

# Annual Report and Accounts 2013/14





**Northumberland, Tyne and Wear NHS Foundation Trust**

**Annual Report and Accounts 2013/14**

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



## Northumberland, Tyne and Wear NHS Foundation Trust

### Annual Report

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## **1 CHAIR AND CHIEF EXECUTIVE'S INTRODUCTION**

Northumberland, Tyne and Wear NHS 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.

Providing high quality services is of paramount importance to us.

Our on-going transformation programme aims to redesign our services around the needs of users and their carers, and ensure that we can provide high quality, safe, recovery focused care, which is sustainable in the long term.

Our goal is the enhancement of community services designed around the needs of service users while investing in inpatient care through improved staffing and new facilities.

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 28 May 2014.**



**Hugh Morgan Williams**  
Chairman



**James Duncan**  
Acting Chief Executive

## **2 STRATEGIC REPORT**

### **Our History**

Northumberland, Tyne and Wear NHS Foundation Trust (NTW) 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.

### **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;

Cherry Knowle Hospital, 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 have recently refreshed, 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:

**We are about Quality and Safety**

**We strive to provide the BEST CARE, delivered by the BEST PEOPLE, to achieve the BEST OUTCOMES**

**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

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.

## **Our Business Model**

In 2011 the Trust implemented, following consultation, the Business Model Review, the aim being to ensure that the Trust was best positioned to meet future challenges. The key aspects of the Business Model Review were to:

- Move from five operational directorates to three Groups: Urgent Care, Planned Care and Specialist Services;
- Increase clinical leadership and decision-making;
- Re-align professional leadership models;
- Re-align corporate support functions;
- Reduce costs of management and bureaucracy to maximise resources committed to front line patient care.

The Business Model Review introduced the concept of triumvirates - three key leaders with management, medical and nursing expertise who work together to provide leadership and manage services at Group and Directorate level and are jointly responsible for:

- The delivery of quality services around the core dimensions of safety, effectiveness and patient experience;
- The development of strategic plans in line with overall Trust strategy;
- The performance management of all services in line with local and national performance targets and standards;
- Ensuring clinical engagement, taking responsibility for clinical governance, safety and risk management;
- Taking a commercial and business approach to services which recognises and adapts to the needs of our customers;
- Providing leadership, support and advice to managers and staff.

The triumvirate approach represents a very different way of working for managers and clinicians.

The Business Model Review has also further strengthened the Trust's leadership by the creation of a professional strategy and advisory group at Group level. These strategy and advisory groups include a range of clinical and non-clinical expertise to support the triumvirate in the on-going management and development of each Group.

Medical Leadership continues to be provided by the Medical Director supported by the Group Medical Directors. At the level below, Clinical Directors take joint responsibility for a major aspect of care, giving clinicians the opportunity to shape and develop services, bringing to bear their specialist knowledge and expertise in partnership with a senior manager and senior nursing colleague.

The Medical Director is responsible for Clinical Governance supported by a Deputy Director of Clinical Governance. This has enabled the Director of Nursing and

Operations to focus on the delivery of standards. The Medical Director also holds executive responsibility for research, innovation and clinical effectiveness, delegated to a Director of Research, Innovation and Clinical Effectiveness.

Within the Trust, nurses are the largest professional group. Key to maintaining professional standards and excellent nursing practice is effective nursing leadership. Nurse leaders are now employed in a range of senior management posts and a proportion of the clinical manager posts. Nursing leadership is embedded across the organisation with each Group having a Group Nurse Director as the strategic and operational nurse leader.

In order to address the wide and complex range of needs of our service users and carers, NTW's vision and services need to be underpinned by a bio-psycho-social understanding of mental health and disability. Trustwide Clinical Director and Group/Directorate level professional lead roles for Psychological Services and for AHP services have been put in place, to ensure that the Trust is able to draw upon multi-disciplinary knowledge and skills at all levels, from strategic decision making to direct delivery of safe and effective clinical services. These roles encompass strategic development and leadership, professional representation and engagement, professional accountability and governance, and assurance of the delivery of safe and effective high quality services.

The Business Model Review also included the review of corporate services structures, where appropriate, with the aim of ensuring that efforts are centred on providing high quality business advice to the operational Groups in a more cohesive way. Multi-disciplinary teams for each of the Groups, whilst still being managed through corporate and professional lines, work together to provide seamless and integrated support and advice for operational services.

There are also a number of supporting programmes, namely: the Principal Community Pathways Programme, Augmenting Services Programme, Corporate Services Programme, Care Pathways and Packages Programme and the Workforce Programme.

### **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.

### **Capacity to Handle Risk**

The Trust has structures in place, as described above, together with 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 Risk and Control Framework**

The 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, maintained and managed through the Board of Directors Assurance Framework and Corporate Risk Register, supported by Group and Directorate Risk Registers. The Trust's principal risks and mechanisms to control them are identified through the Assurance Framework, which is reviewed by the Board of Directors every two months.

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 take place through the following among others: Board of Directors; Quality and Performance Sub-committee; Group Quality and Performance Committees and Senior Management Team meetings.

### **Our Clinical Strategy**

In acknowledgement of the need to radically change and improve the way we provide services the Executive Directors asked a group of clinicians from across the organisation to form a Clinical Project Group to draw together all of the evidence and best practice relating to service provision, to seek feedback from a range of interested parties in mental health and disability services, to produce a vision for future services that truly does what is right for service users and carers. The result (the Service Model Review) is a high level model, which is underpinned by a single set of values and principles key to its quality and success.

Our service redesign is underpinned by information derived from the Care Pathways and Packages approach which is mandated by the Department of Health and endorsed by the Trust. It ensures that service users consistently receive the right

service, at the right time and in the right place: depending on the nature of the problem, the level of complexity, the urgency and the risk. The fundamental aspects of the model include:

- Improved access to services;
- Stepping up and stepping down the intensity of care according to need;
- Scaffolding the clinical workforce.

The success of this model depends on the Trust's ability to implement all aspects of it. The key recommendations from the Clinical Project Group form the basis of the Trust's Clinical and Quality Strategy which is as follows:

- Reconfigure Services;
- Develop and improve clinical systems and processes;
- Increase the capacity and capability of the clinical workforce.

The environment in which the Trust now works is such that we have to continue to improve the quality of our services whilst at the same time recognising that resources need to be effectively focused onto our service users. The Trust's spend on the provision of its inpatient services is £92.2m compared to £84.8m on its community services. This means that at any time 3% of patients are consuming 52% of resources. Many inpatients don't necessarily need to be in an inpatient service but there are not always the necessary community services to support them out of hospital. The Trust is therefore committed to working with Commissioners to rebalance resources by improving community pathways/services and so reducing the reliance on inpatient beds. This will enable us to balance our resources to maximise quality over cost whilst at the same time ensuring the continued safety of our service users and the wider community.

The Trust's Transforming Services Programme is the vehicle for implementing the new service model, improving community pathways and reducing the reliance on inpatient beds and providing sustainable specialist services.

The Programme is configured as a set of delivery projects that will change over time, supported by a central clinical reference group and a communications and engagement group. The objectives of each component element of the Programme over the period of this Plan are summarised below.

### **Principal Community Pathways Programme**

The Principal Community Pathways Programme is responsible for implementing the changes required across all community services in order to deliver new community-based care pathways. This includes improving access to services.

## **The PRiDE Development (including the reprovision of Cherry Knowle Hospital)**

The PRiDE development (providing improved mental health and learning disability environments in Sunderland and South Tyneside) is a keenly awaited development to provide state of the art inpatient and support services to replace Cherry Knowle Hospital.

### **Augmentation Programme**

The Augmentation Programme includes leading on the design and implementation of the future configuration of inpatient services based on patient need.

### **Specialist Care Services Programme**

The Specialist Care Services Programme is responsible for ensuring the Trust retains sustainable specialist services as part of the overall service model.

### **Social and Residential Services**

The Trust's service portfolio includes social and residential services for adults with a learning disability and adults requiring mental health residential long stay services. The Trust and Commissioners have a long standing commitment to work together to transfer responsibility for the provision of these services to alternative providers.

## **Our Performance in 2013/14**

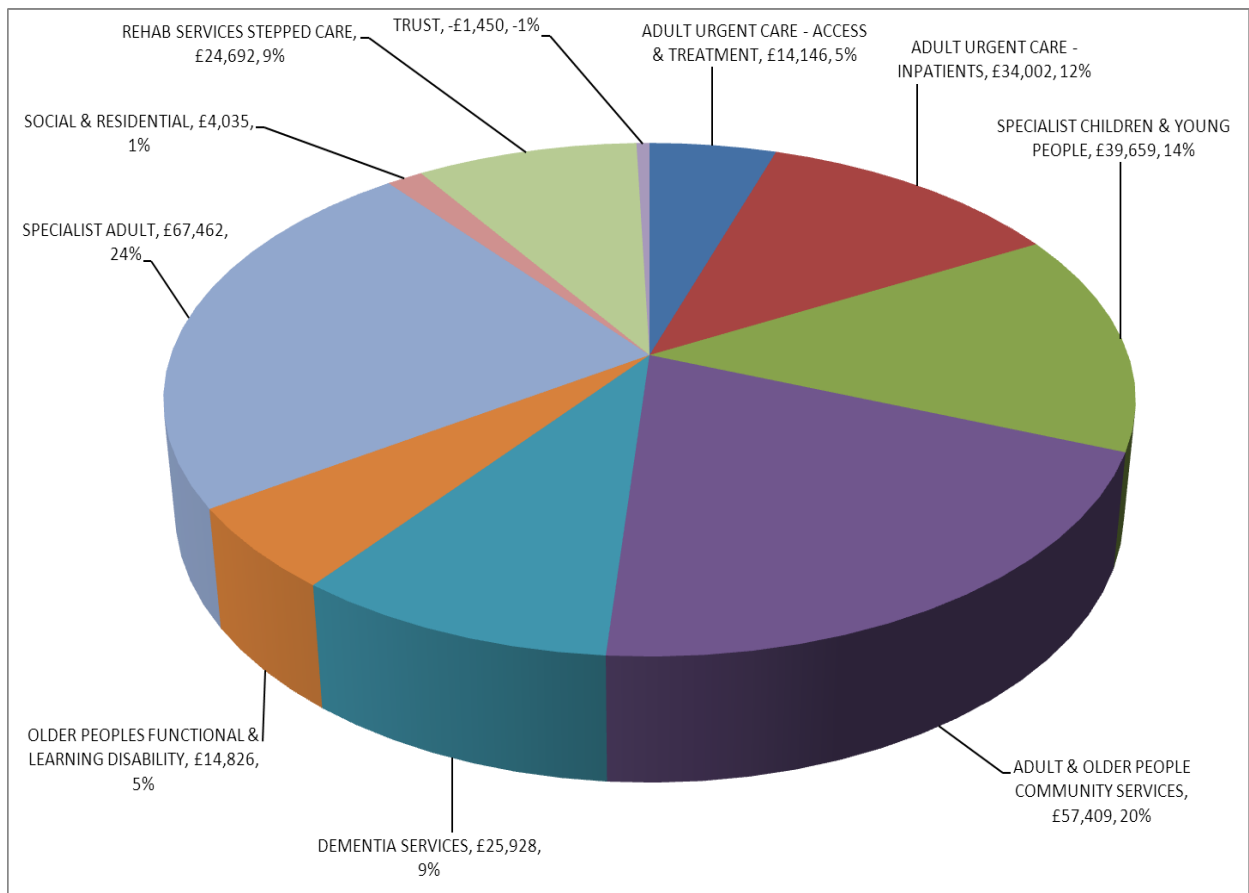
### **Performance against contracts**

The Trust provides services to a broad range of Commissioners. The main commissioners for the Trust in 2013/14 were as follows:

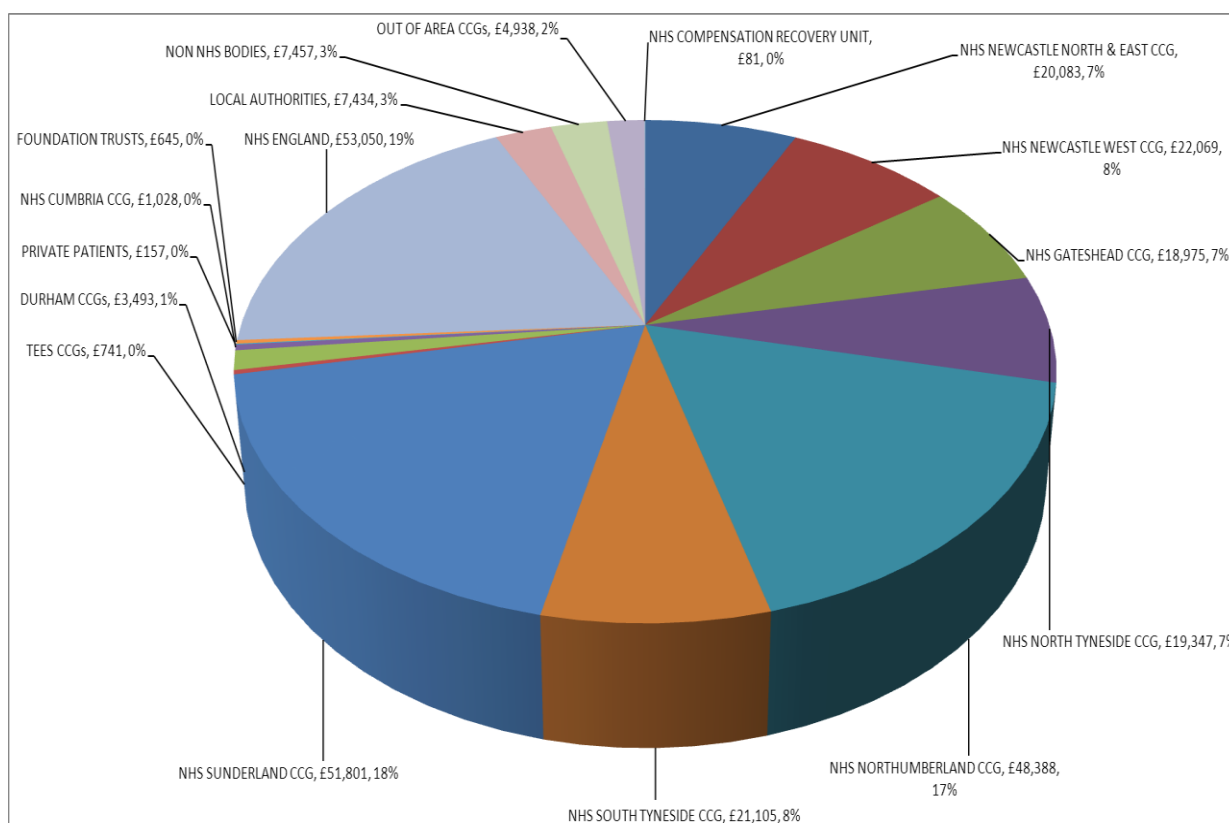
- Seven Clinical Commissioning Groups across Northumberland, Tyne and Wear;
- Five Clinical Commissioning Groups across Durham, Darlington and Tees;
- Cumbria, Northumberland, Tyne and Wear Area Team which is the local area Team of NHS England;
- CCGs out of area plus Scottish, Welsh and Irish health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

In 2013/14 86% 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.

**Figure 1 – 2013/2014 Patient Care Income per Service £000**



**Figure 2 – 2013/2014 Patient Care Income per Commissioners £000**



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 2013/2014 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 2014/15.

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

### **Performance relating to the quality of NHS services provided**

The Trust's Quality Report 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 2013/14, 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 Essential Standards Management Group.

Details relating to CQC Registration Activity during 2013/14 is shown in the Quality Report.

## **Financial Performance**

The Trust continued to perform well during 2013/14, in terms of its underlying financial performance, and met all of its planned targets. During the year the Trust continued to progress its Transformation Programme, with significant investment in the change programme for our community services (Principal Community Pathways). 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, four wards were closed. As wards were 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 strategy is seeing a marked change in the estate, and the Trust aims to go out to consultation on future models of delivery for inpatient services in autumn of 2014. The Trust is required to undertake a full valuation of its estate on a five yearly basis, and this process is undertaken independently on behalf of the Trust through the District Valuer. In line with national guidance the Trust employs Modern Equivalent Asset valuation, under which the estate is valued at the optimum configuration to meet the requirements of service. The Transformation Programme has resulted in a significant reduction in the value of the Trust's land and buildings of £109m. Of this total £99m is recognised as a loss in year, with the remainder being charged against the revaluation reserve. In addition the Trust recognised a loss of £5m, when a newly built inpatient unit was brought into operational use on the Northgate site. Overall this meant that a charge of £104m was made to the Statement of Comprehensive income resulting in a deficit of £101m being recorded for the year.

This deficit does not impact on the underlying viability of the Trust, and 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 £3.2m, which was broadly in line with our plan agreed with Monitor. Our performance against the requirements set by Monitor is shown below.

<b>Monitor Risk Ratings</b>	<b>Plan</b>	<b>Achieved</b>	<b>Risk Rating</b>	<b>Weight</b>	<b>YTD Risk</b>
Capital Service Capacity	2	1.57x	2	50%	Green
Liquidity Ratio	4	-3.1 days	3	50%	Green
<b>Overall Rating</b>	<b>3</b>		<b>3</b>		Green

The Trust's liquidity ratio was reduced due to delays in the completion of a significant land sale of part of the Northgate site. This was originally expected to be completed in 2013/14, but is now expected in 2014/15. Capital spend in the year was £38.7m, which was £8.1m behind plan, largely due to delays in progressing the autism unit scheme, also on the Northgate site.

The Trust delivered 95% of its planned recurring Financial Delivery Programme, with only £0.4m carried forward of the £11.8m planned to be delivered in year. This delivery was fundamentally linked to our Transformation Programme, details of which are provided in this report.

The major pressures in-year were experienced on ward staffing and specialist care income.

The Trust's Transformation Programme involves a reduction in the number of wards, accompanied by a realignment of sites. This gives us the opportunity to continue to increase staffing levels and skill mix across wards, allow for more effective cross cover, introduce more effective standardisation of care and deliver economies of scale. This will reduce pressures on ward budgets over the coming two years.

Specialist services experienced lower than expected levels of occupancy in the first half of the year which have largely been addressed in the latter quarter.

Going forward, the most significant financial risks over the next three years are the on-going delivery of our Transformation Programme as described in this report, and managing the national re-structuring of specialist services. This will require continuing effective working across multiple stakeholders. The Trust is investing in change over the next two years, 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. 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 Audit Committee has considered the above issues in detail, and as a result of these and other enquiries, the directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts

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 of our performance is shown below.

### Payment of Trade Invoices

Better Payment Practice Code	2012/13 Number of invoices paid within target	2012/13 Value of invoices paid within target	2013/14 Number of invoices paid within target	2013/14 Value of invoices paid within target
Non-NHS Trade Invoices	95.4%	96.8%	86.6%	92.6%
NHS Trade Invoices	76.3%	94.8%	71.2%	94.9%

There were no payments made in year under the Late Payment of Commercial Debts (Interest) Act 1998. This was also the case in 2012/13.

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

The Directors have confirmed that there are no expected post balance sheet events which will materially affect the disclosures made within these accounts.

## **Service Developments**

### **Principal Community Pathways Programme**

The Programme commenced in 2013/14 the design, testing and implementation of effective, evidence based 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 in Sunderland and South Tyneside.

This work will be rolled out across Newcastle, Northumberland, Gateshead and North Tyneside. The Programme will redesign services to meet the following needs in adults: Psychosis; Non-psychosis; Cognitive Disorders and Learning Disability.

### **The PRiDE Development (including the re-provision of Cherry Knowle Hospital)**

The Specialist Care Dementia Centre at Monkwearmouth Hospital opened in November 2013 and Hope wood Park is due for completion in August 2014.

### **Augmentation Programme**

The Trust has already made significant progress in this programme of work, achieving the following during 2013/14:

- The review of the dementia care pathway in Newcastle, particularly long term care provision, with the aim of the Trust focusing its service and resources on the provision of care to those at an earlier stage of the illness who may exhibit challenging behaviour;
- The review of long term complex care services North of Tyne as a part of the move towards an improved stepped care pathway;
- Expansion of hospital liaison services in Sunderland in line with the recognised Rapid Assessment, Interface and Discharge (RAID) model;
- Realignment of female adult mental health assessment and treatment services North of Tyne, in line with demand.

### **Specialist Care Services Programme**

During 2013/14 the Trust achieved the following:

- Progressed the review of Neurological Services with the aim of optimising the use of inpatient facilities, improving operational procedures and practices in the outpatient department. Reviewed the community teams;
- Remodelled the services provided from Alnwood and increased the bed occupancy following the completion of the refurbishment of the unit. Alnwood provides medium secure inpatient assessment and treatment for young people up to 18 years old who have complex mental health needs, including those with a learning disability;

- Commenced the review of Forensic Services including the changing commissioner environment, the estate requirements for these services and patient pathway so that patients can be moved on safely;
- Evaluated the Big Diversion Project, in preparation for the next stage of development;
- Secured full Business Case approval for the development of a purpose built unit for people with autism on the Northgate Hospital site to support the new model of care and replace the existing buildings.

### **Social and Residential Services**

In terms of the Trust's Social and Residential Services, during 2013/14 the Trust achieved the following:

- Concluded the lengthy programme aimed at transferring responsibility for the provision of social care for people with learning disabilities to alternative providers;
- Agreed with Commissioners a new model of care for one mental health residential long stay home, which the Trust had historically provided, and transferred the service to alternative providers.

### **New Services**

During 2013/14 the Trust was awarded the following services following a competitive tender process:

- Regional Veterans Awareness Training in the North East;
- Northumberland Integrated Drug and Alcohol Recovery Service;
- CYPS IAPT Training (part of national programme). This bid was submitted as a part of the Newcastle CAMHS Partnership;
- Liaison and Diversion Pilot Services (part of national programme);
- North Tyneside Integrated Drug and Alcohol Recovery Service.

### **Partnerships**

The Trust has developed partnerships with NHS organisations, the community voluntary sector, and independent sectors which we value highly. These include:

- Care UK who were successful in winning the North East Offender Health Tender, but invited the Trust and Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) to work in partnership to provide mental health input to North East prisons;
- Our partnership with Insight (formerly Mental Health Concern Oakdale Ltd) who we work with in the provision of Newcastle Talking Therapies;

- The partnership with TEWV and Revolving Doors in the implementation of the Big Diversion Project;
- The provision of a new model for Tier 3 Children and Young People's Services South of Tyne in partnership with Barnado's, Action for Children and Investing in Children;
- A partnership with TEWV, Combat Stress and The Royal British Legion to deliver Veterans Wellbeing Assessment and Liaison Service in the North East;
- A partnership with TEWV to deliver Veterans Awareness Training in the North East;
- A partnership with Changing Lives (formerly The Cyrenians) and Turning Point to provide the Northumberland Integrated Drug and Alcohol Recovery Service and the North Tyneside Integrated Drug and Alcohol Recovery Service;
- 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 TEWV, 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 Barnardo's in the provision of assessment and treatment for individuals at risk of sex offending who are outside of the criminal justice system.

## **The Workforce**

### **Employee Numbers**

As at 31 March 2014, the Board of Directors consisted of six Executive Directors (three female and three male) and six Non-Executive Directors (one female and five male). The Trust has determined that Senior Managers are the Executive Directors.

As at 31 March 2014, excluding Executive Directors, the Trust had 5,934 employees (4,171 female and 1,763 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 5,449 (3,744 female and 1,705 male). In addition, the Trust has 508 bank staff (355 female and 153 male).

## **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 during 2013/14.

The Trust's Communications Strategy was reviewed by the Board of Directors at its meeting in January 2014.

The Trust supports a number of regular communications:

- Weekly CEO bulletin, including the Medical Director's Spotlight on Safety
- Chatterbox
- Foundation Trust Newsletter

Key messages relating to the Trust's Transformation of Services Programme and quality/safety issues are featured in most bulletins. If urgent, an immediate message is circulated to all relevant staff groups. Areas of good practice are also disseminated in this way and via mail shots.

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 Joint Development Reviews/Personal Development Plans and inclusion of targets in the Trust's Performance Targets;
- Investment in leadership programmes which includes the completion of a specific project by the participant on quality improvement;
- The commitment of time and resources to enable a number of staff to the application of LEAN principles/Rapid Process Improvement Workshops (RPIWs) across the Trust;
- Staff participation in AIMS Accreditation processes, Productive Ward, LIPS (Leading Improvement in Patient Safety);
- Staff engagement in the Chief Executive's 150 Group and 250 Events;
- The involvement of clinicians and staff in the Service Model Review, Principal Care Pathway work and Transformation of Services Programme;

- Staff and staff side representatives are consulted, where appropriate, on proposed service developments/changes;
- Meeting members of the Board of Directors and Senior Management 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.

In the 2013 NHS staff survey 91% of respondents from the Trust confirmed that they are able to contribute towards improvements at work. The Trust was assessed against the Investors in People and Health and Wellbeing Good Practice Awards in January 2014 and successfully achieved both awards achieving the required standards. Areas of good practice highlighted by the assessor included:

- The Trust has a comprehensive corporate strategy and service plans formulated through consultation with stakeholders, and the majority of those interviewed have a good understanding of the Trust's aims and priorities, including the rationale behind the transformation of services to ensure appropriate support is provided for all patients/service users.
- Considerable effort goes into communication and employee engagement, including the 150 Group and 250 Events and regular Chief Executive Bulletins. There were numerous examples of consultation exercises having been undertaken and the outcomes of these having influenced policy or strategy.

Continuing the engagement work with our Transforming Services Programme was a high priority over the year, and as part of our work in this area we held a number of staff engagement events, which were attended by significant numbers of staff from a diverse range of services and functions. These events provided a valuable opportunity for staff to receive an update on the work and to help shape the future of our services, and we value the input staff give to these events.

The Board of Directors continued their on-going programme of visits to services and departments to meet and discuss key issues with staff. Any issues highlighted by staff are then followed through and resolved.

The Senior Management Team also continued to undertake eight hour observational shifts on wards, and positive feedback was received in relation to this from front line staff. Having completed shifts across our inpatient units our more recent focus has been with community teams.

A Staff Survey Working Group was developed following feedback from a 250 Event which looked at the previous year's staff survey results. This Group is made up from staff across all areas who work together to take forward actions from the results of the staff survey. The Group has also started to visit service areas across the Trust



to meet staff and listen to other ideas and suggestions which can be taken forward to improve the working lives of our staff.

The 2013 National Annual Staff Survey indicates that we need to build on our previous work on staff engagement, ensure that we involve staff in making important decisions and in encouraging suggestions for improving services. Hence this work will be a priority again for the year ahead. We believe good local line management is at the heart of meaningful engagement and we have again invested in leadership and management development programmes over the last year and are commencing discussions about a management skills framework.

During 2013 we refreshed the Trust's values. The work commenced in March 2013 at a Chief Executive's 150 event and over 1,000 staff contributed to the work over a series of large scale events and local sessions. Work is already underway to embed the values across the Trust.

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.

### **Employee Consultation**

We continue to value the strong working relationships we have developed with our staff side representatives. Following the Business Model Review we revisited our consultative mechanisms and agreed with staff side representatives to have three main consultative forums; a Trustwide meeting, an Operational meeting and a Corporate Services meeting, the latter two addressing Corporate or Group business leaving the Trustwide forum as an opportunity to discuss key Trustwide and strategic issues with trade union representatives.

All three 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 also attend key Trust committees and are members of all Programme Boards associated with our Service Transformation Programme. 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, and work relating to health and safety.

Working together we have achieved the following:

- Development of a partnership agreement to underpin joint working arrangements;
- As a part of our preparations to launch the Transforming Services Programme we worked together to progress our plans and prepare for the formal launch;
- Worked together to continue to develop the Human Resource Framework and the Transitional Employment and Development approach (TED);
- Continued our on-going review of a number of human resource policies and associated guidance notes.

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

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

In addition, values and attitudes training continues to be part of the training curriculum and is also part of the Trust induction, along with specific discussions around quality of services and raising standards.

During 2013/2014 specific consultations with staff have included the following:

#### Urgent Care

Within Urgent Care Services a number of successful staff consultations took place during the year linked to more effective working practices and ward re-alignments. These include:

- Changes to shift patterns for CRHTs across Newcastle, North Tyneside and Northumberland;
- Closure of Newton Ward (female assessment and treatment unit) in December 2013;
- Change to shift patterns in the Sunderland Liaison Team.

A current consultation linked to the review of Learning Disabilities Inpatient services commenced in March 2014 and remains on-going.

## Planned Care

The Trust consulted with Planned Care on the following matters. The dates and numbers attending are also shown.

- Blyth and Cramlington CMHTs and Northumberland AOT – change of base from Beaconhill to Greenacres. June 2013, 32 staff;
- LD Nurses, CTLD – change in roles/job descriptions. July 2013, 7 staff;
- Central Northumberland Older People’s Community Team – change of base from Coulson House to Greenacres. July 2013, 8 staff;
- Acacia House – closure of house and change of base for staff to either The Willows or Easterfield Court. October 2013, 11 staff;
- Cook at Elm House – role ceased to exist. December 2013, 1 member of staff;
- Kiff Kaff – closure, roles changing January 2014, 5 staff;
- Newcastle Challenging Behaviour Team, dementia – move of base from CAV to Silverdale. January 2014, 8 staff
- Northumberland Psychological Wellbeing Service – move of base from St. Georges Park and Fairnington Centre to West House Farm and Plessey Centre. February 2014, 32 staff;
- Alnwick Older People’s CMHT – move of base from Greensfield to Hawkhill. March 2014, 7 staff.

Other consultations related to changes of base of staff and changes to roles and job descriptions.

## Specialist Care

- Service redesign of the Northumberland Addictions Service to a recovery focused model;
- Service redesign of the North Tyneside Addictions Service to a recovery focused model;
- Expansion of the Criminal Justice liaison and Diversion Service to a 24/7 service (extended hours and out of hours “on call”).

## Support Services

- Downsize of laundry services to reflect loss of Northumbria Healthcare NHS Foundation Trust laundry contract, with new arrangements implemented in October 2013;
- Disestablishment of Housekeeping Services at St George’s Park Hospital with new arrangements to be introduced in June 2014;

- Changes to the way Reception Services are provided at Northgate Hospital with new arrangements to be introduced in June 2014;
- Changes to the portering establishment at Northgate Hospital, St George's Park Hospital and Campus for Ageing and Vitality (formally Newcastle General Hospital) with new rotas being introduced in June 2014.

## **Future Consultations**

We will carry out future consultations in line with our Transformation of Services Programme.

## **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, Trust's Senior Management Team, Senior Managers and Clinical Leaders. The weekly Chief Executive's Bulletin highlights issues that are discussed at the Board and Senior Management 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.

Staff are also involved in discussions relating to strategy and performance through the Chief Executive's 150 Group, and 250 Events which gives them the opportunity to recommend the action required to ensure continued success and delivery of high quality services.

We value the effort and involvement that our staff make to improving quality and performance and the weekly Chief Executive's Bulletin and Chatterbox (on the intranet) feature thank you's and compliments from patients and carers together with local and national recognition awards which our staff have achieved. The Trust holds an annual "Shining a Light on Excellence" Awards which celebrates the achievements of individuals and teams.

## **Staff Satisfaction**

The National Annual Staff Survey indicates how the Trust is perceived by our staff, relative to other comparable Trusts locally and nationally. A more satisfied workforce is likely to be more sustainable and provide better patient care, with motivated and

involved staff being better placed to know what is working well and how to improve services for the benefit of patients and the public.

The 2013 survey findings confirmed that when compared to other mental health and learning disability Trusts in the country the Trust performs better than average on 14 key findings. As in previous years the staff survey results have been reported to the Trust for each Clinical Group and Corporate Department and work has already commenced to identify key areas of work and priorities for the coming year.

In this Annual Report we have provided specific details on the top five and bottom five ranking scores and these are shown in the tables below. These results are taken from the Department of Health report (850 sample).

**Table 1: Staff Survey 2013 Response Rates**

	2012		2013		Trust improvement / deterioration
Response Rate	Trust	National average	Trust	National average	
	44%	50%	49%	49%	Increase of 5%

**Table 2: Staff Survey 2013 Top Ranking Scores**

Top ranking scores	2012		2013		Trust improvement / deterioration
	Trust	National average	Trust	National average	
Work pressure felt by staff	2.97	3.02	2.93	3.07	Decrease of 0.04
Percentage of staff feeling pressure in the last three months to attend work when feeling unwell	18%	22%	18%	22%	No change
Fairness and Effectiveness of Incident Reporting Procedures	3.59	3.52	3.59	3.52	No change
Percentage of staff receiving job-relevant training, learning or development in the last 12 months	80%	82%	83%	82%	Increase of 3%
Percentage of staff receiving health and safety training in the last 12 months	81%	73%	81%	75%	No change

*The table above shows the top five ranking scores compared to other mental health and learning disability Trusts in England, some of these scores are scale summary scores, comprising responses from a number of questions and are measured on a scale of 0 to 5.*

**Table 3: Staff Survey 2013 Bottom Ranking Scores**

	2012		2013		Trust improvement / deterioration
	Trust	National average	Trust	National average	
Bottom ranking scores					
Percentage of Staff able to contribute towards improvements at work	68%	71%	69%	72%	Increase of 1%
Staff motivation at work	3.74	3.84	3.78	3.85	Increase of 0.04
Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	26%	20%	24%	19%	Decrease of 2%
Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month	28%	27%	29%	26%	Increase of 1%
Percentage of staff experiencing physical violence from staff in the last 12 months	3%	4%	4%	4%	Increase of 1%

*The table above shows the bottom five ranking scores compared to other mental health and learning disability Trusts in England, some of these scores are scale summary scores, comprising responses from a number of questions and are measured on a scale of 0 to 5.*

In this sample, there have been no significant changes in NTW survey results since 2012. However compared to other mental health trusts we are:

Better than average on:

- Staff job satisfaction;
- Staff recommending the Trust as a place to work or receive treatment;
- Staff reporting work pressure (we are in the best 20% of mental health trusts);

- Staff feeling pressure in the last two months to attend work when feeling unwell (we are in the best 20% of mental health trusts);
- The number of appraisals carried out and those being well structured appraisals;
- The provision of job relevant training, learning or development in the last 12 months;
- The provision of health and safety training in the last 12 months;
- Fairness and effectiveness of incident reporting procedures;
- The availability of hand washing materials;
- Providing equal opportunities for career progression or promotion.

Worse than average on:

- Staff feeling satisfied with the quality of work and patient care they are able to deliver;
- Staff witnessing potentially harmful errors, near misses or incidents in the last month;
- Staff being able to contribute toward improvements at work (we are in the worst 20% of mental health trusts);
- Staff motivation at work;
- Staff experiencing physical violence from patients, relatives or the public in the last 12 months;
- Staff experiencing physical violence from staff in the last 12 months.

Since 2011 there are four areas where there have been statistically significant changes:

- Decreases in health and safety training;
- More staff suffering work related stress;
- Improved fairness and effectiveness of incident reporting procedures;
- Increased job satisfaction.

For the third year running the Trust chose to survey all staff alongside the Department of Health's sample of 850 staff. The Trust had a 50% response rate for the wider survey and a 49% response rate in the smaller sample, which was an increase from the response rate last year.

In summary, during 2014/15 we propose to focus a lot of work on Staff Pledge 4 which focuses on engagement and empowerment of staff through involving them in decisions that affect them and the services they provide. We are also planning our work relating to the Friends and Family Test and will provide all of our staff with an opportunity to participate in this every quarter.



## **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 support 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, Absence Management 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, with the support of human resource surgeries/clinics and dedicated support from Human Resources.

Sickness absence remains a key priority with current levels of absence at 5.86% compared with 6.23% in 2013. A substantial amount of work has been undertaken over the past year to reduce the levels of absence, including the introduction of Cognitive Behavioural Therapy sessions as part of the Occupational Health Contract for the services provided by Team Prevent, fast-tracking of mental health and muscular skeletal problems, improved recording and reporting, a revised policy and training.

In addition a half day event with representatives from staff side was held early in the year to explore initiatives for managing absence and supporting staff to stay well and remain at work. The Trust also took part in a health and wellbeing pilot with NHS Employers and is currently working through the subsequent action plan from the findings of that work. All of this is supported by a range of other policies and initiatives including flexible working, managing stress at work and the promotion of health and wellbeing campaigns.

The introduction of changes to the way in which sick pay is received across the NHS was implemented from 1 April 2013 due to amendments to national terms and conditions.

The Trust has seen a direct impact on sickness absence levels due to the Transformation of Services Programme. Those areas that have been affected by organisational change have experienced higher absence levels than those not impacted by the programme, and a targeted approach to areas where change is planned to occur has now been put in place.

An Absence Strategy Group has recently been established to explore a more strategic approach to absence management and health and wellbeing, and work is expected to be completed early summer 2014.

## **Whistleblowing Policy**

The Trust's Whistleblowing Policy was revised in October 2012 reflecting:

- The NHS Staff Councils' agreement relating to a new contractual right and duty for NHS staff to raise concerns about malpractice, patient safety, financial impropriety or any other serious risks at work that are in the public interest;
- The principle of the revised NHS Constitution and Whistleblowing consultation paper which outlines the legal right for existing staff to raise concerns.

The Whistleblowing Policy is accessible from the Trust intranet and through the Chief Executive's Bulletin. The Trust has promoted the behaviours and standards of conduct expected from staff together with the Trust's Whistleblowing Policy with the aim of ensuring staff raise any concerns.

The 2013 National NHS Staff Survey confirmed:

- 97% of those who saw an error/near miss that could hurt patients/service users reported it (mental health trust average score 96%);
- 95% confirmed that they would know how to report fraud, malpractice or wrong doing;
- 97% confirmed that the Trust encouraged the reporting of errors;
- 95% confirmed that the Trust takes action to ensure errors are not repeated.

## **Occupational Health, Counselling and Health Promotion**

Team Prevent, the UK division of one of Europe's leading occupational health and safety companies, 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 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 during 2013/14 referrals were greater than the contract level by 8%. Additional occupational health resource has been employed to meet the increased demand and other solutions were implemented to enable the demand to be met e.g. the continued encouragement of telephone consultations rather than face to face appointments.

Team Prevent continue to provide health promotion days. These are very successful and prove popular amongst staff; the events are now more focused to Health and Wellbeing with the sessions based around a “passport to better health”. Checks carried out during health promotion days include:

- Blood pressure checks;
- BMI checks;
- Cholesterol checks;
- Awareness of alcohol consumption;
- The effects of smoking;
- Exercise regimes.

Team Prevent is also assisting us in undertaking a health surveillance programme for staff.

In terms of wider health promotion work we promoted information in accordance with national events including No Smoking Day, Men’s Health Week, as well as promotions for Fruity Friday and Healthy Heart. Exercise initiatives were piloted and have continued this year and include Zumba, Yoga and Boot Camp. Information is placed on the intranet including access to a seasonal health and wellbeing magazine, information about our counselling service, information to encourage physical activity, working in partnership with gyms and offers of discounted gym membership.

### **Employee Equality and Diversity**

The Trust has a robust approach to policy making to ensure that all new and due for review policies, procedures and functions 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:

- A refreshed Equality and Diversity Committee which meets bi-monthly in order to take forward the equality and diversity agenda;
- An Equality Strategy for 2012-2016 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;
- Benchmarking against NHS England’s Equality Delivery Scheme;

- Dignity and Respect at Work Policy that has been updated in light of the Equality Act 2010 requirements;
- Equality and Diversity Briefings for staff;
- A mandatory requirement for Equality and Diversity Training, which includes as part of its purpose to provide information on matters of concern to them as employees. The training has been substantially revised this year;
- Attendance and Sickness Policies – containing our approach to making reasonable adjustments for disabled employees.

The Trust has maintained its “Two Ticks” status. The symbol is a recognition given by Jobcentre Plus to employers who have agreed to make certain positive commitments regarding the employment, retention, training and career development of disabled people.

These commitments are:

- To interview all disabled applicants who meet the minimum criteria for a job vacancy and to consider them on their abilities;
- To ensure there is a mechanism in place to discuss, at any time but at least once a year, with disabled employees, what both parties can do to make sure disabled employees can develop and use their abilities;
- To make every effort when employees become disabled to make sure they stay in employment;
- To take action to ensure that all employees develop the appropriate level of disability awareness needed to make sure these commitments work;
- To review these commitments each year and assess what has been achieved, plan ways to improve on them and let employees and Jobcentre Plus know about progress and future plans.

### **Mindful Employer**

The Trust has maintained the Mindful Employer Charter.

The Charter shows that the Trust:

- Shows others and our staff that we are a good employer;
- Expresses our corporate social responsibility;
- Reduces recruitment and training costs;
- Helps towards complying with legislation (e.g. Equality Act 2010 and Health and Safety legislation);
- Reduces sickness levels;
- Enhances customer service;
- Improves productivity;

- Makes the Trust a more attractive place to work for people with mental health issues and others;
- Helps the Trust retain staff who have experienced discrimination in the past;
- Makes our Trust a healthier workplace.

### **Health, Safety and Security Management**

The Safety Department have 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, with a plan in place to have over 1,000 devices in use keeping front line staff safe. The approach the Trust has taken to its lone worker system, 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. NTW is now one of three NHS Trusts working with the company to improve the activity reports and performance management software, to further enhance the system.

The Trust, in partnership with Northumbria Police, has successfully recruited a search dog handler and Coco the Trust's search dog, who is now actively working on the wards with clinical teams, to reduce the impact of illicit substance misuse within the Trust. This has been extremely well received across the organisation, and this best practice approach, has gathered interest from other Mental Health Providers. The Trust has shared the learning of this approach with them.

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) have not made any requests to visit or audit the Trust within the last financial year. The Trust continues to report its RIDDOR related incidents in the time frames set by the legislation.

The Trust continues to work with Tyne and Wear Fire and Rescue Service with the aim of ensuring that the organisation 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.

### **Serious Incidents and Incident Reporting**

As reported to the Board of Directors through the Safety Report, throughout 2013/14 there has been a steady increase in the total number of serious incidents in comparison to previous years, the majority of which occur in community services of

the Trust. Some of this increase relates to individual service expansion, with more patients coming into contact with our services. An increase has also been noted in other mental health organisations nationally.

The Trust has, throughout 2013/14, developed robust reporting systems with our Clinical Commissioning Groups and the North East Commissioning Support Unit, as their new governance systems have been created. This also 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 has built on the systems we already had in place in respect to our Being Open principles in line with the Trust's Incident Policy.

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.

### **National Community Mental Health Survey 2013**

The 2013 survey of people who use community mental health services involved 58 NHS Trusts in England (including combined mental health and social care trusts, foundation trusts and community healthcare social enterprises that provide mental health services). Responses were received from more than 13,000 service users giving an overall response rate of 29%.

846 Trust service users were sent a questionnaire, of which 824 were eligible for the survey, with a total of 229 responses. The Trust response rate was 28%, which is 1% lower than the national average (compared to a 26.47% Trust response rate in the 2012 survey).

The results of the survey are outlined in the Quality Report.

There are nine distinct sections of the survey and in all nine areas NTW scored "about the same" as the other mental health trusts included.

Each of the nine sections are made up of a subset of questions to provide the overall rating.

The Trust was scored as BETTER than most other mental health trusts for the following two questions:

- Medications - Were the purposes of the medication explained to you? (Q12)
- Care Plan - Have NHS mental health services helped you start achieving these goals?(Q25)

The Trust had one question which scored significantly higher than the same Trust score for 2012:

- Medications - Were the purposes of the medication explained to you? (Q12)

The Trust had one question which scored significantly lower than the same Trust score for 2012:

- Health and Social Care Workers – Did you have confidence and trust in this person? (Q6)

There are 38 individual questions (excluding section scores) in the survey for which the Trust improved its score in 19 questions, stayed the same in four questions and decreased in 15 questions (although all scores still fall within the limits of 'about the same' as the other mental health trusts).

### **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 considered to be 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 dealt with 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.

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 the 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 (Patient Advice and Liaison Service) 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.

### **The Trust's response to the Francis, Berwick and Keogh Reports**

The Trust's review and reflections on the findings of the Francis, Berwick and Keogh reports has included the Board of Directors, the Council of Governors and all key Board sub-committees across the organisation including the Senior Management Team, Group Business Meeting, Quality and Performance Committee, together with Joint Meetings with Staff Side and Staff Listening Events. Key messages were also shared with all staff through the Chief Executive's weekly Bulletin, Group and Team meetings and key professional groupings.

In response to the reports the Trust developed, and has now implemented, a comprehensive action plan. A summary of the actions taken is as follows:

- Developing a shared set of values;
- Development of a "Safety Culture";
- Working more collaboratively with service users and carers;
- Strengthening the role of the Council of Governors;
- Developing a strong and positive medical culture;
- Strengthening the Nursing Culture including the launch of a new Nursing Strategy - "Delivering Compassion in Practice";
- Increasing openness, transparency and candour;
- Review of Complaints Procedure;
- Using information more effectively;
- Developing leadership in the workplace;
- Investment in staffing across inpatient areas.

In summary therefore the Trust has responded to the Francis, Berwick and Keogh Reports across a wide front prioritising the issues of values, safety culture and professional cultures. The Trust will continue to keep quality, safety and patient experience as its main focus with additional scrutiny and challenge being sustained via the Trust Board, the Board's Confirm and Challenge Events, Safety Programme Board and Quality and Performance Committee.

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

During 2013/14, the Trust has undertaken a number of public involvement exercises to fulfil our duties under section 242 of the NHS Act 2006.

Working in partnership with South Tyneside Clinical Commissioning Group, the Trust has supported a full public consultation regarding mental health services in South Tyneside which ran from 11 December 2013 until 17 March 2014.



The Trust consulted with the public and patients, local groups and Overview and Scrutiny Committees on a number of smaller changes during the year. These are included in the table below.

**Consultation with the public and patients, local groups and Overview and Scrutiny Committees on proposed service changes during 2013/14**

Area	Service
Northumberland	Female bed based Assessment and Treatment Services (2013) Inpatient Learning Disability Services (2013) Rehabilitation Services (2013)
North Tyneside	Female bed based Assessment and Treatment Services (2013) Inpatient Dementia Services (2013) Inpatient Learning Disability Services (2013) Rehabilitation Services (2013) Rehabilitation Services (2014)
Newcastle	Female bed based Assessment and Treatment Services (2013) Inpatient Dementia Services (2013) Inpatient Learning Disability Services (2013) Rehabilitation Services (2013) Rehabilitation Services (2014) Dementia Services (2014) Psychiatric Intensive Care (2014)
South Tyneside	Public consultation on all inpatient services and Community Services (2013 – 2014) Rehabilitation Services (2014)
Gateshead	Rehabilitation Services (2014)
Sunderland	New Dementia Unit (2013) Principal Community Pathways (2013)

The Trust has strong links with each of the Overview and Scrutiny Committees in the area, facilitated through attendance at committees, regular meetings between the Chairman and Chief Executive and the Committee Chairs, and regular communication through the Deputy Director, Partnerships.

**Principal Risks**

The principal risks facing the Trust, and how they are managed, are set out in the Board of Director's Assurance Framework and Corporate Risk Register. The Framework is linked to the Trust's Strategic Objectives and covers risks associated with all aspects of the Trust's business including finance, quality and the workforce.

During 2013/14 the Board Assurance Framework and Corporate Risk Register was reviewed regularly by the Senior Management Team, monitored by the Audit Committee and Quality and Performance Committee and presented quarterly to the Board of Directors, as a part of the Integrated Performance Report.

The Trust's principal risks are considered as those rated over 15 at a corporate level on the standard 5 by 5 risk assessment measure. The table in the Trust's Annual Governance Statement summarises those risks and the key controls as reported in the Board Assurance Framework and Corporate Risk Register. All risks identified are considered as in year and future risks.

### **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 the PRiDE development (providing improved mental health and learning disability environments in Sunderland and South Tyneside), the keenly awaited development to provide state of the art, inpatient and support services to replace Cherry Knowle Hospital. The Specialist Care Dementia Centre at Monkwearmouth Hospital opened in November 2013 and Hopewood Park is due to open in August 2014. 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.

Investment also continued in other patient environments in line with the Trust's Transformation of Services Programme.

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.

### **Our Plans Going Forward**

The Trust's Plans going forward 2014-2017 are outlined in the Trust's Operational Plan submitted to Monitor in April 2014. The Operational Plan confirms that the Trust will continue to progress the strategy of Transforming Services including the following service developments:

#### **Principal Community Pathways Programme**

The programme of implementing effective, evidence based 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, will be rolled out initially across Sunderland and South Tyneside and then subsequently Newcastle, Northumberland, Gateshead and North Tyneside over the period of the Plan. The programme will

redesign services to meet the following needs in adults: Psychosis; Non-psychosis; Cognitive Disorders and Learning Disability.

### **The PRiDE Development (including the reprovision of Cherry Knowle Hospital)**

With the opening of Hopewood Park in August 2014 the Trust will be focusing during 2014/15 on the final realignment of adult assessment and treatment services, older people's and stepped care services across South of Tyne into Hopewood Park, in line with the agreed South of Tyne Model of Care including:

- The redesign of Stepped Care Services (Move on/Relapse Prevention Services) South of Tyne bringing together inpatient provision in Hopewood Park supported by additional investment in the Community Rehabilitation Service;
- The rationalisation of the Sunderland and South Tyneside Dementia Services optimising the use of the new Dementia Care Centre at Monkwearmouth Hospital;
- The realignment of the secondary care pathway South of Tyne (assessment and treatment services) optimising the use of Hopewood Park;
- The rationalisation of older people's functional in patient services South of Tyne optimising the use of Hopewood Park.

### **Augmentation Programme**

The Augmentation Programme includes leading on the design and implementation of the future configuration of inpatient services based on patient need and over the period of the Plan the Trust will continue to progress the programme of work, subject to Commissioner approval and, where required, the outcome of consultation, including the following:

- Completion of the review of the dementia care pathway in Newcastle;
- The redesign of Stepped Care Services (Move on/Relapse Prevention Services) North of Tyne bringing together inpatient provision for Newcastle and North Tyneside into one unit on the St. Nicholas Hospital site;
- Consolidation of the Trust's two existing Psychiatric Intensive Care Unit Services into a purpose built unit at Hopewood Park;
- Establishment of a specialist Augmentation Personality Disorder (PD) Hub Team;
- Development of a male High Dependency Unit, North of Tyne and a female High Dependency Unit to serve both North and South of Tyne;
- Further expansion of hospital liaison services across localities in line with the recognised Rapid Assessment, Interface and Discharge (RAID) model.

The implementation and roll out of Principal Community Pathways in 2013/14 and 2014/15, with evidence based interventions focused on recovery and more effective support for people to live and work in their own communities, will:

- Result in improved quality outcomes and experience for service users accessing community services and their carers, leading to;
- A reduced need for inpatient services;
- A reduction in the number of beds (around 400), wards and hospital sites;
- Improved quality environments.

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

- Clinical Fit - is the solution clinically appropriate;
- Safety-is the solution safe;
- Financial viability-is the solution affordable.

A long list of options were evaluated to produce a shortlist and further workshops were then held to consider the merits of the four shortlisted options. During 2014/15 the Trust will be consulting on the next phase of the inpatient bed model and the outcome of this will shape the next phase of the Augmentation Programme which, subject to the outcome of consultation, will be implemented during 2015/16 and 2016/17.

### **Specialist Care Services Programme**

The Specialist Care Services Programme will continue to ensure that the Trust retains sustainable specialist services as part of the overall service model and over the period of the plan, the work of this programme will include, subject to commissioner approval and, where required, the outcome of consultation, the following:

- The further review of Neurological Services to ensure long term sustainability including the review of the future of Heppell House, a 4 bedded Head Injury Unit in Corbridge offering long term rehabilitation and care;
- Review of the Children's and Young People's Medium Secure and Forensic Outreach Services;
- Reviewing the Trust's Forensic Services to ensure long term sustainability including developing a Specialist Learning Disability Community Transitions Team to support and expedite the discharge of

patients in Learning Disability Forensic inpatient services from North and South of Tyne (re-providing the existing Hebron service);

- Securing capital to support the development of a purpose built assessment and treatment unit for people with autism;
- Review of the Regional Affective Disorder Service, including the potential to relocate and expand the inpatient service;
- Establishment of an Attention Deficit Hyperactivity Disorder (ADHD) service on a sustainable basis (pilot service currently provided);
- Reconfiguration of Eating Disorder Services.

The Specialist Care Services Programme will also work with NHS England with regard to their strategy and proposals for specialised commissioning.

### **Social and Residential Services**

In terms of the Trust's Social and Residential Services over the period of the plan the Trust will:

- Progress the next phase of the review of Northumberland Adult Residential Mental Health Care Services;
- Review of Northumberland Mental Health Day Services.

### **Corporate Services Programme**

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 redesigned and reshaped through our Transformation of Services Programme so too must corporate services. They must work in different ways and be provided as efficiently and effectively as possible.

During 2014/15 the Corporate Services Programme will commence a programme of work to focus on the realignment of the existing corporate services model and methods of delivery to support the priorities and objectives of the Trust's service model.

This Strategic Report was approved by the Trust Board of Directors on 28 May 2014.

A handwritten signature in black ink, consisting of a series of loops and a long horizontal stroke extending to the right.

**James Duncan**  
**Acting Chief Executive**  
**28<sup>th</sup> May 2014**

### **3 DIRECTORS' REPORT**

#### **Enhanced quality governance reporting**

An overview of the arrangements in place to govern the Trust, including service quality, is included in the Strategic Report and in the Trust's Annual Governance Statement 2013/14, Section 13 of this Report.

In 2010 the Trust supported Monitor in the development of a Quality Governance Framework. The Trust's Annual Governance Statement 2013/14, Section 12 of this report, 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.

With regard to action taken to improve the quality of governance, the Trust's Governance arrangements were reviewed in May 2013 with the Clinical Governance arrangements being reviewed and strengthened in January 2013 to ensure their robustness in the context of the Trust's overarching integrated governance arrangements. They 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 continues to keep the governance arrangements under review to ensure their effectiveness.

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 in the Strategic Report and other parts of the Annual Report as identified below. This includes:

- How the Trust is using its Foundation Trust status to develop its services and improve patient care. Also see the Quality Report and the Directors Report;
- Performance against key health targets. Also see the 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. Also see the Quality Report and the Annual Governance Statement;

- Progress towards targets as agreed with local commissioners, together with details of other key quality improvements. Also see the Quality Report;
- Any new or significantly revised services;
- Service improvements following staff or patient surveys/comments and Care Quality Commission Reports. Also see the Quality Report;
- Improvement in patient/carer information;
- Information on complaints handling. Also see the Quality Report.

Information relating to the Trust's stakeholder relations is outlined in the Strategic 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 2013/14 patients and carers were involved in the following:

- The design and development of Principal Community Pathways;
- Public consultation on the Trust's specific Transformation of Services plans for 2013/14;
- The development of the Trust's Annual Plan 2013/14 and Operational Plan 2014-2017, through the Council of Governors and Annual Plan Working Group;
- The review of the Trust's values;
- Involvement in the appointment of the new Chair and Chief Executive, through the Council of Governors.

### **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, including formal public consultation on specific proposals.



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:

- Service User and Carer Network for Transforming Services;
- AIMS (Service User and Carer Questionnaires);
- Essence of Care;
- See It Say It Campaign;
- Complaints, Incidents and PALS 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).

A Carers' Charter has been developed and monitoring of progress is reported to the Trust Board on a six monthly basis. The Trust hosted a Carers Conference and established a Support for New Carers Group involving carers and representatives from the Council of Governors.

Service user and carer representatives are actively involved on a number of Trust Forums, e.g. PRiDE, SUI Review Group, Learning Lessons Group. "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.

During 2013 the Trust joined a local pilot of a proposed new national patient/carers feedback system called Care Connect, which is accessed through the existing NHS Choices portal. This allows patients and carers to rate the quality of services they have received, raise any concerns or ask any questions about their care or treatment. If the pilot is successful then the system will be rolled out nationally and information on any comments or concerns raised will be sent to relevant commissioners as well as the providers of care.

With regard to 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 Trust are also including the standard Family and Friends Questionnaire within this to also provide us with a Patient Reported Experience Measure

(PREM). 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.

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

The Trust also has a number of good examples where users and carers have been actively involved in the development of services e.g.:

- Alnwood;
- Tyne;
- PRiDE Project, where a carer representative is a member of the Project Board.

## **Patient Information**

The Trust's Patient Information Centre aims to provide a central point of access to appropriate 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 media in order to meet the requirements of all potential users, including easy read information. Information can be accessed on line and the Centre hold 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.

## **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 Trusts 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.

## **Register of Directors' Interests**

The Foundation Trust maintains a formal Register of Directors' Interests. The Register is available for inspection on the internet at [www.ntw.nhs.uk](http://www.ntw.nhs.uk) or on request, from Eric Jarvis, Board Secretary, Chief Executive's Office, St. Nicholas Hospital, Jubilee Road, Gosforth, Newcastle upon Tyne, NE3 3XT. ([eric.jarvis@ntw.nhs.uk](mailto:eric.jarvis@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.

## **Our Governance Arrangements including the directors' details**

Please refer to the Governance Report.

## 4 REMUNERATION REPORT

### Remuneration Report

#### Salary and Pension Entitlements of Senior Managers

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 eight times during 2013/14. The table below shows the membership of the Remuneration Committee during 2013/14 along with their attendance.

Name	Meetings	
	Total	Attended
Hugh Morgan Williams (chair)	3	3
Martin Cocker	8	7
Ken Grey	8	3
Paul McEldon	8	7
Nigel Paton	8	6
Fiona Standfield (chair for 5 meetings attended)	7	5
Chris Watson	8	6

The policy on the remuneration of senior managers is that the Committee's remit covers the remuneration of the Chief Executive and Executive Directors.

In considering the remuneration of senior managers, the 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. During 2013/14 a report was commissioned from an independent market specialist to inform the Remuneration Committee's review of Executive Directors' salaries.

All substantive Executive Directors' contracts are permanent with three months' notice (except the Director of Finance whose notice period is four months) and termination payments (including redundancy and early retirement) are as per the general NHS terms and conditions applicable to other staff.

Performance pay did not apply for 2013/14 and will not apply during 2014/15.

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.

During 2013/14, there were 15 individuals fulfilling the role as director, with eight of them receiving expenses in the reporting period totalling £9,800, which included relocation expenses. The equivalent for 2012/13 was 15 individuals with 6 receiving expenses totalling £1,200.

During 2013/14, there were 41 individuals in governors' roles, but at any one time there was an average of 31 governors. 18 governors received expenses totalling £2,400. The equivalent for 2012/13 was 41 individuals in governors' roles with an average of 29 at any one time. 15 governors received expenses totalling £1,500.

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, although there are a very small number of staff who still choose to remain on local terms and conditions of services. 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 2013/14, the Remuneration Committee was required to oversee the arrangements to replace the Medical Director and the Chief Executive. The Remuneration Committee recognised both roles as being complex, specialist and crucial to the success of the Trust and agreed that external search consultancies should be employed to optimise the process of attracting the best candidates possible.

For the Medical Director post, the Remuneration Committee approached Odgers Berndtson for a quote having recognised the organisation as a nationally based independent search adviser with particular expertise in this field. Given their good reputation and the timescales involved, the Remuneration Committee agreed that the appointment should be on a single quotation basis at a cost of £25,000.

For the Chief Executive post, the Remuneration Committee undertook a mini competition between two national independent search advisers that had been recently employed by the Trust for high profile appointments. Both processes had produced positive outcomes with the Trust being satisfied with the service provided and both organisations knew the Trust. On that basis, the Remuneration Committee appointed Gatenby Sanderson at a fee of £15,000.

In both cases the Remuneration Committee was satisfied with the service provided and the quality of the candidates put forward by the organisations.

There have not been any off-payroll arrangements to Board members during 2013/14.

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



**James Duncan**  
**Acting Chief Executive**  
**28<sup>th</sup> May 2014**

<b>Board of Directors 1 April 2013 to 31 March 2014</b>		
<b>Non-Executive Directors</b>		
Hugh Morgan Williams	01.11.13 – 31.03.14	Trust Chair
Fiona Standfield	01.04.13 – 31.12.13	Acting Trust Chair (01/04/13 to 31/10/13) Vice Chair (01/11/13 to 31/12/13)
Paul McEldon	01.04.13 – 31.03.14	Acting Vice Chair (01/04/13 to 31/10/13) Non-Executive Director (01/11/13 to 19/02/14) Vice Chair (20/02/14 to 31/03/14)
Ken Grey	01.04.13 – 31.03.14	Non-Executive Director/Senior Independent Director
Chris Watson	01.04.13 – 31.03.14	Non-Executive Director
Martin Cocker	01.04.13 – 31.03.14	Non-Executive Director/Audit Committee Chair
Nigel Paton	01.04.13 – 31.03.14	Non-Executive Director
<b>Executive Directors</b>		
Dr Gillian Fairfield	01.04.13 – 31.03.14	Chief Executive
James Duncan	01.04.13 – 31.03.14	Deputy Chief Executive/Executive Director of Finance
Elizabeth Latham	01.04.13 – 31.03.14	Executive Director of Workforce and Organisational Development
Dr Suresh Joseph	01.04.12 – 31.11.13	Executive Medical Director
Dr Douglas Gee	01.12.13 – 31.03.14	Executive Medical Director
Gary O'Hare	01.04.13 – 31.03.14	Executive Director of Nursing and Operations
Lisa Quinn	01.04.13 – 31.03.14	Executive Director of Performance and Assurance
Lisa Crichton-Jones	01/04/13 – 31/03/14	Acting Executive Director of Workforce and Organisational Development

Board of Directors remuneration								
Name	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	
	2013/14	2012/13	2013/14	2012/13	2013/14	2012/13	2013/14	2012/13
Hugh Morgan Williams	15-20	0	0	0	0	0	17	0
Fiona Standfield	25-30	20-25	0	0	0	0	25	25
Paul McEldon	10-15	10-15	0	0	0	0	10	10
Ken Grey	10-15	10-15	0	0	0	0	11	11
Chris Watson	10-15	5-10	0	0	0	0	10	10
Martin Cocker	10-15	10-15	0	0	0	0	12	11
Nigel Paton	10-15	5-10	0	0	0	0	10	7
Dr Gillian Fairfield	215-220*	180-185	0	0	10.0-12.5	(5.0)-(7.5)	231	176
James Duncan	125-130	120-125	13	9	27.5-30.0	(0.0)-(2.5)	156	123
Dr Suresh Joseph	170-175	185-190	0	0	12.5-15.0	(85.0)-(87.5)	185	99
Dr Douglas Gee	50-55	0	0	0	17.5-20.0	0	74	0
Gary O'Hare	105-110*	105-110	74	13	(65.0)-(67.5)	(27.5)-(30.0)	50	79
Elizabeth Latham	125-130*	90-95	0	0	52.5-55.0	(7.5)-(10.0)	180	84
Lisa Quinn	120-125*	95-100	13	0	5.0-7.5	(5.0)-(7.5)	131	93
Lisa Crichton-Jones	115-120*	80-85**	12	15	117.5-120.0	12.5-15.0	235	97

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

There were two Executive Directors who have opted out of the NHS Pension Scheme since 2010/11. Payments in lieu of pension were made of £23,000 to Gillian Fairfield and £14,000 to Dr Suresh Joseph (£21,000 each in 2012/13). These amounts are included in all pension-related benefits along with the annual increase in pension entitlement determined in accordance with the 'HMRC method'.

Dr Gillian Fairfield served as a non-executive director for the Youth Justice Board from October 2012. Dr Fairfield's remuneration as a non-executive director was paid to the Trust for this period and earnings as an executive director of the Trust were retained.

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

All director posts were subject to 1% uplift in 2013/14. Dr Gillian Fairfield declined the uplift.

\* The Remuneration Committee undertook an Executive Directors salary review during 2013/14, which was the first review since the Trust became a Foundation Trust on 1 December 2009. The salaries column for 2013/14 includes any arrears as a result of the review. Dr Gillian Fairfield declined arrears relating to the period 1 December 2010 to 31 March 2013. Arrears paid were to Dr Gillian Fairfield £18,560; Gary O'Hare £5,846; Elizabeth Latham £19,840; Lisa Quinn, £19,778; and Lisa Crichton-Jones £10,268.

\*\* Lisa Crichton-Jones' salary for 2012/13 related to the period from 14 May 2012 to 31 March 2013.

### 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 2014 on an annualised basis.

	2013/14	2012/13
Median total remuneration	£25,783	£25,528
Ratio to mid-point of the banded remuneration of highest paid director	8.84	8.16

### Pension analysis

<b>Board of Directors pension analysis</b>							
	Real increase (decrease) in pension at age 60	Real increase (decrease) in lump sum at age 60	Total accrued pension at 31/03/14	Lump sum at age 60 related to accrued pension at 31/03/14	Cash Equivalent Transfer Value at 31/03/14	Cash Equivalent Transfer Value at 31/03/13	Real increase in Cash Equivalent Transfer Value
	Bands £2.5k £000	Bands of £2.5k £000	Bands of £5k £000	Bands of £5k £000	£000	£000	£000
Dr Gillian Fairfield	(0)–(2.5)	0)–(2.5)	50-55	150-155	1176	1105	47
James Duncan	0–2.5	2.5–5.0	30-35	100-105	532	487	34
Dr Douglas Gee	0–2.5	0–2.5	40-45	120-125	671	601	19
Gary O'Hare	(2.5)–(5.0)	(7.5)–(10.0)	50-55	150-155	925	929	(25)
Elizabeth Latham	0–2.5	5.0-7.5	35-40	105-110	0	743	0
Lisa Quinn	0–2.5	0–2.5	30-35	95-100	470	443	18
Lisa Crichton-Jones	5.0-7.5	15.0–17.5	15-20	55-60	284	200	80

Note:

Dr Douglas Gee's increases in pension relate to the period in post only.

Dr Suresh Joseph retired on 30th November 2013 reducing all pension funds to £nil.



## Cash equivalent transfers

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.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and 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. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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.

## **5 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;
- In preparing the Trust's forward plan, 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 a self-assessment of effectiveness supported by post Board of Directors' meeting reflections, Board time outs, a development programme, the review of governance arrangements and its committees' annual self-assessment exercise.

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. Prior to his appointment, Fiona Standfield had been Acting Chair from 1 October 2012.

Neither Hugh Morgan Williams nor Fiona Standfield had other significant commitments during the period of review and this was reported to the Council of Governors prior to appointment.

## **The Vice Chair**

Paul McEldon was appointed as Vice Chair from 20 February 2014. He had previously been Acting Vice Chair from 1 October 2012 to 31 October 2013. Fiona Standfield was Vice Chair from 1 November 2013 to 31 December 2013.

## **Senior Independent Non-Executive Director**

Ken Grey was appointed on 1 December, 2009 as Senior Independent Director of the Foundation Trust and continued in that role throughout the period of review. The Senior Independent Director leads the performance appraisal of the Chairman.

## **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 which are done 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.

## **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 2013 to 31 March 2014, 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](http://www.ntw.nhs.uk) or on request, from Eric Jarvis, Board Secretary, Chief Executive's Office, St. Nicholas Hospital, Jubilee Road, Gosforth, Newcastle upon Tyne, NE3 3XT. ([eric.jarvis@ntw.nhs.uk](mailto:eric.jarvis@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 eight times per year, including one joint meeting with the Council of Governors. The Board of Directors also meets three times per year in Board "Confirm and Challenge" meetings. This concept is a two way process whereby Operational Groups present to the Board of Directors their contribution and delivery of the Trust's strategy and their operational performance, both historic and forward plan. The Board of Directors are then able to confirm and challenge the work of the Groups. Conversely, the Groups also have an opportunity

to debate Trust strategy with the Trust Board and inform future Board decisions in relation to strategic direction.

**The table below shows the members of the Board of Directors during 2013/14 along with directors' titles and attendance at Board meetings.**

Name Title	Date of:			Meetings	
	Appoint	Cessation	Current expiry of term	Total	Attended
<b>Martin Cocker</b> Non-Executive Director/Audit Committee Chair	01.01.12	-	31.12.14	11	10
<b>James Duncan</b> Deputy Chief Executive/Director of Finance	01.12.09	-	N/A	11	9
<b>Gillian Fairfield</b> Chief Executive	01.12.09	31.03.14	N/A	11	9
<b>Douglas Gee</b> Medical Director	01.12.13	-	N/A	4	4
<b>Ken Grey *</b> Non-Executive Director/Senior Independent Director	01.12.09	-	31.12.14	11	5
<b>Lisa Crichton-Jones</b> Acting Director of Workforce and Organisational Development	14.05.12	-	N/A	11	10
<b>Suresh Joseph</b> Medical Director	01.12.09	31.11.13	N/A	7	6
<b>Elizabeth Latham *</b> Director of Workforce and Organisational Development	01.12.09	31.03.14	N/A	11	0
<b>Paul McEldon</b> Non-Executive Director Note: Acting Vice Chair Vice Chair	01.12.09 01.10.12 20.02.14	31.10.13 -	31.12.14	11	10
<b>Gary O'Hare</b> Director of Nursing and Operations	01.12.09	-	N/A	11	10
<b>Nigel Paton</b> Non-Executive Director	01.07.12	-	30.06.15	11	8
<b>Lisa Quinn</b> Director of Performance and Assurance	01.12.09	-	N/A	11	10
<b>Fiona Standfield</b> Non-Executive Director (Vice Chair) Note: Acting Trust Chair	01.12.09 01.10.12	31.03.13 31.10.13	N/A	8	6
<b>Chris Watson</b> Non-Executive Director	01.12.09	-	31.12.15	11	7
<b>Hugh Morgan Williams</b> Trust Chair	01.11.13	-	31.10.16	5	4

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 Chairman, 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 2013/14 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.

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 2014 are shown below.

#### 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, Tinkoff Credit Systems Group PLC;
- Significant 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.

#### 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 including:
  - Director of Finance, Northgate and Prudhoe NHS Trust (including six months as Acting Chief Executive);
  - Director of Finance, Newcastle, North Tyneside and Northumberland Mental Health NHS Trust;
  - Previous member of Shared Systems Partnership Board Procurement NE Project Board;
  - National Case Mix Office – Mental Health Project Board;
  - Chair of Care Pathways and Packages Consortium Project Team and Member of Programme Board;
  - Chair of National Finance Group for Mental Health Payment Systems and Member of National Product Review Group for same project;
  - Vice Chair of HFMA Mental Health Faculty.

#### Dr Gillian Fairfield

Qualifications include an MA in Business Administration (MBA), MA in Public Health (MPH), Member of the Faculty of Public Health Medicine (MFPH) and a Qualified Medical Practitioner MB ChB, DCH

Experience and skills/expertise:

- Previously Chief Executive of Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust 2004-2008;
- Medical Director of Hull and East Riding Community Mental Health NHS Trust 2000–2004;



- Medical Director and Deputy Head of the National Prison Health Task Force 1999;
- Policy Advisor in Mental Health at the Department of Health 1998;
- British Medical Association Travelling Fellow studying managed care in USA 1997;
- Qualified Medical Practitioner with wide clinical experience including general practice and public health;
- General Medical Council Associate;
- Member of NHS Top Leaders.

#### Dr Douglas Gee

Qualifications include MB ChB (University of Edinburgh) 1990, MRCPsych 1995 and MMedSc (University of Leeds) 1997.

Experience and skills/expertise:

- Medical Director - Humber NHS Foundation Trust from 2006-2013;
- Experience included FT application, various service redesigns, and acquisition of community services;
- Responsibilities included professional management of Medical, Psychology and AHP staff as well as the Integrated Governance Department and Clinical Pharmacy;
- Medical Management role since 2001;
- Experience included some of the early implementation of New Ways of Working;
- Consultant General Adult Psychiatrist since 1998.

#### Ken Grey

Qualifications include BSc Electrical Engineering, BA Economics, Diploma in Management Studies and NVQ Assessor.

Experience and skills/expertise:

- Trustee of New Prospects Association Ltd;
- Non-Executive Director, Northgate and Prudhoe NHS Trust;
- Significant business experience including as a senior manager with British Telecom;
- Chairman of Newcastle upon Tyne Healthcare Charity;
- Independent Chairperson of the Newcastle Children's Fund (2001- 2008);
- Secretary to the Neurosciences Foundation of West Bengal;
- Magistrate.

#### Elizabeth Latham

Qualifications include Diploma for Bi-lingual Secretaries and Member of Chartered Institute of Personnel and Development (MCIPD)

Experience and skills/expertise:

- Extensive human resources experience including:
  - Member of the NHS Pension Scheme Governance Group;
  - Head of Personnel South Durham Health NHS Trust;
  - Director of HR, Newcastle, North Tyneside and Northumberland Mental Health NHS Trust.

#### 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.

#### Gary O'Hare

Qualifications include EN (MH), RMN 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, including formerly 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 & Learning Disability Nurse Directors and Leads National Forum;
- Strong academic links with Northumbria University.

#### Nigel Paton

Qualifications include LLb (Hons) Newcastle University, Law Society final Examination and Programme for Executives, Carnegie Mellon University, Pittsburgh.

Experience and skills/expertise:

- Director Legal of the Marine and Protective Coatings Business of Akzo Nobel;

- General Counsel, ICI Paints;
- Lead M&A counsel, ICI PLC;
- Extensive experience as international commercial lawyer.

#### Lisa Quinn

Qualifications include Member of the Chartered Institute of Management Accountants.

Experience and skills/expertise:

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

#### Chris Watson

Qualifications include BSc Civil and Environmental Engineering, Member of Institution of Civil Engineers and MBA.

Experience and skills/expertise:

- Significant management and business expertise including Senior Manager, Northumbria Water.

#### 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;
- Experienced chairman of large and small organisations with particular skill in change management, 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 continue to be regarded as fit for purpose. 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. There is a further committee, the Trustwide Programme Board, which is a time limited committee providing 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 will be reviewed by the Audit Committee. Each committee self-assesses its effectiveness at least 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 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 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 eight times during

2013/14. The table below shows the membership of the Remuneration Committee during 2013/14 along with their attendance.

Name	Meetings	
	Total	Attended
Hugh Morgan Williams (chair)	3	3
Martin Cocker	8	7
Ken Grey	8	3
Paul McEldon	8	7
Nigel Paton	8	6
Fiona Standfield (chair for 5 meetings attended)	7	5
Chris Watson	8	6

Changes to Executive Directors during 2013/14 were as follows:

- Dr Suresh Joseph retired as Medical Director on 30 November 2013 and was replaced by Dr Douglas Gee on 1 December 2014;
- Elizabeth Latham retired as Director of Workforce and Organisational Development on 31 March 2014. A substantive replacement will be sought in 2014/15;
- Dr Gillian Fairfield, whose last day of office as Chief Executive was 31 March 2014, prior to moving to another Trust from 1 April 2014. The Trust has appointed John Lawlor as replacement from 23 June 2014.

External search advisers were appointed to assist the Trust in appointing to the roles of Medical Director and Chief Executive.

The Remuneration Committee undertook an Executive Directors salary review during 2013/14. This being the first review since the Trust was established as a Foundation Trust on 1 December 2009.

### **Audit Committee**

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 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 seven times during the financial year and twice shortly after the year end. Attendance at those meetings was as follows:

Member	Meetings	
	Total	Attended
Martin Cocker	9	9
Nigel Paton	9	8
Chris Watson	9	7

In addition, the Director of Finance, Director of Performance and Assurance, 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 Performance and Assurance who were unable to attend the meeting in March 2014. However, alternates did attend.

The Chief Executive was invited to, and attended, the April 2014 meeting at which the Annual Governance Statement was considered.

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.

During the year, the Trust reviewed the operation of Clinical Audit. In previous years, Clinical Audit has reported to the Quality and Performance Committee. Following the review, it was determined that it was more appropriate for any clinical audits that addressed risks on the Trust's Board Assurance Framework ('BAF') to be reported through the Audit Committee. Therefore, from March 2014, Clinical Audit has been invited to, and attended, Audit Committee meetings.

#### Audit Committee Programme of Works

The Audit Committee follows an annual work programme which covers the principal responsibilities set out within its terms of reference. In 2013/14, this included, amongst other matters, the following activities:

- Assessed the integrity of the Trust's financial statements for the year ended March 31 2014;
- 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 BAF and Corporate Risk Register was complete, fit for purpose and in line with Department of Health expectations;
- Reviewed 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 strategy, counter fraud plan and internal audit, operational plan 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 and counter fraud 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 supported or contradicted the work of the Audit Committee;
- Supported the Council of Governors in the selection of external auditor for the period 2015 to 2017.

### 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 compiled with and debated over 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.

The significant matters considered were:

#### *Impairment and Revaluation of the Trust's Specialist NHS Buildings*

The Trust's 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 our existing buildings in their current locations. Rather, it is a valuation of the specialist buildings that the Trust would 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.

Therefore, use of the DRC typically results in a significant provision for impairment.

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

Any movement between the fair value of assets at successive balance sheet dates is reported as a revaluation.

Non-specialist buildings are carried at market value.

During the year, the Trust completed the construction of the Monkwearmouth Hospital. The construction cost was £9m but the fair value using the DRC method was calculated as £4.2m, resulting in an impairment of £4.8m.

The fair value of specialist buildings existing at April 1 2014 has been impacted by the major transformation programme started in the year by the Trust. The hypothetical configuration, location and build costs of specialist NHS buildings required to deliver the Trust's services and occupancy levels as at March 31 2014 is fundamentally different to the actual assets in use.

This has resulted in a reduction in fair value during the year calculated using the DRC method of approximately £109m. Of this, £9m has been charged to the revaluation reserve in line with the Trust's accounting policy. The remaining £99m has been charged against income in the Statement of Comprehensive Income.

The Audit Committee reviewed management's assumptions made in determining the Trust's services and occupancy levels as at March 31 2014 and in mapping those services onto assets of equivalent capacity and function. The Audit Committee agreed with the assumptions made and concluded that the buildings carried at market values at March 31 2014 were properly defined as non-specialist.

The Audit Committee also debated and challenged the work performed by Mazars LLP, including their review of the work of the District Valuer.



After careful consideration, the Audit Committee was satisfied that the assumptions used in the DRC method valuation were appropriate. Therefore, the Audit Committee concluded that the provisions for impairment and revaluation had been properly calculated and disclosed in the financial statements.

#### *Assets Held for Resale*

The Trust carries any asset held for resale at the lower of its carrying amount and fair value less costs to sell. Fair value is the amount an asset could be exchanged for between knowledgeable, willing parties in an arm's length transaction.

Any asset intended for disposal must meet a number of criteria before it is classified as being 'held for resale' and disclosed within current assets in the financial statements, The criteria are outlined in International Financial Reporting Standard 5 *Non-current Assets Held for Sale and Discontinued Operations* ('IFRS 5').

The Audit Committee has reviewed the assets considered by management as being held for resale. The Audit Committee is satisfied that those assets meet the criteria as outlined in IFRS 5 and so are correctly disclosed within current assets 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 2014. After consideration, the Audit Committee is satisfied that the level of provision made in the financial statements reflects the best estimate of the economic outflow likely to occur.

#### *Going Concern*

The Audit Committee formally considered the assumptions relating the going concern basis of reporting of the financial statements, including reviewing the Trust's three-year financial plan submitted to Monitor in April 2014. After careful analysis and debate, the Audit Committee recommended to the April 2014 Board meeting that the use of going concern basis for the preparation of the annual financial statements was appropriate.

## 2. Clinical Audit

During the year, the Trust reviewed the operation of its Clinical Audit Group. Historically, Clinical Audit has reported to the Quality and Performance Committee and not to the Audit Committee.

As part of the review, the Trust has determined that Clinical Audit should report to the Audit Committee in respect of any engagement that covers one of the Trust's key risks as recorded in the BAF.

### 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, e.g. Board Assurance Framework, Corporate Risk Register, CQC registration, etc.

After due challenge and debate, the Audit Committee concluded that the matters identified together with the remedial actions taken meant that its 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.

#### 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.

The external auditor, Mazars LLP, 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;
- 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;
- 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 2013, Mazars LLP presented to the Audit Committee its audit plan for the year. 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 LLP team.

The cost of the external audit plan was proposed at £48,000 including VAT. The Audit Committee challenged whether Mazars LLP 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 2013.

Throughout the audit process, Mazars LLP 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 LLP identified one misstatement (other than amendments to disclosures) during the course of their audit which was above the level of trivial.

An adjustment of £2.13m was made to reduce both the revaluation reserve and the value of assets held for resale. At March 31 2014, the assets' value had been increased to the revaluation amount. However, in accordance with Monitor's Annual Reporting manual, the valuation of assets held for resale should be the lower of the carrying value or the fair value.

Therefore, the adjustment was proposed by the auditors, accepted by management and reflected in the financial statements.

The Audit Committee has discussed with Mazars LLP the causes of all the misstatements identified by the audit, regardless of whether or not the financial statements were adjusted as a result. The Audit Committee is satisfied that the causes of the misstatements were isolated errors and do not indicate any systematic failures in any of the Trust's internal controls.

At the conclusion of the audit, the Audit Committee performed a specific evaluation of Mazars' LLP 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 Audit Committee has also been made aware that the Mazars LLP audit of the Trust's financial statements for 2012/13 has been subject to a review by the Quality Assurance Department of the Institute of Chartered Accountants ('QAD'). The

review was made on behalf of Monitor and took place in July/August 2013. Mazars LLP have reported that QAD made no findings in respect of the audit of the Trust. This has been confirmed by QAD directly to the Trust.

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.

#### *Tender Process for external auditor services*

The contract with Mazars LLP expired upon completion of the 2013/14 audit. Accordingly, during the year, the Trust conducted a tender process to select the external auditor for the next three years.

The Audit Committee assisted the Council of Governor Audit Working Group in the tender process. The selection criteria were skills mix, service implementation, audit methodology, the level of back-up and support from the wider firm and cost.

Four firms tendered for the audit and following presentations from each the decision was made to re-appoint Mazars LLP for a further period of three years.

The ultimate decision to re-appoint Mazars LLP was made by the Council of Governors. However, the Audit Committee was involved throughout the process, including determining the selection criteria, assessment of proposals and attendance at each presentation. Therefore, the Audit Committee is satisfied that Mazars LLP will continue to provide a robust audit, appropriate challenge in areas requiring management judgment and quality within the senior members of the audit team.

#### 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 and employs around 22 whole time equivalent staff.

## **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;
- 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;
- A joint Board and Council of Governors meeting;
- Joint development sessions including the full Board of Directors and Council of Governors, wherever possible.

## **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 and have twelve seats, i.e. two for each local government area. However 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 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 Groups.

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, up to a maximum of six years in total. Such elections took place during the autumn of 2013 resulting in some changes from 1 December 2013 and 1 March 2014. Appointed Governors also hold office for a period of three years and are eligible for re-appointment at the end of that period and may not hold office for more than six years.

During 2013/14, the Trust was required to amend its constitution. It had previously had two governors representing Primary Care Trusts, i.e. the Trust's Commissioners, but Primary Care Trusts ceased to exist after 31 March 2013. The Trust changed its Constitution to include the seven newly established Clinical Commissioning Groups and six additional public governors. The Council of Governors was then made up of 46 governors.

The table below shows the individuals making up the Council of Governors during 2013/14, their constituencies, whether they were elected and their attendance during 2013/14. All governors have been elected for 3 years.

Richard Tomlin was the lead governor during 2013/14.

Two public governors' tenure ceased on 28 February 2014 when they did not seek re-election, one public governor resigned during the year and two nominated governors that were stood down by their organisation during the period under review.

Twelve governors commenced during 2013/14.

Seven governors were elected from 1 December 2013 as follows:

- Colin Brown - Public – South Tyneside;
- Karen Copeland – Public – Sunderland;
- Madeleine Elliott – Public – Northumberland;
- Dianne Graham – Public – North Tyneside;
- Christine Heron – Public – Gateshead;
- Grahame Martin – Public - Newcastle upon Tyne (and the rest of England and Wales);
- Jack Wilson - Service User – Children and Young Peoples.

Two governors were elected from 1 March 2014 as follows:

- Margaret Adams – Public – South Tyneside;
- Steve Manchee – Public – North Tyneside.

Three governors were nominated by their organisation as follows:

- Susan Dungworth by Northumberland County Council from 10 June 2013;
- Veronica Dunn by Newcastle City Council from 8 July 2013;
- Gladys Hobson by South Tyneside Council on 25 February 2014.

As at the 31 March 2014 the Council of Governors had vacancies for one public governor (Northumberland) one local authority nominated governor (North Tyneside) one community and voluntary sector nominated governor and seven Clinical Commissioning Groups governors.

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.

Governor	Constituency	Elected	Date		Period of office (months)	No. of meetings	
			Start	Left		Total	Attended
<b>Margaret Adams</b>	Public South Tyneside	Yes	01.03.14		1	1	1
<b>Nigel Atkinson</b>	Staff Clinical	Yes	01.12.09		52	6	4
<b>Phil Brown</b>	Staff Clinical	Yes	01.12.12		16	6	3
<b>Colin Browne</b>	Public South Tyneside	Yes	01.12.13		4	2	2
<b>Alasdair Cameron *</b>	Community and Voluntary Launchpad	No	01.12.12		16	6	2
<b>Margaret Chambers</b>	Public North Tyneside	Yes	01.03.11	28.02.14	36	5	3
<b>Ann Clark</b>	Carer Adult Services	Yes	01.12.09		52	6	5
<b>Stephanie Collier</b>	Service User Adult Services	Yes	01.12.12		16	6	3
<b>Karen Copeland</b>	Public Sunderland	Yes	01.12.13		4	2	2
<b>Alan Currie</b>	Staff Medical	Yes	01.12.09		52	6	3
<b>Susan Dungworth</b>	Local Authority Northumberland County Council	No	10.06.13		10	5	0
<b>Veronica Dunn</b>	Local Authority Newcastle City Council	No	08.07.13		9	5	1
<b>Madeleine Elliott</b>	Public Northumberland	Yes	01.12.13		4	2	2
<b>Grahame Ellis</b>	Staff Non Clinical	Yes	01.12.12		16	6	6
<b>Mary Foy</b>	Local Authority Gateshead Council	No	01.12.09		52	6	1
<b>Janet Fraser</b>	Carer Children and Young People's Service	Yes	01.12.09		52	6	3
<b>Glenys Goodwill</b>	Public Gateshead	Yes	01.12.12		16	6	2
<b>Dianne Graham</b>	Public North Tyneside	Yes	01.12.13		4	2	1
<b>Kevin Graham</b>	Local Authority Newcastle City Council	No	06.10.11	08.07.13	21	1	0
<b>Jane Hall</b>	Public Sunderland	Yes	01.12.09		52	6	3
<b>George Hardy</b>	Carer Learning Disability Services	Yes	01.12.09		52	6	5
<b>Christine Heron</b>	Public Gateshead	Yes	01.12.13		4	2	0



Governor	Constituency	Elected	Date		Period of office (months)	No. of meetings	
			Start	Left		Total	Attended
<b>Norman Hildrew</b>	Carer Adult Services	Yes	01.12.09		52	6	5
<b>Barry Hirst</b>	University Newcastle University	No	01.12.09		52	6	2
<b>Gladys Hobson</b>	Local Authority South Tyneside Council	No	25.02.14		1	1	0
<b>Claire Keys</b>	Service User Adult Services	Yes	01.12.12		16	6	4
<b>Ian Lindley</b>	Local Authority Northumberland County Council	No	12.09.12	31.05.13	8	1	0
<b>Steve Manchee</b>	Public North Tyneside	Yes	01.03.14		1	1	1
<b>Graham Martin</b>	Public Newcastle/rest of England and Wales	Yes	01.12.13		4	2	1
<b>Graeme Miller</b>	Local Authority Sunderland City Council	No	16.05.12		22	6	4
<b>Claire Mills</b>	Public Northumberland	Yes	01.12.09	02.01.14	49	5	2
<b>Marian Moore</b>	Service Users Older Peoples Services	Yes	01.03.11		37	6	5
<b>Austin O'Malley</b>	Public Newcastle/rest of England and Wales	Yes	01.12.12		16	6	5
<b>Pauline Pearson</b>	University Northumbria University	No	01.02.13		14	6	3
<b>Lucy Reynolds</b>	Service User Neuro Disability Services	Yes	01.12.12		16	6	6
<b>Rachel Simpson</b>	Service User LD Services	Yes	01.12.12		16	6	3
<b>Anneva Spark</b>	Carer Older Peoples Services	Yes	01.12.09		52	6	4
<b>Jeanette Telfer</b>	Public South Tyneside	Yes	01.03.11	28.02.14	36	5	4
<b>Richard Tomlin</b>	Carer Neuro Disability Services	Yes	01.12.09		52	6	6
<b>Bob Waddell</b>	Staff Non Clinical	Yes	01.12.12		16	6	4
<b>Jack Wilson</b>	Service User Children and Young Peoples Service	Yes	01.12.13		4	2	1

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

Although there have been six formal meetings of the Council of Governors during 2013/14, one of the meetings was an extraordinary meeting where it was inappropriate for Board members to be present apart from Nigel Paton, who chaired

the meeting, and Dr Gillian Fairfield who provided advice. The table below therefore focuses on the other five meetings.

### **Analysis of attendance of Board members at formal Council of Governors' meetings.**

Council of Governors' meetings attended by Board members		
Director	Total	Attended
Martin Cocker	5	2
James Duncan	5	1
Gillian Fairfield	5	2
Douglas Gee	2	1
Ken Grey	5	2
Lisa Crichton-Jones	5	2
Suresh Joseph	3	1
Elizabeth Latham	0	0
Paul McEldon	5	0
Gary O'Hare	5	3
Nigel Paton	5	2
Lisa Quinn	5	4
Fiona Standfield	4	3
Chris Watson	5	1
Hugh Morgan Williams	3	2

### **Nominations Committee**

The Council of Governors has established a Nominations Committee and its membership and terms of reference are prescribed by the Trust's constitution. Its role is to make recommendations to the full Council of Governors on the appointment of the Chair and Non-Executive Directors and the associated remuneration and allowances and other terms and conditions.

**Membership and attendance at meetings is shown below:**

Nominations Committee membership and attendance		
Director	Total	Attended
Barry Hirst	6	4
Grahame Ellis	6	6
Janet Fraser	6	5
Jane Hall	6	5
Claire Mills	5	3
Richard Tomlin (Chair)	6	6

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 Non-Executive Directors' 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 Non-Executive Director 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 Non-Executive Director.

During the period under review following Nominations Committee, the Council of Governors appointed Hugh Morgan Williams as Trust Chair from 1 November 2013 for three years and Ruth Thompson from 1 April 2014 for three years, and reappointed Ken Grey from 1 January 2014 for one year. Appointments were subject to open advertising and the Nominations Committee was assisted by external search agencies.

For the appointment of the Chair and Non-Executive Directors, the Nominations Committee assessed the time commitment expected recognising the need for availability in the event of a crisis in the case of the Chair. The Chair's other significant commitments have been disclosed to the Board of Directors and the Council of Governors.

## **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 update 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 forward plan. The Council of Governors are consulted on the development of forward plans and any significant changes for the delivery of the Trust's business plan. Governors' views including the public and the membership and organisation represented are included in the forward plan paper for consideration by the Board of Directors. An annual plan working group consisting of key trust staff and governors representation takes these issues forward with appropriate reporting to the Board and Council of Governors.

### **Declaration of Interests**

All Governors are asked to declare any interest on the Register of Governors' Interests at the time of appointment. This is reviewed and maintained by the Trust Board Secretary.

The Register is available for inspection on the internet at [www.ntw.nhs.uk](http://www.ntw.nhs.uk) or on request from Eric Jarvis, Board Secretary, Chief Executives Office, St. Nicholas Hospital, Jubilee Road, Gosforth, Newcastle upon Tyne, NE3 3XT ([eric.jarvis@ntw.nhs.uk](mailto:eric.jarvis@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 the Governance Review of the Annual Report.

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. The Trust implements these requirements through key governance documents, policies and procedures. The Trust considers itself compliant with all of the Code’s provisions. However some of the new requirements of the Code have not been complied with for the whole year and cannot be applied retrospectively.

## **Information, development and evaluation**

Reports from the Executive Directors, which include in-depth performance and financial information, are circulated to Board 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 four 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 2014, we have a consistent 12,000 public and 6,300 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 our 2013 governor elections, held to re-elect and elect a further 10 governors.

Regular communication with our members through newsletters, and invitations to events, 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 sub 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 223 2903 or email [governors@ntw.nhs.uk](mailto:governors@ntw.nhs.uk))

**The table below shows an analysis of our membership as at 31 March 2013**

<b>Constituency</b>	<b>31 March 2014</b>
<b>General Public</b>	
Gateshead	956
Northumberland	1,469
Newcastle upon Tyne	2,640
Rest of England and Wales	632
North Tyneside	1,512
South Tyneside	817
Sunderland	2,193
<b>Sub total</b>	<b>10,219</b>
<b>Service Users</b>	
Adults	325
Children and young people	143
Older people	57
Learning disability	189
Neuro-disability	143
Unknown*	20
<b>Sub total</b>	<b>877</b>
<b>Carers</b>	
Adults	126
Children and young people	575
Older people	93
Learning disability	101
Neuro-disability	93
<b>Sub total</b>	<b>988</b>
<b>Total All Public</b>	<b>12,084</b>
<b>Staff</b>	
Medical	231
Other Clinical	2,510
Non Clinical	3,564
<b>Total All Staff</b>	<b>6,305</b>
<b>Total Members</b>	<b>18,389</b>

Note: \*Included in total are 20 service users who have not stated which service they use and are therefore recorded as unknown.



## **6 QUALITY REPORT**

### **Introduction to the Quality Account**

#### **About Northumberland, Tyne and Wear NHS Foundation Trust**

Working from over 60 sites and covering more than 2,200 square miles, our 6,000 staff providing 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 also provide a range of specialist regional and national services. This makes Northumberland, Tyne and Wear NHS Foundation Trust one of the largest NHS Trusts of its kind in the country.

Northumberland, Tyne and Wear NHS Foundation Trust has a vision to improve the wellbeing of everyone we serve through delivering services that match the best in the world.

#### **Why are we producing a Quality Account?**

All NHS Trusts are required to produce an annual Quality Account, to provide information on the quality of services to service users and the public.

Northumberland, Tyne and Wear NHS Foundation Trust welcomes the opportunity to demonstrate how well we are performing, taking into account the views of service users, carers, staff and the public, and comparing ourselves with other Mental Health and Disability Trusts. We can use this information to make decisions about our services and to identify areas for improvement.

## **Acting Chief Executive's Statement**

Our Board of Directors are committed to developing services of the highest quality, which enable and empower our patients to reach their potential and live fulfilling lives.

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

Our Quality Account outlines how we are doing in relation to these aspirations and gives an honest review of the progress we have made on the priorities we set last year and the work that remains for us to do.

Our Quality Account has been developed in partnership with our service users, carers, clinicians, managers, commissioners, local healthwatch and local authority health overview and scrutiny committees (OSCs).

### **Our commitment to quality**

Providing high quality services is of paramount importance to us. We primarily measure this through the experiences of our patients and their carers and by the outcomes of our clinical interventions. We gather data from a variety of sources to ensure that we truly understand these experiences and do our best to respond quickly and appropriately with all necessary improvements. This report focuses on providing meaningful information and data that we use to continually monitor and plan improvements to the quality of our services.

Our Quality Account for 2013/14 reports on the progress made against our three quality goals which are:

Patient Safety – Reduce incidents of harm to patients

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

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

The quality priorities reported have been measured using our internal assurance structures such as patient records, clinical audits and internal/external inspections. We have used information from participation in national NHS surveys and conversations with patients and carers to help us in writing our Quality Account for 2013/14.

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

A handwritten signature in black ink, consisting of several loops and a long horizontal stroke extending to the right.

**James Duncan**  
**Acting Chief Executive**  
**28<sup>th</sup> May 2014**

## **Medical Director and Director of Nursing and Operations statement**

This Quality Account includes information which demonstrates to our service users, carers, commissioners and the public that we provide Mental Health, Learning Disability and Neurological services that are among the best.

We constantly strive to improve our services. In the past year we have developed and launched a range of new services which have strengthened and improved quality. We have improved access to our urgent care services, implemented new memory protection and Children's and Young People's community services and we also continue to invest heavily in new inpatient environments. These efforts will continue to roll into 2014/15 as we continue our on-going transformation programme.

We have set out in this Quality Account how well we have performed against local and national priorities including how well we progressed with those areas we highlighted as our improvement priorities for 2013/14.

Positive outcomes from Care Quality Commission inspections alongside a comprehensive set of performance metrics demonstrate that we have established high standards of core service quality. We recognise that we have more work to do and continue to pursue excellence in all our service areas.

We recognise some of the quality priorities we set ourselves are challenging but we are committed to always delivering any unmet standards from previous years. Our Trust's quality goals are co-developed with stakeholders and communicated within the Trust and the community it serves. Each year the Trust holds events to engage service users, carers and other internal and external stakeholders to define quality goals and priorities for the coming year.

Our focus is always and will remain on patient safety, clinical effectiveness and the service user experience.



**Douglas Gee**  
**Medical Director**  
**28<sup>th</sup> May 2014**



**Gary O'Hare**  
**Director of Nursing & Operations**  
**28<sup>th</sup> May 2014**

## **Quality Priorities**

### **Introduction to our quality goals and priorities**

In this section we will report our progress against our quality goals and priorities.

Using feedback from service users, carers staff and partners as well as information gained from incidents, complaints and other quality reports the Trust has identified three quality goals covering the 5 year period from 2009 to 2014, based on safety, patient experience and clinical effectiveness.

Each year we set new quality priorities to help us to achieve our quality goals.

Taking each Quality Goal in turn, we will look back on the last year to assess progress against the Quality Priorities we set in 2013/2014, we will reflect on how these actions have affected progress against the Quality Goal and we will look forward to next year, setting new Quality Priorities for 2014/2015.

As in previous years, we remain committed to taking any Quality Priorities that are not fully achieved during 2013/14 forward to 2014/15 to ensure we meet the targets that were set in these important areas.

The progress of all Quality Priorities will be monitored every month at the Trust Quality and Performance Committee as part of the integrated performance report.

Our Quality Goals support the delivery of the Trust Strategic objectives.

### **NTW Strategic Objectives:**

1. Modernise and reform services across all directorates in line with local and national strategies and the needs of individuals and communities; providing first class care in first class environments;
2. Be a sustainable and consistently high performing organisation;
3. Be a Model Employer, an Employer of Choice and an Employer that makes the best use of the talents of the entire workforce;
4. Fully embrace and support service user, carer, staff and public involvement, including our membership, in all aspects of our work;
5. Provide high quality evidence based and safe services, supported by effective integrated governance arrangements;
6. Improve clinical and management decision making through the provision and development of effective information;
7. Be an influential organisation which supports and enables social inclusion.

## **Our Quality Goals 2009 – 2014**

### **Patient Safety**

Quality Goal One: Reduce incidents of harm to patients

We will demonstrate success by reducing the severity of incidents and the number of serious incidents across the Trust.

### **Patient Experience**

Quality Goal Two: 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.

### **Clinical Effectiveness**

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

We will demonstrate success by delivering demonstrable improvements in service delivery.

The Trust is currently providing care for just over 42,500 people. Working from over 60 sites and covering more than 2,200 square miles, we provide a range of mental health, learning disability and neuro-rehabilitation services to a population of 1.4 million people in the North East of England. Table 1 below shows the number of current service users as at 31<sup>st</sup> March 2014, split by locality, with a comparison of the same figures from 2010/11, 2011/12, 2012/13 & 2013,14:

## NTW Service Users by locality 2010/11, 2011/12, 2012/13 & 2013/14:

CCG/PCT	2010/11	2011/12	2012/13	2013/14
Durham Dales Easington & Sedgefield CCG	*	*	*	388
North Durham CCG	*	*	*	561
Durham (old PCT)	1110	1208	1049	*
Darlington CCG	112	128	115	89
Gateshead CCG	2900	3422	3620	3706
Hartlepool & Stockton CCG	38	38	40	115
Middlesbrough CCG	84	95	113	175
Newcastle (old PCT)	7839	8582	8907	*
Newcastle North & East CCG	*	*	*	4499
Newcastle West CCG	*	*	*	4487
North Tyneside CCG	3361	3520	3526	3778
Northumberland CCG	9060	9201	9425	10739
Redcar and Cleveland (old PCT)	60	65	58	*
South Tyneside CCG	3038	4017	4561	4599
Stockton (old PCT)	79	84	81	*
Sunderland CCG	6843	8725	8575	9084
other areas	208	545	395	413
<b>Total</b>	<b>34732</b>	<b>39630</b>	<b>40465</b>	<b>42530</b>
<b>% Increase in service user numbers</b>		<b>14.1% (4898)</b>	<b>2.1% (835)</b>	<b>5.1% (2065)</b>
<b>% Increase in service user numbers since 2010</b>		<b>14.1% (4898)</b>	<b>16.2% (5733)</b>	<b>21.3% (7798)</b>

**Table 1**

The table shows that our Service User numbers have increased by 2,065 during 2013/14.

Most locality areas have seen an increase in numbers of Service Users with the biggest increases being in Northumberland, North Tyneside and Sunderland.

During the four year period of the data presented service user numbers have increased in total by 21.3% or 7,798 service users.

\*Due to changes to the commissioning structure in 2013/14 when Primary Care Trusts (PCT's) were dissolved and Clinical Commissioning Groups (CCG's) were established there is no longer a direct comparison available for all of our locality areas.

### **Quality Goal One: Reduce Incidents of harm to patients**

This goal will improve patient safety. We will demonstrate success against this goal by reducing the severity of incidents and the number of serious incidents across the Trust.

Looking back: progress against our quality priorities to support this goal in 2013/2014.

Quality Priority 2013/2014	Rationale	Target by 31 March 2014	Progress
1. Ensure relevant staff are trained in leave management	Nationally, evidence would suggest patients may be exposed to increased risk whilst on leave from in patient care. Effective leave management has been identified as a way of reducing harm to patients.	To achieve a target of 85% of applicable staff trained in this area by 31 March 2014.	<b>ACHIEVED</b> – at the 31 March 2014 87.3% of applicable staff had received training in leave management.
2. To ensure GPs receive care plan information within seven days of a review. This quality priority is being continued from 2012-13	It is a Trust priority to reduce risk by improved communication and multidisciplinary/inter agency working	To carry out baseline audits of numbers of forms that are electronically generated and set improvement trajectories for the year.	<b>ONGOING</b> – at 31 March 2014 we could demonstrate that 34.2% of care plans were sent to GPs within seven days. This will no longer be a Quality Priority for 2014/15 as it will become part of a nationally mandated CQUIN.
3. To ensure GPs receive discharge summaries with 24 hours of discharge. This quality priority is being continued from 2012-13 and aligned to a CQUIN target.	It is a Trust priority to reduce risk by improved communication during periods of transition.	To carry out baseline audits of numbers of forms that are electronically generated and set improvement trajectories for the year.	<b>ONGOING</b> – at 31 March 2014 we could demonstrate that 47.1% of discharge summaries were sent to GPs within 24hours. This will no longer be a Quality Priority for 2014/15 as it will become part of a nationally mandated CQUIN.



Quality Priority 2013/2014	Rationale	Target by 31 March 2014	Progress
<p>4. To improve the quality of transitions of care from inpatient units to community services, improving the links with community teams throughout the admission and ensuring joint involvement in discharge planning. This quality priority achieved the milestones set for 2012/13 but will continue through 2013/14 as an important part of our ongoing transformation programme.</p>	<p>Significant risks occur if transitions are not properly managed. Delayed discharges are a key factor on lengths of stay within inpatient units.</p>	<p>To assess current transition arrangements between adult community teams and adult assessment and treatment teams.</p> <p>To conduct an audit of the impact of transition arrangements and create an action plan for improvement based upon the findings.</p>	<p><b>ACHIEVED</b> – during 2013/14 we undertook an assessment of the current arrangements in place to manage transitions and an audit of any impact caused. A plan for improvement is now in place and being monitored as part of our ongoing programme of transformation.</p>
<p>5. To ensure all relevant staff undertake falls risk assessment training.</p>	<p>To improve and standardise knowledge and practice in relation to risks associated with, and prevention of, falls in older people.</p>	<p>To review and revise the current training materials and set trajectories for numbers of applicable staff to be trained. To report each quarter on numbers of patient falls.</p>	<p><b>ACHIEVED</b> – the key milestones for this priority were achieved during 2013/14 as an additional part of our nationally mandated Safety Thermometer CQUIN. This work will continue, as part of that CQUIN, in 2014/15</p>

Quality Priority 2013/2014	Rationale	Target by 31 March 2014	Progress
6. To improve the management of service users who do not attend appointments (DNA's)	To better understand the issues around service users who do not attend appointments and develop a plan to reduce non-attendance.	To establish a baseline and set trajectories for improvement in this area in agreement with our Commissioners.	<b>ACHIEVED</b> – at 31 March 2014 the trajectories for improvements in DNA rates were met. Work will continue in this area as part of our ongoing programme of transformation.

**How have the quality priorities in 2013/2014 helped progress towards this goal?**

The aim of this goal is to reduce the number and severity of patient safety incidents. Table 2 shows the number of patient safety incidents reported by the Trust over the past 5 years:

Patient Safety Incidents reported:	2009/10	2010/11	2011/12	2012/13	2013/14
Patient Safety Incidents	<b>9,887</b>	<b>11,722</b>	<b>12,621</b>	<b>13,709</b>	<b>12,676</b>

**Table 2**

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 included near misses.'

## Patient Safety Incidents by impact

Number of Patient Safety Incidents reported, by impact:	2009/10	2010/11	2011/12	2012/13	2013/14
No harm	3,123	3,014	3,769	3,333	3,388
Minor, Non-permanent harm	6,009	7,839	7,912	8,144	8,344
Moderate, Semi Permanent harm	602	756	804	1,990	766
Major, Major Permanent harm	73	49	59	169	70
Catastrophic, Death	80	64	77	73	108
<b>Total patient safety incidents reported</b>	<b>9,887</b>	<b>11,722</b>	<b>12,621</b>	<b>13,709</b>	<b>12,676</b>

**Table 3** \*some numbers differ from previous reports due to on-going data quality improvement work and the results of coroners verdicts

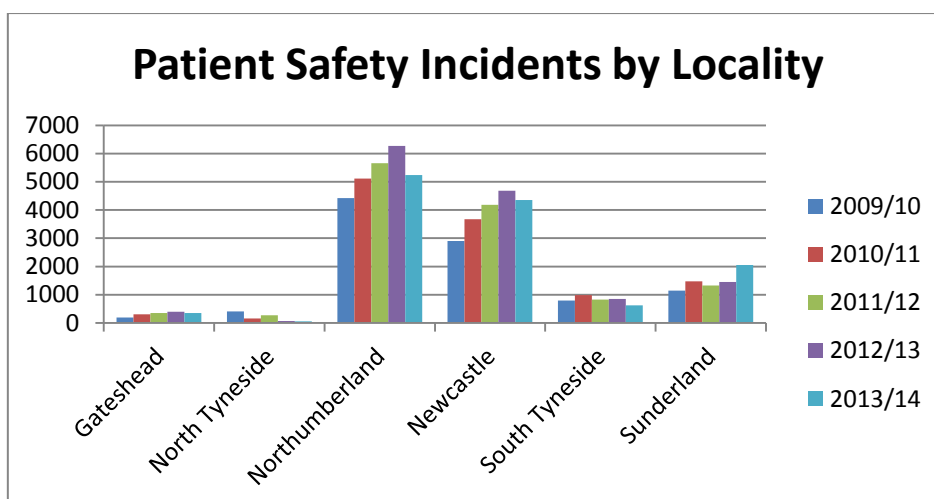
As demonstrated in Table 3 above during 2013/14 the numbers of Moderate and Major harm incidents have reduced from previous years while the No harm and Minor have increased. This is partly due to improved recording and categorising processes of our patient safety incidents and the Trust will be using the 2013/14 data as a solid baseline to identify trends in future years.

It is important to note that the figure presented for 2013/14 Catastrophic/Death related patient safety incidents will be revised in-year as more coroner conclusions are received. This will change some incidents and mean they no longer meet the patient safety definition for example the verdict may be that of natural causes.

### Quality Goal One: Reduce incidents of harm to patients

#### Patient Safety Incidents by locality

Graph one shows all of the patient safety incidents which have been reported over the past five years split by locality:



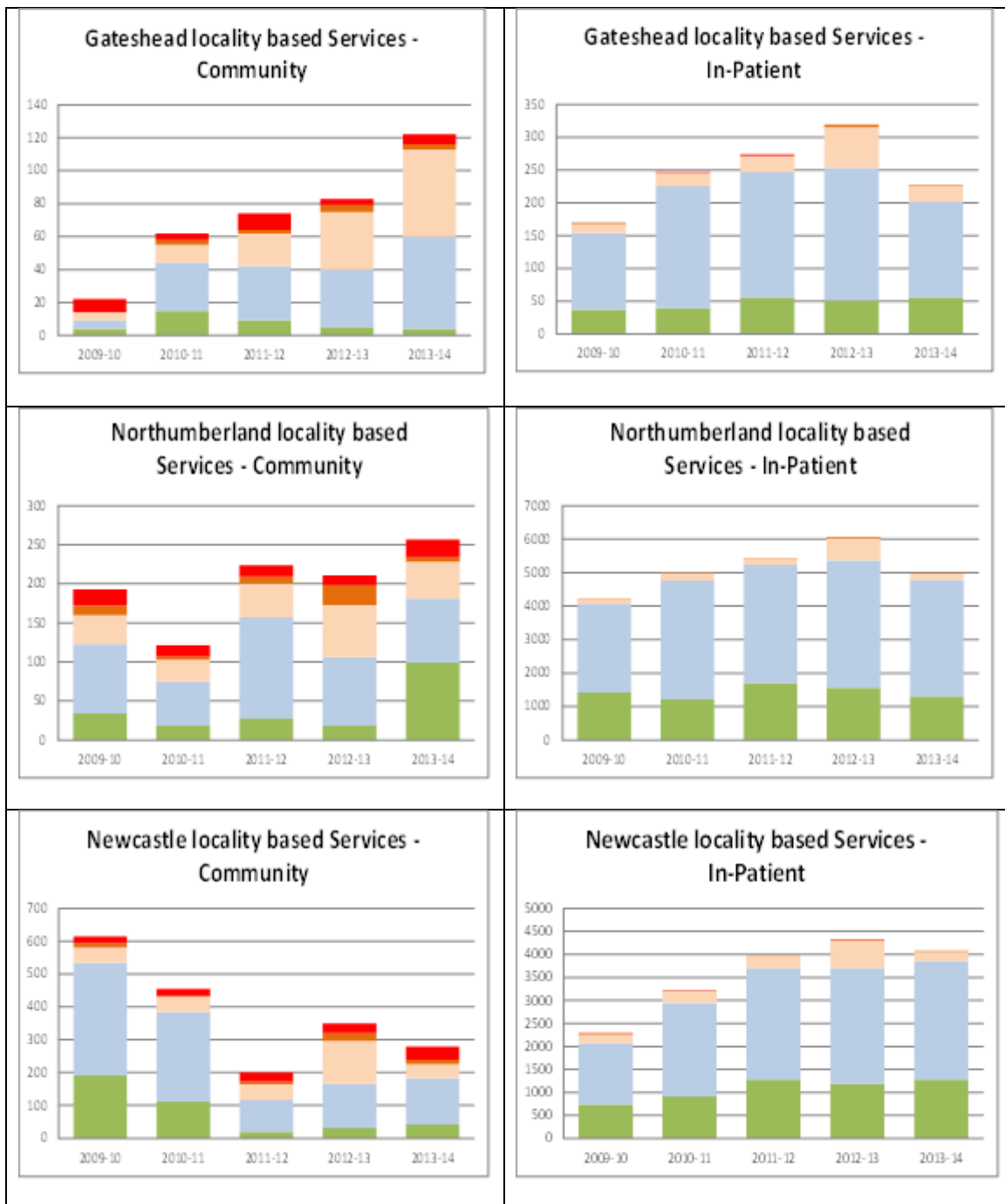
The localities of Newcastle and Northumberland have more reported patient safety incidents due to the number of specialised services located in those areas. This means the numbers are not purely population specific but rather where the services are located.

In the following section we have shown patient safety incidents, by locality, and the severity of harm caused, using the 5 categories reported in Table 3. The information has been divided into patient safety incidents which happen in the community and those that happen when our service users are inpatients

	2009-10	2010-11	2011-12	2012-13	2013-14
Community	913	749	653	979	1040
Inpatient	8974	10973	11968	12730	11636
<b>Total patient safety incidents</b>	<b>9887</b>	<b>11722</b>	<b>12621</b>	<b>13709</b>	<b>12676</b>

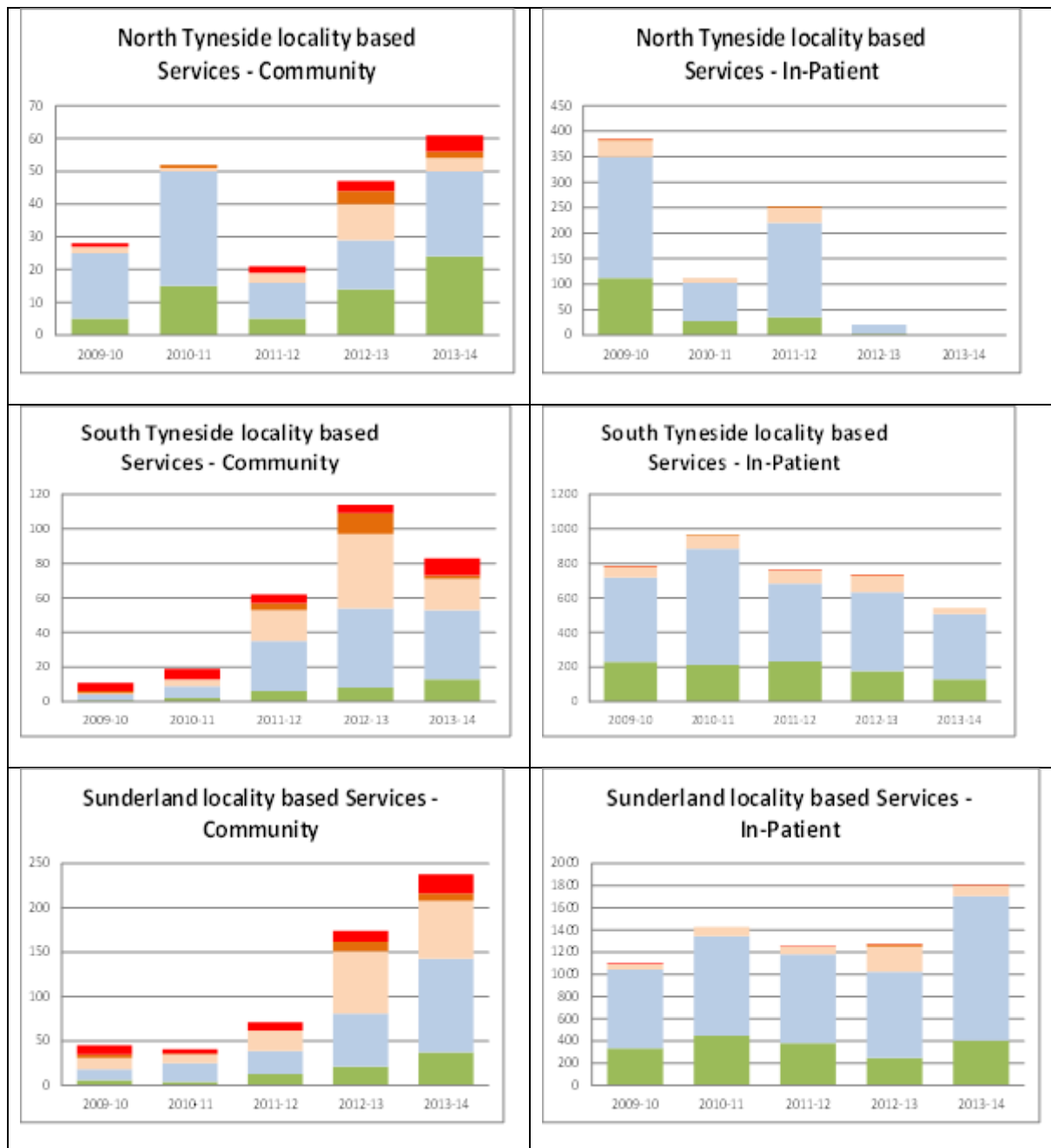
Table 4 shows the numbers of incidents reported in the community and in our inpatient services over the five year period.

## Patient Safety Incidents by Locality and Level of Harm



Patient Safety Incident Category	
<span style="color: red;">■</span>	Catastrophic, Death
<span style="color: orange;">■</span>	Major, permanent harm
<span style="color: lightorange;">■</span>	Moderate, semi-permanent harm
<span style="color: lightblue;">■</span>	Minor, non-permanent harm
<span style="color: green;">■</span>	No harm

## Quality Goal One: Reduce incidents of harm to patients



These graphs show each the patient safety incidents in our inpatient and community services, for each locality over a 5 year period.

National benchmarking information on our serious incident reporting can be found on page 46 of this report.

For any further updates on our patient safety incident information please access our publically available Trust Board patient safety reports which are published quarterly and can be found at <http://www.ntw.nhs.uk/section.php?l=2&p=26>

**Looking forward: What are our quality priorities in 2014/15 to support this goal?**

Priority	Aim/Objective	Rationale	Target & Trajectory
1	To improve the assessment and management of risk.	Evidence from serious incident reviews has highlighted that if we can undertake more effective risk assessment it can reduce clinical risk and increase patient safety.	A programme of work to support this priority will be developed during Q1 2014/15 which will include enhanced staff training and improving the quality of risk assessment.

**Quality Goal Two: Improve the way we related to patients and carers**

This quality goal will improve patient experience.

Looking back: progress against our quality priorities to support this goal in 2013/2014:

Quality Priority 2013/2014	Rationale	Target by 31 March 2014	Progress
1. Greater availability or variety of activities within inpatient services.	This is a key area of improvement demonstrated through patient feedback.	To achieve timely and appropriate activities with 85% being offered out of hours by 31/03/14.	<p><b>ACHIEVED</b> – March 2014 position for activities being delivered Monday-Friday between 9-5pm we continue to deliver 100% compliance.</p> <p>For activities being delivered/offered Out of Hours/After 5pm and at weekends – we have achieved 86% compliance rate.</p> <p>The types of activities available are:</p> <p>Art sessions</p>

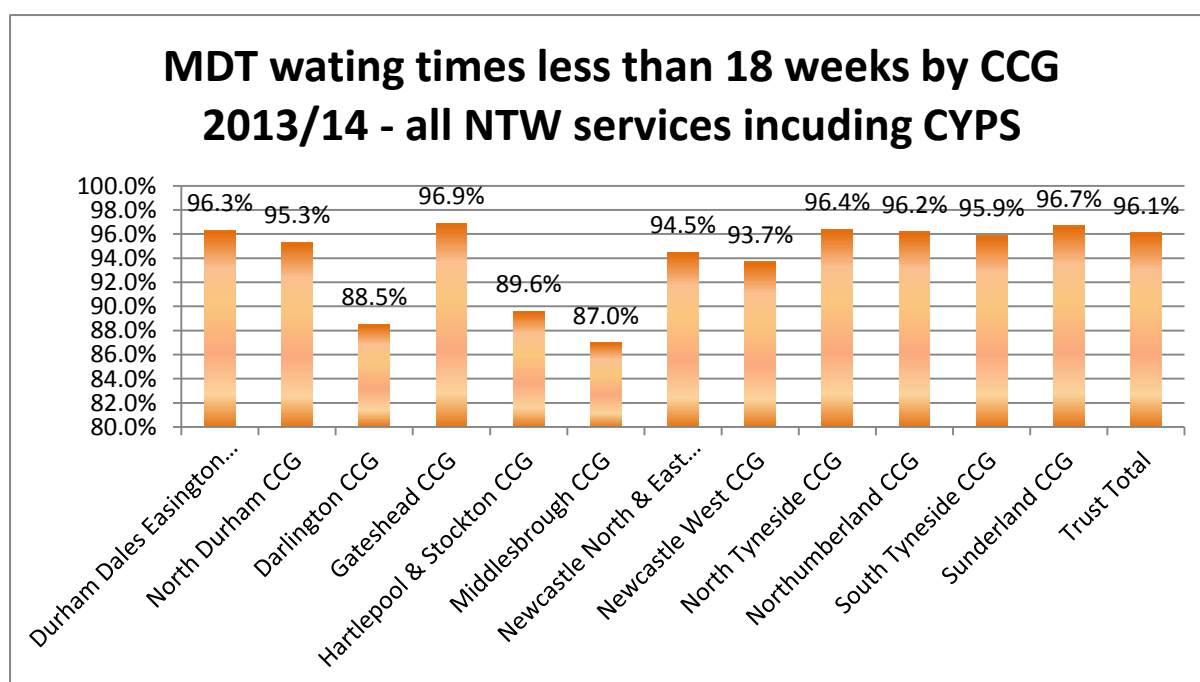
			<p>Pamper sessions Drama sessions Local walks Shopping trips</p>
<p>2. Greater Choice, quality of food and timings of meals to inpatient areas.</p>	<p>This is a key area of improvement demonstrated through patient feedback.</p>	<p>To complete nutritional analysis of patient meals. To conduct a trial of electronic meal ordering and evaluate before rolling out across inpatient areas.</p>	<p><b>ONGOING</b> – There have been technical problems with the new electronic meal ordering system which has delayed its implementation. The expectation is these will be resolved very soon and the system will be rolled out during summer 2014.</p> <p>Due to other priorities placed on the dietetics staff the patient menu analysis is not yet complete. Additional resources have been put into the process and the expectation is that this work will be completed by the end of May 2014.</p>
<p>3. To improve waiting time for referrals to multidisciplinary teams.</p>	<p>To ensure Trust services are responsive and accessible.</p>	<p>100% of all patients (excluding CYPS) to wait less than 18 weeks by 31/03/14. CYPS North and South to achieve 95% wait less than 12 weeks by 31/03/14.</p>	<p><b>ONGOING</b> – as at 31 March 2014 98% of all patients (excluding CYPS) waited less than 18 weeks. CYPS North achieved 72.9% and CYPS South achieved 81.1% waiting less than 12 weeks.</p>
<p>4. To roll out the 'Family and Friends' test in line with national</p>	<p>To establish a robust method of recording and reporting this</p>	<p>To determine the best method and time to capture this information and</p>	<p><b>ACHIEVED</b> – the process is now in place to capture the 'Friends and</p>



guidance.	information.	begin to report on findings from October 2013.	Family' questions and reporting has commenced.
5. To implement the 6Cs initiative (based on the national guidance 'Developing the culture of compassionate care: Creating a new vision and strategy for Nurses, Midwives and Care Givers)	To continue to improve the services we deliver to our service users and carers in line with this national guidance.	60% of all staff to have undertaken Values and Attitudes training by March 2014.	<b>ACHIEVED</b> – at the 31 March 2014 60.2% of staff had undertaken the Values and Attitudes training which equates to 3,857 of our staff.

### Multi-disciplinary waiting times by locality (Including CYPS)

Graph 4 shows the percentage of service users in each locality (including our Children and Young Peoples Services) who have waited less than 18 weeks for their first appointment with a multidisciplinary team during 2013/14.



Graph 4

## How have the quality priorities in 2013/2014 helped progress towards this goal?

We have made progress against our overall goal of improving patient experience and this is reflected in our 2013 Community Patient Survey scores.

The Care Quality Commission uses national surveys to find out about the experiences of service users when receiving care and treatment. The most recent survey, completed in 2013 by 224 community service users, showed the following results:

Summary scores for patient survey question	Score out of 10: (a higher score is better)	How this score compares with other Trusts
For questions about Health and Social Care Workers	8.7	About the same
For questions about Medications	7.4	About the same
For questions about Talking Therapies	7.2	About the same
For questions about Care co-ordinator	8.0	About the same
For questions about Care Plan	6.8	About the same
For questions about Care Review	7.5	About the same
For questions about Crisis Care	6.7	About the same
For questions about Day to Day Living	5.5	About the same
Overall questions	7.0	About the same

**Table 4**

### Comparison to previous year's scores:

<b>Section</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Health & Social Care Workers	8.6	8.5	9.0	8.7
Medications	7.4	7.0	7.2	7.4
Talking Therapies	6.9	7.3	7.4	7.2
Care Co-ordinator	8.5	8.4	8.6	8.0
Care Plan	6.3	6.8	7.1	6.8
Care Review	7.4	7.6	7.5	7.5
Crisis Care	-	6.8	6.5	6.7
Day to Day Living	5.8	6.0	5.7	5.5
<b>Overall</b>	<b>6.9</b>	<b>6.5</b>	<b>7.3</b>	<b>7.0</b>

**Table 5**

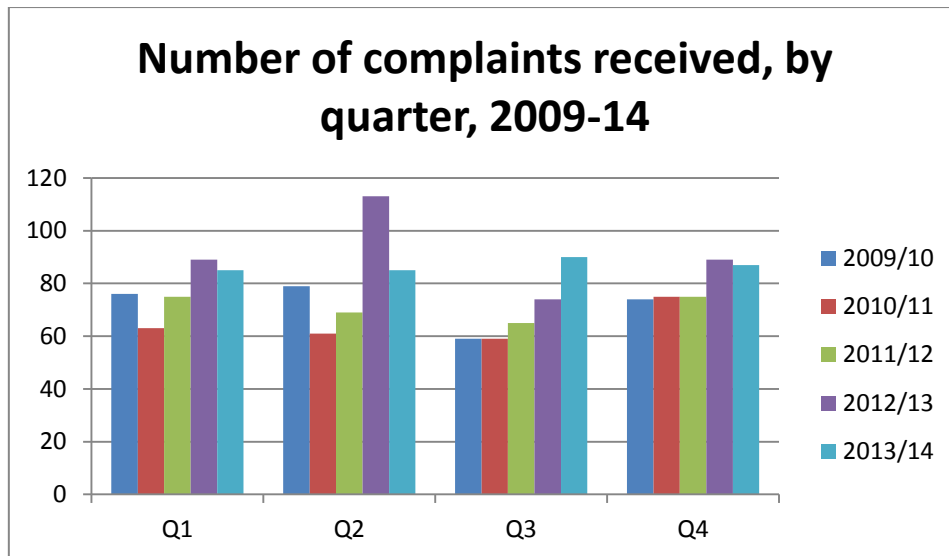
More details on the 2013 survey results for this Trust can be found at the following link: <http://www.cqc.org.uk/survey/mentalhealth/RX4>

### Complaints

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

Complaints that are received in the Trust are reported on a weekly basis to Directors of our Clinical Services, to consider immediate improvements and learning and also to consider who are the most appropriate members of staff to support the complainant and investigate the complaint. Complaints activity and the learning from each one are considered within each clinical group's quality and performance structures, as well as Northumberland Tyne and Wear NHS Foundation Trust's Board Sub Committee which reviews complaints and has Non-Executive Director Membership and independent scrutiny. Each complaint response is considered by the Executive Medical Director and Executive Director of Nursing and Operations before being formally signed off by the Chief Executive.

Complaints have decreased during 2013/14 with a total of 345 received during the year from our 42,500 service users. This is a decrease of 19 complaints from 2012/13 (there were 365 in 2012/13 and 284 in 2011/12).



**Graph 5**

### **Complaints by Category Type**

In line with national reporting of category types of complaints that are reported to the Health & Social Care Information Centre Table 6 shows the numbers of complaints and the category types for the year 2013 / 14 compared to previous years.

During 2013/14 we are pleased to report that complaints relating to attitude of staff have decreased from 78 to 58. This is in line with our work undertaken with all Trust staff to attend Values and Attitudes training (60.2% of staff had completed the course by 31<sup>st</sup> March 2014 which equates to 3,857 staff). Due to the complaints team realigning activity to more accurately reflect national reporting requirements an increase in the categories of 'all aspects of clinical treatment,' 'admission, transfer and discharge arrangements' and 'communication and information to patients' was noted in the year. This activity can now be compared to nationally available information.

<b>Category Type</b>	<b>2009-10</b>	<b>2010-11</b>	<b>2011-12</b>	<b>2012-13</b>	<b>2013-14</b>
Admission, Discharge & Transfer Arrangements	12	11	9	14	17
Aids and Appliances, Equipment, Premises	1	4	4	0	1
All Aspects of Clinical Treatment	91	83	105	130	151
Appointments, Delay, Cancellations- Inpatients	2	2	2	1	3
Appointments, Delay, Cancellations - Out-Patients	15	24	20	47	23
Attitude of Staff	75	63	75	78	58
Communication/Information to patients	24	17	31	34	40
Complaints Handling	0	0	2	1	0
Consent to Treatment	0	0	1	0	0
Failure to Follow Agreed Processes	3	6	6	4	4
Hotel Services	18	5	4	13	6
Others	18	9	0	0	0
Patient Privacy & Dignity	9	18	7	6	8
Patient Property and Expenses	6	3	5	7	6
Patient Status / Discrimination	5	1	9	18	14
Personal Records	6	9	3	10	14
Policy and Commercial Decision	3	3	1	2	0
<b>Totals</b>	<b>288</b>	<b>258</b>	<b>284</b>	<b>365</b>	<b>345</b>

**Table 6**

### **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 5 year reporting period

<b>Outcome</b>	<b>2009-10</b>	<b>2010-11</b>	<b>2011-12</b>	<b>2012-13</b>	<b>2013-14</b>
Closed – Not Upheld	103	90	109	123	82
Closed – Partially Upheld	70	80	91	109	99
Closed - Upheld	68	47	36	62	85
Complaint withdrawn	44	29	23	40	34
Decision not to investigate	0	0	0	0	1
Still awaiting completion	0	0	0	2	30
Unable to investigate*	3	12	26	29	14
<b>Total</b>	<b>288</b>	<b>258</b>	<b>284</b>	<b>365</b>	<b>345</b>

**Table 7 \* category relates to complaints received which are not about our services.**

## 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 14 NTW complaints referred to the PHSP during 2013/14 and the following table provides both the Trust complaint outcome and the PHSO outcome for those that were completed at the time of writing this report.

	<b>Trust Outcome</b>	<b>PHSO Outcome</b>
1.	Closed - Partially Upheld	Closed - Not Upheld
2.	Closed - Partially Upheld	Closed - Not Upheld
3.	Closed - Partially Upheld	Closed - Not Upheld
4.	Closed - Partially Upheld	Closed - Not Upheld
5.	Closed - Partially Upheld	Still Awaiting Completion
6.	Closed - Partially Upheld	Decision by PHSO Not To Investigate
7.	Closed - Not Upheld	Decision by PHSO Not To Investigate
8.	Closed - Partially Upheld	Still Awaiting Completion
9.	Unable To Investigate	Decision by PHSO Not To Investigate
10.	Closed - Partially Upheld	Closed - Not Upheld
11.	Closed - Not Upheld	Still Awaiting Completion
12.	Closed - Partially Upheld	Still Awaiting Completion
13.	Closed - Upheld	Still Awaiting Completion
14.	Closed - Partially Upheld	Still Awaiting Completion

**Table 8**

**Looking Forward: What are our quality priorities in 2014/2015 to support this goal?**

Priority	Aim/Objective	Rationale	Target & Trajectory
1	Greater choice, quality of food and timing of meals to inpatient areas.	This is a key area of improvement demonstrated through patient feedback.	To roll out the electronic food ordering system to all inpatient wards and complete nutritional analysis of all menus by 31/03/2015.
2	To improve the referral process and the waiting times for referrals for multi-disciplinary teams.	To ensure Trust services are responsive and accessible.	100% of all patients to wait less than 18 weeks by 31/03/15.  Implement an improved access/referral process across NTW services.

**Quality Goal Three: Ensuring the right services are in the right place at the right time for the right person**

This quality goal will improve clinical effectiveness. We will demonstrate success against this goal by delivering demonstrable improvements in service delivery.

Looking Back: Progress against our quality priority to support this goal in 2013/2014:

Quality Priority 2013/2014	Rationale	Target by 31 March 2014	Progress
Enhancing the Quality of care in inpatient units and developing fit for purpose community teams.	Significant improvements have been demonstrated through the consolidation of expertise in inpatient units and the development of more responsive community teams and access model.	To ensure on-going development, each of the three discreet clinical groups have identified priorities for development throughout 2013/14.	<b>ACHIEVED</b> – at the end of March 2014 this priority has achieved its objectives for 2013/14 but will be carried forward to 2014/15 as our transformation programme continues.
To develop an approach to outcome measurement using HoNOS 4 factor model and	As the Trust transforms its clinical services it is essential to understand the impact of the care	To produce a viable implementation plan in line with national guidance. From July 2013	<b>ACHIEVED</b> – a process is now in place within the Trust to capture this information and reporting

SWEMWEBS	delivered (both before, during and after any changes) in order to understand whether the changes have delivered the anticipated benefits.	report on HoNOS 4 factor model and from October 2013 also report on SWEMWEBS.	commenced in July 2013 on HoNOS 4 factor model and from October 2013 on SWEMWEBS
To develop a programme of work to define the competencies to deliver NICE compliant psychological therapies.	To ensure our workforce is suitably trained to deliver the highest quality patient care.	Report against skills acquisition plan developed during 2012/13. Implement the skills acquisition plan. Assessment of gaps in meeting NICE psychological therapy competencies where these are not covered by the skills acquisition plan developed in 12/13. Develop a training plan, to include targets for numbers of staff to be trained with timescales and any additional resources required.	<b>ACHIEVED</b> – a skills gap analysis was undertaken which led to the development of a training plan with agreed trajectories for staff training. At the end of March 2014 these trajectories were all met. The courses the staff were trained in for this priority were:  Cognitive Behavioural Therapy  Dialectical Behavioural Therapy  Family Therapy  WRAP (Wellness Recovery Action Plan) Training

**How have the quality priorities in 2013/2014 helped progress towards this goal?**

This goal is centred around the transformation of our services to ensure we can continue to deliver and improve our services to best suit the needs of our service users and carers.



## **Service Improvement and Developments throughout 2013/14**

These are some of the key service developments that the Trust has made during 2013/14:

### **Principal Community Pathways Programme**

The Programme commenced in 2013/14 the design, testing and implementation of effective, evidence based interventions focussed on recovery and effective support for people to live and work in their own communities with the aim of reducing reliance on hospital beds in Sunderland and South Tyneside.

This work will be rolled out across Newcastle, Northumberland, Gateshead and North Tyneside over the period of this Plan. The Programme will redesign services to meet the following needs in adults: Psychosis; Non-psychosis; Cognitive Disorders and Learning Disability.

### **The PRiDE Development (including the reprovision of Cherry Knowle Hospital)**

The Specialist Care Dementia Centre at Monkwearmouth Hospital opened in November, 2013 and Hopewood Park is due for completion in August, 2014.

### **Augmentation Programme**

The Trust has already made significant progress in this programme of work achieving the following during 2013/14:

- The review of the dementia care pathway in Newcastle, particularly long term care provision, with the aim of the Trust focusing its service and resources on the provision of care to those at an earlier stage of the illness who may exhibit challenging behaviour;
- The review of long term complex care services North of Tyne as a part of the move towards an improved stepped care pathway;
- Expansion of hospital liaison services in Sunderland in line with the recognised Rapid Assessment, Interface and Discharge (RAID) model;
- Realignment of female adult mental health assessment and treatment services in North of Tyne, in line with demand.

### **Specialist Care Services Programme**

During 2013/14 the Trust achieved the following:

- Progressed the review of Neurological Services with the aim of optimising the use of inpatient facilities, improving operational procedures and practices in the outpatient department and reviewed the community teams;
- Remodelled the services provided from Alwood and increased the bed occupancy following the completion of the refurbishment of the unit. Alwood provides medium secure inpatient assessment and treatment for young

people up to 18 years old who have complex mental health needs, including those with a learning disability;

- Commenced the review of Forensic Services including the changing commissioner environment, the estate requirements for these services and patient pathway so that patients can be moved on safely;
- Evaluated the Big Diversion Project, in preparation for the next stage of development;

Secured Full Business Case approval for the development of a purpose built unit for people with autism on the Northgate Hospital site to support the new model of care and replace the existing buildings.

### **Social and Residential Services**

In terms of the Trust's Social and Residential Services, during 2013/14 the Trust achieved the following:

- Concluded the lengthy programme aimed at transferring responsibility for the provision of social care for people with learning disabilities to alternative providers;
- Agreed with Commissioners a new model of care for one mental health residential long stay home, which the Trust had historically provided, and transferred the service to alternative providers.

### **New Services**

During 2013/14 the Trust was awarded the following services following a competitive tender process:

- Regional Veterans Awareness Training in the North East;
- Northumberland Integrated Drug and Alcohol Recovery Service;
- CYPY IAPT Training (part of national programme). This bid was submitted as a part of the Newcastle CAMHS Partnership;
- Liaison and Diversion Pilot Services (part of national programme);
- North Tyneside Integrated Drug and Alcohol Recovery Service.

### **Partnerships**

The Trust has developed partnerships with NHS organisations, the community voluntary and independent sectors which we highly value. These include:

- Care UK who were successful in winning the North East Offender Health Tender, but invited the Trust and Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) to work in partnership to provide mental health input to the North East prisons;
- Our partnership with Insight (formerly Mental Health Concern Oakdale Ltd) who we work with in the provision of Newcastle Talking Therapies;
- The partnership with TEWVFT and Revolving Doors in the implementation of the Big Diversion Project;

- The provision of a new model for Tier 3 Children and Young People's Services South of Tyne in partnership with Barnado's, Action for Children and Investing in Children;
- A partnership with TEWVFT, Combat Stress and The Royal British Legion to deliver Veterans Wellbeing Assessment and Liaison Service in the North East;
- A partnership with TEWVFT to deliver Veterans Awareness Training in the North East;
- A partnership with Changing Lives (formerly the Cyrenians) and Turning Point to provide the Northumberland Integrated Drug and Alcohol Recovery Service and the North Tyneside Integrated Drug and Alcohol Recovery Service ;
- 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 TEWV, 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.

There is more detail about our transformation programme in our Annual Report 2013/14.

### **NTW Equality Strategy 2012-2016**

The Equality Strategy 2012-2016 contains the Equality Objectives that the Trust has set to meet its Public Sector Duties in line with the Equality Act 2010. Our equality objectives are SMART, with targets and measures set for each. The objectives are aligned to the findings and recommendations of the Trust's Service Model Review and to the Department of Health initiative, the Equality Delivery System, which has

the intention of driving Equality and Diversity performance across the whole of the NHS.

During this year we have undertaken the following:

- Monitored the implementation of the Single Access Point for interpretation and advised the supplier of areas where further language support was required
- Introduced a telephone interpreting service
- Reported on the findings of equality and diversity inspections to three inpatient areas
- Undertaken an inspection of Community-Based Services
- Provided access advice to the design of new services
- Drafted guidance on the provision of reasonable adjustments
- Amalgamated and redesigned Equality and Diversity Training

In the coming year the Trust will undertake an evaluation of its Equality and Diversity provision using the revised Equality Delivery System 2 from NHS England. This will enable us to refresh and renew following consultation our Equality Objectives to meet the requirements of the Public Sector Equality Duty.

Our Equality and Diversity Work is aligned to the work that we undertake as a result of the findings of our Staff Survey, as a result we will be introducing:

- Intranet Forums for staff with protected characteristics under the Equality Act 2010
- Equality and Diversity Open Forums
- Whistleblowing Campaign
- Campaign and Event to coincide with International Day of Disabled People

**Looking forward: What are our quality priorities in 2014/15 to support this goal**

Priority	Aim/Objective	Rationale	Target and Trajectory
1	Enhancing the Quality of care in inpatient units and developing fit for purpose community teams.	Significant improvements have been demonstrated through the consolidation of expertise in inpatient units and the development of more responsive community teams and access model.	To ensure ongoing development, each of the three discreet clinical groups will identify priorities for development throughout 2014/15 by the end of Q1.

2	To widen the roll out across the Trust of the Wellness Recovery Action Plan (WRAP) tool.	WRAP planning is service user led and helps to promote recovery and long term stability.	Identify current use of WRAP and set improvement trajectory. Revise policies to incorporate WRAP. Assess training requirements and set trajectory.
3	To improve service user recovery-using the Improving Recovery Through Organisation Change (ImROC) 10 Key Challenges to Support Service User Recovery Tool.	Implementing Recovery through Organisational Change initiative, known as ImROC, is the leading source of support for mental health service provider organisations who wish to progress towards more recovery-orientated services. Embedding on principals of co-production where professionals and people with lived experience work together to design and produce better services, and implementing the 10 Key Challenges to support recovery will significantly improve the quality and effectiveness of community services delivered through Community Principal Pathway.	

### **How NTW uses NICE guidance to promote clinical effectiveness**

The Trust is committed to ensuring that the interventions and treatments that we provide are evidence based, effective and based on the principles of good practice. We do this by the implementation of best practice including National Institute for Health and Care Excellence (NICE) guidance and quality standards. Design and reconfiguration of Trust services through the Transforming Services Programme

ensures all relevant NICE guidance is incorporated and our electronic patient record (RiO) system ensures that care packages and pathways for Service Users reflect current guidance.

NICE provide guidance, based on best available evidence, for high quality care and preventing ill health. The Trust reviews all guidance, technology appraisals and quality standards issued by NICE to ascertain their applicability to services provided by the Trust. Where applicable a thorough assessment of Trust compliance is completed and action plans put in place as necessary to implement recommendations.

In 2013/14 we have continued to work through baseline assessments in Schizophrenia, Autism in Children and the Management of Violence. Baseline reports are well in progress in a number of areas where NICE has made recommendations including Dementia, the Management of Depression, Bipolar Disorder and Service User Experience.

Early 2014 saw the approval of the NTW Clinical Effectiveness Strategy, this promotes the adoption and dissemination of NICE guidance within and across the organisation and also ensures gathering of outcomes data and other internal measurement to provide evidence of how clinically effective our services are. We have a robust process in place to assess current Trust practice against all new relevant guidance released from NICE. This ensures that we can regularly evaluate our approach whenever new guidance relevant to our services is released and determine the best way of modifying our services to incorporate appropriate evidence-based changes to practice.

### **Mandatory statements relating to the quality of NHS services provided**

#### **Review of Services**

During 2013/2014 the Northumberland, Tyne and Wear NHS Foundation Trust provided and/or sub-contracted 257 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 257 of these relevant health services.

The income generated by the relevant health services reviewed in 2013/14 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 2013/14.

## Participation in Clinical Audits

During 2013/14, 6 national clinical audits and 1 national confidential enquiry 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 enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Northumberland, Tyne and Wear NHS Trust was eligible to participate in during 2013/2014 are as follows:

<b>National Clinical Audits 2013/2014</b>
1. National audit of Psychological Therapies for Anxiety and Depression
2. Prescribing for ADHD (POMH-UK Topic 13a)
3. Monitoring of Patients Prescribed Lithium (POMH-UK Topic 7d)
4. National Audit of Schizophrenia (Royal College of Psychiatrists)
5. Use of Anti-Psychotic Medicine in CAMHS (POMH-UK Topic 10c)
6. Prescribing for Substance Misuse: Alcohol Detoxification (POMH-UK Topic 14a)
<b>National Confidential Enquiries 2013/2014</b>
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 2013/2014, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

<b>National Clinical Audits 2013/2014</b>	<b>Cases submitted</b>	<b>Cases required</b>	<b>%</b>
National audit of Psychological Therapies for Anxiety and Depression	Completed & Action Plan due 2014	-	-
Prescribing for ADHD (POMH-UK Topic 13a)	50	50	100%
Monitoring of Patients Prescribed Lithium (POMH-UK Topic 7d)	139	No minimum requested	-
National Audit of Schizophrenia (Royal College of Psychiatrists)	89	75	-
Use of Anti-Psychotic Medicine in CAMHS (POMH-UK Topic 10c)	Audit on going at time of report	-	-
Prescribing for Substance Misuse: Alcohol Detoxification (POMH-UK Topic 14a)	Audit on going at time of report	-	-
<b>National Confidential Enquiries 2013/2014</b>			
National Confidential Enquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)	Summary published Dec 2013	-	-

The reports of 2 national clinical audits were reviewed by the provider in 2013/2014, and Northumberland, Tyne and Wear NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

<b>Project</b>	<b>Actions</b>
Prescribing for ADHD (POMH-UK Topic 13a)	<p>Reports were reviewed by the Trust's Medicines Management Committee and appropriate actions taken from the audit recommendations.</p> <ul style="list-style-type: none"> <li>- Identify information that must be provided to patients and their carers before treatment starts and to record that this has been done in the electronic notes.</li> <li>- Develop a standardised approach for recording physical health monitoring and cardiovascular risk assessments for ADHD patients in the electronic medical record.</li> <li>- Develop guidance for service clinicians in the assessment and documentation of the risk of</li> </ul>



	<p>substance diversion</p> <p>Agree the use of appropriate standardised rating scales as part of on-going reviews for children and young people with ADHD.</p>
Monitoring of Patients Prescribed Lithium (POMH-UK Topic 7d)	<p>Reports were reviewed by the Trust's Medicines Management Committee and appropriate actions taken from the audit recommendations.</p> <ul style="list-style-type: none"> <li>- Develop a list of patients prescribed lithium within RiO</li> <li>- Incorporate lithium monitoring into the integrated physical health &amp; medicines management clinics which are being developed across the Trust</li> <li>- Rebuild the RiO lithium documentation so that there is a one page document which is suitable for both clinic use and for the individual clinician</li> </ul> <p>Weight/BMI/waist circumference not being monitored and recorded on RiO – address this issue via the Physical Health and Wellbeing Group</p>

The reports of 61 local clinical audits were reviewed by the provider in 2013/2 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 2013/2014 that were recruited during that period to participate in research approved by a research ethics committee was 1290.

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. This means involvement in large-scale NIHR Portfolio research which aims to influence practice and deliver real benefits to patients.

The Trust was therefore involved in the conduct of 75 clinical research studies in mental health related topics during 2013/2014, 41 of which were large-scale nationally funded NIHR Portfolio studies.

Staff participation in research increased during 2013/2014 and there were 58 clinical staff participating in ethics committee approved research employed by the Trust.

In addition we have retained a strong collaborative focus with the Trust continuing to act as Host organisation up to 31<sup>st</sup> March 2014 for the two north east based NIHR Clinical Research Networks (Mental Health Research Network and Dementias and Neurodegenerative Diseases Research Network). Although the Research Network transition has meant we no longer host these networks in future we expect to have a similarly collaborative relationship with the new Clinical Research Network North East and North Cumbria. Excellent research partnerships with both Newcastle and Northumbria Universities continue to lead to successes in obtaining research grant funding.

### **Goals agreed with Commissioners**

#### Use of the CQUIN payment 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 2013/2014 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 2013/14, £6m of Northumberland, Tyne and Wear NHS Foundation Trust's contracted income was conditional on the achievement of these CQUIN indicators (£6m in 2012/13).

At the time of writing this Quality Report the majority of indicators were fully achieved with the exception of Children and Young Peoples Waiting times (North and South).

Further details of the agreed goals for 2013/2014 and for the following 12 month period are available electronically

[http://www.institute.nhs.uk/commissioning/pct\\_portal/2012\\_and\\_2013\\_cquin\\_schemes\\_for\\_the\\_north\\_of\\_england/](http://www.institute.nhs.uk/commissioning/pct_portal/2012_and_2013_cquin_schemes_for_the_north_of_england/)

## CQUIN Indicators

A summary of the agreed CQUIN indicators for 2013/2014 and 2014/15 is shown below. The tick marks show which year the indicator applies to:

<b>CQUIN Indicators to improve Safety</b>	<b>2013/14</b>	<b>2014/15</b>
Reduction of inappropriate anti-psychotic prescribing	✓	
NHS Safety Thermometer	✓	✓
Enhancing the quality of communication between NTW and the service users' GP	✓	
Management of patients failing to attend appointments	✓	
To implement the use of a specialised services clinical dashboard	✓	✓
Collaborative Risk Assessment		✓
Improving CPA process for specialised services	✓	✓

<b>CQUIN Indicators to improve Patient Experience</b>	<b>2013/14</b>	<b>2014/15</b>
Reduce waiting times from referral to actual treatment for service users accessing Primary and Secondary mental health services treatment	✓	✓
To build on the findings of the Carers survey	✓	✓
To introduce and implement a recovery and outcomes based approach to the care pathway	✓	
Service user involvement and experience	✓	
Implement the 6C's initiative focussing on 'Compassionate Care'	✓	
Access to mental health services – first time, right place	✓	
Diversity – improving links to community groups		✓
Enhancing family support		✓
Improve the use of communication technology	✓	
Improving patient experience of gender identity clinics		✓
Literacy, IT, numeracy and vocational support for secure services	✓	

<b>CQUIN Indicators to improve Clinical Effectiveness</b>	<b>2013/14</b>	<b>2014/15</b>
Transformation programme – South CCG's	✓	✓
Transformation programme – North CCG's	✓	✓
To increase the percentage of people with mental health illness who receive appropriate physical health care.	✓	✓
Deaf recovery package		✓
Care Pathways and Packages Project (CPPP)	✓	
Children and Young Peoples services	✓	✓
Optimising pathways in specialised services	✓	
To implement the Essen Ward Climate scale	✓	
Assuring appropriateness of unplanned admissions		✓
Training and supervision of clinical staff to deliver interventions to improve mother/infant relationships		✓
Highly specialised services clinical audit outcome workshop	✓	

### **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 2013/2014. 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 therefore licenses Northumberland, Tyne and Wear NHS Foundation Trust as a provider of care services as long as we meet essential standards of quality and safety. The CQC monitors us to make sure that we continue to meet these standards.

### **CQC Quality & Risk Profile**

The Quality & Risk Profile (QRP), published by the Care Quality Commission (CQC), gathers together key information about the Trust to help CQC monitor our compliance with the essential standards of quality and safety required for registration.

The QRP is a useful tool to help us to continually monitor the quality of our services, so that we can identify any areas of lower than average performance and take action to address them where necessary.

The latest QRP identifies the Trust as being a low risk of non-compliance against each of the following areas:

1. Involvement and Information
2. Personalised Care, Treatment and Support

3. Safeguarding and Safety
4. Suitability of Staffing
5. Quality and Management

## CQC Registration Activity 2013/14

During 2013/14, the Care Quality Commission visited the following Trust locations as part of their review of compliance with Essential Standards of Quality and Safety:

	Location Visited	Location Type
April 2013	No visits received	-
May 2013	St Georges Park	Healthcare
June 2013	No visits received	-
July 2013	Campus for Aging and Vitality	Healthcare
July 2013	St Nicholas Hospital	Healthcare
July 2013	Walkergate Park	Healthcare
July 2013	Cherry Knowle Hospital	Healthcare
July 2013	Ferndene	Healthcare
July 2013	Royal Victoria Infirmary	Healthcare
July 2013	Heppell House	Healthcare
July 2013	Brooke House	Healthcare
July 2013	Craigavon	Healthcare
July 2013	Elm House	Healthcare
July 2013	Monkwearmouth Hospital	Healthcare
July 2013	Queen Elizabeth Hospital	Healthcare
July 2013	The Grange	Healthcare
August 2013	No visits received	-
September 2013	Rose Lodge	Healthcare
October 2013	No visits received	-
November 2013	Easterfield Court	Residential Care Home
December 2103	The Willows	Residential Care Home
January 2014	No visits received	-
February 2014	No visits received	-
March 2014	No visits received	-

We received 17 CQC compliance visits during 2013/14 and were fully compliant in all outcomes that were inspected in all of those visits.

Reports from all of the planned reviews of compliance are available via the Care Quality Commission website at <http://www.cqc.org.uk>

## External Accreditations

The Trust has gained national accreditation for the quality of service it provides in many wards and teams. The table below provides a summary of our current clinical accreditations.

External Accreditation	Ward/Department	Location
Accreditation for Inpatient Mental Health Services (AIMS)	Bede 1	South Tyneside District Hospital
	Bede 2	South Tyneside District Hospital
	Collingwood Court	St Nicholas Hospital
	East Willows	Cherry Knowle Hospital
	Embleton	St George's Park
	Fellside Ward	Queen Elizabeth Hospital
	Gainsborough Ward	St Nicholas Hospital
	Lamesley Ward	Queen Elizabeth Hospital
	Lowry Ward	St Nicholas Hospital
	Warkworth Ward	St George's Park
	West Willows	Cherry Knowle Hospital
	Rosewood	Cherry Knowle Hospital
	Akenside (OP)	Centre for Ageing and Vitality
	Hauxley (OP)	St George's Park
	Hawthorn (OP)	Cherry Knowle
	Castleside Ward (OP)	Campus for Ageing and Vitality
	Sycamore (OP)	Cherry Knowle Hospital
	Cresswell (OP)	St George's Park
	Dene Ward (PICU)	Cherry Knowle Hospital
	Greentrees (PICU)	St Nicholas Hospital
	Bluebell Court (Rehab)	St George's Park
	The Grange (Rehab)	North Tyneside
	Lower Willows (Rehab)	Cherry Knowle
Meadow View (Rehab)	Cherry Knowle	
Ward 31a Eating Disorders Service (QED)	Royal Victoria Infirmary	
Quality Network for Forensic Mental Health Services	Bamburgh Clinic	St Nicholas Hospital
	Kenneth Day Unit	Northgate Hospital
Quality Network for Inpatient CAMHS	Alnwood	St Nicholas Hospital
	Riding	Ferndene
	Redburn	Ferndene
	Stephenson	Ferndene

External Accreditation	Ward/Department	Location
	Fraser	Ferndene
Quality Network for Community CAMH	Northumberland CYPS	Villa 9, Northgate Hospital
	Newcastle CYPS	Benton House
	South of Tyne and Wearside Community 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	Older People's Liaison Psychiatry services	Newcastle
	Liaison Psychiatry Team	Northumberland
	Liaison Psychiatry Team,	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
Home Treatment Accreditation Scheme (Pilot starting in April 2012)	Newcastle CRHT	Newcastle
Forum of Mobility Centres	North East Drive Mobility	Walkergate Park

## Data Quality

Northumberland, Tyne and Wear NHS Foundation NHS Trust will be taking the following actions to improve data quality:

On-going actions:	
Dashboard Information	We will further embed the use of the Dashboard reporting system and implement a systematic training programme relating to data quality and performance management across the organisation.
RIO documentation	We will consolidate the way that information is recorded on RIO to be a more streamlined process.
Awareness of data quality	We will continue to implement standards for Data Quality to increase awareness of the importance of data quality.
Clinical Standards for Record Keeping	We will continue to implement the Clinical Standards for record keeping, measuring staff adherence to the requirements.
Incident reporting process	We will continue to ensure that robust systems are implemented to review the grading of all incidents reported through our internal systems to provide a consistent and accurate picture of incident activity in the trust.
Complaint reporting process	As per the incident reporting process above the Trust is committed to continually refining our internal processes to ensure complaints are recorded and graded appropriately.

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 2014/15 the Trust will build upon the actions taken to ensure that we continually improve the quality of information we provide.

### North East Quality Observatory (NEQOS) Benchmarking of 2012/13 Quality Account

The North East Quality Observatory System (NEQOS) provides expert clinical quality measurement services to most NHS organisations in the north east.

During 2013 NTW once again commissioned NEQOS to undertake a benchmarking exercise. It compares NTW's Quality Account 2012/13 with those of 56 other NHS Mental Health organisations.



A summary of the top 11 indicators found in all Quality Accounts has been provided in the following table:

	Top 11 Quality Account Indicators	Target	Average	Peer	NTW	# Trusts
1	National Clinical Audit participation (%)	100%	90.8	83.6	100.0	56
2	National Confidential Enquiry participation (%)	100%	99.8	100.0	100.0	56
3	MHMDS data completeness: NHS number (%)	99%	99.4	99.5	99.5	56
4	Admissions to adult urgent care wards gate kept by CRT (%)	95%	98.4	97.6	99.8	54
5	% inpatients receiving follow up contact within 7 days of discharge	95%	97.5	96.9	96.7	55
6	Inpatients classed as delayed transfers of care (%)	<= 7.5%	3.6	3.5	5.4	44
7	CPA formal review within 12 months (%)	-	96.0	96.9	96.2	30
8	Serving new psychosis cases by early intervention teams (%)	95%	116.2	128.3	119.6	30
9	Proportion of all incidents for severe harm/death	-	1.6	1.1	1.5	53
10	Staff who would recommend the trust to their family/friends	-	3.48	3.54	3.52	29
11	Proportion of inpatients readmitted	-	6.1	6.2	8.4	34

NTW has a higher than average score in 9 of the top 11 Quality Account indicators that were included in the benchmarking exercise. Delayed transfers of care and inpatient readmissions are areas that the Trust has worked on improving throughout 2013/14 and it is anticipated the scores in these areas will improve during 2014/15.

### **NHS Number and General Medical Practice Code Validity**

Northumberland, Tyne and Wear NHS Foundation Trust submitted records during 2013/2014 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:

**99.6%** for admitted patient care;  
**99.2%** for outpatient care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

**100%** for admitted patient care;  
**100%** for outpatient care.

### **Information Governance Tool kit attainment**

The Northumberland, Tyne and Wear NHS Foundation Trust Information Governance Assessment Report overall score for 2013/2014 was 75% 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 2013/2014 by the Audit Commission.

### **Performance against mandated core indicators**

The mandated indicators applicable to Northumberland, Tyne and Wear NHS Foundation Trust are as follows:

- **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)**

The 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 has taken the following actions to improve this percentage, and so the quality of its services by ensuring clinicians are reminded of the requirement by either a telephone call or by sending automated reminders.

7 day follow up	Q1 13/14	Q2 13/14	Q3 13/14
NTW %	95.8%	97.5%	97.6%
National Average %	97.4%	98.8%	96.7%
Highest national %	100.0%	100.0%	100.0%
Lowest national %	94.1%	90.7%	77.2%

(Higher scores are better)

- **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)

The Northumberland, Tyne and Wear NHS Foundation Trust considers that this data is as described for the following reasons - 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.

Gatekeeping	Q1 13/14	Q2 13/14	Q3 13/14
NTW %	99.6%	99.6%	100.0%
National Average %	97.7%	98.7%	98.6%
Highest national %	100.0%	100.0%	100.0%
Lowest national %	74.5%	89.8%	85.5%

(Higher scores are better)

- **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.

Family & Friends recommendation	2011 Staff Survey	2012 Staff Survey	2013 Staff Survey
NTW	3.46	3.52	3.61
National Average	3.42	3.54	3.54
Highest national	3.94	4.06	n/a
Lowest national	3.07	3.06	n/a

(5 is the highest score)

- **‘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 engaging with patients and carers to ensure we are responsive to their needs and continually improve our services.

Patient experience of community mental health indicator scores	2010	2011	2012	2013
NTW	86.5	85.8	90.9	87.4
National Average	87.1	86.7	86.5	85.8
Highest national	91	91.4	91.8	91.8
Lowest national	81.8	81.9	82.6	80.9

(Higher scores are better)

- **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)**

The 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). The 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

<b>Oct 11 - Mar 12</b>	<b>NTW</b>	<b>National average</b>	<b>Highest national</b>	<b>Lowest national</b>
Number of PSI reported (per 1000 obd)	22.8	19.2	86.9	0
Number of 'Severe' PSI(% of incidents reported)	0.7%	0.5%	2.8%	0
Number of 'Death' PSI(% of incidents reported)	0.9%	0.8%	5.2%	0
<b>Apr 12 - Sept 12</b>				
Number of PSI reported (per 1000 obd)	31	23.8	72	0
Number of 'Severe' PSI(% of incidents reported)	0.8%	0.8%	8.9%	0
Number of 'Death' PSI(% of incidents reported)	0.6%	0.8%	4.3%	0
<b>Oct 12 - Mar 13</b>				
Number of PSI reported (per 1000 obd)	30.2	26.8	99.8	0
Number of 'Severe' PSI(% of incidents reported)	1.8%	0.5%	1.8%	0
Number of 'Death' PSI(% of incidents reported)	0.7%	0.8%	4.5%	0
<b>Apr 13 - Sept 13</b>				
Number of PSI reported (per 1000 obd)	33.9	28.0	67.1	0
Number of 'Severe' PSI(% of incidents reported)	0.4%	0.4%	1.6%	0
Number of 'Death' PSI(% of incidents reported)	1.0%	0.9%	4.7%	0

(Lower scores are better)

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 patient and staff surveys.

We will report separately on each of the quality domains (safety, patient experience and clinical effectiveness). Some of the indicators from our 2012/13 report are no longer included and we have added some new indicators this year as we feel this gives a more appropriate balance of our performance measures. For indicators which relate to our CQUIN goals no comparator information is included as the milestones change from year to year.

The information included in this section has been developed in conjunction with staff, our Council of Governors, commissioners and partners, to ensure that we include relevant, meaningful information about the quality of services we provide.

### Review of Quality Performance – Patient Safety

Quality Indicator	Why did we choose this measure?	Performance in 2013/2014 (2012/13)
*Same Sex Accommodation Requirements	Reducing mixed sex accommodation is a national priority and Department of Health requirement Data source: Safeguard	There have been no breaches of same sex accommodation requirements during 2013/14(also none in 2012/13)
*Patients on CPA have a formal review every 12 months	Monitor Compliance Framework requirement Data source: RiO	As at the end of March 2014, <b>97.2%</b> of applicable patients had a CPA review in the last 12 months, meeting the Monitor target of 95% (96.2% March 2013)
2013 Staff Survey - 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 annual staff survey is a valuable tool for understanding how our staff think the Trust is performing against the four pledges to staff in the NHS constitution Data source: CQC NHS Staff Survey 2011	The 2013 staff survey showed that our staff scored the question regarding recommending the trust as a place to work or receive treatment as 3.61 out of 5 (2012 3.52 out of 5).  The average score for mental health trusts for this question is 3.54.  (the survey is available via the following link: <a href="http://nhsstaffsurveys.com/cms/index.php?page=mental-health-trusts">http://nhsstaffsurveys.com/cms/index.php?page=mental-health-trusts</a> )
Safeguarding Awareness Training	The Safeguarding Adults and Safeguarding Children courses are essential training for all staff and must be completed every three years Data source: ESR	By the end of March 2014: The number of staff trained in Safeguarding Adults – <b>95.1%</b> The number of staff trained in Safeguarding Children – <b>96.7%</b>  (2012/13 – Safeguarding Adults 92.6% and Safeguarding Children 94.3%)

\*data for this indicator governed by a national definition

## Review of Quality Performance – Patient Experience

Quality Indicator	Why did we choose this measure?	Performance in 2013/2014 (2012/13)
*Delayed transfers of care	Monitor and CQC requirement to minimise the number of patients in hospital who are ready for discharge Data source: RiO	At 31 <sup>st</sup> March 2014, <b>4.2%</b> of total inpatients were classed as delayed transfers of care, thus meeting the target to have no more than 7.5% of patients delayed (5.4% in 2012/13).
Embedding the 'Getting to Know You' process for Carers in inpatient wards and rolling out the process to community teams	Locally agreed CQUIN indicator in 2013/14 to capture carers' views and measure satisfaction so that we can improve carers' experiences and ensure that the standards within the carers' charter are being met. Data source: manual	During 2013/14, <b>61.5%</b> of inpatients had a completed Getting to Know You form.  At the end of March 2014 <b>82.5%</b> of community team staff have received training in the Getting to Know You process and it is expected that completion rates of the forms will continue to improve during 2014/15.
Waiting times from referral to actual treatment for adult primary care mental health, psychological therapies and IAPT services and secondary care psychological therapy in Northumberland.	Locally agreed CQUIN indicator in 2013/14 to reduce waiting times Data source: RiO	March 2014: Primary care: 100% of patients were seen within 18 weeks of referral. Secondary care 97.9% of patients were seen within 18 weeks of referral. (March 2013: Primary care 90%, Secondary care 190%)

Quality Indicator	Why did we choose this measure?	Performance in 2013/2014 (2012/13)
Comments left via the Trust or other websites	<p>Reviewing comments left on websites about the quality of our services by patients and the public is valuable feedback.</p> <p>Data source: Patient Opinion website</p>	<p>My daughter was a patient at Ferndene for 7 months in 2013, I cannot recommend this hospital enough, without the care and intervention I dread to think were we would be a special thank you goes to the Consultant and the team on Redburn for giving me my daughter back!</p> <p>Me and my daughter stayed at the Mother and Baby unit for around 5 wks. The staff were extremely caring and reassuring as I was so scared. The nurses are just amazing, very friendly and I was able to trust them very quickly with their support with my baby. They were so accommodating to my husband and let him sleep over regularly with me as we live 35 miles away. My care co-coordinator was great and my Consultant was lovely. The unit itself has been made to look and feel very homely and is cosy with 6 rooms so it's never over crowded. Most importantly, you keep your independence, you can cook, and nurses even can take you to the local shops when you're feeling lots better. I'm so glad I agreed to this unit as it helped speed up my recovery and helped me with my baby.</p>

\*data for this indicator governed by a national definition



## Review of Quality Performance – Clinical Effectiveness

Quality Indicator	Why did we choose this measure?	Performance in 2013/2014 (2012/13)
*CRHT Gate kept Admissions	Both Monitor and CQC require us to demonstrate that certain inpatients have been assessed by a CHRT prior to admission Data source: RiO	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.  As at March 2014, <b>100%</b> 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%.  In 2012/13 the performance was 99.8%
*7 Day Follow Up contacts	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	During 2012/13, 2,020 service users (96.7% of those discharged from inpatient care in the year) were followed up within seven days of discharge.  In 2013/14, 1,967 service users ( <b>97.1%</b> 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: Gateshead CCG: 95.9% Newcastle West CCG: 95.9% Newcastle North & East CCG: 99.0% North Tyneside CCG: 97.8% Northumberland CCG: 98.3% South Tyneside CCG: 97.3% Sunderland CCG: 96.4%
7 Day Follow Up contacts conducted face to face	'Face to face' follow ups give a better quality of service and improved outcomes for service users Data source: RiO	By the end of March 2014 <b>93.8%</b> of seven day contacts were conducted face to face.  During 2012/13 this figure was 95.5%.

Quality Indicator	Why did we choose this measure?	Performance in 2013/2014 (2012/13)
Emergency re-admission rates	Emergency re-admission rates are an important tool in the planning of mental health services and the reviewing of quality of those services Data source: RiO	During 2012/13, 270 (8.4%) of mental health inpatients were readmitted within 28 days and 22 (16.1%) of learning disability patients were readmitted within 90 days of discharge.  In 2013/14, 236 (7.9%) of mental health inpatients were readmitted within 28 days and 11 (9.7%) of learning disability patients were readmitted within 90 days of discharge.
*Patient outcomes – numbers of patients in settled accommodation	CQC and Monitor require us to calculate how many of our service users are in settled accommodation Data source: RiO	At the end of March 2014, the number of service users recorded as living in settled accommodation was <b>75.1%</b> (77.1% in 2012/13).
Improving Physical Healthcare for mental health patients	2013/14 Locally agreed CQUIN.  Data source: manual	During 2013/14 Health Champions were identified within certain teams and a Trust-wide group was established to share best practice and raise key issues in relation to community physical healthcare. Members of the group have attended a programme of awareness sessions on key health promotion issues including smoking cessation, healthy eating, exercise therapy and lifestyle advice.
Staff Survey results 2013	The annual staff survey is a valuable tool for understanding how our staff think the Trust is performing against the four pledges to staff in the NHS constitution Data source: NHS Staff Survey 2012	The 2013 staff survey showed that <b>90%</b> of staff who responded agreed that their role makes a difference to patients (89% in 2012). <b>75%</b> of staff who responded felt satisfied with the quality of work and patient care they are able to deliver (77% in 2012).  (The survey is available via the following link: <a href="http://nhsstaffsurveys.com/cms/index.php?page=mental-health-trusts">http://nhsstaffsurveys.com/cms/index.php?page=mental-health-trusts</a> )

Quality Indicator	Why did we choose this measure?	Performance in 2013/2014 (2012/13)			
Staff absence through sickness	High levels of staff sickness impact on patient care: therefore the Trust monitors sickness absence levels carefully Data source: ESR	The 12 month rolling average staff sickness absence figures have decreased when compared to 2013. The Board of Directors continue to monitor this important target.			
			<b>Short term sickness</b>	<b>Long term sickness</b>	<b>Total average sickness</b>
		31 <sup>st</sup> March 2010	2.23%	4.01%	6.24%
		31 <sup>st</sup> March 2011	1.76%	3.75%	5.51%
		31 <sup>st</sup> March 2012	1.57%	4.19%	5.76%
		31 <sup>st</sup> March 2013	1.81%	4.42%	6.23%
		31 <sup>st</sup> March 2014	1.53%	4.33%	5.86%

\*data for this indicator governed by a national definition

## Performance against contracts with local commissioners

During 2013/14 the Trust had several contractual targets to meet with local commissioners (CCG's). The below table highlights the targets and the performance of each CCG against them, as at 31<sup>st</sup> March 2014.

Contract performance targets as at 31/3/2014	Gateshead CCG	Newcastle North & East CCG	Newcastle West CCG	N'land CCG	North Tyneside CCG	Cumbria CCG	Sunderland CCG	South Tyneside CCG
Number of long term inpatients that have received and Annual Health Check (95%)	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%
Current admissions to adult wards that are gatekept by crisis home resolution teams (95%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
CPA Service Users with a risk assessment undertaken/reviewed in the last 12 months (95%)	99.2%	97.8%	96.8%	96.8%	99.5%	100.0%	99.4%	99.3%
CPA Service Users with identified risks who have at least a 12 monthly crisis and contingency plan (95%)	100.0%	97.0%	95.0%	97.0%	98.6%	95.1%	98.4%	98.1%
Number of inpatient discharges from adult mental health illness specialties followed up within 7 days (95%)	97.4%	98.1%	96.9%	97.6%	97.4%	96.7%	96.0%	97.3%
Safeguarding Adults Training (90%)	95.1%	95.1%	95.1%	95.1%	95.1%	95.1%	95.1%	95.1%
Safeguarding Children Training (90%)	96.7%	96.7%	96.7%	96.7%	96.7%	96.7%	96.7%	96.7%
Current delayed transfers of care -including social care (<7.5%)	2.5%	10.8%	4.3%	5.9%	7.1%	0.0%	0.0%	2.2%
The number of people who have entered psychological therapies during the reporting period (IAPT)	N/A	N/A	N/A	N/A	N/A	N/A	4750	N/A
The number of people who have completed IAPT treatment during the reporting period (50%)	N/A	N/A	N/A	42.2%	N/A	N/A	46.3%	N/A

\*N/A = those services are not commissioned in the CCG areas

The Trust also has specific contractual targets for specialised services with NHS England and 100% of the targets were achieved by 31.3.2014.

## Staff Survey

Looking at the results of the all staff surveys and comparing results with other mental health trusts that use Picker as their survey contractor, the Trust has scored significantly better than average on 40 questions, significantly worse than average on 2 questions and average on 49 questions.

For the national sample, the overall response rate was 49%, an increased response rate from last year's rate of 44%.with the biggest improvements since last year being:

- Staff motivation
- Communication and involvement
- Staff reporting incidents
- The number of staff attending training courses.

Whilst the Trust has seen improvements in these areas there needs to be ongoing programmes of work relating to these areas given their importance.

- The results have already been considered by the Senior Management Team and have been shared with the wider leadership team at the February 2014 Trust Board confirm and challenge event
- Groups are analysing their local reports and acting on findings with support from the Staff Survey Working Group
- The Director of Nursing and Operations will be leading a new Violence Reduction Strategy
- The Staff Survey Working Group are preparing a year-long programme relating to raising concerns and whistleblowing awareness.

The staff survey group meet on a monthly basis and will conduct further detailed analysis of the results – particularly a qualitative analysis of the free text data. The group have also recently commenced a programme of visits to wards and departments to talk to staff about the staff survey and the issues which matter to them most.

In addition, early work is underway relating to the friends and family test for staff as this commences this year to run alongside the annual staff survey

### **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 Healthwatch will be included within this document, and any comments from other localities will be made available on our website ([www.ntw.nhs.uk](http://www.ntw.nhs.uk)).

## **Joint statement from North Clinical Commissioning Group**

### **Northumberland, North Tyneside, Newcastle North & East, Newcastle West and Gateshead Clinical Commissioning Groups for Northumberland Tyne & Wear NHS Foundation Trust Quality Accounts 2013/2014**

The CCGs welcome the opportunity to review and comment on the Quality Account for 2013/14 and would like to offer the following commentary.

As commissioners, Northumberland, North Tyneside, Newcastle North and East, Newcastle West and Gateshead 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 patients' needs are met by the provision of safe, high quality services and that the views and expectations of patients and the public are listened to and acted upon.

The CCGs would like to commend the Trust for the improvements that are demonstrated in the report, particularly the achievement of most of its goals relating to patient safety, patient experience and clinical effectiveness and the ongoing work to address gaps.

The CCGs are supportive of the Trust priorities for 2014/15 relating to the reduction of harm through assessment and management of risk including improving referral processes and waiting times.

The CCGs acknowledge that the Trust has a challenging Transformation Programme ahead which should reflect the CCGs Commissioning Intentions. We would also encourage working together on the programme to avoid any unintended consequences.

The CCGs are pleased to note the efforts being made to discuss and improve the patient's experience recognising the reduction in overall score in 2013 CQC survey of patient experience compared to the previous year. The CCGs recognise the good work that is underway and actions that are being taken to address some of the specific issues in the report such as the technical problems with the proposed electronic meal ordering system.

The Trust has reported improvements in the national staff survey with an overall response rate of 49%, an increased response rate from last year's rate of 44%. The CCG welcome the Trusts actions to address staff issues on an ongoing basis.

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.

Yours sincerely

A handwritten signature in black ink, reading "Lesley Young-Murphy". The signature is written in a cursive style with a large initial 'L' and 'M'.

Lesley Young-Murphy  
Executive Director of Nursing & Transformation  
NHS North Tyneside CCG

## **Joint statement from Sunderland and South Tyneside Clinical Commissioning Groups.**

NHS Sunderland and South Tyneside Clinical Commissioning Groups (CCG) aims to commission safe, effective and efficient services that provide a positive experience for patients, carers and staff. Commissioners of health services have a duty to ensure that the services commissioned are of good quality. The CCG's have taken this responsibility very seriously and considers this to be an essential component of the commissioning function.

Throughout 2013 up to March 2014, the CCG's held monthly quality and contract review meetings with Northumberland Tyne and Wear NHS Foundation Trust. These meetings were reviewed in line with the CCG's quality agenda and agreement has been sought to split the contract review meeting into two separate parts. The first will focus on the quality agenda with clinical involvement from the CCG's and NTW. The second part will focus on the transactional contract requirements.

The purpose of the quality review meetings is to:

- Monitor a broad range of quality indicators linked to patient safety, clinical effectiveness and patient experience
- Review and discuss relevant Trust reports e.g. Incident and Complaints reports
- Review and discuss relevant external reports e.g. Care Quality Commission patient surveys
- Monitor action plans arising from the above reports
- Monitor performance against national targets
- Monitor the quality impact of PCP implementations.

The information contained within the Quality Account will be used as part of the quality monitoring process described above e.g. performance against locally agreed quality measures achievement against CQUIN indicators.

As required by the NHS Quality Reports regulations, the CCG's have taken reasonable steps to check the accuracy of this information and can confirm that it is believed to be correct.

NTW set 13 priorities under the headings of:

- **Patient Safety** - Reducing harm to patients, this section included 5 key priorities. We would like to make note, significant progress has been made in the development of NTW electronic systems to improved timely communication to GP's. Improved transitions arrangements have been put in place for patients moving from hospital to community. This important priority



will continue in 2014/15 as an integral part of NTW transformation programme.

- **Patient Experience** - Improving the way NTW relates to patients, this section included 5 key priorities. We would like to make note the implementation of the 6C's (attitudes & values) has led to 3,857 staff have undertaken this training. Waiting times have been reduced with 98% of services users seen within 18 weeks. Commissioners are now receiving information from Friends and Family Test.
- **Clinical effectiveness** - Ensuring the right service in the right place at the right time for the right person this section included 3 key priorities. We would like to make note that a skills gap analysis was undertaken which led to the development of a training plan with agreed trajectory with commissioners for staff training in line with NICE guidance, which has been met. To understand the improvements in patient outcomes, commissioners are now receiving the following outcome measures, Health of Nation Outcome Score (HoNOS) 4 factor model and Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS).

NTW have achieved 10 of the 13 priorities, with two being rolled over and one forming part of the 14/15 national mandated CQUIN. The CCG is pleased to note that during 14/15 account NTW will focus on improving the assessment and management of risk, improving waiting times and have a greater focus on recovery.

The CCG is supportive of the overall account and it is positive to note that the priorities for improvement in 2014/15 identified within the report have been developed collaboratively with commissioners, carers and the people who use services. In particular, the continued innovative development of CQUIN measures to improve service quality and meaningful outcomes for service users and carers through the recovery agenda initiatives.

Yours sincerely



**Dr Geoff Stephenson**  
Medical Director  
NHS Sunderland CCG



**Ann Fox**  
Director of Nursing, Quality  
and Safety, NHS Sunderland  
and South Tyneside CCG's

## **Statement from local Healthwatch**

### **Healthwatch Newcastle's statement for Northumberland, Tyne and Wear NHS Foundation Trust's Quality Account 2013/2014**

Healthwatch Newcastle was pleased to read Northumberland, Tyne and Wear NHS Foundation Trust's Quality Account 2013/2014 and to learn more about some of its successes this year. We were particularly pleased to see that the Trust has achieved its targets with regards to training. It achieved its goals in training staff on:

- Leave management
- Falls risk assessment
- 6Cs initiative on values and attitudes
- NICE psychological therapies competencies so staff are compliant

There were also apparent improvements in the quality of provision of out-of-hours activities and in the quality of care across inpatient and community boundaries.

In terms of the Quality Priorities selected for 2014/2015, we are pleased to see that some of these focus on recovery tools and action plans, with a continuing emphasis on transitions. We are also pleased that the Trust has carried forward the Quality Priorities for quality and choice of food and the timing of meals as well as waiting times to access services. We are keen to see improvements in both these areas, particularly the waiting times for children and young people.

We noticed that the Trust has chosen not to continue the Quality Priorities that focus on ensuring GPs get discharge summaries within 24 hours and care plans within 7 days of discharge. This is a shame as the percentage of cases in which this was occurring is quite low. However, we do notice that these will continue to be monitored through national Commissioning for Quality and Innovation targets. We think it is important for improvements to occur in this area and we hope to see improvements in 2014/2015.

In 2014/2015, we would also like to see:

- An increase in the Care Quality Commission Community Patient Survey Scores
- A decrease in the number of non-patient and patient safety incidents
- A decrease in the number of complaints

We wish the Trust success in 2014/2015 and look forward to receiving updates about their progress.

## Appendix 1: Monitor Compliance Framework

MONITOR PERFORMANCE 2013-14 (by quarter)						
Risk Assessment Framework	Target	Q1 2013/ 14	Q2 2013/ 14	Q3 2013/14	Q4 2013/ 14	
Overall Governance Risk Rating	Green	Green	Green	Green	Green	●
Overall Finance Risk Rating	3	3	3	3	3	●
Referral to treatment waiting times - non-admitted	95%	99.1%	99.1%	99.4%	99.6%	●
Referral to treatment waiting times - incomplete	92%	99.6%	99.6%	100.0%	100.0%	●
CPA 7 day follow up	95%	95.8%	98.9%	97.6%	96.8%	●
CPA review within 12 months	95%	96.8%	97.0%	96.4%	97.2%	●
Minimising mental health delayed transfers of care (including social care)	≤7.5%	3.4%	3.4%	3.0%	4.2%	●
Admissions to inpatient services had access to crisis resolution home treatment teams	95%	99.6%	99.6%	100.0%	100.0%	●
Data Completeness: 6 indicators	97%	99.7%	99.7%	99.8%	99.8%	●
Data Completeness: outcomes for patients on CPA 3 indicators	50%	86.7%	89.2%	90.9%	91.9%	●
Self certification against LD access requirements	Green	Green	Green	Green	Green	●
Clostridium Difficile - meeting the C Diff objective	0	0	0	0	0	●
MRSA - meeting the MRSA objective	0	0	0	0	0	●
Risk of, or actual, failure to deliver Commissioner Requested Services	No	No	No	No	No	●
CQC compliance action outstanding	No	No	No	No	No	●
CQC enforcement action within the last 12 months	No	No	No	No	No	●
CQC enforcement action currently in effect	No	No	No	No	No	●
Moderate CQC concerns or impacts regarding the safety of healthca	No	No	No	No	No	●
Major CQC concerns or impacts regarding the safety of healthca	No	No	No	No	No	●
Trust unable to declare ongoing compliance with minimum stan	No	No	No	No	No	●

●	Achieving Monitor target
●	Breaching Monitor target

## Appendix 2: CQC Registered locations and services

The following table outlines the Trust's primary locations for healthcare services as at 31 March 2014:

Locations	Regulated Activities			Service Types							
	Treatment of Disease, Disorder of 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	●	●	●							●	
Cherry Knowle Hospital	●	●	●			●		●		●	
Craigavon Short Break Respite Unit	●	●	●					●			
Elm House	●	●	●					●			
Ferndene	●	●	●			●		●		●	
Heppell House	●	●	●			●		●		●	
Monkwearmouth Hospital	●	●	●			●		●		●	
Campus for Ageing and Vitality	●	●	●					●			
Northgate Hospital	●	●	●					●		●	
Queen Elizabeth Hospital	●	●	●			●		●		●	
Rose Lodge	●	●	●					●			
Royal Victoria Infirmary	●	●	●					●			
South Tyneside District Hospital	●	●	●					●		●	
St George's Park	●	●	●			●	●	●		●	
St Nicholas Hospital	●	●	●	●	●	●	●	●	●	●	●
The Grange	●	●	●							●	
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**

	Regulated Activity	Service Type
Registered Home / Service	Accommodation for persons who require nursing or personal care	Care home service without nursing
Easterfield Court	•	•
The Willows	•	•

### Appendix 3: Local Clinical Audits

Clinical Audit
1. Quality Monitoring Tool (CA-13-0117)
2. Food & Nutrition Policy Compliance (988)
3. Sharing Letters with Patients – Planned Care Community Services (962)
4. Serious Untoward Incidents: Review of identified actions following 3 SUIs within Specialist Care (982)
5. Audit of Discharge Packs (986)
6. Mental Capacity Act (2005) and deprivation of liberty safeguarding audit. (997)
7. Audit of prescribing combined antipsychotic medication (1012)
8. Driving Audit (1015)
9. Audit of Discharge Checklist (1016)
10. Enhanced coordination in LD CAMHS patients (1018)
11. LD CAMHS patients on Risperidone (1023)
12. GP Letter Audit (1027)
13. Audit of the Clinical Supervision policy within the South of Tyne Children & Young Peoples Service (1030)
14. Mental Health Act Documentation Audit (1038)
15. The use of Psychological treatments in patients with a diagnosis of Schizophrenia in the Northeast CMHT (1042)
16. Physical examination on admission at Ferndene (1049)
17. NTW CRHT Risk Formulation(CA-13-0002)
18. Audit of Documentation of diagnostic classification on RIO in the MAM Service (CA-13-0003)
19. The use of unlicensed medications in children and adolescent services and learning difficulties Services who attend Benton House (CA-13-0007)
20. Closing the Trust Audit Cycle (CA-13-0008)
21. Physical Health Monitoring for Patients on Risperidone in a tier 3 community service for children and young people (CA-13-0012)
22. Audit of Drug and Alcohol Testing within Medium Secure Forensic Rehabilitation Services (CA-13-0014)
23. Audit HDAT in Community Patients (00-13-0016)
24. Record Keeping and Information Governance (CA-13-0017)
25. Are patients prescribed high dose anti-psychotics receiving ECG checks as per the Trust Guidelines?(CA-13-0020)
26. Clinical Audit on the Quality and Accuracy of Information in FACE Risk Documents(CA-13-0024)
27. Clozapine Titration - Inpatient and Outpatient (CA-13-0030)
28. Prescription policy for PRN medication (CA-13-0034)
29. Nutrition Screening in adults over 18 years old within Inpatient units (CA-13-0037)
30.. Improving CPA Process(CA-13-0066)

<b>Clinical Audit</b>
31. Anti-psychotic medication for first episode psychosis: an audit of NICE clinical guideline recommendations for Psychosis and schizophrenia in children and young people (CG 155) (CA-13-0068)
32. Physical Investigations done on Inpatient Admissions to Gainsborough Ward May 2013 (CA-13-0069)
33. Adherence to NICE guidelines standards for ADHD( physical monitoring) RE Audit (CA-13-0070)
34. Audit to identify if local and national Memantine prescribing guidelines are being met by NTW (CA-13-0072)
35. Audit of Prescribing Practice in Old Age Psychiatry Ward at CKH (CA-13-0074)
36. An audit into the management of depression in children and young people in the South of Tyne CAMHS - are we following NICE guidelines?(CA-13-0078)
37. Is the AUDIT (alcohol use disorders identification test) tool being used to assess the nature and severity of alcohol misuse (CA-13-0080)
38. Do Gateshead WAA Inpatient and CRHT Services satisfy minimum criteria for the physical health monitoring of patients prescribed antipsychotic medications (CA-13-0084)
39. Monitoring of Patients on Lithium Treatment (CA-13-0085)
40.. Transition of care (CA-13-0086)
41. Physical Health Monitoring in Patients with High Dose Anti-Psychotics at RTS (Wellfield Unit) (CA-13-0087)
42. Complex Neurodevelopmental Disorders Service (CNDS) Satisfaction Questionnaire Audit (CA-13-0088)
43. Audit on Physical Health Baseline Checks for patients Admitted to Redburn between 15th August and 31st December 2013 (CA-13-0089)
44. Audit on Physical Health Baseline Checks for patients Admitted to the Learning Disability Wards at Ferndene between 10th November 2012 and 31st December 2013 (CA-13-0090)
45. Attention Deficit Hyperactivity Disorder (NICE Guideline 72) (CA-13-0092)
46. Audit on Physical Health Monitoring Baseline Checks for Patients accepted by ABS between 1st January 2012 and 31st December 2013 (CA-13-0093)
47. Prevalence of Benzodiazepines Prescriptions in Patients who are also on Opiate Substitute Treatment in Northumberland Recovery Partnership (CA-13-0094)
48. Urine Drug Screen for the newly admitted patient to Redburn Ward, Ferndene Hospital (CA-13-0096)
49. Clinical Audit of Case Support (CA-13-0097)
50. Survey of Police Officers attending 136 Suite. (CA-13-0099)
51. Pharmacological interventions in Emotionally Unstable Personality Disorder (CA-13-0102)
52. Audit of Current Medical Standards of Fitness to Drive as Assessed by Psychiatrists (CA-13-0103)
53. Documented consent to treat Looked After Children at Aspire in Child and Adolescent Mental Health Service (CA-13-0110)
54. Re-Audit of the Risk Assessment incorporated into FCMHT reports standardised recognised tools (CA-13-0111)

**Clinical Audit**

55. Time taken to change community medications post advice from Castleside Day Unit (CA-13-0114)

56. Audit of Physical Health Monitoring in Patients on Antipsychotic Medication (Excluding Clozapine) Referred to the Physical Health and Medicines Management (PHMM) Team (CA-13-0118)

57. Re-Audit of the Management of Osteopenia / Osteoporosis in Patients with Eating Disorders (CA-13-0119)

58. Audit of Pulse Rate Monitoring on Cholinesterase Inhibitors in Memory Assessment and Management Services (MAMS) (CA-13-0121)

59. Measurement of cognitive function before, during and after electroconvulsive therapy (CA-13-0124)

60. Do all patients attending hospital following an episode of self-harm receive a comprehensive psychosocial assessment as defined in NICE CG16? (CA-13-0125)

61. An Audit of Side Effect Monitoring of Patients in Longbenton & Whitely Bay patches of North Tyneside who are Receiving Antipsychotic Depot Injections (CA-13-0126)



## **Appendix 4: Statement of Directors Responsibilities in respect of the Quality Account**

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 2013/14;
- 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 2013 to May 2014
  - Papers relating to Quality reported to the Board over the period April 2013 to May 2014
  - Feedback from the Commissioners dated May 2014
  - Feedback from the Local healthwatch organisations dated May 2014
  - 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, date;
  - The 2013 national patient survey
  - The 2013 national staff survey
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2014
  - CQC quality and risk profiles dated 31 March 2014
- The Quality Report presents a balanced picture of the NHS Foundation Trusts 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) as

well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

A handwritten signature in black ink, consisting of several overlapping loops and a long horizontal stroke at the end.

**Hugh Morgan Williams**  
**Chairman**  
**28<sup>th</sup> May 2014**

A handwritten signature in black ink, featuring a large, stylized 'D' followed by a series of loops and a long horizontal stroke.

**James Duncan**  
**Acting Chief Executive**  
**28<sup>th</sup> May 2014**

## **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 Annual 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 2014 (the "Quality Report") and certain performance indicators contained therein.

#### **Scope and subject matter**

The indicators for the year ended 31 March 2014 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 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*;
- the Quality Report is not consistent in all material respects with the sources specified in section 2.1 of Monitor's 2013/14 *Detailed Guidance for External Assurance on Quality Reports*; 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 aspects in accordance with the *NHS Foundation Trust Annual Reporting Manual* 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 and papers for the period April 2013 to April 2014;
- Papers relating to quality reported to the Board over the period April 2013 to April 2014;
- Feedback from the Commissioners, Northumberland, North Tyneside, Newcastle North & East, Newcastle West and Gateshead Clinical Commissioning Groups received on 22 May 2014; and Sunderland and South Tyneside Clinical Commissioning Groups received on 28 May 2014;
- Feedback from local Healthwatch organisations received on 14 May 2014;
- 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, covering the period April 2013 to March 2014;
- The 2013 national patient survey;
- The 2013 national NHS staff survey;
- Care Quality Commission quality and risk profiles dated 31 March 2014;
- The Head of Internal Audit's annual opinion over the Trust's control environment for the period April 2013 to March 2014; and
- Any other information included in our review.

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 2014, 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 save where terms are expressly agreed and with our prior consent in writing.

## **Assurance work performed**

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). 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 thereof, 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 2014:

- the Quality Report is not prepared in all material respects in line with criteria set out in the NHS Foundation Trust *Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified in section 2.1 of Monitor's 2013/14 *Detailed Guidance for External Assurance on Quality Reports*; and
- the indicators in the Quality Report subject of limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual*.

Cameron Waddell CPFA and on behalf of Mazars LLP  
Chartered Accountants and Statutory Auditor  
Rivergreen Centre, Aykley Heads, Durham DH1 5TS

28 May 2014

## Appendix 6: Glossary of Terms

<b>AIMS</b>	Accreditation for inpatient mental health services
<b>Care Co-ordinator</b>	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
<b>Care Packages and Pathways</b>	A project to redesign care pathways that truly focus on value and quality for the patient
<b>Commissioners</b>	Members of Primary Care Trusts (PCT's), regional and national commissioning groups responsible for purchasing health and social care services from NHS Trusts
<b>CQUIN</b>	Commissioning for Quality and Innovation – a scheme whereby part of our income is dependant upon improving quality
<b>CMHT</b>	Community Mental Health Team
<b>CRHT</b>	Crisis Resolution Home Treatment – a service provided to patients in crisis.
<b>Clinician</b>	A clinician is a health professional. Clinicians come from a number of different healthcare professions such as psychiatrists, psychologists, nurses, occupational therapists etc
<b>Clusters</b>	Clusters are used to describe groups of patients with similar types of characteristics
<b>CQC</b>	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

<b>CPA</b>	Care Programme Approach. CPA is a term for describing the process of how mental health services patients' needs, plan ways to meet them and check that they are being met
<b>CYPS</b>	Children and Young Peoples Services – also known as CAMHS
<b>Dashboard</b>	An electronic system that presents relevant information to staff, service users and the public
<b>Dual Diagnosis</b>	Service users who have a mental health need combined with alcohol or drug usage
<b>Forensic</b>	Forensic teams provide services to service users who have committed serious offences or who may be at risk of doing so
<b>HoNOS/HoNOS 4 factor model</b>	Health of the Nation Outcome Scales. A clinical outcome measuring tool
<b>IAPT</b>	Improving Access to Psychological Therapies – a national programme to implement <u>National Institute for Health and Clinical Excellence (NICE)</u> guidelines for people suffering from depression and anxiety disorders
<b>LD</b>	Learning Disabilities
<b>Lead Professional</b>	A named person to co-ordinate the service a patient receives if their needs are not complex
<b>Leave</b>	A planned period of absence from an inpatient unit which can range from 30 minutes to several days
<b>MHA</b>	Mental Health Act
<b>MHMDS</b>	Mental Health minimum data set – a standard set of information sent from mental health providers to the Information Centre
<b>Monitor</b>	The independent regulator of NHS Foundation Trusts, ensuring they are well led and financially robust
<b>Monitor Compliance Framework</b>	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



<b>Multi- Disciplinary Team</b>	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
<b>Next Steps</b>	A group of projects to ensure that the organisation is fit for the future and provides services that match the best in the world
<b>NEQOS</b>	North East Quality Observatory System – an organisation that helps NHS Trusts to improve quality through data measurement
<b>NHS Performance Framework</b>	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
<b>NHS Safety Thermometer</b>	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
<b>NICE</b>	National Institute for Health and Clinical Excellence – a group who produce best practice guidance for clinicians
<b>NIHR</b>	National Institute of Health Research – an NHS organisation undertaking healthcare related research
<b>NPSA</b>	National Patient Safety Agency
<b>NTW</b>	Northumberland, Tyne and Wear NHS Foundation Trust
<b>Out of area placements</b>	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.
<b>Pathways of care</b>	Service user journey through the Trust – may come into contact with many different services
<b>PCT</b>	Primary Care Trust – a type of NHS Trust that commissions primary, community and secondary care from providers
<b>Points of You/How's it Going</b>	NTW service user/carer feedback processes allowing us to evaluate the quality of services provided
<b>Productive Ward</b>	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

<b>QRP</b>	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
<b>RIO</b>	Electronic patient record
<b>Shared Care</b>	A partnership between two different healthcare organisations involved in an individual’s care, i.e. between the Trust and the patient’s GP
<b>SMART</b>	Specific, Measurable, Achievable, Realistic, Timely – a way of setting objectives to make sure they are achievable
<b>Serious Incident</b>	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
<b>SWEMWEBS</b>	Warwick-Edinburgh Mental Wellbeing Scale – a clinical outcome measuring tool
<b>Transition</b>	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

## 7 STAFF SURVEY

Included in the Strategic Report.

## 8 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.

**The Trust's risk ratings for 2013/14 are shown in the table below, including expected performance as identified in the Annual Plan 2013/14 :**

Risk Rating	Annual Plan 2013/14	Quarter 1	Quarter 2	Quarter 3	Quarter 4
<b>Under the Compliance Framework</b>					
Financial risk rating	3	3	3		
Governance risk rating	Green	Green	Green		
<b>Under the Risk Assessment Framework</b>					
Continuity of service rating				3	3
Governance rating				Green	Green

The change in the regulatory regime in 2013/14 had no impact on the Trust's ratings. The Trust's risk ratings for 2013/14 were in line with the expected performance as identified in the Annual Plan 2013/14.

There were no formal interventions from Monitor during 2013/14.

**The Trust's risk ratings for 2012/13 are shown in the table below including expected performance as identified in the Annual Plan 2012/13 :**

<b>Risk Rating</b>	<b>Annual Plan 2012/13</b>	<b>Quarter 1 2012/13</b>	<b>Quarter 2 2012/13</b>	<b>Quarter 3 2012/13</b>	<b>Quarter 4 2012/13</b>
<b>Under the Compliance Framework</b>					
<b>Financial risk rating</b>	4	5	5	5	5
<b>Governance risk rating</b>	Green	Green	Green	Green	Green

The Trust's risk ratings for 2012/13 were in line with the expected performance as identified in the Annual Plan 2012/13.

## **9 INCOME DISCLOSURES REQUIRED BY SECTION 43(2A) OF THE NHS ACT 2006 (AS AMENDED BY THE HEALTH AND SOCIAL CARE ACT 2012)**

### **Private Patient Income**

	<b>2013/14</b>	<b>2012/13</b>
	<b>£000</b>	<b>£000</b>
Private patient income	<b>157</b>	<b>148</b>
Total patient related income	<b>280,710</b>	<b>286,551</b>
Proportion (as percentage)	<b>0.06%</b>	<b>0.05%</b>

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.

## **10 OTHER DISCLOSURES IN THE PUBLIC INTEREST**

### **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 on line at <http://www.reportnhsfraud.nhs.uk>

### **Early Retirements due to Ill Health**

During the year there were 11 early retirements (2012/13; 7) from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £624,000 (2012/13; £545,000). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

### **Information Governance**

The Trust places great importance on the protection of the personal information that it holds.

The Trust reports any serious Information Governance incidents in accordance with the NHS Information Governance reporting requirements. These requirements changed from 1 June 2013. The Trust used the previous reporting standard from 1 April 2013 and the new standards since 1 June 2013.

Under the previous and current reporting rules, the Trust is required to report any serious incidents involving the loss of inappropriate disclosure of personal data to the Health and Social Care Information Centre (NSCIC) and to the Information Commissioners Office. Between 1 April 2013 and 31 March 2014, the Trust reported 6 incidents, which are categorised level two and above under the HSCIC guidance and are summarised below:

**Summary of Serious Incident requiring Investigations involving Personal Data as Reported to the Information Commissioner's Office in 2013/2014**

<b>Date of Incident (Month)</b>	<b>Nature of incident</b>	<b>Nature of data involved</b>	<b>Number of Data subjects potentially affected</b>	<b>Notification steps</b>
July 2013	Disclosed in error	Demographic and employee status information	16	Due to the remedial actions taken and limited impact, the Trust did not inform data subjects in this case.
<b>Further action on information risk</b>	A proactive review of all person identifiable data flows internally and externally is carried out annually by the Trust. During 2014 the Trust plans to undertake further testing of the processes to provide additional assurance that transfers are safe and secure.			

<b>Date of Incident (Month)</b>	<b>Nature of incident</b>	<b>Nature of data involved</b>	<b>Number of Data subjects potentially affected</b>	<b>Notification steps</b>
July 2013	Disclosed in error	Clinical letter containing demographic data.	1	Families of both patients contacted and support offered.
<b>Further action on information risk</b>	The Trust has discussed correctly addressing patient correspondence at its senior management team meeting and a safety message has been issued to all staff via the Trust's chief executive bulletin on the subject.			

<b>Date of Incident (Month)</b>	<b>Nature of incident</b>	<b>Nature of data involved</b>	<b>Number of Data subjects potentially affected</b>	<b>Notification steps</b>
July 2013	Disclosed in Error	Information, relating to the circumstances of untoward incidents that could have identified patients was contained in the Trust safety report	47	Individuals notified by post/telephone/ face to face.
<b>Further action on information risk</b>	A Serious incident review was undertaken and an action plan developed with a number of actions to prevent reoccurrence.			

<b>Date of Incident (Month)</b>	<b>Nature of incident</b>	<b>Nature of data involved</b>	<b>Number of Data subjects potentially affected</b>	<b>Notification steps</b>
October 2013	Disclosed in error.	Clinical handover information contained in notebook.	11+	As there was limited risk of information disclosure, the Trust did not inform the data subjects.
<b>Further action on information risk</b>	Immediate measures put in place to minimise risk of reoccurrence.			

<b>Date of Incident (Month)</b>	<b>Nature of incident</b>	<b>Nature of data involved</b>	<b>Number of Data subjects potentially affected</b>	<b>Notification steps</b>
November 2013	Disclosed in error.	Complaint resolution and covering letter.	1	Individuals contacted via telephone.
<b>Further action on information risk</b>	Process has been reviewed by the department and checking mechanisms in place.			

<b>Date of Incident (Month)</b>	<b>Nature of incident</b>	<b>Nature of data involved</b>	<b>Number of Data subjects potentially affected</b>	<b>Notification steps</b>
January 2014	Disclosed in error.	Limited Demographic information	2	1 Individual informed face to face. 1 individual not contact as deceased and breach was limited.
<b>Further action on information risk</b>	A Serious incident review was undertaken and an action plan developed with a number of actions to prevent reoccurrence.			

The Trust also has an obligation to publish in the annual report, the number of Information Governance Incidents reported and categorised as level 1 under the HSCIC guidance. These are summarised below:

<b>SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS IN 2013-2014</b>		
<b>Category</b>	<b>Breach Type</b>	<b>Total</b>
A	Corruption or inability to recover electronic data	0
B	Disclosed In error	52
C	Lost in transit	1
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	10
F	Non-secure Disposal – Hardware	0
G	Non-secure Disposal – Paperwork	2
H	Upload to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	20
K	Other	14
	<b>TOTAL</b>	<b>99</b>

The Trust is a large organisation and handles significant amounts of personal data each day. There are strong processes and policies in place to protect information but a relatively small number of incidents do occur. The Trust strives to be an open and learning organisation and encourages its staff to report any untoward information governance incidents so that immediate remedial action can be taken to reduce the impact of incidents, and so lessons can be learned to prevent reoccurrences.



## **11 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*.

A handwritten signature in black ink, consisting of a series of loops and a long horizontal stroke extending to the right.

**James Duncan**  
**Acting Chief Executive**  
**28<sup>th</sup> May 2014**

## **12 ANNUAL GOVERNANCE STATEMENT**

### **ANNUAL GOVERNANCE STATEMENT 2013/14**

#### **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 2014 and up to the date of approval of the annual report and accounts.

#### **3 Capacity to handle risk**

The Executive Director of Performance and Assurance has overall lead responsibility for performance risk management within the Foundation Trust. While the Executive Director of Performance and 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 Senior Management Team. The Foundation Trust has a Board of Directors approved Risk Management Strategy in place.

Sub-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 every two months. The Senior Management 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 every two months. 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 table below summarises those risks and the key controls as reported in the Board Assurance Framework and Corporate Risk Register. All risks identified below are considered as in year and future risks

<b>Reference</b>	<b>Risk</b>	<b>Key Controls</b>
SO1.1	That we do not develop and correctly implement service model changes.	Evidence base developed through Service Model Review.  Governance arrangements, including programme management structure under Business Case Process.
SO1.2	That we do not effectively engage commissioners and other key stakeholders leading to opposition or significant delay in implementing service model review changes and other major planned service changes.	Partnership arrangements, including Customer Relationship Management. Engagement with Clinical Commissioning Groups.  Membership of Health and Wellbeing Boards for 4 out of 6 localities.  Staff Side Engagement and Partnership Agreement.  Service User and Carer Network Groups.  Community Strategy.
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).	Annual Plan/IBP/Long term financial model/ Updated Financial Strategy.  Transforming Services Programme – aligning long term strategy / service redesign with funding.  Annual Delivery Plan (including Cost Improvement Plan) – management by FIBD Committee.
SO2.7	That we do not meet compliance and performance standards and/or misreport on these through data quality errors.	Financial and Performance Management reporting systems; other business critical systems.  Trust Essential Standards Working Group.  Group Governance – Q&P Committees / Essential Standards

		<p>sub groups.</p> <p>Quality Accounts.</p> <p>Data Quality Policy.</p>
SO3.1	That we do not effectively manage significant workforce and organisational changes, including increasing staff productivity.	<p>Workforce Strategy.</p> <p>Workforce Programme Board.</p> <p>Workforce KPIs monitored through Q&amp;P Committee.</p> <p>Group/Directorate Workforce Plans.</p> <p>Time and Attendance and e-rostering system.</p> <p>Transitional Employment &amp; Development Approach (TED).</p> <p>Revalidation process.</p>
SO5.1	That there are risks to the safety of service users and others if the key components to support good patient safety governance are not embedded across the Trust.	<p>Monitoring of Quality Account Goal 1 (reducing harm to patients).</p> <p>Complaints, Litigation, Incidents, PALS and Point of You (CLIPP) reporting system in place across Clinical Services.</p> <p>Patient Safety Incidents reporting system, including Serious and Untoward Incidents (SUIs).</p> <p>Incidents Policy Infection Prevention and Control Policy and Practice Guidance Notes (PGNs).</p> <p>Medicines Management Policy and PGNs.</p> <p>Safety Alerts Policy.</p>
SO5.3	That there are risks to the safety of service users and others if the key components to support good care co-ordination are not embedded	<p>Care Co-ordination and Care Programme Approach Policy and Practice Guidance Notes.</p>

	across the Trust.	Care Co-ordination training.
SO5.4	That there are risks to the safety of service users and others if the key components to support good Safeguarding and MAPPA arrangements are not embedded across the Trust.	Safeguarding Children and Safeguarding Adults Policies, Trust Action Plan.  Local Safeguarding Boards.  Trust-wide structure for Safeguarding in place.  Trust Safeguarding – Public Protection Meeting.
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.	Service Model Review.  Urgent Access Model.  Waiting Times Monitoring and Management.
SO5.10	That we do not ensure that we have effective governance arrangements in place to maintain safe services whilst implementing the Transforming Services Programme.	Governance Arrangements.  Programme Management arrangements.  Decision Making Framework.  Board Assurance Framework.
SO6.3	That we do not further develop integrated information systems across partner organisations.	Local partnerships to support integrated information across organisational boundaries.  Trust Information Sharing Policy. Information Protocols.
From Corporate Risk Register	Risk of injury or death of an inpatient from ligature use, including compliance with the Trust's Observation Policy.	Observation Policy and training arrangements.  SUI review process.  Anti-ligature programme.  Clinical Environmental Risk Assessment process and programme.

From Corporate Risk Register	That uncertainties during the transition to embedding new NHS structures and systems affect the ability of the Trust to progress its strategic objectives.	Contractual arrangements.  Customer Relationship Management. Engagement with Clinical Commissioning Groups.
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The governance structures supporting and underpinning this are the Quality and Performance Committee, Finance, Infrastructure and Business Development Committee, and Mental Health Legislation Committee. There is also a Trust Programmes Board, which provides the Board with assurance regarding the Trust's programmes, which deliver on the Trust's transformation and development agenda. These structures were reviewed by the Trust Board in May 2012. Committees' terms of reference were reviewed by the Board in April 2014.

Each of the above 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 every two months. 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.

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 sub-committee
3. Group Quality and Performance committees
4. Senior Management Team meetings

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



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 2013-14 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 Essential Standards Group. This Group reports into the Senior Management 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. During 2013-14 the Essential Standards Group has undertaken a programme of audits across all 16 outcomes under Care Quality Commission (CQC) Standards.

This formal governance framework is supplemented by an on-going programme of Board visits, which are reported through the Senior Management Team, and a rolling programme of observational shifts with wards and teams for Senior Management Team members.

The Foundation Trust is registered with the CQC and has maintained full registration, with no non-routine conditions, from 1<sup>st</sup> April 2010. During the year, the CQC undertook a number of registration visits. No compliance actions have been identified through these visits. The CQC has now inspected all 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 putting 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 receives an update on Trust Programmes at every Board meeting.

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 Trust Assurance framework and corporate risk register. The board has reviewed its governance structures and the Board and all Board sub-committees complete an annual self-

assessment. The Trust Board reviewed its Corporate Governance Statement at its April and May meetings, where it considered evidence of assurance against each of the 17 statements required. This evidence documented where the Board had considered appropriate information in its public and private meetings, where internal and external assurances had been gained, mapped across to the Assurance Framework, how the Board had received further evidence and assurance through Board visits and quarterly Confirm and Challenge sessions with the wider Trust management team, and how the board and governance structures monitored and assured compliance with the requirements as set out in the statement. The management of future risks was comprehensively mapped against the past evidence of delivery.

The Senior Management 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 Senior Management Team reviews the Foundation Trust 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 Senior Management 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 will undertake an external assessment of its governance arrangements through 2014-15.

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 of Partnerships Role 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 Report, 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.

The Foundation Trust also has effective arrangements in place for Information Governance with performance against the Information Governance Toolkit reported through the Caldicott and Health Information Group, Quality and Performance Committee and the Senior Management Team. Appropriate action is taken to address any cases of non-compliance. The Foundation Trust put in place a range of measures to manage risks to data security and has met the required standard of level 2 across all key standards in the Information Governance Toolkit.

## **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 has been reviewed and approved by the Board of Directors in

March 2013, updated in May 2013, and approved again as part of the annual plan in March 2014. The Financial Strategy has been considered by the Finance Infrastructure and Business Development Committee, the Senior Management Team and the Board of Directors. The financial strategy as adopted in March 2013 supported the Foundation Trust's Annual Plan and the updated Integrated Business Plan, which was formally approved by the Board in September 2012, and identifies clear plans for the longer term use of resources to meet the organisational objectives and the financial demands generated by the prevailing economic climate. The strategy included detailed plans for financial delivery 2012-13 as well as setting out the longer term requirements for use of financial resources, and required investments to support significant organisational change through the Trust's Transforming Services Programme. This strategy has been updated as part of the preparation for submission of the 2014-15 Annual 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 Senior Management 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 Board of Directors 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 reviewed through the Senior Management Team and the Board of Directors. 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 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*.

2013-14 is the 5th 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 2013-14 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 the table below.

<b>Goal</b>	<b>Description</b>
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

Our Quality Governance arrangements are set out in section 4 of the Annual Governance Statement. The Executive Director of Performance and 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 (Senior Management 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 improved across the Trust during 2013-14 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 Trust Board now reviews it's performance against Monitor's published Quality Governance Framework on an annual 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 drilldown. 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.

## **7 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 Board of Directors, 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 Trustwide 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 North East (v) Monitor's ongoing assessment of the Foundation Trust's performance, and (vi) on-going review of performance and quality by our commissioners.

Throughout the year the Audit Committee has operated as the key standing committee of the Board of Directors 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:

- Review of the Assurance Framework in place across the organisation and detailed review of the Foundation Trust's self-assessment against essential standards.
- Scrutiny of the corporate governance manual 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 Board of Directors itself has a comprehensive system of performance reporting, which includes analysis against the full range of performance and compliance standards, review of the Assurance Framework and Corporate Risk Register every two months, 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 on a quarterly basis an epidemiological review of suicides, presented by our Trust lead for Public Health.

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.

## **8 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.

A handwritten signature in black ink, appearing to read 'JD', with a long horizontal line extending to the right.

**James Duncan**  
**Acting Chief Executive**  
**28<sup>th</sup> May 2014**



## **13 ANNUAL ACCOUNTS**

### **Independent Auditor's report to the Council of Governors of Northumberland, Tyne and Wear NHS Foundation NHS Foundation Trust**

We have audited the financial statements of Northumberland, Tyne and Wear NHS Foundation Trust for the year ended 31 March 2014 under the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under applicable law and the accounting policies set out in the Statement of Accounting Policies.

We have also audited the information in the Remuneration Report that is described as having been audited.

This report is made solely to the Council of Governors of Northumberland, Tyne and Wear NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of 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.

#### **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.

## **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 2014 and of its income and expenditure for the year then ended;
- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

## **Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts**

In our opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- the information given in the Directors Report and Strategic Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

## **Matters on which we are required to report by exception**

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, 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 Annual Governance Statement or that risks are satisfactorily addressed by internal controls.

## **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 Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Cameron Waddell (CPFA) Engagement Lead, for and on behalf of Mazars LLP  
Chartered Accountants and Statutory Auditor  
Rivergreen Centre, Aykley Heads, Durham, DH1 5TS

28 May 2014

## **Foreword to the Accounts**

### **Northumberland, Tyne and Wear NHS Foundation Trust**

These accounts for the period ended 31 March 2014 have been prepared by the Northumberland, Tyne and 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.

A handwritten signature in black ink, consisting of a series of loops and a long horizontal stroke extending to the right.

**James Duncan**  
**Director of Finance and Acting Chief Executive**  
**28<sup>th</sup> May 2014**

**Statement of Comprehensive Income**

	Note	2013/14 £000	2012/13 £000
<b>Operating income from continuing operations</b>	<b>3</b>	<b>301,260</b>	316,442
<b>Operating expenses from continuing operations</b>	<b>4</b>	<b>(393,744)</b>	(304,991)
<b>Operating (deficit)/surplus</b>		<b>(92,484)</b>	11,451
<b>Finance costs</b>			
Finance income	11	94	355
Finance expense - financial liabilities	12	(5,401)	(4,758)
Finance expense - unwinding of discount on provisions		(97)	(108)
PDC dividends payable		(3,078)	(4,949)
<b>Net finance costs</b>		<b>(8,482)</b>	(9,460)
Share of (loss)/profit from associates and joint ventures		(38)	127
<b>(Deficit)/Surplus for the year</b>		<b>(101,004)</b>	2,118
<b>Other comprehensive income</b>			
Impairments		(9,488)	(3,324)
Revaluations		693	11,568
<b>Total comprehensive (expense)/income for the year</b>		<b>(109,799)</b>	10,362

**Statement of Financial Position**

	Note	31st March 2014 £000	31st March 2013 £000
<b>Non-current assets</b>			
Intangible assets	14	102	0
Property, plant and equipment	15	151,065	233,795
Investments in associates and joint ventures	16	10	229
Trade and other receivables	21	101	112
<b>Total non-current assets</b>		<b>151,278</b>	<b>234,136</b>
<b>Current assets</b>			
Inventories	20	396	423
Trade and other receivables	21	12,375	11,640
Non-current assets for sale and assets in disposal groups	17	14,098	14,422
Cash and cash equivalents	22	15,295	33,373
<b>Total current assets</b>		<b>42,164</b>	<b>59,858</b>
<b>Current liabilities</b>			
Trade and other payables	23	(20,890)	(24,252)
Borrowings	24	(5,507)	(3,822)
Provisions	28	(3,244)	(3,286)
Other liabilities	26	(490)	(1,009)
<b>Total current liabilities</b>		<b>(30,131)</b>	<b>(32,369)</b>
<b>Total assets less current liabilities</b>		<b>163,311</b>	<b>261,625</b>
<b>Non-current liabilities</b>			
Borrowings	24	(93,987)	(83,494)
Provisions	28	(5,057)	(4,248)
Other liabilities	26	(261)	(361)
<b>Total non-current liabilities</b>		<b>(99,305)</b>	<b>(88,103)</b>
<b>Total assets employed</b>		<b>64,006</b>	<b>173,522</b>
<b>Financed by</b>			
<b>Taxpayers' equity:</b>			
Public Dividend Capital		201,677	201,394
Revaluation reserve	30	12,344	22,009
Income and expenditure reserve		(150,015)	(49,881)
<b>Total taxpayers' equity</b>		<b>64,006</b>	<b>173,522</b>

The financial statements were approved by the Board on 28th May 2014 and signed on its behalf by:



James Duncan  
Director of Finance and Acting Chief Executive  
28th May 2014

**Statement of Changes in Taxpayers' Equity: 1st April 2013 to 31st March 2014**

	Total £000	Taxpayers' Equity		
		Public Dividend Capital £000	Revaluation Reserve £000	Income & Expenditure Reserve £000
<b>Others' and Taxpayers' equity at 1st April 2013</b>	<b>173,522</b>	201,394	22,009	(49,881)
Deficit for the year	(101,004)	0	0	(101,004)
Transfer between reserves	0	0	(489)	489
Impairments	(9,488)	0	(9,488)	0
Revaluations - property, plant and equipment	693	0	693	0
Transfer to retained earnings on disposal of assets	0	0	(381)	381
Public Dividend Capital received	283	283	0	0
<b>Others' and Taxpayers' equity at 31st March 2014</b>	<b>64,006</b>	<b>201,677</b>	<b>12,344</b>	<b>(150,015)</b>

**Statement of Changes in Taxpayers' Equity: 1st April 2012 to 31st March 2013**

	Total £000	Taxpayers' Equity		
		Public Dividend Capital £000	Revaluation Reserve £000	Income & Expenditure Reserve £000
<b>Others' and Taxpayers' equity at 1st April 2012</b>	<b>163,160</b>	201,394	16,005	(54,239)
Surplus for the year	2,118	0	0	2,118
Transfer between reserves	0	0	(1,414)	1,414
Impairments	(3,324)	0	(3,324)	0
Revaluations - property, plant and equipment	11,568	0	11,568	0
Asset disposals	0	0	(826)	826
<b>Others' and Taxpayers' equity at 31st March 2013</b>	<b>173,522</b>	<b>201,394</b>	<b>22,009</b>	<b>(49,881)</b>

<b>Statement of Cash Flows</b>			
	Note	2013/14 £000	2012/13 £000
<b>Cash flows from operating activities:</b>			
Operating (deficit)/surplus from continuing operations		(92,484)	11,451
<b>Operating (deficit)/surplus</b>		<b>(92,484)</b>	<b>11,451</b>
<b>Non-cash income and expense:</b>			
Depreciation and amortisation		7,565	7,387
Impairments		104,757	16,163
Reversals of impairments		(518)	(3,747)
Loss on disposal		0	59
Interest accrued and not paid		0	(47)
Dividends accrued and not paid or received		0	149
(Increase)/Decrease in trade and other receivables		(29)	4,163
Decrease in inventories		27	26
(Decrease) in trade and other payables		(784)	(3,899)
(Decrease) in other liabilities		(619)	(5,869)
Increase in provisions		670	567
Other movements in operating cash flows		(1,447)	128
<b>Net cash generated from operations</b>		<b>17,138</b>	<b>26,531</b>
<b>Cash flows from investing activities:</b>			
Interest received		93	354
Purchase of intangible assets		(102)	0
Purchase of Property, Plant and Equipment and Investment Property		(41,137)	(27,809)
Sales of Property, Plant and Equipment and Investment Property		2,446	2,089
<b>Net cash generated (used in) investing activities</b>		<b>(38,700)</b>	<b>(25,366)</b>
<b>Cash flows from financing activities:</b>			
Public dividend capital received		283	0
Loans received from the Independent Trust Financing Facility		16,000	24,000
Loans repaid to the Department of Health		(2,766)	(2,766)
Capital element of finance lease rental payments		(60)	(60)
Capital element of PFI, LIFT and other service concession payments		(977)	(921)
Interest paid		(1,000)	(651)
Interest element of finance lease		(46)	(48)
Interest element of PFI, LIFT and other service concession obligations		(4,178)	(4,059)
PDC Dividend paid		(3,772)	(5,098)
<b>Net cash generated financing activities</b>		<b>3,484</b>	<b>10,397</b>
<b>(Decrease)/Increase in cash and cash equivalents</b>		<b>(18,078)</b>	<b>11,562</b>
<b>Cash and cash equivalents at 1st April</b>		<b>33,373</b>	<b>21,811</b>
<b>Cash and cash equivalents at 31st March</b>	22	<b>15,295</b>	<b>33,373</b>



# **Northumberland, Tyne & Wear NHS Foundation Trust - Accounts for the Period 1st April 2013 to 31st March 2014**

## **Notes to the Accounts**

### **1. Accounting Policies and other Information**

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 HM Treasury. Consequently, the following financial statements have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FRoM) to the extent that they are meaningful and appropriate to NHS Foundation Trusts. 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.

#### **1.2 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 the Modern Equivalent Asset (MEA) revaluation as at the 31st March 2014. 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 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 2014.

### **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 £2,896,000 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 £1,133,000 and £183,000 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 the following 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 life

## **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.

### **(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 follow

- 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 2013, a review of the values of land and buildings was undertaken as at 31st March 2014.

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 an asset 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the construction of the asset is complete and is brought into use.

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. NHS Foundation Trusts adhere 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 2013-14, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the

lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss 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 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 fair value. Revaluations gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

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.

### **1.8 Government Grants**

Government grants are grants from Government bodies other than income from Clinical Commissioning Groups, NHS England 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 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 stocks.

### **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 Trusts 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) for 2013/14 only, net assets and liabilities transferred from bodies which ceased to exist on 1st April 2013, and (iv) 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 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 2014.

## **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 Accounting Standards that have been issued but have not yet been adopted**

The standards which have been released but which are not mandatory in the 2013/14 accounts are set out below:

- IFRS 10 Consolidated Financial Statements
- IFRS 11 Joint Arrangements
- IFRS 12 Disclosure of Interests in Other Entities
- IFRS 13 Fair Value Measurement
- IAS 27 Separate Financial Statements
- IAS 28 Associates and Joint Ventures
- IAS 32 Financial Instruments presentation - offsetting
- IAS 39 Financial Instruments - recognition and measurement
- IFRIC Interpretation 21 Levies

There are also proposed changes to IAS 17 Leases. The expected effective date is 2015/16.

With the exception of the proposed changes to IAS 17, 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**

There are no accounting standards that have been adopted early.

### **1.24 Investments in Associates and Joint Ventures**

#### ***Joint Ventures***

Joint ventures are separate entities over which the Trust has joint control with one or more other parties.

#### ***Associates***

Associate entities are those over which the Trust has the power to exercise a significant influence.

Associate entities are recognised in the Trust's financial statements using the equity method. The investment 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 associate.

The Trust has a 50% share in a limited liability partnership 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.

### **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.

The Trust benefits from charitable funds held by the Newcastle Healthcare Charity as Special Trustee. 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, so consolidation is not appropriate

<b>2. Segmental Analysis</b>		
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, £261,139,000, 87% of total income, was received from Clinical Commissioning Groups (CCGs) and NHS England (2012/13: 83%). As CCGs and NHS England are under common control they are classed as a single customer for this purpose.		
<b>3. Income</b>		
<b>3.1 Operating Income (by classification)</b>		
	<b>2013/14</b>	2012/13
	<b>£000</b>	£000
<b>Income from activities</b>		
Cost and volume contract income	36,655	44,529
Block contract income	239,465	232,174
Private patient income	157	148
Other clinical income	4,433	9,700
<b>Total income from activities</b>	<b>280,710</b>	286,551
<b>Other operating income</b>		
Research and development	2,282	3,392
Education and training	9,435	12,071
Non-patient care services to other bodies	1,638	2,608
Other*	3,875	4,708
Reversal of impairments of property, plant and equipment	518	3,747
Rental revenue from operating leases - minimum lease receipts	303	473
Income in respect of staff costs where accounted on gross basis	2,499	2,892
<b>Total other operating income</b>	<b>20,550</b>	29,891
<b>Total operating income</b>	<b>301,260</b>	316,442
<b>of which:</b>		
Related to Continuing Operations	301,260	316,442
Related to Discontinued Operations	0	0
<b>*Analysis of "Other operating income - Other"</b>		
Car Parking	52	54
Estates recharges	264	362
IT Recharges	27	50
Pharmacy Sales	1	1
Clinical Tests	58	32
Clinical excellence awards	510	615
Catering	953	991
Grossing up consortium arrangements	1,695	2,430
Other	315	173
<b>Total</b>	<b>3,875</b>	4,708

<b>3.2 Private Patient Income</b>			
		<b>2013/14</b>	2012/13
		<b>£000</b>	£000
	Private patient income	<b>157</b>	148
	Total patient related income	<b>280,710</b>	286,551
	<b>Proportion (as percentage)</b>	<b>0.06%</b>	0.05%
<p>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.</p>			
<b>3.3 Operating Lease Income</b>			
<p>The Trust leases land and buildings to a number of external bodies, mainly other NHS bodies.</p>			
		<b>2013/14</b>	2012/13
		<b>£000</b>	£000
<b>Operating lease income</b>			
	Rental revenue from operating leases - minimum lease receipts	<b>303</b>	473
	<b>Total operating lease income</b>	<b>303</b>	473
<b>Future minimum lease payments due:</b>			
<b>on leases of land expiring</b>			
	- not later than one year;	<b>1</b>	1
	- later than one year and not later than five years;	<b>4</b>	4
	- later than five years.	<b>88</b>	89
	<b>sub total</b>	<b>93</b>	94
<b>on leases of buildings expiring</b>			
	- not later than one year;	<b>259</b>	339
	- later than one year and not later than five years;	<b>57</b>	57
	- later than five years.	<b>172</b>	186
	<b>sub total</b>	<b>488</b>	582
	<b>Total future minimum lease payments due</b>	<b>581</b>	676

<b>3.4 Operating Income (by type)</b>			
		<b>2013/14</b>	2012/13
		<b>£000</b>	£000
<b>Income from activities</b>			
NHS Foundation Trusts		645	386
NHS Trusts		0	4
Strategic Health Authorities		0	7,697
CCGs and NHS England		261,139	0
Primary Care Trusts		0	261,539
Local Authorities		10,918	11,059
Non-NHS: private patients		157	148
NHS injury scheme (was RTA)		81	0
Non NHS: other		7,770	5,718
<b>Total income from activities</b>		<b>280,710</b>	<b>286,551</b>
<b>Other operating income</b>			
Research and development		2,282	3,392
Education and training		9,435	12,071
Non-patient care services to other bodies		1,638	2,608
Other*		3,875	4,708
Reversal of impairments of property, plant and equipment		518	3,747
Rental revenue from operating leases - minimum lease receipts		303	473
Income in respect of staff costs where accounted on gross basis		2,499	2,892
<b>Total Other Operating Income</b>		<b>20,550</b>	<b>29,891</b>
<b>Total Operating Income</b>		<b>301,260</b>	<b>316,442</b>
<b>*Analysis of "Other operating income - Other"</b>			
Car Parking		52	54
Estates recharges		264	362
IT Recharges		27	50
Pharmacy Sales		1	1
Clinical Tests		58	32
Clinical excellence awards		510	615
Catering		953	991
Grossing up consortium arrangements		1,695	2,430
Other		315	173
<b>Total</b>		<b>3,875</b>	<b>4,708</b>
<b>3.5 Analysis of Income from activities arising from Commissioner Requested Services and all other Services</b>			
		<b>2013/14</b>	2012/13
		<b>£000</b>	£000
Commissioner Requested Services		276,277	276,851
Non-Commissioner Requested Services		4,433	9,700
<b>Total income from activities</b>		<b>280,710</b>	<b>286,551</b>
Up to the 2012/13 accounts, Foundation Trusts were required to include an analysis of income between mandatory and non-mandatory services, under the terms of their authorisation. In the 2013/14 annual accounts, this has been replaced with an analysis of income arising from Commissioner Requested Services. Income received from commissioners for these services is disclosed in note 3.4 above.			

<b>4. Operating Expenses</b>			
			Restated
	2013/14		2012/13
	£000		£000
Services from NHS Foundation Trusts	683		645
Services from NHS Trusts	2		0
Purchase of healthcare from non NHS bodies	2,547		1,466
Employee Expenses - Executive directors	1,302		1,078
Employee Expenses - Non-executive directors	103		105
Employee Expenses - Staff	229,243		229,592
Supplies and services - clinical (excluding drug costs)	3,410		3,760
Supplies and services - general	4,512		4,888
Establishment	2,819		3,776
Research and development - (not included in employee expenses)	369		1,345
Research and development - (included in employee expenses)	1,817		1,632
Transport (Business travel only)	2,622		2,673
Transport (other)	1,772		2,003
Premises	12,893		13,068
Increase/(decrease) in provision for impairment of receivables	469		(137)
Change in provisions discount rate(s)	264		0
Inventories written down (net, including inventory drugs)	32		26
Drug costs (non-inventory drugs only)	1,408		1,281
Drug inventories consumed	3,268		3,397
Rentals under operating leases - minimum lease receipts	5,464		4,638
Rentals under operating leases - contingent rent	89		69
Rentals under operating leases - sublease payments	(13)		(13)
Depreciation on property, plant and equipment	7,565		7,387
Impairments of property, plant and equipment	104,757		16,087
Impairments of assets held for sale	0		76
Audit services- Statutory audit	48		54
Clinical negligence	317		490
Loss on disposal of land & buildings	0		59
Legal fees	1,140		714
Consultancy costs	568		838
Training, courses and conferences	1,234		1,163
Patient travel	358		388
Redundancy - (Not included in employee expenses)	134		418
Early Retirements - (Not included in employee expenses)	62		399
Hospitality	70		10
Insurance	995		654
Losses, ex gratia & special payments - (Not included in employee expenses)	84		44
Other	1,337		918
<b>Total</b>	<b>393,744</b>		<b>304,991</b>
<b>of which:</b>			
Related to Continuing Operations	393,744		304,991
Related to Discontinued Operations	0		0
The prior year comparator has been restated due to staff travel and subsistence being reclassified as transport (business travel).			
<b>5. Senior Managers Remuneration</b>			
	2013/14		2012/13
	£000		£000
<b>Total of key management personnel compensation:</b>			
Short-term employee benefits	1,137		975
Post-employment benefits	89		72
<b>Total key management compensation</b>	<b>1,226</b>		<b>1,047</b>
Payments in lieu of pension were made of £23,000 and £14,000 to 2 directors who have opted out of the NHS Pension scheme (2012/13: £21,000 to 2 directors).			
Key management personnel includes the executive and non-executive directors, which together comprised 15 directors in the financial year 2013/14. There is 1 non-executive and 1 executive director in post for part-year periods and 1 executive director included to cover a period of sickness absence. Short-term employee benefits include pay arrears for 5 of the executive directors and 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 2013/14								
	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
<b>Exit package cost band:</b>								
< £10,000	0	0	1	8	1	8	0	0
£10,001 to £25,000	0	0	3	50	3	50	0	0
£25,001 to £50,000	0	0	2	73	2	73	0	0
£50,001 to £100,000	0	0	0	0	0	0	1	95
£100,001 to £150,000	0	0	0	0	0	0	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
<b>Total</b>	<b>0</b>	<b>0</b>	<b>6</b>	<b>131</b>	<b>6</b>	<b>131</b>	<b>1</b>	<b>95</b>
Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change terms and conditions.								
The termination benefits included in exit packages relate to redundancy and early retirements and the special payment relates to a compromise agreement.								
6.2 Exit Packages 2012/13								
	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
<b>Exit package cost band:</b>								
< £10,000	0	0	3	9	3	9	0	0
£10,001 to £25,000	1	12	1	12	2	24	0	0
£25,001 to £50,000	0	0	2	82	2	82	0	0
£50,001 to £100,000	0	0	1	57	1	57	1	52
£100,001 to £150,000	0	0	2	279	2	279	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
<b>Total</b>	<b>1</b>	<b>12</b>	<b>9</b>	<b>439</b>	<b>10</b>	<b>451</b>	<b>1</b>	<b>52</b>
Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change terms and conditions.								
The termination benefits included in exit packages relate to redundancy and early retirements and the special payment relates to a compromise agreement.								



<b>7. Employee Expenses</b>						
<b>7.1 Employee Expenses</b>						
	Total 2013/14 £000	Permanently Employed 2013/14 £000	Other 2013/14 £000	Restated Total 2012/13 £000	Restated Permanently Employed 2012/13 £000	Restated Other 2012/13 £000
Salaries and wages	185,247	183,713	1,534	185,718	184,138	1,580
Social security costs	13,898	13,898	0	14,220	14,220	0
Pension cost - defined contribution plans: Employers contributions to NHS Pensions	23,296	23,296	0	22,518	22,518	0
Pension cost - other contributions	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0
Agency/contract staff	10,445	0	10,445	10,272	0	10,272
<b>Total staff costs</b>	<b>232,886</b>	<b>220,907</b>	<b>11,979</b>	<b>232,728</b>	<b>220,876</b>	<b>11,852</b>
included within:						
<b>Costs capitalised as part of assets</b>	<b>524</b>	<b>524</b>	<b>0</b>	<b>426</b>	<b>426</b>	<b>0</b>
<b>Analysed into operating expenditure</b>						
Employee Expenses - Staff	229,243	217,349	11,894	229,592	217,759	11,833
Employee Expenses - Executive Directors	1,302	1,302	0	1,078	1,078	0
Research & Development	1,817	1,732	85	1,632	1,613	19
<b>Total employee benefits excluding capitalised costs</b>	<b>232,362</b>	<b>220,383</b>	<b>11,979</b>	<b>232,302</b>	<b>220,450</b>	<b>11,852</b>
The 2012/13 comparators have been restated due to changes in Monitor reporting requirements.						
<b>7.2 Average Number of Employees (whole time equivalent basis)</b>						
	Total 2013/14 Number	Permanently Employed 2013/14 Number	Other 2013/14 Number	Restated Total 2012/13 Number	Restated Permanently Employed 2012/13 Number	Restated Other 2012/13 Number
Medical and dental	333	310	23	338	300	38
Administration and estates	1,185	1,134	51	1,104	1,070	34
Healthcare assistants and other support staff	504	461	43	515	475	40
Nursing, midwifery and health visiting staff	3,440	3,319	121	3,540	3,475	65
Scientific, therapeutic and technical staff	661	651	10	625	610	15
Other	0	0	0	0	0	0
<b>Total average numbers</b>	<b>6,123</b>	<b>5,875</b>	<b>248</b>	<b>6,122</b>	<b>5,930</b>	<b>192</b>
of which:						
Number of employees (WTE) engaged on capital projects	12	12	0	9	9	0
The 2012/13 comparatives have been restated to recategorise staff included in other to administration and estates						
<b>7.3 Exit Packages: other (non-compulsory) departure payments</b>						
	Payments Agreed 2013/14 Number	Total Value of Agreements 2013/14 £000	Payments Agreed 2012/13 Number	Total Value of Agreements 2012/13 £000		
Voluntary redundancies including early retirement contractual costs	6	131	9	439		
<b>Total Exit packages</b>	<b>6</b>	<b>131</b>	<b>9</b>	<b>439</b>		

<b>7. Employee Expenses (continued)</b>						
<b>7.4 Employee Benefits</b>						
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 (2012/13: £nil).						
<b>7.5 Early Retirements due to Ill Health</b>						
During the year there were 11 early retirements (2012/13 : 7) from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £624,000 (2012/13 : £545,000). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.						

<b>8. Operating Miscellaneous</b>			
<b>8.1 Operating Leases</b>			
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).			
		<b>2013/14</b>	2012/13
		<b>£000</b>	£000
Minimum lease payments		<b>5,464</b>	4,638
Contingent rents		<b>89</b>	69
Less sublease payments received		<b>(13)</b>	(13)
<b>Total</b>		<b>5,540</b>	<b>4,694</b>
<b>Future minimum lease payments due:</b>			
- not later than one year;		<b>5,659</b>	2,133
- later than one year and not later than five years;		<b>5,429</b>	3,713
- later than five years.		<b>2,531</b>	4,597
<b>Total</b>		<b>13,619</b>	<b>10,443</b>
<b>Total of future minimum sublease lease payments to be received</b>		<b>(13)</b>	<b>(87)</b>
<b>8.2 Limitations on Auditors Liability</b>			
There is no specified limitation on the auditors liability for the year (2012/13 : £nil).			

<b>8. Operating Miscellaneous (continued)</b>									
<b>8.3 The Late Payment of Commercial Debts (Interest) Act 1998</b>									
	The Trust had no late payment of interest on commercial debts or compensation paid to cover debt recovery costs as at 31st March 2014 (31st March 2013 : £nil).								
<b>8.4 Audit Remuneration</b>									
	The Trust had no other audit remuneration as at 31st March 2014 (31st March 2013 : £nil).								
<b>9. Discontinued Operations</b>									
	The Trust had no discontinued operations as at 31st March 2014 (31st March 2013: £nil).								
<b>10. Corporation Tax</b>									
	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 2014 (31st March 2013: £nil).								

<b>11. Finance Income</b>				
			<b>2013/14</b>	2012/13
			<b>£000</b>	£000
	Interest on bank accounts		97	352
	Interest on loans and receivables		(3)	3
	<b>Total</b>		<b>94</b>	<b>355</b>
<b>12. Finance Costs</b>				
			<b>2013/14</b>	2012/13
			<b>£000</b>	£000
	<b>Interest expense:</b>			
	Loans from the Independent Trust Financing Facility		692	90
	Capital loans from the Department of Health		485	561
	Finance leases		46	48
	<b>Finance Costs on PFI and other service concession arrangements (excluding LIFT)</b>			
	Main finance costs		3,062	3,121
	Contingent finance costs		1,116	938
	<b>Total</b>		<b>5,401</b>	<b>4,758</b>

### **13. Impairment of Assets**

During the year, the Trust recognised impairments totalling £113,727,000 made up of net impairments totalling £104,239,000 (£104,757,000 impairments and £518,000 reversals) being charged to the Statement of Comprehensive Income and impairments totalling £9,488,000 being charged to the revaluation reserve utilising positive balance.

Of this total, an impairment charge of £4,753,000 was recognised relating to a newly built inpatient unit brought into operational use within the year.

The remaining impairments recognised during the year are as a result of a valuation carried out by the District Valuer to reflect current market conditions as at 31<sup>st</sup> March 2014. The Trust has reviewed the application of accounting policy for the measurement of Property, Plant and Equipment due to the commencement of the significant programme of transformation which will affect how the Trust delivers its services. Work has been undertaken to redesign the Trust's modern equivalent asset replacements to optimise the Trust's use of land and buildings in light of the Trust's transformation programme. This is based on the capacity required to deliver our current services as at 31<sup>st</sup> March 2014.

Within the valuation, £2,952,000 of the impairments relates to consumption of economic benefits for tenants improvements where the Trust is renting accommodation. The impairment relates to a reduced future economic benefit where the Trust has reduced the time the asset will be leased for.

<b>14 Intangible Assets</b>			
<b>14.1 Intangible Assets 2013/14</b>			
	<b>Total 2013/14 £000</b>	<b>Software Licences purchased 2013/14 £000</b>	<b>2012/13 £000</b>
<b>Valuation/gross cost at 1st April 2013</b>	<b>0</b>	<b>0</b>	<b>0</b>
Additions - purchased	102	102	0
<b>Valuation/gross cost at 31st March 2014</b>	<b>102</b>	<b>102</b>	<b>0</b>
<b>Amortisation at 1st April 2013</b>	<b>0</b>	<b>0</b>	<b>0</b>
Provided during the year	0	0	0
<b>Amortisation at 31st March 2014</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>14.2 Economic Life of Intangible Assets</b>			
	<b>Minimum Life Years</b>	<b>Maximum Life Years</b>	
Software licences purchased	5	5	

15. Property, Plant and Equipment									
15.1 Property, Plant and Equipment 2013/14									
	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
<b>Valuation/gross cost at 1st April 2013</b>	<b>243,252</b>	46,224	151,730	89	27,338	4,143	120	10,388	3,220
Additions - purchased	38,587	5	9,008	56	26,978	212	0	2,112	216
Impairments	(9,488)	(58)	(9,426)	(4)	0	0	0	0	0
Reclassifications	0	0	6,575	49	(6,820)	11	0	160	25
Revaluations	(108,751)	(20,916)	(87,735)	(100)	0	0	0	0	0
Transfers to/from assets held for sale & assets in disposal groups	(716)	(290)	(426)	0	0	0	0	0	0
Disposals	(3,309)	0	0	0	0	(609)	(24)	(2,470)	(206)
<b>Valuation/gross cost at 31st March 2014</b>	<b>159,575</b>	24,965	69,726	90	47,496	3,757	96	10,190	3,255
<b>Accumulated depreciation at 1st April 2013</b>	<b>9,457</b>	0	0	0	0	2,247	110	5,706	1,394
Provided during the year	7,565	0	5,196	7	0	424	3	1,609	326
Impairments	104,757	21,182	83,482	93	0	0	0	0	0
Reversal of impairments	(518)	(81)	(437)	0	0	0	0	0	0
Revaluations	(109,442)	(21,101)	(88,241)	(100)	0	0	0	0	0
Disposals	(3,309)	0	0	0	0	(609)	(24)	(2,470)	(206)
<b>Accumulated depreciation at 31st March 2014</b>	<b>8,510</b>	0	0	0	0	2,062	89	4,845	1,514
<b>Net book value by ownership:</b>									
Owned	131,055	24,965	49,750	90	47,465	1,692	7	5,345	1,741
Finance leased	624	0	624	0	0	0	0	0	0
On-Statement of Financial Position PFI contracts	19,041	0	19,010	0	31	0	0	0	0
Government granted	21	0	21	0	0	0	0	0	0
Donated	324	0	321	0	0	3	0	0	0
<b>Net book value by ownership total at 31st March 2014</b>	<b>151,065</b>	24,965	69,726	90	47,496	1,695	7	5,345	1,741
To ensure that asset values at 31st March 2014 reflect current market conditions a revaluation was carried out by the District Valuer using the Modern Equivalent Asset (MEA) method.									
Of the totals at 31 March 2014, £4,008,000 related to land, £5,551,000 related to buildings and £90,000 related to dwellings valued on an existing use basis.									
Of the totals at 31 March 2014, £25,112,000 related to land, £1,835,000 related to buildings valued on a market value basis. These relate to non-operational assets									

**15.2 Property, Plant and Equipment 2012/13**

	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
<b>Valuation/gross cost at 1st April 2012</b>	<b>237,059</b>	<b>46,847</b>	<b>160,570</b>	<b>90</b>	<b>14,355</b>	<b>3,931</b>	<b>132</b>	<b>8,134</b>	<b>3,000</b>
Additions - purchased	27,987	129	5,465	0	19,685	242	0	2,229	237
Additions - leased	72	0	72	0	0	0	0	0	0
Impairments	(3,324)	0	(3,324)	0	0	0	0	0	0
Reclassifications	0	968	5,701	0	(6,694)	0	0	25	0
Revaluations	(6,060)	10,479	(16,530)	(1)	(8)	0	0	0	0
Transfers to/from assets held for sale & assets in disposal group	(12,423)	(12,199)	(224)	0	0	0	0	0	0
Disposals	(59)	0	0	0	0	(30)	(12)	0	(17)
<b>Valuation/gross cost at 31st March 2013</b>	<b>243,252</b>	<b>46,224</b>	<b>151,730</b>	<b>89</b>	<b>27,338</b>	<b>4,143</b>	<b>120</b>	<b>10,388</b>	<b>3,220</b>
<b>Accumulated depreciation at 1st April 2012</b>	<b>7,407</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,891</b>	<b>115</b>	<b>4,304</b>	<b>1,097</b>
Provided during the year	7,387	0	5,287	1	0	382	7	1,402	308
Impairments	16,087	168	15,911	0	8	0	0	0	0
Reversal of impairments	(3,747)	(83)	(3,664)	0	0	0	0	0	0
Revaluations	(17,628)	(85)	(17,534)	(1)	(8)	0	0	0	0
Disposals	(49)	0	0	0	0	(26)	(12)	0	(11)
<b>Accumulated depreciation at 31st March 2013</b>	<b>9,457</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2,247</b>	<b>110</b>	<b>5,706</b>	<b>1,394</b>
<b>Net book value by ownership:</b>									
Owned	185,736	46,174	103,732	89	27,327	1,896	10	4,682	1,826
Finance leased	655	50	605	0	0	0	0	0	0
On-Statement of Financial Position PFI contracts	46,673	0	46,662	0	11	0	0	0	0
Government granted	34	0	34	0	0	0	0	0	0
Donated	697	0	697	0	0	0	0	0	0
<b>Net book value by ownership total at 31st March 2013</b>	<b>233,795</b>	<b>46,224</b>	<b>151,730</b>	<b>89</b>	<b>27,338</b>	<b>1,896</b>	<b>10</b>	<b>4,682</b>	<b>1,826</b>
To ensure that asset values at 31st March 2013 reflect current market conditions a revaluation was carried out by the District Valuer using the Modern Equivalent Asset (MEA) method.									
Of the totals at 31 March 2013, £5,412,000 related to land, £4,748,000 related to buildings and £90,000 related to dwellings valued on an existing use basis.									

**15. Property, Plant and Equipment (continued)**
**15.3 Economic Life of Property, Plant and Equipment**

	Minimum Life Years	Maximum Life Years
Land	21	Infinite
Buildings excluding dwellings	1	80
Dwellings	10	45
Assets under construction	0	0
Plant & machinery	0	13
Transport equipment	0	2
Information technology	0	5
Furniture & fittings	0	9

<b>16. Investments</b>		
<b>16.1 Investments</b>		
	<b>2013/14</b>	2012/13
	<b>Investments in associates and joint ventures</b>	Investments in associates and joint ventures
	<b>£000</b>	£000
<b>Carrying value at 1st April</b>	229	181
Share of profit	(38)	127
Other equity movements	(181)	(79)
<b>Carrying value at 31st March</b>	<b>10</b>	<b>229</b>
<p>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.</p>		
<b>16.2 Fair value of investments in associates and joint ventures</b>		
	<b>Profit</b>	<b>Interest Held</b>
	<b>£000</b>	<b>%</b>
<b>As at 31st March 2014</b>		
Insight Ltd (formerly MHCO) / NTW LLP	(38)	50%
<b>As at 31st March 2013</b>		
MHCO / NTW LLP	229	50%
<b>17. Non-current Assets for Sale and Assets in Disposal Groups</b>		
<b>17.1 Non-current Assets for Sale and Assets in Disposal Groups 2013/14</b>		
	<b>Total</b>	Property, Plant & Equipment
	<b>£000</b>	£000
<b>Net book value at 1st April 2013</b>	<b>14,422</b>	14,422
Plus assets classified as available for sale in the year	716	716
Less assets sold in year	(1,040)	(1,040)
Less Impairment of assets held for sale	0	0
<b>Net book value at 31st March 2014</b>	<b>14,098</b>	<b>14,098</b>
<p>At 1st April 2013 the Trust held 1 area of land including associated professional fees and marketing costs (£11,864,000) and 13 buildings with associated land (£2,558,000).</p>		
<p>During the year, 3 buildings and their associated land were reclassified as held for sale £716,000 and sales totalling £1,040,000 were made relating to 5 buildings and their associated land.</p>		





<b>20 Inventory</b>					
<b>20.1 Inventory 2013/14</b>					
	<b>Total</b>	<b>Drugs</b>	<b>Consumables</b>	<b>Energy</b>	<b>Other</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
<b>Carrying Value at 1st April 2013</b>	<b>423</b>	<b>307</b>	<b>11</b>	<b>19</b>	<b>86</b>
Additions	<b>3,910</b>	3,299	192	18	401
Inventories consumed (recognised in expenses)	<b>(3,889)</b>	(3,268)	(185)	(23)	(413)
Write down of inventories recognised as an expense	<b>(32)</b>	(22)	(6)	0	(4)
Other	<b>(16)</b>	(16)	0	0	0
<b>Carrying Value at 31st March 2014</b>	<b>396</b>	<b>300</b>	<b>12</b>	<b>14</b>	<b>70</b>
<b>20.2 Inventory 2012/13</b>					
	<b>Total</b>	<b>Drugs</b>	<b>Consumables</b>	<b>Energy</b>	<b>Other</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
<b>Carrying Value at 1st April 2012</b>	<b>449</b>	<b>326</b>	<b>10</b>	<b>22</b>	<b>91</b>
Additions	<b>4,001</b>	3,400	186	18	397
Inventories consumed (recognised in expenses)	<b>(4,001)</b>	(3,397)	(184)	(21)	(399)
Write down of inventories recognised as an expense	<b>(26)</b>	(22)	(1)	0	(3)
Other	<b>0</b>	0	0	0	0
<b>Carrying Value at 31st March 2013</b>	<b>423</b>	<b>307</b>	<b>11</b>	<b>19</b>	<b>86</b>

<b>21. Trade Receivables and Other Receivables</b>				
<b>21.1 Trade Receivables and Other Receivables</b>				
			<b>31st March</b>	Restated
			<b>2014</b>	31st March
			<b>£000</b>	2013
				£000
<b>Current</b>				
	NHS receivables - revenue		4,312	5,288
	Receivables due from NHS charities - Revenue		9	34
	Other receivables with related parties - revenue		1,199	1,046
	Provision for impaired receivables		(758)	(303)
	Deposits and advances		10	1
	Prepayments (non-PFI)		2,658	2,197
	Accrued income		386	(84)
	Interest receivable		2	1
	Operating lease receivables		1	0
	PDC dividend receivable		892	198
	VAT receivable		581	879
	Other receivables - Revenue		3,083	2,383
	<b>Total current trade and other receivables</b>		<b>12,375</b>	<b>11,640</b>
<b>Non-current</b>				
	Prepayments (non-PFI)		101	112
	<b>Total non-current trade and other receivables</b>		<b>101</b>	<b>112</b>
The 2012/13 comparatives have been restated for the reclassification of some receivables moving other receivables to prepayments				
<b>21.2 Provision for Impairment of Receivables</b>				
			<b>2013/14</b>	2012/13
			<b>£000</b>	£000
	<b>At 1st April</b>		<b>303</b>	545
	Increase in provision		692	242
	Amounts utilised		(14)	(105)
	Unused amounts reversed		(223)	(379)
	<b>At 31st March</b>		<b>758</b>	<b>303</b>
<b>21.3 Analysis of Impaired Receivables</b>				
		<b>Trade</b>	<b>Other</b>	
		<b>Receivables</b>	<b>Receivables</b>	
		<b>31st March</b>	<b>31st March</b>	
		<b>2014</b>	<b>2014</b>	
		<b>£000</b>	<b>£000</b>	
			<b>Trade</b>	<b>Other</b>
			<b>Receivables</b>	<b>Receivables</b>
			<b>31st March</b>	<b>31st March</b>
			<b>2013</b>	<b>2013</b>
			<b>£000</b>	<b>£000</b>
<b>Ageing of impaired receivables:</b>				
	0 to 30 days	155	15	113
	30 to 60 days	32	6	4
	60 to 90 days	0	11	8
	90 to 180 days	205	22	25
	over 180 days	260	52	103
	<b>Total</b>	<b>652</b>	<b>106</b>	<b>253</b>
<b>Ageing of non-impaired receivables past their due date:</b>				
	0 to 30 days	38	8	1,889
	30 to 60 days	103	5	190
	60 to 90 days	307	8	79
	90 to 180 days	457	15	436
	over 180 days	230	67	168
	<b>Total</b>	<b>1,135</b>	<b>103</b>	<b>2,762</b>
				164

<b>21. Trade Receivables and Other Receivables (continued)</b>		
<b>21.4 Finance Lease Receivables</b>		
The Trust had no finance lease receivables at 31st March 2014 (31st March 2013 : £nil).		
<b>22. Cash and Cash Equivalents</b>		
	<b>2013/14</b>	2012/13
	<b>Cash and cash equivalents</b>	Cash and cash equivalents
	<b>£000</b>	£000
<b>At 1st April</b>	<b>33,373</b>	21,811
Net change in year	<b>(18,078)</b>	11,562
<b>At 31st March</b>	<b>15,295</b>	<b>33,373</b>
Broken down into:		
Cash at commercial banks and in hand	<b>545</b>	241
Cash with the Government Banking Service (GBS)	<b>14,750</b>	33,132
Other current investments	<b>0</b>	0
<b>Cash and cash equivalents as per the Statement of Financial Position</b>	<b>15,295</b>	<b>33,373</b>
Bank Overdrafts - (GBS and commercial banks)	<b>0</b>	0
Drawdown in committed facility	<b>0</b>	0
<b>Cash and cash equivalents as per the Statement of Cash Flows</b>	<b>15,295</b>	<b>33,373</b>
The Trust held £1,994,000 cash and cash equivalents at 31st March 2014 (31st March 2013 : £2,509,000) which relates to monies held on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.		
<b>23. Trade and Other Payables</b>		
<b>23.1 Trade and Other Payables</b>		
	<b>31st March 2014</b>	31st March 2013
	<b>£000</b>	£000
<b>Current</b>		
NHS payables - revenue	<b>736</b>	2,014
Amounts due to other related parties - revenue	<b>108</b>	150
Other trade payables - capital	<b>1,958</b>	4,508
Other trade payables - revenue	<b>3,203</b>	2,912
Social Security costs	<b>2,161</b>	2,200
Other taxes payable	<b>2,236</b>	2,167
Other payables	<b>5,307</b>	5,080
Accruals	<b>5,181</b>	5,221
<b>Total current trade and other payables</b>	<b>20,890</b>	<b>24,252</b>
The Trust had no non-current trade and other payables at 31st March 2014 (31st March 2013 : £nil).		
<b>23.2 Early Retirements included in NHS Payables above</b>		
The Trust has no liabilities for early retirements payable over 5 years (31st March 2013 : £nil).		



<b>26. Other Liabilities</b>					
			<b>31st March 2014 £000</b>	<b>31st March 2013 £000</b>	
<b>Current</b>					
	Other Deferred income		<b>490</b>	1,009	
	<b>Total current other liabilities</b>		<b>490</b>	<b>1,009</b>	
<b>Non-current</b>					
	Other Deferred income		<b>261</b>	361	
	<b>Total non-current other liabilities</b>		<b>261</b>	<b>361</b>	
<b>27. Other Financial Liabilities</b>					
The Trust had no other financial liabilities at 31st March 2014 (31st March 2013 : £nil).					
<b>28. Provisions for Liabilities and Charges</b>					
<b>28.1 Provisions for Liabilities and Charges</b>					
		<b>Current</b>		<b>Non-current</b>	
		<b>31st March 2014 £000</b>	<b>31st March 2013 £000</b>	<b>31st March 2014 £000</b>	<b>31st March 2013 £000</b>
	Pensions relating to former directors	<b>61</b>	93	<b>331</b>	425
	Pensions relating to other staff	<b>96</b>	97	<b>971</b>	989
	Other legal claims	<b>268</b>	159	<b>0</b>	0
	Agenda for Change	<b>0</b>	239	<b>0</b>	0
	Equal pay	<b>1,563</b>	1,606	<b>0</b>	0
	Redundancy	<b>282</b>	396	<b>0</b>	0
	Other	<b>974</b>	696	<b>3,755</b>	2,834
	<b>Total</b>	<b>3,244</b>	3,286	<b>5,057</b>	4,248

**28. Provisions for Liabilities and Charges (continued)**

**28.2 Provisions for Liabilities and Charges Analysis**

	Total	Pensions: former directors	Pensions: other staff	Other Legal Claims	Agenda for Change	Equal Pay	Redundancy	Other
	£000	£000	£000	£000	£000	£000	£000	£000
<b>At 1st April 2013</b>	<b>7,534</b>	518	1,086	159	239	1,606	396	3,530
Change in the discount rate	264	20	39	0	0	0	0	205
Arising during the year	1,909	0	60	255	0	0	3	1,591
Utilised during the year - accruals	(117)	(24)	(24)	0	0	0	0	(69)
Utilised during the year - cash	(975)	(73)	(73)	(70)	0	(43)	(117)	(599)
Reversed unused	(411)	(56)	(40)	(76)	(239)	0	0	0
Unwinding of discount	97	7	19	0	0	0	0	71
<b>At 31st March 2014</b>	<b>8,301</b>	392	1,067	268	0	1,563	282	4,729
<b>Expected timing of cashflows:</b>								
- not later than one year;	3,244	61	96	268	0	1,563	282	974
- later than one year and not later than five years;	1,171	73	367	0	0	0	0	731
- later than five years.	3,886	258	604	0	0	0	0	3,024
<b>Total</b>	<b>8,301</b>	392	1,067	268	0	1,563	282	4,729

The total value of clinical negligence provisions carried by the NHS Litigation Authority on behalf of the Trust is £1,637,000 at 31st March 2014 (31st March 2013 : £1,784,000) 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 58 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 18 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 1.80% (previously 2.35%).

<b>29. Contingencies</b>					
			<b>31st March 2014 £000</b>	31st March 2013 £000	
<b>Value of contingent liabilities:</b>					
Other			<b>(749)</b>	(958)	
<b>Gross value of contingent liabilities</b>			<b>(749)</b>	(958)	
<b>Net value of contingent liabilities</b>			<b>(749)</b>	(958)	
<b>Net value of contingent assets</b>			<b>0</b>	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.					
<b>30. Revaluation Reserve</b>					
<b>30.1 Revaluation Reserve 2013/14</b>					
			<b>Total £000</b>	Property, Plant & Equipment £000	Assets Held for Sale £000
<b>Revaluation reserve at 1st April 2013</b>			<b>22,009</b>	11,357	10,652
Impairments			<b>(9,488)</b>	(9,488)	0
Revaluations			<b>693</b>	691	2
Transfers to other reserves			<b>(489)</b>	(489)	0
Asset disposals			<b>(381)</b>	(31)	(350)
Other reserve movements			<b>0</b>	(374)	374
<b>Revaluation reserve at 31st March 2014</b>			<b>12,344</b>	1,666	10,678
<b>30.2 Revaluation Reserve 2012/13</b>					
			<b>Total £000</b>	Property, Plant & Equipment £000	Assets Held for Sale £000
<b>Revaluation reserve at 1st April 2012</b>			<b>16,005</b>	15,098	907
Impairments			<b>(3,324)</b>	(3,324)	0
Revaluations			<b>11,568</b>	11,568	0
Transfers to other reserves			<b>(1,414)</b>	(1,414)	0
Asset disposals			<b>(826)</b>	(22)	(804)
Other reserve movements			<b>0</b>	(10,549)	10,549
<b>Revaluation reserve at 31st March 2013</b>			<b>22,009</b>	11,357	10,652



<b>31. Related Parties</b>				
<b>31.1 Related Party Transactions 2013/14</b>				
			<b>Income</b>	<b>Expenditure</b>
			<b>£000</b>	<b>£000</b>
<b>Transactions with board members:</b>				
	James Duncan, Executive Director of Finance & Deputy Chief Executive			
	- brother in law is a partner at Bond Dickinson (formerly Dickinson Dees). The Trust processed purchase invoices for legal fees.			56
	- Vice Chair of the HFMA Mental Health Faculty			3
	Chris Watson, Non-Executive Director			
	- Head of Asset Planning at Northumbrian Water. The Trust processed purchase invoices for water rates.			384
	Dr Gillian Fairfield, Chief Executive			
	- Non-Executive Board Director of the National Youth Justice Board for England and The Trust processed invoices for Dr Fairfield's remuneration as a non-executive director which was paid to the Trust		3	
<b>Value of transactions with board members</b>			<b>3</b>	<b>443</b>
<b>Value of transactions with key staff members</b>			<b>0</b>	<b>0</b>
<b>Value of transactions with other related parties:</b>				
	Department of Health		1,545	1,916
	Other NHS bodies		276,182	8,116
	Charitable Funds		0	0
	Subsidiaries / Associates / Joint Ventures		505	0
	Other		19,594	39,268
	NHS Shared Business Services		0	0
<b>Total value of transactions with related parties in 2013/14</b>			<b>297,829</b>	<b>49,743</b>

31.2 Related Party Transactions 2012/13			
		Income £000	Restated Expenditure £000
<b>Transactions with board members:</b>			
James Duncan, Executive Director of Finance & Deputy Chief Executive			
- brother in law is a partner at Dickinson Dees. The Trust processed purchase invoices for legal fees.			80
- Vice Chair of the HFMA Mental Health Faculty			2
Chris Watson, Non-Executive Director			
- Head of Asset Planning at Northumbrian Water. The Trust processed purchase invoices for water rates.			415
Dr Gillian Fairfield, Chief Executive			
- Non-Executive Board Director of the National Youth Justice Board for England and Wales.		3	
The Trust processed invoices for Dr Fairfield's remuneration as a non-executive director which was paid to the Trust			
Fiona Standfield, Acting Chair			
- Associate Tutor in the Faculty of Business Law at Sunderland University		6	3
The Trust processed invoices for lecture fees and staff secondment arrangements and paid invoices in relation to course fees			
<b>Value of transactions with board members</b>		<b>9</b>	<b>500</b>
<b>Value of transactions with key staff members</b>		<b>0</b>	<b>0</b>
<b>Value of transactions with other related parties:</b>			
Department of Health		2,261	93
Other NHS bodies		289,421	8,938
Charitable Funds		0	0
Subsidiaries / Associates / Joint Ventures		304	0
Other		17,489	38,278
NHS Shared Business Services		0	3,006
<b>Total value of transactions with related parties in 2012/13</b>		<b>309,484</b>	<b>50,815</b>
The 2012/13 Other Expenditure has been restated in line with adjustments to agreement of balances with Central Government Bodies.			

31. Related Parties (continued)				
31.3 Related Party Balances at 31st March 2014				
			Receivables £000	Payables £000
<b>Balances (other than salary) with board members:</b>				
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.				20
James Duncan, Executive Director of Finance & Deputy Chief Executive				
- brother in law is a partner at Bond Dickinson (formerly Dickinson Dees). The Trust held purchase invoices and accrued for invoices payable in respect of legal fees.				3
Dr Gillian Fairfield, Chief Executive				
- Non-Executive Board Director of the National Youth Justice Board for England and The Trust has 1 invoice due in respect of Dr Fairfield's remuneration and travelling			3	
<b>Value of balances (other than salary) with board members</b>			<b>3</b>	<b>23</b>
<b>Value of balances (other than salary) with key staff members</b>			<b>0</b>	<b>0</b>
<b>Value of balances (other than salary) with related parties in relation to doubtful debts</b>			<b>0</b>	<b>0</b>
<b>Value of balances (other than salary) with related parties in respect of doubtful debts written off in year</b>			<b>0</b>	<b>0</b>
<b>Value of balances with other related parties:</b>				
Department of Health			1,178	15
Other NHS bodies			4,088	2,678
Charitable Funds			9	0
Subsidiaries / Associates / Joint Ventures			0	0
Other			1,860	8,141
NHS Shared Business Services			0	0
<b>Total balances with related parties at 31st March 2014</b>			<b>7,138</b>	<b>10,857</b>
31.4 Related Party Balances at 31st March 2013				
			Receivables £000	Payables £000
<b>Balances (other than salary) with board members:</b>				
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.				38
James Duncan, Executive Director of Finance & Deputy Chief Executive				
- brother in law is a partner at Dickinson Dees. The Trust held purchase invoices and accrued for invoices payable in respect of legal fees.				6
Dr Gillian Fairfield, Chief Executive				
- Non-Executive Board Director of the National Youth Justice Board for England and Wales. The Trust has 1 invoice due in respect of Dr Fairfield's remuneration and travelling expenses			3	
<b>Value of balances (other than salary) with board members</b>			<b>3</b>	<b>44</b>
<b>Value of balances (other than salary) with key staff members</b>			<b>0</b>	<b>0</b>
<b>Value of balances (other than salary) with related parties in relation to doubtful debts</b>			<b>0</b>	<b>0</b>
<b>Value of balances (other than salary) with related parties in respect of doubtful debts written off in year</b>			<b>0</b>	<b>0</b>
<b>Value of balances with other related parties:</b>				
Department of Health			312	161
Other NHS bodies			5,075	3,402
Charitable Funds			32	0
Subsidiaries / Associates / Joint Ventures			23	0
Other			1,925	7,289
NHS Shared Business Services			72	160
<b>Total balances with related parties at 31st March 2013</b>			<b>7,442</b>	<b>11,056</b>

<b>31. Related Parties (continued)</b>				
<b>31.5 Related Party Balances at 31st March 2014</b>				
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:				
	<b>Income</b>	<b>Expenditure</b>	<b>Receivables</b>	<b>Payables</b>
	<b>2013/14</b>	<b>2013/14</b>	<b>31st March</b>	<b>31st March</b>
	<b>£000</b>	<b>£000</b>	<b>2014</b>	<b>2014</b>
			<b>£000</b>	<b>£000</b>
<b>NHS Foundation Trusts:</b>				
Gateshead Health NHS Foundation Trust	-	1,033	-	1,326
Newcastle upon Tyne Hospitals NHS Foundation Trust	1,404	2,425	-	-
Northumbria Healthcare NHS Foundation Trust	-	1,231	-	-
South Tyneside NHS Foundation Trust	-	1,041	-	-
<b>NHS CCGs, NHS England, Department of Health and Other Special Health Bodies:</b>				
NHS Cumbria CCG	1,028	-	-	-
NHS Durham Dales, Easington and Sedgefield CCG	2,290	-	-	-
NHS Gateshead CCG	19,126	-	-	-
NHS Newcastle Noth and East CCG	20,155	-	-	-
NHS Newcastle West CCG	22,108	-	-	-
NHS North Durham CCG	1,351	-	-	-
NHS North Tyneside CCG	19,395	-	-	-
NHS Northumberland CCG	48,471	-	-	-
NHS South Tyneside CCG	21,243	-	-	-
NHS Sunderland CCG	51,911	-	-	-
NHS England	53,642	-	1,006	-
Health Education England	9,284	-	-	-
Department of Health	1,545	1,916	1,178	-
<b>Local Government bodies:</b>				
Newcastle upon Tyne City Council	3,020	1,009	-	-
North Tyneside Metropolitan Borough Council	1,632	-	-	-
Northumberland Unitary Authority	6,368	-	-	-
<b>Central Government bodies:</b>				
HM Revenue & Customs - Other taxes and duties	-	-	-	2,373
National Insurance Fund (E'ers & E'ees contributions)	-	13,898	-	2,161
NHS Pension Scheme (Own staff E'ers and E'ees contributions)	-	23,296	-	3,048
Scottish Government	6,639	-	-	-
In addition, the Trust has had material transactions (under £1,000,000) with other related parties including: 2Gether NHS Foundation Trust, City Hospitals Sunderland NHS Foundation Trust, North East Ambulance Service NHS Foundation Trust, Tees Esk and Wear Valley Foundation Trust, NHS Darlington CCG, NHS Hartlepool and Stockton-on-Tees CCG, NHS South Tees CCG, NHS Litigation Authority, Gateshead Council, Sunderland City Metropolitan Borough Council and Belfast Health and Social Care Trust - Northern Ireland				
The Trust has also had transactions with an associate, Insight Ltd in relation to the Trust's investment in a joint venture.				
The Trust has also received payments from a number of charitable funds administered by the Newcastle Healthcare Charity. Some of the trustees for the Northumberland, Tyne & Wear charitable funds are also members of the Trust Board.				
<b>32. Commitments</b>				
<b>32.1 Contractual Capital Commitments</b>				
			<b>2013/14</b>	2012/13
			<b>£000</b>	<b>£000</b>
<b>Commitments in respect of capital expenditure at 31st March:</b>				
Property, plant and equipment			<b>3,189</b>	30,548
<b>Total</b>			<b>3,189</b>	<b>30,548</b>

<b>32. Commitments (continued)</b>				
<b>32.2 Other Financial Commitments</b>				
			<b>31st March 2014</b>	31st March 2013
			<b>£000</b>	£000
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 2014 as follows, analysed by the period during which the payment is made:				
	not later than 1 year		<b>5,560</b>	2,371
	after 1 year and not later than 5 years		<b>3,287</b>	8,637
	paid thereafter		<b>18</b>	123
	<b>Total</b>		<b>8,865</b>	11,131
<b>33. Finance Lease Obligations</b>				
			<b>31st March 2014</b>	31st March 2013
			<b>£000</b>	£000
	<b>Gross lease liabilities</b>		<b>1,733</b>	1,839
	<b>of which liabilities are due</b>			
	- not later than one year;		<b>104</b>	106
	- later than one year and not later than five years;		<b>394</b>	403
	- later than five years.		<b>1,235</b>	1,330
	Finance charges allocated to future periods		<b>(480)</b>	(526)
	<b>Net lease liabilities</b>		<b>1,253</b>	1,313
	- not later than one year;		<b>60</b>	60
	- later than one year and not later than five years;		<b>240</b>	240
	- later than five years.		<b>953</b>	1,013

<b>34. Private Finance Initiative (PFI) Obligations deemed to be on the Statement of Financial Position</b>	
The Trust has two PFI schemes deemed to be on-Statement of Financial Position.	
<b>St Georges Park</b> (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: 20 years	
<b>Walkergate Park</b> (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: 23 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 affect 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.	

<b>34. Private Finance Initiative (PFI) Obligations deemed to be on the Statement of Financial Position (continued)</b>				
<b>34.1 Total Obligations for PFI contracts on the Statement of Financial Position</b>				
			<b>31st March 2014 £000</b>	31st March 2013 £000
<b>Gross PFI liabilities</b>			<b>84,439</b>	88,498
<b>of which liabilities are due</b>				
	- not later than one year;		3,973	4,059
	- later than one year and not later than five years;		15,198	15,506
	- later than five years.		65,268	68,933
	Finance charges allocated to future periods		(41,417)	(44,480)
<b>Net PFI liabilities</b>			<b>43,022</b>	44,018
	- not later than one year;		977	997
	- later than one year and not later than five years;		3,939	3,980
	- later than five years.		38,106	39,041
<b>34.2 On-Statement of Financial Position PFI Commitments</b>				
			<b>Total 31st March 2014 £000</b>	Total 31st March 2013 £000
Commitments in respect of the service element of the PFI:				
	not later than one year		2,336	2,171
	later than one year and not later than five years		10,948	10,125
	later than five years		51,375	53,818
<b>Total</b>			<b>64,659</b>	66,114
The commitments disclosed include future estimated indexation applied to service charges.				
<b>35. Events after the Reporting Period</b>				
There are no events after the reporting period to disclose which have not already been included in the accounts as adjusting events.				
<b>36. Financial Instruments</b>				
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 Clinical 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.				

<b>36. Financial Instruments (continued)</b>		
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.		
<i>Currency Risk</i>		
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.		
<i>Credit Risk</i>		
The Trust can borrow within the limits set by Monitor's Prudential Borrowing Code, and 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.		
<i>Liquidity Risk</i>		
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 £55,219,000 which is within its available borrowing limit. The Trust is not, therefore, exposed to		
<i>Market Risk</i>		
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.		
<b>36.1 Financial Assets by Category</b>		
	<b>Total</b>	Loans & Receivables
	<b>£000</b>	£000
<b>Assets as per the Statement of Financial Position at 31st March 2014:</b>		
Trade and other receivables excluding non financial assets (at 31 March 2014)	3,123	3,123
Cash and cash equivalents at bank and in hand	15,295	15,295
<b>Total at 31st March 2014</b>	<b>18,418</b>	<b>18,418</b>
<b>Assets as per the Statement of Financial Position at 31st March 2013:</b>		
NHS trade and other receivables excluding non-financial assets	3,009	3,009
Cash and cash equivalents at bank and in hand	33,373	33,373
<b>Total at 31st March 2013</b>	<b>36,382</b>	<b>36,382</b>
<b>36.2 Financial Liabilities by Category</b>		
	<b>Total</b>	Other Financial Liabilities
	<b>£000</b>	£000
<b>Liabilities as per the Statement of Financial Position at 31st March 2014:</b>		
Borrowings excluding finance lease and PFI liabilities	55,219	55,219
Obligations under finance leases	1,253	1,253
Obligations under Private Finance Initiative contracts	43,022	43,022
NHS trade and other payables excluding non-financial assets	270	270
<b>Total at 31st March 2014</b>	<b>99,764</b>	<b>99,764</b>
<b>Liabilities as per the Statement of Financial Position at 31st March 2013:</b>		
Borrowings excluding finance lease and PFI liabilities	41,985	41,985
Obligations under finance leases	1,313	1,313
Obligations under Private Finance Initiative contracts	44,018	44,018
NHS trade and other payables excluding non-financial assets	32	32
<b>Total at 31st March 2013</b>	<b>87,348</b>	<b>87,348</b>
<b>36.3 Maturity of Financial Liabilities</b>		
	<b>31st March 2014</b>	31st March 2013
	<b>£000</b>	£000
In one year or less	5,777	3,835
In more than one year but not more than two years	6,035	5,353
In more than two years but not more than five years	16,044	13,979
In more than five years	71,908	64,181
<b>Total at 31st March</b>	<b>99,764</b>	<b>87,348</b>



36. Financial Instruments (continued)		
36.4 Fair Values of Financial Assets at 31st March 2014		
	Book Value £000	Fair Value £000
Non-current trade and other receivables excluding non-financial assets	0	0
<b>Total</b>	<b>0</b>	<b>0</b>
36.5 Fair Values of Financial Liabilities at 31st March 2014		
	Book Value £000	Fair Value £000
Loans	55,219	55,219
<b>Total</b>	<b>55,219</b>	<b>55,219</b>

## 37. Pension

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://www.nhsbsa.nhs.uk/pensions). The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the 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 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 2014 is based on valuation data as 31 March 2013, updated to 31 March 2014 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, published annually. These accounts can be viewed on the NHS Pensions website. 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 scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

### **(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.

<b>38. Losses and Special Payments (continued)</b>					
<b>38.1 Losses</b>					
		<b>Total number of cases 2013/14</b>	<b>Total value of cases 2013/14</b>	<b>Total number of cases 2012/13</b>	<b>Total value of cases 2012/13</b>
		<b>Number</b>	<b>£000</b>	<b>Number</b>	<b>£000</b>
Losses of cash due to:					
- theft, fraud etc		7	0	6	0
- overpayment of salaries		22	8	26	13
Fruitless payments and constructive losses		34	8	26	8
Bad debts and claims abandoned		17	15	34	94
Stores losses		3	32	3	27
<b>Total losses</b>		<b>83</b>	<b>63</b>	<b>95</b>	<b>142</b>
<b>Special Payments</b>					
		<b>Total number of cases 2013/14</b>	<b>Total value of cases 2013/14</b>	<b>Total number of cases 2012/13</b>	<b>Total value of cases 2012/13</b>
		<b>Number</b>	<b>£000</b>	<b>Number</b>	<b>£000</b>
Ex gratia payments in respect of:					
- loss of personal effects		54	29	57	11
- personal injury with advice		16	58	20	120
<b>Total Special Payments</b>		<b>70</b>	<b>87</b>	<b>77</b>	<b>131</b>
<b>Total Losses and Special Payments</b>		<b>153</b>	<b>150</b>	<b>172</b>	<b>273</b>
These amounts are reported on an accruals basis but exclude provisions for future losses.					



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