directors accruing benefits under the NHS Pension Scheme</b>	<b>2</b>	<b>2</b>
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\* Non-executive directors are not members of the NHS Pension Scheme.

#### Highest paid executive director

Total remuneration	<b>249</b>	249
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### 5.5 Staff costs and numbers

#### 5.5.1 Staff costs

	Permanently employed		Other		Total	
	2016/17 £000	2015/16 £000	2016/17 £000	2015/16 £000	2016/17 £000	2015/16 £000
Salaries and wages *	408,220	397,893	67,641	64,006	475,861	461,899
Social security costs	40,068	30,823	0	0	40,068	30,823
Pensions cost	52,690	50,917	0	0	52,690	50,917
- Employer's contributions to NHS Pensions						
Pensions cost - Other	32	21	0	0	32	21
Termination benefits	0	4	0	0	0	4
Agency and contract staff	0	0	4,613	7,107	4,613	7,107
<b>Total gross staff costs</b>	<b>501,010</b>	479,658	<b>72,254</b>	71,113	<b>573,264</b>	550,771
Recoveries from DH Group bodies in respect of staff cost netted off expenditure	(4,026)	(4,048)	0	0	(4,026)	(4,048)
Recoveries from Other bodies in respect of staff cost netted off expenditure	(2,735)	(2,992)	0	0	(2,735)	(2,992)
<b>Total staff costs</b>	<b>494,249</b>	472,618	<b>72,254</b>	71,113	<b>566,503</b>	543,731
included within:						
Costs capitalised as part of assets	114	152	0	0	114	152
<b>Analysed into operating expenditure - Note 5.1</b>						
Employee expenses - staff	493,125	471,465	72,254	71,113	565,379	542,578
Employee expenses - executive directors	1,010	1,001	0	0	1,010	1,001
<b>Total employee benefits excluding capitalised costs</b>	<b>494,135</b>	472,466	<b>72,254</b>	71,113	<b>566,389</b>	543,579

\* Included within salaries and wages is an amount of £33,557k (2015/16 £31,666k) relating to recharges from County Durham and Darlington NHS Foundation Trust, the host body for Junior Doctors in training.

# Notes to the Accounts (continued)

## 5 Operating Expenses (continued)

### 5.5.2 Staff numbers

Staff numbers are included within the staff report section of the Annual Report.

### 5.5.3 Retirements due to ill-health

During 2016/17 there were 9 (2015/16 10) early retirements from the NHS Foundation Trust agreed on the grounds of ill-health

The estimated additional pension liabilities of these ill-health retirements will be £445k (2015/16 £319k).

The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

### 5.5.4 Reporting of other compensation packages

Staff exit and compensation packages are included within the staff report section of the Annual Report.

## 6 Better payment practice code

### 6.1 Better Payment Practice Code - measure of compliance

GROUP and NHS FOUNDATION TRUST	2016/17 Number	2016/17 Value £000	2015/16 Number	2015/16 Value £000
Total Non-NHS trade invoices paid in the year	<b>221,942</b>	<b>431,903</b>	222,692	431,564
Total Non-NHS trade invoices paid within target	<b>204,624</b>	<b>380,621</b>	209,469	377,248
<b>Percentage of Non-NHS trade invoices paid within target</b>	<b>92%</b>	<b>88%</b>	94%	87%
Total NHS trade invoices paid in the year	<b>6,627</b>	<b>108,560</b>	6,400	102,797
Total NHS trade invoices paid within target	<b>5,332</b>	<b>95,843</b>	5,487	79,743
<b>Percentage of NHS trade invoices paid within target</b>	<b>80%</b>	<b>88%</b>	86%	78%

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

### 6.2 The Late Payment of Commercial Debts (Interest) Act 1998

No payments were made under this legislation during the current or previous financial year.

## 7 Finance income

	GROUP		NHS FOUNDATION TRUST	
	2016/17 £000	2015/16 £000	2016/17 £000	2015/16 £000
Interest on bank accounts	<b>291</b>	501	<b>291</b>	501
Interest on loans and receivables	<b>11</b>	15	<b>11</b>	15
NHS Charitable funds - investment income	<b>801</b>	313	<b>0</b>	0
<b>Total</b>	<b>1,103</b>	829	<b>302</b>	516

## 8 Finance expense - financial liabilities

GROUP and NHS FOUNDATION TRUST	2016/17 £000	2015/16 £000
PFI - Main finance costs	<b>14,173</b>	13,785
PFI - Contingent finance costs	<b>8,033</b>	7,462
Capital loans from the Department of Health	<b>303</b>	406
<b>Total</b>	<b>22,509</b>	21,653

## 9 PDC dividends payable

The NHS Foundation Trust is required to pay a dividend to the Department of Health equal to 3.5% of the average of opening and closing net relevant assets for the year. As set out in the Foundation Trust Annual Reporting Manual, the calculation of the dividend excludes donated assets.

PDC dividend payable for the year is £7,691k (2015/16 £9,083k).

# Notes to the Accounts (continued)

## 10 Impairments and gains/losses on disposal

### 10.1 Impairments of assets

GROUP and NHS FOUNDATION TRUST	2016/17 £000	2016/17 £000	2016/17 £000	2015/16 £000	2015/16 £000	2015/16 £000
	Net impairments	Impairments	Reversals	Net impairments	Impairments	Reversals
Changes in market price and optimal site valuation	38,651	38,812	(161)	11,750	11,860	(110)
Other *	11,589	11,589	0	2,596	2,596	0
<b>Total impairments charged/(credited) to operating surplus</b>	<b>50,240</b>	<b>50,401</b>	<b>(161)</b>	14,346	14,456	(110)
Impairments charged to the revaluation reserve	47,625	53,934	(6,309)	(2,339)	12,425	(14,764)
<b>Total impairments</b>	<b>97,865</b>	<b>104,335</b>	<b>(6,470)</b>	12,007	26,881	(14,874)

\* Other impairments are due to loss of economic benefit from buildings declared surplus when activities have been transferred to other NHS Foundation Trust facilities.

The impairment movements in year in relation to property, plant and equipment values are disclosed as exceptional items in the Consolidated and Trust Statements of Comprehensive Income.

### 10.2 Gains/(losses) on disposal/derecognition of assets

GROUP and NHS FOUNDATION TRUST	2016/17 £000	2015/16 £000
Gains on disposal of other property, plant and equipment	58	0
Losses on disposal of other property, plant and equipment	(162)	(26)
	<b>(104)</b>	(26)

# Notes to the Accounts (continued)

## 11 Intangible Assets

### GROUP AND NHS FOUNDATION TRUST

	Software and software licences (purchased) £000	Assets under development £000	Total £000
<b>Cost at 1 April 2016</b>	<b>6,787</b>	<b>92</b>	<b>6,879</b>
Additions purchased	495	233	728
Reclassifications *	(132)	0	(132)
Disposals	(43)	0	(43)
<b>Cost at 31 March 2017</b>	<b>7,107</b>	<b>325</b>	<b>7,432</b>
<b>Accumulated amortisation at 1 April 2016</b>	<b>3,846</b>	<b>0</b>	<b>3,846</b>
Provided during the year	873	0	873
Disposals	(43)	0	(43)
<b>Accumulated amortisation at 31 March 2017</b>	<b>4,676</b>	<b>0</b>	<b>4,676</b>
<b>Net book value</b>			
Purchased	2,431	325	2,756
Donated	0	0	0
<b>Total at 31 March 2017</b>	<b>2,431</b>	<b>325</b>	<b>2,756</b>
<b>Cost at 1 April 2015</b>	5,680	0	5,680
Additions purchased	1,093	92	1,185
Reclassifications	14	0	14
<b>Cost at 31 March 2016</b>	<b>6,787</b>	<b>92</b>	<b>6,879</b>
<b>Accumulated amortisation at 1 April 2015</b>	<b>3,142</b>	<b>0</b>	<b>3,142</b>
Provided during the year	704	0	704
<b>Accumulated amortisation at 31 March 2016</b>	<b>3,846</b>	<b>0</b>	<b>3,846</b>
<b>Net book value</b>			
Purchased	2,941	92	3,033
Donated	0	0	0
<b>Total at 31 March 2016</b>	<b>2,941</b>	<b>92</b>	<b>3,033</b>

There is no difference between the Group and the NHS Foundation Trust's intangible assets.

The NHS Foundation Trust does not hold any donated or leased intangible assets (31 March 2016 £Nil) and has no intangibles funded by government grant (31 March 2016 £Nil).

#### Reclassifications \*

Reclassifications relate to the transfer of hardware costs to information technology within note 12.

#### Revaluations

At the year end a review was carried out to determine if the fair value of intangible assets was still appropriately stated. No adjustment to fair value was deemed necessary.

# Notes to the Accounts (continued)

## 12 Property, Plant and Equipment

### 12.1 Property, plant and equipment at the Statement of Financial Position date comprise the following elements:

#### 2016/17 Financial Year

##### GROUP

	Land	Buildings	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Charity assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2016	57,569	452,924	1,090	3,422	154,877	414	20,774	853	0	<b>691,923</b>
Additions purchased	0	3,774	0	6,110	8,477	18	138	0	555	<b>19,072</b>
Additions leased	0	11,397	0	0	0	0	0	0	0	<b>11,397</b>
Additions purchased from cash donations	0	0	0	0	336	0	27	0	0	<b>363</b>
Reclassifications	0	2,798	0	(3,392)	55	20	651	0	0	<b>132</b>
Impairments charged to operating expenses	(9,988)	(40,087)	0	0	0	0	0	0	0	<b>(50,075)</b>
Impairments charged to the revaluation reserve	(21,647)	(32,287)	0	0	0	0	0	0	0	<b>(53,934)</b>
Reversal of impairments credited to the revaluation reserve	5,925	356	28	0	0	0	0	0	0	<b>6,309</b>
Depreciation eliminated on revaluation	0	(14,805)	(18)	0	0	0	0	0	0	<b>(14,823)</b>
Reversal of impairments credited to operating expenses	112	49	0	0	0	0	0	0	0	<b>161</b>
Transfers to assets held for sale	(603)	0	(435)	0	0	0	0	0	0	<b>(1,038)</b>
Disposals	0	0	0	0	(5,041)	0	(2,006)	(27)	0	<b>(7,074)</b>
<b>Cost or valuation at 31 March 2017</b>	<b>31,368</b>	<b>384,119</b>	<b>665</b>	<b>6,140</b>	<b>158,704</b>	<b>452</b>	<b>19,584</b>	<b>826</b>	<b>555</b>	<b>602,413</b>
Accumulated Depreciation at 1 April 2016	0	202	0	0	104,974	370	16,350	780	0	<b>122,676</b>
Provided during the year	0	14,968	28	0	9,646	15	1,811	23	22	<b>26,513</b>
Depreciation eliminated on revaluation	0	(14,805)	(18)	0	0	0	0	0	0	<b>(14,823)</b>
Transfers to assets held for sale	0	0	(10)	0	0	0	0	0	0	<b>(10)</b>
Disposals	0	0	0	0	(4,883)	0	(2,001)	(24)	0	<b>(6,908)</b>
<b>Accumulated Depreciation at 31 March 2017</b>	<b>0</b>	<b>365</b>	<b>0</b>	<b>0</b>	<b>109,737</b>	<b>385</b>	<b>16,160</b>	<b>779</b>	<b>22</b>	<b>127,448</b>
<b>Net book value As at 31 March 2017</b>	<b>31,368</b>	<b>383,754</b>	<b>665</b>	<b>6,140</b>	<b>48,967</b>	<b>67</b>	<b>3,424</b>	<b>47</b>	<b>533</b>	<b>474,965</b>
Net book value As at 31 March 2016	57,569	452,722	1,090	3,422	49,903	44	4,424	73	0	<b>569,247</b>
<b>Financing of property, plant and equipment</b>										
Owned	31,368	193,947	665	6,140	43,567	67	3,047	41	533	<b>279,375</b>
PFI	0	180,809	0	0	0	0	0	0	0	<b>180,809</b>
Government granted	0	354	0	0	41	0	0	0	0	<b>395</b>
Donated	0	8,644	0	0	5,359	0	377	6	0	<b>14,386</b>
<b>Total at 31 March 2017</b>	<b>31,368</b>	<b>383,754</b>	<b>665</b>	<b>6,140</b>	<b>48,967</b>	<b>67</b>	<b>3,424</b>	<b>47</b>	<b>533</b>	<b>474,965</b>

# Notes to the Accounts (continued)

## 12 Property, Plant and Equipment (continued)

### Reclassifications

The reclassifications relate to transfers from assets under construction to other asset categories once the projects to which they relate to have been completed.

### Impairments and revaluations

During 2016/17 the following took place which resulted in movements to the income and expenditure account, the revaluation reserve and the income and expenditure reserve.

a) Phase 9 of the TNH PFI scheme was handed over in December 2016 at a value of £11,397k and the value immediately impaired. Phase 9 per the contract was valued at £13,397k however the NHS Foundation Trust estimated that £2,000k of works were still to be completed and, as a result of the negotiated settlement, responsibility for this work was transferred to the NHS Foundation Trust. This has resulted in an impairment of £11,397k charged to Operating expenses which is included within impairments charged to operating expenses of £50,075k. Phase 9 of the TNH scheme relates predominantly to demolitions and landscaping works.

b) A desktop update to the valuation of the NHS Foundation Trust's estate was also carried out as at 31 March 2017 by a qualified valuer within the Valuation Office Agency. The valuation was based on both national and regional Building Cost Indices. The District valuer was instructed to prepare the valuation on a single site basis. This recognises any efficiencies that could be obtained if the site were to be rebuilt maintaining the current level of service provision. In addition, in the current year, the District Valuer has removed VAT from the buildings acquired via PFI procurement methods and Trust direct purchases. This has been carried out in line with recent guidance from the Department of Health and in agreement with the NHS Foundation Trust's external auditors. The valuation resulted in the following income and reserve movements:

#### Income and expenditure account

- i) an impairment charge of £50,075k; made up of £11,397k from a) above and £38,678k resulting from the revaluation;
- ii) a £161k credit to operating expenditure as a reversal of prior year impairments;

#### Revaluation reserve

- i) a £53,934k charge to the revaluation reserve for impairments in year;
- ii) a £6,309k credit to the revaluation reserve relating to a reversal of prior years' impairments;

#### Depreciation

Depreciation eliminated on revaluation amounted to £14,823k.

The dwelling held by the Charitable Trust was not included within the NHS Foundation Trust's year end valuation exercise. This dwelling was valued under a separate exercise as at 31 March 2016 by Sanderson Weatherall, Chartered Surveyors. The property is valued every five years.

### Donated assets

None of the assets donated during the financial year have had restrictions in use imposed upon them by the donor.

There is no difference between the cash donated and the fair value of the assets acquired.

### Transfer to assets held for sale

During 2016/17 the NHS Foundation Trust placed on the open market property and land known as Grainger Park Road and Westville. Completion of the sale is expected early during 2017/18. Therefore the dwellings and land were transferred from property, plant and equipment to non current assets held for sale and impaired to their fair value less costs to sell.

### NHS FOUNDATION TRUST

The only differences between the Group property, plant and equipment and the NHS Foundation Trust property, plant and equipment is in the treatment of donated assets and the inclusion of the Charity's dwelling at a net book value of £533k.

For the NHS Foundation Trust this would result in a movement of £530k between additions purchased and additions donated and the removal of the Charitable dwelling. The overall net book value at 31 March 2017 is reduced by £533k to £474,432k. As a result the NHS Foundation Trust's property, plant and equipment note has not been included within the accounts.

# Notes to the Accounts (continued)

## 12 Property, Plant and Equipment (continued)

### 12.1 Property, plant and equipment at the Statement of Financial Position date comprise the following elements:

#### 2015/16 Financial Year - Restated

GROUP	Land	Buildings	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2015	57,569	451,839	1,090	1,072	147,583	400	20,347	853	<b>680,753</b>
Additions purchased	0	9,616	0	3,169	11,430	14	403	0	<b>24,632</b>
Additions leased	0	17,520	0	0	0	0	0	0	<b>17,520</b>
Additions purchased from cash donations	0	0	0	0	1,002	0	121	0	<b>1,123</b>
Reclassifications	0	809	0	(819)	(4)	0	0	0	<b>(14)</b>
Impairments charged to operating expenses	0	(14,346)	0	0	0	0	0	0	<b>(14,346)</b>
Impairments charged to the revaluation reserve	0	(12,425)	0	0	0	0	0	0	<b>(12,425)</b>
Reversal of impairments credited to the revaluation reserve	0	14,735	29	0	0	0	0	0	<b>14,764</b>
Depreciation eliminated on revaluation	0	(14,824)	(29)	0	0	0	0	0	<b>(14,853)</b>
Disposals	0	0	0	0	(5,134)	0	(97)	0	<b>(5,231)</b>
<b>Cost or valuation at 31 March 2016</b>	<b>57,569</b>	<b>452,924</b>	<b>1,090</b>	<b>3,422</b>	<b>154,877</b>	<b>414</b>	<b>20,774</b>	<b>853</b>	<b>691,923</b>
Accumulated Depreciation at 1 April 2015	0	158	0	0	98,521	363	14,581	752	<b>114,375</b>
Provided during the year	0	14,868	29	0	11,505	7	1,860	28	<b>28,297</b>
Depreciation eliminated on revaluation	0	(14,824)	(29)	0	0	0	0	0	<b>(14,853)</b>
Disposals	0	0	0	0	(5,052)	0	(91)	0	<b>(5,143)</b>
<b>Accumulated Depreciation at 31 March 2016</b>	<b>0</b>	<b>202</b>	<b>0</b>	<b>0</b>	<b>104,974</b>	<b>370</b>	<b>16,350</b>	<b>780</b>	<b>122,676</b>
<b>Net book value As at 31 March 2016</b>	<b>57,569</b>	<b>452,722</b>	<b>1,090</b>	<b>3,422</b>	<b>49,903</b>	<b>44</b>	<b>4,424</b>	<b>73</b>	<b>569,247</b>
Net book value As at 31 March 2015	57,569	451,681	1,090	1,072	49,062	37	5,766	101	<b>566,378</b>
<b>Financing of property, plant and equipment</b>									
Owned	57,569	231,410	1,090	3,422	44,266	44	3,859	60	<b>341,720</b>
PFI	0	210,636	0	0	0	0	0	0	<b>210,636</b>
Government granted	0	378	0	0	60	0	0	0	<b>438</b>
Donated	0	10,298	0	0	5,577	0	565	13	<b>16,453</b>
<b>Total at 31 March 2016</b>	<b>57,569</b>	<b>452,722</b>	<b>1,090</b>	<b>3,422</b>	<b>49,903</b>	<b>44</b>	<b>4,424</b>	<b>73</b>	<b>569,247</b>



# Notes to the Accounts (continued)

## 12 Property, Plant and Equipment (continued)

### Reclassifications

The reclassifications relate to transfers from assets under construction to other asset categories once the projects to which they relate to have been completed.

### Impairments and revaluations

During 2015/16 the following took place which resulted in movements to the income and expenditure account, the revaluation reserve and the income and expenditure reserve.

a) The Clinical Resource Block, Phase 8 of the TNH PFI scheme, was handed over in December 2015. Several buildings which were being used temporarily as office accommodation have now been vacated. These vacated buildings are to be demolished and have been impaired as at 31 March 2016. This has resulted in an impairment of £2,596k charged to I and E and the remaining revaluation reserve balance of £1,190k transferred to the I and E reserve.

b) A desktop update to the valuation of the NHS Foundation Trust's estate was also carried out as at 31 March 2016 by a qualified valuer within the Valuation Office Agency. The valuation was based on both national and regional Building Cost Indices. Where appropriate, the District Valuer has continued to adopt an 'optimal site' valuation. This recognises any efficiencies that could be obtained if the site were to be rebuilt maintaining the current level of service provision. In addition, in the current year, the District Valuer has removed VAT from the buildings acquired via PFI procurement methods. This has been carried out in line with recent guidance from the Department of Health and in agreement with the NHS Foundation Trust's external auditors. The valuation resulted in the following income and reserve movements:

#### Income and expenditure account

i) an impairment charge of £14,346k; made up of £2,596k from a) above and £11,750k resulting from the revaluation;

#### Revaluation reserve

i) a £12,425k charge to the revaluation reserve for impairments in year;

ii) a £(14,764)k credit to the revaluation reserve relating to a reversal of prior years' impairments;

#### Depreciation

Depreciation eliminated on revaluation amounted to £14,853k.

### Donated assets

None of the assets donated during the financial year have had restrictions in use imposed upon them by the donor.

There is no difference between the cash donated and the fair value of the assets acquired.

### NHS FOUNDATION TRUST

The only difference between the Group property, plant and equipment and the NHS Foundation Trust property, plant and equipment is in the treatment of donated assets.

For the NHS Foundation Trust this would result in a movement of £198k between additions purchased and additions donated. The overall net book value at 31 March 2016 remains unchanged. As a result the NHS Foundation Trust's property, plant and equipment note has not been included within the accounts.

# Notes to the Accounts (continued)

## 12 Property, Plant and Equipment (continued)

### 12.2 Assets held at open market value

Of the closing balance at 31 March 2017, £16,045k (2015/16 £16,003k) relates to land valued at open market value.

### 12.3 Analysis of assets held under PFI contracts

PFI assets	£000
Valuation at 1 April 2016	<b>210,838</b>
Additions	12,767
Revaluation - including depreciation eliminated *	(42,432)
<b>Valuation at 31 March 2017</b>	<b>181,173</b>
Accumulated Depreciation at 1 April 2016	<b>202</b>
Provided during the year	7,040
Depreciation eliminated on revaluation	(6,878)
<b>Accumulated Depreciation at 31 March 2017</b>	<b>364</b>
<b>Net book value at 31 March 2017</b>	<b>180,809</b>
Valuation at 1 April 2015	214,260
Additions	18,974
Revaluation	(22,396)
<b>Valuation at 31 March 2016</b>	<b>210,838</b>
Accumulated Depreciation at 1 April 2015	113
Provided during the year	7,245
Depreciation eliminated on revaluation	(7,156)
<b>Accumulated Depreciation at 31 March 2016</b>	<b>202</b>
<b>Net book value at 31 March 2016</b>	<b>210,636</b>

The PFI arrangements relate to the Transforming Newcastle Hospitals scheme and the Boiler Houses at the RVI and Freeman sites. See Note 21 for further information.

The PFI assets detailed above are included within the column headed 'Buildings excluding dwellings' in Note 12.1.

\*The impairment in year is a result of the NHS Foundation Trust adopting a single site approach to the valuation of relevant land and buildings. VAT was excluded from the valuation of the Trust's PFI buildings in both the current and prior year.

## 13 Investments in Subsidiaries and Joint Ventures

GROUP AND NHS FOUNDATION TRUST	2016/17 £000	2015/16 £000
<b>Cost and NBV at 1 April</b>	<b>193</b>	193
Acquisitions in the year	0	0
Impairments in the year	(193)	0
<b>Cost and NBV at 31 March</b>	<b>0</b>	193

The investments relate to the shareholdings detailed below. The investments in companies which would qualify as subsidiaries have not been consolidated into the group accounts on the basis of immateriality. The results of the Newcastle upon Tyne Hospitals NHS Charity are consolidated.

The investments in subsidiaries and joint ventures are not supported by the underlying net assets of these companies and therefore the investments have been impaired to £Nil in the current financial year.

**Freeman Clinics Limited** - The NHS Foundation Trust holds 100% (2015/16 100%) of the ordinary share capital of Freeman Clinics Limited, a company incorporated in the UK for the purpose of providing primary care services. The NHS Foundation Trust's investment is in ordinary shares at a cost of £80k which has been impaired to £Nil in year. The company commenced trading in July 2009. The loss after tax for the year is estimated at £221k based on management accounts pro rated for twelve months (2015/16 profit £73k).

# Notes to the Accounts (continued)

## 13 Investments in Subsidiaries and Joint Ventures (continued)

**Pulse Diagnostics Limited** - The NHS Foundation Trust holds 89% (2015/16 89%) of the total share capital of Pulse Diagnostics Limited (86% of the ordinary share capital and 93% of the preference share capital). The company is incorporated in the UK for the purpose of developing a method of measuring and analysing pulse wave data for application in early detection of Peripheral Vascular Disease. The NHS Foundation Trust's investment of £113k (2015/16 £113k) has been impaired in year. The company has not yet commenced trading.

**Newgene Limited** - The NHS Foundation Trust owns 55% of the £100 ordinary share capital of Newgene Limited, a company incorporated in the UK for the purpose of providing DNA diagnostics and rapid DNA sequencing services. The profit after tax for the year is estimated at £122k based on unaudited management accounts to 31 December 2016 pro rated for twelve months (2015/16 profit £210k).

**Limbs Alive Limited** - The NHS Foundation Trust owns 33% (2015/16 33%) of the ordinary share capital of Limbs Alive Limited, a company incorporated in the UK for the development of interactive software, primarily for the therapy of medical disorders in children, in particular for movement disorders such as stroke and cerebral palsy. The company has not yet commenced trading.

**Changing Health Limited** - The NHS Foundation Trust owns 5% of the ordinary share capital of Changing Health Limited, a company incorporated in the UK to provide health education support services.

The NHS Foundation Trust also has a shareholding in the following dormant company:

**Newcastle Healthcare Property Limited** - The NHS Foundation Trust owns 100% of the £1 ordinary share capital of Newcastle Healthcare Property Limited, a company incorporated in the UK for general commercial activities. The company has not yet commenced trading.

The NHS Foundation Trust acts as Corporate Trustee for the Newcastle upon Tyne Hospitals NHS Charity the results of which are consolidated into the Group accounts.

## 14 Other investments

GROUP	2016/17 £000	2015/16 £000
Market value at 1 April	7,309	7,622
Acquisitions in year - other *	14,766	1
Movement in fair value of available for sale financial assets recognised in Other Comprehensive Income	2,825	(314)
Market value at 31 March	24,900	7,309

The 'other investments' are held within the Newcastle upon Tyne Hospitals NHS Charity. The NHS Foundation Trust does not hold any 'other investments'.

The Investments are held in a Common Deposit Fund or a Common Investment Fund and are administered on behalf of the Newcastle upon Tyne Hospitals NHS Charity by CCLA Investment Management Ltd. The investments include equities, property and cash. The equities comprise shareholdings in public companies with stock market quotations however the portfolio manager refrains from direct investment in companies that derive a substantial amount of their profit from investment in tobacco.

\*Acquisitions in year include the transfer of funds from the former Newcastle Healthcare Charity. Further detail can be found in note 1.2.1.

## 15 Inventories

GROUP	2016/17 £000 Total	2016/17 £000 Drugs	2016/17 £000 Consumables	2016/17 £000 Charitable funds inventory	2015/16 £000 Total	2015/16 £000 Drugs	2015/16 £000 Consumables	2015/16 £000 Charitable funds inventory
As at 1 April	18,533	5,461	13,045	27	16,202	5,389	10,792	21
Additions	274,437	156,037	118,400	0	275,193	150,938	124,255	0
Inventories recognised in expenses	(277,995)	(155,875)	(122,120)	0	(272,596)	(150,634)	(121,962)	0
Write down of inventories	(251)	(192)	(59)	0	(272)	(232)	(40)	0
Movement in Charitable funds inventories	1	0	0	1	6	0	0	6
As at 31 March	14,725	5,431	9,266	28	18,533	5,461	13,045	27
<b>NHS FOUNDATION TRUST</b>	<b>2016/17 £000 Total</b>	<b>2016/17 £000 Drugs</b>	<b>2016/17 £000 Consumables</b>		<b>2015/16 £000 Total</b>	<b>2015/16 £000 Drugs</b>	<b>2015/16 £000 Consumables</b>	
As at 1 April	18,506	5,461	13,045		16,181	5,389	10,792	
Additions	274,437	156,037	118,400		275,193	150,938	124,255	
Inventories recognised in expenses	(277,995)	(155,875)	(122,120)		(272,596)	(150,634)	(121,962)	
Write down of inventories	(251)	(192)	(59)		(272)	(232)	(40)	
As at 31 March	14,697	5,431	9,266		18,506	5,461	13,045	

# Notes to the Accounts (continued)

## 16 Trade and Other Receivables

### 16.1 Analysis of trade and other receivables

	GROUP		NHS FOUNDATION TRUST	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
<b>Current</b>				
NHS receivables - revenue	22,181	23,758	22,181	23,758
Receivables due from NHS Charity	0	0	613	120
Other receivables - revenue	17,191	31,302	17,191	31,302
Provision for impaired receivables	(7,925)	(19,698)	(7,925)	(19,698)
Other receivables with related parties	1,911	3,548	1,911	3,548
PFI prepayment (lifecycle replacement)	1,328	1,454	1,328	1,454
Other prepayments	6,579	5,576	6,579	5,576
Accrued income	25,798	22,736	25,798	22,736
PDC dividend receivable	509	0	509	0
VAT receivable	3,283	3,254	3,283	3,254
Interest receivable	15	20	15	20
NHS Charitable funds: Trade and other receivables	378	317	0	0
<b>Sub total</b>	<b>71,248</b>	<b>72,267</b>	<b>71,483</b>	<b>72,070</b>
<b>Non-current</b>				
PFI prepayment (lifecycle replacement)	11,106	9,931	11,106	9,931
Other prepayments	318	442	318	442
Other receivables - revenue	425	525	425	525
Provision for impaired receivables	(425)	(525)	(425)	(525)
<b>Sub total</b>	<b>11,424</b>	<b>10,373</b>	<b>11,424</b>	<b>10,373</b>
<b>Total trade and other receivables</b>	<b>82,672</b>	<b>82,640</b>	<b>82,907</b>	<b>82,443</b>

### 16.2 Provision for impaired receivables

GROUP and NHS FOUNDATION TRUST	2016/17 £000	2015/16 £000
At 1 April	20,223	14,405
Increase in provision	7,201	16,837
Amounts utilised	(15,607)	(1,518)
Unused amounts reversed	(3,467)	(9,501)
<b>At 31 March</b>	<b>8,350</b>	<b>20,223</b>

Included within the above is a provision of £1,436k (2015/16 £1,331k) relating to the NHS Injury Cost Recovery Scheme, which is classified as a non-financial asset. The Compensation Recovery Unit have advised that the probability of not receiving income is 22.94% (2015/16 21.99%).

# Notes to the Accounts (continued)

## 16 Trade and Other Receivables (continued)

### 16.3 Analysis of provision for impaired trade receivables

	31 March 2017 £000 Trade receivables	31 March 2016 £000 Trade receivables
<b>Ageing of impaired receivables</b>		
0-30 days	215	12
30-60 days	89	24
60-90 days	228	9
90-180 days	3,184	11,577
Over 180 days	3,197	7,270
	<u>6,913</u>	<u>18,892</u>
<b>Ageing of non-impaired receivables past their due date</b>		
0-30 days	45,305	47,613
30-60 days	3,988	2,893
60-90 days	2,014	2,729
90-180 days	401	2,082
Over 180 days *	143	480
	<u>51,851</u>	<u>55,797</u>

The analysis of impaired receivables has been amended in the current year to more fully meet the definition within IFRS 7 paragraph 37. The comparative amounts have been restated accordingly.

\* Non-impaired trade receivables over 180 days old include the NHS Injury Compensation Scheme (formerly the Road Traffic Accident Scheme) receivables.

The NHS Foundation Trust does not hold any collateral over these balances.

## 17 Non current assets held for sale

	GROUP		NHS FOUNDATION TRUST	
	2016/17 £000	2015/16 £000	2016/17 £000	2015/16 £000
Assets classified as available for sale in year	1,028	0	1,028	0
Impairment of assets held for sale	(133)	0	(133)	0
	<u>895</u>	<u>0</u>	<u>895</u>	<u>0</u>

During the year land and buildings at the NHS Foundation Trust's Grainger Park Road site were placed on the open market. Completion of the sale is due early in 2017/18. The values transferred comprise land £603k and dwellings £425k. The value has been impaired to fair value less costs to sell.

## 18 Cash and cash equivalents

	GROUP		NHS FOUNDATION TRUST	
	2016/17 £000	2015/16 £000	2016/17 £000	2015/16 £000
Balance at 1 April	102,593	105,688	93,076	97,893
Net change in year	12,089	(3,095)	9,737	(4,817)
<b>Balance at 31 March</b>	<u>114,682</u>	<u>102,593</u>	<u>102,813</u>	<u>93,076</u>
<b>Made up of:</b>				
Cash at commercial banks and in hand	17,219	16,818	5,350	7,301
Cash with the Government Banking Service	97,463	5,775	97,463	5,775
Cash with National Loans Fund	0	80,000	0	80,000
<b>Cash and cash equivalents as per the Statement of Financial Position</b>	<u>114,682</u>	<u>102,593</u>	<u>102,813</u>	<u>93,076</u>

There is no difference between cash and cash equivalents as detailed above and cash and cash equivalents in the Statement of Cash Flows.

# Notes to the Accounts (continued)

## 19 Trade and other payables

	GROUP		NHS FOUNDATION TRUST	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
<b>Current</b>				
Receipts in advance	18,622	15,942	18,622	15,942
NHS payables	2,139	3,247	2,139	3,247
Amounts due to other related parties	7,673	7,514	7,673	7,514
Other taxes payable	10,867	9,777	10,867	9,777
Accruals	33,897	37,796	33,897	37,797
Other trade payables - capital	4,292	2,873	4,292	2,873
Other trade payables - revenue	5,318	4,600	5,318	4,600
Other payables	15,734	12,026	15,734	12,026
PDC dividend payable	0	695	0	695
NHS Charitable funds: Trade and other payables	40	85	0	0
<b>Total trade and other payables</b>	<b>98,582</b>	<b>94,555</b>	<b>98,542</b>	<b>94,471</b>

The Group and NHS Foundation Trust have no non-current trade and other payables.

## 20 Other liabilities

GROUP and NHS FOUNDATION TRUST	31 March 2017 £000	31 March 2016 £000
<b>Current</b>		
Deferred income	7,965	11,162
<b>Non-current</b>		
Deferred income	0	5,103
<b>Total other liabilities</b>	<b>7,965</b>	<b>16,265</b>

## 21 Borrowings

### 21.1 Total Borrowings

GROUP and NHS FOUNDATION TRUST	31 March 2017 £000	31 March 2016 £000
<b>Current</b>		
Capital loans from the Department of Health	3,500	3,500
Obligations under PFI agreements	5,083	5,040
	<b>8,583</b>	<b>8,540</b>
<b>Non-current</b>		
Capital loans from the Department of Health	5,250	8,750
Obligations under PFI agreements	239,086	234,518
	<b>244,336</b>	<b>243,268</b>
<b>Total borrowings</b>	<b>252,919</b>	<b>251,808</b>

# Notes to the Accounts (continued)

## 21 Borrowings (continued)

### 21.2 Loans

GROUP and NHS FOUNDATION TRUST	31 March 2017 £000	31 March 2016 £000
Current	3,500	3,500
Non-current	5,250	8,750
<b>Total loans</b>	<b>8,750</b>	<b>12,250</b>

During 2009/10 the NHS Foundation Trust entered into a £28,000k loan agreement with the Department of Health. The loan bears interest at a fixed rate of 2.92%. Repayments commenced in December 2011 and are payable in 16 equal six monthly instalments. The loan is held at fair value through profit or loss, as amortised value is not materially different.

### 21.3 Obligations under PFI arrangements

GROUP and NHS FOUNDATION TRUST	31 March 2017 £000	31 March 2016 £000
<b>Gross liabilities which are due:</b>		
Not later than one year	20,955	21,243
Later than one year and not later than five years	82,813	82,799
Later than five years	392,914	412,031
<b>Total gross liabilities</b>	<b>496,682</b>	<b>516,073</b>
Finance charges allocated to future periods	(252,513)	(276,515)
<b>Net obligations</b>	<b>244,169</b>	<b>239,558</b>
<b>Net PFI obligations which are due:</b>		
Not later than one year	5,083	5,040
Later than one year and not later than five years	23,165	19,923
Later than five years	215,921	214,595
	<b>244,169</b>	<b>239,558</b>

### 21.4 PFI schemes

The NHS Foundation Trust has three PFI schemes which are included within the Statement of Financial Position.

The NHS Foundation Trust has determined that in accordance with the relevant accounting standards, it should recognise an asset of the relevant buildings as an item of property, plant and equipment and a corresponding finance lease liability. This then requires the NHS Foundation Trust to apportion the Unitary Payment for accounting purposes only into the following components: (a) a finance lease rental/asset financing component, (b) a services component and (c) a component in respect of funding for the replacement of parts of the asset over the life of the contract (lifecycle replacement).

#### Transforming Newcastle Hospitals (TNH) PFI scheme:

Capitalised value to 31 March 2017	£281,635k
Contract Start date	May 2005
Contract End date	May 2043

The Transforming Newcastle Hospitals PFI scheme, for a major service configuration at the Freeman Hospital and Royal Victoria Infirmary, reached financial close on 27 April 2005. After a negotiated settlement the final phase of the scheme, Phase 9, was handed over to the NHS Foundation Trust during the current financial year.

The initial Unitary Payment became payable from April 2005, when the scheme became partly operational (Freeman Multi-Storey Car Park). Construction of the Freeman Multi-Storey Car Park commenced prior to contract completion and was subsequently incorporated into the scheme. The District Valuer has prepared a Modern Equivalent Asset valuation for the separate elements of the scheme and this value is used when capitalising the assets.

The NHS Foundation Trust pays the operator a monthly Unitary Payment covering the provision of the assets and services. These cash flows can vary due to the following factors:

- The Unitary payment is adjusted each year for the effects of price changes by applying changes in the RPI to the whole Unitary Payment.
- The contract provides for the NHS Foundation Trust to deduct amounts from the Unitary Payment to the extent that any part of the buildings are unavailable for use, or if services are not provided to the standards set out in the contract.

# Notes to the Accounts (continued)

## 21 Borrowings (continued)

### 21.4 PFI schemes (continued)

The operator is responsible for ensuring the buildings remain in the required condition over the life of the contract, undertaking property maintenance and replacement of components of assets when required. The contract does not include the provision of any 'soft' facilities management provision, e.g. security, cleaning or portering.

At the completion of the PFI contract the buildings will revert to the NHS Foundation Trust at no additional cost. There is no option in the contract for its extension.

#### RVI Boiler House PFI scheme:

Capitalised value	£5,704k
Contract Start date	October 2002
Contract End date	June 2023

The RVI Boiler House PFI scheme is for the provision of energy through the RVI Boiler House. The scheme commenced on 22 December 2000, with the NHS Foundation Trust paying the PFI contractor to run the transferred plant.

The Unitary Payment became payable from October 2002 when the PFI scheme became fully operational.

#### Freeman Boiler House PFI scheme:

Capitalised value	£5,428k
Contract Start date	December 1997
Contract End date	June 2027

The Freeman Boiler House PFI scheme covers two stages, both for the upgrade of facilities and the provision of energy through the Freeman Boiler House. The first stage became operational on 1 December 1997 and the second on 1 January 2008.

### 21.5 Total PFI arrangements - payments in year

	31 March 2017 £000	31 March 2016 £000
Service element	6,831	6,884
Repayment of finance lease liability	6,785	6,620
Interest charge	14,173	13,785
Contingent rent	8,033	7,462
Capital lifecycle costs - including prepayment element	2,418	2,470
Total unitary payment	<u>38,240</u>	<u>37,221</u>

The NHS Foundation Trust made additional payments of £NIL (2015/16 £3k) to the PFI operator during the year. The NHS Foundation Trust has recognised £6,866k (2015/16 £4,621k) PFI support income within the Statement of Comprehensive Income.

### 21.6 Total PFI arrangements - commitments

#### Maturity analysis of unitary payments

The NHS Foundation Trust is committed to make the following Unitary Payments over the remaining period of the PFI schemes:

	31 March 2017 £000	31 March 2016 £000
Total future payments committed	<u>1,302,836</u>	<u>1,371,859</u>
Of which payments due:		
Not later than one year	39,325	38,838
Later than one year and not later than five years	168,532	167,454
Later than five years	1,094,979	1,165,567
	<u>1,302,836</u>	<u>1,371,859</u>

The amounts shown in the category 'Not later than one year' include an actual inflation rate charge of 3.2% (2015/16 1.3%). Other amounts are shown inclusive of an anticipated annual inflation rate of 2.5% as per the contract. The actual inflation rate incorporated into the Unitary Payment is based on the Retail Price Index (RPI) issued in the February preceding the financial year, therefore the figures above will vary depending on the actual rate issued.



# Notes to the Accounts (continued)

## 21 Borrowings (continued)

### 21.7 Asset financing component of PFI schemes

	Gross payments		Present value of payments	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Not later than one year	20,955	21,243	5,083	5,040
Later than one year and not later than five years	82,813	82,799	23,165	19,923
Later than five years	392,914	412,031	215,921	214,595
Sub-total	496,682	516,073	244,169	239,558
Less: finance cost attributable to future periods	(252,513)	(276,515)		
<b>Total</b>	<b>244,169</b>	<b>239,558</b>		

The RPI indexation increase which would be applied to the lease element of the unitary payment is not included in payments detailed above. Instead, and in accordance with IAS17, the RPI indexation amount is treated as contingent rent when paid and, because in substance it is part of the cost of financing, it is treated and disclosed as a finance cost.

During 2016/17 £8,033k (2015/16 £7,462k) was expensed as a contingent finance cost.

### 21.8 Services component of PFI schemes

	Gross payments	
	31 March 2017 £000	31 March 2016 £000
Not later than one year	7,270	7,196
Later than one year and not later than five years	30,459	29,950
Later than five years	138,655	146,862
	176,384	184,008

The services component excludes the impact of inflation in future years.

The amount charged to operating expenses during the year in respect of services was £6,831k (2015/16 £6,884k).

The actual amounts paid vary to forecast due to inflation, contract variations and credits received for service failures.

### 21.9 Lifecycle replacement component of PFI schemes

	Gross payments	
	31 March 2017 £000	31 March 2016 £000
Not later than one year	2,410	2,502
Later than one year and not later than five years	9,640	10,008
Later than five years	50,604	55,049
	62,654	67,559

The lifecycle component excludes the impact of inflation in future years.

# Notes to the Accounts (continued)

## 22 Provisions

### GROUP and NHS FOUNDATION TRUST

	31 March 2017 £000	31 March 2016 £000
Pensions - early departure costs	2,541	2,208
Legal claims - other	1,163	982
Equal Pay (including Agenda for Change)	0	67
Other	3,661	8,892
<b>Total</b>	<b>7,365</b>	<b>12,149</b>
<b>Analysed by:</b>		
Current	1,547	6,662
Non-current	5,818	5,487
<b>Total</b>	<b>7,365</b>	<b>12,149</b>

Movement in year:	Pensions early departure costs £000	Legal claims - other £000	Equal Pay (including Agenda for Change) £000	Other £000	Total £000
	At 1 April 2016	2,208	982	67	8,892
Change in the discount rate	437	0	0	0	437
Arising during the year	0	754	0	0	754
Utilised during the year - cash	(109)	(377)	(2)	(109)	(597)
Reversed unused	(69)	(196)	(65)	(5,122)	(5,452)
Unwinding of discount *	74	0	0	0	74
<b>At 31 March 2017</b>	<b>2,541</b>	<b>1,163</b>	<b>0</b>	<b>3,661</b>	<b>7,365</b>
<b>Expected timing of cash flows</b>					
- not later than one year	113	1,163	0	271	1,547
- later than one year and not later than five years	2,428	0	0	3,390	5,818
- later than five years	0	0	0	0	0
<b>Total</b>	<b>2,541</b>	<b>1,163</b>	<b>0</b>	<b>3,661</b>	<b>7,365</b>

Pensions - relates to sums payable to former employees having retired prematurely due to injury at work. The outstanding liability is based upon current and expected benefits advised by the NHS Pensions Agency and the computed life expectancies of pension recipients.

Legal Claims - based upon professional assessments, which are uncertain to the extent that they are an estimate of the likely outcome of individual cases. Due dates of settlement of claims are based upon estimates supplied by the NHS Litigation Authority and/or Legal Advisers.

Other - the opening balance relates to building related provisions resulting from the on-going development of the Royal Victoria Infirmary (RVI) and the Campus for Ageing and Vitality (CAV) sites. The reversed unused amounts in year relate to a £4,621k PFI scheme delay claim no longer required as settlement has been reached and a £499k asbestos removal provision deemed not necessary.

The NHS Foundation Trust has an insurance arrangement through the NHS Litigation Authority in respect of clinical negligence, with liabilities covered by an annual insurance premium payment. Excluded from this note therefore is a sum of £267,877k (2015/16 £220,422k restated) which is included within the provisions of the NHS Litigation Authority in respect of clinical negligence liabilities of the NHS Foundation Trust.

Where it is not considered probable that a payment will be made, non-provided amounts are disclosed in Note 26, Contingent Liabilities.

\* Unwinding of discount relates to the inflation effect on existing provisions of their payment in the future.

# Notes to the Accounts (continued)

## 23 Notes to the Statement of Cash Flows

### 23.1 Reconciliation of operating surplus to net cash flow from operating activities

	GROUP		NHS FOUNDATION TRUST	
	2016/17 £000	2015/16 £000	2016/17 £000	2015/16 £000
Total operating surplus	9,788	20,005	(6,675)	18,310
Depreciation and amortisation	27,364	29,001	27,364	29,001
Net Impairments	50,240	14,346	50,240	14,346
Income recognised in relation to donated assets - cash and non cash	(363)	(1,123)	(893)	(1,321)
(Increase)/decrease in inventories	3,809	(2,325)	3,809	(2,325)
Decrease/(increase) in trade and other receivables	1,582	(14,706)	1,087	(14,532)
Increase/(decrease) in trade and other payables	3,348	17,035	3,348	17,035
Increase/(decrease) in other liabilities	(8,300)	(5,514)	(8,300)	(5,514)
Increase/(decrease) in provisions	(4,858)	3,840	(4,858)	3,840
Other movements in operating cash flows	29	1,050	29	1,050
NHS Charitable funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	(85)	(112)	0	0
<b>Net cash generated from operating activities</b>	<b>82,554</b>	<b>61,497</b>	<b>65,151</b>	<b>59,890</b>

## 24 Contractual Capital Commitments

Commitments under capital expenditure contracts at 31 March 2017 were £6,937k (2015/16 £21,789k).

## 25 Events after the Reporting Date

There were no events after the reporting date which are required to be incorporated into the accounts in the current or prior year.

## 26 Contingent Liabilities

GROUP and NHS FOUNDATION TRUST

	31 March 2017 £000	31 March 2016 £000
Gross and net value of contingent liabilities	(84)	(49)

The contingent liability figure relates to the non-provided risks for Employer and Public Liability claims based upon risk assessments supplied by the NHS Litigation Authority.

## 27 Related Party Transactions

### 27.1 Ultimate parent

The NHS Foundation Trust is a public benefit corporation established under the National Health Service Act 2006. Monitor (operating as NHS Improvement) the Independent Regulator for NHS Foundation Trusts, has the power to control the NHS Foundation Trust within the meaning of IAS 27 Consolidated and Separate Financial Statements. Monitor does not prepare group accounts but does prepare separate NHS Foundation Trust Consolidated Accounts. The NHS Foundation Trust Consolidated Accounts are included within the Whole of Government Accounts. Monitor is accountable to the Secretary of State for Health and therefore the NHS Foundation Trust's ultimate parent is HM Government.

### 27.2 Whole of Government Accounts Bodies

All government bodies which fall within the Whole of Government accounts boundary are regarded as related parties because they are all under the common control of HM Government and Parliament. This includes for example all NHS bodies, all local authorities and central government bodies.

# Notes to the Accounts (continued)

## 27 Related Party Transactions (continued)

### 27.3 Transactions with related parties

The NHS Foundation Trust had no transactions with board members in the current or previous financial year and had no outstanding payable or receivable balances at 31 March 2017 or 31 March 2016. The table below details the total value of other related party transactions in the current and previous year and the outstanding balances as at 31 March 2017 and 31 March 2016.

	31 March 2017 £000	31 March 2017 £000	31 March 2017 £000	31 March 2017 £000	31 March 2016 £000	31 March 2016 £000	31 March 2016 £000	31 March 2016 £000
	Payables	Receivables	Income	Expenditure	Payables	Receivables	Income	Expenditure
Department of Health (excluding PDC)	0	578	29,671	7	695	41	29,966	11
Other NHS bodies	3,160	41,117	933,377	34,164	3,247	38,905	899,287	32,183
Subsidiaries / associates / joint ventures	5	1,653	183	1,018	1	673	1,439	1,035
Other *	19,685	7,698	26,353	109,729	20,011	89,836	33,179	104,155
<b>Total value of transactions with other related parties and balances as at 31 March</b>	<b>22,850</b>	<b>51,046</b>	<b>989,584</b>	<b>144,918</b>	<b>23,954</b>	<b>129,455</b>	<b>963,871</b>	<b>137,384</b>

\* Included within Other receivables are balances of £NIL (2015/16 £80m) resulting from cash on deposit with the National Loans Fund. Included in Other expenditure are payments in respect of Employer's NI and Pension contributions.

### 27.4 Significant transactions and balances with other NHS and government bodies

The table below identifies the ten organisations with which the NHS Foundation Trust has had the largest value of revenue transactions during the current and previous year. The NHS Pension Scheme and HM Revenues and Customs (Excluding VAT) are also included due to the material value of payments made.

	31 March 2017 £000	31 March 2017 £000	31 March 2017 £000	31 March 2017 £000	31 March 2016 £000	31 March 2016 £000	31 March 2016 £000	31 March 2016 £000
	Payables	Receivables	Income	Expenditure	Payables	Receivables	Income	Expenditure
NHS England	22	17,883	401,710	31	87	16,478	389,863	1,022
NHS Newcastle Gateshead CCG	1,010	8,658	252,435	228	0	5,972	235,357	0
NHS Northumberland CCG	70	1,493	66,849	41	0	4,536	65,143	0
NHS North Tyneside CCG	203	2,777	63,989	51	0	1,770	62,603	0
Health Education England	0	111	58,631	12	10	829	61,101	10
DOH (excluding PDC)	0	69	29,671	7	695	41	29,966	11
NHS North Durham CCG	37	542	15,099	11	0	470	14,671	0
NHS South Tyneside CCG	28	950	13,966	39	0	535	12,198	0
NHS Cumbria CCG	0	95	12,631	8	0	190	12,139	0
NHS Sunderland CCG	0	146	11,322	5	0	128	9,899	0
NHS Pension Scheme (Employer's contributions)	7,348	0	0	52,690	7,118	0	0	50,917
HM Revenues and Customs (Excluding VAT)	10,867	0	0	40,068	9,777	0	0	30,836

None of the receivable or payable balances are secured. Amounts are usually due within 30 days and will be settled in cash.

### 27.5 Commitments at 31 March 2017

The NHS Foundation Trust continues to negotiate income contracts with the organisations detailed above. Negotiations are expected to be concluded at an overall value not significantly different to those entered into for 2016/17.

### 27.6 Charitable funds

The NHS Foundation Trust receives revenue and capital payments from a number of charitable funds, including the Newcastle upon Tyne Hospitals NHS Charity, for which the NHS Foundation Trust acts as 'Corporate Trustee'. The results for this Charity are consolidated within these group accounts.

# Notes to the Accounts (continued)

## 27 Related Party Transactions (continued)

### 27.7 Directors

A Non-Executive Director, Mrs H A Parker, is a member of Sintons LLP solicitors. During the year the NHS Foundation Trust used Sintons to provide legal advice in relation to specific projects. The legal services were provided on commercial terms and amounted to expenditure of £450k (2015/16 £482k) and a year end payable balance of £47k (2015/16 £21k).

A Non-Executive Director, Mr E Weir is the Director of Adult and Culture Services with Newcastle City Council. During the year the NHS Foundation Trust had the following transactions with Newcastle City Council. Income of £12.7m (2015/16 £10.5m restated) relating to Genitourinary medical services and the joint community loan equipment store and expenditure of £7.1m (2015/16 £6.4m). The year end receivable balance was £Nil (2015/16 £Nil restated) and payable balance was £17k (2015/16 £123k).

During the year the NHS Foundation Trust had a Director in common with Newcastle University (Professor C P Day). Transactions with the University were both financial and non financial relating principally to income received of £2.8m (2015/16 £3.0m restated) and expenditure of £14.3m (2015/16 £13.5m) in relation to staff who work across both organisations. The year end receivable balance was £891k (2015/16 £2.0m restated) and payable balance was £1.1m (2015/16 £2.7m).

During the year the following Director and senior managers of the NHS Foundation Trust were Non-Executive Directors of Freeman Clinics Ltd, Mrs H Lamont, Mrs K Simpson, Mr D Reynolds and Dr J S Skinner. Transactions during the year were income of £162k (2015/16 £162k restated) and expenditure of £374k (2015/16 £355k). Year end balances were £1.6m (2015/16 £1.6m restated) receivable and £Nil (2015/16 £Nil) payable. All transactions were undertaken on a commercial basis.

The NHS Foundation Trust's Chief Executive Sir L R Fenwick was Chairman and Director of Newgene Ltd during the year. The NHS Foundation Trust's Finance Director Mrs A Dragone and senior manager Dr M J Wright, were also Directors of Newgene Ltd during the year. Transactions during the year were income of £20k (2015/16 £19k restated) and expenditure of £644k (2015/16 £680k). Year end balances were £38k (2015/16 £28k restated) receivable and £5k (2015/16 £Nil) payable. All transactions were undertaken on a commercial basis.

The NHS Foundation Trust's Chief Executive Sir L R Fenwick, Non-Executive Director Mrs H A Parker and senior manager Mr D D Ward, were Directors of Newcastle Healthcare Property Company Limited during the year. The company has not yet commenced trading.

The NHS Foundation Trust's Chairman Mr K W Smith and senior manager Dr A J Sims, were Chairman and Director respectively of Pulse Diagnostics during the year. The company has not yet commenced trading.

The NHS Foundation Trust's Chief Executive Sir L R Fenwick and a Non-Executive Director Professor C P Day were Directors of Academic Health Science Network North East and North Cumbria (AHSN NENC) during the year. The NHS Foundation Trust provides financial services support to AHSN NENC. Transactions during the year, excluding funds transfers in respect of receipts and payments made to and by the NHS Foundation Trust on behalf of AHSN NECN, were income of £347k (2015/16 £288k restated) and expenditure of £31k (2015/16 £49k restated). Year end balances were £400k (2015/16 £109k) receivable and £Nil (2015/16 £Nil) payable.

A Non-Executive director, Professor K McCourt, is a Pro-Chancellor at Northumbria University. During the year the NHS Foundation Trust had the following transactions with Northumbria University. Income of £3k (2015/16 £32k restated) and expenditure of £146k (2015/16 £254k). Year end balances were receivable £6k (2015/16 £5k restated) and payable £22k (2015/16 £36k).

### 27.8 Remuneration of key management personnel

The remuneration of the executive and non executive directors, who are the key management personnel of the NHS Foundation Trust, is set out in Note 5.4. Further information about the remuneration of individual directors is provided in the Remuneration report.

There were no amounts owing to key management personnel at the beginning or end of the financial year.

# Notes to the Accounts (continued)

## 28 Financial Instruments and Financial Risk Management

*IFRS 7* requires disclosure of the role that financial instruments have had during the year in creating or changing the risks an entity faces in undertaking its activities. Because of the continuing service-provider relationship that the NHS Foundation Trust has with local Clinical Commissioning Groups (CCGs) and the way those CCGs are financed, the NHS Foundation 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 the listed companies to which the financial reporting standards mainly apply. Financial assets and liabilities are generated by day-to-day operational activities rather than being held in order to change the risks facing the NHS Foundation Trust.

The NHS Foundation Trust's capital and treasury management operations are carried out by the finance department, within parameters defined formally within the NHS Foundation Trust's standing financial instructions and policies agreed by the Board of directors.

*IFRS 7* also requires disclosures relating to the risks associated with financial instruments. There are three types of risk:

### Credit Risk

Credit risk is the risk that one party to a financial instrument will cause a financial loss for the other party by failing to discharge an obligation. For the NHS Foundation Trust, credit risk arises mainly from NHS and other receivable balances. Credit risk is mitigated as a substantial part of the NHS Foundation Trust's activity is carried out with other Health Bodies. For other transactions specific checks are made regarding credit worthiness before the NHS Foundation Trust enters into any new contracts. The NHS Foundation Trust manages this risk by regular review of aged receivable balances, prompt follow up on those which are overdue and provides for any deemed to be impaired. Once the balance is determined to be irrecoverable the amount is written off.

Of the Group's cash and cash equivalents balance at the year end, 85% was held with the Government Banking Service and the remaining 15% with the NHS Foundation Trust's and Charity's bankers, HSBC and Clydesdale Bank plc. (Yorkshire Bank). The credit risk arising, i.e., that the banks may default on repayment, is considered to be low.

The NHS Foundation Trust held no short term deposits at the year end. During the year the NHS Foundation Trust placed cash with the National Loans Fund which is deemed to be zero risk. The average investment with the National Loans Fund over the year April 2016 to March 2017 was £81,865k. (April 2014 to March 2015 £99,932k).

An analysis of aged and impaired receivables is given in Note 16.

The credit risk associated with all other financial instruments is considered to be low. The Group's maximum exposure to credit risk at the balance sheet date is £201,706k (2015/16 £175,258k restated). There are no amounts held as collateral against these balances.

At 31 March 2017 a review was undertaken of financial assets not past their due date. Those where the credit risk was anticipated to be significant were impaired. Therefore the credit risk of those remaining financial assets neither past their due date nor impaired is deemed to be low.

At 31 March 2017 there are £Nil (2015/16 £Nil) financial assets that would otherwise be past due or impaired whose terms have been renegotiated.

### Liquidity risk

Liquidity risk is the risk that the NHS Foundation Trust will encounter difficulty in meeting obligations associated with financial liabilities. The NHS Foundation Trust's net operating costs are incurred under contracts with various commissioning bodies, which are financed from resources voted annually by Parliament. The NHS Foundation Trust receives such income month by month, based on a contracted annual level of activity, with quarterly corrections made to adjust for actual activity carried out and resultant income due.

The NHS Foundation Trust largely finances its capital expenditure from internally generated resources. Funds have also been made available from Government, in the form of additional Public Dividend Capital, to progress specific capital schemes. In addition, the NHS Foundation Trust can borrow from commercial sources to finance capital schemes. Such financing would be drawn down to match the spend profile of the scheme concerned and the NHS Foundation Trust is not, therefore, exposed to significant liquidity risk in this area.

The NHS Foundation Trust has a loan agreement with the Department of Health (formerly with the Independent Trust Financing Facility) with an outstanding balance at 31 March 2017 of £8,750k (balance at 31 March 2016 £12,250k). Further details can be found in Note 20. An extended five year plan was prepared and submitted to Monitor prior to this loan being authorised.

The NHS Foundation Trust is also subject to liquidity risk in relation to the long term PFI contracts into which it has entered. The maturity analysis for payments under these schemes can be found in Note 21. Expenditure savings have been identified to mitigate the liquidity risk of the PFI contracts. Prior to the contract being entered into the scheme was reviewed by HM Treasury and, subsequently, by Monitor when the NHS Foundation Trust was applying for Foundation Trust status.

# Notes to the Accounts (continued)

## 28 Financial Instruments and Financial Risk Management (continued)

### Market Risk - Interest-rate risk

Interest rate risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in market interest rates.

Of the NHS Foundation Trust's cash and cash equivalents 100% attract variable rates. As the variable rates are based on base rate less either 0.25% or 0.05%, any reduction would have an immaterial impact on cash flow and hence interest rate risk on these financial assets is deemed to be immaterial.

An element of the Newcastle upon Tyne Hospitals NHS Charity's cash balance is held on a 95 day fixed term deposit with Yorkshire Bank plc. The interest rate on this deposit is currently fixed at 0.5%. The Newcastle upon Tyne Hospitals NHS Charity also holds a variable cash balance with HSBC which attracts an interest rate at 0.08%.

The cash held within the Newcastle upon Tyne Hospitals NHS Charity investment portfolio is held within a Charities' Deposit Fund account which attracts interest on a variable basis. The interest rate at 31 March 2017 was 0.43%.

Within trade and other receivables falling due after more than one year is a loan to a company of which the NHS Foundation Trust owns 55%. This loan bears interest at base rate +1%. As the base rate at 31 March 2017 was 0.5%, any reduction in market rate would not have a material impact on future cash flows.

The NHS Foundation Trust has a loan agreement with the Department of Health (formerly with the Independent Trust Financing Facility). This loan bears interest at a fixed rate of 2.92%.

The NHS Foundation Trust's PFI arrangements are on fixed interest terms.

Other than as described above, none of the other remaining NHS Foundation Trust financial assets or liabilities carry interest rates which vary with market rates and therefore interest rate risk is not deemed material and a sensitivity analysis is not considered necessary.

## 29 Financial Assets and Liabilities

### 29.1 Financial assets by category

	GROUP		NHS FOUNDATION TRUST	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
<b>Loans and receivables</b>				
Trade and other receivables excluding non-financial assets	61,746	65,039	62,360	65,039
Cash and cash equivalents - NHS Foundation Trust	102,813	93,076	102,813	93,076
Other financial assets - NHS Charitable Fund	37,147	17,143	0	0
<b>Total</b>	<b>201,706</b>	<b>175,258</b>	<b>165,173</b>	<b>158,115</b>

Fair value is not considered significantly different from book value.

### 29.2 Financial liabilities by category

	GROUP		NHS FOUNDATION TRUST	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
<b>Other financial liabilities</b>				
Borrowings excluding finance lease and PFI liabilities	8,750	12,250	8,750	12,250
Trade and other payables excluding non-financial liabilities	69,053	68,751	69,053	68,751
Provisions under contract	7,364	12,149	7,364	12,149
PFI finance lease obligations	244,169	239,558	244,169	239,558
NHS Charitable Fund - financial liabilities	40	85	0	0
<b>Total</b>	<b>329,376</b>	<b>332,793</b>	<b>329,336</b>	<b>332,708</b>

Fair value is not considered significantly different from book value.

### Maturity of financial liabilities

In one year or less	79,223	81,038	79,223	80,953
In more than one year but not more than two years	8,913	8,132	8,913	8,132
In more than two years but not more than five years	23,339	24,361	23,339	24,361
In more than five years	217,901	219,262	217,901	219,262
<b>Total</b>	<b>329,376</b>	<b>332,793</b>	<b>329,376</b>	<b>332,708</b>

# Notes to the Accounts (continued)

## 30 Third Party Assets

The NHS Foundation Trust held £2k (2015/16 £5k) cash at bank, which relates to monies held by the NHS Foundation Trust on behalf of patients. These monies have not been included in the cash and cash equivalents figure reported in the accounts.

## 31 Losses and Special Payments

There were 304 cases of losses and special payments totalling £931k during the year (2015/16 280 cases totalling £629k). One case in the current year (2015/16 no cases) cost the NHS Foundation Trust £300k or more. Losses and special payments are accounted for on an accruals basis. An analysis of losses and special payments by category is given in the table below.

### Analysis of losses and special payments by category

Category	2016/17 Total number of cases No.	2016/17 Total value of cases £000	2015/16 Total number of cases No.	2015/16 Total value of cases £000
<b>Losses</b>				
Cash losses - theft and fraud	3	2	0	0
Cash losses - overpayment of salaries	16	8	22	14
Bad debts and claims abandoned in relation to:				
a) private patients	25	5	15	6
b) overseas visitors	28	81	31	138
c) other *	79	374	33	33
Damage to buildings, property etc. (including stores losses) due to:				
a) theft, fraud etc.	0	0	1	1
b) stores losses	8	250	6	271
c) other	57	28	83	19
<b>Total losses</b>	<b>216</b>	<b>748</b>	191	482
<b>Special payments</b>				
Ex-gratia payments in respect of:				
a) loss of personal effects	36	5	15	2
b) personal injury with advice	19	168	15	135
c) other	31	6	58	9
d) maladministration, no financial loss	2	4	1	1
<b>Total special payments</b>	<b>88</b>	<b>183</b>	89	147
<b>Total losses and special payments</b>	<b>304</b>	<b>931</b>	280	629

\* Other includes a loss of £300k in relation to an invoice raised to NHS Northumberland CCG for winter resilience funding in 2015/16.



# Notes to the Accounts (continued)

## 32 NHS Retirement Benefit Scheme

### 32.1 NHS Retirement Benefit Scheme

Past and present employees are covered by the provisions of the two NHS Pensions Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at [www.nhsba.nhs.uk/pensions](http://www.nhsba.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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Foundation Trust of participating in each scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

#### a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period.

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

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

#### b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend the contribution rates payable by employees and employers. The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

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

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

The NHS Foundation Trust estimates that its employer contributions into the scheme in 2017/18 will be £53,198k.

### 32.2 National Employment Savings Trust (NEST)

During the year the NHS Foundation Trust made contributions into the National Employment Savings Trust. This is a defined contribution scheme into which eligible staff are automatically enrolled. These employees are not eligible to join the NHS Retirement Benefit scheme. Employer's contributions by the NHS Foundation Trust for the year were £33k (2015/16 £23k).

# Notes to the Accounts (continued)

## 33 The Newcastle upon Tyne Hospitals NHS Charity

### 33.1 Merger of funds

With effect from 1 April 2016 the NHS Foundation Trust was appointed as Trustee of charitable funds formerly held on behalf of the NHS Foundation Trust by Newcastle Healthcare Charity (Reg. 502473) under a scheme formally approved by the Charity Commission for England & Wales on 21 March 2016. The funds were subsequently merged under the umbrella of the Trust's appointed charitable body, Newcastle upon Tyne Hospitals NHS Charity (Reg. 1057213) and form part of that Charity's and therefore also the NHS Foundation Trust Group accounts for the year ended 31 March 2017.

### 33.2 Funds

	<b>31 March 2017 £000</b>	31 March 2016 £000
Restricted	<b>18,516</b>	16,837
Unrestricted	<b>18,539</b>	129
	<b>37,055</b>	16,966

As at 31 March 2017 the total funds as disclosed in the Newcastle Upon Tyne Hospitals NHS Charity accounts amount to £32,109k. This balance has been adjusted for IFRS accounting policies and is disclosed in the group accounts as £37,055k. The adjustment to funds of £4,946k has been included within unrestricted funds.

#### Restricted funds

Restricted funds are those funds on which a legal restriction has been placed for the purpose to which the fund may be put.

#### Unrestricted funds

Unrestricted funds are those funds on which no legal restriction has been placed for the purpose to which the fund may be put.

The aim of the Charitable fund is to use the available funds to complement NHS resources in The Newcastle upon Tyne Hospitals NHS Foundation Trust to increase patient comfort and enhance facilities for both patients and staff.

### 33.3 Further information

Further information relating to the use of the Charitable funds and the Trustees' report can be found within the Newcastle upon Tyne Hospitals NHS Charity Annual Report and Accounts which form part of The Newcastle upon Tyne Hospitals NHS Foundation Trust Annual Report and Accounts.



# Openness and Accountability

## Information

The Trust is keen to share information and wherever possible respond positively to requests for detail relating to the performance of the organisation and how it operates. The Members Council papers are published routinely on the website and the Trust has a detailed Publication Scheme under the Freedom of Information Act, which makes a significant volume of information readily available, including via the website.

### Meetings in Public

The Council of Governors meets at 1-30pm on the third Thursday of alternate months, at the Freeman Hospital. These meetings are open to the public. Details may be found on the website at [www.newcastle-hospitals.org.uk/about-us/council-of-governors-papers.aspx](http://www.newcastle-hospitals.org.uk/about-us/council-of-governors-papers.aspx)

The Board of Directors meets in public session at 12-45pm on the fourth Thursday of every month except August (no meeting) and December (third Thursday). Details may be found on the website at [http://www.newcastle-hospitals.org.uk/about-us/board-of-directors\\_board-meeting-papers.aspx](http://www.newcastle-hospitals.org.uk/about-us/board-of-directors_board-meeting-papers.aspx)

### Annual General Meeting

The Trust's Annual General Meeting is held each year on the fourth Wednesday of September at 6.00pm in the Education Centre, Freeman Hospital, Newcastle upon Tyne.

### Feedback

Whether it be a complaint or a compliment or simply an enquiry, we do want to hear from you. There are Suggestion Boxes around our sites, or any member of staff would be happy to listen. Alternatively, contact:

**Louise Robson & Andy Welch**  
*Acting Chief Executives*

The Newcastle upon Tyne Hospitals NHS Foundation Trust  
Freeman Hospital, High Heaton, Newcastle upon Tyne NE7 7DN  
Telephone: (0191) 233 6161 Fax: (0191) 213 1968



# Charitable Fundraising

There are many ways to help the Newcastle Hospitals and we have listed here the most common forms of support. We are keen to protect both the hospitals' good name and integrity as well as those individuals who offer support and we therefore ask that anyone wishing to fundraise in our name seeks permission before the fundraising commences. Help and support is available from the Charity Fund Office and a letter of authorisation will be issued to the fundraiser.

## Donation

Single or periodic donations are the most common form of contribution and cheques can be made payable to "The Newcastle upon Tyne Hospitals NHS Charity (no. 1057213).

All donations should be sent to:

### Charity Fund Office

**Peacock Hall, Royal Victoria Infirmary,**

**Queen Victoria Road, Newcastle upon Tyne NE1 4LP**

Standing Order forms are available on request from the same address.

## Payroll giving

Individuals can elect to make donations to a charity of their choice by having an agreed sum deducted from their salary (weekly/monthly/annually). The effect of this is twofold: the charity receives both the donation and also the tax that would have been deducted on that particular sum. Thus a donation of £50 is increased to £62.50, with the donor only paying the agreed sum of £50 and HM Revenue and Customs providing the difference. Ask your employer for details.

## Share giving

Gifts of shares and securities can be transferred to the hospital charity and at the same time offer tax relief for the donor at the date of the transfer. This has become an increasingly popular form of charitable giving and allows individuals to benefit charities, often with minimal impact on income, in a simple and effective manner.

## Fundraising

Helping the hospitals in this way can be fun and at the same time generate vital funds for the local hospitals. It is important that fundraisers are aware of local regulations and what is considered acceptable practice. The Charity Fund team will offer advice and support and arrange a letter of authorisation for those involved. Sponsorship forms are available on request.

## Gift aid

Any donation made to a registered charity can be increased by 25% by using the Gift Aid Scheme. Anyone who pays income tax (or capital gains tax) can elect to have their donation "Gift Aided" and this will allow the Trust's charities to recover the tax paid on the contribution. A gift of £250 will be increased to £312.50 using the Gift Aid Scheme, with the extra £62.50 coming from HM Revenue and Customs and if the donor pays higher rate tax the personal liability will be reduced by £64.

## Legacy

After providing for their family, many people make a gift to their local hospitals in recognition of personal treatment or that provided to a loved one or friend. Help maintain and improve the healthcare for future generations by remembering your local hospital in your Will.

## Matched giving

Many local businesses support charities by matching any fundraising efforts by their own staff. This in effect doubles any money raised by those individuals and is an excellent way of inspiring and increasing contributions.

## Help and advice

For further information, help and advice, please contact:

### Charity Fund Office

**Peacock Hall, Royal Victoria Infirmary,**

**Queen Victoria Road, Newcastle upon Tyne NE1 4LP**

**Tel: 0191 223 1434**

**Email: [Charity.Matters@nuth.nhs.uk](mailto:Charity.Matters@nuth.nhs.uk)**

**Website: [www.newcastle-hospitals.org.uk](http://www.newcastle-hospitals.org.uk)**



**FREEMAN HOSPITAL**

High Heaton,  
Newcastle upon Tyne.  
NE7 7DN  
Telephone (0191) 233 6161  
Fax (0191) 213 1968

**NEWCASTLE HOSPITALS  
COMMUNITY HEALTH**

Molineux NHS Centre,  
Molineux Street,  
Newcastle upon Tyne.  
NE6 1SG  
Telephone (0191) 282 6605

**THE DENTAL HOSPITAL**

Richardson Road, Newcastle  
upon Tyne.  
NE2 4AZ  
Telephone (0191) 233 6161  
Fax (0191) 282 4671

**NORTHERN GENETICS  
SERVICE**

Institute of Human Genetics,  
International Centre for Life,  
Central Parkway, Newcastle  
upon Tyne. NE1 4EP  
Telephone (0191) 241 8600  
Fax (0191) 241 8799

**CAMPUS FOR  
AGEING & VITALITY**

Westgate Road, Newcastle  
upon Tyne. NE4 6BE  
Telephone (0191) 233 6161

**ROYAL VICTORIA  
INFIRMARY**

Queen Victoria Road,  
Newcastle upon Tyne.  
NE1 4LP  
Telephone (0191) 233 6161  
Fax (0191) 201 0155

**NORTHERN CENTRE  
FOR CANCER CARE**

Freeman Hospital,  
High Heaton, Newcastle  
upon Tyne. NE7 7DN  
Telephone (0191) 233 6161  
Fax (0191) 213 1968

**NEWCASTLE FERTILITY  
CENTRE**

Biosciences Centre,  
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NE1 4EP  
Telephone (0191) 219 4740  
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