Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Annual Report and Accounts 2015/16

Northumberland, Tyne and Wear NHS Foundation Trust

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

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Introduction from the Chairman and Chief Executive

Northumberland, Tyne and Wear NHS (NTW) Foundation Trust is committed to developing services of the highest quality, which enable and empower our service users to reach their potential and live fulfilling lives.

We aim to provide services that are patient centred, accessible and focused on recovery. We also aim to support our service users as close to their home as possible. We work closely with our service users, their carers and our partners in other agencies to deliver integrated care in the best place and at the best time.

We recognise that providing effective treatment relies on a three way partnership between service users, their families and carers, and professionals and we recognise the vital role that families and carers play in supporting our service users.

By continually developing and improving our services around the needs of users and their carers, we want to ensure that we can provide high quality, safe, recovery focused care, which is sustainable in the long term.

To the best of our knowledge, the information in this document is accurate.

This Annual Report was approved by the Trust's Board of Directors on 25th May 2016.

Hugh Morgan Williams OBE
Chairman

John Lawlor
Chief Executive

Section 2
The Performance Report

Part 1 Overview

Our Services

NTW provides a wide range of mental health, learning disability and neuro-rehabilitation services to a population of 1.4 million people in the North East of England. We are now one of the largest mental health and disability organisations in the country with an income of approximately £300 million. We employ over 6,000 staff, operate from over 60 sites and provide a range of comprehensive services including some regional and national services.

We support people in the communities of Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland working with a range of partners to deliver care and support to people in their own homes and from community and hospital based premises. Our main hospital sites are:

Walkergate Park, Newcastle upon Tyne;

St. Nicholas Hospital, Newcastle upon Tyne;

St. George's Park, Morpeth;

Northgate Hospital, Morpeth;

Hopewood Park, Sunderland;

Monkwearmouth Hospital, Sunderland;

Ferndene, Prudhoe

Our Vision and Values

Our vision, developed through wide involvement and consultation with patients, carers, staff and partners is as follows:

'Improve the wellbeing of everyone we serve through delivering services that match the best in the world'

We will do this by:

- Modernising and reforming services, in line with local and national strategies and the needs of individuals and communities; providing first class care in first class environments;
- Maximising the benefits of NHS Foundation Trust status and being a sustainable and consistently high performing organisation;
- Supporting the provision and development of high quality services by being a model employer, an employer of choice, and making the best use of the talents of all of our workforce;
- Fully embracing and supporting service user, carer, staff and public involvement, including our membership in all aspects of our work;
- Providing high quality evidence-based and safe services supported by effective integrated governance arrangements;
- Improving clinical and management decision making through the provision and development of effective information;
- Being an influential organisation that supports and enables social inclusion.

Our vision is underpinned by a set of core values which we refreshed during 2013, in consultation with a range of partners, including service users, carers, staff and governors.

Our values ensure that we will strive to provide the best care, delivered by the best people, to achieve the best outcomes. Our concerns are quality and safety and we will ensure that our values are reflected in all we do:

Figure 1: Our Mission and Values

Our Vision

To improve the wellbeing of everyone we serve through delivering services that match the best in the world

Our Mission

We strive to provide the best care, delivered by the best people, to achieve the best outcomes

Our Values

Caring and compassionate

- Put ourselves in other people's shoes
- Listen and offer hope
- Focus on recovery
- Be approachable
- Be sensitive and considerate
- Be helpful
- Go the extra mile

Respectful

- Value the skill and contribution of others
- Give respect to all people
- Respect and embrace difference
- Encourage innovation and be open to new ideas
- Work together and value our partners

Honest and transparent

- Have no secrets
- Be open and truthful
- Accept what is wrong and strive to put it right
- Share information
- Be accountable for our actions

Our History

Northumberland, Tyne and Wear NHS Foundation Trust was authorised as an NHS Foundation Trust on 1 December 2009.

We were established on 1 April 2006 following the merger of three Trusts: Newcastle, North Tyneside and Northumberland Mental Health NHS Trust, South of Tyne and Wearside Mental Health NHS Trust and Northgate and Prudhoe NHS Trust.

As a Public Benefit Corporation NTW has members. We have four membership constituencies to represent stakeholder interests:

- Public constituency;
- Service users and carers constituency;
- Staff constituency;
- Partner organisation constituency.

The Trust's Strategy

In November, 2014 the Board reviewed:

- The progress made in delivering the Trust's Strategy 2014 - 2019, including individual Service Developments and performance in terms of the Finance Strategy / Financial Delivery Plan;
- The Trust's performance, including quality performance;
- The factors influencing the future direction of the Trust, including the policy direction, national strategies and financial environment together with the likely impact on the Trust's Strategy and plans going forward.

As a consequence of this review the Board reaffirmed the Trust's existing Strategy 2014 - 2019 going forward, as agreed in May, 2014, and the continued focus during 2015/16 on three core areas:

- Completion of the Trust's existing programme of service transformation, including the implementation of new models of community care and the consolidation of in-patient and specialist services, focusing on quality of outcomes and value for money;
- Development of the integration agenda and the development of "place based services", including promoting the benefits and opportunities from the integration of pathways across physical and mental health and social care;
- Identifying and exploiting opportunities for growth, including geographical expansion.

The Board of Directors are however in the process of reviewing the Trust's five year Strategy going forward 2016-2021 in the light of:

- The Trust nearing the end of its existing community and local mental health inpatient transformation programme;
- The emerging organisational forms and care models locally and the need to promote and achieve an equal response to mental and physical health and towards the two being treated together, and as a part of this;
- NHS England's future commissioning intentions for our Specialist Services and the Trust's strategic response;
- The impact of the national Transforming Care for People with Learning Disabilities Programme and the North East and Cumbria implementation plans;
- The need to support high quality sustainable services going forward in an ever increasing challenging environment.

Our new Strategy going forward 2016-2021 is scheduled to be completed in September 2016.

The key issues and risks to the delivery of the Trust's Strategy

The Trust faces a number of risks to the delivery of its Strategy. A full analysis of the Trust's principal strategic risks, together with the controls and mitigation, are included in our Board Assurance Framework. The Trust's principal risks are shown in Figure 2 on page 11.

Figure 2: The Trust's Principal Risks-Extract from Board Assurance Framework

Strategic Objective SO1:To Modernise and reform services, in line with local and national strategies and the needs of individuals and communities; providing first class care in first class environments.	
Reference	Principal Risk
SO1.1	That we do not develop and correctly implement service model changes.
SO1.2	That we do not effectively engage public, commissioners and other key stakeholders leading to opposition or significant delay in implementing our service strategy.
Strategic Objective SO2: To be a sustainable and consistently high performing organisation.	
Reference	Principal Risk
SO2.1	That we have a significant loss of income through competition and choice, including the possibility of losing large services and localities.
SO2.2	That we do not manage our financial resources effectively to ensure long term financial stability (including the differential between income and inflation, impact of QIPP and the Cost Improvement Programme).
Strategic Objective SO3: To be a model employer, an employer of choice and employer that makes the best use of the talents of the entire workforce.	
Reference	Principal Risk
SO3.1	That we do not effectively manage significant workforce and organisational changes, including increasing staff productivity and staff engagement.
SO3.3	That we are unable to recruit and retain staff in key posts.
Strategic Objective SO5: Provide high quality evidence based and safe services supported by effective integrated governance arrangements.	
Reference	Principal Risk
SO5.6	The risk that high quality, evidence-based and safe services will not be provided if there are difficulties in accessing services in a timely manner and that services are not sufficiently responsive to demands.
SO5.9	That the scale of change and integration agenda across the NHS could affect the sustainability of services and the Trust's financial position.

Capacity to Handle Risk

The Trust has structures and systems in place to support the delivery of integrated risk management across the organisation.

The standing committees of the Board of Directors ensure effective governance for the major operational and strategic processes and systems of the Trust, and also provide assurance that risk is effectively managed. Operations for the Trust are managed through an organisational structure, with operations divided into three Groups, and each has governance committees in place for quality and performance and operational management.

The Annual Governance Statement (Section 3 iv) provides assurance that the Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Going Concern Disclosure

After making enquiries, the directors have a reasonable expectation that Northumberland, Tyne and Wear 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.

Section 2
The Performance Report

Part 2 Performance Analysis

Performance Management and Reporting Framework

The Trust has an integrated performance reporting structure, which mirrors the key reporting requirements of the "Intelligent Mental Health Board" and is therefore aligned to our strategic objectives.

The Trust has developed the use of Dashboards with a clear set of key performance indicators reflecting not only national targets, but local targets linked to the Trust's strategic and annual objectives balanced across clinical, operational, financial and staff dimensions. This ensures that our strategy, objectives and targets are linked to ensure delivery, with strengthened accountability for performance using key metrics. In addition to providing a robust analysis of new and existing quality and performance targets and the risk register, the report provides evidence links for the Trust's compliance to CQC registration requirements and supports Board assurance in its annual Monitor self-declaration process.

The Trust provides services to a broad range of commissioners. The main commissioners for the Trust in 2015/16 were as follows:

- Five Clinical Commissioning Groups across Northumberland, Tyne and Wear;
- Five Clinical Commissioning Groups across Durham, Darlington and Tees;
- Cumbria and North East Commissioning Hub which is the local team of NHS England;
- CCGs out of area plus Scottish, Welsh and Irish health bodies who commission on an individual named patient contract basis and;
- Local Authorities.

In 2015/16 87% of the Trust's contractual income was covered under block contract arrangements and the remainder was commissioned through cost and volume and cost per case contracts for named patients.

The Trust had legally binding contracts in place to deliver commissioned services and has a positive relationship with commissioners. Commissioners monitor our performance through monthly monitoring reports and regular contract review meetings. We performed broadly in line with 2015/16 patient care contracts over the year.

We have continued to work closely with the main commissioners to develop the mental health payment system which supports tariffs associated with individual service users and their interactions with mental health services. The Trust agreed activity and income baselines with commissioners using new contract currencies based on mental health care clusters. The Trust will continue to monitor and report activity and income against both existing contract currencies and the new proposed clusters. Further development will continue in 2016/17.

The Trust's performance against the agreed CQUIN Indicators relating to improving safety, patient experience and clinical effectiveness is shown in the Quality Report.

Figure 3: 2015/2016 Patient Care Income per Service £000

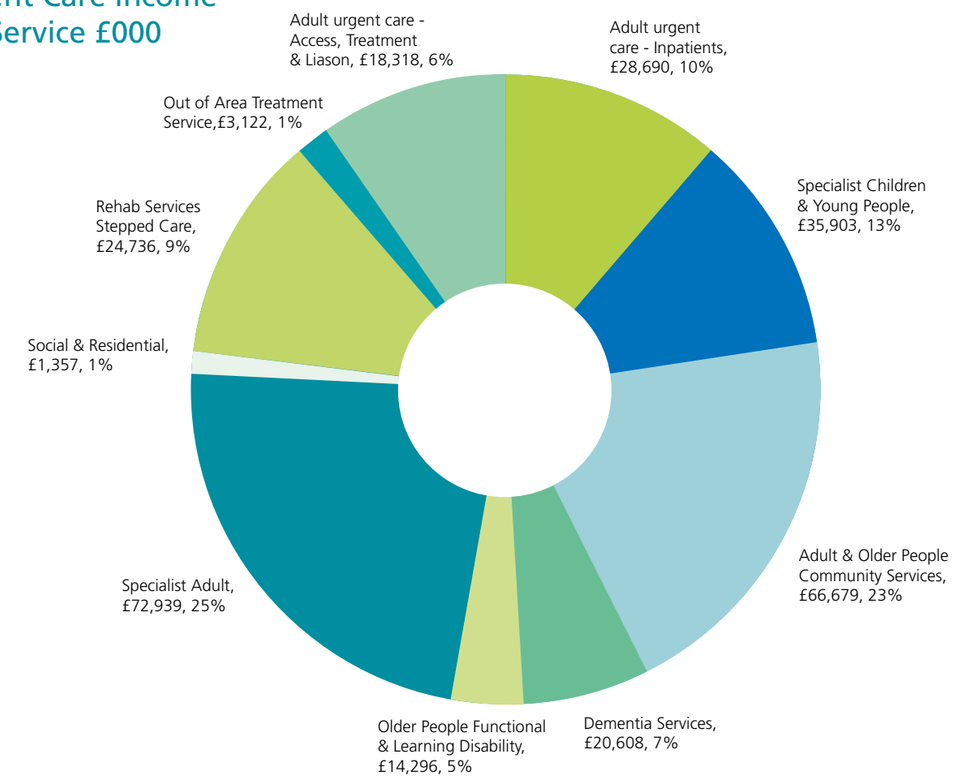
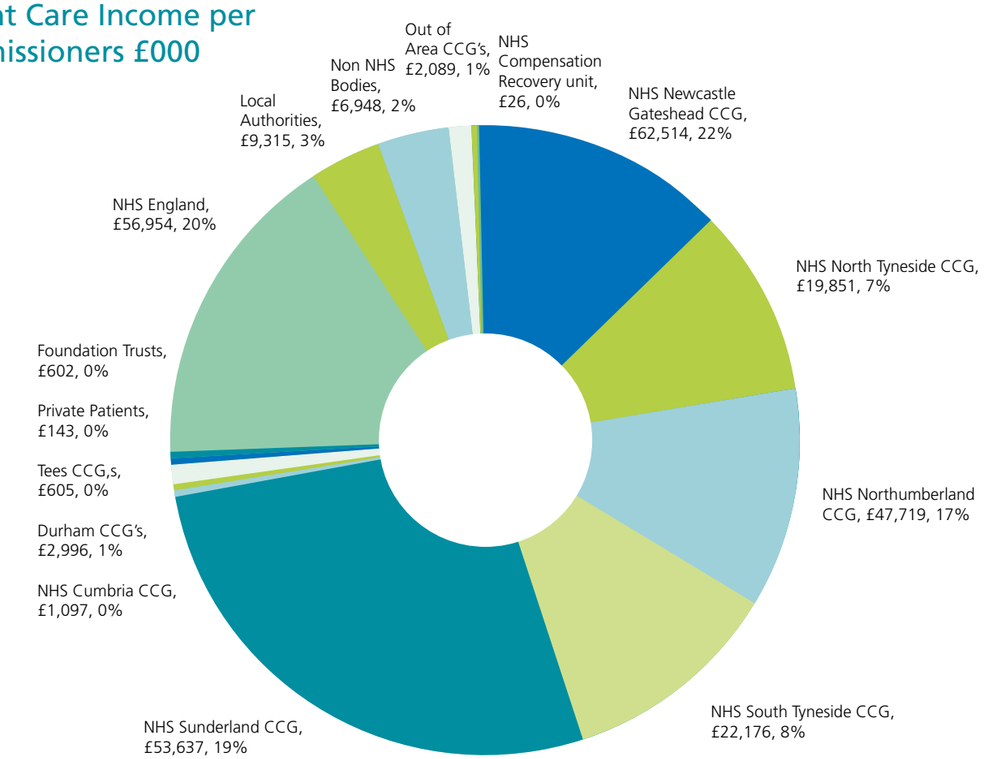


Figure 4: 2015/16 Patient Care Income per Commissioners £000



Performance relating to the quality of NHS services provided

The Trust's Quality Report in Section 4 provides comprehensive information on the Trust's performance in terms of the provision of quality services, including performance against mandated Core Indicators, Quality Indicators and the Trust's Quality Goals.

Registration with the Care Quality Commission (CQC)

The Trust is registered with the Care Quality Commission and has maintained full registration, with no non-routine conditions, from 1 April 2010. During 2015/16, the CQC undertook a number of registration visits to Trust sites. Where compliance actions were identified through these visits, the Trust delivered these in full and on time. The Trust is fully compliant with the requirements of registration with the CQC. Registration compliance is managed through the Trust's governance structures and is supplemented by a Group Director being responsible for the oversight of all compliance assessments and management of on-going compliance through the Trust Quality Compliance Group.

Details relating to CQC Registration Activity during 2015/16 is shown in Section 4, the Quality Report.

Financial Performance

The Trust continued to perform well during 2015/16, in terms of its underlying financial performance, and met all of its planned targets. During the year the Trust continued to progress its Transformation of Services Programmes, with significant investment in the change programme to transform community services. At the same time the Trust continued its programme of reducing the number of wards it operates from, as demand for beds decreases. This reduction in demand is being managed through the delivery of more effective inpatient services, enabling more timely discharge of patients, and improvements in community services. During the year, 2 wards were closed. As the wards closed the Trust continued its investment in staffing levels across remaining wards, both in terms of numbers of staff and in the ratio of qualified to unqualified staff.

The Trust's transformation of services strategy is seeing a marked change in the estate, and the Trust has been working with the Newcastle Gateshead CCG on the formal consultation relating to the future models of delivery for inpatient services during the year. Building of the Trust's new autism unit also started in the summer.

The Trust undertakes an interim revaluation of its estate each year and this year this resulted in additional impairments of £3.4m mainly for enhancements to assets and an increase in the value of buildings, resulting in a net reversal of impairments of £11m. The net total of £7.6m was recognised as a gain in year the Statement of Comprehensive Income resulting in a surplus of £11.7m being recorded for the year.

Any losses through revaluations or impairments are discounted in terms of the financial risk ratings used by the Trust's regulator Monitor.

Excluding revaluations and impairments, the Trust generated a surplus of £4.2m, which was above our plan agreed with Monitor. This maintained a Financial Sustainability Risk Rating of 4. Our performance against the requirements set by Monitor is shown in Figure 5 below.

Figure 5: Performance against Monitor requirements 2015/16

Financial Sustainability Risk Ratings	Plan	Achieved	Risk Rating	Weight	YTD Risk
Capital Service Capacity	1	1.28x	2	25%	Amber
Liquidity Ratio	4	10.4 days	4	25%	Green
I&E Margin	3	1.16%	4	25%	Green
I&E Margin Variance	4	0.50%	4	25%	Green
Overall Rating	2		4		Green

In December 2014, the Trust completed a significant land sale of part of the Northgate site. The second instalment for the Northgate land sale was received in January 2016. This, together with the sale of social & residential homes in Sunderland and the Willows in Morpeth, resulted in receipts for asset sales totalling £9.3m. Capital spend in the year was £15.8m, which was £6.4m behind plan, largely due to delays in starting the development of a new autism unit, also on the Northgate site, and progressing in-patient developments to meet the future service delivery model.

The Trust delivered 68% of its planned recurring Financial Delivery Programme, with £4.2m carried forward of the £13.2m planned to be delivered in year. This delivery was fundamentally linked to our Transformation of Services Programmes, details of which are provided in this report.

The main financial pressures in year were experienced on children and young people's in-patient and community services. A new service model for 2016/17 has been agreed with NHS England in relation to in-patient services at Alnwood and some additional non-recurrent funding and service changes have been agreed with CCG's for community services. This will reduce the pressures in these areas in the coming year.

The programme for the Trust's specialised services is focused on delivering service within a price that the market will bear for the quality of services offered, at a cost which supports long term sustainability. The Trust will continue to explore opportunities to expand and grow where it can deliver on this, and continues to have an excellent record in successfully winning tenders.

Going forward, the most significant financial risks over the next two years are the on-going delivery of our transformation approach as described in this report, managing any national re-structuring of specialist services, and managing of the wider financial risks across health and social care. This will require continuing effective working across multiple stakeholders. The Trust continues to invest in change, in order to ensure that we have the capacity to manage while maintaining our focus on on-going quality. This will be a significant area of emphasis for the Board in the coming year.

Over the longer term, there is more uncertainty. The Trust is in discussions with partners across each of our localities around the development of more integrated pathways, in an environment which is increasingly financially challenged across health and social care. The Trust is connected to and involved in three vanguard bids and one pioneer site. While recognising the significant opportunities to improve care, particularly for those people who cross the boundaries of mental and physical health care and social care, there remains significant risk to the system, as plans for future service delivery models are worked through. The Trust is in a good position to influence these discussions and is working to be an effective partner in continuing to design more effective, safe and good quality care around the needs of the people we look after. The Trust is integrally involved in the development of the Sustainability and Transformation Plan for Northumberland Tyne and Wear

We continue to monitor our performance in terms of paying our trade suppliers in line with our target of paying 95% within 30 days of receiving a valid invoice or within term, whichever is the shorter. An analysis is shown in Figure 6 below.

Figure 6: Payment of Trade Invoices

Better Payment Practice Code	2015/16 Number of invoices paid within target	2015/16 Value of invoices paid within target	2014/15 Number of invoices paid within target	2014/15 Value of invoices paid within target
Non-NHS Trade Invoices	90.6%	94.6%	90.3%	91.7%
NHS Trade Invoices	90.0%	99.8%	81.2%	97.2%

There were no payments made in year under the Late Payment of Commercial Debts (Interest) Act 1998. This was also the case in 2013/14.

Service Developments

During 2015/16, the Trust moved away from the Programme Management approach previously undertaken, and towards a more devolved decision making and development approach for new service developments. The Trust programme board has therefore been stood down. Two programmes continue to exist – Community Transformation and Transforming Care for People with a Learning Disability.

Community Transformation Programme

The Community Transformation Programme is responsible for implementing the changes required across all community services in order to deliver new community-evidenced based care pathways. This includes improving access to services. The programme focuses on the redesign of services to meet the following needs in adults: psychosis; non-psychosis; cognitive disorders and learning disability.

In 2013/14, the programme began the design, testing and implementation of effective, evidence based interventions focused on recovery. It also developed effective support for people to live and work in their own communities with the aim of reducing reliance on inpatient services, initially focusing on Sunderland and South Tyneside.

During 2014/15 the Trust commenced the roll out the new improved community pathways in Sunderland and South Tyneside and this work continued through 2015/16.

Work with commissioners and stakeholders also commenced on the principles and design of improved community pathways in Northumberland, North Tyneside, Newcastle and Gateshead.

In December, 2015 the Northumberland Initial Response Service was launched. The service, based at St. George's Park in Morpeth, provides a single point of access for urgent requests for help including signposting to relevant services within and outside the organisation. The service is staffed 24 hours a day, 7 days a week.

The new improved community pathways are to be fully introduced into Northumberland, North Tyneside, Newcastle and Gateshead during 2016/17.

The implementation of these new models will result in improved quality outcomes and experience for service users accessing community services and their carers.

Last year saw the introduction of the South of Tyne Street Triage Service and this service was so successful that it was expanded during 2015/16 with the introduction of a North of Tyne service covering Newcastle, Northumberland and North Tyneside. This service sees the police and mental health nurses jointly supporting incidents involving people experiencing mental health crisis. This ensures the person receives the best and most appropriate care at that time.

Developing New Models for In Patient Care

During 2013 the Board of Directors asked a group of senior clinicians, managers and service users to help model the options available for the future configuration of services and hospital sites in the light of the roll out of the improved community pathways and the anticipated reduced demand for inpatient services. It was agreed that the options must satisfy three principal objectives:

- Clinical Fit - is it clinically appropriate;
- Safety – is it safe;
- Financial viability - is it affordable.

A long list of options was evaluated to produce a shortlist of options. This work supported the public consultation in South Tyneside which led to the agreed closure of the Bede Unit.

Together with local partners, Newcastle City Council, Gateshead Council, the Trust and representatives of users, carers and the voluntary and community sector, the Newcastle Gateshead CCG worked together to consider the services for people living in Newcastle and Gateshead with serious mental health conditions. As a result of this work the CCG led a listening and engagement process from November 2014 to February 2015 called "Deciding Together" with the aim of collecting views and experiences about specialist mental health services. The feedback from this process then informed the development of scenarios for change which were the subject of formal consultation with those living in Newcastle and Gateshead, during 2015/16.

The public consultation has sought views on three possible locations for adult acute assessment and treatment and rehabilitation services and two possible locations for older people's services.
A full Case for Change document is scheduled to be completed in May 2016, which will include the outcome of the public consultation and following the approval of the CCG Governing Body the Trust will begin to plan the implementation of the agreed changes during 2016/17.

Specialist Care Services

The Specialist Care Services Programme is responsible for ensuring the Trust retains sustainable specialist services, as part of the overall service model and high quality competitive services, in preparation for the tendering of any existing services by commissioners. The Trust continued to make significant progress in this programme of work achieving the following during 2015/16:

- Work started on the development of our new autism assessment and treatment facility at Northgate Hospital, the Mitford Unit, which is due to be completed in the summer of 2016.The new facility has been designed to meet the very specific environmental needs of service users with extremely complex needs and will include single and shared accommodation.
- The continual review of Neurological Services and Secure Services with the aim of ensuring the services long term sustainability, as part of the overall service model.
- With the support of commissioners developed an integrated attention deficit hyperactivity disorder service providing a service across the pathway from children and young people's services into adult services.

Social and Residential Services

During 2015/16 the Trust continued to review Northumberland Mental Health Day Services, in partnership with stakeholders, and agreed a strategy relating to the redesign of the services. It has been agreed that the Trust will continue to provide Level 2 activities which will be health focused and integrated into the overall model of the Community Mental Health team, as part of the Community Transformation Programme.

This will enable service users to have access to a wide range of recovery focused and evidenced based interventions around psycho-education, self management and physical wellbeing services.

Learning Disability Services

The Trust provides a comprehensive range of services for people with learning disabilities and/or autism including those with a mental illness and whose behaviour challenges services. These services include community services, inpatient assessment and treatment services for people with a learning disability, secure services and autism services.

Transforming Care for People with Learning Disabilities – Next Steps (2015) reaffirmed the Government's commitment to transforming care for people with learning disabilities and/or autism who have a mental health condition or whose behaviour challenges services. In February, 2015 NHS England publicly committed to a programme of closing inappropriate and outmoded inpatient facilities and establishing stronger support in the community. To speed up the process and to help shape the national approach to supporting change, six "Fast Track" areas (including the North East and Cumbria) drew up plans over the summer of 2015. Together they envisage reallocating resources from inpatient services into the community in order to reduce the usage of inpatient provision by approximately 50% over the coming three years. Their plans will result in the development of a range of new community services and the closure of inpatient beds, including some assessment and treatment beds and secure beds provided by the Trust.

The Trust is an active member of the North East and Cumbria Learning Disability Transformation Board and during 2015/16 we contributed to the development of a new service model which involves strengthening the community infrastructure, developing a consistently highly skilled, confident and value driven workforce in all providers, early intervention and effective crisis support. The overall aim is to better support people in the community and help to reduce the need for hospital admission. As a part of this we also worked with commissioners regarding a programme for the closure of an agreed number of specialist learning disability assessment and treatment inpatient beds and secure inpatient beds.

The Trust has also established a work programme to review the recommendations and implement actions arising from the Mazars report into deaths of people with a learning disability at Southern Health NHS Foundation Trust.

Corporate Services Transformation

The Trust's corporate services provide direct support to clinical services and also ensure that the Trust meets the requirements of external partners and complies with the law, regulatory / compliance frameworks and performance monitoring and reporting frameworks which are applicable to us as an NHS Foundation Trust.

The Trust is committed to improving the quality of services provided by our corporate services whilst at the same time reducing the costs incurred in providing these services.

As clinical services are re-designed and reshaped so too must corporate services, they must work in different ways and be provided as efficiently and effectively as possible.

The corporate services programme was established in 2014 with the aim of redesigning corporate services to align with the transformation of clinical services both in terms of a proportionate level of overhead and meeting the changing needs of a broad range of corporate customers. Consultation on the new model of delivery and implementation commenced in 2015 / 16 and phase 1 was implemented.

The development of integrated and "place based services"

The Trust's Strategic Plan 2014 - 2019 highlighted that there is a common view across all stakeholders that the status quo is not sustainable and the development of integrated services designed around the needs of the population must replace the existing institutional based models. Across Northumberland, Tyne and Wear leaders have embraced the identification of new models of care, with the aim of achieving solutions to local challenges. Overall progress across the Trust's six localities has been positive with differing approaches and priorities and the Trust has been an active partner in the discussions and decisions during 2015/16 as we are fully committed to developing integrated models of care which are designed around the whole needs of our local populations and see significant benefits in aligning the approach to physical and mental health long term conditions, and in aligning delivery of support and care across health and social services. The development of Strategic Transformation Plans (STP) supports this work, and the Trust is fully engaged in STP discussions in each locality.

New Services

During 2015/16 the Trust successfully tendered for additional monies to support the development of new services and service improvements. This included:

- Funding to support the implementation of evidenced based IAPT (improving access to psychological therapies) interventions in children and young people's services in Northumberland and North Tyneside, in line with the national programme. This bid was submitted in partnership with Northumbria Healthcare NHS Foundation Trust.
- The award of the contract relating to Sunderland Integrated Substance Misuse and Harm Reduction Service in partnership with DISC and Changing Lives. The new service is to commence on the 1st July 2016.
- Inclusion on a framework to provide mental health inpatient services to Sussex Clinical Commissioning Groups (CCGs). This is for patients that the CCGs were having difficulty placing locally.
- A contract for North East Quality Observatory System (NEQOS), hosted by the Trust and South Tees Hospitals NHS Foundation Trust, to deliver opportunities for County Durham and Darlington NHS Foundation Trust staff to participate in benchmarking studies, with local and national comparators. This will be particularly valuable with services where national comparator data is not routinely available.
- A successful bid to Heath Education England to enter onto a framework to provide Cognitive Behavioural Therapy for Psychosis training for Early Intervention in Psychosis.
- The Academic Health Science Network for the North East and Cumbria invited project submissions under the Patient Safety Collaborative programme. NEQOS was successful and secured funding to support a project aimed at identifying the population in each participating Trust diagnosed with community acquired pneumonia and sepsis.
- Adult ADHD service based in Newcastle, providing an assessment and treatment service for adults with attention deficit hyperactivity disorder.

Partnerships

The Trust continues to work in partnership with NHS organisations, the community, voluntary and independent sectors which we highly value. These include:

- Our partnership with Insight, who we work with in the provision of Newcastle Talking Therapies.
- The partnership with Tees, Esk and Wear Valley NHS Foundation Trust (TEWVFT) and Revolving Doors in the implementation of the Big Diversion Project.
- The provision of Tier 3 Children and Young People's Services South of Tyne in partnership with Barnardos, Action for Children and Investing in Children.
- A partnership with TEWVFT, Combat Stress and The Royal British Legion to provide a Veterans Wellbeing Assessment and Liaison Service in the North East.
- A partnership with Changing Lives and Turning Point to provide both the Northumberland and North Tyneside Recovery Partnership services (integrated drug and alcohol services).
- Partnership working with Northumbria and Cumbria Probation Trusts to develop Community Personality Disorder services within the respective Probation Trust areas.
- Hosting of the North East Quality Observatory System (NEQOS) in partnership with South Tees Hospitals NHS Foundation Trust.
- Working in partnership with TEWVFT, Her Majesty's Courts and Tribunal Service and Youth Offending Teams from Northumbria, Durham and Cleveland in the provision of Liaison and Diversion Pilot Services.
- Our partnership with Byker Bridge Housing Association in the provision of Westbridge, a 24 hour staffed step down accommodation for individuals moving out of Adult Forensic Services.
- The provision of Sunderland Psychological Wellbeing Services in partnership with Sunderland Counselling Services and Washington MIND.
- The provision of a Macmillan Clinical Nurse Specialist in Palliative Care for people with learning disabilities in partnership with Macmillan Cancer Care.
- Our partnership with Northumbria Probation Service and Barnardos in the provision of assessment and treatment for individuals at risk of sex offending who are outside of the criminal justice system.
- The provision of the Sunderland and Gateshead Acquired Brain Injury Service in partnership with Headway, Momentum and Neuro Partners.
- A partnership with Newcastle upon Tyne Hospitals NHS Foundation Trust and Newcastle University to establish the newly formed "Newcastle Academic Health Partners" to deliver world class health care through collaborative scientific research, education and patient care and mobilise the collective capabilities of the three organisations in support of economic growth.
- An innovative partnership between the Trust and the Malhotra Group PLC, a provider of nursing, dementia and residential care for the elderly and vulnerable people across the North East, to share expertise and best practice in estates management, development and accommodation needs to help deliver enhanced health and social care solutions in the region.

Environmental Matters

The Trust has continued to invest in high quality patient environments, ensuring that they are safe, welcoming and support the delivery of care. Significant investment has been made in recent years in the development of state of the art, inpatient and support services and these developments incorporate features designed to reduce our environmental impact, and include designs which minimise energy consumption, the use of material from sustainable sources, recycling of materials and sustainable construction methods.

Hopewood Park in Ryhope is the Trust's most recent major development. It opened in 2014 and was awarded a top prize at the Constructing Excellence National Awards. The award was made to the Trust, Laing O'Rourke and Medical Architecture in recognition of the use of 3D models in the design and construction of Hopewood Park.

Investment also continued in other patient environments in line with the Trust's Transformation of Services Programme and the work of the Trust's Capital Projects Team won the Estates Team of the Year Award at the Building Better Healthcare Awards in November 2015. As well as recognising the Trusts ongoing commitment to improve facilities for service users and carers the award also recognised the successful NHS Procure 21 partnership with Laing O'Rourke.

Environmental sustainability remains a key priority, not only for its general benefit but also the benefit of reduced cost. The Trust's Sustainable Development Management Plan aims to ensure that the Trust integrates sustainable development into all aspects of the work we undertake in the management and delivery of our services.

Social and Community Issues

Mental health problems are common but nine out of ten people who experience them say they face stigma and discrimination as a result. "Time to Change" is England's biggest programme to challenge mental health stigma and discrimination and the Trust has embraced the opportunity to work with " Time to Change" to tackle the difficult issue of stigma. In April 2015 a pilot was launched involving the Trust, the 2gether NHS Foundation Trust and people with mental health problems to look at what can be done to tackle stigma and discrimination reported in mental health services, this aimed to identify the small things that could make a big difference to both people's experience of mental health services and the experiences of staff. Positive examples of where staff have challenged stigma and discrimination are being used to empower others to do the same.

The Trust is now pleased to have a number of Recovery Colleges established. People living in Northumberland can now access more help and information following the launch in 2015 of Positive Pathways Northumberland, a Recovery College which delivers innovative free courses to help people experiencing mental health problems. The College is run by the Trust and is supported by voluntary groups, charities and Clinical Commissioning Groups. Positive Pathways Northumberland is the third Recovery College across the North East, the others being in Sunderland and in Newcastle, with a further college being developed in North Tyneside.

Dementia touches the lives of millions of people across the UK. Dementia Friends was launched by the Alzheimer's Society to tackle the stigma and lack of understanding that means many people with the condition experience loneliness and social exclusion. We need to create more communities and businesses that are dementia friendly so that people affected by dementia feel understood and included.

The Dementia Friends programme is the biggest ever initiative to change people's perceptions of dementia and in May 2015 staff and Governors starred in a new video to focus on the importance of being a Dementia Friend which was launched during Dementia Awareness week. Dementia Champions have also been identified and the Trust has met its aim of over 1,000 staff becoming Dementia Friends and understanding more about dementia and the little ways people can help those with the condition.

In recent years the employment rates for people with a learning disability have dropped and now stand at just 6% in England. NHS Employers and NHS England joined forces during 2015 and wrote to senior NHS leaders informing of the tools and guidance to help.

The Trust signed up to the Learning Disability Employment Pledge in October 2015, to run alongside and complement the organisation's longstanding commitment as a Two Ticks and Mindful Employer, with the aim of taking positive action to encourage applications from people with disabilities as well as developing an action plan to make this happen.

For people who have profound and multiple learning disabilities or a physical disability such as spinal injury, it can be difficult to access changing facilities when out and about as accessible toilets do not contain the right equipment to meet their needs.

In March 2016 the Trust became the first NHS facility in the region to install a Changing Places facility. The facility is at Walkergate Park in Newcastle and has more space and the right equipment including a height adjustable changing bench and a hoist.

The national Changing Places Consortium launched its campaign in 2006 on behalf of the quarter of a million people who cannot use standard disabled toilets.

In 2015 the Trust and Tees, Esk and Wear Valleys NHS Foundation Trust joined forces on the developing a joint nicotine management and stop smoking programme with the aim of both Trusts going 'smoke free' from March 2016. On average people with a serious mental illness die 15-20 years earlier than the rest of the population and smoking is responsible for over half this difference. By reducing smoking levels both organisations hope to see a positive improvement in service user's overall health. As a part of this work the Trust launched a new "smoke free" animation which tackles common misconceptions about smoking and explains how staff can support smokers to use nicotine replacement products. The animation was launched on YouTube as well as on social media and our hospital sites successfully implemented smoke free status in March 2016.

Flu is a key factor in NHS winter pressures. It impacts on those who become ill, the NHS services that provide direct care, and on the wider health and social care system that supports people in at-risk groups. NTW once more ran a successful flu campaign achieving high levels of vaccinations across the trust. The annual NHS flu fighter awards celebrates outstanding flu fighter campaigns and the Trust won the Best Flu Fighter Team award in March 2016 and were also finalists in the award for digital and social media. For the first time the Trust's System Developers in the IT Department joined the campaign team and helped to develop a concept of "good" and "bad" animated characters and produce a series of animations. Each week the animated characters provided important messages which dispelled myths and encouraged the uptake on the vaccine.

Equality and Diversity

The NHS Equality and Diversity Council works to bring people and organisations together to realise a vision for a personal, fair and diverse health and care system where everyone counts and the values of the NHS Constitution are brought to life. It pledged its commitment to implementing two measures to improve equality across the NHS:

- A workforce race equality standard that require organisations to demonstrate progress against a number of indicators relating to workforce equality, including a specific indicator to address the low levels of Black Minority Ethnic (BME) Board representation;
- The Equality Deliver System, known as EDS2, which is a toolkit to be used by organisations to improve equality performance across the NHS.

At the heart of EDS2 are 18 outcomes against which NHS organisations are required to assess and grade themselves. They are grouped under four goals:

1. Better Health and outcomes;
2. Improved patient access and experience;
3. A representative and supported workforce;
4. Inclusive leadership

The Trust carried out a self assessment against the 18 outcomes and with the help of stakeholders came to a consensus as to the rating for each of the outcomes. This work was presented to the Board of Directors in June 2015 and the agreed ratings are shown in the table below.

Figure 7: Equality Delivery System 2 (EDS2) outcomes

Outcome		Trust Rating
GOAL 1 Better Health Outcomes		
1.1	Services are commissioned, procured, designed and delivered to meet health needs of local communities	Achieving
1.2	Individual people's health needs are assessed and met in appropriate and effective ways	Achieving
1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	Achieving
1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	Achieving
1.5	Screening, vaccination and other health promotion services reach and benefit all local communities	Developing
GOAL 2 Improved patient access and experience		
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
2.2	People are informed and supported to be as involved as they wish to be in decisions about their care	Achieving
2.3	People report positive experiences of the NHS	Achieving
2.4	Peoples complaints about services are handled respectively and efficiently	Achieving
GOAL 3 A representative and supportive workforce		
3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Developing
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	Undeveloped
3.3	Training and development opportunities are taken up and positively evaluated by all staff	Developing
3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	Developing
3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Achieving
3.6	Staff report positive experiences of their membership of the workforce	Developing

GOAL 4 Inclusive leadership		
4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	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	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	Developing

Actions are being progressed in respect of those areas requiring improvement and these include:

- Working closer with our colleagues in primary and acute care services to address existing inequalities and achieve better health and outcomes;
- Collecting the key data required to better track our progress in respect of achieving a more representative and supported workforce;
- Establishing Staff Networks grouped by protected characteristics with the remit of addressing diversity specific issues which were raised as part of the NHS Staff Survey;
- Undertaking an Equal Pay Audit.

Important Post Year End Events

The directors have confirmed that there are no expected post balance sheet events which will materially affect the disclosures made within the Accounts 2015/16

Overseas Operations

The Trust does not engage in any commercial overseas operations.

Accountability report

i. Directors' Report
ii. Remuneration Report
iii. Staff Report
iv. Disclosures set out in the code
v. Regulatory Ratings
vi. Statement of Accounting Officer's Responsibilities
vii. Annual Governance Statement

i) Directors' Report

Enhanced quality governance reporting

An overview of the arrangements in place to govern the Trust, including service quality, is included in the Trust's Annual Governance Statement 2015/16, Section 3 vii) of this Report.

In 2010 the Trust supported Monitor in the development of a Quality Governance Framework. The Trust's Annual Governance Statement 2015/16, outlines how the Trust has had regard to Monitor's quality governance framework in arriving at its overall evaluation of the organisation's performance, internal control and Board Assurance Framework. Trust evidence against the ten components of the Quality Governance Framework is provided quarterly, structured around the areas of good practice as set out in the Framework and this is reviewed by the Quality and Performance Committee.

The Trust's governance arrangements take account of the Integrated Governance Handbook (Department of Health 2006), Monitor's NHS Foundation Trust Code of Governance and other best practice guidance.

The Trust undertook an external review of its governance arrangements, using the Well Led Framework, during 2015/16, supported by Deloitte, in line with Monitor's recommendations relating to foundation trusts. Deloitte provided feedback to the Board at a development session in December 2015 and the Board of Directors reviewed the final report, including the recommendations in January 2016.

The independent review confirmed that there were no material governance concerns.

Deloitte noted a number of areas of good practice particularly:

- High levels of clinical engagement in the transformation of services with senior clinicians developing pathways in support of the service model review;
- A clear focus on values and the culture of the Trust;
- Employment of a range of mechanisms to engage with internal and external stakeholders;
- The introduction of a variety of initiatives in relation to raising concerns, including the appointment of a Freedom to Speak Up Guardian;
- The use of staff and patient level dashboards to monitor performance.

Some areas for further work and opportunities for improvement which the Board of Directors has acknowledged and is addressing:

- Arrangements pertaining to risk management at all levels within the Trust;
- A need to embed formal Quarterly Accountability Review meetings with the Clinical Groups; and
- A review of the purpose and effectiveness of key committees and operational meetings, with a focus on remit, agenda and streamlining of papers.

Northumberland, Tyne and Wear 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.

The Trust confirms that there are no material inconsistencies between:

- The Annual Governance Statement;
- Annual and Quarterly Board Statements;
- Reports from the Care Quality Commission planned and responsive reviews of the Trust and any consequent action plans developed by the Trust.

Information relating to the Trust's patient care activities is outlined throughout this Annual Report. This includes:

- How the Trust is using its Foundation Trust status to develop its services and improve patient care. Section 2 Performance Report and Section 4 Quality Report;
- Performance against key health targets. Section 2 Performance Report and Section 4 Quality Report;
- Arrangements for monitoring improvements in the quality of health care and progress towards meeting any national and local targets, incorporating Care Quality Commission assessments and reviews and NHS Foundation Trust's response to any recommendations made. Section 4 Quality Report and the Annual Governance Statement;
- Progress towards targets as agreed with local commissioners, together with details of other key quality improvements. Section 4 Quality Report;
- Any new or significantly revised services Section 2 Performance Report;

- Service improvements following staff or patient surveys/comments and Care Quality Commission Reports. Section 3 iii Staff Report Section 4 Quality Report;
- Information on complaints handling. Section 4 Quality Report.

Information relating to the Trust's stakeholder relations is outlined in Section 2 the Performance Report. This includes descriptions of significant partnerships and alliances entered into by the Trust to facilitate delivery of improved healthcare and development of services involving other local services/agencies and involvement in local initiatives.

Patients and Carers

Involvement

The Trust actively engages patients, carers and other stakeholders in seeking their views on what they require of the Trust's services and how the Trust's services should transform and develop. This engagement includes regular surveys, patient/carer feedback work and specific engagement/involvement in initiatives together with formal consultation on the Trust's plans, including formal public consultation on specific proposals.

During 2015/16 patients and carers were involved in the following:

- The ongoing development and roll out of community transformation programme;
- The development of the Trust's Operational Plan 2015/16, through the Council of Governors and Annual Plan Working Group;
- The 'Deciding Together' public consultation relating to potential changes to the way our specialist mental health inpatient services in Newcastle and Gateshead are arranged;
- Shaping our quality priorities for 2016/17;
- Shaping the development of our new Trust Strategy through, for example, the Council of Governors and Service User and Carer Reference Group.

Patient Feedback

The Trust actively engages patients, carers and other stakeholders in seeking their views on what they require of the Trust's services and how the Trust's services should transform and develop. This engagement includes regular surveys, patient/carer feedback work and specific engagement/involvement in initiatives together with formal consultation on the Trust's plans.

Patient feedback is actively sought and reviewed through a number of initiatives which are supported through the Trust's dedicated Patient and Carer Engagement Team including:

- Friends and Family Test;
- Service User and Carer Network;
- AIMS (Service User and Carer Questionnaires);
- Essence of Care;
- See It Say It Campaign;
- Complaints, Incidents and PALS (Patient Advice and Liaison Service) Reports;
- Service visits by Directors;
- Patient Opinion, including 'Points of You';
- Service user and carer groups for particular wards and services;
- Director visits;
- Council of Governors;
- Review of feedback to the CQC regarding the Trust's services;
- Royal College of Psychiatry Quality Network peer reviews;
- Consultation and involvement regarding proposed service changes/developments;
- Care Connect;
- SWEMWEBS (The Short Warwick and Edinburgh Mental Wellbeing Scale);
- Local and national surveys.

A Carers' Charter has been developed which outlines how we will work in partnership with carers and provide support and help. We recognise that providing effective treatment relies on a three way partnership between service users, their families and carers, and professionals and have also developed practice guidance for staff relating to a common sense approach to sharing information with carers.

'Points of You' gathers 'real time' feedback from service users and carers using a variety of methods, including patient and carer postcards, interviews and video clips.

SWEMWEBS: through the Trust's involvement in the Care Pathways and Packages Project, a short wellbeing scale has been nationally recommended as the Patient Reported Outcome Measure (PROM) for the treatment packages we deliver. The ratings for scales allow clinical outcomes to be measured at the end of a patient's episode of care and compared to the start of the episode. SWEMWEBS is now being sent/given to patients at these same time points. The Trust is also reporting the standard Friends and Family Questionnaire which provides us with a Patient Reported Experience Measure (PREM).

A quarterly report on service user and carer experience is now presented to the Board. This includes an analysis of the feedback received through 'Points of You' and other experience measures, recurrent themes and actions to be taken to address these themes.

Patient Information

The Trust's Patient Information Centre aims to provide a central point of access to information about health and related services, leading to increased understanding which will help people to feel in control of their own health and treatments.

The services offered by the centre are available to everyone, not only to patients. As well as a drop-in resource centre they take telephone enquiries and respond to written requests for information. Staff are available to explain information and this is followed up with written material to take away. The Centre has established good working relationships with other statutory and voluntary organisations so that they can make referrals with confidence.

Information is available in different formats in order to meet the requirements of all potential users, including easy read information. Information can be accessed on line and the centre holds the Information Standard Accreditation. Information is provided about Trust services and how to access them; treatments; medication; other service providers; self-help and support groups and advocacy. At the British Medical Association Patient Information Awards in September 2015 the self help guide relating to Post Natal Depression was commended.

With the support of NHS England's Regional Innovation Fund the Patient Information Centre worked in partnership with the Deaf Health Charity, Sign Health, to publish a series of mental health self-help guides in British Sign Language (BSL). Providing information in BSL on common mental health problems such as depression and anxiety is an important step in improving access to information and giving individuals greater control. The self help guides were launched on World Mental Health Day in October 2015.

Complaints and Compliments

The Trust acknowledges that it is not only important that we offer patients the right care at the right time, but that their experience of care whilst with us is as positive as it possibly can be. Comments, compliments and complaints are valuable learning tools and provide information that enables services to improve. The Trust's Comments, Compliments and Complaints Policy and accompanying Practice Guidance Notes provides the framework in which they can be managed effectively in line with the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009 (2009 Complaints Regulations) and the Ombudsman's principles.

We have seen a reduction in the number of complaints received compared to previous years, but are confident that patients, carers and family know how to raise a complaint.

One of the Trust's Quality Goals is to improve the way we relate to patients and carers, and our performance in terms of complaints is shown in Section 4 Quality Report.

The Quality and Performance Committee regularly analyse the complaints received and identify trends. Lessons learnt are disseminated across services with the aim of improving the quality of care.

PALS gives service users and carers an alternative to making a formal complaint. The service provides advice and support to patients, their families, carers and staff, providing information, signposting to appropriate agencies, listening to concerns and following up concerns with the aim of helping to sort out problems quickly.

Consultation with local groups and organisations, including the Overview and Scrutiny Committees.

The Trust has positive relationships with each of the six main local authorities where we provide services and we have continued to develop our partnership working. We continue to strengthen our links at Chief Officer, senior manager and operational manager levels in each locality. A named Executive director leads this work in each locality.

The Trust is actively involved in a range of strategic locality meetings, including Health and Wellbeing Boards, Vanguard Programme Boards and the sustainability and transformation plan (STP's) processes.

We have productive engagement with the main health scrutiny committees in each locality. Directors and senior clinical managers attend the Overview

and Scrutiny Committee (OSC) meetings to present updates on the Trust's plans and make specific presentations on any proposed changes to services. A list of issues presented to Health Overview and Scrutiny Committees is shown below. For many changes, the relevant CCG will be the lead organisation and NTW will work in partnership with those officers.

The 'Deciding Together' Consultation which considers future services in Newcastle and Gateshead has continued been a major focus this year. The process has been led by Newcastle Gateshead CCG and supported by the North East Commissioning Support Unit, working closely with NTW. The process has been overseen by the 'Deciding Together' steering group which includes representatives from the local healthwatch organisations and the community and voluntary sector.

As part of the process we have hosted visits to NTW sites from both Newcastle and Gateshead Overview and Scrutiny Committees.

The Trust has positive relationships with the 6 Local Healthwatch organisations. Each Healthwatch has different ways of working, and we have engaged in different ways. Newcastle Healthwatch invited the Trust to take part in their first engagement event at St James Park, and we supported the mental health services questionnaire undertaken by North Tyneside Healthwatch over the year.

In 2015/2016 all Committees and Healthwatch organisations were invited to consider and comment upon the NTW Quality Account. This year, they were also invited to take part in the development of the Trusts quality priorities which was welcomed by a number of committees. They were also invited to the Annual Members Meeting and other events.

Figure 8: Income disclosures as required by section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012

Private Patient Income

	2015/16	2014/15
	£000	
Private patient income	143	143
Total patient related income	286,647	280,620
Proportion (as percentage)	0.05%	0.05%

The statutory limitation on private patient income in Section 44 of the 2006 Act was repealed with effect from 1 October 2012 by the Health and Social Care Act 2012. The Health and Social Care Act 2012 requires Foundation Trusts to make sure that the income they receive from providing goods and services for the NHS (their principle purpose) is greater than their income from other sources.

Statement as to disclosure to auditors

Each director has stated that as far as he/she is aware, there is no relevant audit information of which the Trust's auditors are unaware and he/she has taken all steps that he/she ought to have taken as a director in order to make himself/herself aware of any relevant audit information and to establish that Mazars LLP are aware of that information.

Political Donations

The Trust did not make any political donations during the period.

ii) Remuneration Report

Annual statement on remuneration

Members of the Board of Directors are the individuals who have responsibility for controlling the major activities of the Trust and their remuneration is included in this report. This is in line with the requirement to include those who influence the decisions of the Trust as a whole rather than decisions of individual directorates or sections within the Trust.

The Trust Chair makes his annual statement as Chair of the Remuneration Committee, whose remit covers Executive Directors, and as Chair of the Council of Governors (Nominations Committee), whose remit covers Non-Executive Directors.

He has confirmed that there have been no changes to the remuneration of Executive Directors during 2015/16, other than to agree the remuneration of the Acting Medical Director, which is covered later in the report in the Senior Managers' Remuneration Policy.

He has also confirmed that the Council of Governors had reviewed the remuneration of the Non-Executive Directors (NEDs) and the Chair during 2015/16.

The Council of Governors at its September 2015 meeting approved increased NEDs' remuneration on the basis of increased workload. NEDs' pay had been established in 2010 on the basis of three days per month commitment. Significant workload increases have meant that the duties could not be performed in less than four days per month, and the proportionate uplift results in a basic remuneration of £13,500 per annum. Furthermore as the estimated time commitment makes no allowance for the additional work involved in chairing standing Board committees, the Vice Chair's additional duties and the Senior Independent Director's duties, it was agreed that each of these functions should receive a supplement of £2,000 per annum. The Council of Governors were satisfied that these measures placed the NEDs' remuneration around the median point compared both to other mental health and learning disabilities foundation trusts in the northern region and to the other foundation trusts in the region.

The Council of Governors at its November 2015 meeting approved an increase to the Chair's remuneration following the acceptance of a formula for determining the Chair's remuneration to arrive at figure of £50,794 per annum. This is in line with the remuneration of Chairs of local NHS Foundation Trusts and mental health and learning disability foundation trusts in the northern region.

The Nominations Committee had reported to the Council of Governors that it had taken into account of the view of the Senior Independent Director on the significant increases in the time commitment required by the Chair and the level of personal responsibility carried by the Chair.

The formula was based on three principles, namely:

- remuneration based on the NEDs' day rate, i.e. currently £3,375 per annum;
- the number of days per month required to perform the role (i.e. the current best assessment being 14 days per month); and
- the application of a percentage uplift on the NEDs' day rate to recognise the Chair's leadership role and the collegiate nature of his relationship with the other NEDs, i.e. 7.5%.

Senior Managers' Remuneration Policy

The Trust complies with all aspects of Monitor's Code of Governance. This includes the main principle, 'Levels of remuneration should be sufficient to attract, retain and motivate directors of quality, and with skills and experience required to lead the NHS Foundation Trust successfully, but an NHS Foundation Trust should avoid paying more than is necessary for this purpose and should consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements.'

Senior managers remuneration comprises basic pay and NHS pension contribution only (variations are salary sacrifice benefits as set out in the table.) This applies to all senior managers. No performance related pay applies to senior managers.

A full Remuneration Policy for Senior Managers will be developed in the trust alongside local pay arrangements during 2016-17.

There are no provisions for the recovery of sums paid to senior managers or for withholding the payments of sums to senior managers.

Service contract obligations

There are no obligations on the Foundation Trust related to remuneration payments or payments for loss of office.

Policy on payment for loss of office

The Remuneration Committee is responsible for considering appropriate arrangements regarding loss of office of a senior manager.

Statement of consideration of employment conditions elsewhere in the foundation trust

Senior managers remuneration is set by the Remuneration Committee, taking into account cost of living rises applying elsewhere in the NHS.

The policy will be subject to consultation with relevant staff. A comparison of senior manager salaries across the NHS was not considered in 2015/6. This is planned in line with the policy development.

In considering the remuneration of Executive Directors, the Remuneration Committee, is provided with information on the annual uplifts given to 'medical and dental' staff and those under 'agenda for change', and considers circulars from the Department of Health on the pay of very senior managers in the NHS. External reports on job evaluation and market forces are commissioned when needed, the latest being in 2013/14. Similarly the Nominations Committee considers the remuneration of non-executive directors prior to providing recommendations to the Council of Governors. Monitor's Code of Governance requires that external professional advisers are consulted to market test the remuneration of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive. This market testing took place in 2014/15.

All substantive Executive Directors' contracts are permanent with three months' notice (except the Director of Finance whose notice period is four months) and all Executive Directors' termination payments (including redundancy and early retirement) were as per the general NHS terms and conditions applicable to other staff. However with the introduction of new redundancy terms for NHS staff, service contracts for three of the Executive Directors require amendment to reflect the up-to-date wording.

Performance pay did not apply for 2015/16.

The Trust reimburses the Chief Executive and Executive Directors any reasonable travelling, hotel, hospitality and other expenses wholly, exclusively and necessarily incurred in the proper performance of his/her duties. This is subject to the production of relevant invoices or other appropriate proof of expenditure in respect of claims submitted.

Pay for other directors, senior managers and all other non-medical and dental staff is in accordance with the national Agenda for Change terms and conditions, (With the exception of a small number of senior staff appointed through the transforming corporate services process who have been appointed onto a single point within a local pay range, using the flexibilities within Agenda for Change for bands 8C and above.) Pay for medical staff is in accordance with the national terms and conditions of service for hospital, medical and dental staff, and may include clinical excellence awards.

During 2015/16, the Trust has had two substantive Executive Directors paid more than £142,500, namely the Chief Executive Officer and the Executive Medical Director.

The Trust has undertaken benchmarking by external consultants, which demonstrates that the salaries are considerably below those in the private sector, bearing in mind that the Trust is a £300 million business employing over 6,000 staff with the added complications of the mental health legislation environment and issues of deprivation of liberty. Both directors were earning in excess of £142,500 prior to joining the Trust. The Trust's previous Chief Executive was remunerated more than the current Chief Executive Officer. The Executive Medical Director's package is based on an executive contract and not a clinical contract, where the remuneration levels would have been considerably higher. Remuneration reflects the complexity of the task and its responsibility.

The Trust is satisfied that both pay packages are reasonable.

The Executive Medical Director stood down from his role on 15 January 2016 and was replaced in the short term by one of the Trust's Group Medical Directors as an interim appointment. The Group Medical Director's existing terms and conditions, i.e. a consultant contract with a management allowance along with a clinical excellence award, was already in excess of £142,500. An additional management allowance of £5,781 was agreed to acknowledge the change in managerial responsibilities.

The Trust is satisfied that this short term amendment is reasonable.

Benefits in kind relate to lease cars and salary sacrifice schemes.

A term of office for the Chair and Non-Executive Directors is three years. The re-appointment of the Chair or Non-Executive Director after their first term of office is subject to a satisfactory performance appraisal. Any term beyond six years (i.e. two terms) should only be in exceptional circumstances and subject to annual re-appointment and is subject to a particularly rigorous interview and satisfactory appraisal, and should take into account the need for progressive refreshing of the Board of Directors. The Annual statement on remuneration above provides details of the fees payable to the Chair and NEDs.

Figure 9 shows the Board members that have served during 2015/16; their date of appointment; the cessation date of the current tenure of the Chair and each Non-Executive Director; and the notice period of Executive Directors.

Figure 9: Board Membership Details

Name Title	Date of:		Current expiry of term	Notice period (months)
	Appointment	Cessation		
Dr Les Boobis Non-Executive Director	01.07.15	-	30.06.18	N/A
Alexis Cleveland Non-Executive Director	01.07.15	-	30.06.18	N/A
Martin Cocker Non-Executive Director / Audit Committee Chair / Senior Independent Director (from 1 March 2016)	01.01.12	-	31.12.17	N/A
Lisa Crichton-Jones Director of Workforce and Organisational Development	04.08.14	-	N/A	3
James Duncan Deputy Chief Executive/Director of Finance	01.12.09	-	N/A	4
Dr Douglas Gee Medical Director	01.12.13	15.01.16	N/A	N/A
Neil Hemming Non-Executive Director	01.01.15	-	31.12.17	N/A
John Lawlor Chief Executive	23.06.14	-	N/A	3
Paul McEldon Non-Executive Director/Vice Chair	01.12.09	-	31.12.16	N/A
Dr Rajesh Nadkarni Interim Medical Director	16.01.16	-	-	3
Gary O'Hare Director of Nursing and Operations	01.12.09	-	N/A	3
Nigel Paton Non-Executive Director	01.07.12	30.06.15	N/A	N/A
Lisa Quinn Director of Performance and Assurance/ (from January 2016) Director of Commissioning and Quality Assurance	01.12.09	-	N/A	3
Peter Studd Non-Executive Director	01.01.16	-	31.12.18	N/A
Ruth Thompson Non-Executive Director / Senior Independent Director (from 1 January 2016 to 29 February 2016)	01.04.14	-	31.03.17	N/A
Chris Watson Non-Executive Director / Senior Independent Director	01.12.09	31.12.15	N/A	N/A
Hugh Morgan Williams Trust Chair	01.11.13	-	31.10.16	N/A

The Trust has a Remuneration Committee, whose role is to determine and review all aspects of the remuneration and terms and conditions of the Chief Executive and other Executive Directors and to agree associated processes and arrangements including appointments. The Committee is chaired by the Trust Chair and its membership is made up of all non-executive directors. The Committee met four times during 2015/16. Figure 10 below shows the membership of the Remuneration Committee during 2015/16 along with their attendance.

Figure 10: Membership of the Remuneration Committee and Attendance

Name	Meetings	
	Total	Attended
Hugh Morgan Williams (chair)	4	4
Dr Les Boobis	3	3
Alexis Cleveland	3	3
Martin Cocker	4	3
Neil Hemming	4	1
Paul McEldon	4	4
Nigel Paton	1	1
Peter Studd	1	1
Ruth Thompson	4	4
Chris Watson	3	2

The Council of Governors has established a Nominations Committee to provide it with recommendations relating to the appointment of the Chair and NEDs and the associated remuneration and allowances and other terms and conditions. Details of the work of the Nominations Committee are included in the section on "Disclosures set out in the NHS Foundation Trust Code of Governance"

During 2015/16, there were 17 individuals fulfilling the role as director, 10 of them receiving expenses (including relocation expenses) in the reporting period totalling £17,302. The equivalent for 2014/15 was 14 individuals with 9 receiving expenses (including relocation expenses) totalling £15,692.

During 2015/16, there were 48 individuals in governors' roles, but at any one time there was an average of 36 governors. 13 governors received expenses totalling £1,607. The equivalent for 2014/15 was 46 individuals in governors' roles with an average of 38 at any one time. 10 governors received expenses totalling £1,940.

Board of Director's remuneration

Figure 11 shows the remuneration for each board member who served during 2015/16 along with prior year comparatives.

Figure 11: Board of Directors Remuneration

Board of Directors remuneration								
	Salary Bands of £5,000		Taxable benefits Rounded to the nearest £100		Pension Related Benefits Bands of £2,500		Total Remuneration Bands of £5,000	
Name	2015/16	2014/15	2015/16	2014/15	2015/16	2014/15	2015/16	2014/15
Hugh Morgan Williams	50-55	40-45	0	0	0	0	50-55	40-45
Dr Les Boobis	10-15	0	0	0	0	0	10-15	0
Alexis Cleveland	10-15	0	0	0	0	0	10-15	0
Martin Cocker	15-20	10-15	0	0	0	0	15-20	10-15
Ken Grey	0	5-10	0	0	0	0	0	5-10
Neil Hemming	10-15	0-5	0	0	0	0	10-15	0-5
Paul McEldon	15-20	10-15	0	0	0	0	15-20	10-15
Nigel Paton	0-5	10-15	0	0	0	0	0-5	10-15
Peter Studd	0-5	0	0	0	0	0	0-5	0
Ruth Thompson	15-20	10-15	0	0	0	0	15-20	10-15
Chris Watson	10-15	10-15	0	0	0	0	10-15	10-15
John Lawlor	180-185	140-145	0	0	85.0- 87.5	175.0–177.5	270-275	315-320
Lisa Crichton-Jones*	95-100	100-105	72	49	20.0-22.5	0	125-130	100-105
James Duncan*	115-120	125-130	65	41	0	15.0-17.5	125-130	145-150
Dr Douglas Gee	130-135	160-165	0	0	40.0-42.5	67.5-70.0	170-175	230-235
Dr Rajesh Nadkarni*	30-35	0	37	0	7.5-10	0	40-45	0
Gary O'Hare*	100-105	100-105	30	80	5.0-7.5	0	110-115	50
Lisa Quinn*	95-100	95-100	72	14	30.0-32.5	0	135-140	95-100

There were no performance related bonus payments made or exit packages awarded to Executive and Non-Executive Directors included as senior managers.

Douglas Gee stood down as medical director on 15th January to take up a clinical post within the organisation. In total, transitional pay protection associated with the step down from the medical director role will equate to a discretionary payment of £60,000 over two years.

Benefits in kind relate to lease cars and salary sacrifice schemes. The salaries of Directors highlighted * have salary sacrifice schemes.

For Dr Radjesh Nadkarni, £14,000 of the remuneration for the period in post relates to clinical duties. The remuneration of all other Executive Directors relates to management posts.

Median remuneration

The median remuneration of all Trust staff and the ratio between this and the mid-point of the banded remuneration of the highest paid director are shown below. The calculation is based on full time equivalent staff of the Trust at 31 March 2016 on an annualised basis.

Figure 12: Median remuneration

Fair pay multiple	2015/16	2014/15
Median total remuneration	£24,415	£25,020
Ratio to mid-point of the banded remuneration of highest paid director	7.47	7.39

Total pension entitlement

Figure 13: Board of Director Pension Analysis

Board of Directors pension analysis							
	Real increase (decrease) in pension at age 60	Real increase (decrease) in lump sum at age 60	Total accrued pension at 31/03/16	Lump sum at age 60 related to accrued pension at 31/03/16	Cash Equivalent Transfer Value at 31/03/16	Cash Equivalent Transfer Value at 31/03/15	Real increase in Cash Equivalent Transfer Value
	Bands of £2.5k £000	Bands of £2.5k £000	Bands of £5k £000	Bands of £5k £000	£000	£000	£000
John Lawlor	2.5-5.0	10.0-12.5	70-75	210-215	1406	1306	84
Lisa Crichton-Jones	0.0-2.5	(0.0)–(2.5)	20-25	55-60	309	296	9
James Duncan	(0.0)–(2.5)	(5.0)–(7.5)	35-40	100-105	565	572	(14)
Dr Douglas Gee	0.0–2.5	0–2.5	45-50	145-150	810	759	33
Gary O'Hare	0.0–2.5	0.0–2.5	50-55	155-160	964	942	10
Dr Rajesh Nadkarni	0.0–2.5	(0.0)–(2.5)	40-45	125-130	727	681	8
Lisa Quinn	0.0–2.5	(0.0)–(2.5)	30-35	95-100	520	496	18

The remuneration and pension benefits tables disclosed have been subject to audit and an unqualified opinion has been given.

Cash equivalent transfer values are not applicable where individuals are over 60 years old.

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

The Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. CETV's are calculated within the guidelines and framework prescribed by the Institute and Faculties of Actuaries. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Exit Packages

The table below (Figure 14) shows the total exit packages from the Trust in 2015/16 and 2014/5

Figure 14: Exit Packages: Exit Packages 2015/16

Cost band £	Compulsory redundancies Number	Compulsory redundancies £000	Other departures agreed number	Other departures agreed £000	Total Exit Packages number	Total Exit Packages £000	Special payment number	Special payments £000
<10,000	0	0	6	30	6	30	0	0
10,001 – 25,000	0	0	0	0	0	0	0	0
25,001 – 50,000	0	0	3	105	3	105	0	0
50,001 – 100,000	0	0	7	482	7	482	0	0
100,001 – 150,000	0	0	2	269	2	269	0	0
150,001 – 200,000	0	0	0	0	0	0	0	0
>200,001	0	0	0	0	0	0	0	0
Total	0	0	18	886	18	886	0	0

Redundancy and other departure costs have been paid within the provisions of Agenda for Change Terms and Conditions. The termination benefits included in exit packages relate to redundancy and early retirement contractual costs.

Exit Packages 2014/15

Cost band £	Compulsory redundancies Number	Compulsory redundancies £000	Other departures agreed number	Other departures agreed £000	Total Exit Packages number	Total Exit Packages £000	Special payment number	Special payments £000
<10,000	0	0	1	8	1	8	0	0
10,001 – 25,000	0	0	2	38	2	38	0	0
25,001 – 50,000	0	0	0	0	0	0	0	0
50,001 – 100,000	0	0	3	207	3	207	0	0
100,001 – 150,000	0	0	1	114	1	114	0	0
150,001 – 200,000	0	0	0	0	0	0	0	0
>200,001	0	0	0	0	0	0	0	0
Total	0	0	7	367	7	367	0	0

Redundancy and other departure costs have been paid within the provisions of Agenda for Change Terms and Conditions. The termination benefits included in exit packages relate to redundancy and early retirement contractual costs.

John Lawlor, Chief Executive, 25th May 2016

iii) Staff Report

Employee Numbers

As at 31 March 2016, the Board of Directors consisted of six Executive Directors (two female and four male) and eight Non-Executive Directors (two female and six male). The Trust has determined that Senior Managers are Board members.

As at 31 March 2016, excluding Executive Directors, the Trust had 6,121 employees (4,369 female and 1,752 male). Many of the Trust's employees are part time, and when the total number of employees is converted to full time equivalents, this shows a total full time equivalent of 5,655 (3,957 female and 1,698 male). In addition, the Trust has 549 bank staff (396 female and 153 male).

Figure 15 shows the average number of employees (whole time equivalent basis)

	Total 2015/16	Permanently employed 2015/16	Other 2015/16	Total 2014/15	Permanently employed 2014/15	Other 2014/15
Medical and dental	331	303	28	326	300	26
Administration and estates	1236	1162	74	1206	1137	69
Healthcare Assistants and other support staff	494	449	45	493	458	35
Nursing, Midwifery and Healthcare staff	3524	3357	167	3453	3312	141
Scientific, therapeutic and technical staff	391	375	16	366	353	13
Healthcare science staff	334	334	0	319	319	0
Other	0	0	0	0	0	0
Total average numbers	6310	5980	330	6163	5879	284
Of which, av numbers engaged on capital projects	14	14	0	13	13	0

The 2014/5 comparatives have been restated for an additional disclosure for healthcare science staff

Sickness Absence

The Trust's Workforce Strategy sets out the corporate approach to the management of absence. The Trust is committed to promoting wellbeing and supporting staff to achieve good levels of attendance; however we recognise that some absence due to personal sickness is inevitable within any large organisation. The Trust's Policy, Managing Sickness Absence NTW (HR)10 aims to ensure that where absence does occur it is managed through a fair and consistent approach. Managers are responsible for the management of absence within their own areas, providing support and assistance wherever possible to employees. Allocated cases are supported by the HR Advisory (HRA) service with general advice and support provided from the core HR team. A management skills development programme has been in place for the past year which has a big focus on managing absence and the importance of doing this right and reflects the principles set out in the new managing absence policy.

Management of sickness absence remains a key priority. Figure 16 below shows the Trust's sickness absence data using data drawn from January 2014 to December 2014 (ie one calendar year) from the Health and Social Care Information Centre system.

Figure 16: Sickness absence data provided by the Health and Social Care Information Centre January 2015-December 2015

Average of 12 months (2015 Calendar Year)	Average Full Time Equivalent 2015	Full Time Equivalent-Days available	Average days recorded sickness absence	Average Sick Days per Full Time Equivalent
5.5%	5572	2033777	111693	12.4

A substantial amount of work has been undertaken to reduce levels of absence including the review of our sickness policy. The revised policy came into operation in February 2015. Absence management training for managers has been made mandatory and the continued support for managers, sickness clinics and publicising and monitoring timescales for referral to Occupational Health have all seen positive results.

Over the last 12 months the absence rate has steadily decreased to its lowest level for more than four years.

In late 2015, the Trust introduced a 5 year Health and Wellbeing Strategy which will not only enable the Trust to support staff but will allow us to understand better their health needs as well as to encourage staff to take responsibility for their own health. An organisational health needs assessment has been undertaken which will allow for a more focused approach to health related activities.

The Trust has also signed the Time to Change Employer Pledge to demonstrate our commitment to removing the stigma associated with mental health and actively encourage staff to come forward to talk about their mental health issues.

We continue to hold the Healthy People, Healthy Business Continuing Excellence Awards for our work in this area and we continue to work in accordance with the Investors in People standards all of which was reflected in the Investors in People and Health and Wellbeing Good Practice Awards.

Staff Engagement

The Trust remains truly committed and passionate about engaging effectively with our staff and listening and learning from staff feedback. The size of the Trust, both in terms of geography and staff numbers, presents us with a challenge in achieving meaningful engagement with our whole staff group. However, engagement with our workforce continued to be a key priority this year.

The Trust supports a number of regular communications:

- Weekly Bulletin
- Chatterbox
- Foundation Trust Newsletter
- Social media
- Conversations

Staff are encouraged to participate in decision making including quality/continuous improvement training and development through the following:

- The Council of Governors, which includes staff Governors;
- The promotion of Appraisals/Personal Development Plans and inclusion of targets in the Trust's Performance Targets;
- Continued investment in leadership programmes;

- Staff participation in AIMS Accreditation processes, Productive Ward, LIPS (Leading Improvement in Patient Safety);
- Staff and staff side representatives are consulted, where appropriate, on proposed service developments/changes;
- Meeting members of the Board of Directors and Corporate Decisions Team through an on-going programme of visits to services and departments where staff get the opportunity to discuss and debate issues of operational and strategic importance;

There were also numerous examples of consultation exercises having been undertaken and the outcomes of these having influenced policy or strategy.

Throughout 2015 the Trust continued to develop innovative ways of engaging with staff, service users and carers. Improving staff engagement is supported by solid evidence that says that when we are valued; listened to and respected, we are more effective, healthier, productive and less likely to make errors. In fact engaged healthcare teams have a positive impact on the health of those they serve. The new initiative Speak Easy, Be Heard enables local honest conversations through a number of listening events hosted by Executive Directors and the Corporate Decisions Team. The Speak Easy Be, Heard events seek to:

- Find out how things are for staff, and the teams they work in;
- Establish that the needs of service users are at the heart of how we make decisions;
- Find out about what staff do well, we need to share our success stories and promote what we are good at doing;
- Have honest, two-way and sometimes uncomfortable conversations;
- Build mutual trust and respect and really listen to and show that we have heard genuine concerns.

Speak Easy, Be Heard hears more about how the world feels to our staff: to share both good and not so good news, to celebrate success, to identify difficulties and to encourage shared decision making and problem solving.

Part of the Speak Easy, Be Heard philosophy is devolution. Teams have the ability to solve problems and make decisions at a local level with support from the Executive Directors and Corporate Decisions Team to not feel blamed if things go wrong, supporting our managers and leaders to be both visible and accommodating. We have an obligation to make sure that we care for and support each other through good or difficult times and to ensure that we communicate in way that is in keeping with our values: to be caring and compassionate, respectful and honest and transparent. We have engaged the support of a management consultant to ease our transition into a culture that is more devolved and that embraces collective leadership. Monthly events have engaged a large number of staff and teams in the pursuit of these goals.

Four rounds of Speak Easy, Be Heard staff engagement events have taken place since they commenced in February of 2015. From the first event, we picked up a small number of corporate actions, resulting in some actions being taken to address the concerns raised. Subsequently, we have encouraged teams to run their own events, supported from the centre of the organisation. Dozens of events have taken place, with the emphasis on teams feeling able and supported to identify what works well, what is not working so well and how these issues may be addressed locally. Three subsequent rounds of Speak Easy events have had 'set themes,' exploring 'stuck issues' from the 2014 staff survey, the development of guiding principles for the organisation and early engagement in the development of the Trusts five year emerging strategy. The emphasis is always on encouraging staff to believe that they can make a difference, that their views are listened to and heard and that they hold the key to the solutions of problems at a local level and that they can influence the direction of the Trust.

In 2015 a modified Team Brief system called 'Conversations,' was also rolled out. The goal is to share some key news headlines and to encourage staff to talk about them.

The 2015 National Annual Staff Survey indicates that improvements have been made overall in respect of staff engagement and this is encouraging. However, we need to continue to build on this work and this area of work will therefore be a priority again in 2016/17.

Employee Consultation

We continue to value the strong working relationships we have developed with our staff side representatives. We have reviewed our consultative mechanisms and agreed with staff side representatives to have all of our consultative forums on the same day which will streamline and strengthen the previous process. Trade Union Management Forum remains the Trustwide forum to discuss key Trustwide and strategic issues with trade union representatives.

All consultative forums have met on a regular basis and are supported by regular informal meetings where staff side and management representatives discuss issues and ensure they are addressed at an appropriate level.

Staff side representatives play a crucial role in promoting good employee relations and supporting effective change management, as well as assisting in the training and development of staff, conducting work relating to health and safety and involvement in other key pieces of work such as assisting in the areas of work relating to the Equality Act.

We also have a number of policies which allow staff to raise any matters of concern and we run a series of HR training events which relate to these areas. These include:

- Grievance NTW(HR)05;
- Raising Concerns NTW(HR)06;
- Handling Concerns about Doctors NTW(HR)02;
- Dignity and Respect at Work NTW (HR)08.

During 2014/2015 specific consultations with staff have included the following:

Urgent Care

Closure of Belsay Ward, a learning disability assessment and treatment service in Northumberland.

Planned Care

- Tans restaurant, Coopies Lane and Opus Employment Services – consultation following decommissioning of the services
- IAPT TUPE – transfer out of IAPT Northumberland staff to Talking Matters Northumberland following unsuccessful tender
- Allied Health Professionals North of Tyne – reconfiguration of services to align with new model of care and service delivery (in conjunction with In Patient Services Group)
- Transformation of Community Services North of Tyne and Gateshead – redesign the model of community care and service delivery
- Talking Helps Newcastle – formation of newly integrated psychological well-being service 'Talking Helps Newcastle' involving three organisations (NTW, Insight and Newcastle upon Tyne Hospitals). 3 staff from NTW are affected by change of base.
- Psychiatric Liaison Teams (Northumberland, North Tyneside, Newcastle, Gateshead, South Tyneside) – to redesign and implement new Trust wide psychiatric liaison services based on core 24/7 principles.
- Newcastle/North Tyneside crisis response and home treatment services – realignment of home based treatment services.

Specialist Care

Staff consultations were carried out in relation to services at:

- Community Brain Injury Service (CABIS)
- HMP Northumberland
- HMP Frankland
- Newcastle Addictions Services

Support Services

Over the past 18 months there has been a significant review of the Trust's corporate services model. This has resulted in the move towards a more devolved model of operation with functions previously managed within corporate services now being managed within operations.

Future Consultations

We will carry out future consultations in line with our Trustwide and Group strategies.

Involvement of staff in our Foundation Trust's performance.

The Trust is committed to fully involving all of our staff in taking an active role and interest in the quality and performance of our services.

A detailed Performance Report is prepared on a monthly basis for the Board of Directors, Corporate Decisions Team, senior managers and clinical leaders.

The weekly bulletin highlights issues that are discussed at the Board and Corporate Decisions Team meetings, including an update on performance against key indicators and steps being taken to improve performance and the quality of services.

The continued development of the performance dashboards has enabled managers to easily access a wide range of performance information relating to their teams, and staff can access their own personal information in 'my dashboard' relating to, for example, training records and absence history.

Raising Concerns Policy

The Trust's Whistle-blowing Policy was reviewed in 2015 and has been renamed as "Raising Concerns". It was refreshed to incorporate the recommendations from the Francis Review and also to reflect the appointment of the Trust's Freedom to Speak Up Guardian who was appointed in December 2015. Work is currently underway to appoint a number of staff at all levels across the Trust who have volunteered to provide a network of Freedom to Speak Up Champions to support the Guardian in this important area of work.

The raising concerns policy is accessible from the Trust intranet. The Trust has promoted the behaviours and standards of conduct expected from staff together with the Trust's raising concerns policy with the aim of ensuring staff raise any concerns.

During the past year we have also conducted an extensive review of whistle-blowing processes.

Occupational Health, Counselling and Health Promotion

Team Prevent, the UK division of one of Europe's leading occupational health and safety companies continues to provide to the Trust a full Employee Health and Wellbeing Service. The service is provided locally by Occupational Health Nurse Advisors and Physicians and also includes the promotion of positive health and wellbeing. Counselling services are provided by Care First and staff can self-refer or a referral can be made through an individual's line manager or via Team Prevent.

These arrangements have been in place since 1 December 2010. We meet regularly with both organisations to make continuous improvements to the services provided to our staff. We receive a range of comprehensive data regarding performance against the contract, and this is shared with Managers within the Groups and Directorates as they continue to manage absence, stress and promote health and wellbeing within the workforce.

The Occupational Health contract is in place for an agreed level of business but since its commencement has been continuously over agreed activity. Additional occupational health resource has been employed to meet the increased demand and other solutions have been implemented to enable the demand to be met e.g. the continued encouragement of telephone consultations rather than face to face appointments.

This continued effort in promoting absence management in partnership with the Trust has seen some excellent improvements in referral times for employees accessing Occupational Health services.

Team Prevent also assisted the Trust in undertaking a health surveillance programme for staff which was carried out in 2015.

Employee Equality and Diversity

The Trust has a robust approach to policy-making to ensure that all new policies, procedures and functions due for review are subject to equality analysis (equality impact assessment under previous legislative terminology), to ensure that they do not discriminate against people who share a protected characteristic under the Equality Act 2010. Equality analysis ensures that recruitment, career development and promotion within the organisation is a transparent process based on merit and without protected characteristic defined barriers.

In addition to these measures we have the following:

- Equality and Diversity Committee which meets bi-monthly in order to take forward the equality and diversity agenda;
- Equality Delivery System 2 (EDS2) and Workforce Race Equality Standard (WRES) benchmarking and action plans which ensures that the Trust remains compliant with the Equality Act 2010, but also sets out our key equality objectives and the measures that we will use to gauge our performance against them;
- Mandatory Equality and Diversity Training, which includes as part of its purpose to provide information on matters of concern to them as employees. The training content is regularly reviewed.

Equality and Diversity Work Highlights 2015-16

In the past 12 months we have engaged in benchmarking and action planning for EDS2 and WRES. Our ratings were signed off by Trust Board in June 2015 and a detailed action plan was approved by CDT in July. We rated as developing for Better Health Outcomes in EDS2 and developed an action to conduct an assessment to identify barriers to health promotion services. A similar exercise on the EDS2 goal of improved patient access and experience, where we are rated achieving has shown that we need to be consistent in our approach to the collection of equality data and that we need to widen the scope to collect on all protected characteristics routinely and this will form part of our action plans for 2016-17.

Linking to our 2015-2020 Workforce Strategy, we have rated developing for the EDS2 goal of a representative and supported workforce. We established from looking at results of the 2014 Staff Survey and the data from the WRES that we should establish staff network groups based on protected characteristics. We have worked with staff side to establish these and the first BAME (black and minority ethnic) group meeting took place in March 2016, groups for disabled staff, LGBT (lesbian, Gay, bisexual and transgender) and Faith have expressed interest for establishment and will be starting in 2016.

In June 2015 we were finalists in the Chartered Institute for Personnel and Development North East Awards for the Diversity and Inclusion in the Workplace Award. This recognised our contribution to the creation of over 1000 Dementia Friends from members of staff, governors and public who have attended awareness sessions run by a team of 30 staff who volunteered to be trained as Dementia Friends Champions by the Alzheimer's Society.

The Trust was awarded NHS Employers Diversity and Inclusion Partnership status for 2015-16. Partner status is awarded to organisations that can demonstrate they are delivering against the following measurable criteria:

- improving patient access and experience
- empowered, engaged and well-supported staff
- inclusive leadership at all levels
- better health outcomes for all

Partner Status has provided us with ideas for running staff networks but also for how going forward we will devolve the EDS2 process so that E&D becomes embedded firmly in mainstream work. As part of working with the Partners Programme the E&D Lead has also become a member of the National Working Longer Group and will be working with NHS England on the introduction of the Workforce Disability Equality Standard.

In Spring 2015 we were reassessed for the Two Ticks Positive about Disability scheme and the Mindful Employer Charter. We satisfied the renewal criteria for both of these.

In 2015 we started work with the Time to Change campaign and at the start of 2016 signed the Employer's pledge. The Time to Change Employer Pledge is an aspirational statement with meaning, indicating to employees, service users and the public that an organisation wants to take action to tackle the stigma and discrimination around mental health, focusing on the workplace in particular. This work will link with that of our emerging staff networks.

Information on health and safety performance

Health, Safety and Security Management

The Safety Department has continued to provide sound advice and support across the organisation in relation to Health, Safety and Security Management, which demonstrates the Trust's commitment to ensuring and maintaining a safe and security focused environment for our patients, staff and visitors to the Trust.

The Trust has expanded its Identicom lone worker system. The Trust has continued the roll out programme and now has 1,600 devices in use keeping front line staff safe. Work has progressed to ensure effective use of the devices. The Trust has received national recognition from both NHS Protect and Reliance the device provider, who the Trust works in partnership with to continually improve the system, and has shared its learning experiences with other NHS organisations.

The Trust continues to work in partnership with Northumbria Police, and the Clinical Police Liaison role has been nationally recognised, winning a number of awards, and is now the national lead in the Mental Health Collaborative.

The Trust Health, Safety and Security Group continues to be well represented by staff side unions, managers and Team Prevent which proves very useful in further developing our partnership working. It has met regularly over the last year, to improve the safety culture of the Trust.

The Health and Safety Executive (HSE) has not investigated or carried out any fact finds in 2015/16, however the Trust continues to report its RIDDOR related incidents in the time frames set by the legislation.

The Trust continues to work closely with Northumberland, Tyne and Wear Fire and Rescue Services with the aim of ensuring that the Trust continues to comply with the Regulatory Reform (Fire Safety) Order 2005.

Fire Safety Training is an integral part of our essential training programme for staff; it is delivered in a number of ways including hands on practical training delivered by the Trust's four Fire Officers who all previously worked for the Fire and Rescue Service.

Serious Incidents and Incident Reporting

As reported transparently to the open Board of Directors meeting through the Safety Report and the Unexpected Deaths Report, serious incidents of which the most are unexpected deaths of patients in receipt of services increased in 2015/16 from the previous year.

Throughout 2015/16 the Trust has maintained robust reporting systems with our Clinical Commissioning Groups and the North East Commissioning Support Unit, as their governance systems continue to develop. This includes the new NHS Contractual requirement relating to Duty of Candour to report all our serious incidents, with supplementary information relating to post incident support mechanisms for the patient, and their families and carers. This is now embedded in our incident reporting system.

The Trust has continued to be fully compliant with reporting regimes into the Strategic Executive Information System (STEIS) for Commissioners and NHS England and has also continued to report our Patient Safety Incidents into the National Reporting and Learning System, which allows NHS England and the Care Quality Commission access to all our activity, as well as continuing to regularly report all our security incidents into the Security Incident Reporting System (SIRS) at the request of NHS Protect in line with the NHS Contractual requirements.

One of the Trust's Quality Goals is to reduce incidents of harm to patients. Information relating to the number and type of incidents reported and the progress in achieving the goal is outlined in the Quality Report.

Counter Fraud Activities

The Trust receives a dedicated local counter fraud specialist service from the Northern Audit and Fraud Service and has developed a comprehensive counter fraud work plan in accordance with guidance received from NHS Protect. The Trust also has a Fraud and Corruption Policy and Response Plan approved by the Audit Committee.

Anyone suspecting fraudulent activities within the Trust's services should report their suspicions to the Executive Director of Finance or to the Trust's Local Counter Fraud Specialists on 0191 203 1406 or 07876 594661. Alternatively fraud can be reported through the confidential freephone reporting line on 0800 028 40 60 between 8am and 6pm, Monday to Friday or online at www.reportnhsfraud.nhs.uk

Staff Survey

Since 2010 the Trust has continued to adopt a census approach to the Annual Staff Survey as this gives all staff the opportunity to contribute and feed in their views. The results listed below are relating to the National Survey (ie, a sample of staff), however our action planning also takes into account the findings from our census report as well as the free text comments.

Staff Survey results are disseminated widely throughout the Trust with presentation of key findings at meetings with Trust Board, Corporate Decisions Team, Council of Governors, Staff Side and Corporate and Operational Directorates. The Trust wide Staff Survey Action Plan is agreed by Trust Board and is monitored through the Trust's Organisational Development Group. In addition, local plans are being developed. We are also continuing the work that we have made good progress on from 2014 in particular around Engagement and Involvement.

In this Annual Report we have provided specific details on the top four and bottom four ranking scores and these are shown in tables below.

Figure 17: Summary of performance – NHS staff survey

	2015		2014		Trust improvement/ deterioration
Response rate	Trust	National Average	Trust	National Average	
	47%	47%	38%	42%	Increase 9% points

Figure 18: Staff survey 2015 compared to Staff Survey 2014

	2015		2014		Trust improvement/ deterioration
Top 4 ranking scores	Trust	National Average	Trust	National Average	
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last12 months	17%	22%	15%	21%	deterioration 2% points
KF17. Percentage of staff suffering work related stress in last 12 months	34%	39%	35%	42%	Improvement 1% points
KF31. Staff confidence and security in reporting unsafe clinical practice	3.79	3.62	NA	NA	No comparable data from previous year
KF14. Staff satisfaction with resourcing and support	3.46	3.31	NA	NA	No comparable data from previous year

	2015		2014		Trust improvement/ deterioration
Bottom 4 ranking scores	Trust	National Average	Trust	National Average	
KF27. Percentage of staff / colleagues reporting most recent experience of harassment,bullying or abuse	42%	49%	64%	NA	New key finding but based on previously asked questions 22% points deterioration
KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	24%	21%	23%	18%	Deterioration 1% points
KF23. Percentage of staff experiencing physical violence from staff in last 12 months	3%	3%	2%	3%	Deterioration 1% points
KF13. Quality of non-mandatory training, learning or development	4.00	4.01	NA	NA	No comparable data from previous year

Future priorities and targets

Figure 19: 2015 Staff Survey Agreed Trust wide Actions

Issue	Proposed Action
Last experience of harassment/bullying/abuse not reported	Coordinated campaign of action, relaunching a number of initiatives under one banner. Work around induction, training and the importance of communications. Review of policy
Appraisal: needs not identified	Targeted work on training needs identification and analysis
Violence and aggression	Implementation of Trust's Positive and Safe work. Local review

Where we need to continue our focus:

Violence and Aggression. Unfortunately, we have not seen any significant improvements or changes in the results in this area for several years and whilst we are mindful that we provide many specialist services and care for some acutely unwell patients, this results remains of concern to us.

Harassment and Bullying. Whilst the levels of harassment and bullying are lower than other comparable trusts, we need to look at how we prevent having any concerns on harassment and bullying in the first place but also increasing the confidence in the reporting of these issues.

Staff Development and Support. There needs to be a specific focus on how we can better identify training needs for staff and review some of the content of our statutory and mandatory training programme. We also need to ensure that management, at all levels, can do more to support staff in local areas of work which is perhaps reflective of the many changes arising from our transformation work.

Figure 20: Off-Payroll Engagements

Number of Off-Payroll Engagements as of 31st March 2016, for more than £220 per day and that have lasted for longer than six months

Number of existing engagements as of 31st March 2016	15
Of which…	
No. that have existed for less than one year at time of reporting	7
No. that have existed for between one and two years at time of reporting	3
No. that have existed for between two and three years at time of reporting	5
No. that have existed for between three and four years at time of reporting	0
No. that have existed for four or more years at time of reporting	0

All existing off-payroll engagements outlined above have been subject to a risk based assessment and assurance has been sought that the individual is paying the right amount of tax. All of these arrangements relate to Medics operating on a self-employment basis through Personal Services Companies (PSCs) and through Stafflow.

Figure 21: Number of New Off-Payroll Engagements, or those that reached six months in duration between 1st April 2015 and 31st March 2016, for more than £220 per day and that have lasted for longer than six months

Number of new engagements, or those that reached six months in duration between 1st April 2015 and 31st March 2016	8
No. of the above which include contractual clauses giving the Trust right to request assurance in relation to income tax and National Insurance obligations	7
No. for whom assurance has been requested	1
Of which…	
No. for whom assurance has been received	7
No. for whom assurance has not been received	1
No. that have been terminated as a result of assurance not being received	0

Contractual clauses are included in the contacts which indemnify the Trust from being liable for the tax obligations of the Personal Services Companies (PSCs). Should any tax liabilities arise, the Trust can seek reimbursement from the PSC. During 2015/16 new contracts were issued and signed which confirm agreement that the personal services company will meet any tax liabilities payable and that the Trust has the right to seek assurances from the PSC. There was 1 leaver prior to the new contracts being issued.

Figure 22: Number of New Off-Payroll Engagements of Board Members or Senior Officials with significant financial responsibility between 1st April 2015 and 31st March 2016.

Number of Off-Payroll engagements of Board members or senior officials with significant financial responsibility during the year	0

iv) Disclosures set out in the NHS Foundation Trust code of governance (The Governance Report)

Accountability - types of decision taken by the Board and Council of Governors

The Board of Directors is collectively responsible for the exercise of the powers and the performance of the Trust. As a unitary Board all directors have joint responsibility for every decision of the Board of Directors and share the same liability. This does not impact upon the particular responsibilities of the Chief Executive as the accounting officer.

The Board has a Scheme of Decisions Reserved to the Board and delegates as appropriate to committees or senior management, e.g. the delegation to officers to certify payments up to pre-determined levels. However, the Board remains responsible for all of its functions, including those delegated.

The general duty of the Board and of each director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the Trust as a whole and for the public.

Its role is to provide entrepreneurial leadership of the Trust within a framework of prudent and effective controls, which enables risk to be assessed and managed. It is responsible for:

- Ensuring the quality and safety of healthcare services, education, training and research delivered by the Trust and applying the principles and standards of clinical governance set out by the Department of Health, NHS England, the Care Quality Commission, and other relevant NHS bodies;
- Setting the Trust's vision, values and standards of conduct and ensuring that its obligations to its members are understood clearly communicated and met. In developing and articulating a clear vision for the Trust, it should be a formally agreed statement of the Trust's purpose and intended outcomes which can be used as a basis for the Trust's overall strategy, planning and other decisions;
- Ensuring compliance by the Trust with its licence, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations;
- Setting the Trust's strategic aims at least annually, taking into consideration the views of the Council of Governors, ensuring that the necessary financial and human resources are in place for the Trust to meet its priorities and objectives and then periodically reviewing progress and management performance;
- Ensuring that the Trust exercises its functions effectively, efficiently and economically.

The general duties of the Council of Governors are:

- To hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, which includes ensuring the Board of Directors acts so that the Trust does not breach the terms of its licence;
- To represent the interests of the members of the NHS Foundation Trust as a whole and the interests of the public.

In addition, the statutory roles and responsibilities of the Council of Governors are to:

- Appoint and, if appropriate, remove the Chair;
- Appoint and, if appropriate, remove the other non-executive directors;
- Decide the remuneration and allowances, and other terms and conditions of office, of the Chair and the other non-executive directors;
- Approve (or not) any new appointment of a Chief Executive;
- Appoint and, if appropriate, remove the Trust's auditor;
- Receive the Trust's annual accounts, and the annual report at a general meeting of the Council of Governors;
- Provide views to the Board when the Board is preparing the document containing information about the Trust's forward planning, noting that the

Board must have regard to the views of the Council of Governors;

- Approve significant transactions;
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution;
- Decide whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services in England;
- Approve amendments to the Trust's constitution;
- Require, if necessary, one or more directors to attend a Council of Governors meeting to obtain information about performance of the Trust's functions or the directors' performance of their duties, and to help the Council of Governors to decide whether to propose a vote on the Trust's or directors' performance.

The Council of Governors is not responsible for the day to day running of the organisation and cannot therefore veto decisions made by the Board.

The Board of Directors

The Board of Directors keeps its performance and effectiveness under on-going review. It undertakes self-assessment of effectiveness including Board 'time outs', a development programme, the review of governance arrangements, the annual review of the Board and its committees' terms of reference and the annual committees' self-assessment exercise.

Information on the recent review of governance undertaken by Deloitte is included in section 2, performance report.

The Board of Directors maintains continuous oversight of the Trust's risk management and internal control systems with regular reviews covering all material controls, including financial, operational and compliance controls. The Board of Directors reports on internal control through the Annual Governance Statement.

The Trust Chair

The Chair is responsible for providing leadership to the Board of Directors and the Council of Governors, ensuring governance principles and processes of the Board and Council are maintained whilst encouraging debate and discussion. The Chair is also responsible for ensuring the integrity and effectiveness of the governors' and directors' relationship. The Chair leads the performance appraisals of the Council of Governors, Non-Executive Directors and the Chief Executive.

Hugh Morgan Williams was appointed Trust Chair on 1 November 2013 and prior to appointment he reported to the Council of Governors that he had no other significant commitments. This position has not changed.

The Vice Chair

Paul McEldon was appointed as Vice Chair from 20 February 2014.

Senior Independent Non-Executive Director

Chris Watson was Senior Independent Director until the end of his tenure on 31 December 2015 with Ruth Thompson taking over the role from 1 January 2016 and Martin Cocker from 1 March 2016. The Senior Independent Director leads the performance appraisal of the Chair.

The Chief Executive

The Chief Executive's principal responsibility is the effective running and operation of the Foundation Trust's business. The Chief Executive is also responsible for proposing and developing the Trust's strategy and business plan objectives in close consultation with the Chair of the Board of Directors. The Chief Executive is responsible for preparing forward planning information, which forms part of the Annual Plan, taking into consideration the views expressed by the Council of Governors. The Chief Executive is responsible, with the executive team, for implementing the decisions of the Board of Directors and its committees.

The Chief Executive leads the performance appraisals of the Executive Directors.

John Lawlor was appointed as the Chief Executive from 23 June 2014.

Independent Non-Executive Directors

The Board of Directors is satisfied that the Non-Executive Directors, who served on the Board of Directors for the period under review, 1 April 2015 to 31 March 2016, were independent. The Board of Directors is satisfied that there were no relationships or circumstances likely to affect independence, and the criteria at B1.1 of Monitor's Code of Governance were taken into account in arriving at their view. This was reinforced through the appointments/re-appointments process applied by the Nominations Committee.

Register of Directors' Interests

The Trust maintains a formal Register of Directors' Interests. The Register is available for inspection on the internet at www.ntw.nhs.uk or on request, from Caroline Wild, Deputy Director, Corporate Relations and Communications, Chief Executive's Office, St. Nicholas Hospital, Jubilee Road, Gosforth, Newcastle upon Tyne, NE3 3XT. (caroline.wild@ntw.nhs.uk)

The Board of Directors do not consider any of the interests declared to conflict with their management responsibilities and therefore do not compromise the directors' independence.

Number of meetings and attendance

The Board of Directors meets in public ten times per year.

The table below shows the members of the Board of Directors during 2015/16 along with directors' titles and attendance at Board meetings.

Figure 23: Membership of the Board of Directors and Attendance

Name Title	Date of:		Current expiry of term	Meetings	
	Appointment	Cessation		Total	Attended
Dr Les Boobis Non-Executive Director	01.07.15	-	30.06.18	7	6
Alexis Cleveland Non-Executive Director	01.07.15	-	30.06.18	7	5
Martin Cocker Non-Executive Director / Audit Committee Chair / Senior Independent Director (from 1 March 2016)	01.01.12	-	31.12.17	10	8
Lisa Crichton-Jones Director of Workforce and Organisational Development	04.08.14	-	N/A	10	10
James Duncan Deputy Chief Executive/Director of Finance	01.12.09	-	N/A	10	9
Dr Douglas Gee Medical Director	01.12.13	15.01.16	-	7	6
Neil Hemming Non-Executive Director	01.01.15	-	31.12.17	10	4
John Lawlor Chief Executive	23.06.14	-	N/A	10	10
Paul McEldon Non-Executive Director/Vice Chair	01.12.09	-	31.12.16	10	9
Dr Rajesh Nadkarni Interim Medical Director	16.01.16	-	N/A	3	3
Gary O'Hare Director of Nursing and Operations	01.12.09	-	N/A	10	7
Nigel Paton Non-Executive Director	01.07.12	30.06.15	-	3	3
Lisa Quinn Director of Performance and Assurance/ (from January 2016) Director of Commissioning and Quality Assurance	01.12.09	-	N/A	10	10
Peter Studd Non-Executive Director	01.01.16	-	31.12.18	3	3
Ruth Thompson Non-Executive Director / Senior Independent Director (from 1 January 2016 to 29 February 2016)	01.04.14	-	31.03.17	10	7
Chris Watson Non-Executive Director / Senior Independent Director	01.12.09	31.12.15	-	7	6
Hugh Morgan Williams Trust Chair	01.11.13	-	31.10.16	10	9

The above table illustrates the date of appointment and the expiry date of the current tenure of the Chair and each Non-Executive Director.

The appointment of the Chair and Non-Executive Directors requires approval by the majority of the governors attending the relevant general meeting, but

their removal requires the approval of three-quarters of the entire Council of Governors. In addition to the Chair and Non-Executive Directors not being re-appointed at the end of their tenure, there are other possible reasons for termination depending on the particular circumstances. The reasons may include, but are not limited to, gross misconduct or a request from the Board for the removal of a particular Non-Executive Director, the Chair losing the confidence of the Board or Council of Governors and the severe failure of the Chair to fulfil the role.

A term of office for the Chair and Non-Executive Directors is three years. The re-appointment of the Chair or Non-Executive Director after their first term of office is subject to a satisfactory performance appraisal. Any term beyond six years (i.e. two terms) should only be in exceptional circumstances and subject to annual re-appointment and is subject to a particularly rigorous interview and satisfactory appraisal, and should take into account the need for progressive refreshing of the Board of Directors.

Director's skills, expertise and experience

The Board of Directors believes the Trust is led by an effective Board. The Chair, on behalf of the Board of Directors keeps the size, composition and succession of directors under review, in line with the Trust's business objectives, and makes recommendations as appropriate to the Council of Governors via the Nominations Committee. The work of the Nominations Committee (and subsequently the Council of Governors) relating to the Non-Executive Directors' appointment/reappointment process for 2015/16 was informed by such recommendations and it was formally acknowledged that the future process would seek to redress gender and ethnic minority imbalance with the Board of Directors, if possible.

In advance of the appointment of Non-Executive Directors, the Board of Directors reviews the balance of the Board and the desired qualifications, skills and experience for upcoming Non-Executive Directors' vacancies. The Board of Directors believes that there is a balance of Executive and Non-Executive Directors and that no individual group or individuals dominate the Board meetings.

The qualifications, skills, expertise and experience of directors as at 31 March 2016 are shown below.

Dr Les Boobis

Qualifications include MB ChB (University of Glasgow), FRCS (England and Edinburgh) and MD (University of Leicester). Also level 3 UKCHIP Member and Member of BCS.

Experience and skills/expertise:

- Extensive NHS senior management experience latterly as Medical Director of large NHS Acute Trust;
- 42 years' experience of working in the NHS, 27 of which have been as a Consultant Surgeon;
- Eight years' experience as Medical Director;
- Eight years' experience as the Director of Infection Prevention and Control;
- Ten years' experience as Trust's Caldicott Guardian;
- Four years' experience as the GMC Responsible Officer;
- Ten years' experience as the Trust's lead for Health Informatics, the latter two years as the Chief Clinical Information Officer;
- Four years' experience as the Clinical Safety Officer;
- 15 years' experience as an academic surgeon with the University of Newcastle;
- Ten years' experience as visiting Professor at University of Loughborough during which time acted as an external examiner for two other universities;
- Three years' experience working as a Physician Consultant for US company Meditech, providers of integrated electronic patient record system.

Alexis Cleveland

Qualifications include BSc in Statistics and Geography

Experience and skills/expertise:

- Director General for Transformational Government and Cabinet Office Management at the Cabinet Office;
- Chief Executive The Pension Service;
- Chief Executive Benefits Agency, Department of Works and Pensions;
- Head of Analytical Services Division DSS;
- Experience at Board level in both Executive and Non Executive roles with major government departments, agencies, non departmental public bodies and in the voluntary sector;
- Currently serves as Trustee of Barnardos, Deputy Chair and Trustee of Durham University Council and Chair of University College Durham University.

Martin Cocker

Qualifications include BSC Joint Honours Mathematics and Economics and Member of the Institute of Chartered Accountants of England and Wales.

Experience and skills/expertise:

- Independent non-executive director and chairman of the Audit Committee, Etalon Group Limited;
- Independent non-executive director and chairman of the Audit Committee, EFKO Foods PLC;
- Significant previous business-advisory experience, including Managing Partner North Russia Region, Deloitte and Touche, Managing Partner Deloitte and Touche Central Asia Audit Group and Partner and Leader of Ernst and Young's Energy Group in Moscow, Russia.

Lisa Crichton-Jones

Qualifications include Fellow of Chartered Institute of Personnel and Development (CIPD); MA (Human Resource Management); Postgraduate Certificate in Strategic Workforce Planning; Postgraduate Diploma in Leadership through Effective Human Resource Management and BA (Hons) Italian and French.

Experience and skills/expertise:

- Significant Human Resources experience across mental health and disability services;
- Deputy Director of Workforce and Organisational Development, Northumberland, Tyne and Wear NHS Foundation Trust;
- Programme Director for Workforce and Leadership programmes;
- Senior workforce lead supporting Foundation Trust application;
- Associate Director of both People Management and Workforce Development, Northumberland, Tyne and Wear NHS Trust;
- Deputy Director of HR, Newcastle, North Tyneside and Northumberland Mental Health Trust;
- Board Governor East Durham College.

James Duncan

Qualifications include BA Politics and History and member of the Chartered Institute of Public Finance and Accountancy.

Experience and skills/expertise:

- Extensive financial experience in the NHS;
- Experience in managing mergers, FT application process, PFI and significant capital investment, transformation leadership and development of shared system solutions;
- Director of Finance, Newcastle, North Tyneside and Northumberland Mental Health NHS Trust;
- Director of Finance, Northgate and Prudhoe NHS Trust (including 6 months as Acting Chief Executive);
- Member of National Payment Systems Steering Group;
- Chair of National Business Systems Group for Mental Health Payment Systems and Member of National Steering Group for same project;
- Vice Chair of HFMA (Healthcare Financial Management Association) Mental Health Faculty.

Neil Hemming

Qualifications include graduating in computing science from Newcastle University.

Experience and skills/expertise:

- Global Managing Partner at SAP;
- Group Director-level roles with two FTSE 25 companies - Vodafone and British Telecom;
- A breadth of knowledge across strategy, financial and commercial management, sales and marketing, product development and service delivery, with extensive experience of business transformation and improvement programmes;
- Member of the North East Local Enterprise Partnership (LEP) Innovation Board.

John Lawlor

Qualifications include BSc (Hons) Mathematics (first class); Post Graduate Certificate of Education, Maths and Physics, secondary level; and Post Graduate Diploma in Leading Innovation and Change.

Experience and skills/expertise:

- Executive Coaching programme;
- Yorkshire and Humber Chief Executive Leadership development programme;
- NHS Top Leaders' Programme member;
- Member of NHS England's 'Leadership forum';
- Area Director in NHS England, responsible for the Cumbria, Northumberland, Tyne and Wear part of the north of England;
- Chief Executive of Leeds Primary Care Trust (PCT) and then of the Airedale, Bradford and Leeds PCT;
- Chief Executive of Harrogate and District NHS Foundation Trust;
- Executive Director/Deputy Chief Executive of Calderdale and Huddersfield NHS Trust;
- Civil Servant, in the Department of Health and in the Department of Employment;
- Secondary School Mathematics Teacher in South Yorkshire.

Paul McEldon

Qualifications include Member of the Institute of Chartered Accountants for England and Wales; BA (Hons) Accountancy and Financial Analysis; and Member of Sunderland City Software Project.

Experience and skills/expertise:

- Audit Manager for KPMG;
- Extensive business and finance experience, currently Chief Executive of North East Business and Innovation Centre;
- Financial Director of Sunderland City Training and Enterprise Council;
- Founding Director and Company Secretary of Sunderland Science Park;
- Chairman of the National Enterprise Network.

Dr Rajesh Nadkarni

Qualifications include FRCPsych, MMedSc in Psychiatry (University of Leeds), Doctorate of Medicine (MD) and Diplomate of the National Board in Psychiatry from India and Bachelor of Medicine and Bachelor of Surgery (MBBS).

Experience and skills/expertise:

- 16 years' experience as a Consultant Forensic Psychiatrist;
- Extensive expertise in the clinical assessment and management of mentally disordered offenders;
- Specialist expertise in management of offenders presenting with stalking behaviour having published papers, contributed to national and international conferences and influenced policy and legislation changes within this field;
- Significant experience in medical education and training having previously held the position of Training Programme Director for Forensic Psychiatry within the North East region;
- Served as an elected member of the Forensic Executive Faculty and the Joint Chair of the Community Diversion and Prison Psychiatry Group of the Royal College of Psychiatrists;
- Currently provide clinical expertise to the Newcastle Crown Court Mental Health Team, one of the only two services commissioned nationally. Significant experience of service development in the area of offender health, including being an invited member of the National Health and Justice Clinical Reference Group and Department of Health Expert Reference Group tasked with Police Custody Liaison and Diversion.

Gary O'Hare

Qualifications include Enrolled Nurse; Registered Mental Nurse and Diploma in the Care and Management of the Mentally Disordered Offender (ENB A71).

Experience and skills/expertise:

- Extensive clinical experience in Psychiatric Intensive Care and Forensic Mental Health nursing;
- Extensive nursing and operational delivery experience, both clinical and managerial, at local and national level;
- Director of Nursing at Newcastle, North Tyneside and Northumberland Mental Health NHS Trust;
- Led a number of national initiatives on the management of violence and aggression for the Department of Health and the National Patient Safety Agency;
- Member of the Mental Health and Learning Disability Nurse Directors and Leads National Forum;
- Strong academic links with Northumbria University.

Lisa Quinn

Qualifications include Member of the Chartered Institute of Management Accountants (CIMA).

Experience and skills/expertise:

- Extensive NHS business, performance and finance experience;
- Associate Director of Financial Delivery and Business Support, Northumberland, Tyne and Wear NHS Trust;
- Associate Director of Finance and Business Support, Newcastle, North Tyneside and Northumberland Mental Health NHS Trust;
- Business Development & Planning Accountant, Newcastle City Health NHS Trust.

Peter Studd

Qualifications include BSc (Econ) Hons in Business Administration (University of Wales Institute of Science and Technology UWIST, Cardiff).

Experience and skills/expertise:

- Independent Board Member at Dale and Valley Homes;
- Member Group Audit and Risk Committee, County Durham Housing Group;
- Governor at Middlesbrough College;
- Director UK Skills Education – A4e;
- Group Board Director at Newcastle College Group (NCG);
- Divisional Board Director at Mouchel Group plc;
- Board Director at HBS - £124m turnover limited Business Services Co;
- Operating Board Director at Capita plc;
- Director on the Board of Cumbria Inward Investment Agency (CIIA);
- Worked in partnership with both central and local government overseeing change programmes delivering service improvement and efficiencies on a variety of £multi-million public private partnerships;
- Project Management Consultant at IBM.

Ruth Thompson, OBE

Qualifications include LLB (Hons) Durham University; LLM (Distinction) Commercial Law; Diploma in Accountancy and Finance; Fellow of Energy Institute (FEI); and Fellow of the Royal Society of Arts (FRSA)

Experience and skills/expertise:

- Experienced portfolio non-executive director;
- Solicitor in local government and energy industry;
- Director, Transco PLC;
- Group Corporate Affairs Director, National Grid Plc dealing with public policy and communications across UK, EU and USA;
- Significant change management experience across operational, emergency and support services, in private, public, charity and voluntary sectors;
- High Sheriff of the County of Tyne and Wear 2014/15;
- Awarded OBE for services to New Deal in 2002.

Hugh Morgan Williams, OBE

Qualifications include BA Hons Modern History (Durham University).

Experience and skills/expertise:

- Senior industry figure in the north of England, with significant national and European exposure;
- Experience chairman of large and small organisations with particular skill in change management, Small and Medium enterprise (SME) start-ups, funding, acquisition and divestment;
- A strong understanding and practical experience of the interface between the private and public sector;
- Highly skilled communicator with extensive experience of national print and broadcast media;
- Significant lobbying experience at ministerial level as well as policy formulation;
- Awarded OBE for services to business in 2008.

Committees

The Trust's Constitution requires the Board to convene a Remuneration Committee and an Audit Committee and any other committees as it sees fit to discharge its duties.

The governance structures of the Trust were extensively reviewed in May 2012 and the Trust's Clinical Governance arrangements were also reviewed and strengthened in January 2013 to ensure their robustness in the context of the Trust's overarching integrated governance arrangements. The Board of Directors routinely review and approve changes to the Terms of Reference for the Board, its committees and the Corporate Decisions Team. The Trust undertook an external review of its governance arrangements, using the Well Led Framework, during 2015/16, supported by Deloitte, in line with Monitor's recommendations to all foundation trusts. No material governance concerns were identified. Some areas for improvement were identified to strengthen the Trust's governance arrangements and these are the subject of an Action Plan, progress against which is being monitored by the Board.

In addition to the Remuneration Committee and Audit Committee reporting to the Board, there are also three other standing committees delivering a statutory and assurance function, i.e. the Mental Health Legislation Committee, the Finance, Infrastructure and Business Development Committee and the Quality and Performance Committee.

A further committee, the Trustwide Programmes Board, which was a time limited committee, was stood down in January 2016. This committee provided the Board of Directors with assurance regarding the Trust's programmes, which deliver on the Trust's transformation and development agenda.

Each committee is chaired by a Non-Executive Director and has robust Non-Executive Director input along with Executive Director Membership. While reporting to the Board of Directors, the work of the committees in relation to risk management is reviewed by the Audit Committee. Each committee self-assesses its effectiveness annually.

Remuneration Committee

The purpose of the Remuneration Committee is to decide and review the terms and conditions of office of the Executive Directors and comply with the requirements of Monitor's Code of Governance and any other statutory requirements. The Remuneration Committee's terms of reference are included on the Trust website, and its role includes agreeing processes and arrangements and receiving and considering the outcome and recommendations from such processes for approval, e.g. interview processes. Ensuring compliance with the requirements of "NHS Employers: Guidance for employers within the NHS on the process for making severance payments" was added to the committee's remit during 2013/14 following instruction by Monitor.

All Executive Director's appointments and terms of office are considered by the Remuneration Committee. This includes the Chief Executive, whose appointment must be agreed by the Council of Governors.

The Council of Governors is responsible for the appointment/reappointment of the Chairman and Non-Executive Directors with the associated work carried out by its Nominations Committee, which provides the Council with recommendations. The work of the Nominations Committee is described later in this report.

The Remuneration Committee is chaired by the Trust Chair and its membership is made up of all Non-Executive Directors. The Committee met four times during 2015/16. The table below shows the membership of the Remuneration Committee during 2015/16 along with their attendance.

Figure 24: Membership of the Remuneration Committee and Attendance

Name	Meetings	
	Total	Attended
Hugh Morgan Williams (chair)	4	4
Dr Les Boobis	3	3
Alexis Cleveland	3	3
Martin Cocker	4	3
Neil Hemming	4	1
Paul McEldon	4	4
Nigel Paton	1	1
Peter Studd	1	1
Ruth Thompson	4	4
Chris Watson	3	2

There was one change to Executive Directors during 2015/16. Dr Douglas Gee stood down as Medical Director on 15 January 2016 and was replaced initially by Dr Rajesh Nadkarni as Acting Medical Director.

Interim Audit Committee Annual Report 2015/16

Annual Report entry on the work of the Audit Committee

Overview

The Audit Committee provides a central means by which the Board of Directors ensures effective internal control arrangements are in place. The Committee also provides a form of independent check upon the executive arm of the Board of Directors. It is the job of Executive Directors and the Accountable Officer to establish and maintain processes for governance. The Audit Committee independently monitors, reviews and reports to the Board of Directors on the process of governance, and, where appropriate, facilitates and supports, through its independence, the attainment of effective processes.

Audit Committee Composition and Attendance:

The Audit Committee comprises three non-executive directors. Each of the members is considered to be independent and the Board is satisfied that the Chairman of the Audit Committee has recent and relevant financial experience.

The Audit Committee met six times during, and twice shortly after the end of, the financial year. Attendance at those meetings was as follows:

Figure 25: attendance at the Audit Committee

Member	Meetings	
	Total	Attended
Martin Cocker	8	8
Nigel Paton	2	1
Chris Watson	5	4
Alexis Cleveland	5	3
Peter Studd	3	2

Nigel Paton and Chris Watson ceased to be non-executive directors of the Trust on June 30, 2015 and December 31, 2015, respectively and left the Audit Committee on those dates.

Alexis Cleveland was appointed to the Audit Committee on July 1, 2015 and Peter Studd on January 1, 2016.

In addition to the non-executive directors, the Director of Finance, Director of Quality and Performance, External Audit and Internal Audit, including Counter Fraud were all invited to each meeting during the year. All attended each meeting with the exception of the Director of Finance and the Director of Quality and Performance who were both unable to attend the meeting in February 2016. However, alternates did attend.

A representative of the Governors attended each Audit Committee meeting as an observer.

The Chief Executive and the Chairman of the Board were invited to, and attended, the April 2016 meeting at which the Annual Governance Statement was considered as well as the Opinion of the Head of Internal Audit which supports the conclusions within the Annual Governance Statement.

External Audit and Internal Audit were given opportunities at the end of each meeting to discuss confidential matters with the Audit Committee without Executive management being present.

Programme of Works

The Audit Committee follows an annual work programme that covers the principal responsibilities set out within its terms of reference.

In 2015/16, this included, amongst other matters, the following activities:

- Assessed the integrity of the Trust's financial statements for the year ended March 31, 2016;
- Considered the effectiveness, independence and objectivity of the external auditor throughout the audit cycle;
- Reviewed the Annual Governance Statement in light of the Head of Internal Audit opinion, the External Audit opinion relating to the year end and any reports issued by CQC and Monitor;
- Reviewed External Audit's findings and opinions on the Quality Report, the securing of economy, efficiency and effectiveness, and the areas of the Annual Report subject to audit review;
- Considered whether the Trust's Business Assurance Framework ('BAF') and Corporate Risk Register are complete, fit for purpose and in line with Department of Health expectations;
- Reviewed the arrangements by which staff may raise in confidence concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters;
- Reviewed the process established by the Trust to ensure compliance with Monitor's Code of Governance;
- Challenged and approved the internal audit programme, counter fraud and informatics plan, operational plans and detailed programmes of work for the year. The Audit Committee confirmed the effectiveness of internal audit and counter fraud and the adequacy of their staffing and resources;
- Considered the major findings of internal audit, counter fraud and informatics throughout the year. The Audit Committee agreed that the remedial actions proposed were appropriate and then monitored the timely implementation of those remedial actions by management;
- Reviewed the work of other Board Committees and considered how matters discussed at those committees impacted the work of the Audit Committee;

Significant Issues

Throughout the year, the Audit Committee has debated and concluded on a number of matters. The more significant issues to have come before the Audit Committee, and the actions taken by the Audit Committee to ensure that those issues were dealt with promptly and in an appropriate manner, are noted below.

1. Integrity of financial reporting

The Audit Committee reviewed the integrity of the financial statements of the Trust. This process included reviewing the accounting policies to ensure that they remained appropriate and had been complied with and debating the areas of significance in relation to the integrity of financial reporting. The review and debate took into account the views of the External Auditors, Mazars LLP ('Mazars').

The significant matters considered were:

Impairment and Revaluation of the Trust's Specialist NHS Buildings.

The Trust records its specialist NHS buildings initially at cost and subsequently at their fair value. The fair value is calculated using the 'depreciated replacement cost' ('DRC') method.

The DRC method seeks to calculate the cost of an asset that would provide a similar function and equivalent utility to the asset being valued, but which is of a current design, constructed using current materials and techniques and is built on a site of optimal size and location.

Therefore, the valuation of the Trust's specialised NHS buildings is not a valuation of the existing buildings in their current locations. Rather, it is a valuation of the specialist buildings that the Trust could hypothetically build to deliver the services and occupancy levels as at the balance sheet date on a site that was of the optimal size and location.

Application of the DRC method typically results in an asset value that is significantly lower than the actual cost.

In addition, subsequent remedial capital expenditure on assets already revalued under the DRC method and which does not significantly increase either the value or expected life of the asset is unlikely to result in an increase in the fair value of the asset calculated using the DRC method.

Any reduction in value between the original cost and the fair value calculated under the DRC method is reported as an impairment in the financial statements.

Accordingly, the initial use of the DRC typically results in a significant provision for impairment. In addition, subsequent remedial capital expenditure on assets already revalued under the DRC method is likely to result in an additional provision for impairment.

Any increase in the fair value of specialised NHS assets at successive balance sheet dates is reported as a revaluation.

Non-specialist buildings fall outside the DRC valuation methodology and are carried at market value.

For the year ended March 31, 2016, the Trust has reported within 'Other Operating Income' a reversal of impairment of £11 million and a revaluation gain of £0.8 million within 'Other Comprehensive Income'.

In respect of these movements in valuation of specialised NHS assets, the Audit Committee has debated and challenged the work performed by Mazars, including their review of the work of the District Valuer.

Additionally, the Audit Committee has confirmed with management that assumptions made in determining the Trust's services and occupancy levels as at March 31, 2015 and in mapping those services onto an asset of equivalent capacity and function have not changed during the year.

The Trust has also reported a charge for impairment for the year of £3.4 million within 'Operating Expenses'. This relates mainly to capital expenditure incurred on specialised NHS assets in the year or specialised NHS assets that have been brought into use during the year and where the expenditure has not resulted in an increase in values or estimated lives of the assets.

In respect of this movement, the Audit Committee has questioned management as to the nature of the expenditure. The Audit Committee also challenged the work performed by Mazars to gain comfort that the expenditure had not resulted in any increase in value or estimated life of the asset.

After careful consideration, the Audit Committee has concluded that the adjustments to the level of impairment have been properly calculated and disclosed in the financial statements.

Provisions

The Trust has a number of legal or constructive obligations of uncertain timing or amount. Provision for these obligations is made where it is probable that there will be a future outflow of cash or other resources and where a reliable estimate can be made of the amount.

The Audit Committee has discussed with management the provisions made at March 31, 2016. The Audit Committee also challenged the work performed during the audit by Mazars to determine if the provisions were accurately calculated and complete.

After consideration, the Audit Committee was satisfied that the level of provision made in the financial statements reflects the best estimate of the economic outflow likely to occur.

Impairment of Accounts Receivable

The Trust makes provision against accounts receivables over 3 months past due unless there is a specific reason not to provide. Specific reasons include debts subsequently paid or balances where credible assurances have been received that the debts will be paid. In addition, where disputes are known, the Trust may provide for certain debts less than 3 months old.

The charge for the impairment of accounts receivables was approximately £819,000 for the year ended March 31, 2016.

The Audit Committee considered the methodology for identifying and assessing accounts receivable that may be subject to impairment and concluded that it remained appropriate.

The Audit Committee also discussed with the external auditors the work that they had performed during the audit to satisfy themselves that the provisions being made were complete and appropriate.

After consideration, the Audit Committee concluded that the provision for impairment of receivables was complete and appropriate.

Going Concern

The Audit Committee formally considered the assumptions relating the going concern basis of reporting of the financial statements. After careful analysis and debate, the Audit Committee recommended to the March 2016 Board meeting that the use of going concern basis for the preparation of the annual financial statements was appropriate.

2. Board Assurance Framework

The Audit Committee has a responsibility to ensure that the Trust's system of risk management is adequate in both identifying risks and how those risks are managed.

The Trust's principal risks and the mitigating controls are reflected in the Board Assurance Framework ('BAF'). The BAF is maintained by the Trust's Performance and Assurance group and formally reviewed by the Quality and Performance Committee ('Q&P').

The Audit Committee considered the review performed by Q&P. It questioned directly the Director of Performance and Assurance as to the system for the regular re-assessment of the principal risks and mitigating controls reflected in the BAF.

The Audit Committee also questioned directly the Head of Internal Audit to determine if the results of audits conducted to date and a comparison of the Trust's BAF to the equivalent documents in other similar organisations indicated any significant duplications or omissions in the Trust's governance systems.

Finally, the Audit Committee reviewed the Head of Internal Audit Opinion, presented to the Audit Committee in May 2016.

After careful scrutiny and consideration, the Audit Committee concluded that:

- The system of risk management is adequate in identifying risks and allowing the Board to understand the appropriate management of those risks; and
- The BAF was comprehensive and fit for purpose; and
- There were no significant omissions or duplications in the Trust's systems of governance.

3. Annual Governance Statement

The Audit Committee is required to consider the Annual Governance Statement and determine whether it is consistent with the Committee's view on the Trust's system of internal control.

During the year, a number of matters have been brought to the attention of the Audit Committee, mainly through the reports of Internal Audit. Therefore, the Audit Committee needed to formally consider these matters in forming its conclusion on the Annual Governance Statement. This was supported by other Audit Committee reviews such as of the Board Assurance Framework, Corporate Risk Register, the Head of Internal Audit Opinion and CQC registration.

After due challenge and debate, the Audit Committee concluded that the matters identified together with the remedial actions taken meant that it's view on the Trust's system of internal control was consistent with the Annual Governance Statement. Accordingly, the Audit Committee supported the Board's approval of the Annual Governance Statement.

4. Clinical Audit

Clinical Audit continues to report to the Q&P and not to the Audit Committee. The Audit Committee continues to monitor the issues raised by Clinical Audit through a review of the minutes of the Q&P Meetings.

In addition, the Chair of Q&P brings to the attention of the Audit Committee any matters raised by Clinical Audit, and the proposed remedies, which impact any of the Trust's key risks as recorded in the BAF.

This ensures that the Audit Committee is aware of any key issues raised by Clinical Audit but does not add unnecessary bureaucracy, duplication or contradiction into the process.

External Audit

The Audit Committee places great importance on ensuring that there are high standards of quality and effectiveness in the Trust's external audit process.

Mazars was required to report to the Trust whether:

- The financial statements for the year have been prepared in accordance with directions under Paragraph 25 of Schedule 7 of the National Health Service Act 2006; and
- The financial statements comply with the requirements of all other provisions contained in, or having effect under, any enactment which is applicable to the financial statements; and
- The Trust has made proper arrangements for securing economy, efficiency and effectiveness; and
- The Trust's Quality Report has been prepared in accordance with detailed guidance issued by Monitor.

In September 2015, Mazars presented the audit plan for the year to the Audit Committee. The audit plan was challenged robustly, particularly in terms of timing, resources required, impact on the Trust's day-to-day activities, areas of audit risk, interaction

with internal audit and the quality and independence of the Mazars' team.

The cost of the external audit plan was proposed at £40,000 (excluding VAT). The Audit Committee challenged whether Mazars could deliver the audit plan as described for the fee proposed.

Following the challenge and debate, the Audit Committee was satisfied that the audit plan was appropriate for achieving the goals of the audit and that the proposed fee was reasonable for the audit of an entity of the size and complexity of the Trust.

Accordingly, the fee proposal was recommended by the Audit Committee to, and approved by, the Council of Governors in November 2015.

Throughout the audit process, Mazars reported to the Audit Committee, noting any issues of principle or timing identified by the audit, changes in the external auditor's assessment of risk and any significant control weaknesses or errors identified.

Mazars identified no changes in their assessment of risk nor did they identify any significant control weaknesses. The audit did identify some instances of minor misstatement. None of the misstatements identified were assessed above 'trivial'. The Trust's financial statements were adjusted for all the matters identified.

At the conclusion of the audit, the Audit Committee performed a specific evaluation of Mazars' performance with the aid of a comprehensive questionnaire and with input from the Trust's management and internal audit.

Based on the interaction with the auditor throughout the audit process and the feedback from Trust's management and internal audit, the Audit Committee has concluded that the Trust received an effective and cost-efficient audit for the year.

The Trust has a policy in place for non-audit services provided by External Audit, which has been approved by the Council of Governors. External Audit has not been asked to provide any non-audit services during the year.

Internal Audit

An effective internal audit function is one of the key requirements for an Audit Committee to be effective.

The Trust has an internal audit function, which provides independent and objective appraisal and assurance. The function provides an opinion to the Chief Executive, the Board of Directors and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisations agreed objectives. Risk management, control and governance comprise the policies, procedures and operations established to ensure the achievement of objectives, the appropriate assessment of risk, the reliability of internal and external reporting and accountability processes, compliance with applicable laws and regulations, and compliance with the behavioural and ethical standards set for the organisation. Internal audit plans are based on a risk assessment of all activities in the Trust (clinical, financial and other) using the Trust's objectives and risk assessment processes recorded in the Board Assurance Framework as a primary source.

The Trust's internal audit service is provided by Northern Internal Audit and Fraud Service (NIAFS) through a consortium of NHS statutory bodies. The consortium is hosted by Northumberland, Tyne and Wear NHS Foundation Trust.

Annual Report and Accounts

The directors are responsible for preparing the annual report and accounts and they consider that the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

The directors regard the annual accounts as giving a true and fair view of the financial position of the Trust and of the income and expenditure, changes in taxpayer's equity and cash flows for the year. In preparing the accounts, directors are satisfied that:

- Accounting policies have been applied on a consistent basis;
- Judgements and estimates are reasonable and prudent;
- Accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Understanding the views of governors and members

The Board of Directors ensure that the members of the Board develop an understanding of the views of the governors and members about the Foundation Trust by:

- Board members attending governor engagement sessions and Council of Governor Meetings;
- The minutes of the Council of Governors' meetings being received at meetings of the Board of Directors;
- The attendance of directors at Council of Governor meetings;
- Joint development sessions including the full Board of Directors and Council of Governors.
- Informal opportunities to network
- Governors attending committees as observers provides a further opportunity for sharing of views.

The Council of Governors

The Council of Governors has been established to include both elected and appointed governors and their roles and responsibilities are set out in the Trust's constitution. Elected governors consist of public governors, service user and carer governors and staff governors, and appointed governors are from partner organisations.

Service users and carers are represented separately with six seats each, reflecting our commitment to these groups. Public governors represent those in their local government area. The number of seats for public Governors has reduced from twelve to six, following a change in the constitution in September 2015 i.e. one for each local government area. Any individual who lives outside one of the six local government areas but within England and Wales may become a public member and he/she will be represented by the Newcastle upon Tyne public governor. The number of Governors representing the public will be reduced over time as those incumbent governors come to the end of their term of office.

At the same time, the final three CCG Governors were removed. Following this change in the constitution, the number of Governors reduced from 42 to 33 governors.

Substantively employed staff are automatically members unless they decide to opt out, which was determined by the Trust in partnership with Staff Side. They are represented by one governor for medical staff and two each from Non-Clinical and Clinical areas.

We have also sought to ensure that our partners including local authorities, commissioners, universities and voluntary organisations are represented.

An elected governor's tenure comes to an end after three years, but he/she may seek re-election by the members of their constituency for a further three years, and then a further two years up to a maximum of eight years in total. An election took place during the autumn of 2014 resulting in some changes from 1 December 2014. Appointed governors also hold office for a period of three years and are eligible for re-appointment at the end of that period for a further three years and then a further two years and may not hold office for more than eight years.

The table below shows the individuals making up the Council of Governors during 2015/16, their constituencies, whether they were elected and their attendance during 2015/16.

Fiona Grant became the lead governor on 1st December 2015, taking over from Richard Tomlin.

During 2015/16, there were significant changes to the Council of Governors, due to elections and some resignations for other reasons. These are set out in the table below.

As at the 31 March 2016 the Council of Governors had vacancies for three carer Governors and one Medical Governor. Two of the carer Governor posts and the medical governor post were filled on 1st April 2016 following an election process which took place in March 2016.

It is a fundamental principle of the NHS Act 2006 that no governor shall receive any form of salary but reasonable reimbursement will be made for allowable expenses. The Trust's policy is that reasonable expenses will be reimbursed to attend authorised training and induction events, and meetings arranged by the Trust of the Council of Governors, members and local constituency, and where applicable, meetings of the Nominations Committee and governor working groups. Details are included in a policy document issued to governors.

Figure 26: Membership of the Council of Governors and Attendance

Governor	Constituency	Elected	Date		Period of office (months)	No. of meetings	
			Start	Left (and reason)		Total	Attended
Margaret Adams	Public South Tyneside	Yes	01.03.14		25	5	4
Julia Allison	Public Gateshead	Yes	01.12.14		16	5	2
Nigel Atkinson	Staff Clinical	Yes	01.12.09	30.11.15 (end of term)	72	4	2
Phil Brown	Staff Clinical	Yes	01.12.12	30.11.15 (end of term)	36	4	1
Colin Browne	Public South Tyneside	Yes	01.12.13		28	5	4
Michael Butler	Public Sunderland	Yes	01.12.15		4	1	0
Alasdair Cameron *	Community and Voluntary	No	01.12.12		40	5	0
Ann Clark	Carer Adult Services	Yes	01.12.09	30.11.15 (end of term)	72	4	3
Dr Alan Currie	Staff Medical	Yes	01.12.09	30.11.15 (end of term)	72	4	4
Anne Dale	Local Authority Sunderland	No	15.06.15		10	4	3
****Pauline Dawson	Service User Neuro Disability Services	Yes	01.12.15	08.12.15 (resigned)	0	0	0
Stuart Dexter	Community and Voluntary	No	07.04.14		24	5	3
Catherine Donovan	Local Authority Gateshead	No	24.06.14		21	5	2
Madeleine Elliott	Public Northumberland	Yes	01.12.13	30.11.15 (end of term)	28	4	0
Grahame Ellis	Staff Non-Clinical	Yes	01.12.12		40	5	5
Janet Fraser	Carer Children & Young People's Service	Yes	01.12.09	30.11.15 (end of term)	72	4	0
Alan Gibbons	Carer Children & Young People's Service	Yes	01.12.15		4	1	0
Glenys Goodwill	Public Gateshead	Yes	01.12.12	15.10.15 (resigned)	34	3	1
Fiona Grant	Service User Adult Services	Yes	01.12.14		16	5	4
Jane Hall	Public Sunderland	Yes	01.12.09	25.09.15 (resigned)	70	3	1
George Hardy	Carer Learning Disability Services	Yes	01.12.09	30.11.15 (end of term)	72	4	1
Norman Hildrew	Carer Adult Services	Yes	01.12.09	30.11.15 (end of term)	72	4	4
Barry Hirst	University Newcastle University	No	01.12.09		76	5	4
Gladys Hobson	Local Authority South Tyneside	No	25.02.14		25	5	2
Claire Keys **	Staff Clinical	Yes	01.12.15		0	1	1
Karen Kilgour	Local Authority Newcastle	No	05.06.15		10	4	1
Christine Lumsdon	Public North Tyneside	Yes	01.04.15		12	5	3
Keith McCririck	Public Sunderland	Yes	01.12.14	08.09.15 (dismissed)	9	3	2
Steve Manchee	Public North Tyneside	Yes	01.03.14		25	5	3
Chris Macklin	Carer Adult Services	Yes	01.12.15		4	1	1
Graham Martin	Public Newcastle/rest of England & Wales	Yes	01.12.13	31.07.15 (resigned)	20	2	1
Graeme Miller	Local Authority Sunderland	No	16.05.12		46	5	1
Marian Moore	Service Users Older Peoples Services	Yes	01.03.11		61	5	2
Austin O'Malley	Public Newcastle/rest of England & Wales	Yes	01.12.12		40	5	4
Pauline Pearson	University Northumbria University	No	01.02.13		38	5	4
Lucy Reynolds ***	Service User Neuro Disability Services	Yes	01.12.12 09.12.15	30.11.15 (see note)	40	5	4
Bill Scott	Public Northumberland	Yes	01.12.14		16	5	4
Elizabeth Simpson	Local Authority Northumberland	No	01.04.14	15.06.15 (portfolio change)	14	1	0
Rachel Simpson	Service User Learning Disability Services	Yes	01.12.12		40	5	4
Anneva Spark	Carer Older Peoples Services	Yes	01.12.09	30.11.15 (end of term)	72	4	3
Lesley Spillard	Local Authority North Tyneside	No	12.06.15		10	4	1
Jane Streather	Local Authority Newcastle City Council	No	18.06.14	05.06.15 (portfolio change)	12	1	1
Lisa Strong	Staff Clinical	Yes	01.12.15		4	1	1
Richard Tomlin	Carer Neuro Disability Services	Yes	01.12.09	30.11.15 (end of term)	72	4	4
David Twist	Service User Adult Services	Yes	01.12.14		16	5	1
Bob Waddell	Staff Non-Clinical	Yes	01.12.12		40	5	3
Alison Waggott-Fairley	Local Authority North Tyneside	No	19.06.14	12.06.15 (portfolio change)	11	1	0
Jack Wilson	Service User Children & Young People's Service	Yes	01.12.13		28	5	2

* Alisdair Cameron served as a Service User Governor for adult services between 1 December 2009 and 30 November 2012, i.e. 36 months.

** Claire Keys served as a Service User governor for adult services between 1 December 2012 and 14 September 2014, i.e. 21 months.

***Lucy Reynolds was unsuccessful in the elections in November 2015, however the successful candidate resigned immediately after being elected. Lucy Reynolds as the second placed candidate was therefore re-elected.

****Pauline Dawson was elected in the elections in November 2015, but subsequently resigned.

Although there have been five formal meetings of the Council of Governors during 2015/16, one of the meetings was in closed session where it was inappropriate for Board members to be present. The table below therefore focuses on the other four meetings.

Figure 27: Analysis of attendance of Board members at formal Council of Governors' meetings.

Council of Governors' meetings attended by Board members		
Director	Total	Attended
Dr Les Boobis	3	2
Alexis Cleveland	3	1
Martin Cocker	4	2
Lisa Crichton-Jones	4	0
James Duncan	4	2
Dr Douglas Gee	3	0
Neil Hemming	4	0
John Lawlor	4	2
Paul McEldon	4	0
Dr Rajesh Nadkarni	1	0
Gary O'Hare	4	0
Nigel Paton	1	0
Lisa Quinn	4	4
Peter Studd	1	1
Ruth Thompson	4	0
Chris Watson	3	0
Hugh Morgan Williams	4	3

Nominations Committee

The Council of Governors has established a Nominations Committee in line with the requirement within the Trust's Constitution, and its terms of reference are included on the Trust website. Its role includes making recommendations to the full Council of Governors on the appointment of the Chair and Non-Executive Directors (NEDs) and the associated remuneration and allowances and other terms and conditions. Membership and attendance at the Nominations Committee is shown below:

Figure 28: Nominations Committee Membership and Attendance

Nominations Committee membership and attendance		
	Total	Attended
Colin Browne	7	6
Stuart Dexter	7	3
Grahame Ellis	7	7
Janet Fraser	5	3
Fiona Grant	2	1
Jane Hall	3	1
Barry Hirst	7	7
Chris Macklin	2	2
Austin O'Malley	2	2
Richard Tomlin (Chair)	5	5
Hugh Morgan Williams	2	1

Following a review of the committee's terms of reference, the Council of Governors approved changes at its meeting in November 2015.

The work undertaken by the Nominations Committee entails reviewing job descriptions and person specifications, process for appointment, considering the need for external support and the subsequent selection of such support, reviewing applications, appraisals, independence and time commitments, interviewing candidates and reporting to the Council of Governors. In addition the Committee performs an annual review of the Chair's and other NEDs' remuneration for Council of Governors' approval.

The Nominations Committee's role also includes termination, where this is not as a result of resignation or the Chair or another NED coming to the end of his/her term. This role applies in limited circumstances such as gross misconduct or a request from the Board of Directors for the removal of a particular NED.

During the period under review following Nominations Committee recommendations, the Council of Governors appointed Dr Les Boobis and Alexis Cleveland as Non-Executive Directors for a period of three years from 1st July 2015 and Peter Studd was appointed from 1st January 2016 (following a shadow period). Paul McEldon was reappointed from 1 January 2015 for one year. The appointment was subject to open advertising and the Nominations Committee was assisted by an external search agency.

The Committee has previously undertaken a competitive process to select a recruitment agency to support the NEDs' appointment process. In addition the Committee has reviewed the balance of the Board by considering a recommendation from the Board relating to the qualifications, skills and experience for upcoming NED vacancies. The NED's job role and person specification and the process for the appointment/re-appointment of NEDs have also been reviewed by the Committee.

Engagement with the public, members and partner organisations and their views relating to the forward plan.

An important part of the governors' role is to communicate with the group of people who elected them and we support the governors to achieve this. Governors have been supported to establish regular links between governors and the directors and the local community, especially our members to ensure targeted and specific programmes of engagement relevant to the diverse needs of each community is developed and progressed.

A range of engagement and communication methods are used by the individual governors with support from the Trust. The Membership Strategy includes a list of communication methods from the Trust to the governors, including the Members Newsletter, continuously updating the Foundation Trust pages on the website, ensuring all new members receive information on the benefits of membership, holding open meetings for members to discuss local issues, inviting members to the Trust's Annual Members Meeting, inviting members to participate in surveys and questionnaires, ensuring members are aware of ways to contact the Trust, the availability of the leaflet "A Guide to Becoming a Governor" and establishing communication routes between members and their governor representatives.

The Board has regard to the views of the Council of Governors in preparing the Trust's Operational Plans and Strategic Plans. The Council of Governors is consulted on the development of forward plans and any significant changes for the delivery of the Trust's Operational Plan.

Governors' views, including the public and the membership and organisations represented, are included in the Operational Plan paper for consideration by the Board of Directors.

Declaration of Interests

All governors are asked to declare any interest on the Register of Governors' Interests at the time of appointment. The Register is available for inspection on the internet at www.ntw.nhs.uk or on request, from Caroline Wild, Deputy Director, Corporate Relations and Communications, Chief Executive's Office, St. Nicholas Hospital, Jubilee Road, Gosforth, Newcastle upon Tyne, NE3 3XT. (caroline.wild@ntw.nhs.uk).

Compliance with the Code of Governance

Monitor, the Independent Regulator for NHS Foundation Trusts has published a Code of Governance by bringing together the best practice of public and private sector corporate governance. Monitor has classified the requirements into six categories.

Four of the categories do not require disclosure, but the Trust can confirm that it complies with the statutory requirements quoted in the Code and it has made relevant supporting information available to governors, members and the public on its website.

One of the categories requires supporting explanation to be included in the Annual Report and these explanations are included in this section of the Annual Report, i.e.

"Disclosures set out in the NHS Trust Code of Governance."

The final category has a "comply or explain" requirement, where the Trust must explain the reasons for any departures from the Code, including how the alternative arrangements continue to reflect the main principles of the Code. Northumberland, Tyne and Wear NHS Foundation Trust has applied all of the principles of the NHS Foundation Trust Code of Governance.

The Trust continues to keep the governance arrangements under review to ensure their effectiveness and the Trust undertook an external review of its governance arrangements, using the Well Led Framework, during 2015/16, supported by Deloitte, in line with Monitor's recommendations to all foundation trusts. No material governance concerns were identified. Some areas for improvement were identified to strengthen the Trust's governance arrangements and these are the subject of an Action Plan, progress against which is being monitored by the Board.

Information, development and evaluation

Reports from the Executive Directors, which include in-depth performance and financial information, are circulated to Directors prior to every Board meeting to enable the Board to discharge its duties.

The Council of Governors receive regular presentations from the Executive Team and updates from governors on the work of the Nominations Committee and working groups. On appointment or election all directors and governors undertake appropriate induction and are encouraged to keep abreast of matters affecting their duties as a director or governor and to attend training relevant to their role.

Robust processes are in place for the annual appraisal of the Board of Directors. The Chair leads the Non-Executive Directors in their appraisals and the Chief Executive for Executive Directors. The Chief Executive is appraised by the Chair. The Senior Independent Director leads on the Chair's appraisal. The Board of Directors routinely reviews its performance and the Committees self-assess performance against their terms of reference annually. The Council of Governors also assesses its effectiveness on an annual basis.

Indemnities

In accordance with the Trust's Constitution as at the date of this report indemnities are in place under which Northumberland, Tyne and Wear NHS Foundation Trust has agreed to indemnify its directors and governors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this respect will be met by Northumberland, Tyne and Wear NHS Foundation Trust.

Membership

Our approach to membership is one of inclusivity, with membership available to everyone who:

- Is at least 14 years old and;
- Lives in the areas served by the Trust i.e. Northumberland, Newcastle, North Tyneside, South Tyneside, Gateshead, Sunderland and North Easington or the rest of England and Wales;
- Has used our services in the last four years or;
- Has cared for someone who has used our services in the last six years or;
- Is a member of staff on a permanent contract or who has worked for the Trust for 12 months or more.

At 31 March 2016, we have a consistent 12,000 public and 6,400 staff members. (See the table below for details of numbers per constituency). During the past year we have engaged with the membership and encouraged nominations to governor elections.

Regular communication with our members through newsletters, has continued and we are committed to sustaining our membership and their involvement, to ensure that the benefits of having a robust and vibrant membership are attained. The Trust continues to work hard to build, develop and maintain the membership base to ensure appropriate community representation.

Membership targets are set via the Membership and Communications working group of the Council of Governors, with consideration given to the balance between quantity of members and quality of engagement with members.

Our target is to maintain a public membership of 12,000 people with the focus of activity on:

- Ensuring the membership is refreshed and that membership figures are maintained;
- Improving user and carer membership numbers;
- Maintaining a good spread of members in the different localities;
- Engaging in new and meaningful ways with members.

Members are free to contact governors and/or directors at any time via the Chairman's/Chief Executive Office (telephone number 0191 245 6827 or email governors@ntw.nhs.uk

Members are also encouraged to comment, make suggestions or submit articles to the Trust's quarterly Foundation Trust Membership News, either via email to ftnewsletter@ntw.nhs.uk or by telephone.

The table below shows an analysis of our membership as at 31 March 2016.

Figure 29: Analysis of membership as at 31 March 2016

Constituency	31 March 2016
General Public	
Gateshead	913
Northumberland	1,414
Newcastle upon Tyne	2,614
Rest of England and Wales	762
North Tyneside	1,487
South Tyneside	773
Sunderland	2,114
Sub total	10,077
Service Users	
Adults	339
Children and young people	146
Older people	55
Learning disability	179
Neuro-disability	130
Unknown*	24
Sub total	873
Carers	
Adults	128
Children and young people	568
Older people	95
Learning disability	99
Neuro-disability	90
Sub total	980
Total All Public	11,930
Staff	
Medical	242
Other Clinical	2,549
Non Clinical	3,647
Total All Staff	6,438
Total Members	18,368

Note: *Included in total are 24 service users who have not stated which service they use and are therefore recorded as unknown

v) Regulatory Ratings

Monitor Regulatory risk ratings

On the 1 April 2013, the provider licence came into effect for all NHS Foundation Trusts, the licence replacing the terms of Authorisation as Monitor's primary tool for overseeing NHS Foundation Trusts. It incorporates a set of requirements covering governance and financial viability as well as other areas reflecting Monitor's expanded role within the health sector.

Monitor's Compliance Framework historically set out the approach Monitor took to assess compliance of NHS Foundation Trusts with their Terms of Authorisation, with a particular focus on financial and governance risk. From the 1 October 2013 the Risk Assessment Framework replaced the Compliance Framework in the areas of Monitor's oversight of providers of key NHS services (not just Foundation Trusts) and the governance of Foundation Trusts.

In August, Monitor issued an updated risk assessment framework, this replaced the Continuity of Services risk rating for finance with a new Financial Sustainability risk rating.

The Trust's risk ratings for 2015/16 are shown in the table below, including expected performance as identified in the Annual Plan 2015/16:

Figure 30: Risk ratings for 2015/16 including expected performance as identified in the Annual Plan 2015/16

Risk Rating	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Continuity of service rating (Q1) /Financial Sustainability Rating (Q2 – Q4)				
Plan	3	2	2	2
Actual	4	4	4	4
Governance rating				
Plan	Green	Green	Green	Green
Actual	Green	Green	Green	Green

The Trust's risk ratings for 2015/16 were above expected performance as identified in the Annual Plan 2015/16 due to the Trust achieving a higher surplus than plan.

There were no formal interventions from Monitor during 2015/16.

Risk ratings for 2014/15 are shown in the table below including expected performance as identified in the Annual Plan 2014/15:

Figure 31: Risk ratings for 2014/15 including expected performance as identified in the Annual Plan 2014/15

Risk Rating	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Continuity of service rating				
Plan	2	3	3	3
Actual	3	3	4	3
Governance rating				
Plan	Green	Green	Green	Green
Actual	Green	Green	Green	Green

The Trust's risk ratings for 2014/15 were in line with the expected performance as identified in the Annual Plan 2014/15.

vi) Statement of accounting officer's responsibilities

Statement of the chief executive's responsibilities as the accounting officer of Northumberland, Tyne and Wear 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 Monitor.

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

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- Observe the Accounts Direction issued by Monitor, 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 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; and
- Prepare the financial statements on a going concern basis.

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

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

John Lawlor
Chief Executive
25th May 2016

vii) Annual governance statement 2015/16

1 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.

2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Northumberland, Tyne and Wear NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Northumberland, Tyne and Wear NHS Foundation Trust for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

3 Capacity to handle risk

The Executive Director of Commissioning and Quality Assurance has overall lead responsibility for performance risk management within the Foundation Trust. While the Executive Director of Commissioning and Quality Assurance has a lead role in terms of reporting arrangements, all directors have responsibility for the effective management of risk within their own area of direct management responsibility, and corporate and joint responsibility for the management of risk across the organisation.

Structures and systems are in place to support the delivery of integrated risk management, across the organisation. A wide range of risk management training has continued to be provided throughout the Foundation Trust during the year. This includes providing training for all new staff as well as training specific to roles in areas of clinical and corporate risk. Delivery of training against planned targets is monitored by the Board of Directors, and managed through the Trust Corporate Decisions Team and devolved management structures. The Foundation Trust has a Board of Directors approved Risk Management Strategy in place.

Committees of the Board of Directors are in place both to ensure effective governance for the major operational and strategic processes and systems of the Foundation Trust, and also to provide assurance that risk is effectively managed. Operations for the Foundation Trust are managed through an organisational structure, with operations divided into three Groups, and each has governance committees in place for quality and performance and operational management. Risk registers are maintained and reviewed by each Group and reviewed through the Foundation Trust-wide governance structures. The Quality and Performance Committee consider Group top risks and the Assurance Framework and Corporate Risk Register regularly. The Corporate Decisions Team also undertake this review from an operational perspective to ensure that risks are recorded effectively and consistently and that controls in place are appropriate to the level of risk. The Audit Committee considers the systems and processes in place to maintain and update the Assurance Framework, and considers the effectiveness and completeness of assurances that documented controls are in place and functioning effectively. The Mental Health Legislation Committee has delegated powers to ensure that there are systems, structures and processes in place to support the operation of mental health legislation, within both inpatient and community settings and to ensure compliance with associated codes of practice and recognised best practice.

4 The risk and control framework

The Foundation Trust continually reviews its risk and control framework through its governance and operational structures. It has identified its major strategic risks, and these are monitored and maintained and managed through the Board of Directors Assurance Framework and Corporate Risk Register, supported by Group and Directorate risk registers. The Foundation Trust's principal risks and mechanisms to control them are identified through the Assurance Framework, which is reviewed by the Board of Directors regularly. These risks are reviewed and updated through the Foundation Trust's governance structure. Outcomes are reviewed through consideration of the Assurance Framework to assess for completeness of actions, review of the control mechanisms and on-going assessment and reviews of risk scores.

The principal risks are considered as those rated over 15 at a corporate level on the standard 5 by 5 risk assessment measure. The Assurance Framework and Corporate Risk Register was the subject of a review during the latter part of 2015-16 to reflect best practice and the table below summarises those risks and the key controls, as reported to the Board in the Assurance Framework in February 2016. All risks identified below are considered as in year and future risks.

Figure 32: Principal Risks

Reference	Risk	Key Controls
SO1.1	That we do not develop and correctly implement service model changes.	Integrated Governance Framework Programme and Project governance reporting arrangements Business Case and Tender Process Commissioner involvement and scrutiny Service User and Carer Network Reference Group
SO1.2	That we do not effectively engage commissioners and other key stakeholders leading to opposition or significant delay in implementing service strategy.	Integrated Governance Framework Stakeholder and partner matrix and reporting process on engagement and activity Business Case and Tender Process Communication Strategy Requirement re public and staff consultation
SO2.1	That we have a significant loss of income through competition and choice, including the possibility of losing large services and localities.	Integrated Governance Framework Financial Strategy Agreed contracts in place and framework for managing change Customer Relationship approach, including with Commissioners Marketing Strategy Business Case and Tender Process Horizon Scanning
SO2.2	That we do not manage our financial resources effectively to ensure long term financial stability (including differential between income and inflation, impact of QIPP and the cost improvement programme).	Integrated Governance Framework Financial Strategy (including Financial Delivery Plan) Standing Financial Instructions Decision Making Framework Financial and Operational Policies and Procedures Quality Goals and Quality Account
SO3.1	That we do not effectively manage significant workforce and organisational changes, including increasing staff productivity and staff engagement.	Workforce and OD Strategy. Integrated Governance Framework Performance review monitoring and reporting including KPIs Staff Survey and Friends and Family Feedback and Action Plans Communications Strategy Policy review process relating to systems to support the deployment of staff across services

SO3.3	That we are unable to recruit and retain staff in key posts.	Workforce and OD Strategy. Integrated Governance Framework Recruitment and Selection Policy HR Policies which support Health and Wellbeing, including Pay and Reward Staff Survey and Friends and Family Feedback and Action Plans Communications Strategy Controls re use of Agency Staff.
SO5.6	The risk that high quality, evidence-based and safe services will not be provided if there are difficulties in accessing services in a timely manner and that services are not sufficiently responsive to demands.	Integrated Governance Framework Performance review monitoring and reporting including compliance with standards, indicators, CQIN Operational and Clinical Policies and Procedures Agreed Service Specifications NICE Guidance Annual Quality Account
SO5.9	That the scale of change and integration across the NHS could affect the sustainability of services and the Trusts financial position.	Integrated Governance Framework Stakeholder and partner matrix and reporting processes Horizon scanning and intelligence Financial Strategy

The governance structures supporting and underpinning this are the Quality and Performance Committee, Finance, Infrastructure and Business Development Committee, and Mental Health Legislation Committee. The Trust Programmes Board, a time limited Committee, provided the Board with assurance regarding the Trust's Programmes, established to deliver on the Trust's transformation and development agenda.

- The Trust's governance structures are the subject of periodic review and in October 2015 the Board agreed that the Programmes Board should be disestablished on the 31st December 2015 with the elements of the Committee business being picked up through the Corporate Decisions Team.
- The Board also agreed to establish a new sub Group to support the Board, overseeing the development of the Trust's new Integrated Business Plan (IBP)/Strategy and by providing a strategic forum for environmental and horizon scanning and a review of intelligence to inform and input into the IBP/Strategy and the Trust's decision making.

Each of the committees is chaired by a Non-Executive Director and has Executive Director membership. The Quality and Performance Committee acts as the core risk management committee of the Foundation Trust Board of Directors, ensuring that there is a fully integrated approach to performance and risk management. This Committee provides oversight to the performance and assurance framework, Foundation Trust risk management arrangements for both clinical and non-clinical risk, and has full responsibility for overseeing the Foundation Trust's performance against essential standards for quality and safety as part of this role. The Quality and Performance Committee reviews the top risks for each Group, and the Assurance Framework and Corporate Risk Register periodically. The Committee also considers all aspects of quality and performance, in terms of delivery of internal and external standards of care and performance. The Finance, Infrastructure and Business Development Committee provides assurance that all matters relating to Finance, Estates, Information Management and Technology and Business and Commercial Development are effectively managed and governed.

The Research and Development Committee, a sub Committee of the Quality and Performance Committee, oversees the implementation and review of the Trust's Research and Development Strategy and ensures that the organisation's research governance responsibilities are met, including the cost effective use of research and development income.

Quality Governance arrangements are through the governance structures outlined above, ensuring there are arrangements in place from ward to Board. Review, monitoring and oversight of these arrangements takes place through the following, among others:

1. Trust Board
2. Quality and Performance Committee
3. Group Quality and Performance Committees
4. Corporate Decisions Team meetings

In 2010 the Trust supported Monitor in the development of a Quality Governance Framework. The Trust now reviews it's performance against Monitor's published Quality Governance Framework on a quarterly basis through the Quality and Performance Committee.

The Trust supports an open reporting culture and encourages its staff to report all incidents through its internal reporting system .The Trust's Incident Policy NTW(O)05 and supporting practice Guidance Notes provides the framework for staff for the reporting, management investigation and dissemination of lessons learnt. The Trust has adopted the principles of the National Patient Safety Agency's "Seven Steps to Patient Safety" and embedded them in day to day practice.

The Trust has a data quality improvement plan in place to ensure continuous improvement in performance information and has made continued advances in this area through 2015-16 with continued development of dashboard reporting from patient and staff level to Trust position. The Trust audit plan includes a rolling programme of audit against all performance and quality indicators.

Registration compliance is managed through the above quality governance structures and is supplemented by a Group Director being responsible for the oversight of all compliance assessments and management of on-going compliance through the Trust CQC Compliance Group. This Group reports into the Corporate Decisions Team. There is a central log of all evidence supporting registration requirements and a process in place through the governance arrangements highlighted above to learn from external assessments and improve our compliance. The CQC Compliance Group undertakes regular reviews of compliance against the CQC Fundamental Standards including undertaking mock visits and identifying Improvement requirements.

This formal governance framework is supplemented by an on-going programme of visits by Executive Directors and members of the Corporate Decisions Team, which are reported through the Corporate Decisions Team, as well as service visits by Non-Executive Directors.

The Foundation Trust is registered with the CQC and has maintained full registration, with no non-routine conditions, from 1st April 2010. The CQC has inspected all of the Trust registered locations. The Foundation Trust is fully compliant with the requirements of registration with the CQC.

The Trust recognises the significant organisational change that is required to meet the challenges of the external environment, the changing NHS and the requirement to improve the quality of our services with reducing resources. In response to this the Trust has developed its Transforming Services Programme. This programme is focussed on developing a new service model for the Trust, having implemented a new business model, which included seeking to put clinicians at the heart of the Foundation Trust decision making process. The Service Model Review, which was clinically led has developed a blueprint for the future development of the Foundation Trust services to meet our future challenges, and was presented to our Board of Directors in July 2011. The Board of Directors received an update on Trust Programmes from the Chair of the Trust Programmes Board every two months, up until the disestablishment of the Trust Programmes Board.

As described above the Trust has robust arrangements for governance across the Trust. Risks to compliance with the requirements of NHS Foundation Trust condition 4 (FT governance) are set out where appropriate within the Assurance Framework and Corporate Risk Register. The Board has reviewed its governance structures and the Board and its Committees undertake an annual self-assessment of effectiveness and annual review of their terms of reference.

The Corporate Decisions Team is responsible for the co-ordination and operational management of the system of internal control and for the management of the achievement of the Foundation Trust's objectives agreed by the Board of Directors. Operational management, through the Foundation Trust's directors, is responsible for the delivery of Foundation Trust objectives and national standards and for managing the risks associated with the delivery of these objectives through the implementation of the Foundation Trust's risk and control framework. Governance groups have been in place across all areas throughout this accounting period, with each directorate, and then Group having in place an Operational Management Group, and a Quality and Performance Group. To fulfil this function the Corporate Decisions Team reviews the Assurance Framework and Corporate Risk Register, as well as reviewing Group top risks. It also receives and considers detailed reports on performance and risk management across the Foundation Trust. Summary reports on the work of internal audit and the counter fraud team are also presented to the Corporate Decisions Team on a regular basis, with the emphasis on lessons learned and follow up actions required.

The Risk Management Strategy, the associated Risk Management Policy and the governance structure identified above have been developed in line with nationally identified good practice and assurance of this have previously been received through independent assessment of performance against standards assessed through the National Health Service Litigation Authority scheme, where the Foundation Trust had Level 1 compliance, with 100% delivery against all standards. The Assurance Framework and arrangements for governance were subjected to external review through the Foundation

Trust application process, including review by Monitor, the Department of Health and independent auditors during 2009, and are subject to on-going review through Internal Audit.

The Trust undertook an external assessment of its governance arrangements using the Well Led Framework through 2015-16, supported by Deloitte, in line with Monitor's recommendations relating to foundation trusts. Deloitte provided feedback to the Board at a Board Development Session in December 2015 and the Board of Directors reviewed the final report, including the recommendations in January 2016.

The independent review confirmed that there were no material governance concerns.

Deloitte noted a number of areas of good practice particularly:

- High levels of clinical engagement in the transformation of services with senior clinicians developing pathways in support of the service model review;
- A clear focus on values and the culture of the Trust;
- Employment of a range of mechanisms to engage with internal and external stakeholders;
- The introduction of a variety of initiatives in relation to raising concerns, including the appointment of a Freedom to Speak Up Guardian;
- The use of staff and patient level dashboards to monitor performance.

Some areas for further work and opportunities for improvement were also highlighted, which the Board of Directors has acknowledged, and these are the subject of an Action Plan which is being progressed.

The Foundation Trust involves public stakeholders in identifying and managing risks to its strategic objectives in a number of ways. These include:

- Working with partners in health and social services in considering business and service change. The Foundation Trust has a framework for managing change to services agreed as part of its contracts with its main commissioners across the North East. The Foundation Trust also has good relationships with Overview and Scrutiny Committees, with an excellent record of obtaining agreement to significant service change.
- Active relationships with Healthwatch and user and carer groups, and works with these groups on the management of service risks.
- A Deputy Director, Communications and Corporate Relations reporting directly into the Chief Executive for sustaining effective relationships with the key public stakeholders.
- Active engagement with governors on strategic, service, and quality risks, including active engagement in the preparation of the Annual Plan, Quality Accounts and the setting of Quality Priorities.

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

Control measures are in place to ensure that the organisation's obligations under equality, diversity and human rights are complied with. All policies implemented across the organisation have been subject to equality impact assessments.

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

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

The Foundation Trust has a Financial Strategy, which is approved by the Board of Directors, and which was reviewed and approved by the Board of Directors in March 2013, updated in May 2013, and approved again as part of the Operational Plan in March 2014 and March 2015. The Financial Strategy has been considered by the Finance Infrastructure and Business Development Committee, and adopted by the Trust Board. The Financial Strategy as adopted in March 2013 supported the updated five year Integrated Business Plan, which was formally approved by the Board in September 2012, and identified clear plans for the longer term use of resources to meet the organisational objectives and the financial demands generated by the prevailing economic climate. This Strategy was most recently updated as part of the submission of the 2016-17 Operational Plan, and now includes detailed plans for delivery of service and financial objectives to March 2017. The financial position is reviewed on a monthly basis through the Finance Infrastructure and Business Development Committee, through the Corporate Decisions Team and through the Board of Directors. The Financial Delivery Plan is reviewed on a monthly basis by the Finance Infrastructure and Business Development Committee, for both the deliverability and impact of the overall plan and individual schemes. The Trust Board receives an update on the Financial Delivery Plan at each meeting. On-going plans for financial delivery have been developed through the Transforming Services Programme and Groups, and reviewed through the Corporate Decisions Team and the Trust Board. An integrated approach has been taken to financial delivery with resources allocated in line with the Trust Service Development Strategy. Financial and Service Delivery Plans are integrally linked with Workforce Development Plans, which are in place for each Group. Each Group reviews its own performance on its contribution to the Trust Financial Delivery Plan at its monthly Operational Management Group. The Foundation Trust actively benchmarks its performance, through a range of local, consortium based and national groups.

Internal Audit provides regular review of financial procedures on a risk based approach, and the outcomes of these reviews are reported through the Audit Committee. The Internal Audit Plan for the year is approved on an annual basis by the Audit Committee, and the Plan is derived through the consideration of key controls and required assurances as laid out in the Trust Assurance Framework. The Audit Committee have received significant assurance on all key financial systems through this process.

6 Information Governance

The Foundation Trust also has effective arrangements in place for Information Governance with performance against the Information Governance Toolkit reported through the Caldicott Health Informatics Group, Quality and Performance Committee and the Corporate Decisions Team. The Foundation Trust has put in place a range of measures to manage risks to data security. Version 13 of the Toolkit was released in May 2015 and the Trust has met the required standard of level 2 across all key standards in the Information Governance Toolkit.

The Trust has reported one incident during the current year classified at level 2 in the Governance Incident Reporting Tool. In this incident clinical correspondence in relation to two service users was sent in error to another service user along with their own clinical correspondence. This was reported to the Information Commissioner but no action was taken as they were satisfied that remedial steps had been put in place by the Trust to minimise reoccurrence.

7 Annual Quality Report

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

2015/16 is the 7th year of developing of Quality Accounts/Report for Northumberland, Tyne and Wear NHS Foundation Trust. The Trust has built on the extensive work undertaken to develop the Trust Integrated Business Plan and has drawn on the various guidance published in relation to Quality Accounts.

The Trust has drawn upon service user and carer feedback as well as the Council of Governors to inform the Quality Account/Report. We have also listened to partner feedback on areas for improvement and our response to these are incorporated in the 2015-16 Quality Account.

Whilst the national requirement is to set annual priorities the Trust has established 3 overarching Quality Goals which span the life of the Integrated Business Plan, ensuring our annual priorities enable us to continually improve upon the three elements of quality: Patient Safety, Clinical Effectiveness and Patient Experience as shown in Figure 33 below.

Our Quality Governance arrangements are set out in section 4 of the Annual Governance Statement.

Figure 33: Elements of Quality

Goal	Description
Safety	Reduce incidents of harm to patients
Experience	Improve the way we relate to patients and carers
Effectiveness	Ensure the right services are in the right place at the right time for the right person

The Executive Director of Commissioning and Quality Assurance has overall responsibility to lead the production and development of the Quality Account/ Report. A formal review process was established, the Quality Account/Report drafts were formally reviewed through the Trust governance arrangements (Corporate Decisions Team, Quality and Performance Committee, Audit Committee, Council of Governors and Board of Directors) as well as being shared with partners.

The Trust has put controls in place to ensure the accuracy of the data used in the Quality Account/ Report. These controls include:

- Trust policies on quality reporting, key policies include:
  - NTW(O)05 - Incident Policy (including the management of Serious Untoward Incidents)
  - NTW(O)07 - Comments, Compliments and Complaints Policy
  - NTW(O)09 - Management of Records Policy
  - NTW(O)26 - Data Quality Policy
  - NTW(O)28 - Information Governance Policy
  - NTW(O)34 - 7 Day Follow Up
  - NTW(O)62 - Information Sharing Policy
- Systems and processes have been further improved across the Trust during 2015-16 with the continued expansion of the near real-time dashboard reporting system, reporting quality indicators at every level in the Trust from patient/staff member to Trust level.
- The Trust has training programmes in place to ensure staff have the appropriate skills to record and report quality indicators. Key training includes:
  - Electronic Patient Record (RiO)
  - Trust Induction
  - Information Governance
- The Trust audit plan includes a rolling programme of audits on quality reporting systems and metrics.
- The Internal Audit Plan is fully aligned to the Trust's Corporate Risk Register and Assurance Framework, and integrates with the work of clinical audit where this can provide more appropriate assurance.
- In 2010 the Trust supported Monitor in the development of a Quality Governance Framework. The Quality and Performance Committee reviews performance against Monitor's published Quality Governance Framework on a quarterly basis.
- The Foundation Trust has a near real-time reporting system which connects all our business critical systems. The system presents information at varying levels enabling board to patient drill down. It is accessible by all Trust staff.

Through the engagement and governance arrangements outlined above the Trust has been able to ensure the Quality Account/Report provides a balanced view of the Organisation and appropriate controls are in place to ensure the accuracy of data.

8 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, the counter fraud team, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit Committee, and the Foundation Trust governance committees and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Performance and Assurance Framework provide me with evidence that the effectiveness of controls in place to manage the risks associated with achieving key organisational objectives have been systematically reviewed. Internally I receive assurance through the operation of a governance framework as described above, including the Trust wide Governance Structure, Group level governance structures, internal audit reviews and the Audit Committee.

My review is also informed by (i) On-going registration inspections and Mental Health Act reviews by the Care Quality Commission (ii) the National Health Service Litigation Authority, having achieved 100% at Level I for the Risk Management Standards for Mental Health and Learning Disability, (iii) External Audit, (iv) NHS England (v) Monitor's ongoing assessment of the Foundation Trust's performance, (vi) on-going review of performance and quality by our Commissioners and vii) the external assessment of the Trust's governance arrangements using the Well Led Framework through 2015-16, supported by Deloitte.

Throughout the year the Audit Committee has operated as the key standing Committee of the Trust Board with the responsibility for assuring the Board of Directors that effective processes and systems are in place across the organisation to ensure effective internal control, governance and risk management. The Audit Committee is made up of three Non-Executive Directors, and reports directly to the Board of Directors. The Committee achieves its duties through:

- Consideration of the systems and processes in place to maintain and update the Assurance Framework, and consideration of the effectiveness and completeness of assurances that documented controls are in place and functioning effectively.
- Scrutiny of the corporate governance documentation for the Foundation Trust.
- The agreement of external audit, internal audit and counter fraud plans and detailed scrutiny of progress reports. The Audit Committee pays particular attention to any aspects of limited assurance, any individual areas within reports where particular issues of risk have been highlighted by internal audit, and on follow up actions undertaken. Discussions take place with both sets of auditors and management as the basis for obtaining explanations and clarification.
- Receipt and detailed scrutiny of reports from the Foundation Trust's management concerning the governance and performance management of the organisation, where this is considered appropriate.
- Review of its own effectiveness against national best practice on an annual basis. The terms of reference for the committee were adopted in line with the requirements of the Audit Committee Handbook and Monitor's Code of Governance.

The Trust Board itself has a comprehensive system of performance reporting, which includes analysis against the full range of performance and compliance standards, regular review of the Assurance Framework and Corporate Risk Register, ongoing assessment of clinical risk through review of complaints, SUIs, incidents, and lessons learned. The Quality and Performance Committee receives a regular update on the performance of clinical audit. The Board of Directors also considers periodically a review of unexpected deaths which includes a comparison with national data, when available.

There are a number of processes and assurances that contribute towards the system of internal control as described above. These are subject to continuous review and assessment. The Assurance Framework encapsulates the work that has been undertaken throughout the year in ensuring that the Board of Directors has an appropriate and effective control environment. This has identified no significant gaps in control and where gaps in assurance have been identified, actions are in place to ensure that these gaps are addressed.

9 Conclusion

My review confirms that Northumberland, Tyne and Wear NHS Foundation Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives. No significant internal control issues have been identified.

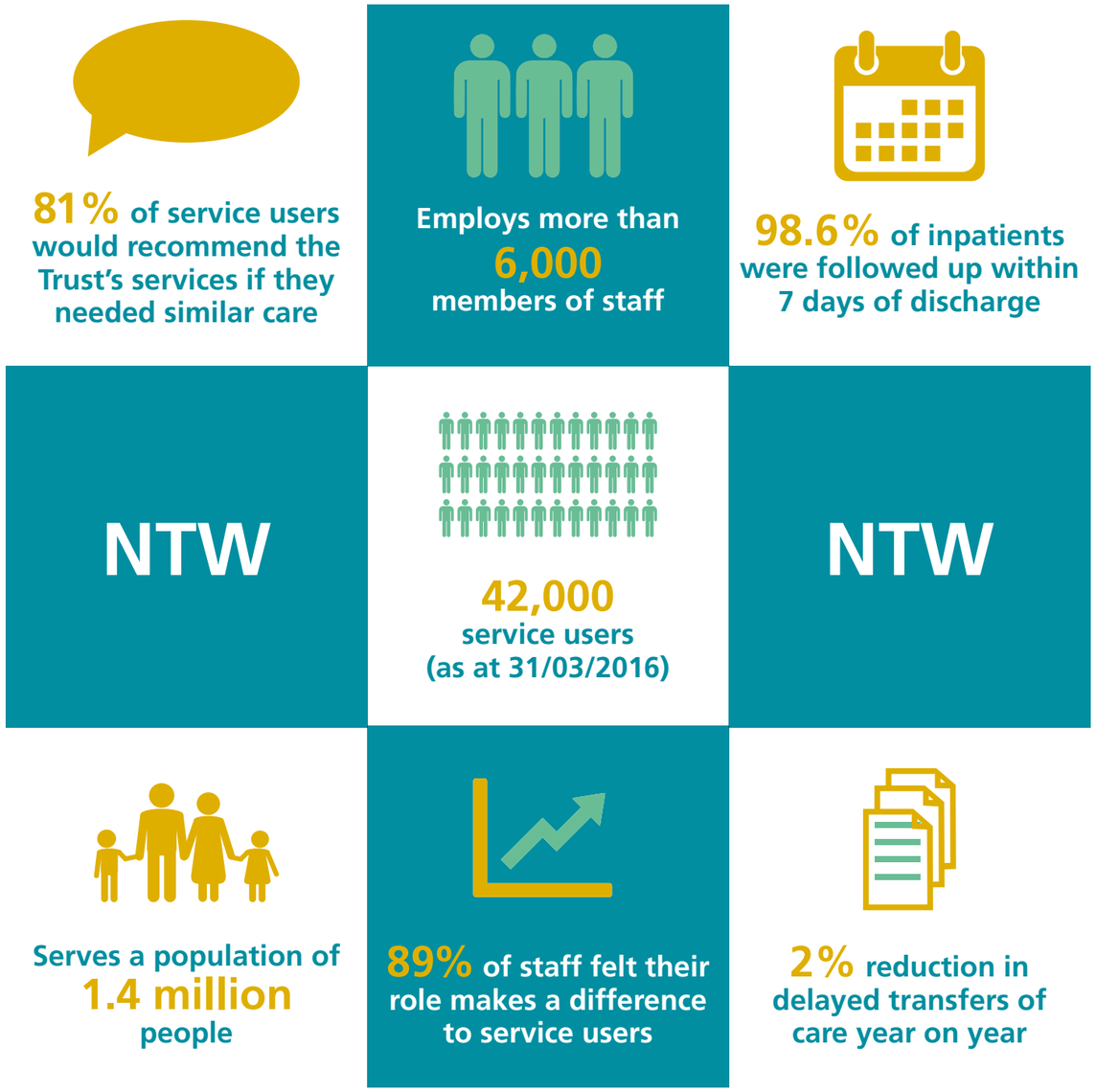
John Lawlor

Chief Executive Officer
(on behalf of the Board)

Quality Account 2015/16

Northumberland, Tyne and Wear NHS Foundation Trust

Northumberland, Tyne and Wear NHS Foundation Trust 2015-16 at a glance...



Part 1

Welcome and Introduction to the Quality Account

Northumberland, Tyne and Wear NHS Foundation Trust is one of the largest mental health and disability organisations in the country with an income of more than £300 million.

About our Trust

Northumberland, Tyne and Wear NHS Foundation Trust provides a wide range of mental health, learning disability and neuro-rehabilitation services to a population of 1.4 million people in the North East of England. We employ over 6,000 staff, operate from over 60 sites and provide a range of comprehensive services including some regional and national services.

We support people in the communities of Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland working with a range of partners to deliver care and support to people in their own homes and from community and hospital based premises. Our main hospital sites are:

- Walkergate Park, Newcastle upon Tyne
- St. Nicholas Hospital, Newcastle upon Tyne
- St. George's Park, Morpeth
- Northgate Hospital, Morpeth
- Hopewood Park, Sunderland
- Monkwearmouth Hospital, Sunderland
- Ferndene, Prudhoe

What is the Quality Account?

All NHS healthcare providers are required to produce an annual Quality Account, to provide information on the quality of services they deliver.

Northumberland, Tyne and Wear NHS Foundation Trust welcomes the opportunity to outline how well we have performed over the course of 2015-16, taking into account the views of service users, carers, staff and the public, and comparing ourselves with other Mental Health and Disability Trusts. This Quality Account outlines the good work that has been undertaken, the progress made in improving the quality of our services and identifies areas for improvement.

To help with the reading of this document we have provided explanation boxes alongside the text.

This is an "explanation" box

It explains or describes a term or abbreviation found in the report.

This is a 'news' box

It reports news stories from 2015-16

This is a 'quote' box

It quotes statements from staff, service users and their families.

Statement of Quality from the Chief Executive

Thank you for taking the time to read our Quality Account. As Chief Executive, I am committed to ensuring that everything we do strives to meet the highest quality standards. We aim to provide services that have our service users and carers at the centre, and which are both easy and quick to access and also focussed on recovery.

This year we have continued to endeavour to ensure that our services meet the highest standards, and in this document we aim to tell the story of our journey to develop excellent services, led by our quality priorities which are developed in partnership with our stakeholders. During the year:

- We have gained national accreditations in many services – for example, nearly 65% of adult and older people's mental health wards have achieved the Accreditation for Inpatient Mental Health Services (AIMS) and 100% of the children and young people's wards in the Ferndene unit have been accredited by the Quality Network for Inpatient Children and Adolescent Mental Health Services.
- We achieved during the last quarter of the year all of the quality standards as set out by local Clinical Commissioning Groups.
- We have achieved the Monitor Risk Assessment Framework governance requirements during the year.
- 81% of those who responded to the Friends and Family Test during the year indicated that they would recommend the service they received to their friends and family.

I feel honoured to be Chief Executive of this organisation, and I am very proud of our staff, and of the services we provide. Equally, I know that we have more to do to ensure that we consistently provide services that are safe, effective, responsive, well led and that every service user and family feels that we are providing the best care.

I hope you will find the information in the document useful. To the best of my knowledge, the information in this document is accurate.

John Lawlor
Chief Executive

The Northumberland, Tyne and Wear NHS Foundation Trust is often referred to as "NTW" or "NTWFT".

Operations Statement from Interim Executive Medical Director and Executive Director of Nursing and Operations

This Quality Account includes information which demonstrates to our service users, carers, commissioners and the public that we provide high quality Mental Health, Learning Disability and Neuro Rehabilitation services.

We continuously strive to improve the quality of our services, and below is a list of just some of our successes and developments we have achieved in the past year:

Safety – we have:

- Developed a Positive and Safe Strategy to better support service users and reduce the incidents of violence and aggression.
- Appointed a "Freedom to Speak Up" Guardian to help staff speak up when they have concerns.
- Reflected on the NHS England independent report into the deaths of people with a learning disability or mental health problems at Southern Health NHS Foundation Trust to help us learn from what went wrong there.

Physical Health for service users with mental illness – we have:

- Embedded good practice in monitoring physical health and providing interventions where needed.
- Gone "smokefree" across all of our sites from March 2016.

Transforming Services – we have:

- Rolled out the new community services model (already in place South of Tyne) to Northumberland.
- Participated in the "Deciding Together" consultation about the future of specialist mental health inpatient services in Newcastle & Gateshead.
- Started building a new £8.3m specialist adult autism unit (the Mitford Unit).

We are also proud of our work in developing a new Trust Strategy, we have employed new staff who have demonstrated that their personal values and behaviours align with our Trust values and we have also changed the way we work so that decisions are made as close as possible to the service user.

We have set out in this Quality Account how well we have performed against local and national priorities - including how we have progressed with those areas we highlighted as our Quality Priorities for 2015-16. We have also set out our Quality Priorities for 2016-17, and look forward to reporting our progress against these in next year's Quality Account.

Dr Rajesh Nadkarni
Executive Medical Director

Gary O'Hare
Executive Director of Nursing & Operations

People receiving treatment from NTW are often referred to as "patients", "service users" or "clients". To be consistent, we will predominantly use the term "service users" throughout this document.

Statement of Quality from Council of Governors Quality Scrutiny Group

The Council of Governors considers the quality of services provided by Northumberland, Tyne and Wear NHS Foundation Trust via a Quality Scrutiny Group who meet every two months. The group has a comprehensive workplan in place, ensuring that all aspects of quality are considered, including environmental issues, safety, complaints, safer staffing, service user and carer feedback and other quality indicators.

During 2015-16 the group received a number of presentations from the Trust on varied topics such as clinical audit, values based recruitment, transformation of services and serious incident reporting processes, providing Governors with a valuable opportunity to discuss quality issues with a wide range of Trust staff.

Alongside this ongoing work, Governors have also attended the Trust Quality and Performance Committee – a sub-committee of the Board, they have participated in mock CQC inspection visits to a number of clinical services and they have also contributed towards the development of the 2016-17 Trust Quality Priorities.

The Quality Scrutiny Group is planning to further develop their quality remit in 2016-17, by identifying specific areas of focus and also increasing the level of involvement in the Trust's Quality Priorities.

Margaret Adams
Chair, Northumberland, Tyne and Wear NHS Foundation Trust
Council of Governor's Quality Scrutiny Group

Northumberland, Tyne and Wear NHS Foundation Trust aim at all times to work in accordance with our visions, mission and values.

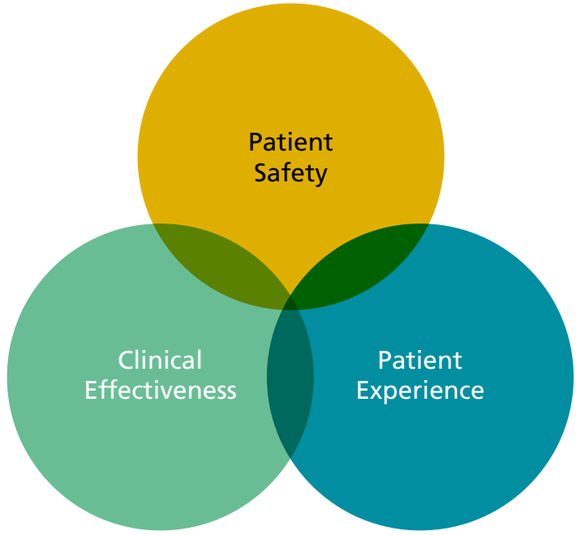
Figure 1: Northumberland, Tyne and Wear NHS Foundation Trust Vision, Mission and Values

Part 2a

Looking Ahead – Our Quality Priorities for Improvement in 2016-17

This section of the report outlines the annual key Quality Priorities identified by the Trust to improve the quality of our services in 2016-17. We have developed our Quality Priorities in line with our long term Quality Goals (shown below), which are based on patient safety, patient experience and clinical effectiveness.

Figure 2:
Quality Goals



Quality Goal One - Patient Safety: Reduce incidents of harm to patients

Quality Goal Two - Patient Experience: Improve the way we relate to patients and carers

Quality Goal Three - Clinical Effectiveness: Ensure the right services are in the right place at the right time for the right person

Each year we set new Quality Priorities to help us to achieve our Quality Goals. The Trust has identified these priorities in partnership with staff, service users, carers and partners from their feedback, as well as information gained from incidents, complaints and other quality reports.

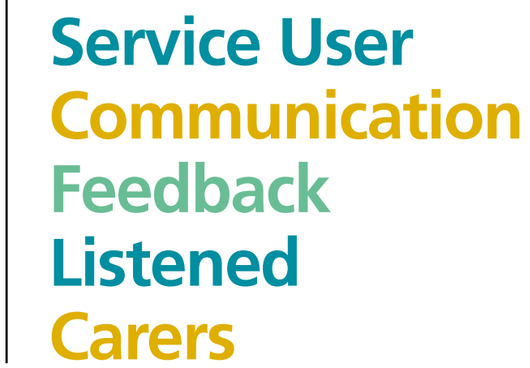
As in previous years, we remain committed to taking any Quality Priorities that are not fully achieved during 2015-16, or priorities which we feel should continue, forward to 2016-17 to ensure we meet and maintain targets that were set in these important areas.

Quality Engagement

An engagement exercise with stakeholders (including Trust staff, service users, carers, Governors and commissioners) took place in late 2015 to gather suggestions, for new Quality Priorities to be developed for 2016-17. Over fifty people attended a series of workshops and many people contributed their ideas via an online survey.

As part of this exercise, we asked everyone the question "what does "quality" mean to you?" and the diagram below summarises the results:

Figure 3: Recurring themes about "What does quality mean to you?"



We were delighted to receive more than 150 ideas for quality improvement, and these were summarised into a list of themes, alongside themes arising from serious incidents, complaints, Mental Health Act Review visits and service user/carer feedback received in 2015.

We then approached stakeholders once again to understand better which of the quality improvement themes identified were considered the most important. The Trust reviewed this valuable feedback and the ideas identified as most suitable were approved by the Trust Board for implementation in 2016-17 as new Quality Priorities as follows:

Figure 4: 2016-17
New Quality Priorities

Any Quality Priorities from 2015-16 that we have not fully achieved in the year will also continue to be progressed into 2016-17. Progress against our Quality Priorities will be monitored regularly by the Quality and Performance Committee.

The full list of Quality Priorities to be progressed during 2016-17, including those continuing from 2015-16 plus the new Quality Priorities identified, are:

Quality Goal One – Patient Safety Reduce incidents of harm to patients		
Quality Priority One	Embed suicide risk training for staff	Continues from 2015-16
Quality Priority Two	Improve transitions between young people's services and adulthood	New
Quality Priority Three	Improve transitions between inpatient and community mainstream services	New

Quality Goal Two – Patient Experience Improve the way we relate to patients and carers		
Quality Priority Four	Improve the referral process and the waiting times for referrals to multidisciplinary teams	Continues from 2015-16
Quality Priority Five	Implement principles of the Triangle of Care	New

Quality Goal Three – Clinical Effectiveness Ensure the right services are in the right place at the right time for the right person		
Quality Priority Six	Improve the recording and use of Outcome Measures	Continues from 2015-16
Quality Priority Seven	Develop staff and their skills to prevent and respond to violence and aggression, through implementing the Positive and Safe Strategy	New

Part 2b

Looking Back – Review of Quality Goals and Quality Priorities in 2015-16

In this section we will review our progress and performance against our 2015-16 Quality Goals and Quality Priorities.

Taking each Quality Goal in turn, we will look back on the last year to assess progress against the Quality Priorities we set in 2015-16, and we will reflect on how these actions have affected progress against the overarching Quality Goal.

The Trust is currently providing care for just under 42,000 people. Table 1 below shows the number of current service users as at 31st March 2016, by locality, with a comparison of the same figures from the last 3 years:

Table 1: Service Users by locality 2013-14 to 2015-16

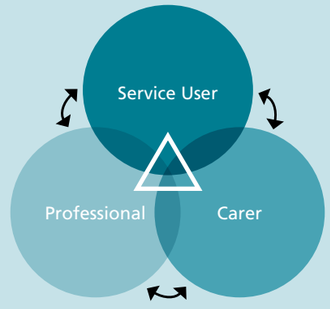
Clinical Commissioning Group (CCG)	2013-14	2014-15	2015-16
Durham Dales Easington & Sedgefield CCG	388	371	375
North Durham CCG	561	557	578
Darlington CCG	89	86	111
Hartlepool & Stockton CCG	115	131	137
Newcastle	8986	8913	8741
Gateshead	3706	3868	4138
Newcastle & Gateshead CCG (Total)	12692	12781	12879
North Tyneside CCG	3778	4031	3996
Northumberland CCG	10739	10345	10361
South Tees CCG	175	189	198
South Tyneside CCG	4599	4336	3990
Sunderland CCG	9084	8786	9020
Other areas	413	171	310
Total Service Users	42530	41784	41955

Table 1 opposite shows that the number of service users as at 31st March 2016 increased by 171 when compared with 31st March 2015.

What is the Triangle of Care?

The Triangle of Care guide was developed by the Carers Trust and the National Mental Health Development Unit, emphasising the need for better involvement of carers and families in the care planning and treatment of people with mental ill-health.

The Trust will also consider the suitability of the tool for use with people with learning disabilities and those with neurological conditions.



Quality Goal 1

Patient Safety: Reduce incidents of harm to patients

We will demonstrate success against this goal by reducing the severity of incidents and the number of serious incidents across the Trust's services

2015-16 Quality Priority: To improve the assessment and management of risk

Target

In 2015-16 our aim was for 85% of qualified clinical staff to have completed the enhanced suicide risk training, develop a Risk of Harm training package and review the FACE risk assessment tool, implementing any recommended changes and training staff on those changes.

Partially Met

Progress

As at the 31st March 2016, 69% of the applicable 2,600 staff had completed the enhanced suicide risk training, which represented an increase from 31% the year before. This element of the Quality Priority will continue into 2016-17 until 85% of applicable staff have completed the enhanced suicide risk training – this had been our intention in 2015-16 however there has been issues with availability of appropriately trained facilitators to deliver the training.

The risk of harm training package has been developed as planned. The FACE risk assessment tool has been evaluated, updated and the clinical risk training package has been amended to reflect the changes made.

What is the FACE risk tool?

Functional Analysis of Care Environments (FACE) – The FACE assessment tool is nationally accredited by the Department of Health, and used to assess risks for people with mental health problems, learning disabilities, substance misuse problems, young and older people, and in perinatal services.

How have the Quality Priorities in 2015-16 helped support this Quality Goal?

The aim of this Quality Goal is to reduce the impact and severity of patient safety incidents. Table 2 below shows the total number of patient safety incidents reported by the Trust over the past 3 years:

Table 2: Number of reported patient safety incidents 2013-14 to 2015-16

Patient Safety Incidents reported:	2013-14	2014-15	2015-16
Patient Safety Incidents	12,725	11,067	10,775

(Data is as at 5/4/16)

A patient safety incident is defined as 'Any unintended or unexpected incident, which could have or did lead to harm for one or more patients receiving NHS funded healthcare. This is also referred to as an adverse event/ incident or clinical error and includes near misses.'

Throughout 2015-16 the Trust fully implemented a web based incident reporting system, allowing immediate incident reporting to managers and relevant specialists within the Trust, facilitating enhanced support for both clinical and operational teams. This has resulted in improved quality and more timely reporting of patient safety incident data into the National Reporting and Learning System.

Most serious incidents reported are unexpected deaths in mainstream community services or substance misuse services. The Trust throughout 2015-16 has continued to develop investigation and learning processes, reporting themes from serious incidents to the Board of Directors on a quarterly basis and further thematic analysis is planned for 2016-17.

The Trust's Incident Policy was also recently updated to reflect the NHS England Serious Incident Framework and the new internal incident reporting system.

Figure 5: Incident Policy Process

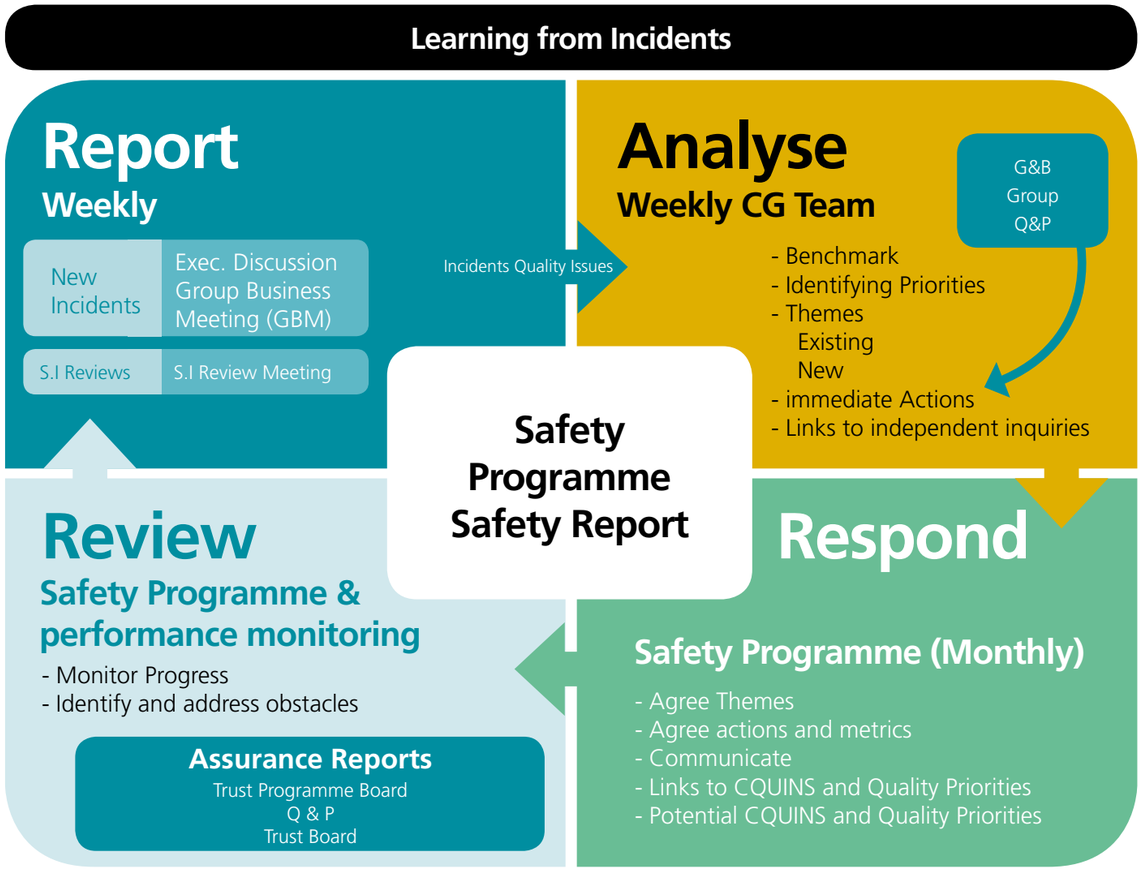


Figure 5 shows how information reported from incidents is considered analysed and responded to so that the Trust continuously learns from the process.

Patient Safety Incidents by impact

Table 3: Number of Patient Safety Incidents by impact 2013-14 to 2015-16:

Number of Patient Safety Incidents reported, by impact:	2013-14		2014-15		2015-16	
No Harm	3401	27%	4215	38%	5129	48%
Minor Harm	8355	66%	6093	55%	4940	46%
Moderate Harm	771	6%	587	5%	603	6%
Major Harm	65	1%	55	0%	22	0%
Catastrophic, Death	133	1%	117	1%	81	1%
Total patient safety incidents reported*	12,725	100%	11,067	100%	10,775	100%

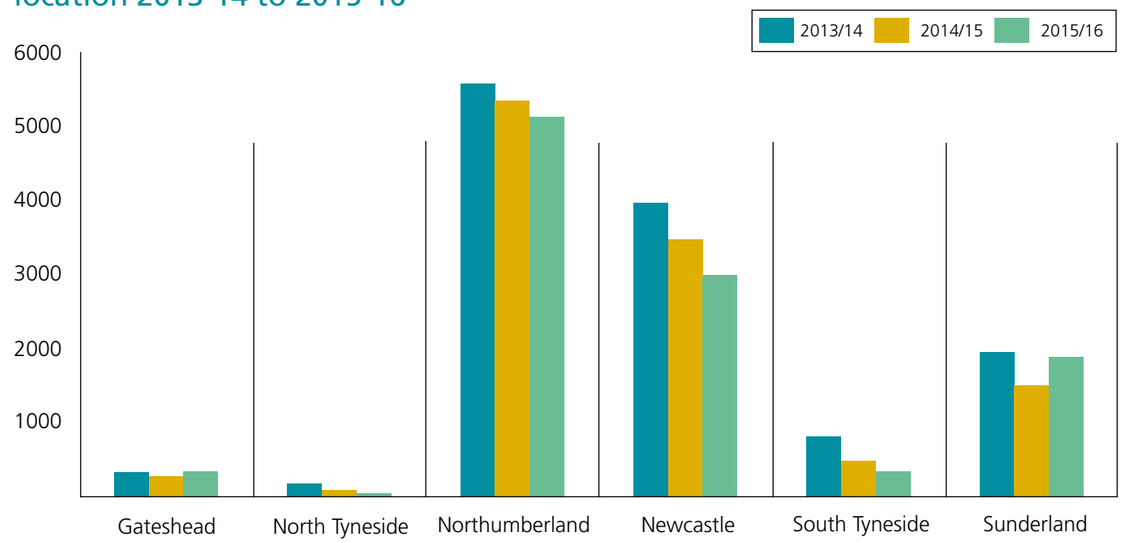
(NB Annual totals for previous years may differ from previously reported data due to on-going data quality improvement work and to reflect coroner's conclusions when known. Data is as at 5/4/16).

As demonstrated in Table 3, opposite during 2015-16, both the total numbers and the proportion of "major" and "catastrophic harm" patient safety incidents continue to reduce from previous years while the number and proportion of "no harm" incidents have increased. The work we have done in relation to the Quality Priorities, combined with enhancements in recording and categorisation of patient safety incidents have contributed to the reduction in severity of incidents reported.

Patient Safety Incidents by locality

Figure 6 below shows patient safety incidents which have been reported over the past 2 years by location of the incident (i.e. where the incident took place):

Figure 6: Patient Incidents by location 2013-14 to 2015-16



Services based in Newcastle and Northumberland continue to report more patient safety incidents than others areas, which reflects the volume and types of inpatient services located in those areas – for example, these areas include a number of specialist inpatient services supporting service users with complex needs, often resulting in higher numbers of incidents reported. Table 4 below shows patient safety incidents by both location and the severity of harm caused. The information shows patient safety incidents which happen in community based services and those which happened in inpatient units.

Table 4: Number of Patient Safety Incidents in Community and Inpatient Services 2013-14 to 2015-16

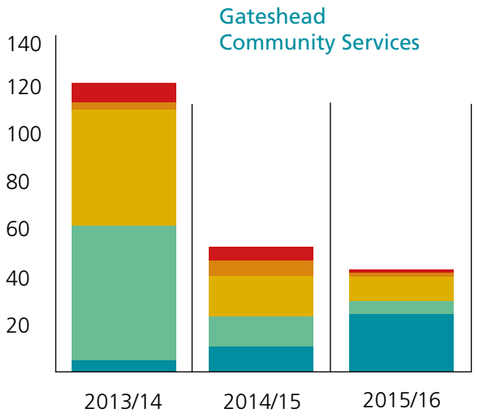
Patient Safety Incidents reported:	2013-14	2014-15	2015-16
Community Services	844	818	887
Inpatient Services	11,881	10,249	9,888
Total patient safety incidents	12,725	11,067	10,775

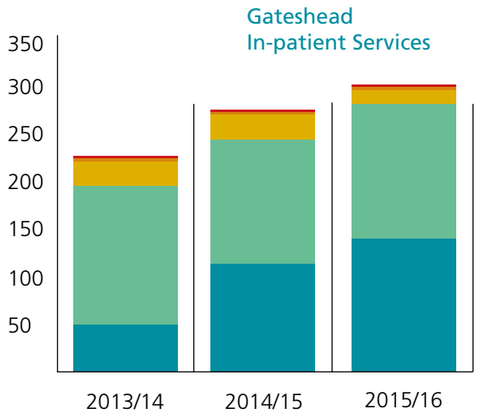
(Data is as at 5/4/16)

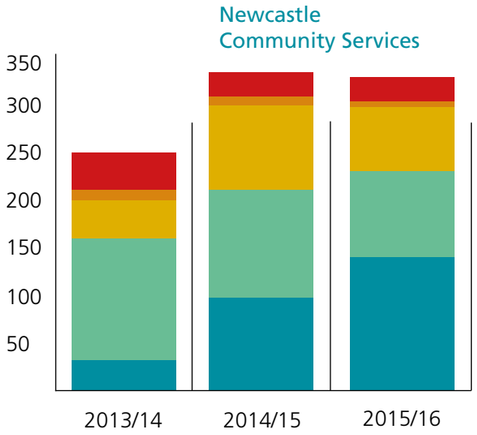
Patient Safety Incidents by Location and Level of Harm

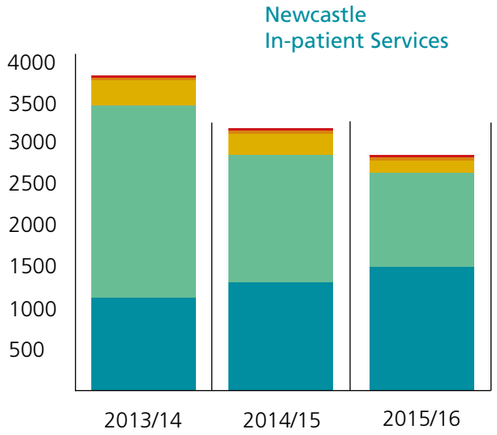
Figure 7 shows patient safety incidents by location and level of harm.

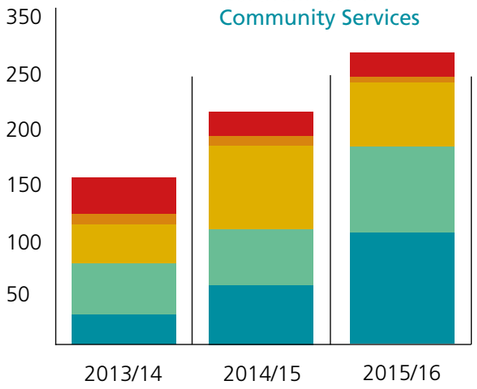
Figure 7: Patient Safety Incidents by Location and Level of Harm

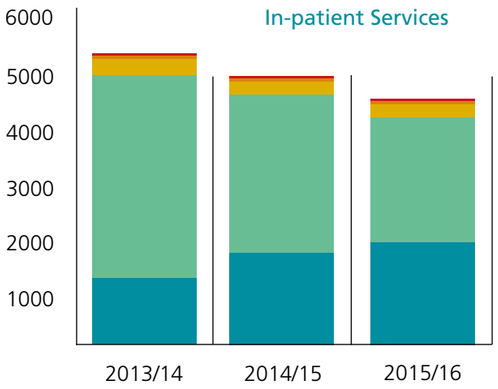


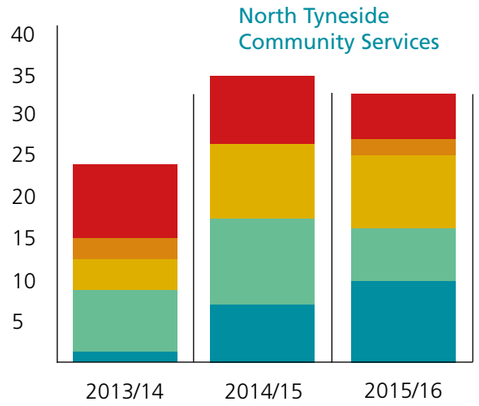


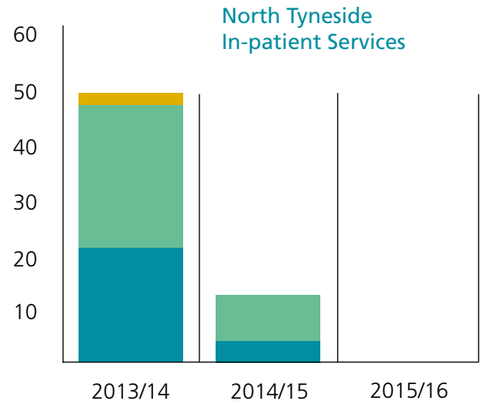


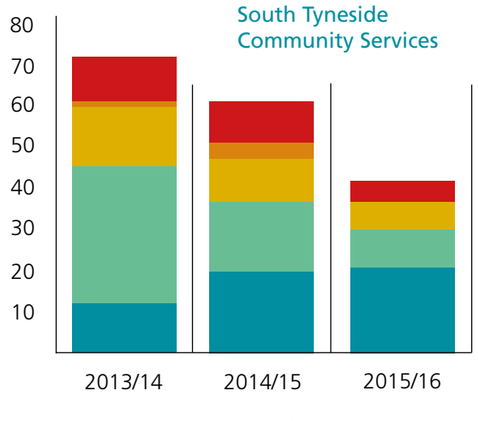


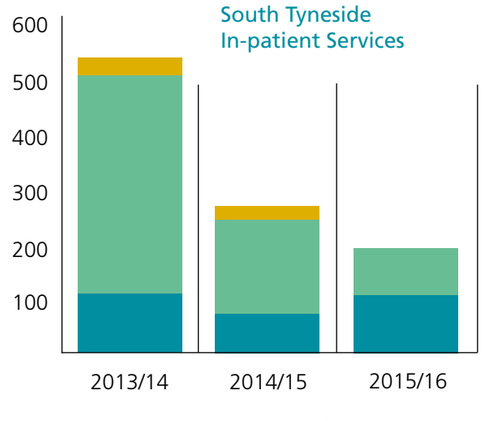


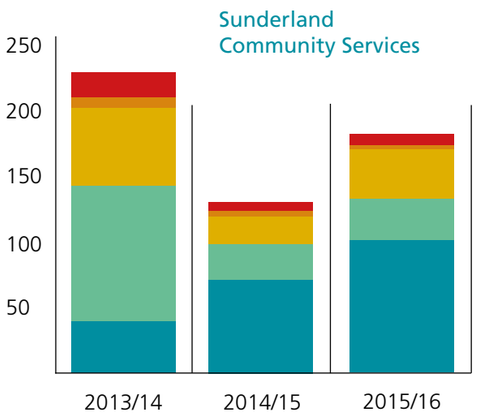


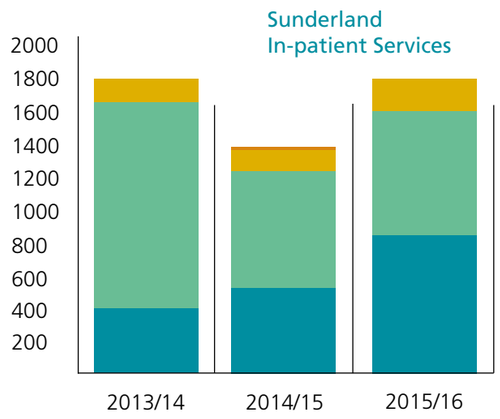












Patient Safety Incident Category	
	Catastrophic, Death
	Major, permanent harm
	Moderate, semi-permanent harm
	Minor, non-permanent harm
	No harm

NB The numbers shown relate to where the services are located. For example, Trust sites in Newcastle and Northumberland include a number of specialist inpatient services treating service users with complex needs, often resulting in higher numbers of incidents reported.

Note that the vertical scales on each graph differ to reflect variation by location.

National benchmarking information on our serious incident reporting (during 2013-14 to 2015-16) can be found on page 59 of this report.

For further updates on patient safety incident information please access the Trust Board patient safety reports – these are published quarterly and can be found at www.ntw.nhs.uk/section.php?l=2&p=26.

News from 2015-16

NHS providers have been publically ranked on their openness and transparency under a new 'Learning from Mistakes League' launched by Monitor and the NHS Trust Development Authority in March 2016. Data for 2015-16, drawn from the 2015 NHS staff survey and from the National Reporting and Learning System, ranked Northumberland, Tyne and Wear NHS Foundation Trust as "Good".
The league table scores providers on the fairness and effectiveness of procedures for reporting errors, near misses and incidents; staff confidence and security in reporting unsafe clinical practice and the percentage of staff who feel able to contribute towards improvements at their trust.

Positive & Safe Strategy – Reduction in Restrictive Practices

Northumberland, Tyne and Wear NHS Foundation Trust are implementing a 'Positive and Safe Strategy' to reduce the use of restrictive practices in response to managing challenging behaviour, aggression and violence. Increasing our understanding of the causes of violence and aggression and training staff appropriately will help us to provide services that are safe for our service users and staff. We have a duty to minimise the use of all forms of restraint and where certain circumstances merit the need for physical restraint to be used (in order to prevent a greater harm from occurring) it is vital that staff are fully aware of the risks involved.

It should be noted that clinical environments play a significant part in reducing aggression and violence and appropriate clinical environments can reduce both restraints and seclusions. NTW have made significant investment in high quality, state of the art clinical facilities across inpatient areas, with many developments winning awards and receiving very positive feedback from service users, staff and carers. They have proven to be effective in improving service user and staff experience and have reduced levels of restraint as a result. Our overall aim is to minimise the use of all restrictive interventions and promote collaborative working to ensure our service users are cared for in environments that are safe and focus on evidence based therapeutic intervention and recovery.

Openness and Honesty when things go wrong: the Professional Duty of Candour

All healthcare professionals have a duty of candour which is a professional responsibility to be honest with service users and their advocates, carers and families when things go wrong. The key features of this responsibility are that:

Every healthcare professional must be open and honest with service users when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that healthcare professionals must:

- Tell the service user (or, where appropriate, the service user's advocate, carer or family) when something has gone wrong.
- Apologise to the service user. Offer an appropriate remedy or support to put matters right (if possible).
- Explain fully to the service user the short and long term effects of what has happened.

A key requirement is for individuals and organisations to learn from events and implement change to improve the safety and quality of service user care. We have implemented the Duty of Candour, developed a process to allow thematic analysis of reported cases, raised awareness of the duty at all levels of the organisation and we are also reviewing how we can improve the way we learn and ensure that teams and individuals have the tools and opportunities to reflect on incidents and share learning with colleagues. Healthcare professionals must also be open and honest and take part in reviews and investigations when requested. All staff are aware that they should report incidents or raise concerns promptly, that they must support and encourage each other to be open and honest, and not stop anyone from raising concerns.

Sign up to Safety

Northumberland, Tyne and Wear NHS Foundation Trust participates in the Sign up to Safety campaign. This is a national patient safety campaign launched in 2014 to strengthen patient safety and make it the safest healthcare system in the world, aiming to halve avoidable harm across all areas of the NHS and saving 6,000 lives as a result. The Trust aims to listen to service users, carers and staff, learn from what they say when things go wrong and take action to improve safety helping to ensure service users receive harm free care every time, everywhere.

The five national Sign up to Safety pledges

1. **Putting safety first**. Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans.
2. **Continually learn.** Make our organisation more resilient to risks, by acting on the feedback from service users and staff and by constantly measuring and monitoring how safe our services are.
3. **Being honest.** Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with service users and their families if something goes wrong.
4. **Collaborating.** Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.
5. **Being supportive.** Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress.

During 2015-16, there were three components to NTW's Sign up to Safety Improvement programme:

1.	Reduction in avoidable harm from falls within in-patient wards
2.	Improvement of physical health care and outcomes.
3.	Safer Care and Violence Reduction

In 2016-17 the focus of the programme will be exclusively on Safer Carer and Violence reduction via the implementation of the Positive & Safe Strategy. Progress towards the Inpatient Falls and Physical Health Campaigns will also continue to be monitored via the Trust wide Physical Health Group.

News from 2015-16
Freedom to Speak Up Guardian

In June 2014, the Secretary of State for Health commissioned Sir Robert Francis QC to carry out an independent review into the culture within the NHS for employees wanting to raise concerns about safety, quality and the effectiveness of the service. A key recommendation of the resulting report, 'Freedom to Speak Up', was the appointment of a National Guardian to provide national leadership and drive the creation of an environment in which all NHS staff are able to speak up safely. The National Guardian's Office will be sponsored by Care Quality Commission, NHS England and NHS Improvement but will set its own priorities, have its own budget and speak independently. The national post is currently vacant.

The report also called for the appointment of a Freedom to Speak Up Guardian in every NHS Trust to give independent support and advice to staff who want to raise concerns and to hold the board to account if they fail to focus on patient safety. NTW was one of the earliest Trusts to embrace the role of Trust Freedom To Speak Up Guardian and appointed Neil Cockling into this role in December 2015. Neil reports directly to the Chief Executive and it is his role to help the Trust ensure the culture is such that all staff know it is part of their responsibility to speak up when things go wrong and they feel safe to do so. His job is not to investigate concerns raised, but to make sure that concerns are investigated and appropriate staff support mechanisms are in place. Neil's skills and experience make him ideal for this role - as an experienced chaplain familiar with the Trust, Neil has well-honed listening skills and experience of working with staff, service users and carers. He will not be alone in his role as Guardian as he is developing a network of trained Freedom to Speak Up Champions across the whole of NTW.

As part of our commitment to this important work we have agreed to publish information in the Quality Accounts of concerns raised. In 2015/16 three formal whistle-blowing concerns were raised and a further 10 cases which do not meet the Disclosure Act's definition of whistle-blowing were investigated as a concern. Due to the small numbers of concerns raised it is too early to do a thematic analysis on these concerns but this work will continue during 2016-17 and reports will be produced for the Workforce Group on a quarterly basis.

Quality Goal 2

Patient Experience: Improve the way we relate to patients and carers

We will demonstrate success by improving the overall score achieved in the patient survey and by reducing the number of complaints received.

2015-16 Quality Priority: Greater choice, quality of food and timing of meals to inpatient areas

Target We aimed to roll out across our inpatient services our meal ordering system, introduce nutritionally adequate menu options, update the pictorial menus and advise Trust café's and shops on appropriate portion sizes and nutritional information.

✓ Met

Progress Whilst we have met our target the Trust will continue to aim for continuous improvement of food and nutrition issues, ensuring that feedback from service users is reviewed and acted upon. This work will be monitored through the Trust wide Food and Nutrition Group.

2015-16 Quality Priority: To improve the referral process and the waiting times for referrals for multi-disciplinary teams

Northern Region Gender Dysphoria Service

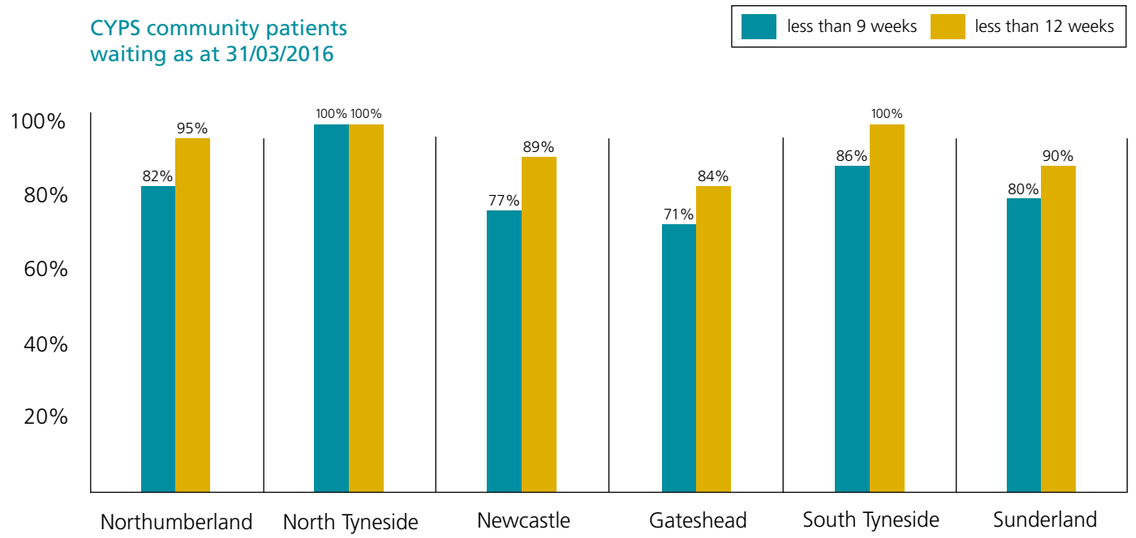
The Northern Region Gender Dysphoria Service provides a specialist assessment and treatment service for people who experience persistent confusion and / or discomfort with their gender. This includes people who want to change physical aspects of their gender as well as those who do not.

Target To meet waiting times targets for Children's and Young Peoples' services, reduce waiting times for the Gender Dysphoria service and ensure that 100% of service users in all other services will wait no longer than 18 weeks for their first contact with a service by March 2016.

– Partially Met

Progress The Children's and Young Peoples' Community Services had locality specific CQUIN targets in relation to access to treatment. These targets were aimed at reducing overall the length of time children and young people were waiting for a service with those waiting the longest being seen first whilst continuing to provide timely access to anyone who presented with urgent needs. Continuous improvement was expected to be demonstrated each quarter and this has been achieved. Alongside this all areas also saw in treatment all of their longest waits (throughput cases) in the timeframe specified. Each Clinical Commissioning Group area achieved their nine weeks % target from referral to treatment and the % target of 12 weeks was achieved in Northumberland and South Tyneside. The table below demonstrates the % of children and young people waiting less than 9 and 12 weeks to enter treatment as on the 31/03/2016.

Figure 8: Percentage of children and young people waiting less than 9 and 12 weeks to enter treatment as on the 31/03/2016



The Gender Dysphoria service is subject to specific development needs in line with similar services nationally during 2016-17. Additional investment was provided by commissioners in 2014 to increase the capacity of the team, with the expectation that waiting times would reduce to less than 18 weeks by the end of Quarter 2 2016-17. A recruitment strategy and service model redesign was implemented during 2015-16, however difficulties in recruiting highly specialist staff into the service along with continuing increase in demand has resulted in continued long waits to access the service. Some improvement has been noted in the overall waiting time across the year however the total waiting has increased. It is anticipated that the waiting times will further decrease in 2016-17 as the newly recruited staff become embedded into the team and further work on streamlining the care pathway is completed.

Adult Autism Spectrum Disorders Diagnostic Service & Adult Attention Deficit Hyperactivity Disorder Service: In 2015-16 commissioners invested in the further development of this element of service provision moving it from a pilot to a fully commissioned service in order to support the increasing demand for assessment and for treatment for Attention Deficit Hyperactivity Disorder. The service is being developed in two phases with Phase 1 being to set up the care pathways and to recruit a staff team with the clinical knowledge to meet the demand and to reduce the waiting time to access both pathways. It is intended that this service will meet the18 week maximum waiting time for first contact by September 2016. Once this has been achieved Phase 2 is to transition the service into mainstream adult community services to support the sustainability of this element of provision. The graphs below indicate the % of patient waiting less than 18 weeks for first contact as at 31/03/2016.

Figure 9: Percentage of patient waiting less than 18 weeks for first contact as at 31/03/2016 for Adult Autism Spectrum Diagnosis Service

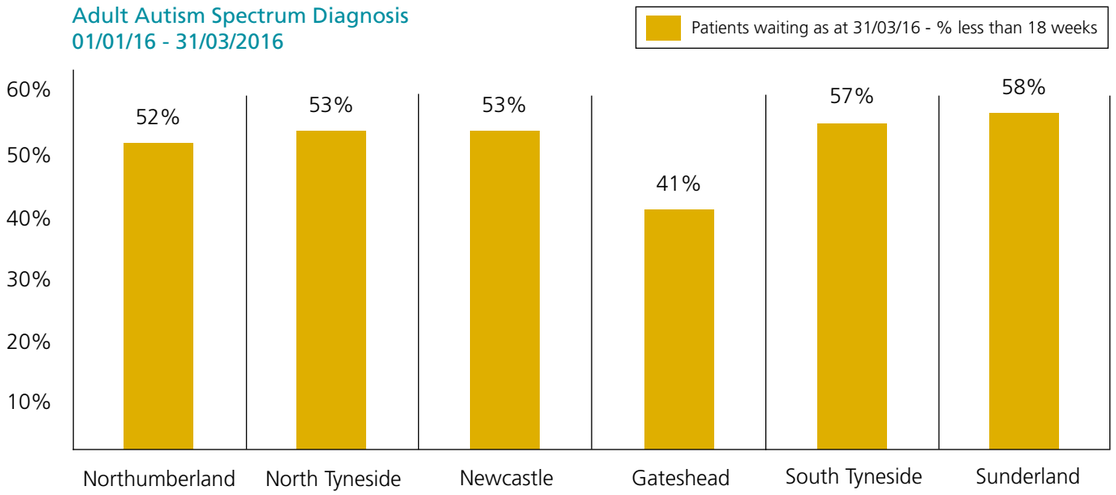
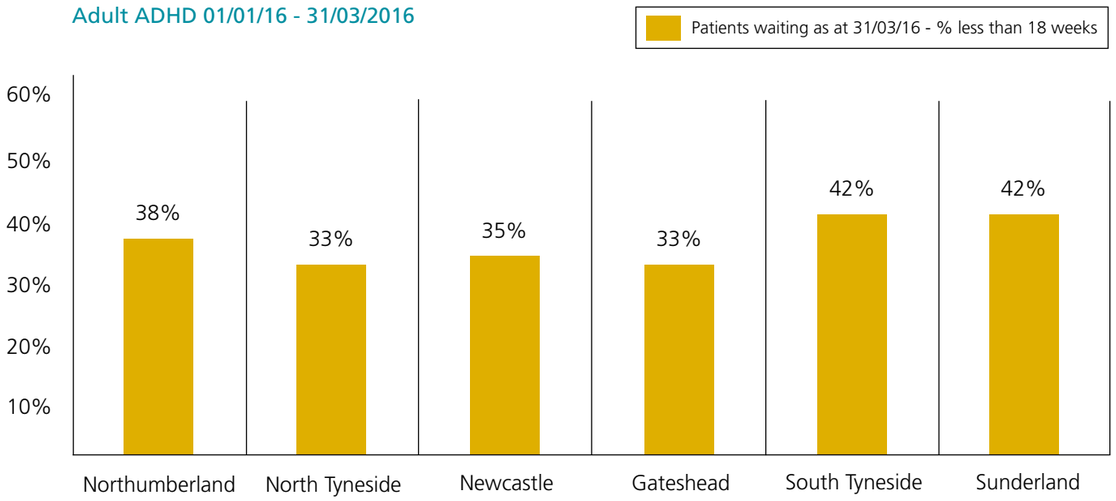


Figure 10: Percentage of patient waiting less than 18 weeks for first contact as at 31/03/2016 for Adult Attention Deficit Hyperactivity Disorder Service



All other services: on 31st March 2016, 99.5% of service users on a waiting list for all other multi-disciplinary teams had waited less than 18 weeks.

What is a multi-disciplinary team?

A multi-disciplinary team is composed of staff members from different healthcare professions with specialised skills and expertise. The members collaborate together to make treatment recommendations to ensure improved patient care.

2015-16 Quality Priority: To improve communication to, and involvement of carers and families (focus on young carers)

Target To map the current provision of support for young carers, developing plans to address any gaps identified and provide guidance to Trust staff to help them identify, support and work with young carers.

Met

Progress The focus on issues affecting carers will continue during 2016-17 with a Quality Priority to develop the use of the Triangle of Care across the organisation (see page 16).

"Consistently happy with the care and the support and communication provided to my daughter and I over the last 9 months." (Fraser House)

"Everything that was explained to me, that they were just a phone call away if I was experiencing some difficulty and I am very appreciative of all their help. Thank you."

(Sunderland CRHT)

How have the Quality Priorities in 2015-16 helped support this Quality Goal?

We aim to continue to ensure that service users and carers have a positive experience of care and treatment when accessing our services and we use national surveys to find out about people's experiences of the Trusts services. The annual CQC Community Mental Health Patient Survey was completed in 2015 by 227 community service users (27% of those asked). There are 10 sections of the Survey and the table below reports the NTW patient response score per section of the survey, along with the 2014 NTW score and a comparison with other Mental Health Trusts. (NB scores are out of 10).

Table 5: National Mental Health Community Patient Survey Results for 2014 and 2015

Survey Section	2015 NTW Score	2015 NTW Lowest - Highest Score	2015 Position relative to other Mental Health Trusts	2014 NTW Score
1.Health or Social Care Workers	7.6	6.8 – 8.2	About the Same	8.1
2. Organising your Care	8.7	7.9 – 9.1	About the Same	8.9
3. Planning your Care	7.3	6.1 – 7.6	Best Performing Trust	7.5
4. Reviewing your Care	7.5	6.8 – 8.2	About the Same	8.0
5. Changes in who you see	6.3	4.7 – 7.5	About the Same	7.0
6. Crisis Care	6.5	5.1 – 7.2	About the Same	6.9
7. Treatments	7.3	6.3 – 7.9	About the Same	7.4
8. Other Areas of Life	5.2	3.9 – 5.8	About the Same	5.2
9. Overall View of Care and Services	7.3	6.4 – 7.7	About the Same	7.5
10. Overall Experience	7.0			7.2

The Trust emerged as a 'best performing trust', in comparison to other providers in one section of the survey – Section 3: Planning your Care. Our services did not receive any scores where performance was judged to be lower than the majority of other providers.

Comparison to previous year's scores:

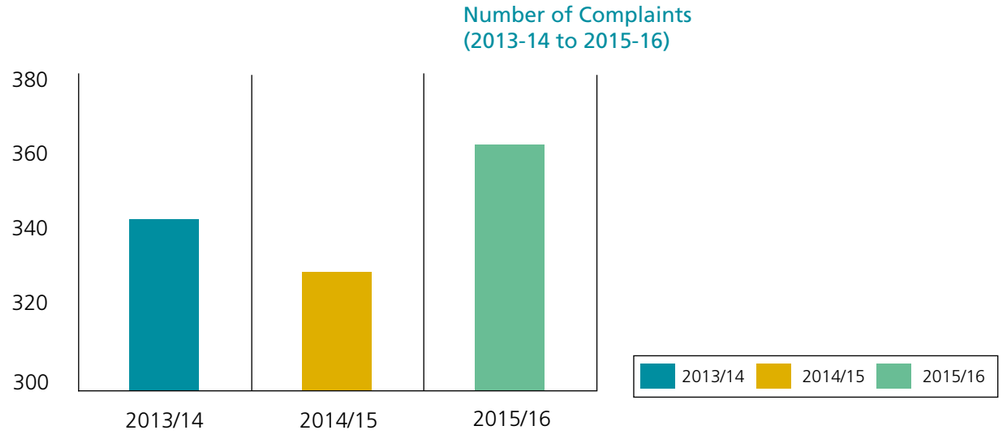
Previous surveys of community mental health services were carried out between 2004 and 2014 (with the exception of 2009). The questionnaire for the 2014 survey was substantially redeveloped and updated in order to reflect changes in policy, best practice and patterns of service, therefore the detailed results from the 2014 and 2015 surveys are not comparable with the results from previous national community mental health surveys. When compared with the 2014 survey, 2015 scores have deteriorated in nine out of ten sections of the survey and remained static in one section (Section 8 – Other Areas of Life). Analysis of published data shows that patient experience of community mental health service also decreased nationally between 2014 and 2015.

Complaints

NTW welcomes the valuable information gathered through our complaints process as this is used to inform our service improvements and ensure we provide the best possible care to our patients and carers.

Complaints have increased during 2015-16 with a total of 362 received during the year. This is an increase of 32 complaints (or 10%) from 2014-15 and we are looking at the information to understand the underlying cause of this increase.

Figure 11: Number of complaints received 2013-14 to 2015-16



Complaints received 2015-16 (using new nationally defined categories)

Table 6: 2015-16 Number of complaints received by the new national categories types

Complaint Category Type	2015-16	Trust Admin/Policies/Procedures	11
Patient Care	76	Waiting Times	10
Communications	72	Access to Treatment or Drugs	9
Values and Behaviours	58	Privacy, Dignity and Wellbeing	9
Admissions and Discharges	24	Restraint	9
Prescribing	24	Facilities	6
Appointments	22	Consent	1
Clinical Treatment	15	Integrated Care	1
Other	15	**Total Complaints**	**362**

Outcomes of complaints

Within the Trust there is continuing reflection on the complaints we receive, not just on the subject of the complaint but also on the complaint outcome. Table 7 indicates the numbers of complaints and the associated outcomes for the 3 year reporting period:

Table 7: Number (%) of complaints and outcomes 2013-14 to 2015-16

Complaint Outcome	2013-14	2014-15	2015-16
Closed – Not Upheld	90 (26%)	88 (27%)	91 (25%)
Closed – Partially Upheld	109 (32%)	99 (30%)	89 (25%)
Closed – Upheld	95 (28%)	75 (23%)	76 (21%)
Complaint withdrawn	34 (10%)	47 (14%)	29 (8%)
Decision not to investigate	2 (1%)	1 (0%)	3 (1%)
Still awaiting completion	0 (0%)	0 (0%)	51 (14%)
Unable to investigate*	15 (4%)	20 (6%)	23 (6%)
Total	**345**	**330**	**362**

*category relates to complaints received which are not about our services, or the Trust was unable to contact the complainant. Data is as at 22/4/16).

Complaints referred to the Parliamentary and Health Service Ombudsman

If a complainant is dissatisfied with the outcome of a complaint investigation they are given the option to contact the Trust again to explore issues further. However if they choose not to do so, or remain unhappy with responses provided, they are able to refer their complaint to the Parliamentary and Health Service Ombudsman (PHSO).

The role of the PHSO is to investigate complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England.

There were 10 NTW complaints referred to the PHSO during 2015-16.

The following table provides the PHSO outcome for those that were completed at the time of writing this report. The Trust has been fully compliant with the timescales for response to PHSO requests and the results demonstrate an improvement on 2014-15, with a reduction to zero of PHSO complaints upheld or partially upheld.

Table 8: Outcome of complaints considered by the Parliamentary and Health Service Ombudsman

Closed - Upheld	0
Closed - Partially Upheld	0
Closed - Not Upheld	6
Decision Not To Investigate	1
Still Awaiting Completion	3

NB as at 31/03/16 there were 3 cases still ongoing, including two from previous years.

News from 2015-16
Time to Change

Staff at one of the UK's largest mental health and disability NHS Trusts have publicly pledged to end mental health stigma.

John Lawlor, Chief Executive at Northumberland, Tyne and Wear NHS Foundation Trust (NTW) signed the 'Time to Change' Employer Pledge on Wednesday 14 January 2016 and in doing so joined over 300 employers in England who are working to tackle mental health stigma and to help keep their staff well for work.

Time to Change is a national mental health campaign, launched in 2009 by mental health charities MIND and Rethink with the objective of reducing health related stigma and discrimination.

The Time to Change Employer pledge is an aspirational statement with indicates to employees, service users and the public that an organisation wants to take action to tackle the stigma and discrimination around mental health, focussing on the workplace in particular.

John Lawlor, Chief Executive said: "Here at NTW we have made a commitment to actively ending mental health stigma. Mental ill health is common with one in four of us experiencing a mental health problem at some point in our lives. The social stigma attached to mental ill health and the discrimination people experience can make life more difficult. There are small things that each of us can do every day to challenge stigma and I feel privileged to publicly sign the pledge."

The pledge was signed in front of members of staff at NTW, as well as representatives from the mental health charity, Rethink. Staff from the Trust, Time to Change and a staff member gave presentations and spoke about their own personal stories and their hopes and aspirations for the future.

The Time to Change Employer Pledge is backed by an action plan which sets out exactly how we will deliver and demonstrate our commitment to tackle mental health stigma. For more information see www.time-to-change-org.uk

Friends and Family Test – Service Users

The NHS Service User Friends and Family Test was implemented nationally in January 2015 and has become an important part of the Trust's patient experience feedback programme. The Service User Friend and Family Test enables service users to have the opportunity to give feedback at any point in time. It is a single question survey that asks service users the following question:

"How likely are you to recommend our service to friends and family if they needed similar care or treatment?"

Scores range from extremely likely (positive response) to extremely unlikely (negative response).
The Friends and Family Test has increasingly become embedded into practice. During 2015-16, 2,001 Friends and Family Test responses were received.

Figure 12: Percentage of respondents who would/not recommend the service they received to their friends and family

81% of respondents indicated they would recommend the service they received to their friends and family (rating of extremely likely or likely); whereas 4% indicated that they would not (ratings of extremely unlikely or unlikely).

Many other patient feedback measures are in use across the organisation such as "Points of You", "How's It Going" (often used in learning disability services) and "Experience of Service Questionnaire" (ESQ - used in community Children and Young People's Services).

The Trust regularly considers themes arising from all service user feedback mechanisms, including compliments, thank you letters and comments made on websites such as NHS Choices and Patient Opinion.

Example comments received during 2015-16:

"After being discharged from hospital too early, my GP referred myself to the crisis team. Within less than half an hour they were on the phone offering to come out and assess me. They were a great support to my family who were also at the end of their tether. I will always be grateful for their help."

"I went into Hopewood Park at a very dark time of my life, but during my 11 day stay I was kept both safe and helped to feel that there was still hope. Overall they were great and you can't really get a better accolade than someone saying you saved my life".

"I was admitted on a voluntary basis for treatment. I have to say that without exception all the staff were very professional and helpful. The medical help I received is helping me a great deal and I now feel much more confident about my future."

News from 2015-16
Recovery College launched for Northumberland

People living in Northumberland can now access more help and information following the launch of a new service by the region's mental health and disability care provider.

Positive Pathways Northumberland is a recovery college which will deliver innovative free courses to help people experiencing mental health problems, and is being run by Northumberland, Tyne and Wear NHS Foundation Trust (NTW).

NTW Senior Occupational Therapist Lynsey Martin said: "Living with or caring for someone with a mental health condition can be extremely challenging so this new recovery college for Northumberland will give people a safe place to learn, connect with other people and develop skills.

"Everyone needs to feel supported and understood so our free courses have been developed and will be facilitated by a mix of people with lived experiences and those who are interested in recovery.

"We want all our students to feel empowered to understand and manage their condition and find a course which can help with their recovery pathway; from mental illness, substance misuse, trauma or distress."

Positive Pathways Northumberland has been supported by voluntary groups, charities and clinical commissioning groups.

There are already two NTW Recovery Colleges across the North East, in Sunderland and one in Newcastle, which offer a safe and supportive environment for those with mental health issues and their carers.

You can download the Northumberland prospectus and find out more about the new recovery college here or email ppn@ntw.nhs.uk.

Quality Goal 3

Clinical Effectiveness: Ensure the right services are in the right place at the right time for the right person

Underpinned by the organisation's approach to delivering the Clinical Effectiveness Strategy, we will demonstrate success by delivering demonstrable improvements in service delivery.

2015-16 Quality Priority: To continue to embed the Recovery Model

What is the Recovery Model (ImROC)?

The Implementing Recovery through Organisational Change (ImROC) programme is a new approach to helping people with mental health problems. In mental health, 'recovery' means the process through which people find ways to live meaningful lives, with or without the on-going symptoms of their condition.

Target To introduce Peer Support Workers into all localities, ensuring an appropriate recruitment and induction process, develop the ImROC strategy and continue to progress Recovery Colleges.

Met

Progress The specific aims of the above Quality Priority have been achieved and whilst this will no longer be a Quality Priority into 2016-17, work will continue in this important work and will be overseen by the Clinical Groups.

2015-16 Quality Priority: To ensure comprehensive diagnosis information is available in relation to community service users

Target To increase recording of ICD10 diagnosis codes in community Early Intervention in Psychosis, Older People's and Memory Protection teams to 30% by Quarter four 2015-16.

Met

Progress The specific aim of this Quality Priority has been met, however this important work will continue and will be monitored in 2016-17 as part of the Trust's Data Quality Improvement Plan.

2015-16 Quality Priority: To improve the recording and use of outcome measures by improving suppression rates of patient rated outcome measures (PROM)

What is our Patient Rated Outcome Measurement (PROM)?

The Trust uses the Short Warwick and Edinburgh Mental wellbeing Scale (SWEMWBS) to provide service users with an opportunity to feedback their views on their clinical outcomes.

Target To increase the rates of SWEMWBS forms being sent to service users to 45% by quarter four.

Met

Progress The specific aim of this Quality Priority has been met. This overall priority to improve the recording and use of outcome measures will continue during 2016-17 and will focus more broadly on embedding a culture of valuing outcome measures while also trialling different approaches in specific teams, aligning with a CQUIN indicator supported by local Clinical Commissioning Groups.

How have the 2015-16 Quality Priorities helped support this Quality Goal?

Service Improvement and Developments throughout 2015-16

These are some of the key service improvements and developments that the Trust has made during 2015-16:

Community Transformation Programme

The Community Transformation Programme aims to deliver new community evidence based care pathways with improved access to services, improved quality outcomes and improved experience for service users and carers. The programme is focusing on the redesign of Psychosis; Non-psychosis; Cognitive Disorders and Learning Disability services.

The programme started in 2013-14 in Sunderland and South Tyneside, testing interventions focused on recovery and effective support for people to live and work in their own communities with the aim of reducing reliance on hospital beds. During 2014-15 the Trust commenced the roll out of the redesigned Community Pathways across Sunderland and South Tyneside and this work continued through 2015-16, while engagement on the principles and design of improved community pathways in north of Tyne resulted in the launch of the Northumberland Initial Response Team in December 2015. This 24/7 service, based at St. George's Park, provides a single point of access for urgent requests including signposting to relevant services within and outside the organisation. New Community Pathways are to be fully introduced into Northumberland, North Tyneside, Newcastle and Gateshead during 2016-17.

Last year also saw the introduction of Street Triage Teams both North and South of Tyne, with the police and mental health nurses jointly dealing with incidents involving people experiencing a mental health crisis. This ensures the best and most appropriate care at that time, resulting in a reduction in individuals detained by the police.

Developing New Models for Inpatient Care Programme

Since 2013, the Trust, in collaboration with partners, has considered a range of options to determine the most appropriate future configuration of services and hospital sites for people with serious mental health conditions in the light of the roll out of the improved Community Pathways and the anticipated reduction in demand for inpatient services, ensuring that services remain clinically appropriate, safe and affordable.

This work led to the agreed closure of the Bede Unit in South Tyneside. In Newcastle and Gateshead, partners have together looked carefully at the services for people living in Newcastle and Gateshead. Newcastle and Gateshead CCG led a listening and engagement process from November 2014 to February 2015 called "Deciding Together" with the aim of collecting views and experiences about specialist mental health services. The feedback from this process informed the development of scenarios for change which were the subject to a formal consultation during 2015-16. The public consultation has sought views on three possible locations for adult acute assessment and treatment and rehabilitation services and two possible locations for older people's services.

A full Case for Change document is scheduled to be completed in May 2016, reflecting on the outcome of the public consultation. Alongside the CCG we will begin to plan the implementation of the agreed changes during 2016-17.

Specialist Care Services Programme

The Specialist Care Services Programme is responsible for ensuring the Trust continues to provide sustainable specialist services.

Significant progress in this programme of work has been achieved during 2015-16, including:

- Development of the Mitford Unit at Northgate Hospital commenced and is due to be completed mid-2016. This new autism assessment and treatment facility will meet the very specific needs of service users with highly complex needs.
- Ongoing review of both Neurological Services and Secure Services long term sustainability.
- With the support of commissioners, the development of an integrated Attention Deficit Hyperactivity Disorder service providing a service across children and young people's services into adult services.

Social and Residential Services

During 2015-16 the Trust continued to review Northumberland Mental Health Day Services in partnership with stakeholders, and agreed a redesign of services strategy. It has been agreed that the Trust will provide health focused activities, integrated into the overall model of the Community Mental Health team, enabling service users access to a wide range of recovery focused and evidenced based interventions around psycho-education, self-management and physical wellbeing services.

Learning Disability Services

The Trust provides a wide range of services for people with learning disabilities and/or autism spectrum disorder including those with a mental illness and whose behaviour challenges services, including community services, inpatient assessment and treatment services and secure services.

"Transforming Care for People with Learning Disabilities – Next Steps (2015)" reaffirmed the Government's and leading organisations across health and social care commitment to transforming care for people with learning disabilities and / or autism spectrum disorder who have a mental health condition or whose behaviour challenges services. In 2015 NHS England publicly committed to a programme of closing inappropriate and outmoded inpatient facilities and establishing stronger support in the community. Six "Fast Track" areas were identified and included the North East and Cumbria, working towards reallocating resources from inpatient services into new community services and reducing usage of inpatient provision by approximately 50% over the coming three years. A highly skilled, confident and value driven community workforce delivering early intervention and effective crisis support will support the closure of some assessment and treatment beds and secure beds provided by the Trust.

The development of integrated and "place based services"

The Trust's Strategic 5 Year Plan 2014-19 supported the development of integrated services designed around the needs of the population, replacing any remaining institutional based models of care. Overall progress across the Trust's six localities during 2015-16 has been positive with differing approaches and priorities and we are fully committed to working with partners to develop integrated models of care, designed around the needs of local populations delivering significant benefits in aligning the approach to physical and mental health long term conditions, and in aligning delivery of support and care across health and social services.

New Services

During 2015-16 the Trust successfully tendered for a number of new services and service improvements, including:

- The implementation of evidenced based IAPT interventions in Children and Young People's services in Northumberland and North Tyneside in partnership with Northumbria Healthcare NHS Foundation Trust.
- Sunderland Integrated Substance Misuse and Harm Reduction Service in partnership with DISC and Changing Lives, to commence on the 1st July 2016.
- Inclusion on a framework to provide mental health inpatient services to Sussex Clinical Commissioning Groups (CCGs) out of area placements.
- Inclusion on a framework to provide Cognitive Behavioural Therapy for Psychosis training for Early Intervention in Psychosis.

News from 2015-16
New mental health service

A 24hour mental health service is being launched in Northumberland.

A new 24hour urgent mental health service is being launched in Northumberland to help local people access the help they need in times of crisis.

The service is being established by the region's mental health and disability care provider, Northumberland, Tyne and Wear NHS Foundation Trust (NTW), and goes live on Friday 4 December.

The creation of a Northumberland Initial Response Team follows a successful pilot scheme in the Sunderland area which was set up two years ago and now supports more than 10,000 people every month.

NTW Northumberland Initial Response Team Clinical Lead Kate Miller said: "The aim of the service, based at St George's Park in Morpeth, is to provide a single point of access for urgent requests for help to NTW including signposting to relevant services within and outside of the organisation.

"We offer a service to anyone living in Northumberland who feels they need urgent mental health care and we support people to access the right to help to resolve their current difficulties.

"The service is made up of clinical leads, qualified mental health clinicians and experienced support staff.

"We provide practical advice, emotional support from qualified nursing staff and when appropriate, routing to the right service. The team recognise that some people need to be seen quickly and in these cases we will aim to see the person within a few hours."

The new urgent mental health care and treatment service is staffed 24 hours a day, seven days a week, and can be reached on 0303 123 1146.

Partnerships

The Trust continues to work in partnership with NHS organisations, the community, voluntary and independent sectors and this partnership work is highly valued.

NTW Clinical Effectiveness Strategy

The Trust's Clinical Effectiveness Strategy forms an overarching framework aligning with other relevant strategies and programmes. This collaborative approach will optimise the benefits for all service users by rapidly implementing evidence-based practice and measuring, as well as learning from, the outcomes of the care provided by the Trust. The mission for the Clinical Effectiveness Strategy is for the Trust to provide safer, better quality care that enables service users to live better for longer. The three year strategy is in the context of a ten-year aim to demonstrate a significant measurable improvement in the extent to which service users are living better for longer.

The Trust already has a wide range of policies, processes and programmes that are addressing clinical effectiveness, for example Transformation, Physical Health and Informatics programmes. In 2016-17, NTW will be refreshing the Clinical Effectiveness Strategy implementation plan to ensure delivery of the following objectives:

1. All service users (and carers where relevant) will have the outcomes that are important to them measured, reported and tracked over time;
2. There is evidence that the culture of the organisation is supporting staff in delivering clinically effective care;
3. Routine measurements demonstrate that evidence-based guidelines, including but not limited to NICE quality standards, will inform care that is given to all service users;
4. There is evidence that the infrastructure of the Trust will support staff to deliver clinically effective care;
5. Routine measurements demonstrate that the physical health care needs of our service users are consistently recognised, monitored and managed.

Part 2c

Mandatory Statements relating to the Quality of NHS Services Provided

Review of Services

During 2015-16 the Northumberland, Tyne and Wear NHS Foundation Trust provided and/or sub-contracted 181 NHS Services.

The Northumberland, Tyne and Wear NHS Foundation Trust have reviewed all the data available to them on the quality of care in all 181 of these relevant health services.

The income generated by the relevant health services reviewed in 2015/16 represents 100 per cent of the total income generated from the provision of relevant health services by the Northumberland, Tyne and Wear NHS Foundation Trust for 2015-16.

Participation in clinical audits

During 2015-16, 8 national clinical audits and 1 national confidential enquiries covered relevant health services that Northumberland, Tyne and Wear NHS Foundation Trust provides.

During that period Northumberland, Tyne and Wear NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquires which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Northumberland, Tyne and Wear NHS Foundation Trust was eligible to participate in during 2015-16 are as follows:

Table 9: National Clinical Audits 2015-16 and National Confidential Enquiries 2015-16

National Clinical Audits 2015-16	
1	National Audit of Schizophrenia (Royal College of Psychiatrists)
2	Prescribing for Substance Misuse: Alcohol Detoxification (POMH-UK Topic 14a)
3	Prescribing for People with a Personality Disorder (POMH-UK Topic 12b)
4	Use of Anti-Psychotic Medicine in CAMHS (POMH-UK Topic 10c)
5	Assessment of Side Effects of Depot Anti-Psychotic Medication (POMH-UK Topic 6d)
6	Use of Anti-Psychotic Medication in People with Learning Disabilities (POMH-UK Topic 9c)
7	Prescribing for ADHD in Children, Adolescents and Adults (POMH-UK Topic 13b)
8	Early Intervention in Psychosis Audit
National Confidential Enquiries 2015-16	
1	National Confidential Enquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)

The national clinical audits and national confidential enquiries that Northumberland, Tyne and Wear NHS Foundation Trust participated in, and for which data collection was completed during 2015-16, are shown in Table 13 below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 10: National Clinical Audits 2015-16 and National Confidential Enquiries 2015-16

National Clinical Audits 2015-16	Cases submitted	Cases required	%
National Audit of Schizophrenia (Royal College of Psychiatrists)	89 cases submitted. Trust action plan was submitted in May 2015. Quarterly monitoring is on-going – latest update of action plan is February 2016.	75	100%
Prescribing for Substance Misuse: Alcohol Detoxification (POMH-UK Topic 14a)	21 cases submitted. Trust action Plan reported as complete in July 2015.	No minimum requirement.	-
Prescribing for People with a Personality Disorder (POMH-UK Topic 12b)	50 cases submitted. Trust action plan reported as complete in August 2015.	No minimum requirement.	-
Use of Anti-Psychotic Medicine in CAMHS (POMH-UK Topic 10c)	83 cases submitted. Trust action plan reported as complete in September 2015	No minimum requirement.	-
Assessment of Side Effects of Depot Anti-Psychotic Medication (POMH-UK Topic 6d)	Postponed indefinitely at a National level	n/a	n/a
Use of Anti-Psychotic Medication in People with Learning Disabilities (POMH-UK Topic 9c)	90 cases submitted in 2015. Trust Action Plan reported as complete in February 2016	No minimum requirement.	-
Prescribing for ADHD (POMH-UK Topic 13b)	80 cases submitted. Report complete October 2015 and Trust action plan is due for completion October 2016	No minimum requirement.	-
Early Intervention in Psychosis Audit	48 cases submitted. Data analysis currently underway and proposed completion date is April 2016	No minimum requirement.	-
National Confidential Enquiries 2014/2015	**Cases submitted**	**Cases required**	**%**
National Confidential Enquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)	Reported directly to NCI	n/a	99%

The reports of 6 national clinical audits were reviewed by the provider in 2015-16, and Northumberland, Tyne and Wear NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Table 11: Actions to be taken in response to national clinical audits

Project	Actions
National Audit of Schizophrenia (Royal College of Psychiatrists)	A Trust action plan was developed and is monitored at the Clinical Effectiveness Committee. While the findings for NTW were generally average for the audit, the report authors commented that national performance was generally below what should be provided. Individual team action plans are in place to improve practice in physical health, psychological therapies and prescribing practices.
Prescribing for Substance Misuse: Alcohol Detoxification (POMH-UK Topic 14a)	The Medicines Management Committee developed actions from the audit recommendations: • Development of an evidence-based guideline and approval for use in NTW • Key card developed and circulated to all clinical staff to raise awareness of the guideline • Increase compliance with baseline bloods being taken • POMH-UK will request a re-audit of this topic in 2016
Prescribing for People with a Personality Disorder (POMH-UK Topic 12b)	The Medicines Management Committee developed actions from the audit recommendations: • Share the learning from the audit widely and agree local action plans where appropriate • Review prescribing in community Emerging Unstable Personality Disorder patients
Use of Anti-Psychotic Medicine in CAMHS (POMH-UK Topic 10c)	The Medicines Management Committee developed actions from the audit recommendations: • Ensure medication reviews are undertaken and recorded every 6 months • Standardise where information is recorded on the electronic record • Ensure side effects are assessed and recorded as part of the medication review
Use of Anti-Psychotic Medication in People with Learning Disabilities (POMH-UK Topic 9c)	The Medicines Management Committee developed actions from the audit recommendations: • The actions have been added as a CPA review agenda point • Sharing of physical health monitoring results. • A separate action plan from an audit of NICE NG 11 standards has been used to record indication and review of antipsychotics in line with NICE guidance
Prescribing for ADHD (POMH-UK Topic 13b)	A Trust-level report was provided for this audit and appropriate actions taken from the audit recommendations: • Discuss results with Specialist Care Safe group • Circulate and discuss results with CYPS managers & consultants • Discuss results at CYPS Prescribers • Discuss Results with CYPS ADHD Team Leads and standardise information recording and update clinic Standard Operating procedures.

The reports of 74 local clinical audits were reviewed by the provider in 2015-16 and the details can be found at Appendix 3 of this report.

Research

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Northumberland, Tyne and Wear NHS Foundation Trust in 2015-16 that were recruited during that period to participate in research approved by a research ethics committee was 1226.

Increased participation in clinical research demonstrates Northumberland, Tyne and Wear NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. The Trust was involved in 94 clinical research studies in mental health, learning disability and neuro-rehabilitation related topics during 2015-16, 45 of which were large-scale nationally-funded studies, and was ranked as the second most research active mental health trust in England by The National Institute for Health Research (NIHR).

Staff participation in research increased during 2015-16 with 60 clinical staff participating in ethics committee approved research employed by the Trust. We have continued to work closely with the NIHR Clinical Research Networks North East and North Cumbria Local Clinical Research Network to support national portfolio research and have achieved continued success with applications for large-scale research funding in collaboration with Newcastle and Northumbria Universities.

Goals agreed with commissioners

Use of the Commissioning for Quality & Innovation (CQUIN) framework

The CQUIN framework aims to embed quality improvement and innovation at the heart of service provision and commissioner-provider discussions. It also ensures that local quality improvement priorities are discussed and agreed at board level in all organisations. It enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

A proportion of Northumberland, Tyne and Wear NHS Foundation Trust income in 2015-16 was conditional on achieving quality improvement and innovation goals agreed between Northumberland, Tyne and Wear NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

For 2015-16, £6.4m of Northumberland, Tyne and Wear NHS Foundation Trust's contracted income was conditional on the achievement of these CQUIN indicators (£6.1m in 2014-15).

CQUIN Indicators

At the time of writing this Quality Account the majority of CQUIN indicators were fully achieved, although there are ongoing challenges in relation to some of the physical health requirements and also waiting times for Children and Young People's in some locality areas.

A summary of the agreed CQUIN indicators for 2015-16 and the new indicators for 2016-17 is shown in Tables 12 to 14 below. The tick marks show which financial year the indicator applies to:

Table 12: CQUIN Indicators to improve Safety

CQUIN Indicators to improve Safety	2015-16	2016-17
Collaborative Risk Assessment in Secure Services	✓	
Reducing Restrictive Practices within adult low and medium secure inpatient services		✓
Reducing avoidable repeat detentions under the Mental Health Act		✓

Table 13: CQUIN Indicators to improve Patient Experience

CQUIN Indicators to improve Service User & Carer Experience	2015-16	2016-17
Reduce waiting times for Children and Young Peoples services (CYPS)	✓	
Involvement & engagement with service users and carers: - support for young carers - support for service users & carers accessing crisis services	✓	✓
Perinatal inpatient services involvement and support for partners/ significant others	✓	✓
Liaison Services North Tyneside - Improving diagnoses and re-attendance rates of service users with mental health needs at A&E	✓	
Improving inpatient CAMHS Care Pathway Journeys by enhancing the experience of the family/carer		✓

Table 14: CQUIN Indicators to improve Clinical Effectiveness

CQUIN Indicators to improve Clinical Effectiveness	2015-16	2016-17
To increase the percentage of people with mental health illness who receive appropriate physical health care.	✓	
Mental Health & Deafness recovery and outcomes	✓	✓
Development of Recovery Colleges for adult medium and low secure inpatients		✓
Embedding Clinical Outcomes: - Adult mental health community teams - People with learning disabilities - Community Children and Young Peoples' services		✓ ✓ ✓

Note that the CQUIN indicators are developed in collaboration with NHS England and local Clinical Commissioning Groups (CCG's). The range of CQUIN indicators varies by commissioner, reflecting the differing needs and priorities of different populations.

Statements from the Care Quality Commission (CQC)

Northumberland, Tyne and Wear NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions and therefore licensed to provide services. The Care Quality Commission has not taken enforcement action against Northumberland, Tyne and Wear NHS Foundation Trust during 2015-16. Northumberland, Tyne and Wear NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC registers and licenses Northumberland, Tyne and Wear NHS Foundation Trust as a provider of care services as long as we meet the fundamental standards of quality and safety. The CQC monitors us to make sure that we continue to meet these standards.

CQC Intelligent Monitoring Report

The Intelligent Monitoring Report, published by the Care Quality Commission (CQC) is a useful tool to help us to continually monitor the quality of our services. It allows us to identify any areas of lower than average performance and take action to address them if necessary.

The report gathers together a range of key indicators about the Trust in relation to the CQC's five key questions - is the Trust safe, effective, caring, responsive and well-led. These indicators are used by the CQC to highlight potential risks about the quality of care provided by the Trust.

The most recent Intelligent Monitoring Report was published by the CQC in February 2016 and it identifies the Trust as having an overall risk score of 6 out of a possible maximum score of 142. The report can be found on the CQC website at www.cqc.org.uk/sites/default/files/RX4_103v6_WV.pdf.

CQC Registration Activity 2015-16

In January 2016, the Care Quality Commission undertook a focussed inspection of Stephenson ward at Ferndene and at the time of writing this report, the findings from this inspection had not yet been published.

A comprehensive inspection of services is due to take place in June 2016.

External Accreditations

The Trust has gained national accreditation for the quality of services provided in many wards and teams.

- Nearly 65% of adult and older people's mental health wards have achieved the Accreditation for Inpatient Mental Health Services (AIMS).
- 67% of the adult forensic medium and low secure wards have been accredited by the Quality Network for Forensic Mental Health Services.
- 100% of the children's wards in the Ferndene unit have been accredited by the Quality Network for Inpatient Children and Adolescent Mental Health Services (CAMHS).

Table 15 below provides a breakdown of current clinical accreditations as at March 2016.

Table 15: Current clinical external accreditations (March 2016)

External Accreditation	Ward/Department	Location
Accreditation for Inpatient Mental Health Services (AIMS)	Beckfield (PICU)	Hopewood Park
	Collingwood Court	Campus for Ageing and Vitality
	Embleton	St George's Park
	Fellside Ward	Queen Elizabeth Hospital
	Gainsborough Ward	Campus for Ageing and Vitality
	Lamesley Ward	Queen Elizabeth Hospital
	Lowry Ward	Campus for Ageing and Vitality
	Warkworth Ward	St George's Park
	Rosewood	Hopewood Park
	Longview	Hopewood Park
	Shoredrift	Hopewood Park
	Springrise	Hopewood Park
	Akenside (OP)	Centre for Ageing and Vitality
	Hauxley (OP)	St George's Park
	Castleside Ward (OP)	Campus for Ageing and Vitality
	Cresswell (OP)	St George's Park
	Mowbray Ward (OP)	Monkwearmouth Hospital
	Roker Ward (OP)	Monkwearmouth Hospital
	Bluebell Court (Rehab)	St George's Park
	Clearbrook (Rehab)	Hopewood Park
Quality Network for Forensic Mental Health Services	Bamburgh Clinic	St Nicholas Hospital
	Bede Ward	St Nicholas Hospital
	Kenneth Day Unit	Northgate Hospital
Quality Network for Inpatient CAMHS	Stephenson	Ferndene
	Fraser	Ferndene
	Riding	Ferndene
	Redburn	Ferndene
	Alnwood	St Nicholas Hospital
Quality Network for Community CAMHS	Northumberland CYPS	Villa 9, Northgate Hospital
	Newcastle & Gateshead CYPS	Benton House
	South of Tyne CYPS	Sunderland and South Tyneside
ECT Accreditation Service	Hadrian Clinic	Campus for Ageing and Vitality
	Treatment Centre	St George's Park
Psychiatric Liaison Accreditation Network	Psychiatric Liaison Team Sunderland Royal Hospital	Sunderland
	Northumberland Liaison Psychiatry and Self Harm Team	Northumberland
	Newcastle Integrated Liaison Psychiatric Service, RVI	Newcastle
Memory Service National Accreditation Programme	Newcastle Memory Assessment and Management Service	Newcastle
	Monkwearmouth Memory Protection Services	South Tyneside
Quality Network for Perinatal Mental Health Services	Beadnell Mother and Baby Unit	St George's Park
	Newcastle & North Tyneside Perinatal Community Team	Northumberland (based alongside the inpatient unit)
Home Treatment Accreditation Scheme	Crisis Assessment & Home Based Treatment Service Newcastle	Newcastle

Data Quality

Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made. The Trust has already made extensive improvements in data quality. During 2016-17 the Trust will build upon the actions taken to ensure that we continually improve the quality of information we provide.

Northumberland, Tyne and Wear NHS Foundation Trust will be continuing to take the following actions to improve data quality:

Table 16: Actions to be taken to improve data quality

Clinical Record Keeping	We will continue to provide training in the use of the RIO clinical record system and raise awareness of the linkages to quality dashboards, measuring adherence to the Clinical Records Keeping Guidance, highlighting the impact of good practice on data quality and on quality assurance recording. This work will link clinical record keeping, data quality and quality assurance reporting, highlighting the importance of CPA status recording and supporting the planned upgrade of the RIO clinical record system.
Business Intelligence and NTW Dashboard development	We will continue to further refine the NTW dashboards, providing greater analysis of complex metrics, developing metric definitions and implementing service line reporting. We will implement a new business intelligence system, providing greater availability and transparency of management information to clinical services.
Data Quality Kite Marks	We will develop and implement a policy for measuring the data quality of all reported information using a recognised methodology.
Mental Health Services Dataset (MHSDS)	We will continue to implement this new national dataset, understanding data quality issues and improving the use of national benchmarking data. Improving demographic recording eg NHS number, ethnicity, gender etc. We will continue to use the MHSDS Clinical Reference Group to improve data quality, raise awareness of data quality issues and focus on specific improvements (e.g. enhancing discharge information recording and sharing with GPs).
Consent recording	We will redesign the consent recording process in line with national guidance and increase the recorded consent status rates.
CQC Intelligent Monitoring reports	We will ensure that we have a good understanding of the data used by the CQC in their Mental Health Intelligent Monitoring Reports.
ICD10 Diagnosis Recording	Building upon the 2015-16 quality priority, we will increase the level of ICD10 diagnosis recording across community services.
Mental Health Clustering	We will increase the numbers of clinicians trained in the use of the Mental Health Clustering Tool and improve data quality and data completeness, focusing on issues such as cluster waiting times analysis, casemix analysis, national benchmarking and four factor analysis to support the implementation of outcomes contracting in mental health.
Contract and national information requirements	We will continue to develop quality assurance reporting to commissioners and national bodies in line with their requirements.
Outcome Measures	We will enhance the current analysis of outcome measures in line with the 2016-17 CQUIN requirements, focusing on implementing a system for reporting information back to clinical teams.
Principal Community Pathways	We will further develop the availability of management information for clinicians and benefits realisation analysis.

North East Quality Observatory (NEQOS) Benchmarking of 2014-15 Quality Account Indicators

The North East Quality Observatory System (NEQOS) provides expert clinical quality measurement services to most NHS organisations in the North East.

During 2015 NTW once again commissioned NEQOS to undertake a benchmarking exercise, comparing the Trust's Quality Account 2014-15 with those of 56 other NHS Mental Health organisations. A summary of the top 10 indicators found in all Quality Accounts has been provided in Table 17 below.

Table 17: Top 10 Quality Account Indicators

	Top 10 Quality Account Indicators	Target	Average	Peer*	NTW	Number of Trusts
1	National Clinical Audit participation (%)	100%	93.4	81.9	100.0	56
2	National Confidential Enquiry participation (%)	100%	96.4	100.0	100.0	56
3	Admissions to adult urgent care wards gatekept by CRT (%)	95%	98.2	97.9	100.0	56
4	Inpatients receiving follow up contact within 7 days of discharge (%)	95%	97.5	97.6	97.4	56
5	Incidents for severe harm/death (%)	-	1.3	1.0	1.3	56
6	Patient experience of community MH services	-	7.8	7.9	8.1	45
7	Inpatients classed as delayed transfers of care (%)	< 7.5%	3.4	2.8	2.6	45
8	CPA formal review within 12 months (%)	95%	96.6	96.5	95.6	43
9	Proportion of inpatients readmitted	-	7.9	8.8	6.2	37
10	Staff who would recommend the trust to their family/friends (%)	-	3.51	3.46	3.64	18

*Peer includes data for (C&W, Lancashire, Norfolk, North Essex, Oxford, Southern, Sussex, TEWV)

The Trust scored equal to or higher than average on 6 of the 10 indicators.

Likewise, when compared to the peer cohort the Trust scored equally or higher on the same 6 of the 10 indicators (highlighted in green in Table 17).

NHS Number and General Medical Practice Code Validity

Northumberland, Tyne and Wear NHS Foundation Trust submitted records during 2015-16 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

99.5% for admitted patient care; and

99% for outpatient care."

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

99.9% for admitted patient care; and

99.9% for outpatient care."

Information Governance Toolkit attainment

The Northumberland, Tyne and Wear NHS Foundation Trust Information Governance Assessment Report overall score for 2015-16 was 74% and was graded green.

Clinical Coding error rate

Northumberland, Tyne and Wear NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2015-16 by the Audit Commission.

Performance against mandated core indicators

The mandated indicators applicable to Northumberland, Tyne and Wear NHS Foundation Trust are as follows:

1. The percentage of patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period (data governed by a national definition)

Northumberland, Tyne and Wear NHS Foundation Trust considers that this data is as described for the following reason - we have established, robust reporting systems in place through our electronic patient record system (RiO) and adopt a systematic approach to data quality improvement.

Northumberland, Tyne and Wear NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services by ensuring clinicians are aware of their responsibilities to complete these reviews.

Table 18: 7 day follow up data 2013-14 to 2015-16

7 day follow up	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
NTW %	**95.8%**	**97.5%**	**97.6%**	**97.0%**	**98.3%**	**95.8%**	**98.2%**	**98.4%**	**99.1%**	**98.5%**	**98.7%**	**98.0%**
National Average %	97.4%	98.8%	96.7%	97.4%	97.0%	97.3%	97.3%	97.2%	97.0%	96.8%	96.9%	97.2%
Highest national %	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Lowest national %	94.1%	90.7%	77.2%	93.3%	95.0%	91.5%	90.0%	93.1%	88.9%	83.4%	50.0%	80.0%

(higher scores are better)

2. The percentage of admissions to acute wards for which the Crisis Home Treatment Team acted as a gatekeeper during the reporting period (data governed by a national definition)

Northumberland, Tyne and Wear NHS Foundation Trust considers that this data is as described for the following reason - we have established, robust reporting systems in place through our electronic patient record system (RiO) and adopt a systematic approach to data quality improvement.

The Northumberland, Tyne and Wear NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services by closely monitoring this requirement and quickly alerting professionals to any deterioration in performance.

Table 19: Gatekeeping data 2013-14 to 2014-15

Gate-keeping	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
NTW %	**99.6%**	**99.6%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.7%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
National Average %	97.7%	98.7%	98.6%	98.2%	98.0%	98.5%	97.8%	98.1%	96.3%	97.0%	97.4%	98.2%
Highest national %	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Lowest national %	74.5%	89.8%	85.5%	75.2%	33.3%	93.0%	73.0%	59.5%	18.3%	48.5%	61.9%	84.3%

(higher scores are better)

3. The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends

The Northumberland, Tyne and Wear NHS Foundation Trust consider that this data is as described for the following reasons – this is an externally commissioned survey.

The Northumberland, Tyne and Wear NHS Foundation Trust has taken the following actions to improve this number, and so the quality of its services by continuing to hold multidisciplinary staff engagement sessions regarding the results of the staff survey and identifying actions for improvement.

Table 20: Staff recommendations data 2013 to 2015

Staff recommendation of the organisation as a place to work or receive treatment	2013 Staff Survey	2014 Staff Survey	2015 Staff Survey
NTW	**3.61**	**3.64**	**3.71**
National Average	3.54	3.57	3.66

Table 20 shows that NTW scored above (better than) the national average.

4. 'Patient experience of community mental health services' indicator score with regard to a patients experience of contact with a health or social care worker during the reporting period

The Northumberland, Tyne and Wear NHS Foundation Trust considers that this data is as described for the following reasons – this is an externally commissioned survey.

The Northumberland, Tyne and Wear NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services by constantly engaging with service users and carers to ensure we are responsive to their needs and continually improve our services.

Table 21: Patient experience of community mental health indicator scores 2013 to 2015

Patient experience of community mental health indicator scores	2013	2014	2015
NTW	**87.4**	In 2014 the national survey was substantially redeveloped and updated in order to reflect changes in policy, best practice and patterns of service. The removal of the question regarding patients' experience of contact with a health or social care worker during the reporting period prevents comparative data to be determined and reported on during 2014 and 2015.	
National Average	85.8		
Highest national	91.8		
Lowest national	80.9		

(higher scores are better)

Please see page 34 for the results from the National Community Mental Health Patient Survey for 2014 and 2015.

5. The number and , where available the rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death (data governed by a national definition)

Northumberland, Tyne and Wear NHS Foundation Trust considers that this data is as described for the following reasons – this is data we have uploaded to the National Learning and Reporting System (NRLS).

Northumberland, Tyne and Wear NHS Foundation Trust has taken the following actions to improve this rate/number/percentage, and so the quality of its services by ensuring all serious Patient Safety Incidents are robustly investigated and lessons shared throughout the organisation (including the early identification of any themes or trends).

Table 22: Patient Safety Incident (PSI) data April 2013 – September 2015. This is the most up to date data released by the NRLS.

Indicator	Performance	2013-14 Q1-Q2	2013-14 Q3-Q4	2014-15 Q1-Q2	2014-15 Q3-Q4	2015-16 Q1-Q2
Number of PSI reported (per 1000 obd)	**NTW**	**33.9**	**38.5**	**39.3**	**36.3**	**38.6**
	National average	28.0	28.0	35.6	31.1	38.6
	Highest national	67.1	58.7	90.4	92.5	83.7
	Lowest national*	0	0	0	0	0
Severe PSI (% of incidents reported)	**NTW**	**0.4%**	**0.6%**	**0.5%**	**0.6%**	**0.4%**
	National average	0.4%	0.4%	0.3%	0.4%	0.3%
	Highest national	1.6%	2.9%	2.9%	2.1%	2.5%
	Lowest national*	0.0%	0.0%	0.0%	0.0%	0.0%
PSI Deaths (% of incidents reported)	**NTW**	**1.0%**	**0.9%**	**1.0%**	**1.2%**	**0.9%**
	National average	0.9%	0.7%	0.7%	0.7%	0.8%
	Highest national	4.7%	3.5%	3.0%	3.7%	3.2%
	Lowest national*	0.0%	0.0%	0.0%	0.0%	0.0%

(lower scores are better). obd = occupied bed days *nb some organisations report zero patient safety incidents

News from 2015-16

A Sunderland NHS team has won a prestigious award for helping people with learning disabilities improve their hearing.

Lynzee McShea, senior clinical scientist in audiology and Chris Corkish, senior lecturer in learning disability nursing won the Unite the Union Award at the 2015 Advancing Healthcare Awards for their work.

Chris and Lynzee created the 3As pathways, which stands for Access, Assessment and Aftercare and aims to identify and remove barriers to services, which has had a huge impact in addressing inequalities when people with a learning disability access healthcare services.

Once the new pathway was set up it was expected around 40% of patients would have some sort of hearing impairment. Astonishingly, almost all patients were found to have a significant hearing loss. Once given the right support, those who came to the clinic showed significant improvements in communicating.

Their work is very important as on average people with learning disabilities die 16 years earlier than the rest of the population. Often, routine health checks such as sight and hearing tests are missed. This can lead to issues such as an undiagnosed hearing impairment being mistaken for other conditions such as mental illness or dementia.

Part 3

Review of Quality Performance

In this section we will report on the quality of the services we provide, by reviewing progress against indicators for quality improvement, and feedback from sources such as service user and staff surveys.

We have included three key measures for each of the quality domains (safety, patient experience and clinical effectiveness) that we know are meaningful to our staff, our Council of Governors, commissioners and partners.

Table 23: Patient Safety, Patient Experience and Clinical Effectiveness Quality Indicators Performance 2015-16

Patient Safety

*7 Day Follow Up contacts

Why did we choose this measure? –

Seven day follow up is the requirement to visit or contact a service user within seven days of their discharge from inpatient care, to reduce the overall rate of death by suicide. This is a Monitor and CQC requirement. (Data source: RiO).

Performance in 2015-16 (2014-15 comparison in brackets)

- During 2015-16, 1,654 service users (98.6% of those discharged from inpatient care in the year) were followed up within seven days of discharge.
- In 2014-15, 1,702 service users (97.4% of those discharged from inpatient care in the year) were followed up within seven days of discharge.

Note: the target for this indicator is 95% and applies to adult service users on CPA. Further analysis by locality is as follows:

Newcastle Gateshead CCG: 96.7%
North Tyneside CCG: 98.2%
Northumberland CCG: 98.3%
South Tyneside CCG: 98.1%
Sunderland CCG: 97.1%

*Same Sex Accommodation Requirements

Why did we choose this measure? –

Reducing mixed sex accommodation is a national priority and Department of Heath requirement. (Data source: Safeguard).

Performance in 2015-16 (2014-15 comparison in brackets)

There have been no breaches of same sex accommodation requirements during 2015/16(also none in 2014/15).

*Patients on CPA have a formal review every 12 months

Why did we choose this measure? –

Monitor Compliance Framework requirement. (Data source: RiO).

Performance in 2015-16 (2014-15 comparison in brackets)

As at the end of March 2016, 97.2% of applicable service users had a CPA review in the last 12 months, meeting the Monitor target of 95% (95.6% March 2015).

Patient Experience

Friends and Family Test (FFT) – Service User and Staff

Why did we choose this measure? –

The Friends and Family Test is a nationally mandated tool which allows service users and staff to give their feedback on NHS services (Data source: CQC NHS Staff Survey 2015).

Performance in 2015-16 (implemented in January 2015) –

i) Service User FFT

Service User recommendation to family and friends	
"How likely are you to recommend our ward/service/team to friends and family if they needed similar care or treatment?"	
Would Recommend	Would Not Recommend
81%	4%

The Trust has been working hard to embed the test into practice.

ii) Staff FFT

Northumberland, Tyne & Wear NHS Foundation Trust 2015 Annual Staff Survey			
Q21d "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"			
	NTW 2015	Average (median) for mental health	NTW 2014
Recommendation rate	65%	59%	61%

The staff survey is available via the following link:
www.nhsstaffsurveys.com/Page/1053/Latest-Results/Mental-Health-Learning-Disability-Trusts/

Patient Led Assessment of the Care Environment (PLACE)

Why did we choose this measure? –

Department of Health and the NHS Commissioning Board annual requirement.

Performance in 2015-16 (2014-15 comparison in brackets)

Between February and June 2015 a total of 71 NTW locations were visited at 13 locations and the results are summarised in the table below (NTW overall organisation score set against the national average for each of the five domains).

	NTW Average Score	National Average Score
Cleanliness	99.15%	95.57%
Food & Hydration	88.90%	88.49%
Privacy, Dignity & Wellbeing	88.64%	86.03%
Condition & Appearance	88.57%	90.11%
Dementia	82.89%	74.51%

*Delayed transfers of care

Why did we choose this measure? –

Monitor and CQC requirement to minimise the number of patients in hospital who are ready for discharge. (Data source: RiO).

Performance in 2015-16 (2014-15 comparison in brackets)

During March 2016, 2.4% of total inpatient bed days were classed as delayed transfers of care, thus meeting the target to have no more than 7.5% of inpatient bed days delayed (2.6% in March 2015).

Clinical Effectiveness

Emergency re-admission rates

Why did we choose this measure? –

Emergency readmission rates are an important tool in the planning of mental health services and the reviewing of quality of those services. (Data source: RiO).

Performance in 2015-16 (2014-15 comparison in brackets)

In 2015-16, 181 mental health inpatients (7.3%) were readmitted within 28 days of discharge and 10 learning disability patients (12.3%) were readmitted within 90 days of discharge.

In 2014-15, 172 mental health inpatients (6.2%) were readmitted within 28 days of discharge and 10 learning disability patients (8.1%) were readmitted within 90 days of discharge.

During 2013-14, 236 mental health inpatients (7.9%) were readmitted within 28 days of discharge and 11 learning disability inpatients (9.7%) were readmitted within 90 days of discharge.

*CRHT Gate kept Admissions

Why did we choose this measure? –

Both Monitor and CQC require us to demonstrate that certain inpatients have been assessed by a CHRT prior to admission. (Data source: RiO).

Performance in 2015-16 (2014-15 comparison in brackets)

A Crisis Resolution Home Treatment Team provides intensive support for people in mental health crisis in their own home. It is designed to prevent hospital admissions.

In the last two financial years, 100% of the North East CCG admissions to adult urgent care wards were gatekept by a CRHT prior to admission, thus exceeding the target of 95%.

*Patient outcomes – numbers of patients: (1) in settled accommodation

Why did we choose this measure? –

This is an outcome measure. (Data source: RiO).

Performance in 2015-16 (2014-15 comparison in brackets)

(1) At the end of March 2016, the number of English service users recorded as living in settled accommodation was 73.5% (73.2% in 2014-15).

*data for this indicator governed by a national definition

Statutory and Mandatory Training for 2015-16

It is important that our staff receive the training they need in order to carry out their roles safely. An improvement plan is in place to increase training where it is below the standard required, to be achieved by July 2016.

Table 24: Training Position with Trend as at 31.03.2016

Training	Target	M12 Position		Trend	Forecast Position
Fire Training	90%	89.0%	●	▼	89.0%
Health and Safety Training	90%	95.0%	●	▼	95.0%
Moving and Handling Training	90%	95.3%	●	▼	95.3%
Clinical Risk Training	90%	86.7%	●	▲	86.7%
Clinical Supervision Training	90%	79.0%	●	▼	79.0%
Safeguarding Children Training	90%	94.4%	●	▲	94.4%
Safeguarding Adults Training	90%	93.1%	●	▲	93.1%
Equality and Diversity Introduction	90%	93.5%	●	▼	93.5%
Hand Hygiene Training	90%	92.4%	●	▲	92.4%
Medicines Management Training	90%	89.5%	●	▲	89.5%
Rapid Tranquillisation Training	90%	87.8%	●	▲	87.8%
MCHT Clustering Training	90%	86.6%	●	▲	86.6%
Mental Capacity Act Training	90%	88.3%	●	▲	88.3%
Mental Health Act Training	90%	85.0%	●	▲	85.0%
Deprivation of Liberty Training	90%	86.5%	●	▲	86.5%
Seclusion Training (Priority Areas)	90%	95.9%	●	▲	95.9%
Dual Diagnosis Training (80% target)	80%	85.3%	●	▲	85.3%
PMVA Basic Training	90%	76.3%	●	▼	76.3%
PMVA Breakaway Training	90%	77.0%	●	▲	77.0%
Information Governance Training	90%	87.7%	●	▼	87.7%
Records and Records Keeping Training	90%	97.6%	●	—	97.6%

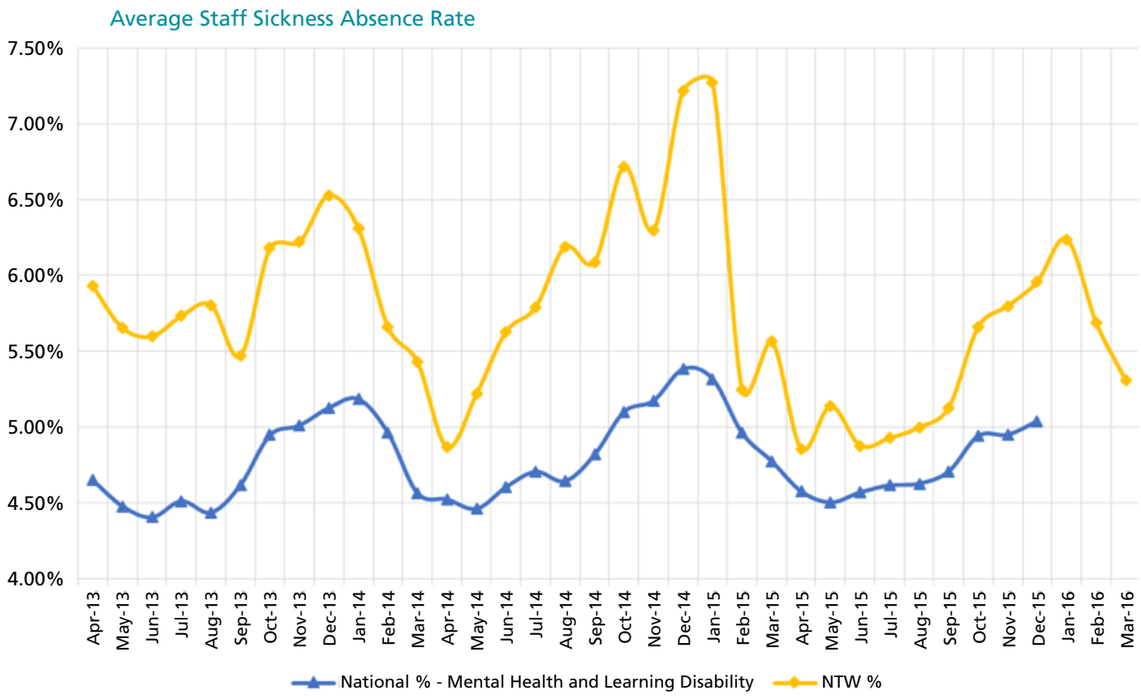
●	Performance at or above target
●	Performance within 5% of target
●	Under-performance greater than 5%

▲	Trend improving on previous month
—	Trend the same as previous month
▼	Trend worse than previous month

Staff Absence through Sickness Rate

High levels of staff sickness impact on patient care: therefore the Trust monitors sickness absence levels carefully. (Data source: ESR).

Figure 13: Staff Sickness Absence Rates (2013-14 to 2015-16)



There is a decreasing trend in staff sickness and this is largely attributed to the implementation of the Trusts new sickness absence policy during 2015. There is a narrowing gap between the national sickness rate for Mental Health and Learning Disability Trusts and NTW. Please note that the peaks represent increased sickness during winter months.

Performance against contracts with local commissioners

During 2015-16 the Trust had a number of contractual targets to meet with local commissioners (CCG's). Table 25 below highlights the targets and the performance of each CCG against them for quarter four 2015-16 (1.1.16-31.3.16).

Table 25: Contract Performance Targets 2015-16 Quarter 4:

*N/A = those services are not commissioned in the CCG areas

CCG Contract performance targets quarter 4 2015-16 (target in brackets)	Newcastle Gateshead CCG	Northumber-land CCG	North Tyneside CCG	Sunderland CCG	South Tyneside CCG
CPA Service Users reviewed in the last 12 months (95%)	96.3%	98.5%	96.7%	98.3%	98.4%
CPA Service Users with a risk assessment undertaken/reviewed in the last 12 months (95%)	97.6%	98.4%	97.1%	98.8%	99.3%
CPA Service Users with identified risks who have at least a 12 monthly crisis and contingency plan (95%)	95.3%	97.3%	95.8%	98.5%	98%
Number of inpatient discharges from adult mental health illness specialties followed up within 7 days (95%)	97.5%	98.9%	100%	97.3%	98.3%
Current delayed transfers of care -including social care (<7.5%)	2.9%	0.9%	1.6%	1.9%	2.8%
RTT percentage of incomplete (unseen) referrals waiting less than 18 weeks (92%)	100%	100%	97.9%	100%	97.3%
Current service users aged 18 and over with a valid NHS Number (99%)	100%	99.8%	100%	100%	100%
Current service users aged 18 and over with valid Ethnicity completed (90%)	94.2%	95%	94.2%	94.6%	94.6%
The number of people who have completed IAPT treatment during the reporting period (50%)	n/a	n/a	n/a	52.3%	n/a

The Trust also has specific contractual targets for specialised services with NHS England for which the majority of quality standards were achieved in 2015-16. There were no significant areas of underachievement and the marginal issues identified are being addressed with relevant services.

Staff Survey 2015

The NHS Staff Survey ensures that the views of staff working in the NHS inform local improvements and input in to local and national assessments of quality, safety, and delivery of the NHS Constitution. The 2015 staff survey questions were structured around the following issues:

• Personal development	• Staff health
• Job roles	• Staff well-being and safety at work
• How staff feel about managers	• Background (demographic) information
• How staff feel about their organisation	

The 2015 score, for Key Finding 1(KF1) – 'Staff recommendation of the organisation as a place to work or receive treatment' was 3.71 out of 5 (the scoring system is a scale of 1 to 5 minimum score being 1 and the maximum score being 5). Our 2015 score was an improvement on the 2014 score 3.64, and above the average score for all mental health trusts at 3.66 out of 5.

Top 5 Ranking Scores - The five Key Findings for which the Trust compares most favourably with other Mental Health Trusts in England are:

KF26. 17% of staff experiencing harassment, bullying or abuse from staff in last 12 months compared to the national average of 22%.

KF17. 34% of staff suffering work related stress in last 12 months compared to the national average of 39%.

KF31. Staff scored the level of confidence and security in reporting unsafe clinical practice as 3.79 out 5 (1 being not confident/ secure and 5 being confident and secure), compared to the national average of 3.62 out of 5.

KF14. Staff scored the level of satisfaction with resourcing and support as 3.46 out of 5 (1 being unsatisfactory resourcing/ support and 5 being highly satisfactory resourcing/ support), compared to the national average of 3.31 out of 5.

KF21. 90% of staff believed that the organisation provides equal opportunities for career progression or promotion compared to the national average of 84%.

Bottom 5 Ranking Scores - The five Key Findings for which the Trust compares least favourably with other Mental Health Trusts in England are:

KF27. 42% of staff / colleagues reported most recent experience of harassment, bullying or abuse compared with national average of 49%.

KF22. 24% of staff experiencing physical violence from patients, relatives or the public in last 12 months compared with the national average of 21%.

KF23. 3% of staff experiencing physical violence from staff in last 12 months compared with the national average of 3%.

KF13. Staff scored the quality of non-mandatory training, learning or development as 4.00 out of 5 (1 being low-quality training and 5 being high quality training), compared with the national average of 4.01% out of 5.

KF28. 26% of staff witnessing potentially harmful errors, near misses or incidents in last month compared with the national average of 26%.

2015 Agreed Trust Wide Actions in response to the Staff Survey

Issue	Proposed Action
Last experience of harassment/bullying/abuse not reported	Coordinated campaign of action, relaunching a number of initiatives under one banner, including induction, training and the importance of communications and review of policy
Appraisals: needs not identified	Targeted work on training needs identification and analysis
Violence and aggression	Implementation of Trust's Positive and Safe Strategy

Staff Survey ongoing themes:

Violence and Aggression. This remains a high priority for the organisation and a range of measures are in place to address this issue, including the implementation of the Positive and Safe Strategy in 2016-17.

Harassment and Bullying. Whilst our reported levels of harassment and bullying are lower than other comparable trusts, we aim to reduce instances of harassment and bullying while also increasing staff confidence in reporting these issues. Alongside local programmes of work being developed in areas of concern in this area, the Trust is reviewing the content of all training programmes, reviewing provision of support to affected staff and continuing staff engagement and involvement activities.

Statements from lead Clinical Commissioning Groups (CCG) and local Healthwatch

We have invited our partners from all localities covered by Trust Services to comment on our Quality Account. It has been agreed that responses from partners in Newcastle, North Tyneside, Northumberland, Gateshead, Sunderland and the local Healthwatchs will be included within this document, and any comments from other localities will be made available on our website (www.ntw.nhs.uk).

Corroborative statement from Northumberland, North Tyneside, Newcastle Gateshead, Sunderland and the South Tyneside Clinical Commissioning Groups:

The CCGs welcome the opportunity to review and comment on the Trust Quality Account for 2015/16 and would like to offer the following commentary.

As commissioners, Northumberland, North Tyneside, Newcastle Gateshead, Sunderland and South Tyneside Clinical Commissioning Groups (CCGs) are committed to commissioning high quality services from Northumberland Tyne and Wear NHS Foundation Trust (NTWFT) and take seriously their responsibility to ensure that patient' needs are met by the provision of safe, high quality services and that the views and expectations of patients and the public are listened to and acted upon.

The CCGs would like to commend the Trust for the improvements that are demonstrated in the report, particularly the achievement of its goals relating to patient safety, patient experience and clinical effectiveness. It is hoped that the ongoing work to address the quality priorities that were not achieved in year will yield the desired results in 2016/17.

Although the Trust was not able to fully meet all of its quality priorities, the CCGs recognise that it remains committed to achieving those which have been identified as incomplete or ongoing in 2016/17. Whilst progress in training of staff in the enhanced suicide risk training did not meet the Trust goal, positive progress was made and the CCGs support the continuation of this programme although a stretched target of 95% of staff trained would have been preferable for such an important area of risk reduction. The CCGs also felt that it would have been helpful to have some detail on the reasons why the 85% target was not achieved, as well as what positive effects the training had achieved on the rates of suicide and self-harm in patients.

The CCGs note that the largest number of serious incidents reported by the Trust were unexpected deaths in community services and substance misuse services. The CCGs felt that the Trust's ongoing work to undertake a comparative analysis of these deaths deserves some recognition within their report and look forward to working with the Trust to understand this area of work and support the Trust to respond accordingly to the analysis findings.

The CCGs understand the difficulties in ensuring the continual improvement in waiting times for more specialist services such as gender dysphoria and the autistic spectrum disorder and ADHD services and approve of the Trust plans to continually monitor and improve access. The CCGs also recognise the progress that has been made in improving access to children and young people's community services across the organisation. It is hoped that access to these services for patients is South Tyneside and Northumberland will continue to improve to meet the standards of the rest of the CCG areas. The CCGs felt, however, that some detail on why the access targets for the Autism Spectrum Disorder & ADHD Services were not met in 2015/16 would be helpful in understanding how they would be achieved in 2016/17.

The CCGs are supportive of the newly developed Trust priorities for 2016/17 relating to improving transitions between young people's services and adult services and between inpatient and community mainstream services. The CCGs feel that this will contribute significantly to the safety of patients moving between services by ensuring that they get the right care in the right place.

The CCGs are also supportive of the implementation of the 'triangle of care' to improve communication and liaison with carers, which will be key to increasing positive patient and carer experience, and to the work to develop staff skills to prevent and respond to violence and aggression. Ensuring that staff are able to manage these difficult aspects of mental health care will be key to ensuring the effectiveness of the staff and the services.

The CCGs acknowledge the positive comments given by service users as part of the Friends & Family Test in 2015/16 but would like to emphasise to the Trust the importance of increasing both response rates and recommendation rates to above the England averages which will provide a more representative sample of service user experiences.

The CCGs are supportive of the Trust's 'Positive and Safe' strategy to minimise the use of restrictive practices inclusive of all forms of restraint. The Trust's significant investment in high quality inpatient facilities, training, monitoring and reporting demonstrates the organisation's commitment to managing these interventions in order to keep their service users, staff and the wider community safe.

The CCGs are pleased to note the progress being made within the Trust Transformation Programmes, particularly in the development and implementation of community pathways in Sunderland and South Tyneside, and look forward to introduction of the new community pathways across the North of Tyne in 2016/17.

In so far as we have been able to check the factual details, the CCG's view is that the report is materially accurate. It is clearly presented in the format required by NHS England and the information it contains accurately represents the Trust's quality profile. Finally, the CCGs would like to offer congratulations to the Trust on the achievements outlined in this report which we believe accurately reflects the Trust commitment to delivering high quality, patient centred services. The CCGs look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned in 2016/17.

Annie Topping, Director of Quality & Patient Safety, NHS Northumberland CCG

Lesley Young Murphy, Executive Director of Nursing & Transformation, NHS North Tyneside CCG

Chris Piercy, Director of Nursing, NHS Newcastle Gateshead CCG

Ann Fox, Director of Nursing, Quality & Safety, NHS Sunderland CCG & NHS South Tyneside CCG

Healthwatch Newcastle's statement:

Healthwatch Newcastle was pleased to read the Northumberland, Tyne and Wear NHS Foundation Trust's quality account for 2015/16. It is an interesting and informative read and it is clear the Trust has endeavoured to make improvements against the priorities it set itself.

Quality goal 1: safety

Whilst the Quality Account document reveals that this goal was only partially met, it is good to see that the goal will continue into 2016/17 with additional priorities around transition being added.

Quality goal 2: patient experience

We are pleased to see that the quality priority around food choice and quality has been met.

It is unfortunate that the target around referral processes and waiting times has not been met, however we are pleased that this will remain as a priority next year as this is an issue which Healthwatch Newcastle occasionally receives comments about.

We are also pleased that the quality priority around the involvement of carers and families is to continue into 2016/17 as this issue was raised by carers at a recent Healthwatch Newcastle engagement event.

Quality goal 3: clinical effectiveness

We note that all targets in this section have been achieved and congratulate the Trust. We will continue to monitor these throughout 2016/17.

The Trust's new and continuing priorities for 2016/17 are reasonable and comprehensive. We are happy to see the inclusion of Quality Priorities around Transition and the Triangle of Care and we are particularly pleased to note that Trust will continue to focus on improving the use of Patient rated outcome measurements.

We note that the Trust will receive a full inspection by the Care Quality Commission in June this year, which we hope will go well.

We wish NTW continued success and look forward to receiving updates on progress.

Newcastle Council's statement:

As Chair of the Health Scrutiny Committee, I welcome the opportunity to comment on your draft Quality Account for 2015/16. Members discussed this at their meeting on 12 May 2016 and this letter provides a summary of our views.

2015/16 Priorities

The committee welcome all opportunities that the trust takes to train staff in order to make improvements that can support patient care and welfare. However, it is important that the trust links these back to improvements in services if it is to understand how successful the training has been. Committee recommend that data on this is reflected in future Quality Account documents.

We note that the trust continues to be an outlier trust in terms of incidents of harm and use of restraint. Committee understands that NTW deal with cases referred nationally or specialist cases and may therefore have higher incidents than other trusts, and that reporting between trusts may differ. However, this remains a cause of concern for us and we would welcome a presentation from the trust later in the year on your Positive and Safer Strategy.

We are pleased to see that the trust is making year on year improvements around healthy and nutritious food options. Providing the opportunity for people to make healthy food choices is very important, but needs to be underpinned by support to help them make good choices, particularly for patients who may suffer from weight gain due to medication.

We understand the important role that young carers can play in helping to support patient recovery and we will liaise with the Director of Wellbeing, Care and Learning to ensure that he is confident that appropriate support is in place.

We are concerned about waiting times for services both between referral and first contact and between contact and the start of treatment and we have requested additional data on this. We know that progress has been made over the last year, particularly to respond to referrals where there is an urgent need; however some of which may have arisen due to the long waiting times. Committee will review progress on this priority during the coming year.

We welcome the introduction and progress of Recovery Colleges, but are concerned that there is a level of anxiety among service users with long term conditions, who consider that development of the Recovery Model will have a negative impact on their care. We understand that the model will not result in discharges for people who need long term care, but the trust may need to consider how it can better manage communications around this.

We note that the Quality Account describes a deterioration in the experience of community mental health services, from the 2014 survey. Although we understand that this mirrors a national trend, it would be prudent for the trust to investigate this future and any appropriate action taken, particularly given the future focus on community based services.

In terms of data provided in the Quality Account we would welcome:

- A breakdown of service users by gender, age and ethnicity.
- Information on the locality of repeat detentions under the mental health act.

We note that the trust does a considerable amount of work to help support the physical health of its patients including smoking cessation and weight management, which is not reflected in the Quality Account document, but which plays an important part in the overall health and wellbeing of patients.

Finally, we were particularly pleased to note the approach the trust has taken to understand the views of stakeholders and to seek ideas for quality improvement, on which the Quality Account is based. And we have suggested that this is a model of best practice that other trusts may wish to consider.

Healthwatch Northumberland's statement:

We welcome the opportunity to respond to the draft quality account of Northumberland, Tyne & Wear NHS Foundation Trust and would like to congratulate the Trust on some good results. Healthwatch Northumberland is looking forward to continued working in collaboration with the Trust.

We have identified below areas where we believe the Trust has performed well –

- Good 'Friends and Family' result with 81% of responders saying that they would recommend the service.
- Reduction in delayed transfers of care.
- The introduction of Street Triage Teams, working alongside the police to deal with incidents involving people experiencing a mental health crisis is a useful initiative, and it would be good to see this rolled out across the wider NTW area.

We have identified below areas for improvements –

- Complaints – these have increased by 10% compared to 2014/2015
- We note that whilst Patient Safety Incidents under the 'catastrophic and death' categories have improved, 'no harm' incidents have more than doubled for Northumberland Community Services. There is also a significant increase in 'moderate harm' safety incidences.
- Ongoing issues in relation to waiting times for Children's and Young People's services.
- Community Transformation Programme. This is already one year behind schedule. Compared to Sunderland. Northumberland seems to have been delayed by staff problems and rural area issues. We feel this is a serious matter and should be prioritised.
- We note that the 2015 Quality Priority score is lower than that recorded in 2014 in nine out of the ten sections. We would like to see this improve.

We have listed below comments regarding the Trust's priorities for 2016/17 -

- Plans to improve performance for 2016/17 appear positive and achievable.
- We agree with the Trust's priorities /Quality Goals for 2016/17, but would like to see higher level of priority given to the Community Transformation Programme.

We felt that the document despite being very detailed is in general, easy to read and understand. We found the glossary to be useful and the report, on the whole, to be clear and concise.

Overall we considered that the report gives a fair reflection of the service provided by the Trust, but there were a large number of figures and statistics that were missing in the draft, or that referred to the previous year, making it difficult or impossible to comment objectively.

We look forward to working with NTW in the coming year and continuing to build on the positive working relationship we have established.

Northumberland Council's statement:

Members of the Care and Wellbeing Overview and Scrutiny Committee welcome the opportunity to examine and scrutinise the information you have provided over the course of the past year, and to submit a commentary for inclusion in the Northumberland, Tyne and Wear NHS Foundation Trust's Quality Account.

We have continued our ongoing engagement with the Trust and mental health issues featured prominently in our Work Programme for 2015/2016. NTW Reports to the Committee were:

1. Northumberland Tyne & Wear NHS Trust Transforming Services Programme - Joint Update with Adult Services.

This Report was given at our 17 November 2015 Meeting jointly with the County Council's Social Services and provided an update to your January 2015 Report introducing your 'Improving the Northumberland Dementia Pathway' plans for remodelling inpatient services, community services, the organic pathway, a rationale for change and the anticipated outcomes. The November Meeting heard about progress made in the intervening period, details of admissions and discharges, and the usage of the Cresswell and Druridge wards at St George's hospital between October 2014 and November 2015. Our Members' comments and questions included:

- How had the increasing rate of dementia had been gauged to reduce the number of beds available, and where would patients go if they remained seriously ill. The Meeting was informed that some patients went home with the right support and others might need to be referred to other placements. Under the Dementia Strategy, patients were cared for in places as near to home as possible but with the right care. A key aim was to organise support at an early stage of dementia rather than referral at a later stage in a crisis. A key aim was to support people at home or in the community as long as possible.
- The Committee had heard of dementia-friendly communities such as Dementia-Friendly Corbridge and the support offered there, but what happened when people with dementia needed to be accompanied all the time? Members were informed that some patients would be treated at the Cresswell ward with a high level of support, but could be discharged back in certain cases. Most people tended to be discharged to care homes. Hospital treatment was useful, but it was better to use it on a short term basis with a view to transferring to a home environment. This involved work between care homes and in the community, and joint working with social services was essential.
- The presentation showed that the staff-patient ratio had narrowed. How had this happened? Members were advised that it was not due to an increase in staff but a result of removing the administrative/bureaucratic requirements of staff, so they had more time to see patients. Changes had followed the Cheshire West judgement in April 2014 about thresholds for deprivation of liberty.
- Regarding the decrease in patient beds from 48 to 24, was there a back-up plan if there was a sudden spike in demand? Members were informed that greater capacity in community support increased options, and other services could be used as contingencies in the short term so that individuals received the appropriate care. Such contingencies were subject to patient repatriation to their own area as soon as possible. Scrutiny had a role in overseeing this ongoing transformational work, also tracking demographic changes and the national agenda. This would be included on the Committee's work programme.

2. Northumberland Tyne & Wear NHS Trust Future Priorities and Quality Account 2015/2016.

At our 15 March 2016 Meeting we received a presentation on your draft Quality Account for 2015/2016 and your priorities for 2016/2017. At that meeting we also received presentations from the Northumbria Healthcare and North East Ambulance Service NHS Foundation Trusts on their own quality accounts. This was an interactive session which also included contributions from the Northumberland Clinical Commissioning Group and proved useful and stimulating for our Members and, we believe, all partners involved.

Members responded favourably to the information you presented and the Committee will continue to invite you to provide updates on the Transforming Services Programme.

In addition to interactions in Committee meetings, to further improve our Committee's engagement with the Trust, the Chairman, Vice-Chairman and Scrutiny Officer attended and participated in the following NTW events:

- Visit to Northumberland, Tyne & Wear (NTW) NHS Trust, St George's Park Morpeth, on 16 September 2015
- NTW Quality Priorities Engagement Event, Gateshead, on 26 November 2015
- NTW Quality Account 2015/2016 Briefing, Walkergate Park, Newcastle, on 14 April 2016.

Your ongoing commitment to forge links with partners and the community was clear at these events. We found them informative and valuable interactions and hope that we added value to the process.

From the information you have provided, including the final draft of the Quality Account, our Members believe that the document is a fair reflection of the services provided by the Trust and reflects the priorities of the community. Members also support your planned priorities for improvement in 2016/2017.

Healthwatch North Tyneside's statement:

Based on Healthwatch North Tyneside's (HWNT) intelligence gathered during 2015-2016 regarding local residents' experience of using the services of the Trust, we feel able to comment as follows:

Quality Goal 1- Patient safety

HWNT recognise the work of the Trust in improving its employee base skills set in Suicide Risk Management, though more is still to be done. However, in addition to the skills of staff in this area, local people have expressed concern about how challenging it is to access support when they feel at risk and how they are supported to prevent, during, or after an attempt on their life. Furthermore, concerns raised locally about the Crisis support available indicates that whilst people have had a positive experience of street triage and the new liaison psychiatry service, they continue to find it difficult to access crisis support.

This is perhaps reflected in the relatively high percentage of Catastrophic, Major and Moderate harm PSI rating reported in community services for North Tyneside in comparison to other areas. HWNT feel that the trust would benefit from reviewing how this service performs under the relevant NICE Guidelines and discussions between Trusts to improve service pathways for people at risk.

HWNT welcome the addition of a priority to improve transitions between young people's services and adulthood. This is a particular challenge in North Tyneside where parents report to us that there have been difficulties linked to the transition being dependent on good relationships between different Trusts.

Quality Goal 2- Patient experience

HWNT welcome the efforts of the Trust to reduce waiting times for services. In particular for the ADHD, which has been raised by HWNT with Scrutiny Committee and Gender Dysphoria service which is something HW England has been lobbying for. Local people have told us that waiting times is a real issue for them across MH services and whilst the national standards are being largely complied with, for some people 18 weeks is just too long. In some cases people report longer waits due to delays in initial referral to point of treatment and further focus on the total wait should be given.

Local people have suggested the Trust consider what interim support is in place for people during their wait to avoid further escalation of their needs.

HWNT welcome the decision to continue to focus on improving communication to and involvement of carers and families as they have told us they often feel uninformed and unsupported in their role. Family and Carers feel that greater involvement would mean that the impact of treatment would improve.

During 2015-2016, HWNT has received feedback from local people which indicates they are concerned about the performance of the Trust in relation to discharge from Community Services. Their concerns indicate that further focus is required on the process of discharge, involvement in decision making of service users and the development of robust discharge plans.

Quality Goal 3 - Clinical effectiveness

HWNT has received large numbers of reports of positive experience of services whilst accessing them in particular in the Community Mental Health Teams in North Tyneside in assessment, diagnosis and receiving of treatment.

However, the feedback indicates that involvement in decision making and reviewing of care and treatment is an area which people would like to see improve. They also state that stronger Multi-Disciplinary working would improve their experience of using services. We acknowledge that in North Tyneside this is a shared responsibility between multiple providers.

Whilst HWNT understand that the Recovery Model is operating well and achieving good results in other parts of the region and will no longer feature as a Quality Goal, we are keen to see how a properly resourced recovery college model will be rolled out further in North Tyneside.

HWNT acknowledges the efforts to implement a major change process during this year and is under the understanding that some of the concerns raised by local people will be addressed in the coming year as the community transformation programme is rolled out in North Tyneside. We are looking forward to continuing to work with the Trust to understand how they are involving service users in monitoring the performance of the trust and the impact of these changes in 2016/17.

Healthwatch Gateshead's statement:

Thank you for giving Healthwatch Gateshead (HWG) the opportunity to respond to Northumberland, Tyne and Wear (NTW) NHS Foundation Trust's quality account for 2015/16.

It is clear the Trust has worked hard making improvements based on progress against the priorities from 2015/16

We would like to comment on the following which relate specifically to Gateshead:

Looking back - review of quality priorities 2015/16

Quality Goal 1 Improving Patient Safety

We note that the quality priority of enhanced suicide training of qualified staff has been partially met and are pleased this will continue until 85% qualified staff have completed the training.

There has been a slight increase of safety incidents overall in Gateshead. It is difficult to identify from the graphs exactly how this is broken down and any increase is a concern to HWG.

Quality Goal 2 Patient Experience: Improve the way we relate to patients and carers.

HWG are pleased that NTW came out as best performing trust in the section Planning Care, however the referral process and waiting times for multi disciplinary teams (Children and young people's services) has only

been partially met overall and the 12 week referral has not been met in Gateshead. We would seek continuous monitoring for improvement in 2016 - 17.

Looking Ahead – Quality for improvements in 2016/17

HWG welcome the fact that 150 ideas support formed part of the priority setting process. We support this practice of engaging with stakeholders and HWG would welcome the opportunity to provide service user feedback in the future priority setting of the NTW Quality Accounts.

Overall our view is that the draft Quality Account demonstrates NTWs commitment to continuous improvement in, service user experience, safety and clinical effectiveness.

Gateshead Council's statement:

Based on Gateshead Care, Health and Wellbeing OSC's knowledge of the work of the Trust during 2015-16 we feel able to comment as follows:-

Patient Safety

The OSC was very pleased to note that the number of patient safety incidents where no harm is found is continuing to increase and the numbers of incidents of moderate / major harm are continuing to decrease.

2015-16 Quality Priority – To improve the assessment and management of risk

The OSC noted that during 2015-16 the Trust had still not met the target for staff to complete enhanced suicide risk training and queried whether there were any specific challenges in implementing this training. The OSC noted that the Trust has achieved 69% out of 2,600 staff which has been an increase of 31 % on the previous year. The OSC was reassured by the Trust that the approach was to fully embed the training within the organisation and this was taking slightly longer than anticipated and as such it was to remain a priority for 2016-17.

However, the OSC also highlighted an emerging issue in relation to an increase in drug related deaths in Gateshead where analysis indicates that individuals with a drug or alcohol problem have been unable to access mental health services as a result of these issues. A dual diagnosis group has been set up in Gateshead following its Review of Mental Health Services and the OSC considered that increased representation from the Trust at a strategic clinical level would be very helpful in addressing this issue.

Patient Experience

The OSC had previously raised the fact that the 2014-15 Quality Account had not included information from the Friends and Family Test although the Trust had implemented the test. The OSC was very pleased to note that the Trust has taken on board the OSC's comments and the 2015-16 Account includes this important information.

Waiting Times

Previously the OSC raised concerns around performance in relation to achieving waiting times of less than 18 weeks. The OSC acknowledges that there are no national standards for waiting times for mental health services, and applauds the fact that the Trust has prioritised this area and is committed to reducing waiting times. The OSC was pleased to note that this Account indicates that all of the nine week targets for children's services have been achieved and work is ongoing in relation to achieving the twelve week targets for this locality. However, the OSC also considered that it might be helpful to review the wording used in relation to the targets as currently it appears to suggest that children have to wait twelve weeks to be seen when in actual fact this target does not relate to first contact but to the time when treatment commences.

Transition from Children to Adult Services

The OSC noted that the Trust services which bridge children and adult services has been identified by the Trust as a priority area of focus for 2016/17 and supported a flexible approach being taken to best meet people's needs and their particular circumstances.

The OSC is supportive of the Quality Account overall and is pleased to note that CQC has no compliance issues in regard to the Trust.

Sunderland City Council's statement:

We are pleased to be able to comment on your 2015/16 Quality Account, which once again provides an accurate account of services and the performance of the trust during the year. Scrutiny Councillors have been reviewing the Children and Young People's Community Services this year and are pleased to note many improvements to the service whilst also acknowledging the scope for further improvements. It is in light of this that Scrutiny in Sunderland will continue to look at, and provide a robust challenge in this particular area of service delivery over the coming year.

Sunderland City Council's Overview and Scrutiny Function are therefore happy to endorse the draft quality account for 2015/16 and look forward to a continued dialogue with Northumberland, Tyne and Wear NHS Foundation Trust in the future.

South Tyneside Council's statement:

Thank you for giving us the opportunity to comment on your Accounts for 2015-16.

Our OSC and Select Committees have dealt far less with mental health issues in this municipal year than in previous years. This is certainly not a reflection of the priority that we give mental health services, but more the fact that mental health issues have featured quite prominently over the previous two years and the committees felt they needed to focus on other priority areas.

However, following your participation in our Commission on the Mental Health and Emotional Wellbeing of Children, we were delighted to have feedback on progress on the subsequent action plan coordinated through the Children and Young People & Emotional Wellbeing Strategy Group at the People Select Committee in March.

We are particularly pleased that the tier 2 service is now firmly embedded and that significant progress has been made in reducing waiting times for CYPS.

The Committee was also most impressed with the work that has been carried out to enable the Trust to become Smoke Free in March, presented to our Smoking Commission in February.

I was encouraged to see that transition issues feature in your priorities for 16-17. We look forward to some feedback on progress on this theme in the next municipal year.

We have always found the Trust most cooperative and helpful with an understanding and respect for the scrutiny process.

We look forward to working with you further next year.

Appendix 1

Monitor Risk Assessment Framework

NB from 1st April 2016 Monitor is known as "NHS Improvement".

All NHS foundation trusts require a licence from Monitor to operate, with compliance against these requirements assessed using a risk assessment framework. NHS foundation trusts are assigned a **financial sustainability risk rating** and a **governance rating.** The ratings indicate when there is a cause for concern at a provider.

The financial sustainability risk rating determines the level of financial risk a foundation trust faces to the ongoing delivery of key NHS services and its overall financial efficiency. The rating ranges from 1, the most serious risk, to 4, the lowest risk. **During 2015-16 NTW's financial sustainability risk rating was 4 – the lowest risk.**

NHS foundation trusts should be well governed; this includes how care is overseen for patients, delivery of national standards and remaining economic, efficient and effective. A range of methods are used to gain assurance that required governance standards are met, including a specified set of national metrics as proxies for overall standards of governance, including waiting times and rates of C. difficile infection.

The governance rating has three categories:

- green: no evident grounds for concern
- under review: a concern has been identified at a trust but not yet taken action
- red: enforcement action.

During 2015-16 NTW's governance risk rating was green – no evident grounds for concern.

Performance against the risk assessment framework for each month during 2015-16 is shown overleaf. New waiting times standards for Improving Access to Psychological Therapies (IAPT) and early Intervention in Psychosis (EIP) services were introduced during the year and there was one instance of C-Difficile reported at Walkergate Park in October 2016.

Monitor Compliance Dashboard 2015-16:

Key Indicators:		Standard	Q1 2015-16			Q2 2015-16			Q3 2015-16			Q4 2015-16		
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Governance Risk Rating														
Financial Sustainability Risk Rating			4	4	4	4	4	4	4	4	4	4	4	4
Access	7 day follow up	95%	98.6%	99.3%	99.4%	99.3%	98.1%	98.2%	98.4%	98.6%	97.9%	98.5%	98.2%	97.7%
	Service users on CPA 12 month review	95%	95.4%	95.4%	96.7%	96.5%	96.5%	96.9%	96.3%	97.0%	97.2%	96.0%	97.0%	97.2%
	Gatekeeping admissions by CRHT teams	95%	99.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	EIP 2 week wait	50%										35.3%*	76.1%	74.7%
	IAPT 6 week wait	75%							98.8%	98.8%	99.6%	98.4%	99.1%	98.8%
	IAPT 18 week wait	95%							100.0%	99.6%	100.0%	100.0%	99.6%	100.0%
	RTT waiting times (incomplete)	92%	99.5%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Clostridium Difficile objective								1					
Outcomes	Delayed Transfers of care	7.5%	3.9%	3.4%	2.5%	3.2%	2.6%	2.5%	2.2%	2.0%	2.2%	2.7%	2.7%	2.0%
	Data Quality : Outcomes	50%	91.5%	91.4%	92.4%	92.4%	92.3%	92.6%	92.4%	92.8%	93.0%	92.4%	92.8%	93.5%
	Data Quality: completeness	97%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%
	LD access requirements													
Risk/failure to deliver Commissioner Requested Services			None	None	None	None	None	None	None	None	None	None	None	None
CQC Compliance action outstanding			None	None	None	None	None	None	None	None	None	None	None	None
CQC enforcement action in the last 12 months			None	None	None	None	None	None	None	None	None	None	None	None
CQC enforcement action in effect			None	None	None	None	None	None	None	None	None	None	None	None
Moderate CQC concerns			None	None	None	None	None	None	None	None	None	None	None	None
Major CQC concerns			None	None	None	None	None	None	None	None	None	None	None	None
Non compliance with CQC registration			None	None	None	None	None	None	None	None	None	None	None	None

*Note that performance is measured on quarterly basis and the EIP target was achieved overall in 2015-16 quarter 4.

Appendix 2

CQC Registered locations

The following table outlines the Trust's primary locations for healthcare services as at 31st March 2016.

Locations	Regulated Activities			Service Types						
	Treatment of Disease, Disorder or Injury	Diagnostic and Screening Procedures	Assessment or medical treatment for persons detained under the Mental Health Act 1983	CHC	LDC	LTC	MHC	MLS	PHS	RHS	SMC
Brooke House	•	•	•							•	
Craigavon Short Break Respite Unit	•	•	•					•			
Elm House	•	•	•					•			
Ferndene	•	•	•			•		•		•	
Heppell House	•	•	•			•				•	
Hopewood Park	•	•	•			•				•	
Monkwearmouth Hospital	•	•	•			•		•		•	
Campus for Ageing and Vitality	•	•	•					•		•	
Northgate Hospital	•	•	•			•		•		•	
Queen Elizabeth Hospital	•	•	•					•			
Rose Lodge	•	•	•					•			
Royal Victoria Infirmary	•	•	•					•			
St George's Park	•	•	•			•		•		•	
St Nicholas Hospital	•	•	•	•	•	•	•	•	•	•	•
Walkergate Park	•	•	•					•			

Key

CHC – Community health care services
LDC – Community based services for people with a learning disability
LTC – Long-term conditions services
MHC – Community based services for people with mental health needs
MLS – Hospital services for people with mental health needs, and/or learning disabilities, and/or problems with substance misuse
PHS – Prison healthcare services
RHS – Rehabilitation services
SMC – Community based services for people who misuse substances

CQC Registered Locations, Regulated Activities and Service Types – Social and Residential

Registered Home/Service	Regulated Activity	Service Type
	Accommodation for persons who require nursing or personal care	Care home service without nursing
Easterfield Court	•	•

Appendix 3

Local Clinical Audits

Project (Local Clinical Audits)	
Board Assurance Framework	
CA-15-0020	Care Co-ordination Audit – IAPT
CA-15-0021	Care Co-ordination Audit – Specialist Care
Trust Programme	
CA-15-0045	Audit of Transition Between Inpatient & Community Services
Inpatient Care Group (Urgent Care) Programme	
CA-15-0011	Audit of Mental State Examination Recording in Admission Documentation (Core Assessment Document)
CA-15-0013	Quality Improvement Audit: Prescribing Practice in Old Age Psychiatry
CA-15-0014	Improving psychotropic medication side effect information given to patients admitted to Rosewood, Hopewood Park.
CA-15-0028	An analysis of current rapid tranquilisation monitoring in relation to policy requirements
CA-15-0060	Cardio-Metabolic Monitoring of Inpatients at Rose Lodge
Medicines Management Programme	
CA-15-0026	Medical Gas Storage
Community Services Group Programme	
CA-15-0005	Audit of anti-psychotic monitoring in a Crisis Team setting
CA-15-0035	Physical monitoring of patients prescribed anti-psychotics
CA-15-0047	Advance Statements / Advance Directives Record Keeping
CA-15-0056	Physical health monitoring of anti-psychotic medication according to Trust Guidelines
CA-15-0066	Audit of dementia diagnosis recording across secondary and primary care
CA-15-0101	Use of CRHT prescription chart within the Sunderland Crisis Team – does it comply with Trust Policies?
Specialist Care Group Programme	
CA-15-0086	Urine drug screening for newly admitted patients to Redburn Ward (Re-audit)
CA-15-0006	Audit of departmental Clinical Professional Development (CPD) Activities 2015
CA-15-0008	Clinical audit on prescription of psychotropic medications for referred patients for admission to Learning Disability Child & Adolescent Services at Ferndene, comparing practice against standards like NICE Guidelines
CA-15-0009	Record Keeping Audit
CA-15-0010	Assessing the quality of smoking cessation provision and documentation in a Forensic Inpatient Unit
CA-15-0016	5-A-Day – Are young people with a learning disability supported to meet this target?
CA-15-0039	Audit determining compliance with the legislation relating to Capacity & Consent, Codes of Practice relating to the legislation and the Trust's Electronic Record (RiO) Systems with regards to CT012 Forms
CA-15-0074	Re-audit of referrals process for Bamburgh Clinic
CA-15-0082	Audit of letter quality at the Regional Affective Disorder Service
CA-15-0083	Audit on physical health monitoring for patients accepted by Adolescent Bipolar Services (ABS)
CA-15-0085	Timeliness of medical assessment when admitted to NTW Mother & Baby Unit, St George's Park Hospital
CA-15-0111	Benzodiazepine prescribing: assessment of reduction plan implementation for patients above the BNF guided dose of Benzodiazepines and z-drugs?

Appendix 4

Statement of Directors' Responsibilities in respect of the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015-16;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period April 2015 to May 2016
- papers relating to Quality reported to the Board over the period April 2015 to May 2016
- feedback from Commissioners dated May 2016
- feedback from governors dated May 2016
- feedback from Local Healthwatch organisations dated May 2016
- feedback from Overview and Scrutiny Committee dated May 2016
- the Trusts complaints information presented to the Board that has not yet been published under regulation 18 of the Local Authority, Social Services and NHS Complaints Regulations 2009, dated May 2016
- the 2015 national patient survey
- the 2015 national staff survey
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2016
- CQC Intelligent Monitoring Report dated February 2016

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report; and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts Regulations published at **www.monitor.gov.uk/annualreportingmanual)** as well as the standards to support data quality for the preparation of the Quality Report **(available at www.monitor.gov.uk/annualreportingmanual).**

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

By order of the Board

Hugh Morgan-Williams
Chairman
25th May 2016

John Lawlor
Chief Executive
25th May 2016

Appendix 5

Limited Assurance Report on the content of the Quality Report

Independent Auditor's Report to the Council Of Governors of Northumberland, Tyne And Wear NHS Foundation Trust on the Quality Report.

We have been engaged by the Council of Governors of Northumberland, Tyne and Wear NHS Foundation Trust to perform an independent assurance engagement in respect of Northumberland, Tyne and Wear NHS Foundation Trust's Quality Report for the year ended 31 March 2016 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital; and
- minimising delayed transfers of care

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in Monitor's Detailed Guidance for External Assurance on Quality Reports 2015/16; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and considered the implications for our report if we became aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2015 to April 2016;
- Papers relating to quality reported to the Board over the period April 2015 to April 2016;
- Feedback from Commissioners, Northumberland, North Tyneside, Newcastle Gateshead, Sunderland and the South Tyneside Clinical Commissioning Groups;
- Feedback from governors;
- Feedback from local Healthwatch organisations, Healthwatch Newcastle, Healthwatch Northumberland, Healthwatch North Tyneside and Healthwatch Gateshead;
- Feedback from Overview and scrutiny committee, Newcastle Council, Northumberland Council, Gateshead Council, Sunderland City Council, and South Tyneside Council;
- The trust's complaints information that has not yet been published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, covering the period April 2015 to March 2016;
- The 2015 national patient survey;
- The 2015 national NHS staff survey;
- Care Quality Commission Intelligent Monitoring Reports, dated June 2015 and February 2016;
- The Head of Internal Audit's annual opinion over the trust's control environment for the period April 2015 to March 2016; and
- Any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Northumberland, Tyne and Wear NHS Foundation Trust as a body, to assist the Council of Governors in reporting Northumberland, Tyne and Wear NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the Council of Governors to demonstrate that it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Northumberland, Tyne and Wear NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

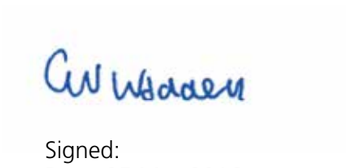
The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Northumberland, Tyne and Wear NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in Monitor's Detailed Guidance for External Assurance on Quality Reports 2015/16; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.



Signed:
Date: 25 May 2016

Cameron Waddell (CPFA) Engagement Lead, for and on behalf of Mazars LLP
Chartered Accountants and Statutory Auditor
Rivergreen Centre, Aykley Heads, Durham, DH1 5TS

Appendix 6

Glossary of Terms

AIMS	Accreditation for inpatient mental health services
Care Co-ordinator	A named person to co-ordinate the services a patient receives where their needs are numerous or complex, or where someone needs a range of different services.
Care Packages and Pathways	A project to redesign care pathways that truly focus on value and quality for the patient.
Commissioners	Members of Primary Care Trusts (PCT's), regional and national commissioning groups responsible for purchasing health and social care services from NHS Trusts.
CQUIN	Commissioning for Quality and Innovation – a scheme whereby part of our income is dependant upon improving quality
CMHT	Community Mental Health Team
CRHT	Crisis Resolution Home Treatment – a service provided to service users in crisis.
Clinician	A clinician is a health professional. Clinicians come from a number of different healthcare professions such as psychiatrists, psychologists, nurses, occupational therapists etc.
Clusters	Clusters are used to describe groups of service users with similar types of characteristics.
CQC	Care Quality Commission – the independent regulator of health and adult social care in England. The CQC registers (licenses) providers of care services if they meet essential standards of quality and safety and monitor them to make sure they continue to meet those standards.
CPA	Care Programme Approach. CPA is a term for describing the process of how mental health services service users' needs, plan ways to meet them and check that they are being met.
CYPS	Children and Young Peoples Services – also known as CAMHS
Dashboard	An electronic system that presents relevant information to staff, service users and the public
Dual Diagnosis	Service users who have a mental health need combined with alcohol or drug usage
Forensic	Forensic teams provide services to service users who have committed serious offences or who may be at risk of doing so
HoNOS/HoNOS 4 factor model	Health of the Nation Outcome Scales. A clinical outcome measuring tool.

IAPT	Improving Access to Psychological Therapies – a national programme to implement National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders.
LD	Learning Disabilities
Lead Professional	A named person to co-ordinate the service a patient receives if their needs are not complex.
Leave	A planned period of absence from an inpatient unit which can range from 30 minutes to several days
MHA	Mental Health Act
MHMDS	Mental Health minimum data set – a standard set of information sent from mental health providers to the Information Centre
Monitor	The independent regulator of NHS Foundation Trusts, ensuring they are well led and financially robust.
Monitor Compliance Framework	Monitor asks Foundation Trusts to assess their own compliance with the terms of their authorisation. NHS foundation Trusts submit an annual plan, quarterly and ad hoc reports to Monitor.
Multi- Disciplinary Team	Multi-disciplinary teams are groups of professionals from diverse disciplines who come together to provide care – i.e. Psychiatrists, Clinical Psychologists, Community Psychiatric Nurses, Occupational Therapists etc.
Next Steps	A group of projects to ensure that the organisation is fit for the future and provides services that match the best in the world.
NEQOS	North East Quality Observatory System – an organisation that helps NHS Trusts to improve quality through data measurement
NHS Performance Framework	An assessment of the performance of NHS Trusts against minimum standards. As a Foundation Trust we are not required to report against these standards however we have decided to utilise the framework to strengthen our performance management function.
NHS Safety Thermometer	The NHS Safety Thermometer provides a quick and simple method of surveying patients harms and analysing results so that you can measure and monitor local improvement
NICE	National Institute for Health and Clinical Excellence – a group who produce best practice guidance for clinicians
NIHR	National Institute of Health Research – an NHS organisation undertaking healthcare related research
NPSA	National Patient Safety Agency
NTW	Northumberland, Tyne and Wear NHS Foundation Trust
Out of area placements	Service users who are cared for out of the North East area or service users from outside of the North East area being cared for in the North East.
Pathways of care	Service user journey through the Trust – may come into contact with many different services
PCT	Primary Care Trust – a type of NHS Trust that commissions primary, community and secondary care from providers
Points of You/How's it Going	NTW service user/carer feedback processes allowing us to evaluate the quality of services provided
Productive Ward	The Productive Ward focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency

QRP	Quality and Risk Profile – produced by the Care Quality Commission, this document gathers together key information about Northumberland, Tyne and Wear NHS Foundation Trust to support CQC's role in monitoring our compliance with the essential standards of quality and safety.
RIO	Electronic patient record
Shared Care	A partnership between two different healthcare organisations involved in an individual's care, i.e. between the Trust and the patient's GP.
SMART	Specific, Measurable, Achievable, Realistic, Timely – a way of setting objectives to make sure they are achievable
Serious Incident	Serious incident - an incident resulting in death, serious injury or harm to service users, staff or the public, significant loss or damage to property or the environment, or otherwise likely to be of significant public concern. This includes 'near misses' or low impact incidents which have the potential to cause serious harm.
SWEMWEBS	Warwick-Edinburgh Mental Wellbeing Scale – a clinical outcome measuring tool.
Transition	When a service user moves from one service to another i.e. from an inpatient unit to being cared for by a community team at home.

Accounts for the Period

1st April 2015 to 31st March 2016

Northumberland, Tyne and Wear NHS Foundation Trust

Independent Auditor's Report to the Council of Governors of Northumberland, Tyne and Wear NHS Foundation Trust

We have audited the financial statements of Northumberland, Tyne and Wear NHS Foundation Trust for the year ended 31 March 2016 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Net Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. 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 the 2015-16 Government Financial Reporting Manual (the 2015-16 FReM) and Monitor's NHS foundation trust annual reporting manual 2015/16.

We have also audited the information in the Remuneration and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers and related narrative notes;
- disclosure of payments for loss of office;
- the table of exit packages and related notes;
- analysis of staff numbers; and
- the table of pay multiples and related narrative notes.

This report is made solely to the Governors of Northumberland, Tyne and Wear NHS Foundation Trust in accordance with part 5 of the Local Audit and Accountability Act 2014 and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the accounting officer and the auditor

As described more fully in the Statement of Accounting Officer's Responsibilities, the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

The Chief Executive as accounting officer is also 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.

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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.

Our assessment of the risks of material misstatement

During the course of the audit we identified the following risks that had the greatest effect on our overall audit strategy:

- the risk of management override of controls. The ISAs mandate that this risk is deemed to be significant on all audits;
- income and expenditure recognition; and
- property valuation.

Our assessment and application of materiality

We apply the concept of materiality both in planning and performing our audit, and in evaluating the effect of misstatements on the financial statements and our audit. Materiality is used so we can plan and perform our audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free from material misstatement. The level of materiality we set is based on our assessment of the magnitude of misstatements that individually or in aggregate, could reasonably be expected to have influence on the economic decisions the users of the financial statements may take based on the information included in the financial statements. The overall materiality level we set for the Northumberland, Tyne and Wear NHS Foundation Trust financial statements was £2.994 million, which is approximately 1% of expenditure.

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £89,000, as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds.

Scope of the audit of the financial statements

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

We scoped our audit approach in response to the risks outlined above as follows:

RiskManagement override of controls

In all entities, management at various levels within an organisation are in a unique position to perpetrate fraud because of their ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. Due to the unpredictable way in which such override could occur, we consider there to be a risk of material misstatement due to fraud and thus a significant risk on all audits.

Revenue and expenditure recognition

There is a risk of fraud in the financial reporting relating to revenue and expenditure recognition due to the potential to inappropriately record revenue and expenditure in the wrong period. Due to there being a risk of fraud in revenue and expenditure recognition we consider it to be a significant risk on all audits.

Property valuation

Land and buildings are the Trust's highest value assets. Management engage an expert, to assist in determining the fair value of property to be included in the financial statements. Changes in the value of property may impact on the Statement of Comprehensive Income depending on the circumstances and the specific accounting requirements of the Annual Reporting Manual.

Audit approach

Our approach involved:

- testing the appropriateness of journal entries and other adjustments made in preparing the financial statements;
- reviewing the key areas within the financial statements where management has used judgement and applied estimation techniques; and
- reviewing significant transactions outside the normal course of business or that otherwise appear to be highly unusual.

Our approach involved evaluating the design and implementation of controls to mitigate these risks and undertaking a range of substantive procedures including:

- testing of material income and expenditure including tests to ensure transactions are recognised in the correct year;
- testing material year end receivables, payables, accruals and provisions;
- reviewing intra-NHS reconciliations and data matches;
- reviewing management oversight of material accounting estimates and any changes to accounting policies;
- reviewing judgements about whether the criteria for recognising provisions were satisfied; and
- testing of material adjustment journals.

Our approach involved:

- updating our understanding on the approach taken by the Trust in its valuation of land and buildings;
- reviewing the scope and terms of the engagement with the valuer and how management used the valuation report to value land and buildings in the financial statements;
- obtaining information on the methodology and the valuer's procedures to ensure objectivity and quality; and
- considering evidence of regional valuation trends.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General (C&AG), having regard to the guidance on the specified criterion issued by the C&AG in November 2015, 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 C&AG 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 2016.

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 to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of Northumberland, Tyne and Wear NHS Foundation Trust's affairs as at 31 March 2016 and of its income and expenditure for the year then ended;
- have been prepared properly in accordance with the accounting policies directed by Monitor; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Opinion on other matters

In our opinion:

- the part of the Remuneration and Staff Report subject to audit has been prepared properly in accordance with the requirements directed by Monitor with the consent of the Treasury as relevant to NHS Foundation Trusts; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not comply with Monitor's guidance;
- we refer the matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have a reason to believe that the Trust, or an 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;
- we issue a report in the public interest under Section 24, Schedule 7 of the Local Audit and Accountability Act 2014; or
- the Trust has not put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

In particular we are required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable and whether the annual report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed.

We are also required to report to you if, in our opinion, the governance statement is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements. We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the governance statement or that risks are satisfactorily addressed by internal controls.

We have nothing to report in these respects.

Certificate

We certify that we have completed the audit of the accounts of Northumberland, Tyne and Wear NHS Foundation Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Cameron Waddell, CPFA for and on behalf of Mazars LLP
Chartered Accountants and Statutory Auditor
Rivergreen Centre, Aykley Heads, Durham, DH1 5TS

25 May 2016

Foreword to the Accounts

These accounts for the period ended 31st March 2016 have been prepared by the Northumberland, Tyne & Wear NHS Foundation Trust under Schedule 7 of the National Health Service Act 2006, paragraphs 24 and 25 and in accordance with directions given by Monitor, the Independent Regulator of Foundation Trusts, and have been prepared on a going concern basis.

John Lawlor
Chief Executive
25th May 2016

Statement of Comprehensive Income

	Note	2015/16 £000	2014/15 £000
Operating income from patient care activities		**286,647**	280,620
Other operating income		**30,503**	34,358
Operating income from continuing operations	3	**317,150**	314,978
Operating expenses from continuing operations	4	**(299,425)**	(340,052)
Operating surplus/(deficit)		**17,725**	(25,074)
Finance costs			
Finance income	11	**116**	69
Finance expense - financial liabilities	12	**(5,694)**	(5,484)
Finance expense - unwinding of discount on provisions		**(84)**	(84)
PDC dividends payable		**(339)**	(1,031)
Net finance costs		**(6,001)**	(6,530)
Share of (deficit)/surplus from joint ventures		**(8)**	49
Surplus/(deficit) for the year		**11,716**	(31,555)
Other comprehensive income			
Impairments		**(88)**	(163)
Revaluations		**859**	758
Other reserve movements		**2**	0
Total comprehensive income/(expense) for the year		**12,489**	(30,960)

Statement of Financial Position

	Note	2015/16 £000	2014/15 £000
Non-current assets			
Intangible assets	14	**561**	453
Property, plant and equipment	15	**140,186**	122,952
Investments in associates and joint ventures	16	**38**	50
Trade and other receivables	21	**366**	102
Total non-current assets		**141,151**	123,557
Current assets			
Inventories	20	**303**	312
Trade and other receivables	21	**13,441**	20,701
Non-current assets for sale and assets in disposal groups	17	**0**	1,645
Cash and cash equivalents	22	**27,433**	20,566
Total current assets		**41,177**	43,224
Current liabilities			
Trade and other payables	23	**(24,511)**	(25,026)
Borrowings	24	**(5,858)**	(6,156)
Provisions	28	**(978)**	(1,039)
Other liabilities	26	**(1,192)**	(999)
Total current liabilities		**(32,539)**	(33,220)
Total assets less current liabilities		**149,789**	133,561
Non-current liabilities			
Borrowings	24	**(96,973)**	(92,431)
Provisions	28	**(6,046)**	(6,149)
Other liabilities	26	**(301)**	(301)
Total non-current liabilities		**(103,320)**	(98,881)
Total assets employed		**46,469**	34,680
Financed by			
Taxpayers' equity:			
Public Dividend Capital		**202,611**	203,311
Revaluation reserve	30	**2,982**	2,298
Income and expenditure reserve		**(159,124)**	(170,929)
Total taxpayers' equity		**46,469**	34,680

The financial statements were approved by the Board on 25th May 2016 and signed on its behalf by:

John Lawlor, Chief Executive, 25th May 2016

Statement of Changes in Taxpayers' Equity: 1st April 2015 to 31st March 2016

		Taxpayers' Equity		
	Total	Public Dividend Capital	Revaluation Reserve	Income & Expenditure Reserve
	£000	£000	£000	£000
Others' and Taxpayers' equity at 1st April 2015	**34,680**	203,311	2,298	(170,929)
Surplus for the year	**11,716**	0	0	11,716
Transfer between reserves	**0**	0	0	0
Impairments	**(88)**	0	(88)	0
Revaluations - property, plant and equipment	**859**	0	859	0
Transfer to retained earnings on disposal of assets	**0**	0	(88)	88
Other reserves movements	**2**	0	1	1
Public Dividend Capital repaid	**(700)**	(700)	0	0
Others' and Taxpayers' equity at 31st March 2016	**46,469**	202,611	2,982	(159,124)

Statement of Changes in Taxpayers' Equity: 1st April 2014 to 31st March 2015

		Taxpayers' Equity		
	Total	Public Dividend Capital	Revaluation Reserve	Income & Expenditure Reserve
	£000	£000	£000	£000
Others' and Taxpayers' equity at 1st April 2014	**64,006**	201,677	12,344	(150,015)
Deficit for the year	**(31,555)**	0	0	(31,555)
Transfer between reserves	**0**	0	0	0
Impairments	**(163)**	0	(163)	0
Revaluations - property, plant and equipment	**758**	0	758	0
Transfer to retained earnings on disposal of assets	**0**	0	(10,622)	10,622
Other reserves movements	**0**	0	(19)	19
Public dividend capital received	**1,634**	1,634	0	0
Others' and Taxpayers' equity at 31st March 2015	**34,680**	203,311	2,298	(170,929)

Statement of Cash Flows

	Note	2015/16 £000	2014/15 £000
Cash flows from operating activities:			
Operating surplus/(deficit) from continuing operations		17,725	(25,074)
Operating surplus/(deficit)		17,725	(25,074)
Non-cash income and expense:			
Depreciation and amortisation		6,007	5,851
Impairments		3,364	51,850
Reversals of impairments		(10,950)	(13,478)
Loss/(gain) on disposal of property, plant and equipment		107	(1,426)
Decrease/(increase) in trade and other receivables		6,925	(9,149)
Decrease in inventories		9	84
(Decrease)/increase in trade and other payables		(564)	2,799
Increase in other liabilities		193	549
(Decrease) in provisions		(248)	(1,197)
Other movements in operating cash flows		(6,976)	6,987
Net cash generated from/(used in) operations		15,592	17,796
Cash flows from investing activities:			
Interest received		118	68
Purchase of intangible assets		(154)	(377)
Purchase of Property, Plant and Equipment and Investment Property		(15,615)	(14,131)
Sales of Property, Plant and Equipment and Investment Property		9,290	6,889
Net cash (used in) investing activities		(6,361)	(7,551)
Cash flows from financing activities:			
Public dividend capital received		0	1,634
Public dividend capital repaid		(700)	0
Loans received from the Department of Health		10,400	4,600
Loans repaid to the Department of Health		(4,590)	(4,470)
Capital element of finance lease rental payments		(60)	(60)
Capital element of PFI, LIFT and other service concession payments		(1,505)	(977)
Interest paid		(1,291)	(1,225)
Interest element of finance lease		(42)	(44)
Interest element of PFI, LIFT and other service concession obligations		(4,345)	(4,224)
PDC Dividend paid		(231)	(208)
Net cash (used in) financing activities		(2,364)	(4,974)
Increase in cash and cash equivalents		6,867	5,271
Cash and cash equivalents at 1st April		20,566	15,295
Cash and cash equivalents at 31st March	22	27,433	20,566

Notes to the Accounts

1. Accounting Policies and other Information

Monitor is responsible for issuing an accounts direction to NHS Foundation Trusts under the NHS Act 2006. Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting Convention

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

1.1.1 Going Concern

These accounts have been prepared on a going concern basis following an assessment by the Trust of the historical, current and future performance of the Trust and an assessment of the risk to the continuity of services.

1.2 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trusts accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of revision and future periods if the revision affects both current and future periods.

1.2.1 Critical judgements in applying accounting policies

The following are critical judgements, apart from those involving estimations (see 1.2.2) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

The Trust has made critical judgements, based on accounting standards, in the classification of leases and arrangements containing a lease.

The Trust has made critical judgements in relation to the Modern Equivalent Asset (MEA) revaluation as at the 31st March 2016. The District Valuer carries out a professional valuation of the modern equivalent asset required to have the same productive capacity and service potential as existing Trust assets. Judgements have been made by the Trust in relation to floor space, bed space, garden space, car parking areas and all areas associated with the capacity required to deliver the Trust's services as at 31st March 2016.

1.2.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Under International Accounting Standard (IAS) 37, significant provisions totalling £626,000 were made for probable transfers of economic benefits in respect of employee claims, legal costs and redundancy provisions. Legal claims are based on professional assessments, which are uncertain to the extent that they are an estimate of the probable outcome of individual cases. Also, under IAS 19, accruals have been made for the value of carried forward annual leave owed totalling £1,211,000 and £18,000 receivable for leave taken in advance.

The Trust's revaluations of land and buildings are based on professional valuations provided by the District Valuer on a Modern Equivalent Asset basis as per note 1.6. Impairments are recognised on the basis of these valuations.

1.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with Commissioners in respect of health care services.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

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

1.4 Expenditure on Employee Benefits

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

Pension Costs: NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

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

1.5 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.

1.6 Property, Plant and Equipment

1.6.1 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; and
- the cost of the item can be measured reliably
- the item has cost at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

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

(a) Property Assets
Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with

sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

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

For non-operational properties including surplus land, the valuations are carried out at open market value.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. The Trust has applied the modern equivalent asset approach to valuations since 1 April 2009. The Trust's appointed professionally qualified valuer is the District Valuer (North) based at the Durham Valuation Office. IAS 16 requires that the carrying value of property is not materially different to fair value at the balance sheet date. To reflect changes in the property market and building cost indexation since the last valuation as at 31 March 2015, a review of the values of land and buildings was undertaken as at 31st March 2016.

Additional alternative valuations of open market value or value in existing use have been obtained for non-operational assets held for sale or operational properties where disposal is planned and imminent.

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

(b) Non-property Assets
NHS bodies may elect to adopt a depreciated historical cost basis as a proxy for fair value for assets that have short useful lives or low values (or both). For depreciated historical cost to be considered as a proxy for fair value, the useful life must be a realistic reflection of the life of the asset and the depreciation method used must provide a realistic reflection of the consumption of that asset class.

Assets that are not covered by the above paragraph should be carried at fair value and should be valued using the most appropriate valuation methodology available.

Until 31st March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1st April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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.

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

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

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by the Trust's professional valuers. Leaseholds are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the estimated life. The Trust adheres to standard lives for equipment assets except where it is clear that the standard lives are materially inappropriate. Standard equipment lives are:

Short life engineering plant and equipment	5 years
Medium life engineering plant and equipment	10 years
Long life engineering plant and equipment	15 years
Vehicles	7 years
Furniture	10 years
Office and IT equipment	5 years
Soft furnishings	7 years

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

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

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

Impairments
In accordance with the NHS Foundation Trust Annual Reporting Manual 2015-16, 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 income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

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

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

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

The revaluation surplus included in equity in respect of an item of property, plant and equipment is transferred in full to retained earnings at the point in time when an asset is derecognised. This applies when an asset is sold or when an asset is retired or disposed of.

Donated, government grant and other grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/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.

Private Finance Initiative (PFI) Transactions
PFI transactions which meet the International Financial Reporting Interpretations Committee (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. The underlying assets are recognised as Property, Plant and Equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for the services. The finance cost is calculated using the implicit interest rate for the scheme, which is in accordance with guidance issued by the Department of Health: 'Accounting for PFI under IFRS'.

The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

For each year of the contract, an element of unitary payment is allocated to lifecycle replacement based on the capital costs that the operator expect, at financial close, to incur for that year. Life-cycle expenditure is capitalised in accordance with IAS 16 when the expenditure meets the Trust's recognition criteria as detailed above to the extent that the capital is funded by the unitary payment. Where all or part of the capital cost is unanticipated, or the cost of the asset is greater than planned, the Trust treats it as a free asset. Where the operator replaces lifecycle components earlier or later than planned but the cost of the replacement was anticipated in the operator's model, this is recognised as a temporary liability or temporary prepayment.

1.7 Intangible Assets

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 and where the cost is at least £5,000.

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 e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the 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 e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

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

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

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

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Software is amortised on current cost evenly over the estimated life. The Trust adheres to standard lives for software assets except where it is clear that the standard lives are materially inappropriate. The asset lives for standard software is 5 years.

1.8 Government Grants

Government grants are grants from Government bodies other than income from Commissioners or NHS 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.

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) basis. This is considered to be a reasonable approximation to fair value due to the high turnover of inventories.

1.10 Cash and cash equivalents

Cash and cash equivalents include cash held in the Government Banking Service, cash with commercial banks and cash in hand. Cash and bank balances are recorded at the current values of these balances in the Trust's cash book. Interest earned on bank accounts is recorded as finance income in the period to which it relates. Bank charges are recorded as operating expenditure in the periods to which they relate.

As the Trust has no bank overdrafts, there is no difference between the amounts disclosed as cash and cash equivalents in the Statement of Financial Position and in the Statement of Cash Flows.

1.11 Financial Instruments and Financial Liabilities

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

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described in note 1.12.

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

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

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

Classification and Measurement
Financial assets are categorised as 'Fair Value through Income and Expenditure', Loans and receivables or 'Available-for-sale financial assets'.

Financial liabilities are classified as 'Fair Value through Income and expenditure' or as 'Other Financial Liabilities'.

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

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

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

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

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

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

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

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

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

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

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance Property, Plant and Equipment or intangible assets is not capitalised as part of the cost of those assets.

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

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

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a provision for irrecoverable debt. Irrecoverable debt provisions are made when debts are over 3 months old, unless there is a reason not to make the provision, such as an agreement to pay. In the case of disputes, provisions are made for debts less than 3 months old.

1.12 Leases

1.12.1 Trust as Lessee

Finance Leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

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

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

Operating Leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Contingent rentals are recognised 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.

1.12.2 Trust as 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 lease. Income is allocated to accounting periods so as to reflect a constant periodic rate of return.

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 on a straight-line basis over the lease term.

1.12.3 Disclosures

In accordance with IAS 17 the Trust will disclose a description of significant leasing arrangements including;

i) the basis on which contingent rent is determined;

ii) the existence and terms of renewal, purchase options and escalation clauses; and

iii) any restrictions imposed by lease arrangements.

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 the discount rates published and mandated by HM Treasury.

Clinical Negligence Costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed in note 28.2 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 the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

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 29 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 29, 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.

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 Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set

by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

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.

1.17 **Corporation Tax**

Foundation Trusts are exempt from corporation tax on their principle health care income under section 519A Income and Corporation Taxes Act 1988. In determining whether other income may be taxable, a full review of the Trust's activities has been carried out in accordance with guidance published by HM Revenue and Customs to establish any activities that are subject to Corporation Tax. Based on this review there is no corporation tax liability in the period ended 31st March 2015.

1.18 **Foreign Exchange**

The functional and presentational currencies of the Trust are sterling.

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

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

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

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

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

1.19 **Third Party Assets**

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

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 NHS Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

1.21 **Transfers of Functions**

For functions that have been transferred to the Trust from another NHS or Local Government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain/ loss corresponding to the net assets/ liabilities transferred is recognised within income/expenses, but not within operating activities.

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

For functions that the Trust has transferred to another NHS/Local Government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss/gain corresponding to the net assets/ liabilities transferred is recognised within expenses/ income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

Adjustments to align the acquired function to the Foundation Trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

1.22 **Standards, amendments and interpretations in issue but not yet effective or adopted**

The standards or amendments which have been released but which are not mandatory in the 2015/16 accounts are set out below:

- IFRS 11 (amendment) - acquisition of an interest in a joint operation
- IAS 16 (amendment) and IAS 38 (amendment) - depreciation and amortisation
- IAS 16 (amendment) and IAS 41 (amendment) - bearer plants
- IAS 27 (amendment) - equity method in separate financial statements
- IFRS 10 (amendment) and IAS 28 (amendment) - sale or contribution of assets
- IFRS 10 (amendment) and IAS 28 (amendment) - investment in entities applying the consolidation exception
- IAS 1 (amendment) - disclosure initiative
- IFRS 15 Revenue from contracts with customers
- IFRS 9 Financial Instruments
- Annual improvements to IFRS: 2012:15 cycle

The Trust expects that there will be no material impact on the Financial Statements as a result of the adoption of these standards.

1.23 **Accounting Standards issued that have been adopted early**

No new accounting standards or revisions to existing standards have been early adopted in 2015/16.

1.24 **Investments in Associates and Joint Arrangements**

An entity is an associate of an NHS Foundation Trust where the Trust has significant influence over it and yet the entity is not a subsidiary or a joint arrangement. Where an associate exists, the Trust must recognise its activities through the equity accounting method in accordance with IAS 28.

Joint arrangements apply where two or more parties have joint control. Joint control is the contractually agreed sharing of control of an arrangement, which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control. A joint arrangement is either a joint operation or a joint venture.

Joint operations

Joint operations are arrangements in which the Trust has joint control with one or more other parties. Joint arrangements generally operate without the establishment of a separate formal entity and the Trust therefore has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statements its share of the assets, liabilities, income and expenses for joint operations.

The Trust has a joint operation with South Tees Foundation Trust for the provision of North East Quality Observatory System.

Joint Ventures

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Accounting as a joint venture generally applies where arrangements are structured through a separate vehicle which confers a separation between the parties and the vehicle and as a result, the assets, liabilities, revenues and expenses held are those of the separate vehicle and

the Trust only has an investment in the net assets of the vehicle. Joint ventures and investments in associates are accounted for using the equity method and reported in its separate financial statements in accordance with IAS 27. The joint venture is initially recognised at cost. It is increased or decreased subsequently to reflect the Trust's share of the entity's profit or loss or other gains and losses. It is also reduced when any distribution, e.g. share dividends, are received by the Trust from the joint venture.

The Trust has a 50% share in a limited liability partnership with independent healthcare providers Insight Ltd (formerly MHCO) which is a Joint Venture. The Newcastle Talking Therapies LLP has been commissioned by NHS North of Tyne to deliver a service aimed at 'Improving Access to Psychological Therapies - IAPT' for the people of Newcastle.

1.25 Consolidation of NHS Charitable Funds

Prior to 2013/14, the FT Annual Reporting Manual permitted NHS Foundation Trusts not to produce consolidated accounts to include NHS charitable funds. From 2013/14, where the NHS Foundation Trust is the corporate trustee of the charitable funds and where the fund balances held are material, Foundation Trusts are required to assess their relationship to the charitable funds and account for the funds as a subsidiary where the Trust has the power to govern the financial and operating policies of the charitable fund.

For 2015/16 the Trust benefited from charitable funds held by the Newcastle Healthcare Charity as Special Trustee. For 2015/16, the Trust is not corporate trustee of the charitable funds and does not have the power to govern the financial and operating policies of the charitable funds held on behalf of the Trust. Consolidation is therefore not appropriate. From 1st April 2016, the Trust is the Corporate Trustee of the Northumberland, Tyne and Wear NHS Foundation Trust Charity (charity number 1165788) which holds these charitable funds.

2. Segmental Analysis

The Trust is solely involved in health care activities and does not consider that its clinical services represent distinct operating segments.

Of the total income reported during the financial year, £268,912,000, 85% of total income, was received from Clinical Commissioning Groups (CCGs) and NHS England (2014/15: £261,060,000 and 83%). As CCGs and NHS England are under common control they are classed as a single customer for this purpose.

3. Income

3.1 Operating Income (by nature)

	2015/16	Restated 2014/15
	£000	£000
Income from activities		
Cost and volume contract income	**36,190**	39,120
Block contract income	**249,614**	241,357
Additional income for delivery of healthcare services	**700**	0
Private patient income	**143**	143
Total income from activities	**286,647**	280,620
Other operating income		
Research and development	**2,352**	2,212
Education and training	**8,472**	9,112
Cash donations received from other bodies	**0**	33
Non-patient care services to other bodies	**1,676**	1,521
Other*	**4,021**	4,162
Profit on disposal of land and buildings	**3**	1,543
Reversal of impairments of property, plant and equipment	**10,950**	13,478
Rental revenue from operating leases - minimum lease receipts	**199**	231
Income in respect of staff costs where accounted on gross basis	**2,830**	2,066
Total other operating income	**30,503**	34,358
Total operating income	**317,150**	314,978
of which:		
Related to Continuing Operations	**317,150**	314,978
Related to Discontinued Operations	**0**	0

* Other operating income - Other is analysed in note 3.4

The 2014/15 comparator has been restated for the recategorisation of income for non-commissioner requested services previously classified in other clinical income.

3.2 Private Patient Income

	2015/16	2014/15
	£000	£000
Private patient income	**143**	143
Total patient related income	**286,647**	280,620
Proportion (as percentage)	**0.05%**	0.05%

The statutory limitation on private patient income in section 44 of the 2006 Act was repealed with effect from 1 October 2012 by the Health and Social Care Act 2012. The Health and Social Care Act 2012 requires Foundation Trusts to make sure that the income they receive from providing goods and services for the NHS (their principle purpose) is greater than their income from other sources.

3.3 Operating Lease Income

The Trust leases land and buildings to a number of external bodies, mainly other NHS bodies.

	2015/16	2014/15
	£000	£000
Operating lease income		
Rental revenue from operating leases - minimum lease receipts	**199**	231
Total operating lease income	**199**	231
Future minimum lease payments due:		
on leases of land expiring		
- not later than one year;	**1**	1
- later than one year and not later than five years;	**4**	4
- later than five years.	**86**	87
sub total	**91**	92
on leases of buildings expiring		
- not later than one year;	**156**	229
- later than one year and not later than five years;	**523**	56
- later than five years.	**347**	158
sub total	**1,026**	443
Total future minimum lease payments due	**1,117**	535

3.4 Operating Income (by source)

	2015/16	2014/15
	£000	£000
Income from activities		
NHS Foundation Trusts	**602**	532
CCGs and NHS England	**268,912**	261,060
Local Authorities	**9,315**	9,718
Non-NHS: private patients	**144**	143
NHS injury scheme (was RTA)	**26**	1
Non NHS: other	**6,948**	9,166
Additional income for delivery of healthcare services	**700**	0
Total income from activities	**286,647**	280,620
Other operating income		
Research and development	**2,352**	2,212
Education and training	**8,472**	9,112
Cash donations received from other bodies	**0**	33
Non-patient care services to other bodies	**1,676**	1,521
Other*	**4,021**	4,162
Profit on disposal of land and buildings	**3**	1,543
Reversal of impairments of property, plant and equipment	**10,950**	13,478
Rental revenue from operating leases - minimum lease receipts	**199**	231
Income in respect of staff costs where accounted on gross basis	**2,830**	2,066
Total Other Operating Income	**30,503**	34,358
Total Operating Income	**317,150**	314,978

***Analysis of "Other operating income - Other"**		
Car Parking	**60**	50
Estates recharges	**151**	234
IT Recharges	**68**	79
Pharmacy Sales	**1**	5
Clinical Tests	**79**	85
Clinical excellence awards	**366**	404
Catering	**995**	979
Grossing up consortium arrangements	**2,058**	1,900
Other	**243**	426
Total	**4,021**	4,162

3.5 **Analysis of Income from activities arising from Commissioner Requested Services and all other Services**

	2015/16	2014/15
	£000	£000
Commissioner Requested Services	**285,102**	278,817
Non-Commissioner Requested Services	**1,545**	1,803
Total income from activities	**286,647**	280,620

4. Operating Expenses

	2015/16	Restated 2014/15
	£000	£000
Services from NHS Foundation Trusts	**1,063**	736
Services from NHS Trusts	**1**	0
Services from CCGs and NHS England	**28**	139
Purchase of healthcare from non NHS bodies	**5,953**	4,580
Employee Expenses - Executive directors	**968**	925
Employee Expenses - Non-executive directors	**169**	113
Employee Expenses - Staff	**234,172**	232,261
Supplies and services - clinical (excluding drug costs)	**3,708**	3,667
Supplies and services - general	**3,942**	4,110
Establishment	**3,570**	1,548
Research and development - (not included in employee expenses)	**710**	770
Research and development - (included in employee expenses)	**1,402**	1,327
Transport (business travel only)	**2,631**	2,431
Transport (other)	**1,824**	1,860
Premises - business rates payable to local authorities	**822**	1,046
Premises other	**11,964**	11,580
Increase/(decrease) in provision for impairment of receivables	**44**	(50)
Change in provisions discount rates	**(54)**	338
Inventories written down (net, including inventory drugs)	**17**	10
Drug costs (non-inventory drugs only)	**1,274**	1,426
Drug inventories consumed	**3,562**	3,140
Rentals under operating leases - minimum lease receipts	**5,481**	5,621
Rentals under operating leases - contingent rent	**96**	93
Rentals under operating leases - sublease payments	**(13)**	(13)
Depreciation on property, plant and equipment	**5,961**	5,825
Amortisation on intangible assets	**46**	26
Impairments of property, plant and equipment	**3,364**	51,763
Impairments of assets held for sale	**0**	87
Audit services - Statutory audit	**48**	48

4. Operating Expenses (continued)

	2015/16	Restated 2014/15
	£000	£000
Clinical negligence	**298**	308
Loss on disposal of property, plant and equipment	**110**	117
Legal fees	**696**	(138)
Consultancy costs	**815**	374
Internal audit costs (not included in employee expenses)	**40**	40
Internal audit costs (included in employee expenses)	**190**	190
Training, courses and conferences	**1,401**	972
Patient travel	**421**	363
Redundancy - (Not included in employee expenses)	**1,229**	226
Early Retirements - (Not included in employee expenses)	**33**	175
Hospitality	**22**	30
Insurance	**512**	665
Losses, ex gratia & special payments - (Not included in employee expenses)	**35**	9
Other	**870**	1,314
Total	**299,425**	340,052
of which:		
Related to Continuing Operations	**299,425**	340,052
Related to Discontinued Operations	**0**	0

The prior year comparator has been restated due to additional disclosures in relation to additional internal audit disclosures.

5. Senior Managers Remuneration

	2015/16	2014/15
	£000	£000
Total of key management personnel compensation:		
Short-term employee benefits	**921**	838
Post-employment benefits	**110**	103
Total key management compensation	**1,031**	941

Key management personnel includes the executive and non-executive directors, which together comprised 17 directors in the financial year 2015/16. There are 10 non-executive and 7 executive directors in post for full or part-year periods. Full directors remuneration details for individual senior managers are provided within the Trust's Annual Report.

Post employment benefits include contributions made by the Trust to the NHS Pension Scheme only.

There were no other long-term benefits, termination benefits or share-based payments made to senior managers during the year.

No advances were made and no credits were granted by the Trust to directors during the year. The Trust has not provided any guarantees on behalf of directors during the year.

6. Exit Packages

6.1 Exit Packages 2015/16

	Compulsory Redundancies	Compulsory Redundancies	Other Departures Agreed	Other Departures Agreed	Total Exit Packages	Total Exit Packages	Special Payments	Special Payments
	Number	£000	Number	£000	Number	£000	Number	£000
Exit package cost band:								
< £10,000	**0**	0	6	30	**6**	**30**	0	0
£10,001 to £25,000	**0**	0	0	0	**0**	**0**	0	0
£25,001 to £50,000	**0**	0	3	105	**3**	**105**	0	0
£50,001 to £100,000	**0**	0	7	482	**7**	**482**	0	0
£100,001 to £150,000	**0**	0	2	269	**2**	**269**	0	0
£150,001 to £200,000	**0**	0	0	0	**0**	**0**	0	0
> £200,001	**0**	0	0	0	**0**	**0**	0	0
Total	**0**	0	18	886	**18**	**886**	0	0

Redundancy and other departure costs have been paid within the provisions of Agenda for Change terms and conditions.

The termination benefits included in exit packages relate to redundancy and early retirement contractual costs.

6.2 Exit Packages 2014/15

	Compulsory Redundancies	Compulsory Redundancies	Other Departures Agreed	Other Departures Agreed	Total Exit Packages	Total Exit Packages	Special Payments	Special Payments
	Number	£000	Number	£000	Number	£000	Number	£000
Exit package cost band:								
< £10,000	**0**	0	1	8	**1**	**8**	0	0
£10,001 to £25,000	**0**	0	2	38	**2**	**38**	0	0
£25,001 to £50,000	**0**	0	0	0	**0**	**0**	0	0
£50,001 to £100,000	**0**	0	3	207	**3**	**207**	0	0
£100,001 to £150,000	**0**	0	1	114	**1**	**114**	0	0
£150,001 to £200,000	**0**	0	0	0	**0**	**0**	0	0
> £200,001	**0**	0	0	0	**0**	**0**	0	0
Total	**0**	0	7	367	**7**	**367**	0	0

Redundancy and other departure costs have been paid within the provisions of Agenda for Change terms and conditions.

The termination benefits included in exit packages relate to redundancy and early retirement contractual costs.

7. Employee Expenses

7.1 Employee Expenses

	Total	Permanently Employed	Other	Restated Total	Permanently Employed	Other
	2015/16	2015/16	2015/16	2014/15	2014/15	2014/15
	£000	£000	£000	£000	£000	£000
Salaries and wages	**186,112**	184,823	1,289	**187,315**	186,172	1,143
Social security costs	**13,525**	13,525	0	**13,692**	13,692	0
Pension cost - defined contribution plans:						
Employers contributions to NHS Pensions	**24,048**	24,048	0	**23,157**	23,157	0
Pension cost - other contributions	**0**	0	0	**0**	0	0
Termination benefits	**0**	0	0	**0**	0	0
Agency/contract staff	**13,616**	0	13,616	**11,149**	0	11,149
Total staff costs	**237,301**	222,396	14,905	**235,313**	223,021	12,292
included within:						
Costs capitalised as part of assets	**569**	569	0	**610**	610	0
Analysed into operating expenditure						
Employee Expenses - Staff	**234,172**	219,304	14,868	**232,261**	219,984	12,277
Employee Expenses - Executive Directors	**968**	968	0	**925**	925	0
Research & Development	**1,402**	1,400	2	**1,327**	1,312	15
Internal audit costs	**190**	155	35	**190**	190	0
Total employee benefits excluding capitalised costs	**236,732**	221,827	14,905	**234,703**	222,411	12,292

The 2014/15 comparatives have been restated for an additional disclosure of internal audit costs.

7.2 Average Number of Employees (whole time equivalent basis)

	Total	Permanently Employed	Other	Restated Total	Permanently Employed	Other
	2015/16	2015/16	2015/16	2014/15	2014/15	2014/15
	Number	Number	Number	Number	Number	Number
Medical and dental	**331**	303	28	**326**	300	26
Administration and estates	**1,236**	1,162	74	**1,206**	1,137	69
Healthcare assistants and other support staff	**494**	449	45	**493**	458	35
Nursing, midwifery and health visiting staff	**3,524**	3,357	167	**3,453**	3,312	141
Scientific, therapeutic and technical staff	**391**	375	16	**366**	353	13
Healthcare science staff	**334**	334	0	**319**	319	0
Other	**0**	0	0	**0**	0	0
Total average numbers	**6,310**	5,980	330	**6,163**	5,879	284
of which:						
Number of employees (WTE) engaged on capital projects	**14**	14	0	**13**	13	0

The 2014/15 comparatives have been restated for an additional disclosure for healthcare science staff.

7.3 Exit Packages: other (non-compulsory) departure payments

	Payments Agreed	Total Value of Agreements	Payments Agreed	Total Value of Agreements
	2015/16	2015/16	2014/15	2014/15
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	**8**	**886**	7	367
Total Exit packages	**8**	**886**	7	367

7.4 **Employee Benefits**

The cost of leave 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. There were no other employee benefits during the year (2014/15 : £nil).

7.5 **Early Retirements due to Ill Health**

During the year there were 10 early retirements (2014/15 : 9) from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £588,000 (2014/15 : £363,000). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

8. Operating Miscellaneous

8.1 **Operating Leases**

The Trust has operating lease arrangements for the use of land, buildings, vehicles and equipment. Within some of these arrangements contingent rent is paid based on an annual uplift for future price indices (RPI).

	2015/16	2014/15
	£000	£000
Minimum lease payments	**5,481**	5,621
Contingent rents	**96**	93
Less sublease payments received	**(13)**	(13)
Total	**5,564**	5,701
Future minimum lease payments due:		
- not later than one year;	**5,870**	5,701
- later than one year and not later than five years;	**5,740**	5,038
- later than five years.	**2,041**	2,379
Total	**13,651**	13,118
Total of future minimum sublease lease payments to be received	**(13)**	(13)

8.2 **Limitations on Auditors Liability**

There is no specified limitation on the auditors liability for the year (2014/15 : no specified limitation).

8.3 **The Late Payment of Commercial Debts (Interest) Act 1998**

The Trust had no late payment of interest on commercial debts or compensation paid to cover debt recovery costs as at 31st March 2016 (31st March 2015 : £nil).

8.4 **Audit Remuneration**

The Trust had no other audit remuneration as at 31st March 2016 (31st March 2015 : £nil). Auditors remuneration for the statutory audit is shown in note 4.

9. Discontinued Operations

The Trust had no discontinued operations as at 31st March 2016 (31st March 2015: £nil).

10. Corporation Tax

Foundation Trusts are exempt from corporation tax on their principle health care income under section 519A Income and Corporation Taxes Act 1988.

A full review of the Trusts activities has been carried out in accordance with guidance published by HM Revenue & Customs to establish any activities that are subject to Corporation Tax. Based on this review there is no corporation tax liability in the year ended 31st March 2016 (31st March 2015: £nil).

11. Finance Income

	2015/16	2014/15
	£000	£000
Interest on bank accounts	**116**	69
Interest on loans and receivables	**0**	0
Total	**116**	69

12. Finance Costs

	2015/16	2014/15
	£000	£000
Interest expense:		
Capital loans from the Department of Health	**1,307**	1,216
Finance leases	**42**	44
Finance Costs on PFI and other service concession arrangements (excluding LIFT)		
Main finance costs	**2,921**	2,996
Contingent finance costs	**1,424**	1,228
Total	**5,694**	5,484

13. Impairment of Assets

During the year, the Trust recognised net reversals of impairments totalling (£7,498,000) made up of reversal of impairments credited to other operating income of (£10,950,000) and impairments charged to operating expenses of £3,364,000 and impairments totalling £88,000 being charged to the revaluation reserve utilising positive reserve balances.

The net reversal of impairments recognised during the year are predominantly as a result of a valuation carried out by the District Valuer to reflect current market conditions as at 31st March 2016. NHS specialised buildings have increased in value by approximately 11% in 2015/16.

14. Intangible Assets

14.1 Intangible Assets 2015/16

	Total	Software Licences purchased	Intangible Assets under Construction	
	2015/16	2015/16	2015/16	2014/15
	£000	£000	£000	£000
Valuation/gross cost at 1st April 2015	479	228	251	102
Additions - purchased	154	49	105	377
Valuation/gross cost at 31st March 2016	633	277	356	479
Amortisation at 1st April 2015	26	26	0	0
Provided during the year	46	46	0	26
Amortisation at 31st March 2016	72	72	0	26
Net book value by ownership:				
NBV - purchased at 31st March	561	205	356	453

14.2 Economic Life of Intangible Assets

	Minimum Life	Maximum Life
	Years	Years
Software licences purchased	3	5

15. Property, Plant and Equipment

15.1 Property, Plant and Equipment 2015/16

	Total	Land	Buildings exc. Dwellings	Dwellings	Assets under Construction	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1st April 2015	130,509	16,671	92,695	90	4,101	4,142	81	8,657	4,072
Additions - purchased	15,594	150	2,040	0	11,140	123	0	1,896	245
Additions - leased	15	0	15	0	0	0	0	0	0
Impairments charged to the revaluation reserve	(88)	0	(88)	0	0	0	0	0	0
Reclassifications	0	0	1,449	0	(2,099)	599	0	51	0
Revaluations	5,154	(105)	5,259	0	0	0	0	0	0
Transfers to/from assets held for sale & assets in disposal groups	(672)	(268)	(404)	0	0	0	0	0	0
Disposals	(1,632)	0	0	0	0	(55)	(9)	(1,294)	(274)
Valuation/gross cost at 31st March 2016	148,880	16,448	100,966	90	13,142	4,809	72	9,310	4,043
Accumulated depreciation at 1st April 2015	7,557	0	0	0	0	2,097	77	3,597	1,786
Provided during the year	5,961	0	3,288	3	0	450	4	1,793	423
Impairments charged to operating expenses	3,364	118	3,246	0	0	0	0	0	0
Reversal of impairments credited to operating income	(10,950)	(11)	(10,936)	(3)	0	0	0	0	0
Revaluations	4,295	(107)	4,402	0	0	0	0	0	0
Disposals	(1,533)	0	0	0	0	(44)	(9)	(1,294)	(186)
Accumulated depreciation at 31st March 2016	8,694	0	0	0	0	2,503	72	4,096	2,023
Net book value by ownership:									
Owned	113,489	16,398	74,319	90	13,142	2,306	0	5,214	2,020
Finance leased	822	50	772	0	0	0	0	0	0
On-Statement of Financial Position PFI contracts	25,842	0	25,842	0	0	0	0	0	0
Government granted	33	0	33	0	0	0	0	0	0
Donated	0	0	0	0	0	0	0	0	0
Net book value by ownership total at 31st March 2016	140,186	16,448	100,966	90	13,142	2,306	0	5,214	2,020

To ensure that asset values at 31st March 2016 reflect current market conditions valuations were carried out by the District Valuer.
Of the totals at 31 March 2016, £12,495,000 related to land, £92,458,000 related to buildings valued on a Modern Equivalent Asset alternative site basis.
Of the totals at 31 March 2016, £50,000 related to land, £3,214,000 related to buildings valued on a Modern Equivalent Asset no alternative site basis in relation to tenants improvements
Of the totals at 31 March 2016, £2,556,000 related to land, £4,060,000 related to buildings and £90,000 related to dwellings valued on a Market Value in Existing Use basis.
Of the totals at 31 March 2016, £1,347,000 related to land, £1,234,000 related to buildings valued on a fair value basis. These relate to surplus non-operational assets
Of the totals at 31st March 2016, plant and machinery, transport equipment, information technology and furniture and fittings are all valued on the basis of depreciated replacement cost.

15.2 Property, Plant and Equipment 2014/15

	Total	Land	Buildings exc. Dwellings	Dwellings	Assets under Construction	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1st April 2014	159,575	24,965	69,726	90	47,496	3,757	96	10,190	3,255
Additions - purchased	15,477	0	8,779	0	3,651	716	0	1,394	937
Impairments charged to the revaluation reserve	(163)	(29)	(134)	0	0	0	0	0	0
Reclassifications	0	0	46,928	0	(47,046)	91	0	0	27
Revaluations	(40,435)	(8,265)	(32,170)	0	0	0	0	0	0
Transfers to/from assets held for sale & assets in disposal groups	0	0	0	0	0	0	0	0	0
Disposals	(3,945)	0	(434)	0	0	(422)	(15)	(2,927)	(147)
Valuation/gross cost at 31st March 2015	130,509	16,671	92,695	90	4,101	4,142	81	8,657	4,072
Accumulated depreciation at 1st April 2014	8,510	0	0	0	0	2,062	89	4,845	1,514
Provided during the year	5,825	0	3,328	3	0	440	3	1,679	372
Impairments charged to operating expenses	51,763	8,510	43,253	(3)	0	0	0	0	0
Reversal of impairments credited to operating income	(13,478)	(147)	(13,328)	0	0	0	0	0	0
Revaluations	(41,193)	(8,363)	(32,830)	0	0	0	0	0	0
Disposals	(3,870)	0	(423)	0	0	(405)	(15)	(2,927)	(100)
Accumulated depreciation at 31st March 2015	7,557	0	0	0	0	2,097	77	3,597	1,786
Net book value by ownership:									
Owned	98,881	16,621	68,677	90	4,098	2,045	4	5,060	2,286
Finance leased	776	50	726	0	0	0	0	0	0
On-Statement of Financial Position PFI contracts	22,927	0	22,924	0	3	0	0	0	0
Government granted	29	0	29	0	0	0	0	0	0
Donated	339	0	339	0	0	0	0	0	0
Net book value by ownership total at 31st March 2015	122,952	16,671	92,695	90	4,101	2,045	4	5,060	2,286

To ensure that asset values at 31st March 2015 reflect current market conditions valuations were carried out by the District Valuer.
Of the totals at 31 March 2015, £12,495,000 related to land, £83,350,000 related to buildings valued on a Modern Equivalent Asset alternative site basis.
Of the totals at 31 March 2015, £50,000 related to land, £3,827,000 related to buildings valued on a Modern Equivalent Asset no alternative site basis in relation to tenants improvements.
Of the totals at 31 March 2015, £2,713,000 related to land, £4,284,000 related to buildings and £90,000 related to dwellings valued on a Market Value in Existing Use basis.
Of the totals at 31 March 2015, £1,413,000 related to land, £1,234,000 related to buildings valued on a fair value basis. These relate to surplus non-operational assets
Of the totals at 31st March 2015, plant and machinery, transport equipment, information technology and furniture and fittings are all valued on the basis of depreciated replacement cost.

15.3 Economic Life of Property, Plant and Equipment

	Minimum Life	Maximum Life
	Years	Years
Land	19	100
Buildings excluding dwellings	1	90
Dwellings	9	44
Plant & machinery	0	15
Transport equipment	0	0
Information technology	0	5
Furniture & fittings	0	10

16. Investments

16 .1 Investments

	Investments in associates and joint ventures 2015/16	Investments in associates and joint ventures 2014/15
	£000	£000
Carrying value at 1st April	**50**	10
Share of profit	**37**	49
Other equity movements	**(49)**	(9)
Carrying value at 31st March	**38**	50

The Trust has a 50% share in a Limited Liability Partnership (LLP) established on 1st March 2011 with independent healthcare providers Insight Ltd (formerly MHCO). The Newcastle Talking Therapies LLP has been commissioned by NHS North of Tyne to deliver a new service aimed at 'Improving Access to Psychological Therapies - IAPT' for the people of Newcastle.

16.2 Fair value of investments in associates and joint ventures

	Value	Interest Held %
	£000	£000
As at 31st March 2016		
Insight Ltd (formerly MHCO) / NTW LLP	**38**	50%
As at 31st March 2015		
MHCO / NTW LLP	**50**	50%

17. Non-current Assets for Sale and Assets in Disposal Groups

17.1 Non-current Assets for Sale and Assets in Disposal Groups 2015/16

	Total	Property, Plant & Equipment: Land	Property, Plant & Equipment: Buildings
	£000	£000	£000
Net book value at 1st April 2015	**1,645**	651	994
Plus assets classified as available for sale in the year	**672**	268	404
Less assets sold in year	**(2,317)**	(919)	(1,398)
Less Impairment of assets held for sale	**0**	0	0
Net book value at 31st March 2016	**0**	0	0

At 1st April 2015 the Trust held 11 buildings with associated land (£1,645,000). These buildings and associated land were sold during 2015/16.

During the year, 1 property was reclassified as held for sale and was sold in 2015/16.

17.2 Non-current Assets for Sale and Assets in Disposal Groups 2014/15

	Total	Property, Plant & Equipment: Land	Property, Plant & Equipment: Buildings
	£000	£000	£000
Net book value at 1st April 2014	14,098	12,826	1,272
Plus assets classified as available for sale in the year	0	0	0
Less assets sold in year	(12,366)	(12,140)	(226)
Less Impairment of assets held for sale	(87)	(35)	(52)
Net book value at 31st March 2015	1,645	651	994

At 1st April 2014 the Trust held 1 area of land including associated professional fees and marketing costs (£11,864,000) and 11 buildings with associated land (£2,234,000).

During the year, there was no land or buildings reclassified as held for sale.

The area of land and 2 buildings and their associated land were sold in year, leaving 9 buildings and the associated land. These buildings are in the process of being sold as part of 1 sale transaction.

17.3 Liabilities in Disposal Groups

The Trust has no liabilities in disposal groups as at 31st March 2016; (31st March 2015 : £nil).

18. Other Assets

The Trust has no other assets as at 31st March 2016; (31st March 2015 : £nil).

19. Other Financial Assets

The Trust has no other financial assets as at 31st March 2016; (31st March 2015 : £nil).

20. Inventory

20.1 Inventory 2015/16

	Total	Drugs	Consumables	Energy	Other
	£000	£000	£000	£000	£000
Carrying Value at 1st April 2015	**312**	245	12	12	43
Additions	**3,892**	3,581	79	2	230
Inventories consumed (recognised in expenses)	**(3,884)**	(3,562)	(84)	(5)	(233)
Write down of inventories recognised as an expense	**(17)**	(13)	0	0	(4)
Carrying Value at 31st March 2016	**303**	251	7	9	36

20.2 Inventory 2014/15

	Total	Drugs	Consumables	Energy	Other
	£000	£000	£000	£000	£000
Carrying Value at 1st April 2014	**396**	300	12	14	70
Additions	**3,348**	3,093	111	2	142
Inventories consumed (recognised in expenses)	**(3,422)**	(3,140)	(111)	(4)	(167)
Write down of inventories recognised as an expense	**(10)**	(8)	0	0	(2)
Carrying Value at 31st March 2015	**312**	245	12	12	43

21. Trade Receivables and Other Receivables

21.1 Trade Receivables and Other Receivables

	31st March 2016	31st March 2015
	£000	£000
Current		
NHS receivables - revenue	6,666	7,212
Receivables due from NHS charities - Revenue	24	17
Other receivables with related parties - revenue	761	1,740
Provision for impaired receivables	(687)	(674)
Deposits and advances	0	0
Prepayments (non-PFI)	3,356	2,966
Accrued income	368	576
Interest receivable	1	3
Operating lease receivables	1	1
PDC dividend receivable	0	69
VAT receivable	1,068	767
Other receivables - Revenue	1,883	8,024
Total current trade and other receivables	13,441	20,701
Non-current		
Prepayments (non-PFI)	366	102
Total non-current trade and other receivables	366	102

21.2 Provision for Impairment of Receivables

	2015/16	2014/15
	£000	£000
At 1st April	674	758
Increase in provision	819	882
Amounts utilised	(31)	(34)
Unused amounts reversed	(775)	(932)
At 31st March	687	674

21.3 Analysis of Impaired Receivables

	Trade Receivables 31st March 2016	Other Receivables 31st March 2016	Trade Receivables 31st March 2015	Other Receivables 31st March 2015
	£000	£000	£000	£000
Ageing of impaired receivables:				
0 to 30 days	155	11	72	47
30 to 60 days	26	12	35	3
60 to 90 days	0	12	54	3
90 to 180 days	213	22	117	13
over 180 days	169	67	241	89
Total	563	124	519	155
Ageing of non-impaired receivables past their due date:				
0 to 30 days	23	4	498	140
30 to 60 days	181	20	1,002	4
60 to 90 days	655	7	72	4
90 to 180 days	(95)	6	82	5
over 180 days	1	182	(14)	54
Total	765	219	1,640	207

21.4 Finance Lease Receivables

The Trust had no finance lease receivables at 31st March 2016 (31st March 2015 : £nil).

22. Cash and Cash Equivalents

	Cash and cash equivalents 2015/16	Cash and cash equivalents 2015/16
	£000	£000
At 1st April	20,566	15,295
Net change in year	6,867	5,271
At 31st March	27,433	20,566
Broken down into:		
Cash at commercial banks and in hand	217	302
Cash with the Government Banking Service (GBS)	216	764
Deposits with the National Loans Fund	27,000	19,500
Other current investments	0	0
Cash and cash equivalents as per the Statement of Financial Position	27,433	20,566
Bank Overdrafts - (GBS and commercial banks)	0	0
Drawdown in committed facility	0	0
Cash and cash equivalents as per the Statement of Cash Flows	27,433	20,566

23. Trade and Other Payables

23.1 Trade and Other Payables

	31st March 2016	31st March 2015
	£000	£000
Current		
NHS payables - revenue	412	3,150
Amounts due to other related parties - revenue	9	71
Other trade payables - capital	3,298	3,304
Other trade payables - revenue	1,951	2,275
Social Security costs	2,160	2,027
Other taxes payable	2,432	2,236
Other payables	5,574	5,241
Accruals	8,636	6,722
PDC dividend payable	39	0
Total current trade and other payables	24,511	25,026

The Trust had £nil non-current trade and other payables at 31st March 2016 (31st March 2015 : £nil).

23.2 Early Retirements included in NHS Payables above

The Trust has £nil liabilities for early retirements payable over 5 years (31st March 2015 : £nil).

24. Borrowings

	31st March 2016	31st March 2015
	£000	£000
Current		
Capital loans from Department of Health	5,091	4,590
Obligations under finance leases	60	60
Obligations under PFI contracts (excl. lifecycle)	707	1,506
Total current borrowings	5,858	6,156
Non-current		
Capital loans from Department of Health	56,068	50,759
Obligations under finance leases	1,073	1,133
Obligations under Private Finance Initiative contracts	39,832	40,539
Total non-current borrowings	96,973	92,431

25. Prudential Borrowing Limit

The prudential borrowing code requirements in section 41 of the NHS Act 2006 have been repealed with effect from 1 April 2013 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required.

26. Other Liabilities

	31st March 2016	31st March 2015
	£000	£000
Current		
Other Deferred income	1,192	999
Total current borrowings	1,192	999
Non-current		
Other Deferred income	301	301
Total non-current other liabilities	301	301

27. Other Financial Liabilities

The Trust had £nil other financial liabilities at 31st March 2016 (31st March 2015 : £nil).

28. Provisions for Liabilities and Charges

28.1 Provisions for Liabilities and Charges

	Current		Non-current	
	31st March 2016	31st March 2015	31st March 2016	31st March 2015
	£000	£000	£000	£000
Pensions relating to former directors	**24**	24	**423**	442
Pensions relating to other staff	**92**	93	**885**	933
Other legal claims	**228**	245	**0**	0
Equal pay	**0**	246	**0**	0
Redundancy	**396**	143	**0**	0
Other	**238**	288	**4,738**	4,774
Total	**978**	1,039	**6,046**	6,149

28.2 Provisions for Liabilities and Charges Analysis

	Total	Pensions: former directors	Pensions: other staff	Other Legal Claims	Equal Pay	Redundancy	Other
	£000	£000	£000	£000	£000	£000	£000
At 1st April 2015	**7,188**	466	1,026	977	246	143	5,062
Change in the discount rate	**(54)**	(3)	(5)	0	0	0	(46)
Arising during the year	**1,483**	3	53	166	60	951	250
Utilised during the year - accruals	**(91)**	(6)	(24)	0	(2)	0	(59)
Utilised during the year - cash	**(1,301)**	(19)	(70)	(87)	(304)	(555)	(266)
Reversed unused	**(285)**	0	(16)	(96)	0	(143)	(30)
Unwinding of discount	**84**	6	13	0	0	0	65
At 31st March 2016	**7,024**	447	977	228	0	396	4,976
Expected timing of cashflows:							
not later than one year;	**978**	24	92	228	0	396	238
later than one year and not later than five years;	**1,361**	94	355	0	0	0	912
later than five years.	**4,685**	329	530	0	0	0	3,826
Total	**7,024**	447	977	228	0	396	4,976

The total value of clinical negligence provisions carried by the NHS Litigation Authority on behalf of the Trust is £3,648,000 at 31st March 2016 (31st March 2015 : £1,709,000) and these liabilities are not recognised in the Trust's accounts.

Pensions
The pension provisions are based on pension payments and average life expectancies of former employees. The value and timing of the provision would therefore not be expected to vary significantly.

Legal Claims
There are 47 provisions for employers and public liability claims against the Trust. Information regarding the probability of success, values and timings of these claims has been provided by the NHS Litigation Authority. All of the cases are subject to future change, in particular they may take longer to settle, due to the nature of legal cases.

Other
This represents provisions by the Trust for the following:

- future payments in respect of injury benefit claims. This provision is based on actual injury benefit payments and average life expectancies. The value and timing of the provision would therefore not be expected to vary significantly. This provision relates to 22 people and the value is based on current life expectancy data.
- provisions for employee litigation cases.

The Treasury Pension rate applied to the Pensions and Injury Benefits provision has changed to 1.37 % (previously 1.30%).

29. Contingencies

	31st March 2016	31st March 2015
	£000	£000
Value of contingent liabilities:		
NHS Litigation Authority Legal Cases	**(197)**	(172)
Employment tribunal and employee related litigation cases	**0**	(2)
Other	**0**	0
Gross value of contingent liabilities	**(197)**	(174)
Amounts recoverable against liabilities	**0**	0
Net value of contingent liabilities	**(197)**	(174)
Net value of contingent assets	**0**	0

Contingent liabilities include:

- estimates provided by the NHSLA for public liability and employer liability cases.
- estimates provided by the Trusts legal advisor for employee litigation cases.

The Trust has a possibility of future liabilities or future assets in relation to the Northgate Land sale which completed in 2014/15. The asset sale relates to a sale of land to Taylor Wimpey for the purpose of the construction of a housing development and was based on a sale value of £17m less an estimate for costs of £3.1m. Within the contract, it is agreed to review the costs on an ongoing basis throughout the construction and sewerage works and also to undertake overage reviews at each stage of the construction to assess if more monies are owed to the Trust due to an increase in property values.

30. Revaluation Reserve

30.1 Revaluation Reserve 2015/16

	Total	Property, Plant & Equipment	Assets Held for Sale
	£000	£000	£000
Revaluation reserve at 1st April 2015	**2,298**	2,213	85
Impairments	**(88)**	(88)	0
Revaluations	**859**	859	0
Asset disposals	**(88)**	(3)	(85)
Other reserve movements	**1**	1	0
Revaluation reserve at 31st March 2016	**2,982**	2,982	0

30.2 Revaluation Reserve 2014/15

	Total	Property, Plant & Equipment	Assets Held for Sale
	£000	£000	£000
Revaluation reserve at 1st April 2014	**12,344**	1,666	10,678
Impairments	**(163)**	(163)	0
Revaluations	**758**	758	0
Asset disposals	**(10,622)**	(48)	(10,574)
Other reserve movements	**(19)**	0	(19)
Revaluation reserve at 31st March 2015	**2,298**	2,213	85

31. Related Parties

31.1 Related Party Transactions 2015/16

	Income	Expenditure
	£000	£000
Transactions with board members:		
Hugh Morgan Williams, Chairman		
Council Member : University of Durham. The Trust has raised and paid invoices in relation to training	45	1
Ruth Thompson, Non-Executive Director		
Governor : University of Sunderland. The Trust has raised and paid invoices in relation to training.	5	3
Paul McEldon - Non-Executive Director		
Director of North East of England Business and Innovation Centre Ltd. The Trust has paid purchase invoices.		1
James Duncan, Executive Director of Finance and Deputy Chief Executive		2
brother in law is a partner at Bond Dickinson LLP. The Trust has paid/accrued for purchase invoices in respect of legal fees.		21
Vice Chair of the HFMA Mental Health Faculty. The Trust has paid/accrued for purchase invoices in respect of fees.		8
Chris Watson, Non-Executive Director		
Head of Asset Planning, Northumbrian Water Ltd. The Trust has paid invoices in respect of water rates.		399
Gary O'Hare, Executive Director of Nursing and Operations		
wife is employed by the North of England Mental Health Development Unit which has been commissioned to support work to repatriate out of area placements and invoices have been paid in respect of professional services.		62
Value of transactions with board members	**50**	**497**
Value of transactions with key staff members	**0**	0
Value of transactions with other related parties:		
Department of Health	1,721	0
Other NHS bodies	284,007	8,392
Charitable Funds	0	0
Subsidiaries / Associates / Joint Ventures	226	0
Other	11,881	38,881
NHS Shared Business Services	0	0
Total value of transactions with related parties in 2015/16	**297,885**	**47,770**

31.2 Related Party Transactions 2014/15

	Income	Expenditure
	£000	£000
Transactions with board members:		
Hugh Morgan Williams, Chairman		
Council Member : University of Durham. The Trust has raised and paid invoices in relation to training	46	3
Ruth Thompson, Non-Executive Director		
Governor : University of Sunderland. The Trust has raised and paid invoices in relation to training.	4	7
James Duncan, Executive Director of Finance and Deputy Chief Executive		
brother in law is a partner at Bond Dickinson (formerly Dickinson Dees). The Trust paid purchase invoices and accrued for invoices payable in respect of legal fees.		51
Vice Chair of the HFMA Mental Health Faculty. The Trust has paid invoices in respect of fees.		3
Chris Watson, Non-Executive Director		
Head of Asset Planning, Northumbrian Water Ltd. The Trust has paid invoices in respect of water rates.		417
Gary O'Hare, Executive Director of Nursing and Operations		
wife is employed by the North of England Mental Health Development Unit which has been commissioned to support work to repatriate out of area placements and invoices have been paid in respect of professional services.		138
Value of transactions with board members	**50**	**619**
Value of transactions with key staff members	**0**	**0**
Value of transactions with other related parties:		
Department of Health	853	39
Other NHS bodies	275,861	8,708
Charitable Funds	0	0
Subsidiaries / Associates / Joint Ventures	233	0
Other	19,884	39,164
NHS Shared Business Services	0	0
Total value of transactions with related parties in 2014/15	**296,881**	**48,530**

31.3 Related Party Balances at 31st March 2016

	Receivables	Payables
	£000	£000
Balances (other than salary) with board members:		
Chris Watson, Non-Executive Director		
Head of Asset Planning, Northumbrian Water Ltd. The Trust has paid invoices in respect of water rates.		47
James Duncan, Executive Director of Finance and Deputy Chief Executive		
Brother in Law is a partner with Bond Dickinson LLP. The Trust held a purchase invoice in respect of fees.		1
Hugh Morgan Williams, Chairman		
Council Member : University of Durham. The Trust has an outstanding receivable due	43	
Gary O'Hare, Executive Director of Nursing and Operations		
Wife is employed by the North of England Mental Health Development Unit, which has been commissioned by the Trust to support work to repatriate out of area placements.The Trust has an accrual in relation to a charge due.		8
Value of balances (other than salary) with board members	**43**	**56**
Value of balances (other than salary) with key staff members	**0**	**0**
Value of balances (other than salary) with related parties in relation to doubtful debts	**0**	**0**
Value of balances (other than salary) with related parties in respect of doubtful debts written off in year	**0**	**0**
Value of balances with other related parties:		
Department of Health	0	39
Other NHS bodies	6,190	4,304
Charitable Funds	0	0
Subsidiaries / Associates / Joint Ventures	20	0
Other	29,149	8,117
NHS Shared Business Services	0	0
Total balances with related parties at 31st March 2016	**35,402**	**12,516**

31.4 Related Party Balances at 31st March 2015

	Receivables	Payables
	£000	£000
Balances (other than salary) with board members:		
Chris Watson, Non-Executive Director		
Head of Asset Planning at Northumbrian Water. The Trust held purchase invoices and accrued for invoices payable for water rates and has some prepaid invoices.	3	37
James Duncan, Executive Director of Finance and Deputy Chief Executive		
Vice Chair of the HFMA Mental Health Faculty. The Trust held a purchase invoice in respect of fees.		2
Hugh Morgan Williams, Chairman		
Council Member : University of Durham. The Trust has an outstanding receivable and held a purchase invoice.	44	3
Ruth Thompson, Non-Executive Director		
Governor : University of Sunderland. The Trust held a purchase invoice in relating to training.		3
Value of balances (other than salary) with board members	**47**	**45**
Value of balances (other than salary) with key staff members	**0**	**0**
Value of balances (other than salary) with related parties in relation to doubtful debts	**0**	**0**
Value of balances (other than salary) with related parties in respect of doubtful debts written off in year	**0**	**0**
Value of balances with other related parties:		
Department of Health	208	62
Other NHS bodies	6,736	5,609
Charitable Funds	0	0
Subsidiaries / Associates / Joint Ventures	19	0
Other	22,423	7,991
NHS Shared Business Services	0	0
Total balances with related parties at 31st March 2015	**29,433**	**13,707**

31.5 **Related Party Balances at 31st March 2016**

The Department of Health is regarded as a related party. During the period the Trust has had a significant number of material transactions with the department, and with other entities for which the department is regarded as the parent organisation. Details of collectively significant transactions and balances:

	Income	Expenditure	Receivables	Payables
	2015/16	2015/16	31st March 2016	31st March 2016
	£000	£000	£000	£000
NHS Foundation Trusts:				
Gateshead Health NHS Foundation Trust				1,192
Newcastle upon Tyne Hospitals NHS Foundation Trust	**2,123**	2,220		1,329
Northumbria Healthcare NHS Foundation Trust		1,363		
South Tyneside NHS Foundation Trust			1,040	
NHS CCGs, NHS England, Department of Health and Other Special Health Bodies:				
NHS Cumbria CCG	1,107			
NHS Durham Dales, Easington and Sedgefield CCG	1,331			
NHS Newcastle Gateshead CCG	62,647			
NHS North Durham CCG	1,363			
NHS North Tyneside CCG	21,897			
NHS Northumberland CCG	45,787			
NHS South Tyneside CCG	22,194			
NHS Sunderland CCG	53,681			
NHS England	57,272		1,058	
Health Education England	8,481			
Department of Health	1,721			
Local Government bodies:				
Newcastle upon Tyne City Council	2,797			
North Tyneside Metropolitan Borough Council	2,026			
Northumberland Unitary Authority	3,977			
Central Government bodies:				
HM Revenue & Customs - Other taxes and duties		13,525	1,068	4,592
NHS Pension Scheme (Own staff E'ers and E'ees contributions)		24,048		3,236
Scottish Government				
National Loans Fund			27,000	
Belfast Health and Social Care Trust - Northern Ireland	1,068			

In addition, the Trust has had other material transactions (under £1,000,000) with other related parties including: City Hospitals Sunderland NHS Foundation Trust, Gateshead Health NHS Foundation Trust, North East Ambulance Service NHS Foundation Trust, South Tyneside NHS Foundation Trust, Tees Esk and Wear Valleys NHS Foundation Trust, NHS Mansfield and Ashfield CCG, NHS Litigation Authority, NHS Property Services and Leeds City Council.

The Trust has had transactions with Insight Ltd as part of the Trust's joint venture.

The Trust has also received payments from a number of charitable funds administered by the Newcastle Healthcare Charity.

32. Commitments

32.1 **Contractual Capital Commitments**

	31st March 2016	31st March 2015
	£000	£000
Commitments in respect of capital expenditure at 31st March:		
Property, plant and equipment	**6,653**	1,017
Total	**6,653**	1,017

32.2 **Other Financial Commitments**

The Trust is committed to making the following annual payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangements) at 31 March 2016 as follows, analysed by the period during which the payment is made:

	31st March 2016	Restated 31st March 2015
	£000	£000
not later than 1 year	**6,386**	6,238
after 1 year and not later than 5 years	**2,843**	5,438
paid thereafter	**77**	77
Total	**9,306**	11,753

The 2014/15 comparators have been restated. Other financial commitments relate to non-cancellable supplies contracts which are not leases.

33. Finance Lease Obligations

	31st March 2016	31st March 2015
	£000	£000
Gross lease liabilities	1,527	1,629
of which liabilities are due		
- not later than one year;	100	102
- later than one year and not later than five years;	377	386
- later than five years.	1,050	1,141
Finance charges allocated to future periods	(394)	(436)
Net lease liabilities	1,133	1,193
- not later than one year;	60	60
- later than one year and not later than five years;	240	240
- later than five years.	833	893

The finance lease obligations relate to building lease liabilities.

34. Private Finance Initiative (PFI) Obligations deemed to be on the Statement of Financial Position

The Trust has two PFI schemes deemed to be on-Statement of Financial Position.

St Georges Park (hospital accommodation for the provision of mental health services):

Estimated Capital Value:	£27.5m
Total Length of Project:	30 years
Contract Start Date:	10 May 2004
Number of Years to End of Project:	18 years

Walkergate Park (hospital accommodation providing specialised services for people with neurological and neuropsychiatric conditions):

Estimated Capital Value:	£23.7m
Total Length of Project:	32 years
Contract Start Date:	21 July 2005
Number of Years to End of Project:	21 years

Both contracts contain payment mechanisms providing for deductions in the unitary payment made by the Trust for poor performance and unavailability.

The unitary charge for both schemes is subject to an annual uplift for future price indices (RPI).

The operators are responsible for providing a full service for the length of each contract, after such time these responsibilities revert to the Trust.

During the reporting period there were no changes to the contractual arrangements of either scheme. However, the Trust signed a contract variation in respect of buildings works at St Georges Park which came into effect during 2012/13 and results in a increase to the Unitary Charge going forward.

Both schemes are treated as an asset of the Trust and the substance of each contract is that the Trust has a finance lease. Payments comprise two elements; imputed finance lease charges and service charges.

34.1 Total Obligations for On-SoFP PFI obligations on the Statement of Financial Position

	31st March 2016	31st March 2015
	£000	£000
Gross lease liabilities	76,039	80,465
of which liabilities are due		
- not later than one year;	3,534	4,426
- later than one year and not later than five years;	14,540	14,203
- later than five years.	57,965	61,836
Finance charges allocated to future periods	(35,500)	(38,420)
Net PFI liabilities	40,539	42,045
- not later than one year;	707	1,506
- later than one year and not later than five years;	3,735	3,189
- later than five years.	36,097	37,350

34.2 Total On-SoFP PFI Commitments

	31st March 2016	31st March 2015
	£000	£000
Total future payments committed in respect of PFI arrangements	188,865	196,480
of which liabilities are due		
- not later than one year;	7,713	7,615
- later than one year and not later than five years;	32,829	32,028
- later than five years.	148,323	156,837
Total	188,865	196,480

34.3 On-Statement of Financial Position PFI Commitments (service element)

	31st March 2016	31st March 2015
	£000	£000
Commitments in respect of the service element of the PFI:		
- not later than one year;	2,982	1,788
- later than one year and not later than five years;	12,103	12,605
- later than five years.	43,943	47,930
Total	59,028	62,323

The commitments disclosed include future estimated indexation applied to service charges.

34.4 Analysis of amounts payable to service concession operator

	31st March 2016	31st March 2015
	£000	£000
Unitary payment payable to service concession operator	7,615	7,541
Consisting of:		
- interest charge	2,921	2,996
- repayment of finance lease liability	1,505	977
- service element	1,765	2,340
- contingent rent	1,424	1,228
Total	7,615	7,541

35. Events after the Reporting Period

There are no events after the reporting period to disclose which have not already been included in the accounts as adjusting events (31st March 2015 : £nil).

36. Financial Instruments

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. Due to the continuing service provider relationship that the Trust has with Clincal Commissioning Groups (CCGs) and NHS England and the way those NHS organisations are financed, the 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 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 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. 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 and therefore has low exposure to currency rate fluctuations.

Credit Risk
The Trust can borrow within affordable limits and Monitor will assess the affordability of material borrowing. The Trust can invest surplus funds in accordance with Monitor's guidance on Managing Operating Cash. This includes strict criteria on permitted institutions, including credit ratings from recognised agencies. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to manage the risks facing the Trust in undertaking its activities.

Liquidity Risk
The Trust's net operating income is received under legally binding contracts with local Clinical Commissioning Groups (CCGs) and NHS England, which are financed from resources voted annually by Parliament. The Trust has financed capital expenditure from internally generated resources, and net borrowing of £55,349,000 which is within its affordable limits. The Trust is not, therefore, exposed to significant liquidity risks.

Market Risk
The main potential market risk to the Trust is interest rate risk. The Trust's financial liabilities carry nil or fixed rates of interest. Cash balances are held in interest bearing accounts for which the interest rate is linked to bank base rates and changes are notified to the Trust in advance. The Trust is not, therefore, exposed to significant interest-rate risk.

36.1 Financial Assets by Category

	Total	Loans & Receivables
	£000	£000
Assets as per the Statement of Financial Position at 31st March 2016:		
Trade and other receivables excluding non financial assets	9,017	9,017
Other investments	38	38
Cash and cash equivalents at bank and in hand	27,433	27,433
Total at 31st March 2015	36,488	36,488
Assets as per the Statement of Financial Position at 31st March 2015:		
NHS trade and other receivables excluding non-financial assets	16,901	16,901
Other investments	50	50
Cash and cash equivalents at bank and in hand	20,566	20,566
Total at 31st March 2015	37,517	37,517

36.2 Financial Liabilities by Category

	Total	Other Financial Liabilities
	£000	£000
Liabilities as per the Statement of Financial Position at 31st March 2016:		
Borrowings excluding finance lease and PFI liabilities	61,159	61,159
Obligations under finance leases	1,133	1,133
Obligations under Private Finance Initiative contracts	40,539	40,539
NHS trade and other payables excluding non-financial assets	19,879	19,879
Total at 31st March 2016	122,710	122,710
Liabilities as per the Statement of Financial Position at 31st March 2015:		
Borrowings excluding finance lease and PFI liabilities	55,349	55,349
Obligations under finance leases	1,193	1,193
Obligations under Private Finance Initiative contracts	42,045	42,045
NHS trade and other payables excluding non-financial assets	20,763	20,763
Total at 31st March 2015	119,350	119,350

36.3 Maturity of Financial Liabilities

	31st March 2016	31st March 2015
	£000	£000
In one year or less	**25,738**	26,919
In more than one year but not more than two years	**5,953**	5,429
In more than two years but not more than five years	**14,219**	15,250
In more than five years	**76,800**	71,752
Total at 31st March	**122,710**	119,350

36.4 Fair Values of Financial Assets at 31st March 2016

	Book Value	Fair Value
	£000	£000
Non-current trade and other receivables excluding non-financial assets	0	0
Total	**0**	**0**

36.5 Fair Values of Financial Liabilities at 31st March 2016

	Book Value	Fair Value
	£000	£000
Loans	56,067	56,067
Total	**56,067**	**56,067**

37. Pensions

Past and present employees are covered by the provisions of the two NHS Pensions Schemes. Details of the benefits payable and the rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both schemes 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 the scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

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

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

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

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

38. Losses and Special Payments

38.1 Losses

	Total number of cases 2015/16 Number	Total value of cases 2015/16 £000	Total number of cases 2014/15 Number	Total value of cases 2014/15 £000
Losses of cash due to:				
theft, fraud etc	5	0	4	0
overpayment of salaries	32	20	23	8
Fruitless payments and constructive losses	41	17	16	5
Bad debts and claims abandoned	31	15	13	27
Stores losses	2	17	2	10
Total losses	111	69	58	50

Special Payments

	Total number of cases 2015/16 Number	Total value of cases 2015/16 £000	Total number of cases 2014/15 Number	Total value of cases 2014/15 £000
Ex gratia payments in respect of:				
loss of personal effects	52	12	57	17
personal injury with advice	22	100	24	102
Total Special Payments	74	112	81	119
Total Losses and Special Payments	185	181	139	169

These amounts are reported on an accruals basis but exclude provisions for future losses.

This report is available on request in other formats; we will do our best to provide a version of this report in a format that meets your needs.

For other versions telephone 0191 246 6977 or email us at qualityassurance@ntw.nhs.uk.

Copies of the Annual Report can be obtained from our website (www.ntw.nhs.uk) and the NHS Choices website (www.nhs.uk).

If you have any feedback or suggestions on how we could improve our Annual Report, please do let us know by emailing communications@ntw.nhs.uk or calling 0191 245 6877.

Copies can be obtained by contacting:

Communications Department
St. Nicholas Hospital
Jubilee Road, Gosforth
Newcastle upon Tyne
NE3 3XT
Tel: 0191 245 6877