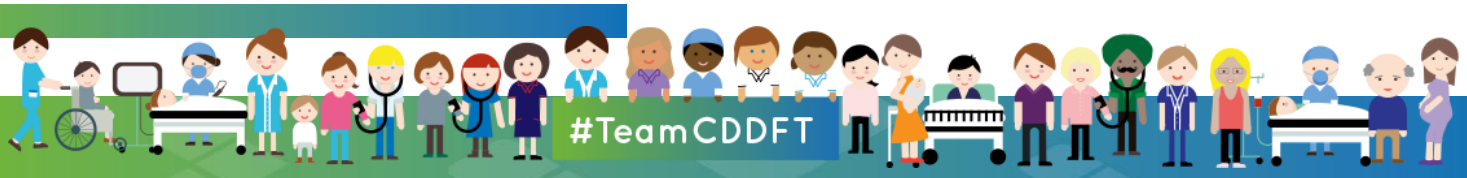
NHS
County Durham and Darlington
NHS Foundation Trust



County Durham and Darlington NHS Foundation Trust

Annual Report and Accounts

1 April 2019 – 31 March 2020

safe • compassionate • joined-up care

www.cddft.nhs.net

County Durham and Darlington NHS Foundation Trust

Annual Report and Accounts

1 April 2019– 31 March 2020

Presented to Parliament pursuant to Schedule 7, Paragraph 25 (4) (a) of the National Health Service Act 2006

Contents

1. INTRODUCTION

1.1 Chairman's Statement

It is my privilege to introduce the 2019/20 Annual Report for County Durham and Darlington NHS Foundation Trust. This past year has been my fifth year as Chairman and I have taken great pride in seeing the Trust becoming more successful as well as growing its reputation for delivering good quality care. I wish to immediately record my sincere thanks to all of our staff and volunteers for their remarkable commitment and compassion in advancing the standards of care, both in our hospitals and in the community.

There has, once again, been an increase in activity through the past financial year and in particular in relation to accident and emergency which, by and large, was similar to the national picture. In the midst of all this we had a Care Quality Commission (CQC) inspection and you will read later about the positive outcomes for our Trust, its staff, but more importantly our patients, who are at the centre of everything we do. This has been a real morale boost for all concerned and substantiated what we believed we were achieving through the implementation of our "Patient Matters" strategy.

The latter part of the year saw the unwelcome arrival of COVID-19 with the consequence that all our services had to be reviewed to provide the best care possible to patients who had contracted this highly infectious virus. The rapid expansion of our inpatient, ITU capacity and supporting capacity was nothing short of amazing but the superb response of our staff throughout the Trust was even more remarkable, as they adapted to new and changed roles rapidly to support the front-line response. As a Trust Board, we have always subscribed to collaborative and partnership working for the benefit of patients. That approach reaped its benefits during this situation resulting in a most supportive system wide strategy in dealing with the virus. Our staff were, and are, well supported during these difficult times in several ways and this is complemented by the resources we receive from NHS Charities Together which we were fortunate to join in 2019.

This report provides a very transparent account of the business of the Trust for the past financial year and you will observe that we realised most of our targets. There have been many new developments with regard to clinical services, innovation, research and staff development. We have continued to play a full part in the emerging Integrated Care System (ICS) as well as the two Integrated Care Partnerships (ICP's) which coexist across our boundaries. In an ever evolving NHS with increasing activity and sometimes rather unexpected crisis, there is always very much more to do. We are fortunate in that we have a unitary Board who respectively scrutinise and constructively criticise proposals and business cases and who seek robust assurance before approval. Our Lead Governor is invited to our Private and Confidential Board meetings as an observer, so that there is clear link with our Council of Governors. I wish to thank the Council for their support with the Trusts' success and achievements, as well as keeping us grounded on the issues of the day.

I do hope you take the opportunity to read this report so that you are aware of the many improvements we have made and will continue to make for our patients. The patient experience is the core of everything we do so feedback is very important to us. There are many ways you can communicate with us not least by attending our Open Board or Annual General Meeting (AGM).

Professor Paul Keane OBE
Chairman
24th June 2020

1.2 Chief Executive Officer's Review

It is with great pleasure that I am able to introduce you to the Trust's Annual Report for 2019/20 and take this opportunity to reflect on some of the many highlights and achievements seen across County Durham and Darlington during the year.

It is only fitting that I begin this introduction by recognising the outstanding progress that has been made and is set out in this document, helping us better support our patients and local populations by providing the safest, most compassionate and joined-up care. This has only been possible thanks to the tremendous commitment and dedication of our 7,000 strong workforce, alongside our volunteers, partners, Governors and our local communities.

This has been no ordinary year to report upon. On 30th January 2020, a national Level 4 major incident was declared as the NHS responded to the COVID-19 pandemic and we therefore spent the final quarter of the financial year 2019/20 in unprecedented territory.

Locally, in County Durham and Darlington, this saw the organisation move at pace to change services, first in preparation for the forecasted number of patients with COVID-19 and then transitioning to the management and treatment of those patients. #TeamCDDFT have been truly outstanding in all that they have done.

The response to, and impact of, COVID-19 will continue for many months to come. For us locally, and across the NHS nationally, the year ahead will largely focus on balancing our continued response to COVID-19 and resetting our services and the care we also need to provide for our non-COVID patients and our local communities.

However, at this point I would like to reflect on some of our achievements and successes during the year, in response to the challenges the Trust faced during 2019/20 prior to the pandemic and which are reported within this document.

The Trust's strategy 'Our Patients Matter', continues to drive how we manage our business and ultimately the care and experience we are delivering to patients each and every day and night, as we strive to fulfil our mission of providing the safest, most compassionate and joined up care.

It is underpinned by a number of key plans and knitted together by our four 'bests' – best experience, best outcomes, best efficiency and best employer - as we work to realise our vision of delivering care which is 'right first time, every time'.

2019/20 saw the Trust achieve a 'Good' overall rating from the CQC for the first time, with end of life services being rated 'outstanding'. We were also one of the most improved Trust's nationally in the NHS Staff Survey.

The CQC visited the Trust's two main hospital sites, University Hospital of North Durham and Darlington Memorial Hospital between 2nd and 4th July and carried out an assessment of end of life care, urgent and emergency care and surgery. The inspection highlighted the Trust's delivery of high quality patient services, with a clear commitment to continuous improvement.

We were extremely pleased to receive this rating which recognised the tremendous effort and commitment of our workforce in continually driving through improvements in services for our patients and local populations.

The CQC also commented positively on the Trust's engagement work and collaboration with partners across the health system. The theme of integration and partnership working is central to the NHS Long Term Plan. During 2019/20 the Trust continued to work closely with local commissioners and local authority partners to provide joined-up care and services for local populations, while also playing a role in the establishment of the ICS for Cumbria and the North East region.

There have many highlights to reflect upon in 2019/20 and just some of these are included within this report. The Trust continues to perform well in terms of supporting and leading research projects, and embracing technology and innovative approaches to improving the delivery of care. This includes the development of a tele-skin service, which enables GPs to send referrals of patients with suspected skin cancer alongside photographs, enabling consultant dermatologists to make a rapid diagnosis. Approximately 13% of patients have received almost immediate re-assurance that their condition can be managed by the GP, with consultant guidance; and a further 9% have been re-assured they do not have cancer and can wait to be seen in a routine clinic appointment. This service has been short-listed for an Innovation Award by the Health Service Journal. The Trust, working with HealthCall Solutions Ltd. – a joint venture between North East NHS Foundation Trusts and the private sector - also launched a new digital platform to support the management and care of residents in our local care homes, which is helping to reduce hospital admissions.

The Trust was delighted to receive a Bronze Employer Recognition Award for its commitment to the armed forces. In November 2019, the Trust demonstrated its commitment by signing the Armed Forces Covenant in partnership with Darlington Borough Council. It has also joined the "Step into Health" programme, which helps members of the armed forces make the transition to civilian employment from the armed forces, and has applied for a Silver Employer Recognition Award.

This focus on improvement and innovation was further demonstrated through the response to the Trust's quality improvement plan with a bespoke training programme being designed and delivered to over 400 colleagues. The Improvement Matters Programme supports staff with the tools, techniques, training and support needed to deliver quality improvements and for this to become embedded across the organisation.

CDDFT plays an important role in the local economy and community; employing more than 7,000 staff across a wide range of careers and bringing families and business to the area. We are fortunate to have an excellent Council of Governors drawn from our communities as well as our staff and more than 11,000 members who have a say in how we operate.

In addition to this we have hundreds of volunteers supporting our services in many different ways, including directly helping with patient care. We are grateful as well for the support we receive from the 'Friends' groups at a number of our hospitals and the County Durham and Darlington NHS Foundation Trust Charity.

We have been truly humbled by the continued support we receive through our Charity and the generosity and kindness which has been magnified during our response to COVID-19. We are indebted to all of our supporters. We could not manage our Trust without them, our committed and loyal workforce and our partners across the health and social care system

I would, therefore, like to take this opportunity to thank all #TeamCDDFT colleagues, partners and stakeholders for their commitment and support as we continue to work together on delivering our vision; 'Right First Time, Every Time'.

Sue Jacques
Chief Executive
24th June 2020

1.3 Highlights of the Year 2019/20

We are proud to share just some of the many highlights for the Trust during 2019/20, ranging from being rated 'Good' by the CQC to continuing to expand our use of technology across services for the benefit of our patients. Our focus on being a research-led organisation and providing opportunities for our staff to learn, innovate and lead change, helps to ensure we're the best employer to our 7,000 staff.

Rated 'Good' by the CQC
A team of inspectors visited our two main hospital sites, University Hospital of North Durham and Darlington Memorial Hospital in July 2019, carrying out an assessment of end of life care, urgent and emergency care and surgery services. We were delighted that the inspectors' final report gave us a rating of 'Good', highlighting many areas of excellent and outstanding practice; indeed, our end of life services were rated 'Outstanding'. In particular, the report praises the compassion and kindness staff show to our patients and the way in which patients' privacy and dignity is respected and their individual needs are taken into account. This result recognises the hard work, and dedication of our teams in continually driving through improvements in services for our patients and local populations.

Virtual fracture clinic
We've redesigned the way we run the fracture clinic at Darlington Memorial Hospital, improving our patients' experience and helping our specialist team focus on more serious fractures and patients with more complex needs.

Modern diagnostic tools such as Magnetic Resonance Imaging (MRI) scans, and the skills of the emergency department team, mean the majority of fractures no longer need to be 'checked' by an orthopaedic specialist. Many patients can now be given written information and a number to ring with any concerns. Their medical records and test results are reviewed by a team of specialists – 'the virtual clinic' - which decides what, if any, action to take, following which the patients are updated by phone. This virtual fracture clinic happens every day (apart from Christmas Day) meaning patients are reviewed within 24 hours of their attendance in the emergency department. Any concerns lead to a follow up appointment being offered and patients are asked to get in touch if their fracture does not heal as expected.

There's been no change to the management of patients requiring surgery, or those who are admitted. Patient feedback is excellent as the majority can begin their recovery at home rather than having to make an unnecessary visit to a busy fracture clinic.

New UHND paediatric assessment area
Coming to hospital can be particularly daunting for children, so, in order to give children referred to hospital by their GP the smoothest patient journey, we opened our new Paediatric Assessment Area at University Hospital of North Durham in September 2019. Open between 10.00am and 10.00pm, seven days a week, the unit team works alongside the Emergency Department, to ensure children are assessed as soon as possible in an area designed specifically for them.

Digital care home

We were one of the first Trusts to recognise the potential benefits of digital technology, combining the advantages of a digital platform, HealthCall, with the clinical expertise of our medical and other health specialists. Digital technology means we can offer more effective and convenient care, transforming the experience of many patients.

The latest ambitious project using HealthCall is 'The Digital Care Home', a joint initiative between the Trust, the local authorities of County Durham and Darlington, our local Clinical Commissioning Groups and HealthCall Solutions Ltd. This initiative focuses on monitoring care home residents to enable early identification of even small signs of deterioration, so intervention can be earlier and hospital visits or admissions avoided where possible. It can sometimes be difficult to tell when an elderly care home resident is starting to become unwell as there may be no obvious signs and they may not always be able to communicate how they are feeling. Care home staff are trained to take basic but vital patient observations, such as blood pressure, pulse, oxygen saturations, temperature and respiratory rates. They then use the technology we've given them to report the results electronically so they can be reviewed by the local nursing team for possible further action.

A pilot saw emergency hospital admissions drop by between 20-30%. The Digital Care Home is now being rolled out to all care homes across County Durham and Darlington.

Delivering excellence in radiology

During 2019, we agreed a ground breaking £43 million, 14 year contract with Philips Electronics UK Ltd to ensure that nearly 100 pieces of the Trust's radiology equipment are replaced regularly and then well-maintained, so that our patients can benefit from some of the latest technology in the region.

The contract has already seen the installation of a new MRI scanner at University Hospital of North Durham, in a purpose built department, similar to one constructed in Darlington in 2018. A new computerised tomography (CT) scanner has also been installed at Bishop Auckland Hospital with plans in place for a new scanner at Darlington Memorial Hospital and two new CT scanners at University Hospital of North Durham.

Through our contract with Philips, we're also creating nine fully automated digital x-ray rooms which will enable us to perform a wider range of x-rays more expediently, enabling us to see more patients and to access imaging of a consistent quality. This advanced technology produces digital x-rays, which are easily accessible to anyone involved in the patient's care.

Each year we perform 187,000 x-rays and 16,000 MRIs, with equipment used round the clock, so maintaining that equipment is vital to keep it in tip top condition. The contract includes having an engineer constantly available so any concerns can be addressed quickly.

A research-led organisation

Through the hard work of our research teams and their close collaboration with clinical teams across specialties, we've developed a national and even international reputation for being a committed and reliable partner for organisations leading trials. Over a 12 month period we were involved in an impressive 95 clinical trials, across 25 specialties including: cancer, cardiology, critical care, dermatology, ENT, diabetes, gastro intestinal, hepatology, obstetrics and gynaecology, paediatrics, respiratory and stroke services. We recruited over 2,000 patients to take part. Trials can involve new medications, pathways and investigations such as scans. Being involved in trials gives our patients access to the very latest in medical advancements and also ensures colleagues are at the forefront of developing techniques for delivering the very best care.

During the year the Trust joined forces with neighbouring trusts at North and South Tees to form the Durham and Tees Valley Research Alliance, a ground-breaking arrangement which shares resources in order to maximise the range and scope of the research we are collectively able to carry out.

Improved discharge lounge facilities for patients

Patients at University Hospital of North Durham, who are ready to leave hospital, are now being directed to a newly enhanced discharge lounge, where they can wait for medication, transport and make other last-minute arrangements before going home.

The discharge lounge, located on the ground floor of the hospital, has been extended and improved, offering a much better experience for patients. There is a lot of evidence that if people stay in hospital longer than they need to, it can have a negative impact on their outcome. We know that people recover better and more quickly at home or in their usual place of residence. Improvements to our discharge lounges have allowed us to offer a better experience for patients on the final part of their journey home.

#100Faces

Our #100Faces campaign was launched as part of NHS Equality, Diversity and Human Rights Week and encouraged staff to contribute around 100 words about an aspect of their identity, life story or experience in celebration of the diversity of #TeamCDDFT. This might relate to their faith, nationality, family status, sex, race, gender expression, disability, age, class or sexual orientation.

NHS rainbow badges

In October 2019, the Trust joined a national initiative, NHS Rainbow Badges, which aims to make a positive difference by promoting a message of inclusion for LGBT+ colleagues and patients accessing our services. The Rainbow Badge initiative is a way for NHS staff to demonstrate that they are aware of the issues that LGBT+ people can face when accessing or working in healthcare.

The badge itself is intended to be a simple visual symbol identifying its wearer as someone who an LGBT+ person can feel comfortable talking to about issues relating to sexuality or gender identity. It shows that the wearer is there to listen without judgment and who can signpost to further support if needed. Over 300 members of staff have signed up for the initiative so far.

Armed Forces Covenant

Demonstrating our commitment to support the Armed Forces community, we signed an Armed Forces Covenant in November 2019, in a joint ceremony with Darlington Borough Council which reaffirmed its commitment to the Covenant. The Covenant is an acknowledgement of the valuable contribution that serving personnel, both regular and reservists, veterans, and military families make to public services and the wider community.

A number of our staff have been members of the Armed Forces, or are reservists, combining their role with us and serving their country, using their medical and nursing skills during deployments to areas including Iraq, Afghanistan and Sierra Leone during the Ebola crisis, caring for members of our forces and civilians.

Memorial sculpture in honour of organ donation

In November 2019 a memorial was unveiled at Darlington Memorial Hospital to honour the 32 members of the local community who, at that time, had donated organs at the hospital since 2010. As a result of their most precious gifts, over 100 people have had their lives either saved or transformed.

A stone memorial with brass hearts was placed in the sensory garden in the hospital grounds and was unveiled during a dedication ceremony. The memorial records the name of each donor in recognition of their generosity and the courage of their families to see through their loved ones' wish. The intention is that the names of future donors will be added. The sculpture was funded through the Trust's Charity and was commissioned from local craftsmen. There are plans to develop a similar memorial at University Hospital of North Durham.

Conferences
Our programme of conferences has become an annual fixture, providing opportunities for shared learning, celebrating achievements and engagement. In May 2019 we held our International Day of the Midwife and International Nurses Day Conferences. In June 2019 we held our annual "Leading a Highly Reliable Organisation" Conference which focuses on quality improvement and innovation. Each of these conferences saw well over 100 delegates benefit from presentations from speakers who are leaders in their field, together with "marketplace" events to showcase good practice and innovation.

In May 2019 we also held our second Palliative Care Symposium; 'Let's talk about it; Are we ready?' with external delegates as well as many from the Trust coming together to share, shape and develop end of life care locally.

2019 also saw new conferences added to the list: our first Allied Health Professionals Day; a Safeguarding Conference and an Innovation Day.

Recognition and awards
A number of our talented individuals, teams and services won, or were shortlisted for, awards during 2019, including:

- The development of the MRI facility at Darlington which was 'Highly Commended' in the National Patient Experience Awards;
- Dr Hannah Whinn, Consultant Anaesthetist, who was named Acute Pain Consultant of the Year at the National Acute Pain Symposium;
- Rikki Siddle from our finance team, who was named national Future Focused Finance 'Team Player';
- Our newly qualified nurse recruitment team which was shortlisted for a Nursing Times Workforce Award;
- Our use of the Nervecentre patient observations and tracking system, which was also shortlisted for a Nursing Times Workforce Award in the 'Best use of technology to improve the working environment' category;

- Durham Hospitals Radio, which was shortlisted in six categories, winning three, in the Hospital Broadcasting Association National Awards;
- One of our Adult Community Services “Teams Around Patients” who were finalists in the national 2020 Student Nursing Times Awards;
- Out of 120 trusts nationally who submitted their costing assessment tool, CDDFT ranked number one; and
- At the regional Bright Ideas in Health Awards, Business Development Manager Ian Dove, was named Innovation Champion and our Cardiac Arrest Reduction strategy came second in the “Demonstrating an Impact Upon Patient Safety” category.

2. GOVERNANCE

2.1. Trust Board of Directors

The Trust's Board of Directors ('the Board') is responsible for exercising all of the powers of the Trust and is the body that sets its strategic direction, allocates its resources and monitors its performance.

The Board is made up of six Non-Executive Directors, including a Non-Executive Chairman, and five Executive Directors including the Chief Executive. The Chairman and Non-Executive Directors are appointed by the Nominations Committee of the Council of Governors for varying terms not exceeding three years. All of the Non-Executive Directors identified in Table 1 on pages 13-15 were assessed as independent, or reassessed as such on reappointment, and in the opinion of the Council of Governors remain so. The Executive Directors are appointed by the Nominations Committee of the Board on permanent contracts. The appointments of Non-Executive Directors are for fixed terms and may be terminated for a number of reasons specified within their terms and conditions. Principal reasons include: failure to maintain compliance with the criteria for appointment and / or the Board's Standing Orders; unsatisfactory performance or attendance; and failure to retain the Council of Governors' confidence.

The Board has established a framework of regulation and control for the Trust's business which includes the Trust's Constitution, Standing Orders, a Scheme of Decisions Reserved to the Board and a Scheme of Delegation. The Board sets the strategic aims of the Trust, taking account of the Governors' and members' views; approves annual plans and budgets; and monitors performance across the whole range of Trust business. The Board delegates the relevant statutory functions to its Audit, Nominations and Remuneration Committees and has established further committees charged with ratifying management policies and seeking assurance on quality, delivery and risk management. Management functions and financial powers are delegated to Executive Directors in line with their portfolios, within the limits imposed by the Scheme of Delegation, Standing Orders and Standing Financial Instructions.

The Board has an annual schedule of business which ensures that it focuses on its responsibilities and the long term strategic direction of the Trust. It meets every month to conduct its business and there is a Board Development Programme comprising seminars and training events throughout the year.

The following persons served as Board members for County Durham and Darlington NHS Foundation Trust during the year April 2019 to March 2020. Table 1 overleaf includes details of each Board member's professional background, committee membership and attendance. The Board remains confident that it has a sufficiently balanced and complete range of skills appropriate to the leadership of a Foundation Trust, an assessment supported by the findings of the well-led inspection completed in August 2019 by CQC.

2.1.1 Board Membership

Table 1: The Board of Directors 2019/20

Name and Position	Background	Trust Board, Joint Board & CoG, and AGM*1	Audit Committee*1	Nominations & Remuneration Committees*1	Council of Governors**2
Prof Paul Keane OBE Trust Chairman Appointed 1st March 2015 until 28th February 2018. Re-appointed 1st March 2018 until 28th February 2021.	Qualified and registered nurse. Successful career initially in the NHS and then as the Dean of the School of Health and Social Care at Teesside University. An Appointed Governor of the Trust from 2007 until appointed as the Trust's Chairman.	21/21		4/4	4/4
Mr Michael Bretherick Non-Executive Director and Vice Chair Appointed 1st June 2016 to 31st May 2019. Re-appointed 1st June 2019 to 31st May 2022	Experienced Non-Executive Director, having served on the Board of North Tees and Hartlepool NHS Foundation Trust and with Tees Valley Housing. Former Principal and Chief Executive of Hartlepool College of Further Education. Serves on the Boards of two local charities and as a Director of a local primary school.	20/21	7/7	4/4	2/4
Mrs Jennifer Flynn MBE Non-Executive Director and Senior Independent Director Appointed 1st October 2014 until 30th September 2017. Re-appointed 1st October 2017 until 30th September 2020.	Qualified solicitor. Former Non-Executive Director on the Board of Durham Dales Primary Care Trust (PCT) and County Durham PCT previously. Member of the Joint Audit Committee for the Office of the Police and Crime Commissioner and Durham Constabulary. Awarded an MBE for services to her community of Tow Law in 2001 and in 2005 was appointed a Deputy Lieutenant for County Durham.	19/21		4/4	2/4
Mr Paul Forster-Jones Non-Executive Director Appointed 1st June 2016 to 31st May 2019. Re-appointed 1st June 2019 to 31st May 2022	Management Consultant with experience in performance, turnarounds, re-engineering, contract negotiation and supply chain. Has held a variety of Board roles for blue chip companies, gaining extensive experience in the Pharmaceuticals sector, and has held Non-Executive (including Chairman) positions with several third sector organisations. Interim Chairman of the Trust's wholly owned subsidiary, Synchronicity Care Ltd.	18/21		3/4	3/4

Name and Position	Background	Trust Board, Joint Board & CoG, and AGM*1	Audit Committee*1	Nominations & Remuneration Committees*1	Council of Governors**2
Mr Simon Gerry Non-Executive Director Appointed 1st June 2017 to 31st May 2020 Reappointed 1st June 2020 to 31st May 2023.	Chief Executive of a national charity. Previous roles in the Ministry of Defence covering resource management, estates, governance and human resources. Formerly the Trust's Lead Governor until his appointment as a Non-Executive Director.	19/21	7/7	4/4	4/4
Mr Steve Crosland Non-Executive Director Appointed 1st June 2018 to 31st May 2021	Owner and Director of a HR Consultancy firm. Extensive experience at Director level in the utility and aviation sectors focusing on HR strategy, governance and commercial delivery. Previous roles in economic regeneration in the public sector. Non-Executive Director of Port of Tyne and Trustee of a major leisure service provider. Non-Executive Director of the Trust's wholly owned subsidiary, Synchronicity Care Ltd.	19/21	7/7	4/4	3/4
Mrs Sue Jacques Chief Executive	Appointed as Chief Executive on 1st March 2012, having previously held the position of Deputy Chief Executive and Chief Operating Officer at the Trust. A Director of Finance for more than 10 years before that and holds an MA in Financial Management.	21/21			4/4
Mr David Brown Executive Director of Finance	Fellow of the Association of Chartered Certified Accountants and NHS finance professional, with many years' experience in senior finance roles in a range of Trusts and commissioning organisations	21/21			3/4
Mr Jeremy Cundall Executive Medical Director	Consultant Surgeon for the Trust since 2008 and Care Group Director for Surgery from August 2014 to 31st January 2017. Trained at St George's Hospital Medical School in London, graduating in 1995 and then completed a thesis at Hull before completing his higher surgical training in the North East.	19/22			4/4

Name and Position	Background	Trust Board, Joint Board & CoG, and AGM*1	Audit Committee*1	Nominations & Remuneration Committees*1	Council of Governors**2
Mr Noel Scanlon Executive Nursing Director	Registered nurse for over 30 years, including 10 years' experience of Executive roles within the NHS.	20/21			4/4
Ms Carole Langrick Executive Director of Operations	Former Director of Strategic Development and a former Chief Executive. Extensive health service career commencing as a nurse and encompassing a variety of clinical, managerial and leadership roles in hospital and community services, as well as working in commissioning and Strategic Health Authorities areas.	18/21			1/4

**Note 1: Information recorded = number of attendances at meetings / number of meetings required to attend*

***Note 2: Board attendance at Council of Governors meetings is not compulsory; board members attend by invitation to specific meetings or otherwise on attend on a voluntary basis.*

2.1.2 Audit Committee

The Audit Committee comprises three Non-Executive Directors. During 2019/20, the Committee was chaired by Mr Simon Gerry. Mr Michael Bretherick and Mr Steve Crosland also served on the Audit Committee during the year. The Committee met on seven occasions during the year with the Executive Director of Finance, the Senior Associate Director of Assurance and Compliance and both the Trust's internal and external auditors in attendance. Members' attendance is shown in Table 1 above.

The Audit Committee completed an annual programme of work, as agreed with the Board and in line with its terms of reference, to: seek assurance in respect of the Trust's risk management, control and governance systems; monitor the effectiveness of both internal and external audit services; review the Trust's accounting policies and financial statements; seek assurance on anti-fraud controls; and examine the extent to which controls ensure efficiency, effectiveness and economy in the use of resources.

The table below summarises the key elements of the Committee's work during the year and in respect of the 2019/20 financial statements:

Table 2: Key elements of the Audit Committee's work

Financial statements	The Audit Committee received a detailed briefing on the accounts from the Associate Director of Finance (Financial Services) which enabled them to review significant judgments made in areas such as asset valuations, credit risks, provisions and deferred income. The Committee reviewed the conclusions of the external auditors in respect of the risks identified in their external audit plan and satisfied themselves of the reasonableness of the Trust's approach and accounting judgments. In particular, the Committee considered the extent to which judgments made in preparing the accounts were balanced and were pleased to note the external auditors' views that judgments made reflected a generally balanced approach.
Operations	The Committee agreed a wide ranging programme of Internal Audit work covering all aspects of the Trust's operations, supplemented by reports on the assurance framework and key risks from the Senior Associate Director of Assurance and Compliance. The Committee oversaw the delivery of internal audit plans by the Internal Auditors. Significant matters identified by the auditors are summarised in the Annual Governance Statement on page 96 of this report. The Audit Committee reviewed the adequacy of the management response, including meeting with relevant Executive Directors where it considered necessary, and sought evidence that remedial actions were implemented in respect of weaknesses highlighted. The Committee reviewed the conclusions of the external auditor with respect to the Trust's value for money arrangements. The Committee further reviewed and assured itself with respect to management's response to the external auditor's findings.
Compliance	The Committee received and scrutinised reports from the Senior Associate Director of Assurance and Compliance at regular intervals during the year, which included reporting on regulatory compliance with the Foundation Trust Code of Compliance and Standards of Conduct. These reports supplemented information included in the Board Assurance Framework. The Committee also monitored on-going work to develop a more detailed compliance assurance framework, and to update the Trust's arrangements to manage conflicts of interest in line with national policy.

The Trust's external auditor is Mazars LLP, appointed in 2019/20 for an initial period of 3 years, dependant on annual reappointment. The external auditor appointment was subject to a tender process, overseen by the Council of Governors' Audit and Governance sub-committee. The appointment panel, which comprised members of both Committees and the Director of Finance, assured themselves of the suitability of the appointment by evaluating the competence of the bidding audit firms, their independence and objectivity, and the way in which they proposed to work with the Council of Governors. The appointment panel's recommendation was to appoint Mazars LLP as the Trust's external auditor and this was agreed by the Council of Governors' Audit and Governance Sub Committee on 4 September 2019 and by the full Council on 11th September 2019.

Mazars LLP provided non-audit services to the Trust during the year with respect to the audit of the Quality Accounts, up until the point at which the Government withdrew the requirement for external assurance in support of the National response to the Covid-19 pandemic. The Trust paid £3,500 to Mazars LLP for work undertaken to that date.

Internal audit services to the Trust were provided in the year through 'Audit One': an NHS consortium, hosted by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust. Audit One completed the majority of their annual plan of work, agreed with the Trust Board Audit Committee, covering financial, operational, governance and related systems based on an annual risk assessment. A small number of audits could not be completed due to the Covid-19 pandemic response; however, the Head of Internal Audit concluded that this did not impact on the sufficiency of the evidence available to enable him to provide an annual opinion to the Trust.

2.1.3 Charitable Funds Committee

The Trust is the Corporate Trustee of the County Durham and Darlington NHS Foundation Trust Charity and Related Charities which is comprised of over 100 individual charitable funds. The Board, as corporate trustee, delegates oversight of the management and use of charitable funds to the Charitable Funds Committee. During 2019/20, the Committee was chaired by Mrs Jenny Flynn MBE who was joined on the Committee by the Trust Chairman, the Director of Finance, a representative from the Council of Governors and a representative of the individual charitable fund managers.

The Charity is concerned with enhancing the care and improving the facilities for patients and staff across both acute and community sectors in County Durham and Darlington. That includes the Trust's main hospitals in Durham, Darlington and Bishop Auckland, and a wide range of community hospitals and health centres. In addition, healthcare is increasingly being delivered within the homes of patients and within nursing homes.

During 2019/20, income from voluntary sources (Appeals, donations, fundraising events and legacies) was £284k and income from investments was £90k (unaudited figures).

During the year the Committee approved a range of patient-focused projects such as:

- £193,000 for the provision of high quality technology and equipment to set up brand new multi-disciplinary team video conferencing facilities at two of our Hospital sites. This investment has helped maximise staff time and resource, minimise unnecessary travel and enhance connectivity between CDDFT Trust sites. The facilities are used extensively to support clinical decision-making for patients with cancer.

- £50,000 on Sherlock Tip Confirmation Systems for guidance and positioning of peripherally inserted central catheters. This minimally invasive technology helps reduce risk of infection and enhances the patient experience.

- £10,000 to refurbish the mortuary viewing rooms at UHND. This refurbishment has helped create more ambient surroundings for families grieving the loss of a loved one.

- £10,000 on stimulation and biofeedback machines for the continence service. This investment enables immediate treatment and reduces patient waiting times.

- £7,000 for the implementation of the "Smokefree" campaign. This campaign helped to communicate to patients and staff, that Trust sites are "Smokefree" zones.

- £17,000 to purchase 24 iPads to improve the quality audit processes in Adult Community Services by enabling the process to be performed with more efficiently, and quality improvements to be identified and acted on promptly.

- £70,000 on 11 Bladders Scanners for CDDFT Community Services to support the clinical services that are offered to patients in the Community.

- £1,000 for a diabetes training day for staff. The training provided staff with the opportunity to listen, network, share information and gain training competencies in the relevant areas.

In total, the individual charitable funds have invested £579k in developments and equipment to enhance services, facilities and amenities for our patients during the financial year.

Towards the end of March 2020, the Charity Team were extremely busy dealing with public positivity generated by the COVID-19 pandemic. Financial donations from the public have increased and the Charity

has also benefitted, as members, from grants via NHS Charities Together (previously the Association of NHS Charities). There has also been surge in donations in kind from local businesses, groups, associations, schools, colleges and universities. These gifts have benefitted both staff and patients during unprecedented times.

Numerous fundraising activities and events have needed to be cancelled or postponed due to Covid 19 so the additional support received from our communities has been invaluable to our charity.

2.1.4 Nominations and Remuneration Committees

The Board has a Nominations Committee in place to oversee the appointment of Executive Directors and a Remuneration Committee in place to oversee Executive Directors' pay. In practice the two Committees have common membership and meet as one Committee.

During the year, the Board's Nominations and Remuneration Committees agreed the objectives and performance measures for all of the Executive Directors, together with their remuneration.

The Council of Governors has established a separate Nominations Committee to oversee the appointment of the Chairman and Non-Executive Directors and a Remuneration Committee to oversee their remuneration. These two Committees also share a common membership and meet, in practice, as one Committee. Recommendations are taken to the full Council of Governors for ratification. Meetings are chaired by the Trust Chairman, except where the subject matter concerns his own appointment or remuneration.

During the year, the Governors' Nominations and Remuneration Committee endorsed the reappointment for Simon Gerry as a Non-Executive Director, for a further three years. The Committee also agreed recommendations from a review of the remuneration policy for Non-Executive Directors. It also nominated Committee members to support the Chairman in completing the appraisals of the Chairman and Non-Executive Directors and agreed the process for appraisals.

Further information on attendance and the work of the Remuneration Committees can be found within the Remuneration Report on pages 66 to 74.

2.1.5. Directors' Register of Interests

A register is maintained of the interests of Directors in companies or related parties that are likely to do, or may seek to do, business with the Trust. This register is available on our website **www.cddft.nhs.uk** for inspection by the public, or by arrangement with the Trust Secretary. Contact details for the Trust Secretary are outlined in the section "How to find out more" on page 186 of this report.

2.2 Council of Governors

The Council of Governors is comprised of thirty-nine seats representing the Trust's public and staff constituencies and those stakeholder organisations which are entitled to appoint governors under the Trust's constitution.

The Council of Governors has a number of statutory duties, most importantly holding the Non-Executive Directors to account, individually and collectively for the performance of the Board, and representing the views of the Trust's members and stakeholders. Specific responsibilities include: the appointment and removal of the Chairman and Non-Executive Directors, the appointment of the Trust's auditor and the approval of changes to the constitution of the Trust. The Trust values the contribution of its Governors and the particular perspectives that they bring to the development of services. Consequently, the Governors are active in supporting the development of the Trust's strategies and its Annual Plan, providing views through their own Strategy and Planning Committee. Governors act as a conduit between the Trust, its members, members of the public and, in the case of Appointed Governors, the bodies they represent, by canvassing opinions and providing feedback at meetings of the Council of Governors and at sub-committees.

The Council of Governors has strong working links with the Board. Joint meetings between the Board and Governors are held at different times during the year and Board members attend relevant Council of Governors' meetings, committee meetings and participate in joint seminars. Similarly, elected governors are engaged in some Committees and working groups established by the Board. The Board considers that these

arrangements are an effective way to understand the views of the Council of Governors and maintain engagement with the Trust's members.

The Trust's nominated Lead Governor is Dr Richard Scothon, Public Governor for Durham City. Dr Scothon has been the Trust's nominated Lead Governor since 1st June 2017.

2.2.1 Council of Governors' Elections

Governors from the public and staff constituencies are elected to office for varying terms up to three years and may seek election for further terms up to a maximum of three. Elections were held in 8 constituencies during the year as shown in Table 3 below. A by-election was due to be commenced in March 2020 to attempt to fill current vacancies, comprising those where no nominations were previously received and a small number of other seats becoming vacant following resignations. This was stood down before voting could take place because of the Covid-19 pandemic; the vacant seats will be incorporated into the Annual 2020 Elections to be commenced in October. Two Governors were elected unopposed prior to the suspension of the election and they are due to be inducted shortly.

Table 3 - Elections to Council of Governors 2019/20

Constituency Type	Name of Constituency	No of candidates	No of Votes cast	Turnout	No of Eligible voters	Date of election
Public	Darlington	6	383	15.4%	2488	10/12/2019
Public	Derwentside	2	199	13.5%	1478	10/12/2019
Public	Durham City	1	n/a	n/a	n/a	10/12/2019
Public	Durham City	1	n/a	n/a	n/a	10/12/2019
Public	Tees Valley, Hambleton, Richmondshire	1	n/a	n/a	n/a	10/12/2019
Public	Wear Valley and Teesdale	1	n/a	n/a	n/a	10/12/2019
Staff	Community Based Staff	1	n/a	n/a	n/a	10/12/2019
Staff	AHP, Prof & Tech and Pharmacists	2	179	9.0%	1978	10/12/2019

During 2020/21 we plan to work with our CCGs, other system partners and local networks to seek to elicit nominations for seats where we have found it difficult to attract candidates in the current year.

2.2.2 Council of Governors' Membership

The overall makeup of the Council of Governors over the year, together with details of the appointments of individual governors and their attendance at council meetings is shown in Table 4.

Table 4 - Council of Governors Members 1st April 2018 to 31 March 2019

Governor	Appointment	Constituency	Meetings*[1] from 01 April 2019 to 31 March 2020
Public Governors			
Kathryn Featherstone	Elected: February 2015 Re-elected: 3 years from February 2018	Chester le Street	10/12
Dr Carmen Martin-Ruiz	Elected: February 2013 Re-elected: February 2016 Re-elected: 3 years from February 2019	Chester le Street	6/11
Kath Fawcett	Elected: 3 years from February 2018	Darlington	12/12
Borsha Sarker	*Elected: 3 years from February 2017* *Retired February 2020*	*Darlington*	*7/15*
Marian French	Elected: 3 years from February 2019	Darlington	15/19
Patricia Gordon	Elected: 2 years from February 2020	Darlington	0/1
David Lindsay	*Elected: 3 years from May 2017* *Retired: February 2020*	*Derwentside*	*4/13*
Ethel Armstrong	Elected: February 2016 Re-elected: February 2019	Derwentside	3/11
Iain Beange	Elected: 3 years from May 2018	Derwentside	10/15
Nancye Carr	Elected: 3 years from February 2020	Derwentside	2/3
Cliff Duff	*Elected: February 2016* *Re-elected: February 2019* *Resigned: October 2019*	*Durham City*	*0/5*
Carole Reeves	Elected: February 2015 Re-elected: 3 years from February 2018	Durham City	5/12
Dr Richard Scothon	Elected: February 2014 Re-elected: February 2017 Re-elected: 2 years from February 2020	Durham City	15/19

Governor	Appointment	Constituency	Meetings*[1] from 01 April 2019 to 31 March 2020
Mac Williams (JP)	Elected: 3 years from February 2020	Durham City	4/4
Chris Boyd	Elected: May 2017 Re-elected: 3 years from February 2019	Easington	9/15
Vacant	Vacant	Gateshead, South Tyneside, Sunderland	n/a
Frank White	Elected: 2 years from February 2020	Hambleton, Richmondshire and Tees Valley	*2/3*
Vacant	Vacant	Sedgefield	n/a
David Taylor	Elected: 3 years from February 2018	Sedgefield	10/16
Vacant	Vacant	Sedgefield	n/a
Alan Cartwright	Elected: February 2017 Re-elected: 3 years from February 2020	Wear Valley & Teesdale	16/19
Dr Ken Davison	Elected: Feb 2012 Re-elected: February 2015 Re-elected: February 2018 Re-elected: 2 years from February 2019	Wear Valley & Teesdale	10/17
Ian McArdle	Elected: 3 years from February 2019	Wear Valley & Teesdale	8/16
Staff Governors			
Neil Williams	Elected: February 2016 Re-elected: 3 years from February 2019	Administrative, Clerical and Managers	13/17
Joanne Ashton	*Elected: February 2019* *Resigned: September 2019*	*AHPs, Professional & Technical & Pharmacists*	*3/8*
Linu George	*Elected:2 years from February 2020*	*AHPs, Professional & Technical & Pharmacists*	*2/3*
Vacant	Vacant	Ancillary	n/a
Kevin Morley	*Elected: April 2016* *Re-elected: February 2017* *Retired February 2020*	*Community Based Staff*	*0/7*

Governor	Appointment	Constituency	Meetings*[1] from 01 April 2019 to 31 March 2020
Susan Hind	Elected: 3 years from February 2020	Community Based Staff	0/1
Vacant	Vacant	Community Based Staff	n/a
Vacant	Vacant	Medical	n/a
Bill Sloane	Elected: 3 years from February 2019	Nursing & Midwifery	*0/11*
Jason Joseph Grand	Elected: 2 years from February 2019	Nursing & Midwifery	*7/10*
Patricia Gordon	*Elected: June 2013* *Re-elected: February 2014* *Re-elected: February 2017* *Retired: February 2020*	*Nursing & Midwifery*	*7/16*
Vacant	Vacant	Nursing & Midwifery	n/a
Appointed Governors			
Cllr Joy Allen	Appointed: June 2015	Appointed by Durham County Council	2/13
Jennifer Boyle	Appointed: October 2015	Appointed by North East Ambulance Service NHS Trust	5/10
Mr Joseph Chandy	Appointed: September 2013	Appointed by the Clinical Commissioning Group – Durham Dales, Easington and Sedgefield	0/8
Cllr Andy Scott	*Appointed: June 2017* *Resigned: May 2019*	*Appointed by Darlington Borough Council*	*0/5*
Cllr Lorraine Tostevin	Appointed: June 2019	Appointed by Darlington Borough Council	3/5
Gordon Mitchell	Appointed: November 2016	Appointed by Universities for the North East	5/10
Dr Boleslaw Posmyk	Appointed: May 2018	Appointed by the Clinical Commissioning Group - Darlington	3/7
Dr David Robertson	*Appointed: November 2016* *Resigned: June 2019*	*Appointed by the County Durham Local Medical Committee* – following a trial the Council of Governors agreed to retire the seat in favour of a	*0/4*

Governor	Appointment	Constituency	Meetings*[1] from 01 April 2019 to 31 March 2020
		second Healthwatch appointment (see below).	
Levi Buckley	*Appointed: August 2018 Resigned: October 2019*	*Appointed by Tees, Esk and Wear Valleys NHS FT*	*3/6*
Vacant	Vacant	Tees, Esk and Wear Valleys NHS FT	n/a
Dr David Smart	Appointed: September 2014	Appointed by the Clinical Commissioning Group – North Durham	6/7
Shared Post: **Dr Robert Upshall** (1st May to 31st October each year)	Appointed: November 2017	Appointed by Healthwatch (Darlington)	9/14
Val Johnston (1st November to 30th April)	Appointed: January 2020	Appointed by Healthwatch (Darlington)	3/3
Shared Post: **Brian Jackson**	Appointed: July 2018	Appointed by Healthwatch (County Durham)	4/9
Chris Cunnington-Shore (providing absence cover)	Appointed: January 2020	Appointed by Healthwatch (County Durham)	1/2

**Note 1: Information recorded = number of attendances at meetings / number of meetings required to attend*

2.2.3 Council of Governors' Register of Interests

A register is maintained of the interests of Governors in companies or related parties that are likely to do, or may seek to do, business with the Trust. This register is available on our website **www.cddft.nhs.uk** for inspection by the public, or by arrangement with the Trust Secretary. Contact details for the Trust Secretary are outlined in the section "How to find out more" on page 186 of this report.

2.3 Membership

Our members play a vital role in representing the views of our public and patients and in reinforcing our public accountability. In recent years one of our key priorities has been to increase our membership engagement, alongside strengthening links between the Governors and the Board. Feedback from our Governors, as part of the Chairman's appraisal and the Council of Governors' self-assessment, has acknowledged improvements year on year, whist highlighting an on-going need for the Trust to support Governors to most effectively engage with members in their constituencies. The Trust has two membership groups; a public membership and a staff membership. Public membership is open to anyone over the age of 14 who resides within the geographic area served by the Trust. The public membership group is divided into the following nine public constituencies:

- Chester le Street;
- Durham City;
- Darlington;

- Derwentside;
- Easington;
- Gateshead, South Tyneside, Sunderland and beyond;
- Sedgefield;
- Tees Valley, Hambleton, Richmondshire and beyond; and
- Wear Valley and Teesdale.

Of the nine public constituencies above, six reflect local authority borough or ward boundaries and the remaining three reflect traditional links with our hospitals either through the provision of sub-regional services beyond our main catchment areas or because of ease of access.

At 31 March 2020, there were 11,305 members in the public constituency as shown in Table 5 below.

Table 5 - Public Constituency Membership 2019/20

Public Constituency Membership 2019/20	Number of Members
At year start (1st April 2019)	11,215
New Members	221
Members leaving	**131**
At year end (31st March 2020)	**11,305**

Members of Constituency Class	Number of Members	Percentage of Membership
Chester-le-Street	712	6%
Darlington	2,483	22%
Derwentside	1,479	13%
Durham City	1,883	17%
Easington	253	2%
Gateshead, South Tyneside, Sunderland & beyond	180	2%
Sedgefield	1,586	14%
Tees Valley, Hambleton & Richmondshire & beyond	367	3%
Wear Valley & Teesdale	2,362	21%
Grand Total	**11,305**	

Staff who are employed directly by the Trust and / or a wholly owned subsidiary organisation, on permanent contracts or who are employed on temporary or fixed term contracts for more than twelve months, have automatically become members, unless they inform the Trust that they do not wish to do so. In addition, staff working for Trust contractors such as our PFI partners may join a staff constituency after twelve months. Staff members are split into six constituencies which represent the major staff groups in the Trust, as follows:

- Administration, Clerical and Managers;
- AHPs, Professional and Technical & Pharmacists;
- Ancillary;
- Community Based Staff;
- Medical; and
- Nursing and Midwifery.

As at 31 March 2020, there were 5,933 members in the staff group.

The Trust's membership strategy envisages maintaining the public membership constituency but with a strong focus on engaging with the membership. The Trust considers the geographical spread of the membership to be broadly representative, as it reflects the major population centres and demand for the Trust's services.

Membership recruitment activities in 2019/20 included direct recruitment of members by hosting stands in public areas of the Trust such as the restaurants. Additionally, Trust officers attended open days and recruitment fairs at local Universities and Colleges which proved very successful. Other recruitment activities for the year comprised:

- Passive recruitment using TV screens in restaurants and Outpatients Departments, ensuring that there are stocks of membership forms available, banner headlines on the website home page and the Chairman's Twitter Account;
- Hospital open days including tours of some areas;
- Wide and varied distribution of membership application forms, via Governors, staff and third parties and;
- Governors' own recruitment efforts.

Opportunities for the Trust's Directors and Governors to meet the membership were provided through our Board and Council of Governors meetings, and AGM which are held in public. In addition and in keeping with our focus on increasing public engagement, the Trust Chairman and Chief Executive held a number of question and answer sessions at the end of the Hospital Open Days, to allow for the public and members to meet with them on an informal basis.

Members received the annual magazine ("Your Trust") informing them of the latest news and notifying them of events and meetings which they could attend. Public Members also received a personal invite from the Trust's Chairman to attend the Trust's AGM. The Trust runs an "information marketplace" event prior to its AGM, where specialist staff are on hand to provide members of the public with information about their specific service.

Despite seeking to engage members through the various forums and events noted above, attendance and engagement remains lower than the Council of Governors would wish. For 2020/21 Trust teams will support Governors in engaging members and the public appropriately and in accordance with Covid-19 guidance. Where possible and depending on Government guidance, the Trust will endeavour to attend events in each constituency when possible. We also plan to email articles to members, by constituency, introducing their Governors and seeking to prompt them to share their views on particular services, proposed changes or issues.

Members wishing to find out more about the Trust, or to provide views to their local governors, are invited to do so through the Foundation Trust Office. Contact details can be found in the section 'How to Find Out More' on page 186

2.4 Links between the Board, Governors and Members

The Trust has arrangements to ensure that the views of Governors and Members are effectively communicated to the Board, and in particular Non-Executive Directors. These arrangements include:

- Meetings at the Trust's sites with members. Key messages were fed back to the Board by the Chairman;
- Non-Executive Directors have attended Council of Governors meetings to explain their roles and listen to Governors' views;
- Non-Executive Directors are linked with relevant Governor sub-committees and attend two meetings for each linked sub-committee per year;
- Executive Directors are well represented at Council of Governors meetings and frequently take questions and listen to Governors views;
- Joint meetings are held between the Board and Governors, in which the views of Governors can be shared;

- The Chairman meets with the Chairs of the Council of Governors' Committees and the Lead Governor regularly, and makes himself available before Council meetings for informal contact with Governors. The Chairman feeds back key matters from these meetings to the Board;
- All Governors are encouraged to attend public meetings of the Board.
- Lead Governor can remain, as an observer, for any matters discussed in private.
- Governors are invited to provide feedback on the Chairman's progress against objectives as part of the annual appraisal process and two Governor representatives carry out the appraisal, alongside the Senior Independent Director; and
- For 2019/20 appraisals, Governors were asked to feedback on objectives and carry out the appraisal, alongside the Chairman, for Non-Executive Directors, using the same approach as for the Chairman's appraisal.
- Board members and Governors undertook a joint planning seminar to identify the key planning priorities for the Trust for 2020/21, in September 2019.

3 PERFORMANCE REPORT

3.1 Overview of Performance

This overview of performance is intended to provide a short summary with sufficient information to allow our members and the public to understand who we are, what we do, the key risks to the achievement of our objectives and how we have performed during 2019/20.

3.1.1 Chief Executive's Statement

In common with Trusts nationally, CDDFT experienced significant operational challenges in providing unscheduled care, access to elective treatment within 18 weeks of referral and in relation to some cancer standards. For example, from April 2019 to February 2020, Emergency Department (Type 1) attendances were 7.4% higher than during the same period in 2018-19. These pressures were in keeping with, but – to some extent – greater than trends seen nationally and impacted upon our performance which fell short of A&E four hour waiting times standard. Our regulators agreed a revised performance trajectory with us in recognition of these pressures whilst, together with our system partners, we developed and begun to implement a comprehensive plan to mitigate growth pressures, and improve patient flow and waiting times. Despite this, our Friends and Family scores for both A&E Departments remained above the national average.

Mid-March 2020 saw the COVID-19 virus begin to impact. Following national guidance, this necessitated a radical adjustment of Trust priorities. All other priorities had to give way to the need to ensure the Trust had sufficient capacity to provide care, including critical care, for COVID-19 patients whilst continuing to care safely for non-COVID patients with urgent conditions such as cancer. All routine out-patient and elective work was paused, however urgent and cancer referrals continued to be seen. Otherwise, where possible, face to face appointments were replaced by telephone or video consultations, or moved out to community sites. A cancer advice line for patients was put in place and GPs were encouraged to make maximum use of the Trust's advice and guidance services. Up to 270 beds were opened on our acute and community hospital sites. This was achieved by re-opening wards, reducing elective in-patient activity, and moving routine work onto the non-acute sites and into the private sector. Separate respiratory and non-respiratory areas were established in the emergency departments, Medical assessment units and base wards.

Financially, despite national challenges the CDDFT Group ended the year with a surplus of £11.5m, ahead of the control total we agreed with NHS Improvement by £0.2m.

Our Quality Strategy 'Quality Matters' which sets out our targets and priorities for safety, effectiveness and the patient's experience. As we reached the end of the period covered by our Quality Matters Strategy we fully achieved five of the 15 key objectives, and substantially achieved 8 others, allowing the majority of the remaining actions to be subsumed into business as usual activity. We want to go further with respect to urgent and emergency care, and elderly care, so that our services are as modern and responsive as possible. Further work in these areas remains a key priority, and will be integral to the refreshed Quality Matters Strategy for 2020/21 to 2022/23 which is currently in development.

We also saw real improvements in staff engagement during the year, evidenced by the NHS Staff Survey results, the findings of the CQC inspection and the current levels of morale and engagement among our workforce as we come out of the first phase of our own, and the national incident response to Covid-19.

Throughout the peak of the Covid-19 virus, the Trust has retained capacity to care for patients with the virus in inpatient areas and in our Intensive Treatment Units. We have been able to supply our staff with the right Personal Protective Equipment at all times and to support them through very challenging times at work and whilst some patients sadly died in our care, we have treated and discharged over 450 patients and over 800 have been treated in our A&E Departments and recovered at home.

I am enormously grateful for the tremendous contribution of all our staff and of those who volunteered to return from retirement, from primary care or elsewhere, to increase our resources and help us implement our plans. We have seen strong and highly visible senior and clinical leadership and a real sense of ownership, engagement, empowerment and teamwork among our staff. As we move into the next phase of the pandemic, in which we will need to care for those with the virus alongside resetting other services, this a tremendously positive outcome from a challenging time, and we intend to consolidate and build up these new ways of working and even stronger sense of #TeamCDDFT going forwards

Sue Jacques
Chief Executive
24th June 2020

3.1.2 Our, Purpose, Activities, Business Model and Strategy

County Durham and Darlington NHS Foundation Trust is one of the largest hospital and community healthcare providers in the NHS, serving a core population of approximately **600,000** people across County Durham and Darlington, together with patients and service users from further afield in North Yorkshire, the Tees Valley and South Tyneside.

We are also one of the largest employers in the County Durham area, with approximately **7,000** staff employed by the Trust and its wholly-owned subsidiary Synchronicity Care Ltd, across our hospital sites and in the community, delivering integrated hospital and community based health and wellbeing services for patients.

The Trust holds a provider licence from, and is regulated by, NHS Improvement. The quality of care provided by the Trust is regulated by the CQC.

The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England. Services provided by the Trust are commissioned, to meet the health needs of the local population, by the Clinical Commissioning Groups serving the County Durham and Darlington area with some specialist services being commissioned by NHS England (NHSE), and some public health services commissioned by the two local authorities in County Durham and Darlington. Services are funded by our commissioners, and were paid for – in 2019/20 – either on a block contract basis or in line with activity depending on the specific service and contract. The Trust seeks to retain annual surpluses to build up reserves for capital investment to maintain and upgrade the infrastructure to provide services, on an on-going basis.

Services provided include:

- **Acute and planned hospital services**: including emergency medicine and trauma, emergency surgery and also planned surgery, diagnostics, paediatric, maternity and outpatient services.
- **Community based services**: including adult and specialist services provided in the community, in the home and in health centres across the county.
- **Health and wellbeing services**: including health improvement support and advice, such as stop smoking, alcohol reduction, improving diet and taking exercise.

The Trust provides acute hospital services from:

- **Darlington Memorial Hospital (DMH)**
- **University Hospital of North Durham (UHND)**

The Trust also delivers a range of planned hospital services for patients across County Durham at **Bishop Auckland Hospital.** As part of the implementation of the Trust's Covid-19 pandemic response plan, further sub-acute inpatient medical wards have also been opened on this site to provide extra capacity. The Trust also provides outpatient, urgent care and diagnostic services for local people, together with **community services** in patients' homes, and in around 80 premises in the community, including community hospitals at:

- **Shotley Bridge;**
- **Chester-le-Street;**
- **Stanhope (Weardale Community Hospital);**
- **Sedgefield; and**
- **Barnard Castle (Richardson Hospital).**

Please see page 186 for details of how to find out more about County Durham and Darlington NHS Foundation Trust, or visit our website: www.cddft.nhs.uk

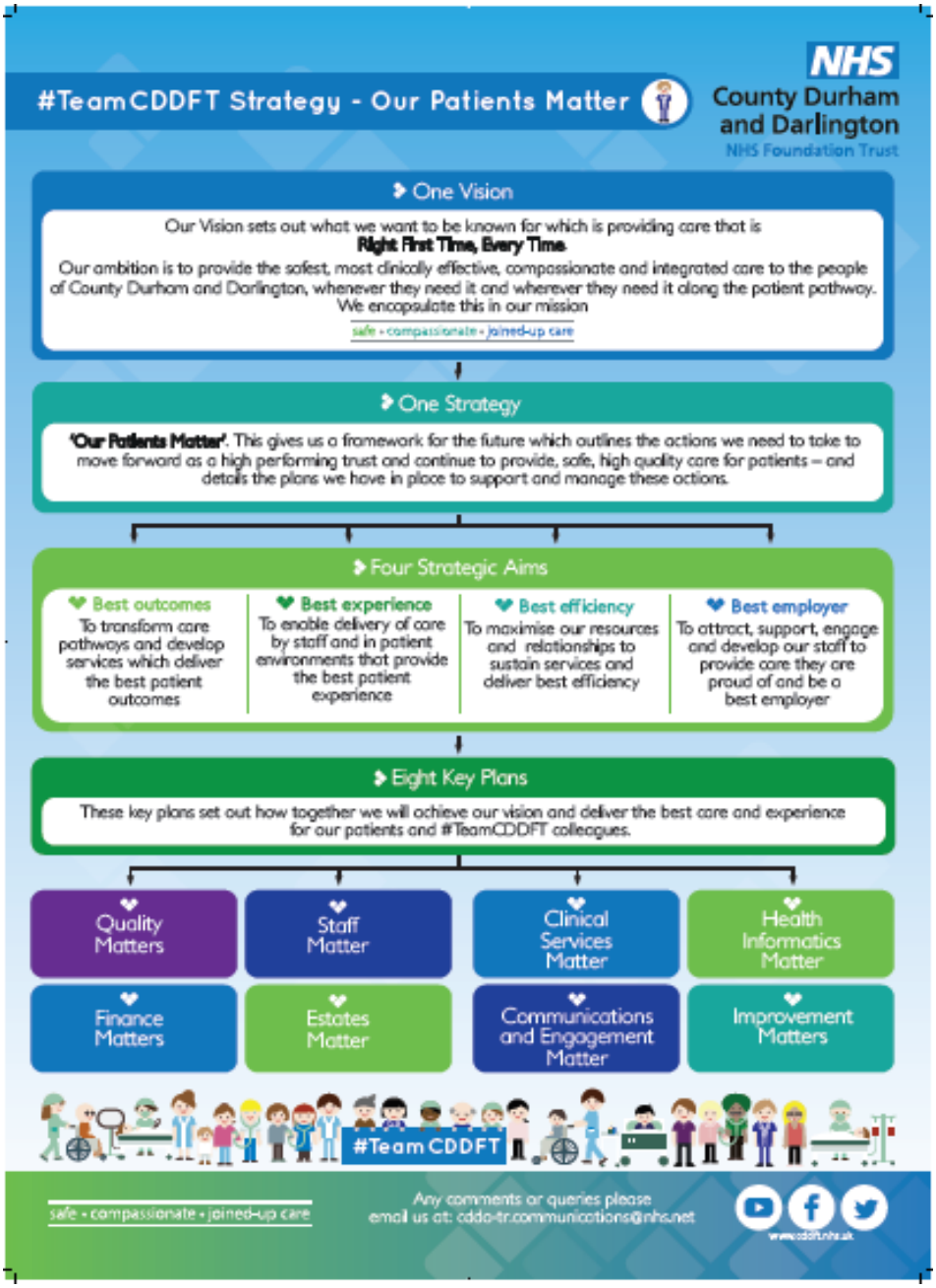
'Our Patient Matters' – Our strategy

The Trust's ambition is to provide:

- Services that are evidenced based, accessible, safe, sustainable and effective;
- Care that delivers improvements in health outcomes and reduces inequalities; and
- Patient pathways that are integrated across providers.

Our strategy 'Our Patients Matter' provides the framework through which we direct operations and developments, year on year, to achieve this ambition. The key components of the strategy are set out below.

Figure 1: Our Strategy



Our vision and goals

Our vision – "Right First Time, Every Time", has been agreed with staff. It summarises how we envisage services in the future: provided by the right professional, in the right place – in hospital or close to home – at the right time, first time, every time, 24 hours a day, where necessary.

Our mission - "safe, compassionate, joined up care" describes our commitment to put patients at the centre of everything we do in delivering the safest, most compassionate, joined up healthcare to our patients.

Underpinning the delivery of our Mission are our four 'touchstones', as follows:

- The **best health outcomes** for patients – we need to achieve the highest possible standards of care and improved results for patients;
- The **best patient experience** – because evidence shows that better outcomes are linked to a better experience;
- The **best efficiency** – reducing our costs so we can continue to invest for the future; and,
- Being a **best employer** – because high levels of staff motivation and satisfaction are closely related to better patient care.

Key plans

We have defined strategic aims under each touchstone and put in place key delivery plans covering:

- Clinical Services;
- Quality;
- Continuous improvement;
- Workforce; and
- Information.

All of these are now subject to review and re-definition alongside planning to restore services, and to embed beneficial changes made during the implementation of our Covid-19 response plan.

"Clinical Services Matter" sets out our priorities for sustaining and improving services, with a focus on urgent and emergency care; elective care and adult community services. It comprises local developments and developments with partners through:

- The County Durham Integration Board, which oversees the integration of adult community services;
- The Tees Valley ICP and the ICP for South Tyneside, Sunderland and County Durham;
- The North East and North Cumbria Integrated Care System; and
- A range of local working arrangements with our local authorities, commissioners and others.

"Quality Matters" and "Improvement Matters" set out our quality improvement priorities, tools and assurance mechanisms. Our strategic quality improvement priorities are under review to update them for the management of Covid-19 and the achievement of many of the strategic objectives set out in the previous strategy from April 2017 to March 2020.

"Staff Matter" sets out how we plan to attract, retain, engage, develop and support high calibre staff in all our clinical and support services.

The Trust's long-term information strategic plan focuses on the implementation and deployment of an electronic patient record system. The priority during the Covid-19 response period is, however, on sustaining legacy systems prior to the implementation of an EPR system from 2021/22.

Enabling plans are in place, setting out how we will deploy our estate and finances, and how we will communicate and engage with all stakeholders, to support the implementation of our core strategies noted above.

3.1.3 Our history

County Durham and Darlington NHS Foundation Trust was authorised as a Foundation Trust on 1st February 2007. In 2011, the Trust took on the community services formerly provided by County Durham and Darlington Community Health Services, with the aim of integrating care pathways requiring both community and hospital based care.

The Trust established a wholly owned subsidiary, Synchronicity Care Ltd (SCL), which commenced trading as County Durham & Darlington Services (CDD Services) on 1st April 2017. Through a managed healthcare

contract model CDD Services provides estates, facilities, procurement, materials and supply chain management, equipment maintenance and transport services to the Trust.

Whilst CDD Services' primary focus is the provision of efficient, effective and quality estates and facilities services to the Trust for the benefit of patient care, it operates as a separate legal entity, along commercial lines, with separate governance arrangements and the ability to employ its own staff and to deliver services to other organisations. The Company's operating model enables it to access the commercial benefits of a private company with the ethos and culture of a quality in-house service to maximise efficiencies and income generation opportunities.

3.1.4 Key risks to the achievement of our objectives

Our principal objectives and the risks to their achievement are summarised in **Table 6** below.

Table 6 – Objectives and risks

Our key objectives	The key risks which we manage to achieve them
• Provide services which are safe, clinically effective and responsive to the needs of patients and their carers, and in compliance with recognised and regulatory standards	• Increases in patient demand for non-elective services, requiring flexing of capacity (including workforce, buildings and equipment) to deliver services which meet our standards. At the present time, this includes maintaining capacity to flex our services to provide an effective response to Covid-19.
• Provide services which are caring and which provide patients with the best possible experience	• The potential for our safety culture and focus on patient care to suffer during times of pressure, requiring relentless focus on patients as our key priority.
• Acquire sufficient skilled staff delivering services which meet our standards	• Inability to attract sufficient skilled medical, nursing and other staff to deliver some specific services, requiring creative and innovative approaches to recruitment and retention.
• Engage, motivate and support staff in delivering high quality and caring patient services	• The potential loss of staff engagement required to deliver and continuously improve services, requiring a strong focus on involving our staff in improving services and tackling challenges as they arise.
• Acquire and maintain the physical capacity, equipment and facilities needed to deliver services which meet our standards in a positive patient environment	• Deterioration of equipment and the patient environment, with age, which must be monitored and addressed • The challenge of understanding the needs of different patient groups and adapting our patient environment to meet their needs
• Secure and maintain the financial resources required to invest in service sustainability and improvements, meeting financial targets agreed with our regulator	• Financial pressures impacting upon the achievement of in-year financial targets and the maintenance of reserves to fund investments in services and facilities.

Our key objectives	The key risks which we manage to achieve them
• Create and maintain excellent relationships with our stakeholders, recognising the need for collaborative working to implement the best services and achieve the best outcomes for patients	• The challenge of aligning different agendas as each commissioner or provider in the locality responds to its own pressures, and the complexity of working together in local and regional partnerships.
• Develop our IT systems to support clinicians in making effective clinical decisions and providing the best possible clinical care	• The need to maintain our IT estate and, alongside it, design and develop, with clinical leadership, systems which are capable of delivering our strategy and vision.

The above sets out a generic outline of the risks handled during 2019/20. The Trust has worked collaboratively: with neighbouring providers, with respect to clinical services and financial sustainability; with commissioners and local authorities in County Durham as part of an ICP, and through similar more informal arrangements in Darlington, and with all NHS bodies and local authorities as part of a wider ICS for Cumbria and the North East. It is expected that this work will result in greater clarity and certainty for long-term planning, and collective opportunities to manage risks for the benefit of all our patients, going forwards. Within this context the specific key risks managed by the Trust during the year were:

- ***Sustaining our safety and reliability:*** The Trust consolidated improvements made in 2018/19 with a further reduction in reported never events and improvements in the rate of reporting for low harm and near miss incidents. However, rates of hospital acquired infections were above thresholds and – despite an extensive programme of risk mitigation measures – there is more to do to minimise patient falls as far as possible. Key risk mitigation measures include ongoing education and training, in both infection control and in falls prevention and treatment and importing good practice from elsewhere where appropriate. Towards the end of 2019/20 the management of this risk included introducing robust measures to manage the transmission of Covid-19.
- ***Meeting the demand for emergency and unscheduled care:*** Despite system-wide initiatives to reduce demand, the Trust saw sustained increases in the complexity of patients attending its Accident and Emergency (A&E) Departments and an associated increase in non-elective admissions until March 2020, when demand reduced with the onset of the Covid-19 pandemic response plan. The actions to mitigate this risk are owned not only by the Trust, but across the local health economy. There is a comprehensive action plan, including short-term process improvements and medium and longer-term actions to improve capacity, overseen by the Local A&E Delivery Board.
- ***Managing waiting times for referral to treatment times:*** The Trust experienced significant pressures, relating to demand and capacity, which impacted upon its ability to meet the NHS Constitution target for 92% of patients to wait no longer than 18 weeks from referral to treatment. The particular pressures varied by specialty; however, the demand for beds for unscheduled care was a generic limiting factor. This reflected regional and national challenges. Recovery plans were in place, but would have taken some time to come to fruition in 2020/21 given demand pressures and staffing constraints. As we move into 2020/21, the need to maintain capacity for Covid-19 and to ensure robust management of the risk of infection in elective patients, including social distancing, will place further constraints on our ability to meet the waiting times target.
- ***Financial pressures:*** Achievement of financial targets and, in particular, implementation of the planned cost improvement programme proved challenging in the context of the increased demand for unscheduled care noted above. Commissioners were able to recognise the financial impact of demand pressures and to agree joint risk mitigation plans which allowed the Trust to meet its control total over the year.
- ***Workforce pressures:*** Regional and national shortages of staff for certain specialist services impacts on NHS Trusts generally and the Trust continues to be impacted in services such as Rheumatology, Dermatology and Radiology. Workforce strategies are in place for each service, including where appropriate international recruitment and other innovative developments such as home working, to secure and sustain sufficient numbers of staff. We are also working with neighbouring trusts in our integrated care partnerships on collaborative, network-based, pathways for some clinical services to maximise the benefit to patients from the workforce available across the locality. We have also rolled out our nursing workforce strategy, including “one stop shop” recruitment days and selective use of international recruitment.

- ***Estates and IT systems renewal in the context of financial pressures:*** One consequence of the financial pressures experienced by the Trust in 2019/20 and previous years has been the need for prioritisation of backlog estates works and replacement of IT systems and infrastructure. Decisions on priorities have continued to be made by Executive Directors on the basis of detailed risk assessments provided by specialist estates and IT capital sub-groups and arrangements put in place to maintain facilities and systems to ensure patient safety. Work continues to secure funding for the implementation of an electronic patient record system and a new Emergency Care Centre at UHND, which are essential to the Trust's longer term plans.
- ***Staff engagement:*** The Trust's prime asset is its staff. As such, Executive Directors and the Board have focused closely on engaging and supporting staff in the context of demand pressures and financial pressures noted above, as well as the potential uncertainties which can arise from change such as the new community services contract noted above, and work on clinical services taking place in the integrated care partnerships of which we are a member. A Workforce Experience Team is in place to co-ordinate the numerous engagement activities taking place, as part of a holistic programme of work endorsed by the Board. This paid dividends during the year, with clear improvements being demonstrated for 8 out of 9 engagement measures in the NHS Staff Survey, and no deterioration on the remaining measure. The rate of improvement in staff engagement was amongst the highest for all Trusts supported by our survey provider. Staff report that through Covid-19 engagement has strengthened further.
- ***Covid-19 Outbreak and Incident Response:*** In March 2020, the Trust stood up formal Incident Management arrangements in response to a forecast surge in Covid-19 cases and rapidly rolled out a plan to expand its bed base, workforce and ITU capacity, together with sourcing equipment and additional staff through national and local schemes. In line with national guidance routine elective services were scaled back to facilitate this response and resources redeployed. Urgent services were, however, maintained, wherever possible. New governance arrangements were deployed to support and wrap around the incident response, ensuring appropriate decision-making, risk management record-keeping and scrutiny whilst maintaining the pace of response required. Ultimately plans proved successful with the Trust maintaining sufficient capacity to manage the numbers of Covid-19 patients received and, at the time of writing we are now standing up urgent services and developing plans to reinstate routine elective and outpatient services on a phased basis.

During the year, the Board was updated in public session on the national expectations on Trusts related to the United Kingdom leaving the European Union. The Trust complied with all relevant national requirements. The Board reviewed the potential risks, and concluded that this was not a significant strategic risk for the organisation given the matters being dealt with directly by NHS central bodies and HM Government.

The risks outlined above are expected to persist, in large part, over the next 12 to 24 months, with the added challenge of managing our resources (staffing, estates and equipment) to deliver on all key objectives whilst living with Covid-19. These include:

- The need to maintain two streams (Covid-19 and non Covid-19) from the front of house, through to discharge, and retaining sufficient capacity in our emergency departments, acute medical units and wards to cope with surges in non-elective demand, from Covid-19 or other presentations.
- The need to maintain strict testing and infection control regimes to protect patients, including strict segregation of elective and non-elective areas.
- Restoring, as far as possible, all urgent services and routine operations and outpatient clinics.
- Utilising new approaches, such as remote consultations, where appropriate.

Routine outpatient and elective services can only be restored in a phased manner, given the additional calls on physical and staffing capacity to allow two streams of activity to be maintained, limitations on physical capacity resulting from social distancing and the need to manage capacity so that we maintain sufficient flexibility and agility to respond to surges in non-elective demand, directly or indirectly related to the impact of Covid-19. The Trust will need to balance out a range of risks to staff, patients and regulatory targets to achieve the optimum approach. Managing these complexities means that it is unlikely that routine elective treatments will be restored in line with the NHS waiting times standard in the near future, although it remains our ambition to do so

Key issues, opportunities and risks that could affect the Trust in delivering its objectives and/or its future success are captured in the above commentary. Key risks to the Trust's long-term sustainability relate to the absence of a long-term financial plan, both for the NHS nationally and regionally, at the present time, resulting in some uncertainty around the available funding for the long-term. There is also similar uncertainty with

respect to long-term workforce planning for the NHS, both nationally and regionally. The Trust has a good track record of working with system partners and commissioners to manage financial risk over the short and medium term horizon, and in continuing to strengthen its workforce whilst – as noted above – challenges remain in some services.

3.1.5 Going concern

The Group delivered a £24.2m Cost Improvement Program (CIP) for 2019/20 and achieved a surplus of £11.5m. The financial results were £0.2m ahead of the Control Total we agreed with NHS Improvement. Control Totals are set by NHS Improvement to measure Group financial performance and exclude items such as revaluations, impairments, gains/losses on disposal and donations. Given the implications of the COVID-19 pandemic NHSE/I announced revised arrangements in March 2020 for NHS contracting and payment to apply for part of the 2020/21 year. In May 2020 NHSE/I issued revised financial management guidance to CCGs for the corresponding period. Although NHSE/I are not yet able to definitively announce the contracting arrangements that will be in place for the rest of 2020/21 and beyond, it remains the case that the Government has issued a mandate to NHS England for the continued provision of services in England in 2020/21 and CCG allocations have been set for the remainder of 2020/21. While these allocations may be subject to minor revision as a result of the COVID-19 financial framework, the guidance has been clarified to inform CCGs that they will be provided with sufficient funding for the year. Providers can therefore continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned. While mechanisms for contracting and payment are not definitively in place, it is clear that NHS services will continue to be funded, and government funding is in place for this.

The Trust's wholly owned subsidiary, Synchronicity Care Ltd, delivered a surplus of £131k in 19-20. Given the revised NHS contracting arrangements the Trust has agreed a continuation of funding which is underpinned by a letter of guarantee.

After making enquiries, the directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future

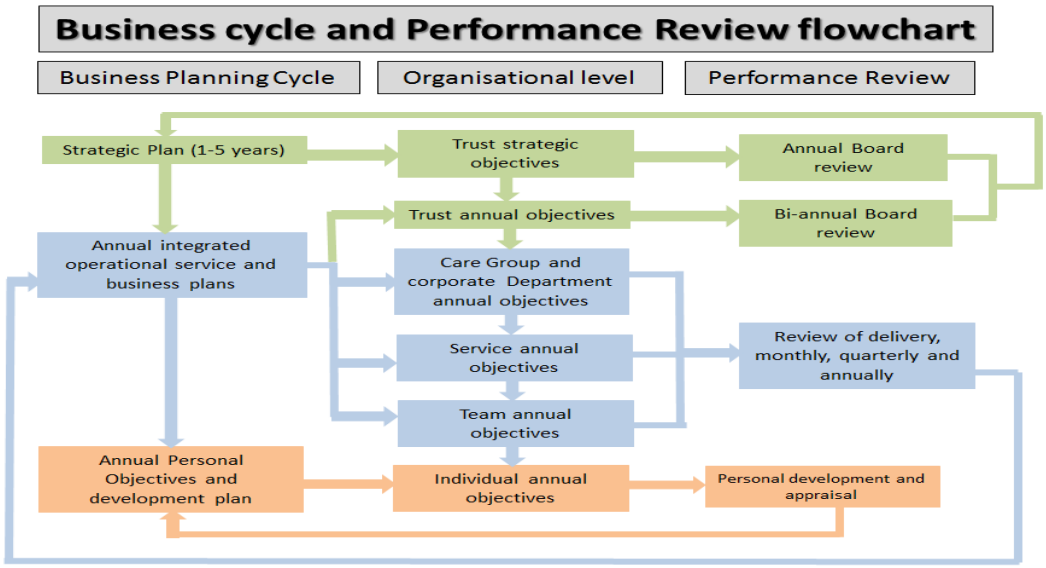
3.2 Performance Analysis

3.2.1 How we measure performance

Our performance management process is outlined in Figure 2 overleaf. Our strategic and annual plans drive the setting of annual objectives, which are cascaded to each of our Care Groups and corporate departments and to individual staff members. The annual objectives for the Trust combine objectives focused on change and improvement with core performance objectives; for example, quality and safety requirements, access targets and regulatory requirements.

Delivery against business plans and core performance objectives is monitored systematically, through monthly Integrated Performance Reports, which are scrutinised in detail by the Board's Integrated Quality and Assurance Committee, and provided to the full Board for assurance. These reports show current and forecast performance, and underlying trends, for all key performance indicators (outlined further below), with commentary and analysis on any areas where performance is particularly strong or off track. Each of our Care Groups owns a subset of core performance objectives, performance is reviewed by the Director of Performance – who is supported by the Heads of corporate monitoring functions every month. Commendations for strong performance, or issues requiring Executive-level support are escalated to bi-monthly meetings between the Executive Directors and the Care Group.

Figure 2: Integrated Performance Framework



Our "*Integrated Quality and Performance Report*" maps the key performance indicators of the Trust's four strategic touchstones *(Best Outcomes, Best Experience, Best Efficiency and Best Employer)* to the CQC's Key Lines of Enquiry Framework. We have chosen to report our Performance Analysis below, by outcome, to how we report to the Board.

Table 7: Trust Touchstones Mapped to CQC Lines of Enquiry and Relevant Section Below

Trust touchstones	CQC lines of enquiry	Sub-section
Best Outcome	**Safe**: harm-free care, infection control, incident reporting, mortality, falls, pressure ulcers, NICE, nurse staffing **Effective**: best practice, sepsis, dementia	3.2.2.2 Quality
Best Experience	**Caring**: admitted patients, ED, out-patients, maternity, discharges **Responsive**: patient access	3.2.2.1 Access
Best Efficiency	**Well led**: financial position and use of resources	3.2.2.3 Finance
Best Employer	**Well Led**: staff experience, learning, occupational health, recruitment and retention, sickness.	3.2.2.4 Workforce

This approach provides the Board with clear oversight of all aspects of the care provided by the Trust to ensure it aligns with standards set out in the NHS Constitution, contractual requirements with commissioners, and delivery of the Trust's Strategy.

Whilst we set targets and forecast trajectories for each key performance indicator, we are increasingly adopting good practice recommended by NHSE/I, by reporting not only current performance, but also on the underlying trend in performance over time. The aim is to understand the level of variation in our performance so that we can identify genuine underlying issues, rather than temporary and – with the benefit of a good understanding of our typical levels of variation – normal fluctuations. We can then focus on statistically significant trends to capitalise on factors driving good performance or to address underlying problems. We use a tool to identify statistically significant fluctuation known as a statistical process control chart (SPC). SPC charts use upper and lower process control limits as markers of normal variation around the mean average performance level. Trends occurring outside of these normal variation markers require investigation, as does any trend involving seven consecutive points above or below the mean average. Such trends point to changes in performance driven by what is known as 'special cause' variation and investigation focuses on the underlying cause. Applying this methodology allows us to flag all key performance measures with icons to indicate the level of variation and the extent to which we are assured of meeting our targets.

Figure 3: Variation and Assurance Indicators

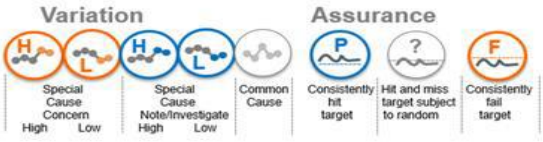
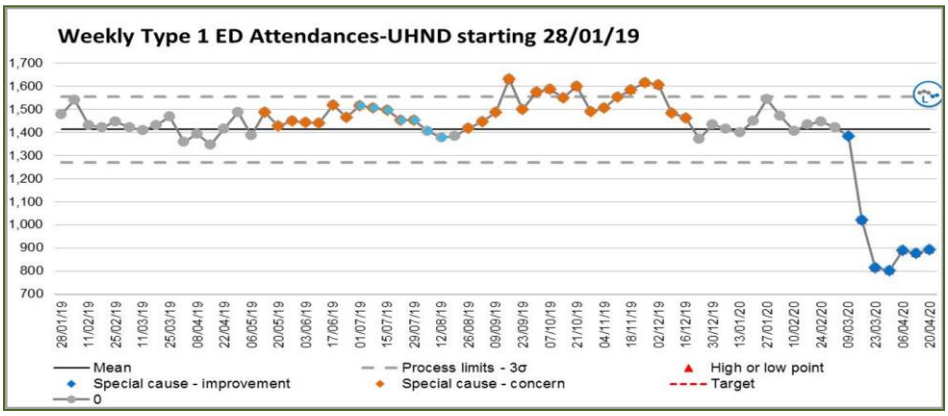


Figure 4 below is an example of an SPC chart showing special cause variation at different times of the year with respect to A&E attendances.

Figure 4: UHND Weekly Type 1 Attendances



The adjacent graph is an SPC chart showing the growth in A&E attendances at UHND over the course of the year caused by growth in demand, particularly between September and December 2019 and the COVID-related fall in March/April, both of which were special cause variations.

In order to manage COVID-19, some of our normal performance review processes have been temporarily stood down since March 2020, being replaced for the duration of the pandemic by:

- A daily Gold Command meeting, responsible for all strategic decision-making, led by the Chief Executive and including other Trust executives and directors.
- A daily operational "War Room", consisting of senior Care Group and corporate managers responsible for implementing plans agreed by Gold Command.

3.2.2 Detailed Performance Analysis

3.2.2.1 Operational Performance (Patient Access)

In line with national trends, for the year prior to mid-March when the impact of the COVID-19 virus began to be felt, the Trust's main operational challenges were:

- Unscheduled care pressures
- Access to elective treatment within 18 weeks of referral (RTT);
- Cancer service standards.

Table 8 below summarises our performance against the key access targets in the NHS Constitution to February 2020, prior to the standing up of our major incident management arrangements for Covid-19.

Table 8: Trust performance on the key NHS Constitution metrics.

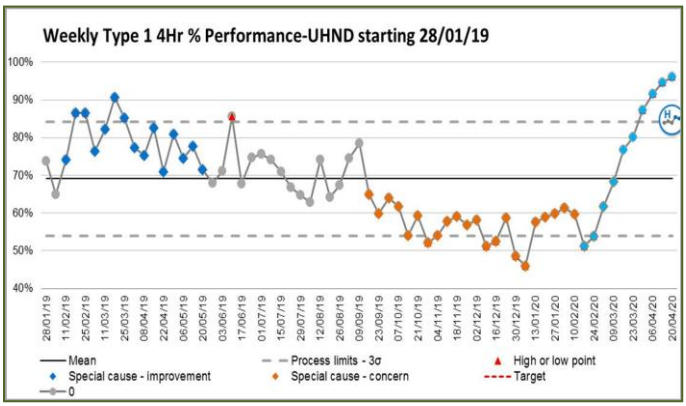
Performance Measure	RO	Last Period		This Period		Variation Indicator	Target Indicator	Target	Target Type
Referral To Treatment % Within 18wks	CL	Jan-20	87.28%	Feb-20	86.06%			92.00%	NHSI Traj
Referral To Treatment Total Incompletes	CL	Jan-20	23,943	Feb-20	24,132			20,357	NHSI Traj
A&E % Seen Within 4 Hours (Type 1 and 3)	CL	Jan-20	75.73%	Feb-20	78.61%			85.95%	NHSI Traj
A&E Attendances (Type 1 and 3)	CL	Jan-20	21,373	Feb-20	20,185			15,468	NHSI Traj
A&E % Seen Within 4 Hours (Inc All UCC)	CL	Jan-20	75.73%	Feb-20	78.61%			85.95%	NHSI Traj
Cancer 2WW to Treatment Within 62 Days	CL	Dec-19	84.83%	Jan-20	79.02%			85.00%	National
DM01 Diagnostics % Within 6 Weeks	CL	Jan-20	96.92%	Feb-20	99.20%			99.00%	National

Unscheduled Care/A&E

A&E activity continued to grow for most of the year. Between April 2019 and February 2020, the Trust's two A&E's experienced a 7.4% increase in attendances (9,148 additional patients), including a 3.6% (1,574 patients) rise in ambulance attendances. This put serious pressure on performance against the main national 4-hour wait and associated standards.

These trends were radically interrupted in March 2020 as the impact of COVID-19 began to be felt. A&E attendances in March 2020 declined by 25% compared to March 2019 (including a fall of 25% in ambulance attendances) as patients heeded warnings to stay at home and only come to A&E in emergency. By the end of March, the impact of COVID-19 had been such that the 4-hour wait performance had improved to 85.05% (since then performance has continued to improve and since mid-April 2020 has regularly exceeded the 95% target). Figures 5 and 6 below show the trend in our performance against the four hour waiting times standard. Table 9 shows month on month Trust-level performance compared to the NHS England average.

Figures 5 and 6: Weekly Type 1 4 hour A&E Attendances at UHND and DMH



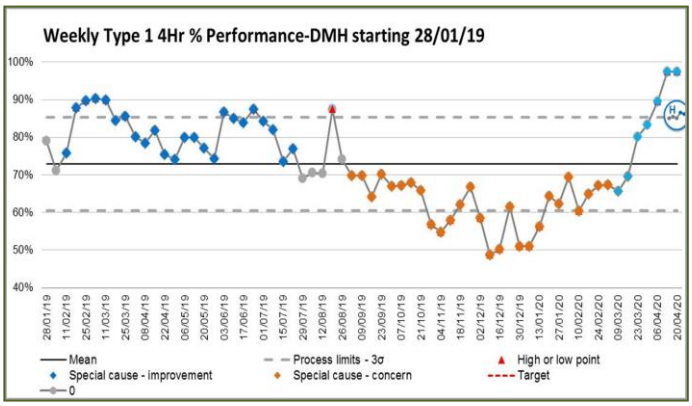


Table 9 - A&E 4-hour wait performance (target 95%)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CDDFT	85.6%	84.4%	86.4%	83.4%	81.3%	79.4%	74.9%	71.5%	70.6%	75.7%	78.6%	83.1%
England	85.1%	86.6%	86.4%	86.5%	86.3%	85.2%	83.6%	81.4%	79.8%	81.7%	82.8%	84.2%

The other important factor impacting on A&E performance was the rate of emergency admissions. For the first 11 months of the year, the rate remained high, putting pressure on performance, but reduced significantly in March, which – coupled with an expansion in COVID-19 related bed capacity – helped to maintain the flow of patients through our A&E Departments and Assessment Areas.

Adult emergency admissions through the first 11 months of the year, fell by 0.6% when compared to the previous year but the decline accelerated to 2.4% by the end of March. Also through the first 11 months of the year, adult bed occupancy typically exceeded the national recommended figure of 80% with non-elective medical patients having to be boarded onto surgical or other wards more or less daily. For example, at the

end of February, 91.79% of the core bed stock was occupied. By contrast, at the end of March, with non-elective admissions falling and increasing numbers of escalation beds opening to accommodate the expected COVID-19 surge, only 55.35% of beds were occupied, including 61.9% of Critical Care beds. Altogether, the Trust opened up to 270 additional beds across its acute and community hospital sites to mitigate COVID-19 risks. This has also had a positive impact on average length of stay. With fewer patients being admitted doctors were able to diagnose, treat and discharge them in a timely manner.

The trend over the whole of the year suggests that our A&E Departments function well but that there are constraints on patient flow at times of high occupancy. Our clinicians tell us that there has been an increase in the acuity of patients seen in our A&E departments over the last two years. Increasing numbers of patients with more complex needs, or requiring longer for diagnosis and / or stabilisation in the department have impacted on our waiting times performance in the first 11 months of the year. We have assurance from a number of audits, visits and third party reviews that our processes are in line with nationally-recommended good practice. Prior to the Covid-19 pandemic the Trust was working closely with its partners in the local system on a range of short, medium and long-term actions to enable patients to access urgent and emergency care in the right place, helping to ensure that – where this involves one of our acute hospitals – we are able to maintain patient flow. Work-streams include optimising our internal processes, working with primary care and community services on providing alternatives to hospital attendance where appropriate and creating capacity off our main acute sites for sub-acute care. Each of these themes will continue to be worked on going forwards; however, the specific actions will be influenced by learning from our response to Covid-19.

In addition to monitoring our performance against the waiting times standard, a second key performance indicator around unscheduled care relates to ambulance handover delays. Delays are deemed to occur when the North East Ambulance Service are unable to handover patients to the A&E Departments within 15 minutes. The growth in ambulance activity during the majority of the year resulted in increased handover delays. Further pressure resulted from the temporary closure of the A&E department at the Friarage, Northallerton, as this led to more patients from the North Yorkshire area needing to be conveyed by ambulance to DMH.

Ambulance handover delays followed the same trend as attendances. The table below shows the average number of minutes lost (over 15 minutes) by NEAS ambulance crews waiting to hand over patients to A&E staff. An improving trend was apparent before the advent of Covid-19, in large part due to the extended opening hours of the ambulance handover bays put in place on both sites as part of winter plans. This improvement was consolidated by Covid-19-related declines in activity in March.

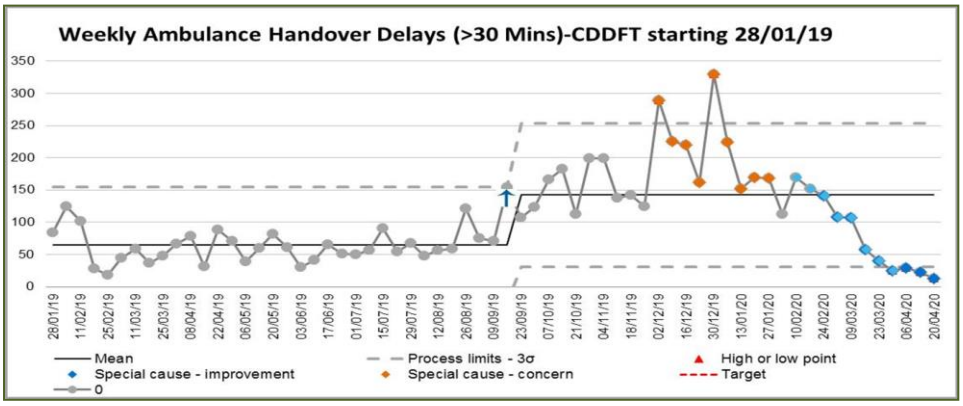
Table 10 - Average minutes per handover lost by NEAS crews over and above the 15 minute target.

2019 - 2020	December	January	February	March
DMH	14	17	7	5
UHND	13	12	11	6

Note: comparable figures are not available for YAS.

Figure 7 shows this improving trend with respect to handover delays over 30 minutes.

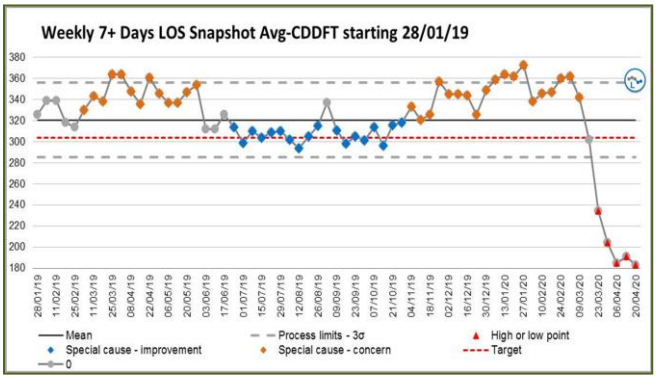
Figure 7 – Ambulance Handover Performance

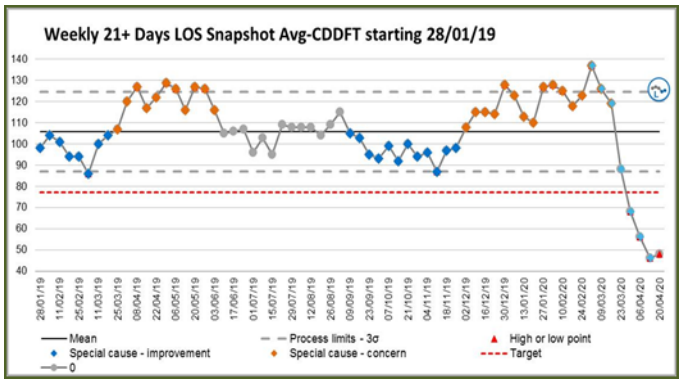


Length of Stay

Figures 8 and 9 show the trend in patients remaining in hospital for more than 7 and 21 days respectively. Again, there is a clear change following the onset of the Covid-19 pandemic. Over the first 11 months of the year there were two periods of special cause variation triggering investigation. The trends support the view of our clinicians – noted above – with respect to the increasing acuity of patients being admitted.

Figures 8 and 9: Average Length of Stays for the Trust





We work well with our colleagues in social care. Formal delayed transfers of care have remained negligible throughout the year. Those which have occurred are the responsibility of the NHS and not social care-related.

Referral to Treatment (RTT)

Commissioners continued to be largely successful in restricting referral growth, as shown in Table 11 below.

Table 11– Referrals Received by the Trust

	2018-19	2019-20	Variance	% variance
GP	89191	86916	(2275)	-2.6%
Non-GP	68546	67910	(636)	-0.9%
Total	**157737**	**154826**	**(2911)**	**-1.8%**

However, the Trust has experienced significant pressures in some specialties, resulting in under-performance against the NHS Constitution Standard of 92% of patients waiting no more than 18 weeks for treatment.

Table 12 - 18 weeks RTT Performance (target – 92%)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CDDFT	90.8%	91.1%	91.1%	90.7%	89.7%	89.9%	90.1%	88.9%	87.9%	87.3%	86.1%	82.0%

These pressures impacted upon breast surgery, dermatology, rheumatology, orthopaedics and cardiology, with common causes being senior clinical staff vacancies and by cancellations in elective work due to non-elective bed pressures. There were, however, some service specific issues, including: the impact of significant increases in demand for MSK and Dermatology services and, temporarily, the need to establish additional checks and controls in theatres on kit transported from our Sterile Services department which impacted, in particular on Orthopaedic services, and shortfalls in theatre staff in some areas.

The pressures experienced by the Trust were not unique to CDDFT, but apparent both regionally and nationally. The Trust's performance was above the NHS England and a performance trajectory was agreed with our regulators, in recognition of these regional and national pressures below the NHS constitutional standard. Our ambition remains, however, to meet the standard; hence the Executive and the Board devoted dedicated time to the development and scrutiny of recovery plans in year. These plans were being worked on towards the year end, albeit that they would have taken time to come to fruition, but were impacted by the Covid-19 outbreak as outlined below.

Plans enacted including working on new ways of delivering care, which included therapy and pharmacy-led rheumatology clinics and a new tele-skin service for all potential two-week wait skin cancer referrals. The tele-skin service has been shortlisted for a Health Service Journal Innovation award and involves GPs sending photographs of the lesion for consultants to triage the patient into the appropriate service. Approximately 13% of patients were returned to the GP with advice on Primary Care management; 70% needed a two-week wait appointment; the remainder were triaged into a routine clinic.

In mid-March, the Trust, in common with many of its peers, stopped accepting non-urgent new referrals. Non-urgent out-patient activity was paused to prioritise the fight against Covid-19. Only cancer and other urgent referral activity has been taking place. This exerted downwards pressure on RTT performance in March. National guidance requires the 18-week RTT clock to keep ticking for all patients currently on the waiting list.

To mitigate the risks from the cessation of non-urgent work, the Trust encouraged GPs to use its consultant-led GP advice services:

- Bed Bureau: for GPs to seek immediate advice as an alternative to sending a patient to ED or admitting them.
- Advice and Guidance: for GPs to seek advice instead of referring for an out-patient appointment.

In line with national guidance, the Trust also accelerated its exploration of other alternatives to the traditional out-patient appointment, such telephone or video consultations or extending the tele-skin service to other Specialties. This work was undertaken in order to help manage the recovery phase of Covid-19 planning and also in recognition of the fact that in a post-Covid-19 environment it is likely that more work will have to be done remotely and digitally.

Cancer waiting times

The latest available data - for March 2020 - shows performance on the main standards to be:

- 2ww (Target 93%): 90.08%
- Breast symptomatic (Target 93%): 78.2%
- 31-day referral to treatment (Target 96%): 98.06%
- 62 day referral to treatment (Target 85%): 82.71%

Performance against the main 31-day standards continues to be strong, largely because the whole pathway is within the control of the Trust to manage. Performance on 62-day waits for treatment is less secure because we rely on support from tertiary centres and pathways are therefore necessarily more complex. Although the Trust has begun to fall short of the target, our performance compares well with other Trusts. Breast symptomatic performance continues to be affected by the reliance of the Breast Radiology service on a small group of key staff, some of whom are on working on a retire and return basis. This is a regional and national issue, with shortages of staff working in breast cancer and a concentration of those staff at screening centres. The North East Cancer Alliance is leading work as part of the Integrated Care System on a regional solution.

The Trust regularly uses independent sector support for endoscopy, pathology reporting, and breast surgery, and is working with other local Trusts to improve pathways and implement best practice standards of care for a range of cancers.

The COVID-19 outbreak, has necessitated careful balancing of the risks from the virus and the risks of delaying cancer treatments. Patients are being risk stratified to decide whether it is safe to proceed with surgery and which site should be used: an acute site, Bishop Auckland or the independent sector. Some tumour groups have temporarily stopped surgery to assess the risks. Chemotherapy treatment has been moved off the acute sites. Telephone assessments or triage arrangements have been introduced into some pathways and a cancer advice line has been established to manage patient enquiries and free up specialist nurses to support patients on wards.

3.2.2.2 Quality

The Trust's Quality Strategy, 'Quality Matters', sets out improvement priorities under three key headings: patient safety, patient experience and clinical effectiveness. These priorities, along with national requirements and other annual priorities agreed with key stakeholders, form the focus of an annual quality plan which is reported upon in the Quality Report. The Quality Strategy is being updated for the next years. Looking back over 2017 to 2020, there has been good progress with respect to the 15 key priorities, in Quality Matters, with notable successes and areas for further improvement summarised below.

Table 13: Quality Matters Strategy Indicators

Key:

	The objective has been met. No / minor issues remaining		Significant progress over the three years (2017 to 2020); however, some further specific actions being taken		Progress has been made; however, there are ongoing developments and the area will remain a priority in the new (2020 – 2023) Quality Matters Strategy

Outcomes

Domain	Priority	Rating	Comment
Safety	**Reducing Harm from Falls**		Falls per 1,000 bed days have been reduced in line with national benchmarks and statistically, falls remain within normal parameters. Over the life of the Quality Matters Strategy there was a substantial reduction in avoidable falls with harm; targets for staff training were achieved, innovative practices were introduced in a number of areas and the Trust achieved good results in local and national audits of falls prevention procedures. Overall, the number of falls remains broadly in line with national benchmarks. Our aspiration was, however, to reduce the number of falls by 10% per annum. Although we have reduced the number of falls over the life of the strategy, we have not achieved this target. Falls prevention therefore remains a key priority for the Trust and we continue to source and implement best practice in order to minimise patient falls in our care.
	Reducing Harm from Sepsis and Acute Kidney Injury (AKI)		The long-term trend in the Trust's rates for screening of patients for sepsis shows performance at or close to 100%. However, we continued to see, and to learn from, a small number of incidents in which Sepsis triggers have been missed. In addition whilst, in normal conditions, we are able to provide antibiotics to patients within one hour in our A&E Departments, this can prove challenging in times of very high demand due to delays in ambulance handover. We have appointed two specialist nurses to educate wards and support care of patients with suspected AKI. Both nurses were expected to commence in post in April 2020; however, we agreed that they should remain in their current posts during the first phase of implementation of Covid-19 pandemic response plans. They are due to join the Trust imminently.
	Improving our safety culture		The Trust saw a significant reduction in never events reported over the life of the strategy. Three never events were reported in 2019/20, broadly in line with other Trusts of similar size. Between 2017 and 2020 we have established a strong culture of preventing and, if necessary, learning from and seeking to minimise never events and our ambition continues to have no such events. Incident reporting and learning has also improved as noted below.
	Learning from incidents		The rate of incident reporting has increased, with the Trust's reporting rate sitting comfortably with peer Trusts in benchmarking comparisons and becoming the second highest reporter in the region based on data from the National Reporting and Learning System. This improvement was driven by an increase in reporting of no harm and near misses, which is a positive development in that it establishes a greater evidence base to support learning from incidents to avoid future harm.

Domain	Priority	Rating	Comment
	Local Safety Standards for Invasive Procedures		The Trust has implemented safety standards for all invasive procedures and has a programme of audits (including observational audits) in place to monitor compliance. The Trust is regarded as an exemplar of good practice nationally in this area. The next phase of work is to integrate the use of the checklists into routine safety monitoring and governance processes.
Patient Experience	**Learning from Patients and Families**		The process of learning from complaints and sharing patient stories at all levels in the Trust has improved over the life of the strategy and a patient engagement strategy is in place. However, the Board declared the implementation of a more comprehensive and proactive approach to patient engagement to be a priority for 2019/20 and 2020/21. Prior to the Covid-19 outbreak, a range of actions were being implemented, working with system partners, to engage patients, the public and our members. At the present time, we cannot, however, currently implement these as planned due to social distancing requirements and this work remains a priority.
	Care of those with Dementia		Patient-Led Assessment of the Care Environment (PLACE) inspection scores for a 'dementia friendly' environment have significantly improved over the life of the strategy as have the screening, assessment and referral of patients with dementia, which now routinely exceed national targets. However, PLACE scores in 2019/20 fell slightly below the national average (78.6% compared to 80.7%). The majority of the issues were found to be minor and remediation plans are in place. The Trust continues to use national audit outcomes to inform training of staff to enhance support for patients and carers with dementia, with a plan for further improvements in place for 2020/21. Areas flagged for further work include governance, discharge of patients with dementia, communication with carers and carers' ratings of care.
	Improving End of Life Care		Our end of life care service has been rated outstanding by CQC in recognition of the significant improvements made over the life of the strategy. These include significant expansion of medical staffing and out of hours support for staff, as well as establishing out of hours' services for patients.
	Improving Elderly Care		Frailty scoring is in place together with a frailty unit at UHND. The Trust has plans in place to increase resources to support patients with frailty more effectively at all stages of the pathway and continues to develop sub-acute elderly care facilities away from its acute sites with partners. The last of these developments has proved more complex and challenging to implement than originally envisaged and drives the amber rating for this objective.
	Improving Nutrition		Observations and care planning for nutrition were imported into our electronic nursing observations system 'Nerve Centre', since which time adherence to policy is much improved. There remains a small number of 'hotspot' areas from monthly audits, where further support is being provided by Dietetics.
Clinical Effectiveness	**Improving Cancer Services**		The Trust continues to perform above the national average for cancer waiting times nationally and has improved MDT working with Tertiary Centres over the life of the strategy. New video conferencing facilities for MDT working have been installed, which support clinical-decision making. Work is well underway to implement the requirements of the national cancer strategy, working with Tertiary Centres and system partners. A particular focus for this work is the improvement of survival rates.
	Reducing Mortality		Mortality rates have remained within statistical parameters over the long-term; however, the Summary Hospital Mortality Index (SHMI) – a national measure of unexpected deaths - has now exceeded the statistical upper tolerance limit. The Trust has implemented the requirements of the national Learning from Deaths initiative, has appointed a Medical Examiner, with further appointments to be

Domain	Priority	Rating	Comment
			made and has a programme of mortality reviews, which has identified no substantive issues with care, other than the need to improve care of those suspected of having Acute Kidney Injury, leading to the decision to appoint specialist AKI nurses. The significant majority of case reviews have concluded that patients received good quality care. It is known that the SHMI indicator is impacted by the depth of coding in the Trust, as patient notes do not always capture full detail regarding all of a patient's relevant illnesses and health conditions ('comorbidities). A working group has been set up to identify and roll out actions to embed best practice in recording of comorbidities in clinical notes. This work has been delayed by our response to Covid-19 but remains a priority for 2020/21 and beyond.
	Improving Urgent and Emergency Care		Despite a huge amount of work, with support from system partners and regulators, the combination of demand pressures (including the acuity of patients) and capacity constraints (staffing and physical) continued – for the majority of the year - to result in the Trust falling short of targets for A&E waiting times. With the fall in attendances and non-elective admissions following the Covid-19 outbreak, performance improved to over 95%. This is, however, seen as a short-term improvement resulting from a combination of strong processes, hard work from A&E staff and reduced workload and underlying pressures are expected to remain going forwards. Therefore there remains an extensive action plan in place, agreed following a summit with system partners, which targets an initial level of improvement. Plans focus on the implementation of same day emergency care (alternative facilities to A&E) and proposals regarding sub-acute elderly care facilities and frailty, together with a long-term plan to improve our infrastructure for emergency care at Durham. We are seeking to capitalise on beneficial changes to our A&E facilities and procedures implemented as part of our Covid-19 response plan, including enabling multi-specialty assessment front of house.
	Enabling People to Live Healthier Lives		All targets for community wellbeing programmes, and cancer support programmes have been exceeded. The Trust has appointed a Public Health Consultant and now hosts social prescribing links, providing active support to the wider public health agenda.
	Seven Day Services		The Trust meets the four national priority standards for 2020, as confirmed by a number of national and local audits.

With respect to other quality indicators covered in the Quality Report, and more generally:

- The Trust continues to perform strongly with respect to pressure ulcer prevention with overall rates of pressure ulcers in line with national and international high-performers.
- Over several years, the Trust has seen sustained reductions in Cardiac Arrest rates in line with high-performing trusts.

There remains, however, further to go if the Trust is to reach its ambitions in a number of other areas:

- The Trust is currently in line with the majority of Trusts for the numbers and profile of incidents reported. We continue to aspire to reporting rates in line with the top quartile of reporters, with particular emphasis on reporting of no harm, near miss and minor harm incidents as the more of these incidents that are captured, the greater the information to draw on for learning.
- Whilst rates of infections per 1,000 bed days benchmark reasonably well, the Trust exceeded its threshold for Clostridium Difficile infections for the year, with 49 cases reported against a threshold of 45. Investigation found no lapses in care for many of these infections; however, in other cases there were common learning points with respect to sampling, isolation and antibiotic stewardship. The Trust also reported six cases of MRSA, resulting in actions to reinforce appropriate cannulation and antibiotic prescribing and stewardship.

The Trust was awarded an overall “Good” rating from CQC, following an inspection carried out between June and September 2019, which focused on Urgent and Emergency Care, Surgery and End of Life Care at both UNHD and DMH. All services are now rated Good, except for End of Life Care on both sites - which received an “Outstanding” rating, with particular recognition for service leadership and responsiveness - and Urgent and Emergency Care at UHND, which was rated “Requires Improvement”. Good ratings were awarded for the Effective, Caring, Responsive and Well-Led Domains, with “Requires Improvement” being the rating for the Safe Domain.

The Trust was delighted with the overall inspection outcome, and the recognition for the services inspected. However, we are not complacent and continue to focus on improving the safety of our services. In their inspection report, published in December 2019, the CQC mandated the following ‘Must Do’ actions with respect to the “Safe” Domain:

- Ensure consistent compliance with policy for syringe driver checks
- Ensure consistent compliance with policy for pain assessments / action (end of life care)
- Ensure safe and secure storage of medicines in all areas
- Ensure consistent compliance for Oxygen prescribing with British Thoracic Society (BTS) recommendations
- Ensure the availability of paediatrics-trained clinicians for children streamed away from the A&E Department
- Continue to strengthen paediatric nursing and medical staffing in A&E Departments

Since the inspection, and by 31st March 2020, we have: updated our policies and procedures for syringe driver checks and pain assessment (including safe storage of medicines); built compliance with oxygen prescribing requirements into our Electronic Prescription Management and Administration System resulting in much improved compliance with BTS recommendations, and brought forward plans to increase access to paediatric trained clinicians and nurses for children attending our A&E Departments. We continually review and deploy a range of options, including specialist agencies and international recruitment, to augment medical staffing in A&E and are developing specialist advanced nursing roles to support the medical staffing rota.

3.2.2.3 Financial Performance

The national financial environment in which the Trust operates has become increasingly challenging with the NHS provider sector. Key contributing factors cited by providers include difficulties in achieving planned efficiency savings, operational cost pressures relating to temporary staffing and substantive workforce pressures including the extent to which the Agenda for Change pay awards are fully funded, contracting difficulties, quality investment and unplanned emergency activity displacing elective income.

Like much of the NHS, in 2019/20 the Trust faced unprecedented challenges in terms of increasing demand for our emergency and unplanned care, significant financial pressures and the impact of Covid-19 being seen and responded to at pace to during the last quarter of the financial year. Despite the challenges and pressures the Trust continued to deliver major achievements thanks to the efforts of our committed workforce operating within a health and social care system dedicated to improving the health and wellbeing of our local

populations. 2019/20 saw the Trust achieve a "Good" overall rating from the CQC in relation to its Use of Resources.

The Long Term Plan, published in January 2019, clearly set out a focus on integration and more collaborative working across health and social care organisations. We are working in this direction within the North Cumbria and North East ICS and the developing ICPs. We are already achieving transformation through the integration of community services which is facilitating the delivery of high quality patient care across organisational boundaries between hospital services and community teams and with health and social care partners.

Use of Resources

Our regulator, NHS Improvement assesses our financial performance with reference to how far we achieve the financial plan agreed with them, the underlying surplus or deficit and a Use of Resources Risk Rating (UoR rating). The UoR rating is a composite risk indicator which takes into account: the Trust's income and expenditure result; its performance against plan; its liquidity; its ability to service capital and its ability to control agency spend. Accordingly the Trust measures performance against these indicators, as well as underlying targets for cost control and cost reduction in year.

The Trust ended the year with a UoR risk rating of 3, which was in line with the plan, reflecting the financial performance noted below as well as the Trust's underlying liquidity and its ability to service capital. A rating of 1 is regarded as the lowest level of risk and a rating of 4 is regarded as carrying the highest level of risk.

Financial Performance

The consolidated accounts for 2019/20 incorporate the results for the Trust, for our wholly owned subsidiary, Synchronicity Care Limited, and for our charitable funds, with the Group posting a surplus for the year of £11.485m which includes:

- £1.525m benefit to income and expenditure relating to the reversal of impairment resulting from the increased revaluation of the land and buildings on the Trust's balance sheet by the Trust's valuer. This reversal of impairment does not impact on cash earnings or on how NHS Improvement assesses the Trust's performance.
- £224k relating to the movement of the Trust's charitable funds. Expenditure exceeded income generated during year as a result of deliberate policy to seek to use accumulated funds for charitable purposes.
- £102k relating to income received by the Trust for donated assets
- £778k relating to 2018/19 PSF received in 2019/20

The Trust and NHS Improvement focus on the surplus/ (deficit) for the year, excluding impairments, revaluations, prior year PSF and movements in charitable funds; this is the primary financial key performance indicator used for regulatory purposes. After excluding those items the Group is reporting a £9.304m surplus.

During 2019/20, the trust was eligible to receive £2.66m of Marginal Rate Emergency Rule funding (MRET) and £8.036m from the Provider Sustainability Fund (PSF) if it was able to deliver its financial control total. The Trust would then achieve an overall planned surplus of £9.505m, as the Trust was required to operate at a deficit control total of £1.191m during 2019/20 prior to the receipt of PSF & MRET funding. The Trust continued to demonstrate financial resilience in the 2019/20 financial year and was able to deliver an overachievement of £188k against the control total set, after adjusting for the impact of the nationally determined change in discount rate which created a £389k expenditure charge for the year. The full PSF of £8.036m was therefore received.

As noted above there were significant challenges which needed to be managed in-year:

- The financial pressure of the continued shortage of key clinical staff required to maintain safe services resulting in expenditure on agency staffing of £8.6m, down £0.3m on the previous year
- Challenging cost improvement targets.
- An inability to reduce the bed base in the Acute Hospitals due to increased emergency and unplanned care activity and patients presenting with higher acuity levels than in prior years.
- A requirement to cancel elective activity due to winter pressures resulting in increased use of the Independent Sector to maintain performance standards.

- An inability to reduce the structural deficit of specific service lines without a health-economy wide solution, which requires formal public consultation.

Delivering Value for Money in the Public Interest

The cost efficiency requirement for 2019/20 was £24.2m and this was fully delivered. The Trust continues to quality impact assess all efficiency schemes ensuring safety and quality is maintained, if not improved, as a result of proposed initiatives.

Balance Sheet

The property, plant & equipment owned by the group were valued at £183.5m on the 31st March 2020. The Trust has valued its land and buildings on a modern equivalent valuation basis, where an alternative site and a revised specification has been identified that would better fit with the current services provided at the trust's hospitals.

The closing year end cash balance at 31st March 2020 was £14.2m (2018/19 £7.9m). While this balance provides strength, the Trust continues to operate in an increasingly challenged financial environment and changing business delivery landscape.

Capital Expenditure

The Trust spent £20.8m on capital investment in its estate, information technology and medical equipment assets; predominantly the replacement of radiology equipment (MRI, CT and digital x-ray machines).

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 cost pressures, as the impact of Covid-19 continues to be seen. Despite financial pressures the Trust remains committed to delivering high quality clinical services to meet and respond to the demand from the population we serve in addition to sustaining 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.

3.2.2.4 Workforce

The following Key Performance Indicators are monitored with respect to workforce, alongside a range of staff engagement performance information which is summarised in more detail in sections 4.3.5.2 and 4.3.6.

Key Performance Indicator	February 2020	Target (Full Year)
Sickness absence rate	4.95%	Less than or equal to 4%
Percentage of staff appraised	79.4%	95%
Percentage of staff completing mandatory training	94.9%	95%
Voluntary Turnover rate (excluding staff rotations, for example)	7.7%	Less than 9%

The data is taken from the latest Integrated Performance Report, prior to the Trust standing up its incident management arrangements to implement its Covid-19 pandemic response plan. The Trust achieved (taking account of additional training delivered in March 2020) its targets with respect to voluntary turnover and mandatory training. The sickness absence rate has – in keeping with many other Trusts – exceeded the challenging target of 4%. A comprehensive programme of staff health and wellbeing support measures has been introduced, with more detail set out in the relevant section of this report (4.3.5.4).

The percentage of staff appraised fell short of the target for the year; however, this was impacted by standing down of appraisals in March in line with national guidance, to support the implementation of the Covid-19 pandemic response plan.

As outlined in section 4.3.6 of this report, the Trust improved its staff engagement score – in the NHS Staff Survey – significantly and improved on 8 out of 9 engagement-focused indicators, remaining at the same level for the ninth question.

3.2.2.5 Covid-19 Outbreak – salient information

Whilst the majority of the information below straddles the year end, the Trust's pandemic response and incident management plans were implemented from March 2020 and it is appropriate to provide the reader with some understanding of their content and impact.

The overriding strategic objective has been – in line with the national strategy – to build sufficient capacity and resilience to remain – at all times – well ahead of the numbers of forecast admissions; in particular, capacity in:

- A&E
- Inpatient wards
- Critical care

Forecast admissions comprise not only confirmed Covid-19 cases but patients who are quarantined whilst awaiting the results of test swabs. Capacity comprises:

- Physical capacity: – beds and related equipment (such as lockers and drip stands), medical gas supplies and side rooms;
- Staffing – sufficient numbers of trained staff, with the right Personal Protective Equipment, allowing for the likelihood of a significant number of staff needing to self-isolate or becoming symptomatic;
- Equipment – such as oxygen masks, ventilators, CPAP machines and NIV equipment;
- Medicines;
- Ancillary equipment – for example, access to IT systems.

Secondary objectives have included maintaining resilience in non Covid-19 services which remain essential: A&E services; emergency medicine and surgery; cancer services / surgery; stroke services and urgent elective surgery. As far as possible, plans were drawn up to protect and ring-fence paediatric, obstetric and maternity services.

The key strategic actions taken to achieve the above objectives comprised:

- Creating segregated streams throughout our acute hospitals for respiratory and non-respiratory complaints. This includes separate A&E Departments, separate Acute Medical Units and separate wards for Covid-19 / quarantined patients.
- Using the national stand down of non-urgent elective surgery to review and optimise the configuration of wards on each site – in effect creating a number of wards ready to take Covid-19 patients - and to use space released in theatres and recovery areas to augment critical care capacity.
- Reopening and equipping wards at Bishop Auckland Hospital to take, initially, non-Covid-19 services and moving other services, such as medical day / investigations and chemotherapy (from DMH) to that site.
- Accessing arrangements put in place nationally to increase the workforce including the release of third-year medical and nursing students to the front-line; the GMC scheme to bring retired practitioners back into the service and arrangements to release GPs to support front-line services. These have been augmented by internal arrangements to re-train and redeploy staff – including doctors, nurses and clinical nurse specialists, from outpatient and elective activities which have been stood down, to work on wards or in critical care.
- Close working with partners at locality and regional level through the appropriate ICS and resilience forums, to escalate issues and secure support as necessary.
- Relocating urgent cancer services to make best use of support from the independent sector and our hospital at Bishop Auckland.

The Trust was able to increase its bed capacity, by making best use of Bishop Auckland Hospital, by around 300 beds. Throughout the peak of the virus, we were able to maintain sufficient capacity in inpatient areas and in our Intensive Treatment Units to look after patients admitted with the virus.

To 31 May 2020 we treated over 800 patients in our A&E Departments with Covid-19, who recovered at home, and treated and discharged over 450 inpatients. Sadly, as has been seen across the country, some 235 patients died and we extend our sincere condolences to their friends and family.

At all stages throughout the implementation of the Trust's response to Covid-19, we have been able to supply our staff with the right personal protective equipment, through a combination of national and local supply arrangements; the latter put in place with the help of a number of local businesses who stepped up to help the NHS at this challenging time. We are enormously grateful for their assistance.

We are equally grateful for the tremendous contribution of all our staff and of those who volunteered to return from retirement, from primary care or elsewhere, to increase our resources and help us implement our plans. We redeployed large numbers of staff from roles in elective and specialist services, which had been stood down in response to national guidance, and large numbers of administrative staff to support our front-line efforts. In addition, we have seen strong and highly visible senior and clinical leadership and a real sense of ownership, engagement, empowerment and teamwork among our staff. As we move into the next phase of the pandemic, in which we will need to care for those with the virus alongside resetting other services, this a tremendously positive outcome from a challenging time, and we intend to consolidate and build up these new ways of working and even stronger sense of #TeamCDDFT going forwards.

3.2.3 Information about Environmental Matters

The Trust is committed to being a sustainable organisation caring for the environment; working within financial, social, and environmental limits by ensuring the efficient and effective use of resources so that we can meet our regulatory targets and obligations.

As a healthcare provider, employer and purchaser of goods and services, we recognise that we have a significant impact on the environment and acknowledges our role in promoting sustainability and improving environmental performance. We are committed to meeting the obligations in the UK's Climate Change Act 2008 which has legally binding targets of reducing carbon emissions by 34% by 2020 and 80% by 2050. We have achieved the 2020 target two years early.

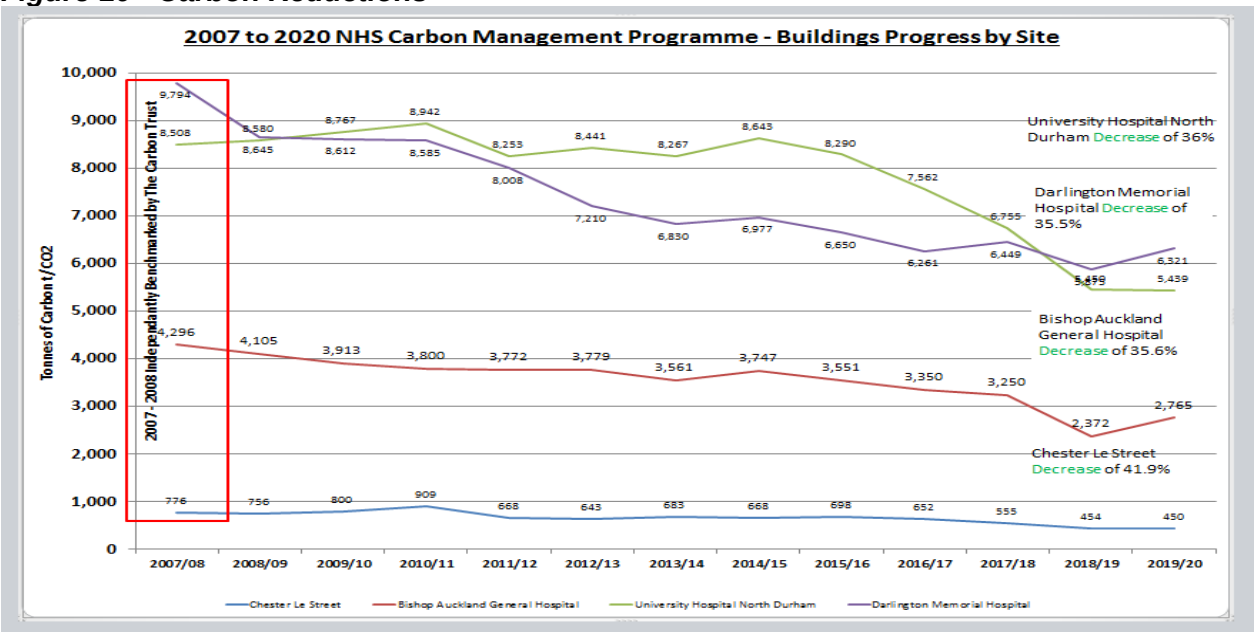
During 2019/20 the Trust has established a Sustainability Development Group comprised of experts and professionals from across the Trust to bring together our ambitions for sustainability. The Sustainability Development Group has prepared a draft Green Plan (formerly known as a Sustainable Development Management Plan) which it intends develop and finalise over the coming financial year.

The draft Green Plan identifies the actions to be taken to deliver the sustainability plan for the CDDFT Group. The actions are mapped to the key focus areas identified by the Sustainable Development Unit and a number of the actions are already underway.

Throughout 2019/20, we maintained our proactive approach to the Carbon Reduction and Sustainability programme, to form an integral part of delivering high quality healthcare efficiently.

Energy consumption has increased on the DMH site as a result of the opening of two additional ultra clean Theatres. Although the new Theatre scheme incorporates highly efficient heat recovery units and energy efficient plant and equipment, Theatres by nature are extremely energy intensive. At all four of our main sites the combined carbon associated with gas and electricity has reduced. In 2007 the Carbon Trust measured our buildings carbon footprint as 23,374t/CO2. In 2019/2020 we have reduced the carbon footprint to 14,976 t/CO2, an overall reduction of 35.93%.

Figure 10 - Carbon Reductions



Summary Performance – Non-Financial and Financial

The table below summarises our performance last year with reference back to the preceding two years.

Figure 11 - Greenhouse Gas Emissions Performance

Greenhouse Gas Emissions Area		Non-Financial data 2017/18	Non-Financial data 2018/19	Non-Financial data 2019/20	Financial data 2017/18	Financial data 2018/19	Financial data 2019/20
	Scope 1 Emissions						
Finite Resources	Electricity	68,517 GJ	62,684 GJ	64,213 GJ	£3,116,541	£3,242,356	£3,763,074
	Gas	196,883 GJ	197,742 GJ	204,348 GJ			
	Oil	481 GJ	1,235 GJ	2,808 GJ			
	Electricity	7,317 t/CO_2	6,691t/CO_2	4,559 tCO2			
	Gas	10,072 t/CO_2	11,298 t/CO_2	10,416 t/CO2			
	Oil	40 t/CO_2	92 t/CO_2	210 t/CO2			
	Scope 3 Emissions						
Waste	Total Waste	2,109.3 t/volume	1,978.1t/volume		£383,080	£479,725	
Hazardous waste	Clinical waste to alternative treatment or incineration	830.7 t	739.9		£261,141	£368,435	
Non Hazardous Waste	Landfill	-			-		
	Reused/Recycled	316.6 t	314.8		£13,886	£13,426	
	Incinerated with energy recovery	945.9 t	902.1		£104,210	£94,655	
	Electrical waste (WEEE)	16.1 t	21.3		£3,843	£3,209	
	Scope 3 Emissions						
Travel	Commercial Vehicles Diesel	273,888 miles	315,348 miles	377,482 miles	£49,572	£57,076	£80,090
		65.93 t.CO2e	75.9 t.CO2e	90.87 t CO2e			
	Leased Vehicles Petrol	906,255 miles	798,660 miles	759,566 miles	£109,432	£95,839	£91,147
		149.75 t/CO2e	129.83 t/CO2e	137.27 t/CO2e			
	Leased Vehicles Diesel	1,769,876 miles	798,288 Miles	392,492 miles	£206,182	£95,795	£47,099
		297.48 t/CO2e	134.90 t/CO2e	65.92 t/CO2e			
	Leased Vehicles Petrol / Plug-In Hybrid			13,749 miles			£1,649
				1.02 t/CO2e			
	Leased Vehicles Petrol / Hybrid			62,466 miles			£7,495
				7.82 t/CO2e			
	Leased Vehicles Electric			3,885 miles			£466
				0.00 t/CO2e			
	Business Miles Petrol	3,574,692 miles	3,122,207 miles	2,636,641 miles	£1,374,684	£1,670,362	£1,368,157
		1,063.15 t/CO2e	928.54t/CO2e	476.87 t/CO2e			
	Business Miles Diesel	20,600 miles	255,452 miles	785,981 miles	£9,905	£134,514	£410,245
		5.02 t/CO2e	62.23 t/CO2e	142.04 t/CO2e			
	Business Petrol / Plug-In Hybrid			7,219 miles			£4,056
				0.54 t/CO2e			
	Business Petrol / Hybrid			32,894 miles			£15,360
				4.12 t/CO2e			
	Business Electric			6,357 miles			£2,601
				0.00 t/CO2e			
Water	Water Consumption	150,974 m3	160,124 m3	132495 m3	£382,848	£398,239	£364,361

CDDFT Ongoing Carbon Reduction Commitment (CRC)

The Trust is one of 3,000 mandatory public and private sector participants to the Government's CRC scheme, which is now in its second phase. As can be seen, we are reducing our impact on the environment and reducing this carbon tax. This is being achieved through continued investment in new technologies and equipment; improved use of existing plant; tight monitoring of energy inefficiencies and consumption and equipment lifecycle management.

The CDDFT Group includes a wholly-owned subsidiary (SCL), which provides a range of services including Estates and Facilities. The Estates team continues to deliver benefits to patients and staff through the delivery of the Trust's investment programme. This program looks to improve the environment, in terms of quality, safety, efficiency and sustainability. Our commitment to energy efficiency and sustainability underpins our selection of plant and equipment for the future.

We allocate capital funds over several years to allow us to maintain, and upgrade, facilities so that they remain energy efficient; for example:

- Replacement of refrigeration units with the latest energy efficiency and less harmful refrigerants.
- Lighting which is provided by high efficiency/LED luminaires controlled using both absence and presence detection.
- Heating and ventilation utilising Low Temperature Hot Water and heat pumps
- Fan motors, which are equipped with variable speed drives (VSD's) to minimise power consumption, and match operation to the prevailing demand.
- Installation of high efficiency circulating pumps.
- Use of energy efficient medical air compressors with ECO mode to meet a variable demand.

Sustainable Procurement
Sustainable Procurement is the way in which we source services, works and utilities to achieve value for money, over the whole life of the product or service, including benefits not only to the organisation, but also to a society and the economy, whilst minimising damage to the environment.

The Trust's Sustainable Procurement Policy[1] considers the economic, environmental, and social consequences when procuring products, services, works and utilities of which some examples are detailed below:

Table 14 – Examples of Procurement Considerations under the Sustainable Procurement Policy

Impact	Examples
Economic Impact	Functioning of the internal market and competition Operating costs and trade of Small and Medium Enterprises Competitiveness and trade Consumer growth International relations
Social Impact	Employment and labour Standards and rights of employment Gender equality, equal treatment, non-discrimination Public health and safety Health and education systems
Environmental Impact	The climate Emission of greenhouse gases Transport and renewable energy Air, water, soil quality Land use Waste

The Trust's sustainable procurement approach complies with the Public Services (Social Value) Act 2012, which makes considering the wider social, environmental, and economic impacts of procurement a public duty.

The Trust is dedicated to ensuring that products, services, works and utilities procured for the NHS:

- are manufactured, delivered, used, and disposed of in an environmentally friendly, sustainable, and socially responsible manner, and
- deliver long-term value for money for the NHS and the Public Sector as a whole.

In addition, the Trust recognises the social impact it can make on a regional basis and endeavours to recognise the importance of sourcing local goods and services where possible.

Examples of our progress
Our on-going efforts, and schemes carried out over this and previous years, continue to generate both revenue and consumption savings including:

Plastics Pledge: The Trust has signed up to the NHS Plastics Reduction Pledge. The scheme requires signatories to commit to:
- By April 2020, no longer purchase single-use plastic stirrers and straws, except where a person has a specific need, in line with the government consultation;
- By April 2021, no longer purchase single-use plastic cutlery, plates or single-use cups made of expanded polystyrene or oxo-degradable plastics;
- By April 2021, go beyond these commitments in reducing single-use plastic food containers and other plastic cups for beverages – including covers and lids.

During 2019/20 we have introduced reusable tumblers for patients' juice as opposed to disposable plastic juice cuplets, removed plastic straws in retail units and removed plastic tea spoons in retail units.

[1] Currently in draft

The Trust is complying with the pledge and no longer purchases single-use plastic stirrers, a small amount of plastic straws are purchased for patients with a clinical need and usage is monitored.

- NHS Supply Chain Multi-Temperature Distribution Model: The Trust Group has taken part in the pilot of a new distribution service that will establish one national route to market for all food deliveries including chilled, frozen and ambient products. Essentially all food items will be delivered working with a multi-temperature distribution partner. . The relatively close location of their depots helps to reduce food miles and the carbon footprint. The Trust Group has committed to joining phase one of the new multi-temperature distribution service.

- Car Park Lighting: Proposals for the replacement of car park lighting with LED fittings have been developed with a view to implementation during 2020/21.

Case studies covering managed print services and anaesthetic gases are set out in figures 12 and 13.

Figure 12 Case Study 1

Case Study 1: Managed Print Service

During 2019/20 the Trust continued to roll out its Managed Print Service (MPS). The objectives of the MPS were to rationalise the number of printers used across the Trust estate, to reduce revenue expenditure and support the realisation of our "Paperless 2020" ambition thereby reducing the Trust's carbon footprint.

Since its introduction, we have removed or replaced 1,744 printers, faxes and scanners and now have just 687 multi-functional devices. The MPS project has reduced paper and consumable usage:

- Follow Me Print: The means that when users print, their printing is stored in the cloud, and only prints out when they go to a printer. This massively reduces the amount of printing that is printed and not collected.

- Lexmark Reporting System (LRS): LRS is the reporting system which identifies users and printers that are using excessive volumes of paper and colour toner allowing us to liaise with individuals to reduce their requirements and/or change behaviours to save on paper and toner usage.

- Default Settings: The default settings are automatically set to duplex printing (2 sided) and the use of black and white printing

We have also introduced the use of recycled paper which is manufactured in line with the highest environmental practice and standards which do not use any harmful bleaching in the process. The paper does not contain products to whiten it because these are not biodegradable and do not break down. Switching from the previous paper to this 100% recycled paper has a positive impact on the environment as it is an ecologically sound alternative.

Following the successful implementation of MPS the Trust is now considering rolling it out to Community Hospitals.

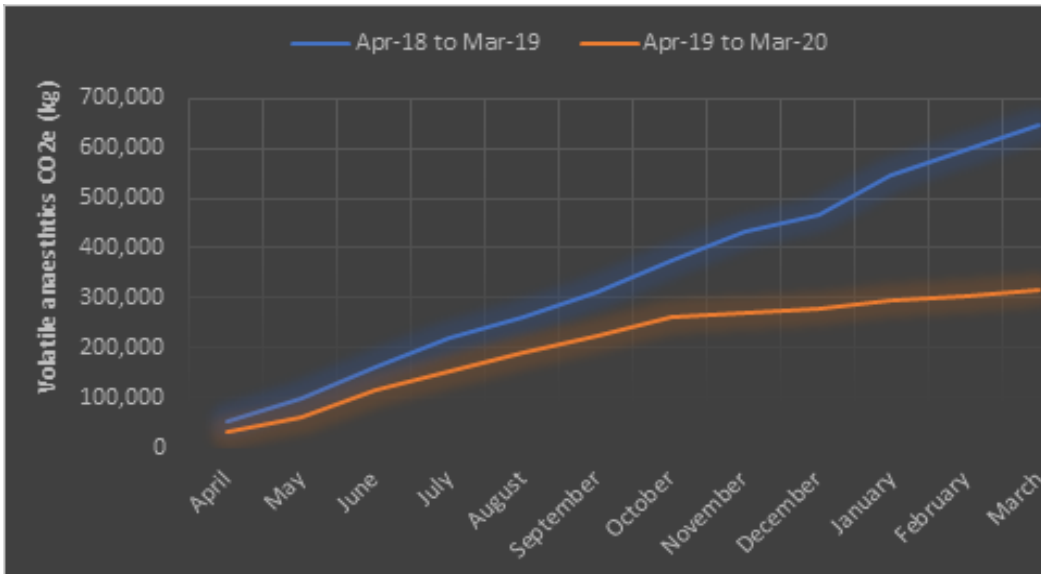
Figure 13 Case Study 2

Case Study 2: Reduction in use of the environmentally harmful anaesthetic gas Desflurane

We identified the reduction of our CO_2 footprint from inhaled anaesthetic agents as a key objective for our anaesthetic team in 2019/20.

Anaesthetic gases are commonly used as part of everyday surgeries. It is acknowledged by NHSE that these gases are responsible for over 2% of all NHS emissions (NHSE Website). The NHS Long Term Plan aims for a 51% reduction in the NHS carbon footprint by 2025, with 2% of this to come through transforming anaesthetic practices.

During 2019/20 the Trust has encouraged use of alternative surgical anaesthesia options to reduce the use of desflurane. The graph below shows the resultant reduction in CO_2 equivalent of 326 tonnes when comparing two successive years.



Waste Management

The overall volume of waste has reduced by 3% on the previous year and has reduced by 16% from the peak of 2016/17, which was the largest recorded annual waste volume for the Trust.

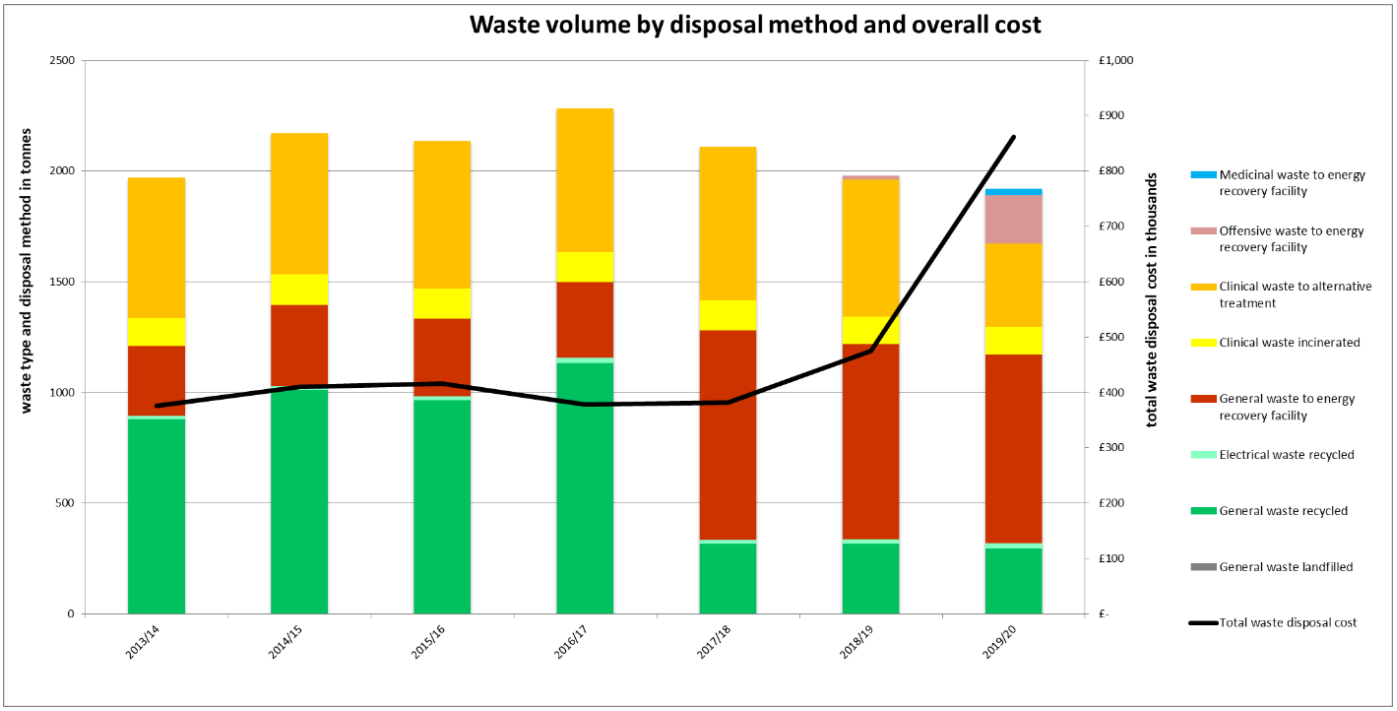
There was a significant increase in waste disposal costs during 2019/20 due to the liquidation of the Trust's former clinical waste contractor. The contract supplied many NHS Trusts and their liquidation led to a steep increase in disposal costs across the country.

During the past year, a 39% reduction in volume of hazardous clinical waste was achieved through the improved segregation of non-infectious waste. This has resulted in a total of 247 tonnes of non-infectious offensive waste and non-hazardous medicinal waste being sent to a local "energy from waste" facility. This waste is used in the generation of electricity and represents a significant reduction in both lifecycle carbon and costs compared to standard clinical waste disposal methods.

Some other notable initiatives during the year included the roll out of a single-use instrument recycling system in the operating theatres whereby instruments are cleaned, crushed and sold for scrap metal as opposed to being incinerated. This has also eliminated the use of single use plastic containers for instrument disposal. Also during 2019, over half a tonne of oxygen masks were collected across the Trust and recycled into tree ties as part of a national PVC recycling initiative.

Moving into 2020/21 there remain some significant challenges; however, we plan to continue with more waste reduction and recycling initiatives; in particular the reduction of single use plastic sharps containers and better segregation and recycling of waste packaging.

Figure 14 - Waste Volumes



3.2.4 Social, Community and Human Rights Issues

The Trust is committed to making the NHS a better and fairer place for all our staff and service users, through the implementation of Equality, Diversity and Inclusion (EDI) Strategy "Diversity Matters", which has just been refreshed to cover 2020/21 to 2022/23. Our EDI Strategic Group develops and drives this strategic agenda, including establishing annual EDI priorities. This group is supported by the EDI Engagement Group, which leads on the practical implementation of the agenda in our wards, service areas and departments, through a programme of genuine staff dialogue and involvement. We have set out below the key outcomes from our EDI work, starting with reporting against national standards, followed by the key EDI activities undertaken in the year, as well as wider social and community involvement activities.

Equality Delivery System (EDS2) National Report

EDS2 has four objectives:

1. Better health outcomes for all;
2. Improved patient access and experience;
3. Empowered, engaged and well-supported staff; and
4. Inclusive leadership at all levels

Each of the four objectives has an associated set of 18 outcomes. The Trust gathers an annual portfolio of evidence for our staff, patients, stakeholders and local communities in order to review and grade our performance against each outcome.

The grading helps the Trust understand where its arrangements are underdeveloped, developing, achieving or excelling:

- Excelling – **Purple**
- Achieving – **Green**
- Developing – **Amber**
- Undeveloped – **Red**

The grading comparisons for EDS reports from 2012 to 2019 for the Trust can be found below.

Table 15 – EDS2 2019

Goal 1 Better Health Outcomes for all				
Outcome Measure	**Outcome Measure**			
	2012	**2016/17**	**2017/18**	**2018/19**
1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities.	**Achieving**	**Achieving**	**Achieving**	**Achieving**
1.2 Individual people's health needs are assessed and met in appropriate and effective ways	**Developing**	**Achieving**	**Achieving**	**Achieving**
1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	**Developing**	**Achieving**	**Achieving**	**Achieving**
1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	**Developing**	**Achieving**	**Achieving**	**Achieving**
1.5 Screening, vaccination and other health promotion services reach and benefit all local communities	**Developing**	**Developing**	**Achieving**	**Achieving**

Goal 2 Improved Patient Access and Experience				
Outcome Measure	**Outcome Measure**			
	2012	**2016/17**	**2017/18**	**2018/19**
2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	**Achieving**	**Developing**	**Achieving**	**Achieving**
2.2 People are informed and supported to be as involved as they wish to be in decisions about their care	**Achieving**	**Achieving**	**Achieving**	**Achieving**
2.3 People report positive experiences of the NHS	**Achieving**	**Achieving**	**Achieving**	**Achieving**
2.4 People's complaints about services are handled respectfully and efficiently	**Achieving**	**Achieving**	**Achieving**	**Achieving**

Goal 3 Representative and Supportive Workforce				
Outcome Measure	**Outcome Measure**			
	2012	**2016/17**	**2017/18**	**2018/19**
3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	**Developing**	**Developing**	**Achieving**	**Achieving**
3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	**Developing**	**Achieving**	**Achieving**	**Achieving**
3.3 Training and development opportunities are taken up and positively evaluated by all staff	**Developing**	**Developing**	**Achieving**	**Achieving**
3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source	**Developing**	**Achieving**	**Achieving**	**Achieving**
3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	**Developing**	**Achieving**	**Achieving**	**Achieving**
3.6 Staff report positive experiences of their membership of the workforce	**Developing**	**Developing**	**Achieving**	**Achieving**

Goal 4 Inclusive Leadership at All Levels				
Outcome Measure	**Outcome Measure**			
	2012	**2016/17**	**2017/18**	**2018/19**
4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	**Developing**	**Achieving**	**Achieving**	**Achieving**
4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	**Developing**	**Achieving**	**Achieving**	**Achieving**
4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	**Under Developed**	**Developing**	**Achieving**	**Achieving**

Conclusion:

For all 18 outcomes, across all four goals the evidence gathered has allowed us to conclude that we are achieving the standards set. Our aim is to move towards excelling under each of the key standards, which requires us to be assured that our equality, diversity and inclusion policies are fully embedded across the organisation, and cover all nine protected characteristics. We have identified key objectives for Equality, Diversity and Inclusion programmes for 2020/21 to work towards this goal.

Workforce Race Equality Standard (WRES) National Report
The WRES was first mandated in July 2015 to ensure that employees from Black, Asian and Minority Ethnic (BAME) backgrounds were granted equal access to career opportunities and received fair treatment in the workplace. It includes nine key metrics to measure equality. The Trust Board agreed and published the 2019 WRES baseline data against the nine metrics on 1 August 2019.

The data used to assess performance against the WRES is taken from the most recent NHS Staff Survey (2018). The report compares the perceptions of those staff from Black and Minority Ethnic (BAME) backgrounds who responded to the survey, with the perceptions of staff from white ethnic backgrounds across the nine key metrics, with significant differences being indicative of areas for improvement. The Trust completed the NHS Staff Survey 2018 on a sample basis; unfortunately, the numbers of staff from BAME backgrounds that responded to the survey were too small to allow meaningful comparisons to be made for indicators covering:

- The percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months;
- The percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months;
- The percentage of staff believing that the Trust provides equal opportunities for career progression or promotion; and
- The number of staff personally experiencing discrimination at work from a manager / team leader or colleague.

We do, however, have a wealth of internal evidence available to identify where we need to improve opportunities and support for staff from BAME backgrounds, and to plan relevant developments and initiatives to support race equality in our workplace. This evidence includes internal surveys of staff from BAME ethnic backgrounds, information provided by staff from BAME backgrounds in face to face workshops and information provided by our BAME staff network group, a closed Facebook Group of BAME staff.

Workforce Disability Standard (WDES) National Report
The WDES is mandated by the NHS Standard Contract and has applied to all NHS Trusts since April 2019. It is similar to the WRES in its approach, in that it seeks to compare the perceptions of disabled staff across a range of equality indicators. However, the report also requires us to set out narrative evidence of actions taken around engagement of staff with disabilities. Data for this report was collated from the NHS Staff Survey 2018, the Trust's Staff Friends and Family Test 2018/19 year-end report, our staff network group for disabled staff and our own Equality Disability Staff Survey 2019. Overall the CDDFT 2019 report was positive but revealed some areas where the Trust could make improvements and these have been included in our overall EDI action plan.

Of the sample of 406 staff who responded to the NHS Staff Survey 2018, 62 (15%) regarded themselves as disabled. Results for key metrics are summarised below.

Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients/ service users, their relatives or other members of the public.
Some 14.0% more disabled staff than non-disabled staff reported that they had experienced harassment, bullying or abuse from patients/service users, their relatives or other members of the public.

Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from managers
Some 7.5% more disabled staff than non-disabled staff reported that they had experienced harassment, bullying or abuse from managers. This is consistent with the findings of our internal Equality, Diversity and Inclusion Survey and the subject of ongoing actions, identified with the help of our Staff Network Group for disabled staff, which comes together through face to face meetings and a closed Facebook page.

Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues
Some 11.0% more disabled staff than non-disabled staff reported that they had experienced harassment, bullying or abuse from other colleagues. This is again consistent with the findings of our internal Equality, Diversity and Inclusion Survey and the subject of ongoing actions.

Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
Some 4.0% fewer disabled staff than non-disabled staff responded that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion
Some 3.0% fewer disabled staff than non-disabled staff responded that they considered that the Trust provides equal opportunities for career progression or promotion.

Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
Some 10.0% more disabled staff than non-disabled staff reported that they had felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. Analysis from our internal Equality Disability staff survey conducted in March 2019 reinforces that this is an issue within the Trust with actions incorporated into our 2019/20 equality action plans.

Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work
Some 12.0% more non-disabled staff than disabled staff responded that they were satisfied with the extent to which their organisation values their work. This is again consistent with the findings of our internal Equality, Diversity and Inclusion Survey and the subject of ongoing actions

The following NHS Staff Survey Metric only includes the responses of Disabled Staff

Percentage of Disabled staff saying that their employer has made adequate adjustment (s) to enable them to carry out their work
22.0% of disabled staff responded that their employer has not made adequate adjustments to enable them to carry out their work.

NHS Staff Survey and the Engagement of Disabled staff
Part a) of the following Metric, compares the staff engagement scores for Disabled, non-disabled staff and the overall Trust score

Table 16 – WDES Metric 9a

a). The staff engagement score for Disabled staff, compared to the Non-disabled staff and the overall engagement score for the organisation.	
Descriptor	**Staff %**
Overall Trust engagement score	**6.7**
Non-disabled Staff engagement score	**6.9**
Disabled staff engagement score	**6.2**

The staff engagement score for disabled staff is slightly lower than the results for the overall Trust and non-disabled staff.

For part b) we have added free format evidence to the Trust's WDES Annual Report as follows.

Table 17 – WDES Metric 9 b)

b). Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard (Yes) or (No) - If Trust response is yes please provide at least one practical example of current action being taken in the relevant section of your WDES Annual Report
Yes - In November 2018 we launched our Staff Facebook Disability Network group. We also had plans to hold across 2019/20 Equality Network group meetings which will be open to all staff in CDDFT; these were developed and commenced monthly. In March 2019 we asked all staff with a disability or long-term Health condition to complete an Equality Disability Staff Survey - the results from this survey will be used in the action plans for this report. We also launched our Health Passport which is completed as an undertaking entered into between a line manager, on behalf of the organisation, and an employee, who has declared they have a disabled or have a long term health condition.

Disabled Persons
The following further activities have been undertaken to help understand and better support the needs of our disabled staff.

A full review of the Disability Confident Standard took place in June 2019 looking at; how we attract and support disabled people during our advertising and recruitment process and how we continue to support and develop our disabled workforce. Following the review CDDFT has been awarded the standard for a further three years.

As a Trust we continue in our aim to support and employ more staff with a learning disability. This is through our continued commitment of signing up to the NHS Learning Disability Employment Pledge which we have been have been awarded at Level 2.

We continue to be committed to NHS Project Choice which is a supported internship hosted by CDDFT and managed by Health Education England North East. The project is designed to give young people with learning difficulties, disabilities or autism, the chance to gain work experience, undertake an employability qualification and complete a work-based internship. The project is tailored to the needs of the young people which enable them to meet and develop their individual skills.

We have continued to promote our Health Passport which is completed as an undertaking entered into between a line manager, on behalf of the organisation, and an employee, who has declared they have a disability or a long term health condition. As part of the action plan for the 2019 WDES the Staff Induction Policy has been updated to require that any new employees joining the Trust should be asked to complete a Health Passport if required as part of their local induction. Completion of the Health Passport is also now discussed, where appropriate during Occupational Health referrals and in back to work interviews.

Equalities, Diversity and Inclusion (EDI) Activity
During 2019/20 we organised a number of promotional events across all main and community sites to promote and launch; key new documents and processes such as the equality staff surveys, Staff Network Groups, the Staff Health Passport and the Support Transgender Colleagues Brief; as well as to promote and celebrate key diversity and celebration events such as local Pride, International Women's day, and Worker's Memorial day. These events have also allowed for the distribution of posters and EDI packs to staff across the Trust to support and advertise the EDI agenda

The national NHS Rainbow badge was launched in CDDFT on the 1st October 2019 promoting support for LGBT+ staff through this initiative with over 300 staff engaging with the programme. Since its launch we have developed posters and flyers, purchased support books for staff to access in our libraries and organised more LGBT+ awareness training for volunteers to attend.

The Trust continues to encourage staff to take part in our #100faces project to demonstrate the rich diversity of #TeamCDDFT. In 2020/21, we will be linking staff contributions to key diversity and celebration events such as International Women's day and Black history month, to expand the profile of the staff involved in #100faces.

As noted earlier in this section, we use closed Facebook Groups for our Staff Networks. There are Staff Network Groups for disabled staff, BAME staff and LGBT+ staff. A fourth staff network group was launched in July 2019 "the Equality Staff Network Group" which is open to all CDDFT staff. Meetings have taken place on a monthly basis since launch for two hours over the lunch period. Meetings have been held in sites across the Trust. Each meeting is broken into two sessions with a guest speaker presenting on a variety of key EDI topics during the first session. The second session is then an open forum for staff to discuss any issues or

topics they wish to raise. Once staff join the group they receive copies of any presentations and resources utilised, which has proven helpful for those unable to attend the session. Members of the group are encouraged to share and disseminate information with their colleagues and teams.

To enhance the data and information contained in the EDS2, WRES and WDES national reports we have undertook three separate equality staff surveys, covering:

- Full Equality Staff Survey, sent to all CDDFT staff based on questions and data required for the EDS2 report and to informs our action planning
- Staff Disability Survey, sent to all staff who have identified as having a disability on our ESR system – information from this survey feeds directly into our WDES report and informs our action planning around supporting staff with disabilities
- Staff Ethnicity Survey, sent to all staff who have identified as being from an ethnic minority background on our ESR system – information from this survey feeds directly into our WRES report and informs our action planning around supporting staff from a BAME background.

These surveys were particularly informative and have helped to refine and further develop our EDI engagement and improvement action plans.

We have compared the demographics of our staff population with the community demographics of the CDDFT footprint. The data and information from this comparison will be used in our national reports, Equality Delivery System, Workforce Race Equality Standard and the Workforce Disability Equality Standard for 2020/21

The Trust has undertaken a piece of collaborative work as part of the Regional EDI Delivery Group objectives. Key dates for religious, celebratory and other important EDI events have been identified. These dates will be used to inform activity to be taken across not only the Trust but the region as a basis for planned celebrations. This work has been delayed during 2020/21 due to the ongoing impact of the Covid-19 pandemic; however, we are actively looking at non face to face ways to mark and celebrate such events.

We share information and policies through a dedicated Equality, Diversity and Inclusion intranet site, which we continue to optimise. All EDI policies are monitored and kept up to date with changes in legislation and contractual requirements.

External stakeholders remain an important aspect of the Trust's EDI work. Joint work with Darlington & Durham Pride, Healthwatch, and Durham County Council aims to assist in raising the profile of CDDFT as an employer of choice. In addition the North East Leadership Academy (NELA) is a valuable resource to encourage and promote the EDI agenda through, for example, "Stepping Up" and "Ready Now" leadership programmes aimed at BAME NHS staff, as well as the range of other leadership and behavioural courses offered by the organisation.

Work has been carried out in partnership with the Patient Experience and Informatics teams to review implementation of the Accessible Information Standard, which is a formal, proactive approach to supporting patients, their families and/or carers who have communication needs, and finding out how to meet and support their needs.

Developing people from our communities to work in CDDFT

CDDFT continues to participate in the training pilot, 'Apprenticeships for All Projects'. The aim of the programme is to cascade training to upskill managers in inclusive recruitment practices relating to apprenticeships with disabilities/learning disabilities or difficulties, and drive forward a shift in recruitment practice nationally.

Developments in how we engage and support patients and the public from our community

A new leaflet has been delivered to clinical areas. 'Preventing Falls in Hospital' which has useful tips for patients over 65 or who are identified as being at particular risk of falling, aiming to keep them safe and steady during their time with us. There is also information for their families and carers. In addition, teams of physiotherapists and occupational therapists work together running falls courses for those who may, for example, be recovering from a fracture that affected their mobility confidence

Innovative 'red bags' that help care home residents admitted to hospital be discharged more expediently have been rolled out across CDDFT. The bags, which contain key paperwork, medication and personal items like glasses, slippers and dentures, are handed to ambulance crews by carers and travel with patients to hospital where they are then handed to the doctor or nurse in charge. Care home staff are trained how to pack the bag correctly, ensure the easy check list is completed, and know who needs to take responsibility for the bag when an emergency admission arises. The same happens at hospital when the patient returns home.

Clown Doctors visit our Treetops children's ward at UHND to help our younger patients have the best experience possible while in our care. Funded by the Children's Foundation, the Clown Doctors support the recovery of both emotional and physical health using storytelling, music, improvisation, humour and play. They have been entertaining children in hospitals in the region for over 12 years and more visits are planned for Treetops, doing what they do best - prescribing laughter as medicine

Our Wellbeing for Life team continues to do a fantastic job in supporting people to live well across our communities. This great work contributes to the improvement of both physical and mental health for those who require help from the service. The team are also delivering a comprehensive training programme to staff from across the Trust in Mental Health First Aid.

The Macmillan funded, 'Joining the Dots' service, delivered by the CDDFT Health Improvement team and the Pioneering Care Partnership, has been developed to support people living with and beyond cancer in County Durham. While there are lots of excellent clinical services available and some really good support services and networks in the community, it is often very hard to navigate through all that is on offer. Joining the Dots is a free, countywide service for anyone 18 or over living in County Durham who has been diagnosed with cancer, or their family and friends. The service helps access the right support with practical issues such as welfare rights and benefits, transport arrangements for appointments, spiritual needs and introductions to local groups. The service also helps with the emotional support that may be needed and the team can help navigate the plethora of charities support groups, grants, and advice available.

Translation and Interpretation Service – Everyday language Service
Over 2019/20 2,750 interpretation sessions were carried out across the Trust, the top ten languages requested were:

Table 18 – Top 10 Languages

Language	Number of translation sessions
Polish	657
Arabic	642
British Sign Language	352
Mandarin	224
Romanian	125
Kurdish	124
Bengali	116
Cantonese	105
Lithuanian	45
Punjabi	43

Face to face interpretation services continue to be the most frequently used format by Care Groups.

To ensure that the Trust continues to provide the highest standard of safe and effective interpretation services, we have organised future training sessions across 2020/21 which will cover the following:

- How to work with an interpreter;
- How to deal with a patient who wishes to use a friend or family member to interpret;
- Understanding the interpreters code of practice;
- Understanding the interpreters confidentiality requirements;
- Understanding the interpreters role in maintaining impartiality;
- When and why an interpreter may interrupt;
- How to utilise an interpreters time to assist in your practice;

- The interpreter timings:
    - Arrival time;
    - Preparation including briefing;
    - Introductions;
    - Appointment time; and
    - Seating arrangements.
- How to prepare and get the best from using a telephone interpreting

The Trust is working closely with the translation service to ensure that it can continue to provide the required and appropriate level of interpretation for patients while adhering to the Covid-19 guidelines to maintain patient and staff safety.

3.2.5 Modern Slavery Act

All clinical and non-clinical staff within the Trust have a responsibility to consider issues regarding modern slavery and to incorporate their understanding of these issues into their day to day practice.

In accordance with the Modern Slavery Act 2015, County Durham and Darlington NHS Foundation Trust is committed to preventing acts of modern slavery i.e. human trafficking and slavery, within both its business and supply chain. Furthermore, the Trust imposes those high standards on its suppliers.

The Trust is fully aware of the responsibilities it bears towards patients, employees and the local community and as such, we have a strict set of ethical values that we use as guidance with regard to commercial activities.

In compliance with consolidation of offences relating to trafficking and slavery within this Act, we review our supply chains with a view to seeking confirmation that suppliers have arrangements to prevent trafficking or slavery.

3.2.6 Important Events since the end of the financial year affecting the Foundation Trust

On 2 April 2020, The Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered as an adjusting event after the reporting period for providers. Outstanding interim loans totalling £30.289m as at 31 March 2020 in these financial statements have been classified as current liabilities as they will be repayable within 12 months.

In addition to the above, the Trust has been impacted by the need to implement its pandemic response plan for Covid-19 and the changes to working arrangements introduced nationally, as part of the Level 4 incident response. The impacts on governance arrangements, risk and performance are captured in the relevant sections of this report.

3.2.7 Details of Overseas Operations

The Trust has had no overseas operations in the year.

4 ACCOUNTABILITY REPORT

4.1 Directors' Report

4.1.1 Details of Directors serving during the year

Details of the Directors serving during the year are set out in Section 2.1.1 (pages 13 to 15) of this report: Trust Board of Directors.

4.1.2 Statement of Compliance with Cost Allocation and Charging Guidance Issued by HM Treasury

The Trust has complied with the costs allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance.

4.1.3 Better Payment Practice Code

4.1.3.1 Public Sector Payment Policy

Unless other terms are agreed, we are required to pay our creditors within 30 days of the receipt of goods or a valid invoice, whichever is the later. This is to ensure that we comply with the Better Payment Practice Code.

The Trust's performance against this metric is shown in Table 19 as follows:

Table 19 – Better Practice Payment Code Compliance

Non NHS Creditors		NHS Creditors	
Target:	95.00%	Target:	95.00%
Result by number:	60.97%	Result by number:	43.48%
Result by value:	83.48%	Result by value:	82.52%

A detailed breakdown of the figures is shown in table 20 below.

Table 20 – Better Practice Payment Code Detailed Breakdown

	Non NHS Creditors		NHS Creditors	
	Number	£000's	Number	£000's
Total bills paid in the year to 31 March 2019	96,115	283,380	2,843	39,526
Total bills paid within target	58,597	236,559	1,236	32,615
Percentage of bills paid within target	60.97%	83.48%	43.48%	82.52%

During most of 2019/20 the Trust, along with many other trusts across the country, experienced cash shortages as a result of the pressures felt across the NHS. This resulted in payment for inter NHS invoices being withheld during the year, and non NHS invoices experiencing payment delays. Local commissioning agreements towards the end of the year helped improve the cash flow and both NHS and non NHS invoices were settled in a timelier manner.

4.1.3.2 Late Payment Interest

Legislation is in force which requires Trusts to pay interest to small companies if payment is not made within 30 days, known as the Late Payment of Commercial Debts (Interest) Act 1998. The Trust and its subsidiary paid £6,059 in claims under this legislation.

The total potential liability to pay interest on invoices paid after their due date during 2019/20 would be £479,511. There have been minimal claims under this legislation, therefore the liability is only included within the accounts when a claim is received.

All of this amount relates to non NHS invoices, and none relates to NHS healthcare contracts.

4.1.4 Statement of Disclosure to Auditors

The Board of Directors of County Durham and Darlington NHS Foundation Trust is responsible for preparing this annual report and the annual accounts. The Board of Directors considers the annual report and accounts, taken as a whole, to be fair, balanced and understandable and to provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

4.1.5 Political Donations

The Trust made no political donations during 2019/20.

4.1.6 Meeting NHS Improvement and CQC's Well-Led Framework

The Trust has arrangements in place to implement good practice as defined in the Well-Led Framework. These are summarised in the table below, for each of the 10 Domains within the framework, signposted to other sections of this report where more detail is available. The Trust completed a detailed self-assessment against the framework July 2019, building on previous internal and external assessment. The most recent external assessment, completed in 2018/19 resulted in all 10 Domains being rated 'Amber-Green', which indicates no significant omissions from the recommended good practice.

The Trust has taken into account the results these external assessments and CQC's well-led inspection completed in August 2019 in preparing the Annual Governance Statement on page 96 of this annual report. The Board has identified no material inconsistencies between the corporate governance statement made to NHS Improvement in June 2019, the annual governance statement and the most recent CQC inspections that require disclosure in this report.

Table 21 – Well-Led Framework

Domain	Arrangements in place
Credible Strategy	The Trust's Strategy is refreshed and approved by the Board annually and progress against all elements of the Strategy is monitored by a Strategic Change Board – comprising Executive Directors and Clinical Leaders – meeting once per month. The vision and mission have been consulted on with staff and wider stakeholders and there is stakeholder consultation on our strategic plans and service strategies. Executive Directors and Non-Executive Directors have engaged with staff on the development and roll out of our strategy through listening events and regular engagement activities such as ward walk-arounds and the Chief Executive's breakfast meetings with groups of staff.
Board Understanding and Management of Risks	A comprehensive risk management strategy is place, supported by training of risk owners, monitoring and oversight by a specialist Assurance and Compliance team and review of risk registers by a Risk Management Committee. More detail is included in the Annual Governance Statement starting on page 96
Board Capacity and Capability	The current experience of the Board is set out in Section 2 of this report. The Board annually reviews the skills, capacity and capability it requires and a range of training is provided through Board seminars. A number of Board development sessions were held during the year covering use of data for decision-making, identifying future quality improvement priorities and training sessions covering areas such as risk management and creating a culture of speaking up.
Board engendering of a Quality-focused culture	Quality is a prominent item on the Board's agenda for each meeting. The Board has a dedicated Integrated Quality and Assurance Committee, the agenda for which covers all quality assurance requirements except for Safe Staffing, which is reported to the Board directly in line with the recommendations of the National Quality Board. Board members perform regular ward walk-arounds and have ready access to Care Group leadership teams to enable them to listen to staff, promote the quality agenda and triangulate assurance. More detail on the Executive Committees in place to drive the quality agenda and the work of the Integrated Quality and Assurance Committee are set out in the Annual Governance Statement starting on page 96.

Domain	Arrangements in place
Culture of Learning and Improvement	The Board has undertaken development activities as outlined above. A Leadership Development Programme is in place for senior managers in the Trust, as part of an overall Talent Management approach. The Trust has invested in facilities to support learning for clinical staff, including a training centre at Prospect House and a Clinical Simulation Centre, used to simulate situations (including some based on incidents) to support learning and improvement. The Trust's IMPS quality improvement methodology has been widely rolled out with over 400 staff trained in the process and a range of quality improvement projects being undertaken. The Board has placed considerable emphasis on the development and roll out of IMPS and all Board Members have been trained to enable them to act as Ambassadors for the programme.
Governance processes	Governance structures are outlined in detail in the Annual Governance Statement starting on page 96
Processes to manage risk, issues and performance	Processes to manage risk, issues and performance are summarised in the Annual Governance Statement starting on page 96. Information on the Integrated Performance Framework is included in 3.2.1 above.
Patient and Public Engagement	The Trust uses the Friends and Family Test interviews, analysis of complaints and compliments, patient stories and both local and national surveys to obtain the views of patients on services. This information is shared with operational teams to improve services by ward or team and with Board Committees for executive direction and assurance. Expert patient groups and Healthwatch are engaged in discussions at service level and through the Council of Governors. An overarching Patient and Public Engagement Programme is in development, with roll out impacted by the implementation of the Covid-19 pandemic response plan. Arrangements to engage our membership through our Governors are set out in section 2.3 above.
Information and reporting	Key reports to the Board include the Integrated Performance Report outlined in Section 3.2.1 above, the quarterly Assurance and Risk report (including the Board Assurance Framework), Monthly Finance Report, and the Monthly Patient Safety and Experience Report. These reports have all been reviewed and improved, taking on good practice shared by NHS Improvement's "Making Data Count" team, in particular re: the use of statistical process control charts. More information on how reports are scrutinised and challenged through the Board Committee structures is set out in the Annual Governance Statement starting on page 96
Reliability and quality of information systems	Arrangements to assure the reliability of information systems are summarised in our Annual Governance Statement starting on page 96. The Trust's Information Services team applies a series of validation controls to key datasets, including kite-marking for some of the most important datasets used to report on regulatory compliance and key performance targets. Internal Auditors carry out testing, based on a risk assessment, of key datasets and further assurance of key datasets used to report mandatory indicators in the quality accounts can be taken from external audit testing when viewed over a number of years (for 2019/20 the national requirement for testing was stood down due to the Covid-19 pandemic).

CQC rated the Trust's Well-Led arrangements as 'Good' based on their most recent inspection. One 'Must Do' action was raised, as a result of which the Trust has expanded the scope of the fit and proper test for senior managers and brought all checks up to date. The Trust identified a number of further improvement actions based on CQC's report, which are in progress.

4.1.7 Income Disclosures

The Trust has met the requirement, within Section 43 (2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2013) that income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purpose.

Other income received during the year related primarily to funding for education and training (for mainly clinical staff) and income from non-patient care services to other bodies. Income from the latter is used to offset the costs of providing such services and any surplus used to support the provision of goods and services for the purposes of the health service in England.

4.2 Remuneration Report

4.2.1 Annual Statement on Remuneration

The Trust has two separate Remuneration Committees:

- The Board's Remuneration Committee, which sets and directs the implementation of remuneration policy for Executive Directors and the most senior managers across the CDDFT Group; and
- The Council of Governors' Remuneration Committee, which sets and directs the implementation of remuneration policy for Non-Executive Directors.

As the Chairman of both Committees, it is my pleasure to set out this Remuneration Report for 2019/20.

The major decisions made by the Committees during the year consisted of:

Decisions by the Board's Remuneration Committee:

- Approval of an increase in pay for Directors' and senior managers across the CDDFT Group. These increases were set in accordance with national guidance to reflect the increased cost of living.

Decisions by the Council of Governors' Remuneration Committee:

- Having considered national benchmarking information from NHS Providers, including the Trust's relative position, the Committee recommended no increase in remuneration for the Trust's Non-Executive Directors during 2019/20. This recommendation was endorsed by the Council of Governors.
- The Committee noted the Trust's intention to follow NHS Improvement's guidance document; *"Structure to align remuneration for chairs and non-executive directors of NHS trusts and NHS foundation trusts",* when reappointing or appointing Non-Executive Directors in future years. This will result in a reduction to the recommended maximum remuneration of £13,000 and the recommended maximum responsibility allowance (where applicable to the Non-Executive Director's duties) of £2,000.

These decisions were made within the context of the Trust's remuneration policies, which remained unchanged during the year, and on the basis of advice from the Trust's Workforce and Organisation Development Director and her senior team, complemented by external benchmarking where appropriate.

In agreeing the remuneration for senior management appointments, both Committees balance the need to attract and retain high calibre managers capable of implementing the strategic changes required within the Trust over the next five years, with the need for any remuneration levels to be justifiable in the context of national guidance and benchmarking, constraints on the pay of our general staff, and the productivity and efficiency targets which the Trust must meet.

Professor Paul Keane OBE
Chair of the Board's Remuneration Committee, and
Chair of the Council of Governors' Remuneration Committee

24th June 2020

4.2.2 Senior Management Remuneration Policy

Tables 22 and 23 shown below and overleaf summarise the components of remuneration for the Trust's most senior managers and Non-Executive Directors respectively. Differences in policy relating to Directors of Synchronicity Care Ltd (SCL) are noted in the table.

Table 22 - Future Policy– the most Senior Managers who are not paid under Agenda for Change

Component	Alignment to strategic objectives	Rules of operation
Annual salary	Salaries are set at a level capable of attracting and retaining high calibre managers with the skills to develop, direct and implement change in line with the Trust's strategic objectives and underpinning strategic plans.	Annual salaries are fixed. Annual uplifts are agreed by the Board's Remuneration Committee on the basis of recommendations from the Director of Workforce and OD, which are presented by the Chief Executive and supported by benchmarking and an assessment of performance against objectives reviewed by the whole Committee. Uplifts for 2019/20, reflected cost of living increases in accordance with national guidance. For the Chief Executive, annual uplifts to salary are agreed by the Board's Remuneration Committee based upon recommendations from the Director of Workforce and OD, which are endorsed by the Chairman and supported by both benchmarking and an assessment of performance against objectives reviewed by the whole Committee. The Trust does not set predetermined maximum limits in respect of annual salary increases. Performance against objectives is reviewed over the financial year. The Trust does not apply weightings to particular performance objectives or attach pre-determined levels of increase to particular performance objectives. The Board's Remuneration Committee considers performance against individual objectives, and Directors' contributions to the Trust's overall objectives alongside benchmarking and the prevailing rates of pay for similar posts in neighbouring and similar Trusts; however, none of the Executive Directors' pay is directly linked to performance. The Committee has discretion not to increase salaries where it considers that increases are not merited.
Access to the NHS Pension Scheme	Determined by the salary level which is set to secure appointments capable of implementing the Trust's strategy.	In line with the rules of the scheme.
SCL Directors	Salary Pension entitlements	Under the company's Articles of Association, Directors salaries are determined by the Trust. This is done through the Board's Remuneration Committee as noted above. Ms A McCree transferred from the Trust on a fixed point salary and with access to the NHS Pension scheme. Pension entitlements for the Finance Director, who served for part of the year were accrued in the NEST scheme rather than the NHS Pension Scheme, in line with the rules of that scheme. Both Directors' salaries were increased in accordance with the national guidance during the year in line decisions made by the Board Remuneration for the CDDFT Group.

There have been no new elements introduced into senior managers' remuneration packages during the year and no changes have been made to existing elements.

The Trust's policy with respect to remuneration of senior managers remains consistent with its general policy on employees' remuneration.

Each Trust Executive Director's annual objectives are agreed by the Chief Executive following review and approval of a draft by the Board's Remuneration Committee. The Chief Executive's objectives are agreed by

the Chairman following review of a draft by that Committee. The Chief Executive and Executive Directors are appraised annually, with performance against objectives reviewed by the Committee in year.

Senior managers paid more than £150,000

Three Executive Directors were paid more than £150,000 during 2019/20, comprising the Chief Executive, the Executive Medical Director and the Executive Director of Operations.

The Chief Executive's remuneration was set on the basis of benchmarking information and external advice when she took up her post in 2012, and the level of remuneration was deemed to be necessary to attract and retain a candidate of suitable calibre. Subsequent increases have been approved based upon consideration of national pay recommendations, review of performance and benchmarking information. The Chief Executive's remuneration is below the upper quartile of NHSI's published pay range.

The remuneration of the Executive Medical Director was – for his duties as Medical Director - capped at the same level as the previous incumbent and set in line with rates of pay for Medical Directors regionally and nationally. Pay for clinical sessions is in line with that paid to senior consultants within the Trust for similar clinical activities. Subsequent increases have been approved based upon consideration of national pay recommendations, review of performance and benchmarking information. The Executive Medical Director's remuneration is within the upper quartile of NHSI's published pay range.

The remuneration of the Executive Director of Operations was set – at the time of her appointment - on external advice from Gatenby Sanderson, who provided benchmarking information to assist the Board's Remuneration Committee in agreeing a remuneration package designed to attract and retain a candidate with suitable skills and experience. The post has a wide range of responsibilities including the requirement for the post-holder to deputise for the Chief Executive. Subsequent increases have been approved based upon consideration of national pay recommendations, review of performance and benchmarking information. The Executive Director of Operations' remuneration, recognising the post holder deputises for the CEO, is below the upper quartile of NHSI's published pay range.

Table 23** - **Future Policy – Non-Executive Directors (NEDs)

Component	Alignment to strategic objectives	Rules of operation
Annual salary	Remuneration is determined at a level capable of attracting and retaining high calibre NEDs with the skills to support the direction and implementation of change in line with the Trust's strategic objectives and underpinning strategic plans.	The Chairman is paid an annual remuneration in accordance with terms and conditions approved by the Council of Governors. Non-Executive Directors' remuneration is specified in their contracts, and agreed with the Council of Governors. All NEDs receive the same basic salary, set in accordance with regional and national benchmarking. This is to be reduced, on reappointment – or for new appointments – in line with the levels now recommended by NHS Improvement in their guidance document *"Structure to align remuneration for chairs and non-executive directors of NHS trusts and NHS foundation trusts".*
Additional salary payments for additional responsibilities	Payable in respect of additional time required from NEDs to chair Committees which are closely involved in scrutinising the achievement of strategic objectives and the management of strategic risk or to fulfil duties on behalf of the Trust with external stakeholders which further the strategy.	Any such additional payments must be recommended by the Council of Governors' Remuneration Committee and approved by the Council of Governors. All NEDs now chair Board Committees and / or have other elements of additional responsibility. Such payments which currently do not exceed £3,500 were frozen for the three years from 2017/18. Going forwards, they will be adjusted on reappointment / appointment in line with the NHS Improvement guidance referred to above.

SCL Directors	Salary Responsibility allowance	The Chairman of SCL's pay is aligned to the salary paid to Trust Non-Executive Directors, adjusted for any difference in the expected time commitment. No responsibility allowance is paid. Following the departure of Ian Robson, Paul Forster-Jones served as Interim Chair of SCL pending a review of future needs, with remuneration deemed to be covered through his existing remuneration and responsibility allowances, following a readjustment of his portfolio. There is no payment to the Trust's Non-Executive Director appointed to the SCL Board. Payment is deemed to be covered by his responsibility allowance paid through the Trust. Decisions on SCL Director's pay are made by the Trust's Board rather than the Council of Governors.

Annual performance objectives for the Chairman are proposed by the Council of Governors' Remuneration Committee and approved by the Council of Governors. The Committee appraises the Chairman's performance annually, a process facilitated by the Senior Independent Director.

Trust Non-Executive Directors' objectives are set annually by the Chairman, taking account of the views of Governors. Annual performance evaluations are carried out by the Chairman, supported by two senior Governors, and reported to the Council of Governors' Remuneration Committee.

End of year appraisals for 2019/20 were, however, stood down as part of the implementation of the Trust's Covid-19 response plan, in line with national guidance. They will be undertaken later in 2020/21.

Service contracts obligations

There are no specific service contract obligations in the senior managers' contracts other than the six month notice period for Executive Directors, the Workforce & Organisation Development Director and Managing Director of SCL, together with standard national NHS redundancy provisions. It is not proposed that any others will be entered. The standard national NHS redundancy provisions are capped and the Trust has applied this cap in its contracts with senior managers.

Policy on diversity and inclusion considered by the Remuneration Committee

The Board's Remuneration Committee follows a policy of setting remuneration for a particular post at a level capable of attracting and retaining high calibre managers of appropriate skills, ensuring that the remuneration is set fairly regardless of the background of any candidate appointed to the role. Through the nominations and appointments process, the Board seeks to encourage applications from those with protected characteristics to promote diversity and inclusion within the Board. The Trust's overall diversity and inclusion policy is covered in Section 3.2.4, with those aspects specific to the Board being rated as 'achieving' in our EDS2 report.

Policy on payments for loss of office

The principles on which determination of pay for loss of office will be based are as detailed above although the Board's Remuneration Committee and the Council of Governors' Remuneration Committee can apply some discretion as they consider necessary. Senior manager performance is not formally relevant in the exercise of discretion, although it is likely to be taken into account. Any severance payment outside of contractual terms must be approved by the Board's Remuneration Committee following receipt of appropriate advice and any required regulatory approval.

Consideration of employment conditions elsewhere in the Trust

The pay and conditions of other employees were considered when setting the pay and conditions of senior managers to ensure that they were in keeping save for any differences arising from specific circumstances.

The Foundation Trust did not consult employees when setting the senior managers remuneration policy. However, as noted above, in 2019/20, pay increases for Executives and the most senior managers in the Trust were limited to cost of living increases in accordance with national guidance. As noted above, there was no pay increase for the Chairman or Non-Executive Directors.

No external advice was taken in respect of senior managers' remuneration during the year. Whilst the Trust did not seek, or take account of expert advice with respect to Non-Executive Directors' remuneration in the year, it is taking into account the external, regulatory advice from NHS Improvement, in the publication *"Structure to align remuneration for chairs and non-executive directors of NHS trusts and NHS foundation trusts"* in setting maximums for remuneration and responsibility allowances for Non-Executive Directors in future years.

4.2.3 Annual Report on Remuneration

Table 24 shown below summarises the components, contract terms and notice periods for those senior managers and Non-Executive Directors serving on behalf of the Trust for all or part of 2019/20:

Table 24 - Senior Managers' Service Contracts (Trust)

Name	Contract date	Term / expiry	Notice period
Mrs S Jacques, Chief Executive	1 March 2012	Permanent contract	Six months
Mr D Brown, Executive Director of Finance (from 25th May 2017)	25th May 2017	Permanent contract	Six months
Mr J Cundall, Executive Medical Director	1 March 2017	Permanent contract	By agreement.
Mrs C Langrick, Executive Director of Operations	9 February 2015	Permanent contract	Six months
Mr N Scanlon, Executive Director of Nursing	4 June 2015	Permanent contract	Six months
Mrs M Smith, Workforce and Organisation Development Director	1 June 2015	Permanent contract	Six months
Professor P Keane OBE (Chairman)	1 March 2018	28 February 2021	None specified
Mr M Bretherick, Non-Executive Director	1 June 2019	31 May 2022	None specified
Mr S Crosland, Non-Executive Director	1 June 2018	31 May 2021	None specified
Mrs J Flynn MBE, Non-Executive Director	1 October 2017	30th September 2020	None specified
Mr P Forster-Jones, Non-Executive Director	1 June 2019	31 May 2022	None specified
Mr S Gerry, Non-Executive Director	1 June 2017	31 May 2020	None specified

The Council of Governors has approved the reappointment of Mr Simon Gerry from 1st June 2020 and is to receive a recommendation to reappoint Mrs Flynn in July 2020.

Table 25 shown below summarises the components, contract terms and notice periods for those senior managers and Non-Executive Directors serving on behalf of the Trust's subsidiary (SCL) for all or part of 2019/20:

Table 25 - Senior Managers' Service Contracts (SCL)

Name	Contract date	Term / expiry	Notice period
Ms A McCree, Executive Director	1 April 2017	Permanent contract	Six months
Ms S Judson, Executive Director **Left following the year-end**	7th January 2019	Permanent contract	Three months
Mr I Robson, Chairman **Left 31st August 2019.**	1 June 2017	Non-specified.	Non-specified.
Mr P Forster-Jones (Non-Executive to 31st August 2019, Interim Chairman from 1st September 2019)	1 April 2017	Under Trust contract (see above)	Non-specified
Mr S Crosland (Non-Executive)	1st September 2019	Under Trust contract (see above)	Non-specified

4.2.4 Membership of the Remuneration Committees

Membership of the two Remuneration Committees is provided in Table 26 shown below. It should be noted that Governors' terms of office may expire at different points during the year and that the Remuneration Committee's membership is refreshed in February each year; hence the number of meetings which would be expected to be attended over a 12 month period varies for different Governors.

Table 26 – Remuneration Committee Membership

Board Nominations and Remuneration Committee		**Council of Governors Remuneration Committee**	
Member	**Meetings attended**	**Member**	**Meetings attended**
Prof. P Keane OBE, Chairman	4/4	Prof. P Keane OBE, Chairman	3/3
Mr M Bretherick, Non-Executive Director	4/4	Mr Ian Beange, Public Governor, Derwentside	3/3
Mrs J Flynn MBE, Non-Executive Director	4/4	Mr C Boyd, Public Governor, Easington	3/3
Mr P Forster-Jones, Non-Executive Director	3/4	Ms Nancye Carr, Public Governor, Derwentside	1/1
Mr S Crosland, Non-Executive Director	4/4	Mr Chris Cunnington-Shore, Appointed Governor, Healthwatch Durham	0/1
Mr S Gerry, Non-Executive Director	4/4	Dr K Davison, Public Governor, Wear Valley and Teesdale	1/3
		Ms Patricia Gordon, Staff Governor, Nursing and Midwifery	0/3
		Mr David Lindsay, Public Governor, Derwentside	0/2
		Ms Carmen Martin-Ruiz, Public Governor, Chester le Street	2/3
		Mr Ian McArdle, Public Governor, Wear Valley and Teesdale	1/1
		Mr Gordon Mitchell, Appointed Governor, Local Universities	2/3
		Mr William Sloane, Staff Governor Nursing and Midwifery	0/3
		Mr Mac Williams, Public Governor, City of Durham	1/1

The Board's Remuneration Committee met on the following dates during the year:

- 14th May 2019;
- 31st July 2019;
- 30th October 2019; and
- 26th February 2020

The Council of Governors' Remuneration Committee met on the following dates during the year:

- 3rd September 2019;
- 3rd December 2019; and
- 18th March 2020.

4.2.5 Expenses paid to Governors and Directors

Governors may claim for basic expenses necessarily incurred in the performance of their duties (such as mileage to and from meetings) in accordance with Trust policies and in compliance with HMRC regulations or other legislation. Mileage and travel expenses are reimbursed in line with the standard rates applied for NHS staff. The time and travel commitment for each Governor differs, depending on which committees they must attend and the location of the meetings/events attended on behalf of the Trust.

Directors may claim reimbursement for basic expenses necessarily incurred in the performance of their duties. Expenses are claimed in compliance with Trust policies and (where applicable) are subject to income tax and national insurance deduction in accordance with HMRC regulation and other legislation.

Table 27 – Expenses paid to Governors and Directors

	2019/20			2018/19		
	Number in office	Number claiming expenses	Total sum paid £'00	Number in office	Number claiming expenses	Total sum paid £'00
Governors	33	7	20	41	22	60
Directors	14	13	100	14	13	120

4.2.6 Senior Managers' Remuneration and Fair Pay Multiple

Information in this section has been subject to audit as part of the external audit of the Trust's financial statements

Table 28 – Salary and Pension-related Benefits of Senior Managers

2019-20	Role	Salary banding £'000s	Taxable expenses and benefits in kind £'00s	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits £'000s	Total £'000s	Effective period
		nearest £5,000	nearest £100			nearest £2,500	nearest £5,000	
Mrs S Jacques	Chief Executive	210-215	0	0	0	52.5-55.0	260-265	
Mrs M Smith	Director of Workforce and Organisation Development	100-105	0	0	0	82.5-85.0	180-185	
Mr N Scanlon	Executive Director of Nursing and Patient Experience	130-135	0	0	0	7.5-10.0	135-140	
Mr D Brown	Executive Director of Finance	125-130	0	0	0	5.0-7.5	130-135	
Mrs C Langrick	Executive Director of Operations	155-160	0	0	0	0	155-160	
Mr J Cundall	Executive Medical Director	165-170	0	0	0	0	165-170	
Miss A McCree	Director - SCL	105-110	46	0	0	22.5-25.0	125-130	
Mrs S Judson	Director of Finance - SCL	80-85	0	0	0	0	80-85	
Prof P Keane	Chairman	55-60	0	0	0	0	55-60	
Mrs J Flynn	Non-Executive Director	15-20	0	0	0	0	15-20	
Mr M Bretherick	Non-Executive Director	15-20	0	0	0	0	15-20	
Mr P Forster-Jones	Non-Executive Director - Trust and Interim SCL Chairman from 01.09.2019	15-20	0	0	0	0	15-20	Interim SCL Chairman from 01.09.2019
Mr S Gerry	Non-Executive Director	15-20	0	0	0	0	15-20	
Mr S Crosland	Non-Executive Director and SCL Non-Executive Director from 01.09.2019	15-20	0	0	0	0	15-20	SCL Non-Executive Director from 01.09.2019
Dr I Robson	Chairman - SCL	5-10	0	0	0	0	5-10	Left 31st August 2019

2018-19	Role	Salary banding £'000s	Taxable expenses and benefits in kind £'000s	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits £'000s	Total £'000s	Effective period
		nearest £5,000	nearest £100			nearest £2,500	nearest £5,000	
Mrs S Jacques	Chief Executive	205-210	0	0	0	50.0-52.5	285-290	
Mrs M Smith	Director of Workforce and Organisation Development	110-115	0	0	0	0	110-115	
Mr N Scanlon	Executive Director of Nursing and Patient Experience	125-130	0	0	0	0	145-150	
Mr D Brown	Executive Director of Finance	120-125	0	0	0	60.0-62.5	195-200	
Mrs C Langrick	Executive Director of Operations	150-155	0	0	0	0	150-155	
Mr J Cundall	Executive Medical Director	170-175	0	0	0	0	170-175	
Miss A McCree	Director - SCL	100-105	4	0	0	7.5-10.0	130-135	
Mrs S Judson	Director of Finance - SCL	80-85	0	0	0	0	80-85	
Prof P Keane	Chairman	55-60	0	0	0	0	55-60	
Mr A Young	Non-Executive Director	15-20	0	0	0	0	0-5	Left 31st May 2018
Mrs J Flynn	Non-Executive Director	15-20	0	0	0	0	15-20	
Mr M Bretherick	Non-Executive Director	15-20	0	0	0	0	15-20	
Mr P Forster-Jones	Non-Executive Director - Trust and SCL	15-20	0	0	0	0	15-20	
Mr S Gerry	Non-Executive Director	15-20	0	0	0	0	15-20	
Mr S Crosland	Non-Executive Director	15-20	0	0	0	0	15-20	From 1st June 2018
Dr I Robson	Chairman - SCL	15-20	0	0	0	0	15-20	From 1st June 2017

In addition to his role as Executive Medical Director, Mr Cundall has continued to practice as a Colorectal Surgeon within the Trust. The salary and total pay quoted in the table above cover both roles, with £154,829 relating to his Executive role, and the remaining £14,819 relating to his clinical role.

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

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The multiple of 20 reflects an assumed payment period within the rules set out in the Foundation Trust Annual Reporting Manual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

The pension benefit table below provides further information on the pension benefits accruing to the individual.

The Board's Remuneration Committee has determined that, in the light of the assets managed by Synchronicity Care Ltd since 1st April 2017 and the Trust's dependence on the estates, facilites and services provided from that date, those senior managers who served exclusively as Directors of SCL during the year – namely Dr I Robson, Miss A McCree and Mrs S Judson - exercise significant inluence on group operations and strategy and should therefore be included in the above table.

Eleven employees earned more than the highest paid director. The salaries for theses individuals were not subject to agreement by the remuneration committee and largely relate to individuals working in excess of their contractual requirement. Remuneration ranged from £208,815 to £6,900 (2018/19 was £206,095 to £6,900).

The midpoint of the banded remuneration of the highest paid director during 2019/20 was £207,500 (2018/19: £206,095). This is 7.91 times (2018/19: 7.95 times) the median remuneration of the workforce, which was £26,220 (2018/19: £25,934). The calculation includes remuneration based on the whole time equivalent of all staff employed within the CDDFT Group at 31st March 2020.

Senior Managers' Total Pension Entitlements

Information in Table 29 below has been subject to audit as part of the external audit of the Trust's financial statements

Table 29 – Pension Benefits

Name and title	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 2020	Lump sum at pension age related to accrued pension at 31 March 2020	Cash Equivalent Transfer Value at 31 March 2020	Cash Equivalent Transfer Value at 01 April 2019	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000	To nearest £100
CDDFT								
Mrs S Jacques	2.5-5.0	0-2.5	75-80	165-170	1430	1,313	55	0
Mr N Scanlon	0.0-2.5	2.5-5.0	55-60	170-175	1391	1,295	45	0
Ms M Smith	2.5-5.0	0-2.5	5-10	0-5	106	0	57	0
Mr D Brown	0.0-2.5	0-2.5	40-45	95-100	706	650	22	0
SCL								
Ms A McCree	0.0-2.5	0-2.5	45-50	115-120	958	890	32	0

Note 1: The method used to calculate CETVs changed, to remove the adjustment for Guaranteed Minimum Pension (GMP) on 8 August 2019. If the individual concerned was entitled to a GMP, this will affect the calculation of the real increase in CETV. This is more likely to affect the 1995 Section and the 2008 Section. This does not affect the calculation of the real increase in pension benefits, column (a) and (b) of Table 29, or the Single total figure table, column (e) of Table 28.
Note 2: Benefits and related CETVs do not allow for any potential future adjustment arising from the McCloud judgment.

Ms S Judson has elected not to join the NHS Pension Scheme and Mr J Cundall withdrew from the scheme in September 2018. Ms M Smith joined the scheme in September 2019.

4.2.7 Payments for loss of office and payments to previous senior managers

There were no payments for loss of office or payments to previous senior managers made during 2019/20.

Sue Jacques
Chief Executive
24th June 2020

4.3 Staff Report

4.3.1 Analysis of Staff Costs

Information in Table 30 below has been subject to audit as part of the external audit of the Trust's financial statements.

Table 30 – Staff Costs Analysis

	2019/20			2018/19
	Total	Permanently employed total	Other total	Total
Staff costs	£000	£000	£000	£000
Salaries and wages	253,524	253,524		247,003
Social security costs	23,550	23,550		22,732
Apprenticeship levy	1,169	1,169		1,150
Pension cost - employer contributions to NHS pension scheme	39,947	39,947		27,335
Pension cost - other				
Other post employment benefits				
Other employment benefits				
Termination benefits				89
Temporary staff - external bank				
Temporary staff - agency/contract staff	8,633		8,633	8,870
TOTAL GROSS STAFF COSTS	**326,823**	**318,190**	**8,633**	**307,179**
Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure	-493	-493		-245
Recoveries from other bodies in respect of staff cost netted off expenditure	-101	-101		-34
TOTAL STAFF COSTS	**326,229**	**317,596**	**8,633**	**306,900**
Included within:				
Costs capitalised as part of assets	885	885		788

4.3.2 Analysis of Average Staff Numbers

The staff group breakdown is based on the average staffing whole time equivalents throughout the financial year. These figures include staff on temporary contracts, staff that have transferred out of the Trust and highlight fluctuations due to starters and leavers. The analysis is provided for the Group as a total.

Table 31 – Average Staff Numbers

Average WTE 2019/20			
Staff Group	**Permanent**	**Temporary**	**Total**
Medical & Dental	360	286	646
Ambulance Staff	17	0	17
Adminstration & Estates	944	31	975
Healthcare Assistants and Other Support Staff	1,780	224	2,005
Nursing, Midwifery and Health Visiting Staff	1,966	227	2,193
Nursing, Midwifery and Health Visiting Learners	0	0	0
Scientific, Therapeutic and Technaical Staff	573	16	589
Healthcare Science Staff	155	2	157
Social Care Staff	0	0	0
Grand Total	**5,795**	**786**	**6,581**

4.3.3 Breakdown of Staff

Table 32 – Breakdown of staff by gender

Trust

CDDFT Gender Summary as at 31st March 2020	Female	Male
Directors	**3**	**8**
Non-Executive Director/Chair	1	5
Executive Directors	2	3
Senior Managers/Managers	**186**	**83**
Senior Managers Including Other Directors	94	45
Managers B6+	59	35
Nurse Managers B6+ (Excluding Sister/Charge Nurse)	33	3
All Other Employees	**5415**	**913**
All Staff	**5604**	**1004**

Subsidiary Company (SCL)

SCL Gender Summary as at 31st March 2020	Female	Male
Directors	**2**	**0**
Non-Executive Director/Chair	0	2
Executive Directors	2	0
Senior Managers/Managers	**12**	**11**
Senior Managers Including Other Directors	7	9
Managers B6+/Grade E+	5	2
All Other Employees	**328**	**136**
All Staff	**342**	**147**

The gender summary details the number of female/male staff in post on 31st March 2020. Staff members are only counted once where they hold they hold multiple posts in the organisation.

The Trust would normally produce an annual report on the Gender Pay Gap however due to the ongoing Covid-19 pandemic, the Government issued guidance that reporting was suspended this year. As a result the Trust has not completed a report for 2019/2020 though reporting is anticipated to resume next year.

4.3.4 Sickness Absence Data

The health and wellbeing of our staff is a priority for the Trust. In an effort to identify absence trends and ensure appropriate interventions are in place to assist staff in maintaining their wellbeing, monthly sickness absence data is reported across all areas of the organisation.

The absence summary details the total number of absences due to sickness over the financial year broken down into long and short term episodes and by staff group. The analysis shows the position for CDDFT staff and for the Trust's subsidiary company's (SCL's) staff separately.

Table 33 – Staff Absence Summary (Trust)

CDDFT Absence Summary			
Staff Group	**Absence Occurrences**	**LT Absence Occurrences**	**ST Absence Occurrences**
Add Prof Scientific and Technic	320	50	270
Additional Clinical Services	2,423	383	2040
Administrative and Clerical	1,286	206	1080
Allied Health Professionals	560	45	515
Estates and Ancillary	32	5	27
Healthcare Scientists	127	10	117
Medical and Dental	474	34	440
Nursing and Midwifery Registered	3,313	517	2796
Students	11	0	11
Grand Total	**8,546**	**1250**	**7296**

Table 34 – Staff Absence Summary (Subsidiary)

SCL Absence Summary			
Staff Group	**Absence Occurrences**	**LT Absence Occurrences**	**ST Absence Occurrences**
Additional Clinical Services	4	3	1
Administrative and Clerical	84	14	70
Estates and Ancillary	510	104	406
Healthcare Scientists	8	0	8
Grand Total	**606**	**121**	**485**

4.3.5 Staff Policies and Actions

The Trust has a wide range of Employment Policies & Procedures which are available on the Trust's Intranet. Relevant policies and procedures are set out in Section 3.2.4 of our annual report: Social, Community and Human Rights Issues

4.3.5.1 Disabled Persons

Our policies and procedures, and developments in year have been summarised in Section 3.2.4 of our annual report: Social, Community and Human Rights Issues.

4.3.5.2 Employee Communications, Consultation, Involvement and Engagement

Work continued on implementing the Trust's people strategy "Staff Matter", which sets out the strategic workforce priorities for the three years covering 2017–2020 and the actions required to realise our workforce ambitions. As this was the final year of the strategy it underwent a complete refresh both in terms of content and reporting process and took account of feedback from both the staff survey and our engagement activities. The new strategy, "People Matter" was launched on 1 April 2020.

Moving to Good – Culture and Leadership Programme
In 2018/19, the Trust embarked on a long-term culture and leadership journey using a methodology from the NHS Improvement 'Moving to Good' Programme. 2019/20 was the second year of this journey. We implemented a range of planned engagement interventions, resulting in improvements in both staff engagement and the experience of our workforce, evidenced by their responses to the NHS Staff Survey set out in 4.3.6.

Examples of key interventions and 'Engagement Enablers' are set out below. These were developed and delivered to enhance meaningful staff-conversations and engagement, and to improve the experience of staffing working for us; which, in turn, helps us to retain and develop them.

- 'Walk in my Shoes' Workshops – aimed at helping everyone within the organisation to understand the nature and purpose of staff engagement, and how to understand the experience of others at work. The session also shared an award winning idea that we can all use for increasing enjoyment at work and to help engender a positive workforce experience.
- 'Engaging Managers/Leaders' Workshops – aimed at those in a formal leadership position helping them to explore their individual engagement style and how to enhance the workforce experience of colleagues. The workshops look at, and gather information around, participants' experience of work, alongside the nature and purpose of staff engagement and how to approach it. The workshops also introduce learning for managers in how to engage with their teams.
- 'Café Conversations' – created to provide an informal space to have meaningful conversations about what matters to our people and promote engagement in the national Staff Survey.

The engagement sessions have captured the views and experiences of a cross section of our people and the data collected has been mapped against the five cultural indicators of vision and values, goals and performance, support and compassion, learning and innovation and teamwork. Using the 'Moving to Good' methodology, the information from the engagement sessions was analysed to identify emerging themes, in order to inform the design and development of our "People Matter" strategy and action plans for 2020/21, including a range of interventions designed to further strengthen our culture and leadership.

Our learning has been shared at the North East Leadership Academy's Organisational Development Network through a presentation as best practice in June 2019 and at the North East & North Cumbria Community of Practice HFE Event in November 2019.

Supporting line managers in engaging with their staff
As part of the Culture and Leadership Journey the Trust recognises the importance of great line management in staff engagement and provides a comprehensive range of leadership and management development programmes to support managers in acquiring the necessary skills.

Strategic Leadership Development Programme
The Strategic Leadership Programme (SLP) is designed as a foundation programme for leaders, both clinical and non-clinical. The programme focuses on developing effective leadership skills using internationally recognised psychometric tools; evidence based research on leadership; and Trust specific data analysis and feedback metrics; to ensure both theory and practice are considered within the context of CDDFT and the future needs of the Trust. The programme has been rolled out across the Trust, with the final two cohorts completing the programme during 2019/20 bringing the total number of senior managers attending the

programme to 189. A full review of the SLP programme has been undertaken along with consideration of the next steps for 2020/21 and a recommendation to review the whole Leadership and Management offering.

Leadership Conferences
The Trust has a programme of leadership conferences to create a space where leaders can gather together to be encouraged and inspired by outstanding speakers. The sessions aim to be thought provoking and give an opportunity to reflect on our own leadership and the challenges we face. The conference in June 2019 was combined with the Trust's "Leading a Highly Reliable Organisation" Conference and included a presentation on Generational Diversity from Dr Paul Redmond. In total 311 senior leaders attended and the next combined conference is planned for September 2020.

Operational Management
The Great Line Management Fundamentals Programme was first introduced in 2017/18. This programme consists of a portfolio of activities designed to develop managers as leaders and prepare them for the SLP. Great Line Management Fundamentals focuses on developing an individual's understanding of their role as a manager and the skills needed to influence and work effectively through others; for example, people management skills. The programme offers a comprehensive range of workshops beginning with an introductory day, followed by a series of free-standing modules covering key areas such as staff engagement, personal resilience, effective communication, workforce policy and processes. In addition to a wide range of workshops, "HR for Managers" mini guides are available and include information on topics such as recruitment and selection and disciplinary and grievance procedures. This programme has been fully refreshed during 2019/20 and is being reviewed for 2020/21.

Mary Seacole Local Leadership Programme
To supplement our internal leadership and management development programme, we are exploring the use of the Mary Seacole Programme, a long established national programme, to help develop staff in Band 5 to Band 7 roles, to support talent management and succession planning. As a result of partnership working, facilitation and negotiation the cost per delegate has significantly reduced to £150 as compared to the national cost of £995. A pilot programme is underway and after a briefing session in January the Virtual Campus opened in February 2020 and the first workshop was facilitated in March in partnership with Sunderland and South Tyneside Foundation Trust and the local Leadership Academy. Once completed there will be an evaluation of the six month programme with a view to rolling it out long term.

Building Leadership for Inclusion (BLFI)
In 2018/19, the Trust took part in a pilot of the BLFI approach, which is aimed to support organisations in recognising and reaping the benefits of diversity in the workplace. The pilot officially ended 31 March 2019. During the first quarter of the financial year 2019/2020 we were asked to showcase the work undertaken as part of the pilot at two "sharing the Learning" events organised by the National Leadership Academy. Following these events the NHSE/I asked us to produce a case study of our work which will feature as an example of good practice in their review of the "Developing People, Improving Care" strategy. The case study is also being used by the National Leadership Academy as part of their report on the BLFI pilot. In

January 2020, we were asked to share our work at the regional inclusion conference which took place at St James Park, Newcastle. We continue to roll out the learning from the pilot, and we have joined the national network of Leadership Learning Organisations.

Talent Management
Talent Management is the systematic attraction, identification, development, engagement, retention and deployment of those individuals who are of particular value to an organisation, either in view of their 'high potential' for the future or because they are fulfilling business/operational-critical roles. We take an inclusive approach focusing on the identification of individuals' strengths in order to further develop the capability of teams across the Trust; recognising that not everyone seeks career progression but that should not preclude them from development opportunities.

Our talent management approach is closely aligned to our annual appraisal and role review framework. This process includes a 'talent conversation' for all staff and ensures both staff and managers discuss the performance, potential, ambition and readiness for progression of all staff across the Trust. These four elements form the basis of a structured approach to considering each individual staff member's development needs, for both personal and career development basis. Talent Management helps to ensure the Trust is able to meet its workforce planning needs for future critical roles by having robust and managed succession planning.

We continue to make maximum use of the apprenticeship levy, which is now being used to develop career pathways for all key roles across the Trust. The apprenticeship levy is a Government initiative where large employers must pay 0.5% of their payroll bill into the levy which can only be used to fund apprenticeship training. The Trust has in the region of £1.1million in its levy pot. The number of apprenticeships currently in place within the trust is 274, which includes 36 young apprentices. The apprenticeships range from Level 2 to Level 7 across a broad spectrum of professional areas.

'**Breakfast with Sue' and Board Visits to Wards and Teams**
These sessions provide a random selection of staff with a genuine opportunity to meet the Chief Executive and talk to her about working life at the Trust. These events were held each month during 2019/20 and were small and personal rather than a large group event, thereby providing every attendee the chance to speak. The Chairman also joins these events when he is able to so that he hear staff views first hand. In addition, Board members undertake frequent visits to wards and teams, on both our acute and community sites, to meet with staff members, listen to any concerns and observe the excellent and compassionate care which they provide.

Staff Annual Awards
In 2019/20, the Trust refreshed its annual awards programme and aligned the nomination categories to the organisation's values. The awards form an important part of the Trust's internal communications and engagement programme providing an opportunity to recognise and celebrate the commitment and dedication of the #TeamCDDFT workforce. The categories therefore included:

- Compassionate Care;
- Improvement and Innovation;
- Working together for patients;
- Respect and Dignity;
- Excellence Award (Clinical);
- Excellence Award (non-clinical);
- Chief Exec Team Award; and
- Chairman's Star Award.

In addition, new awards were introduced aligned to the Trust's on-going excellence reporting scheme, and the Trust also holds an annual programme of nursing and midwifery awards linked to international day of the midwife and nurses day.

In February 2020 we held our third annual awards to fall in line with National Apprenticeship week. Over 20 apprentices were awarded their certificates of achievement in person by the Chairman and once again we invited managers to nominate their staff who had excelled whilst undertaking their apprenticeship programme for Apprentice of the year. We had a number of high calibre nominations making it such a difficult decision that there were two winners for both of our categories, Clinical Apprentice of the year and Non-Clinical Apprentice of the Year.

Support for Teams and Services
In 2019/20 HR and Workforce Experience Teams continued to operate the "Teams In Need" panel process. This enables teams and services to submit a request for support specific to their needs. These requests are considered and a bespoke intervention is then designed and delivered to meet the need.

4.3.5.3 Information on Health and Safety Performance

Compliance with Health and Safety legislation and regulations has continued to be monitored through the Trust Health and Safety committee. This committee meets quarterly with staff, unions and PFI staff in attendance. It monitors Health and Safety incidents/accidents, trends and audits and initiates actions and recommendations to improve staff health, safety and wellbeing. During this year it has strengthened the focus on staff well-being with the Occupational Health team now regularly attending and providing updates.

The Trust's Health and Safety Team investigates all staff-related and contractor/visitor incidents and accidents, monitors trends and, as part of a rolling programme, audits each ward and team's risk assessments and local safety documentation. The team provide monthly reports to each Care Group to support learning and action to enable them to maintain a safe working environment, including implementation of safety measures in their areas of responsibility.

Reporting of health and safety related incidents remained consistent during 2019/20 with 450 incidents reported, which is in line with previous years. 94% of these were no harm or minor harm incidents.

Some 23 incidents were reported to the Health and Safety Executive with regards to incidents that fall under the Reporting of Injuries, Diseases & Dangerous Occurrences Regulations 1995 (RIDDOR). All incidents were investigated at the time by either the Health & Safety Team or the Back Care Team depending on the type of incident.

As part of the rolling programme of audits, 94 wards and departments were audited in the last 12 months. Managers are advised of any corrective action required and followed up by the Health and Safety Team.

There have been no Health and Safety Executive (HSE) inspections in 2019/20 and no Improvement or Enforcement Notices issued during the last 12 months.

The Trust continues to see a reduction in needlestick injuries each year and in 2019/20 achieved a 16% reduction in injuries compared to 2018/19. The Health and Safety Team continue to develop risk assessments for all existing devices, both safe and non-safe, that are used within the Trust as well as for new safe sharp devices as they are introduced.

During the year, the Trust launched its Violence and Aggression Reduction Programme, in response to evidence of an increasing number of incidents of verbal and physical abuse against frontline staff in particular. The issues involved are complex, with the underlying causes of such abuse ranging from simple behavioural issues to a range of medical and related factors, in particular, delirium, confusion due to dementia or medications and mental health issues. The programme launched in July 2019, with key actions including:

- An overhaul of our Violence and Aggression Policy drawing on good practice from other Trusts;
- Publicising our zero tolerance of violence and aggression in our emergency departments;
- Review and strengthening of our approach to identifying and applying proportionate but firm sanctions to persistent offenders;
- Working with medical leaders in specialties such as Gastroenterology to understand the impact of medical factors, and medications increasing the propensity for violence against staff and development of protocols to manage the risks arising.

- Strengthening relationships with the County Durham Constabulary and introducing quarterly meetings between senior staff from our A&E Departments and the local police to share intelligence and good practice on steps to help protect staff from violence and abuse.
- Improving the breadth and depth of reporting on incidents of violence and aggression including the rigour of incident investigation and learning.
- Improving the way that alerts, denoting patients with a risk of violence based on previous history are shared between departments and systems.

The Health and Safety Committee reviewed the progress of the action plan. The Security Group, which reports into the Health and Safety Committee met every quarter to review learning from the most significant incidents, and to identify key messages and learning to be disseminated widely within the Trust, with assurance being sought that key learning points were being acted upon.

4.3.5.4 Staff Health and Wellbeing

The Trust is fully committed to supporting and improving the health and wellbeing of all employees to maximise their engagement, attendance and happiness at work. There is clear evidence that the more engaged and motivated our workforce is, the better the quality of patient care they are able to deliver.

The Occupational Health & Wellbeing Service strives to maintain the highest degree of health, safety and wellbeing of all staff by working in partnership with all employees, line managers and Workforce & Organisation Development (OD) colleagues to encourage everyone to recognise the importance of preventing ill-health, and the key role that the workplace can play in promoting health and well-being.

Our Staff Health & Wellbeing Strategy has just been updated, with the new three year strategy 'Health & Wellbeing Matters' to be ratified by the Trust Board in June 2020. The strategy supports the Trust's overarching 'People Matter' strategy and sets out a framework of employee support mechanisms and initiatives to promote a culture in which wellbeing is embraced by all our employees.

During 2019/20 we established the Health & Wellbeing Focus Group, whose membership includes representatives from Care Groups, Communications, SCL, Workforce & OD and local staff side representatives. This Group is leading on the development of a comprehensive, strategic health & wellbeing plan.

The Occupational Health & Wellbeing Service supports staff by providing independent, expert advice to both employees and managers, and by promoting early intervention, prevention and of staff with health issues. The Service provides a wide range of guidance for staff to improve their health and wellbeing. The Service gained the national accreditation as a Safe, Effective, and Quality Occupational Health Service (SEQOHS) in 2014 (for five years). A full and comprehensive five-year assessment process for accreditation, which was due to take place later in 2020, has been temporarily suspended due to the COVID-19 situation.

A full Employee Assistance Programme is available to all staff. This is a free, confidential, information and counselling service available via a free-phone number 24 hours a day, 365 days a year.

A comprehensive Directory of Support Services and a variety of self-help advice sheets have been developed for staff.

Health Advocates are in place and they support the Occupational Health & Wellbeing team in promoting health and wellbeing to colleagues throughout the Trust, playing an integral part in supporting health and wellbeing events. A variety of health campaigns were undertaken in 2019/20 including: Alcohol Awareness, Mental Health Awareness, Tea & Talk Days, Monthly Health Campaigns linking to National events i.e. Flu, Healthy Eating, Breast Cancer Awareness, Sun Safety Awareness, HIV/Aids Awareness Day, Menopause Awareness, Diabetes information, Prostate Cancer information, Sexual Health information, Organ Donor awareness, four Health & Wellbeing Roadshows and additional health information packs for all sites and community hospitals. The Annual Flu Vaccination Campaign resulted in 87.3% of our frontline healthcare workers being vaccinated (compared to 78.3% in 2018/19).

Occupational health staff have also worked in partnership with Learning & Development colleagues who deliver training for staff in personal resilience and managing stress in others which have been very popular with staff.

4.3.5.5 Information on Policies and Procedures with respect to Countering Fraud and Corruption

The Trust's counter fraud service is provided by Audit One, an NHS shared service providing internal audit, IT audit and counter fraud services to the public sector in the North of England. An Anti-Fraud Policy is in place which outlines the Trust's approach to fraud and identifies the specified fraud reporting lines. In addition, a Raising Concerns (Whistleblowing) Policy is in place which provides contact details for reporting concerns in respect of any potentially fraud related issues. The Trust has a Freedom to Speak Up Guardian, as an independent and impartial point of contact/source of advice. This is in line with the NHS national whistle-blowing policy. Our Local Counter-Fraud Specialist (LCFS) reports to the Audit Committee and performs a programme of work designed to provide assurance to the Board with regard to fraud and corruption. The LCFS provides fraud awareness sessions and induction packs to our staff, investigates any concerns reported by staff and liaises with the national NHS counter fraud service, the Police and the Crown Prosecution Service as appropriate. If any issues are substantiated, we take appropriate criminal, civil or disciplinary measures.

4.3.6 Staff Survey Results

The Trust uses the results of the NHS Staff Survey to inform both local (department / team) and Trust-wide action plans aimed at engaging, supporting, developing and enabling our staff to deliver high quality care. Progress on, and outcomes from, action plans are reviewed every quarter by the Strategic Change Board and by the Board's Integrated Quality and Assurance Committee.

The results from the 2018 staff survey informed a Trust-wide work plan for 2019/20 which focused on employee engagement, culture and building collective leadership. This was informed by the NHSI/E-led 'Moving to Good' programme and involved: design and delivery of a number of engagement enablers; improvements in existing supporting interventions; and joining up of all engagement activity across the Trust, in order to foster a positive shift in organisation culture. Areas for development identified through the 2018 survey were included as additional questions in our quarterly Staff Friends and Family Test survey for the year 2019/20.

Thanks to the very proactive approach taken by our Communications and Workforce Experience Teams, in creating channels for meaningful dialogue with staff on their experience working with us, we saw a huge increase in the survey response rate from 26% in 2018 to 44% in 2019. Our response rate was close to the national average, having been well below it in 2018.

The 2019 survey covered 11 key themes, with the 'Team-working' theme being a new addition in the year. The survey report places more emphasis, than in previous reports, on long-term trend analysis, rather than year on year fluctuations which may not be indicative of the underlying trend in performance. The Trust's scores for each them are set out in Table 35 overleaf, for the last three years, together with the average scores for combined acute and community trusts against which the Trust is benchmarked.

There was no statistically significant change for nine out of the 11 themes when comparing the Trust results for 2019 against the Trust results for 2018. However, there was a statistically significant improvement in the

scores for the Staff Engagement and Safety Culture. The Trust has consistently scored slightly higher than the national average for the new theme of team working for the past three years. There was no statistically significant deterioration in the score for any theme.

The overall Staff Engagement score was 6.9 (out of 10, where 10 is the most and 1 is least engaged). This is an improvement on the 2018 score which was 6.7. There was an improvement in scores for eight out of the nine engagement indicator questions, with one remaining the same. The overall engagement score remains slightly below the national average of 7.1 for combined acute and community trusts; we still have work to do therefore, to fully engage our staff, but the results clearly demonstrate that we are moving in the right direction.

Table 35 – Results by Theme

	2019/20		2018/19		2017/18	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, Diversion and Inclusion	9.3	9.2	9.3	9.2	9.3	9.2
Health and Wellbeing	5.9	6.0	5.8	5.9	6.0	6.0
Immediate Managers	6.8	6.9	6.7	6.8	6.7	6.8
Morale	6.1	6.2	6.0	6.2		
Quality of Appraisals	5.2	5.5	4.8	5.4	4.9	5.3
Quality of Care	7.4	7.5	7.5	7.5	7.4	7.5
Safe Environment – bullying & harassment	8.0	8.2	7.9	8.1	8.1	8.1
Safe environment - Violence	9.3	9.5	9.4	9.5	9.4	9.5
Safety culture	6.8	6.8	6.4	6.7	6.6	6.7
Staff Engagement	6.9	7.1	6.6	7.0	6.7	7.0
Team Working	6.8	6.7	6.8	6.6	6.7	6.6

Areas of Improvement and Deterioration from 2018 to 2019

Table 36 – Positive trends

Questions	2019		2018		Trust improvement/ Deterioration
	Trust	National Average	Trust	National Average	
Q14. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	90.2%	85.6%	89.6%	85.5%	Our score improved and is higher than national average (higher the score the better)
Q17d. We are given feedback about changes made in response to reported errors, near misses and incidents	69.8%	62%	60.6%	59.4%	Our score improved and is much better than the national average (higher the score the better)

Questions	2019		2018		Trust improvement/ Deterioration
	Trust	National Average	Trust	National Average	
Q19a. Percentage of staff being appraised	92.8%	88.6%	92.7%	88.8%	We maintained our score which remains better than national average (higher the score the better)
Q20. Have you had any (non-mandatory) training, learning or development in the last 12 months?	81.1%	70.3%	80.2%	70.3%	We continued to improve our score which remains well above the national average (higher the score the better)
Q21c. I would recommend my organisation as a place to work	57.2%	64%	47.8%	62.3%	We significantly improved our score which moved closer to national average

The Trust score in relation to providing equal opportunities for career progression has been above the national average for the past five years. Further analysis of the 2019 results show that the % of white staff believing that the trust provides equal opportunities for progression has remained at 90% in 2019 which is better than the national average of 87.4%. The % of black and minority ethnic staff believing there is equal opportunity for career progression in 2019 is 85.7% which is significantly better than the national average of 72.9%.

As can be seen from the table there has been a significant improvement in the Trust's score from 2018 to 2019 in relation to staff recommending the organisation as a place to work. We have also narrowed the gap between the Trust score and the national average.

The Trust has outperformed the national average for the number of staff having non-mandatory training for the past five years and also outperformed the national average on the number of staff having an appraisal for the last three years.

Table 37 – Key areas for Development

Overall Theme/Questions	2019		2018		Trust improvement/ deterioration
	Trust	National Average	Trust	National Average	
Q11f. Have you felt pressure from colleagues to come to work?	20.7%	20.5%	14.6%	20.1%	There was a significant deterioration in our score which is now higher than the national average (lower the score the better)
Q12a. In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?	18.4%	13.0%	14.1%	12.7%	There was a significant deterioration in our score which is now higher than the national average (lower the score the better)
Q13a. In the last 12 months how many times have you	33.2%	25.9%	34.2%	25.8%	Our score improved score but is still much higher than the

Overall Theme/Questions	2019		2018		Trust improvement/ deterioration
	Trust	National Average	Trust	National Average	
personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?					national average (lower the score the better)
Q22b. I receive regular updates on patient / service user experience feedback in my directorate / department (e.g. via line managers or communications teams)	55.6%	62.7%	56.6%	61.1%	There was a slight deterioration in our score which remains lower than the national average (higher the score the better)
Q22c. Feedback from patients / service users is used to make informed decisions within my directorate / department	46.7%	58.3%	49.9%	57.2%	There was a deterioration in our score which remains lower than the national average (higher the score the better)

Whilst this year's survey results indicate many improvements, there are also areas for focus and attention as illustrated in the table above.

As outlined in section 4.3.5.3 Information on Health and Safety Performance, the Trust has implemented a wide-ranging programme of work to prevent and deter violence and aggression against staff, with more robust management of persistent offenders, visible promotion of our zero tolerance approach to such violence, and overhaul of policies and procedures, closer working relationships with the police and the development of protocols to help balance out risk factors where violent and abusive behaviour is influenced by medical and related factors. This programme had been running for only two months when the Survey was undertaken and a number of the key actions were in the early stages. There is further to go to embed new policies and procedures and to evaluate their success. To some extent, the impact of the Covid-19 outbreak, resulting in reduced A&E attendances and limitations on visitor attendance, has made it difficult to assess whether the steps taken have proved effective. We will continue to implement and evaluate the effectiveness of the planned actions over the remainder of 2020/21.

There are many examples of local initiatives being undertaken to improve services as a result of patient feedback; however, the extent to which this takes place varies by service. As outlined in the Performance Report - Section 3.2.2.2 Quality **–** the Board has identified Patient and Public Engagement as a priority for 2020/21 and we are working with our partners across the local and wider system to develop systematic engagement programmes with patient and public groups, and hard to reach groups. We are seeking to implement improvements to the way in which we capture and report on all learning from patient feedback.

Next Steps

The Staff Survey results provided further evidence of the improvements in staff morale and engagement observed by CQC's inspection team and noted in their report issued in December 2019.

Moving forwards, the staff survey results will be used to inform the next stage of culture and leadership improvement programme. Trust-wide actions will be integrated into that programme, and actions relating to Equality, Diversity and Inclusion (EDI) incorporated into our EDI action plans, which are also designed to address issues highlighted in our WRES, WDES and EDS2 reports. Implementation of these action plans will be overseen by our EDI Delivery Group. As always, local action plans will be in place for each Care Group and directorate to address local issues. In addition, the Trust has observed further improvements in staff morale, engagement and teamwork through the implementation of our Covid-19 incident response plan and is looking to understand and capitalise on the changes which have underpinned those further improvements.

There are a number of corporate initiatives in place which are designed to further improve how we support and engage our staff as outlined below:

- Appraisal Review – it is clear from the last two annual staff surveys that whilst most staff receive an annual appraisal, the appraisal process does not always help our staff to do their job better or feel valued. Developing the appraisal process to deliver a quality conversation needs to be done collaboratively, with staff, initially through current engagement activity followed by the setting up of a task and finish group to develop the approach that there is a real focus on a meaningful talent conversation. Consideration will also be given to other appraisal formats in use in the Trust and elsewhere.

- Wellbeing – This is already a focus for the Trust, with a wide-ranging offer being showcased senior managers by the Health and Wellbeing focus group. Indicators in the staff survey results suggest that people are coming to work when the may not be well enough to do so and also highlighting that they are stressed at work. We have recently recruited an Occupational Health Consultant lead. We are also working across the region with the Health and Wellbeing delivery group.

- Retention - Continued rollout of our retention strategy, building on work undertaken with medical staff Trust wide, on key determinants of loyalty and retention, the results of which are currently being analysed and will be presented to senior managers. The approach will be rolled out on a quarterly basis to other staff groups the next of which will be corporate directorate and support teams. Once completed an overarching report will be developed with recommendations.

- Restorative approach - A restorative coaching approach has been developed, to help address disputes and issues within teams as a result of which we have seen a significant reduction in grievances and an increase of 50% requests for mediation and coaching as a means of supporting teams in resolving issues and moving forwards. We are working through relevant policies to update them in line with this approach.

- Talent Management – We will look to increase the pace of the roll out of our Talent Matters Strategy and, following on from a recent review of our Strategic Leadership Programme undertake a full review of our current leadership development offer. Research by the King's Fund, and others, has highlighted the benefits of a collective leadership model, where responsibility is distributed among leaders at all levels. This will require us to embed leadership learning throughout all levels of supervision, management and leadership in the Trust. This has already commenced through partnership working with the Leadership Academy and pilot of a local Mary Seacole programme commenced in February 2020 for staff at Bands 5 – 7.

- Engagement – All of the above initiatives are, in fact, engagement-enabling activities. The last year saw an increase in the level of bespoke engagement interventions in response to what we heard from our staff directly, through a number of channels now in place to allow them to share their experience whilst working for us. These interventions have been welcomed by our staff and it is important we continue 'the conversation' with them in the upcoming year to further strengthen our understanding of what it feels like to work in CDDFT and inform the design of ongoing support mechanisms.

- The Communications and Workforce Experience Teams are reviewing the 2019 NHS Staff Survey approach to consider how best to build upon the increase in response rate and plan well in advance for the 2020 survey.

4.3.7 Trade Union Facility Time

The Trade Union (Facility Time Publication Requirement) Regulations 2017 took effect on 1 April 2017. NHS employers are now required to publish certain information on trade union officials and facility time on their websites

The Workforce team have worked actively with our local union colleagues to improve the internal reporting arrangements on union facility time, and this has seen an improvement on the activity captured during the last two years.

It should be noted that the deadline for reporting on 2019/20 has been extended to September 2020 due to the emergency pandemic.

Table 38: Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
47	42.46

Table 39: Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) *0%,* b) *1%-50%,* c) *51%-99%* or d) *100%* of their working time?

Percentage of time	Number of employees
0%	25
1-50%	22
51%-99%	0
100%	0

Table 40: Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period

First Column	Figures
Provide the total cost of facility time	£60,474
Provide the total pay bill	£313,030,384
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.019%

Table 41: Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of the total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	19.9%

4.3.8 Expenditure on Consultancy

Expenditure on consultancy for the year amounted to £14,970 (2018/19: £13,822).

4.3.9 Off-Payroll Engagements

Table 42 – Off-Payroll Engagements

For all off-payroll engagements as of 31 Mar 2020, for more than £245 per day and that last for longer than six months	**2019-20 Number of engagements Number**
No. of existing engagements as of 31 Mar 2020	41
Of which:	
Number that have existed for less than one year at the time of reporting	17
Number that have existed for between one and two years at the time of reporting	18
Number that have existed for between two and three years at the time of reporting	3
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	3

For all new off-payroll engagements, or those that reached six months in duration, between 01 Apr 2019 and 31 Mar 2020, for more than £245 per day and that last for longer than six months	**2019/20 Number of engagements Number**
Number of new engagements, or those that reached six months in duration between 01 Apr 2019 and 31 Mar 2020	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 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

	8A3
For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 Apr 2019 and 31 Mar 2020	**2019/20 Number of engagements Number**
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	14

4.3.10 Exit Packages

Exit packages are summarised below. Redundancy and other departure costs have been paid in accordance with the provisions of the appropriate NHS scheme. Exit costs provided are the full costs of departures agreed in the year. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Information in Table 43 below has been subject to audit as part of the external audit of the Trust's financial statements.

Table 43 - Exit Packages 2019/20

Exit Package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
Less than £10,000	1	7	20	85	21	92	0	0
£10,000 - £25,000	5	81	0	0	5	81	0	0
£25,001 - £50,000	1	27	1	26	2	53	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total number of exit packages	7	0	21	0	28	0	0	0
Total resource cost	0	115	0	111	0	226	0	0

Comparative information is provided below:

Table 44 - Exit Packages 2018/19

Exit Package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
Less than £10,000	1	10	43	165	44	175	0	0
£10,000 - £25,000	4	53	5	62	9	115	0	0
£25,001 - £50,000	4	50	0	0	4	50	0	0
£50,001 - £100,000	1	71	0	0	1	71	0	0
£100,001 - £150,000	0	119	0	0	0	119	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total number of exit packages	10	0	48	0	58	0	0	0
Total resource cost	0	303	0	227	0	530	0	0

Table 45 – Exit packages: non-compulsory departure payments

	2019/20		2018/19	
	Agreements	Total value of Agreements	Agreements	Total value of Agreements
	Number	£000s	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice*	21	111	48	228
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval**	0	0	0	0
Total	21	111	48	228

As a single exit package can be made up of several components each of which will be counted separately in this table (45), the total number above will not necessarily match the total numbers in tables 43 and 44 which will be the number of individuals.

* any non-contractual payments in lieu of notice are disclosed under “non-contractual payments requiring HMT approval” below.
**includes any non-contractual severance payment made following judicial mediation, and X (list amounts) relating to non-contractual payments in lieu of notice.
No (zero) non-contractual payments (£0) were made to individuals where the payment value was more than 12 months’ of their annual salary.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report

4.4 The NHS Foundation Trust Code of Governance Disclosures

The NHS Foundation Trust Code of Governance ("the Code") is published by NHS Improvement. Its purpose is to further the development of corporate governance in individual Foundation Trusts by making Governors and Directors aware of the principles of good governance and how to develop best practice in their application.

The Board ensures compliance with the Code through the arrangements it puts in place for its governance structures, policies and processes and how it keeps them under review. These arrangements are set out in documents that include:

- The Constitution;
- Schedule of Matters Reserved to the Board;
- Standing Orders;
- Standing Financial Instructions;
- Scheme of Delegation and Decisions Reserved to the Board;
- Terms of Reference of the Board and Council of Governors' Committees;
- Dispute Resolution Procedure; and
- Codes of Conduct.

County Durham and Darlington NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a "comply or explain" basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

A full review of compliance has been completed by the Trust Secretary and reviewed by the Trust's Audit Committee. The Directors consider that the Trust complied with the provisions of the Code in full during 2019/20.

4.4.1 Other Disclosures in the Public Interest

The Trust has sought to cover all of the content required by NHS Improvement's NHS Foundation Trust Annual Reporting Manual 2019/20, and additional information to allow the public to understand the Trust's position and prospects elsewhere in this report. The Trust considers that there are no further matters required to be included in the public interest.

4.5 Regulatory ratings

4.5.1 NHS England and Improvement's Single Oversight Framework

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

- Quality of care;
- Finance and use of resources;
- Operational performance;
- Strategic change; and
- Leadership and improvement capability.

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

Following the most recent Quarterly Review Meeting with NHS England and Improvement held on 10th December 2019, the Trust was confirmed as remaining in Segment 2, as it had done throughout 2019/20. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website. The meeting scheduled for March 2020 was converted to a limited telephone call in recognition of the need for the implementation of the Covid-19 pandemic response plan to take precedence.

NHS England and Improvement has not considered it necessary to take enforcement action or to mandate any support to the Trust. We did, however, request and receive additional support in specific areas primarily through NHSI's national 'Moving to Good' programme for Trusts with ratings of 'Requires Improvement' from CQC who are looking to move to an overall rating of 'Good' in the short-term. The programme was commenced in 2018/19 and concluded in the early part of 2019/20, prior to the most recent CQC inspection.

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

Table 46 – Finance and Use of Resources Scores

Area	Metric	2018/19 Quarter 1 score	2018/19 Quarter 2 score	2018/19 Quarter 3 score	2018/19 Quarter 4 score	2019/20 Quarter 1 score	2019/20 Quarter 2 score	2019/20 Quarter 3 score	2019/20 Quarter 4 score (DRAFT)
Financial sustainability	Capital servicing capacity	4	4	4	4	4	4	4	3
	Liquidity	3	4	4	3	3	3	3	4*
Financial efficiency	I&E margin	4	4	4	2	4	4	2	1
Financial controls	Distance from financial plan	2	2	3	3	1	1	1	2
	Agency spend	1	1	1	1	1	1	1	1
Overall score		**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**

*Note - change to liquidity metric in Q4 2019/20 due to change of DHSC loan from non-current borrowings to current borrowings prior to conversion to PDC in 2020/21

5.2 Care Quality Commission

The Care Quality Commission inspected the Trust between July and September 2019, reporting in December 2019. Overall, the Trust was rated as 'Good' with DMH and UHND rated as 'Good' and our Community Services also rated as 'Good'. All of the Trust's individual services are rated as 'Good' with the exception of End of Life Care at both DMH and UHND, which is rated Outstanding, and Urgent and Emergency Care at UHND, which is rated Requires Improvement.

4.6 Statement of the chief executive's responsibilities as the accounting officer of County Durham and Darlington 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 County Durham and Darlington 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 County Durham and Darlington NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts, and overseeing the use of public funds, 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 and disclose any material uncertainties over going concern.

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 them 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.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Sue Jacques

Chief Executive

24th June 2020

4.7 Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to: identify and prioritise risks to the achievement of the policies, aims and objectives of County Durham and Darlington NHS Foundation Trust; evaluate the likelihood of those risks being realised and the impact should they be realised; and manage them efficiently, effectively and economically. The system of internal control has been in place in County Durham and Darlington NHS Foundation Trust for the year ended 31 March 2020 and up to the date of approval of the Annual Report and Accounts.

The Trust relies on the system of control to manage risks to:

- The fulfilment of its core purpose of providing safe, compassionate, joined up care to our patients in County Durham and Darlington and neighbouring areas, in line with our mission statement; and
- The realisation of our vision - 'Right First Time, Every Time' – which captures our intention for services to be provided by the right professional, in the right place, in hospital or close to home, at the right time, first time, every time, 24 hours a day, where necessary.

From 13th March 2020, the Trust was required to stand up full Command and Control arrangements in line with the Level 4 incident declared nationally in response to the Covid-19 pandemic. These arrangements have been in place between 13th March and date of writing. I have set out any resulting variation from the Trust's usual arrangements in the relevant parts of this statement.

Capacity to handle risk

As Chief Executive and Accounting Officer I am responsible for risk management. However, the day to day responsibility for clinical risk management is delegated to the Medical Director and the Director of Nursing. Management of risks to operational performance is delegated to the Director of Operations; financial risk management is delegated to the Director of Finance and responsibility for the overall risk management framework is delegated to the Senior Associate Director of Assurance and Compliance.

Managers with responsibility for the risk management process, patient safety, health and safety, information governance, operational performance and financial risk support the Executive Leads. They also provide support to managers across the Trust on risk assessment, risk management, staff training and the development of good practice. Members of staff receive training via a range of training programmes to ensure that they achieve the appropriate levels of competence and expertise. The Trust has an Assurance, Risk and Compliance (ARC) Team in place to provide expert review of operational risk registers including coaching, challenge and support to risk owners. This team provides formal training in the risk management process to senior and middle managers, together with informal coaching and support provided through ARC team members' support for risk management meetings at Trust, Care Group and directorate levels.

Awareness, understanding and ownership of risk is reinforced by coverage of key risks as part of monthly performance and risk reviews with each Clinical Care Group's management team.

The risk management process is informed by the analysis of incidents, patient feedback, risk identification exercises, performance data, planning processes, national guidance, legislation and audits. There is a commitment within the Trust to being candid when things go wrong and to learn lessons from adverse events and near misses. The Trust has implemented systems to ensure that all staff are aware of their professional

and statutory duties of candour and tracks compliance with the statutory duty of candour through its incident management system.

Following the implementation of Level 4 Incident Command and Control arrangements from 13th March 2020, performance review meetings with the Care Groups noted above were suspended. The Incident Management process has involved the development and management of an active risk register of all relevant risks, overseen by the Senior Associate Director of Assurance and Compliance, with oversight of risks through daily 'Operational Cell' meetings comprising senior managers and weekly review by Executive-level Gold Command. The ARC team have continued to support this process and other specialist advisers have remained in place.

The risk and control framework

Risk management strategy

The Trust's risk management strategy covered the period 2017 to 2020. It is now being reviewed and updated for 2020 to 2023. The overall objectives of the Trust's risk management strategy were to:

- Anticipate and effectively manage: risks to the delivery of safe, effective and responsive care; risks to the achievement of strategic objectives; and risks to operational delivery and regulatory compliance; and

- To support the achievement of the Trust's strategic objectives, and the delivery of the strategic plans which underpin them.

The strategy is published on the Trust's intranet site together with supporting operational policies and procedures. Risk Management Committee receives reports on high-level key performance indicators aligned to the strategy.

The key elements of the Trust's risk management strategy are:

- Agreed standards for the management of risk within the organisation;

- A clear framework of accountability and responsibility for the management of risk, including a requirement for regular, documented reviews of risk registers and emerging risks within each Clinical Care Group and corporate directorate, in accordance with the above standards;

- A defined committee structure, which supports decision-making and actively seeks assurance in response to organisational risk. This includes the Risk Management Committee which reviews the assessments and mitigation plans for significant risks, and which seeks assurance on the operation of the risk management process within Clinical Care Groups and corporate directorates;

- Systems for the identification, analysis, prioritisation and mitigation of risk, with reference to a view of risk appetite endorsed by the Board;

- Monitoring of the status of principal inherent risks to the achievement of objectives, including strategic risks, through the Board Assurance Framework;

- Patient Safety and Health and Safety teams to support risk control processes and the development of capacity within the Clinical Care Groups and Corporate Directorates;

- On-going review, coaching, challenge, training and support from the ARC team to embed risk management processes into the day to day activities of the Trust;

- Communication processes which aim to ensure that, when things go wrong lessons learned are disseminated at all levels of the Trust;

- Quarterly reporting to the Board on all risks with current risk scores beyond the Board's risk appetite within the risk register and the full Board Assurance Framework; and

- External communication with stakeholders and the public through the Council of Governors and other established forums.

Quarterly Risk and Assurance Reports are prepared with reference to the Board's risk appetite. During 2019/20 reports were aligned to the risk appetite and risk tolerances defined by the Board in April 2019.

Trajectories are in place for the principal business risks within the Board Assurance Framework, showing anticipated progress towards target risk scores over time. The Board monitors reductions in risk against the agreed trajectories and seeks further mitigation where required. These trajectories were reviewed in April 2019.

The role of the Board and Committees

The Trust Board sets the strategy and policy framework within which the Trust's operations are handled. The Board has implemented structures and processes to allow it to exercise oversight of Trust affairs, and to provide reasonable assurance that significant risks to the achievement of key Trust objectives are identified and mitigated through the effective operation of systems of control. The Board receives a quarterly report on the Board Assurance Framework and all risks beyond its risk appetite within the Trust's risk register.

The Board delegates oversight of the risk management process to a Risk Management Committee, comprising all of the Executive Directors and senior leaders within each Care Group and corporate function. I chair meetings of the Risk Management Committee, with three meetings being held during 2019/20 to review the significant risks escalated by Care Groups and corporate functions, including validating the assessment of risk and seeking assurance as to the adequacy and implementation of mitigating actions. The meeting planned for March 2020 was stood down, as it coincided with the Trust's standing up of its Incident Management arrangements to respond to Covid-19; however, interim reporting on the Board Assurance Framework and on key risks retained. All risks beyond the Board's risk appetite were scrutinised through the Risk Management Committee meeting, through other Executive Committees, or through more frequent risk and performance review meetings. Once validated, significant risks are presented to the full Board through quarterly Assurance and Risk Reports.

The Board delegates its oversight of Trust business to two Board assurance committees: the Finance Committee and the Integrated Quality and Assurance Committee. Both Committees are constituted from full Board members, are chaired by Non-Executive Directors and include a second Non-Executive Director. The Finance Committee met in 11 months of the year; the Integrated Quality and Assurance Committee met 10 times over the course of the year

The terms of reference of each Committee require the Committee to satisfy itself with respect to the identification of risks and the assurance available that mitigating actions and controls are effective. Both Committees are focused on seeking assurance that action is being taken and achieving desired outcomes where risks and issues are identified. Each Committee reviews the Board Assurance Framework, for the principal objectives within their remit.

The Finance Committee focuses closely on the management of risks to in-year financial performance and the future financial sustainability of the Trust, receiving and reviewing reports on performance against the financial plan and the delivery of cost improvement programmes at each meeting.

The Integrated Quality and Assurance Committee seeks assurance in respect of the safety and effectiveness of the Trust's clinical practice and operations, and the experience of patients' in our care, and on workforce, operational performance, IT systems and the patient environment. The Committee uses a number of sources of assurance including: triangulation of data on incidents, complaints and litigation; the results of compliance audits of individual wards; patient feedback; clinical audit; internal audit and third party visits. Workforce, operational performance, Information Systems and Governance and the patient environment are monitored with reference to key performance indicators, management reports and the results of independent reviews from internal auditors and third parties. The Committee enables the Board to seek a more holistic view of assurance, taking account of the close linkages between quality, workforce and operational performance. Two Executive Committees - the Executive Patient Safety and Experience Committee and the Clinical Effectiveness Committee - both report into the Integrated Quality and Assurance Committee for assurance purposes.

Both Board assurance committees provide formal reports on the outcomes of each meeting, including escalation of any risks, to the Board. They are also able to request that relevant managers recognise risks in the risk register for their particular department or Care Group. Where they are not assured as to performance or the robustness of actions to address emerging risks or actions, the Committees will seek further assurance from the relevant Executive Directors.

The Executive and Clinical Leadership Committee (ECL), a further Board sub-committee, is the Trust's senior and clinical leadership team and met weekly throughout most of 2019/20 to: seek clinical consensus on strategic and significant operational issues; review and communicate action on behalf of the Board, on policy and service issues; and to set performance frameworks in place for Care Groups and corporate functions. ECL is the forum which directs and monitors actions to address risks and issues requiring co-ordinated Trust-wide effort and meets regularly.

A Strategic Change Board (SCB), comprising all Executive Directors and clinical leaders, met on 10 occasions during 2019/20 to facilitate on-going grip on the development of strategy and the delivery of major programmes and projects in support of strategic objectives. The SCB also reviews business cases for investment in support of strategic programmes and related post-implementation reviews.

Two further Executive Committees are in place to provide oversight and direction of quality: the Executive Patient Safety and Experience Committee, chaired by the Director of Nursing, and the Clinical Effectiveness Committee, chaired by the Medical Director. The former met in every month except March 2020 (due to the Covid-19 incident management arrangements being put in place) and the latter met eight times over the course of the year. Both Committees report to the Integrated Quality and Assurance Committee for assurance purposes; both provide Executive-level oversight and co-ordination of the quality agenda, including the identification and response to emerging quality risks and issues.

The Trust has an Integrated Performance Framework in place. This framework requires Clinical Care Groups to monitor their own performance, and to identify and escalate risks for Executive Directors' support where necessary. Each Care Group has a monthly meeting with heads of corporate monitoring functions to validate and, as necessary, strengthen their local risk assessment with key issues identified then forming the agenda for bi-monthly reviews with all Executive Directors. Key risks are also reviewed within these meetings. Any significant risks requiring urgent decision-making, which are identified in-between performance review meetings, are escalated to ECL for support or action as necessary.

The Trust Board has established an Audit Committee charged with seeking reasonable assurance of the adequacy of risk management, control and governance systems within the Trust, including the Trust's overall governance structures. The Committee consists of three Non-Executive directors with extensive, relevant experience. During 2019/20, the Committee met seven times and sought assurance based on reports from the Trust's internal auditors, external audit, through its own enquiries of senior managers and evidence from third party reviews included in management reports. The membership of the Committee includes Non-Executive Directors sitting on the two Board assurance committees, helping to ensure that the assurance agenda is co-ordinated. The Chair of the Committee provides updates to the Board on significant matters arising through formal escalation reports.

The Trust has a wholly owned subsidiary, Synchronicity Care Ltd (SCL), which provides estates, facilities and procurement services to the Trust on an arms-length basis. The Risk Management Committee has sight of SCL's risk register and is able to review any risks impacting at group level. The Audit Committee, Board assurance committees and Risk Management Committee are all constituted with remits covering the group rather than solely the Trust. Accordingly: the Finance Committee reviews SCL's in-year financial performance; the Integrated Quality and Assurance Committee monitors assurance with respect to the patient environment maintained and serviced by SCL and the Audit Committee is able to seek assurance with respect to SCL's governance and management processes from Internal Audit and SCL's senior management team.

Clinical Care Groups

The Trust's healthcare services are provided through five Clinical Care Groups aligned to care pathways. Four of the Care Groups have a leadership team comprising a Clinical Director, Lead Nurse and Associate Director of Operations, with similar teams in place at the general management and speciality levels. Each of these Care Groups has a dedicated Governance structure and a governance support team working to Trust-wide standards. The smaller Clinical Specialist Services Care Group, which looks after diagnostic services

and Pharmacy, is led by an Associate Director of Operations with risk management and governance systems embedded within each department.

The Board Assurance Framework and Risk Register

A Board Assurance Framework is in place, which captures the significant risks to the achievement of the Trust's objectives, together with both the controls in place to mitigate them and the specific evidence available to provide assurance that these controls are effective. Gaps in controls and gaps in assurance are identified and action plans put in place to address them. The Board uses this framework to identify and track the mitigation of strategic risks towards target risk positions, and monitors the progress of action plans against agreed trajectories.

All operational risks are captured in a single risk management system (Safeguard) allowing risk registers to be generated for each Clinical Care Group and corporate directorate, and for reports on significant risks to be extracted for the Risk Management Committee and the Board. SCL's risks are also included, in a separate risk register, in Safeguard. The risk register captures the nature of each risk, its relative priority with regards to other risks, the risk owner and the action plan in place to mitigate or manage it. Decision making about risk management priorities is made by the Risk Management Committee. Priorities are then fed into decision making including the allocation of resources.

The Audit Committee seeks assurance on the robustness of the Board Assurance Framework through periodic scrutiny of reports from the Senior Associate Director of Assurance and Compliance and reports from the Trust's internal auditors. As noted above the Board receives a quarterly report on the Assurance Framework.

The Safeguard system is also used by the Trust for incident reporting. It is available to all staff via a link from the intranet home page ensuring that all staff members have the opportunity to report incidents easily. The Trust has an Incident Management Policy in place which requires that all incidents are investigated within specified timeframes.

The Trust recognises that it is neither possible nor always desirable to eliminate all risks and that systems should not stifle innovation. When all reasonable control mechanisms have been put in place there will inevitably remain some residual risk and this level of risk must be accepted. Risk acceptance within the Trust is systemic and transparent. Risk is assessed both in terms of its current likelihood and impact, and in terms of the target likelihood and impact following implementation of mitigations. Current risk levels can be compared against the Board's risk appetite and, where different, its risk tolerance. Target scores are reviewed by the Risk Management Committee. Once the target position is reached, the risk can be closed. Significant inherent risks continued to be monitored through the Board Assurance Framework.

Further information on risk and assurance with respect to subsidiary companies

SCL provides an Operated Healthcare Facility at Darlington Memorial Hospital and additional estates, facilities and procurement services to the Trust, operating as 'County Durham and Darlington Services (CDD Services). CDD Services maintains a register of risks which are shared with, or which could impact significantly on the Trust. These risks are captured in reports to the Trust's Risk Management Committee and senior officers from CDD Services are able to escalate risks requiring more urgent action by the Trust to the Trust's Executive Directors Group and Executive and Clinical Leadership Committee where required. The risk management approach is consistent across the CDDFT Group.

The Integrated Quality and Assurance Committee has received a quarterly update, through the Board Assurance Framework, with respect to estates and facilities services on all Trust sites. These updates capture the outcomes of management monitoring processes and independent sources of assurance such as inspections and accreditations.

The Finance Committee monitors the overall performance of SCL in meeting its financial plan, data for SCL being included as an appendix to the Director of Finance's monthly reports. The Finance Committee also reviews the implementation of cost improvement schemes involving savings on procurement, where there is dependence on SCL's Procurement Service to the Trust and considers the relative efficiency of the service in the light of benchmarking information such as the 'Model Hospital' datasets.

The Audit Committee commissions a number of audits annually from our Internal Auditors, to provide independent assurance to the Trust Board with respect to the adequacy and effectiveness of corporate governance, financial control and operational performance within SCL. The results of these audits are reported to the Committee and inform quarterly Assurance and Risk Reports to the Board.

Foundation Trust Governance (including 'well-led' arrangements, quality governance and principal risks and mitigations)

The Board actively reviews and seeks assurance over the principal risks to compliance with Condition FT4 of its provider licence, relating to governance. Principal inherent risks include lack of clarity and effectiveness within the governance structure, unclear reporting lines and accountabilities between the Board, its sub-committees and the executive team, omissions or errors in key datasets, and inability to secure succession for key executive and non-executive posts. These are mitigated by an annual review of terms of reference and work plans for the Board and Executive Committees, use of external and internal audit reviews against aspects of the NHSI and CQC 'Well-Led' frameworks and data quality testing and assurance as outlined below.

The Board has a schedule of matters reserved to it and a scheme of delegation for decision-making, together with a set of Standing Financial Instructions and Standing Orders which set out the frameworks in which finance and governance operate. These documents are reviewed annually by the Audit Committee to ensure that they remain up to date and fit for purpose.

The internal auditors complete testing of the procedures to collect, measure and report on a sample of data quality indicators annually. This is, ordinarily, supplemented by external audit testing of certain quality account indicators; however, the national requirement for such testing was stood down in response to the Covid-19 pandemic for 2019/20. Data kite-marking procedures are in place for those indicators relied on for regulatory monitoring by NHS Improvement and data validation procedures are operated by the Trust's Information Services team.

Sources of assurance with respect to the Trust's arrangements for risk management, control and governance are captured and reported to the Board through the Board Assurance Framework. The Assurance Framework, supported by further evidence collated by the Senior Associate Director of Assurance and Compliance, provides the evidence on which the Board is able to consider and make submissions to NHS Improvement, including the self-certification statements required annually including the Corporate Governance Statement. When making these declarations in May and June 2019, the Board took account of the outcomes of previous external and CQC well-led reviews, a follow-up external review completed in 2018/19 and the Head of Internal Audit's annual opinion.

The Trust follows the Quality Governance requirements within the Well-Led Framework set out by NHS Improvement and the Care Quality Commission. The Trust has a quality strategy 'Quality Matters', which defines the key quality priorities for the Trust together with measures of success, owners and key actions. The strategy informs the setting of annual quality priorities within the Annual Quality Report and reflects annual consultation on quality priorities with stakeholders both inside and outside the Trust. This includes consultation with our Public Governors who represent the views of their members.

The Board receives reports at each of its meetings from the Executive Director of Nursing and Executive Medical Director which include performance against annual and longer-term quality priorities, together with any on-going risks to particular services and issues identified from benchmarking (for example, mortality and morbidity information). The Integrated Performance Report provides further detail of performance against key quality metrics. Risks to the achievement of strategic goals are reflected in the Board Assurance Framework and reported on through the quarterly Risk and Assurance reports to the Board. There are six objectives within the Quality Domain covering: mortality; minimising patient harm; providing care in the right place at the right time; clinical effectiveness; patient experience and the patient environment. Sources of assurance include the most recent CQC inspection, the outcomes of internal audit work, key performance indicators and outcomes for third party reviews.

Non-Executive Directors chair and participate in the Trust's Integrated Quality and Assurance Committee, providing challenge to quality governance and leadership of the quality agenda. A network of lower-level committees is in place to give attention to specialist areas: examples include the Clinical Standards and Therapeutics Committee and the Trauma Committee. All such Committees are overseen by two Executive

Committees: the Executive Patient Safety and Experience Committee and the Clinical Effectiveness Committee.

At the Executive-Level, patient outcomes and patient experience comprise two of the four strands of performance (along with workforce and financial performance) monitored through the Integrated Performance Framework. Quality-related risks are also monitored more frequently at fortnightly Patient Safety Forum and Healthcare Acquired Infections Reduction Forum meetings led by the Executive Director of Nursing.

Staff members are actively encouraged to make suggestions to improve quality, and to report harm and errors. Based on national benchmarking data from the National Reporting and Learning System the Trust's incident reporting rates are in line with the majority of similar organisations. Work continues to increase reporting rates in line with the upper quartile, with substantial increases in reporting of no harm and near miss incidents being observed in the last two years. There are defined processes and structures in place for escalating issues through the governance chain to the Board, and for developing and monitoring action plans in respect of issues identified.

The Audit Committee monitors the effectiveness of internal audit processes, together with the implementation of the Trust's Freedom to Speak Up arrangements. The 'Freedom to Speak Up Guardian' reports to the Board every six months and has support from two 'Freedom to Speak Up Champions' to support the Guardian and facilitate ready access to support for staff wishing to report concerns across our sites and teams. Tailored training programmes have been provided to the Board, senior managers and clinical leaders, and senior nursing leaders on fostering a culture of Speaking Up.

A variety of mechanisms are in place to collect patient feedback and to consult with external stakeholders on the design of new pathways and processes, many taking place at the individual service level. A Community Engagement and Patient Experience strategy is in place and we are increasingly working with our system partners in seeking views from the public, patients and stakeholders on planned changes and the related risks which may impact them.

Regulatory risks, including risks to compliance with the Care Quality Commission's standards are monitored through the Board Assurance Framework. Systematic, monthly audits take place to monitor compliance with nursing and regulatory standards at ward and team level – with built in triggers to highlight strong performance and to escalate where performance needs to be improved. In addition, a periodic peer review process is undertaken where teams from one site audit clinical practice on another site, with reference to each of the CQC's Fundamental Standards. Further details of the CQC's most recent inspection of the Trust, and the actions taken are set out on page 44.

With respect to financial governance:

- A Programme Management Office (PMO) is in place to support the development of, and monitor the delivery of, cost improvement programmes. During 2019/20 we continued to work closely with our commissioners' PMO, to support the coordination of system-wide schemes.
- Frequent oversight of the Cost Improvement Programme, together with run rates for income and expenditure, by Executive Directors and Care Group Associate Directors' of Operations.
- Monthly reporting on the all aspects of in-year financial performance, and the cost improvement programme in particular to the Finance Committee. The Finance Committee examines each Care Group's plans and performance in some detail at least twice per annum.

Data Quality and Security

The Trust Board has in place a programme of independent validation of datasets used to report against NHS Improvement's quality governance indicators, taking into account the results of internal and external audit testing over a number of years, supplemented by other sources of assurance through the Board Assurance Framework. No specific external audit testing of data indicators for the quality report took place for the 2019/20 report as the requirement for external audit testing was stood down in response to the Covid-19 pandemic.

In my capacity as Senior Information Risk Owner, I have direct oversight of information governance and data security. The Trust has robust procedures in place for the management of risks associated with the holding and processing of personal information. The Trust has a dedicated manager with responsibility for

information data security and protection. The Trust has in place a full information risk management structure and I am regularly updated on all incidents and risks monthly. Information Asset Owners are responsible for the information held in their areas, recording information on Information Asset Registers, assessing risks and implementing actions to mitigate those risks as required. Procedures have been audited by our IM&T internal auditors during the year and their recommendations implemented.

The Trust's Data Security and Protection Publication Status is "Standards Met". Two internal audits were completed, examining sample evidence in support of this submission. The internal auditors did, however, note shortcomings in data security and quality controls for one system, Badgernet, as outlined further in the section on the Head of Internal Audit Annual Option below.

Emergency Planning, Resilience and Response (EPRR)

The Trust Resilience Forum, which reports into the Risk Management Committee, meets bi monthly to co-ordinate, and seek assurance with respect to, arrangements for contingency planning, handling of major incidents and emergency preparedness. Of the 64 applicable core standards the Trust was fully compliant with 59 (green) and partially compliant with 5 (amber). There were no areas of non-compliance, which equates to significant compliance overall. The Board has agreed a work plan to address the areas of partial compliance to the standard, and the implementation of the actions will be monitored by the Trust's Resilience Forum.

Governors and third parties

As a Foundation Trust, the Trust's Board of Directors is accountable to the Council of Governors. The Council of Governors receives updates on performance and is able to ask questions of Directors at each of its four meetings per annum. The Council has established sub-committees, with particular roles for the Strategy and Planning Committee, and the Quality and Healthcare Governance Committee in respect of risks and controls.

The Strategy and Planning Committee scrutinises draft plans and strategies (including component strategies) and the management of the strategic risks within the Board Assurance Framework on behalf of the Council of Governors. Planning processes commence with the introduction of a joint seminar for Board members and Governors to consider planning priorities for the year ahead.

Quality related risks are discussed by the Council of Governors' Quality and Healthcare Governance Committee. This Committee also reviews the Complaints, Litigation, Incidents and Patient Advice and Liaison Service (CLIPs) report at every meeting and reports on these matters to the Council of Governors. During 2019/20, the Committee received updates on the preparations for, outcome and actions from the 2019 CQC inspection; implementation of the Quality Strategy, audits of nursing standards, medical and nursing staffing, quality-related risks, and patient feedback.

In addition, the Trust reports all Serious Incidents to its commissioners as part of its contractual arrangements and works with the local Overview and Scrutiny Committees, and with Healthwatch, to address issues of concern raised by the public or local councillors.

Variation of the above arrangements from 13th March 2020

Following the implementation of Level 4 Incident Command and Control arrangements from 13th March 2020 the control framework has, necessarily, varied from the above as follows:

- The Incident Management process has involved the development and management of an active risk register of all relevant risks, overseen by the Senior Associate Director of Assurance and Compliance, with oversight of risks through daily 'Operational Cell' meetings comprising senior managers and frequent review by Executive-level Gold Command.
- There have been no meetings of the Executive and Clinical Leadership Committee, nor the SCB; however, their functions have been subsumed into Gold Command meetings which have taken place daily during March and April 2020 and at least twice weekly during May 2020.
- The Executive-level Quality Committees were suspended during the peak of the response in order that all clinical staff and managers could focus on patients with Covid-19. These meetings have been reinstated from May 2020.

- In line with national guidance, meetings with Governors have been stood down. However Governors have received full briefings on the Trust's Covid-19 response, regulatory and performance position from the Senior Associate Director of Assurance and Compliance and further communications from the Chief Executive and Chairman. They have also received the daily Coronavirus bulletin from the Communications teams. Communication is two-way, with Governors able to ask questions and seek further assurance via the Senior Associate Director of Assurance and Compliance. Where possible the Lead Governor and Committee Chairs have also been invited to observe and / or contribute to relevant Board Committee meetings to continue to provide a level of scrutiny.
- Some sources of assurance have been more limited in scope, having been scaled back or suspended in line with national guidance; for example, internal audit and clinical audit. Where possible, internal audit work has been carried out remotely and local clinical audit work has been continued but been focused on improving our developing understanding of Covid-19.
- Patient safety and quality monitoring activities were maintained and, together with other sources of assurance facilitated the production of an interim Board Assurance Framework report to the Board in May 2020, maintaining the quarterly reporting cycle. The Board has received the full Covid-19 risk register to each Board meeting.
- Meetings of the Finance Committee have been suspended during the response period. NHS Trusts are operating under an interim financial framework, with the annual financial planning and contracting process superseded for the present time. The detailed work performed by the Committee at this time of year has therefore reduced in scope and can be done by the Board as a whole.

At the time of writing, the national Level 4 Incident remains in place. The Trust is now restarting suspended services and planning to move to the next phase of the incident response and towards a new normality. The above arrangements will be reviewed as part of this process, with the opportunity being taken to build on any beneficial changes implemented as part of the incident response. Whilst we will maintain the integrity and core principles of the above framework, we may make changes to optimise it going forwards.

Head of Internal Audit Opinion – areas for control improvement

The Head of Internal Audit's Opinion provided good assurance that there is a sound system of internal control, governance and risk management designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, the report also highlighted a number of areas from audits completed during the year where controls were deemed to be in need of improvement. These are summarised below, together with the action taken by the Trust.

- ***Badgernet system – IT controls:*** This clinical management system is used to provide demographic and episodic clinical data relating to new-born babies. Internal Audit found weaknesses in the System Specific Security and with management of user access, third party access and leavers. There were also deficiencies in the business continuity plan with respect to system downtime; assurance over the system supplier's security measures; data classification; data retention periods and the contract review and management processes. The draft report was issued in January 2020, since when the Maternity Service, with support from Health Informatics, implemented a comprehensive action plan to address the issues specific to Badgernet, which was implemented by 31st March 2020. There is a programme of work underway within the Trust to identify any similar locally-owned systems where system management controls might require strengthening with support from Health Informatics.
- ***Cost Improvement Programme:*** The audit found a lack of consistency and rigour in the completion of Quality Impact Assessments and in the evidence retained to demonstrate that issues raised by the Medical and Nursing Director were fully addressed prior to implementation. In addition, the auditors found examples of cost improvement schemes where there was a lack of detail with respect to savings and milestone plans, or where milestones were not closely monitored and inconsistency in the depth of lessons learned reviews between different Care Groups. The draft report was issued early in October 2019 and all actions implemented by 31st December, other than the implementation of a full lessons learned review for 2019/20 schemes which has been delayed due to the implementation of Covid-19 pandemic response arrangements.
- ***Clinical records and coding:*** In keeping with the findings of the Trust's own mortality review process, the auditors identified the need for a more complete and robust approach to capturing patient comorbidities in clinical notes so that they can be fully coded. Whilst forms were in place in some services to assist with this task, their use was not universal. The auditors also identified delays in some clinical documentation being submitted for scanning to the Trust's electronic clinical document management system and examples of documents which were categorised incorrectly creating

difficulty for coders in finding the right information. A Task and Finish Group is being established – drawing on best practice from neighbouring Trusts – to improve the recording of comorbidities. Policy with respect to submission and categorisation of records for scanning is being reinforced to staff on an ongoing basis.

The Head of Internal Audit Opinion highlights further weaknesses in controls for which final internal audit reports have yet to be issued relating to:

- ***Pharmacy Stock Control:*** The audit found: weaknesses in security procedures, including door access codes not being changed regularly, a lack of CCTV coverage of the stores and a need for tighter control over the allocation and return of keys; lack of a secure procedure to record, collect and return drugs from disposal from wards; the absence of an annual physical count of stocks in the Pharmacy Robot store; deficiencies in procedures for stock management, including a lack of separation of duties in identifying and recording stock discrepancies and write-offs and lack of criteria and processes for investigation of stock discrepancies. Several immediate actions were taken, ahead of the issue of the final report, with actions to address the remaining issues in progress.
- ***Ordering and Accounts Payable:*** This audit was concluded shortly before 31st March 2020. The auditors found that checks on user access to the ordering system had lapsed for over two years, before being remediated prior to the audit taking place. Following the accounts payable system being upgraded to a cloud-hosted system, the Trust had been unable to obtain reports to facilitate checks on user accounts and access levels. In addition, the audit noted non-compliance with procedures in relation to checks on high-value BACS payments, new supplier accounts and outstanding invoices and a lack of spot checks to verify transactions on purchasing cards issued by Procurement. The Trust is working with the system provider for the Accounts Payable system to seek to obtain reliable reports for checking and liaising with internal audit to agree remedial actions.
- ***Patient Appointments Follow-up:*** Internal audit reviewed the processes for booking and follow-up of patient appointments in Ophthalmology. The Trust requested the audit, having experienced some issues in the operation of patient appointment procedures, to help identify the improvements required. The auditors have recommended strengthening the clinical oversight of waiting lists to ensure that patients are seen in line with clinical need and strengthening of joint working between medical secretaries and the central bookings team. The recommendations have been recently received and are being taken forwards.

The Head of Internal Audit presented his annual opinion to the Audit Committee in April 2020. The Committee concurs with the Head of Internal Audit's assessment that the data security weaknesses found re: Badgernet and the weaknesses in pharmacy stock controls were of sufficient magnitude to warrant reporting as significant control weaknesses. It is important to note, however, that all agreed actions with respect to Badgernet were implemented by 31st March 2020 and that immediate actions have been taken to strengthen Pharmacy stock controls in advance of the agreement of the final report.

Well-Led Review

The Board received the results of a detailed internal review of its compliance with CQC's Well-Led Framework, using CQC's key lines of enquiry, by the Senior Associate Director of Assurance and Compliance, undertaken in July 2020, which self-assessed the Trust as 'good' and confirmed implementation of actions implemented following the 2017 inspection. This drew upon external well-led reviews undertaken in 2017 and followed up in 2018/19. CQC rated the Trust 'Good' for its well-led arrangements during their most recent inspection noted below.

CQC Inspections

The Trust was awarded an overall "Good" rating from CQC, following an inspection carried out between June and September 2019, which focused on Urgent and Emergency Care, Surgery and End of Life Care at both UNHD and DMH. The inspection report was published in December 2019. All services are rated Good, except for End of Life Care on both sites - which received an "Outstanding" rating, with particular recognition for service leadership and responsiveness - and Urgent and Emergency Care at UHND, which was rated requirements improvement. Good ratings were awarded for the Effective, Caring, Responsive and Well-Led Domains. However "Requires Improvement" for the Safe Domain. The Trust was delighted with the overall inspection outcome, and the recognition for the services inspected. However, we are not complacent and continue to focus on improving the safety of our services.

The trust also received a good rating for the separate Well Led and Use of Resource inspections.

More details of the actions taken following the inspection are set out in our Performance Report on page 26 of the Annual Report. In summary, there has been good progress in implementing the key actions agreed with CQC following the visit, despite the impact of the need to implement our Covid-19 pandemic response plan.

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

NHS Improvement

The Trust has remained within Segment 2 of the Single Oversight Framework throughout 2019/20

Other matters

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

The Trust has implemented the following arrangements to meet the recommendations of NHS Improvement's publication 'Developing Workforce Safeguards':

- Staffing levels are monitored on a daily basis, with a defined escalation route to senior Care Group managers, and ultimately through the senior manager or Executive Director (Silver and Gold Command) in charge wherever risks are identified. Silver and Gold Command can authorise additional bank or agency staffing and other counter-measures. Resilient nursing and medical staffing banks are in place, together with neutral and master vendor arrangements to access agency staff.
- The Board receives regular reports on compliance with the National Quality Board's recommendations for nursing staffing, for all inpatient areas, with a formal assurance statement from the Director of Nursing including details of fill rates, risks and mitigating actions. Each inpatient service, and our maternity and A&E services review their staffing using evidence-based tools, professional judgement and evidence of outcomes twice annually, with the results signed off by the Director of Nursing and reported to the Board. A similar assessment has been performed for Allied Health Professionals.
- The business planning process includes the development of annual workforce plans, to address anticipated service needs and risks, with plans being signed off by the Executive Directors' Group. The overall workforce plan forms part of the annual plan submitted to NHS Improvement, signed off by the Chief Executive, and approved following review by the Board and Council of Governors.
- The Medical Director meets with each Care Group to review the medical workforce strategy for each service at frequencies determined by risk. A range of recruitment options can be put in place to address future staffing needs.
- Any change to a service requires a Quality Impact Assessment approved by the Medical and Nursing Directors.
- Information is available to the Medical and Nursing Directors which enables ward and or team-level workforce indicators and quality outcomes to be considered together.
- Workforce-related risks are captured in the Trust's risk register and the Risk Management Committee monitors the sufficiency and progress of mitigating actions every quarter. The Board Assurance Framework reports on all risks outside of the Board's risk appetite to the Board and provides a macro-level overview of workforce-related risks.
- The Trust is working as part of two ICPs on the development of clinical service pathways to optimise the use of the medical staffing workforce in each area.
- The Medical and Nursing Directors have overall responsibility for quality, which includes a clear remit and full authority to make decisions, as necessary, to modify or suspend services where they consider staffing to be unsafe. No such modifications were necessary in 2019/20.
- A Workforce Planning Group and Workforce Committee are in place to oversee the above arrangements.

As of the date of this statement, the Foundation Trust has published an up-to-date register of interests (including gifts and hospitality) for decision-making staff on its website, within the past 12 months as required by NHS England's 'Managing Conflicts of Interest" guidance.

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

The Foundation Trust 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.

Principal risks managed during the year
The principal risks managed by the Trust during the year were:

- ***Sustaining our safety and reliability:*** The Trust consolidated improvements made in 2018/19 with a further reduction in reported never events and improvements in the rate of reporting for no and low harm incidents. However, rates of hospital acquired infections were above thresholds and – despite an extensive programme of risk mitigation measures – there is more to do to minimise patient falls as far as possible. Key risk mitigation measures include ongoing education and training, in both infection control and in falls prevention and treatment and importing good practice from elsewhere where appropriate. Towards the end of 2019/20 the management of this risk included introducing robust measures to manage the transmission of Covid-19.
- ***Meeting the demand for emergency and unscheduled care:*** Despite system-wide initiatives to reduce demand, the Trust saw sustained increases in the complexity of patients attending its Accident and Emergency Departments and an associated increase in non-elective admissions until late March 2020, when demand reduced with the onset of the Covid-19 pandemic response plan. The actions to mitigate this risk are owned not only by the Trust, but across the local health economy. There is a comprehensive action plan, including short-term process improvements and medium and longer-term actions to improve capacity, overseen by the Local A&E Delivery Board.
- ***Managing waiting times for referral to treatment times:*** The Trust experienced significant pressures, relating to demand and capacity, which impacted upon its ability to meet the NHS Constitution target for 92% of patients to wait no longer than 18 weeks from referral to treatment. The particular pressures varied by specialty; however, the demand for beds for unscheduled care was a generic limiting factor. This reflected regional and national challenges. Recovery plans were in place, but would have taken some time to come to fruition in 2020/21 given demand pressures and staffing constraints. As we move into 2020/21, the need to maintain capacity for Covid-19 and to ensure robust management of the risk of infection in elective patients, including social distancing, will place further constraints on our ability to meet the waiting times target.
- ***Financial pressures:*** Achievement of financial targets and, in particular, implementation of the planned cost improvement programme proved challenging in the context of the increased demand for unscheduled care noted above. Commissioners were able to recognise the financial impact of demand pressures and to agree joint risk mitigation plans which allowed the Trust to meet its control total over the year.
- ***Workforce pressures:*** Regional and national shortages of staff for certain specialist services impacts on NHS Trusts generally and the Trust continues to be impacted in services such as Rheumatology, Dermatology and Radiology. Workforce strategies are in place for each service, including where appropriate international recruitment and other innovative developments such as home working, to secure and sustain sufficient numbers of staff. We are also working with neighbouring trusts in our integrated care partnerships on collaborative, network-based, pathways for some clinical services to maximise the benefit to patients from the workforce available across the locality. We have also rolled out our nursing workforce strategy, including "one stop shop" recruitment days and selective use of international recruitment.
- ***Estates and IT systems renewal in the context of financial pressures:*** One consequence of the financial pressures experienced by the Trust in 2019/20 and previous years has been the need for prioritisation of backlog estates works and replacement of IT systems and infrastructure. Decisions on priorities have continued to be made by Executive Directors on the basis of detailed risk assessments provided by specialist estates and IT capital sub-groups and arrangements put in place to maintain facilities and systems to ensure patient safety. Work continues to secure funding for the implementation of an electronic patient record system and a new Emergency Care Centre at UHND, which are essential to the Trust's longer term plans.

- ***Staff engagement:*** The Trust's prime asset is its staff. As such, Executive Directors and the Board have focused closely on engaging and supporting staff in the context of demand pressures and financial pressures noted above, as well as the potential uncertainties which can arise from change such as the new community services contract noted above, and work on clinical services taking place in the integrated care partnerships of which we are a member. A Workforce Experience Team is in place to co-ordinate the numerous engagement activities taking place, as part of a holistic programme of work endorsed by the Board. This paid dividends during the year, with clear improvements being demonstrated for 8 out of 9 engagement measures in the NHS Staff Survey, and no deterioration on the remaining measure. The rate of improvement in staff engagement was amongst the highest for all Trusts supported by our survey provider. Staff report that through Covid-19 engagement has strengthened further.
- ***Covid-19 Outbreak and Incident Response:*** In March 2020, the Trust stood up formal Incident Management arrangements in response to a forecast surge in Covid-19 cases and rapidly rolled out a plan to expand its bed base, workforce and ITU capacity, together with sourcing equipment and additional staff through national and local schemes. In line with national guidance routine elective services were scaled back to facilitate this response and resources redeployed. Urgent services were, however, maintained, wherever possible. New governance arrangements were deployed to support and wrap around the incident response, ensuring appropriate decision-making, risk management record-keeping and scrutiny whilst maintaining the pace of response required. Ultimately plans proved successful with the Trust maintaining sufficient capacity to manage the numbers of Covid-19 patients received and, at the time of writing we are now standing up urgent services and developing plans to reinstate routine elective and outpatient services on a phased basis.

Principal risks going forward

The risks outlined above are expected to persist, in large part, over the next 12 to 24 months, with the added challenge of managing our resources (staffing, estates and equipment) to deliver on all key objectives whilst living with Covid-19. This includes:

- The need to maintaining two streams (Covid-19 and non Covid-19) from the front of house, through to discharge, and retaining sufficient capacity in our emergency departments, acute medical units and wards to cope with surges in non-elective demand, from Covid-19 or other presentations.
- The need to maintain strict testing and infection control regimes to protect patients, including strict segregation of elective and non-elective areas.
- Restoring, as far as possible, all urgent services and routine outpatient and operations.
- Utilising new approaches, such as remote consultations, where appropriate.

Routine outpatient and elective services can only be restored in a phased manner, given the additional calls on physical and staffing capacity to allow two streams of activity to be maintained, limitations on physical capacity resulting from social distancing and the need to manage capacity so that we maintain sufficient flexibility and agility to respond to surges in non-elective demand, directly or indirectly related to the impact of Covid-19. The Trust will need to balance out a range of risks to staff, patients and regulatory targets to achieve the optimum approach. Managing these complexities means that it is unlikely that routine elective treatments will be restored in line with the NHS waiting times standard in the near future, although it remains our ambition to do so.

The need to retain flexibility and agility to address further surges in emergency and non-elective demand will be particularly important over the winter period, given the potential need to look after patients with influenza and those with Covid-19 at the same time.

During 2020/21, the Trust will need to maintain and sustain the operation of legacy IT systems, pending the implementation of an electronic patient record system, planned for 2021/22. Funding and regulatory approval for the system are still to be confirmed. Given the scale of the change involved, the Trust will not be able to commence implementation whilst managing greatly increased operational demands associated with the Covid-19 response. Much will depend on the scale of activity over the winter period and how far into 2021/22 this might take to clear.

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

The Trust Board monitors performance against the Trust's Annual Plan on a monthly basis, receiving detailed monthly reports on financial performance, associated risks, and the actions in place to mitigate them, as well

as delivery of the Cost Improvement Plan throughout the year. The Trust Board has also reserved to itself decision making with respect to major capital investment and disinvestment. As outlined above, a Finance Committee is in place to provide focus on, and scrutiny over, the identification and realisation of productivity and efficiency improvements and the management of financial risks both in-year and with respect to the Trust's future financial sustainability.

The Trust has a framework of controls, set out in its Standing Financial Instructions, designed to achieve economy, efficiency and effectiveness in the use of resources. The Trust Board receives assurance from the following sources via the Audit Committee:

- Internal Audit reports, including consideration of "value for money" and financial controls within the scope of relevant audits;
- Counter-fraud preventative work and investigations; and
- External Audit reports.

The external auditors have advised that an unmodified opinion on the Trust's arrangements for value for money during 2019/20 is expected to be issued.

The Trust uses benchmarking information from a variety of sources to evaluate the economy, efficiency and effectiveness of its corporate services and its productivity and efficiency in the delivery of healthcare, including reference cost data. Efficiency opportunities highlighted by Model Hospital datasets and local benchmarking for back office services are investigated and schemes developed where appropriate. The Trust's reference cost suggests that it is relatively more efficient than the majority of North East Trusts.

The arrangements outlined above were subject to a formal Use of Resources assessment as part of our 2019 CQC Inspection with the Trust receiving a 'Good' rating for these arrangements.

Information Governance

In the year 2019/20 the Trust has reported six Data Protection incidents via the NHS digital Data Security and Protection incident reporting platform. The incidents have all been contained and staff have followed the Trust duty of candour policy.

The external incident assessment process has confirmed the outcome in all cases is that further escalation to the Trust regulators CQC and the UK supervisory Authority, the Information Commissioners Office is NOT required.

The Trust has also completed the NHS Digital Unified Cyber Risk framework (UCRF) process which included a review of the top three risks that currently face the Trust in relation to Data Protection and Cyber security.

The Trust and its subsidiary company, SCL, made submissions under the Data Security and Protection Toolkit (v2 19/20), with the outcomes as follows:

- CDDFT - 116 mandatory evidence items completed with 40 mandatory of 44 assertions confirmed.
- SCL – 106 mandatory evidence items completed with 39 mandatory of 43 assertions confirmed.

The publication status for both the Trust and SCL was confirmed, nationally, as 'Standards Met'.

Annual Quality Report

In response to the need to prioritise the NHS's response to the Covid-19 pandemic, the timetable for completion and publication of the Quality Report has been put back, with final publication in December 2020. The Trust has already completed much of the drafting which draws on reporting to the Integrated Quality and Assurance Committee and to the Council of Governors' Quality and Healthcare Governance Committee during the year. The following arrangements, which were in place to provide assurance to the Trust Board that the Quality Report for 2018/19 (compiled in April and May 2019) presented a balanced view and that appropriate controls were in place to ensure the accuracy of data, will remain in place for the 2019/20 as the further stages of preparation, review and publication are completed:

- The Executive Director of Nursing provides executive leadership on all aspects of the Quality Report;

- The Trust Board receives monthly performance, patient safety and patient experience reports, the data from which informs the Quality Report. Datasets are subject to validation controls and review with the Trust's Information Services Department;
- The Quality Report priorities were formulated through discussion with the Trust Board, the Council of Governors, staff, commissioners, the local authority Overview and Scrutiny Committees and other stakeholders;
- Both the Board's Integrated Quality and Assurance Committee and the Governors' equivalent committee receive updates on progress against Quality Report targets during the year;
- Prior to formal approval of the Quality Report it is reviewed by the Integrated Quality and Assurance Committee; a Joint Meeting of the Trust Board Audit Committee and the Governors Audit and Governance Committee, and a Joint Board and Council of Governors meeting; and
- The Trust obtains independent assurance with respect to the adequacy and effectiveness of the systems of control over data collection and reporting, including controls to ensure the accuracy of reported data, for the Quality Report, through periodic testing of data systems by Internal Audit.

Review of effectiveness

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 that have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by the external auditors in their reports to those charged with governance and reports from other third party reviewers.

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, the Finance Committee, the Integrated Quality and Assurance Committee and the Risk Management Committee. Plans to address weaknesses and ensure continuous improvement of the system are in place, consolidated through the Board Assurance Framework.

My review of the effectiveness of the system of internal control has been further informed by the outcomes of internal audit work, the Head of Internal Audit Opinion, third party reviews and the outcomes of regulatory assessments, including our quarterly review meetings with NHS Improvement and inspections. In addition, I have taken into account the results of most recent CQC inspection, including their assessments of the Trust's use of resources and well-led arrangements.

Conclusion

My review has identified the significant control weaknesses, taking into account the advice of the Audit Committee and Head of Internal Audit:

- Weaknesses in data security, access control, supplier assurance and contingency planning for the Badgernet system; all of the system-specific issues were remediated by 31st March 2020 as outlined above.
- Weaknesses in pharmacy stock controls outlined in the section on the Head of Internal Audit report, where immediate actions were taken and a detailed action plan is being implemented.

I have also outlined some areas for improvement in controls elsewhere in this Annual Governance Statement, in particular in the references to:

- The annual Head of Internal Audit Opinion; and
- Key risks managed during the year.

Action plans have been, or are being, developed and implemented to strengthen controls in these areas.

During 2019/20 the Trust has continued strengthen its arrangements for governance, performance management, and operational management. Our risk management, governance and internal control systems remain in line with good practice and are continually reviewed and strengthened to fully support the achievement of our objectives.

Signed

Sue Jacques

Chief Executive
Date: 24th June 2020

This Accountability Report set out above, and which forms Section 4 of our overall annual report, was approved by the Board on 24th June 2020.

Sue Jacques

Chief Executive
Date: 24th June 2020

5 ANNUAL ACCOUNTS

5.1 Annual Accounts for the year ended 31 March 2019

Foreword to the accounts

County Durham and Darlington NHS Foundation Trust

These accounts, for the year ended 31 March 2020, have been prepared by County Durham and Darlington NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed …….

Name **Sue Jacques**
Job title **Chief Executive**
Date **24 June 2020**

Consolidated Statement of Comprehensive Income

		Group	
		2019/20	2018/19
	Note	£000	£000
Operating income from patient care activities	3	486,370	445,487
Other operating income	4	38,608	42,362
Operating expenses	6	(497,586)	(486,110)
Operating surplus/(deficit) from continuing operations		**27,392**	**1,739**
Finance income	11	223	223
Finance expenses	12	(14,782)	(14,024)
PDC dividends payable		(1,181)	(1,493)
Net finance costs		**(15,740)**	**(15,294)**
Other gains / (losses)	13	206	73
Corporation tax expense		(372)	(529)
Surplus / (deficit) for the year		**11,486**	**(14,011)**
Other comprehensive income			
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains/(losses) on financial assets mandated at fair value through OCI	21	(499)	(8)
Total comprehensive income / (expense) for the period		**10,987**	**(14,019)**
Surplus for the period attributable to:			
County Durham and Darlington NHS Foundation Trust		11,486	(14,011)
TOTAL		**11,486**	**(14,011)**
Total comprehensive income/ (expense) for the period attributable to:			
County Durham and Darlington NHS Foundation Trust		10,987	(14,019)
TOTAL		**10,987**	**(14,019)**

The results in these accounts are for the group of organisations which comprise County Durham and Darlington NHS Foundation Trust, its wholly owned subsidiary Synchronicity Care Ltd and its associated charity County Durham and Darlington NHS Foundation Trust Charity. The 'Group' columns relate to the results of all three organisations consolidated into one.

Statements of Financial Position

	Note	Group 31 March 2020 £000	Group 31 March 2019 £000	Trust 31 March 2020 £000	Trust 31 March 2019 £000
Non-current assets					
Intangible assets	15	1,052	1,142	1,052	1,142
Property, plant and equipment	16	183,537	170,819	183,537	170,819
Investments in associates and joint ventures	19	-	-	17,803	17,803
Other investments / financial assets	19	2,190	2,878	-	-
Receivables*	23	-	-	37,045	38,266
Total non-current assets		**186,779**	**174,839**	**239,437**	**228,030**
Current assets					
Inventories	22	9,070	9,164	7,618	7,429
Receivables*	23	29,396	32,196	30,865	33,586
Cash and cash equivalents	24	14,212	7,862	11,661	7,802
Total current assets		**52,678**	**49,222**	**50,144**	**48,817**
Current liabilities					
Trade and other payables	25	(45,726)	(41,562)	(47,357)	(43,732)
Borrowings	27	(38,786)	(6,252)	(42,028)	(8,960)
Provisions	29	(491)	(483)	(491)	(483)
Other liabilities	26	(1,824)	(2,788)	(1,824)	(2,788)
Total current liabilities		**(86,827)**	**(51,085)**	**(91,700)**	**(55,963)**
Total assets less current liabilities		**152,630**	**172,976**	**197,881**	**220,884**
Non-current liabilities					
Borrowings	27	(76,496)	(111,132)	(124,314)	(162,194)
Provisions	29	(2,809)	(2,757)	(2,809)	(2,757)
Total non-current liabilities		**(79,305)**	**(113,889)**	**(127,123)**	**(164,951)**
Total assets employed		**73,325**	**59,087**	**70,758**	**55,933**
Financed by					
Public dividend capital		118,210	114,959	118,210	114,959
Revaluation reserve		681	681	681	681
Merger reserve		541	541	541	541
Income and expenditure reserve		(48,085)	(59,795)	(48,674)	(60,248)
Charitable fund reserves	21	1,978	2,701	-	-
Total taxpayers' equity		**73,325**	**59,087**	**70,758**	**55,933**

The notes on pages 7 to 60 form part of these accounts.

* The 18-19 current and non-current receivables has been restated by £1,142k as the apportionment was incorrect.

Name Sue Jacques
Position Chief Executive
Date **24 June 2020**

Consolidated Statement of Changes in Taxpayers' Equity for the year ended 31 March 2020

Group	Public dividend capital	Revaluation reserve	Merger reserve	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**114,959**	**681**	**541**	**(59,795)**	**2,701**	**59,087**
Surplus/(deficit) for the year	-	-	-	11,710	(224)	**11,486**
Fair value gains/(losses) on financial assets mandated at fair value through OCI	-	-	-	-	(499)	**(499)**
Public dividend capital received	3,251	-	-	-	-	**3,251**
Taxpayers' and others' equity at 31 March 2020	**118,210**	**681**	**541**	**(48,085)**	**1,978**	**73,325**

Consolidated Statement of Changes in Taxpayers' Equity for the year ended 31 March 2019

Group	Public dividend capital	Revaluation reserve	Merger reserve	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**115,078**	**681**	**541**	**(46,538)**	**3,463**	**73,225**
Prior period adjustment	**-**	**-**	**-**	**-**	**-**	**-**
Taxpayers' and others' equity at 1 April 2018 - restated	**115,078**	**681**	**541**	**(46,538)**	**3,463**	**73,225**
Surplus/(deficit) for the year	**-**	**-**	**-**	**(13,996)**	**(15)**	**(14,011)**
Fair value gains/(losses) on financial assets mandated at fair value through OCI	-	-	-	-	(8)	**(8)**
Public dividend capital received	120	-	-	-	-	**120**
Public dividend capital repaid	(239)	-	-	-	-	**(239)**
Other reserve movements	-	-	-	739	(739)	**-**
Taxpayers' and others' equity at 31 March 2019	**114,959**	**681**	**541**	**(59,795)**	**2,701**	**59,087**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2020

Trust	Public dividend capital £000	Revaluation reserve £000	Financial assets reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**114,959**	**681**	**541**	**(60,248)**	**55,933**
Surplus/(deficit) for the year				11,573	**11,573**
Public dividend capital received	3,251				**3,251**
Taxpayers' and others' equity at 31 March 2020	**118,210**	**681**	**541**	**(48,675)**	**70,757**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2019

Trust	Public dividend capital £000	Revaluation reserve £000	Financial assets reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2018 - brought forward					**-**
Prior period adjustment	115,078	681	541	(46,969)	**69,331**
Taxpayers' and others' equity at 1 April 2018 - restated	**115,078**	**681**	**541**	**(46,969)**	**69,331**
Surplus/(deficit) for the year				(13,279)	**(13,279)**
Public dividend capital received	120				**120**
Public dividend capital repaid	(239)				**(239)**
Taxpayers' and others' equity at 31 March 2019	**114,959**	**681**	**541**	**(60,248)**	**55,933**

Information on reserves

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

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

Merger reserve
This reserve reflects balances formed on merger of NHS bodies.

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

Charitable funds reserve
This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 21

Statements of Cash Flows

	Note	Group 2019/20 £000	Group 2018/19 £000	Trust 2019/20 £000	Trust 2018/19 £000
Cash flows from operating activities					
Operating surplus / (deficit)		27,392	1,739	27,910	2,666
Non-cash income and expense:					
Depreciation and amortisation	6.1	9,487	9,622	9,487	9,622
Net impairments	7	(1,526)	13,918	(1,526)	13,918
Income recognised in respect of capital donations	4	(255)	-	(255)	
(Increase) / decrease in receivables and other assets		2,591	(327)	5,072	115
(Increase) / decrease in inventories		94	(562)	(189)	(267)
Increase / (decrease) in payables and other liabilities		569	(8,808)	(1,698)	(8,430)
Increase / (decrease) in provisions		74	(399)	74	(399)
Movements in charitable fund working capital		106	270	-	
Tax (paid) / received		(672)	(366)	-	
Other movements in operating cash flows		3	1	1	
Net cash flows from / (used in) operating activities		**37,863**	**15,088**	**38,876**	**17,225**
Cash flows from investing activities					
Interest received		146	103	1,485	1,487
Purchase of intangible assets		(400)	(127)	(400)	(127)
Purchase of PPE and investment property		(13,146)	(21,159)	(11,358)	(19,124)
Sales of PPE and investment property		270	17	270	17
Receipt of cash donations to purchase assets		255	-		
Net cash flows from charitable fund investing activities		519	551	-	
Movement on loans to subsidiaries				(1,338)	(2,616)
Net cash flows from / (used in) investing activities		**(12,356)**	**(20,615)**	**(11,341)**	**(20,363)**
Cash flows from financing activities					
Public dividend capital received		3,251	120	3,251	120
Public dividend capital repaid		-	(239)		(239)
Movement on loans from DHSC		-	30,108	-	30,108
Capital element of finance lease rental payments		(1,691)	(471)	(4,399)	(471)
Capital element of PFI, LIFT and other service concession payments		(4,940)	(4,726)	(4,940)	(4,726)
Interest on loans		(462)	(172)	(462)	(172)
Other interest		(6)	(1)	(6)	(1)
Interest paid on finance lease liabilities		(215)	(150)	(2,026)	(2,407)
Interest paid on PFI, LIFT and other service concession obligations		(14,108)	(13,516)	(14,108)	(13,516)
PDC dividend (paid) / refunded		(986)	(1,342)	(986)	(1,342)
Net cash flows from / (used in) financing activities		**(19,157)**	**9,611**	**(23,676)**	**7,354**
Increase / (decrease) in cash and cash equivalents		**6,350**	**4,084**	**3,859**	**4,216**
Cash and cash equivalents at 1 April - brought forward		**7,862**	**3,778**	**7,802**	**3,586**
Cash and cash equivalents at 31 March	24	**14,212**	**7,862**	**11,661**	**7,802**

Notes to the Accounts

Note 1 Accounting policies and other information (Group and Trust)

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

Note 1.1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern
These accounts have been prepared on a going concern basis.

The Group delivered a £24.2m Cost Improvement Program (CIP) for 2019/20 and achieved a surplus of £11.5m. The financial results were £0.2m ahead of the Control Total we agreed with NHS Improvement. Given the implications of the COVID-19 pandemic NHSE/I announced revised arrangements in March 2020 for NHS contracting and payment to apply for part of the 2020/21 year. In May 2020 NHSE/I issued revised financial management guidance to CCGs for the corresponding period. Although NHSE/I are not yet able to definitively announce the contracting arrangements that will be in place for the rest of 2020/21 and beyond. It remains the case that the Government has issued a mandate to NHS England for the continued provision of services in England in 2020/21 and CCG allocations have been set for the remainder of 2020/21. While these allocations may be subject to minor revision as a result of the COVID-19 financial framework, the guidance has been clarified to inform CCGs that they will be provided with sufficient funding for the year. Providers can therefore continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned. While mechanisms for contracting and payment are not definitively in place, it is clear that NHS services will continue to be funded, and government funding is in place for this.

The Trust's Wholly owned subsidiary, Synchronicity Care Ltd, delivered a surplus of £131k (after concolidation) in 19-20. Given the revised NHS contracting arrangements the Trust has agreed a continuation of funding which is underpinned by a letter of guarantee.

After making enquiries, the directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Note 1.2.1 Critical accounting judegements and key sources of estimation in applying NHS Foundation trust's accounting policies.

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

Valuation of Property Plant and Equipment

The trust's buildings are valued on a 'modern equivalent asset value' basis. An alternative site has been identified and a revised specification has been identified that would better fit with the current services provided at the trust's hospitals.

A desk top valuation was carried out during the final quarter of the year by Cushman & Wakefield, who are qualified surveyors, registered with the Royal Institute of Chartered Surveyors. This valuation reflects the current economic conditions within County Durham.

These assets have been valued net of VAT. MEA valuations require the inclusion of VAT only to the extent that it is an irrecoverable cost. It is assumed that all future building costs will be incurred in such a way that VAT will be recoverable. This may be through a PFI scheme as the majority of the trust's assets were built through PFI, or through the use of the trust's commercial subsidiary.

Embedded Lease

The Trust has identified embedded leases within the Operated Healthcare Facility Agreement with its subsidiary, Synchronicity Care Limited (see note 28).

At inception of an arrangement, the Trust determines whether such an arrangement is, or contains, a lease. This is determined to be the case through a judgemental assessment of whether the following 2 criteria are met:

- The fulfilment of the arrangement is dependent on the use of a specific asset or assets; and
- The arrangement contains the right to use the asset(s).

Subsequently the liability is reduced as payments are made and an imputed finance cost on the liability is recognised using the Trust's incremental borrowing rate.

Income Recognition

In accordance with IFRS 15 the trust recognises income when it is due and revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial period on the basis of bed occupancy as at 31 March 2020, compared to expected length of stay. This is only for contracts that are paid on a payment by results basis. The Trust has a small number of these contracts.

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

Valuation of Property Plant & Equipment

The trust's buildings are valued on a 'modern equivalent asset value' basis. An alternative sites has been identified and a revised specification has been identified that would better fit with the current services provided at the trust's hospitals.

A valuation was carried out on 31st March 2020 by Cushman & Wakefield, who are qualified surveyors, registered with the Royal Institute of Chartered Surveyors. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID -19. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. It is possible that the COVID-19 pandemic will affect the Trust's future assessment of what would be required in a modern equivalent asset, but as yet there is insufficient evidence to affect the assumptions used in the valuation.

The Group's valuation as at 31 March 2020 has been produced through indexing the full valuation supported by inspection that was carried out as at 1 April 2016. Indexing the valuation requires judgement as to the choice of indices, whether averaging is used and the appropriateness of regional factors. The Trust has determined that the most reliable method of valuation is to adopt the BCIS all in tender price index as at the balance sheet date and to adopt a five-year average for the regional factor applied in order to reduce volatility.

These assets have been valued net of VAT. MEA valuations require the inclusion of VAT only to the extent that it is an irrecoverable cost. It is assumed that all future building costs will be incurred in such a way that VAT will be recoverable. This may be through PFI, as the majority of the trust's assets were built under PFI, or through the use of the trust's commercial subsidiary.

Note 1.3 Consolidation

NHS Charitable Funds

The trust is the corporate trustee to County Durham and Darlington NHS Foundation Trust charitable fund. The trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the 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 trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses.

Other subsidiaries

Subsidiary entities are those over which the 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. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the draft financial statements of the subsidiaries for the year to 31st March 2020.

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. 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).

Revenue 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 Trust accrues income relating to performance obligations satisfied in that year. Where the 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.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the 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 Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

For example: Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

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 Trust's interim performance does not create an asset with alternative use for the Trust, and the 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 Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations have been satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work 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.

Provider sustainability fund (PSF) and Financial recovery fund (FRF)
The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Note 1.4.2 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.

Note 1.4.3 Other forms of income

Grants and donations
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income
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 from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs
NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme. The contributions are charged to operating expenses as and when they become due.

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

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

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

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 above. 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.

Note 1.7.2 Measurement

Valuation

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

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery 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.

Depreciation

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

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

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 expenditure.

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

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

Impairments

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

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

Note 1.7.3 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;
- the sale must be highly probable ie:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

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

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

Note 1.7.4 Donated and grant funded assets

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

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

Note 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM* , are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Note 1.7.6 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	1	57
Dwellings	46	46
Plant & machinery	-	22
Transport equipment	-	7
Information technology	-	9

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

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

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

Expenditure on research is not capitalised.

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

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

Software

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

Note 1.8.2 Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	**Max life Years**
Software licences	-	7

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method other than Pharmacy and oil which are valued at weighted average cost.

Note 1.10 Cash and cash equivalents

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

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

Note 1.11 Financial assets and financial liabilities

Note 1.11.1 Recognition

Financial assets and financial liabilities arise where the 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 Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.11.2 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 below.

Financial assets except charity investments are classified as subsequently measured at amortised cost.

Financial liabilities except charity investments are 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 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 and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

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 Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other 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 increases (stage 2).

The Trust identifies receivables into defined categories and applies an impairment percentage based on historic results, other than the Compensation Recovery Unit income where the percentage provided by DoH is used.

Receivables are identified as :

- Overseas Visitors - 43% Credit Risk
- Medical records - 41% Credit Risk
- Pharmacy Prescriptions - 22% Credit Risk
- Compensation Recovery Unit income - 21.79% Credit Risk
- Staff Charges - 10% - Credit Risk
- Private Patients - 4% - Credit risk
- Local Authorities - 3% - Credit Risk
- Other - 2% - Credit Risk

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 asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.11.3 Derecognition

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

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

Note 1.12 Leases

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

Note 1.12.1 The trust as a lessee

Finance leases

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

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

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term.

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

Leases of land and buildings

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

Note 1.12.2 The trust as a lessor

Finance leases

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

Operating leases

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

Note 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2020:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 29.2 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

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

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 30 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 30, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

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

Note 1.15 Public dividend capital

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

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated and grant funded assets,
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.
(iv) assets purchased as a result of the COVID-19 pandemic

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 calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax

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

Note 1.17 Corporation tax

Synchronicity Care Limited is a wholly owned subsidiary of County Durham & Darlington NHS Foundation Trust and is subject to corporation tax on its profits.

Tax on the profit or loss for the year comprises current and deferred tax. Tax is recognised in the profit and loss account except to the extent that it relates to items recognised directly in equity or other comprehensive income, in which case it is recognised directly in equity or other comprehensive income. Current tax is the expected tax payable or receivable on the taxable income or loss for the year using tax rates enacted or subsequently enacted at the balance sheet date, and any adjustments to tax payable in respect of previous years. Deferred tax is provided on provided on temporary differences between the carrying amounts of assets and liabilities, for financial reporting purposes and the amounts used for taxation purposes. The amount of assets and liabilities, using tax rates enacted or substantively enacted on the balance sheet date. A deferred tax asset is recognised only to the extent that it is probable that future taxable profits will be available against which the temporary difference can be utilised.

Note 1.18 Foreign exchange

The functional and presentational currency of the trust is sterling.

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

Note 1.19 Third party assets

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

Note 1.20 Losses and special payments

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

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

Note 1.21 Gifts

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

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments.

For leases commencing in 2021/22, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

As the Department of Health and Social Care Group Accounting Manual (GAM) is yet to be updated and the implementation of IFRS16 has been deferred for NHS bodies until April 2021 it was not possible to provide an accurate estimate at this time.

Note 1.24 Post balance Sheet Events

Note 1.24.1 DHSC Loans

On 2 April 2020, The Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered as adjusting event after the reporting period for providers. Outstanding interim loans totalling £30.289m as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months. This change will not affect the management judgement in relation to going concern as this will see a movement from a liability to tax payers equity.

Note 2 Operating Segments

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 predominately from the provision of secondary care and community services.

Organisations that contributed 5% of more of the NHS Foundation Trusts operating income in either year are set out in the table below. Further information can be found in Note 38, Related Party Transactions.

	2019/20 %	**2018/19 %**
Durham Dales, Easington and Sedgefield CCG	34.4%	34.5%
North Durham CCG	33.9%	34.1%
Darlington CCG	14.9%	15.7%
NHS England;	9.4%	6.8%
DDT Area Team (Inc. Community Dental)	*1.9%*	*1.8%*
Specialised Commissioning	*3.9%*	*4.7%*
Pensions Adjustment	*2.5%*	*0.0%*
COVID-19 Income	*0.7%*	*0.0%*
Other Non Contract Activities (Including Cancer Drugs Fund)	*0.5%*	*0.4%*

Note 3 Operating income from patient care activities (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)	2019/20 £000	2018/19 £000
Acute services		
Elective income	42,795	45,599
Non elective income	131,655	123,114
First outpatient income	33,837	34,089
Follow up outpatient income	26,547	26,617
A & E income	21,697	18,301
High cost drugs income from commissioners (excluding pass-through costs)	35,119	33,608
Other NHS clinical income	87,327	67,092
Community services		
Community services income from CCGs and NHS England	85,488	81,242
Income from other sources (e.g. local authorities)	7,212	7,865
All services		
Private patient income	34	23
Agenda for Change pay award central funding*	-	4,379
Additional pension contribution central funding**	12,229	-
Other clinical income	2,430	3,558
Total income from activities	**486,370**	**445,487**

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2019/20 £000	2018/19 £000
NHS England	45,945	30,611
Clinical commissioning groups	427,685	396,707
Department of Health and Social Care	-	4,379
Other NHS providers	328	318
NHS other	57	35
Local authorities	10,421	11,584
Non-NHS: private patients	34	23
Non-NHS: overseas patients (chargeable to patient)	166	280
Injury cost recovery scheme	1,672	1,481
Non NHS: other	62	69
Total income from activities	**486,370**	**445,487**
Of which:		
Related to continuing operations	486,370	445,487
Related to discontinued operations	-	-

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

	2019/20	2018/19
	£000	£000
Income recognised this year	166	280
Cash payments received in-year	105	190
Amounts added to provision for impairment of receivables	(18)	(37)
Amounts written off in-year	100	37

Note 4 Other operating income (Group)

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	104	-	**104**	197	-	**197**
Education and training	11,167	691	**11,858**	11,483	434	**11,917**
Non-patient care services to other bodies	11,327	-	**11,327**	10,432	-	**10,432**
Provider sustainability fund (PSF)	8,814	-	**8,814**	15,983	-	**15,983**
Marginal rate emergency tariff funding (MRET)	2,660	-	**2,660**	-	-	**-**
Income in respect of employee benefits accounted on a gross basis	-	-	**-**	13	-	**13**
Receipt of capital grants and donations	-	255	**255**	-	-	**-**
Charitable and other contributions to expenditure	-	-	**-**	-	226	**226**
Rental revenue from operating leases	-	238	**238**	-	163	**163**
Charitable fund incoming resources	-	284	**284**	-	469	**469**
Other income	3,068	-	**3,068**	2,962	-	**2,962**
Total other operating income	**37,140**	**1,468**	**38,608**	**41,070**	**1,292**	**42,362**
Of which:						
Related to continuing operations			**38,608**			**42,362**
Related to discontinued operations			**-**			**-**

'Other' other operating income

£1,298,000 (2018/19 £1,143,000) arises from catering services

£1,386,000 (2018/19 £1,235,000) arises from car parking

£226,000 (2018/19 £243,000) arises from accommodation charges

£158,000 (2018/19 £202,000) arises from sponsorship income

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20	2018/19
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,788	546
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	(17)

Note 5.2 Transaction price allocated to remaining performance obligations

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

All consideration therefore relates to the current accounting period.

Note 5.3 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2019/20	2018/19
	£000	£000
Income from services designated as commissioner requested services	484,023	438,530
Total	**484,023**	**438,530**

The proportion of income which relates to the provision of goods and services for the purposes of health services in England is 92.20% (89.89% in 2018/19) of total trust income.

18/19 figures have been restated in line with 19/20 guidance

Note 6.1 Operating expenses (Group)

	2019/20	2018/19
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	1,184	1,949
Purchase of healthcare from non-NHS and non-DHSC bodies	8,207	6,941
Staff and executive directors costs	325,344	306,023
Remuneration of non-executive directors	170	179
Supplies and services - clinical (excluding drugs costs)	39,838	39,706
Supplies and services - general	2,001	2,028
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	41,489	40,451
Consultancy costs	551	650
Establishment	4,034	4,581
Premises	22,700	20,835
Transport (including patient travel)	1,723	2,635
Depreciation on property, plant and equipment	8,997	8,867
Amortisation on intangible assets	490	755
Net impairments	(1,526)	13,918
Movement in credit loss allowance: contract receivables / contract assets	160	(649)
Change in provisions discount rate(s)	389	(61)
Audit fees payable to the external auditor		
audit services- statutory audit	61	80
other auditor remuneration (external auditor only)	3	22
Independent examination (external auditor only)	1	-
Internal audit costs	250	261
Clinical negligence	14,015	13,897
Legal fees	353	141
Insurance	643	616
Research and development	1	52
Education and training	2,497	1,800
Rentals under operating leases	1,437	1,595
Redundancy	-	89
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	18,101	17,334
Losses, ex gratia & special payments	-	12
Other NHS charitable fund resources expended	837	670
Other	3,636	733
Total	**497,586**	**486,110**
Of which:		
Related to continuing operations	497,586	486,110
Related to discontinued operations	-	-

* Education and Training includes £1.0m (£0.5m in 2018/19) of training provided by the North East Leadership Academy, which has been hosted by the trust since 2010.

Other operating expenses' includes :

£331,000 (£338,000 in 2018/19) relates to National Quality Control and accreditation fees
£165,000 (£198,000 in 2018/19) relates to professional fees

Note 6.2 Other auditor remuneration (Group)

The remuneration to the trust's external auditors was all in relation to the audit of the trust, subsidiary and charity annual financial statements.

The audit of the trust's statements (£50k inc VAT)
The audit of the Subsidiary's statements (£9.5k)
The independent valuation of the charity accounts (£1k)

Non Audit Services in 2019/20 included:
The review of the trust's quality report (£4k)

Note 7 Impairment of assets (Group)

	2019/20	2018/19
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Unforeseen obsolescence	-	288
Changes in market price	(1,526)	13,630
Total net impairments charged to operating surplus / deficit	**(1,526)**	**13,918**
Impairments charged to the revaluation reserve	-	-
Total net impairments	**(1,526)**	**13,918**

Impairments (and their reversals) are primarily due to the change in fair value identified as a result of the annual revaluation undertaken.

Accounting Standards require all reductions in the value of assets to be charged to the revaluation reserve where one exists for that asset. Where no revaluation reserve exists for a specific asset, the drop in value is charged straight to the Statement of Comprehensive Income.

Note 8 Employee benefits (Group)

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	253,524	247,003
Social security costs	23,550	22,732
Apprenticeship levy	1,169	1,150
Employer's contributions to NHS pensions	39,947	27,335
Termination benefits	-	89
Temporary staff (including agency)	8,633	8,870
Total gross staff costs	**326,823**	**307,179**
Recoveries in respect of seconded staff	(594)	(279)
Total staff costs	**326,229**	**306,900**
Of which		
Costs capitalised as part of assets	885	788

Note 8.1 Retirements due to ill-health (Group)

During 2019/20 there were no early retirements from the trust agreed on the grounds of ill-health (6 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is 0k (£283k in 2018/19).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 8.2 Directors remuneration

	Group	
The aggregate amounts payable to directors were :		
	2019/20 £000s	2018/19 £000s
Salary	1,075	887
Taxable benefits	5	4
Performance related bonus	0	0
Employer's pension contributions	215	203
	1,295	**1,094**

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest 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 at 20.6%, and the Scheme Regulations were amended accordingly.

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 Subsidiary operates a defined contribution plan. The total expenses relating to this plan in the current year was £84,933 (2018/19: £24,478)

Note 10 Operating leases (Group)

Note 10.1 County Durham and Darlington NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where County Durham and Darlington NHS Foundation Trust is the lessor.

	Group		Trust	
	2019/20	2018/19	2019/20	2018/19
	£000	£000	£000	£000
Operating lease revenue				
Minimum lease receipts	238	163	150	145
Total	**238**	**163**	**150**	**145**

	31 March 2020	31 March 2019	31 March 2020	31 March 2019
	£000	£000	£000	£000
Future minimum lease receipts due:				
- not later than one year;	183	117	150	143
- later than one year and not later than five years;	399	393	571	393
- later than five years.	350	539	1041	1256
Total	**932**	**1,049**	**1,762**	**1,792**

The operating lease income relates to :

WRVS Shop at Bishop Auckland Hospital

WH Smith shop at Darlington Memorial Hospital

North East Ambulance Service lease of the ambulance station at Chester-le-Street Hospital

The Trust's operating lease income includes the lease of land at Darlington Memorial Hospital

Note 10.2 County Durham and Darlington NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where County Durham and Darlington NHS Foundation Trust is the lessee.

	Group	
	2019/20	2018/19
	£000	£000
Operating lease expense		
Minimum lease payments	1,437	1,595
Total	**1,437**	**1,595**

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease payments due:		
- not later than one year;	1,639	1,463
- later than one year and not later than five years;	2,005	765
- later than five years.	-	112
Total	**3,644**	**2,340**
Future minimum sublease payments to be received	-	-

The trust's leasing arrangements relate to building leases, car leases and photocopying and other minor equipment leases.

Note 11 Finance income (Group)

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

	2019/20	2018/19
	£000	£000
Interest on bank accounts	133	110
NHS charitable fund investment income	90	113
Total finance income	**223**	**223**

Note 12.1 Finance expenditure (Group)

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

	2019/20	2018/19
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	467	348
Finance leases	215	150
Interest on late payment of commercial debt	6	1
Main finance costs on PFI and LIFT schemes obligations	6,872	7,221
Contingent finance costs on PFI and LIFT scheme obligations	7,236	6,294
Total interest expense	**14,796**	**14,014**
Unwinding of discount on provisions	(14)	10
Other finance costs	-	-
Total finance costs	**14,782**	**14,024**

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

	2019/20	2018/19
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	480	863
Amounts included within interest payable arising from claims made under this legislation	6	1

Note 13 Other gains / (losses) (Group)

	2019/20	2018/19
	£000	£000
Gains on disposal of assets	-	17
Losses on disposal of assets	(34)	(21)
Total gains / (losses) on disposal of assets	**(34)**	**(4)**
Fair value gains / (losses) on charitable fund investments & investment properties	240	77
Total other gains / (losses)	**206**	**73**

Note 14 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust’s surplus/(defict) for the period was £11.6 million (2018/19: £13.3 million deficit). The trust's total comprehensive income/(expense) for the period was £11.6 million (2018/19: £7.5 million).

Note 15.1 Intangible assets - 2019/20

Group and Trust	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2019 - brought forward	**6,113**	**-**	**6,113**
Additions	108	292	**400**
Valuation / gross cost at 31 March 2020	**6,221**	**292**	**6,513**
Amortisation at 1 April 2019 - brought forward	**4,971**	**-**	**4,971**
Provided during the year	490	-	**490**
Amortisation at 31 March 2020	**5,461**	**-**	**5,461**
Net book value at 31 March 2020	**760**	**292**	**1,052**
Net book value at 1 April 2019	**1,142**	**-**	**1,142**

Note 15.2 Intangible assets - 2018/19

Group and Trust	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2018 - as previously stated	**6,154**	**-**	**6,154**
Valuation / gross cost at 1 April 2018 - restated	**6,154**	**-**	**6,154**
Additions	90	-	**90**
Disposals / derecognition	(131)	-	**(131)**
Valuation / gross cost at 31 March 2019	**6,113**	**-**	**6,113**
Amortisation at 1 April 2018 - as previously stated	**4,347**	**-**	**4,347**
Amortisation at 1 April 2018 - restated	**4,347**	**-**	**4,347**
Provided during the year	755	-	**755**
Disposals / derecognition	(131)	-	**(131)**
Amortisation at 31 March 2019	**4,971**	**-**	**4,971**
Net book value at 31 March 2019	**1,142**	**-**	**1,142**
Net book value at 1 April 2018	**1,807**	**-**	**1,807**

Note 16.1 Property, plant and equipment - 2019/20

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 - brought forward	**6,270**	**139,161**	**756**	**3,657**	**33,719**	**58**	**22,904**	**206,525**
Additions	-	6,096	-	7,479	4,836	7	2,075	**20,493**
Impairments	-	(2,480)	-	-	-	-	-	**(2,480)**
Reversals of impairments	-	(163)	-	-	-	-	-	**(163)**
Reclassifications	-	1,124	(6)	(1,464)	340	-	(43)	**(49)**
Disposals / derecognition	(100)	(200)	-	-	(704)	-	-	**(1,004)**
Valuation/gross cost at 31 March 2020	**6,170**	**143,538**	**750**	**9,672**	**38,191**	**65**	**24,936**	**223,322**
Accumulated depreciation at 1 April 2019 - brought forward	**-**	**951**	**6**	**-**	**18,240**	**57**	**16,452**	**35,706**
Provided during the year	-	3,522	16	-	3,190	1	2,268	**8,997**
Impairments	-	(1,464)	-	-	-	-	-	**(1,464)**
Reversals of impairments	-	(2,689)	(16)	-	-	-	-	**(2,705)**
Reclassifications	-	-	(6)	-	-	-	(43)	**(49)**
Disposals / derecognition	-	-	-	-	(700)	-	-	**(700)**
Accumulated depreciation at 31 March 2020	**-**	**320**	**-**	**-**	**20,730**	**58**	**18,677**	**39,785**
Net book value at 31 March 2020	**6,170**	**143,218**	**750**	**9,672**	**17,461**	**7**	**6,259**	**183,537**
Net book value at 1 April 2019	**6,270**	**138,210**	**750**	**3,657**	**15,479**	**1**	**6,452**	**170,819**

Note 16.2 Property, plant and equipment - 2018/19

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - as previously stated	**6,270**	**134,840**	**756**	**10,447**	**31,126**	**58**	**22,492**	**205,989**
Valuation / gross cost at 1 April 2018 - restated	**6,270**	**134,840**	**756**	**10,447**	**31,126**	**58**	**22,492**	**205,989**
Additions	-	6,909	-	6,217	4,948	-	2,465	**20,539**
Impairments	-	(15,244)	-	-	(1,010)	-	-	**(16,254)**
Reclassifications	-	12,656	-	(13,007)	-	-	351	**-**
Disposals / derecognition	-	-	-	-	(1,345)	-	(2,404)	**(3,749)**
Valuation/gross cost at 31 March 2019	**6,270**	**139,161**	**756**	**3,657**	**33,719**	**58**	**22,904**	**206,525**
Accumulated depreciation at 1 April 2018 - as previously stated	**-**	**186**	**-**	**-**	**17,213**	**55**	**15,449**	**32,903**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2018 - restated	**-**	**186**	**-**	**-**	**17,213**	**55**	**15,449**	**32,903**
Provided during the year	-	2,373	12	-	3,073	2	3,407	**8,867**
Impairments	-	(1,608)	-	-	(722)	-	-	**(2,330)**
Reversals of impairments	-	-	(6)	-	-	-	-	**(6)**
Disposals / derecognition	-	-	-	-	(1,324)	-	(2,404)	**(3,728)**
Accumulated depreciation at 31 March 2019	**-**	**951**	**6**	**-**	**18,240**	**57**	**16,452**	**35,706**
Net book value at 31 March 2019	**6,270**	**138,210**	**750**	**3,657**	**15,479**	**1**	**6,452**	**170,819**
Net book value at 1 April 2018	**6,270**	**134,654**	**756**	**10,447**	**13,913**	**3**	**7,043**	**173,086**

Note 16.3 Property, plant and equipment financing - 2019/20

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020								
Owned - purchased	6,170	51,418	-	9,672	13,793	7	4,935	**85,995**
Finance leased	-	-	-	-	2,828	-	1,210	**4,038**
On-SoFP PFI contracts and other service concession arrangements	-	91,800	750	-	-	-	-	**92,550**
Owned - donated	-	-	-	-	840	-	114	**954**
NBV total at 31 March 2020	**6,170**	**143,218**	**750**	**9,672**	**17,461**	**7**	**6,259**	**183,537**

Note 16.4 Property, plant and equipment financing - 2018/19

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019								
Owned - purchased	6,270	49,830	1	3,657	13,634	1	4,918	**78,311**
Finance leased	-	-	-	-	1,000	-	1,534	**2,534**
On-SoFP PFI contracts and other service concession arrangements	-	88,380	749	-	-	-	-	**89,129**
Owned - donated	-	-	-	-	845	-	-	**845**
NBV total at 31 March 2019	**6,270**	**138,210**	**750**	**3,657**	**15,479**	**1**	**6,452**	**170,819**

Note 17 Donations of property, plant and equipment

The trust received grants of cash of £255,011 (2018/19: £739,038) from the County Durham and Darlington NHS Foundation Trust charity to purchase equipment.

Note 18 Revaluations of property, plant and equipment

During 2019/20 an annual revaluation was carried out that increased the value of assets by £1.5m (£13.9m reduction in 2018/19). This revaluation adjustment has been charged to the income statement. The revaluations were performed in line with the valuation approach set out in the trust's accounting policies. For specialised operational property, in selecting the site on which the modern equivalent asset would be situated, the valuer considered, in discussion with the trust, whether the actual site remains appropriate. For certain assets it was determined that alternative sites would be appropriate.

Note 19 Other investments / financial assets (non-current)

	Group		Trust	
	2019/20	2018/19	2019/20	2018/19
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	**2,878**	**3,429**	**17,803**	**17,803**
Carrying value at 1 April - restated	**2,878**	**3,429**	**17,803**	**17,803**
Acquisitions in year	90	113	-	-
Movement in fair value through income and expenditure	240	77	-	-
Movement in fair value through OCI	(499)	(8)	-	-
Disposals	(519)	(733)	-	-
Carrying value at 31 March	**2,190**	**2,878**	**17,803**	**17,803**

Charitable funds 'other investments' relate to the funds invested in shares on behalf of the Charity

These have been classified as non-current investments on the basis that they are likely to be held for more than twelve months.

	2019/20	2018/19
	£000	£000
UK Gilts	82	79
UK Bonds	233	386
UK Equities	653	994
Overseas Equities	868	1,098
Property	80	105
Alternatives	174	164
Cash	100	52
	2,190	**2,878**

The trust invested in shares in its subsidiary Synchronicity Care Ltd

Note 20 Disclosure of interests in other entities

The accounts of Synchronicity Care Ltd, a wholly owned subsidiary of the trust, are consolidated into these accounts.

	2019/20 £000s	2018/19 £000s
Operating Income	28,993	26,875
Operating Expenditure	(28,962)	(26,809)
Operating Surplus	31	66
Interest Receivable	1,810	1,902
Interest Payable	(1,338)	(1,377)
Corporation Tax	(372)	(529)
Net surplus / (deficit) for the year	131	62

Note 21 Analysis of charitable fund reserves

The accounts of County Durham and Darlington NHS Foundation Trust Charity have been consolidated within these accounts.

	31 March 2020 £000	31 March 2019 £000
Unrestricted funds:		
Unrestricted income funds	1,860	2,301
Restricted funds:		
Other restricted income funds	118	400
	1,978	**2,701**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 22 Inventories

	Group		Trust	
	31 March 2020 £000	31 March 2019 £000	31 March 2020 £000	31 March 2019 £000
Drugs	3,106	2,846	3,106	2,847
Consumables	5,779	6,129	4,354	4,425
Energy	185	189	158	157
Total inventories	**9,070**	**9,164**	**7,618**	**7,429**
of which:				
Held at fair value less costs to sell	-	-	-	-

Inventories recognised in expenses for the year were £39,832k (2018/19: £42,056k). Write-down of inventories recognised as expenses for the year were £0k (2018/19: £0k).

Note 23.1 Receivables

	Group		Trust	
	31 March 2020	31 March 2019	31 March 2020	31 March 2019
	£000	£000	£000	£000
Current				
Contract receivables	25,038	27,688	25,596	28,738
Allowance for impaired contract receivables / assets	(1,015)	(960)	(938)	(883)
Prepayments (non-PFI)	3,262	2,745	3,147	2,449
PFI prepayments	401	-	401	
Interest receivable	-	13	-	13
PDC dividend receivable	254	449	254	449
VAT receivable	734	1,804	1,893	2,363
Other receivables	720	454	512	457
NHS charitable funds receivables	2	3	-	
Total current receivables	**29,396**	**32,196**	**30,865**	**33,586**
Non-current				
Contract receivables*	-	-	37,045	38,266
Total non-current receivables	**-**	**-**	**37,045**	**38,266**
Of which receivable from NHS and DHSC group bodies:				
Current	22,185	22,862	21,923	22,467
Non-current	-	-	-	-

* A current and long term debtor in the trust's accounts relates to a loan made to its subsidiary Synchronicity Care ltd in 2017-18.

The loan is repayable over 25 years at 3.5% interest.

Note 23.2 Allowances for credit losses - 2019/20

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2019 - brought forward	**960**	**-**	**883**	**-**
New allowances arising	160	-	160	-
Utilisation of allowances (write offs)	(104)	-	(104)	-
Allowances as at 31 Mar 2020	**1,016**	**-**	**939**	**-**

Note 23.3 Allowances for credit losses - 2018/19

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2018 - as previously stated	**-**	**2,167**		**2,090**
Allowances as at 1 Apr 2018 - restated	**-**	**2,167**	**-**	**2,090**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	2,167	(2,167)	2,090	(2,090)
New allowances arising	431	-	431	
Changes in existing allowances	(1,080)	-	(1,080)	
Utilisation of allowances (write offs)	(558)	-	(558)	
Allowances as at 31 Mar 2019	**960**	**-**	**883**	**-**

Note 23.4 Exposure to credit risk

Group and Trust

Type of Debt	£000s	Credit Risk %	Provision £000s
Overseas Visitors	234	43%	101
Pharmacy Prescriptions	1	22%	0
Compensation Recovery Unit Income	3,622	21.79%	789
Staff or former Staff	203	10%	20
Private Patients	10	4%	0
Local Authorities	737	3%	22
Other Debtors	303	2%	6
Trust Exposure to Credit Risk			**938**
Specific Risk Provision *	77		77
Group Exposure to Credit Risk			1015

* relates to the provision for South Tees Hospitals NHS FT debt owed to Synchronicity Care Ltd

Note 24.1 Cash and cash equivalents movements

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

	Group		Trust	
	2019/20	2018/19	2019/20	2018/19
	£000	£000	£000	£000
At 1 April	**7,862**	**3,778**	**7,802**	**3,586**
Net change in year	6,350	4,084	3,859	4,216
At 31 March	**14,212**	**7,862**	**11,661**	**7,802**
Broken down into:				
Cash at commercial banks and in hand	2,734	135	183	75
Cash with the Government Banking Service	11,478	7,727	11,478	7,727
Total cash and cash equivalents as in SoFP	**14,212**	**7,862**	**11,661**	**7,802**
Total cash and cash equivalents as in SoCF	**14,212**	**7,862**	**11,661**	**7,802**

Note 24.2 Third party assets held by the trust

County Durham and Darlington NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	31 March 2020	31 March 2019
	£000	£000
Bank balances	1	1
Total third party assets	**1**	**1**

Note 25.1 Trade and other payables

	Group		Trust	
	31 March 2020	31 March 2019	31 March 2020	31 March 2019
	£000	£000	£000	£000
Current				
Trade payables	13,948	14,051	16,417	17,297
Capital payables	3,930	1,104	8,400	4,041
Accruals	10,220	11,665	5,991	8,395
Other taxes payable	10,430	9,671	10,119	9,356
Other payables	6,896	4,874	6,430	4,643
NHS charitable funds: trade and other payables	302	197	-	-
Total current trade and other payables	**45,726**	**41,562**	**47,357**	**43,732**
Of which payables from NHS and DHSC group bodies:				
Current	9,641	5,842	9,405	5784

Note 26 Other liabilities

	Group		Trust	
	31 March 2020	31 March 2019	31 March 2020	31 March 2019
	£000	£000	£000	£000
Current				
Deferred income: contract liabilities	1,824	2,788	1,824	2,788
Total other current liabilities	**1,824**	**2,788**	**1,824**	**2,788**

Note 27 Borrowings

	Group		Trust	
	31 March 2020	31 March 2019	31 March 2020	31 March 2019
	£000	£000	£000	£000
Current				
Loans from DHSC*	30,289	176	30,289	176
Obligations under finance leases	3,055	1,136	6,297	3,844
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	5,442	4,940	5,442	4,940
Total current borrowings	**38,786**	**6,252**	**42,028**	**8,960**
Non-current				
Loans from DHSC	-	30,108	-	30,108
Obligations under finance leases	2,276	1,365	50,096	52,427
Obligations under PFI, LIFT or other service concession contracts	74,220	79,659	74,220	79,659
Total non-current borrowings	**76,496**	**111,132**	**124,316**	**162,194**

On 2 April 2020, The Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow repayment. The affected loans totalling £30.289m are classified as current liabilities within these financial statements. as the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

Note 27.1 Reconciliation of liabilities arising from financing activities (Group)

Group - 2019/20	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2019	**30,284**	**2,501**	**84,599**	**117,384**
Cash movements:				
Financing cash flows - payments and receipts of principal	-	(1,691)	(4,940)	**(6,631)**
Financing cash flows - payments of interest	(462)	(215)	(6,869)	**(7,546)**
Non-cash movements:				
Additions	-	4,521	-	**4,521**
Application of effective interest rate	467	215	6,872	**7,554**
Carrying value at 31 March 2020	**30,289**	**5,331**	**79,662**	**115,282**

Group - 2018/19	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**-**	**183**	**89,325**	**89,508**
Prior period adjustment	**-**	**-**	**-**	**-**
Carrying value at 1 April 2018 - restated	**-**	**183**	**89,325**	**89,508**
Cash movements:				
Financing cash flows - payments and receipts of principal	30,108	(471)	(4,726)	**24,911**
Financing cash flows - payments of interest	(172)	(150)	(7,221)	**(7,543)**
Non-cash movements:				
Additions	-	2,789	-	**2,789**
Application of effective interest rate	348	150	7,221	**7,719**
Carrying value at 31 March 2019	**30,284**	**2,501**	**84,599**	**117,384**

Note 27.2 Reconciliation of liabilities arising from financing activities

Trust - 2019/20	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2019	**30,284**	**56,271**	**84,599**	**171,154**
Cash movements:				
Financing cash flows - payments and receipts of principal	-	(4,399)	(4,940)	**(9,339)**
Financing cash flows - payments of interest	(462)	(2,026)	(6,869)	**(9,357)**
Non-cash movements:				**-**
Additions		4,521		**4,521**
Application of effective interest rate	467	2,026	6,872	**9,365**
Carrying value at 31 March 2020	**30,289**	**56,393**	**79,662**	**166,344**

Trust - 2018/19	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**-**	**56,569**	**89,325**	**145,894**
Prior period adjustment				**-**
Carrying value at 1 April 2018 - restated	**-**	**56,569**	**89,325**	**145,894**
Cash movements:				
Financing cash flows - payments and receipts of principal	30,108	(3,087)	(4,726)	**22,295**
Financing cash flows - payments of interest	(172)	(2,051)	(7,221)	**(9,444)**
Non-cash movements:				**-**
Additions		2,789		**2,789**
Application of effective interest rate	348	2,051	7,221	**9,620**
Carrying value at 31 March 2019	**30,284**	**56,271**	**84,599**	**171,154**

Note 28 Finance leases

Note 28.1 County Durham and Darlington NHS Foundation Trust as a lessor

The Trust has no finance lease receivables

Note 28.2 County Durham and Darlington NHS Foundation Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	Group		Trust	
	31 March 2020	31 March 2019	31 March 2020	31 March 2019
	£000	£000	£000	£000
Gross lease liabilities	**5,806**	**2,918**	**77,670**	**79,300**
of which liabilities are due:				
- not later than one year;	3,486	1,473	8,004	5,991
- later than one year and not later than five years;	2,320	1,400	16,262	16,718
- later than five years.	-	45	53,404	56,593
Finance charges allocated to future periods	(475)	(417)	(21,277)	(23,031)
Net lease liabilities	**5,331**	**2,501**	**56,393**	**56,271**
of which payable:				
- not later than one year;	3,055	1,136	5,858	3,844
- later than one year and not later than five years;	2,276	1,321	10,159	10,288
- later than five years.	-	44	40,376	42,139
Total of future minimum sublease payments to be received at the reporting date	-	-	**-**	**-**
Contingent rent recognised as expense in the period	-	-	-	-

Obligations under finance leases relate to the following non PFI leases.

	Group		Trust	
	31 March 2020	31 March 2019	31 March 2020	31 March 2019
	£000	£000	£000	£000
Lease of a Maldi bio-typer system for the microbiology service.	133	153	133	153
Lease of data centre equipment	1,232	1,538	1,232	1,538
Lease of radiology equipment within a managed service contract	3,966	810	3,966	810
Lease of Darlington Memorial Hospital Site *	-	-	51,062	53,770
	5,331	**2,501**	**56,393**	**56,271**

* The Trust has entered into an arrangement with its subsidiary company Synchronicity Care Limited to provide an Operated Healthcare Facility on the Darlington Memorial Hospital site with effect from 1 April 2017. The land, buildings and equipment on this site have been sold to Synchronicity Care Limited as part of the Asset Transfer Agreement. The finance lease included within the accounts of the Trust relates to the embedded lease of these assets back to the Trust under the operated heathcare facility agreement.

* The Trust has entered into an arrangement with its subsidiary company Synchronicity Care Limited to provide an Operated Healthcare Facility on the Darlington Memorial Hospital site with effect from 1 April 2017. The land, buildings and equipment on this site have been sold to Synchronicity Care Limited as part of the Asset Transfer Agreement. The finance lease included within the accounts of the Trust relates to the embedded lease of these assets back to the Trust under the operated heathcare facility agreement.

Note 29.1 Provisions for liabilities and charges analysis (Group)

Group and Trust	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2019	**1,856**	**1,261**	**98**	**25**	**3,240**
Change in the discount rate	**231**	**158**	**-**	**-**	**389**
Arising during the year	**-**	**-**	**109**	**96**	**205**
Utilised during the year	(235)	(90)	(117)	(5)	**(447)**
Reversed unused	**(33)**	**-**	**(15)**	**(25)**	**(73)**
Unwinding of discount	**(8)**	**(6)**	**-**	**-**	**(14)**
At 31 March 2020	**1,811**	**1,323**	**75**	**91**	**3,300**
Expected timing of cash flows:					
- not later than one year;	235	90	75	**91**	**491**
- later than one year and not later than five years;	940	360	-	**-**	**1,300**
- later than five years.	636	873	-	**-**	**1,509**
Total	**1,811**	**1,323**	**75**	**91**	**3,300**

The provisions all relate to the Trust therefore a separate note is not shown.

(a) Pensions Provisions are anticipated to be released evenly over the remaining years.

(b) Legal Claims relating to Public and Employers liability cases should all be settled within twelve months.

The Trust has recalculated its outstanding pensions provisions using a discount factor of -0.5% provided by HM Treasury (from 0.29% in 2018/19) in order to more accurately reflect the ongoing liability.

Note 29.2 Clinical negligence liabilities

At 31 March 2020, £303,275k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of County Durham and Darlington NHS Foundation Trust (31 March 2019: £313,552k).

Note 30 Contingent assets and liabilities

	Group and Trust	
	31 March 2020 £000	31 March 2019 £000
Value of contingent liabilities		
NHS Resolution legal claims	(36)	(46)
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	**(36)**	**(46)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(36)**	**(46)**
Net value of contingent assets	**-**	**-**

The NHS Foundation Trust is aware of the on-going "Flowers" case which is currently referred to the Supreme Court with no date of review as at the date of the production of the Annual Accounts. The outcome of the case is not yet clear, however, there is a possible obligation for the NHS Foundation Trust dependent upon the outcome. It should also be noted that if the outcome was in the favour of "Flowers" there is uncertainty as to whether the obligation would be statutory or contractual and therefore the potential liability cannot be accurately estimated. The potential liability has numerous ranges of values that could range between £Nil and £0.789m.

Note 31 Contractual capital commitments

	Group and Trust	
	31 March 2020 £000	31 March 2019 £000
Property, plant and equipment	18,083	22,797
Intangible assets	-	-
Total	**18,083**	**22,797**

Capital Commitments in 2019-20 includes £17.755m relating to a fourteen year contract which commenced on 1st November 2018 for a managed service for radiology, which included equipment.

Capital Commitments in 2018-19 includes £22.2m relating to a fourteen year contract which commenced on 1st November 2018 for a managed service for radiology, which included equipment.

Note 32 Other financial commitments

The group / trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	Group		Trust	
	31 March 2020 £000	31 March 2019 £000	31 March 2020 £000	31 March 2019 £000
not later than 1 year	146	503	27,032	28,585
after 1 year and not later than 5 years	298	443	107,841	112,772
paid thereafter	-	-	483,941	505,479
Total	**444**	**946**	**618,814**	**646,836**

Other Group financial commitments relate to payments for the trust's patient record system, and the financial systems.

The Trust financial commitments includes the commitments with its subsidiary Synchronicity Care Ltd for an operated healthcare facility and non operated healthcare facilities. The figures for 2017-18 did not include the non operated healthcare facility.

Note 33 On-SoFP PFI, LIFT or other service concession arrangements

County Durham and Darlington NHS Foundation Trust currently has three PFI Schemes

	£000
PFI 1 : University of North Durham Hospital	
Estimated capital value of the PFI Scheme at 1st April 1998	113,693
Contract Start date:	01/04/1998
Contract End date:	31/03/2028

Our Partner from the Private sector, Consort Healthcare, designed and built the three storey acute hospital and run non-clinical services in the new hospital whilst the Trust continues to run all clinical services.

PFI 2 : Bishop Auckland General Hospital	£000
Estimated capital value of the PFI scheme at 28th June 2002	48,514
Contract Start date:	28/06/2002
Contract End date:	27/06/2032

Criterion are the PFI partners for this scheme which redeveloped Bishop Auckland General Hospital on the old site. It included the re-provision of all existing clinical services into new buildings plus the refurbishment of the existing administration block.

	£000
PFI 3 : Chester le Street Hospital	
Estimated capital value of the PFI Scheme at 1st May 2002	10,000
Contract Start date:	01/05/2002
Contract End date:	20/04/2032

Robertsons Group are the PFI partners for this scheme. They have designed and built the new two storey building on the site of the former Chester le Street General Hospital.

In July 2015, the trust set up a wholly owned subsidiary which would allow any modern equivalent assets to be built net of VAT.

Note 33.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	Group and Trust	
	2020	2019
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**231,364**	**243,979**
Of which liabilities are due		
- not later than one year;	19,735	18,529
- later than one year and not later than five years;	84,536	78,829
- later than five years.	127,093	146,621
Finance charges allocated to future periods	(151,702)	(159,380)
Net PFI, LIFT or other service concession arrangement obligation	**79,662**	**84,599**
- not later than one year;	5,442	4,940
- later than one year and not later than five years;	25,268	22,919
- later than five years.	48,952	56,740

Note 33.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	Group and Trust	
	2020	2019
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**460,383**	**488,074**
Of which payments are due:		
- not later than one year;	42,220	39,911
- later than one year and not later than five years;	180,742	170,846
- later than five years.	237,421	277,317

Note 33.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	Group and Trust	
	2019/20	2018/19
	£000	£000
Unitary payment payable to service concession operator	**41,097**	**38,849**
Consisting of:		
- Interest charge	6,872	7,221
- Repayment of balance sheet obligation	4,940	4,723
- Service element and other charges to operating expenditure	16,973	15,993
- Capital lifecycle maintenance	5,076	4,618
- Revenue lifecycle maintenance	-	-
- Contingent rent	7,236	6,294
- Addition to lifecycle prepayment	-	-

Note 34 Financial instruments

Note 34.1 Financial risk management

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

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

Currency risk

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

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2020 are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained from its income and historic surpluses. The Trust is not, therefore, exposed to significant liquidity risks.

Market risk

The Charity invests its funds in gifts, bonds, equities, property and alternative investments.

UK Gilts

This is a unit of debt issued by HM Treasury and listed on the London Stock Exchange. Investing in gilts is generally considered to be less risky than shares.

UK Bonds

Buying bonds (which are typically known as an IOU) are, put simply, loaning money to the issuer for a fixed period of time. At the end of that period, the value of the bond is repaid. Investors also receive a pre-determined interest rate (the coupon).

UK/Overseas Equities

An equity investment is money that is invested in a company by purchasing shares of that company in the stock market. These shares are typically traded on a Stock Exchange. Investing in both home based and companies abroad allows the Trust to spread risk and make maximum returns from a diverse market base.

Property

Investment in property is generally considered to be a safe strategy where returns can also be generated in the form of rents received but also general increases in land and property values.

Alternatives

Due to the fact that alternatives tend to behave differently than typical stock and bond investments, adding them to a portfolio may provide broader diversification, enhance returns and increase income levels. With low correlation to traditional asset classes, alternatives can be a beneficial way to diversify a portfolio.

Note 34.2 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Held at fair value through OCI	Total
	£000	£000	£000
Trade and other receivables excluding non financial assets	24,697	-	**24,697**
Cash and cash equivalents	14,212	-	**14,212**
Consolidated NHS Charitable fund financial assets	90	2,190	**2,280**
Total at 31 March 2020	**38,999**	**2,190**	**41,189**

Carrying values of financial assets as at 31 March 2019	Held at amortised cost	Held at fair value through OCI	Total
	£000	£000	£000
Trade and other receivables excluding non financial assets	27,120	-	**27,120**
Cash and cash equivalents	7,845	-	**7,845**
Consolidated NHS Charitable fund financial assets	20	2,878	**2,898**
Total at 31 March 2019	**34,985**	**2,878**	**37,863**

Note 34.2 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Total
	£000	£000
Trade and other receivables excluding non financial assets	24,195	**24,195**
Cash and cash equivalents	11,661	**11,661**
Total at 31 March 2020	**35,856**	**35,856**

Carrying values of financial assets as at 31 March 2019	Held at amortised cost	Total
	£000	£000
Trade and other receivables excluding non financial assets	58,820	**58,820**
Cash and cash equivalents	7,802	**7,802**
Total at 31 March 2019	**66,622**	**66,622**

Note 34.3 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Total
	£000	£000
Loans from the Department of Health and Social Care	30,289	**30,289**
Obligations under finance leases	5,331	**5,331**
Obligations under PFI, LIFT and other service concessions	79,662	**79,662**
Trade and other payables excluding non financial liabilities	34,994	**34,994**
Consolidated NHS charitable fund financial liabilities	302	**302**
Total at 31 March 2020	**150,578**	**150,578**

Carrying values of financial liabilities as at 31 March 2019	Held at amortised cost	Total
	£000	£000
Loans from the Department of Health and Social Care	30,284	**30,284**
Obligations under finance leases	2,501	**2,501**
Obligations under PFI, LIFT and other service concessions	84,599	**84,599**
Trade and other payables excluding non financial liabilities	30,949	**30,949**
Consolidated NHS charitable fund financial liabilities	197	**197**
Total at 31 March 2019	**148,530**	**148,530**

* Provisions under contract 18/19 have been restated as is deemed that the provisions provided for within the Group do not meet this criteria.

Note 34.3 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Total
	£000	£000
Loans from the Department of Health and Social Care	30,289	**30,289**
Obligations under finance leases	56,394	**56,394**
Obligations under PFI, LIFT and other service concessions	79,659	**79,659**
Trade and other payables excluding non financial liabilities	37,237	**37,237**
Total at 31 March 2020	**203,579**	**203,579**

Carrying values of financial liabilities as at 31 March 2019	Held at amortised cost	Total
	£000	£000
Loans from the Department of Health and Social Care	30,284	**30,284**
Obligations under finance leases	56,272	**56,272**
Obligations under PFI, LIFT and other service concessions	84,599	**84,599**
Trade and other payables excluding non financial liabilities	33,743	**33,743**
Total at 31 March 2019	**204,898**	**204,898**

Note 34.4 Maturity of financial liabilities

	Group		Trust	
	31 March 2020	31 March 2019	31 March 2020	31 March 2019
	£000	£000	£000	£000
In one year or less	72,915	37,397	77,655	42,702
In more than one year but not more than two years	5,588	5,417	8,489	8,220
In more than two years but not more than five years	23,107	48,932	28,090	55,097
In more than five years	48,968	56,784	89,345	98,879
Total	**150,578**	**148,530**	**203,579**	**204,898**

Note 35 Losses and special payments

Group and trust	2019/20 Total number of cases	2019/20 Total value of cases	2018/19 Total number of cases	2018/19 Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	1	21	-	-
Fruitless payments	8	6	10	1
Bad debts and claims abandoned *	9	104	120	50
Stores losses and damage to property	1	58	22	29
Total losses	**19**	**189**	**152**	**80**
Special payments				
Ex-gratia payments	11	2	20	11
Total special payments	**11**	**2**	**20**	**11**
Total losses and special payments	**30**	**191**	**172**	**91**

* The individual cases mainly relate to small value invoices for prescription charges that proved uneconomical to pursue further.

Note 36 Gifts

The trust made no gifts in 2019/20, nor in 2018/19

Note 37 Related parties

County Durham and Darlington NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

The Trust has had significant related party transactions with the following public sector entities during the year:
Department of Health & Social Care (parent)
Durham County Council
Durham Dales, Easington and Sedgefield CCG
North Durham CCG
Darlington CCG
NHS England

During the year there were transactions between parties related to one of the Board Members of County Durham and Darlington NHS Foundation Trust, and to Five of the Governors of the trust the values of which are listed below :

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party *
	£000s	£000s	£000s	£000s
Board Members				
Ms J Flynn MBE (Durham Constabulary - Audit Committe)	4	1	-	-
Governors				
Dr J Chandy (Dr Joseph Chandy Charitable Trust - Trustee)	6	-	2	-
Dr D Robertson (Barnard Castle Surgery - GP)	131	-	-	-
Dr D Robertson (Durham Dales Health Federation - Chair)	611	2	-	-
Miss B Sarker (BMI Woodlands Hospital, Darlington - Holds practising privileges)	1	-	-	-
Mr G Mitchell (Teesside University - contract with HEE)	-	1	-	-
	753	**4**	**2**	**0**

Ms J Flynn MBE has declared interests in Tow Law Community Association and Durham Community Action. She is also a member of the Joint Audit Committee Durham Constabulary and Durham Police Crime and Victims Commissioner.

Dr J Chandy is a Trust Director of Commissioning Strategy and Delivery (Primary Care) for Durham Dales Easington and Sedgefield (DDES) CCG and North Durham CCG. A Partner and Provider - East Durham Medical Group, a Managing Director - Peterlee Health Centre, a Trustee - Dr Joseph Chandy Charitable Trust incorporating Roseby Road Wellbeing Centre and has connection with Wheatley Hill Property Company.

Dr D Robertson has declared an interest in Durham Dales Health Federation and Barnard Castle Surgery.

Miss B Sarker has declared an interest in BMI Woodlands Hospital.

Mr G Mitchell has declared an interest in Teesside University.

Mr D Smart has declared an interest in Dunelm Medical Practice Durham, but the transaction is less than £500.

Cllr J Allen has declared an interest in Bishop Auckland Community Partnership, but the transaction is less than £500.

All payments and receipts relate to the declared organisations, other than where the interest is with an NHS or other Whole Government Accounting Body organisation.

5.2 Independent auditor's report to the Council of Governors of County Durham and Darlington NHS Foundation Trust in respect of the Financial Accounts

Report on the financial statements

Qualified opinion on the financial statements

We have audited the financial statements of County Durham and Darlington NHS Foundation Trust ('the Trust') and its subsidiaries ('the Group') for the year ended 31 March 2020 which comprise the Consolidated Statement of Comprehensive Income, the Trust and Group Statements of Financial Position, the Consolidated Statement of Changes in Taxpayers' Equity, the Trust Statement of Changes in Taxpayers' Equity, the Trust and Group Statements of Cash Flows, 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 adopted by the European Union, and as interpreted and adapted by HM Treasury's Financial Reporting Manual 2019/20 as contained in the Department of Health and Social Care Group Accounting Manual 2019/20, and the Accounts Direction issued under the National Health Service Act 2006.

In our opinion, except for the possible effects of the matter descried in the 'Basis for qualified opinion' section of our report, the financial statements:

- give a true and fair view of the financial position of the Trust and Group as at 31 March 2020 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 2019/20; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for qualified opinion

The carrying amount of the Group's inventory balance held at the 31 March 2020 is £9.070 million. The Trust's inventory balance held at 31 March 2020 is £7.618 million. We were unable to obtain sufficient appropriate audit evidence about the existence and condition of the inventory balance held by the Trust and Group at 31 March 2020 because we were unable to attend the year-end physical inventory counts due to COVID-19-related travel restrictions. We were unable to satisfy ourselves by alternative means concerning the existence and condition of inventory held by the Trust and Group as 31 March 2020 by using other audit procedures because of the nature of the Trust and Group's accounting records. Consequently we were unable to determine whether any adjustments to this amount were necessary.

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 qualified 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 the 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

In addition to the matter described in the 'Basis for qualified opinion' section of our report, 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) that we identified. These matters included 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 (Group and Trust) The Group recognised £525 million of revenue from activities in the Statement of Comprehensive Income. The primary source of revenue is through contracts with commissioning bodies in respect of the provision of acute, community and other services. Notes 3.1 and 3.2 provide further information on the nature and source of the Trust's and Group's revenue. Auditing standards include a rebuttable presumption that there is a significant risk in relation to the timing of income recognition, and in relation to judgements made by management as to when income has been earned. The pressure to manage income to deliver forecast performance in a challenging economic environment increases the risk of fraudulent financial reporting leading to material misstatement and means that we are unable to rebut the presumption.	Our audit procedures included, but were not limited to: • Testing a sample of receipts and income received around the year-end to confirm the transactions were recognised in the correct financial year. • Testing a sample of year-end receivables to confirm the receivable recognised was appropriate. • Evaluating the Trust's and Group's accounting policy in respect of revenue recognition to ensure that it is in line with the requirements of the GAM. • Testing revenue transactions that had been recorded by journal entries. Journals were selected for testing on the basis of meeting one or more fraud risk indicators that we determined to be applicable to the revenue recognition significant risk. • Considering information provided by the Department of Health and Social Care in respect of year-end intra-NHS transactions. Where we identified any significant differences between the Trust's position and that of the counterparty we obtained assurance that the Trust's position was supported by appropriate evidence. **Observations and conclusions** We obtained sufficient appropriate evidence to conclude that revenue recognised in the financial statements is reasonable.

Valuation of property, plant and equipment (Trust) Land and buildings are the Trust's highest value assets and Note 16 to the financial statements discloses information on the Trust's holding of property, plant and equipment (PPE). This includes £149 million of land and buildings held at current value at 31 March 2020. These assets are subject to periodic revaluation in line with the requirements of the Group Accounting Manual (GAM). Note 1.7 to the financial statements describes the Trust's accounting policy with respect to the valuation of land and buildings. Management engage a valuation expert ('the valuer') to provide the Trust with an estimate of the current value of land and buildings in accordance with Royal Institution of Chartered Surveyors (RICS) requirements. Changes in the value of land and buildings may impact on the Consolidated Statement of Comprehensive Income depending on the circumstances and the specific accounting requirements of the GAM. The valuations require judgement and a high level of estimation in determining current values. The significant risk of material misstatement is further increased due to the additional estimation uncertainty arising from the Covid-19 pandemic and Note 1.2.1 discloses a material valuation uncertainty in relation to this.	Our audit procedures included, but were not limited to: • Obtaining an understanding of the Trust's approach to valuing its land and buildings and its engagement with the valuer. • Writing to the valuer to obtain an understanding of their valuation methodology and compliance with professional requirements, their professional qualifications and their independence from the Trust. • Obtaining an updated understanding of the basis of valuation applied by the valuer in the year. This included understanding and critically assessing the methodology applied to estimate the gross replacement cost of the Trust's operational land and buildings on a modern equivalent asset basis. • Testing the accuracy and completeness of key data provided to and used by the valuer. • Testing the accuracy of how valuation movements were presented and disclosed in the financial statements. • Using relevant market and cost data to assess the reasonableness of the valuation as at 31 March 2020. In doing so, we also considered relevant, publicly-available valuation indices to assess the effect of the material valuation uncertainty disclosed by the valuer and the Trust in the financial statements. **Observations and conclusions** We obtained sufficient appropriate evidence to conclude that property valuations recognised in the financial statements are reasonable.

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 follows:

	Trust	Group
Overall materiality	£9.894 million	£9.951 million
Basis for determining materiality	Approximately 2% of operating expenses.	
Rationale for benchmark applied	Operating expenses 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	£6.926 million	£6.966 million
Reporting threshold	£0.296 million	£0.299 million

The range of financial statement materiality across components, audited to the lower of local statutory audit materiality and materiality capped for group audit purposes, was between £0.616 million and £9.894 million all being below group financial statement materiality.

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 the 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 the Group's accounting processes and controls and their environments, 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 (other than the key audit matter on revenue recognition outlined above).

The risks of material misstatement, including due to fraud, that had the greatest effect on our audit are discussed under 'Key audit matters' within this report.

Our group audit scope included an audit of the Trust and Group financial statements. The Group comprises the Trust, Synchronicity Care Limited and County Durham and Darlington NHS Foundation Trust Charity ('the Charity'). Based on our risk assessment, the Trust was subject to a full scope audit which was performed by the Group audit team. Audit procedures of one or more classes of transactions were completed by the component auditor, Mazars LLP, for the Trust's subsidiary, Synchronicity Care Limited, where these transactions were material to the Group's net assets, revenue and expenditure. The charity balances and transactions were subject to analytical procedures.

At the Group level we also tested the consolidation process and carried out analytical procedures to confirm our conclusion that there were no significant risks of material misstatement of the aggregated financial information.

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 qualified 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.

As described in the 'Basis for qualified opinion' section of our report, we were unable to satisfy ourselves concerning the existence and condition of the £7.618 million of inventory held by the Trust and £9.070million held by the Group at 31 March 2020. We have concluded that where the other information refers to the inventory balance or related balances, it may be materially misstated for the same reason.

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 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 and Group to prepare financial statements 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 2019/20; 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 2019/20; or • the Annual Governance Statement is misleading or is not consistent with our knowledge of the Trust and Group 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 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.	We have nothing to report in respect of these matters.

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 2020.

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) 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 April 2020, 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 2020.

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 County Durham and Darlington 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 County Durham and Darlington NHS Foundation Trust and County Durham and Darlington 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 (Key Audit Partner)
For and on behalf of Mazars LLP

Salvus House
Aykley Heads
Durham
DH1 5TS

25 June 2020

6 HOW TO FIND OUT MORE

For further information about County Durham and Darlington NHS Foundation Trust, including details of all our public meetings please visit the Trust's website: **www.cddft.nhs.uk**

In addition, please feel free to contact the Trust Secretary or a member of the Foundation Trust (FT) office team, if you would like more information about:

- becoming a member or Governor of the County Durham and Darlington NHS Foundation Trust;
- where to view the register of Directors' or Governors' interests;
- how to contact the Chairman or a member of the Board Directors or Council of Governors;
- to find detailed information about our Board of Directors' or Council of Governors' meetings which are open to the public; and
- how to obtain further copies of this report.

Write to: Foundation Trust Office
County Durham and Darlington NHS Foundation Trust
Executive Corridor
Darlington Memorial Hospital
Hollyhurst Road
Darlington
DL3 6HX

FT Office (*Membership*) Telephone: 01325 743 625
FT Office (*Membership*) Email: **cdda-tr.foundation@nhs.net**

Useful Contacts

Below is a list of useful contacts for enquiries of a more general nature than that listed above:

- **Darlington Memorial Hospital** Telephone Number: **01325 380100**;
- **University of Hospital of North Durham Hospital** Telephone Number: **0191 333 2333**;
- **Bishop Auckland Hospital** Telephone Number: **01388 455000**;
- **Chester-le-Street Community Hospital** Telephone Number: **0191 387 6301**;
- **Richardson Hospital** Telephone Number: **01833 696500**;
- **Shotley Bridge Community Hospital** Telephone Number: **0191 333 2333**;
- for communications, press office and media enquiries EMAIL: **cdda-tr.communications@nhs.net**
- for Freedom of Information requests EMAIL: **cdda-tr.cddftFOI@nhs.net**
- for general enquiries EMAIL: **cdda-tr.generalenquiries@nhs.net**
- for compliments, concerns, comments or complaints please contact County Durham and Darlington NHS Foundation Trust's Patient Experience Team: Telephone: **0800 783 5774** or EMAIL: **cdda-tr.patientexperienceCDDFT@nhs.net**

This report can be made available, on request, in alternative languages and formats including large print and Braille.