

**THE NEWCASTLE UPON TYNE HOSPITALS
NHS FOUNDATION TRUST**

Annual Report & Accounts 2018/19

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CHAIR AND CHIEF EXECUTIVE INTRODUCTION

This has been a successful and exciting year for Newcastle Hospitals and it gives us great pleasure to present our Account Report and Accounts for 2018/19.

The Report reviews the progress we have made this year and outlines our priorities for the year ahead. It is a celebration of our achievements, the high quality care we have provided and the improvements that we have delivered for patients, families and staff.

Providing high quality, patient focused care remains our highest priority. Our staff work tirelessly to ensure that patients receive the safest, most clinically effective care and have a positive patient experience each and every time they use one of our services.

On many levels, we have delivered excellent outcomes. We ended the year achieving the vast majority of the standards and targets against which we are measured. Our Quality Report includes many areas where we have improved patient care even further.

One very highly scrutinised area for us is our Emergency Department (ED), our front door to the hospital, which sees huge numbers of patients everyday – the new record being 484 patients in one particularly hectic 24 hour period in March 2019.

It's a great achievement to be one of a select few departments in the country to have met the annual 4 hour target with an overall performance of 95.47%. It's the first time we have met the annual target in 4 years, and is entirely down to the commitment, expertise and teamwork of all staff who work here, as well as colleagues throughout the Trust who have supported flow through the hospital.

Most notably, we continue to rank amongst the best in the country for the positive feedback we receive from our patients and families. We were also delighted at the improved rate of return from the staff survey and the overwhelmingly positive feedback we received. We should take none of this for granted.

Supporting staff to bring the very best of themselves to their work is one of the most important factors in achieving the high clinical standards that the Trust achieves and this year, we launched #FlourishAtNewcastleHospitals. This is a cornerstone programme for the Trust and has been developed to support staff and enable them to reach their full potential at work.

In the later part of the year, we welcomed the Care Quality Commission (CQC) to the Trust and were delighted to be awarded a rating of Outstanding for the second time. This reaffirms our position as one of the UK's top hospital trusts.

We will soon publish our next 5 year strategy which will set out our vision, values and strategic framework for the future, and will set out our ambitions.

2019/20 will be an important year for the NHS and for us at Newcastle Hospitals as we take an even more substantial role in the region and nationally. Delivering the NHS Long Term Plan will give us a huge opportunity to influence and improve specialist pathways, work more closely with NHS and other partners, and develop even more innovative approaches.

A handwritten signature in black ink, appearing to read 'Jackie Daniel', with a large, stylized initial 'J'.

Dame Jackie Daniel
Chief Executive

28th May 2019

A handwritten signature in black ink, appearing to read 'John Burn', with a large, stylized initial 'J'.

Professor Sir John Burn
Chair

REVIEW OF THE YEAR

SERVICE DEVELOPMENTS

Each year our staff, with the support of our commissioners, set up and develop new and existing services and treatments. Here is just a snapshot of some of those developments over the last year:

Enhancing our specialist cancer portfolio

The Northern Centre for Cancer Care (NCCC) treated the UK's first prostate cancer patients using pioneering Magnetic Resonance Imaging (MRI) only planning technology and radiotherapy.

Radiotherapy treatment normally requires patients to attend for a computerized tomography (CT) scan as well as an MRI scan to gain a better image of the target and organs at risk - in this case the prostate, bowel and bladder respectively.

Conventional workflow had been to combine the MRI scan with the CT data needed for accurate radiotherapy dose calculations, meaning patients had to attend hospital on separate occasions. However, under the new MRI-only planning technology, the CT scan can be omitted meaning patients only need to attend for a single scanning session.

Using one image rather than two allows clinicians to better target the tumour and avoid healthy organs, as well as reducing the amount of time patients are in hospital and the severity of side effects, both in the short and longer term.

The NCCC was also the first radiotherapy centre in the country to offer cutting-edge radiosurgery technology to treat patients with brain cancer by using a new treatment planning software system – known as Brainlab Elements.

This rapidly generates radiosurgery plans for the efficient treatment of multiple brain metastases (cancer cells that have spread to the brain from primary tumours in other organs in the body) so multiple tumours can be treated at once, meaning patients spend less time on the treatment bed.

Previously each individual metastasis had to be planned and treated separately.

Our aim at the Trust is to improve the diagnosis and management of cancers in the region by using the best available techniques and equipment and this complements our specialist cancer centre portfolio by ensuring we are keeping up with developing technologies so we can deliver the very best care for our patients.

New complementary therapy suite for cancer patients

Former Newcastle United footballer Shola Ameobi unveiled a new complementary therapy suite allowing patients to 'escape' the normal medical environment with materials and design inspired by nature.

Adjacent to the Sir Bobby Robson Cancer Trials Research Centre, the suite is used by qualified complementary therapists (alongside standard medical treatments) to help

patients cope with the stress caused by cancer, helping to reduce anxiety and sleeping difficulties and provide emotional support and relief from pain.

Sir Bobby was one of thousands of patients to benefit from receiving complementary therapy during his cancer treatment at NCCC and when the Sir Bobby Robson Foundation launched in 2008, helping to fund the complementary therapy service was one of the first grants made and that support has continued every year since.

Hyperacute stroke service celebrates two years of partnership

A mum who suffered a stroke just weeks after giving birth to her daughter has made a full recovery thanks to the hyperacute stroke team based at the Royal Victoria Infirmary (RVI).

Joanne Davies was initially taken to Gateshead's Queen Elizabeth Hospital after a stroke but was quickly transferred to Newcastle where she underwent a thrombectomy (clot extraction), in addition to clot-busting medication on the same day. She was discharged just five days later with no ill effects.

Joanne and her family were special guests at an event to celebrate the second anniversary of the specialist hyperacute stroke unit at the RVI – a merger between the Trust and Gateshead Health NHS Foundation Trust.

The merger has helped to revolutionise treatment for managing strokes in the region as earlier recognition of stroke symptoms, rapid hospitalisation and quicker advanced scanning helps identify patients suitable for advanced treatments.

Radiology training suite

A new training suite for radiologists opened at the RVI's Northern Radiology Academy to help boost the diagnosis and treatment of cancer patients across the North East and North Cumbria.

The suite was funded by the Northern Cancer Alliance (NCA) and Health Education England (HEE) – a partnership that secured National Cancer Transformation funding from NHS England to improve radiology training in the region.

The NHS is seeking to increase the size of its clinical radiology workforce and this new facility means that the Northern Radiology Academy will be able to train a larger future workforce of Consultants and Allied Health Professionals (AHPs).

Currently, 80% of doctors trained in Radiology in our region stay here and it is hoped the new facility will further support staff retention.

The suite enables doctors to hone their skills in reading and reporting images for diagnosis and learn speciality elements of the radiology curriculum. Equipped with state-of-the-art

imaging technology to simulate real life scenarios, it also enables doctors to complete their speciality training in a dedicated, supervised facility.

Transforming childhood cancer treatment

Children with cancer are benefitting nationally from a therapeutic drug monitoring service, which allows doctors to personalise their treatment for the first time and obtain vital information about how much chemotherapy individual young patients should receive.

Before the service, clinicians had to work out the infant or child's chemotherapy dose by the patient's weight and age, with a 'one size fits all' model which could make it particularly difficult at times to decide on the best course of action for very young patients.

The new service - set up at the request of doctors at the Great North Children's Hospital (GNCH) and other childhood cancer primary treatment centres around the UK – works by collecting blood samples after chemotherapy is administered on the first day of treatment.

These are then analysed in real-time to measure individual patient drug exposure, with the results generated used to adjust dosing accordingly. The amount of chemotherapy given over subsequent days is then set to ensure that the patient receives a dose that is most likely to be effective but without causing too much toxicity, such as sickness and diarrhoea.

While the service has been running locally for several years, the National Institute for Health Research (NIHR) has now provided funding to Newcastle University to run a three-year study to expand the service nationally. This will not only positively impact on patients recruited to the study, but also generate data that will have a significant impact on future patient treatments through the provision of national guidelines for anti-cancer drugs in defined patient populations.

Neonatal Home Tube Feeding Partnership

Specialist nurses from the Neonatal Unit and Children's Services have launched the neonatal home tube feeding partnership - an innovative new service to help reunite premature babies with their families at home.

The scheme, available 24 hours a day, seven days a week, was set up to help some premature babies leave the RVI's Neonatal Unit a little earlier than usual, by providing extra support at home.

The final support most premature babies need before being discharged home is with tube feeding until they are able to fully feed through the mouth. Regular home visits by the children's Community Nurses mean that they can now be supported with this important transition at home.

Toy treatment machines to help children with cancer

Children undergoing cancer therapy are being given toy models of the machines used in their treatment to help ease their anxiety as part of 'The Little Linac' project which is being rolled out to children's Radiotherapy Centres across the country

York-based Institute of Physics and Engineering in Medicine (IPEM) wants to give every child in the United Kingdom (UK) undergoing radiotherapy treatment for cancer a free kit of play bricks to make a model linear accelerator machine - Linac for short - which is used in their treatment.

Their aim is to help reduce anxiety through play, by allowing children to see and understand what the machine looks like and how it moves around them during their treatment. The kit also makes three other imaging or treatment machines a child may encounter during their time in hospital – an MRI scanner, a gamma camera and a CT scanner.

Trust commits to major programme to secure congenital heart disease services

In year, the Trust pledged its commitment to investing in new staff and moving services across the city to safeguard the future of paediatric congenital heart disease (CHD) services.

There has been uncertainty about the future of these services for several years as NHS England (NHSE) carried out a national exercise to determine the future configuration of paediatric CHD services. This concluded in November 2017 with an announcement that the Trust could continue to provide level one CHD services until at least 2021.

NHSE wants all providers of CHD services to meet a number of national standards and the Trust was found to have not met two of the standards:

- Having a minimum of four surgeons each carrying out at least 125 surgical procedures a year to a total of 500 per annum by 2021, and
- Paediatric CHD services to be co-located with Paediatric Surgery and Nephrology services by April 2019.

Currently children's CHD services are based at the Freeman Hospital alongside all of our other CHD services while other paediatric surgery services are based at the GNCH.

The Trust is one of only two NHS organisations that provide children's heart transplant surgery in the UK, and the only one in the country to offer transplant surgery to both adults and children with congenital heart disease.

In recognition of this unique position, NHSE allowed the organisation some exceptions to the standards, while it gave further consideration to the future commissioning of the Trust's advanced heart failure and transplant services, and its level one CHD services.

These exceptions were that Newcastle Hospitals:

- Be required to develop and deliver a plan to increase surgical activity so that it has a team of at least three surgeons, each undertaking at least 125 operations per year from 2019/20.

- Will not be required to meet the 2019 deadline for full co-location for paediatric cardiac services, but will be required to meet these standards if NHS England confirms a plan to commission level one CHD services beyond March 2021.

As part of the Trust's commitment to safeguarding the future of those services in Newcastle, the Board of Directors gave its support to a three-phase programme that will ensure we achieve all of the standards determined by NHSE:

- **Phase 1** – recruit extra staff to meet the surgical activity standard and help to support the move to phase 2.
- **Phase 2** - Co-locate paediatric services with paediatric surgery and nephrology services to the Great North Children's Hospital.
- **Phase 3** - move the remainder of the Trust's cardiothoracic services to the RVI.

Work has already begun to recruit extra staff and we continue to work closely with NHSE on options for funding the co-location of services. Moving the rest of the cardiothoracic services will require a major review of our services and estate.

Trust provides ground breaking cancer treatment in a new European first

Adult cancer patients have begun to receive a new game-changing therapy treatment under the first negotiated deal of its kind struck in Europe.

The CAR-T therapy - Axicabtagene ciloleucel, also known as Yescarta - offers new hope for adult patients whose large cell lymphoma has returned or has stopped responding to previous treatment.

It works by re-programming the patient's own immune system to target their cancer. CAR-T cell treatments mark the beginning of a new era of personalised medicine, and form part of the NHS's long-term plan to upgrade cancer services.

This is the first time adult NHS patients have had access to CAR-T in lymphoma, and follows a deal NHS England reached to make CAR-T available for children and young people with a rare form of leukaemia.

Newcastle was among the first wave of hospitals working towards providing this novel therapy for both adults and children, which means patients at Newcastle will be among the first patients in the world to benefit.

Dialysis unit celebrates 40 years at Freeman

Staff on the haemodialysis unit celebrated the 40th anniversary of providing dialysis at the Freeman Hospital. When the unit first opened in 1978, 40 patients received their treatment in a single, ten-station facility.

Since then, the service has grown to provide life-saving treatment to hundreds of patients with kidney failure, not only at the Freeman but also in our satellite dialysis units. Particular highlights have included:

- the first description of aluminium bone disease in dialysis patients (so called 'Newcastle Bone Disease') that led to improved dialysis water standards and benefitting patients across the world;
- the first use of single-needle dialysis ('click-clack' dialysis) that allowed people with poor vascular access to be dialysed successfully; and
- Newcastle's recognition as a centre of excellence for patients with genetic and immune-mediated kidney diseases culminating in the services successful nomination as the UK's National Centre for Complement Therapeutics, managing the treatment of patients across the country with the potentially devastating kidney condition, Atypical Hemolytic Uremic Syndrome (aHUS).

1,000th prostate cancer patient is treated using robotic surgery

Urologists carried out the 1,000th robotic radical prostatectomy on a prostate cancer patient at the Freeman – six years after the pioneering procedure was first introduced – using the Da Vinci robot.

The robot has revolutionised surgical treatment for prostate cancer by making it possible for surgeons to perform minimally-invasive surgery with greater precision and control than ever before. The hi-tech procedure has dramatically improved outcomes and cure rates for men with the disease, while reducing the side effects and complications of surgery and the length of time patients have to stay in hospital.

Since the robotic surgery programme began in Newcastle in 2012, surgeons have carried out complex robotic operations across seven specialties - more than any other robotic centre in Europe.

Pop-up hospital showcased as part of Great Exhibition of the North

A 'pop-up' hospital featuring a fusion of old medicine and new, complete with a four-bedded ward was officially unveiled as part of the Great Exhibition of the North.

The attraction 'inspired by – and created for - local children' was developed by the Great North Children's Hospital to help shatter some of the myths about what a stay in hospital is really like and also to showcase some of the excellent work taking place there.

From the historic, including medical equipment and artefacts such as an 'iron lung' (a half-century old encased tank-like machine, which helped a patient to breathe) to hi-tech virtual reality, the exhibition was held throughout the summer at Newcastle University's Herschel Building.

It was held as part of the 70th anniversary of the NHS and the Trust also held a series of celebrations including '70 years, 70 stories' which captured the thoughts and experiences of our staff and reflected the wide range and diversity of roles in delivering healthcare across the organisation.

Pilot site for bereavement care

The Trust was one of 21 centres to be named as a pilot site for the National Bereavement Care Pathway (NBCP) in the second wave of a project led by the Stillbirth and neonatal death charity – SANDS.

The pathway seeks to consistently improve the overall quality of bereavement care for parents and families whose baby has died before, during or shortly after birth and covers a wide range of healthcare settings both in primary and secondary care.

Newcastle surgeons perform life-saving surgery on baby in her mother's womb

Surgeons performed in utero surgery to save the life of an unborn baby after it developed a rare fetal condition.

Ruth Elder had the revolutionary procedure at the RVI after an ultrasound showed that her unborn baby had developed a condition known as hydrops fetalis - an abnormal accumulation of fluid around the baby's heart, lungs and inside the abdomen.

She had been suffering from severe pregnancy sickness and because of this had additional scans throughout her pregnancy, where the problem was detected. After an initial procedure to drain the fluid (which unfortunately re-accumulated), a decision was made to perform the life-saving in utero surgery which was a success.

Six weeks later, baby Harriet was born at 34 weeks by emergency C-section. To say thank you, Ruth arranged a festive tea party to raise money for the Fetal Medicine Fund raising over £5,000.

PARTNERSHIPS

We recognise that we will not be truly successful if we focus solely on our own organisational performance. We are an important part of a wider health and social care economy and our aim is not simply to collaborate actively with partner organisations but to be the anchor organisation of system-wide change.

Work has begun to develop our own strategic plan for the next five years at Newcastle Hospitals, which is essential if we are to support a sustainable health and care system.

We recognise we need to be 'clinically excellent and operationally efficient' so that we spend the precious resource we have in the areas that make the most difference to patients and this will involve us exploring opportunities to work 'smarter' and differently.

The Trust has a strong history of joint working and continues to develop effective strategic partnerships across health and social care with many of these relationships translating into integrated and multiagency pathways of care for patients.

This work has increased in recent years and will continue to do so in line with the transformation priorities identified within the Integrated Care Partnership (ICP) and

Integrated Care System (ICS) around prevention, out of hospital collaboration and optimal use of the acute sector.

Our operational plan for 2019/2020 has been written in the context of The Long Term Plan for the NHS, the Government's Mandate to NHS England, along with the work of the 'North' Integrated Care Partnership (ICP) and Cumbria and the North East Integrated Care System (ICS) and we will continue to engage in the wider system conversations.

The focus of this work remains the 'triple aim' of:

- Better health for everyone;
- Better care for all patients; and
- Sustainability for the local and wider NHS.

It is widely recognised that the health and wellbeing gap and health inequalities remain high in the North East compared to the rest of the UK and we have an important role in the health prevention agenda – both for our local population and also for our staff.

During 2018/19, we worked closely with our commissioners, local authorities, neighbouring Trusts, Universities, local networks, the Health and Wellbeing Board and the Overview and Scrutiny Committee, as well as other partners, to develop an integrated health service to meet the needs of the patients.

Some of the work the Trust is involved with includes:

- **Newcastle** – focused on the Newcastle £ and three emblematic pieces of work (Healthy Start, Healthy Ageing and Prevention), the Trust is a core member of both the Joint Executive Group (JEG) and Joint Delivery Group (JDG) looking at the aspirations and key deliverables for Newcastle as a City.

Intermediate Care – a collaboration between the Trust, Newcastle City Council, the Clinical Commissioning Group (CCG), primary care and the independent sector that provides bed based and home based intermediate care services.

Community hub – ongoing cross-organisational discussions to develop a community hub to support the delivery of health and care services to the population of Newcastle.

Urgent and Emergency Care – the Trust is part of an Alliance with Newcastle GP Services, North East Ambulance Service (NEAS) and Vocare (GP out of hours service) looking to deliver the urgent care model for Newcastle from April 2019.

- **Gateshead** – around 40% of Gateshead residents access services in the Trust and we have been working closely with partners in Gateshead to look at more co-ordinated ways of delivering better services for the people of Gateshead.

One example in-year was the launch of TIMS – Tyneside Integrated Musculoskeletal Services – a 'single point of access' service for thousands of patients with muscle and joint musculoskeletal (MSK) problems.

The community-based service offers self-care and fast access to information, resources and expert opinion about a variety of back, neck, joint or general muscle conditions. A key aspect of the service is about giving patients greater control of their own care and making it easier for them to self-manage muscular conditions through a dedicated website.

- **Northumberland** - The Northumberland System Transformation Delivery Board are focused on how best to maximise the Northumberland £ with a refreshed Joint Health and Wellbeing Strategy for 2018-2028 that looks to improve the health and wellbeing of Northumberland residents and reduce inequalities.
- **Acute Hospital Collaborations** – working with a range of partners to improve access of services and ensure best possible outcomes for patients, as well as ensuring clinical and workforce sustainability of services.

A vision for ageing

In early 2019, an ambitious vision to re-develop the former General Hospital site was outlined by Newcastle University after an agreement was reached with the Trust to purchase the site for £7.47million.

By 2040, one in seven of us will be over the age of 75 and our ageing society has been identified as one of four Grand Challenges in the UK Government's Industrial Strategy. The vision will address this challenge by developing and expanding the current 29-acre Campus for Ageing and Vitality (CAV) site, incorporating elderly care, research facilities and a residential zone for housing and business development.

Working in collaboration with the Trust and Newcastle City Council, the University's proposal is to develop three zones, which would include:

- an iconic 'Discovery Crucible' housing laboratories alongside cutting-edge clinics, allowing NHS patients to be seen by experts across all disciplines and as part of University research projects, providing teams with the opportunity to learn from expertise outside their field and breed new and innovative solutions.
- an innovative 'spectrum of independence' test-bed development, which would provide a range of care for older people and a centre of excellence in dementia care.
- a residential zone with potential for business development encouraging small and medium sized enterprises and commercial partners as well as opportunities for creative arts.

While plans are still at an early stage and require the relevant planning and building processes, the scheme will ensure that local people are among the first to benefit from world-class health research, developments and innovations within the NHS and on their doorstep. It also further strengthens Newcastle's international status as a leader in healthcare for older people.

Transatlantic exchange to grow ageing market

A transatlantic exchange to build on the North East's expertise in ageing, nutrition, digital science and technology has taken place between a number of partner organisations in Newcastle and Boston.

Professor Joseph F Coughlin - the founder of the Massachusetts Institute of Technology (MIT) AgeLab – visited the region to learn about our knowledge and expertise in ageing, data science and urban partnerships.

The visit was jointly hosted by Newcastle University's National Innovation Centre for Ageing (NICA) and Newcastle City Council, alongside the Innovation SuperNetwork and the Trust.

Professor Coughlin's multidisciplinary research program at MIT was created to understand the behaviour of the 50+ population, the role of technology in their lives, and the opportunity for innovation to improve the quality of life for older adults and their families.

The Trust has been awarded the UK's only National Institute for Health Research Biomedical Research Centre for ageing and long-term conditions, which we deliver in partnership with Newcastle University.

UK's first 18-month nursing degree apprenticeship launched

Northumbria University welcomed its first ever nursing degree apprentices in a new partnership with the Trust, the first in the North East, which will create England's first ever apprenticeship-qualified nurses by March 2020.

Nursing degree apprenticeships were announced by the Government as a way of opening-up nursing careers to more people and bringing more qualified nurses into the NHS. Since then, we have been developing and designing our own degree apprenticeship programme, which received approval from the Nursing and Midwifery Council (NMC).

In total, eight apprentice nurses – all assistant practitioners at the Trust – are currently in the bespoke programme, which will be delivered over 18 months, rather than the standard two to four years. When they graduate in 2020, they will be the first in the country to hold the nursing degree apprenticeship qualification - equivalent to a standard Bachelor's degree. They will also be eligible to apply to become a registered nurse.

Informatics and the Global Digital Exemplar (GDE) Programme

We are a leader in the adoption of digital solutions and will continue to take forward our Global Digital Exemplar (GDE) Programme, which uses digital technologies to support wider transformation.

The Trust's continued investment in its Electronic Patient Record (EPR) further enhances opportunities to improve patient safety. A digital healthcare record will improve the safety of the care we provide by ensuring that all the information to make the best decisions is available to all those responsible with appropriate decision support built in to the way we

work. It will reduce the need for patients to repeat information to different members of the clinical team, increasing their access to appropriate healthcare information and involving them and their carers in healthcare choices through well-informed shared decision-making.

The process of achieving a truly electronic patient record will give the organisation a unique opportunity to review clinical processes and outcomes across all aspects of healthcare. This will allow us to establish systems, which ensure best practice by providing context specific decision support and rigorous audit. In this way, we will reduce unwarranted variation in practice and improve clinical results.

The Trust is leading on the regional implementation of the Great North Care Record (GNCR), Health Information Exchange (HIE) and Patient Exchange Platforms. In March 2019, Cerner was selected to provide the 'Information Exchange' element of the GNCR, which will ultimately securely connect patient information across the North East and North Cumbria. Work began in spring 2019 with the expectation that the first organisations would be fully connected by the autumn.

The GNCR will link the region's hospitals, mental health services, social care, GPs and community services and ambulance services 24 hours a day so that patients can be assured that the staff treating them will have all of the relevant information to hand. Once implemented, appropriate authorised professionals will, for the first time, have sight of a patient's relevant information from the different organisations involved in their care.

In addition, we are in the process of replacing the Business Intelligence platform to support clinical, operational and reporting data as part of the Trust's programme to maintain high quality information as evidenced by the high Data Quality Maturity Index (DQMI) score.

The ongoing programme will add to the core clinical content creating a full EPR. Importantly, this data will be codified and structured to reduce variations in content and to allow further development of decision support and pathway-based care plans with targets and staged interventions.

Progress of some of our other GDE projects includes:

- **Paperlite** - provides the tools and changes needed for our patients to get the full advantages of an integrated health record and to ensure we have the right people with the right information at the right time, wherever they are, to maximise patient safety and give the best quality care.

During the year, we rolled out the eRescue Electronic Patient Observations (EOBS) project to replace paper charts with electronically captured observations, enabling automated risk alerting to improve patient care.

EOBS is now live across 55 RVI and Freeman adult inpatient wards and 347 EOBS stands are in use by 2,000-trained clinical users who have taken 385,000 observations. Data has already shown the system has released 100 nursing hours a day in time to care due to decreased time to take observations.

As part of Paperlite, work also began to implement an electronic drug storage system that is fully integrated with ePrescribing and we also completed a scheme to deliver digitised patient records to our community units.

A digital medical photography system also went live which captures, stores and retrieves medical photographs in a secure method, modernising the way medical images are managed and shared throughout the Trust, making it easier for clinicians to access specialist opinions.

RESEARCH

Our ambition is to continue to grow our reputation as a leading regional and national provider of safe, innovative, high quality care, which is underpinned by a research-led clinical evidence base.

Research plays a huge part in the life of the Trust, with many of our clinicians working in close partnership with local universities to develop new treatments and drugs.

2018/2019 was another ground breaking year for research for us, and in partnership with colleagues in the Faculty of Medical Sciences, Newcastle University and Northumberland Tyne and Wear (NTW) NHS Foundation Trust, a wide variety of high quality research was carried out focusing on improving the health and opportunities for people living in Newcastle and beyond.

During the year, 15,766 patients at the Trust helped to shape the NHS of tomorrow by taking part in clinical research, maintaining a high position on the NIHR league tables for recruitment and reflecting the city's reputation as a global hub for the fast-growing life sciences sector.

A summary of some of the Trust's achievements in research are as follows:

- **Newcastle Phase 3 Unit** - the UK's first clinical trials facility in the NHS to specialise in late phase commercial trials opened in spring 2019. The unit, which focuses on partnerships between patients and industry, is designed to be a stand-alone facility on the Campus for Ageing and Vitality (the former Newcastle General Hospital site) and is run by a dedicated team of commercial research experts to bring the latest innovations into every day practice.

By investing in this facility, the Trust hopes to further increase its research capacity and capability for patients across the North East and the rest of the UK.

- **100,000 Genomes** - The 100,000 Genomes Project reached its goal of sequencing 100,000 whole genomes from NHS patients - with the North East and North Cumbria

- NHS Genomic Medicine Centre successfully enrolling 2,000 rare disease patients and more than 350 cancer patients into this groundbreaking project.

The centre was one of 13 in England set up to deliver the project in 2015 on behalf of Genomics England in partnership with NHS England with Newcastle, which is home to the Northern Genetics Service, the lead organisation for the region.

Harnessing whole genome sequencing technology genomics allows clinicians to uncover new diagnoses and improved treatments for patients with rare inherited diseases. Since its introduction, one in four participants with rare diseases have received a diagnosis for the first time and the project has also provided potential actionable findings in up to half of cancer patients, providing an opportunity to take part in a clinical trial or to receive a targeted therapy.

- **Diagnostics North East** - A platform bringing together world-leading diagnostic resources and expertise to develop new and innovative technologies to improve patient health and wellbeing was launched in-year.

Diagnostics North East aims to support both industry and academia and addresses the need for robust research, development, evaluation and adoption when it comes to the introduction of new patient diagnostic tests and devices.

The partnership – a collaboration between the Trust, Academic Health Science Network for the North East and North Cumbria (AHSN NENC) and Newcastle University – will also result in better diagnostic tests being more rapidly available to patients.

- **First recruiters in global trial to test treatment for rare kidney condition** - Rare kidney disease experts are testing a new treatment for a potentially life-threatening kidney condition known as C3 Glomerulopathy (C3G) which is caused by a fault in the body's immune system resulting in dialysis. The National Renal Complement Therapeutics Centre is the first in the world to recruit into a new early phase clinical trial to test a drug called LNP023.
- **Bone marrow cancer study** - a major breakthrough into new research into the therapeutic drug Lenalidomide was published in The Lancet, offering hope for patients with a serious type of bone marrow cancer.

Professor Graham Jackson, Consultant Haematologist at the Freeman Hospital and the Northern Institute for Cancer Research at Newcastle University, led the UK-wide seven-year study, which showed improved outcomes and survival rates for newly diagnosed myeloma.

The trial was run through the Clinical Trials Research Unit at the University of Leeds and the research involved experts from hospitals around the UK.

- **Respiratory disease and cognitive behavioural therapy research** - A new study found cognitive behavioural therapy sessions delivered by respiratory nurses reduced feelings of anxiety for patients with chronic obstructive pulmonary disease resulting in

- less frequent use of Accident & Emergency (A&E) and hospital services. The research, which is also cost-effective, was led by Nurse Consultant Dr Karen Heslop-Marshall.
- **Gene editing for kidney disease** – Medical researchers identified, for the first time, how to halt kidney disease in the life-limiting genetic condition Joubert syndrome, which may pave the way for personalised treatment in the future.

Not all patients with Joubert syndrome carry the CEP290 gene, but those who do will develop kidney disease during their lifetime and may require a transplant or dialysis.

The research has found it is possible to use a strand of engineered DNA to trick the cells' own editing machinery to bypass the CEP290 mutation that causes kidney damage – a technique known as 'exon-skipping'. Honorary Consultant Nephrologist Professor John Sayer led the research published in the *Proceedings of the National Academy of Sciences* (PNAS).

- **Managing persistent facial pain** – A two-year study by experts at Newcastle University has assessed the hidden costs of people suffering from long-term face and mouth pain that was not caused by toothache.

It is estimated 7% of the population have Persistent Orofacial Pain (POFP), including temporomandibular disorders, phantom tooth pain, burning mouth syndrome, trigeminal neuralgia and atypical facial pain.

Led by Justin Durham, an Honorary Consultant Oral Surgeon at the Trust's Dental Hospital, Professor of Orofacial Pain and Deputy Dean of Clinical Medicine at Newcastle University, the study revealed patients were attending large numbers of appointments with different healthcare professionals but failed to obtain effective diagnosis or a treatment plan quickly.

Findings showed patients' out-of-pocket costs were more than £650 per year, including prescription charges and travel expenses, while costs to employers could be almost £2,500 per annum, due to sickness absence and loss of productivity as a result of dealing with pain.

The team is now re-calling for the introduction of an electronic referral system, which uses a Graded Chronic Pain Scale - a simple seven-item questionnaire to determine who to fast-track to specialists and further research is expected to focus on how care pathways can be designed to better meet the needs of patients.

In partnership with the British Dental Association, the team is helping dentists and GPs manage persistent facial pain by setting up study days for next year.

- **Yorkshire and North East genomic laboratory hub** – A new genomics laboratory hub for the region was announced by NHS England, which will transform genetic testing for people in Yorkshire and the North East.

A major partnership will provide the new laboratory hub, which will be at the centre of a network made up of NHS organisations including the Trust, Leeds Teaching Hospitals NHS Trust, Sheffield Teaching and Children's Hospitals and NewGene - a spin-out

company between the Trust and Newcastle University set up to pioneer new genomic testing.

One of seven newly commissioned hubs across the country, the partnership will be one of the largest providers of genomic testing, focussing on delivering a range of specialised services in Sheffield (neurology, musculoskeletal, gastro-hepatology, respiratory and haematology), inherited cancers, specialist genetic testing and next generation sequencing in Leeds and genome sequencing for mitochondrial conditions in Newcastle.

As well as building a foundation for closer working across the NHS and academia between our three cities, the hub and network model will improve patient access for genetic testing; supporting the development of more personalised healthcare as well as consolidating tests across sites to make more efficient use of resources while not impacting on the diagnostic pathway.

The ultimate ambition is for patients of all ages with rare inherited diseases and cancer to be diagnosed and treated quicker than ever before, wherever they live.

The Trust is also a partner of the Northern Health Science Alliance (NHSA) which links eight universities and eight NHS Teaching Trusts with the Academic Health Science Networks (AHSNs) covering a population of over 15 million people.

The NHSA acts as a single portal bringing together research, health science innovation and commercialisation to provide benefits for researchers, universities, hospitals, and patients as well as commercial partners, and is an excellent platform to promote the value of the North of England to the global Innovation, Health and Wealth agenda.

In the summer, the Trust's Chief Executive Dame Jackie Daniel was elected to represent northern hospitals on the NHSA's Board of Directors and is working with the Alliance to further develop its work to grow the sector for the health and wealth of people in the North of England and the UK as a whole.

This includes taking forward key recommendations from the Alliance's *'Health for Wealth: Building a Healthier Northern Powerhouse for UK Productivity'* report which looked at the relationship between the North's poorer health and its poorer productivity and found that tackling health inequalities between the North and South would put an extra £13.2bn into the economy.

It also underpins the partnership work taking place with the Trust, Newcastle City Council and Newcastle University.

Newcastle Hospitals is also a lead partner in the Academic Health Science Network (AHSN) for the North East and North Cumbria, which focuses on three main aims:

- Supporting economic growth;
- Transforming patient safety and quality improvement; and
- Improving population health.

AWARDS

Newcastle Hospitals, along with its staff and departments, regularly receives local and national recognition through awards, accreditations and other achievements. Here is an overview of some of our accolades over the last year - well done to all our staff, partner organisations and volunteers who helped to achieve them!

A Chance to Live

Experts in Newcastle featured in a groundbreaking documentary, which looked at a year in the lives of seven people in desperate need of a new heart, and the extraordinary medical teams using cutting edge technology to treat them.

It was filmed at the Freeman Hospital's Institute of Transplantation – one of Europe's leading transplant centres – and one of our patients Max Johnson, subsequently won a Pride of Britain Award for being instrumental in changing organ donation rules.

Liver expert recognised in Queen's Birthday Honours

Leading clinician Professor Dave Jones was recognised in the Queen's Birthday Honours for his outstanding contribution to medicine. Professor Jones, an Honorary Consultant who specialises in liver medicine at the Freeman Hospital and an academic at Newcastle University's Institute of Cellular Medicine, received an OBE for his services to liver medicine and clinical academic training.

Perioperative team of the year

The perioperative team was named Perioperative Team of the Year 2018 by the Association for Perioperative Practice (AfPP) which looks at excellence in innovation, best practice and safety. The winning team was awarded a £2,000 bursary to support education, resources or programmes which enable personal development.

Myeloma UK Clinical Service Excellence Programme Accreditation

Newcastle Hospitals received the Myeloma UK Clinical Service Excellence Programme Accreditation (Myeloma UK CSEP Accreditation) from Myeloma UK. The clinical service excellence programme aims to implement best practice standards across the country and looks at core areas such as patient experience, testing and diagnosing and treatment.

The myeloma team, based at the Northern Centre for Cancer Care (NCCC), were recognised for their commitment to providing superior treatment to myeloma patients and helping to make improvements in the wider healthcare community.

Support for our colleagues and patients

Cancer Nurse Specialist Laura Noble – who specialises in bladder cancer – was a finalist in the 'Cancer Nursing' category of the Nursing Times Awards in recognition of her innovative approach towards training colleagues in the delivery of an important form of post-operative chemotherapy.

Staff from ward 8 (FH) were also shortlisted for 'patient safety improvement' for their work to reduce hypoglycaemia (low blood glucose levels) and insulin errors in diabetic vascular patients.

Professor's work in Alzheimers recognised in Europe

Professor Ian McKeith's major contributions in the field of Alzheimer's disease and related disorders have been recognised overseas after he was awarded the European Research Prize by the Foundation for Research on Alzheimer's Disease based at the Hospital Pitié-Salpêtrière, Paris.

Leading the way

The Trust was named winner in the Leadership and Engagement category in the Allocate Awards for implementing the biggest 'roll-out' of Allocate while engaging staff throughout the process and was also shortlisted as finalists in the improving working lives and whole workforce models categories.

The Butterfly Project

Consultant Neonatologist Professor Nick Embleton, who has worked with premature and sick newborn babies on the Neonatal Intensive Care Unit (NICU) at the RVI for more than 25 years, won the Healthcare Professional category at the 2018 Butterfly Awards.

The awards are organised by Finley's Footprints - a national organisation for parents and professionals to find information and support following the death of a baby. Professor Embleton received the accolade for his work to develop the coincidentally named Butterfly Project, which supports bereaved parents of multiple births who still have a baby on the unit.

Veteran Aware

Newcastle Hospitals was accredited as 'Veteran Aware' – a mark of distinction which means that patients who have served in the UK Armed Forces will be cared for by frontline staff who have received training and education on their specific needs, such as around mental health, and who can signpost them to local support services.

We are one of the first NHS organisations to receive accreditation from the Veterans Covenant Hospital Alliance, which is made up of national bodies including NHS Improvement, NHS England, the Department of Health and Social Care, Ministry of Defence and the Confederation of Service Charities.

Dundas Medal for Palliative Care and transplant teams

A team specialising in Palliative Care for heart and lung transplant patients at the Freeman Hospital received the Dundas Medal, which is awarded by the Royal College of Surgeons of Edinburgh and PATCH (Palliation and The Caring Hospital).

The award reflects the innovative work undertaken jointly by the Freeman specialist Palliative Care and Cardiothoracic Transplant Services to improve the quality of Palliative Care for heart and lung transplant patients.

Dream win for sleep team

The Newcastle Regional Sleep Team were named Our Health Heroes winners in the Integrated Team category for commitment to their patients with Obstructive Sleep Apnoea (OSA).

Organised by Skills for Health, the National Skills Academy for Health and Health Education England, the national awards celebrate the unsung healthcare heroes from across the UK.

The team received the award for their work with a high caseload of patients as well as developing an informative video and creating and publishing the findings of a four-week 'Fast Track' Sleep Service for vocational drivers, to ensure prompt investigation and treatment to minimise the impact of OSA on work.

'Pop-Up' Hospital is an innovation champion

A 'pop-up' hospital - developed by patients and staff at the Great North Children's Hospital – won Innovation Champion of the Year at the Bright Ideas in Health Awards. The recreated hospital ward formed part of the Great Exhibition of the North and was designed to give visitors a fun, educational experience, so that if they had to visit hospital in the future, it might be less frightening and more positive. We also had a number of other finalists in four of the categories.

Doing his bit for the environment!

Head of Sustainability and Compliance James Dixon won the national title Sustainable Healthcare Leader of the Year at the Sustainable Health and Care Awards for his longstanding commitment to delivering environmentally sustainable healthcare services at the Trust.

Newcastle Hospitals was also highly commended in two further categories: the 'Our People' category, for employee engagement, diversity and equality and health and wellbeing promotion and the 'Care and Clinical Practice' category for our Breast Cancer care team for improving outcomes following surgery.

First for Sarah

Burns and Plastic Surgeon Dr Sarah Pape OBE, became the first woman to present the McIndoe Lecture at the scientific meeting of the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS), since it began in 1962.

Dr Pape chose as her title for her lecture 'Ten things I have learned about Burns Care in the past 30 years' and spoke of the scientific basis and philosophy of the multi-disciplinary

team she has established at the North East and North Cumbrian Burn Centre, based at the RVI.

Neonatal Nurse of the Year

Matt Cray, who is based in the Special Care Baby Unit (SCBU) at RVI and is a member of the Northern Neonatal Transport Service (NNeTS), was named Neonatal Nurse of the Year by the Neonatal Nurses Association for his work in setting up a team to support fathers of babies born prematurely - the first of its kind in the UK.

Our unsung heroes

The Unsung Hero Awards are the only national awards for non-medical NHS staff and volunteers who go above and beyond the call of duty. In 2019, we had a number of staff shortlisted as finalists:

- Everyday Hero Award (IT) - Sean Dodds – IT Development Manager.
- Team of the Year (IT) - IT Development Team.
- Leader of the Year (Ancillary staff) - Jeff Potts – Mortuary Operations Manager.
- Lifetime Service Award - Derek Airey – Chairman of the Freeman Hospital Lung and Heart Transplant Association.
- Special Mention Award - Donna McKenna – a Biomedical Scientist in Cellular Pathology for around 30 years who continued to work in laboratories despite a diagnosis of long term terminal cancer and died in May last year.

National Award for Newcastle's Project Choice Team

Newcastle Hospitals' Project Choice team received national acclaim when they won the 'Employer of the Year' Award by UK charity Movement to Work which champions and promotes activities to reduce youth unemployment through work experience. The charity commended our employment outcomes achieved through the project to date - 83% over six intakes of students.

Lifetime achievement award

Professor Paul Corris – an internationally renowned lung specialist - was honoured with a prestigious Lifetime Achievement Award by the International Pulmonary Vascular Research Institute (PVRI). The award recognises sustained outstanding clinical developments and translational research in the field of pulmonary hypertension, which has had a major impact on improved patient care on a global scale.

His accolade followed on from the British Thoracic Society's medal, which he was presented with in December 2018.

Nurse consultant scoops national award

Nurse consultant Dr Karen Heslop-Marshall, who specialises in respiratory conditions, won the Respiratory Nursing category of this year's British Journal of Nursing Awards.

Dr Karen Heslop-Marshall, who also carries out research at Newcastle University, was successfully shortlisted after a study she led on has shown how cognitive behavioural therapy (CBT) has reduced anxiety levels, as well as admissions to hospital and visits to A&E, for patients with chronic obstructive pulmonary disease (COPD). The study was published in 'ERJ Open Research' in November 2018, and has since reached a potential 88 million readers worldwide.

A team of nurses led by Nurse Consultant for Continence Jackie Rees, were also finalists in the Continence Nursing category for their 'UTI Collaborative' – a quality improvement programme in partnership with Newcastle/Gateshead Clinical Commissioning Group (CCG) which focused on taking action to reduce urinary tract infections and catheter associated urinary tract infection.

BMJ Awards

The Regional Anaesthesia and Acute Pain service team at the Freeman Hospital were named as finalists in the 'Anaesthesia and Peri-operative Medicine Team' category of the British Medical Journal Awards. The team was shortlisted for their proactive and radical approach to responding to the need for more effective pain management of post amputation surgery.

Also named as finalists in the 'Innovation in Quality Improvement Team' category were respiratory specialists at the Great North Children's Hospital in recognition of their multi-disciplinary approach to ensuring excellent asthma care for all, and preventing avoidable deaths through a unique, region-wide collaboration known as BREATHE.

CAMPAIGNS

Flourish

During the last year we launched Flourish – our cornerstone programme for supporting staff right across the Trust to liberate their full potential.

The concept behind this evolving model of organisational development is simple: to build a framework which creates an environment that enables staff to bring their 'best self' to work, provide the best patient care, and lead innovation and change.

Flourish is also shaping our employee wellbeing agenda by adopting a holistic approach to creating a healthy workplace and, through a series of workshops and focus groups, has explored the key themes of a well workforce, being valued and recognised and behaviour and culture.

We have also visually promoted our ethos of Flourish through a distinct brand and encouraged staff to get involved in new challenges and opportunities such as #LetsMove, #LetsTalk and #LetsWorkBetter.

Other programmes of work are also being explored which are overseen by our Flourish steering group; looking at the additional risk factors when night duty staff are fatigued and examining the flexible options we might create for our workforce aged 60 plus.

Through Flourish, our focus will continue on enhancing the staff experience in 2019/2020.

CHARITABLE SUPPORT

Like many Trusts we have a charity – Newcastle Hospitals NHS Charity – which raises money to support our services, paying for those extras over and above what NHS funding can provide.

It has been another wonderful year of fundraising for our charity and we never fail to be humbled by the people who support us. Behind every one of them are personal stories – some of which make us laugh, cry or are just truly inspirational — and the difference our supporters have made to our patients and staff is, actually, priceless.

That's what the role of the charity is about - to provide those extras that will make a difference - whether that's through research, supporting training and development, state-of-the-art medical equipment or simply improving the patient experience and environment and every penny raised is spent locally to help patients and their families from across the region and beyond.

We would like to say a huge thank you to the generosity of all our supporters who have run, swam, baked, shaved, danced, sang, climbed, cycled and so much more to show their support for the Trust, its services and staff.

In 2018, there were two milestones for the Northern Centre for Cancer Care Fund as it marked 40 years since the Charlie Bear for Cancer Care Charity was launched and a decade since the creation of the Bobby Robson Foundation.

Having previously worked together to bring stereotactic radiotherapy to the region, both funds remain dedicated to supporting cutting-edge treatment, research and facilities at the centre.

To mark the 10th anniversary of the Sir Bobby Robson Clinical Trials Research Centre his family, staff, patients and fundraisers held an open day at the centre, which is now one of the most active cancer clinical trials units in the UK and was recognised as a Cancer Research UK (CRUK) Centre of Excellence in 2016.

The partnership - a collaboration between the Trust, CRUK, the North of England Children's Cancer Research Fund and Newcastle University – aims to speed the delivery of new therapies and improve cancer services.

Newcastle Hospitals NHS Charity would like to thank everyone who has given their time, money and fundraising support over the last year, and everyone who is planning on raising money during 2019/2020.

The charity does not employ professional fundraisers and so relies completely on the enthusiasm and generosity of the public. There are many ways that people can help the charity and here are just some of them. Anyone interested in fundraising for the charity should contact the Charitable Funds Office before they start to receive a letter of authorisation and also information on how the charity can support fundraising efforts.

Donations

Single or periodic donations are the most common form of support to the charity and cheques should be made payable to The Newcastle Upon Tyne Hospitals NHS Charity (no. 1057213) and sent to the Charity Fund Office, which can also provide standing order forms if required.

Payroll giving

Individuals can choose to make donations to a charity of their choice by having an agreed amount deducted from their salary. The chosen charity receives not only the donation but also the tax that would have been deducted on that amount. Employers can provide further information on payroll giving.

Share giving

Gifts of shares and securities can be transferred to the hospital charity and individuals can also receive tax relief on their donation.

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 choose to have their donation Gift Aided and this will allow charities to recover from HM Revenue and Customs the tax paid on the contribution.

Legacies

After providing for their relatives, many people choose to make a gift to their local hospital in their will. This can be in recognition of personal treatment, or care provided to a loved one.

Matched giving

Many local businesses support charities by matching any fundraising efforts by their own staff. This doubles any money raised and is a great way of inspiring and increasing charity contributions.

Help and advice

For further information, help and advice on how you can support our charity contact:

*Charity Fund Office,
Peacock Hall,
Royal Victoria Infirmary,
Queen Victoria Road
Newcastle upon Tyne,
NE1 4LP
Call: 0191 223 1434*

Email: charity.matters@nuth.nhs.uk

1. PERFORMANCE REPORT

A. OVERVIEW OF PERFORMANCE

The purpose of this overview is to provide a summary of:

- The Newcastle upon Tyne Hospitals NHS Foundation Trust,
- its purpose,
- the key risks to the Trust's objectives, and
- how the Trust has performed during the year.

OUR ACTIVITIES

The Newcastle upon Tyne Hospitals NHS Foundation Trust is one of the most successful teaching NHS Trusts in the county. We offer a wider range of specialist services than any other, have more than 2,250 beds, and more than 1.72million patient contacts each year.

We provide innovative high quality services, including community and primary care services, locally, regionally and nationally. We deliver healthcare services from six sites including:

- Freeman Hospital, including the Institute of Transplantation, the Northern Centre for Cancer Care, and Renal Services Centre;
- The 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) which is home to the region's NECTAR service, Westgate Road Walk in Centre, Newcastle Diabetes Service and CRESTA Clinics;
- Newcastle Dental Hospital;
- Newcastle Fertility Centre; and
- Northern Genetics Centre.

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

- The Great North Trauma and Emergency Centre at the RVI – the first hospital in the region and one of only five units in England, who now provide 24/7 resident Emergency Medicine Consultant cover, seeing around 115,000 new patients each year. The Major Trauma Centre at the RVI receives patients from as far afield as Cumbria to the Scottish Borders.
- The Cardiothoracic Centre at the Freeman Hospital – one of the top units in the UK, providing specialist treatment for all types of heart and respiratory related conditions in adults and children.
- The Great North Children's Hospital – one of only 14 major children's medical centres in the UK 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 Newcastle Centre for Cancer Care – the largest centre of its kind in the North of England providing state-of-the-art cancer care for the people of Newcastle and beyond.
- The Institute of Transplantation – where the first successful heart transplant on a child was carried out. It was also the site for the first single and dual lung transplants in Europe, and continues to have exceptional results.
- The Bubble Unit at the RVI – one of just two units in the country where children with severe immune system problems can be treated in an air-tight isolation ward.
- Maternity Unit at the RVI – top-rated Maternity Unit offering a complete range of maternity care for women and their families.

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 we had 26,054 elective inpatient spells, 116,988 day cases, 56,077 emergency inpatient spells, 13,237 non elective inpatient spells, 222,638 attendances at our accident and emergency department and walk-in centres, 295,244 new outpatient appointments, 697,768 review patient appointments and 296,413 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 pioneer 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 area:

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

Work has continued during 2018/19 to refresh the overarching Trust Strategy, including the Trust Vision, Values, Strategic Framework and ambition. The refreshed Strategy will be published during 2019/20.

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 £30.1m Cost Improvement Programme (CIP).
- Affordability by Commissioners of baseline activity and Commissioners’ ability to fund the growing demand for clinical services.
- Significant workforce shortages across key groups of staff such as consultants and junior doctors, radiographers, theatre and ward nurses.
- Achievement of national performance targets, including the four hour A&E waiting time target, cancer waiting times, the six week diagnostic standard and associated financial penalties for breaches, and achievement of the 18 weeks referral to treatment target.
- Increasing emergency activity, including deflections from other Trusts, and intensive care capacity to meet the growing demand for this specialist care.
- Challenges in reducing Healthcare Associated Infections (HCAs).

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 Operational Plan, and achievement of financial targets.

Giving 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 operation 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 2018/19 financial year with a £0.1m surplus (before Provider Sustainability Funding (PSF) and exceptional items). The Trust then received an initial £12.9m PSF, followed by a further £11.3m and this results in a reported surplus to £24.3m (2017/18 surplus of £9.5m).

These results consolidate into an overall Financial Risk Rating of 1. The financial position benefited from £5.7m surplus arising from the sale of surplus land.

The Trust remains well placed to address the funding challenge facing all public services. In particular, the underlying strength in the Balance Sheet provides the opportunity to progress capital schemes in future years.

2. Income

The Trust generated total income of £1,087.0m (2017/18: £1,043.0m) which exceeded the Plan set at the beginning of the year.

In aggregate healthcare contracts agreed with commissioners at the start of the year over-performed by £7.0m, primarily due to additional income from high cost drugs and devices. Areas of under-performance were offset by over-performance in other CCG service lines including out-patients, A&E, radiotherapy and chemotherapy, renal dialysis and a number of specialist services. The specialist contract held by NHS England was close to break-even.

The remaining growth in income arose from gains in income from overseas patients, pay award funding from the Department of Health and Social Care, and non-patient care specifically Research and Development, Training and Education and significantly PSF.

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 £2.7m of over-performance from complex, specialist treatments provided to non-English patients, primarily overseas Severe Combined Immuno Deficiency (SCID) patients. This is great credit to the reputation of our clinical workforce.

What is also notable in this economically constrained environment is that the Trust continues to rely upon non-recurrent income to sustain the 2018/19 financial position and to deliver to the required NHS Improvement Control Total. This will be challenging in the long term.

3. Expenditure

Total expenditure for the year was £1,036.5m (excluding finance costs and impairments), (2017/18: £1,003.7m).

Managing the overall cost base is demanding within the constraints of the Cost Improvement Programme. The consequence of an ageing population with co-morbidities and complex needs are impacting on the need for enhanced patient care and staffing across the organisation. There is continuing pressure to maintain the Trust estate and infrastructure to an acceptable standard and quality.

4. Capital Expenditure Plans

Capital expenditure totalled £34.8m (2017/18: £22.7m).

Expenditure was primarily for the replacement of medical equipment, including a replacement MRI scanner and a further two linear accelerators. In addition investment was provided to reduce backlog maintenance and enhance Information Technology and Estate infrastructure.

5. Delivering Value for Money in the Public Interest

The cost efficiency requirement for 2018/19 was £30.1m and this was fully delivered. However, as in 2017/18, some of this efficiency was delivered on a non-recurrent basis resulting in a shortfall of £5.8m carried forward to 2019/20.

The inability of the Trust to deliver the recurrent saving for a number of years serves to highlight the continuing significant financial challenges faced by the Trust. National efficiencies within tariff, augmented by specific local cost pressures including Clinical Negligence premium increases and a loss of training and education income have resulted in the efficiency requirement remaining at around £30m year-on-year with a reducing opportunity for targeted income growth.

The Trust continues to quality impact assess all efficiency schemes to ensure safety and quality is maintained, if not improved, as a result of proposed initiatives.

The delivery of the efficiency requirement through traditional methods (i.e. a focus on non-pay-related expenditure and driving out value through improved procurement) is becoming increasingly challenging and so the Trust is accelerating the pace of transformation efficiency programmes with the support of McKinsey & Company.

6. The Balance Sheet

The assets of the Trust owned estate were valued at £298.9m on 31st March 2019. In addition, the Trust has a further £181.3m of Private Finance Initiative (PFI) assets.

The Trust has valued its land and buildings on a single, optimal site basis and funded via an alternative to PFI/PF2 arrangements. Such funding is exempt from VAT.

The closing year end cash balance at 31st March 2019 was £94.7m (2017/18: £85.7m). While this balance provides strength as a leading healthcare provider, the Trust continues to operate in an increasingly challenged financial environment and changing business delivery landscape.

7. Future view

As we look to the future, the NHS remains exposed to an uncertain financial environment. If it is to maintain clinical services in the face of inevitable inflationary cost pressures, a significant annual cost improvement requirement prevails. The increased reliance on non-recurrent income to maintain the Trust's position over a number of years is an indication of pressure on the underlying financial position.

Despite financial pressures the Trust remains committed to delivering high quality clinical services to meeting operational and quality targets to respond to demand from the population we serve and sustain financial stability. Nonetheless, financial pressures also present a challenge to all Commissioners and other Trusts operating in the North East of England and Cumbria. The Trust is committed to working with other local NHS bodies and partners such as Local Authorities and Universities. The challenge remains to ensure integration of services to meet the needs of the population.

There are a number of factors that are likely to impact on the Trust's financial position in 2019/20 including:

- The likely development of new contractual arrangements including increased sub-contracting whereby the Trust's financial position will include additional income and expenditure related to services provided in partnership with other Trusts – examples will include genomics and cancer services in Cumbria, and integrated urgent care services within the City of Newcastle.
- Ongoing discussions regarding the development of a "system control total" whereby all local NHS bodies will work together to ensure overall financial stability as opposed to an insular approach.
- Uncertainty over the level of central funding that will be available to meet the cost of increased employer pension contributions.
- Uncertainty over national guidance on asset lives which could lead to a significant cost pressure for all NHS Trusts.
- Potential revisions to the allocation of national funds for Education and Training that may reduce funding to this Trust.

The above issues may impact on the Trust's financial position over the next year and into the future. The Trust does have in place strategies to mitigate the risks identified but the financial environment is likely to remain challenging.

8. Subsidiaries

The Trust is a stakeholder in a number of spin-offs and commercial ventures. During 2018/19, two of those companies were dissolved – Limbs Alive and Freeman Clinics with some of the functions of Freeman Clinics being transferred into the Trust. The Trust also holds shares in and is represented on the Boards of NewGene Limited, which markets novel genetic tests to other NHS bodies; and Pulse Diagnostics Limited, which is seeking to commercialise an invention for the non-invasive detection of Peripheral Vascular Disease.

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

9. In Summary

The Trust has had a successful year in terms of financial performance in the sense that it has met its financial targets without having to compromise clinical quality or comprehensive service portfolio.

Looking to the future, the NHS will continue to face financial challenges, which for this Trust are most visible in the challenging Cost Improvement Programme.

However, we believe we are well placed to face the future with a healthy balance sheet, a financial plan based on realistic activity assumptions and the national tariff system, and measures in place to mitigate the inherent and emerging risks in the financial environment.

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 and that the accounts are prepared on a going concern basis.

B. PERFORMANCE REPORT

ANALYSIS OF PERFORMANCE

We pride ourselves on consistently striving for excellence in healthcare and we closely monitor performance against key targets to ensure high levels are achieved and maintained across the organisation. Monitoring also flags up unplanned changes or under performance, which are reviewed and escalated, as appropriate. This can sometimes require recovery actions by clinical teams.

Our 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 the whole organisation to drive continuous improvement.

While we continually achieve high performance in comparison to local and national peers, there are significant challenges in meeting nationally mandated performance requirements. This is predominately due to high levels of demand, capacity pressures; including national shortages of suitably trained staff, local system pressures and commissioner affordability constraints.

Risks to performance compliance are significant in:

- Underperformance in activity and income;
- A&E four hour standard;
- Ambulance handover delays;
- National cancer standards; and
- 6 week diagnostic standard.

As well as the Performance Management Framework, all clinical directorates and nominated supporting directorates are subject to regular risk-based assessments 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.

The reviews ensure that all directorates are progressing in line with their strategic aims and objectives, including their contribution to the delivery of the Trust's strategy. They also provide an opportunity to address areas of under-performance as well as acknowledge areas of strong performance. They are further complemented by annual directorate quality and patient safety reviews chaired by the Medical Director (as outlined in the Quality Assurance Strategic Plan).

2018/19 activity by point of delivery against 2017/18 out turn

Over the last 12 months, we saw the number of patients admitted for hospital care fall 0.3% below the 2018/19 Plan. This was however still an increase of 10 inpatient spells per working day compared to 2017/18 activity levels. In 2018/19, non admitted activity also increased by 14 spells per working day compared to 2017/18. The level of outpatient

activity was however 2.6% below the 2018/19 Plan. The under delivery of activity against plan was driven by growth in emergency activity displacing planned elective activity, and capacity constraints particularly linked to workforce supply pressures. This has an impact on the financial position of the Trust as it is paid as a tariff for each inpatient and outpatient spell of care.

Activity & Income by point of delivery – March 2019 (Tariff based Outpatients & Inpatients)

Point of Delivery	Activity				Variance by working day (vs 17/18)	Income			
	Plan	Actual	Variance			Plan	Actual YTD	Variance	
			Vol	%				Vol	%
Day Case	116,092	116,400	308	0.3%	6	£70,045,939	£70,374,883	£328,944	0.5%
Elective	27,943	25,890	-2,053	-7.3%	-2	£100,540,664	£95,305,532	-£5,235,132	-5.2%
Emergency	54,578	55,984	1,406	2.6%	5	£129,471,993	£133,895,601	£4,423,608	3.4%
Non Elective	5,055	4,856	-199	-3.9%	0	£23,167,751	£23,564,497	£396,746	1.7%
New Outpatient	260,049	258,233	-1,816	-0.7%	24	£46,951,843	£46,454,925	-£496,918	-1.1%
Review Outpatient	628,504	605,670	-22,834	-3.6%	-1	£52,014,324	£50,199,861	-£1,814,463	-3.5%
Outpatient Procedures	229,304	224,734	-4,570	-2.0%	-9	£30,240,625	£30,885,703	£645,078	2.1%
Admitted Total	203,668	203,130	-538	-0.3%	10	£323,226,347	£323,140,513	-£85,834	0.0%
Outpatient Total	1,117,857	1,088,637	-29,220	-2.6%	14	£129,206,792	£127,540,489	-£1,666,303	-1.3%
Total	1,321,525	1,291,767	-29,758	-2.3%	24	£452,433,139	£450,681,002	-£1,752,137	-0.4%

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

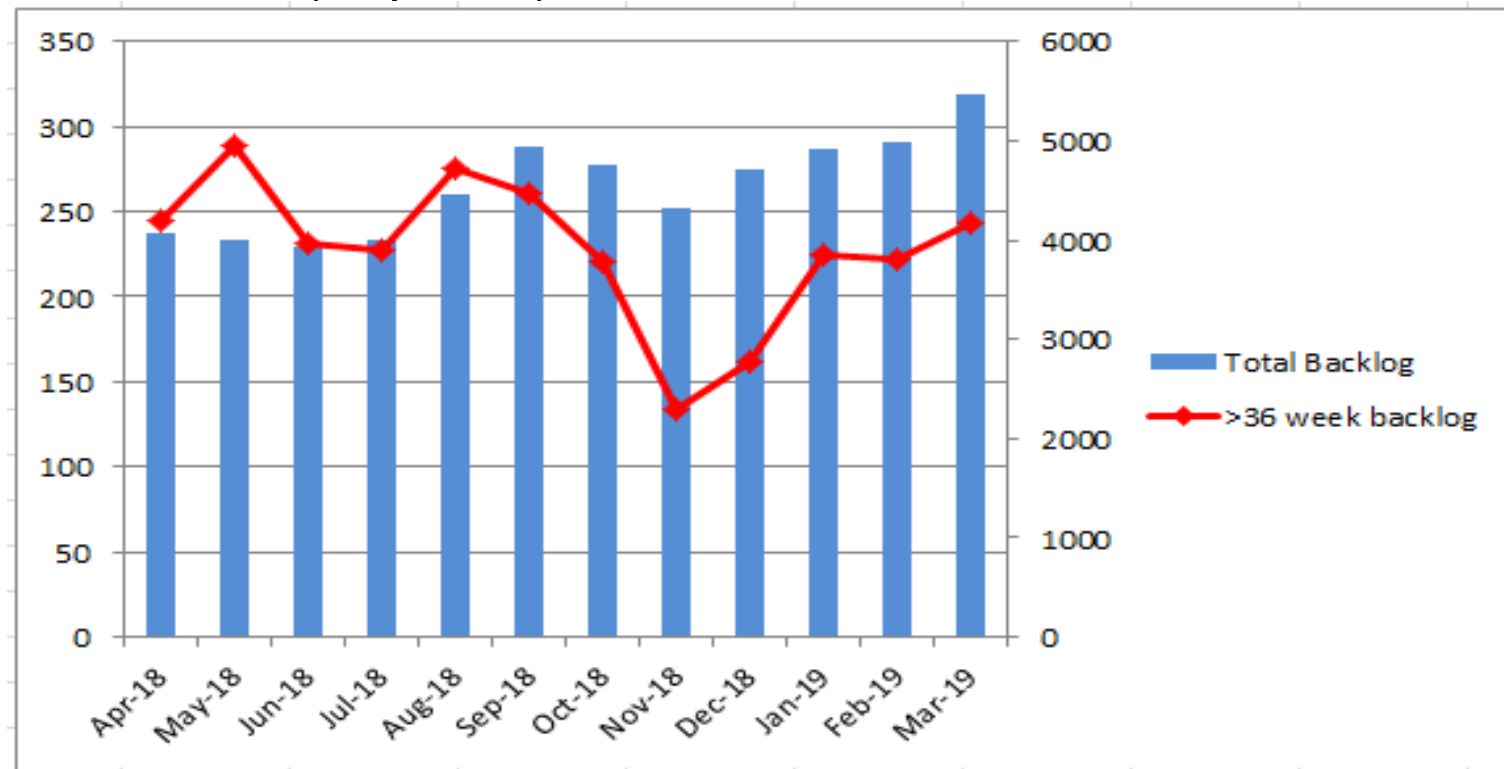
Red <-2.5%, Amber <-2.5% to +2.5%, Green >2.5%

Waiting Times

During 2018/19, and despite significant capacity challenges, the Trust achieved the referral to treatment (RTT) 92% incomplete standard every month. This was contrary to the national picture as the target has not been achieved on a national basis since February 2016, yet the Trust has maintained compliance every month throughout this period.

The Trust ranks highly among comparable Trusts, and for example in February 2019 was the only Trust with a Patient Tracking List (PTL) over 45,000 that met the 92% standard.

Over 36 week waits (All Specialties) Trend



During the year, there was a national drive to reduce provider waiting lists by the end of 2018/19. The Trust was clear that this would always be a challenge due to a number of factors, including services and activity transferring from other providers. The Trust ensured that the March 2019 PTL position was compliant with the trajectory submitted to NHSE. The Trust also closely monitors the number of >36 week waits as shown in the chart above, and as of March 2019 approximately 95.5% of all patients waiting over 18 weeks (the 'Backlog') are waiting between 18 and 36 weeks with around 4.5% of patients waiting over 36 weeks.

Diagnostic Target

Despite being compliant with the target for three successive months between September and November 2018, the Trust failed to meet the 2018/19 target of no more than 1% of patients waiting more than 6 weeks. Radiology continues to have long-standing workforce shortages, whilst there have also been capacity issues within sleep studies. The Trust had predicted that achievement of this standard would be a challenge for the organisation, and this will continue to be the case during 2019/20.

Cancer Waits

The Trust struggled to meet the numerous cancer targets during 2018/19 with the 31 Day Subsequent Treatment Radiotherapy target the only one which was met in all 12 months. In particular, the Suspected Cancer Two Week Wait (2WW) Standard has seen performance worsen in recent months. Performance against the Breast symptomatic standard has not been helped by the fragile nature of the Breast service across the region, with this regional fragility currently being reviewed by the Northern Cancer Alliance. Cancer Services are currently working with NHS Improvement to implement a number of recommendations which are hoped will enable performance levels to improve.

Cancer Targets as at February 2019

Cancer Waiting Times	Target	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19
All cancers: 2 week wait	93%	93.7%	95.0%	94.5%	95.2%	95.1%	93.2%	94.9%	92.4%	91.8%	88.2%	85.3%
2 Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	93%	93.1%	91.7%	94.5%	91.1%	95.0%	93.0%	95.1%	92.3%	91.7%	76.5%	70.6%
All cancers: 1 month diagnosis to first treatment	96%	96.7%	97.1%	97.0%	97.0%	95.3%	95.4%	94.6%	95.5%	94.7%	93.4%	96.0%
All cancers: 1 month diagnosis to subsequent treatment - surgery	94%	94.6%	87.7%	92.3%	93.7%	91.3%	96.0%	87.8%	93.8%	96.2%	92.4%	90.4%
All cancers: 1 month diagnosis to subsequent treatment - drug	98%	98.6%	98.8%	99.4%	98.5%	99.5%	98.3%	98.8%	98.3%	98.6%	97.2%	98.7%
All cancers: 1 month diagnosis to subsequent treatment - radiotherapy	94%	100.0%	99.4%	99.4%	100.0%	99.1%	99.0%	99.3%	100.0%	100.0%	98.6%	99.7%
All cancers: 2 month urgent referral to treatment	85%	79.2%	86.4%	78.6%	81.8%	80.2%	72.7%	76.3%	81.2%	78.0%	75.2%	67.8%
Percentage patients referred from cancer screening service treated within 62 days	90%	92.2%	95.6%	88.9%	85.7%	93.3%	97.0%	86.5%	94.7%	93.3%	87.2%	83.1%

Accident and Emergency (A&E) Activity

During 2018/19 as a whole, the Trust met the considerable achievement of complying with the 95% four hour target, with a performance of 95.48%. This was the first time in four years that the Trust achieved this on an annual basis. This followed the Trust achieving the standard in 10 of the 12 months. The Trust's performance during March 2019 put it within the top 10 Trusts in the whole of England. Any penalties received for A&E were not applicable during 2018/19 due to the agreement of a Control Total and the rules around this and 'double jeopardy'.

Emergency (A&E) Indicators

	Control Total - Suspension of Penalties				
Emergency Indicators	Qtr 1	Qtr 2	Qtr 3	Qtr 4	2018/19
A&E 4hr Standard	95.52%	96.06%	95.92%	93.87%	95.48%
Penalties (Target: 95.0%)	£0k	£0k	£0k	£74.16k	£74.16k
Trolley waits in A&E >12 hours (Target: Nil)	0	0	0	0	0
A&E handovers delays 30-60 minutes	221	251	282	254	1008
Penalties (Target: Nil)	£44.2k	£50.2k	£56.4k	£50.8k	£201.6k
Handover breaches >60 minutes	0	1	6	11	18
Penalties (Target: Nil)	£0k	£1.0k	£6.0k	£11.0k	£18.0k

During the past year, Ambulance Handovers of more than 30 minutes have increased in prominence for the Trust, with the 2018/19 total of 1,008, more than double the 2017/18 figure. Additionally, there were 18 Handover breaches >60 minutes last year, having had none in 2017/18. High levels of ambulance handover delays have been a particular problem since the introduction of a new regional handover process in November 2017, as there have been issues with obtaining the necessary 4-digit PIN from paramedics. Whilst this particular PIN issue is purely an administrative delay and does not detrimentally impact patients, the Trust and the North East Ambulance Service NHS Foundation Trust (NEAS) continue to work together to try and rectify the situation. Any penalties received for Ambulance Handover Delays were not applicable during 2018/19 due to the agreement of a Control Total, and the rules around this and 'double jeopardy'.

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. Throughout 2018/19 we achieved both these targets, despite taking a number of divers from other provider organisations.

Local A&E Indicators

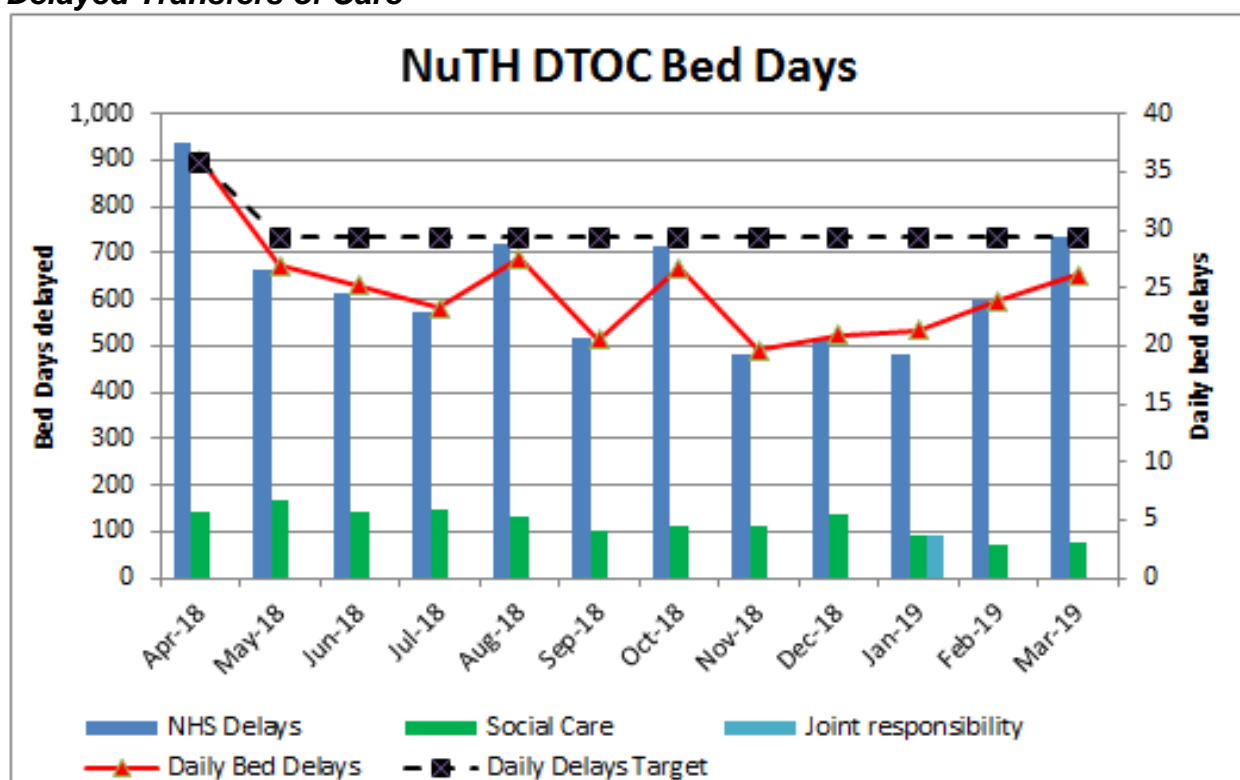
			2018/19										
A&E Key Performance Indicators		Threshold	Apr-18	May-18	Jun-18	Jul-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Unplanned re-attendance rate - 7 days	RVI - Main Emergency Department	5%	3.6%	3.2%	2.8%	3.1%	2.7%	2.3%	2.8%	2.6%	2.4%	2.4%	2.2%
	Eye Casualty	5%	0.0%	0.0%	0.5%	0.2%	0.8%	0.4%	0.3%	0.7%	0.4%	0.3%	0.3%
Left department without being seen rate	RVI - Main Emergency Department	5%	4.2%	2.5%	2.5%	2.2%	3.8%	4.1%	4.0%	2.7%	1.7%	2.7%	2.1%
	Eye Casualty	5%	1.6%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%

Delayed Transfers of Care

The chart below shows the daily bed delays from Delayed Transfers of Care (DTOC). The DTOC guidance was recently updated which should fundamentally support the Trust and Social Care to work towards more collaborative solutions. The new guidance also means it is now possible to attribute joint responsibility for delays between the NHS and Social Care.

During the whole of 2018/19, the Trust reported 9,065 delayed bed days from DTOCs, which was a 36% reduction on the 2017/18 level. 83% of the delays were attributable to the NHS, with patients awaiting non-acute NHS care being the largest contributors to this.

Delayed Transfers of Care



Healthcare Related Infections

In 2018/19, there were two cases of MRSA. This was an improvement on the four cases in 2017/18 and nine cases reported in 2016/17.

As of 11 April 2019, the Trust reported a total of 51 cases of clostridium difficile (C.difficile) in 2018/19 against a target of 76. This takes into account 26 successful appeals. This performance is a huge improvement on 2017/18 when there were 77 cases, and 2016/17 which saw 73 cases.

The trajectory for clostridium difficile cases in 2019/20 is 113 cases. The target has increased due to changes, published by NHSI, to the algorithm for reporting C.difficile infections, although this is not anticipated to increase the total number of C.difficile cases the Trust reports

SUSTAINABILITY

Annual Sustainability Report 2018/19

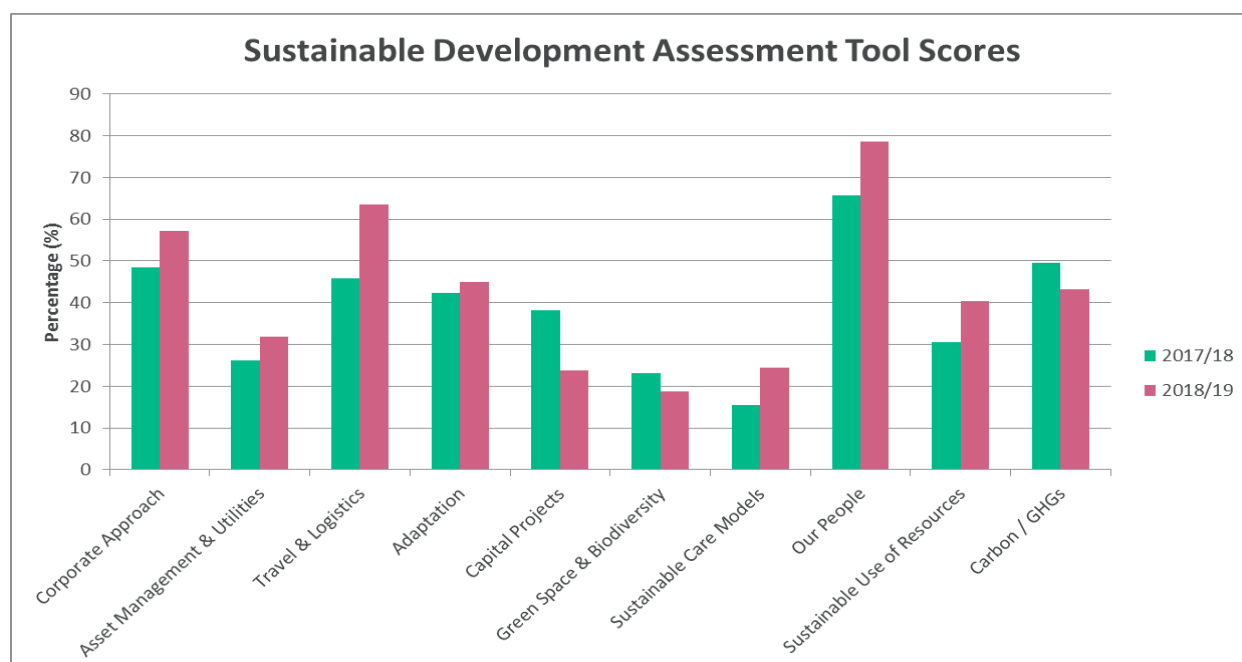


The Trust is committed to delivering outstanding healthcare services, improving health now and for future generations. In order to achieve this commitment to sustainability the Trust recognises that we need to work to reduce carbon emissions, make the best use of scarce resources, build resilience to a changing climate and nurture community strengths and assets. Our Board approved Sustainable Healthcare Strategy (2016-2020) outlines how we hope to achieve this.

Annual Sustainability Reporting is required by the Department of Health Group Accounting Manual and the Foundation Trust Annual Reporting Manual. Along with a regularly updated Sustainable Development Management Plan (SDMP), annual reporting on sustainability is required by the NHS Standard Contract (Service Condition 18). The Trust was awarded a certificate of 'Excellence in Sustainability Reporting' for our Annual Sustainability Reports for 2016/17 and 2017/18. To continue this success, we have again produced a stand-alone, more detailed Sustainability Report for 2018/19. This is available on the [Trust website](#).

Summary of our Sustainability Performance in 2018/19

The Sustainable Development Assessment Tool (SDAT) is a self-assessment tool developed by the Sustainable Development Unit to help healthcare organisations understand their sustainable development work, measure progress and help to plan for the future. Having completed the new SDAT tool for the first time in 2017/18, we can now start to see where we are making progress, and where more effort needs to be concentrated. Our progress is summarised in the graph below and this is explained in more detail in our full report (link above)



The SDAT tool also shows how the Trust is supporting progress against the United Nations Sustainable Development Goals (SDGs), 17 sustainable development goals which aim to end poverty, protect the planet, and bring prosperity to all by 2030.



Based on this year's SDAT submission, the Trust is contributing to these SDGs at a local level:







And the Trust is starting to contribute to these SDGs at a local level:





Key Successes in 2018/19

Shine Theme	What we've achieved...
 Energy	<p>This year has seen the welcome addition of two new Energy Support Officers to the Sustainability Team. They support the Energy Manager in carrying out audits and monitoring trends in energy consumption, enabling more effective targeting of demand reduction initiatives.</p> <p>We also upgraded the Combined Heat and Power (CHP) engines at the RVI to newer, more efficient models helping to reduce RVI carbon emissions by using less natural gas to generate each kWh of electricity. The CHP generates around 90% of the electricity used on site and recovers and utilises the waste heat generated as a by-product of the process.</p>
 Water	<p>There has been an increased focus on water efficiency this year with water management being incorporated in to the Energy Strategy and Policy, enabling progress to be monitored towards the commitment set out in the SDMP.</p> <p>Opportunities to reduce water use have been identified including trailing water efficient products during refurbishments and adjusting water flushing regimes.</p>

Shine Theme	What we've achieved...
 Waste	<p>The majority of our clinical waste is now disposed of as non-infectious waste, avoiding unnecessary heat treatment, as the implementation of this waste stream has been completed. This is an improvement in the outcome for clinical waste by moving more of our waste up the Waste Hierarchy.</p> <p>We've also made great strides in our recycling efforts this year, which resulted in us recycling approximately 40% of our non-clinical waste.</p>
 Buildings & Land	<p>This year we agreed the sale of our Campus for Aging and Vitality (former Newcastle General Hospital site) to Newcastle University. This site rationalisation allows us to reduce the footprint of the Trust, whilst continuing to provide the number of services and level of care, in a more efficient way.</p> <p>In addition to this, we have planted an additional 100 trees at our Freeman Hospital this year in partnership with NHS Forest.</p>

Shine Theme	What we've achieved...
 Purchasing	<p>As a result of the increased media coverage, staff and visitors have become more aware of the impact of plastics in the environment. The Trust has removed disposable plastics from the catering department, and limited the purchase of other single use plastics (such as straws) to areas where there is an identified clinical need.</p> <p>There was also an NHS wide move to 100% recycled paper in 2018, which saves 5,222 tonnes of carbon dioxide a year, whilst reducing costs nationally.</p>
 Journeys	<p>The staff 'hopper' service transports staff between the main sites of the Trust and has been awarded to a new provider this year. The new service will comprise of cleaner, larger vehicles – reducing emissions and reducing the number of journeys required.</p> <p>Improvements made to our courier service this year have also enabled us to consolidate courier mileage with a more efficient fleet, and reduce the number of taxi journeys made for the transportation of goods.</p>

Shine Theme	What we've achieved...
 <p>Care</p>	<p>Following the principle of Making Every Contact Count, training and information was provided to help Community Nursing Staff both to identify when poor quality housing may be affecting a patient's health, and to know how to make a referral to an appropriate housing professional for advice and assistance. This has multiple benefits by reducing the impact poor housing has on health, and improving the energy efficiency of those homes.</p>
 <p>People</p>	<p>Engaging staff in sustainability initiatives is an integral part of embedding a culture of sustainability in the Trust. Over the last year, we ran a number of awareness events including hosting the Northern Sustainability Innovations Conference as part of the Great Exhibition of the North.</p> <p>We launched the NuTH Green Gym in collaboration with local conservation groups, which gives staff and their families an opportunity to part in a wide-range of activities around the region including beach cleans, tree planting and wildlife surveys.</p> <p>Our annual staff sustainability survey showed a significant increase in staff awareness of sustainability work in the Trust, and over 87% said that it was "very important" that the Trust act sustainably.</p>

HEALTH AND SAFETY

We take the health and safety of our staff, patients and visitors very seriously. We have a dedicated Health and Safety Committee that monitors performance 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 reduction action plan;
- needlestick/sharps incidents and training;
- work to reduce violence and aggression by patients towards staff;
- arrangements to manage and reduce staff stress; and
- health and safety training.

During 2018/19, there were 28 incidents that required reporting nationally compared to 29 in 2017/18.

2. ACCOUNTABILITY REPORT

BOARD OF DIRECTORS

Between 1 April 2018 and 31 March 2019, there were ten ordinary meetings of the Board of Directors and no extra-ordinary meetings. In compliance with the requirements of the Health and Social Care Act 2012, the Board holds part of its meeting in public, followed by a private business section. From February 2019, the Trust Board transitioned from meeting monthly (excluding August whereby no meeting is held) to meeting every two months, with a private Board development session being held on the months in between the formal meetings.


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 Operational Plan. Executive and Non-Executive Directors have an open invitation to attend all meetings of the Council of Governors.

The Board is 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 Schedule of Reservation and Delegation of Powers is in place and it 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 are shown on the pages overleaf.


Board member		Attendance at ordinary meetings
 <p>Prof. Sir J Burn, Chairman</p> <p>Appointed 1 December 2017 for three years</p>	<p>Sir John became Chairman of the Trust on 1 December 2017. He obtained a first class honours degree in human genetics and an MD with distinction from Newcastle University, where he has been Professor of Clinical Genetics since 1991. He was appointed as a consultant specialist in Newcastle in 1984 and led the regional NHS Genetics Service for 20 years.</p> <p>As well as helping to create the Centre for Life - which houses an education and science centre alongside the Institute of Genetic Medicine – Sir John chairs Newcastle based DNA device company QuantuMDx Ltd.</p> <p>He was knighted in 2010 and chosen as one of the first 20 ‘local heroes’ to have a brass plaque on Newcastle Quayside in 2014. He also received the Living North award in 2015 for services to the North East 2000 – 2015 and is also Treasurer and Co-Director of the international organisation, Global Variome, which seeks to share knowledge of genetic variation for clinical benefit.</p> <p>Previous roles include President of the European Society of Human Genetics, Lead Clinician of the Northern Strategic Authority and Non-Executive Director at NHS England.</p> <p>As Trust Chairman, Sir John:</p> <ul style="list-style-type: none"> • chairs the Board of Directors and ensures that a corporate vision and strategy is developed and maintained. • chairs the Council of Governors (CoG) and acts as a bridge between the CoGs and the Board of Directors. • ensures the CoG has appropriate arrangements in place to hold the Board of Directors to account through the Non-Executive Directors. • has a close working relationship with 	<p>9 of 10</p>


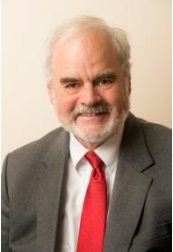
Board member		Attendance at ordinary meetings
	<p>the Trust's Chief Executive.</p> <ul style="list-style-type: none"> • is an Ambassador for Newcastle Hospitals and the wider healthcare system. • Represents the Trust at local, national and international level. 	
 <p>Prof. D Burn, Non-Executive Director</p> <p>Appointed 3 July 2017 for three years</p>	<p>Professor Burn was appointed as a Trust Non-Executive Director in July 2017 and is Pro-Vice-Chancellor of the Faculty of Medical Sciences at Newcastle University. He is also a Professor of Movement Disorders Neurology and Honorary Consultant Neurologist for Newcastle Hospitals.</p> <p>His first degree was at Oxford (Physiological Sciences), returning to his native North East for clinical training and early medical jobs, including neurology. After further neurology training and undertaking research in London (National Hospital for Neurology and Neurosurgery, Queen Square and Hammersmith Hospital) he was appointed as a Consultant Neurologist and Senior Lecturer in Newcastle in 1994.</p> <p>Professor Burn has an international reputation for research in dementia associated with Parkinson's. He is an National Institute for Health Research (NIHR) Senior Investigator, chairs the NIHR Translational Research Collaboration for Dementia and from July 2018, has been Chair of the Northern Health Science Alliance.</p>	7 of 10*
 <p>Ms Maurya Cushlow, Executive Chief Nurse</p> <p>Appointed 1 April 2018 on secondment as Interim</p>	<p>Maurya was appointed as Executive Chief Nurse in January 2019, having held the post of Interim Chief Nurse at Newcastle Hospitals since April 2018.</p> <p>With over 30 years' experience in the NHS, Maurya started off her healthcare career as a registered general nurse in Sunderland and has subsequently enjoyed a varied and successful nursing and management</p>	9 of 10


Board member		Attendance at ordinary meetings
<p>Nursing and Patient Services Director and then appointed to the substantive post of Executive Chief Nurse on 1 January 2019.</p>	<p>career at executive director level, most recently as Executive Director of Nursing and Governance at North Cumbria University Hospitals Trust.</p> <p>Responsible for the overall leadership and development of all nursing, midwifery and therapy services, Maurya's role encompasses the broad remit of Patient Services, which includes approximately 7,500 nurses, midwives, allied healthcare professionals and healthcare assistants including portering, domestics and catering services. This provides strong and professional leadership for our dedicated nurses, midwives and allied healthcare professionals and ensures that both the workforce and patient experience overall is well represented at Board level.</p> <p>Experienced in partnership working across the boundaries of health and social care, Maurya is committed to improving health and care for the local population. As a key Board member, she plays a pivotal role in creating the right conditions for staff to flourish and provide the best possible care for the people we serve. Prior to this, her roles included Accountable Chief Officer for North Tyneside Clinical Commissioning Group, Director of Operations at the NHS North of Tyne and Managing Director of Newcastle and North Tyneside Community Health Services. In parallel, Maurya has also pursued her academic qualifications, achieving an MBA from Durham University in 2000.</p>	
<div data-bbox="193 1704 359 1951" data-label="Image"> </div> <p>Dame J Daniel, Chief Executive</p> <p>Appointed 1 May 2018</p>	<p>Dame Jackie Daniel has been Chief Executive at Newcastle Hospitals since 1 May 2018 and began her NHS professional career as a nurse before moving into NHS management.</p> <p>She has been a Chief Executive Officer for almost 20 years, leading Acute, Mental Health and Specialist Trusts and before</p>	<p>9 of 9</p>



Board member		Attendance at ordinary meetings
	<p>joining Newcastle, was Chief Executive of the University Hospitals of Morecambe Bay NHS Foundation Trust which she led out of special measures.</p> <p>In 2017, Dame Jackie was recognised in the Queen's New Year's Honours for her services to health care. She has a degree in Nursing Studies, a Masters' degree in Quality Assurance in Health and Social Care and is a qualified business and personal coach. She is also an Executive in Residence at Lancaster University Management School.</p> <p>In 2019, Dame Jackie was appointed to the NHS Assembly. She has been influential in developing the NHS Long Term plan and has been appointed as vice Chair of the Shelford Group (representing the ten largest teaching and research hospitals in the NHS).</p> <p>As Chief Executive Officer, Dame Jackie is responsible for:</p> <ul style="list-style-type: none"> • ensuring good governance – Corporate, Clinical, Research, Employment, Statutory and Regulatory. • sustaining a “going concern”. • ensuring service provision and delivery to optimal standards in the public interest. • ensuring good internal and external relations. • providing organisational leadership. 	
 <p>Mrs A Dragone, Finance Director</p> <p>Appointed 9 March 2009</p>	<p>An NHS Career Accountant, Angela has more than 20 years senior leadership experience and is also Director of the Trust's subsidiary company, Newgene.</p> <p>On a national level, she has influenced the development of funding and contracting mechanisms and the training and</p>	10 of 10

Board member		Attendance at ordinary meetings
	<p>education of finance staff.</p> <p>Angela's responsibilities as Finance Director include strategic financial planning (capital and revenue), leading the finance function (financial services, income, financial management), ensuring financial governance and effective financial reporting, financial transformation, supplies and procurement and the Trust's charitable funds.</p>	
 <p>Mr K Godfrey, Non-Executive Director</p> <p>Appointed 27 July 2017 for three years</p>	<p>Keith joined the Board as Clinical Non-Executive Director in July 2017 and since December 2018 has been the Senior Independent Director.</p> <p>After graduating from Manchester Victoria University Medical School in 1973, he initially trained in general surgery, obstetrics & gynaecology and came to Newcastle in 1979 to join the Medical Research Council based in the Princess Mary Hospital, Jesmond.</p> <p>He subsequently worked for Newcastle University before becoming a consultant in obstetrics and gynaecology in Sunderland in 1985, where he was elected chairman of the Medical Staff Committee and BMA Place of Work Accredited Representative.</p> <p>Keith returned to Gateshead Queen Elizabeth Hospital in 2001 to head up the Northern Gynaecological Oncology Centre (NGOC) and as Regional Chairman of the Gynaecological Oncology Site Specific Group, implemented the national guidance on centralisation of gynaecological oncology surgery. He became Deputy Medical Director at Gateshead in 2009 and subsequently Medical Director in 2012 until his retirement in December 2016. Keith is the Trustee and Chair of the Northern Cancer Care & Research Society.</p>	9 of 10

Board member		Attendance at ordinary meetings
 <p>Mr J Jowett, Non-Executive Director</p> <p>Appointed 1 November 2016 for three years</p>	<p>Jonathan joined the Board in November 2016. His executive role is Company Secretary & General Counsel at Greggs plc, where he is a member of the Operating Board, reporting to the Chief Executive. He is a lawyer by profession and has spent most of his career working in-house in international manufacturing companies across a variety of sectors including medical product and consumer healthcare. Jonathan's responsibilities in Greggs include legal and government affairs, risk management & insurances, internal audit, food safety, health and safety, corporate communications, social responsibility, and pensions' administration. He is Secretary to the PLC board and its committees, and so is responsible for governance and corporate policies, and the efficient and effective administration of the Board.</p> <p>He is also Chair of the Percy Hedley Foundation, which provides educational and care services to children, young people and adults with cerebral palsy, communication and sensory impairments and complex learning, social care and therapeutic needs.</p> <p>Jonathan read Business Law at Huddersfield Polytechnic, qualified as a Solicitor in 1989, and attained a Masters Degree in European Union law from the University of Leicester. He gained national recognition from his peers in the 2012 Financial Times Innovative Lawyers awards for his contribution to developing the law on VAT on hot food. In his spare time, he is an advisor to the Board of Darlington Football Club.</p>	<p>8 of 10*</p>

Board member		Attendance at ordinary meetings
 <p>Prof. K McCourt, Non-Executive Director</p> <p>Appointed 1 December 2015 for three years Appointed 1 December 2018 for three years</p>	<p>Professor McCourt joined the Board as a Non-Executive Director in December 2015 and has had an extensive career as a nurse, midwife and educationalist in the UK and overseas. On retirement as Executive Dean of the Faculty of Health and Life Sciences, she became a Pro Chancellor at Northumbria University.</p> <p>During her career Kath has been nominated, elected and represented her employer and the nursing profession in a variety of regional, national and international settings. She has significant Board level experience through chairing committees and groups and has been an advisory consultant to a number of overseas governments and organisations including the World Health Organisation and is presently the President of the Commonwealth Nurses and Midwives Federation.</p> <p>Kath is an Honorary Colonel, 201 Field Hospital - Newcastle upon Tyne, Fellow of the Royal College of Nursing and received the CBE in the Queen's Birthday Honours 2012 for services to nursing.</p>	<p>9 of 10*</p>
 <p>Mr S Morgan, Non-Executive Director</p> <p>Appointed 1 October 2018 for three years</p>	<p>A dual American and UK citizen, Steven is a former director at Sellafield and was the executive director for capital programmes and projects at Heathrow where he was responsible for the design and construction of Terminal 2 and finishing the Terminal 5 complex.</p> <p>Steven retired from the Ministry of Defence as Commercial Director in 2017 where he led the largest procurement function in Europe and is a retired US Navy rear admiral and expert in nuclear projects and major systems acquisition. In America he was Logistics Director of the Defense Logistics Agency.</p> <p>He was also chairman of the Board of</p>	

Board member		Attendance at ordinary meetings
	<p>Directors for a mental health hospital and president of a city economic development commission in Washington State as well as president of an environmental remediation company and chief financial officer of several companies including a shipbuilding company and a nuclear reactor fabrication business. In addition to his role as a Non-Executive Director, Steven is currently involved on the Hinkley Point Nuclear construction board and is chairman of the Calderwood House, a hostel for homeless military veterans and victims of domestic violence in West Cumbria. In May 2019, he was also elected as independent Councillor of Copeland Council.</p> <p>Steven holds an MBA from George Washington University and is a fellow of the Chartered Institute of Procurement and Supply and the Institute of Civil Engineers.</p>	
 <p>Mr D G Stout, Non-Executive Director and Vice Chairman</p> <p>Appointed 1 August 2012 for three years Appointed 1 August 2015 for three years Appointed 1 August 2018 for three years</p>	<p>David, a CIPFA chartered accountant, joined the Trust Board in August 2012 and was formerly the Director of Finance and Communications at the North East Strategic Health Authority (NESHA).</p> <p>David has significant health expertise having worked in Director of Finance roles across a number of NHS organisations and also undertook the role of Acting Chief Executive at the NESHA for a 26 month period.</p> <p>He is also an experienced Local Government finance professional who has held finance roles at three North East local authorities over a 13 year period. David has also undertaken a number of advisory roles including being part of the Arbitration Panel for NHS contracting disputes.</p>	8 of 10*

Board member		Attendance at ordinary meetings
 <p>Mr E Weir, Non-Executive Director</p> <p>Appointed 1 October 2010 and reappointed annually thereafter at the discretion of Newcastle City Council</p>	<p>Ewen Weir is Director for People at Newcastle City Council and has been part of the Board since October 2010.</p> <p>A social worker by professional background, he has worked in the public/voluntary sector throughout his career and previous roles have included Policy and Performance lead at the North East Strategic Health Authority and Assistant Director of Social Services at Darlington Borough Council. Ewen has also worked with voluntary sector in Edinburgh, working with homeless people.</p> <p>Educated at Edinburgh and Newcastle Universities, Ewen has a Masters degree in History, Postgraduate Masters in Philosophy and Social Work and a Diploma in Education.</p>	8 of 10
 <p>Mr A R Welch, Medical Director</p> <p>Appointed to Director role 1 April 2013, appointed to Acting Chief Executive role from 8 June 2017 until 30 April 2018.</p>	<p>Andy has been Medical Director for six years having previously been Associate Medical Director and Cancer Lead. He currently chairs the Northern Cancer Alliance and continues to be actively involved clinically as a Consultant Head and Neck Surgeon.</p> <p>Andy advises on clinical / strategic issues and is the Trust's Responsible Officer and Caldicott Guardian. His team includes eight Associate Medical Directors and six Corporate Clinical Directors, whose extensive portfolios include:</p> <ul style="list-style-type: none"> • Quality and Patient Safety. • Infection Prevention and Control. • Cancer Lead. • Clinical Governance / Clinical Risk Management / Clinical Audit. • Clinical Research and Innovation. • Deputy Responsible Officer. • Medical Education and Training. • Director of Trauma. • Clinical Effectiveness/ New 	9 of 10

Board member		Attendance at ordinary meetings
	<p>Procedures/Drugs.</p> <ul style="list-style-type: none"> • Medical Staff Health and Wellbeing/Performance. • Efficient use of resources – Theatre efficiency / patient flow / job planning / remuneration / working patterns / service sustainability and improvement. <p>The Director of Quality & Effectiveness and Director of Pharmacy also report directly to the Medical Director and in addition there are 21 Clinical Directors who report jointly to the Medical Director and Chief Operating Officer.</p>	
 <p>Mr M Wilson, Chief Operating Officer</p> <p>Appointed 8 October 2018</p>	<p>Martin's role as Chief Operating Officer is to support the thousands of hard working staff working in our hospitals and community services in delivering great care to patients and improving how we work.</p> <p>He joined Newcastle Hospitals in October 2018 from national roles at the Department of Health and Social Care, NHS England and NHS Improvement, where he was the Director of Strategy / Deputy National Director responsible for emergency and elective care across England.</p> <p>Martin works closely with the Medical Director, Executive Chief Nurse and other directors, and leads and oversees the teams of clinical directors and directorate managers who together lead each of the Trust's 16 clinical directorates. He is responsible for ensuring the organisation delivers the highest possible standards of performance, and leads our partnership working with Newcastle City Council around integrated health and care services</p> <p>Martin is a registered nurse and a graduate of the NHS Management Training Scheme. Having grown up and lived most of his life in Newcastle, he worked for a number of years at Northumbria Healthcare before taking on a number of director roles within</p>	5 of 5

Board member		Attendance at ordinary meetings
	the former North East Strategic Health Authority, St George's Hospital NHS Foundation Trust, University College London Hospitals NHS Foundation Trust and McKinsey & Company.	

**unable to attend the May 2018 meeting following a change to the established meetings schedule at short notice.*

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 the membership.

The Board has undertaken a review of its governance structure, including activities in terms of its business agenda, format and content of reports to the Board; 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 been prepared in line with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance. The Newcastle upon Tyne Hospitals 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.

The Trust has not made any political donations during 2018/19.

During the year, the following conflicts of interest were declared during Board of Director 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 D Burn declared an interest in any matters pertaining to Newcastle University and left the room during Board discussions on Estates matters between the Trust and Newcastle University.

During 2018/19 members of the Board of Directors claimed a total of £1,723.02 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 key purposes of the Audit Committee are to provide the Board with:

- an independent and objective review of financial and organisational controls, the system of integrated governance and risk management systems and practice across the whole of the organisation's activities (both clinical and non-clinical);
- 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."

It does this through receipt of assurances from auditors, management and other sources.

In the course of 2018/19 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 control (Group and Trust);
- Fraud in revenue recognition (Trust); and
- Property Valuations (Trust).

These have been considered through the presentation of the external audit plan and discussions with the Trust's external auditors, Mazars LLP.

The Committee is appointed by the Board from the Non-Executive Directors of the Trust and consists of four members with a quorum being two members.

Four ordinary meetings and one extraordinary meeting were held between 1 April 2018 and 31 March 2019 and attendance was as follows:

	Attendance at ordinary meetings	Attendance at extraordinary meeting
Mr D Stout, Non-Executive Director (Committee Chair)	3 of 4	0 of 1
Mr J Jowett, Non-Executive Director	3 of 4	1 of 1
Professor K McCourt, Non-Executive Director	4 of 4	1 of 1
Mrs H Parker, Non-Executive Director – Note 1	1 of 2	1 of 1
Mr S Morgan, Non-Executive Director – Note 1	2 of 2	N/a

Note 1 – Mrs H Parker's term of office as a Trust Non-Executive Director ended in September 2018 and Mr S Morgan joined the Trust, and the Audit Committee, as a Non-Executive Director in October 2018.

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. During 2018, a robust procurement and evaluation process was undertaken regarding the external audit contract. The Council of Governors endorsed a recommendation of the Business and Development Working Group (a sub-group of Governors) that Mazars LLP be appointed as the Trust's external auditors with effect from 1 October 2018 for 3 years to 30 September 2021. The contract includes an option to extend for a further 1 year after the 3 years. The Mazars LLP external audit fees were agreed as:

- Statutory Accounts £65,160 (inclusive of VAT);
- Quality Accounts/Report £11,160 (inclusive of VAT); and
- Charity Accounts £11,190 (inclusive of VAT).

Prior to the appointment of Mazars LLP, the Trust utilised the services of PricewaterhouseCoopers LLP (PwC) as its external auditor.

To ensure that the independence of the external auditors is not compromised where work outside the scope of the Audit Code has been produced 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.

No additional non-audit work was carried out by Mazars LLP during 2018/19; however, PwC did provide the following services:

- CQC preparation support £14,400 (inclusive of VAT); and
- Use of Resource Preparation support £18,281.45 (inclusive of VAT).

The value of non-audit services provided by Mazars LLP in the course of 2018/19 was £9,300 plus VAT for work related to the quality 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 Annual 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;
- payment terms are not varied without prior agreements with traders; and
- 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 (2017/18: 91%) and 73% of NHS trade invoices were paid within target (2017/18: 77%). Full details of the Trust's performance against the Better Payment Practice Code are included within note 6.1 of the Annual Accounts.

INVOICE PAYMENT PERFORMANCE

The total amount of any liability to pay interest which accrued by virtue of failing to pay invoices within the 30 day period where obligated to do so was £4,111k. The total amount of interest actually paid in discharge of any such liability was £1k.

QUALITY GOVERNANCE

In 2015-2018, the Trust launched and delivered its first Quality Strategy which outlined the Trust's commitment to prioritising quality and delivering safe, effective, high quality patient-centred care.

During 2018, the Trust refreshed its Quality Strategy and updated it for 2018-2021 to build upon the progress of the 2015-2018 strategy as well as create a culture of continuous improvement to increase and sustain the quality of our services to people of Newcastle and beyond.

The Newcastle upon Tyne Hospitals NHS Foundation Trust is committed to setting a clear direction for quality and safety and have identified key quality priorities which focus on:

Patient Safety

- Reducing avoidable harm and deterioration.
- Increasing incident reporting and learning from errors.
- Reducing healthcare acquired infections.
- Safe staffing levels.

Clinical Effectiveness

- Ensuring mortality rates are at least within expected limits.
- Participating in national and local audits.
- Effective discharge.

Patient Experience

- Acting on what patients tell us and co-creating solutions to challenges they face.
- Involving patients in their care and embracing the 'nothing about me without me' philosophy.

The Trust measures quality using the CQC Well Led inspection framework and has developed a Patient Safety and Quality Review process (PS&QR) which is an internal reporting process aligned to the CQC Well Led inspection approach. The PS&QR involves an in depth annual inspection including interviews with staff, patients and carers, observations of clinical practice and environmental inspections. The outcomes of the Patient Safety & Quality Review are discussed at an annual panel chaired by the Medical Director and supported by senior clinical leadership from across the Trust.

The Trust has well defined quality assurance processes in place through the established Clinical Governance and Quality Committee, Risk Management and Assurance Committee as well as other committees and management groups which provide a vital role in providing quality assurance to the board of Directors.

There are no known material inconsistencies between the Annual Governance Statement and the information provided by us to NHS Improvement on an in-year, annual and ad-hoc basis or following any reports arising from planned or responsive reviews by the Care Quality Commission. Further information on Quality Governance can be found in the Trust Quality Report and in section 5 of the Annual Governance Statement.

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 notes 3 and 4 of the Accounts and further information is disclosed in the Operating and Financial Performance section.

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, the Committee considered arrangements for the appointment of a Chief Executive, Chief Operating Officer, a Director of Communications

and Engagement, an Executive Chief Nurse and a Director of Enterprise and Business Development.

The Committee met three times during 2018/19 and its work included:

- conducting and concluding recruitment processes for a Chief Executive, Chief Operating Officer, a Director of Communications and Engagement and an Executive Chief Nurse;
- commencement of a recruitment process for a Director of Enterprise and Business Development;
- consideration of the appointment of Deputy Chief Executive;
- consideration of progress on reviewing and refining the Trust's succession plans; and
- reviewing Very Senior Manager Executive Pay.

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 Directors and very senior managers (VSM), account is taken of the NHS Improvement guidance on managing very senior pay in all providers; and of the Department of Health and Social Care VSM Pay Framework.
- Pensions – some, but not all Executive Directors, participate in the NHS Superannuation Scheme. Service as a Non-Executive Director is not pensionable.

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 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	None disclosed	Not applicable	Not applicable	See comment also comments detailed

	objectives agreed with line manager				below this table
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

The remuneration package of Executive Directors and Very Senior Managers (VSMs) is simple and transparent. It comprises:

- Base pay; and
- Employer and employee contribution to NHS Pension Scheme (it does not provide any addition to basic salary should an individual elect either not to join the NHS Pension Scheme or leave the Scheme membership).

In discharging its responsibility, the Appointments and Remuneration Committee is committed to ensuring the Trust is able to offer proportionate and fair remuneration packages, reflective of the responsibility of working in a large and complex environment and to promote the long term success of the Trust by attracting and retaining high calibre VSMs in a competitive marketplace. The following factors are taken into consideration when determining pay for VSMs:

- Prevailing market conditions;
- Responsibilities and duties of the post holder;
- Consideration and recognition of additional responsibilities or achievements relating to business/quality or CQC rating;
- Reviewing remuneration benchmarking reports against relevant regional and peer comparators (e.g. Shelford Group), including any 'cost of living' increases; and
- Individual performance against objectives, alignment to core behaviours and the resulting performance rating from the appraisal process.

The Committee reserves the right to approve specific increases in exceptional cases, for example, significant change to an individual's role.

The Committee has been cognisant of the requirements set out in NHS Improvement (NHSI) Guidance resulting in a revised approach to remuneration including applications for opinion to NHSI where a post attracts a salary of £150,000 per annum or above.

From 2018, and in line with the Guidance, new Executive Director employment contracts now incorporate two key changes to pay:

- An element of earn-back i.e. an element of base pay placed at risk and 'earned back' if agreed performance objectives are achieved; and
- Eligibility for consideration of a non-consolidated, non-pensionable performance-related pay bonus conditional upon achieving performance objectives.

All Executive Directors have substantive contracts of employment with agreed notice periods of between three and six months. No termination payments were made in the course of 2018/19.

The Medical Director's salary is in accordance with the terms and conditions 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 Clinical Excellence Awards (CEA) 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 and Social Care.

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 care. 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 advisor

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

The Committee met on three occasions during 2018/19.

	Attendance at ordinary meetings
Prof. Sir J Burn, Chairman	3 of 3
Mr J Jowett, Non-Executive Director	3 of 3
Mrs H Parker, Non-Executive Director (until 30 th September 2018)	1 of 1
Prof. K McCourt, Non-Executive Director	3 of 3
Prof. D Burn, Non-Executive Director	1 of 3
Mr K Godfrey, Senior Independent Director	1 of 2

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

The remuneration for Non-Executive Directors is determined by the Council of Governors, as delegated to the Nominations Committee, which last considered the fees paid to Non-Executive Directors in November 2018. The level of remuneration for Non-Executive Directors is paid for a minimum of two-and-a-half days per month.

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

2018/19

	<u>2018/19</u>					
	Salary	Expense payments (taxable)	Performance pay and bonuses	Long-term performance pay and bonuses	All pension-related benefits	Total
Name and title	(bands of £5,000)	(to nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
	£000	£	£000	£000	£000	£000
Chairman Mr KW Smith	-	-	-	-	-	-
Chairman Prof Sir J Burn (viii)	50-55	-	-	-	-	50-55
Chief Executive Dame J Daniel (ix)	225-230	500	-	-	-	225-230
Chief Executive Sir LR Fenwick (i)	-	-	-	-	-	-
Chief Executive Mrs CL Robson (ii)	0-5	-	-	-	-	0-5

Chief Executive Mr A Welch (ii)	0-5	-	-	-	-	0-5
Chief Executive Mrs A Dragone (ii)	0-5	-	-	-	-	0-5
Chief Executive Mrs H Lamont (ii)	0-5	-	-	-	-	0-5
Finance Director Mrs A Dragone	160-165	-	-	-	-	160-165
Nursing & Patient Services Director Mrs H Lamont (xv)	0-5	-	-	-	-	0-5
Executive Chief Nurse Ms M Cushlow (x)	145-150	100	-	-	170-175	315-320
Medical Director Mr A Welch (iii)	240-245	-	-	-	-	240-245
Director of Business & Development Mrs CL Robson (xii)	125-130	200	-	-	55-60	185-190
Chief Operating Officer Mr M Wilson (xi)	75-80	100	-	-	155-160	235-240
Non Executive Director Professor CP Day (iv)	-	-	-	-	-	-
Non Executive Director Mr J Jowett	15-20	-	-	-	-	15-20
Non Executive Director Dr P Kesteven (v)	-	-	-	-	-	-
Non Executive Director Professor K McCourt	15-20	-	-	-	-	15-20
Non Executive Director Mrs HA Parker (xiv)	5-10	-	-	-	-	5-10
Non Executive Director Mr D Stout	20-25	-	-	-	-	20-25
Non Executive Director Mr E Weir	10-15	-	-	-	-	10-15
Non Executive Director Mr S Morgan (xiii)	5-10	-	-	-	-	5-10
Non Executive Director Mr K Godfrey (vi)	15-20	1000	-	-	-	15-20
Non Executive Director Prof D Burn (vii)	15-20	-	-	-	-	15-20

2017/18 (restated)

	2017/18 (restated)					
	Salary	Expense payments (taxable)	Performance pay and bonuses	Long-term performance pay and bonuses	All pension-related benefits	Total
Name and title	(bands of £5,000)	(to nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
	£000	£	£000	£000	£000	£000
Chairman Mr KW Smith	35-40	-	-	-	-	35-40
Chairman Prof Sir J Burn (viii)	15-20	-	-	-	-	15-20
Chief Executive Dame J Daniel (ix)	-	-	-	-	-	-
Chief Executive Sir LR Fenwick (i)	80-85	200	-	-	-	80-85
Chief Executive Mrs CL Robson (ii)	45-50	-	-	-	-	45-50
Chief Executive Mr A Welch (ii)	15-20	-	-	-	-	15-20
Chief Executive Mrs A Dragone (ii)	5-10	-	-	-	-	5-10
Chief Executive Mrs H Lamont (ii)	5-10	-	-	-	-	5-10
Finance Director Mrs A Dragone	160-165	-	-	-	85-87.5	215-220
Nursing & Patient Services Director Mrs H Lamont (xv)	145-150	-	-	-	-	145-150
Executive Chief Nurse Ms M Cushlow (x)	-	-	-	-	-	-
Medical Director Mr A Welch (iii)	240-245	200	-	-	-	240-245
Director of Business & Development Mrs CL Robson (xii)	165-170	300	-	-	25-27.5	195-200
Chief Operating Officer Mr M Wilson (xi)	-	-	-	-	-	-
Non Executive Director Professor CP Day (iv)	0-5	-	-	-	-	0-5
Non Executive Director Mr J Jowett	15-20	-	-	-	-	15-20
Non Executive Director Dr P Kesteven (v)	0-5	-	-	-	-	0-5
Non Executive Director Professor K	15-20	-	-	-	-	15-20

McCourt						
Non Executive Director Mrs HA Parker (xiv)	15-20	-	-	-	-	15-20
Non Executive Director Mr D Stout	20-25	-	-	-	-	20-25
Non Executive Director Mr E Weir	10-15	-	-	-	-	10-15
Non Executive Director Mr S Morgan (xiii)	-	-	-	-	-	-
Non Executive Director Mr K Godfrey (vi)	10-15	800	-	-	-	10-15
Non Executive Director Prof D Burn (vii)	10-15	-	-	-	-	10-15

- (i) Sir L R Fenwick's employment with the Trust was terminated with effect from 7 June 2017.
- (ii) Mrs L Robson and Mr A Welch were appointed as joint Acting Chief Executives with effect from 8 June 2017. Mrs Robson, Mr Welch, Mrs A Dragone and Mrs H Lamont were paid an allowance with effect from 8 June 2017 in recognition of the additional workload they took on following the absence of the Chief Executive. This allowance was paid until 30 April 2018.
- (iii) Within the figure reports for Mr Welch's salary and fees are payments of £117k (2017/18 £114k) made in respect of clinical duties.
- (iv) Prof. C P Day resigned as a Non-Executive Director with effect from 30 June 2017.
- (v) Dr P Kesteven resigned as Non-Executive Director with effect from 30th April 2017.
- (vi) Mr K Godfrey was appointed as a Non-Executive Director with effect from 27 July 2017.
- (vii) Prof. D Burn was appointed as a Non-Executive Director with effect from 3 July 2017.
- (viii) Professor Sir J Burn was appointed as Chairman with effect from 1 December 2017.
- (ix) Dame J Daniel was appointed as Chief Executive with effect from 1 May 2018.
- (x) Ms M Cushlow was appointed as Executive Chief Nurse with effect from 1 April 2018.
- (xi) Mr M Wilson was appointed as Chief Operating Officer with effect from 8 October 2018.
- (xii) Mrs CL Robson resigned as Director of Business and Development with effect from 6 January 2019.
- (xiii) Mr S Morgan was appointed as Non-Executive Director with effect from 1 October 2018.
- (xiv) Mrs HA Parker resigned as Non-Executive Director with effect from 30 September 2018.
- (xv) Mrs H Lamont resigned as Nursing and Patient Services Director with effect from 1 April 2018.

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

$$\text{Increase} = ((20 \times \text{PE}) + \text{LSE}) - ((20 \times \text{PB}) + \text{LSB})$$

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 for 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 benefit reported for 2018/19 is due to increases in annual salary following appointment to Executive roles within the Foundation Trust within the year and subsequent changes in salaries. In addition, Mrs C L Robson has since moved to take up the Chief Executive role at Stockport NHS Foundation Trust.

The inflation rate prescribed for use in 2018/19 is 3% (2017/18 1%).

Total Pension Entitlement

	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2019	Lump sum at pension age related to accrued pension at 31 March 2019	Cash Equivalent Transfer Value at 1 April 2018	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019
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 Mrs A Dragone	0-2.5	0	65-70	185-190	1,258	124	1,419
Director of Business & Development Mrs CL Robson	5-7.5	15-17.5	70-75	215-220	1,395	221	1,658
Executive Chief Nurse Ms M Cushlow	0-2.5	2.5-5	65-70	180-185	1,084	72	1,407
Chief Operating Officer Mr M Wilson	2.5-5	7.5-10	30-35	80-85	317	80	494

Dame J Daniel's and Mr A Welch's pension sums are not shown as these were either opted out of or drawn and taken in a previous year.

The Cash Equivalent Transfer Value (CETV) figures for 1 April 2018 have been restated following receipt of updated figures from the NHS Pensions Agency.

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.

FAIR PAY (this section is subject audit)

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

The banded remuneration of the highest paid director in the Trust in the financial year 2018/19 was £240k-£245k (2017/18, £255k-£260k). This was 8.58 times (2017/18, 9.30 times) the median remuneration of the workforce, which was £28,454 (2017/18, £27,600).

In 2018/19, Nil (2017/18, Nil) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £7k to £244k (2017/18 £7k-£256k).

The calculation is based on Trust employees as at 31 March 2019. This number includes locum staff, junior doctors on training rotations employed via Northumbria Foundation Trust as Lead Employer Trust, the Trust's in-house nurse and clerical bank staff and includes external agency staff. Any part time employee numbers are pro-rated to provide whole time equivalents.

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

The Trust did not make any payments to past senior managers in 2018/19.

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

The Trust did not make any payments for loss of office in 2018/19.

The Board of Directors include 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 D Burn, Non-Executive Director appointed by Newcastle University £15,000.

Chairman

Declarations of Interest

Professor Sir John Burn Chair QuantuMDx Group Ltd (which includes Northgene Ltd)

Director and Treasurer - Global Variome Ltd. Global Variome Ltd is the holding company for the UNESCO register NGO of this name responsible for the Human Variome Project - an international effort to have data on genetic variation of relevance to healthcare - it was recognised as a UK charity in 2017

Professor of clinical Genetics in Newcastle University and senior strategic advisor

Sits on the Bowel Cancer UK Medical Advisory Board

Director of the Charity, European Hereditary Tumour Group (EHTG)

Patron of the charity Veteran at Ease

Cultural ambassador for the Durham County Community Foundation

Chairman of Pulse Diagnostics (part owned by Trust) (from December 2017)

Non-Executive Directors

Professor D Burn	Pro-Vice Chancellor and Professor of Movement Disorders Neurology - Faculty of Medical Sciences Executive, Medical Schools Council Board Member, Northern Health Science Alliance Board Member, North East and North Cumbria Academic Health Science Network Chair of the Northern Health Science Alliance Board (from July 2018) Trustee of Parkinson UK
Mr K Godfrey	Trustee and Chair of the Northern Cancer Care & Research Society
Professor K McCourt	Pro Chancellor at Northumbria University (ambassador role) Convenor of Fellows - Royal College of Nursing President Commonwealth Nurses and Midwives Federation Honorary Colonel, 201 Field Hospital, Newcastle upon Tyne Governor - Sacred Heart School, Newcastle upon Tyne Member of the Heath Committee
Mrs H A Parker	Consultant to Sintons Limited Liability Partnership (Trust Solicitors)
(until 30th September 2018)	Newcastle Healthcare Property Management Company Limited
Mr D Stout	Director and Part Owner of David Stout Consulting Limited Controlling shareholding in David Stout Consulting Limited
Mr E Weir	Director for People, Newcastle City Council Chief Officer – Director Adult’s Social Care and Director of Children’s Social Care at Newcastle City Council
Mr Jonathan Jowett	Company Secretary of Darlington 1883 Limited Company Secretary & General Counsel of Greggs PLC Chairman of the Percy Hedley Foundation

	As part of his Company Secretary role at Greggs PLC, Mr Jowett is a Director of a number of dormant companies set up by Greggs PLC
	Daughter is an employee of Talking Health Newcastle
Mr Steven Morgan	Owner/Director - Rowrah Chapel Associates
	Time to Change: parent Community Interest Company (CIC) of Calderwood House, a homeless hostel for military veterans
	Member of Hinkley Point Nuclear Construction Board
Chief Executive	
Dame Jackie Daniel	Director of the Academic Health Science Network North East and North Cumbria
	(AHSN NENC Ltd)
	Director of Northern Health Science Alliance (NHSA)
Executive Directors	
Mrs A Dragone	Director of Trust Subsidiary company NewGene Limited
Finance Director	Secretary and Trustee, Heath Committee
Ms M Cushlow	No items to declare
Executive Chief Nurse	
Mr M Wilson	No items to declare
Chief Operating Officer	
Mrs L Robson	Director of Healthy Life Simulation (Directorship) Pending NIHR
Business & Development	
Director	(until 6 January 2019)
Mr A R Welch	Director, A Welch Limited
Medical Director	Director, Newcastle Healthcare Property Company



Dame Jackie Daniel
Chief Executive
28th May 2019

OUR GOVERNORS

We have 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 included within the 'Governor Elections' section below 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, patient experience, financial performance, and the Quality Account. Other topics included:

- The Long Term Plan;
- Carers Provision;
- Pressure Ulcer Prevention; and
- The Trust Strategy

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 areas of business. In particular, the Business Development Group was given the responsibility to provide input to the Trust Strategy refresh process on behalf of the Council of Governors. During 2018/2019, the Group also led the appointment process for a new Trust External Auditor.

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 Clinical Effectiveness and Audit Group, the Patient Experience Steering Group, and the Patient, Carer and Public Engagement Group.

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 the visits and asked Executive Directors to follow up on any issues highlighted. Some of the areas visited included the:

- Northern Centre for Cancer Care (Freeman Hospital);
- The former Cherryburn Unit – Ward 9 (Freeman Hospital);
- Emergency Department (RVI);
- Great North Childrens Hospital (RVI);
- Newcastle Surgical Training School (Freeman Hospital);
- The CRESTA Clinic;
- A number of Wards covering surgical, urology/renal, ophthalmology and orthopaedic.

The Patients Food Tasting Panel continued to visit patient areas in our hospitals, sampling food at the point of delivery, examining the quality of the services and making recommendations for further improvement.

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.

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

- Medical Physics - "Smaller devices, bigger data: better outcomes?";
- Transformation and Sustainability Market Place;
- Community Services - "Care Co-ordination Team and The Patient's Journey"; and
- Fraud Prevention.

As set out in NHS Improvement's Code of Governance for NHS Foundation Trusts, there is a requirement for a mechanism to be place to resolve 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 try 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 try to reach a mutually acceptable position. The Trust did not need to use this resolution process in 2018/19 and there were no conflicts of interest declared by Governors during the year.

During 2018/19 Governors claimed a total of £3,493.80 in expenses, mainly for business travel.

GOVERNOR ELECTIONS

Governor elections are held annually, with approximately one third of the elected Governorships coming up for re-election each year. In addition, any vacancies which have arisen in the past year, through resignations or having been held over from the previous year's elections, are included in the annual round.

For 2018, 12 Governorships were up for election, and 10 were successfully appointed to.

Below is a chart setting out Governors' attendance at Council of Governors meeting during 2018/19:

Constituency	Governor	Meeting attendance	Comments
Appointed	Mr Derrick Bailey	5 of 6	
Public - 3	Mr John Bedlington	1 of 1	Last term of office ended May 2018
Public - 2	Mr Graham Blacker	5 of 6	
Public - 3	Mr Paul Briggs	5 of 6	
Public - 1	Mr Adam Chaffer	1 of 1	Chose not to be put forward for re-election at end of term.
Staff	Ms Elaine Coghill	0 of 1	Left Trust employment in May 2018
Public - 2	Mr Terence Coleman	5 of 6	
Staff	Miss D Colvin-Laws	4 of 5	Appointed 31 st May 2018
Public - 2	Mr Steven Cranston	5 of 6	
Public - 1	Miss Ruth Draper	2 of 6	
Public - 2	Mrs Carole Errington	5 of 6	
Appointed	Professor Andrew Fisher	4 of 6	
Public - 1	Mr David Forrester	5 of 5	Appointed 31 st May 2018
Staff	Mrs Barbara Goodfellow	4 of 6	
Public - 1	Dr Vanessa Hammond	5 of 5	Appointed 31 st May 2018
Public - 2	Mrs Catherine Heslop	4 of 5	Appointed 31 st May 2018
Staff	Mrs Eleanor Houlston	4 of 6	
Public - 1	Mr Bill Ions	6 of 6	
Public - 3	Dr Alan Johnson	0 of 1	Last term of office ended May 2018
Staff	Dr Phil Laws	2 of 6	
Public - 2	Dr Helen Lucraft	5 of 6	
Public - 2	Mr Matthew McCallum	3 of 5	Appointed 31 st May 2018
Public - 1	Mrs Jean McCalman	5 of 6	
Public - 2	Dr Duncan McKinnon	0 of 1	Chose not to be put forward for re-election at end of term.
Staff	Mrs Victoria Mitchinson	2 of 6	
Public - 3	Dr Lakkur Murthy	4 of 5	Appointed 31 st May 2018
Public - 1	Mrs Susan Nelson	5 of 6	
Public - 2	Mrs Carole Perfitt	5 of 6	
Public - 2	Mr Peter Ramsden	1 of 1	Last term of office ended May 2018
Public - 2	Mr Paul Richardson	3 of 6	
Public - 3	Dr Michael Saunders	4 of 6	
Public - 1	Mr David Stewart-David	5 of 6	
Appointed	Councillor Jane Streather	0 of 1	Retired as a Councillor in March 2018
Public - 2	Mr Derek Thompson	2 of 6	

Constituency	Governor	Meeting attendance	Comments
Public - 1	Mr Eric Valentine	5 of 6	
Public - 3	Mr Michael Warner	3 of 5	Appointed 31 st May 2018
Appointed	Professor Andrew Wathey	0 of 6	
Appointed	Councillor Marion Williams	3 of 5	Appointed June 2018
Public - 2	Mr Fred Wyres	1 of 6	
Public - 1	Mrs Pam Yanez	5 of 5	Appointed 31 st May 2018
Appointed	Vacancy (Charity)	N/a	
Staff	Vacancy (Nursing & Midwifery)	N/a	
Staff	Vacancy (Ancillary and Estates)	N/a	

Key:

1 – Newcastle-upon-Tyne

2 – Northumberland, Tyne and Wear

3 – County Durham, Tees Valley, Cumbria and beyond

NOMINATIONS COMMITTEE

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

Membership consisted of four public governors, the Finance Director (or a nominated Executive Director in their absence), the Trust Senior Independent Director (or a nominated Non-Executive Director in their absence). The Newcastle University appointed NED was a non-voting member of the Committee. They were supported by Trust officers, as appropriate; the Trust Chairman, Trust Vice Chairman and the Trust Secretary.

Attendance of the Committee membership is set out below:

	Number of meetings attended
Dr Michael Saunders, Committee Chair until September 2018 and then became a Committee Member thereafter	5 of 7
Mr Peter Ramsden, Committee Member until May 2018	2 of 2
Mr Fred Wyres, Committee Member	4 of 7
Mr David Stewart-David, Committee Member until September 2018 and then became Committee Chair from October 2018	7 of 7
Mrs Angela Dragone, Finance Director and Committee Member	7 of 7
Professor David Burn, Non-voting Committee Member	3 of 7
Mrs Hilary Parker, Committee Member until September 2018	1 of 4

Mr Paul Briggs, Committee Member from June 2018	4 of 5
Mr Keith Godfrey, Committee Member from November 2018	1 of 3

Note – On the occasions when Public Governor members were unable to attend the meeting and the meeting was not quorate, alternative Public Governors were co-opted to attend to ensure meeting quorum. Further on the occasions when Mrs Parker or Professor D Burn were unable to attend the Committee meeting, an alternative Non-Executive Director attended in their absence.

There were five meetings of the Committee in the period 1 April 2017 to 31 March 2018. On the occasions where the routine Public Governor or Non-Executive member were unavailable, a 'stand-in' Governor or Non-Executive Director was utilised to ensure the Committee was quorum in those instances.

In September 2018, Dr M Saunders stood down as Chairman of the Committee and Mr D Stewart-David commenced this role from 1 October 2018.

During the year, the Committee agreed and led the processes to recruit two new Non-Executive Directors, making recommendations to the Council of Governors on the most suitable candidates to appoint.

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

MEMBERSHIP

The public and our 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 election of Governors.

We have three public constituencies and anyone over 18 and living in those constituency areas can become a member.

The public constituencies are:

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

There are six staff constituencies:

- 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 was to maintain a membership of 8,000 with a view to planning and undertaking activities to promote the benefits of becoming a Trust member.

Membership Report, 1st April 2018 - 31st March 2019

Membership size and movements		
Public constituency	2018/19	
At year start (April 1)	5,556	
New members	90	
Members leaving	264	
At year end (March 31)	5,382	
Staff constituency	2018/19	
At year start (April 1)	2,750	
New members	39	
Members leaving	20	
At year end (March 31)	2,769	
Patient constituency	The Trust does not have a separate patient constituency	
Analysis of current membership		
Public constituency	Number of members	Eligible membership
Age (years):		
0-16	N/a – minimum age of 18	-
17-21	13	91,257
22+	4,977	1,093,234
Ethnicity:		
White	4,984	1,343,747
Mixed	28	12,447
Asian or Asian British	183	47,965
Black or Black British	39	9,006
Other	5	7,688
Socio-economic groupings*:		
AB	1,510	79,024
C1	1,542	140,614
C2	1,098	94,912
DE	1,212	140,140
Gender analysis		
Male	2,238	713,930
Female	3,097	737,065
The analysis section of this report excludes:		
- 392 public members with no dates of birth, 143 members with no stated ethnicity and 47 members with no gender.		

To ensure the membership of the Trust represents the population make-up of the geographic area we serve; further membership engagement activities will be undertaken during 2019/20 with the aim of increasing the Trust membership level.

All new members receive a welcome letter and membership certificate when they sign up. They are then eligible for all benefits of membership, including receiving a regular membership newsletter and invitations to attend membership events.

Membership application forms are available at public locations across the Trust and also on-line on the Trust's website at http://www.newcastle-hospitals.org.uk/about-us/nhs-foundation-trust-status_become-a-member.aspx

Members who want to contact a Governor can do so via the Trust Secretary or the About Us/Governor Information page on the Trust's website. Staff members can also email their representatives of the Council of Governors via the email staff.governors@nuth.nhs.uk.

STAFF REPORT

Workforce Information

Workforce Demographics	As at March 2018				As at March 2019			
	Permanent FTE	Other FTE	Total FTE	% of Total FTE	Permanent FTE	Other FTE	Total FTE	% of Total FTE
Staff Group								
Medical and dental	1,161.93	596.61	1,758.54	13.05%	1,184.47	493.64	1,678.11	12.37%
Ambulance staff	0.66		0.66	0.00%	0.50		0.50	0.00%
Administration and estates	2,677.77		2,677.77	19.87%	2,721.43		2,721.43	20.06%
Healthcare assistants and other support staff	2,091.66		2,091.66	15.52%	2,072.11		2,072.11	15.27%
Nursing, midwifery and health visiting staff	4,295.96		4,295.96	31.88%	4,371.12		4,371.12	32.21%
Nursing, midwifery and health visiting learners	27.90		27.90	0.21%	22.90		22.90	0.17%
Scientific, therapeutic and technical staff	1,730.89		1,725.89	12.81%	1,780.70		1,780.70	13.12%
Healthcare science staff	876.17		876.17	6.50%	900.54		900.54	6.64%
Social care staff		21.06	21.06	0.16%		22.00	22.00	0.16%
Grand Total	12,857.94	617.67	13,475.60		13,053.77	515.64	13,569.41	

	As at March 2018		As at March 2019	
	FTE	% of Total FTE	FTE	% of Total FTE
Full Time/Part Time				
Full Time	9,080	73.70%	9,390	74.09%
Part Time	3,240.16	26.30%	3,283.71	25.91%
Gender				
Female	9,446.54	76.68%	9,687.98	76.44%
Male	2,873.61	23.32%	2,985.73	23.56%
Disabled				
No	8,496.98	68.97%	9,127.17	72.02%
Not recorded	3,529.03	28.64%	3,208.47	25.32%
Yes	294.14	2.39%	338.07	2.67%
Ethnic Group				
BME	1,088.25	8.83%	1,150.11	9.07%
Not recorded	259.95	2.11%	253.51	2.00%
White	10,971.96	89.06%	11,270.09	88.92%
Age				
16-25	1,132.26	9.19%	1,197.88	9.45%
26-35	2,983.23	24.21%	3,130.40	24.70%
36-45	2,814.32	22.84%	2,866.32	22.62%
46-55	3,476.62	28.22%	3,436.07	27.11%
56-65	1,819.64	14.77%	1,926.16	15.20%
66+	94.08	0.76%	116.87	0.92%

Turnover	Apr 18 - Mar 19	Apr 17 - Mar 18
	8.85%	9.78%
Staff Sickness Absence	Apr 18 - Mar 19	Apr 17 - Mar 18
	No.	No.
Total days lost	119,574	115,173
Total staff years	12,453	12,299
Average working Days Lost (per WTE)	9	9

Staff Costs

	Total	Permanently employed total	Other total	Total	Permanently employed total	Other total
	2017/18 £000	2017/18 £000	2017/18 £000	2018/19 £000	2018/19 £000	2018/19 £000
Salaries and wages	488,824	420,229	68,595	507,741	436,655	71,086
Social security costs	41,254	41,254	0	42,894	42,894	0
Apprenticeship levy	2,156	2,156	0	2,255	2,255	0
Pension cost - employer contributions to NHS pension scheme	53,796	53,796	0	55,720	55,720	0
Pension cost - other*	43	43	0	105	105	0
Temporary staff - agency/contract staff	3,822	0	3,822	3,710	0	3,710
TOTAL GROSS STAFF COSTS	589,895	517,478	72,417	612,425	537,629	74,796
Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure	(4,144)	(4,144)	0	(4,949)	(4,949)	0
Recoveries from other bodies in respect of staff cost netted off expenditure	(3,093)	(3,093)	0	(4,226)	(4,226)	0
TOTAL STAFF COSTS	582,658	510,241	72,417	603,250	528,454	74,796

“Off-payroll” Engagements

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months

Number of existing engagements as of 31 March 2019	12
Of which:	
Number that have existed for less than one year at time of reporting	11
Number that have existed for between one and two years at time of reporting	1
Number that have existed for between two and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting.	0

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	17
Of which:	
Number assessed as within the scope of IR35	17
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

The Trust is cognisant of NHS Improvement's guidance on pay for very senior managers in NHS Foundation Trusts, and the expectation that they should be appointed on payroll. Such appointments are considered by the Appointments and Remuneration Committee, which would assure itself that proposed pay is commensurate with market conditions by referencing relevant benchmarking data regarding market pay, the requirements of the role, and that the Trust is receiving value-for-money. Where appropriate, any proposal would be referred to NHS Improvement and the HM Treasury for approval for new appointments.

Exit Packages (subject to audit)				
	Total number of exit packages	Total cost of exit packages	Total number of exit packages	Total cost of exit packages
	2018/19	2018/19	2017/18	2017/18
	No.	£000	No.	£000
Exit package cost band				
£10,000 - £25,000	-	-	1	15
£25,001 - £50,000	1	48	-	-
£100,001 - £150,000	-	-	1	136
> £200,000	1	253	-	-
There were no compulsory redundancies made during 2018/19.				
There were two compulsory redundancies made during 2017/18 at a cost of £151,000.				
There were two special payments for exit payments made following employment tribunals or court orders at a cost of £301k made in 2018/19. There were no special payments made in 2017/18.				
There were no non-compulsory departure payments during 2018/19.				
The Trust spent £922,000 on consultancy fees in 2018/19 (£269,000 2017/18).				

Senior Staff Gender Breakdown	Male	Female
Executive Directors	2	3
Non-Executive Directors	7	1
Other Senior Employees	5	5

Human Resources Indicators at March 2019

Directorate	Training	Appraisals	Sickness	Turnover
	> 95%	> 80%	< 3%	< 8%
Business & Development	97.09%	83.33%	3.95%	14.29%
Cancer Services/ Clinical Haematology	89.25%	87.33%	3.74%	11.35%
Cardiothoracic	91.04%	82.88%	4.52%	9.30%
Chief Executive	98.17%	33.33%	0.76%	3.03%
Chief Operating Officer	93.48%	81.36%	3.45%	5.88%
Children's Services	88.26%	71.86%	4.79%	11.04%
Clinical Research Facility	95.15%	72.11%	4.57%	9.91%
Community Services	90.08%	85.74%	6.04%	10.32%
Dental Services	91.51%	78.00%	3.40%	7.54%
ENT, Plastics, Ophthalmology & Dermatology	88.18%	85.74%	3.85%	6.59%
Estates	94.03%	86.88%	4.15%	11.37%
Finance	95.59%	77.23%	3.43%	11.21%
Human Resources	98.54%	89.57%	3.50%	17.04%
Information Management & Technology	97.67%	87.25%	3.85%	12.40%
Integrated Laboratory Medicine	94.01%	80.30%	4.19%	9.12%
Internal Medicine - General	80.23%	71.04%	5.75%	6.81%
Internal Medicine - Urgent Care	84.23%	85.32%	3.72%	8.67%
Medical Director	94.76%	78.00%	2.89%	13.71%
Medical Physics	86.48%	92.11%	3.01%	5.65%
Musculoskeletal Services	89.06%	80.79%	5.39%	8.11%
Neurosciences	91.67%	85.45%	3.33%	7.56%
Outpatients & Medical Records	97.96%	99.53%	3.25%	8.30%
Patient Services	90.07%	86.16%	4.06%	8.93%
Peri-operative & Critical Care - FH	94.45%	93.29%	5.13%	7.33%
Peri-operative & Critical Care - RVI	93.52%	92.02%	4.59%	7.46%
Pharmacy	96.99%	70.04%	2.06%	10.11%
Radiology	89.32%	81.12%	3.04%	5.56%
Regional Drugs & Therapeutics	94.06%	53.33%	1.27%	11.11%
Supplies	94.17%	83.33%	4.60%	13.16%
Surgical Services	88.64%	80.77%	3.15%	8.10%
Urology & Renal Services	90.59%	89.54%	4.49%	8.79%
Women's Services	87.04%	73.09%	5.69%	7.00%

% Appraisal Compliance by Staff Group	
Staff Group	%
Add Prof Scientific and Technic	81.50%
Additional Clinical Services	81.18%
Administrative and Clerical	82.55%
Allied Health Professionals	80.97%
Estates and Ancillary	90.99%
Healthcare Scientists	85.69%
Managers (Band 8c and above)	77.42%
Medical and Dental	81.37%
Nursing and Midwifery Registered	82.22%
Total	82.90%

Enhancing the Staff Experience - #Flourish at Newcastle Hospitals

Staff engagement is an integral part of the Trust's People Strategy and in the last year, we have launched #Flourish at Newcastle Hospitals. This framework enables our focus on promoting the "employee voice", involves and engages staff at all levels across the organisation to share and develop ideas which can be harnessed into tangible action, and provide ways of working to create an environment for staff to flourish at work.

#Flourish underpins the commitment made to staff in the NHS Constitution and is shaping our employee wellbeing agenda.

Our staff engagement policy outlines how we build on current practices which help foster increased levels of staff engagement and acknowledges the strong correlation between how staff feel they are being managed and the patient experience.

Our Chief Executive Dame Jackie Daniel has taken the lead in reshaping and prioritising our engagement and communications with staff across the Trust.

Our 'People' objective is to be the recognised employer and educator of choice and key to achieving that aim is to use information and feedback to shape our efforts to learn, develop and enhance the staff experience.

A number of Flourish engagement events have taken place in recent months – extending an invitation to staff to participate in identifying our priorities. In response to feedback, the themes which emerged from these workshops have been transformed into an annual calendar of events providing a common focus of activity.

This is supported by high profile communications and use of social media to promote and encourage participation by all.

We are committed to engaging with all staff at all levels and have various forums and groups, including the Trust Consultative group, the Employees Partnership Forum,

Policies and Procedures Group, Medical Advisory Group and a number of staff network groups to support our efforts to increase the diversity of our workforce, champion improved health and wellbeing, and support our Armed Forces staff.

These 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 and shaping of policy is encouraged.

The Junior Doctor Forum has been refreshed to support proactive engagement, build the membership base and advise our new Guardian of Safe Working Hours and Director of Medical Education in overseeing the working hours and educational opportunities of Junior Doctors in training. The Guardian has been building collaborative relationships across the region to support and share learning.

We recognise that leadership is key to enabling staff liberate their potential through setting the tone and content of how we work, promoting a learning culture which is open and transparent and aligning our priorities.

Leaders at every level have a role to play in supporting the Trust achieve its ambitions, and new forums have been established to facilitate and debate development of our strategic direction. These include the 'Leadership Congress', an event which takes place around three times a year involving the top 200+ of our leaders, and providing a forum in which they network, reflect and influence how to work differently both across the organisation and increasingly, with our civic partners and across systems to co design our approach to the provision of future health and social care.

The Trust Management Group (TMG) brings together the clinical and senior leadership and is a forum in which Trust operational performance is discussed, risks to achieving strategic objectives are considered, and members contribute to and support cultural development, organisational strategy, communications and engagement with staff.

Feedback received via the NHS Staff Survey is a key indicator for the Trust regarding how effective its staff engagement activities are. 2018/19 has seen a significant increase in the Trust response rate and our staff engagement score remains in the top 20% nationally.

The Trust has extensive intranet and internet sites providing information on a range of subjects including all Trust policies, procedures and guidelines.

The increased utilisation of social media has successfully enabled the Trust to engage more directly with both prospective and current employees, support the recruitment and retention strategy as well as build a platform from which to promote our staff experience 'brand'. They are also a platform through which we reinforce our support for the armed forces and our reservists.

This has been particularly evident in promoting our bi-annual 'Careers Events', which provides the opportunity for staff to share their experience, increase the supply of staff for recruitment purposes, and inspire the next generation to consider employment in the NHS. In July 2018, we launched our Careers website (NuTH Careers) to promote job vacancies, and also to provide insight into the range of career opportunities and showcase the city and surrounding area as a great place to live and work.

There are a range of networks to ensure the involvement and engagement of our professional nursing, midwifery and allied health professional staff, led by the Executive Chief Nurse and senior nursing team.

The appointment of a Chief Operating Officer has improved engagement, and he has introduced the weekly 'Stand Up Wall' through which to review operational performance and joint problem resolution.

Schwartz Rounds continue to be well attended and evaluate well as a forum for multi-disciplinary staff to share and reflect on a range of experiences; our Administration and Clerical and Safeguarding Communication Forums continue to facilitate 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 and 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'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 the Annual Innovation Recognition event.

We are very proud of our volunteer workforce which is over 300 people strong, and who provide support to a number of different wards and departments across the Trust in a range of volunteer roles. There has been a particular emphasis on encouraging young people to volunteer which we have found supports them in building confidence and experience to make informed career choices.

Employee Health and Wellbeing

We shape our employee and wellbeing agenda particularly to increase staff availability and to create a 'healthy workplace'.

Having achieved the Gold 'Better Health at Work Award' last year, we were proud to have our efforts recognised through achieving the Gold 'Continuing Excellence' Award in December 2018 and have an action plan to support this journey.

We are supported by over 116 trained 'Flourish Champions', led by the Better Health at Work Coordinator, who have translated their passion for this programme into a wide range of activity and support for their peers.

Having signed the 'Time to Change' mental health and wellbeing pledge, we also have an action plan to demonstrate our commitment to tackling stigma and ensuring staff who are facing mental health issues feel supported. We have a number of 'Time to Change Champions' as well as Mental Health First Aiders and have established a Suicide Prevention Group to look at crisis support measures for staff. Further training events are planned for 2019 for all of our health and wellbeing champions.

Our 'Early Access Advice' Project is a collaboration between HR, Occupational Health and line managers to reduce sickness absence and promote wellbeing. It has been

piloted within Facilities management and our Cardiothoracic Directorate with the impact of reducing the overall sickness rate.

Health and wellbeing groups are being implemented to identify barriers and enablers to improve attendance at work; risk assessments are used to assist in developing and implementing an action plans to address the key issues and this work is also being informed by the results of the 2018 annual staff survey.

The 'Call for Action on Bullying and Harassment' invites NHS organisations to achieve an overarching leadership and cultural change to tackle bullying and support staff to respectfully challenge problem behaviours, and publish their plans and progress.

Analysis and triangulation of Trust data from a number of areas, including complaints, exit questionnaires, employee relations activity, Freedom to Speak-up, Datix, Annual Staff Survey and the Workforce Race Equality Standard completed last year will be refreshed and repeated to further understand issues and themes, and to help inform an action plan. This year's review will also include data from the Workforce Disability Equality Standard and a report in the Trust's Quality Account on cases of speaking up (including whistleblowing, quality of care, patient safety, and bullying and harassment).

Equality and Inclusion

We continue to be highly committed to being instrumental in delivering a health service where, equality, diversity and human rights are embraced and communicated in the everyday work of staff.

We remain committed to the employment and career development of people with disabilities, working towards Disability Confident Leader status. 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.

We continue to actively engage with our disabled staff by promoting our Disability Staff Network and are preparing for the implementation of the Workforce Disability Standard in August 2019.

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 via our staff network groups representing British, Asian, Minority Ethnic (BAME), Lesbian, Gay, Bi-sexual and Transgender (LGBT) and people with disabilities.

A new network of allies - Equality Champions - has also been formed to support and embed our equality agenda; Joint staff network meetings have taken place and have seen the development of a Workforce Race Equality Sub Group to monitor progress against our WRES action Plan.

Members of the BAME Staff network have also hosted BAME staff focus groups and our increasingly positive action will be evidenced in our first BAME Recruitment Event in

April 2019 in partnership with six local NHS Providers. Our inaugural Trust BAME Conference will be hosted in Autumn 2019.

A number of key events are recognised and celebrated each year, including (but not limited to) LGBT History Month, Black History Month, Disability History Month and NHS Equality and Diversity Week where associated skills based workshops are developed and offered to all staff Trust-wide. We continue to ensure an annual programme of awareness sessions across all protected characteristics, including raising appropriate flags to celebrate LGBT History Month, Transgender Day of Visibility and Remembrance and Bi-Visibility Day.

Our use of rainbow lanyards; both the colours of the LGBT flag and the Trust's own equality and diversity branding visibly demonstrate to all staff, patients and visitors our commitment to a diverse and inclusive workforce. That commitment means that we remain an exemplar organisation within the Shelford Group of NHS Trusts.

The Trust's Gender Pay Gap position has not changed significantly in the last 12 months since first publication, and remains strongly influenced by the pay and gender make-up of the Medical and Dental Staff Group (i.e. Doctors and Dentists). This group is predominantly male and their higher pay and bonus payments relative to other employees significantly increases the level of male average pay and bonuses compared to females. An action plan is in place to implement measures to address this and other key issues.

The Stonewall Workplace Equality Index (WEI) is the definitive benchmarking tool for employers to measure their progress on LGBT inclusion in the workplace. The Trust annually submits to the WEI demonstrating our work in 10 key areas of employment policy and practice. Our goal is to be included in the WEI Top 100 Employers by 2020. Our annual Stonewall staff survey results showed a continuing improvement with the majority of areas significantly better than the average for the Health Sector.

2018 NHS Staff Survey Results

We aim to be recognised as the NHS employer and educator of choice, and a key element of that is how feedback shapes our efforts to learn, develop and improve the staff experience.

We benchmark our performance in the annual NHS Staff Survey against regional and Shelford Group NHS organisations. The results of our performance in the 2018 survey are summarised here:

- Over 6,500 staff responded to the survey - a response rate of 47% which was a significant increase in the number that took part in 2016 (approximately 4,500).
- We scored highest in the country against other combined acute and community Trusts for staff recommending the organisation as a place to receive care.

A standard survey was sent via email to all employees of the Trust (via external post for those on maternity leave), giving all 14,109 members of our staff a voice. 6,655 staff participated in the survey, resulting in a response rate of 47% which is above the sector average of 41%, and was a significant improvement on the 2017 response rate of 33%.

The results are now arranged under 10 themes:

- THEME 1: Equality, diversity & inclusion
- THEME 2: Health & wellbeing
- THEME 3: Immediate managers
- THEME 4: Morale
- THEME 5: Quality of appraisals
- THEME 6: Quality of care
- THEME 7: Safe Environment - Bullying & Harassment
- THEME 8: Safe Environment - Violence
- THEME 9: Safety Culture
- THEME 10: Staff Engagement

The Staff Engagement score is measured across three sub-themes:

- Advocacy = Staff recommendation of the Trust as a place to work or receive treatment
- Motivation = Staff motivation at work
- Involvement = Staff ability to contribute towards improvement at work

In The Newcastle upon Tyne Hospitals NHS Foundation Trust (NuTH) this score was:

- Overall: rating of staff engagement 7.3 (out of possible 10).

This score was only 0.1 below top position in the sector (Combined Acute & Community Trusts) and is 0.1 above the Trust's score in 2017.

The Trust scored significantly better on 7 of the 10 themes when compared with other Combined Acute & Community Trusts in England and the Trust did not score below sector average in any themes.

- Safety Culture
 - NuTH Score: 7.2 out of 10
 - Sector Score: 6.8 out of 10
- Staff Engagement
 - NuTH Score: 7.4 out of 10
 - Sector Score: 7.1 out of 10
- Equality, Diversity & Inclusion
 - NuTH Score: 9.4 out of 10
 - Sector Score: 9.2 out of 10
- Morale
 - NuTH Score: 6.5 out of 10
 - Sector Score: 6.3 out of 10
- Quality of Care
 - NuTH Score: 7.7 out of 10
 - Sector Score: 7.5 out of 10
- Safe Environment – Bullying & Harassment
 - NuTH Score: 8.4 out of 10
 - Sector Score: 8.2 out of 10
- Safe Environment – Violence
 - NuTH Score: 9.6 out of 10
 - Sector Score: 9.6 out of 10

The Trust is also in top position for a number of themes against various comparators:

- #1 in Sector for
 - Safety Culture: 7.2 out of 10
- #1 in Region for
 - Safe Environment – Bullying & Harassment: 8.4 out of 10
 - Safe Environment – Violence: 9.6 out of 10
 - Safety Culture: 7.1 out of 10
- #1 in Shelford Group for
 - Equality, Diversity & Inclusion: 9.4 out of 10
 - Immediate Managers: 6.9 out of 10
 - Morale: 6.4 out of 10
 - Safe Environment – Bullying & Harassment: 8.4 out of 10
 - Safe Environment – Violence: 9.6 out of 10
 - Safety Culture: 7.1 out of 10

The Trust compares favourably against the sector in 67 of the 90 questions in the survey. Some to note include:

- 90% agree that they would be happy with the standard of care provided by the organisation should a friend or relative need treatment. This is 16% higher than sector average.
- 89% agree that care of patients/service users is the organisation's top priority. This is 10% higher than sector average.
- 81% agree that when errors, near misses or incidents are reported, the organisation takes action to ensure that they do not happen again. This is 7% higher than sector average.
- 70% agree that they are given feedback about changes made in response to reported errors, near misses and incidents. This is 8% higher than sector average.
- 67% are confident that the organisation would address their concerns. This is 7% higher than sector average
- 32% stated they have felt unwell due to work related stress in the last 12 months. This is 5% under the sector average.

The lowest 3 scoring themes for the organisation were:

- Morale: 6.5 out of 10
- Health & Wellbeing: 6.1 out of 10
- Quality of Appraisals: 5.6 out of 10

Other areas of note:

- 'Care of patients/service users is my organisation's top priority' has seen an increase this year from 87.6% to 88.7% of staff agreeing.
- 'I feel that my role makes a difference to patients/service users' has declined from 91.5% to 90.8%. However, it remains above sector average in a sector average which has also declined.
- 'I am able to deliver the care I aspire to' has increased from 72.6% to 73.9% against a declining sector average.
- A significant improvement in the response to 'my organisation treats staff who are involved in an error, near miss or incident fairly', from 57.8% to 64.0%.
- 'I am confident that my organisation would address my concern' has increased from 64.7% to 67.4% where the sector average has declined.

- 'My organisation acts on concerns raised by patients/services users' has improved from 82.8% to 83.8%.
- 'Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age' has declined from 90.8% to 89.7%.

Looking forward, a number of key priority areas to focus on have been identified:

- Implementation of a Staff Survey Engagement plan to support provision of feedback about the results using "Together, we did" reflective evaluation on how results are informing change. This will support identification of specific themes that require further understanding.
- A coordinated approach to ensure that in response to provision of their local reports, all Directorates create local and relevant action plans.
- Expanding opportunities for flexible working options to support retention.
- Continued development of well-structured quality appraisals.
- Refreshed leadership education and development to underpin good people management practices.
- Sustained investment in Better Health at Work initiatives.
- Correlating data from other sources, including Datix, Friends and Family Test, and Employee Relations activity.

Employment of disabled people

As a major employer in the city, 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.

We remain committed to the employment and career development of disabled people. As a 'Disabled Confident Employer' we give 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. We look forward to engaging with our Disability Staff Network as we report our first the Workforce Disability Standard in August 2019.

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.

We continue to recognise that positive action can help remove barriers to employment and pro-actively address the under-representation of disabled staff in employment. Now in its seventh year the project has had fantastic results. In the academic year 2017/18, the project achieved a 91% transition (into employment) rate.

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.

In February 2019, we were delighted to be named 'Employer of the Year' by the national Movement to Work scheme in recognition of the Project's success.

As a result, we are regularly asked to attend NHS events and other regional employer events to highlight good practice and promote the business impact of the project, which includes:

- 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 demonstrating an ongoing commitment to promote access to work to those with learning disabilities.

Newcastle Occupational Health Service (NewcastleOHS)

Our Occupational Health (OH) service aims to improve employees' health and wellbeing to ensure they can deliver the best quality patient care.

In 2018 the service was awarded the Safe, Effective, Quality Occupational Health Service (SEQOHS) accreditation for the fourth consecutive year. This is a nationally recognised standard for quality. A full departmental assessment also took place in March 2019 and we await the result of this assessment.

The service has continued to work with Human Resources colleagues and managers to deliver a service that is valued by staff. The review of the year's survey results showed that more than 85% of staff would recommend the service to a friend or colleague.

Key Messages:

- On commencement activity performance stands at 6,867 for the Trust with an average time to full clearance of 3 days. Streamlining across the region and sharing of immunisation data has reduced delays to certification of fitness for work.
- Management referrals – 6,702 in this period, which is an increase by 610 from the previous year. The Key Performance Indicator (KPI) is average time to appointment within 10 working days however this is very flexible dependent upon the needs of the employee and manager.

- Immunisations and needlestick exposure management – Hepatitis B immunisation and BCG are now available and a catch up programme is in place throughout 2019. Proactive immunisation with MMR is also part of OHS strategy to support Public Health England. Needlesticks and blood borne virus exposures are managed with early advice and follow up across the Trust sites. The Trust Sharps Working Group is establishing training and review of incidents. Mandatory field for OH referral built into Datix to improve reporting of needlesticks to OH.
- Health Surveillance –
 - Skin sensitizers and wet work is ongoing by the Health and Safety team to raise the awareness amongst staff and managers of the risk of contact dermatitis associated with wet work. The work has seen an increase in referrals associated with skin conditions. NewcastleOHS have an agreed referral pathway a robust health surveillance recall system in place for those staff highlighted by managers as at risk of contact dermatitis.
 - Ionising radiation medicals for classified workers are now undertaken by HSE appointed Doctor Ionising Radiation, Dr Elizabeth Murphy.
 - Musculoskeletal (MSK) risks - Collaborative working between Health and Safety, Moving and Handling and specialties in Women's Services has established a training, education and monitoring system for MSK risks.
 - Drivers of 'Daft as a Brush' and Trust vehicles are being assessed and recalled in line with Group 2 DVLA Drivers Standards.
- 2018/19 Flu campaign – staff vaccinated 11,383 of 16,332 compared with 10,497 in 2017-2018.
- Proactive support for Trust Health and Wellbeing – includes departmental training and information sessions for Human Resources, Matrons, Managers, Education fora and ward level interventions.
- Dr Kiera McDowall, occupational health speciality trainee, has been appointed Consultant Occupational Physician starting in August 2019.

Partnership with the Armed Forces

As one of the largest employers in the North East, we recognise the importance that healthcare plays in supporting the country's defence and security, and so we are committed to supporting the UK's Armed Forces community, from cadet adult volunteers to reservists, veterans and their families. We have demonstrated this commitment not only by developing our own covenant, but also by achieving the Gold Defence Employer Recognition Scheme Award in 2018, becoming an accredited Veterans Covenant Hospital Alliance Trust and signing up to the Step into Health programme.

There is significant support from the Board of Directors for this work as well as a management champion, clinical champions and human resources who work together to promote the Forces and ensure both staff and patients are supported and not disadvantaged.

Some of the ways staff are supported include:

- Dedicated reserve forces training and mobilisation policy;
- Guaranteed interviews for service leavers, veterans and reservists who meet the essential criteria for roles;
- An additional 10 days paid annual leave for reservists and cadet adult volunteers to attend their annual camps;
- Supporting reserves and their managers with mobilisation and demobilisation;

- Working alongside the Carers Transition Partnership (CTP) to develop rotational work placements for service leavers to help ease their transition back to ‘civvy street’; and
- Creation of the Armed Forces Staff Network, which has 85 members since launching in October 2018.

The core values of the Trust and the Armed Forces are closely aligned, with a focus on people and partnerships, pioneering services and staff pride in what they do. As a result, we strive to ease the path for service leavers to work in healthcare and offer an internal mentor on an ad hoc basis, where appropriate or necessary while working alongside CTP.

We currently employ 39 reservists, 41 veterans and 5 cadet force volunteers, however we may employ more as veterans do not have to make their status known to the organisation.

Staff Social Club

As part of the employment package and to extend the benefits of employment with the Trust, a very well supported ‘Staff Social Club’ aims to provide social and recreational facilities for staff. Signing up as a member gives staff the benefits of being including in a monthly lottery with a top prize of £1,000, as well as the opportunity to buy subsidised tickets for a range of events including cultural, musical and sporting events. They are also eligible to join the RVI and Freeman Fitness Centres.

Over the last year 582 staff signed up as new members, taking total membership to 7,774. During 2018/19 members had access to more than 30 events, which were attended by almost 5,000 people. These events included family days out to various theatre performances, trips away to Alton Towers and London, a number of music events and a 2,000 place Christmas Party. Theatre trips were particularly popular with over 1,000 tickets sold by the club, as were vouchers for various hotels, spas and restaurants across the region.

More information about the club is available at www.benefitseveryone.co.uk/staff-social-club/.

Support to Speak Up

The Public Interest Disclosure Act 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;
- breach of a legal obligation;
- a miscarriage of justice;
- a danger to the health and safety of an individual;
- damage to the environment; or
- deliberate concealment of information tending to show any of the above.

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, or charitable purposes”; or
- reasonably believe that the information disclosed and any allegation contained in it are substantially true.

We take our responsibilities under the Act very seriously and the Trust was one of the first in the country to appoint a truly independent Freedom to Speak Up Guardian. The role was undertaken by Caroline Parnell until December 2018. During quarter three of 2018/19, the Guardian role was reviewed and from the 1st January 2019, Andy Pike was appointed as the Trust’s Freedom to Speak Up Guardian, utilising his background in Patient Experience, Complaints, Quality Assurance and Clinical Effectiveness. During the last year, two Freedom to Speak Up Guardian reports have been received by the Board which outline the key themes associated with the role, with a particular emphasis on awareness raising. Additional activity has been undertaken to further raise staff awareness of the Freedom to Speak Up Guardian service including distributing posters, social media campaigns and open drop in sessions at all Trust locations.

Since the 1 April 2018, 44 cases from members of staff have been handled which have required further action via the Freedom to Speak Up Guardian route.

In addition to the Freedom to Speak Up Guardian, a number of other routes are open for staff to voice concerns such as:

- Speak in Confidence – the anonymous dialogue system;
- Chaplaincy Service;
- Trust Contact Officers; and
- Directly with Human Resources.

Countering Fraud

The Trust takes a proactive and robust stance against fraud, bribery and corruption. This includes the professional investigation of suspicions of wrong doing and by protecting anyone who raises concerns of this kind. This approach has seen a continual increase in referrals to the Fraud Team and demonstrable positive outcomes in terms of criminal sanctions, disciplinary sanctions and pursuing financial redress.

CODE OF GOVERNANCE

We apply the main and supporting principles of NHS Improvement’s Code of Governance for NHS Foundation Trusts on a comply or explain basis. The Code, most recently revised in July 2014 is based on principles of the UK Corporate Governance Code issued in 2012.

During 2018/19 the Board reviewed and considered the Code and considered that it complied with all recommended practice, including the identification of a Senior Independent Director. This role was filled by Mrs H Parker, Non-Executive Director, until 30 September 2018 and then Mr K Godfrey, Non-Executive Director, commenced the role in November 2018.

The Board conducted a review of the effectiveness of our 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 Executive Directors 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 for the Board and which are delegated to committees and officers.

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 external auditors, approval of the appointment of the Chief Executive, receiving the annual Audit Letter, and providing 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 a process for overseeing NHS provider organisations and identifying potential support needs. The framework looks at five themes:

- quality of care;
- finance and the use of resources;
- operational performance;
- strategic change; and
- leadership and improvement capability (well-led).

Based on information from these themes provider organisations are segmented into four categories from 1 to 4, where 4 is for providers receiving the most support and 1 for those with maximum autonomy. An NHS Foundation Trust will only be in segments 3 or 4 where it has found to be in breach, or suspected of breaching, its licence.

The Trust was placed in segment 1 and this was the Trust's position as at 31 March 2019.

The Finance and Use of Resources theme is based on the scoring of five of 67 measures on a scale of 1 to 4, where 1 reflects the strongest performance. These scores are weighted to give an overall score. Given that Finance and Use of Resources is only one of five themes in the Single Oversight Framework, the segmentation of the Trust may not be the same as the overall financial score.

<u>Area</u>	<u>Metric</u>	<u>2018/19 Q1 score</u>	<u>2018/19 Q2 score</u>	<u>2018/19 Q3 score</u>	<u>2018/19 Q4 score</u>
Financial sustainability	Capital service capacity	4	3	3	3
	Liquidity	1	1	1	1
Financial efficiency	I&E margin	3	2	2	1
Financial controls	Distance from financial plan	2	2	1	1
	Agency spend	1	1	1	1
Overall scoring		3	2	2	1

STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

Statement of the Chief Executive's responsibilities as the accounting officer of The Newcastle upon Tyne Hospitals NHS Foundation Trust

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 including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require The Newcastle upon Tyne Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of The Newcastle upon Tyne Hospitals NHS Foundation 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 Department of Health and Social Care Group Accounting 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 the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting 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;
- Confirm that the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy; and
- 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 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.

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

A handwritten signature in black ink, appearing to read 'Jackie Daniel', with a large, stylized initial 'J'.

Dame Jackie Daniel

Chief Executive

28th May 2019

ANNUAL GOVERNANCE STATEMENT

1.0. 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.

2.0. The purpose of the system of internal control

This 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 Newcastle upon Tyne Hospitals NHS Foundation Trust and Group, 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 Newcastle upon Tyne Hospitals NHS Foundation Trust and Group for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

3.0. Capacity to handle risk

The Chief Executive Officer has overall responsibility and accountability for all aspects of the Risk Management Policy, and delegates this responsibility to the Executive Medical Director. While the Executive Medical Director has a lead role in terms of reporting arrangements, all Executive Directors have a responsibility for effective management of risk within their own area of direct management responsibility, as well as corporate and joint responsibility for the management of risk across the organisation.

Structures and systems are in place to support the delivery of risk management, across the Trust and Group. Risk management training and support has been provided to staff throughout the year. This has included basic risk management training and Datix risk management system training as well as a repository of guidance accessible on the Trust Intranet.

Committees of the Board of Directors are in place to ensure effective governance for the strategic, corporate and operational risk processes and systems. The Risk Management and Assurance Committee (RMAC) receive and consider a regular report on the Trust and Group Risk Register, and an annual Risk Management Report. The Risk Management and Assurance Committee meets bi-monthly and consider the systems and processes in place to maintain and update the Board Assurance Framework (BAF). In addition to this, RMAC considers the effectiveness and completeness of assurances within the BAF and ensure that documented controls are in place and are functioning effectively.

The Audit Committee meets four times per year as a minimum requirement and provide the Board with an independent and objective review of risk management systems and practice.

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

4.0. The Risk and Control Framework

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 this strategy is overseen by the Risk Management and Assurance Committee with individual officers having specific delegated responsibilities.

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 organisations risks;
- robust systems for the identification, analysis, prioritisation and actions in relation to risks affecting all areas of Trust and Group activity;
- risk management processes that are integrated and embedded into the day-to-day activities of the Trust and Group;
- a Clinical Governance and Risk Department to support risk control processes;
- a tailored training programme to address key risk areas; and
- comprehensive communication processes for governance and risk management policies and procedures, and the dissemination of learning from lessons learned.

A Trust-wide risk register is maintained, which records when a risk has been identified, its' owners, likelihood of occurrence, potential impact and mitigating action. Directorate Managers, Clinical Directors and Heads of Departments are responsible for ensuring effective risk management in their areas, in line with the Trust and Group strategy and policies. This includes primary responsibility for the identification, investigation and follow-up of all risk related actions as defined in job descriptions and objectives. The Trust and Group continually reviews its risk and control framework through its governance and operational structures. It has identified its major strategic risks, and these are monitored, maintained and managed through the Board Assurance Framework (BAF), Corporate Risk Register and supported by Directorate Risk Registers. The Trust and Group principal risks and mechanisms to control them are identified through the BAF, which is reported to the Board of Directors regularly. These risks are reviewed and updated through Trust's governance structure.

The table below details the top three risks identified in 2018/19 and continue to be risks to the strategic objectives pertinent to 2019-20. All risks have action plans in place and are effectively managed through the risk governance arrangements.

Reference	Risk	Key Controls
D.2.1a	Inability to recruit and retain Qualified Nurses, Specialist Staff and Medics could result in the inability to provide safe, effective, high-class services.	Recruitment and Retention Strategy Planned and actual staffing data management Role Development Group Monitoring and review of staffing arrangements
A2.5e	Capacity constraints and demand pressure could result in the Trust not achieving quality and operational standards.	SITREP Meeting and Monitoring Emergency Department Winter Plan Monthly performance monitoring Weekly operational stand up meetings
A.2.5g	Due to complexity of patient conditions and the associated patient pathway, there is a risk of HCAI whilst in the care of the Trust which could result in harm, serious illness and affect the Trust's ability to achieve IPC standards of care.	Infection Prevention and Control (IPC) Leadership and Governance meeting Regional HCAI partnership HCAI reporting to Board of Directors IPC Training

The Trust and Group has adopted a risk appetite statement which shows the amount of risk the Board of Directors are willing to accept in seeking to achieve its Strategic Objectives. This risk appetite statement was developed and implemented by the Trust Board of Directors in June 2017. The Trust and Group risk appetite statement is shown below.

4.1. Risk Appetite Statement

Key Elements	Risk Level	Appetite	Statement
Quality/ Outcomes	1 (Minimal)	Low	The quality of our services, measured by clinical outcomes, patient safety and patient experience is paramount. We will provide high quality and safe services to our patients and will rarely accept risks that could limit our ability to fulfil this objective. We are strongly averse to risks that could result in poor quality care or unacceptable clinical risk, non-compliance with standards or poor clinical or professional practice.
Financial/ VFM	2 (Cautious)	Moderate	We will strive to deliver our services within the budgets modelled in our financial plans and will only consider exceeding these constraints if a financial response is required to mitigate risks associated with patient safety or quality of care. All such financial responses will be undertaken ensuring optimal value for money in the utilisation of public funds.
Compliance/ regulatory	2 (Cautious)	Moderate	The Trust sees regulatory compliance as important in optimising quality and financial sustainability. The Trust Board is willing to take a cautious approach to risks in this area.
Innovation	4 (Seek)	Significant (High)	We will continue to encourage a culture of innovation within the Trust. We are willing to accept risks associated with innovation, research and development to enable the integration of care, development of new models of care and improvements in clinical practice that could support the delivery of our person and patient centred values and approach.
Commercial	2 (Cautious)	Moderate	We will consider commercial opportunities as they arise noting that the Board's tolerance for risks relating to its commercial factors is limited to those events where there is little or no chance of impacting on the Trust's core purpose – to deliver health

Key Elements	Risk Level	Appetite	Statement
			services to those in need.
Reputation	1 (Minimal)	Low	<p>We will maintain high standards of conduct, ethics and professionalism.</p> <p>The Board's tolerance for risks relating to its reputation is limited to those events where there is little or no chance of significant repercussion for the organisation.</p>

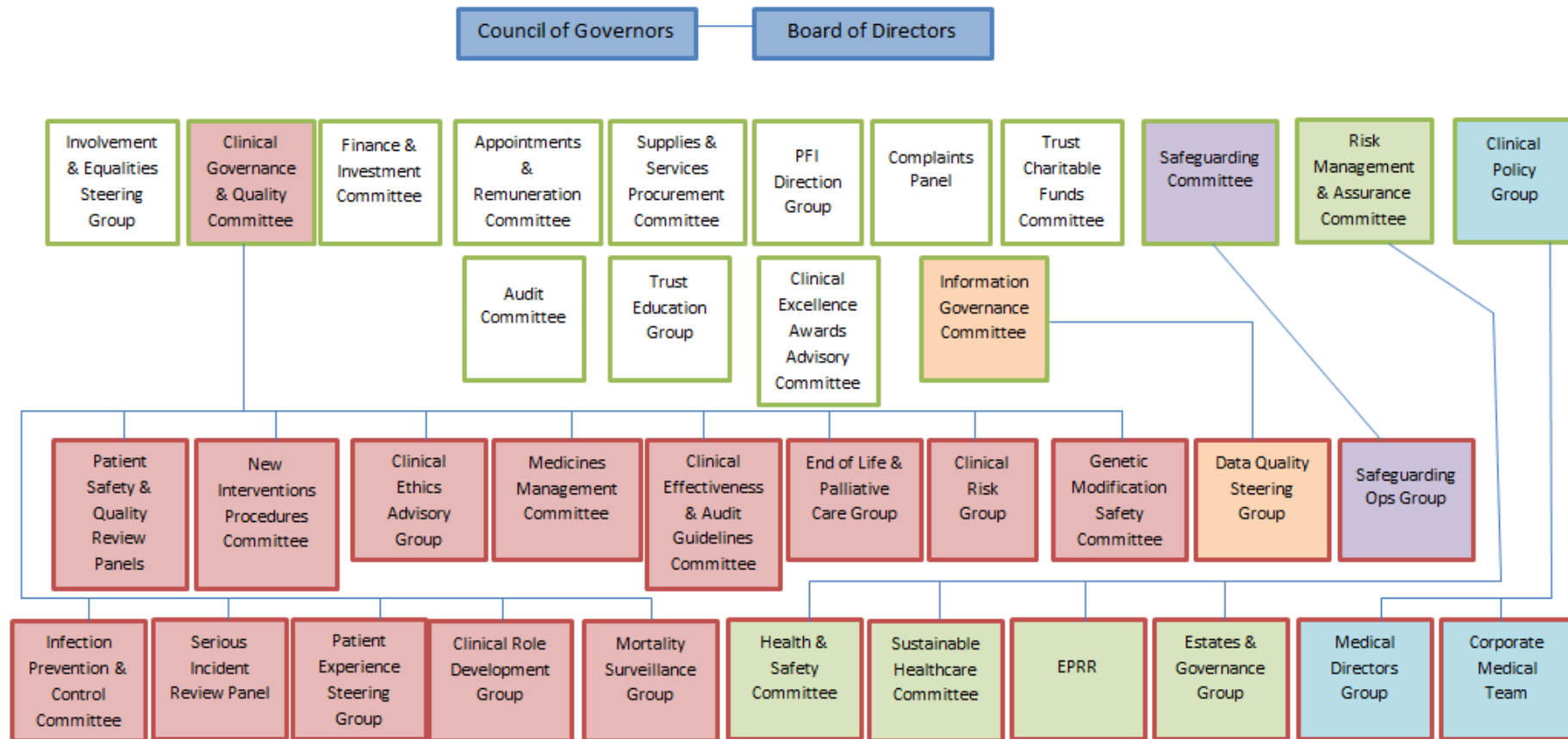
The Risk Management and Assurance Committee is the core committee for ensuring there is a robust approach to risk management throughout the Trust and Group. The Risk Management and Assurance Committee is chaired by a Non-Executive Director and has Executive Director Membership.

This committee has oversight of the BAF and risk management arrangements for both corporate and operational risk.

The Trust Quality Governance arrangements are delivered through the quality governance structure detailed below. There are established and robust Trust-wide systems to facilitate the monitoring, review and oversight of quality governance and ensure that the key commitments described in the Quality Strategy are delivered.

The Integrated Quality and Performance Report is a standing agenda item for the Trust Board and is used for reporting on quality and performance metrics to the Trust Board of Directors. The Quality section of the Report is also shared at a number of meetings including the Clinical Risk Group, Clinical Policy Group, Governors and Commissioners at the CCG Quality Review Group.

5.0. Quality Governance Structure



The Clinical Governance and Quality Committee have oversight of the Quality Governance framework detailed above. The Trust conducts a detailed annual self-assessment against the NHSI/CQC Well-Led Framework.

Care Quality Commission (CQC) Registration compliance is managed through the quality and governance structure. The Medical Director is responsible for the oversight of all compliance assessments and management of on-going compliance.

The Trust has an established quality surveillance programme designed to provide assurance to the Board that high quality care is being delivered across all services to ensure areas requiring improvement are identified. The Patient Safety and Quality Review process was launched in 2015 and is aligned to the CQC inspection approach. Further information on the Patient Safety and Quality Review Process can be found in the Trust Quality Strategy 2018-2021. This is also supplemented by a programme of 'Leadership Walkabout' visits to services across the Trust by the Executive Team members and Non-Executive Directors.

The Trust is registered with the CQC and has maintained full CQC registration since 2010. The CQC conducted a full comprehensive inspection in 2016 and rated the Trust as 'Outstanding'.

6.0. Principal risks to compliance with NHS Foundation Trust governance

The Newcastle upon Tyne Hospitals NHS Foundation Trust and Group ensures compliance with NHS Foundation Trust Licence condition FT4 Corporate Governance. The Board is satisfied that Trust has established and implemented all requirements of the licence condition with no material risks identified.

The Board of Directors, Audit Committee and Risk Management and Assurance Committee all play a role in ensuring the Trust and Group 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 Board sub-committees are presented to the Board as standing agenda items

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

Systems are in place to ensure the Trust and Group 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.

The Board of Directors, as required under NHS Foundation Trust condition 4(8)(b) assures itself of the validity of its Corporate Governance Statement. The Board of Directors review the Corporate Governance Statement every year to ensure that declarations being made can be supported with evidence. It considers the risks and mitigating actions that management provided to support the Statements and determine, both from its own work throughout the year - particularly the testing of the controls set out in the Board Assurance Framework - and assurances provided from the work of the Trust and Group's internal, external auditors and other external audits or reviews, whether the Statements are valid.

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 and Group 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 receives business cases which are over a specified threshold. All business cases are reviewed at the Business Case Review Meeting who meet on a monthly basis. This process is underpinned by quarterly performance reviews and scrutiny by the Finance and 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.

The Trust and Group supports an open reporting culture and encourages staff to report incidents through its Datix internal reporting system. Policy, guidance and training are provided to staff on the reporting, management and dissemination of lessons learnt. The Trust has adopted the principals of the 'Sign up to Safety' national patient safety campaign and is committed to the ambition of halving avoidable harm in the NHS. The Trust and Group involves stakeholders in identifying and managing risks to its strategic objectives in a number of ways. These include:

- Partnership working with health and social care services, regional NHS care providers and good working relationships with Overview and Scrutiny Committees.
- Regular engagement with governors on strategic, service and quality risks as well as engagement on quality priorities and the development of the quality account.
- Active engagement with patient experience forums and staff and public members meetings working on quality improvement and service risks.

The Trust and Group has also appointed a Director of Communications and Engagement during 2018, a key role of this post will be to develop and maintain effective relationships with key stakeholders of the Trust.

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

NHS Foundation Trusts are required to publish an up to date register of interests for decision-making staff within the past twelve months as per the 'managing conflicts of interest in the NHS' guidance. The Trust and Group has published its Board of Directors register of interests on its website. Declaration of interest forms are sent to all relevant staff on an annual basis and a register of interests is published in the Trust Annual Report and Accounts.

6.1. Workforce Safeguards

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

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

The Trust and Group workforce strategy is endorsed by the Trust Board with the principle objective to be the 'Employer of Choice'. A key aim within this strategy is to enhance the staff experience, promote the 'employee voice', and increase diversity and inclusion across all workforce groups. The strategy informs action plans and objectives, which are, measured through the Trust's performance management framework and appraisal processes.

The Trust and Group reviewed equality data annually in relation to:

- recruitment (applicants, shortlisted and appointed);
- staff currently in post;
- distribution of the workforce;
- employee relations events (including disciplinary, capability, grievance, dignity and respect);
- flexible working applicants;
- access to training; and
- leavers.

Monitoring provides data, which informs plans and strategies to achieve an inclusive workplace and make improvements to the working environment for all staff. The outcomes are reported to the Trust Board annually and the equality and diversity action plan is updated as appropriate.

The Equality Duty requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations in the course of developing policies and delivering services. Equality Analysis is completed on all policies, procedures, strategies and service developments.

The Equality Delivery System is designed to specifically support service delivery that is fair, providing equality of access to employment and delivery of services that meets the needs of a diverse population. The Trust and Group introduced the audit tool a number of years ago and annually undertakes a full grading exercise. The outcomes are reported to the Trust Board annually and the equality and diversity action plan is updated as appropriate.

The Trust and Group publishes its Gender Pay Gap Report annually on its own website and the designated government website. It has an action plan to address the issues identified.

The Trust and Group uses Workforce Race Equality Standard data to track progress against nine metrics to identify and help eliminate any differential in the treatment of staff. Information is presented to the Trust Board annually and a Workforce Race Equality Standard action plan is agreed. The Trust and Group is cognisant of the national requirements outlined in the NHSE/I 2019 'Model Employer' strategy to increase Black, Asian, Minority Ethnic (BAME) representation at senior level across the NHS and action plans are in place develop to achieve this ambition.

The Trust and Group has a Health Equality and Wellbeing Committee in place and the aims and objectives of the Committee include: ensuring the Trust is compliant with national and local legislation, initiatives, policies and standards; influencing the culture of the organisation to ensure that involvement and equality is embedded at every level; and ensuring the Trust and Group contributes effectively to reducing health inequalities and promoting wellbeing. Staff networks are represented and the Committee provides a direct reporting route to the Trust Board.

The Trust and Group has established staff networks in place for BAME, disability and LGBT staff. These groups help review and inform the Trust's action plans, policies and procedures. The terms of reference for these groups include:

- to promote a work environment in which staff feel supported and valued, whilst enabling them to fulfil their potential and contribute fully to the benefit of the service and our patients.
- to challenge discrimination and to positively promote equality.
- to manage a network of staff that can offer advice and support to others.
- to ensure that good practice and initiatives to promote issues are shared.
- to provide a forum for discussion and debate which draws on knowledge and experience.
- to act as a driving force to promote continuous practice improvement.
- to develop and coordinate an action plan for positive change and ensure Trust policies are inclusive.
- to assist the Trust and Group in meeting its obligations regarding its duty under the Equality Act and NHS Equality Delivery System (EDS).
- to provide a place for staff receive peer support i.e. raise concerns and ideas in a safe and confidential environment.

Equality and Diversity is a Trust and Group Mandatory Training requirement for all staff and is one of the Trust's Human Resources Key Performance Indicators. Compliance with requirements is monitored and reported throughout the year to managers, Staff-side, and the Trust Board.

The Trust and Group has undertaken risk assessments and has a sustainable development management plan in place, which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust and Group is committed to delivering sustainable healthcare at its very best, within available environmental and social resources, protecting and improving health now and for future generations. The Trust and Group sustainability strategy concentrates on the delivery of three goals:

Goal 1 – A healthier environment.

Goal 2 – Communities and services are ready and resilient for changing times and climate.

Goal 3 – Every opportunity contributes to healthy lives, healthy communities and healthy environments.

A Board approved sustainability development management plan is in place, which sets out how the key aims of the strategy will be achieved. A sustainability report is produced annually demonstrating progress towards the achievement of the sustainability goals.

7.0. Review of economy, efficiency and effectiveness of the use of resources

The Trust and Group has a range of processes to ensure that resources are used economically, efficiently and effectively. This includes regular reporting to Board on quality, operational performance, finance and safety with further review and scrutiny at sub-committees of the Board and management levels throughout the Trust.

Systems are in place to ensure the Trust and Group complies with its duty to operate efficiently, effectively and economically 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.

The Trust Board has agreed an annual audit programme with the Trust and Group internal auditors through delegated authority to the Trust Audit Committee. The Audit Committee receives internal audit reports in line with an agreed work plan that aims to test the economy, efficiency and effectiveness of Trust and Group systems and processes, including financial management and control. The audit plan is reviewed and agreed by the Audit Committee in April each year.

Any report which offers 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.

8.0. Information Governance

The threat to digital services through cyber-attack is recognised by the Trust and we are committed to ensuring the organisation complies with the UK Data Protection Act 2018, NHS Data Security Standards and achieving the Cyber Essentials Plus certification.

The Trust and Group have effective arrangements in place for Information Governance and monitoring of performance against the Data Protection and Security Toolkit with reporting through the Information Governance Committee and reporting to Board of Directors.

In May 2018 the UK Data Protection Act 2018 came into force. This act aligns with the NHS Data Security Standards and includes requirements for new or changed IT systems to be developed with data privacy by design as a pre-requisite with the starting point being the protection and security of the personal data held and processed by the Trust and Group. The Trust and Group has implemented processes and procedures to monitor the privacy throughout the lifecycle of developments.

The Data Protection and Security Toolkit is the mandated method for monitoring the Trust and Group performance in the key areas of Data Protection and technical/cyber security. This will be based on the NHS Data Security Standards and is focussed on ensuring the Trust and Group remains compliant with laws concerning personal information handling and sharing, along with remaining resilient to current and future cyber threats.

In 2018/2019 the Trust and Group reported two Information Governance incidents to the Information Commissioners Office (ICO) which was classified at level 2 in accordance with ICO guidance. Details of the incidents can be found in the table below.

The first Data Security and Protection Toolkit submission was completed on 31 March 2019, the evidence to show our progress with the toolkit was externally assessed and the Trust and Group are currently graded as 'standards not fully met (plan agreed)'.

Nature of incident	No of data subjects potentially affected	Action	Outcome from ICO
Departmental patient records incorrectly disposed.	10	Full investigation and review undertaken in accordance with Trust information governance procedure. Initial findings and actions were reported to ICO on 25.06.18.	No further action taken.
Ward handover information found by member of the public.	15	Full investigation and review undertaken in accordance with Trust information governance procedure. Reported to ICO on 28.02.2019.	No further action taken.

9.0. 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 issues 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.

The Quality Account represents a balanced view and there are appropriate controls in place to ensure the accuracy of the data.

The Trust consults widely with public, staff, Trust Governors and Trust Members drawing on feedback and patient experience to inform the Quality Account/Report. The Trust seeks comments from a wide range of partners and outside agencies including Newcastle and Northumberland Health and Wellbeing Overview and Scrutiny, Healthwatch and Commissioners on areas of improvement and formal feedback received is incorporated in the annual Quality Account report.

The Trust Quality Account sets out to demonstrate the Trust's commitment to the delivery of driving quality and putting patients first through the establishment of the Trust Quality Priorities enabling the Trust to continue to improve and deliver high quality, effective care.

Quality governance arrangements are detailed in section five of the Annual Governance statement. The Director of Quality and Effectiveness is the responsible lead for the production and development of the Quality Account/Report. A detailed development plan and process for review and production of the Quality Account/Report ensures a robust formal review takes place. The Quality Account/Report drafts are formally reviewed through the Trust Governance meeting arrangements as well as being shared with our partners.

The Trust has controls in place to ensure the quality of care provided and accuracy of the data used in the Quality Account. Key policies include:

- Management and reporting of accidents and incidents;
- Concerns and complaints policy;
- Clinical records policies;
- Data quality policy; and
- Standards of Business Conduct policy.

The Trust have an extensive range of clinical governance policies and these are reviewed at appropriate intervals but no later than three years to ensure our operating policies reflect the best practice. We have robust policies for the recruitment and the development of staff. In addition, mandatory and statutory training of staff is a key performance indicator and this is also reported to the Board of Directors at quarterly intervals.

Systems and processes are in place to ensure the Trust continues to improve and maintain the quality of patient related data. The core principles of the Trust's Data Quality Policy is to improve and maintain the quality of patient related data and this is underpinned by a range of regular audit reports and initiatives such as regular validation of clinical and administrative data, in particular inpatient and outpatient waiting lists and the production of regular data quality reports to identify and collect missing data items and errors.

To assure the data used in the Quality Report and Quality Account, the Trust has an Information Governance Committee. 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 validation.

The Trust has a robust Performance Management Framework to define the structure and process for effective management of performance throughout the Trust and processes, roles and responsibilities are well defined at all levels of the organisation. The Performance Management Framework is firmly integrated throughout the Trust to ensure Directorate/ Department level processes and systems feed into and support the high-level organisational objectives and priorities. An Integrated Quality and Performance Report is produced and reported routinely to the Board of Directors, which details performance against metrics and quality priorities.

Directorate Quality and Performance Reviews take place throughout the Trust at Directorate level, which focuses on performance on a range of metrics. The purpose of

Performance Reviews is to ensure that Trust Directorates and Departments are progressing in line with aims, objectives and priorities, as well as focussing on any outliers in performance metrics.

10.0. Review of effectiveness of internal control

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit, and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. 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 2018/19 provided a good level of 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.

Executive managers within the organisation, who have responsibility for the development and maintenance of the system of internal control, provide me with assurance. The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principle 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 Trust and Group, 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 2018 to 31 March 2019, and up to the date of approval of the Annual Report and Accounts, that supports preparation for the Annual Accounts on an ongoing basis.

Regular reports have been reviewed from sub-committees and individual offers in relation to all key risks. Annual reports have been received by the Board of Directors in 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 Corporate Risk Management and the Clinical Governance and Risk Department. Individual Directors and senior manager are empowered to assess and manage risks within their own areas of responsibility, linking closely with wider Trust and Group processes. Significant support was provided via training, advice and guidance documentation to enable senior staff to effectively fulfil their functions.

An analysis of controls and assurance 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 risk for all departments and key functions. The Risk Management and 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 and monitors action in response to specific risks identified via the Complaints Panel. The Risk Management and Assurance Committee provide 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 and Group 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, the National Patient Safety Agency, Care Quality Commission, and National Audit Office.

Conclusion

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



Dame Jackie Daniel
Chief Executive
28th May 2019

3. ANNUAL QUALITY REPORT



QUALITY REPORT

2018/19

**Unconditionally registered with the
CQC since April 2010**

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Part 1

Quality Account – Statement on Quality from the Chief Executive

It gives me great pleasure to present our Quality Account for 2018/19.

The Quality Account reviews the progress we have made this year and outlines our priorities for the year ahead. It is a celebration of our achievements and improvements for patients, families and staff.

Providing high quality, patient focused care remains our highest priority. Our staff work tirelessly to ensure that patients receive the safest, most clinically effective care and a positive patient experience each and every time they use one of our services. Feedback from our patients shows that 97% of our inpatients would recommend our care to family and friends.

We are continually learning and improving and I am committed to encouraging a culture of openness and honesty.

I am very conscious of how busy staff and our leadership teams are right now and want to take this opportunity to thank them. It's a challenging time but one with many opportunities as we begin working to deliver a new long -term plan for the NHS and at the same time lay out our own strategic plan for the next five years here at Newcastle Hospitals. Delivering great care today, whilst co-designing our approach for our future, is essential if we are to support a sustainable health and care system. That doesn't mean it's easy, but we have a strong track record of leading the NHS from the North East.

Last year, Newcastle's Dialysis Unit celebrated its 40th birthday. Based at the Freeman Hospital, the service has offered pioneering, revolutionary procedures to improve the efficacy of patient care. A particular highlight was the first description of aluminium bone disease in dialysis patients (so called 'Newcastle Bone Disease') which led to improved dialysis water standards benefitting patients across the world.

The Northern Centre for Cancer Care (NCCC) continues to be at the forefront of lifesaving treatment and has become the first radiotherapy centre in the UK to offer cutting-edge radiosurgery technology to treat patients with brain cancer. It has also treated the first UK prostate cancer patients using pioneering MRI-only planning technology and radiotherapy.

We have also been able to bring care closer to patients by introducing the new 'single point of access' musculoskeletal service for people across Gateshead and Newcastle offering self-care and fast access to information, resources and expert opinion about a variety of back, neck, joint or general muscle conditions.

Much of this pioneering work is a result of our commitment to research and a culture focussed on continuous improvement. The Trust currently tops the NHS Research Activity league; conducting more research programmes than any other NHS provider - an incredible 550 studies last year and an increase on the previous year.

It is with pride that I note we have received a "Gold Award" for our outstanding support to the armed forces. We were one of 50 organisations in the UK, to receive the highest

badge of honour in the Defence Employer Recognition Scheme for our long-term commitment to the armed forces community.

Our second Quality Strategy was launched in 2018. This new strategy outlines our aim to create a culture of continuous improvement to increase and sustain the quality of our services for the people of Newcastle and beyond. Quality Improvement has become an integral part of everyone's daily work.

I would like to end by thanking and commending all of our staff. Without their skill, loyalty and commitment we would not be able to achieve such high quality services. Their dedication and focus is firmly on ensuring the very best outcomes for our patients.

A handwritten signature in black ink, appearing to read 'J. Daniel', with a large, stylized initial 'J'.

Dame Jackie Daniel
Chief Executive
The Newcastle upon Tyne Hospitals NHS Foundation Trust
28th May 2019

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

Part 2

Review of Quality Performance 2018/19

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 18 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 to ensure that the indicators presented in this document are what the public expect to be reported. Comments have been requested from the Newcastle Health Scrutiny Committee, Newcastle Gateshead Clinical Commissioning Group (CCG) and the Newcastle and Northumberland Healthwatch teams. Amendments will be made in line with this feedback.

Quality Priorities for Improvement 2018/19

Patient Safety

Priority 1 - Reducing Infection – focus on MSSA/E.coli

Why we chose this?

Staph aureus bacteraemias are infections that can cause significant harm. E. coli bacteraemias are the most common cause of Gram negative sepsis. At The Newcastle Upon Tyne Hospitals NHS Foundation Trust (NUTH), these are most commonly associated with lines and indwelling devices; achieving excellent standards of care and improving practice is essential to reduce these infections in line with our zero tolerance approach.

E.coli and other Gram negative bacteraemias constitute the biggest cause of sepsis nationwide. Proportionally, at NUTH, the main source of infection is urinary tract infections, mostly catheter associated, reflecting the national picture. An integrated approach engaging with the multidisciplinary team across the whole patient journey, focusing on antibiotic stewardship, early identification of risks and timely intervention formulate the basis for our strategy to reduce these infections.

What we aimed to achieve?

We aimed to achieve

- 10% reduction year on year of MSSA bacteraemias.
- 50% reduction of E.coli bacteraemias by 2021.

What we achieved?

- Worked in partnership with the CCG on a quality improvement programme to reduce healthcare associated urinary tract infections (UTIs), and catheter associated urinary tract infections (CAUTIs).
- Increased understanding and awareness of the causative factors, avoidance, earlier recognition and diagnosis of UTI/CAUTI, as well as timely removal of indwelling devices.
- Introduction of a urethral catheter care plan incorporating the HOUDINI tool, based on best evidence practice.
- Held focus groups to recruit champions and discuss improvement strategies.
- Introduced Aseptic non-touch technique (ANTT) assessment mandatory for medical staff (as an addition to the current competency for all other staff groups).
- Introduced care bundles to prevent line-related infections and surgical site infections.
- Introduced care plans for surgical wounds.
- National guidance for surgical skin prep with 2% chlorhexidine AND 70% alcohol incorporated into the Infection Control Practice in the Operating Department Policy.
- Introduced peripheral IV cannula packs.
- Undertaken quality improvement projects that have led to MSSA reductions in areas of high prevalence, for example, a quality improvement project to prevent line related sepsis in patients undergoing long-term renal replacement therapy.
- Created working groups to look at specific areas, such as central venous lines in paediatrics.
- IV Nurse Specialist-led audits of practice in areas of high incidence which have assisted in identifying areas for improvement and focused education.
- Developed education resources such as posters, screensavers, bedside prompts, catheter safety cross, use of mobile education boards.
- Undertook a Quality improvement project with surgical services to focus on hepatobiliary sepsis.

How we measured success?

- Sustained reductions of bacteramias in individual directorates.
- Audited compliance with best practice which demonstrated:
 - **25%** decrease of the use of urinary catheters;
 - **21%** reduction in the use of catheters used for **over 28 days**;

- **34.75%** reduction in the number of older people living in care homes being admitted to hospital with a UTI; and
- Improved management of IV devices.

Priority 2 – Pressure Ulcer Reduction

Why we chose this?

Reducing hospital acquired pressure ulcers was chosen as a priority as it was recognised that the incidence within the Trust and nationally remained high and therefore targeted work around reducing harm from pressure damage was required. Pressure ulcers are a key indicator of the quality and experience of patient care. Despite national campaigns to reduce them, they remain a significant healthcare problem:

- over 1,300 new pressure ulcers are reported nationally each month;
- treating pressure ulcers costs the NHS more than £1.4 million every day; and
- developing a pressure ulcer leads to an increased length of hospital stay (an increase on average of 5-8 days).

The increase in patient age, acuity and frailty means that the Trust are seeing more patients with a higher risk of acquiring pressure ulcers and therefore the risk of the incidence of pressure ulcers increasing is great. It is therefore essential that the Trust identified this as a priority to ensure the risks of this were mitigated with accurate assessment throughout admission and on discharge, together with the implementation of best practice interventions.

Furthermore, pressure ulcers are largely preventable if the correct assessment and prevention plans are implemented and therefore the organisation is committed to reviewing and embedding processes which would improve patient care and outcomes.

What we aimed to achieve?

- To minimise the episodes of preventable harm which occur in the Trust related to pressure damage.
- Undertake focused work to achieve a reduction in the development of heel damage by 10%.
- Ensure we have a skilled and educated workforce with sound knowledge base related to pressure damage.
- Sustain Critical Care Task Force sharing best practice across all areas to support sustained pressure ulcer reduction.

What we achieved?

Despite various work streams, and the efforts of the Tissue Viability team working with staff on the wards and in the community, a significant reduction in Trust acquired pressure damage has not been achieved.

In spite of this, some success has been achieved including:

- A 6% reduction in pressure damage incidence to heels.
- 20 wards or departments did successfully achieve a 20% reduction or more in pressure ulcer incidence (35% of the wards and departments across the organisation).

- On-going face to face training has been delivered via the Preceptorship Course, the Healthcare Academy, link nurse study days, compression bandage study days, wound debridement course and mattress champion training.
- The Trust e-learning package for pressure ulcer prevention remains best practice and compliance with this has increased.

The critical care task force group has been revised and now has a new Chair (Nurse Consultant for Critical Care) who is working closely with the Tissue Viability Team to refocus the work streams ongoing in the 4 critical care units.

How we measured success?

Despite not reporting a significant reduction in Trust acquired pressure ulcers overall across the organisation, the ongoing monitoring and analysis of incidents has been maintained by the Tissue Viability team. Every pressure ulcer or moisture lesion incident is reviewed by the team to ensure validity of reporting and consistency in grading of incidents. This ensures that the organisation is consistent in reporting and gives an accurate baseline to measure improvement.

In the latter half of the year, an innovative approach to pressure ulcer prevention was therefore implemented. The Trust took the opportunity to re-focus and strengthen the approach to reduction in pressure ulcers and falls under single leadership. The Clinical Improvement Lead (Falls and Pressure Ulcers) is now working with the team to embed Quality Improvement (QI) methodology in targeted areas where there is a high rate and incidence of pressure ulcers and falls. It is too early to measure improvement with this strategy but it will be continually monitored via the Integrated Quality Report.

Priority 3 – Management of Abnormal Results

Why have we chosen this?

There have been over 60 reported incidents, over the two years, where abnormal or unexpected diagnostic results had not been seen or acted upon by medical staff. Causes were varied but included failure to receive, view or act on the relevant report, errors in communication and/administration and the lack of a failsafe mechanism for dealing with abnormal results when physicians were away from the hospital. In some instances, this has resulted in serious incidents by causing delays in the patients' treatment pathway.

What we aimed to achieve?

A long-term solution for the effective and efficient communication of abnormal results across all of the reporting specialties to the responsible clinician in order to minimise incidents. The solution will be, user-friendly and accessible offering consistency 365 days of the year. It will be unaffected by busy periods of work, staff sickness or annual leave. Abnormal results will be automatically highlighted for action to the clinician and auditable. This will be distinct from the reporting of normal test or investigation results. A failsafe system will also be in place to ensure that abnormal results are acted upon within a short, pre-defined period by another designated responsible clinician if the primary physician is away from the Trust or has not taken action.

What we achieved?

The way in which the reporting system will operate has now been finalised by the working group after exploring the lessons learned from incidents within the Trust, reviewing national guidelines and observing systems used in other Trusts. Abnormal results will be sent as a red flag message from the reporting specialty to the requesting consultant, viewable in the eRecord message centre. Red flag messages can only be deleted by the consultant. Action may have been taken by another member of the team and this will be viewable. Red flag messages will move with the patient through their admission journey e.g. from Accident and Emergency to a general medical ward, so a change of location or specialty does not lead to results being missed.

A recent Serious Incident (SI) concerning missed radiology results further highlighted the need for our robust system. The incident was reviewed by the Healthcare Safety Investigation Branch and gave us an opportunity to share our vision and concept and gain feedback. The plan was well received.

If a red flag message remains in a consultant's inbox for more than a defined period (e.g. 5 days) it will automatically be forwarded for action to another team member. By default, this will be the Clinical Director but Directorates may define an alternate failsafe. This will ensure that patient management is unaffected by absence or periods of inaction.

There have been ongoing discussions regarding alert thresholds and their definition. It is important to avoid a situation where inboxes are filled with red flag messages as the impact will diminish. In radiology these can be well defined through existing guidelines and medical judgment at the time of reporting. In other disciplines, such as haematology and biochemistry, defining thresholds is more challenging particularly where "normal abnormal" and "abnormal normal" results may occur. To assist with this we have visited neighbouring Trusts to review their mechanisms, protocols and thresholds for reporting abnormal results electronically to inform our own processes.

How we measured success?

There is now a shared vision of how the abnormal diagnostic results system will operate and how it will look to users in parallel with the full implementation of the GDE project. Through strong links with the IT and GDE teams, we have determined that the concept is now fully deliverable using our current and proposed electronic clinical records system. The implementation time-frame is now of great importance to avoid further incidents or the need for an interim solution. Implementation will require a change in culture and workflow for consultants to focus on the message centre inbox to be notified of abnormal results. As radiology missed abnormal results account for the vast majority of incidents we will focus on this reporting specialty at the start of implementation in the Trust.

The working group continues to analyse incidents to highlight common causative themes and map the incident to the new alerting system to determine whether it could have been prevented.

Priority 4 – Local Safety Standards for Invasive Procedures (LocSSIPs)

Why we chose this?

National Safety Standards for Invasive Procedures (NatSSIPs) are essentially a set of key standards that should govern the delivery of care that involves an invasive

procedure(s). Their aim is to reduce the risk of the 3 surgical never events that can occur during invasive procedures:

- Wrong Site / Procedure.
- Retained foreign body.
- Wrong implant inserted.

It is recognised that they should govern practice throughout the hospital, not just in the operating theatres.

The aim of NatSSIPs is that they should standardise key elements of procedural care. The process involves the use of checklists, but not limited to them. The standards should be implemented against a background of education in human factors and working as teams and a key element is that they should reinforce the importance of education to patient safety. As part of the process, organisations should review their invasive procedures and adapt the NatSSIPs to develop local standards for invasive procedures (LocSSIPs) that reflect local circumstances. The standards for a major surgical procedure performed under general anaesthesia in an operating theatre cannot and should not be identical to those supporting a procedure under local anaesthesia in a ward.

Each LocSSIP should address each of the 13 standards set out in the NatSSIPs:

Organisational

- 1 Governance and audit
- 2 Documentation of invasive procedures
- 3 Workforce
- 4 Scheduling and list management
- 5 Handovers and information transfer

Sequential

- 6 Procedural verification and site marking
- 7 Safety briefing
- 8 Sign in
- 9 Time out
- 10 Prosthesis verification
- 11 Prevention of retained foreign objects
- 12 Sign out
- 13 Debriefing

What we aimed to achieve?

- All Directorates would look at the range and number of invasive procedures carried out (not including those performed in operating theatres).
- Teams involved in performing these invasive procedures would then review their current processes and start to incorporate the NatSSIPs process to develop their own LocSSIPs.
- Directorates produce and share their own LocSSIPs.
- Areas deemed to be of particular priority (based upon national reporting of complications rates) included:
 - Endoscopy.

- Cardiac catheter labs.
 - Interventional radiology.
 - Dermatology.
 - Chair dentistry.
- By the end of 2018/19 a minimum of ten LocSSIPs will have been implemented.

What we achieved?

LocSSIPs have managed to make their way up the safety agenda of all Directorates within the Trust and the process has become embedded in practice in most, if not all, of our clinical areas where invasive procedures are performed. The process was never about throwing out old and trusted methods of approaching safety, but building on the success of many years' experience in delivering safe care by incorporating these newer ideas to create a standardised and up-to date approach to team working. As such, the introduction of the LocSSIP process has allowed multidisciplinary teams to review their working practices and create updated processes that ensure a more team based approach, standardisation of care and better education for all staff around human factors and risk reduction.

The introduction of LocSSIPs was initially part of the surgical stream of the Sign Up to Safety campaign: a multi-disciplinary group initially developed two complete LocSSIPs; one highly complex (governing all invasive procedures undertaken in the Trust's operating theatres) and one relatively simple (covering the insertion of chest drains in the ward setting). Using these two exemplar LocSSIPs, Directorates had a template to develop their own set of local standards. Following presentations at the Trust Clinical Risk Group, individual Directorate risk management teams identified the range and breadth of invasive procedures within each clinical area, reviewed current safety practice and then developed LocSSIPs for individual invasive procedures.

All of the above planned aims for introducing the LocSSIP process into Newcastle Hospitals have been achieved, and in particular, LocSSIPs have been developed and introduced into the 5 priority areas. Directorates have taken ownership of their own areas and are responsible for ensuring that the LocSSIP process is ongoing in terms of staff education and audit of outcomes updating of safety processes when is necessary.

How we measured success?

Our measure of success is the introduction of a standardised safety process for invasive procedures within the Trust that minimises risk to our patients. We have identified all invasive procedures and where they are performed, in each Directorate, each invasive procedure has a LocSSIP process underway. The progress of this forms part of each Directorate's Clinical Governance review process, and this feeds back to the Clinical Risk Group which has overall responsibility to ensure that compliance is monitored.

Priority 5 – Human Factors Training

Why we chose this?

From learning nationally, we know that patients can come to harm from avoidable errors in hospitals. Such errors are not intentional but can occur if the processes and equipment used are not designed well enough to fit along-side human capabilities and limitations. Giving staff an understanding of this enables them to design ways of working

that makes it easier for staff to get work done in the right way and reduces the likelihood of errors occurring.

Having a human factors approach to patient safety differs from traditional safety training in that the focus is less on the technical knowledge and skills required to perform tasks and administer care, and rather on the cognitive and interpersonal skills needed to effectively manage patient care safely.

What we aimed to achieve?

Through Human Factors education, we aimed for all grades of staff to have an understanding of human factors in order to apply this understanding to enable them to improve the systems and processes that they work with day after day.

By using a human factors approach, we aimed to improve the Trust's safety culture due to the potential for reducing risk and avoidable harm, improving our investigation processes when things do go wrong, and by developing a culture where staff are confident to speak up when they have concerns.

What we achieved?

- Multiple human factors staff education sessions (including Simulation training) and ad hoc human factors awareness sessions delivered to staff across the Trust to a range of staff groups.
- All Foundation Doctors receive Human factors Training.
- Leadership from the Trust Board with a commitment to quality improvement, which is linked to higher quality care. Human Factors education was delivered to the Trust Board in April 2018.
- A human factors approach has been incorporated into Trust processes for investigating patient safety incidents including; Serious Incident (SI) investigation; the development of a *Trust Incident Investigation Tool* and revision of the Trust incident investigator training course.
- A human factors approach is incorporated into the Trust's Quality Improvement Strategy.


How we measured success?

A change in culture within an organisation, which is the main focus of this Quality Account Priority, is difficult to measure however it is hoped that adopting a Human Factors approach across multiple staff disciplines and specialities (both clinical and non-clinical) will ultimately support a reduction in patient harm and improved patient experience.

It is difficult to evidence that these are a result of Human Factors training. However, measurable outputs which indicate that these aims are being delivered include:

- The completion of a Human Factors education sessions to raise awareness.

- The evaluation of feedback from staff undertaking training and awareness was uniformly good. This was from a diverse cross-section of the hospital team including nursing, portering, medical, and allied professional staff.
- New Incident investigation training course development (incorporating human factors & NHSI 'A Just Culture').
- New generic Trust Incident Investigation Tool (incorporating human factors) available for staff to use.
- All Serious Incident (SI) investigations incorporate Human Factors approach.
- Ongoing development of short & long-term objectives to help facilitate Trust-wide roll-out of Human Factors training.

The Newcastle upon Tyne Hospitals 
 NHS Foundation Trust

**GENERIC INCIDENT INVESTIGATION TOOL FOR INCIDENTS AND NEAR MISSES:
 Incorporating a HUMAN FACTORS approach.**

(For FALLS, PRESSURE ULCER AND MEDICATION INCIDENTS please use SEPARATE CUSTOMISED TOOL)

DATIX Incident Report Number: W

Patient Initials & MRN:

Brief Overview of incident:

(Cut & paste from Datix)

Stage of admission (Delete if not appropriate)

Pre-operative assessment / Inpatient / Discharge / Outpatient / Community / A&E

Incident Contributory Factors Assessment:

Equipment factors	If yes:	Additional information/comments
Was there a problem with the equipment or supplies?	Was equipment/supplies : <ul style="list-style-type: none"> Maintained Available Trust approved Appropriate for that purpose Well designed (ie not confusing to use) Unambiguously labelled/ packaged 	

Version No.:	3	Effective From:	March 2019	Expiry Date:	March 2021
Issued by:	CGARD and Pharmacy				

Clinical Effectiveness

Priority 6 – Digital enhancements to care

Why we chose this?

Information Technology (IT) offers the ability to overcome several limitations of the human mind (Human Factors) but is also recognised for potentially introducing new or unintended risks into the system. One of NHS Improvements top priorities is Deteriorating Patients and this focus is being driven through the Patient Safety Collaborative. Moving from the paper-based observation charts to electronic enables a significant lift in patient safety. Targeting the known weaknesses in the paper-based system of missing observations, incorrect scores and delayed observations.

What we aimed to achieve?

Establish a data warehouse, analyse data to identify factors involved in determining the effectiveness of the IT healthcare interface. Build, test and deploy an electronic observations system for adults across the organisation. Refine the interface, educational model and make data available to all frontline staff. Share identified areas of good practice.

What we achieved?

The new data warehouse was installed in December 2018 and is now in a trial phase, moving towards the ability to give front-line staff access to clinical data very close to real time. Data from the whiteboards has been analysed locally and externally. We have identified critical factors associated with improved outcomes related to the clinical alerts. Two critical factors are good clinical leadership and ward processes that have an integrated multidisciplinary team morning board round. The combination of these two factors was associated with significantly reduced variation and improved glycaemic control.

The electronic observation system has been developed and tested on wards 16 and 30 at the RVI. After several iterative rounds of improvement to the design, the system was rolled out. A novel educational strategy was used where the electronic tablets were deployed to the wards two weeks before the system went live. This enabled the staff to upskill as the education was built into the tables as we had designed a training mode. This approach significantly reduced the time staff required away from the clinical area to be trained and enabled a large scale go live of 25 wards in a single day, which we repeated two weeks later moving from the RVI to the FH, without incident. This was a transformative step in educational approach in terms of effectiveness and efficiency. Following the go live in November, we are already approaching one million observation sets. This has placed us in a position to collaborate with the academic teams in the local Universities to look at this big data set to make further improvements in the detection of deterioration.

Our approach to the implementation of NEWS 2 and risk rating has been shared on the Future NHS Collaboration platform. The National Lead for Deteriorating Patients, Dr Matt Inada-Kim, has expressed a real interest in our integrated approach, which we are continuing to share with colleagues around the UK.

How we measured success?

Run charts of diabetic control showed reduced variation and improvement in well-led wards with integrated multidisciplinary team morning board rounds.

Staff feedback, following the electronic observation deployment, over 80% positively fed back about the new electronic observations.

Time in motion studies demonstrated over 1 minute, on average, saving per full set of observations on the electronic system compared to the paper system. We take on average around 6,000 observation sets per day across the adult wards at the RVI and the FH. This equates to over 100 hours of released time per day.

Observation completeness has improved from 90% on paper audits to 98%.

Observation scores correctly calculated has improved from 90% on paper to 100%. Oxygen alerts built into the tablets have improved compliance with patients in their target oxygen zones to 92%.

This has all been achieved without any negative impact on critical care admissions. There has been stable numbers of unplanned admissions to the adult critical care units and average predicted mortality. Nor has there been an increase in clinical incidents related to the electronic observations system. This is important as new IT has the potential to introduce unwanted unintended consequences.

Priority 7 – Closing the Loop

Why we chose this?

We wanted to establish a robust IT system that would ensure action plans identified by either internal or external reviews were monitored, prioritised, completed and reviewed within given timescales. All actions were captured but in a variety of different forms and were not available collectively in order to allow prioritisation, monitoring and discussion. It was envisaged that this project would enhance support for Directorates in implementing action plans and provide enhanced governance.

What we aimed to achieve?

In Year one, we aimed to achieve the following:

- Map Trust key performance targets.
- Map individual Directorate profiles – looking at requirements in each area.
- Propose a process to manage (record/monitor/complete/review/alert).
- Prioritise actions/performance targets.
- Complete a scoping exercise in relation to available IT systems to support the recording/monitoring of performance targets.

What we achieved?

- We renamed the project SAMM (**S**ystem for **A**ction **M**anagement & **M**onitoring).
- Key meetings were undertaken with each Directorate management team to discuss SAMM and its benefits.

- Individual Directorate profiles have been mapped out (looking at key requirements within each area).
- Meetings have also taken place with the Trust's Senior Management team in order to map out Trust key performance targets/actions.
- We have process mapped and proposed a process that will enable action plans to be collated/identified/ monitored/prioritised/alerted/reviewed and completed.
- A scoping exercise was undertaken to see if there is a suitable IT system that can provide what is required.
- Key meetings with the Trusts' IT development team, in order to discuss the project and consider whether there is another IT system that is Trust supported and suitable for the project.
- Establishment of the Trust multi-disciplinary SAMM Task and Finish group. This group is made up of key individuals that have a particular interest, knowledge or influence. The group has key involvement in the design/functionality processes of SAMM as well as reviewing and support during the pilot and final roll-out phases.
- Pilot Directorates in place ready to test SAMM.

How we measured success?

Trust key performance requirements and actions have been mapped out and prioritised. The project has full engagement with all Directorates and we have recruited key individuals to membership of the SAMM Task and Finish Group.

Patient Experience

Priority 8 – Deciding Right

Why we chose this?

Intensive Care Medicine has contributed to significant improvements in survival since the publication of Comprehensive Critical Care (DoH, 2000); however, 1 in 5 intensive care survivors die within 12 months of their admission. Furthermore, 24% of Scottish intensive care survivors (2005-2013) are re-admitted to hospital within 90 days of discharge home. Causes of readmission are often related to long-standing health problems rather than the acute illness that precipitated intensive care admission.

In many of these circumstances, survival of intensive care is also associated with significant burdens (physical and psychological) and, when death occurs, over 80% of patients lack capacity when decisions are made in relation to withholding or withdrawing treatments and have no advance statement referencing their wishes and beliefs (Ethicus 2 Study). As a result, many patients could therefore be subjected to inappropriate and burdensome treatments without having any documented input into the process.

Additionally, within general ward settings in England and Wales (2015-2016), approximately 36% of hospital in-patients were in their last year of life. The use of Advance Care Plans (ACPs) has demonstrated an increase in shared decision-making and reduced death within hospital, enabling more structured, individualised care.

What we aimed to achieve?

- Develop and perform a *baseline survey* and *needs assessment* to gauge awareness and levels of engagement with *Deciding Right* amongst NUTH clinical staff.
- Audit acute admissions in patient groups with potential to need Emergency Health Care Plans.
- Reviewing North of England Critical Care Network audit of Consultant Review and Treatment Escalation Plans in acute care areas.
- Develop an awareness programme in line with regional initiatives.
- Document the number of clinical staff trained.
- Work with patient representatives and colleagues involved in Consent, Mental Capacity Act (MCA)2005 and *Shared Decision Making*.
- Develop a video for patients and those close to them; be shown in out-patients and primary care outlining the principles and purpose of *Deciding Right*.
- Review the role of the group after two years (January 2020).

What we achieved?

- Survey performed demonstrating that approximately 60% of front-line staff felt they required more training and awareness in relation to having *Difficult Conversations*.
- Audit completed showing 36 of 39 patients admitted to intensive care had missed opportunity for ACP and the median stay in hospital prior to intensive care admission was 16 days.
- 1.57% of NUTH adult inpatients had Emergency Health Care Plans (EHCP) or Treatment Escalation Plans (TEP); whilst 36% of in-patients are in their last year of life which highlights an area for improvement.
- Ongoing work with patients and relatives to describe experiences to staff, including the Trust Board.
- An educational video has been produced and is ready for launch in Autumn 2019.

How we measured success?

- Implementation of workstreams.
- Production of the video and other educational resources.
- Numbers of staff trained.

- Improvement in EHCP or TEP usage (January 2019 audit results awaited from North of England Critical Care Network).

Priority 9- Enhancing Patient and Public Involvement in Quality Improvement (QI)

Why we chose this?

As part of the Trust's commitment to creating a culture of Quality Improvement, we recognised that it was essential to engage patients, carers and families in the early stages of project design.

What we aimed to achieve?

We set out to create a sustainable, accessible model of involvement and engagement which enabled staff to work in collaboration with patients and members of the public from an early project design stage.

It was important to ensure patients and members of the public were empowered and aware of QI initiatives and were able to attend forums through which they could make a meaningful contribution to the scope and ambition of projects.

The importance of capturing the overall impact of patient and carer involvement was also recognised, to help ensure that the views and feedback of patients were being embedded in the QI plan.

What we achieved?

Over the past 12 months, we have made a number of changes to meet our ambitions in this area. We have created a range of role profiles for individuals interested in engaging in QI projects, recruited a large group of diverse individuals interested in engaging in this work and created a group, APEX (Advising on Patient Experience) through which this work can be undertaken. APEX has been established since October 2018 and several QI projects have been presented, discussed and subsequently informed by the group with more planned over the coming months. The work of the APEX group built upon the work of its predecessor group, the Community Advisory Panel.

How we measured success?

We have developed a framework which supports staff to consider how best to involve patients and members of the public in their QI projects. We routinely capture feedback from staff presenting their QI project and from the APEX attendees. This feedback is evaluated following each meeting and is shared with staff and APEX members to provide reassurance that discussions have been embedded in the QI project plan. The success of the initiative will be monitored by the number of QI projects being presented to APEX and the evaluation of the impact it has had on both staff and patients.

Priority 10 – Improving the experience of vulnerable patients

Why we chose this?

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report "Treat as One" was published in 2017 highlighting the inconsistencies in the delivery of

physical health care to adult patients with co-existing mental health conditions in NHS hospitals. The study identified a number of areas that could be improved in the delivery of care to this group of patients.

Deprivation of Liberty Safeguarding (DoLS) has been another key area of focused attention for healthcare institutions in the last few years and remains an important area to ensure appropriate delivery.

The consent process for vulnerable adults who lack capacity to consent for treatment has also featured as a prominent area for scrutiny.

The Learning from Deaths NHS Guidance (July 2018) called for enhanced awareness of learning from mortality review, in particular for those patients with known mental health conditions.

Although many aspects of Mental Health conditions are complex and challenging to address, it is a subject which is gaining much greater public awareness and appreciation. There is a clear need to make progress towards achieving equality of care for this patient group.

What we aimed to achieve?

We aimed to use the key recommendations made in the NCEPOD report to guide a co-ordinated review of current practices and processes within Newcastle Hospitals and Northumberland, Tyne and Wear (NTW). Where those aspects of care fall short of NCEPOD recommendations, we will continue to work towards optimising and adapting care to meet those standards where possible.

A focus on raising awareness and understanding of the DoLS process for all staff groups in all clinical areas.

A review of the consent process for all patient groups in the last year and an update of Trust policy. A focus area was the use of Form 4 Consent and the application of Mental Capacity Assessments (1 and 2).

Mortality review has also been given attention to improve the process as a whole and to include highlighting the added importance of enhanced review of deaths of patients with mental health conditions to scrutinize aspects of care and identify learning issues.

What we achieved?

A joint Newcastle Hospitals and NTW Quality Forum has been established and meets on a quarterly basis to discuss issues and work collaboratively to ensure that patients with mental health needs receive the best holistic care when accessing treatment.

In addition, a steering group has been established in the Trust which will manage and monitor progress against the 22 recommendations of the 'Treat as One' publication. Having held a number of meetings, progress has been made in a number of areas, including:

- Completion of a full baseline assessment of services against the recommendations.

- Identification that the Trust are compliant, or partially compliant, with the majority of recommendations.
- Identification of key areas where there is room for improvement (and the development of associated action plans) such as communication, information sharing between Trusts and workforce training and education.
- Documentation and practice has been adapted to normalise the discussions about mental health. Plans are being developed to hold a cross-site educational forum later in 2019 which will raise staff awareness of 'Treat as One' and their role in improving care for patients with mental health needs.
- A patient representative has been identified to join the steering group to offer opinion and insight on service developments.
- The Newcastle Hospitals DoLS policy has been revised and updated and compliance of its' use assessed by the Safeguarding Team. Review of DoLS awareness for staff, in all areas of the Trust, has become a key part of recent internal peer reviews.
- The Consent process review included a specific video training module for completion of consent for patients who lack capacity.
- The Consent Form 4 was modified to standardise the recording of a mental capacity assessment (MCA 1 and 2) as an integral part of the Trust Consent Form 4.
- The Trust mortality review process has been standardised and the use of an intranet-based mortality database established. That database requires the teams completing the mortality review to notify if any patient reviewed had mental health problems to enable a specific in-depth review of the patient's care to identify any learning points that could improve care for future patients.

How we measured success?

Compliance with the recommendations of the Treat as One publication, will be monitored and reported to the joint Quality Forum on a quarterly basis.

The Trust has assessed and amended the Newcastle Hospitals DoLS policy and has used compliance with this policy and an assessment of staff awareness of the policy and practice in recent directorate peer reviews. It was a key aspect of recent CQC assessments.

Consent processes and particularly Consent Form 4 use, receive scrutiny in the form of departmental audits and peer review processes.

Mortality review is a formal part of the Trust Clinical Governance Framework and review of patients with mental health conditions forms part of that review.

National guidance requires Trusts to include the following updates in the Annual Quality Account:

Update on Duty of Candour (DoC)

Being open and transparent is an essential aspect of patient safety. Promoting a just and honest culture helps us to ensure we communicate in an open and timely way on those occasions when things go wrong. If a patient in our care experiences harm or is involved in an incident as a result of their healthcare treatment, we explain what

happened and apologise to patients and/or their carers as soon as possible after the event.

There is a contractual requirement to implement the Being Open guidance and the Trust Duty of Candour (DoC) Policy has helped staff to achieve this. Our compliance with DoC is assessed by the CQC; however, we also monitor our own performance on a monthly basis at the Serious Incident (SI) Panel to ensure verbal and written apologies are provided. This reassures us that those affected by an incident are offered a truthful account and fully understand what happened. This open and fair culture encourages staff to report incidents, to facilitate learning and continuous improvement to help prevent future incidents, improving the quality of care.

Duty of Candour requirements are regularly communicated across the organisation using a number of corporate communication channels including presentations at a range of Trust-wide forums such as Clinical Policy Group, Clinical Risk Group as well as other Corporate Governance and Risk committees. Throughout the year, regular updates on progress with implementation and audit results have been submitted via the Clinical Risk Group.

Training has been targeted at those staff with responsibility for leading both serious incident investigations and also for staff involved in local investigations. DoC is included in Incident Investigator Training which is delivered to a wide range of staff once a month. An educational video is available to all staff, via the Trust intranet, and the requirement to be open with patients and their relatives is emphasised every month at the Patient Safety Briefings.

Statement on progress in implementing the priority clinical standards for seven day hospital services

The Trust has been implementing the priority clinical standards for seven day hospital services in a number of ways.

An early implementer site:

The Trust became one of the national early implementer sites for 7 Day Service (7DS) at the beginning of the financial year 2016/2017.

Implementation of new Board Assurance Framework to identify compliance:

This new measurement system replaced the previous self-assessment survey in 2018. It consists of a standard measurement and reporting template, which all providers of acute services complete with self-assessments of their delivery of the 7DS clinical standards. This self-assessment is formally assured by the Trust Board and the completed template submitted to regional 7DS leads to enable measurement against national ambitions. The Trust has taken part in the new Board Assurance Framework and the compliance was:

- **Standard 2:** The national compliance threshold is 90% for weekdays and weekends. Data shows 80% compliance with documented evidence of consultant reviews. However; we are confident that actual compliance is 90% as we can evidence consultant rotas/job plans which ensure patients have access to consultant reviews on a 24/7 basis. In addition, the intensive care units and Emergency Assessment Suite have twice daily consultant ward rounds. We will

continue to make best efforts to demonstrate compliance by improving record keeping in all emergency areas.

- **Standard 5 and 6:** Audits have demonstrated that we were compliant with these standards.
- **Standard 8:** We are confident that compliance is above 90% indicated by previous audit data for daily and twice daily reviews. The majority of Directorates have board round systems in place and a clear process for identifying patients who do not require a daily ward round.

Staff engagement/awareness

A 7 Day Services Delivery group reports to a 7 Day Services Steering Group. This group has worked towards compliance with the four priority standards. The group has identified interventions and changes to improve compliance plus supports and coordinates the changes. Staff awareness sessions have been delivered and a Trust intranet page is available for staff.

Implementation of a new Electronic Review Board

The Trust developed a new system to focus on consultant activity in the Assessment Suite. This electronic review system helps to identify which emergency patients need to be reviewed by length of time in hospital and flags patients needing ongoing clinical review based on clinical need, which is identified by consultants. The new system was designed collaboratively by consultants and IT staff, and the benefits are evidenced by improved compliance with standard 2. Consultant feedback, on the new system, highlights the ability to identify where to start ward rounds, provides a good way of handing over patients and that also provides mechanisms to ensure a second review is completed when required.

Gosport Independent Panel Report and ways in which staff can speak up

"In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS Trusts and NHS foundation trusts in England to report annually on staff who speak up (including whistleblowers). Ahead of such legislation, NHS Trusts and NHS Foundation Trusts are asked to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment. This disclosure should explain the different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the Trust".

Staff and temporary workers, across the Trust, are informed at their induction on day one with the Trust, and subsequently reminded regularly, that there are a number of routes through which to report concerns and raise issues that may occur in the workplace. By offering a variety of options to staff, should they have an issue to report, including the ability to provide information anonymously, it is hoped that anyone working for Newcastle Hospitals will feel they have a voice should they wish to raise a concern or put forward a positive suggestion.

Any of the reporting methods below can be used to log an issue, query or question; this may relate to patient safety or quality, staff safety including concerns about inappropriate behaviour, leadership, governance matters or ideas for best practice and

improvements. These systems and policies enable the Trust to provide high quality patient care and a safe and productive working environment where staff can securely share comments or concerns.

Speak in confidence – the anonymous dialogue system.

The Newcastle upon Tyne Hospitals NHS Foundation Trust continues to use the anonymous dialogue system 'Speak in Confidence'. This secure web-based system is run by a third-party supplier. It enables staff to engage in a dialogue with senior leaders in the Trust, safe in the knowledge that they cannot be identified – this is a promise by the supplier of the system. Conversations are categorised into subject areas and there are 20 very senior leaders, including the Chief Executive, who can be accessed directly to 'start' a dialogue.

Freedom to Speak up Guardian

The Trust Freedom to Speak Up Guardian acts as an independent, impartial point of contact to support, signpost and advise staff who wish to raise serious issues or concerns. This person can be contacted, in confidence, about possible wrongdoing, by email or in person. Posters promoting the role of the Guardian have been distributed Trustwide and open drop-in sessions held for staff at all Trust locations.

Speak up – We Are Listening Policy (Voicing Concerns about Suspected Wrongdoing in the Workplace)

This policy gives employees, who raise such concerns, the assurance from the Trust that they will be supported to do so, and will not be penalised or victimised as a result of raising their concerns. The Trust proactively fosters an open and transparent culture of safety and learning to protect patients and staff. It recognises that the ability to engage in this process and feel safe and confident to raise concerns is key to rectifying or resolving issues and underpins a shared commitment to continuous improvement.

Being open (Duty of Candour) Policy

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.

Trust Contact Office

The function of the contact officer is to act as a point of contact for all staff if they have work related or interpersonal problems involving colleagues or managers in the working environment. Officers are contactable throughout the working day, with their details available under A-Z index on the Trust Intranet.

Union and Staff Representatives

The Trust recognises a number of unions and works in partnership with their representatives to improve the working environment. Staff are able to engage from these representatives to obtain advice and support if they wish to raise a concern.

A summary of the Guardian of Safe Working Hours Annual Report

This consolidated Annual Report covers the period April 2018 – March 2019. The aim of the report is to highlight the vacancies in junior doctor rotas and steps taken to resolve these.

Junior doctor rota vacancies occur due to gaps in the regional training rotations and problems with recruitment of locally employed doctors. The main areas of recurrent or residual concern for vacancies are neurosurgery, accident and emergency, obstetrics and gynaecology, anaesthesia and intensive care medicine, paediatrics and general medicine. The Trust takes a proactive approach to minimise the impact of these by active recruitment, attempts to make the jobs attractive to the best candidates, and by rewriting work schedules to ensure that key areas are covered.

Additional actions taken to resolve the issues are outlined below:

Where vacancies exist, the gaps in service coverage are mainly addressed by rewriting work schedules and the use of locums, mainly from the internal locum bank. In some areas, trainee shifts are being covered by consultants when junior doctor locums are unavailable.

In addition to the specific actions above, the Trust takes a proactive role in management of gaps with a coordinated weekly junior doctor recruitment group meeting. Members of this group include the Director of Medical Education, Finance Team representative and Medical Staffing personnel. In addition to recruitment to locally employed doctor posts, the Trust runs a number of successful Trust based training fellowships and a teaching fellow programme to fill anticipated gaps in the rota. These are 12 month posts aimed to maintain doctors in post and avoid the problem of staff retention. There are also Foundation Year 3 posts to encourage doctors to work at Newcastle Hospitals.

Learning from deaths

The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. These added new mandatory disclosure requirements relating to 'Learning from Deaths' to Quality Accounts from 2017/18 onwards. These new regulations are detailed below:

1. During 2018/19, 1795 of The Newcastle upon Tyne Hospitals NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 467 in the first quarter; 429 in the second quarter; 451 in the third quarter; 448 in the fourth quarter.
2. During 2018/19, 1451 case record reviews and 24 investigations have been carried out in relation to 1795 of the deaths included in point 1 above. In 20 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was; 307 in the first quarter; 350 in the second quarter; 382 in the third quarter and 436 in the fourth quarter.
3. Seven, cases representing 0.4% of the patient deaths during the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: Two cases representing

0.1% deaths for the first quarter, two cases representing 0.1% for the second quarter and three cases representing 0.2% for the third quarter. All deaths resulting in a serious incident in quarter four are currently being investigated. (To date, not all incidents have been fully investigated. Once all investigations have been completed, any death found to have been due to problems in care will be summarised in the 2019/20 Quality Account. All deaths will continue to be reported via the Integrated Quality Report). These numbers have been estimated using the HOGAN evaluation score as well as root cause analysis and infection prevention control investigation toolkits.

Summaries from the seven cases judged to be more likely than not to have had problems in care which have contributed to patient death are detailed in the table below: Summary	Lessons learned from review	Action	Impact/Outcome
Unexpected death of a patient following admission due to severe trauma.	Alternative rigid collars to be available in Emergency Department. Neuro Nurse Specialists to provide training on the application of alternate options. Review spinal injury pathway.	Spinal injury pathway to include timing of removal of neck collars. Trainee Induction information to include specific reference to guideline for a neck collar removal.	Heightened awareness of staff regarding management of unusual presentations in high risk patients.
Death related to a post-operative complication.	Verbal handover supported by comprehensive transfer documentation when transferring patients from cath lab to recovery.	Standardisation of procedures for handover and transfer. Communication during handover to include transfer checklist for all patients. Cardiac monitoring on transfer for all patients.	Robust transfer checklist now routinely carried out by staff.
Delay in recognition of abnormal radiological findings may have been a contributory factor in a patient's death.	Improved timely communication of abnormal results recognised as a local & Trust-wide quality priority.	Local arrangements to improve communication of abnormal radiology results between departments. Trust-wide quality project to improve process for communication of abnormal results is underway aligned to Global Digital Exemplar (GDE) work-stream.	Learning shared Trust-wide via Patient Safety Briefing and internal governance mechanisms.
Unexpected death of a high risk patient awaiting invasive procedure.	More robust review of anti-coagulation requirements is required for high risk patients across the referral pathway.	Consideration of alternative anti-coagulation usage in specific patient groups. Review of patient radiology referral pathway to ensure a more robust process for prioritisation of high risk patients.	Heightened awareness of staff regarding complications in high risk patients. Learning shared Trust-wide via Patient Safety Briefing and internal governance mechanisms.
Unexpected death of a vulnerable patient in the post-operative period.	Improve local guidance and staff awareness to ensure this reflects Trust's standards for assessing and meeting vulnerable patients' care needs.	Review of local Learning Disability (LD) guidelines in-line with Trust pathways and acute care needs assessment. Raise awareness of LD Team's staff support role	Heightened staff awareness of importance of assessing how post-operative complications may present in vulnerable patients.

Summaries from the seven cases judged to be more likely than not to have had problems in care which have contributed to patient death are detailed in the table below: Summary	Lessons learned from review	Action	Impact/Outcome
		locally and Trust-wide.	Learning shared Trust-wide via Patient Safety Briefing and internal governance mechanisms.
Sepsis related death.	Sepsis identification and medical handover between departments required further review.	Review of Emergency Department (ED) sepsis identification processes, handover and audit of practice undertaken. Appointment of Sepsis Nurse Specialist to work closely with Trust Clinical Leads to improve timely detection and management of sepsis and deteriorating patients.	New easy to use handover proforma routinely used by all ED staff, to be integrated into paperless solutions, including e-observations in the future. Learning shared Trust-wide via Patient Safety Briefing and internal governance mechanisms.
Sepsis related death.	Processes for the recognition of the deteriorating patient and triage to be reviewed.	Development of revised sepsis pathway in Paediatrics which includes; Improved triage process, standardised Paediatric Early Warning Score (PEWS) documentation and to improve completion of "parental concern" score.	Recruitment of additional nurses and introduction of a formal triage process within Paediatric Emergency Department. Heightened awareness of staff of importance of compliance with PEWS. Improvements to the sepsis trigger tool after collaborative working with staff. PEWS scores now on the patient white boards and planned for forthcoming introduction of e-observations.

4. 186 case record reviews and one investigation were completed after April 2018 which related to deaths which took place before the start of the reporting period.
5. 0 representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.
6. Seven representing 0.4% of the patient deaths during 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

The Trust will monitor and discuss mortality findings at the quarterly Mortality Surveillance Group and Serious Incident Panel which will be monitored and reported to the Trust Board and Quality Governance Group.

Quality Priorities for Improvement 2019/20

Following discussion with the Board of Directors, the Council of Governors, patient representatives, staff and public the following priorities for 2019/20 have been agreed. A public consultation event was held in January 2019 and presentations have been provided at various staff meetings across the Trust.

Patient Safety

Priority 1 - Reducing Infection – focus on Methicillin-Sensitive Staphylococcus Aureus (MSSA) / E.coli

Why have we chosen this?

Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemias are important infections which can cause significant harm. They have substantial personal, reputational and resource implications. At The Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH), these are most commonly associated with lines and indwelling devices; achieving excellent standards of care and improving practice is essential to reduce these infections in line with our zero tolerance approach.

E.coli and other Gram negative bacteraemias constitute the most common cause of sepsis (also known as blood poisoning, which is the reaction to an infection in which the body attacks its own organs and tissues) nationwide. Proportionally, at NUTH, the main source of infection is urinary tract infections, mostly catheter associated, reflecting the national picture. An integrated approach engaging with the multidisciplinary team across the whole patient journey, focusing on antibiotic stewardship, early identification of risks and timely intervention formulate the basis for our strategy to reduce these infections. C.difficile infection is a potentially severe or life threatening infection which remains a national and local priority to continue to reduce our rates of infection in line with the national objectives.

What we aim to achieve?

- 10% year on year reduction of MSSA bacteraemias.
- 50% reduction of E.coli and other Gram negative bacteraemias by 2021/22.
- Sustain a reduction in C.difficile infections in line with national trajectory.

How will we achieve this?

- Board level leadership and commitment to reduce the incidence of Health Care Associated Infection (HCAI).
- Quality improvement projects in key directorates running in parallel with Trust-wide awareness campaigns, education projects, and audit of practice, with a specific focus on:
 - Antimicrobial stewardship and safe prescribing
 - Insertion and ongoing care of invasive and prosthetic devices
 - Ward monitoring of device compliance for peripheral Intravenous (IV) and urinary catheters
 - Prevention of surgical site infection
 - Improve diagnosis of infection in all steps of the patient journey

- Working with partner organisations to reduce infections throughout the Health Care Economy
- Early recognition and management of suspected infective diarrhoea
- Root cause analysis for all health care associated C.difficile infections.

How we will measure success?

- Sharing data with Directorates whilst focusing on best practice and learning from Root Cause Analysis (RCA).
- Continue to report MSSA, C.difficile and E.coli infections on a monthly basis, internally and nationally.

Where we will report this to?

- Quality Governance Group.
- Trust Board.
- The public via the Integrated Quality Report.
- Public Health England.
- NHS England.

Priority 2 - Pressure Ulcer Reduction

Why have we chosen this?

Reducing harm from pressure damage will remain a priority as the Trust has not yet achieved the significant, sustained reduction it set out to achieve last year. Whilst reductions have been made specifically in relation to heel damage, the overall incidence and rate of all pressure damage has remained higher than we are satisfied with.

We believe there is further work to be done to reduce the incidence of harm, improve the patient experience and support staff to embed evidence-based best practice. We want to drive the key messages that pressure ulcers are largely preventable and together with the correct assessment and prevention plans, pressure ulcers can be significantly reduced.

What we aim to achieve?

- Significantly reduce hospital acquired pressure ulcers (specifically those graded category II, III and IV).
- Undertake focused quality improvement work on targeted adult inpatient wards who currently report the highest incidence and rate of pressure damage.
- Increase the visibility and support provided by the Tissue Viability team to frontline clinical staff to assist in the prevention of pressure ulcers.
- Ensure we have a skilled and educated workforce with a sound knowledge base of prevention of pressure ulcers and quality improvement methodology.

How will we achieve this?

- The Clinical Improvement Lead (Falls and Pressure Ulcers) will lead targeted quality improvement work to reduce pressure ulcers using methodology that has already been successful in reducing inpatient falls. This will include supporting clinical staff to embed best practice, analyse data and take ownership of improvement projects at ward level.

- The skill mix and resources in the Tissue Viability team are being reviewed to deliver a change in practice to a more preventative, evidence-based quality improvement approach.
- Collaboration between clinical leads, will be enhanced with work to ensure data is triangulated with nurse staffing data to provide senior support to wards where problems or risks have been identified.
- The Root Cause Analysis process will continue to provide learning and actions from serious incidents and the communication strategies used to promote the learning from these will be strengthened.

How we will measure success?

- Recognised quality improvement methodology strategies of measuring data embedded over time.
- The incidence and rate of pressure damage will be monitored at ward, Directorate and Trust level.

Where we will report this to?

- Falls and Pressure Ulcer Taskforce Group.
- Quality Governance Group.
- Trust Board via the Integrated Quality Report.

Priority 3 - Management of Abnormal Results

Why have we chosen this?

Incidents continue to occur nationally where abnormal or unexpected diagnostic results have not been seen or acted upon by medical staff. This can directly lead to delays in treatment which can have serious consequences for patients.

What we aim to achieve?

We are developing a long-term solution for effective communication of abnormal results across all of the reporting specialties to the responsible clinician. This will highlight abnormal results automatically with a failsafe system in place to ensure that results are acted upon within a short, pre-defined time period.

How will we achieve this?

The concept has been finalised after the analysis of themes arising from over 60 previous incidents. Abnormal results will be sent as a red flag message to the requesting consultant, viewable in the eRecord message centre. Red flag messages will move with the patient through their admission journey.

If a red flag message remains in a consultant's inbox for more than a defined period (e.g. 5 days), it will automatically be forwarded to another Directorate defined team

member. This ensures that patient management is unaffected by absence at work or inaction.

Alert thresholds require careful development, as it is important to avoid a situation where inboxes are filled with inappropriate red flag messages. In radiology, these can be well defined through existing guidelines and medical judgment. In other disciplines, such as haematology and biochemistry, defining thresholds is more challenging as “normal abnormal” and “abnormal normal” results may occur.

Strong links with the IT/Global Digital Exemplar (GDE) teams have ensured that the concept is now deliverable using our electronic clinical records system.

How we will measure success?

- Define reporting specialty thresholds for escalation.
- Implementation of clinician alerting system within the GDE project.
- The implementation timeframe is of great importance to avoid further incidents or the need for interim solutions. To be notified of abnormal results a change in culture/workflow for consultants to focus on their message centre inbox is needed. Radiology missed abnormal results account for the majority of incidents so this will be our focus at the start of implementation.
- Measurable reduction in incidents resulting from delayed action over abnormal results.

Where we will report this to?

- Clinical Policy Group.
- Quality Governance Group.
- Trust Board.

Clinical Effectiveness

Priority 4 System for Action Management AND Monitoring (SAMM)

Why have we chosen this?

Previously entitled ‘Closing the Loop’, the project and IT system that will be used, has been named SAMM (System for Action Management & Monitoring).

There continues to be a drive to establish and embed a centralised, robust IT system to enable the capture of all actions identified by either internal or external reviews. This project will enhance support for Directorates in implementing action plans and provide enhanced governance.

What we aim to achieve?

To establish and embed a robust Information Technology (IT) system (SAMB) across the Trust which will enable staff to record, prioritise, monitor and complete all required actions identified by internal and external assessments within the agreed timescales.

How will we achieve this?

In Year 2 (2019-2020), we will look to:

Create

- Establish an IT system (SAMB) that encompasses the scope of the project and has the required functionality.
- Incorporate a reporting function in SAMB that will enable monitoring reports and dashboards to be produced at both a Directorate and corporate level. This will ensure that key themes and trends are identified in order to allow prioritisation.

Communication plan/consultation

- Establish a multi-disciplinary SAMB Task and Finish Group, which will meet to discuss the design/functionality of SAMB and support its roll-out Trust-wide.

Test and Refine

- Pilot SAMB in selected Directorates. This will involve staff training for end users.
- Evaluate SAMB over time, and refine the system if required.

Plan Roll-out Trust-wide

- Once SAMB is established and embedded in pilot Directorates, we will begin a Trust-wide roll-out programme.

How we will measure success?

- Trust and Directorate level key performance action plans entered into SAMB.
- Pilot SAMB with Directorates.
- Full engagement with Directorates.
- Measure outcomes and results.

Where we will report this to?

- SAMB Task and Finish Group.
- Quality Governance Group.
- Trust Board via Integrated Quality Report.

Priority 5 – Enhancing capability in Quality Improvement (QI)

Why have we chosen this?

We are in the era of increasing complexity of healthcare; continuous change is therefore required to deliver high quality care. Our patients and front-line staff operate in this complex position and hold the knowledge of what works, what doesn't and what is needed. Effective change must use the collective intelligence, of our patients and staff, to inform where change is needed and to generate creative ideas to make continuous improvement. A structured organisational approach to Quality Improvement (QI) will increase the capability to support, learn and deliver effective and efficient change.

What we aim to achieve?

Grow the capacity for continuous change, improvement and learning.

How will we achieve this?

- Adopt across the whole system, the Institute of Health Care Improvement's Model for Quality Improvement as our organisational approach.
- Establish a Quality Faculty to co-ordinate the system-wide approach to quality and learning at NUTH. The Faculty will facilitate learning from change, training programmes on QI for all staff, online resources and workbooks and co-ordinated support structure for staff embarking on Quality Improvement. The Quality Faculty will build on, and integrate, the work and expertise from the Service Improvement, Transformation and Financial Improvement and Quality Improvement teams.
- Central co-ordination for learning and facilitated data management to support quality improvement work.
- Deliver Board level training in the principles and practice of QI.
- Use data in a meaningful way to identify change early with increased use of Run charts or Statistical Process charts throughout the organisation in clinical and non-clinical areas.
- Integrate the growing understanding and application of Human Factors Principles in healthcare.
- Integrate with a patient-centred collaborative design approach for QI.
- Support with leadership that embraces change and acknowledges failures as learning opportunities.

How we will measure success?

- Number of completed Plan Do Study Act (PDSA) cycles with central learning that all can access.
- Numbers trained in Institute for Healthcare Improvement (IHI) model of improvement, numbers of trained IHI support network.
- Numbers of successful projects.

Where we will report this to?

- Quality Governance Group.
- Trust Board.

Patient Experience

Priority 6 – Deciding Right

Why have we chosen this?

Within England and Wales, over 30% of in-patients are in their last year of life and across Europe, greater than 80% of intensive care patients having treatments withheld or withdrawn lack capacity at the time such decisions are made. Furthermore, less than 15% of such patients have ever indicated (verbal or written) what their wishes would be i.e. the majority lack an Advance Care Plan (ACP).

Deciding Right is an initiative that aims to improve and increase the process of ACP for Children, Young People and Adults and, in doing so, inform health care professionals about values and beliefs enabling the delivery of care that is more focused on an individual's Best Interests.

What we aim to achieve?

- Improved focus on shared decision-making.
- Improved information relating to patients' beliefs and values.
- Greater transparency about the advantages and disadvantages of serious medical treatments.
- Increased usage of Treatment Escalation Plans and Emergency Health Care Plans. Potentially this could involve 30-35% of in-patients (DoH: in 2015-16, 35% of adult in-patients were in the last year of their life).

How will we achieve this?

- Establish a multi-disciplinary group (including lay representation) to oversee the implementation.
- Awareness programmes for staff about the purpose and processes of Deciding Right.
- Intranet information and guidance: achieved <http://nuth-intranet/cms/GeneralInformation/DecidingRightandAdvanceCarePlanning.aspx>.
- Awareness programme within Primary Care.
- Inclusion of *Deciding Right* in *Healthy Conversations Project* for Allied Health professionals (AHPs) within NUTH.
- Patient/relative presentation to Trust Board.
- Video and hard-copy information available within Out-Patient Departments and Primary Care (Autumn 2019).

How we will measure success?

- Number of staff trained.

- Monitoring of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) discussions and documentation. In time, this may change to the ReSPECT Forms (Recommended Summary Plan for Emergency Care and Treatment).
- Increased presence of Treatment Escalation Plans (TEP)/ Emergency Health Care Plans (EHCP) in patient notes and ongoing improvements in the implementation of such documentation.
- Patient/ Relative feedback.

Where we will report this to?

- Quality Governance Group.
- Trust Board.

Priority 7 – Treat as one

Why have we chosen this?

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report “Treat as One” was published in 2017, highlighting the inconsistencies in the delivery of physical health care to adult patients with co-existing mental health conditions in NHS hospitals. The study identified a number of areas that could be improved in the delivery of care to this group of patients. Although many aspects of Mental Health conditions are complex and challenging to address, it is a subject which is gaining much greater public awareness and appreciation. There is a clear need to make progress toward achieving equality of care for this patient group.

What we aim to achieve?

We aim to use the key recommendations made in the NCEPOD report to guide a coordinated review of current practices and processes within NUTH, Northumberland and Tyne and Wear (NTW). Where those aspects of care fall short of NCEPOD recommendations, we will work towards optimising and adapting care to meet those standards where possible.

How will we achieve this?

The scope of this project is extensive and the potential need for system change far reaching. The first step has been to formalise a joint committee between NUTH and NTW with regular, minuted, meetings to establish cooperative working at a senior level. This group has met on a number of occasions to date and will continue to meet quarterly. In addition, a smaller steering committee, within NUTH, has been established to define immediate priorities for a task and finish approach. Effective information sharing is a key priority and must be designed to work in a paper-lite format across NUTH and NTW. We will review current admission paperwork to assess inclusion of Mental Health review on admission to hospital. Education is another immediate priority as well as raising awareness. A day of seminars is planned for late 2019 and we will look to national organisations to assist with educational materials.

How we will measure success?

We will measure success using the self-assessment template from the NCEPOD report as the main guide. We aim to begin initial audits of some aspects of current practice against NCEPOD standards that can then be repeated in the future to assess effectiveness of change.

Where we will report this to?

- Joint NUTH and NTW Quality Committee.
- Quality Governance Group.
- Trust Board via the Integrated Quality Report.

Priority 8 – Ensure reasonable adjustments are made for patients with suspected, or known, Learning Disabilities

Why have we chosen this?

People with a Learning Disability are four times more likely to die of something which could have been prevented than the general population (Disability Rights Commission, 2006).

The Trust is fully committed to ensuring that patients with a Learning Disability have access to services that will help to improve people's health so this doesn't happen in the future.

What we aim to achieve?

We aim to improve the experience for patients and their families who need to access hospital services and to improve health outcomes.

How will we achieve this?

We aim to achieve this by:

- Improving access to healthcare by ensuring reasonable adjustments are available.
- Supporting STOMP (STop Over Medicating People with a learning disability or autism).
- Supporting STAMP (Supporting Treatment and Appropriate Medication in Paediatrics).
- Learning from LeDeR Mortality Reviews.
- Embedding the use of the Hospital Passport across adult and children's services.
- Ensuring that records for patients with a Learning Disability are clearly identified to support staff in tailoring care and reasonable adjustments for the individual.
- Contributing to multi-agency safeguarding processes within Newcastle that support improving the quality of care for individuals from residential care settings.
- Asking patients and their families about their personal experience of their journey through Trust services and enabling communication and engagement with the Trust to express their views and experiences of services.

How we will measure success?

- Audits of patient records to ensure that reasonable adjustments have been made and application of the Mental Capacity Act has been documented.
- Reviewing the use and application of Hospital Passports.
- Implementation of learning from LeDeR reviews.
- Review the implementation of STOMP and STAMP.
- Conduct surveys of patient and family carers' experience of hospital services.
- Inviting Quality Checkers to review Trust services.

Where we will report this to?

- Trust Safeguarding Committee.
- Learning Disability Steering Group.
- The Trust Board will receive updates from the Safeguarding Committee within the Trust Governance Structure.

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 2019/2020.

2019/2020 CQUIN Indicators

CQUIN Indicators - Acute Hospital – (NHS England)	CQUIN Indicators - Acute Hospital – (CCG)
<ul style="list-style-type: none"> • Medicines Stewardship: Medicines Optimisation • Toward HCV Elimination • Personalised Care: Cystic Fibrosis • Medicines Stewardship: Immunoglobulin • Appropriate Spinal Care: Spinal Surgery • High Cost Drug Stewardship • Severe Asthma 	<ul style="list-style-type: none"> • Staff Flu Vaccinations • Alcohol and Tobacco brief advice • Three High Impact Actions to Prevent Falls • Antimicrobial Resistance: Urinary Tract Infections and Antibiotic prophylaxis for Elective Colorectal Surgery • Same day Emergency Care – Pulmonary Embolus/Tachycardia with ATRIAL Fibrillation /Pneumonia
CQUIN Indicators - Acute Hospital – (Public Health/Dental/other)	CQUIN Indicators - Community
<ul style="list-style-type: none"> • Dental • Breast screening • Stereotactic Radiosurgery • Armed Forces Covenant 	<ul style="list-style-type: none"> • Staff Flu Vaccinations • Alcohol and Tobacco brief advice

Statement of assurance from the Board

During 2018/19, The Newcastle upon Tyne Hospitals NHS Foundation Trust provided and/or sub-contracted 18 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 all 18 of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19, 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 2018/19.

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 Clinical Governance and Risk Department, 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, implemented 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 bi-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.

Information on participation in National Clinical Audits and National Confidential Enquiries

During 2018/19, 66 national clinical audits and six 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 63 (95%) national clinical audits and 100% of the national confidential enquiries / review outcome programmes which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Newcastle upon Tyne Hospitals NHS Foundation Trust was eligible to participate in during 2018/19 and

the national clinical audits / national confidential enquiries that the Newcastle upon Tyne Hospitals NHS Foundation Trust participated in during 2018/19 are as follows:

National Clinical Audits			National Confidential Enquiries
Adult Cardiac Surgery	Diabetes - The National Diabetes Inpatient Audit (NaDIA) - Harms - reporting on diabetic inpatient harms	Myocardial Ischaemia National Audit Programme (MINAP)	Child Health Outcome Review Programme - Long-term ventilation in children, young people and adults
Adult Community Acquired pneumonia	Diabetes - Pregnancy in Diabetes	Neonatal Audit Programme	Medical and Surgical Clinical Outcome Review Programme (NCEPOD) - Acute Heart Failure
Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Adult Asthma	Diabetes (Paediatric)	Neurosurgical National Audit Programme	NCEPOD - Cancer in Children, Teens and Young Adults
Asthma and COPD Audit Programme – COPD in Secondary care	Early Inflammatory Arthritis	Non-invasive Ventilation (Adults)	NCEPOD - Perioperative Diabetes
Asthma and COPD Audit Programme – Pulmonary Rehabilitation	Elective Surgery Patient Reported Outcome Measure (PROMS) Programme - Hip	Oesophago-gastric Cancer	NCEPOD - Pulmonary Embolism
British Association Urological Surgeons (BAUS) Audits: Cystectomy	Elective Surgery (PROMS) Programme - Knee	Ophthalmology Audit	NCEPOD Acute Bowel Obstruction
BAUS Urology Audits: Female Stress Urinary Incontinence	Emergency Laparotomy Audit	Percutaneous Coronary Interventions	
BAUS Urology Audits - Nephrectomy	Falls and Fragility Fractures Audit Programme – Fracture Liaison Service database	Prostate Cancer	
BAUS Urology Audits - Percutaneous Nephrolithotomy	Falls and Fragility Fractures Audit Programme – National Hip Fracture Database	Paediatric Intensive Care	
BAUS Urology Audits - Radical Prostatectomy	Falls and Fragility Fractures Audit Programme – Falls Audit	Pulmonary Hypertension	
Bowel Cancer	Feverish Children (Care in Emergency Department)	Reducing the Impact of Serious Infections - Antibiotic consumption	
Breast Cancer in Older People	Heart Failure	Reducing the Impact of Serious Infections - Antimicrobial stewardship	
Cardiac Arrest	Inflammatory Bowel Disease Programme	Seizures and Epilepsies in Children and Young People (Epilepsy 12)	
Cardiac Rehabilitation	Intermediate Care	Sentinel Stroke National Audit Programme	
Cardiac Rhythm Management	Joint Registry	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	
Care at End of Life	Learning Disability Mortality Review Programme	Seven Day Hospital Services	

National Clinical Audits			National Confidential Enquiries
Case mix Programme	Lung Cancer	Surgical Site Infection Surveillance Service	
Comparative audit of Blood Transfusion Programme - Use of fresh frozen plasma and Cryoprecipitate in neonates and children	Major Trauma Audit	UK Cystic Fibrosis Registry	
Comparative audit of Blood Transfusion Programme - Management of massive haemorrhage	Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Vascular Registry	
Congenital Heart Disease	Maternal, Newborn and infant Clinical Outcome review programme - Perinatal Mortality Surveillance	Vital Signs (Care in Emergency Department)	
Dementia	Maternal, Newborn and infant Clinical Outcome review programme - Maternal Mortality Surveillance	Venous thromboembolism (VTE) Risk in Lower Limb Immobilisation (Care in Emergency Department)	
Diabetes (Adults) - Footcare Audit	Maternal, Newborn and infant Clinical Outcome review programme - Maternal Morbidity and Mortality Confidential Enquiry		
Diabetes - Inpatient audit	Maternity and Perinatal		

The national clinical audits and national confidential enquiries that the Newcastle upon Tyne Hospitals NHS Foundation Trust participated in during 2018/19, 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 2018/19	Percentage Data completion	Outcome
Adult Cardiac Surgery		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.	✓	100%	No publication date yet identified
Adult Community Acquired pneumonia	British Thoracic Society	The audit includes all adult cases admitted through an acute admission area with a diagnosis of pneumonia.	✓	Data collection December 2018 – May 2019	Published report expected December 2019
Asthma and COPD Audit Programme - Adult Asthma	Royal College of Physicians	This audit programme brings together primary care, secondary care, and pulmonary rehabilitation, along with patient experience and pilot linkage. Its partnership approach with multidisciplinary,	✓	Data Collection November 2018 – March 2019	Published report expected September 2019
Asthma and COPD Audit Programme – COPD in Secondary	Royal College of Physicians		✓	Continuous data collection	Published report expected

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2018/19	Percentage Data completion	Outcome
Care		collaborative working aims to drive improvements in COPD patient care. The audit programme supports the Department of Health (DH) aim to improve the quality of services for people with COPD by measuring and reporting the delivery of care as defined by standards embedded in guidance.		April 2018 – March 2019	April 2019
Asthma and COPD Audit Programme – Pulmonary Rehabilitation	Royal College of Physicians		✓	Continuous data collection April 2018 – March 2019	No publication date yet identified
BAUS Urology Audits: Cystectomy	British Association of Urological Surgeons	The audit addresses open, keyhole or robotic-assisted removal of the bladder for cancer.	✓	100%	Published report expected September 2019
BAUS Urology Audits: Female Stress Urinary Incontinence	British Association of Urological Surgeons	The audit addresses open surgery for stress incontinence of urine in women.	✓	100%	Published report expected May 2019
BAUS Urology Audits - Nephrectomy	British Association of Urological Surgeons	The audit addresses partial or complete kidney removal (± the ureter) using open or "keyhole" techniques.	✓	100%	Published report expected September 2019
BAUS Urology Audits - Percutaneous Nephrolithotomy	British Association of Urological Surgeons	The audit addresses percutaneous "keyhole" removal of stones from the kidney (or upper ureter).	✓	100%	Published report expected September 2019
BAUS Urology Audits - Radical Prostatectomy	British Association of Urological Surgeons	The audit addresses open, keyhole or robotic removal of the prostate gland (± lymph nodes) for cancer.	✓	100%	Published report expected September 2019
Bowel Cancer	Royal College of Surgeons of England	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.	✓	100%	Published report expected August 2019
Breast Cancer in Older People	Clinical Effectiveness Unit, The Royal College of Surgeons of England	The audit will assess the processes of care and outcomes for women aged over 70 years. The National Audit of Breast Cancer in Older Patients (NABCOP) results will help NHS breast cancer services in England and Wales to benchmark and improve the care delivered to these women. NABCOP is a new project that began in April 2016. It is run by the Association of Breast	□	Continuous data collection April 2018 – March 2019	Published report expected May 2019

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2018/19	Percentage Data completion	Outcome
		Surgery and the Clinical Effectiveness Unit at the Royal College of Surgeons of England. The clinical audit will focus on the patient pathway from diagnosis to the end of primary therapy, for women diagnosed with breast cancer from 2014 onwards.			
Cardiac Arrest	Intensive Care National Audit & Research Centre	The purpose of the audit is to monitor the incidence of, and outcome from, in-hospital cardiac arrest in the UK and Ireland.	<input type="checkbox"/>	Continuous data collection April 2018 – March 2019	Published report expected June 2019
Cardiac Rehabilitation	Univeristy of York	The audit aims to support cardiovascular prevention and rehabilitation services to achieve the best possible outcomes for patients with cardiovascular disease, irrespective of where they live.	<input type="checkbox"/>	Continuous data collection April 2018 – March 2019	Published report expected November 2019
Cardiac Rhythm Management	National Institute for Cardiovascular Outcomes Research (NICOR)	The audit aims to monitor the use of implantable devices and interventional procedures for management of cardiac rhythm disorders in UK hospitals.	<input type="checkbox"/>	100%	No publication date yet identified
Care at End of Life	Royal College of Physicians	The audit has been designed to ensure that the priorities for care of the dying person outlined in the document One Chance to Get it Right are monitored at a national level.	<input type="checkbox"/>	100%	Action plan in place
Case mix Programme	Intensive Care National Audit Research Centre	The aim of the audit is to improve resuscitation care and patient outcomes for the UK and Ireland.	<input type="checkbox"/>	Continuous data collection April 2018 – March 2019	Published report expected December 2019
Comparative audit of Blood Transfusion Programme - Use of fresh frozen plasma and Cryoprecipitate in neonates and children	NHS Blood and Transplant	The audit aims to determine the dosage used, whether standard coagulation testing is performed pre and post administration, assess changes in standard coagulation testing after administration and evaluate clinical use in infants and paediatrics.	<input type="checkbox"/>	100%	Published report expected May 2019
Comparative audit of Blood Transfusion Programme - Management of massive haemorrhage	NHS Blood and Transplant	The audit addresses all patients who have been transfused due to experiencing large volume blood loss.	<input type="checkbox"/>	100%	No publication date yet identified.
Congenital Heart Disease	National Institute for Cardiovascular Outcomes Research (NICOR)	The congenital heart disease website profiles every congenital heart disease centre in the UK, including the number and range of	<input type="checkbox"/>	100%	Published report expected November 2019

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2018/19	Percentage Data completion	Outcome
		procedures they carry out and survival rates for the most common types of treatment.			
Dementia	Royal College of Psychiatrists	The audit measures the performance of general hospitals against criteria relating to care delivery which are known to impact upon people with dementia while in hospital.	<input type="checkbox"/>	100%	Published report expected May 2019
Diabetes (Adults) - Footcare Audit	NHS Digital	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%	Published report expected March 2020
Diabetes - Inpatient audit	NHS Digital	The National Diabetes Inpatient Audit (NaDIA) is an annual snapshot audit of diabetes inpatient care.	<input type="checkbox"/>	100%	Published report expected May 2019
Diabetes - NaDIA-Harms - reporting on diabetic inpatient harms	NHS Digital	The National Diabetes Inpatient Audit - Harms (NaDIA-Harms) is a continuous collection of four diabetic harms which can occur during an inpatient stay.	✓	100%	Published report expected May 2019
Diabetes - Pregnancy in Diabetes	NHS Digital	The audit aims to support clinical teams to deliver better care and outcomes for women with diabetes who become pregnant.	✓	Continuous data collection April 2018 – March 2019	Published report expected October 2019
Diabetes (Paediatric)	Royal College of Paediatrics and Child Health	The audit covers registrations, complications, care process and treatment targets.	<input type="checkbox"/>	100%	Published report expected July 2019
Early Inflammatory Arthritis	British Society of Rheumatology	The audit aims to improve the quality of care for people living with inflammatory arthritis.		Data collection May 2018 – April 2019	Published report expected November 2019
Elective Surgery (PROMS) Programme - Hip	NHS Digital	This audit looks at the change in patients' self-reported health status.	<input type="checkbox"/>	As Newcastle had less than 30 records for 2018/19 no PROMs figure is available. This is in line with national modelling.	
Elective Surgery (PROMS) Programme - Knee	NHS Digital		<input type="checkbox"/>		
Emergency Laparotomy Audit	Royal College of Anaesthetists	The National Emergency Laparotomy Audit aims to look at structure, process and outcome measures for the quality of care received by patients undergoing emergency laparotomy.	<input type="checkbox"/>	95%	Published report expected September 2019

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2018/19	Percentage Data completion	Outcome
Falls and Fragility Fractures Audit Programme – Fracture Liaison Service database	Royal College of Physicians	Fracture Liaison Services (FLS) are the key secondary prevention service model to identify and prevent primary and secondary hip fractures. The audit has developed the Fracture Liaison Service Database to benchmark services and drive quality improvement.	The Trust did not participate as this was not Mandatory for 2018/2019. However the Trust is looking to participate in 2019/2020 as it is anticipated that then audit will then become mandatory.		
Falls and Fragility Fractures Audit Programme – National Hip Fracture Database	Royal College of Physicians	The audit measures quality of care for hip fracture patients, and has developed into a clinical governance and quality improvement platform.	□	Data collection May 2018 – April 2019	Published report expected September 2019
Falls and Fragility Fractures Audit Programme – Falls Audit	Royal College of Physicians	The audit provides the first comprehensive data sets on the quality of falls prevention practice in acute hospitals.	□	100%	Published report expected March 2020
Feverish Children (Care in Emergency Department(ED))	Royal College of Emergency Medicine	The audit addresses the care of children, under the age of 5 years, who present to the Emergency Department with fever or febrile illness as part of their prescribing practice.	□	100%	Published report expected May 2019
Heart Failure	National Institute for Cardiovascular Outcomes Research	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%	No publication date yet identified
Inflammatory Bowel Disease (IBD) Programme	Inflammatory Bowel Registry	The IBD Registry biological therapies audit collected data on all patients of all ages diagnosed with the ICD-10 codes and receiving biological therapy at any time during the year. The data was requested at three time points: initiation, post-induction review and 12-month review.	The Trust did not participate in the audit due to national IT infrastructure issues. Local resolution has been achieved and it is planned to participate in 2019/20.		
Intermediate Care	NHS Benchmarking Network	The audit focuses on services which support, usually frail, elderly people, at times of transition when stepping down from hospital or preventing them being admitted to secondary or long term care.	Community Directorate did not participate in the 2018/19 data collection but rather concentrated on the action plan to address previous areas highlighted. Directorate does plan to participate in next audit.		
Joint Registry	Healthcare Quality Improvement Partnership	The audit covers clinical audit during the previous calendar year and outcomes including survivorship, mortality and length of stay.		82.6%	Published report expected September 2019
Learning Disability Mortality Review	University of Bristol	The programme was established to drive	□	100%	No publication

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2018/19	Percentage Data completion	Outcome
Programme		improvement in the quality of health and social care service delivery for people with learning disabilities by looking at why people with learning disabilities typically die much earlier than average.			date yet identified
Lung Cancer	Royal College of Physicians	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.	<input type="checkbox"/>	Return not due until late 2019	Published report expected April 2019
Major Trauma Audit	The Trauma Audit & Research Network (TARN)	TARN is working towards improving emergency health care systems by collating and analysing trauma care.	<input type="checkbox"/>	98%	Quarterly dashboard
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Public Health England	Mandatory Health Care Acquired Infection surveillance outputs are used to monitor progress on controlling key health care associated infections and for providing epidemiological evidence to inform action to reduce them.	<input type="checkbox"/>	Continuous data collection April 2018 – March 2019	Quarterly national stats
Maternal, Newborn and infant Clinical Outcome review programme - Perinatal Mortality Surveillance	MBRRACE (Mothers and Babies, Reducing Risk through Audits and Confidential Enquiries across the UK) -UK, National Perinatal Epidemiology Unit, University of Oxford	The study addresses late fetal losses – baby delivered between 22+0 and 23+6 weeks of pregnancy showing no signs of life, irrespective of when the death occurred. Terminations of pregnancy - resulting in a pregnancy outcome from 22+0 weeks gestation onwards. Stillbirths – baby delivered from 24+0 weeks gestation showing no signs of life. Early neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth. Late neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g	<input type="checkbox"/>	Continuous data collection April 2018 – March 2019	Published report expected October 2019

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2018/19	Percentage Data completion	Outcome
		where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.			
Maternal, Newborn and infant Clinical Outcome review programme - Maternal Mortality Surveillance	MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	All deaths of women who die during pregnancy or up to one year after the end of the pregnancy regardless of how the pregnancy ended or the cause of death.	<input type="checkbox"/>	Continuous data collection April 2018 – March 2019	Published report expected November 2019
Maternal, Newborn and infant Clinical Outcome review programme - Maternal Morbidity and Mortality Confidential Enquiry	MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	The aim is to identify avoidable illness and deaths so the lessons learned can be used to prevent similar cases in the future.	<input type="checkbox"/>	Continuous data collection April 2018 – March 2019	Published report expected November 2019
Maternity and Perinatal	Royal College of Obstetricians and Gynaecologists	The Audit (NMPA) is a new large scale audit of the NHS maternity services across England, Scotland and Wales.	<input type="checkbox"/>	Continuous data collection April 2018 – March 2019	No publication date yet identified
Myocardial Ischaemia National Audit Project (MINAP)	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.	<input type="checkbox"/>	100%	No published date yet identified
Neonatal Audit Programme	Royal College of Paediatrics and Child Health	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.	<input type="checkbox"/>	Continuous data collection April 2018 – March 2019	Published report expected October 2019
Neurosurgical National 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.	✓	Continuous data collection April 2018 – March 2019	No publication date yet identified
Non-invasive Ventilation (NIV) Adults	British Thoracic Society	The audit addresses patients with acute hyperapnic respiratory failure treated with acute NIV.	<input type="checkbox"/>	February 2019 – June 2019	Published report expected December 2019
Oesophago-gastric Cancer	NHS Digital	The oesophago-gastric (stomach) cancer audit aims to examine the quality of care given to patients and thereby help services to improve. The	<input type="checkbox"/>	Continuous data collection April 2018 – March 2019	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2018/19	Percentage Data completion	Outcome
		audit evaluates the process of care and the outcomes of treatment for all O-G cancer patients, both curative and palliative.			
Ophthalmology Audit	The 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	<input type="checkbox"/>	Data collection September 2018 – August 2019	Published report expected July 2019
Percutaneous Coronary Interventions (PCI)	National Institute for Cardiovascular Outcomes Research (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 which has developed secure data collection, analysis and monitoring tools and provides a common infrastructure for all the coronary heart disease audits.	<input type="checkbox"/>	100%	No publication date yet identified
Prostate Cancer	Royal College of Surgeons of England	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.	<input type="checkbox"/>	100%	Compliant
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.	<input type="checkbox"/>	100%	No publication date yet identified
Pulmonary Hypertension	NHS Digital	The audit measures the quality of care provided to people referred to pulmonary	<input type="checkbox"/>	Continuous data collection	No publication date yet

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2018/19	Percentage Data completion	Outcome
		hypertension services.		April 2018 – March 2019	identified
Reducing the Impact of Serious Infections - Antibiotic consumption	Public Health England	This is currently part of the national Commissioning for Quality and Innovation (CQUIN) payment framework for NHS Acute Trusts in England.	<input type="checkbox"/>	Continuous data collection April 2018 – March 2019	Q4 data expected 30 April 2019
Reducing the Impact of Serious Infections - Antimicrobial stewardship	Public Health England	This is currently part of the national Commissioning for Quality and Innovation (CQUIN) payment framework for NHS Acute Trusts in England.	<input type="checkbox"/>	Continuous data collection April 2018 – March 2019	Q4 data expected 30 April 2019
Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Royal College of Paediatrics and Child Health	The audit aims to address the care of children and young people with suspected epilepsy who receive a first paediatric assessment from April 2018 within acute, community and tertiary paediatric services.	<input type="checkbox"/>	100%	No publication date yet identified
Sentinel Stroke National Audit Programme	Royal College of Physicians	The audit collects information about care provided to stroke patients in first three days of hospital. Data is continuous.	<input type="checkbox"/>	100%	Compliant
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Serious Hazards of Transfusion	The scheme collects and analyses anonymised information on adverse events and reactions in blood transfusion from all healthcare organisations that are involved in the transfusion of blood and blood components in the United Kingdom.	<input type="checkbox"/>	100%	Published report expected July 2019
Seven Day Hospital Services	NHS England	The audit addresses the care of patients admitted as an emergency.	✓	100%	Published report expected December 2019
Specialist Rehabilitation for Patients with Complex Needs following major Injury	London North West Healthcare NHS Trust	The audit aims to provide a comparative assessment of services provided in relation to specialist injuries caused by events such as road accidents and falls.	<input type="checkbox"/>		No publication date yet identified
Monitoring of Surgical Site Infection (SSI) through Surveillance Service	Public Health England	The aim of the national surveillance program is to enhance the quality of patient care by encouraging hospitals to use data obtained from surveillance to compare their rates of SSI over time and against a national benchmark, and to use this information to review and guide clinical practice.	✓	100%	Compliant
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	The audit addresses the care of all patients with a	<input type="checkbox"/>	100%	Published report

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2018/19	Percentage Data completion	Outcome
		diagnosis of UK.			expected August 2019
Vascular Registry	Royal College of Surgeons of England	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. The second is a carotid endarterectomy.	✓	100%	Published report expected November 2019
Vital Signs (Care in Emergency Department)	Royal College of Emergency Medicine	The audit addresses adults over the age of 18 years of age which presented to the Emergency Department and were triaged to the major areas of the Emergency Department.	✓	100%	Published report expected May 2019
VTE Risk in Lower Limb Immobilisation (Care in Emergency Departments)	Royal College of Emergency Medicine	The audit includes adults and adolescents 17 years and over presenting to the Emergency Department or a Minor Injuries unit with a lower limb injury and is discharged with temporary immobilisation of the limb using a plaster cast or airboot.	✓	100%	Published report expected May 2019
Child Health Outcome Review Programme – Long-term ventilation in children, young people and adults	The National Confidential Enquiry into Patient Outcome and Death	The audit includes patients up to 25 th birthday who are receiving, or have received long-term ventilation where the intention of to discharge patient home on same level of continuing respiratory support.	✓	Data collection remains ongoing	Published report expected December 2019
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) - Acute Heart Failure	NCEPOD	To identify and explore avoidable and remediable factors in the process of care for patients treated with acute non-invasive ventilation (NIV).	✓	100%	Action plan in place
NCEPOD - Cancer in Children, Teens and Young Adults	NCEPOD	The aims of this study are to study the process of care of children, Teens and Young Adults under the age of 25 years who died/ or had an unplanned admission to critical care within 30 days of receiving systemic anti-cancer therapy.	✓	100%	Action plan in place
NCEPOD - Perioperative Diabetes	NCEPOD	A review of the quality of care provided to patient over the age of 16 who had diabetes and underwent a surgical procedure.	✓	100%	Action plan in place
NCEPOD - Pulmonary Embolism	NCEPOD	To identify and explore avoidable and remediable factors in the process of care for patients diagnosed with	✓	83.3%	Published report expected June 2019

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2018/19	Percentage Data completion	Outcome
		pulmonary embolism.			
NCEPOD Acute Bowel Obstruction	NCEPOD	To identify remedial factors in process of care of patients with both large and small intestinal obstruction.	✓	Data collection ongoing	Published report expected December 2019

An additional 4 audits have been added to the list for inclusion in 2019/20 Quality Account and all 4 audits are relevant to services provided by the Trust. The 4 audits include:

- Assessing cognitive impairment in older people (Care in Emergency Departments);
- Endocrine and thyroid;
- Mental Health – Care in Emergency Department; and
- Seizure management in hospitals.

The reports of national clinical audits were reviewed by the provider in 2018/19 and the Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- The Trust has firmly embedded monitoring arrangements for national clinical audits with the identified 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 six 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 monitored accordingly.
- Non-compliance with recommendations from National Clinical Audit and National Confidential Enquiries are considered in the Annual Business Planning process.

The reports of 792 local audits were reviewed by the provider in 2018/19 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 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 14,814 of which 13,859 were UK Clinical Research Network (UKCRN) National Portfolio studies which equates to 33% of all patients recruited to National Portfolio studies in the region.

Newcastle in 2018/19 is ranked 2nd in the top league of fourteen Trusts for completing commercial trials to Time and Target.

Information on the use of the CQUIN framework

A proportion of The Newcastle upon Tyne Hospitals NHS Foundation Trust income in 2018/2019 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 with for the provision of relevant health services, through Commissioning for Quality Innovation (CQUIN) payment framework.

The monetary total for the amount of income in 2018/19, conditional upon achieving quality improvement and innovation goals is £16.9 million. The monetary total for the amount of income on 2017/18 was £17.7 million.

Information on the use of the CQUIN framework

CQUIN Indicators - Acute Hospital – (NHS England)	CQUIN Indicators - Acute Hospital – (CCG)
<ul style="list-style-type: none"> Shared Decision Making – Year 2 SACT (Dose banding for intravenous anticancer therapy) Year 2 Optimising palliative chemo decision making Year 2 Enhanced supportive care Year 3 Cystic fibrosis patient adherence Year 2 Auto-immune management Year 2 Paediatric networked care Year 2 Neonatal community outreach Year 2 Improving HCV treatment pathways Year 3 TECS Project Year 3. 	<ul style="list-style-type: none"> Improving staff health and wellbeing Year 2 Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Year 2 Improving services for people with mental health needs who present to A&E Year 2 Offering advice and guidance Year 2 Preventing ill-health by risky behaviours - Alcohol and Tobacco – 1 year scheme.
CQUIN Indicators - Acute Hospital – (Public Health/Dental/other)	CQUIN Indicators - Community
<ul style="list-style-type: none"> Dental Quality Dashboards Breast screening Stereotactic Radiosurgery Armed Forces Covenant. 	<ul style="list-style-type: none"> Improving staff health and wellbeing Year 2 Improving the assessment of wounds Year 2 Personalised care and support Year 2 Preventing ill-health by risky behaviours - Alcohol and Tobacco 1 year scheme.

Further details of the agreed goals for 2018/19 and for the following 12 month period are available electronically at: <https://www.england.nhs.uk/nhs-standard-contract/cquin>

Information relating to registration with the Care Quality Commission (CQC)

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 Hospitals NHS Foundation Trust has no conditions on registration. 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 2018/19. An Improvement Notice was issued in August 2018 following a CQC IR(ME)R inspection. This was lifted following a re-inspection in November 2018.

The Newcastle upon Tyne Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

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'. There has been a well-led visit in January 2019, with management interviews held in February 2019. The Trust was awarded a rating of 'Outstanding' for the second time.

Overall Trust Rating - Outstanding



Information on the Quality of Data

The Newcastle upon Tyne Hospitals NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service (SUS+) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data (April 2018 to January 2019). The percentage of records in the published data:

which included the patients valid NHS number was:

- 99.3% for admitted patient care
- 99.7% for outpatient care
- 98.1% 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.

Clinical Coding Information

Score for 2018/19 for Information Quality and Records Management, assessed using the Data Security & Protection (DSP) Toolkit

The threat to digital services through cyber-attack is recognised by the Trust and we are committed to ensuring the organisation complies with the UK Data Protection Act 2018, NHS Data Security Standards and achieving the Cyber Essentials Plus certification.

The Trust has effective arrangements in place for Information Governance and monitoring of performance against the Data Protection and Security Toolkit with reporting through the Information Governance Committee and reporting to Board of Directors.

In May 2018 the UK Data Protection Act 2018 came into force. This act aligns with the NHS Data Security Standards and includes requirements for new or changed IT systems to be developed with data privacy by design as a pre-requisite with the starting point being the protection and security of the personal data held and processed by the Trust. The Trust has implemented processes and procedures to monitor the privacy throughout the lifecycle of developments.

The Data Protection and Security Toolkit is the mandated method for monitoring the Trust performance in the key areas of Data Protection and technical/cyber security. This will be based on the NHS Data Security Standards and is focussed on ensuring the Trust remains compliant with laws concerning personal information handling and sharing, along with remaining resilient to current and future cyber threats.

In 2018/2019 the Trust reported two Information Governance incidents to the Information Commissioners Office (ICO) which was classified at level 2 in accordance with ICO guidance.

The first Data Security and Protection Toolkit submission was completed on 31 March 2019, the evidence to show our progress with the toolkit was externally assessed and the Trust are currently graded as 'standards not fully met (plan agreed)'.

The Newcastle upon Tyne Hospitals NHS Foundation Trust was not subject to a Payment by Results clinical coding audit at any time during the reporting period.

The Newcastle upon Tyne Hospitals NHS Foundation Trust Clinical Coding Audit achieved DSP advisory level (Good) in all four coding indicators. This is the highest level of attainment and was achieved for all areas reviewed. Please see table below for results.

Table shows the - levels of attainment of coding of inpatient activity

Area	Levels of Attainment		
	Mandatory	Advisory	NUTH Score
Primary diagnosis	>=90%	>=95%	98.0%

Secondary diagnosis	>=80%	>=90%	98.1%
Primary procedure	>=90%	>=95%	98.7%
Secondary procedure	>=80%	>=90%	98.1%

The services were reviewed within the sample included Major Trauma (50), General Surgery (75) and Ophthalmology (75). The audit results were good, exceeding the percentages required to achieve the highest level of attainment in all areas. Only 4 spells in the audit of 200 case notes impacted on payment. The results should not be extrapolated further than the actual sample audited.

The Newcastle upon Tyne Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

- Feedback all areas of error found during the audit to the coders including the importance of recording all relevant conditions and the importance of data extraction skills within the coding process.
- Ensure all coders understand the national coding guidance relating to intravenous infusions, external cause code, site codes and laterality codes.
- Ensure that coders access histology and update the coded data.
- Review and update the local clinical coding policy on cataracts.

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	2018/2019				2017/18				2016/17			
1. The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust	https://indicators.ic.nhs.uk/webview/	Band 2 "as expected"		Oct 17-Sept 18 NUTH Value: .9847	July 17-June 18 NUTH Value: .9553	Apr 17-Mar 18 NUTH Value: 0.9359	Jan 17-Dec 17 NUTH Value: 0.9282	Oct 16-Sept 17 NUTH Value: .93	July 16-June 17 NUTH Value: .95	Apr 16-Mar 17 NUTH Value: .95	Jan 16-Dec 16 NUTH Value: .96	Oct 15-Sept 16 NUTH Value: .97	July 15-June 16 NUTH Value: .98	April 15-March 16 NUTH Value: .98	Jan 15-Dec 15 NUTH Value: .98
				NUTH Band 2	NUTH: Band 2	NUTH: Band 2	NUTH: Band 2	NUTH: Band 2	NUTH: Band 2	NUTH: Band 2	NUTH: Band 2	NUTH: Band 2	NUTH: Band 2	NUTH: Band 2	NUTH: Band 2
			National average	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
			Highest national	1.268	1.257	1.2321	1.2181	1.25	1.23	1.21	1.19	1.16	1.17	1.18	1.17
			Lowest national	0.692	0.698	0.6994	0.7204	0.73	0.73	0.71	0.69	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	https://indicators.ic.nhs.uk/webview/	N/A		29.2%	28.7%	28.4%	27.3%	25.1%	24.3%	22.5%	22.1%	22.6%	21.8%	23.0%	22.9%
			National average	33.6%	33.1%	32.5%	32.2%	31.5%	Not available	Not available	Not available	Not available	Not available	Not available	Not available
			Highest national	59.5%	58.7%	59.0%	60.3%	59.8%	58.6%	56.9%	55.9%	48.9%	44.5%	54.6%	54.7%
			Lowest												

			national	14.3%	13.4%	12.6%	11.7%	11.5%	11.2%	11.1%	7.3%	0.4%	0.6%	18.2%	17.7%
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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 continue to monitor and discuss mortality findings at the quarterly Mortality Surveillance Group; representatives attend this group from multiple specialities and 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	2018/2019	April 2017/ March 2018	April 2016/ March 2017	April 2015- March 2016	April 2014- March 2015	2013/14
3. The patient reported outcome measures scores (PROMS) for groin hernia surgery (average health gain score)	NHS Digital information portal http://content.digital.nhs.uk/proms	NUTH	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	0.11	0.08	0.09	0.07
		National average:	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	0.09	0.08	0.08	0.08
		Highest national:	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	0.14	0.15	0.15	0.14
		Lowest national:	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	0.01	0.03	0.03	0.01
4. The patient reported outcome measures scores (PROMS) for varicose vein surgery (average health gain)	NHS Digital information portal http://content.digital.nhs.uk/proms	Trust score:	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	0.12	0.10	0.08	0.11
		National average:	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	0.09	0.09	0.09	0.09
		Highest national:	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	0.15	0.15	0.15	0.16
		Lowest national:	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	0.01	0.02	-0.01	- 0.02
5. The patient reported	NHS Digital information	Trust Score	Not Yet	0.47	0.44	0.42	0.43	0.43

outcome measures scores (PROMS) for primary hip replacement surgery (average health gain)	portal http://content.digital.nhs.uk/prom		Published					
		National average:	Not Yet Published	0.47	0.44	0.43	0.44	0.44
		Highest national:	Not Yet Published	0.38	0.54	0.50	0.52	0.54
		Lowest national:	Not Yet Published	0.57	0.31	0.39	0.33	0.31
6. The patient reported outcome measures scores (PROMS) for primary knee replacement surgery (average health gain)	NHS Digital information portal http://content.digital.nhs.uk/proms	Trust Score	Not Yet Published	0.33	0.33	0.31	0.32	0.33
		National average:	Not Yet Published	0.34	0.32	0.32	0.31	0.32
		Highest national:	Not Yet Published	0.42	0.40	0.38	0.42	0.42
		Lowest national:	Not Yet Published	0.23	0.24	0.23	0.20	0.21

Please note that in relation to PROMs - 2018/19 data is not available for most providers, the reason for this is that the EQ-5D survey is sent to patients 6 months post-surgery, these survey scores can then be modelled. The data published by NHS Digital requires a provider to have at least 30 modelled records before a score can be calculated.

Measure 3. The patient reported outcome measures scores (PROMS) for groin hernia surgery.

Collection of groin procedure scores ceased on 1 October 2017.

Measure 4. The patient reported outcome measures scores (PROMS) for varicose vein surgery.

Collection of varicose vein procedure scores ceased on 1 October 2017.

Measure 5. The patient reported outcome measures scores (PROMS) for hip replacement surgery.

The Newcastle upon Tyne Hospitals NHS Foundation Trust did not meet the Participation in Assessment requirement against PROMS figures for Hips target for reasons explained above.

The Newcastle upon Tyne Hospitals NHS Foundation Trust PROMS outcomes are good and we are committed to increasing our participation rates going forward to meet and surpass the target levels. We encourage patients to complete these and discuss completion rates and results in the Arthroplasty Multidisciplinary team (MDT).

Measure 6. The patient reported outcome measures scores (PROMS) for knee replacement surgery.

The Newcastle upon Tyne Hospitals NHS Foundation Trust did not meet the Participation in Assessment against PROMS figures for Knee replacement target for reasons explained above.

The Newcastle upon Tyne Hospitals NHS Foundation Trust PROMS outcomes are good and we are committed to increasing our participation rates going forward to meet and surpass the target levels. We encourage patients to complete these and discuss completion rates and results in the Arthroplasty MDT.

Measure 7. The percentage of patients aged— (i) 0 to 15; and (ii) 16 or over readmitted within 28 days of being discharged from hospital.

This indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review. Therefore, the Trust has reviewed its own internal data and used its 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
2017/18	35,009	2,077	5.9
2018/2019	36,388	1,991	5.5

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
2017/18	182,535	10,157	5.6
2018/2019	185,672	10,452	5.6

Measure	Data Source	Value	2018/19	2017/18	2016/17	2015/16	2014/15	2013/14
8. The Trust's responsiveness to the personal needs of its patients	NHS Information Centre Portal https://indicators.ic.nhs.uk/	Trust percentage	Not available until Summer 2019	74.9%	74.6%	76.1%	76.8%	77.3%
		National average:	Not available until Summer 2019	68.6%	68.1%	69.6%	68.9%	68.7%
		Highest national:	Not available until Summer 2019	85.0%	85.2%	86.2%	86.1%	84.2%
		Lowest national:	Not available until Summer 2019	60.5%	60.0%	54.4%	59.1%	54.4%

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

Measure	Data Source	Value	2018/19	2017/18	2016/17	2015/16	2014/15	2013/14
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	http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/Results/	Trust percentage	90%	96%	95%	91%	89%	85%
		National average:	70%	81%	80%	72%	69%	65%
		Highest national:	95%	100%	100%	95%	89%	89%
		Lowest national:	33%	43%	44%	48%	46%	38%

experience and improve its services. Data for 2018/2019 has not yet been released, but data for 2017/2018 has been populated.

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 2017/2018 has been added as it was not available at time of publication last year.

Measure	Data Source	Target	2018/2019				2017/2018				2016/2017				2015/16			
10. The percentage of patients that were admitted to hospital who were risk assessed for Venous thromboembolism (VTE)	https://www.england.nhs.uk/statistics/statistical-work-areas/vte/	Trust (CQUIN Target-95%)	Q1 96.49%	Q2 95.72%	Q3 97.23%	Not available	Q1 96.25%	Q2 96.73%	Q3 96.07%	Q4 95.61%	Q1 91.7%	Q2 95.8%	Q3 95.6%	Q4 95.47%	Q1 95.9%	Q2 96.4%	Q3 96.2%	Q4 95.8%
		National average	95.63%	95.49%	95.65%	Not available	95.20%	95.25%	95.36%	95.21%	95.7%	95.5%	95.6%	95.50%	96%	95.8%	95.4%	95.2%
		Highest national	100%	100%	100%	Not available	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Lowest national	75.84%	68.67%	54.86%	Not available	51.38%	71.88%	76.08%	67.04%	80.6%	72.1%	76.4%	63.02%	86.1%	75%	100%	78%

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. Data for Q4 2018/19 will not be published until June 2019.

Measure	Data Source	Target	2018/2019	2017/2018	2016/2017	2015/2016	2014/15	2013/14	2012/13
11. The number and rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over	PHE Data Capture System	Trust number of cases	77 National figure 51 (minus successful appeals)	88 National figure 77 (minus successful appeals)	74 National figure 57 (minus successful appeals)	94 National figure 67 (minus successful appeals)	89 National figure 73 (minus successful appeals)	86 National figure 75 (minus successful appeals)	76 National figures (no appeal process at this time)
		Trust Rate (per 100,000 bed days)	16.32 (national)	18.65 (national)	15.44 (national)	19.44 (national)	18.37 (national)	18.18 (national)	15.43 (national)
		National Average rate (per 100,000 bed days)	11.92	13.48	13.22	15.26	14.87	14.31	16.69
		Highest National rate (per 100,000 bed days)	78.75	92.75	82.59	67.19	62.57	44.41	46.83
		Lowest National rate (per 100,000 bed days)	0	0	0	0	0	0	0

Measure	Data Source	Target	2018/2019	2017/2018		2016/2017		2015/2016		2014/2015		2013/2014	
12. The number and rate per 100 admissions of patient safety incidents reported <i>NB: Changed to rate per 1000 bed days April 2014</i>	NHS Information Centre Portal http://www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports/	Trust no.	April-2018 Sept 2018 8661	Oct 2017- March 2018 8662	April-2017 Sept 2017 8215	Oct 2016- March 2017 6483	April 2016- Sept 2016 6501	Oct 2015- March 2016 7015	April 2015- Sept 2015 7741	Oct 2014- March 2015 7313	April 2014- Sept 2014 7084	Oct 2013- March 2014 6619	April 2013- Sept 2013 5727
		Trust %	38.3	36.53	35.57	27.02	27.15	28.88	32.34	29.66	28.4	5.3	5.4
		National average	44.52	42.5	42.8	41.1	40.8	39.6	39.2	35.3	35.1	8.7	8.0
		Highest National	107.4	124	111.56	69	71.8	75.9	74.7	82.2	74.9	14.9	12.8
		Lowest National	13.1	24.2	23.5	23.1	21.15	14.8	18.1	3.6	0.24	4.6	4.9

Measure	Data Source	Target	2018/2019		2017/2018				2016/17				2015/16			
13. The number and percentage of patient safety incidents that resulted in severe harm or death	NHS Information Centre Portal http://www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports/	Trust no.	April-2018 Sept 2018	April-2018 Sept 2018	Oct 2017- March 2018	Oct 2017- March 2018	April-2017 Sept 2017	April-2017 Sept 2017	Oct 2016- March 2017	Oct 2016- March 2017	April-2016 Sept 2016	April-2016 Sept 2016	Oct 2015- March 2016	Oct 2015- March 2016	April-2015 Sept 2015	April-2015 Sept 2015
			Severe Harm	Death	Severe Harm	Death	Severe Harm	Death	Severe Harm	Death	Severe Harm	Death	Severe Harm	Death	Severe Harm	Death
			23	3	20	1	23	4	23	1	18	3	26	5	32	4
		Trust %	0.3%	0%	0.2%	0%	0.3%	0%	0.4%	0	0.3%	0%	0.4%	0.1%	0.4%	0%
		National average	0.26%	0.11%	0.27%	0.1%	0.3%	0.1%	0.3%	0.1%	0.3%	0.1%	0.3%	0.1%	0.3%	0.1%
		Highest National	0.9%	0.6%	1.2%	0.5%	1.5%	0.5%	2.1%	0.5%	1.4%	0.5%	1.7%	0.4%	2.9%	0.7%
		Lowest National	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

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 Health Care Acquired Infection (HCAI) Report to share lessons learned and best practice from the RCAs and Serious Infection Review Meetings.

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. No further information after September 2018 is currently available.

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 after September 2018 is currently available.

Part 3 – Other Information - Overview of monthly Board assurance 2018/19

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 2018/19. 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. In addition to the 13 local priorities outlined in section 2, the indicators below demonstrate the quality of the services provided by the Trust over 2018/19 has been positive overall.

Patient Safety	Data source	Standard	Actual 2017/18	Target 2018/19	Monthly Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2018/19
MSSA per 100,000 bed days	PHE's Data Capture System	Mandatory reporting by NHSI/NHSE	20.35	Not defined	Not defined	25.51	22.71	15.98	12.89	19.29
MRSA per 100,000 bed days	PHE's Data Capture System	Mandatory reporting by NHSI/NHSE	0.84	Zero Tolerance	Not defined	0.85	0.84	0.00	0.00	0.42
C.difficile per 100,000 bed days	PHE's Data Capture System	Mandatory reporting by NHSI/NHSE	18.65	No more than 16.1	Not defined	12.75	21.02	16.82	14.61	16.32
E.coli per 100,000 bed days	PHE's Data Capture System	Mandatory reporting by NHSI/NHSE	36.88	Not defined	Not defined	49.31	32.80	35.32	35.25	38.15
Klebsiella per 100,000 bed days	PHE's Data Capture System	Mandatory reporting by NHSI/NHSE	15.90	Not defined	Not defined	22.11	15.98	21.02	18.91	19.50
Pseudomonas per 100,000 bed days	PHE's Data Capture System	Mandatory reporting by NHSI/NHSE	4.24	Not defined	Not defined	8.50	7.57	5.05	6.02	6.78
Hand Hygiene audits (opportunity)	Internal	Local CAT tool	99.5%	98%	98%	98.82%	99.40%	99.40%	98.87%	99.13%
Hand Hygiene audits (technique)	Internal	Local CAT tool	98.8%	98%	98%	98.58%	98.86%	98.20%	98.97%	98.71%
Total number of patient incidents reported (Datix)	Internal Datix Incident reporting system	Local Incident Policy	17,802	Not defined	Not defined	4,426	4,520	4,581	4,832	18,359

Patient Incidents per 1000 bed days (Datix)	Internal Datix Incident reporting system	Local Incident Policy	34.9	Not defined	Not defined	35.3	37.2	37.2	37.0	36.7
% Patient incidents that result in severe harm or death	Internal Datix Incident reporting system	Local	0.35%	Not defined	Not defined	0.25%	0.36%	0.38%	0.31%	0.33%
Slip, trip and fall - patient (Datix)	Internal Datix Incident reporting system	N/A	3,100	Not defined	Not defined	743	626	653	744	2,766
Slip, trip and fall - patient (Datix) per 1,000 bed days	Internal Datix Incident reporting system	National definition	6.1	Not defined	Not defined	5.9	5.2	5.3	5.7	5.5
Patient Safety	Data Source	Standard	Actual 2017/18	Target 2018/19	Monthly Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2018/19
Inpatients acquiring pressure damage	Internal Datix Incident reporting system	National	789	Not defined	Not defined	205	247	242	241	935
Pressure Ulcers per 1000 bed days	Internal Datix Incident reporting system	Local	1.6	Not defined	Not defined	1.6	2.0	2.0	1.8	1.9
Total number of Never Events reported	Internal Datix Incident reporting system	National definition	7	Not defined	Not defined	1	4	0	1	6
Total number of Serious Incidents reported	Internal Datix Incident reporting system	Local SI Policy	85*	Not defined	Not defined	21	26	26	29	102**

Clinical Effectiveness		Data Source	Standard	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	
Medication incidents	Internal Datix Incident reporting system	Local	1,839	Not defined	Not defined	438	481	450	448	1,817
Needlestick injury or other incident connected to sharps	Internal Datix Incident reporting system	Local Policy	355	Not defined	Not defined	96	96	88	103	383
Reporting of Injuries, Disease and Dangerous Occurances (RIDDOR)	Internal Datix Incident reporting system	Local Policy	29	Not defined	Not defined	8	6	8	5	27
Slip, Trip, Fall – Staff/Visitors/relatives	Internal Datix Incident reporting system	Local Policy	204	Not defined	Not defined	43	45	48	41	177
Female Genital Mutilation cause for concern numbers	Internal – Safeguarding Dashboards	Local	28	Not defined	Not defined	9	13	10	12	44
Maternity cause for concern numbers	Internal – Safeguarding Dashboards	Local	873	Not defined	Not defined	231	182	218	187	820
Adult cause for concern numbers	Internal – Safeguarding Dashboards	Local	1996	Not defined	Not defined	560	646	657	761	2624
Children cause for concern numbers	Internal – Safeguarding Dashboards	Local	2246	Not defined	Not defined	651	695	496	433	2483
Deprivation of Liberty Application numbers	Internal – Safeguarding Dashboards	Local	400	Not defined	Not defined	124	132	169	288	713

Summary Hospital Mortality Index (SHMI)	CHKS	100	98.82	106.23	96.68	91.50	Not available	Not available
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Patient Experience	Data source	Standard	Actual 2017/18	Target 2018/19	Monthly Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2018/19
Number of complaints received	Internal Datix Incident reporting system	Local Complaints Policy	610	Not defined	Not defined	130	119	139	178	566
National Inpatient Survey	CQC	National standard	74.9%	Not defined	Not defined	N/A	N/A	N/A	N/A	Not available until Summer 2019
Friends and Family response rates (inpatients and A&E)	Locally collected reported	National standard	9.3%	Not defined	Not defined	7.83%	7.04%	6.36%	6.48%	6.74%

Inconsistencies in data reported in the 2018/19 report

There have been some slight variations in the reported 2017/2018 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.

*This figure includes 5 Serious Incidents that have been subsequently de-registered from 2017/18 since initial reporting.

**This figure includes 6 Serious Incidents that have been subsequently de-registered in 2018/19 since initial reporting.

Please note that the HCAI figures for per 100,000 bed days is taken from Public Health England's Data Capture System (DCS) which means that they differ from the in-house figures we have previously produced due to the number of bed days fluctuating within Business Objects system

1. The Trust will continue to set a clear direction and identify quality priorities each year.
2. Bringing clarity to quality by defining what high quality care looks like.
3. Measuring and publishing quality to monitor standards and benchmark performance. We will aim to reduce duplication by measuring what matters.
4. Recognising and sharing quality and best practice to increase the pace of change and avoid duplication.
5. Maintaining and protecting quality to ensure we continue to deliver the best quality care. We will act quickly when this is not the case.
6. Building capacity in front line staff to ensure more staff have an understanding of quality improvement techniques and human factors.
7. Staying ahead by continuing to champion innovation and research.

Quality Strategy 2018-2021

The Trust has launched a new Quality Strategy 2018-21 to inform staff and service users how the Trust intends to deliver Safe, Effective, and High Quality Patient Care.

As a Trust we are committed to providing services which:

- Maintain patient safety at all times and in all respects;
- Are clinically effective and lead to the best possible health outcomes for patients;
- Provide a positive patient experience;
- Are timely, equitable and efficient; responding to the needs of our population;
- Are well-led, open and collaborative and are committed to learning and improvement.

This strategy sets out how NuTH aims to continue to deliver the high quality care for which it is renowned and continue to put patients at the heart of all we do.

Seven Steps to Improve Quality

This strategy follows the 'Seven Steps' to improving quality as outlined by the National Quality Board but have been modified to align with the Trust's own goals and expectations. The steps define what we need to do, to continually improve the quality of care we provide to our patients and ensure we have a skilled and motivated workforce for the future.

We are confident that by implementing this strategy and continuing to put patients at the heart of everything we do, we will continue to ensure that our services are safe, effective, caring, responsive and well-led. By working hard to foster a culture of continuous improvement, by empowering staff and patients to make the changes they want to see, we will continue to deliver the best possible care to the people of Newcastle and beyond. We will monitor the implementation of this strategy closely and look forward to working together to make The Newcastle upon Tyne Hospitals NHS Foundation Trust even better.



The Newcastle upon Tyne Hospitals NHS Foundation Trust Quality Assurance process

The Trust has developed and embedded a robust quality surveillance programme designed to provide assurance to the Board that high quality care is being delivered across all services and that areas requiring improvement can be quickly identified. The Patient Safety and Quality Review (PS&QR) process is aligned to the CQC inspection approach.

The PS&QR process involves an in-depth annual inspection including:

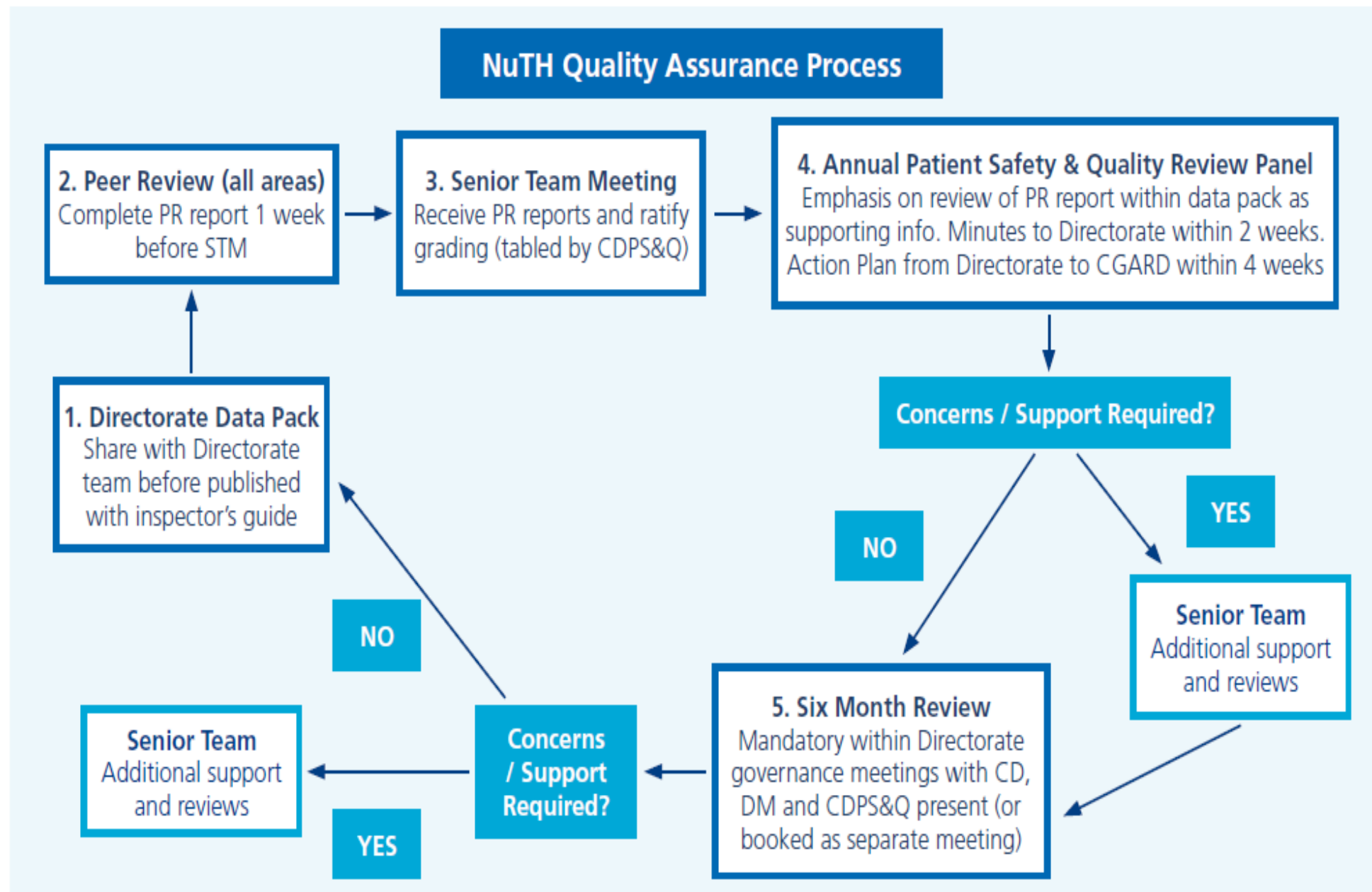
- Staff interviews – a range of professional groups and staff of varying seniority
- Patient and family/carer opinion
- Direct observations of clinical practice
- Documentation of care
- An inspection of the physical environment.

This process is supported by a data pack. The data pack is based on the 5 CQC inspection domains and contains a variety of indicators pertinent to each Directorate. In preparation for the review visit, Key Lines of Enquiry (KLOE) are developed, based on analysis of the data pack. The outcomes of the peer review and data pack are discussed at an annual PS&QR panel chaired by the Medical Director and supported by senior clinical leadership from across the Trust.

The objectives of the PS&QR process are as follows:

- To ensure each Directorate attends a PS&QR panel every 12 months as a minimum. This will be supported by a 6 month follow-up meeting
- For each Directorate to participate in a peer review inspection prior to each PS&QR panel
- To provide a framework for monitoring Quality Indicators at a Directorate level

To provide a structure to help identify areas of care requiring improvement and the support and expertise to address the more difficult issues that may be impacting on quality and patient safety





Quality Assurance Strategy—Internal Peer Reviews 2018- 2019

For the period 2018-2019, the Clinical Governance and Risk Department have facilitated 18 internal peer reviews. This robust quality surveillance programme provides assurance to the Board that high quality care is being delivered across all services and quickly identifies both areas of excellence and opportunities for improvement.

A common theme throughout the review process is that staff are always very welcoming and receptive when the inspection team arrive unannounced. The review process provides a valuable opportunity for services to be observed by ‘a fresh pair of eyes’ and also offers an opportunity for learning and sharing for both the clinical teams being reviewed and the inspection team, who often report having observed innovations or ideas which they will replicate in their service.

Examples of innovations and improvements resulting from peer reviews are as follows:

- Patient Safety - introduction of electronic Venous thromboembolism (VTE) risk assessment which links to prescribing of thrombo-prophylaxis reducing the risk of avoidable thromboembolism, increased length of stay and costly drug treatments.
- Patient Safety - Enhanced Patient ID with wristbands introduced in Rheumatology Day Unit, reducing the likelihood of harm caused by errors resulting in inadvertent administration of drugs to the incorrect patient.
- Patient Safety - Promotion of best practice in Infection Prevention and Control. Introduction of initiatives to minimise the likelihood of cross-infection and provision of specific training to clinical teams in ANTT.
- Patient Experience - NCCC/Haematology are exploring the introduction of electronic communication to patients waiting for appointments.
- Patient Experience - Improved signage in a number of areas to reduce late arrivals for clinics, DNA's and to minimise anxiety for patients.
- Patient Experience - Improved staff experience and increased efficiency by clearly defining roles and responsibilities and providing protected time for disseminating key safety messages during and after ward rounds.
- Patient Experience - Raised awareness of reasonable adjustments made to accommodate carers and where appropriate include them in the provision of care.

These internal reviews could not take place without the support of multi-disciplinary staff from all services across the Trust who volunteer as inspectors. In 2018/19, 149 staff have acted as inspectors, some of them multiple times. An additional 34 staff have registered to participate in the next annual cycle of reviews. The Trust is extremely grateful to all staff involved for their commitment to the process.

Workforce factors

Wellbeing –the tables below provide data on the loss of work days. The table directly below reports on the Trust and Regional position rate (data taken from the NHS Information Centre) and the next table provides an update on the Trust number of staff sick days lost to industrial injury or illness caused by work.

This table shows the loss of work days (rate)

	<i>Jan 18</i>	<i>Feb 18</i>	<i>Mar 18</i>	<i>Apr 18</i>	<i>May 18</i>	<i>Jun 18</i>	<i>Jul 18</i>	<i>Aug 18</i>	<i>Sep 18</i>	<i>Oct 18</i>	<i>Nov 18</i>
The Newcastle Upon Tyne Hospitals	5.42%	4.81%	4.13%	3.90%	3.85%	3.97%	4.06%	3.77%	3.87%	4.28%	4.57%
City Hospitals Sunderland	5.11%	4.33%	4.12%	4.13%	4.08%	3.81%	3.95%	3.82%	3.97%	4.28%	4.70%
County Durham and Darlington	5.53%	4.97%	4.63%	4.18%	4.32%	4.41%	4.60%	4.37%	4.56%	4.65%	4.74%
Gateshead Health	5.77%	5.04%	4.97%	4.13%	4.00%	3.89%	4.43%	4.01%	4.26%	4.48%	4.91%
North Tees and Hartlepool	5.53%	4.59%	4.38%	4.13%	4.31%	4.04%	4.26%	4.13%	3.99%	4.44%	4.51%
Northumbria Healthcare	5.48%	4.41%	4.01%	3.80%	3.87%	4.01%	4.04%	3.94%	3.96%	4.21%	4.48%
South Tees Hospitals	5.57%	4.70%	4.23%	4.01%	3.90%	4.27%	4.53%	4.45%	4.52%	4.99%	4.92%
South Tyneside	6.04%	5.12%	4.61%	4.47%	4.48%	4.82%	4.70%	4.46%	3.99%	4.43%	4.93%
England	5.11%	4.53%	4.12%	3.89%	3.85%	3.96%	4.15%	4.12%	4.19%	4.41%	4.53%

The table below shows 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
2017/2018 no. of days	137	90	51	122	400
2018/2019 no. of days	214	131	188	172	705

2018 NHS Staff Survey Results Summary

A standard survey was sent via email to all employees of the Trust (via external post for those on maternity leave), giving all 14,109 members of our staff a voice. 6,655 staff participated in the survey, equalling a response rate of 47% which is above the sector average of 41%, and was a significant improvement on the 2017 response rate of 33%.

The results are arranged under 10 themes:

- THEME 1: Equality, diversity & inclusion
- THEME 2: Health & wellbeing
- THEME 3: Immediate managers
- THEME 4: Morale
- THEME 5: Quality of appraisals
- THEME 6: Quality of care
- THEME 7: Safe Environment - Bullying & Harassment
- THEME 8: Safe Environment - Violence
- THEME 9: Safety Culture
- THEME 10: Staff Engagement

The Staff Engagement score is measured across three sub-themes:

- Advocacy, measured by Q21a, Q2c and Q21d (Staff recommendation of the Trust as a place to work or receive treatment)
- Motivation, measured by Q2a, Q2b and Q2c (Staff motivation at work)
- Involvement, measured by Q4a, Q4b and Q4d (Staff ability to contribute towards improvement at work)

In NuTH this score was:

- Overall: rating of staff engagement 7.3 (out of possible 10).

This score was only 0.1 below top position in the sector (Combined Acute & Community Trusts) and is 0.1 above the Trusts score in 2017.

The Trust scored significantly better on 7 of the 10 themes when compared with other Combined Acute & Community Trusts in England. It is also worth noting that the Trust did not score below sector average in any themes.

- Safety Culture
 - NuTH Score: 7.1 out of 10
- Sector Score: 6.7 out of 10
- Staff Engagement
 - NuTH Score: 7.3 out of 10
 - Sector Score: 7.0 out of 10
- Equality, Diversity & Inclusion
 - NuTH Score: 9.4 out of 10
 - Sector Score: 9.2 out of 10
- Morale
 - NuTH Score: 6.4 out of 10
 - Sector Score: 6.2 out of 10
- Quality of Care
 - NuTH Score: 7.7 out of 10
 - Sector Score: 7.4 out of 10
- Safe Environment – Bullying & Harassment
 - NuTH Score: 8.4 out of 10
 - Sector Score: 8.1 out of 10
- Safe Environment – Violence
 - NuTH Score: 9.6 out of 10
 - Sector Score: 9.5 out of 10

Of note, the Trust is also in top position for a number of themes against various comparators:

- #1 in Sector for
 - Safety Culture: 7.1 out of 10
- #1 in Region for
 - Safe Environment – Bullying & Harassment: 8.4 out of 10
 - Safe Environment – Violence: 9.6 out of 10
 - Safety Culture: 7.1 out of 10
- #1 in Shelford Group for
 - Equality, Diversity & Inclusion: 9.4 out of 10
 - Immediate Managers: 6.9 out of 10
 - Morale: 6.4 out of 10
 - Safe Environment – Bullying & Harassment: 8.4 out of 10
 - Safe Environment – Violence: 9.6 out of 10
 - Safety Culture: 7.1 out of 10

The Trust is also compare favourably against the sector in a number 67% of the 90 questions in the survey. Some to note include:

- 90% agree that they would be happy with the standard of care provided by the organisation should a friend of relative need treatment. This is 20% higher than sector average.
- 89% agree that care of patients/service users is the organisation top priority. This is 12% higher than sector average.
- 81% agree that when errors, near misses or incidents are reported, the organisation takes action to ensure that they do not happen again. This is 11% higher than sector average.
- 70% agree that they are given feedback about changes made in response to reported errors, near misses and incidents. This is 11% higher than sector average.
- 67% are confident that the organisation would address their concerns. This is 9% higher than sector average.
- 32% stated they have felt unwell due to work related stress in the last 12 months. This is 7% under the sector average.

As previously stated, the Trust did not fall below sector average for any of the 10 themes. However, the lowest 3 scoring themes for the organisation were:

- Morale: 6.4 out of 10
- Health & Wellbeing: 6.1 out of 10
- Quality of Appraisals: 5.6 out of 10

There are several other areas which are worth nothing:

- Q21a – Care of patients/service users is my organisation top priority has seen an increase this year from 87.6% to 88.7% of staff agreeing.
- Q7b – I feel that my role makes a different to patients/service users has declined from 91.5% to 90.8% however still remains above sector average. It is also worth noting that the sector average has also declined.
- Q7c – I am able to deliver the care I aspire to has increased from 72.6% to 73.9% where the sector average has declined.
- Q17a – My organisation treats staff who are involved in an error, near miss or incident fairly has significantly improved from 57.8% to 64.0%.
- Q18c – I am confident that my organisation would address my concern has increased from 64.7% to 67.4% where the sector average has declined.

- Q21b – My organisation acts on concerns raised by patients/services users has improved from 82.8% to 83.8%.
- Q14 – Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age has declined from 90.8% to 89.7%

Involvement and engagement 2018-19

Patient, carer and public involvement and engagement is at the heart of everything we do within The Newcastle Upon Tyne Hospitals NHS Foundation Trust. The Trust offers a variety of opportunities for patients and members of the public to get actively involved including a diverse range of volunteering roles, public governors, patient steering and support groups. Patients and members of the public are also able to participate in an active patient research ambassador and engagement campaign.

We have been extremely busy this year, having successfully refreshed and relaunched the patient engagement and involvement group, APEX (Advising on the Patient Experience) which has provided a strong model of involvement for quality improvement. We have also developed the Newcastle Maternity Voices Partnership, which has a large and active social media membership. We have recruited a dedicated role to support YPAGne, (Young Person's Advisory Group, North England) ensuring the voices of children and young people are also being clearly heard.

The Trust works very closely and maintains strong links with local community and voluntary groups to ensure that we are listening to the diverse views of all our patients and that their views and feedback are informing the shape of services we are delivering.

Patients and members of the public are also actively encouraged to give feedback through NHS Friends and Family Test, social media, NHS Choices and Care Opinion websites, Take Two Minutes postcards and a variety of local and national surveys.

In 2019/20 the focus will be to invest in a structured approach to capture real time patient experience feedback to help provide further assurance that we are delivering safe and excellent quality care to all of our patients and members of the public.

Key National Priorities 2018/19

The key national priorities are performance targets for the NHS which are determined by the Department of Health and Social Care 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 2018/19 are detailed in the table below:

Operating and Compliance Framework Target	Target	Annual Performance 2018/19
Incidence of Clostridium <i>difficile</i> (<i>C. difficile</i> : variance from plan)	No more than 76	77 (26 appealed, 51 against target, with potentially further appeals to be heard)*
Incidence of MRSA Bacteraemia	Zero tolerance	2
All Cancer Two Week Wait	93%	91.9%**
Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	93%	86.7%**
31-Day (Diagnosis To Treatment) Wait For First Treatment	96%	95.5%**
31-Day Wait For Second Or Subsequent Treatment: Surgery	94%	92.3%**
31-Day Wait For Second Or Subsequent Treatment: Drug treatment	98%	98.2%
31-Day Wait For Second Or Subsequent Treatment: Radiotherapy	94%	99.4%
All cancers: 62-day wait for first treatment from: • urgent GP referral for suspected cancer	85%	79%**
All cancers: 62-day wait for first treatment from: • NHS Cancer Screening Service referral	90%	90.8%
RTT – Referral to Treatment - Admitted Compliance	90%	85.1% ***
RTT – Referral to Treatment - Non-Admitted Compliance	95%	92%***
RTT – Referral to Treatment - Incomplete Compliance	92%	93.5%
Maximum 6-week wait for diagnostic procedures	99%	98.3%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	95%	95.4%
Delayed Transfers	3.5%	1.6%
Cancelled operations – those not admitted within 28 days	0	54****
Maternity bookings within 12 weeks and 6 days	Not defined	86.6%
Data completeness: Community Services comprising: Referral to treatment information	Not defined	99.8%

Data completeness: Community Services comprising: Referral information	Not defined	95.2%
Data completeness: Community Services comprising: Treatment activity information	Not defined	98.5%
Certification against compliance with requirements regarding access to health care for people with learning disabilities	<p>The Learning Disability Liaison Nurses work to promote access to Trust services for patients with a known Learning Disability. This provides assurance to the Trust Board by implementing:</p> <ul style="list-style-type: none"> • The NHS Improvement Standards (2018) to measure the quality of care the Trust provides to people with learning disabilities. • Implementing the learning from LeDeR Mortality Reviews • Training and development to ensure Trust staff have the skills and competencies to support patients with Learning Disabilities to access Trust services. <p>Monitor the provision of reasonable adjustments and any restrictions or deprivations of liberty associated with the delivery of care and treatment to people with learning disabilities.</p>	

Details on Hospital-level Mortality Indicator please refer to pages 177,178 and 192.
Details on Venous thromboembolism (VTE) risk assessment please refer to page 184.

Rational for any failed targets in free text please note below:

*Appeals likely to increase to 29, a decision on this will be made on 23/04 which may impact on final breach figure.

**The reasons for cancer performance deterioration have included increased volume of referrals particularly into the Urology service, pressure on diagnostics (radiology) and capacity with respect to theatres and surgeons. Ongoing work is in place to reach targets set. Please also note that the cancer figures included at this time are not fully validated until circa 30th April and may change.

*** As per recommendations from Sir Bruce Keogh that the incomplete pathway operational standard should be the sole measure of patients' constitutional right to start treatment within 18 weeks. The admitted and non-admitted completed pathway data is used solely for monitoring against operational standards.

**** With regards to the cancelled operations all Directorates involved have been made aware of breaches and there is a planned workshop in May 2019 to agree actions to reduce the 28 day breach.

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 2018/19

As commissioners, Newcastle Gateshead, Northumberland and North Tyneside Clinical Commissioning Groups (CCGs) are committed to commissioning high quality services from Newcastle Upon Tyne Hospitals NHS Foundation Trust 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. The CCGs welcome the opportunity to submit a statement on the Annual Quality Account for Newcastle Upon Tyne Hospitals NHS Foundation Trust.

The CCGs can confirm to the best of their ability, the information provided within the Annual Quality Account is an accurate and fair reflection of the Trust's performance for 2018/19. The CCGs would like to provide the following statement:

The CCGs continue to hold regular quality review group meetings with the Trust which are well attended and provide positive engagement for the monitoring, review and discussion of quality issues. Newcastle Gateshead CCG has also continued throughout 2018/19 to conduct a programme of assurance visits to a number of Trust sites to gain assurances and an insight into the quality of care being delivered to patients. This has resulted in valuable partnership working with the Trust and has provided the CCG with an opportunity to make recommendations on suggested areas of improvement. A programme of CCG visits has been planned for 2019/20.

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. It is acknowledged that a lot of work has been undertaken to deliver the Trust's ambitions in a number of key areas and the Trust is to be commended on their achievements during 2018/19. We are happy to see that quality remains the Trust's number one priority for 2019/20 and it is reassuring to see that this is reflective of the CCGs and national priorities.

The Trust aimed to achieve a 10% reduction year on year of MSSA bacteraemia and a 50% reduction of E.coli bacteraemia by 2021. The figures per 100,000 bed days demonstrate a decrease for MSSA and an increase of E.coli compared to 2017/18. Working in partnership with the CCG the Trust has implemented a number of initiatives, for example increased understanding and awareness of UTI/CAUTI, introduction of an evidenced based urethral catheter care plan, quality improvement projects that have led to MSSA reductions in areas of high prevalence. This continues to be a priority for 2019/20.

It is noted that a significant reduction in Trust acquired pressure damage has not been achieved despite the various improvement work streams. This is reflected in the number of pressure ulcers per 1000 beds days which shows an increase on 2017/18. However, the CCGs note that the Trust achieved a 6% reduction in pressure damage to heels and 35% of wards and departments achieved a minimum 20% reduction in pressure ulcer incidence. The CCGs fully support the continued work around reducing pressure ulcers as a priority in 2019/20.

The CCGs note the progress the Trust has made in developing a long-term solution for the management of abnormal results. During 2018/19 the Trust finalised how the reporting system will operate and identified that this will be fully deliverable using current and proposed electronic clinical records system. This continues to be a priority for 2019/20.

Never Events are serious incidents which are preventable when appropriate procedures are in place and can have significant effects on the people affected. It is noted that the Trust reported six never events in 2018/19. The CCGs acknowledge that the Trust has continued to improve surgical safety and has achieved the Local Safety Standards for Invasive Procedures (LocSSIPs) priority; which included identifying all invasive procedures and introducing LocSSIPs into five priority areas. Excellent progress has been made in the human factors training priority. This approach has been incorporated into their investigation processes and also included in their Quality Improvement Strategy.

The CCGs would like to congratulate the Trust on the excellent progress made in implementing the digital enhancements to care priority. This included establishing a data warehouse and developing an electronic observation system; which has been rolled out to 25 wards at the Royal Victoria Infirmary and 28 wards at Freeman Hospital. The Trust is now in a position to collaborate with local universities to look at the data set to make further improvements in the detection of the deteriorating patient. It is pleasing to note that the National Lead for Deteriorating Patients has expressed interest in the Trust's integrated approach.

The CCGs recognise the progress the Trust has made with the Closing the Loop priority by establishing a robust IT system to ensure action plans are monitored, prioritised, completed and reviewed within timescales. The Trust has undertaken mapping and scoping exercises to identify a suitable IT system, as well as establishing a multi-disciplinary task and finish group 'System for Action Management and Monitoring' (SAMM). This continues to be a priority for 2019/20.

The CCGs acknowledge the progress undertaken on Deciding Right including a baseline survey, audit of acute admissions, ongoing work with patients and relatives and production of an educational video. The CCG notes that the Trust has identified further areas of improvement and this continues to be a priority for 2019/20.

The Trust has made good progress in the 'enhancing patient and public involvement in quality improvement (QI)' priority. This has included developing a framework to support staff to consider how best to involve patients and the public in QI projects and the creation and launch of the Advising on Patient Experience (APEX) group. The CCGs note that the success of this initiative will be monitored by the number of QI projects presented to the APEX group and the evaluation of the impact it has had on patients and staff.

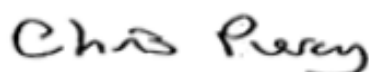
The CCGs are pleased to note the excellent progress the Trust has made in improving the experience of vulnerable patients. The Trust is working collaboratively with Northumberland Tyne & Wear NHS Foundation Trust and a steering group has been established to monitor progress of the 22 recommendations of the 'Treat as One' publication. The mortality review process has been standardised and the use of an intranet-based database established. The Deprivation of Liberties Safeguards (DoLS) policy and consent form have been updated. An increase has been noted in the number of DoLS applications received in 2018/19. The CCGs fully support this as a continuing priority in 2019/20.

The emphasis that the Trust gives to national clinical audits demonstrates that the Trust is focussed on delivering evidence-based best practice. The CCGs commend the Trust for being top of the national league for clinical research studies for the seventh year.

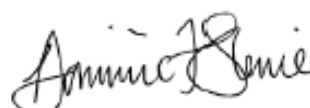
The CCGs would like to congratulate the Trust and staff for their excellent achievements in 2018/19, including winning a number of national awards and the service innovations identified within the report. The CCGs also noted that the Trust has received their 2000th GREATIX submission which is used to capture excellence in practice and is a huge achievement.

The CCGs note the positive results from the NHS staff survey. The CCGs would also like to congratulate the Trust for the excellent results from the national maternity survey and being rated as among the best in the country. Although not included in the Quality Accounts report, the CCGs would also like to congratulate the Trust on receiving it's best ever results in the national cancer patient survey, where patients rated their overall care 9 out of 10 and reported a positive experience in many areas.

The CCGs welcome the specific priorities for 2019/20 which are highlighted within the report and consider that these are appropriate areas to target for continued improvement. The CCGs look forward to continuing to work in partnership with the Trust in delivering high quality effective care for patients.



Chris Piercy
Executive Director of Nursing,
Patient Safety & Quality



Dr Dominic Slowie
Interim Medical Director

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 Newcastle Health Scrutiny Committee



Ms Anne Marie Troy-Smith
Quality Development Manager
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20 May 2019

Our Reference: FM/KC19

Dear Anne Marie,

Newcastle upon Tyne Hospitals NHS Foundation Trust Quality Account 2018/19 Response of Health Scrutiny Committee

As Vice-Chair of the Health Scrutiny Committee, I welcome the opportunity to comment on your draft Quality Account for 2018/19, which we discussed at our meeting on 9 May 2019.

We recognise the importance of the Quality Account as a tool in ensuring that services are reviewed objectively and as a means of illustrating to patients, carers and partners the performance of the trust in relation to your quality priorities.

In relation to progress against your 2018/19 priorities:

- We acknowledge the ongoing reduction in E.coli infections and MSSA over the past three years, but we note that although MRSA infections have reduced to two, they remain above the trust's zero tolerance target. We welcome the trust's approach to reviewing these cases to understand how the infection has been acquired and sharing lessons learned and best practice.
- We welcome the trust's approach to 'red flag' abnormal or unexpected diagnostic results with the requesting consultant but note that the system needs to be accessed for the red flag to be visible. Although, we understand that results that require immediate attention would be highlighted by telephone.
- We welcome actions the trust has taken on human factors training, particularly training for security staff on dealing with patients presenting at the hospital with an acute episode of a mental health related condition, who may need support until a crisis team referral is made.

If you need this information in another format or language, please contact the writer.

- We welcome the trust's approach to creating a culture of quality improvement and involvement of patients in providing feedback on quality improvement initiatives. In particular, we note the involvement of the RNIB and other local voluntary organisations in looking at how the environment and signage could be improved.
- In respect of improving the experience of vulnerable patients, we acknowledge the progress the trust has made with NTW to share patient information and the joint commitment that has been made to the Great North Care Record. We would like an update on this work, during the coming year.
- We noted in our meeting that there are approximately eight serious incidents per month that would be eligible for the professional duty of candour and understand this is similar to that of the Shelford Group of NHS hospital trusts. For transparency, it may be helpful to report this in the quality account.

We also note that there have been seven cases during the year judged to have been more likely than not to have had problems in care which contributed to patient death. We acknowledge the trust's commitment to improving patient safety and learning from the deaths of patients in its care and we will review this against next year.

- In relation to board assurance (part 3), we queried the requirement to report on Department of Health prescribed indicators, that do not have defined targets. This clearly needs to be reviewed by the Department of Health.
- In relation to days lost through industrial injury or illness we suggested that it may be helpful to also report annual figures.
- We welcome the trust's approach to providing help for employees dealing with work related stress, access to psychologists and physiotherapists that could support people back into work and trying to create a culture where staff feel free to talk about their problems and receive support.
- We commend the trust on the high response rate to the staff survey and acknowledge that across a range of themes the trust has performed very well in comparison to other combined acute and community trusts.
- Overall, we found that the quality account clearly presented the targets for the year, but information on outcomes was often presented in a different format and was as a result, less clear. The trust may wish to consider this when preparing the 2019/10 quality account.

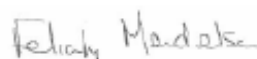
In relation to the 2019/20 priorities, we believe the document is a fair and accurate representation of the services provided by the trust and reflects the areas that are of high importance to Newcastle residents.

If you need this information in another format or language, please contact the writer.

We note the level of detail that the trust is required to provide in the quality account; with commentary provided across a wide range of services to a broad range of audiences, whilst also attempting to respond to quality improvement goals and public accountability. Inevitably, this can result in a detailed document that can be a challenge to consider and comment on within the short timescales imposed nationally. In this respect, it may be helpful for the trust to develop an executive summary.

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

A handwritten signature in black ink, appearing to read 'Felicity Mendelson'.

Cllr Felicity Mendelson
Vice-Chair, Health Scrutiny Committee



To:
Annemarie Troy-Smith, Newcastle upon
Tyne Hospitals NHS Foundation Trust

By email -
annemarie.troy-smith@nuth.nhs.uk

Your ref:
Our ref: MDB/OSC/QA/19/2
Enquiries to: Mike Bird
Email: Mike.Bird01@northumberland.gov.uk
Tel direct: (01670) 622616
Date: 7 May 2019

Dear Ms Troy-Smith

**NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST ANNUAL PLAN AND
QUALITY ACCOUNT 2018/19**

**Statement from Northumberland County Council's Health and Wellbeing Overview and
Scrutiny Committee**

The Health and Wellbeing Overview and Scrutiny Committee welcomes the opportunity to submit a commentary for inclusion in your Annual Plan and Quality Account for 2018/19 as presented to the committee in draft.

At our 5 March 2019 meeting we received a presentation on your draft Quality Account for 2018/19 and your priorities for 2019/20. At that meeting we also received a presentation from the Northumbria NHS Foundation Trust on their own quality account. We then received presentations from the North East Ambulance Service and Northumberland, Tyne and Wear NHS Foundation Trusts about their accounts at the committee's next meeting on 26 March 2019. We believe that considering all four Trusts' quality accounts in the same month provides a good joined up picture of the many NHS services in Northumberland. Members responded favourably to the information you presented, with reference to the highly valued staff and clinical support provided.

Following your presentation of the draft Annual Quality Account 2018/19 and future priorities for 2019/20, a copy of the full extract from the minutes of the OSC's meeting are appended to this letter for your information to form part of our response to your presentation. From the detail presented in these minutes, I would like to highlight some key comments from the committee and additionally what further information has been requested or actions recommended:

- members were reassured that your identified priorities all reflected the importance of emergency department work and the reasoning for why accident and emergency



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- targets are treated as business as usual work
- members welcomed your offer to provide details of healthcare acquired infections. We thank you for this information that you supplied following the meeting on 5 March, which has been circulated to all members of our committee
- members praised your strong no blame culture and commitment to learn from any mistakes, plus your approach to identify areas for improvement and if any such examples could be shared with other Trusts. Your approach to working with other local Trusts and key partner organisations was also praised
- members also welcomed your proactive work to support people with learning disabilities and mental health needs.

From the information you have provided to the committee over the past year, including the presentation about your draft 2018/19 Quality Account, we believe the information provided is a fair and accurate representation of the services provided by the Trust and reflects the priorities of the community. Members also support your priorities for improvement planned for 2018/19, but also request that you note and consider the various points that they have raised in relation to your work going forward.

We also would be very grateful if I could get in contact with you again soon to discuss possible agenda items for the Health and Wellbeing Overview and Scrutiny Committee to consider about the Trust's services during the next council year from 1 May 2019 onwards.

We would also appreciate if we could diarise when you will attend to give next year's equivalent Quality Account and future priorities presentation. I would be very grateful if you could confirm whether the OSC's meeting on Tuesday 3 March 2020 (beginning at 1.00pm) would be suitable please?

If I can be of any further assistance about the committee's response, please do not hesitate to contact me.

Yours sincerely,



Mike Bird
Senior Democratic Services Officer
Democratic Services

On behalf of Councillor Jeff Watson
Chair, Northumberland County Council Health and Wellbeing Overview and Scrutiny Committee

**EXTRACT FROM THE MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING
OSC HELD ON 5 MARCH 2019**

**(a) Newcastle upon Tyne NHS Foundation Trust Annual Plan and Quality
Account 2017/18**

A presentation was provided by Angela O'Brien, Director of Quality & Effectiveness, Andy Pike, Head of Quality Assurance & Clinical Effectiveness, and Liz Harris, Deputy Director of Nursing & Patient Services, all from Newcastle upon Tyne NHS Foundation Trust. (Copy of presentation enclosed with the official minutes of the meeting.) Key headlines and details of the presentation included details of progress made on priorities:

Patient Safety:

- Priority 1 - to reduce all forms of healthcare associated infection (HCAI)
- Priority 2 - to reduce inpatient acquired Pressure Ulcers (PU)
- Priority 3 - management of abnormal results
- Priority 4 - local safety standards for invasive procedures (LocSSIPs)
- Priority 5 - Human factors training

Clinical Effectiveness:

- Priority 6 - digital enhancements to care
- Priority 7 - closing the loop

Patient Experience:

- Priority 8 - deciding right
- Priority 9 - enhancing patient and public involvement in quality improvement
- Priority 10 - improving the experience of vulnerable patients.

2019/20 proposed quality priorities:

- patient safety: reducing infection; pressure ulcer reduction; management of abnormal results
- clinical effectiveness: alignment of quality and clinical effectiveness - SAMM (systems for action management and monitoring); enhancing capability in quality improvement
- patient experience: deciding right; implementation of 'treat as one'; ensure reasonable adjustments are made for patients with suspected or known learning disabilities.

Detailed discussion followed of which the key details of questions from members and answers from Ms Harris, Ms O'Brien and Mr Pike were:

Regarding differences between the two Trusts' presentations as for example accident and emergency services had not featured in Newcastle's, members were advised that this was because it was spread across many of their priority areas. Emergency department work included identifying people with pressure ulcers and sepsis. The priorities all reflected the importance of emergency department work.

The four hour accident and emergency targets were not being currently met in light of winter pressures faced, but the priorities did not include areas considered business as usual.

Regarding the management, frequency and outcomes of abnormal results, members were advised that they were occasionally experienced. Two incidents were referred to of which one case concerned a lesion not being picked up earlier which did not affect the patient's life expectancy but could have enabled more palliative care support to have been organised.

Mr Young of the CCG acknowledged that it was important that the Trust was identifying areas for improvement and if it was successful in local initiatives that addressed national problems it was important to share them with other local Trusts. It was noted that the Healthcare Safety and Investigation Branch picked up examples of good practice; the Trust worked closely with them.

It was explained that infections could kill or contribute to death if undetected, although it could depend on the health of the individual patient. Members welcomed an offer to provide statistics about healthcare acquired infections after the meeting.

In response to why the referral of any abnormal results to another consultant could not be quicker than three to five days, members were reassured that there needed to be a cut off point and if it bounced quicker, it could lose the link to the original consultant for them to act. The timescale had been agreed on the basis of risk, and this was not expected to occur very often, as it had been introduced to anticipate any results not being picked up in the event of any consultants' absence from work.

In connection with any risk of any initial data entries of people's being incorrect, members were advised that it was machines rather than people who recorded blood pressure and temperature, and blood results were then analysed in the lab.

Replying to a question about reducing infections from catheters by 5% and what caused the infections, work took place to educate staff, patients and families about safer catheter use and support. The nurse consultant oversaw both equipment and education provision; staff observed patients and ensured that catheters were safely put in and taken out as soon as reasonably possible.

Regarding the sharing of other best practice, networks existed including regional collaborative programmes and regular meetings between groups of equivalent directors; members welcomed this.

Reference was made to the challenge of mental health conditions as they could be less visible; how was work undertaken and was there any lower age limit for services to be provided? Members were advised about arrangements for identifying people with a learning disability, including work of the Learning Disability Liaison Team. The learning disability passport service, which was not age specific, helped to recognise the behaviour of people in particular scenarios, for example they might respond differently to certain symptoms than other patients. The service provided access to screening and advice. Learning disability death reviews were also carried out as people with learning disabilities were more likely to die younger, and assessed what communication the carers and/or family received.

Regarding what services were provided for people with learning disabilities or mental health problems before they needed to enter the hospital setting, members were

advised that proactive work took place with community groups, including Deaf Link, to ask them for details of their experiences.

In reply to a question about other work not included within the priorities detailed, this presentation had provided a brief summary; full details of all services provided by the Trust would be included in their complete Quality Account report.

In connection with concerns about MRSA infections, members were advised that there was more than one type of MRSA and infections in the blood were more serious. The procedure for discharging patients with MRSA/C-difficile would depend on the condition of the individual patient.

A member welcomed the digital observation system but warned of the impact of any other factors such as power supply, plus also enabling the removal of human error from some situations; members were very pleased to hear that the Trust had a strong no-blame culture as it was the best way to learn from experiences including mistakes.

Regarding consultation undertaken with people and groups outside of Newcastle who used the Trust's services, members were advised of consultation work with representatives of Northumbria Trusts, Northumberland County Council and work to seek patients' views using a range of engagement exercises. Their chief executive embraced a culture of working together, for example the development of an Integrated Care System. Patient and public involvement continued to be priority piece of work, but the foundations had been laid for taking it forward when it had previously been one of the Trust's priorities. The Trust were held to account on delivering their Quality Account aims and continued their patient and public involvement.

Ms Harris, Ms O'Brien and Mr Pike were thanked for their attendance and very good presentation and level of information provided. Following this it was:

RESOLVED that written responses be sent to Northumbria NHS Foundation Trust and Newcastle upon Tyne Hospitals NHS Foundation Trust about the committee's views on their quality accounts and future priorities.



Healthwatch Newcastle and Healthwatch Gateshead combined statement for the Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH) Quality Account 2018/19

Firstly we would like to congratulate the Trust on receiving the 'Gold Award' for its outstanding support to the armed forces. We also welcome the description of the various quality improvement initiatives implemented and would like to congratulate the Trust on the achievements detailed in this section.

The GREATIX initiative is interesting and we are pleased it is being used more and more each year. In future Quality Accounts we would like to learn more about what you have heard via GREATIX and what you did with the information.

The NHS Staff Survey results compare favourably with other Trusts, and NUTH should be proud of this. We are keen to learn more about what the Trust plans to do in the lowest performing areas (Morale, Health and Wellbeing and Quality of Appraisals).

We are pleased that the Trust continues to run a public engagement event for the Quality Account and we would like to learn more about how the public are involved further.

Results from 2018-19 priorities

Priority 1: Reducing infection - focus on *MSSA/E.coli*

It is good to read that there have been sustained reductions in most bacteraemias in individual directorates last year. In particular, we welcome the Trust's approach of delivering quality improvement initiatives in areas where the prevalence of *MSSA* is high. We also congratulate the Trust on the reductions made in catheter usage and prolonged catheter usage via the Houdini tool. We hope that further reductions continue in the future.

As there have been only slight reductions in *MSSA* and *C.difficile* and slight increases in *E.coli*, *Klebsiella* and *Pseudomonas*, we are pleased to see that this priority is carrying forward into 2019/20.

Priority 2: Pressure Ulcer Reduction

It is pleasing to see that there have been reductions in pressure damage to heels and that certain wards and departments have also achieved reductions in pressure ulcer instances. However, it is unfortunate that there was an increase in pressure damage last year.

We welcome the Trust's implementation of an innovative approach to pressure ulcer prevention as a result of focussing on this area last year and that there is a focus to embed this approach into areas where pressure ulcer instances are high.

As there has been an increase in pressure damage last year, we welcome the inclusion of this as a priority for 2019/20.

Priority 3: Management of abnormal results

The Trust has made good progress in implementing a solution to this problem and we look forward to seeing the results as the system gets rolled out across departments. We are pleased that this will be a priority for 2019/20.

Priority 5: Human Factors Training

It is good to see the progress the Trust has made in this area. However, as this priority's main focus is on changing organisational culture, we feel it would have been good to continue this as a priority for several years, to ensure that it is fully embedded.

We recognise that it will still continue in years to come even though it is not remaining as a Quality Account priority. We would welcome more information on how the Trust plans to monitor the progress of 'Human Factors' over the years.

Priority 6: Digital enhancements to care

The Trust made good progress and we were pleased to learn the following:

- 80% of staff have fed back positively about the system
- The system has released about 100 hours of staff time per day
- Observation completeness has improved from 90% to 98%

It is also good to learn that it has been implemented so effectively across all adult inpatient wards and that the large data sets gathered has opened doors for the Trust to work with the local universities.

Priority 7: Closing the loop

The Trust has made good progress with this priority and we are pleased it is being carried forward into 2019/20 as 'System for Action Management and Monitoring (SAMM)'. We look forward to learning more about the piloting of SAMM in the next Quality Account and hope the Trust achieves its plan to roll out SAMM across the Trust.

Priority 8: Deciding right

The information gathered through this work shows that the Trust really needs to focus on training staff in Deciding Right so that they feel able to have discussions with patients and help them put in place Advanced Care Plans, Emergency Health Care Plans and Treatment Escalation Plans.

Considering this, we are pleased to see that this priority will be continuing into 2019/20 and that one of the ways that the Trust will measure success is via patient and relative feedback. We would be happy to offer advice and support to the Trust in gathering feedback if needed.

Priority 9: Enhancing Patient and Public Involvement in Quality Improvement (QI)

The process the Trust has put in place to ensure that this becomes part of its day to day business looks robust. We are pleased that a framework has been designed to support staff to involve patients and the public in their Quality Improvement projects. We would welcome a visit to see this system in action.

Priority 10: Improving the experience of vulnerable patients

We are pleased to see that the Trust and Northumberland, Tyne and Wear NHS Foundation Trust are working together to ensure that the physical health care provided to adult patients with co-existing mental health conditions is delivered consistently and is meeting

their needs. It is also good to see that a patient representative is part of the steering group taking this work forward.

As this work is in its early stages and will likely take some time to be implemented and fully embedded, we are pleased to see that this priority will continue into 2019/20.

2019/20 priorities

We notice that most of the priorities for 2019/20 have been carried on from last year and we support this decision.

We are pleased to see the inclusion of a new priority, 'Ensure reasonable adjustments are made for patients with suspected or known Learning Disabilities'. We welcome that the Trust is committed to ensuring that patients with learning disabilities have access to services that will help improve their health. We particularly welcome the commitment to gathering more patient and carer views and inviting Quality Checkers to review Trust services.

We wish the Trust continued success with these priorities in the coming year and look forward to supporting the Quality Account engagement event next year.

Statement on behalf of Healthwatch Northumberland:

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Anne Marie Troy-Smith
The Newcastle upon Tyne Hospitals NHS Foundation Trust
Freeman Hospital,
Freeman Road,
High Heaton,
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Tyne and Wear,
NE7 7DN

20 May 2019

Dear Anne Marie

Draft Quality Account for year ending 31 March 2019

Thank you for the draft quality account of Newcastle upon Tyne Hospitals NHS Foundation Trust and would like to congratulate the Trust on some excellent results. The report gives a lot of performance information which will be useful as reference material for Healthwatch Northumberland (HWN) in the coming year.

We felt that although the document is technical, it is in general, easy to read and understand. We found the report, on the whole, to be clear and concise although it would benefit from a 'dashboard' system to highlight progress on individual priorities and overall which could then be explained within the narrative. This point was raised in our response for the last two years.

We commend the Trust on the many positive achievements that have been made and all of the work that has been done to learn lessons from outcomes, the rigour with which monitoring and auditing has taken place and the overall commitment to quality and improving patient outcomes.

We welcome the increased use of digital technology giving easier recognition of the deteriorating patient and producing early "red flag" warnings. We look forward to the results of the pilot project in Children's Services.



We welcome the priority given to reducing the number of healthcare acquired infections.

As a Healthwatch, our focus is that “the health care system works for the people of Northumberland and that “the views, knowledge and experiences of health service users of Northumberland are listened to and influence health service developments in health in Northumberland and beyond”. We welcome the progress made in 2018/19 with the APEX system of feedback under Priority 9 Enhancing Patient and Public Involvement in Quality Improvement.

We note this it to be part of ‘normal business’ from now would ask that an explicit focus to include patients from Northumberland who are using Newcastle hospitals.

Access to services, particularly for rural areas remains a key priority identified in feedback to Healthwatch Northumberland and we would encourage the Trust to look at how to recognise and address this issue in delivery and reporting. Northumberland residents particularly raise;

Appointment times – for appointments to be set taking account of home postcodes so that people travelling from a distance, both by their own car and especially on public transport, have suitable appointment times. People report instances of having to travel the night before and therefore incurring additional expense or missing transport connections to get home. The latter adding to the stress, cost and discomfort of treatment.

Alternatively, where it is appropriate, to ensure that appointments, particularly routine checks and pre-operative assessments are routinely offered as close to the patient’s home as possible and not only when requested request.

Patient Transport Services – that all the Trust’s departments are aware of their responsibility in booking Patient Transport for patients undergoing a course of treatment or with an enduring condition.

Regarding the Trust’s priorities for 2019/20 in our view the plans to improve performance appear positive and achievable with priorities that align with areas highlighted for improvement.

In summary, we consider the report does give a fair reflection of the service provided by the Trust and 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



Statement on behalf of Healthwatch North Tyneside:

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22 May 2019

Healthwatch North Tyneside statement for The Newcastle upon Tyne Hospitals NHS Foundation Trust's Quality Account 2018/19

Thank you for the opportunity to comment on the draft 2018/19 Quality Account. We would like to congratulate the Trust on some outstanding achievements this year.

Your quality accounts were very informative and it was good to see the details of your planned actions. Whilst it was relatively easy to read, it could be made more accessible by adopting a more dashboard style of reporting - perhaps something to consider next year.

A further suggestion for future improvements in the way to present your information and report your impact would be to better indicate what services you provide in the different geographical areas you serve. We understand over 40% of your staff live in North Tyneside and North Tyneside ranks third in terms of where your patients come from, but the area isn't mentioned in your quality accounts. We felt your quality accounts missed an opportunity to show how the Trust relates to the local communities it serves.

We would like to note the following:

We were pleased to see the progress with, and continued commitment to achieving your priorities of reducing health care acquired infections, pressure ulcers, and abnormal results.

We welcome your priority, 'treat as one', and to further embedding your relationship with Northumberland Tyne and Wear NHS Foundation Trust on this issue. We would encourage you to be ambitious in your aims whilst looking at tangible benefits that will improve your services.

Your continued work on your 'deciding right' priority responds to an issue we are increasingly hearing about. Some people tell us that they wish they could have had these difficult conversations earlier.

We welcome the focus on supporting patients with suspected or known Learning Disabilities and are pleased that your aim includes support for families too.

It was good to see the progress made with Patient and Public involvement in Quality Improvement. We encourage you to continue to focus on service user involvement and would want to see that you are talking to people from North Tyneside as this becomes embedded in your day to day activity.

We look forward building our working relationship over the coming year and working together to ensure the people of North Tyneside's voice is heard in the services the Trust provide.

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 2018/19 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 2018 to April 2019.
 - papers relating to quality reported to the Board over the period April 2018 to April 2019.
 - feedback from commissioners dated May 17th 2019.
 - feedback from governors dated March 21st 2019.
 - feedback from local Healthwatch organisations dated May 16th 2019/20th May 2019.
 - feedback from Overview and Scrutiny Committee dated May 20th 2019.
 - feedback from Northumberland Council dated May 7th 2019.
 - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated February 8th 2019.
 - the 2018 national patient survey will be published in June 2019.
 - the 2018 national staff survey 26th February 2019.
 - the Head of Internal Audit Opinion of the Trust's control environment dated 21st May 2019.
 - CQC inspection report dated June 6th 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 of Directors



.....Chairman



.....Chief Executive

The Newcastle upon Tyne Hospitals NHS Foundation Trust

28th May 2019

Independent auditor's report to the Council of Governors of The Newcastle upon Tyne Hospitals NHS Foundation Trust on the Quality Report

We have been engaged by the Council 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 2019 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

We refer to these national priority indicators collectively as the "indicators".

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 criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.

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 is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's Detailed Requirements for External Assurance for Quality Reports 2018/19; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Detailed Requirements for External Assurance on Quality Reports.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting

guidance, 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:

- Board minutes for the period April 2018 to February 2019;
- Papers relating to quality reported to the Board over the period April 2018 to April 2019;
- Feedback from Commissioners, Newcastle Gateshead, Northumberland and North Tyneside CCGs (undated);
- Feedback from governors;
- Feedback from local Healthwatch organisations, Healthwatch Gateshead and Healthwatch Newcastle (undated), Healthwatch Northumberland (dated 20 May 2019) and Healthwatch North Tyneside (dated 22 May 2019);
- Feedback from Overview and Scrutiny Committee, Northumberland County Council (dated 7 May 2019), and Newcastle City Council dated (20 May 2019);
- The Trust's complaints information that will inform its complaints report to be published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- The latest national patient survey;
- The latest national NHS staff survey (dated February 2019);
- Care Quality Commission inspection (dated June 2016);
- The Head of Internal Audit's annual opinion over the trust's control environment (dated 21 May 2019); and
- Any other information included in our review.

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.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of The Newcastle upon Tyne Hospitals NHS Foundation Trust as a body, 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 2019, to enable the Council of Governors to demonstrate that it has 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 Council of Governors as a body and The Newcastle upon Tyne Hospitals NHS Foundation Trust for our work or this report, except 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'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller 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 of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by The Newcastle upon Tyne Hospitals 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 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's Detailed Requirements for External Assurance for Quality Reports 2018/19; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

Signed:



Cameron Waddell

Partner, for and on behalf of Mazars LLP

Date: 28 May 2019

Chartered Accountants and Statutory Auditor
Salvus House
Aykley Heads
Durham
DH1 5TS

Annex 3: Abbreviations

Abbreviations	
ACP	Advance Care Plan
AHP	Allied Health Professional
ANTT	Aseptic Non Touch Technique
APEX	Advising on Patient Experience
BAUS	British Association of Urological Surgeons
CAT	Clinical Assurance Tool
CAUTI	Catheter Associated Urinary Tract Infection
CCGs	Clinical Commissioning Group
<i>C.diff</i> (CDI)	<i>Clostridium difficile</i>
CGARD	Clinical Governance and Risk Department
CRN	Clinical Research Network
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation (CQUIN) payment framework
CT	Computerised Tomography
CTP	Career Transition Partnership
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DoC	Duty of Candour
DOH/DH	Department of Health
<i>E.coli</i>	<i>Escherichia coli</i>
ED	Emergency Department
EHCP	Emergency Health Care Plans
EPOD	Ear, Nose & Throat, Plastics ,Ophthalmology and Dermatology
FLS	Fracture Liaison Services
GDE	Global Digital Exemplar
GP	General Practitioner
HCAI	Healthcare Associated Infection
HES	Hospital Episode Statistics
HR	Human Resources

Abbreviations	
HSMR	Hospital Standardised Mortality Ratio
IBD	Inflammatory Bowel Disease
IHI	Institute for Healthcare Improvement
IoT	Institute of Transplantation
IT	Information Technology
IV	Intravenous
KF	Key Finding
LED	Locally Employed Doctor
LET	Lead Employer Trust
Loc SSIPs	Local Safety Standards for Invasive Procedures
MBRACE	Mothers and Babies, Reducing Risk through Audits and Confidential Enquiries across the UK
MCA	Mental Capacity Act
MINAP	Myocardial Ischaemia National Audit Programme
MDT	Multi-Disciplinary Team
M&M	Morbidity & Mortality
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant <i>Staphylococcus aureus</i>
MSSA	Methicillin Sensitive <i>Staphylococcus Aureus</i>
MSU	Musculoskeletal Services
Nat SSIPs	National Safety Standards for Invasive Procedures
N/A	Not Applicable
NABCOP	National Audit of Breast Cancer in Older Patients
NaDIA	The National Diabetes Inpatient Audit
NCCC	Northern Centre for Cancer Care
NCEPOD	National Confidential Enquiries into Patient Outcome & Death
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
NIV	Non-Invasive Ventilation
NSF	National Service Framework

Abbreviations	
NTW	Northumberland, Tyne and Wear
NUTH	Newcastle upon Tyne NHS Foundation Trust
PCI	Percutaneous Coronary Intervention
PDSA	Plan do Study Act
PICU	Paediatric Intensive Care Unit
PROMs	Patient Reported Outcome Measures
QI	Quality Improvement
RCA	Root Cause Analysis
ReSPECT	Recommended Summary Plan from Emergency Care and Treatment
RVI	Royal Victoria Infirmary
SAMM	Systems for Action Management and Monitoring
SCBU	Special Care Baby Unit
SHOT	Serious Hazards of Transfusion
SHMI	Summary Hospital-level Mortality Indicator
SIs	Serious Incidents
SS1	Surgical Site Infection
SUS	Secondary Users Service
STAMP	Supporting Treatment and Appropriate Medication in Paediatrics
STOMP	STop OverMedicating People with a learning disability or autism
TARN	Trauma Audit Research Network
TEP	Treatment Escalation Plans
TIMS	Tyneside Integrated Musculoskeletal Services
UK	United Kingdom
UKCRN	United Kingdom Clinical Research Network
UTI	Urinary Tract Infection
VTE	Venous thromboembolism

Annex 4: Glossary of Terms

1. *C. difficile* infection (CDI)

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.

2. 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.

3. 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.

4. 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.

5. *E.coli*

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.

6. Global Digital Exemplar

Global Digital Exemplar is an internationally recognised NHS provider delivering improvements in the quality of care, through the world-class use of digital technologies and information.

7. Gram-negative Bacteria

Gram-negative bacteria cause infections including pneumonia, bloodstream infections, wound or surgical site infections, and meningitis in healthcare settings.

Gram-negative bacteria are resistant to multiple drugs and are increasingly resistant to most available antibiotics. These bacteria have built-in abilities to find new ways to be resistant and can pass along genetic materials that allow other bacteria to become drug-resistant as well.

8. HOGAN evaluation score

Retrospective case record reviews of 1000 adults who died in 2009 in 10 acute hospitals in England were undertaken. Trained physician reviewers estimated life expectancy on admission, to identified problems in care contributing to death and judged if deaths were preventable taking into account patients' overall condition at that time. The Hogan scale, ranging from 1 (definitely not preventable) to 6 (definitely preventable), was used to determine if deaths were potentially avoidable, taking into account a patient's overall condition at the time.

Source: Dr Helen Hogan, Clinical Lecturer in UK Public Health,

1	Definitely not preventable
2	Slight evidence for preventability
3	Possibly preventable, but not very likely, less than 50-50 but close call
4	Probably preventable more than 50-50 but close call
5	Strong evidence of preventability
6	Definitely preventable

9. 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.

10. MRSA

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.

10. MSSA

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.

11. 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.

Audit and Controls

Investment manager

CCLA Investment Management Ltd & Newton Investment Management Ltd

Banker

HSBC, RBS (Government Banking Service, Yorkshire Bank)

Payroll

NHS Payroll Services

Internal Auditor

AuditOne

Legal advisors

Samuel Phillips Law Firm

Ward Hadaway

Sintons LLP

Addleshaw Goddard LLP

Capsticks Solicitors LLP

DAC Beachcroft LLP

Hempsons Solicitors

Keating Chambers

External Auditor

PricewaterhouseCoopers LLP (until 30 September 2018)

Mazars LLP (from 1 October 2018)

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 NHS Improvement, the independent regulator of NHS Foundation Trusts, which by necessity ensures compliance with International Standards of Audit (UK & Ireland) issued 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 over-riding 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.

4. ANNUAL ACCOUNTS 2018/19

FOREWORD TO THE ACCOUNTS

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

The accounts for the year ended 31 March 2019 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 three columns for 2018/19 showing the Income & Expenditure of the NHS Foundation Trust (as shown in column 1), the impact of the Charitable Fund consolidation (column 2) and the consolidated final result for the year (column 3).

A handwritten signature in black ink, appearing to read 'J Daniel', with a large, stylized initial 'J'.

Dame J Daniel
Chief Executive

28 May 2019

Independent auditor's report to the Council of Governors of The Newcastle upon Tyne Hospitals NHS Foundation Trust

Opinion on the financial statements

We have audited the financial statements of The Newcastle upon Tyne Hospitals NHS Foundation Trust ('the Trust') and its subsidiary ('the Group') and for the year ended 31 March 2019 which 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 (Group and NHS Foundation Trust), and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as interpreted and adapted by the Government Financial Reporting Manual 2018/19 as contained in the Department of Health and Social Care Group Accounting Manual 2018/19, and the Accounts Direction issued under section 25(2) of Schedule 7 of the National Health Service Act 2006 ("the Accounts Direction"). In our opinion, the financial statements:

- give a true and fair view of the state of the Trust's and the Group's affairs as at 31 March 2019 and of the Trust's and the Group's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006 and the Accounts Direction issued thereunder.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the Trust and Group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's

or Group's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) we identified, including those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key audit matter	Our response and key observations
Revenue recognition There is a risk of fraud in the financial reporting relating to revenue recognition due to the potential to inappropriately record revenue in the wrong period.	<p>We undertook a range of substantive procedures including:</p> <ul style="list-style-type: none"> • testing of income around the year-end to ensure transactions are recognised in the correct financial year; • testing year-end receivables to ensure transactions are recognised in the correct financial year; • reviewing and challenging intra-NHS reconciliations and data matches provided by the Department of Health and Social Care; • review of management oversight of material accounting estimates, review of changes to accounting policies and challenge and testing of material accounting estimates including income accruals; and • testing of adjustment journals, including material journals posted to revenue accounts. <p>Our work provided the assurance we sought in respect of this key audit matter.</p>

Property valuations

Land and buildings are the Trust's highest value assets. Management engage the District Valuer, as an expert, to assist in determining the current value of property to be included in the financial statements. There is a high degree of estimation uncertainty and changes in the value of property may impact on the Statement of Comprehensive Income depending on the circumstances and the specific accounting requirements of the Department and Health and Social Care Group Accounting Manual.

We liaised with management to update our understanding on the approach taken by the Trust in its valuation of land and buildings, which included review and challenge of the methodology that the Trust uses of valuing an alternative site as part of its modern equivalent asset valuation. Our work also included review of the underlying data, and sample testing to gain assurance of its accuracy.

We reviewed and considered:

- the scope and terms of the engagement with the District Valuer; and
- how management use the District Valuer's report to value land and buildings in the financial statements.

We wrote to the District Valuer to obtain information on the methodology and their procedures to ensure objectivity and quality, including compliance with professional standards.

We also considered evidence of regional valuation trends.

During 2018/19 the Royal Institute of Chartered Surveyors (RICS) issued guidance relating to the assessment of useful economic lives (UEL) of assets for accounting purposes. We assessed the impact of this guidance upon the Trust's approach to estimating the UEL of property assets and identified a non-material misstatement that was not adjusted by management. There is no impact upon our opinion on the financial statements in relation to the matter identified, and our work provided the assurance we sought in respect of this key audit matter.

Our application of 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 on the individual financial statement line items and disclosures, and in evaluating 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:

Overall materiality	Trust	Group
	£21.473m	£21.538m
Basis for determining materiality	Approximately 2% of operating expenses of continuing operations.	
Rationale for benchmark applied	Operating expenses of continuing operations, adjusted for impairments, was chosen as the appropriate benchmark for overall materiality as this is a key measure of financial performance for users of the financial statements.	
Performance materiality	£15.031m	£15.077m
Reporting threshold	£0.3m	£0.3m

An overview of the scope of our audit

As part of designing our audit, we determined materiality and assessed the risk of material misstatement in the financial statements. In particular, we looked at where the Accounting Officer made subjective judgements such as making assumptions on significant accounting estimates.

We gained an understanding of the legal and regulatory framework applicable to the Trust and Group and the sector in which they operate. We considered the risk of acts by the Trust and Group which were contrary to the applicable laws and regulations including fraud. We designed our audit procedures to respond to those identified risks, including non-compliance with laws and regulations (irregularities) that are material to the financial statements.

We focused on laws and regulations that could give rise to a material misstatement in the financial statements, including, but not limited to, the National Health Service Act 2006.

We tailored the scope of our audit to ensure that we performed sufficient work to be able to give an opinion on the financial statements as a whole. We used the outputs of our risk assessment, our understanding of the Trust's and Group's accounting processes and controls and its environment and considered qualitative factors in order to ensure that we obtained sufficient coverage across all financial statement line items.

Our tests included, but were not limited to:

- 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 irregularities including fraud or error;
- review of minutes of board meetings in the year; and

- enquiries of management.

As a result of our procedures, we did not identify any Key Audit Matters relating to irregularities, including fraud.

The risks of material misstatement that had the greatest effect on our audit, including the allocation of our resources and effort, are discussed under 'Key audit matters' within this report.

Other information

The directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We are also required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the Annual Report is fair, balanced and understandable and whether the Annual Report appropriately discloses those matters that we communicated to the Audit Committee which we consider should have been disclosed.

We have nothing to report in these regards.

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The Accounting Officer is required to comply with the Department of Health and Social Care Group Accounting Manual and prepare the financial statements on a going concern basis, unless the Trust/Group is informed of the intention for dissolution without transfer of services or function to another entity. The Accounting Officer is responsible for assessing each year whether or not it is appropriate for the Trust/Group to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities for the audit of the financial statements

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

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2018/19; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Annual Governance Statement

We are required to report to you if, in our opinion:

- the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2018/19; or
- the Annual Governance Statement is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in respect of these matters.

Reports to the regulator and in the public interest

We are required to report to you if:

- we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006

We have nothing to report in respect of these matters.

because we have a reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or

- we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.

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

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

We have nothing to report in this respect.

Responsibilities of the Accounting Officer

The Chief Executive as Accounting Officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by Schedule 10(1)(d) 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. 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 review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

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.

Use of the audit report

This report is made solely to the Council of Governors of The Newcastle upon Tyne Hospitals NHS Foundation Trust as a body in accordance with Schedule 10(4) of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust as a body for our audit work, for this report, or for the opinions we have formed.

Certificate

We certify that we have completed the audit of The Newcastle upon Tyne Hospitals NHS Foundation Trust and The Newcastle upon Tyne Hospitals NHS Foundation Trust Group in accordance with the requirements of chapter 5 of part 2 of the National Health Service Act 2006 and the Code of Audit Practice.



Cameron Waddell
For and on behalf of Mazars LLP

Salvus House
Aykley Heads
Durham
DH1 5TS

28 May 2019

CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME				
for the year ended 31 March 2019				
		2018/19 NHS Foundation Trust	2018/19 Charitable fund	2018/19 Total
	Note	£000	£000	£000
OPERATING INCOME				
Income from activities	3	927,113	0	927,113
Other operating income*	4	158,956	2,632	161,588
TOTAL OPERATING INCOME		1,086,069	2,632	1,088,701
Operating expenses	5	(1,040,987)	(3,284)	(1,044,271)
OPERATING SURPLUS		45,082	(652)	44,430
FINANCE INCOME AND COSTS				
Finance income	7	703	1,055	1,758
Finance expense - financial liabilities	8	(25,634)	0	(25,634)
PDC dividends payable	9	(7,004)	0	(7,004)
Net finance costs		(31,935)	1,055	(30,880)
Other gains and losses	10.2	5,692	0	5,692
SURPLUS FOR THE YEAR		18,839	403	19,242
SURPLUS FOR THE YEAR		18,839	403	19,242
Other Comprehensive Income				
Will not be reclassified to income and expenditure:				
Impairments		1,128	0	1,128
Revaluation gains on property, plant and equipment		0	0	0
Other movements on reserves		0	0	0
May be reclassified to income and expenditure when certain conditions are met:				
Fair value gains on available-for-sale financial investments		0	2,040	2,040
Total Other Comprehensive Income		1,128	2,040	3,168
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		19,967	2,443	22,410

* The other operating income for the NHS Foundation Trust is net of income eliminated on consolidation of £385k. This relates to cash donations made by the Charitable fund to the NHS Foundation Trust for the purchase of capital assets.

CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME for the year ended 31 March 2018				
	Note	2017/18 NHS Foundation £000	2017/18 Charitable fund £000	2017/18 Total £000
OPERATING INCOME				
Income from activities	3	898,528	0	898,528
Other operating income*	4	144,252	3,875	148,127
TOTAL OPERATING INCOME		1,042,780	3,875	1,046,655
Operating expenses	5	(1,000,925)	(2,775)	(1,003,700)
OPERATING SURPLUS		41,855	1,100	42,955
FINANCE INCOME AND COSTS				
Finance income	7	341	755	1,096
Finance expense - financial liabilities	8	(24,976)	0	(24,976)
PDC dividends payable	9	(6,131)	0	(6,131)
Net finance costs		(30,766)	755	(30,011)
Losses on disposal of assets	10.2	(74)	0	(74)
SURPLUS FOR THE YEAR		11,015	1,855	12,870
SURPLUS FOR THE YEAR		11,015	1,855	12,870
Other Comprehensive Income				
Will not be reclassified to income and expenditure:				
Revaluation gains on property, plant and equipment		7,343	0	7,343
Other movements on reserves		1	0	1
May be reclassified to income and expenditure when certain conditions are met:				
Fair value gains on available-for-sale financial investments		0	136	136
Total Other Comprehensive income		7,344	136	7,480
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		18,359	1,991	20,350

* The other operating income for the NHS Foundation Trust is net of income eliminated on consolidation of £248k. This relates to cash donations made by the Charitable fund to the NHS Foundation Trust for the purchase of capital assets.

**NHS FOUNDATION TRUST
STATEMENT OF
COMPREHENSIVE INCOME**

for the year ended 31 March 2019

		2018/19 Total	2017/18 Total
	Note	£000	£000
OPERATING INCOME			
Income from activities	3	927,113	898,528
Other operating income	4	159,341	144,500
TOTAL OPERATING INCOME		<u>1,086,454</u>	<u>1,043,028</u>
Operating expenses	5	(1,040,987)	(1,000,925)
OPERATING SURPLUS/(DEFICIT)		<u>45,467</u>	<u>42,103</u>
FINANCE INCOME AND COSTS			
Finance income	7	703	341
Finance expense - financial liabilities	8	(25,634)	(24,976)
PDC dividends payable	9	(7,004)	(6,131)
Net finance costs		<u>(31,935)</u>	<u>(30,766)</u>
Gains/losses on disposal of assets	10.2	5,692	(74)
SURPLUS FOR THE YEAR		<u>19,224</u>	<u>11,263</u>
SURPLUS FOR THE YEAR		19,224	11,263
Other Comprehensive Income			
Will not be reclassified to income and expenditure:			
Impairments (net)		1,128	7,343
Other movements on reserves		0	1
Total Other Comprehensive Income		<u>1,128</u>	<u>7,344</u>
TOTAL COMPREHENSIVE INCOME		<u>20,352</u>	<u>18,607</u>

The Trust's performance for the year against the agreed NHS Improvement control total is detailed in Note 1.28

CONSOLIDATED STATEMENT OF FINANCIAL POSITION
as at 31 March 2019

		GROUP	
		31 March	31 March
		2019	2018
	Note	£000	£000
NON-CURRENT ASSETS			
Intangible assets	11	4,309	3,651
Property, plant and equipment	12	489,442	486,944
Investments in subsidiaries and joint ventures	13	0	0
Other investments	14	32,076	25,036
Trade and other receivables	16	13,740	12,319
TOTAL NON-CURRENT ASSETS		539,567	527,950
CURRENT ASSETS			
Inventories	15	17,242	14,756
Trade and other receivables	16	94,535	89,008
Non current assets held for sale	17	0	0
Cash and cash equivalents	18	103,135	98,891
TOTAL CURRENT ASSETS		214,912	202,655
CURRENT LIABILITIES			
Trade and other payables	19	(105,718)	(99,949)
Other liabilities	20	(9,195)	(7,687)
Borrowings	21	(6,947)	(8,399)
Provisions	22	(1,706)	(1,281)
TOTAL CURRENT LIABILITIES		(123,566)	(117,316)
NON-CURRENT LIABILITIES			
Borrowings	21	(228,907)	(236,121)
Provisions	22	(2,252)	(5,678)
TOTAL NON-CURRENT LIABILITIES		(231,159)	(241,799)
TOTAL ASSETS EMPLOYED		399,754	371,490
TAXPAYERS' EQUITY			
Public dividend capital *		238,811	232,957
Revaluation reserve *		78,170	86,698
Income and expenditure reserve *		41,917	13,037
TOTAL TAXPAYERS' EQUITY		358,898	332,692
OTHERS' EQUITY			
Charitable fund reserves *		40,856	38,798
TOTAL TAXPAYERS' AND OTHERS' EQUITY		399,754	371,490

* Reserves:

a) Public dividend capital represents the Secretary of State for Health and Social Care's 'equity' investment in the NHS Foundation Trust.

b) The revaluation reserve is used to record revaluation gains and losses on property, plant and equipment. This reserve is currently used solely for tangible assets only.

c) The NHS Foundation Trust's surplus for the year is recognised in the Income and Expenditure reserve.

d) Charitable reserves relate to those held by the Newcastle upon Tyne Hospitals NHS Charity. Further analysis can be found in Note 34.

The accounts on pages 245 to 325 were approved by the Board on 28th May 2019 and signed on its behalf

Dame J Daniel
Chief Executive
28 May 2019

**NHS FOUNDATION TRUST STATEMENT
OF FINANCIAL POSITION
as at 31 March 2019**

NHS FOUNDATION TRUST

	Note	31 March 2019 £000	31 March 2018 £000
NON-CURRENT ASSETS			
Intangible assets	11	4,309	3,651
Property, plant and equipment	12	488,954	486,433
Investments in subsidiaries and joint ventures	13	0	0
Trade and other receivables	16	13,740	12,319
TOTAL NON-CURRENT ASSETS		507,003	502,403
CURRENT ASSETS			
Inventories	15	17,216	14,732
Trade and other receivables	16	94,672	88,934
Non current assets held for sale	17	0	0
Cash and cash equivalents	18	94,724	85,667
TOTAL CURRENT ASSETS		206,612	189,333
CURRENT LIABILITIES			
Trade and other payables	19	(105,710)	(99,878)
Other liabilities	20	(9,195)	(7,687)
Borrowings	21	(6,947)	(8,399)
Provisions	22	(1,706)	(1,281)
TOTAL CURRENT LIABILITIES		(123,558)	(117,245)
NON-CURRENT LIABILITIES			
Borrowings	21	(228,907)	(236,121)
Provisions	22	(2,252)	(5,678)
TOTAL NON-CURRENT LIABILITIES		(231,159)	(241,799)
TOTAL ASSETS EMPLOYED		358,898	332,692
TAXPAYERS' EQUITY			
Public dividend capital *		238,811	232,957
Revaluation reserve *		78,170	86,698
Income and expenditure reserve *		41,917	13,037
TOTAL TAXPAYERS' EQUITY		358,898	332,692

* Reserves:

- a) Public dividend capital represents the Secretary of State for Health and Social Care's 'equity' investment in the NHS Foundation Trust.
- b) The revaluation reserve is used to record revaluation gains and losses on property, plant and equipment.
- c) The NHS Foundation Trust's surplus for the year is recognised in the Income and Expenditure reserve.

The accounts on pages 245 to 325 were approved by the Board on 28th May 2019 and signed on its behalf by:

Dame J Daniel
Chief Executive
28 May 2019

**CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS'
AND OTHERS' EQUITY**
for the year ended 31 March 2019

GROUP 2018/19		Public dividend capital*	Revaluation reserve*	Income and expenditure reserve*	Charitable fund reserves *	Total taxpayers' and others' equity
	Note	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018		232,957	86,698	13,037	38,798	371,490
Total comprehensive income for 2018/19						
Surplus for the year		0	0	18,839	403	19,242
Revaluation gains on property, plant and	12.1	0	1,128	0	0	1,128
Fair value gains on financial assets		0	0	0	2,040	2,040
Transfer from revaluation reserve to I&E reserve for impairments arising from consumption of economic benefits		0	(1,253)	1,253	0	0
Other reserve movements		0	(8,403)	8,403	0	0
Other reserve movements - Charitable funds consolidation movement		0	0	385	(385)	0
Total comprehensive income for 2018/19		0	(8,528)	28,880	2,058	22,410
Public dividend capital received		6,480	0	0	0	6,480
Public dividend capital repaid		(626)	0	0	0	(626)
Total reserve movements for 2018/19		5,854	(8,528)	28,880	2,058	28,264
Taxpayers' and others' equity at 31 March 2019		238,811	78,170	41,917	40,856	399,754

**CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS'
AND OTHERS' EQUITY**
for the year ended 31 March 2019

GROUP 2017/18	Public dividend capital*	Revaluation reserve*	Income and expenditure reserve*	Charitable reserves *	Total taxpayers' and others' equity
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017	230,581	79,903	1,225	37,055	348,764
Total comprehensive expense for 2017/18					
Surplus for the year	0	0	11,015	1,855	12,870
Revaluation gains on property, plant and equipment 12.1	0	7,343	0	0	7,343
Fair value gains on financial assets	0	0	0	136	136
Transfer from revaluation reserve to I&E reserve for impairments arising from consumption of economic benefits	0	(548)	548	0	0
Other reserve movements	0	0	1	0	1
Other reserve movements - Charitable funds consolidation movement	0	0	248	(248)	0
Total comprehensive expense for 2017/18	0	6,795	11,812	1,743	20,350
Public dividend capital received	2,376	0	0	0	2,376
Total reserve movements for 2017/18	2,376	6,795	11,812	1,743	22,726
Taxpayers' and others' equity at 31 March 2018	232,957	86,698	13,037	38,798	371,490

* An explanation of the purpose of each reserve can be found in the Statement of Financial Position

**NHS FOUNDATION TRUST STATEMENT OF
CHANGES IN TAXPAYERS' EQUITY
for the year ended 31 March 2019**

NHS FOUNDATION TRUST 2018/19		Public dividend capital*	Revaluation reserve*	Income and expenditure reserve*	Total taxpayers' equity
		£000	£000	£000	£000
Taxpayers' equity at 1 April 2018		232,957	86,698	13,037	332,692
Total comprehensive income for 2018/19					
Surplus for the year		0	0	19,224	19,224
Revaluation gains on property, plant and equipment	12.1	0	1,128	0	1,128
Transfer from revaluation reserve to I&E reserve for impairments arising from consumption of economic		0	(1,253)	1,253	0
Other reserve movements		0	(8,403)	8,403	0
Total comprehensive income for 2018/19		0	(8,528)	28,880	20,352
Public dividend capital received		6,480	0	0	6,480
Public dividend capital repaid		(626)	0	0	(626)
Total reserve movements for 2018/19		5,854	(8,528)	28,880	26,206
Taxpayers' equity at 31 March 2019		238,811	78,170	41,917	358,898
NHS FOUNDATION TRUST 2017/18		Public dividend capital*	Revaluation reserve*	Income and expenditure reserve*	Total taxpayers' equity
		£000	£000	£000	£000
Taxpayers' equity at 1 April 2017		230,581	79,903	1,225	311,709
Total comprehensive expense for 2017/18					
Surplus for the year		0	0	11,263	11,263
Revaluation gains on property, plant and equipment	12.1	0	7,343	0	7,343
Transfer from revaluation reserve to I&E reserve for impairments arising from consumption of economic		0	(548)	548	0
Other reserve movements		0	0	1	1
Total comprehensive expense for 2017/18		0	6,795	11,812	18,607
Public dividend capital received		2,376	0	0	2,376
Total reserve movements for 2017/18		2,376	6,795	11,812	20,983
Taxpayers' equity at 31 March 2018		232,957	86,698	13,037	332,692

* An explanation of the purpose of each reserve can be found in the Statement of Financial Position

STATEMENTS OF CASH FLOWS
for the year ended 31 March 2019

		GROUP		NHS FOUNDATION TRUST	
	Note	2018/19 £000	2017/18 £000	2018/19 £000	2017/18 £000
Cash flows from operating activities					
Net cash generated from operating activities	23	66,728	41,998	67,211	41,150
Cash flows from investing activities					
Interest received		707	312	707	312
Purchase of intangible assets		(1,754)	(1,553)	(1,754)	(1,553)
Purchase of property, plant and equipment		(37,016)	(21,473)	(37,016)	(21,473)
Sales of property, plant and equipment		14,876	951	14,876	951
Receipt of cash donations to purchase capital assets		115	209	500	457
NHS Charitable funds - net cash flows from investing activities		(3,945)	755	0	0
Net cash used in investing activities		(27,017)	(20,799)	(22,687)	(21,306)
Cash flows from financing activities					
Public dividend capital received		6,480	2,376	6,480	2,376
Public dividend capital repaid		(626)	0	(626)	0
Loans repaid to the Department of Health and Social Care	21	(3,500)	(3,500)	(3,500)	(3,500)
Capital element of private finance initiative obligations		(5,182)	(4,899)	(5,182)	(4,899)
Interest paid		(129)	(230)	(129)	(230)
Other interest	8	(1)	0	(1)	0
Interest element of private finance initiative obligations		(25,532)	(24,746)	(25,532)	(24,746)
Public dividend capital dividend paid		(6,977)	(5,991)	(6,977)	(5,991)
Net cash used in financing activities		(35,467)	(36,990)	(35,467)	(36,990)
(Decrease)/increase in cash and cash equivalents		4,244	(15,791)	9,057	(17,146)
Cash and cash equivalents at 1 April		98,891	114,682	85,667	102,813
Cash and cash equivalents at 31 March	18	103,135	98,891	94,724	85,667

NOTES TO THE ACCOUNTS

1 Accounting policies and other information

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the NHS Foundation Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board (FRAB). Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS Foundation Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

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 except for the adoption of IFRS9 Financial Instruments and IFRS15 Revenue from Contracts with Customers in the current year. The impact of the adoption of these two new standards can be found in Note 30.

Going concern

Following enquiries the directors have an expectation that 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, inventories and certain financial assets and financial liabilities including the investments held within the charitable fund.

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 work in progress 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 the Royal Institution of Chartered Surveyors (RICS) 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.

1.1 Accounting convention (continued)

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 an alternative to 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 2019 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.

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

Where income is derived from contracts with customers, it is accounted for under IFRS15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3(b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of the initial application (1 April 2018).

Income in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the NHS Foundation Trust accrues income relating to performance obligations satisfied in that year. Where the NHS Foundation Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

1.3.1 Income from NHS contracts

The main source of income for the NHS Foundation Trust is contracts with commissioners for health care services. A performance obligation relating to the delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the NHS Foundation Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the NHS Foundation Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the NHS Foundation Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the NHS Foundation Trust is aware of a penalty based on contractual performance, the NHS Foundation Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The NHS Foundation Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. An estimate of readmissions is made at the year end and this portion of revenue is deferred as a contract liability.

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 transaction price by activity.

Other contracts particularly those for specialised services, 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.

1.3.2 CQUIN income

The NHS Foundation Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The NHS Foundation Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

1.3.3 NHS injury cost recovery scheme

The NHS Foundation Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The NHS Foundation Trust recognises the income when it receives notification from the Department of Works and Pension's Compensation Recovery unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

1.3.4 Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the NHS Foundation Trust's interim performance does not create an asset with alternative use for the NHS Foundation Trust, and the NHS Foundation Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the NHS Foundation Trust recognises revenue each year over the course of the contract.

1.3.5 Revenue grants and other contributions to expenditure

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.

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken in the Statement of Comprehensive Income to match that expenditure. Government grants fall under and are accounted under IAS 20.

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

1.3.6 Other income

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.

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.

Expenditure not aligned to a purchase order and which is non routine with a value below £1,000 are not standardly accrued for.

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.

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 benefits, 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 held at depreciated historic cost.

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 current 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 depreciated replacement cost on a modern equivalent asset basis. The NHS Foundation Trust adopts an 'optimal build' valuation and 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 excludes VAT. For non-operational buildings, including surplus land, the valuations are carried out at market value for exiting use.

All land and buildings are valued on a frequent basis to ensure that the current value is not materially misstated. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors (RICS) *Appraisal and Valuation Manual*. The latest full asset valuation exercise concluded as at 31 March 2018 when the District Valuer prepared an updated valuation, a desktop exercise has been carried out as at 31 March 2019 to update the asset valuation for all changes since the latest full valuation exercise.

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

NOTES TO THE ACCOUNTS (continued)

1.6 Property, plant and equipment (continued)

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.

IT equipment, transport equipment, furniture and fittings and plant and equipment that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

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 incurred to replace a component of such item will flow to the enterprise and 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 de-recognised. 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 GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss 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.

1.6 Property, plant and equipment (continued)

De-recognition

Assets intended for disposal are reclassified as 'Held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales; 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 abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'current value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'current 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 disposed of 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 disposal 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 their estimated accountancy based lives. Accountancy based lives differ from the remaining life of the asset as assessed by the NHS Foundation Trust's professional valuers and RICS guidance. The impact is to increase the asset life of building components and therefore reduce annual depreciation. The accountancy based approach to asset lives was agreed by the Trust Board prior to implementation on the basis it provides a more realistic representation of the remaining useful life of the Trust's buildings.

Equipment is depreciated on current value evenly over the estimated life of the asset. Useful economic lives reflect the total life of an asset and not the remaining life of an asset. During 2018/19 the NHS Foundation Trust has extended the asset lives for plant and machinery by 1 year where applicable, to more accurately reflect their true useful economic lives.

- Land - Not depreciated
- Buildings - 24 years - 90 years
- Dwellings - 31 years - 39 years
- Assets under construction - Not depreciated
- Plant and machinery - 5 years - 11 years
- Transport equipment - 3 years - 7 years
- Information technology - 5 years - 10 years
- Furniture and fittings - 5 years - 10 years

NOTES TO THE ACCOUNTS (continued)

1.7 Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their current value on receipt. The donation or grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation 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.

1.8 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.

1.8 Private Finance Initiative (PFI) transactions (continued)

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 cumulative indexation 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.

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 no non-current assets held for 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 transferred to 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

All 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 are recognised initially as liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

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

Obsolete and defective stock are charged to the Statement of Comprehensive Income as an expense.

1.13 Cash and cash equivalents

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

1.14 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 0.76% (2017/18 minus 2.42%), except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 0.29% (2017/18 0.10%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to NHS Resolution which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by NHS Resolution 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 NHS Resolution 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 potential remedial 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 assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the NHS Foundation Trust's control) are not recognised as assets, but are disclosed in Note 26 where an inflow of economic benefits is probable.

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.

1.16 Expenditure on employee benefits

Short term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the 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. The scheme is not designed in a way that would enable the NHS Foundation Trust to identify its share of the underlying scheme assets and 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. The NHS Foundation Trust does not have any corporation tax liability in the current or prior year.

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 31 to the accounts in accordance with the requirements of the HM Treasury Financial Reporting Manual.

NOTES TO THE ACCOUNTS (continued)

1.21 Public Dividend Capital and Public Dividend Capital - 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.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from the NHS Foundation Trust. PDC is recorded at the value received.

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,
- (iii) any PDC dividend balance receivable or payable, and
- (iv) any incentive or bonus Provider and Sustainability Funding (PSF) funding receivable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any 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, including losses which would have been made good through insurance cover had the 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 (Note 32) 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 assets and financial liabilities

Recognition

Financial assets and financial liabilities which arise where the NHS Foundation Trust is party to the contractual provisions of a financial instrument and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes 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 and are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or service is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through profit and loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest rate method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive income as financing income or expense. In the case of loans held from the DHSC, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the NHS Foundation Trust recognises an allowance for expected credit losses.

receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increase (stage 2).

1.23 Financial assets and financial liabilities (continued)

The expected credit loss is arrived at by reviewing the length of time a specific debt has been outstanding. Generally the NHS Foundation Trust will recognise an impairment against a receivable if i) it is older than 90 days for non-NHS customers and ii) it is older than 180 days for NHS customers. In addition further credit losses may be recognised sooner if there is a known factor that will influence the customers ability to pay the debt due to the NHS Foundation Trust.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial assets' original effective interest rate.

De-recognition

All financial assets are de-recognised when the contractual 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.

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. As detailed in note 1.23 Impairment of Financial Assets, a provision for impairment of trade receivables is established when there is an expectation that the NHS Foundation Trust will not be able to collect all amounts due according to the original terms of the receivables. Future expected credit losses are determined by; 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 Non NHS and 180 days overdue NHS) are considered indicators that the trade receivable is impaired. The amount of the provision is the difference between the asset's gross 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 CRC Energy Efficiency Scheme aims to incentivise energy efficiency and cut emissions in large energy users in the UK's public and private sectors. Organisations that meet the qualification criteria are required to participate, and must buy allowances for every tonne of carbon they emit. A liability and related expense is recognised in respect of this obligation as CO₂ it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO₂ emissions are made. The cost of the CRC scheme to the NHS Foundation Trust for 2018/19 is £22k (2017/18 £15k).

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

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

NOTES TO THE ACCOUNTS (continued)

1.27 Accounting standards

The GAM does not require the following Standards and Interpretations to be applied in 2018/19. These standards are still subject to HM Treasury FReM adoption, with IFRS 16 Lease expecting to be adopted in 2020/21 in the public sector.

IFRS 16 Leases - Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM until 2020/21: early adoption is not therefore permitted. The adoption of this standard will result in an increase in both assets and liabilities in the SoFP as Leases are taken onto the SoFP. Due to discounting, there will also be a resulting increase in the charge to the expenditure position in the earlier part of the lease, with a resulting decrease in the charge to the expenditure position in the latter part of the lease. Although this change in accounting standards will impact the financial position of the Group, it is not expected to be material.

IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRIC23 Uncertainty over Income Tax Treatments - Application required for accounting periods beginning on or after 1 January 2019.

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

The effect of the adoption of these standards in future years is not expected to have a material impact.

1.28 Provider Sustainability Funding (PSF) receipts and control total

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 year 2018/19 the NHS Foundation Trust earned £24,207k (2017/18 £13,876k). Detail is noted below:

During 2018/19 the Group and NHS Foundation Trust earned the following PSF monies:

	2018/19	2017/18
	£000	£000
Core award	12,947	6,300
Incentive bonus - over achievement of control total	473	93
Bonus PSF	2,605	1,561
General distribution	8,182	5,922
Total PSF receivable	24,207	13,876
	2018/19	2017/18
	£000	£000
Reconciliation to control total		
Surplus for the year (SOCI Trust)	19,224	11,263
Less/Add: Reversal of impairments/impairments	4,446	(2,742)
Less: PSF monies receivable	(24,207)	(13,876)
Add: Donated asset depreciation	1,164	1,405
Less: Donated income received for asset purchases	(500)	(457)
Underlying result	127	(4,407)
Plan control total (2018/19 break even)	0	(4,500)
Underlying result plus PSF funding	24,334	9,469

NOTES TO THE ACCOUNTS (continued)

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 the impact of impairments and consolidation.

	2018/19 %	2017/18 %
NHS England	42	41
NHS Newcastle Gateshead CCG	24	25
NHS Northumberland CCG	6	6
NHS North Tyneside CCG	6	6
Health Education England	5	5

The following is an analysis of the financial information provided to the Board of Directors in relation to the years ended 31 March 2019 and 31 March 2018.

	2018/19 £000	2017/18 £000
Operating income (within EBITDA)	1,085,887	1,042,571
Operating expenses (within EBITDA)	(1,017,654)	(983,887)
Earnings before interest, tax, depreciation and amortisation (EBITDA)	68,233	58,684
Operating expenses (outside EBITDA)	(27,772)	(19,733)
Non-operating income	1,203	798
Non-operating expenditure	(26,886)	(31,228)
Surplus for the year excluding reversal of impairments/(impairments)	14,778	8,521
Net reversal of impairments/(impairments)	4,446	2,742
Surplus/(deficit) for the year after reversal of impairments	19,224	11,263

Differences between the amounts presented to the Board in May 2019 and those included within these accounts are purely presentational. See note 1.28.

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 nature

GROUP and NHS FOUNDATION TRUST

	2018/19 £000	2017/18 £000
<u>Acute Trusts</u>		
Elective income	165,037	168,681
Non elective income	169,590	166,727
First outpatient income	75,318	75,376
Follow up outpatient income	51,021	51,375
A & E income	17,140	16,336
High cost drugs income from commissioners	132,809	127,285
Other NHS clinical income *	244,812	235,124
	855,727	840,904
<u>Community Trusts</u>		
Income from CCGs and NHS England	35,684	34,011
Income from other sources	10,833	10,767
	46,517	44,778
<u>All Services</u>		
Private patient income	3,759	3,882
Agenda for change pay award central funding	8,302	0
Other clinical income **	12,808	8,964
	24,869	12,846
	927,113	898,528
Of which:		
Income from Commissioner Requested services	908,924	880,455
Income from Non-Commissioner Requested services ***	18,189	18,073
	927,113	898,528

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.

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.

NOTES TO THE ACCOUNTS (continued)

3. Operating income (continued)

3.2 Income from activities by source

GROUP and NHS FOUNDATION TRUST

	2018/19 £000	2017/18 £000
NHS Foundation Trusts	5,291	4,807
NHS Trusts	148	153
CCGs	461,051	449,459
NHS England	418,383	410,104
Local Authorities	11,151	11,197
Department of Health and Social Care	8,361	48
NHS Other	4,539	4,687
Non NHS (including non-English NHS):		
- Private patients	3,759	3,882
- Overseas patients (chargeable to patient)	821	272
- Injury cost recovery scheme*	4,016	3,493
- Other **	9,593	10,426
	927,113	898,528

All income relates to continuing operations

* Injury Cost Recovery 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 21.89% (2017/18 22.94%). 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.

3.3 Income from overseas visitors

	2018/19 £000	2017/18 £000
Income recognised in the year	821	272
Cash payments received in-year (relating to invoices raised in the current and previous years)	502	203
Amounts added to the provision for impairment of receivables (relating to invoices raised in the current and prior years)	595	215
Amounts written off in-year (relating to invoices raised in the current and previous years)	85	143

NOTES TO THE ACCOUNTS (continued)

4. Other operating income

	GROUP		NHS FOUNDATION	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Other operating income recognised in accordance with IFRS 15				
Research and development	34,332	32,829	34,332	32,829
Education and training	55,781	55,373	55,781	55,373
Non-patient care services to other bodies *	16,081	13,738	16,081	13,738
Sustainability and Transformation Fund income	24,207	13,876	24,207	13,876
Income in respect of employee benefits accounted on a gross basis	26	0	26	0
Other income **	27,821	27,466	27,821	27,466
Other operating income recognised in accordance with other standards				
Cash donations for the purchase of capital assets - received from NHS charities	0	0	385	248
Cash donations for the purchase of capital assets - received from other bodies	115	209	115	209
Rental revenue from operating leases	526	736	526	736
Education and training - notional income from £	67	25	67	25
Charitable fund incoming resources	2,632	3,875	0	0
	<u>161,588</u>	<u>148,127</u>	<u>159,341</u>	<u>144,500</u>

* 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 and Social Care funding for clinical excellence awards, clinical test income, property utilities income and catering and nursery income.

4.1 Fees and charges

The Group and NHS Foundation Trust had no schemes which individually had a cost exceeding £1,000k in the current or preceding year.

4.2 Additional information on contract revenue (IFRS 15) recognised in the period

2018/19
£000
Revenue recognised in the reporting period that was previously included in the contract liability balance (i.e. release of deferred IFRS 15 income)
<u>2,399</u>

Revenue recognised in the reporting period from performance obligations satisfied (or partially satisfied) in previous periods (e.g. changes in transaction price)
<u>0</u>

NOTES TO THE ACCOUNTS (continued)

4. Other operating income (continued)

4.3 Operating lease income

GROUP and NHS FOUNDATION TRUST

	2018/19 £000	2017/18 £000
Building rental recognised in other income	<u>526</u>	<u>736</u>
Future minimum lease payments due		
- not later than one year	452	562
- later than one year and not later than five years	815	885
- later than five years	184	97
	<u>1,451</u>	<u>1,544</u>

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	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Purchase of healthcare from NHS and DHSC bodies	8,105	8,366	8,105	8,366
Purchase of healthcare from non NHS bodies	9,156	8,105	9,156	8,105
Employee expenses - non-executive directors	173	171	173	171
Employee expenses - staff and executive directors	584,911	564,637	584,911	564,637
Supplies and services - clinical (excluding drugs costs)	114,522	109,434	114,522	109,434
Supplies and services - general	12,376	12,537	12,376	12,537
Establishment	4,684	4,874	4,684	4,874
Research and development - staff costs	18,339	17,830	18,339	17,830
Research and development - non staff costs	15,187	13,450	15,187	13,450
Transport - other	4,942	4,497	4,942	4,497
Transport - business	1,799	1,989	1,799	1,989
Premises - business rates payable to Local Authorities	6,353	4,794	6,353	4,794
Premises - other	40,554	37,171	40,554	37,171
Movement in credit loss allowance: contract receivables/assets (Note 16.2)	(971)	0	(971)	0
Movement in credit loss allowance: all other receivables & investments (Note 16.2)	(250)	2,029	(250)	2,029
Provisions arising /(released) in year	724	65	724	65
Change in provisions - discount rate	(58)	48	(58)	48
Inventories written down (net, including inventory drugs)	564	392	564	392
Charges to operating expenditure for on-SoFP IFRIC 12 schemes on an IFRS basis - PFI schemes	7,820	7,388	7,820	7,388
Drugs inventories consumed	166,611	166,610	166,611	166,610
Rentals under operating leases - minimum lease payments (Note 5.3)	2,088	2,648	2,088	2,648
Amortisation on intangible assets (Note 11)	971	856	971	856
Depreciation on property, plant and equipment (Note 12)	17,909	18,878	17,908	18,878
NHS Charitable funds: Depreciation and amortisation on charitable fund assets (Note 12)	22	22	0	0
Net impairments of property, plant and equipment * (Note 12)	4,446	(2,742)	4,446	(2,742)
External audit fees - Statutory audit	65	63	65	63
External audit fees - Other auditors' remuneration	11	10	11	10
External audit fees - Charitable fund accounts	11	10	0	0
Clinical negligence - amounts payable to NHS Resolution (premium)	17,273	13,540	17,273	13,540
Internal audit costs not included within employee expenses	235	220	235	220
Legal fees	589	374	589	374
Consultancy costs	922	269	922	269
Education and training - non-staff	1,355	1,318	1,355	1,318
Education and training - notional expenditure funded from apprenticeship fund	67	25	67	25
Insurance	609	533	609	533
Losses ex-gratia and special payments	0	50	0	50
Redundancy costs - non-staff	0	151	0	151
NHS Charitable fund - other resources expended	3,250	2,743	0	0
Other	(1,093)	345	(1,093)	345
	1,044,271	1,003,700	1,040,987	1,000,925

* Net impairments total £4,446k (2017/18 £2,742k credit).

NOTES TO THE ACCOUNTS (continued)

5. Operating Expenses (continued)

5.2 Auditors' remuneration

The amounts paid by the Newcastle Upon Tyne Hospitals NHS Foundation Trust for auditors' remuneration are disclosed inclusive of VAT in 2018/19 and exclusive of VAT in 2017/18.

'Statutory audit' remuneration excludes the charge for the audit of the NHS Foundation Trust's Quality Report which is included within 'Other auditors' remuneration.'

'Other auditors' remuneration' of £11k (2017/18 £12k) was paid in the year for the audit of the NHS Foundation Trust's Quality Report.

The NHS Foundation Trust approved the principal terms of engagement with its auditors, Mazars, covering the period of 1 October 2018 to 30 September 2021 as auditors.

NOTES TO THE ACCOUNTS (continued)

5. Operating Expenses (continued)

5.3 Arrangements containing an operating lease:

GROUP and NHS FOUNDATION TRUST

	2018/19 £000	2017/18 £000
Minimum lease rentals	<u>2,088</u>	<u>2,648</u>

	2018/19 £000	2018/19 £000	2018/19 £000	2017/18 £000	2017/18 £000	2017/18 £000
	Buildings	Other leases	Total	Buildings	Other leases	Total
Future minimum lease payments due:						
- not later than one year	626	1,504	2,130	574	1,778	2,352
- later than one year and not later than five years	1,251	3,149	4,400	210	3,724	3,934
- later than five years	0	1,853	1,853	0	2,525	2,525
Total	<u>1,877</u>	<u>6,506</u>	<u>8,383</u>	<u>784</u>	<u>8,027</u>	<u>8,811</u>

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

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

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

GROUP and NHS FOUNDATION TRUST

The single total figure table, the total pension entitlement disclosures and the fair play multiple are included within the remuneration report.

	2018/19 £000	2017/18 £000
Executive directors' remuneration	912	804
Employer's contribution to pension	<u>53</u>	<u>44</u>
	965	848
Non-executive director's remuneration *	173	160
Total	<u>1,138</u>	<u>1,008</u>

The remuneration costs disclosed above exclude employer's national insurance contributions.

**The total number of directors
accruing benefits under the NHS
Pension Scheme**

<u>2</u>	<u>2</u>
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* Non-executive directors are not members of the NHS Pension Scheme.

Highest paid executive director

Total remuneration	<u>245</u>	<u>256</u>
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NOTES TO THE ACCOUNTS (continued)

5. Operating Expenses (continued)

5.5. Staff costs and numbers

5.5.1 Staff costs

GROUP AND NHS FOUNDATION TRUST

	2018/19	2017/18
	£000	£000
Salaries and wages *	507,741	488,824
Social security costs	42,894	41,254
Apprenticeship levy	2,255	2,156
Pensions cost - Employer's contributions to NHS Pensions	55,720	53,796
Pensions cost - Other	105	43
Termination benefits	0	0
Agency and contract staff	3,710	3,822
Total gross staff costs	612,425	589,895
Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure	(4,949)	(4,144)
Recoveries from Other bodies in respect of staff cost netted off expenditure	(4,226)	(3,093)
Total staff costs	603,250	582,658
included within:		
Costs capitalised as part of assets	0	191
Analysed into operating expenditure - Note 5.1		
Employee expenses - staff and executive directors	584,911	564,637
Research and development	18,339	17,830
Total employee benefits excluding capitalised costs	603,250	582,467

* Included within salaries and wages is an amount of £35,031k (2017/18 £34,250k) relating to recharges from Northumbria NHS Foundation Trust, the host body for Junior Doctors in training.

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 2018/19 there were 4 (2017/18 5) 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 £96k (2017/18 £143k).

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

NOTES TO THE ACCOUNTS (continued)

5. Operating Expenses (continued)

5.5.4 Reporting of other compensation packages

During 2018/19 there was zero compulsory redundancies (2017/18 2 redundancies at a cost of £151k). There were 2 special payments for exit payments following employment tribunals or court orders at a cost of £301k made in the current year. (No special payments were made in the prior year).

Further details can be found 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

	2018/19 Number	2018/19 Value £000
Total Non-NHS trade invoices paid in the year	223,891	492,079
Total Non NHS trade invoices paid within target	205,496	442,509
Percentage of Non-NHS trade invoices paid within target	92%	90%
Total NHS trade invoices paid in the year	5,574	95,777
Total NHS trade invoices paid within target	4,092	87,024
Percentage of NHS trade invoices paid within target	73%	91%
	2017/18 Number	2017/18 Value £000
Total Non-NHS trade invoices paid in the year	215,539	413,311
Total Non NHS trade invoices paid within target	196,655	369,181
Percentage of Non-NHS trade invoices paid within target	91%	89%
Total NHS trade invoices paid in the year	5,637	117,247
Total NHS trade invoices paid within target	4,327	107,712
Percentage of NHS trade invoices paid within target	77%	92%

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

GROUP and NHS FOUNDATION TRUST

	2018/19 £000	2017/18 £000
Total liability accruing in year under this legislation as a result of late payments	4,111	4,998
Amounts included within interest payable arising from claims made under this legislation	1	0
Compensation paid to cover debt recovery costs under this legislation	0	0

NOTES TO THE ACCOUNTS (continued)

7. Finance income

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

	GROUP		NHS FOUNDATION TRUST	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Interest on bank accounts	698	332	698	332
Interest on loans and receivables	5	9	5	9
NHS Charitable fund - investment income	1,055	755	0	0
Total finance income	1,758	1,096	703	341

8. Finance expense - financial liabilities

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

GROUP and NHS FOUNDATION TRUST

	2018/19	2017/18
	£000	£000
PFI - Main finance costs	15,523	15,872
PFI - Contingent finance costs	10,009	8,874
Capital loans from the Department of Health and Social Care	99	200
Interest on the late payment of commercial debt	1	0
Total interest expense	25,632	24,946
Unwinding of discount on provisions	2	30
Total finance expense	25,634	24,976

9. PDC dividends payable

GROUP and NHS FOUNDATION TRUST

The NHS Foundation Trust is required to pay a dividend to the Department of Health and Social Care 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 £7,004k (2017/18 £6,131k).

NOTES TO THE ACCOUNTS (continued)

10. Impairments and gains/(losses) on disposal

10.1 Impairments of assets

GROUP and NHS FOUNDATION TRUST

	2018/19 £000	2018/19 £000	2018/19 £000	2017/18 £000	2017/18 £000	2017/18 £000
	Net impairments	Impairments	Reversals	Net impairments	Impairments	Reversals
Changes in market price and optimal site valuation	(707)	44	(751)	(2,742)	7,948	(10,690)
Other *	5,153	5,153	0	0	0	0
Total impairments (credited)/charged to operating surplus	4,446	5,197	(751)	(2,742)	7,948	(10,690)
Net impairments credited to the revaluation reserve	(1,128)	148	(1,276)	(7,343)	3,377	(10,720)
Total impairments	3,318	5,345	(2,027)	(10,085)	11,325	(21,410)

* Other impairments are due to loss of economic benefit from buildings declared surplus following the sale of Land.

10.2 Gains/(losses) on disposal/derecognition of assets

GROUP and NHS FOUNDATION TRUST

	2018/19 £000	2017/18 £000
Gains on disposal of other property, plant and equipment	5,503	38
Gains on disposal of assets held for sale	281	0
Losses on disposal of other property, plant	(92)	(112)
	5,692	(74)

NOTES TO THE ACCOUNTS (continued)

11. Intangible Assets

GROUP AND NHS FOUNDATION TRUST

	£000	£000	£000
Cost at 1 April 2018	7,766	1,417	9,183
Additions purchased	1,091	663	1,754
Reclassifications*	615	(474)	141
Disposals	(81)	(266)	(347)
Cost at 31 March 2019	9,391	1,340	10,731
Accumulated amortisation at 1 April 2018	5,532	0	5,532
Provided during the year	971	0	971
Disposals	(81)	0	(81)
Accumulated amortisation at 31 March 2019	6,422	0	6,422
Net book value			
Purchased	2,969	1,340	4,309
Donated	0	0	0
Total at 31 March 2019	2,969	1,340	4,309
Cost at 1 April 2017	7,107	325	7,432
Additions purchased	296	1,257	1,553
Reclassifications	363	(165)	198
Disposals	0	0	0
Cost at 31 March 2018	7,766	1,417	9,183
Accumulated amortisation at 1 April 2017	4,676	0	4,676
Provided during the year	856	0	856
Disposals	0	0	0
Accumulated amortisation at 31 March 2018	5,532	0	5,532
Net book value			
Purchased	2,234	1,417	3,651
Donated	0	0	0
Total at 31 March 2018	2,234	1,417	3,651

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 2018 £Nil) and has no intangibles funded by government grant (31 March 2018 £Nil).

Reclassifications*

Reclassifications relate to the transfer of software 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:

2018/19 Financial Year

GROUP

	Land £000	Buildings £000	Dwellings £000	Assets under construction £000	Plant and Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & fittings £000	Charity assets £000	Total £000
Cost or valuation at 1 April 2018	28,063	394,946	700	9,315	162,839	316	19,947	826	555	617,507
Additions purchased	0	9,867	0	12,080	7,823	0	2,804	0	0	32,574
Additions purchased from cash donations	0	0	0	0	484	0	16	0	0	500
Reclassifications	0	1,221	0	(8,565)	6,817	166	209	11	0	(141)
Impairments charged to operating expenses	0	(5,197)	0	0	0	0	0	0	0	(5,197)
Impairments charged to the revaluation reserve	(115)	(33)	0	0	0	0	0	0	0	(148)
Reversal of impairments credited to the revaluation reserve	0	1,260	16	0	0	0	0	0	0	1,276
Depreciation eliminated on revaluation	0	(7,386)	(16)	0	0	0	0	0	0	(7,402)
Reversal of impairments credited to operating expenses	0	751	0	0	0	0	0	0	0	751
Transfer to assets held for sale	(5,000)	0	0	0	0	0	0	0	0	(5,000)
Disposals	(3,288)	(660)	(155)	0	(8,041)	0	(432)	0	0	(12,576)
#REF!	19,660	394,769	545	12,830	169,922	482	22,544	837	555	622,144

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 (continued)

2018/19 Financial Year

GROUP

	Land £000	Buildings £000	Dwellings £000	Assets under construction £000	Plant and Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & fittings £000	Charity assets £000	Total £000
Accumulated Depreciation at 1 April 2018	0	0	0	0	111,670	237	17,812	800	44	130,563
Provided during the year	0	7,439	17	0	8,990	20	1,419	23	23	17,931
Depreciation eliminated on revaluation	0	(7,386)	(16)	0	0	0	0	0	0	(7,402)
Reclassifications	0	0	0	0	0	166	(166)	0	0	0
Disposals	0	(10)	(1)	0	(7,947)	0	(432)	0	0	(8,390)
#REF!	0	43	0	0	112,713	423	18,633	823	67	132,702
Net book value										
As at 31 March 2019	19,660	394,726	545	12,830	57,209	59	3,911	14	488	489,442
Net book value										
As at 31 March 2018	28,063	394,946	700	9,315	51,169	79	2,135	26	511	486,944
Financing of property, plant and equipment										
Owned	19,660	204,443	545	12,830	52,954	59	3,798	14	488	294,791
PFI	0	181,348	0	0	0	0	0	0	0	181,348
Government granted	0	303	0	0	12	0	0	0	0	315
Donated	0	8,632	0	0	4,243	0	113	0	0	12,988
#REF!	19,660	394,726	545	12,830	57,209	59	3,911	14	488	489,442

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 (continued)

2018/19 Financial Year

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 2018/19 the following took place which resulted in movements to the income and expenditure account, the revaluation reserve and the income and expenditure reserve.

A desktop update of the NHS Foundation Trust's estate was carried out as at 31 March 2019 by a qualified valuer within the Valuation Office Agency. The resulting valuation was based on both national and regional Building Cost Indices. The district valuer was instructed, as in the prior year, to prepare the valuation on a single site basis. This recognises any efficiencies that could be obtained if the NHS Foundation Trust's buildings were to be rebuilt maintaining the current level of service provision on a single site. In addition the district valuer was instructed to prepare the valuation excluding VAT from the value of buildings acquired via PFI procurement methods and NHS Foundation Trust direct purchases. The valuation resulted in the following income and reserve movements:

Income and expenditure account

- i) a £44k charge to operating expenditure relating to impairments in year.
- ii) a £751k credit to operating expenditure reversing prior year impairments.

Revaluation reserve

- i) a £148k charge to the revaluation reserve for impairments in year.
- ii) a £1,276k credit to the revaluation reserve relating to an increase in asset values.

Depreciation

Depreciation eliminated on revaluation amounted to £7,340k.

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.

Land and building disposals

During the year land and the Biomedical Research Centre building at the Campus for Ageing and Vitality were sold to Newcastle University. The Leyburn Drive dwelling was also disposed of in year. These transaction resulted in the following movements to PPE:

Income and expenditure account

- i) a £5,153k charge to operating expenditure relating to impairments in year.

Depreciation

Depreciation eliminated on disposal of £62k.

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 the year the Sanderson site land was transferred to non current assets held for sale at a value of £5,000k. The site was sold in March 2019. The profit on disposal is reflected in note 10.2.

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 *(continued)*

2018/19 Financial Year

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 £489k.

For the NHS Foundation Trust this would result in a movement of £385k between additions purchased and additions donated and the removal of the Charitable dwelling. The overall net book value at 31 March 2019 is reduced by £489k to £488,954k. 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 (continued)

2017/18 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 2017	31,368	384,119	665	6,140	158,704	452	19,584	826	555	602,413
Additions purchased	0	4,050	0	8,936	7,558	30	91	0	0	20,665
Additions leased	0	0	0	0	0	0	0	0	0	0
Additions purchased from cash donations	0	0	0	0	436	0	21	0	0	457
Reclassifications	0	1,318	0	(5,761)	3,994	0	251	0	0	(198)
Impairments charged to operating expenses	0	(7,948)	0	0	0	0	0	0	0	(7,948)
Impairments charged to the revaluation reserve	(3,329)	(48)	0	0	0	0	0	0	0	(3,377)
Reversal of impairments credited to the revaluation reserve	24	10,642	54	0	0	0	0	0	0	10,720
Depreciation eliminated on revaluation	0	(7,877)	(19)	0	0	0	0	0	0	(7,896)
Reversal of impairments credited to operating expenses	0	10,690	0	0	0	0	0	0	0	10,690
Disposals	0	0	0	0	(7,853)	(166)	0	0	0	(8,019)
Cost or valuation at 31 March 2018	28,063	394,946	700	9,315	162,839	316	19,947	826	555	617,507

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 (continued)

2017/18 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
Accumulated Depreciation at 1 April 2017	0	365	0	0	109,737	385	16,160	779	22	127,448
Provided during the year	0	7,512	19	0	9,656	18	1,652	21	22	18,900
Depreciation eliminated on revaluation	0	(7,877)	(19)	0	0	0	0	0	0	(7,896)
Disposals	0	0	0	0	(7,723)	(166)	0	0	0	(7,889)
Accumulated Depreciation at 31 March 2018	0	0	0	0	111,670	237	17,812	800	44	130,563
Net book value As at 31 March 2018	28,063	394,946	700	9,315	51,169	79	2,135	26	511	486,944
Net book value As at 31 March 2017	31,368	383,754	665	6,140	48,967	67	3,424	47	533	474,965
Financing of property, plant and equipment										
Owned	28,063	202,328	700	9,315	46,450	79	1,928	23	511	289,397
PFI	0	183,292	0	0	0	0	0	0	0	183,292
Government granted	0	330	0	0	22	0	0	0	0	352
Donated	0	8,996	0	0	4,697	0	207	3	0	13,903
Total at 31 March 2018	28,063	394,946	700	9,315	51,169	79	2,135	26	511	486,944

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 (continued)

2017/18 Financial Year

GROUP

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 2017/18 the following took place which resulted in movements to the income and expenditure account, the revaluation reserve and the income and expenditure reserve.

a) A full valuation (including building inspections) of the NHS Foundation Trust's estate was carried out as at 31 March 2018 by a qualified valuer within the Valuation Office Agency. The resulting valuation was based on both national and regional Building Cost Indices. The district valuer was instructed, as in the prior year, to prepare the valuation on a single site basis. This recognises any efficiencies that could be obtained if the Trust's buildings were to be rebuilt maintaining the current level of service provision on a single site. In addition the district valuer was instructed to prepare the valuation excluding VAT from the value of buildings acquired via PFI procurement methods and NHS Foundation Trust direct purchases. The valuation resulted in the following income and reserve movements:

Income and expenditure account

- i) a £7,948k charge to operating expenditure relating to impairments in year.
- ii) a £10,690k credit to operating expenditure reversing prior year impairments.

Revaluation reserve

- i) a £3,377k charge to the revaluation reserve for impairments in year.
- ii) a £10,720k credit to the revaluation reserve relating to an increase in asset values.

Depreciation

Depreciation eliminated on revaluation amounted to £7,896k.

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

The NHS Foundation Trust has no assets held for sale.

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 *(continued)*

2017/18 Financial Year

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 £511k.

For the NHS Foundation Trust this would result in a movement of £249k between additions purchased and additions donated and the removal of the Charitable dwelling. The overall net book value at 31 March 2018 is reduced by £511k to £486,433k. 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

#REF!

12.3 Analysis of assets held under PFI contracts

PFI assets	£000
Valuation at 1 April 2018	183,292
Additions	1,381
Revaluation - including depreciation eliminated	(3,283)
Valuation at 31 March 2019	181,390
Accumulated Depreciation at 1 April 2018	0
Provided during the year	3,446
Depreciation eliminated on revaluation	(3,404)
Accumulated Depreciation at 31 March 2019	42
Net book value at 31 March 2019	181,348
Valuation at 1 April 2017	181,173
Additions	1,328
Revaluation - including depreciation eliminated*	791
Valuation at 31 March 2018	183,292
Accumulated Depreciation at 1 April 2017	364
Provided during the year	3,516
Depreciation eliminated on revaluation	(3,880)
Accumulated Depreciation at 31 March 2018	0
Net book value at 31 March 2018	183,292

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 the prior year is a result of the NHS Foundation Trust adopting a single site approach to the valuation of relevant land and buildings. VAT is excluded from the valuation of the Trust's PFI buildings in both the current and prior year.

NOTES TO THE ACCOUNTS (continued)

13. Investments in Subsidiaries and Joint Ventures

GROUP AND NHS FOUNDATION TRUST

	2018/19 £000	2017/18 £000
Cost and NBV at 1 April and 31 March	0	0

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 are impaired to £Nil (2017/18 £Nil).

Freeman Clinics Limited

The NHS Foundation Trust held 100% (2017/18 100%) of the ordinary share capital of Freeman Clinics Limited, a company incorporated in the UK for the purpose of providing primary care services. The company underwent a Members Voluntary Liquidation as at 30 September 2018. The result after tax for the year 2018/19 up to 30 September 2018 is estimated at a profit of £463k (2017/18 £8k restated).

Pulse Diagnostics Limited

The NHS Foundation Trust holds 89% (2017/18 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 at cost of £113k (2017/18 £113k) has previously been impaired. 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 £358k based on unaudited management accounts to 31 December 2018 pro rated for twelve months (2017/18 profit £280k). During the year the company made a loan repayment to the NHS Foundation Trust of £250k. The loan balance outstanding at 31 March 2019 amounts to £75k (2017/18 £325k). It is likely that the services which are currently provided by Newgene will move into the NHS Foundation Trust during 2019/20.

Limbs Alive Limited

Limbs Alive Limited was dissolved on 11 December 2018. The NHS Foundation Trust's investment in the company was impaired in a prior year.

Changing Health Limited

The NHS Foundation Trust owns 12.5% of the ordinary share capital of Changing Health Limited, a company incorporated in the UK to provide health education support services.

NOTES TO THE ACCOUNTS (continued)

13. Investments in Subsidiaries and Joint Ventures (continued)

Health Call

Health Call was created to develop a regional telehealth platform. The Trust is entitled to nominate one Director.

The NHS Foundation Trust also has a shareholding in the following dormant company

Newcastle Healthcare Property Company Limited

The NHS Foundation Trust owns 100% of the £1 ordinary share capital of Newcastle Healthcare Property Company 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.

NOTES TO THE ACCOUNTS (continued)

14. Other investments

GROUP

	2018/19	2017/18
	£000	£000
Carrying value at 1 April	25,036	24,900
Additions	5,000	0
Fair value movements taken to Other Comprehensive Income	2,040	136
Fair value at 31 March	<u>32,076</u>	<u>25,036</u>

The 'other investments' are held within the Newcastle upon Tyne Hospitals NHS Charity. The NHS Foundation Trust does not hold any 'other investments'. During 2018/19 a further £5,000k investment was made, representing cash balances not immediately required by the Charity for grant making activities.

The Investments are held in a (i) Charities Ethical Investment Fund* and a (ii) Growth & Income Fund for Charities ** and are administered on behalf of the Newcastle upon Tyne Hospitals NHS Charity by CCLA Investment Management Ltd* and Newton Investment Management**. 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.

NOTES TO THE ACCOUNTS (continued)

15. Inventories

GROUP	2018/19 £000	2018/19 £000	2018/19 £000	2018/19 £000 Charitable funds inventory
	Total	Drugs	Consumables	
As at 1 April	14,756	6,444	8,288	24
Additions	284,906	166,727	118,179	0
Inventories recognised in expenses	(281,858)	(165,560)	(116,298)	0
Write down of inventories	(564)	(238)	(326)	0
Movement in Charitable funds inventories	2	0	0	2
As at 31 March	17,242	7,373	9,843	26

	2017/18 £000	2017/18 £000	2017/18 £000	2017/18 £000 Charitable funds inventory
	Total	Drugs	Consumables	
As at 1 April	14,725	5,431	9,266	28
Additions	278,959	166,913	112,046	0
Inventories recognised in expenses	(278,532)	(165,666)	(112,866)	0
Write down of inventories	(392)	(234)	(158)	0
Movement in Charitable funds inventories	(4)	0	0	(4)
As at 31 March	14,756	6,444	8,288	24

NHS FOUNDATION TRUST

	2018/19 £000	2018/19 £000	2018/19 £000
	Total	Drugs	Consumables
As at 1 April	14,732	6,444	8,288
Additions	284,906	166,727	118,179
Inventories recognised in expenses	(281,858)	(165,560)	(116,298)
Write down of inventories	(564)	(238)	(326)
As at 31 March	17,216	7,373	9,843

	2017/18 £000	2017/18 £000	2017/18 £000
	Total	Drugs	Consumables
As at 1 April	14,697	5,431	9,266
Additions	278,959	166,913	112,046
Inventories recognised in expenses	(278,532)	(165,666)	(112,866)
Write down of inventories	(392)	(234)	(158)
As at 31 March	14,732	6,444	8,288

All stock is held at the lower of cost and net realisable value.

NOTES TO THE ACCOUNTS (continued)

16. Receivables

16.1 Receivables

	GROUP		NHS FOUNDATION TRUST	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Current				
Contract receivables invoiced	37,435	0	37,435	0
Contract receivables not yet invoiced	44,470	0	45,033	0
Contract assets	8,271	0	8,271	0
Trade receivables (comparative only)	0	26,900	0	26,900
Allowance for impaired contract receivables / assets	(5,770)	(8,194)	(5,770)	(8,194)
PFI prepayment (lifecycle replacement)	1,415	1,381	1,415	1,381
Other prepayments	5,743	12,218	5,743	12,218
Accrued income (comparative only)	0	35,655	0	35,655
PDC dividend receivable	342	369	342	369
VAT receivable	2,025	1,901	2,025	1,901
Interest receivable	40	44	40	44
Other receivables	138	18,398	138	18,660
NHS Charitable funds: Receivables	426	336	0	0
Total current receivables	94,535	89,008	94,672	88,934
Non-current				
PFI prepayment (lifecycle replacement)	13,225	12,134	13,225	12,134
Other prepayments	515	185	515	185
Other receivables - revenue	75	325	75	325
Allowance for impaired other receivables	(75)	(325)	(75)	(325)
Total non - current receivables	13,740	12,319	13,740	12,319
Total receivables	108,275	101,327	108,412	101,253
Of which:				
NHS and DHSC group bodies	54,261	53,983	54,261	53,983
Non NHS and DHSC group bodies	54,014	47,344	54,151	47,270
	108,275	101,327	108,412	101,253

The above disclosure has been amended in year to comply with the new reporting requirements of IFRS15. Further detail can be found in note 30.2.

NOTES TO THE ACCOUNTS (continued)

16. Receivables (continued)

16.2 Allowances for credit losses (doubtful debts)

GROUP and NHS FOUNDATION TRUST

	2018/19 £000	2018/19 £000 Contract receivables and contract assets	2018/19 £000 All other receivables	2017/18 £000 Total
At 1 April	8,519	0	8,519	8,350
Impact of IFRS 9 implementation	0	8,194	(8,194)	0
New allowances arising	4,341	4,341	0	7,313
Reversals of allowances	(5,562)	(5,312)	(250)	(1,860)
Utilisation of allowances	(1,453)	(1,453)	0	(5,284)
At 31 March	5,845	5,770	75	8,519
Loss/gain recognised in expenditure	(1,221)	(971)	(250)	2,029

Included within the above is a provision of £1,542k (2017/18 £1,491k) relating to the NHS Injury Cost Recovery Scheme. The Compensation Recovery Unit have advised that the probability of not receiving income is 21.89% (2017/18 22.84%).

16.3 Receivables past due but not impaired

	2018/19 £000
31 to 90 days	7,965
91 to 180 days	1,337
By more than 180 days	4,371
Total	13,673

NOTES TO THE ACCOUNTS (continued)

17. Non current assets held for sale

The NHS Foundation Trust holds no non current assets held for sale as at 31 March 2019. During the year the Sanderson site was placed on the open market and a transfer of £5,000k was made from PPE to Non current assets held for sale. The site was sold in March 2019.

18. Cash and cash equivalents

	GROUP		TRUST	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Balance at 1 April	98,891	114,682	85,667	102,813
Net change in year	4,244	(15,791)	9,057	(17,146)
Balance at 31 March	<u>103,135</u>	<u>98,891</u>	<u>94,724</u>	<u>85,667</u>
Made up of:				
Cash at commercial banks and in hand	11,421	21,367	3,010	8,143
Government Banking Service	91,714	77,524	91,714	77,524
Deposits with the National Loans Fund	0	0	0	0
Cash and cash equivalents as per the Statement of Financial Position	<u>103,135</u>	<u>98,891</u>	<u>94,724</u>	<u>85,667</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		TRUST	
	31 March	31 March	31 March	31 March
	2019	2018	2019	2018
	£000	£000	£000	£000
Current				
Receipts in advance	19,928	20,266	19,928	20,266
Other taxes payable	6	258	6	258
Accruals	45,016	46,956	45,016	46,956
Capital payables	2,205	5,022	2,205	5,022
Trade payables	18,143	9,717	18,143	9,717
Other payables	20,412	17,614	20,412	17,614
PDC dividend payable	0	0	0	0
Accrued interest on loans	0	45	0	45
NHS Charitable funds: Trade	8	71	0	0
Total trade and other payab	105,718	99,949	105,710	99,878
Of which payable to NHS and	2,845	4,217	2,845	4,217

The Group and NHS Foundation Trust have no non-current trade and other payables.

20. Other liabilities

GROUP and NHS FOUNDATION TRUST

	31 March	31 March
	2019	2,018
	£000	£000
Current		
Deferred income	9,195	7,687
Total other liabilities	9,195	7,687

NOTES TO THE ACCOUNTS (continued)

21. Borrowings

21.1 Total Borrowings

GROUP and NHS FOUNDATION TRUST

	31 March 2019 £000	31 March 2018 £000
Current		
Capital loans from DHSC	1,765	3,500
Obligations under PFI agreements	5,182	4,899
Total current borrowings	<u>6,947</u>	<u>8,399</u>
Non-current		
Capital loans from DHSC	0	1,750
Obligations under PFI agreements	228,907	234,371
Total non-current borrowings	<u>228,907</u>	<u>236,121</u>
Total borrowings	<u>235,854</u>	<u>244,520</u>

21.2 Loans

GROUP and NHS FOUNDATION TRUST

	31 March 2019 £000	31 March 2018 £000
Current	1,765	3,500
Non-current	0	1,750
Total loans	<u>1,765</u>	<u>5,250</u>

During 2009/10 the NHS Foundation Trust entered into a £28,000k loan agreement with the Department of Health and Social Care. 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. The final payment of the Loan is due in June 2019.

NOTES TO THE ACCOUNTS (continued)

21. Borrowings (continued)

21.3 Reconciliation of liabilities arising from financing activities - 2018-19

GROUP and NHS FOUNDATION TRUST

	31 March 2019 £000	31 March 2019 £000	31 March 2019 £000
	DHSC loans	PFI obligations	Total
Carrying value at 31 March 2018 brought forward	5,250	239,270	244,520
Impact of applying IFRS 9 as at 1 April 2018	45	0	45
Cash movements			
Financing cash flows - principal	(3,500)	(5,182)	(8,682)
Financing cash flows - interest (for liabilities measured at amortised cost)	(129)	(15,522)	(15,651)
Non-cash movements			
Application of effective interest rate (interest charge arising in year)	99	15,523	15,622
Carrying value at 31 March 2019	1,765	234,089	235,854

NOTES TO THE ACCOUNTS (continued)

21. Borrowings (continued)

21.4 Obligations under PFI arrangements

GROUP and NHS FOUNDATION TRUST

	31 March 2019 £000	31 March 2018 £000
Gross liabilities which are due:		
Not later than one year	20,317	20,422
Later than one year and not later than five years	81,277	82,570
Later than five years	353,637	372,957
Total gross liabilities	455,231	475,949
Finance charges allocated to future periods	(221,142)	(236,679)
Net obligations	234,089	239,270
Net PFI obligations which are due:		
Not later than one year	5,182	4,899
Later than one year and not later than five years	25,106	24,615
Later than five years	203,801	209,756
	234,089	239,270

21.5 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).

NOTES TO THE ACCOUNTS (continued)

21. Borrowings (continued)

21.5 PFI schemes (continued)

Transforming Newcastle Hospitals (TNH) PFI scheme:

Capitalised value to 31 March 2019	£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 2016/17.

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 was 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:

- a) The Unitary payment is adjusted each year for the effects of price changes by applying changes in the RPI to the whole Unitary Payment.
- b) 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.

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.

NOTES TO THE ACCOUNTS (continued)

21. Borrowings (continued)

21.5 PFI schemes (continued)

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.

21.6 Analysis of amounts payable to service concession operators

	31 March 2019 £000	31 March 2018 £000
Unitary payment payable to service concession operators	41,040	39,443
Consisting of:		
Service element	7,820	7,388
Repayment of finance lease liability	5,182	4,899
Interest charge	15,523	15,872
Contingent rent	10,009	8,874
Capital lifecycle costs- including prepayment element	2,506	2,410
Total amount paid to service concession operators	41,040	39,443

The NHS Foundation Trust made additional payments of £NIL (2017/18 £NIL) to the PFI operator during the year. The NHS Foundation Trust has recognised £Nil (2017/18 £Nil) PFI support income within the Statement of Comprehensive Income.

NOTES TO THE ACCOUNTS (continued)

21. Borrowings (continued)

21.7 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 2019 £000	31 March 2018 £000
Total future payments committed	<u>1,239,565</u>	<u>1,281,456</u>
Of which payments due:		
Not later than one year	41,878	40,906
Later than one year and not later than five years	175,596	175,084
Later than five years	<u>1,022,091</u>	<u>1,065,466</u>
	<u>1,239,565</u>	<u><u>1,281,456</u></u>

The amounts shown in the category 'Not later than one year' include an actual inflation rate charge of 2.5% (2017/18 4.0%). 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)

21.8 Asset financing component of PFI schemes

	Gross payments		Present value of payments	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Not later than one year	20,317	20,422	5,182	4,899
Later than one year and not later than five years	81,277	82,570	25,106	24,615
Later than five years	353,637	372,957	203,801	209,756
Sub-total	<u>455,231</u>	<u>475,949</u>	<u>234,089</u>	<u>239,270</u>
Less: finance cost attributable to future periods	(221,142)	(236,679)		
Total	<u>234,089</u>	<u>239,270</u>		

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 2018/19 £10,009k (2017/18 £8,874K) was expensed as a contingent finance cost .

21.9 Services component of PFI schemes

	Gross payments	
	31 March 2019 £000	31 March 2018 £000
Not later than one year	8,088	7,686
Later than one year and not later than five years	31,185	31,818
Later than five years	132,560	135,928
	<u>171,833</u>	<u>175,432</u>

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 £7,820k (2017/18 £7,388k).

The actual amounts paid vary to forecast due to inflation, contract variations and credits received for service failures.

NOTES TO THE ACCOUNTS (continued)

21. Borrowings (continued)

21.10 Lifecycle replacement component of PFI schemes

	Gross payments	
	31 March 2019 £000	31 March 2018 £000
Not later than one year	2,569	2,506
Later than one year and not later than five years	10,276	10,026
Later than five years	48,806	52,628
	61,651	65,160

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 2019 £000	31 March 2018 £000
Pensions - early departure costs	2,365	2,442
Legal claims - other	664	831
Other	929	3,686
Total	3,958	6,959
Analysed by:		
Current	1,706	1,281
Non-current	2,252	5,678
Total	3,958	6,959

	Pensions- early departure costs £000	Legal claims - other £000	Other £000	Total £000
Movement in year:				
#REF!	2,442	831	3,686	6,959
Change in the discount rate	(58)	0	0	(58)
Arising during the year	93	633	0	726
Utilised during the year - cash	(114)	(707)	(59)	(880)
Reversed unused	0	(93)	(2,698)	(2,791)
Unwinding of discount *	2	0	0	2
#REF!	2,365	664	929	3,958

Expected timing of cash flows

-not later than one year	113	664	929	1,706
-later than one year and not later than five years	2,252	0	0	2,252
-later than five years	0	0	0	0
Total	2,365	664	929	3,958

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.

NOTES TO THE ACCOUNTS (continued)

22. Provisions (continued)

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 amount in year arises as a result of the partial sale of the CAV site.

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 £435,176k (2017/18 £352,319k) 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	
	2018/19 £000	2017/18 £000	2018/19 £000	2017/18 £000
Total operating surplus/(deficit)	44,430	42,955	45,467	42,103
Depreciation and amortisation	18,902	19,756	18,879	19,734
Net impairments	4,446	(2,742)	4,446	(2,742)
Income recognised in relation to donated assets - cash	(115)	(209)	(500)	(457)
(Increase) / decrease in inventories	(2,484)	(35)	(2,484)	(35)
(Increase)/decrease in trade and other receivables	(5,764)	(17,727)	(6,065)	(17,376)
Increase in other assets	0	0	0	0
Increase in trade and other payables	8,694	635	8,694	635
Decrease in other liabilities	1,508	(278)	1,508	(278)
Decrease in provisions	(3,003)	(436)	(3,003)	(436)
Other movements in operating cash flows	269	2	269	2
NHS charitable funds: other movements in operating cash flows	0	4	0	0
NHS Charitable funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	(155)	73	0	0
Net cash generated from operating activities	66,728	41,998	67,211	41,150

24. Contractual Capital Commitments

Commitments under capital expenditure contracts as at 31 March 2019 amount to £16,109k (2017/18 £14,052k).

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 2019 £000	31 March 2018 £000
Gross and net value of contingent liabilities- other	(27)	(61)

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.

NOTES TO THE ACCOUNTS (continued)

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 Social Care (DHSC) and therefore the NHS Foundation Trust's parent department is the DHSC and 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.

27.3 Transactions with other 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 2019 or 31 March 2018. 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 2019 and 31 March 2018. Further details can be found in note 27.7. This table excludes balances with other whole of government entities.

	31 March 2019 £000 Payables	31 March 2019 £000 Receivables	31 March 2019 £000 Income	31 March 2019 £000 Expenditure
Non-consolidated subsidiaries and associates / joint ventures	3	837	1,005	949
Other bodies or persons outside of the whole of government accounting boundary	853	1,971	9,868	10,652
Total value of transactions with other related parties and balances as at 31 March	856	2,808	10,873	11,601

NOTES TO THE ACCOUNTS (continued)

27. Related Party Transactions (continued)

27.3 Transactions with other related parties (continued)

	31 March 2018 £000 Payables restated	31 March 2018 £000 Receivables restated	31 March 2018 £000 Income restated	31 March 2018 £000 Expenditure restated
Non-consolidated subsidiaries and associates / joint ventures	7	431	1,166	1,068
Other bodies or persons outside of the whole of government accounting boundary	818	2,025	7,085	9,839
Total value of transactions with other related parties and balances as at 31 March	825	2,456	8,251	10,907

To note, the above prior year balances for the period to 31st March 2018 have been restated to exclude bodies previously included who were part of the whole government accounts boundary.

27.4 Significant transactions and balances with other NHS and whole of 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 2019 £000 Payables	31 March 2019 £000 Receivables	31 March 2019 £000 Income	31 March 2019 £000 Expenditure
NHS England	11	27,515	451,410	69
NHS Newcastle Gateshead CCG	853	10,923	259,834	(338)
NHS North Tyneside CCG	27	1,358	65,444	(210)
NHS Northumberland CCG	295	0	63,509	(453)
Health Education England	0	424	56,581	2
DOHSC (excluding PDC)	0	248	35,100	0
NHS North Durham CCG	0	147	15,908	(83)
NHS South Tyneside CCG	0	7	14,002	(137)
NHS North Cumbria CCG	0	689	12,719	18
NHS Sunderland CCG	0	69	11,099	0
NHS Pension Scheme (Employer's contributions)	7,916	0	0	55,720
HM Revenues and Customs (excluding VAT)	6	0	0	45,149

NOTES TO THE ACCOUNTS (continued)

27. Related Party Transactions (continued)

27.4 Significant transactions and balances with other NHS and whole of government bodies (continued)

	31 March 2018 £000 Payables	31 March 2018 £000 Receivables	31 March 2018 £000 Income	31 March 2018 £000 Expenditure
NHS England	93	21,587	423,489	38
NHS Newcastle Gateshead CCG	49	9,442	254,837	12
NHS North Tyneside CCG	0	2,194	64,691	194
NHS Northumberland CCG	0	473	64,234	95
Health Education England	0	219	55,944	5
DOHSC (excluding PDC)	0	120	26,396	7
NHS North Durham CCG	0	404	15,680	37
NHS South Tyneside CCG	0	1,127	14,300	33
NHS North Cumbria CCG	0	119	12,177	0
NHS Sunderland CCG	0	149	11,115	0
NHS Pension Scheme (Employer's contributions)	429	0	0	53,796
HM Revenues and Customs (excluding VAT)	258	0	0	43,410

None of the receivable or payable balances are secured. Amounts are usually due within 30 days and will be settled in cash.

NOTES TO THE ACCOUNTS (continued)

27. Related Party Transactions (continued)

27.5 Commitments at 31 March 2019

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 2018/19.

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.

27.7 Directors

Mrs H A Parker resigned as a non-executive director during the year. Mrs H A Parker is a former partner of and currently a consultant to Sintons LLP solicitors. During the year the NHS Foundation Trust engaged Sintons LLP to provide legal advice in relation to specific projects. The legal services were provided on commercial terms and amounted to expenditure of £284k (2017/18 £282k) and a year end payable balance of £2k (2017/18 £40k).

A non-executive director, Mr E Weir is the Director for People for Newcastle City Council. During the year the NHS Foundation Trust had the following transactions with Newcastle City Council. Income of £9,380k (2017/18 £10,853k) relating to genitourinary medical services and the joint community loan equipment store and expenditure of £1,355k (2017/18 £15,003k). The year end receivable balance was £433k (2017/18 £114k) and payable balance was £49k (2017/18 £41k).

The NHS Foundation Trust's Chairman, Professor Sir J Burn holds the post of Senior Strategic Advisor with Newcastle University and Professor D Burn holds the post of Pro -Vice chancellor, Faculty of Medical Sciences. Transactions with the University were both financial and non financial relating principally to income received of £6,125k (2017/18 £6,634k) and expenditure of £10,999k (2017/18 £9,577k) in relation to staff who work across both organisations. The year end receivable balance was £982k (2017/18 £1,990k) and payable balance was £807k (2017/18 £575k).

The following senior managers of the NHS Foundation Trust were directors of Freeman Clinics Limited during the year, Mr D Reynolds, Mrs K Simpson - appointed 18 May 2018 and Mrs T Creighton - appointed 18 May 2018. Freeman Clinics limited ceased trading on 1 October 2018 and entered into a members voluntary liquidation. Transactions to the date the company ceased trading were income of £635k (2017/18 £889k) and expenditure of £258k (2017/18 £372k). Year end balances were £784k (2017/18 £343k) receivable and £Nil (2017/18 £ Nil) payable. All transactions were undertaken on a commercial basis.

The NHS Foundation Trust's finance director Mrs A Dragone and senior manager Dr M J Wright were directors of Newgene Limited during the year. Transactions during the year were income of £370k (2017/18 £277k) and expenditure of £694k (2017/18 £695k). Year end balances were £53k (2017/18 £89k) receivable and £3k (2017/18 £7k) payable. All transactions were undertaken on a commercial basis.

The NHS Foundation Trust's former non-executive director Mrs H A Parker and Mr A Welch the NHS Foundation Trust's medical director were directors of Newcastle Healthcare Property Company Limited during the year. The company has not started trading.

The NHS Foundation Trust's chairman, Professor Sir John Burn, continues as a director of Pulse Diagnostics Limited alongside senior manager Dr A J Sims. The company is not currently trading.

27. Related Party Transactions (continued)

27.7 Directors (continued)

The NHS Foundation Trust's Chief Executive Dame Jackie Daniel and non-executive director Professor David Burn are directors of Academic Health Science Network North East and North Cumbria (AHSN NENC). 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 NENC, were income of £ 3,550k (2017/18 £233k) and expenditure of £34k (2017/18 £34k). Year end balances were £570k (2017/18 £6k) receivable and £24k (2017/18 £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 £51k (2017/18 £7k) and expenditure of £171k (2017/18 £122k). Year end balances were receivable £9k (2017/18 £1k) and payable £8k (2017/18 £1k).

The NHS Foundation Trust's Chief Executive Dame Jackie Daniel and non-executive director, Professor D Burn, are a Director and Board member respectively of Northern Health Science Alliance (NHSA). During the year the NHS Foundation Trust had transactions of £18k of expenditure with NHSA (2017/18 £18k). There were no outstanding balances at the Year end.

A non-executive director, Professor K McCourt is a Convenor of Fellows of Royal College of Nursing. During the year the NHS Foundation Trust had the following transaction with Royal College of Nursing, expenditure of £2k (2017/18 £2k). There were no outstanding balances at the Year end.

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.

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 which the NHS Foundation Trust has assessed which are detailed below:

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, 89% was held with the Government Banking Service and the remaining 11% with the NHS Foundation Trust's and Charity's bankers, HSBC, Barclays 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 current and prior year the NHS Foundation Trust placed no cash on deposit with the National Loans Fund.

An analysis of aged and impaired receivables is given in Note 16.2.

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 £208,948k (2017/18 £184,656k). There are no amounts held as collateral against these balances.

At 31 March 2019 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 2019 there are £Nil (2017/18 £Nil) financial assets that would otherwise be past due or impaired whose terms have been renegotiated.

28 Financial Instruments and Financial Risk Management (continued)

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 and Social Care with an outstanding balance at 31 March 2019 of £1,765k (balance at 31 March 2018 £5,250k). Further details can be found in Note 21. 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 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. Deposits held with HSBC attract interest at base rate less 0.05% currently 0.70%. Deposits with the Government banking service (RBS) currently attract interest at 0.64%. Any reduction in the base rate or interest rate would have an immaterial impact on cash flows 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 0.9%. The Newcastle upon Tyne Hospitals NHS Charity also holds a variable cash balance with HSBC which attracts an interest rate at 0.20%.

The cash previously held within a Charities' Deposit Fund account was amalgamated with the Newcastle upon Tyne Hospitals NHS Charity investment portfolio on 1st April 2018 and, therefore, no interest has been earned in 2018/19.

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 2%.

The NHS Foundation Trust has a loan agreement with the Department of Health and Social Care. 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

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

29.1 Carrying values of financial assets

	GROUP		NHS FOUNDATION TRUST	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Receivables (excluding non financial assets) - with NHS and DHSC bodies	45,180	45,945	45,180	45,945
Receivables (excluding non financial assets) - with other	30,993	14,448	31,556	14,448
Cash and cash equivalents	94,724	85,667	94,724	85,667
Charitable fund financial assets	40,913	38,596	0	0
Total	211,810	184,656	171,460	146,060

The Group and NHS Foundation Trust financial assets are held at amortised costs, with the exception of the Charitable Investments which are held at fair value through other comprehensive income.

NOTES TO THE ACCOUNTS (continued)

29. Financial Assets and Liabilities (continued)

29.2 Carrying values of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	GROUP		NHS FOUNDATION TRUST	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Other financial liabilities				
DHSC loans	1,765	5,250	1,765	5,250
Trade and other payables (excluding non financial liabilities) - with other bodies	62,604	73,933	62,604	73,933
Trade and other payables (excluding non financial	2,760	4,687	2,760	4,687
IAS 37 provisions which are financial liabilities	3,958	6,959	3,958	6,959
PFI finance lease obligations	234,089	239,270	234,089	239,270
NHS Charitable fund - financial liabilities	8	71	0	0
Total	305,184	330,170	305,176	330,099

All of the Group and NHS Foundation Trust other financial liabilities are carried at amortised cost. Fair value is not considered significantly different from book value.

Maturity of financial liabilities

In one year or less	74,026	88,371	74,018	88,371
In more than one year but not more than two years	6,119	7,489	6,119	7,489
In more than two years but not more than five years	19,437	22,661	19,437	22,661
In more than five years	205,602	211,649	205,602	211,578
Total	305,184	330,170	305,176	330,099

30 Application of new standards

30.1 Initial application of IFRS9 Financial Instruments

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the NHS Foundation Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £45k and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £0k.

30.2 Initial application of IFRS15 Revenue from Contracts with Customers

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

The adoption of this standard has had no impact on revenue reported by the NHS Foundation Trust.

NOTES TO THE ACCOUNTS (continued)

31. Third Party Assets

The NHS Foundation Trust held £2k (2017/18 £3k) 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.

32. Losses and Special Payments

There were 198 cases of losses and special payments totalling £842k during the year (2017/18 281 cases totalling £1,035k). No cases in the current year or prior year cost the NHS Foundation Trust £300k or more. Losses and special payments are accounted for on an accruals basis but excluding provisions for future losses. An analysis of losses and special payments by category is given in the table below.

Analysis of losses and special payments by category

Category	2018/19 Total number of cases No	2018/19 Total value of cases £000	2017/18 Total number of cases No	2017/18 Total value of cases £000
Losses				
Cash losses - theft and fraud	3	1	2	0
Cash losses - overpayment of salaries	26	41	21	3
Bad debts and claims abandoned in relation to :				
a. private patients	1	2	7	1
b. overseas visitors	21	85	17	143
c. other	17	30	84	339
Damage to buildings, property etc. (including stores losses) due to:				
a. theft, fraud etc.	0	0	0	0
b. stores losses	9	564	13	392
c. other	66	26	64	29
Total losses	143	749	208	907
Special payments				
Ex-gratia payments in respect of:				
a. loss of personal effects	27	7	39	15
b. personal injury with advice	9	80	13	97
c. other	19	6	20	8
d. maladministration, no financial loss	0	0	1	8
Total special payments	55	93	73	128
Total losses and special payments	198	842	281	1,035

33.1 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.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 for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS 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 scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period.

This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data at 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend the contribution rates payable by employees and employers. The latest published actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016.

The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

The NHS Foundation Trust estimates that its employer contributions into the scheme in 2019/20 will be £59,043k, which is based on the 14.3% contribution. The additional contributions from 14.3% to 20.6%, estimated to be £26,012k is expected to be paid directly by the Department of Health and Social Care on behalf of the NHS Foundation Trust during the financial year 2019/20.

33.2 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. Employers contributions by the NHS Foundation Trust for the year were £105k (2017/18 £43k).

NOTES TO THE ACCOUNTS (continued)

34. The Newcastle upon Tyne Hospitals NHS Charity

34.1 Funds

	31 March 2019 £000	31 March 2018 £000
Restricted	11,339	18,842
Unrestricted	29,517	19,956
	<u>40,856</u>	<u>38,798</u>

As at 31 March 2019 the total funds as disclosed in the Newcastle Upon Tyne Hospitals NHS Charity accounts amount to £35,069k. This balance has been adjusted for IFRS accounting policies and is disclosed in the group accounts as £40,856k. The adjustment to funds of £5,787k 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.

34.2 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.

