ANNUAL REPORT & ACCOUNTS

2013/14

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

• To put patients at the centre of all we do and to provide care of the highest standard in terms of both safety and quality
• To maintain financial viability / stability and achieve required CIP targets whilst also striving for growth to enable the continuing development and success of the organisation
• In partnership with Newcastle University’s Faculty of Medical Sciences, and relevant others, to be nationally and internationally respected as a leader of high quality research and development programmes, which underpin quality
• To continue to work in partnership with Newcastle City Council and other agencies to drive both the delivery of integrated care and the promotion of healthy lifestyles for the people of Newcastle
• To continue to be recognised as a first class teaching hospital, counted amongst the top 10 in the country, which promotes a culture of excellence in all that we do.

Values

• To place our patients at the heart of everything we do
• To value and enhance the contribution of staff, volunteers, members, Governors and other partners and stakeholders
• Zero tolerance of unsatisfactory behaviours
• Consistently high personal and professional standards in all activities
• To focus upon continuous improvement in the pursuit of excellence
• To have pride in public service and all that we do
• To continually seek best value for money.

Our Vision

To be “the health service for Newcastle” and a leading national healthcare provider

The Newcastle upon Tyne Hospitals NHS Foundation Trust was formed under the provisions of the Health and Social Care (Community Care and Standards) Act 2003 (consolidated in the National Health Service Act 2006) and received its Terms of Authorisation from Monitor, the independent regulator of NHS Foundation Trusts, on 1st June 2006. The precursor Trust had been formed on 1st April 1998, when the Freeman Group of Hospitals NHS Trust and the Royal Victoria Infirmary & Associated Hospitals NHS Trust merged.
We have endeavoured and with significant measures of demonstrable success across one of the most comprehensive and complex service delivery portfolios in the National Health Service to meet the expectations of the population catchments, local, regional and national, that we serve.
2013/14 did and most understandably beckon with an air of uncertainty as the NHS faced multi-factorial organisational change and fiscal constraints. However, our pledge to place patients first and foremost in all that we do has served us well, with the busiest and most productive year ever.

An enduring history of self-determination, pride and focused professionalism amongst all of our staff is the enabling factor, much of this emanating from our longstanding self-governing status and associated freedom in being licensed as an NHS Foundation Trust. Without such an underpinning legacy of resilience, so much of which we report upon would not feature as strongly as it does.

Partnership working features prominently across our portfolio and in this regard we wish to commend, amongst others, Newcastle City Council, Newcastle University, Northumbria University and the National Institute of Health Research.

Instrumental too in ensuring our year on year sustainability is the Council of Governors, which, since first being licensed as an NHS Foundation Trust in June 2006, has brought wise counsel complemented by constructive, informed challenge, to complement the work of the Board of Directors (the ‘Trust Board’) in respect of strategic direction and investment, as well as operational delivery from a ‘best in class’ perspective.

The Annual Report and Accounts in our opinion provide a basis to demonstrate a confidence that we have met all of the commitments pledged in the local and national interest as a healthcare provider. However, there is no room for complacency and we can always do better.

2014/15 is underway and we shall be striving to further build upon the platform of achievement and ongoing investment in skills, innovation and infrastructure, both in institutional and community outreach settings.

Sir Leonard Fenwick
Chief Executive
28 May 2014

Note: As in previous years, the statutory Annual Report & Accounts shall be incorporated into the Annual Review that is addressed at the Annual General Meeting, scheduled to be held on Wednesday 24th September 2014, commencing at 6pm, Freeman Hospital Education Centre, Newcastle upon Tyne.
The purpose of this strategic report is to inform users of the accounts and help them to assess how the Directors have performed in promoting the success of the Foundation Trust. It includes a fair review of the Trust’s business and description of the principal risks and uncertainties facing it.

The Trust can be seen to have been robust and with continued growth in overall activity, in associated income and in financial sustainability.
As described in the Operating & Financial Review below, the development and performance of the Trust can be seen to have been robust and with continued growth in overall activity, in associated income and in financial sustainability. At the end of the financial year 2013/14, the Trust was in a strong position, with an Income & Expenditure surplus of some £12.99 million after impairments and excluding the consolidated Charity accounts and with cash holdings of £96 million.

Our staff numbers and our energy performance in the course of the year are described in the relevant sections but suffice to say the Trust has continued to grow, while making strides in energy conservation, waste reduction and recycling. Policies in relation to equality and sustainability have been reviewed and refreshed and will be kept under review in the forthcoming year.

Our strategy, despite an increasingly competitive environment, is to develop further growth in activity and associated income, consolidating and expanding market share. Our business model continues to be as a provider of regional and supra-regional services, whilst striving to become “the health service for Newcastle”.

This is also expected to be reflected in the continued growth in the number of patients who are successfully recruited into clinical trials. Our key objectives remain the same, namely to put patients at the heart of everything we do; to continue to work in partnership with key organisations in the city of Newcastle upon Tyne, including both Universities; and to sustain the drive for further integration of health services and of those services with social care provision where the setting is appropriate.

Further steps will be taken to manage the financial impact of the PFI scheme which has so successfully Transformed the Newcastle Hospitals.

The gender composition of the Board of Directors is as set out in the relevant chapter and details of male/female mix for all other employees is to be found on page 254 below.

After making enquiries, the Directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts. The accounts have been prepared under a direction issued by Monitor under the National Health Services Act 2006.

The Newcastle upon Tyne Hospitals NHS Foundation Trust was formed under the provisions of the Health and Social Care (Community Care and Standards) Act 2003 (consolidated in the National Health Service Act 2006) and received its Terms of Authorisation from Monitor, the independent regulator of NHS Foundation Trusts, on 1st June 2006. The precursor Trust had been formed on 1st April 1998, when the Freeman Group of Hospitals NHS Trust and the Royal Victoria Infirmary & Associated Hospitals NHS Trust merged.

Approved by the Board.

Sir Leonard Fenwick
Chief Executive
28 May 2014
The membership of the Board of Directors in the course of the year can be found below in the chapter entitled “Board of Directors”.

The principal activities of the Trust during the year were, in summary, the provision of diagnostic and acute care services in response to contracts placed by Clinical Commissioning Groups and specialist commissioning bodies, to a population spanning the North East of England (and beyond for certain supra-regional and national services such as organ transplantation). There were more than 1.45 million patient contacts, comprised of 117,000 inpatients, 111,500 daycases, 180,700 Emergency Department/Walk-in Centre attendances and 1,218,000 outpatients. There were 7,446 births under our care. We carried out 293 organ transplants, over 3,100 heart operations and replaced 1,648 joints.
Business Review

All in all, another satisfactory trading year can be advised of with the platform established to enter into our eighth year as a Foundation Trust with some measure of strength from both an operational and strategic perspective.

In addressing the key domains by which success or otherwise can be measured, the following was of note:

a) National Patient Service Targets

(i) A&E Waiting Times (4 hours)

Target fully met. The end of year position was 97.6% against a target of 95%.

(ii) Referral to Treatment Target (18 weeks)

Target fully met. Against a target of 90% for admitted patients and 95% for non-admitted patients up to the end of March 2014, the position was 90.2% and 95.6% respectively. For the 92% target for patients on incomplete pathways, we achieved 93.6%.

Within the 18 week referral to treatment pathway, the 99% contractual target for diagnostic assessment was fully achieved throughout the year.

(iii) Cancer Waiting Time

Targets fully met. Against a target of 93% for 2 week waits (all cancers) and breast symptomatic, we achieved 97.1% and 96.4% respectively. For the 1 month diagnosis to treatment target of 96%, we delivered 98.9%. We continue to achieve the 31 day subsequent treatment targets for all treatment modalities; for the 94% surgery and radiotherapy target, we achieved 97.4% and 99.2% respectively in addition to achieving the 98% drug target at 99.5%. For the 2 month urgent referral to treatment target (85%), we achieved 87.1%. The cancer screening target of 90% of patients referred and treated within 62 days was exceeded, with a performance of 98.9%.

b) Care Quality Commission (CQC)

The Trust has been registered with the CQC without conditions since the introduction of the mandatory registration requirement from 1st April 2010.

c) Monitor Ratings

Our Annual Plan for 2013/14 originally predicted a Financial Risk Ratio (FRR) for the year of 3 (where 1 is poor and 5 is excellent), with an “Amber/Green” rating for Governance (risk of breaching the MRSA bacteraemia target of zero cases in the year).

As described above on page 4, Monitor changed the financial risk assessment mechanism with effect from 1st October 2013 and introduced a “Continuity of Services” (CoS) rating in place of the FRR.

Quarterly performance is set out in the table below. Green demonstrates a service performance score of <1.0, i.e. little or no shortfall in achievement of national measures, i.e. no more than one target not reached. Amber-Green arises when the score is ≥1.0 and <2.0. Amber-red applies when the score is ≥2.0 and <4.0. Red results from a score of ≥4.0.

<table>
<thead>
<tr>
<th></th>
<th>Annual Plan</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>FRR</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>CoS</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Governance</td>
<td>*Amber/Green</td>
<td>**Amber/Green</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
</tr>
</tbody>
</table>

* risk of MRSA bacteraemia >0
** C. difficile trajectory at risk of breach

The Trust had eight MRSA bacteraemias in the course of 2013/14 against the national objective of “zero tolerance”.

d) Other Indicative Measures of Quality in the National Setting

(i) CHKS 2013 40Top Hospitals Programme

Named in the CHKS Top 40 for a fourteenth consecutive year – one of only two Trusts to achieve this accolade (the other being Kingston Hospitals NHS Trust).

(ii) National Inpatient Survey 2013 – (Adult Inpatients)

A standard postal survey was sent to a random sample of 850 patients discharged from the Trust in July 2013. A response rate of 53.2% was achieved (443 responses). This should be seen in the context of overall activity within the Trust as, during the year 2013/14, a total of 228,545 patients (day case, elective and non-elective) were cared for in the Trust. The results highlighted many positive aspects of the patient experience, including:

- 93% rated care as 7+ out of 10
- 88% said they were treated with respect and dignity
- 90% always had confidence and trust in the doctors
- 98% said the room or ward was very/fairly clean
- 95% said the toilets and bathrooms were very/fairly clean
- 92% said there was always enough privacy when being examined or treated

The results above indicate that most patients are highly appreciative of the care that they receive. However, it is evident that there is room for improving the patient experience. The Picker Institute use a score – the ‘problem score’, to indicate where there may be a problem or there is room for improvement (the less desirable results). The problem score shows the percentage of patients for each question who, by their response, indicated that a particular aspect of their care could have been improved; therefore lower scores reflect better performance.

Questions where more than 50% of respondents reported room for improvement are listed below. Focusing on these areas could potentially improve the patient experience for a large proportion of our patients.

**Problem scores 50%+**

<table>
<thead>
<tr>
<th></th>
<th>Trust</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge: delayed by 1 hour or more</td>
<td>85 %</td>
<td>85 %</td>
</tr>
<tr>
<td>Planned admission: not given choice of admission date</td>
<td>70 %</td>
<td>65 %</td>
</tr>
<tr>
<td>Planned admission: not offered a choice of hospitals</td>
<td>67 %</td>
<td>63 %</td>
</tr>
<tr>
<td>Overall: not asked to give views on quality of care</td>
<td>65 %</td>
<td>68 %</td>
</tr>
<tr>
<td>Hospital: nowhere to keep personal belongings safely</td>
<td>63 %</td>
<td>58 %</td>
</tr>
<tr>
<td>Discharge: not told how long delay in discharge would be</td>
<td>60 %</td>
<td>68 %</td>
</tr>
<tr>
<td>Hospital: didn’t get enough information about ward routines</td>
<td>54 %</td>
<td>63 %</td>
</tr>
</tbody>
</table>

*Average is the average of the trusts using Picker to undertake the survey (76 trusts)*
Comparison to previous survey

The Inpatient survey is currently repeated on an annual basis. The Picker report looks at the problem scores for this year’s survey, compared to previous surveys, and may be used to identify areas where performance may be slipping, or improvements have occurred. A total of 85 questions were used in both the 2012 and 2013 surveys. Compared to the 2012 survey, the Trust is:

- Significantly better on 4 questions
- Significantly worse on 0 questions
- The scores show no significant difference on 81 questions.

NB – lower scores are better

The Trust has improved significantly on the following questions:

<table>
<thead>
<tr>
<th>Comparison to previous survey</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital: patients in more than one ward, sharing sleeping area with opposite sex</td>
<td>9 %</td>
<td>1 %</td>
</tr>
<tr>
<td>Overall: rated experience as less than 7/10</td>
<td>11 %</td>
<td>7 %</td>
</tr>
<tr>
<td>Overall: not asked to give views on quality of care</td>
<td>80 %</td>
<td>65 %</td>
</tr>
<tr>
<td>Overall: Did not receive any information explaining how to complain</td>
<td>57 %</td>
<td>49 %</td>
</tr>
</tbody>
</table>

Changes in place since the 2012 survey

The development of a ‘Discharge Wallet’ which gives patients advice on how to give feedback as well as a checklist to ensure patients are aware of their discharge medication and any follow-up appointments and how to contact the ward appears to have had a positive impact on the experience of patients when they leave hospital.

The introduction of the NHS Friends and Family Test in April 2013 for all adult inpatients will have affected the performance in the question asking ‘Were you asked to give your views on the quality of care?’ However 65% of patients still said that they were not asked to provide feedback despite every patient being asked to complete the Friends and Family Test at discharge. It is noted that the Friends and Family Test was still relatively new at that stage and that this is now much more firmly embedded in practice.

The Patient Experience Steering Group and Patient, Carer and Public Involvement Committee will review the findings of the latest Inpatient Survey in order to develop an action plan in response to the survey, in collaboration with patient representatives from the Council of Governors, Community Advisory Panel and Patient Advice and Liaison Services.

Within the scope of this survey, patients report a high level of satisfaction in response to many questions. When compared to the average (compared to other 76 Trusts using the Picker Institute), for 63 questions, we were assessed as significantly better, as average for 22 questions and as worse than average for just one question (nowhere to keep personal belongings safely). However, this should also be viewed in the context of the small sample size (443 completed responses from a possible population of 221,612).

The Trust has extensive intranet and internet sites, providing information on a range of subjects including all Trust policies, procedures and guidelines. There is also a monthly Trust Bulletin giving up to date information on changes across the Trust.

The Trust takes part in the National staff survey on an annual basis and a précis of the key results is given on page 249 above. A Staff travel survey is carried out biennially and we operate a Bicycle Users Group to allow feedback on cycling provision and infrastructure within the organisation.

Health and wellbeing and staff benefit events are held annually and are well attended by staff. These events provide information on benefits accessible to staff, for example salary sacrifice schemes such as the car lease, cycle and child care voucher schemes.

The Trust also has very comprehensive networks in place to ensure the involvement and engagement of its professional Nursing and Midwifery staff.

The Senior Nursing Team, led by the Nursing and Patient Services Director has regular monthly meetings with Sisters and Charge Nurses across the organisation to update on relevant national and local issues, and to provide an opportunity for discussion and engagement.

A similar monthly meeting is in place for all of the Trust’s Matrons, ensuring these staff who have diverse professional needs are provided with an opportunity to meet, and discuss, regularly with the Trust’s Senior Nursing Team.

An additional Nursing & Midwifery Professional Advisory Group was established in 2013, in response to the Trust’s “post-Francis Inquiry” work and in order to maximise two-way communications between the Trust’s Senior Nursing Team and frontline staff. The forum is open to all frontline nursing and midwifery staff and is chaired by one of the Nurse Consultants. This is in line with the Trust’s Nursing Strategy (2013-2016) “Proud of Nursing and Midwifery in Newcastle – Compassion, Quality and Excellence in all we do”, which is underpinned by the need for excellent communication.

Further “communication forums” have also been established during the year and are receiving high levels of attendance and positive evaluation. These include the provision of monthly “Safety Briefings”, for all staff and which are led by the Senior Nursing and Medical Teams across the Trust, addressing emerging concerns or
motivation at work. In Newcastle this score was:
the Trust as a place to work or receive treatment and staff
contribute towards improvements at work, staff recommendation of
calculated using three of the key findings (KF) scores – staff ability to
satisfaction and equality and diversity. The staff engagement score is
The results are arranged under six headings – the four staff pledges
of 52% was achieved which although average for acute Trusts, was
of 850 Staff from across the Trust in October 2013. A response rate
standard survey was sent via the internal post to a random sample
online, or by submitting a paper application.

Involving Our Staff
The Employee Partnership Forum is the primary forum through
which the Board seeks the views of staff, via their representatives,
when making decisions likely to affect their interests. Priorities for
improving staff feedback (whether identified through the national
staff survey or not) are agreed through the Forum, which also
monitors implementation of the agreed actions.
The Forum is also a key element in encouraging the involvement of
staff in the performance of the Trust. This helps to underpin the
Staff Membership of the Trust. All new appointees are offered the
opportunity to join the Membership upon induction. Existing staff
who have not already done so may join the Membership either
online, or by submitting a paper application.

2013 NHS Staff Survey Results Summary
This is described in detail on page 324 below. In summary, a
standard survey was sent via the internal post to a random sample
of 850 Staff from across the Trust in October 2013. A response rate
of 52% was achieved which although average for acute Trusts, was
lower than the response rate of 56% in 2012.
The results are arranged under six headings – the four staff pledges
from the NHS Constitution plus two additional themes of staff
satisfaction and equality and diversity. The staff engagement score is
calculated using three of the key findings (KF) scores – staff ability to
contribute towards improvements at work, staff recommendation of the
Trust as a place to work or receive treatment and staff
motivation at work. In Newcastle this score was:

• Overall: rating of staff engagement 3.89 (out of possible 5).
This score was in the highest (best) 20% compared with acute trusts
and is an improvement on the 2012 trust score; staff engagement
links to several outcomes – motivating staff to perform well, being
committed to the organisation and acting as advocates
recommending the Trust as a place to work or receive treatment.
The top five ranking scores were as follows (average for acute
Trusts shown in brackets):

• % staff saying hand washing materials are always available 76% (60%)
• % staff receiving equality and diversity training in last 12
months 80% (60%)
• % staff believing the trust provides equal opportunities for
care progression
• or promotion 96% (88%)
• % staff suffering from work related stress in last 12 months
30% (37%) (Lower score better)
• % staff witnessing potentially harmful errors, near misses or
incidents in last month 26% (33%)

These are also very encouraging scores – particularly given our
responsibility under the Public Sector Equality Duty to promote equality.
Where the staff experience has improved has been in response to
KF24: staff recommendation of the Trust as a place to work or
receive treatment which in 2013 was 4.05 (3.94). This ranking
places the trust in the highest (best) 20% compared with acute
trusts, and further analysis, very pleasingly suggests an ongoing
improving trend over the last 5 years.
The bottom five ranking scores were (average for acute trusts
shown in brackets):

• % of staff feeling pressure in last 3 months to attend work
when feeling unwell 30% (28%)
• % of staff agreeing that their role makes a difference to
patients 89% (91%)
• % of staff reporting errors, near misses or incidents witnessed
in the last month 89% (90%)
• % of staff experiencing harassment, bullying or abuse from
staff in the last 12 months 23% (24%)
• Staff motivation at work 3.88 (3.66) (higher score the better).

Where the staff experience has deteriorated was % staff
reporting errors, near misses or incidents witnessed in the last
month, which was 89% compared to the Trust score in 2012 of
96%. This is of particular concern given the investment in the
patient quality and safety agenda over the last year, and the wish to
create an open culture in which staff feel safe, supported and able
to raise concerns. This is suggested as a starting point for our local
action plan in response to the staff survey results.
An action plan will be developed to address the key findings, based
on further detailed analysis of the data. This plan is closely aligned
with the “post Francis Report” actions across the Trust, which have
and will continue to include Listening Events for staff, a new
monthly staff Bulletin, standard patient safety and care quality
Agenda items for formal groups such as the Matrons and Sisters
Forums, and regular “You said… We did” reports. Oversight of
these activities is being taken by the Patient Experience Steering
Group.
In 2014 there will be an additional requirement to implement the
NHS Friends and Family NHS Staff Test.

Involvement and engagement

Equality Diversity and Human Rights
The information presented in this report represents information
which has been monitored over the last 12 months by the Board,
Council of Governors, Clinical Governance and Quality Committee
and the Clinical Policy Group. The majority of the Quality Account
represents information from all 17 Clinical Directorates presented as
total figures for the Trust. The indicators to be presented and
monitored were selected following a series of discussions with Non-
Executive members of the Trust Board. They were agreed by the
Executive team and have been developed over the last 12 months
following guidance from senior clinical staff. The priorities for
improvement have been discussed and agreed by the Trust Board,
Clinical Governance and Quality Committee, the Clinical Policy
Group and representatives from the Council of Governors.
Over the last year we have listened to the views and experience of
diverse groups of people and individuals regarding their experiences
of healthcare. Through the Equality, Diversity and Human Rights
group we have reviewed this information along with other local,
regional and national reports. We have used it to revise and further
develop our objectives and action plans. Information about how we
did this can be found on the Trust internet:
http://www.newcastle-hospitals.org.uk/about-us/equality-
and-diversity_equality-delivery-system.aspx
e) Caseload Trends and Throughput (Using FCEs)

- Overall Activity vs Previous Year
  - In patient and day case elective activity = +2.7% (3,716 patients)
  - Non elective inpatients = +3.9% (3,217 patients)
  - New outpatients = +8.4% (25,991 patients)
  - All outpatients = +15.1% (159,644 patients)
  - Emergency Department activity = +1.6% (2,122 patients)
  - Walk in Centre activity = +1.3% (660 patients)
- Key Specialty Trends
  - Liver transplants +14.6% (6 patients)
  - Bone marrow transplants +2.7% (5 patients)
  - Heart operations (CABGs and PCIs) +2.5% (78 patients)
  - Cataracts +0.2% (19 patients)
  - Number of IVF cycles started +0.4% (3 patients)
  - Number of renal dialysis sessions -0.07% (28 sessions)
  - Births +0.07% (5 deliveries)

(f) Key Indicators

For MRSA bacteraemias, against a national target for the year of “zero tolerance” the Trust had eight reportable cases.

The Trust met the requirement for at least 85% of patients to have a maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

18 Weeks Referral To Treatment performance was met, including the requirements for data completeness to be in the range 90 – 110%.

Subsidiaries

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

On a 50:50 basis with the University of Pittsburgh Medical Center (UPMC), the Trust is a shareholder in Crossco (1080) Limited, which was set up to promote the sale of the Newcastle eRecord patient records system. The company was dormant and did not trade in 2013/14. The Trust was also a minority shareholder in Norprime (Wallsend) Limited, which was a dormant company and did not trade during the course of 2013/14.

The Trust also holds shares in and is represented on the Boards of NewGene Limited, which markets novel genetic tests to other NHS bodies; Pulse Diagnostics Limited, which is seeking to commercialise an invention for the non-invasive detection of Peripheral Vascular Disease; and Limbs Alive Limited, which is commercialising advanced games software with a therapeutic benefit for children who have suffered a stroke.

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

Financial Performance

This is described in detail in the “Operating and Financial Review” below but suffice to say that the in-year financial risk rating was most satisfactory (closing the year at 4 out of 4, where 4 is lowest risk), all key financial targets were met and an Income & Expenditure surplus delivered before exceptional items.

Going Concern

Throughout the year and having a mind to the requirement to operate as a going concern, the Board was advised of the liquidity position, trading activity, compliance with the financial model of the Annual Plan, and achievement of financial targets. Given the continuing strength of the Trust in terms of liquidity, the trading position, fit with the financial model and achieving the key financial targets, Directors were content that the Trust was and is a going concern and the annual accounts have been prepared on that basis in consequence. The accounts have also been prepared in line with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Any use of financial instruments is as identified in Note 28 of the Accounts.
Statement of Directors’ Responsibilities

Under the NHS Act 2006, Monitor has directed The Newcastle upon Tyne Hospitals NHS Foundation Trust to prepare, for each financial year, a statement of accounts in the form and on the basis set out in the Accounts Direction. The Directors are responsible for preparing the accounts on an accrual basis, which gives a true and fair view of the state of affairs of The Newcastle upon Tyne Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Directors are required to comply with the requirements of Monitor’s Foundation Trust Annual Reporting Manual 2013/14 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
- prepare the financial statements on a going concern basis.

The Directors are 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 Directors are 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.

The Directors consider the annual report and accounts, taken as a whole, to be fair, balanced and understandable and provide the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust’s performance, business model and strategy.

Code of Governance

The Trust applies the main and supporting principles of Monitor’s “Code of Governance for NHS Foundation Trusts” as follows. The Board of Directors provides effective and proactive leadership, within a framework which enables risk to be assessed and managed appropriately (see Annual Governance Statement section below). The Board ensures compliance with the Terms of Authorisation, the constitution, mandatory guidance, relevant statutory requirements and contractual obligations. It sets the strategic aims of the Trust, taking into account the views of the Council of Governors and ensures that the necessary resources are in place to meet priorities and objectives. There is periodic review of progress and management performance.

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

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

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

The Board complies with the provisions of the Code and its key principles.

NHS Constitution

Throughout the year, the Board was mindful of the NHS Constitution and its provisions and key principles.

Future Development and Performance

The Board is acutely aware of the need to ensure that the benefits to patients of the Transforming the Newcastle Hospitals programme are realised, along with the continuing organisational benefits to be had from the Newcastle eRecord project. Growth rates in hospital based care will reduce as both NHS funding overall diminishes and as national and local policy with regard to moving care out of hospitals and nearer to patients is enacted.

Risks and Uncertainties

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

- Achievement of national performance targets, including Cancer waiting times, the MRSA bacteraemia target of no more than 4 cases in the year, the Clostridium difficile target and associated financial penalties for any breaches (up to a total of 10 above the target ceiling of 95 cases in the year, with a penalty approaching £1.3 million per case) and achievement of the 18 Weeks Referral to Treatment (RTT) target.
- Continuing uncertainty about the allocation of funding streams relating to Education and Training, particularly the risk arising from proposed reductions in the multi-professional education and training (MPET) income stream
- Planning for the impact of the Unitary Payment for the PFI scheme, while maintaining financial strength overall
- Realising the benefits arising out of the Newcastle eRecord.

Development and Performance

Our key developments and overall performance are described in detail in “Operating and Financial Review” below.

Equality of Opportunity

The Trust has a number of policies in place, including a Single Equality Scheme, which set the context for staff to work in a safe environment and free from discrimination on any grounds. This underpins the fair and open recruitment of people with disabilities, appropriate training and development, and promotion. All employees have an annual performance appraisal and a personal development plan which flows from that, identifying training and development needs where required. Employees who are unfortunate enough to become disabled in the course of their employment are counselled and advised as necessary and, where appropriate, may either retain their employment or be retrained and redeployed into another post.
**Equality & Diversity**

An overview of the profile of our staff is set out in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Headcount</th>
<th>% of Total Headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin and Clerical</td>
<td>2673</td>
<td>19.19%</td>
</tr>
<tr>
<td>Allied Health Professions</td>
<td>1016</td>
<td>7.29%</td>
</tr>
<tr>
<td>Ancillary</td>
<td>1139</td>
<td>8.18%</td>
</tr>
<tr>
<td>Building and Maintenance</td>
<td>135</td>
<td>0.97%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>1313</td>
<td>9.43%</td>
</tr>
<tr>
<td>Nursing and Midwifery - Qualified</td>
<td>4595</td>
<td>32.98%</td>
</tr>
<tr>
<td>Nursing and Midwifery - Unqualified</td>
<td>1482</td>
<td>10.64%</td>
</tr>
<tr>
<td>Professional and Technical/Scientific</td>
<td>1578</td>
<td>11.33%</td>
</tr>
<tr>
<td><strong>Trust Total</strong></td>
<td>13931</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Full Time/Part Time</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Time</td>
<td>8524</td>
<td>61.19%</td>
</tr>
<tr>
<td>Part Time</td>
<td>5407</td>
<td>38.81%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>10842</td>
<td>77.83%</td>
</tr>
<tr>
<td>Male</td>
<td>3089</td>
<td>22.17%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disabled</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>6661</td>
<td>47.81%</td>
</tr>
<tr>
<td>Not recorded</td>
<td>7089</td>
<td>50.89%</td>
</tr>
<tr>
<td>Yes</td>
<td>181</td>
<td>1.30%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>443</td>
<td>3.18%</td>
</tr>
<tr>
<td>Black</td>
<td>97</td>
<td>0.70%</td>
</tr>
<tr>
<td>Chinese</td>
<td>45</td>
<td>0.32%</td>
</tr>
<tr>
<td>Mixed</td>
<td>58</td>
<td>0.42%</td>
</tr>
<tr>
<td>Not known</td>
<td>419</td>
<td>3.01%</td>
</tr>
<tr>
<td>Other</td>
<td>306</td>
<td>2.20%</td>
</tr>
<tr>
<td>White</td>
<td>12563</td>
<td>90.18%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>15-24</td>
<td>1026</td>
<td>7.36%</td>
</tr>
<tr>
<td>25-34</td>
<td>3188</td>
<td>22.88%</td>
</tr>
<tr>
<td>35-44</td>
<td>3393</td>
<td>24.36%</td>
</tr>
<tr>
<td>45-54</td>
<td>4141</td>
<td>29.73%</td>
</tr>
<tr>
<td>55-64</td>
<td>2028</td>
<td>14.56%</td>
</tr>
<tr>
<td>65-74</td>
<td>155</td>
<td>1.11%</td>
</tr>
</tbody>
</table>
Ethnicity of Workforce

Sickness Absence Data

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Apr 13 to Jun 13</th>
<th>Jul 13 to Sep 13</th>
<th>Oct 13 to Dec 13</th>
<th>Jan 14 to Mar 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Professional and Technical</td>
<td>1.77%</td>
<td>1.76%</td>
<td>2.30%</td>
<td>2.83%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>5.95%</td>
<td>6.01%</td>
<td>6.05%</td>
<td>5.95%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>3.66%</td>
<td>3.58%</td>
<td>3.75%</td>
<td>3.86%</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>2.86%</td>
<td>2.70%</td>
<td>2.53%</td>
<td>2.66%</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>3.44%</td>
<td>4.42%</td>
<td>4.44%</td>
<td>4.52%</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>2.17%</td>
<td>2.86%</td>
<td>3.15%</td>
<td>2.86%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>1.56%</td>
<td>1.14%</td>
<td>1.06%</td>
<td>1.33%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>3.91%</td>
<td>4.00%</td>
<td>4.17%</td>
<td>4.25%</td>
</tr>
<tr>
<td>Students</td>
<td>0.00%</td>
<td>0.36%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Trust Total</td>
<td>3.80%</td>
<td>3.88%</td>
<td>3.99%</td>
<td>4.07%</td>
</tr>
</tbody>
</table>
As reported to the Department of Health, the key sickness absence data for the period were:

<table>
<thead>
<tr>
<th>Average of 12 months (2013 calendar year)</th>
<th>Average WTE in 2013</th>
<th>WTE days available</th>
<th>Days lost</th>
<th>Average sick days per WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.0%</td>
<td>11,693</td>
<td>2,630,872</td>
<td>105,549</td>
<td>9.0</td>
</tr>
</tbody>
</table>

The Trust has a policy for the reporting, monitoring and management of sickness absence, with a view to reducing rates across all staff groups to 3% or lower and in order to facilitate reduced expenditure on overtime cover for such absence.

In support of the policy, there is an in-house Occupational Health Service, which takes self-referrals from staff, advises managers on the fitness of staff for work, and makes referrals to a range of therapies and counselling services as required.

**Sustainability / Climate Change**

The Trust continues to implement its sustainability strategy, Our Commitment to a Sustainable Future (www.newcastle-hospitals.org.uk/Sustainability_Strategy.pdf), in line with the NHS vision for a more sustainable healthcare system. Our well represented Sustainability Working Group, meeting every other month, has helped to drive forward this strategy and reduce our environmental impact in a number of areas this year.

The following items highlight some of our environmental sustainability achievements in 2013-14.

**Shortlisted in the National Recycling Awards as Healthcare Recycler of the Year**

The work of our Waste Officer, James Dixon, has been shortlisted in the National Recycling Awards 2014 (www.nationalrecyclingawards.com). The award submission is based on waste reduction and recycling initiatives undertaken across the Trust during 2013. We have been finalised along with seven other healthcare organisations/partners and the award ceremony is to be held in July at the London Hilton.

**Recycling Compactor installed at Freeman Hospital due to increase in volume**

Due to the significant increase in the amount of waste segregated for recycling at the Freeman Hospital we were able to put a business case together to invest in a compactor. This now saves us a lot of money in transport costs as we can now store more recycling between collections. The compactor was installed in April 2013 and if the production of segregated recycling continues the compactor is set to pay for itself in less than two years.

The Freeman Hospital now matches the RVI with one compactor for general waste, one for recycling and a mill-sized cardboard baler for cardboard.

**Our award winning Oncology Homecare Programme helps reduce carbon**

One of our award winning clinical programmes, which has helped to shift some oncology services closer to home, has also helped support our Sustainability Strategy by reducing carbon. The Oncology Homecare Programme won the Quality and Productivity Award in the HSJ Awards 2013 for their project which has seen significant improvements in patient experience as well as improving value for money. An additional benefit is reducing the need for patients to travel, sometimes long distances, to receive their care in a hospital setting. This reduction in patient travel reduces the cost burden on patients and the environmental impact associated with this. We have estimated that the programme has saved over 3,000 patient miles and 700kg of CO₂.

**Ultra Efficient LED Lighting installed in our newly refurbished Adult ICU at Freeman Hospital**

Refurbishment of Adult ICU included one of the largest LED lighting schemes in the Trust to date. To the uninitiated the lighting scheme appears to be like any other; however the installation benefits from:

**Energy Efficiency:** It is anticipated that the scheme will achieve a 60% reduction in consumption of power for the lighting in the area. In addition to the reduction in power the fittings have added advantage of reduced heat output from the lamps resulting in improved ambient temperatures.

**Long life:** LED’s are different to standard lighting; they don’t burn out and stop working like a standard light, moreover, they last significantly longer – up to 70,000 hours.

**Maintenance:** fittings are low maintenance with easy clean surfaces and the reduction of lamp replacement on a frequent basis.

Our strategy, despite an increasingly competitive environment, is to develop further growth in activity and associated income, consolidating and expanding market share.
Key Environmental Performance Data 2013/14

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>High Temperature Disposal (t)</td>
<td>165</td>
<td>197</td>
<td>218</td>
<td>239</td>
<td>9.60%</td>
<td>Waste cost £1,581</td>
<td>£1,252</td>
<td>£1,246</td>
<td>£1,237</td>
<td>-0.72%</td>
</tr>
<tr>
<td>Heat Treatment (t)</td>
<td>1,484</td>
<td>1,454</td>
<td>1,472</td>
<td>1,536</td>
<td>4.30%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Landfill (t)</td>
<td>1,726</td>
<td>0</td>
<td>0*</td>
<td>0</td>
<td>0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Energy Recovery (t)</td>
<td>579</td>
<td>1,980</td>
<td>1,875*</td>
<td>1,879</td>
<td>0.20%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recycling (t)</td>
<td>326</td>
<td>710</td>
<td>905</td>
<td>920</td>
<td>1.70%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recycling rate (non-clinical)</td>
<td>12.40%</td>
<td>26.40%</td>
<td>32.6%*</td>
<td>32.90%</td>
<td>0.10%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water (m³)</td>
<td>484,596</td>
<td>491,855</td>
<td>488,417</td>
<td>510,352</td>
<td>4.49%</td>
<td>Water cost £9,690</td>
<td>£1,032</td>
<td>£1,047</td>
<td>£1,063</td>
<td>1.50%</td>
</tr>
<tr>
<td>Electricity (GJ)</td>
<td>227,642</td>
<td>230,377</td>
<td>230,377</td>
<td>262,468</td>
<td>13.92%</td>
<td>Energy cost £10,882</td>
<td>£12,510</td>
<td>£13,567</td>
<td>£14,664</td>
<td>8.00%</td>
</tr>
<tr>
<td>Gas (GJ)</td>
<td>1,019,012</td>
<td>1,052,012</td>
<td>985,159</td>
<td></td>
<td>-6.40%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Correction from last year’s Annual Report data. The 18 tonnes of offensive waste segregated from the clinical waste last year did not go to landfill, but was sent for energy recovery (changing the Landfill total to 0, the Energy Recovery total to 1,875 and the recycling rate to 32.6%).

Public Health

The core business of the Trust is to deliver health care to patients, and this provides a number of opportunities to influence behaviour and lifestyles of the local community, with potential benefits to public health. The Public Health Working Group works closely with the Director of Public Health’s team, which is well represented on the Group. The Trust is committed to these public health responsibilities, particularly with regard to prevention of illness, promotion of healthy living and enabling the most effective life chances for local people. The organisation manages in the region of one million patient contacts every year and it is our aim to make every one of these a public health contact. We aim to have a positive impact on the health of our patients, staff and visitors across all aspects of public health ranging from stopping smoking to reducing alcohol consumption, from improving mental health and wellbeing to tackling obesity. In essence, there are three strands of opportunity, as described here.

(i) As a provider of healthcare

The Newcastle Hospitals have in excess of 1.4 million patient contacts per year, having the opportunity to directly influence the health and well being of these patients by the treatment provided. Access to such a wide section of the population also provides an opportunity to intervene from a public health perspective to influence lifestyle and behaviours. There is evidence that at the time patients are receiving treatment they are more receptive to messages about health and well-being and the Trust takes every opportunity to ensure that they “make every patient contact a public health contact”.

Actively pursuing the Equality, Diversity and Human Rights Agenda can also help to address inequalities by ensuring inclusive approaches to service delivery and access to services.

(ii) As an employer of staff

As an employer of over 13,000 staff the Trust also has the potential to influence the behaviour of a major section of the local population. This can be in terms of, for example, their working environment through the implementation of its Smoke Free Policy, or their economic status through the employment and career opportunities it provides.

Actively pursuing the Equality, Diversity and Human Rights Agenda also helps to address inequalities by ensuring inclusive approaches to recruitment and employment.

(iii) As a “corporate citizen”

There are major opportunities for the Trust to contribute through its strategies to minimise environmental pollution and to promote “green policies”.

- Recognise our responsibility to address the potential adverse impacts of Climate Change
- Promote the health and wellbeing of staff and patients through sustainable behaviour
- Promote the responsible use of resources to minimise costs and maximise funds available for patient care
- Work collaboratively within the NHS and the wider community to promote sustainability
- Embed environmentally sustainable practices within the Trust
- Develop a process to measure and report progress on performance
- Submit a Carbon Management Plan to the Carbon Trust

The themes of the strategy are intended to cover the key areas of sustainability. They are:

- Communications – Communicating sustainability to staff, patients and visitors
- Designing the Built Environment – Building sustainability into the Trust Estate
- Energy and Carbon Management – reducing Carbon Dioxide and other greenhouse gas emissions
- Governance and Finance – Budgeting for and integrating sustainability into Trust processes
- Information Technology and Telephony – Improving the efficiency and reliability of Information Technology
- Low Carbon Travel and Transport – Encouraging active and sustainable travel for patients and staff
• **Staff Engagement** – Training and developing staff to encourage sustainable behaviour

• **Procurement and Food** – Addressing sustainability in what we buy and the supply chain

• **Waste Minimisation** – Promoting appropriate use of materials and sorting of waste

• **Water Minimisation** – Promoting efficient use and innovative solutions for conservation

The NHS Sustainable Development Commission describes how NHS organisations can embrace sustainable development and tackle health inequalities through their day-to-day activities, stating that; “This means using NHS organisations’ corporate powers and resources in ways that benefit rather than damage the social, economic and environmental conditions in which we live. How the NHS behaves - as an employer, a purchaser of goods and services, a manager of transport, energy, waste and water, as a landholder and commissioner of building work and as an influential neighbour in many communities - can make a big difference to people’s health and to the well being of society, the economy and the environment”.

The core business of the Trust is to deliver health care to patients, and this provides a number of opportunities to influence behaviour and lifestyles of the local community.
BOARD OF DIRECTORS

During the period 1st April 2013 to 31st March 2014, there were 11 ordinary meetings of the Board of Directors and one extra-ordinary meeting. In compliance with the requirements of the Health and Social Care Act 2012, the Board meets in public every month (except August), with a private business session thereafter.
The Board has overall responsibility for the strategic direction of the Trust, taking into account the views of Governors and in particular their views on the annual plan. Executive Directors attend all meetings of the Council of Governors and the Non-Executive Directors have an open invitation to do so. In the course of 2013/14 a number of meetings of focused working groups of Governors were held with Executive Directors, in order to gain a fuller understanding of the views of Governors.

The Board is also responsible for ensuring that the day-to-day operations of the Trust are effective, economical and efficient and that all areas of identified risk are managed appropriately. A detailed Scheme of Reservation and Delegation of Powers, which was comprehensively reviewed in the course of 2013/14 and updated in April 2014, is in place, which sets out explicitly those decisions which are reserved to the Board, which may be determined by standing committees, and those which are delegated to managers.

The balance, completeness and appropriateness of the membership of the Board has been reviewed periodically at the away days and upon any vacancies arising amongst either the Executive or Non-Executive Directors.

Details of appointments and the backgrounds of each member are set out below, along with attendance at the Board meetings:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Appointed/term details</th>
<th>Ordinary meetings</th>
<th>Extra-ordinary meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor P H Baylis</td>
<td>Non-Executive, Senior Independent Director and Deputy Chairman</td>
<td>Appointed 1st June 2006, term expired 31st May 2008; re-appointed 19th January 2009 for three years; re-appointed 19th January 2012 for a second term of three years</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Former Pro Vice Chancellor, Faculty of Medical Sciences, University of Newcastle upon Tyne</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professor C P Day</td>
<td>Non-Executive</td>
<td>Appointed 1st April 2008; renewed 1st April 2013 (term of office up to 5 years, at discretion of University of Newcastle upon Tyne)</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pro Vice Chancellor, Faculty of Medical Sciences, University of Newcastle upon Tyne</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr B C Dobson</td>
<td>Non-Executive</td>
<td>Appointed 1st October 2010 for three years; reappointed 1st October 2013 for a second term of three years</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>International Chemical Industries background</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mrs A Dragone</td>
<td>Finance Director</td>
<td>Appointed 9th March 2009</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Career NHS Accountant and Finance Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sir Leonard Fenwick</td>
<td>Chief Executive</td>
<td></td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Career NHS Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms S Kler</td>
<td>Non-Executive</td>
<td>Appointed 1st November 2010 for three years; reappointed 1st November 2013 for a further year</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Housing Association and Primary Care Trust background</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mrs H Lamont</td>
<td>Nursing and Patient Services Director</td>
<td>Appointed 1st April 2009</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Career NHS Nurse and Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mrs H A Parker</td>
<td>Non-Executive</td>
<td>Appointed 1st June 2006, term expired 31st May 2008; re-appointed 1st June 2008 for three years; re-appointed 1st June 2011 for a further three years</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Commercial Property Lawyer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mrs L Robson</td>
<td>Business and Development Director</td>
<td>Appointed 22nd October 2012</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Career NHS Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr K W Smith</td>
<td>Chairman</td>
<td>(appointed 1st September 2006, Interim Chairman from 1st March 2007, appointed Chairman from 19th September 2007; term extended by the Council of Governors to 22nd September 2011, reappointed to 23rd September 2012; reappointed to 24th September 2013; reappointed for three years)</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Former Treasurer then Chief Executive of County Durham County Council; Adviser to global Japanese company NSK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr D G Stout</td>
<td>Non-Executive</td>
<td>Appointed 1st August 2012</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Career NHS Finance Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr E Weir</td>
<td>Non-Executive</td>
<td>Appointed 1st October 2010, reappointed 1st October 2011, reappointed 1st October 2012, reappointed 1st October 2013 (term of office annual, renewal at discretion of Newcastle City Council)</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Director of Adult and Culture Services, Newcastle City Council</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr A R Welch</td>
<td>Medical Director</td>
<td>Appointed 1st April 2013</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consultant Head &amp; Neck Surgeon</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Except where identified above, the Non-Executive Directors were appointed with effect from 1st June 2006 under the transitional arrangements pursuant to paragraph 19 of Schedule 1 of the Health and Social Care (Community Health and Standards Act 2003) and for a period of 12 months or the unexpired portion of their original term of appointment, whichever was longer. The Council of Governors has the power to terminate the appointments of the Chairman and the other Non-Executive Directors, based upon 75% of its membership approving such a measure.

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

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

**Audit Committee**

The Board of Directors has established a formally constituted Audit Committee, comprised of three Non-Executive Directors and with Trust officers, internal and external auditors in attendance. The quorum is two Non-Executive Directors. In the course of 2013/14, the Committee was chaired by Mr D G Stout. The key purposes of the Audit Committee are to provide the Board with:

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

The Audit Committee does not in any way override or diminish the responsibilities of the Board of Directors with regard to the financial and organisational management of the Trust. It provides a forum for direct contact between the Board and its auditors.

Five meetings, including one extraordinary meeting, were held between 1st April 2013 and 31st March 2014 and attendance was as follows:

<table>
<thead>
<tr>
<th>Name</th>
<th>Ordinary</th>
<th>Extraordinary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor P H Baylis, Non-Executive Director</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Dr B C Dobson, Non-Executive Director</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Mrs H A Parker, Non-Executive Director</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Mr D G Stout, Non-Executive Director (Committee Chair)</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

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

The Council of Governors has the statutory responsibility for the appointment of the external auditors. A sub-group of Public Governors, supported by Trust officers, was convened originally in January 2007 and operated a selection process in accordance with applicable EU Public Sector procurement regulations. With effect from 1st October 2007, PricewaterhouseCoopers LLP were appointed for an initial term of three years, to 30th September 2010. The Council of Governors approved a 12-month extension to that contract on 20th May 2010, i.e. to 30th September 2011 and a further and final 12-month extension, i.e. to 30th September 2012 on 17th March 2011.

Planning for a fresh procurement of the external auditor, in accordance with applicable EU Public Sector procurement regulations, commenced in April 2011, under the auspices of the Business Development governor working group, augmented with governors from the Quality of Patient Experience working group and supported by Trust officers and the Chairman of the Audit Committee. The service specification was agreed and procurement then proceeded under the “mini competition” Regulations for public sector procurements, with an advert placed in the Official Journal of the European Union in September 2011 inviting expressions of interest and the tender documentation issued in November 2011, for response by mid-January 2012. Tender evaluation and bidder interviews commenced in February 2012. The governor working group was unable to make a recommendation of an appointment to the Council of Governors and hence sought to abandon the procurement, redraft the specification and issue a revised tender in Autumn 2012. In the interim and using the national CPC Framework for procurement, PricewaterhouseCoopers LLP were appointed for a further 12-month period in order to ensure compliance with the statutory requirement for the Trust to have an auditor in place at all times.

The procurement process was recommenced in Autumn 2012, when the Supplies & Procurement Director and Trust Secretary drafted a first revised version of the service specification and subsequently the assessment methodology. This specification and methodology were formally considered, discussed and signed off by the governor panel as “fit for purpose” on 20th December 2012. Governors had stressed that transparency and professionalism would be key to the process, with the Trust officers providing the latter and the former addressed through the review of the draft, use of the CPC Framework “mini competition” provisions and the nature of the specification itself and the responses to it from bidders, which provided consistent and explicit information. The specification also included a set of key performance indicators, to be used for the annual assessment of the performance of the successful bidder.

The “mini competition” provisions within the NHS CPC Framework allowed the Trust to invite all four Framework-approved companies to submit bids. One firm decided not to participate further in the process. Tender documents were received from the other three bidders on 4th February 2013 and an initial commercial evaluation was conducted by the Director of Supply & Procurement.

Presentations by the bidders to the governor evaluation panel and Trust officers representing Finance and Procurement, plus the Audit Committee Chairman took place on 12th March 2013. Individual members of the panel scored each bidder under two main headings – Key Requirements and Organisational Capability and Experience. The individual scores were then aggregated and the mean value obtained. At that point, the commercial scores were disclosed to the panel and added to the aggregated score for each bidder. The recommendation of the panel, which was endorsed by the Council of Governors on 21st March 2013, was to appoint PricewaterhouseCoopers LLP for a term of five years, subject to satisfactory annual review.
Internal Audit

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

The Trust receives its internal audit service from the Northumbria Internal Audit and Counter Fraud Service. Activity each year is conducted in the context of a rolling three-year strategy and an annual work plan, with an agreed number of days also set aside for ad hoc work at the request of the Trust. The work plan includes reviews of non-financial and financial systems, governance arrangements and IT systems, including security.

Assurance had been achieved by:

• Reviewing and approving the Internal Audit Strategy and operational plan and more detailed programme of work, including regular updates of performance against the plan.
• Consideration of the major findings arising from internal audit work and management’s responses.
• Receipt of the internal audit Annual Report and Head of Internal Audit Opinion.
• Monitoring progress with implementation of agreed audit recommendations.
The Trust has a total of 36 Governorships, with 31 elected by the public and staff and the others appointed to represent a diverse array of stakeholder organisations. The balance between public and stakeholder governors was changed in January 2010 by Constitutional amendment, approved by the Council of Governors and endorsed by Monitor. Two defunct Appointed Governorships were reassigned to Public Constituencies 2 and 3, reflecting the widening scope of the Trust through, for example, the building of a new Institute of Transplantation providing a regional and supra-regional service.

The table below names our Governors, who together comprise the Council of Governors. The Council has a number of statutory powers, including the appointment of the Chairman and Non-Executive Directors and the external auditors. The Council debated key issues of interest, including infection prevention and control, the financial performance of the Trust, the Quality Account and the forward plan. Other topics of continuing interest have included continuing vertical integration of services under our “Better Together” manifesto, and the proposed development by Northumbria Healthcare NHS Foundation Trust of a Specialist Emergency Care Hospital on the outskirts of Cramlington, a few minutes drive from the designated level 1 Major Trauma Centre at the Royal Victoria Infirmary, Newcastle.

In the course of May 2012 elections were held, for those Governorships where the three-year terms of office were due to expire by 31st May 2012 and for a number of other Public and Staff Governor resignations.

The Council of Governors met in alternate months throughout the year and meetings were well attended, with wide-ranging debate across a number of areas of interest. Debate was facilitated by presentation of regular reports from each of the Governor Working Groups, with distinct Terms of Reference:

- Business Development
- Membership & Community Relations
- Quality of Patient Experience

Each of the Working Groups is aligned to a specific Director or Directors, reflecting the applicable spheres of interest. In particular, the Business Development working group was given the responsibility on behalf of the full Council of Governors to provide the Governors’ inputs to the annual planning process. Members of other working groups had an open invitation to participate in the process and several did so. Where possible, all of these Governors sought to canvass views from representative Members of their Constituency. None of the Appointed Governors participated in the planning process.

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

Governors also continued the programme of unannounced visits to clinical and support departments, to learn about how each department worked and the challenges faced. Governors reported back to Council on their findings and charged the Executive Team with following up highlighted issues. Areas visited included:

**Royal Victoria Infirmary:**
- Emergency Assessment Unit
- Internal Medicine
- General Surgery
- Outpatients

**Freeman Hospital:**
- Care of the Elderly
- Internal Medicine
- Outpatients

**Campus for Ageing & Vitality:**
- Care of the Elderly wards

The Patients’ Food Tasting Panel continued its sterling work and visited patient care areas at both Freeman Hospital and the Royal Victoria Infirmary, sampling patient meals at the point of delivery and examining the quality of service overall. The feedback on menu choices and methods of delivery and presentation has been very helpful to the Trust in making further improvements in this important area, including the continuing development and roll-out across the Trust of bespoke menus specifically for children and which take account of nutritional needs.
The Trust holds a register of Governors’ interests, which is available for public inspection upon request to the Trust Secretary, Corporate Services, Freeman Hospital, High Heaton, Newcastle upon Tyne NE7 7DN, telephone 0191 233 6161.

The Board of Directors maintains a close working relationship with the governors and wider membership in a number of ways. The Executive Directors attend every Council of Governors meeting and there is an open invitation for Non-Executive Directors to attend. There is governor engagement in a number of Trust committees, chaired by Non-Executives (as described above). On matters of strategic interest, the Board engages with the membership through mail-outs or mass emailings. In the past year there was significant interest in the Health & Social Care Act 2012 and its ramifications; in the closing phases of the Transforming Newcastle Hospitals investment programme; and in the continuing integration of the Community Health Services for Newcastle with adult social care services for the city.

As set out in Monitor’s Code of Governance for NHS Foundation Trusts, there is a requirement for a mechanism to be in place for the resolution of any disagreements between the Board of Directors and the Council of Governors. In the first instance, it is the responsibility of the Chairman as the leader of both forums to attempt to lead to a consensus. Failing that, the next, formal, step would be for the Chairman to receive formal representation from the designated Lead Governor (currently the Chair of the Nominations Committee) and seek to arrive at a mutually acceptable position. In 2013/14, the Trust has not needed to have recourse to such a mechanism.

Paragraph 10C of schedule 7 of the NHS Act 2006 makes provision for Governors to remove a Governor from Council for any of the reasons set out in the Constitution of the Trust. The 21st March 2013 meeting of the Council of Governors exercised its power to remove a Governor by virtue of his serial non-attendance at Council meetings (which had occurred over more than two years and despite repeated attempts to contact him and seek an explanation for his absences). This seat was then included in the 2013 round of elections – see below.
Governor Elections

In the course of 2013/14 there was a round of elections occasioned by the expiry of original terms of office, some resignations and the removal of a Governor as described above. Elections were held as follows:

May 2013

Newcastle constituency (3 seats; 15 candidates stood)

- Mr Adam Chaffer
- Dr Jim Page
- Mrs Elsie Richardson

Northumberland, Tyne & Wear constituency (4 seats; 3 candidates stood and were returned unopposed)

- Mrs Kay Cartner
- Mrs Mary Ann Hargreave (a former Governor)
- Dr Helen Lucraft
- + one vacancy, carried forward to the next election

Staff Governors (5 seats in total)

- Dr Veronica Oliver-Jenkins (Health Professions Council) (returned unopposed)
- Professor Paul Corris (Medical & Dental) (returned unopposed)
- Mrs Eleanor Houliston (re-elected for Volunteers (2 candidates))
- M Ray Nuttall (re-elected for Ancillary & Estates (returned unopposed))
- + one vacancy for Nursing & Midwifery, carried forward to the next election

In addition, one Appointed Governorship changed: Councillor Veronica Dunn was nominated by Newcastle City Council, to replace Councillor Nick Forbes.

Governors by Constituency

(number of Council of Governors meetings attended shown in brackets)

It should be noted that the former Mandatory Primary Care Trust appointed Governorships were removed from the Constitution with effect from 1st April 2013, following the dissolution of PCTs on 31st March 2013.

Constituency 1

Elected Public Governors

- Newcastle upon Tyne
  - Mr A Chaffer (5 of 5)
  - Mr S Cranston (5 of 6)
  - Mrs J Donnelly (6 of 6)
  - Ms S Harvey (6 of 6)
  - Miss G Jones (1 of 1)
  - Dr J Page (5 of 5)
  - Mrs E Richardson (of )
  - Dr M Snow (5 of 6)
  - Mr P Taylor (5 of 6)

Constituency 2

Elected Public Governors

- Northumberland, Tyne and Wear Strategic Health Authority area (excluding Newcastle)
  - Mrs K Cartner (3 of 5)
  - Mrs C Errington (5 of 6)
  - Mrs G Haigh (1 of 1)
  - Mrs M A Hargreave (3 of 5)
  - Mr M J R Harvey (6 of 6)
  - Ms V Hayden (1 of 1)
  - Dr H Luraft (4 of 5)
  - Dr D McKinnon (5 of 6)
  - Mr P Ramsden (5 of 6)
  - Mr D Thompson (5 of 6)
  - Mr C Venables (6 of 6)
  - Mr F Wyres (5 of 6)

Constituency 3

Elected Public Governors

- County Durham & Tees Valley Strategic Health Authority area and Cumbria & Lancashire Strategic Health Authority area and beyond
  - Mrs E Armstrong (4 of 6)
  - Mr J Bedlington (6 of 6)
  - Dr A G M Johnson (2 of 6)
  - Mr L MacDonald (2 of 4) resigned December 2013
The Council of Governors established a formally constituted Nominations Committee for the purposes of identifying, interviewing and recommending for appointment the Chairman and Non-Executive Directors of the Board. The Committee was comprised of four Public Governors (Mrs J Donnelly (Chair of the Committee), Mr L MacDonald, Mr M J Harvey, and Mr P Ramsden) and supported by Trust officers, the Senior Independent Director and the Chairman (where appropriate). Attendance is set out in the table below.

There were six meetings of the Committee in the period 1st April 2013 to 31st March 2014 and the Committee recommended to the Council of Governors the reappointment of the Chairman, Mr K W Smith, for a second year of his second term of up to three years (subject to annual review). The Nominations Committee also recommended to the Council of Governors the continued appointment of two Non-Executive Directors, Dr B C Dobson and Ms S Kler, for the second year of a second three-year term of office, each subject to annual appraisal.

As there were no new appointments to be made to the Board and the Constitution allows for reappointment of existing Non-Executive Directors (where they have expressed an interest in being reappointed), neither external search nor open advertising of the posts was used in the course of 2013/14.

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

### Nominations Committee

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### Membership

Public and staff are invited to participate in NHS Foundation Trust status by becoming members. Membership brings the important benefits of being able to stand for and vote in the elections for our Governors. As we continue to develop, Members can expect to participate more fully and help to shape the delivery of our services.

The Trust has three Public membership constituencies and seven Staff constituencies. Anyone over 18 and resident in one of the Public constituencies is eligible to apply for Membership. The Public constituencies are:

1) Newcastle upon Tyne
2) Northumberland, Tyne and Wear former Strategic Health Authority area (excluding Newcastle)
3) Co. Durham and Tees Valley and Cumbria and Lancashire former Strategic Health Authority areas and beyond.

The target for membership recruitment for the year end was to maintain 9,000 members in total. By the end of the year the figure for registered public members had fallen from 5,498 to 5,277, while registered staff members increased from 3,478 to 3,820. It is
thought that the decline in Public membership reflects the demographic skewing towards the older end of the age range. Full details are set out in the table below.

Whilst the membership is broadly balanced from a gender mix perspective, with a male to female ratio of 46.4%: 53.6%, representation from ethnic minority members of the local population (at 4.3%) while increased by 0.5% on the previous year; and the under 21 age group at just 0.3% would both benefit from targeted recruitment. It is worth noting however that, in comparison with the local demographic profile, black and Asian membership exceeds the expected levels. In latter regard to the younger population, the Membership and Community Relations Working Group of governors has established links with both Newcastle University and the University of Northumbria, with the specific objective of recruiting more students to the Membership.

Since March 2009, all new Members have automatically received a Membership certificate at the end of the month in which they joined. Outcomes in terms of stimulating awareness and adding additional Public Members have been disappointing, however, with relatively few new Members recruited – 127 in the course of 2013/14 but 348 members were lost in the same period.

The Membership and Community Relations Working Group proposed to the Council of Governors in May 2011 that, whilst there should be no let-up in the Membership recruitment efforts, there could be an increased emphasis on engagement with the existing Membership. This was endorsed and consequently there have been three Members’ Events in the course of 2013/14, each focused on an exposition of a particular clinical service – pioneering dentistry at the Dental Hospital; advances in cancer care; and end of life care. These events have been well attended and have served not only to add new Members but to raise awareness amongst the wider Membership that there is a role to be played as an advocate for Membership. The twice-yearly newsletter for Members facilitates a “sign one up!” campaign, encouraging every member to sign up a family member, colleague or relative. The newsletter continues to be a key recruiting tool. For Staff, the “New in November” campaign was successful in adding around a hundred new Members and hence this will run again in 2014.

Existing communications networks across the region with which governors are engaged, particularly charities related to patient care and established patient interest groups, will also be used as conduits for further promotion.

The Membership application form is available at public-facing locations throughout the Trust and the web address for online sign-up (www.nhs-membership.co.uk/nutt) is included as a matter of course in all Outpatient appointment letters and cards and is also readily accessible from the Trust website.

Members wishing to contact a Governor can do so either through the Trust Secretary, or using the “Contact a Governor” web page. All Governors have a Trust email address. A “know your governor” leaflet for patients and the public is published each year in the wake of the annual elections.
### Membership Report, 1st April 2013 to 31st March 2014

#### Public Constituencies

<table>
<thead>
<tr>
<th>As at 1st April 2013</th>
<th>Eligible Population</th>
<th>Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newcastle</td>
<td>2,231</td>
<td></td>
</tr>
<tr>
<td>Northumberland, etc</td>
<td>2,424</td>
<td></td>
</tr>
<tr>
<td>Co. Durham, etc</td>
<td>843</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,498</strong></td>
<td></td>
</tr>
<tr>
<td>New Members</td>
<td>127</td>
<td></td>
</tr>
<tr>
<td>Members leaving</td>
<td>348</td>
<td></td>
</tr>
<tr>
<td><strong>At year end (31st March 2014)</strong></td>
<td><strong>5,277</strong></td>
<td><strong>1,379,594</strong></td>
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</table>

#### Staff Constituencies

<table>
<thead>
<tr>
<th>As at 1st April 2013</th>
<th>Eligible Population</th>
<th>Index</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3,478</td>
<td></td>
</tr>
<tr>
<td>New Members</td>
<td>348</td>
<td></td>
</tr>
<tr>
<td>Members leaving</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td><strong>At year end (31st March 2014)</strong></td>
<td><strong>3,820</strong></td>
<td></td>
</tr>
</tbody>
</table>

#### Patient Constituency

- The Trust does not have a separate Patient Constituency

#### Public Membership – Age Profile

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Eligible Population</th>
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</tr>
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<tbody>
<tr>
<td>0-16</td>
<td></td>
<td>0</td>
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<tr>
<td>17-21</td>
<td>22</td>
<td>7</td>
</tr>
<tr>
<td>22+</td>
<td>4,708</td>
<td>94</td>
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#### Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Eligible Population</th>
<th>Index</th>
</tr>
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<tbody>
<tr>
<td>White</td>
<td>6,358</td>
<td>127</td>
</tr>
<tr>
<td>Mixed</td>
<td>24</td>
<td>52</td>
</tr>
<tr>
<td>Asian</td>
<td>211</td>
<td>123</td>
</tr>
<tr>
<td>Black</td>
<td>42</td>
<td>128</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>37</td>
</tr>
</tbody>
</table>

#### Socio-Economic Groupings

<table>
<thead>
<tr>
<th>Socio-Economic Grouping</th>
<th>Eligible Population</th>
<th>Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB</td>
<td>1,957</td>
<td>275</td>
</tr>
<tr>
<td>C1</td>
<td>2,671</td>
<td>248</td>
</tr>
<tr>
<td>C2</td>
<td>1,165</td>
<td>184</td>
</tr>
<tr>
<td>DE</td>
<td>934</td>
<td>56</td>
</tr>
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#### Gender Analysis

<table>
<thead>
<tr>
<th>Gender</th>
<th>Eligible Population</th>
<th>Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>2,429</td>
<td>92</td>
</tr>
<tr>
<td>Female</td>
<td>2,802</td>
<td>105</td>
</tr>
</tbody>
</table>
1. Financial Performance

The Trust continues to demonstrate a strong financial base and a surplus of £13 million before exceptional items and the highest possible ‘Financial Risk Rating’ of ‘4’ was reported for 2013/14. This exceeded planned expectations and ensures that, in terms of its finances, the Trust remains one of the highest performing Trusts in the country.

The financial stability of the Trust does stand it in good stead to address the funding challenge facing all public services. There remains an underlying strength and hence the opportunity for capital investment to progress further innovation and in particular to derive the benefits from leading edge technologies.

2. Income

The Trust generated income of £930.8 million which exceeded the plan set at the beginning of the year by £34 million. This included over-performance against the general acute contracts set by commissioners of £35 million and which was driven entirely by increasing numbers of patients choosing to access our services and high cost drugs and devices. Such additional activity came primarily from specialist commissioners and local CCGs including North Tyneside, Northumberland, Gateshead, South Tyneside, Sunderland and Newcastle who all exceeded contractual expectations. The growth in activity reflects patient choice and is a testament to the skill and reputation of Newcastle Hospitals in serving local and national catchments.

Despite funding challenges emerging as a consequence of the wider distribution of monies in the health economy Highly Specialist Services over performed against plan by £3.3 million and this was increased further by the very significant growth in specialist drugs and devices which exceeded £12 million. The international reputation of the Trust has encouraged an increase in overseas activity. Also Research and Development income exceeded all expectations.

Despite challenges to Training and Education funding streams the Trust has seen central investment in recognition of the complexity of case mix and the necessary infrastructure which was not anticipated in the initial plan. This funding makes a generous contribution to the function which does cost the trust far more than it received in income.

It is to be noted that the level of private patient income was £3.8 million. This is 0.48% of total patient care income and hence well within the regulated upper limit of 1.2%.

It can also be advised that some 96% of total income was received for the provision of NHS services in England, with the balance received from health service commissioners in Scotland, Wales, Northern Ireland and the Republic of Ireland.

3. Expenditure

Total expenditure for the year was £917 million (after finance costs) and despite the income growth this was less than prior year expenditure levels.

The underlying position continued to demonstrate recurrent balance and sufficient strength to manage the impact of nationally determined pay awards auto enrolment which proved to be inflationary for the Trust and which placed pressure on the cost base. Such costs, together with the additional cost associated with the growth in caseload, have had no detrimental impact and are underwritten to be funded from the overall order book. Cost reductions arising from the sustained involvement of healthcare professionals in ensuring the cost effective delivery of service have ensured this stability.

Non-recurrent savings and income gains have also provided for investment opportunity, thereby enabling additional expenditure in the estate and IT infrastructure to address the future needs of the organisation.
4. Capital Expenditure Plans

Capital expenditure exceeded £18.9 million.

Most notably the Trust invested £6.7 million in the replacement of medical equipment including the purchase of a second Da Vinci surgical robot and a state of the art Linear Accelerator to support Cancer Treatment. £1.4 million was invested to develop Adult Cardiac ICU facilities and there was further investment in the organisational infrastructure, including the provision of off-site ‘back office’ accommodation and in the Trust Information and Technology systems, improved integration with the community interface and GP services.

The overall strategic intention of the capital programme remains focused on the development of an environment which inspires innovation and excellence in healthcare.

5. Delivering Value for Money in the Public Interest

On closure of the financial year, the total efficiency saving delivered by the Trust was £35.2 million, with the full value delivered on a recurrent basis. This was achieved without compromising on the scope, scale and inherent quality of the service portfolio.

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

In addition, the Trust continues to review the efficiency of clinical pathways in order to improve the patient experience and the quality of the service provided and at the same time reduce costs. Given the economics of the NHS and the anticipation of minimal growth, the Trust is recognising that transformational change, cost reduction and productivity gains must provide a much higher proportion of the future savings requirement.

Slippage in the annual, recurrent efficiency requirement is not an option. This message has been very clearly communicated throughout the Trust and staff are to be commended for their commitment and common purpose in this most challenging context.

6. The Balance Sheet

The assets of the Trust owned estate were valued at £312 million on 31st March 2014.

The closing year end cash balances at 31st March 2013 were £96 million. This balance provides strength and resilience as we move forward into a challenging financial environment and changing land scale.

7. Operational Future

As we look to the future the NHS remains exposed to a challenging cost improvement programme. In order to maintain services in the face of a real-terms cut in tariff and non-tariff income, as well as the inevitable inflationary cost pressures. The Trust will need to save circa £35 million per annum in order to continue to achieve operational targets and sustain financial balance.

The new commissioning environment has taken some time to stabilise. Commissioners are resource constrained and whilst they have met commitments in terms of increasing patient volumes there has been a lack of commitment to any developments or cost pressures linked to volume of caseload presentation. Further ‘market testing’ of specific clinical services is an issue that requires strategic and informed management acumen.

The national ‘Better Care Fund’ initiative serves to encourage engagement with community partners and the challenge remains to ensure true integration and deliverability of the increasing patient throughput through development of effective schemes to ensure patients are treated in the community setting where this is the more appropriate set.

We remain focused on financial stability and a business model which addresses growth and has a focus on the quality of our offer, though patient choice and an effective partnership with primary care. The opportunity for “Whole Service Integration” continues to be a goal pursued with enthusiasm. We have gained experience at first hand of the primary care delivery setting, through three successful “Equitable Access” initiatives and, in pursuing a productive working partnership with Newcastle City Council, we are on a step by step basis providing the platform to bring about genuinely ‘joined up’ service delivery.

The Trust has a capital investment programme funded from depreciation and cash reserves that does serve to ensure maximum benefit from extant and developing infrastructure. We are providing an attractive, safe and sustainable environment for patients and which facilitates cutting edge innovation of clinical and related practice.

In relation to Education and Training funding, there is fundamental concern that Health Education England revision and reconciliation of training levies has resulted in significant funding reductions from 2013/14 onwards, with a detrimental impact on the Trust and our ability to deliver medical and non-medical education and training. It is to be noted funding redistribution to other NHS Foundation Trusts in the region has served to destabilise this spectrum of our commitment as a nationally acknowledged group of teaching hospitals and thereby required rapid mitigation to ensure the public interest was best served. The Trust remains well positioned through partnership with Newcastle University to encourage and implement innovation and research and is engaged at national level to ensure that the appropriate input to influence Tariffs which are proposed to replace the current Tariff mechanism.

8. In Summary

The Trust continues to deliver to all financial targets without compromise to our national standing as a safe, effective service provider and shall continue to instil a climate of prudence and control.

Looking to the future, we are determined to steer through the downside of the economic climate and the obstacles of an overcrowded, multifactorial bureaucracy, by sustaining demonstrable efficiency and effective use of public monies and sustaining the ‘Excellent’ ratings that have been accorded to the Trust year on year.

The Board of Directors is confident of maintaining the long established record of sound financial management and provision of a service portfolio of both national and international esteem.
PUBLIC
INTEREST
DISCLOSURE
This part of the Annual Report is audited. The following interests have been declared by the Directors and the Board is satisfied there is no conflict of interest indicated by any of the external involvement. As described above, where a Director sits on the Board of a spin-off company or other commercial venture, the latter post is unremunerated.

**Chairman and Non-Executive Directors**

**Chairman**
Mr K W Smith

**Non-Executive Directors**

Professor P H Baylis

Professor C P Day

Dr B C Dobson

Ms S Kler

Mrs H A Parker

Mr D Stout

Mr E Weir

**Executive Directors**

**Chief Executive**
Sir Leonard Fenwick CBE

**Finance Director**
Mrs A Dragone

**Nursing & Patient Services Director**
Mrs H Lamont

**Business & Development Director**
Mrs L Robson

**Medical Director**
Mr A R Welch

Chairman and Trustee, St Mary Magdalene & Holy Jesus Trust Holy
Chairman and Trustee, Freemen of the City of Newcastle upon Tyne
Director, Newcastle NE1 Limited
Chairman and Director, NewGene Limited
Director, Shelford Group

Non-Executive Director, NewGene Limited
Secretary, Newcastle Healthcare Charity
Trustee, Heath Committee

Trustee, Heath Committee
Non-Executive Director, Freeman Clinics Limited (80% owned by Trust)
None

Director, A Welch Limited
The National Health Service Act 2006 (“2006 Act”) 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 The Newcastle upon Tyne Hospitals NHS Foundation Trust to prepare, for each financial year, a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accrual basis and must give a true and fair view of the state of affairs of The Newcastle upon Tyne Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Financial 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 Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- prepare the financial statements on a going concern basis.

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

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.

Sir Leonard Fenwick
Chief Executive
28 May 2014
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.

Risk Management Strategy

The risk management strategy sets out the structures and processes by which risks are identified, evaluated and controlled. This is predominantly the responsibility of the Corporate Governance Committee to oversee, with individual officers delegated specific responsibilities and leadership as described below. Appetite for risk is tested at the Corporate Governance Committee, Audit Committee and Board of Directors as required by the perceived scale and potential impact of each risk. A central risk register is held, which records when a risk has been identified, its owner, the likelihood of its occurrence and its potential impact, and, importantly, the action plan for mitigation. The strategy also includes a system of internal control, as described below.

It is recognised that effective Risk Management requires commitment and active involvement of all employees. It is therefore vital that the Risk Management process is communicated and embedded throughout the organisation. In addition to the corporate responsibilities outlined above, Directorate Managers, Clinical Directors and Department Heads are responsible for ensuring effective Risk Management in accordance with Trust strategy and policy within their own specialist areas. This includes primary responsibility for identification, investigation and follow up of all risk issues, as defined in job descriptions and personal objectives. A key element of this approach is the maintenance of a robust risk register. Where initial assessment indicates a high level of risk and for where the level of risk warrants reporting to an external body, the Directorate Manager, Clinical Director or Department Head is responsible for bringing the issue to the attention of the Director – Quality & Effectiveness or appropriate Board Director, in order to agree decisions about subsequent management of the risk.

The Trust recognises the strategic role of Risk Management in underpinning the organisation’s reputation and performance. Implementation of the Risk Management strategy is key to delivery of organisational objectives in relation to governance and controls assurance. In addition, the embedding of effective Risk Management systems and the development of a positive learning environment support improvement of services and delivery of Trust priorities in all areas.

The key elements of the Trust Risk Management Strategy are as follows:

- A clear framework of accountability and delegated responsibility for management of risk
- An integrated Risk Management Strategy outlining the overall purpose and processes, and an associated annual plan detailing specific action
- A clearly defined committee structure, which supports robust and timely decision-making in relation to key organisational risks
- Intranet based governance and Risk Management policies and procedures
- Robust systems for identification, analysis, prioritisation and action in relation to risks affecting all areas of Trust activity
- Risk Management processes integrated and embedded into the day to day activities of the organisation
- A Clinical Governance and Risk Department, to facilitate risk control processes, and also to support the development of capacity within the Directorate and department teams
- A tailored training programme to address key risk issues arising both internally and as a result of national initiatives
- Rigorous communication processes to ensure that information about key risks and lessons learned are effectively disseminated at all levels. Regular communication meetings such as the monthly Trust-wide Communications Forum are supplemented by weekly bulletins and an extensive Intranet information service
- External communication with key stakeholders and the general public via established partnership forums, the Council of Governors, the Annual General Meeting and Trust website.

Decision making about Risk Management priorities within the Corporate Governance Committee was informed by a range of information, including:

- Prioritised risk register information
- Reports from incidents, complaints and claims systems
- Issues highlighted in structured Directorate and Department risk reviews and ad hoc feedback
- Minutes and regular reports from the Risk Management sub-groups and other working groups
- Issues highlighted by the Complaints Panel
- Feedback from stakeholders via the Newcastle Health Partnership, Joint Advisory Group for Physical and Sensory Disability, Trust Community Advisory Panel, Equality and Diversity Working Group, Council of Governors, Patient & Public Involvement Committee, the PALS service and other patient representative groups.

Priorities identified by the Committee are included in the Risk Register and fed in to the risk management plan and, where appropriate, the Assurance Framework, in order to support decision making on prioritisation and allocation of resources. The Corporate Governance Committee also communicates directly with the Board of Directors, the Audit Committee and the Clinical Governance and Quality Committee in relation to specific areas of risk.

The Trust is also required to make decisions regarding acceptable or unacceptable levels of risk in relation to specific risk issues. This
decision making will reflect the financial capacity of the Trust, the need to maintain service provision, and assessment of potential harm to patients, employees or the general public, together with the Trust’s obligations in relation to external regulations, standards or targets.

Decision-making is supported and informed by an increasing use of objective risk assessment processes within the different management functions of the Trust. These tools include a standardised risk assessment matrix based on the Australia/New Zealand Risk Management Standard model, the Assurance Framework and corporate Risk Register. The core Risk Management tools are available for use by all staff via the Trust Intranet.

The tools are designed to enable the Trust to adopt a systematic approach to:

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

The Assurance Framework provides a high level analysis of risks in relation to the Trust’s key objectives across all areas of activity. Risks are identified which might affect the organisation’s ability to achieve its objectives. For each risk, the framework provides an assessment of the controls in place to ensure that the risks are managed effectively and the processes and specific evidence, which give the Board of Directors the necessary assurance that the Risk Management and control measures are effective. Gaps in control or assurance processes are identified, in order to ensure that these can be suitably addressed.

Individual employees have personal responsibility for participating in Risk Management processes in order to identify and address adverse events or potential risks to patients, colleagues or the Trust. This includes responsibility for:

- Maintaining awareness of relevant Trust policies and procedures and for ensuring that their practice complies with the policies laid down and with the requirements of the appropriate professional body
- Reporting of any incidents, accidents or near misses encountered during the course of their work, as defined in the Operational Policy for Incident, Accident and Near Miss reporting
- A range of specific responsibilities in relation to key risk issues, as defined in other Trust policies, including the Health and Safety Policy and Complaints Procedure.

The Risk Management strategy strongly emphasises the need for a knowledgeable workforce, which is actively engaged in the Risk Management process. Delivery of the strategy is therefore underpinned by a wide range of education and training initiatives for staff at all levels. Training delivered by the Training Department and other key staff is informed by Risk Management priorities identified through the systems outlined and via an annual training needs analysis.

These initiatives include:

- Mandatory sessions on Trust induction programmes for all new staff and formal departmental induction programmes in all areas that address key risk issues, including Health and Safety
- Presentations and workshops on various aspects of Risk Management within the clinical governance lecture programme and a wide range of sessions facilitated by the Training Department and Clinical Governance and Risk Department on specific issues. This includes training in relation to controls assurance issues, risk assessment processes, incident and complaint management, and key national developments, including use of Root Cause Analysis techniques, as advocated by the National Patient Safety Agency. In the relevant period, there has also been an extensive programme of Fraud Awareness

- Access to external education and training wherever appropriate, such as those facilitated by the National Patient Safety Agency, NHS Litigation Authority and Department of Health

- The provision of information via the Trust Risk Management intranet site, in order to ensure ready access for all employees.

Wherever possible, opportunities are taken to learn lessons from adverse events and near misses. Trust communication forums and education sessions are used extensively to share information on lessons learned with employees at all levels.

The focus on Risk Management training over recent years is paying clear dividends, with greater risk awareness amongst Trust employees and a more active involvement at all levels in efforts to identify and reduce risk.

System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Newcastle upon Tyne Hospitals 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 The Newcastle upon Tyne Hospitals NHS Foundation Trust for the year ended 31 March 2014 and up to the date of approval of the annual report and accounts.

Risk Management - Leadership

Overall decisions in relation to prioritisation of corporate risk issues and resource allocation are taken by the Board of Directors, with delegation of decisions relating to specific risks to sub-committees and panels or the Executive Team as appropriate. This decision making process is underpinned by information and advice from the Corporate Governance Committee, via regular reports on the Trust Risk Register and an annual review of progress against the Risk Management Strategy. The approach to business risks was supported by the work of the Executive Team, which had a specific role in relation to assessment of the financial and corporate risks arising from business cases for specific developments and from the annual business plan. The remit of the Audit Committee also includes scrutiny of Risk Management processes. With regard to financial and associated risks, the Investment Committee has a remit to ensure that business cases for significant developments are robust, address key risks explicitly and deliver a satisfactory rate of return on the investment made.

Leadership is given to the risk management process in the following ways. The roles and responsibilities of the Executive Directors have been developed to cover all aspects of risk. These arrangements are reflected in their job descriptions. Performance is monitored through the Individual Development Review process. Corporate performance is scrutinised as a matter of routine by the Performance Management Group, comprised of the Executive Directors (except the Chief Executive) and supported by specialists in performance review and analysis. This Group presents key findings to the Executive Team when required and any significant issues are then raised with the Board of Directors as necessary.

As Accounting Officer I delegate particular aspects of my role to the Executive Directors. These arrangements are reflected in job descriptions and performance review mechanisms. The Chief Executive role is
In addition to these Executive responsibilities, has overall responsibility to the Board of Directors, has overall responsibility and accountability for all aspects of the Risk Management Policy and delegates this responsibility to senior managers of the Trust as detailed in the Risk Management Strategy. The Medical Director had delegated executive responsibility for Risk Management and was responsible for ensuring that the Risk Management Strategy, structure and systems were in place and working effectively.

Specific responsibilities are delegated to members of the Executive Team as follows:

- The Medical Director has responsibility for the implementation and further development of the Risk Management strategy, including implementation and monitoring of the former “Standards for Better Health” and oversight of the Care Quality Commission registration requirements. The Trust Secretary is the Responsible person for CQC registration purposes
- In that context, the Medical Director has responsibility for the implementation and continuing development of the clinical aspects of the Risk Management strategy for the Trust, as an integral part of Clinical Governance
- The Finance Director has responsibility for the management of risk in relation to finance issues
- The Trust Secretary has responsibility for non-clinical governance matters, including information governance in his role as Senior Information Risk Owner
- For the year in question, the IT Director, in liaison with the Medical Director, was delegated the responsibility for the implementation and further development of Risk Management in relation to business continuity. Fire, security and related operational and organisational issues remained under the direction of the Acting Head of Estates & Facilities, in liaison with the Chief Executive, during this time
- The Director – Quality & Effectiveness has responsibility for the implementation and further development of the Health and Safety strategy for the Trust
- In recognition of the potential scope and scale of the risks attached to the Transforming the Newcastle Hospitals project, a specific Project Board chaired by a Non-Executive Director oversees the construction and commissioning works, including tight control of any variations and receives regular updates of the project risk register. The Project Board reports key issues to the Board of Directors on an exception basis
- In addition to these Executive responsibilities, the Director – Quality and Effectiveness was accountable to the Medical Director for supporting the overall co-ordination and integration of Risk Management activity. This included the key inputs to the Corporate Governance Committee, responsible for overseeing and co-ordinating activities within the various Risk Management working groups.

**Engaging with External Stakeholders**

The risks are shared with and informed by the joint planning and governance arrangements with respective commissioners, as well as Monitor, the Area Team, the Department of Health and a substantial range of external agencies and regulatory bodies, including the Care Quality Commission.

The Trust works as required with the North East Area Team of NHS England and with Clinical Commissioning Groups across the region and the national Specialist Commissioning Group within NHS England to agree objectives and targets. These are monitored through the Performance Assessment Framework and by Monitor.

**Quality Governance Arrangements**

The Trust has introduced a Quality Governance Framework, which describes how the quality of performance information is assessed and how assurance is routinely obtained with regard to compliance with CQC registration requirements. There are regular reports to the Board in these arenas.

The Trust has introduced a new Patient Safety and Quality Review process to act as a quality assurance mechanism by which Directorates performance against Patient Safety and Quality metrics will be monitored. Up to date patient safety and quality data will be made routinely available to the Directorate and attendance at a Patient Safety and Quality Review Panel (chaired by the Medical Director) will provide an opportunity for the escalation of any areas of underperformance. The Patient Safety and Quality Review Panel will report to the Clinical Governance and Quality Committee (the Board level sub-committee with overarching responsibility for Quality and Patient Safety).

**Risks to Data Security**

**Implementation of Security Software**

The Trust completed the implementation of Single Sign-on software in 2012, which authenticates users and restricts access rights to appropriate software. Encryption software has been installed in the Trust to ensure that patient identifiable material that is required to be carried on transferable media, USBs or CDs is securely encrypted in line with NHS policy.

**Information Governance**

Information Governance Toolkit - In 2013/14, the Trust achieved an overall rating of 87%, an improvement of +5% from the Trust’s rating in 2012/13 (82%). The Trust also maintained its ‘Satisfactory’ rating, which meets the Monitor requirement of achieving Level 2 (≥50%) on all 45 requirements as a minimum.

The focus for 2013/14 was to build upon the work of previous years. This year, work was concentrated on the resilience of evidence for all requirements. Throughout the year, the number of Level 3 requirements rose from 21 to 28. Both the IT technical and the Data Quality Management requirements showed improvements to level 3.

Mandatory Information Governance training for all Trust staff continues to be a focus for the Information Governance Team – through the online presentation for staff who have regular contact with confidential information and face to face presentations for those who do not. The Information Governance Team continue to provide bespoke training sessions for a variety of staff groups including Access to Records and Data Protection training for Medical Records and Outpatients staff and have provided training to Newcastle University staff as they prepare for their first year of Information Governance toolkit.

The Information Governance Toolkit is a performance tool produced by the Department of Health (DH). It draws together the legal rules and central guidance (such as the Data Protection Act and the Common Law Duty of Confidentiality) and presents them in one place as a set of information governance requirements. Organisations are required to carry out self-assessments of their compliance against these. Submissions are made annually in March, with update submissions occurring in July and October. The final submission scores reported by organisations are used by the Care Quality Commission to assist with their assessments.

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

The Trust Secretary has been designated by the Board as the Senior Information Risk Owner. A comprehensive review of corporate records and record keeping arrangements across the Trust was conducted by an independent, external body in the Autumn of 2011. The report on key findings was presented in January 2012 and the Board of Directors briefed in March 2012. That review underpinned the action plan for 2012/13 and the Information Governance Toolkit.

**Law Duty of Confidentiality**

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

The Trust Secretary has been designated by the Board as the Senior Information Risk Owner. A comprehensive review of corporate records and record keeping arrangements across the Trust was conducted by an independent, external body in the Autumn of 2011. The report on key findings was presented in January 2012 and the Board of Directors briefed in March 2012. That review underpinned the action plan for 2012/13 and the Information Governance Toolkit.
Goverance Committee took oversight of implementation of the key actions. A further review has been scheduled for 2014/15 and building upon a recent Internal Audit report in this arena.

The Trust declared no Serious Untoward Incidents with regard to patient confidentiality or data loss in the course of 2013/14.

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

In the course of the year, the Audit Committee has received a series of Internal Audit reports, from an agreed workplan, designed to test the economy, efficiency and effectiveness of a wide array of the Trust’s systems and processes and not just financial management and control. The annual audit plan is reviewed and agreed by the Audit Committee in April each year.

Where required by the nature of the findings, any reports which offer only limited assurance are followed up in terms of a management action plan, to an agreed timetable and progress is monitored by the Audit Committee. In exceptional circumstances, serious issues are escalated to the Board of Directors.

In addition, the external auditors provide a degree of assurance to the Audit Committee and to the Board that the financial control systems are robust (to the extent that these are examined as part of the audit of the annual report and accounts).

**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.

The Quality chapters below describe in detail the measures in place to assure the Board that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data. For example, there are regular data audits. The Director – Quality & Effectiveness has the delegated responsibility for oversight of the Quality Report, including ensuring that processes are in place to ensure that the Quality Report presents a balanced view.

Allied to this, the Clinical Governance & Risk Department takes oversight of all policies and plans, to ensure that quality of care is paramount. This includes a specific requirement for the appropriate approving committee to sign off an Equality Impact Statement to ensure that there are no discriminatory aspects to any policy.

**Review of effectiveness of the System of Internal Control**

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and corporate governance committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed and continued to monitor actions initiated in response to specific risks highlighted. Oversight of incidents was continued by the Corporate Governance Committee in the course of the year, to more closely integrate analysis of and learning from incidents with other risk assessment and risk mitigation processes.

The Corporate Governance Committee was responsible for implementation and further development of the Risk Management strategy and for ensuring that systems are in place to identify and address key risks. This role was complemented by that of the Audit
Committee, the latter being responsible, via the Internal Audit Service, for verifying that the system of internal control was effective in managing risks in the manner approved by the Board of Directors.

In order to support further development, the Trust has taken full advantage of opportunities wherever possible, to benchmark performance against national and international best practice. This included participation in both formal external assessments (including the CHKS and Shelford Group benchmarking groups) and informal processes, including those facilitated by the Department of Health, Area Team, National Patient Safety Agency, Care Quality Commission, and National Audit Office.

**Regulatory Requirements**

NHS Foundation Trusts are required by Monitor, the independent regulator, to make a statement on Equality & Diversity. The Board affirms that all necessary control measures are in place to ensure that the Trust’s obligations under Equality, Diversity and Human Rights legislation are fully met.

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

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission. This is borne out by the regular Intelligent Monitoring Reports produced by the CQC on the Trust’s performance against a very wide range of metrics and risk indicators; and through the publication of any CQC inspection reports. The Quality chapters below provide further detailed information in this regard.

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 Adaptation Reporting requirements are complied with.
Conclusion

Overall, the organisation has a high level of confidence with regard to management of the key risk issues. Analysis of key risks to the Trust within the Assurance Framework identified two gaps in control or assurance processes in relation to the Trust’s corporate objectives and flowing from the continuing drive to integrate the governance arrangements within the Trust:

- Quality Assurance Reference Centre (QARC) visit October 2012. The formal report is still awaited
- Management of corporate records. This relates to appropriately timely scanning, archiving and destruction of such records.

In addition, the Head of Internal Audit Opinion for 2013/14 did identify the following areas of limited assurance, for all of which robust action plans for remediation and improvement have been put in place:

- ERA System – access controls
- Capital Planning & Monitoring - spending approvals and control processes
- Fire Safety - poor definition of accountability and reporting; non-compliance with national guidance on training
- InTime application - access controls and monitoring.

The only significant internal control issues identified as a result of these processes were the issues highlighted in the Head of Internal Audit Opinion (as described above), for which action plans have been developed and implemented. The benchmarking and external assessment processes continued to highlight the Trust as a high performing and effectively managed NHS organisation.

Sir Leonard Fenwick
Chief Executive
28 May 2014
I am pleased to introduce the Quality Report for 2013/14 which serves to demonstrate how we have continued to deliver high quality, cost effective care for patients. In addition we set out our key quality and patient safety priorities for 2014/15. Throughout the Quality Report there are examples of the delivery of high quality care and our commitment to driving up quality and placing the patient at the core of all we do. All in all we endorse the overriding principle of the Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry chaired by Robert Francis QC (Department of Health, February 2013) of placing the patient first and foremost in everything we do.

Without a shadow of a doubt 2013/14 was a challenging year where we have encountered a difficult economic climate and rising demand for services. As one of the largest and most successful teaching hospital groups in England, we continue to provide a world class, high quality service delivered by high calibre and highly committed healthcare professionals. We have completed our 8th year as an NHS Foundation Trust with 2013/14 being another busy and most successful year. Again our excellence in healthcare has been recognised nationally where we have for the 14th consecutive year been awarded the CHKS Top Hospitals Awards in 2014. We were also recommended in the Dr Foster Good Hospital Guide in 2013 and seen as an exemplar organisation in a recent Dementia themed inspection by the Care Quality Commission (CQC), the care of patients with Dementia being an area we are extremely proud of. The CQC spent some two days looking at records and speaking with patients, their relatives and staff about the care and treatment provided by our hospitals. The CQC findings were that patients with Dementia were kept safe because their inherent risks were managed appropriately by committed and caring staff with good personal skills. Care was found to be given in a responsive and unrushed manner and recognition the Trust had made a significant commitment to the Dementia Action Alliance’s ‘Right Care: Creating dementia friendly hospitals’ initiative.

Delivering high class quality care and being the healthcare provider for Newcastle continues to be our long standing ambition and aim. Throughout 2013/14 we saw more patients than ever before and continued to deliver safe, quality care in first class facilities. All in all this experience can be seen in our performance in the National Annual Inpatient Survey 2013 and the NHS Friends and Family Test. New cutting edge pioneering healthcare continues to be delivered at the Trust and includes the pioneering surgery that was undertaken last year where surgeons in an 18 hour operation removed a man’s tumour and rebuilt his body using leg muscles and tissue they had removed and attached to his arm. It is believed that this may well prove to be the first operation of its kind in the world and it opens up a new approach to surgery. Research and development also continue to play a significant part in the delivery of specialist healthcare where the Trust are also core members of both the North East and Cumbria Academic Health Science Network and the Northern Health Science Alliance linking Leeds, Sheffield and Manchester with ourselves.

The Trust recognises and highly commends the performance and excellence of its most loyal and dedicated workforce and throughout this Quality Report you can read achievements of...
individuals and teams across the organisation. A staff recognition scheme reinforces the value we place on the contribution staff make to providing high quality patient care. As a leading employer here in the North East who work closely with higher education institutes to develop our workforce who continue to recommend the Trust as a place to work or receive care and treatment which can be observed via the findings in the National Annual Staff Survey.

As an NHS Foundation Trust we have continued to develop effective strategic partnership across health and social care with our clinicians contributing to policy and clinical practice guidelines by actively engaging in various National and Local Clinical Networks and Senates across a range of clinical specialties. This work is enhanced further by activities and projects developed as part of the nationally acknowledged Shelford Group encompassing the ten leading teaching hospital groups (2011) who have so positively contributed to national decision making and ultimately benefitted local health economies.

We continue to provide a world class, high quality service delivered by high calibre and highly committed healthcare professionals

This Quality Report for 2013/14 shows the Trust in a strong position as we move forward into 2014/15 and continue to sustain being a leading healthcare provider.

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

Sir Leonard Fenwick  
Chief Executive  
The Newcastle upon Tyne Hospitals NHS Foundation Trust
The information presented in this Quality Report represents information which has been monitored over the last 12 months by the Trust Board, Council of Governors, Clinical Governance and Quality Committee and the Clinical Policy Group.

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

The Trust has as intended in 2013/14 consulted more widely with members of the public and local committees in ensuring that the indicators presented in this document are what the public expect to be reported. Comments have still to be received from Newcastle Health Scrutiny Committee, Newcastle Clinical Commissioning Group (CCGs) and the Local Healthwatch teams.

Quality Priorities for improvement 2013/14

Patient Safety

Priority 1 - To reduce healthcare associated infection (HCAI) by:

- Aiming for the annual number of Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia cases to be no more than zero
- Reducing hospital acquired infections related to Clostridium difficile (C.diff.) to be no more than 66 cases in the next year.

From April 2013 to March 2014, there were eight MRSA bacteraemia cases attributable to the Trust. This is a ‘zero tolerance’ approach to MRSA infections. In the same period, there were 75 cases of hospital acquired C. difficile, against an annual target of 66 cases.

Table 1: Trust rate - MRSA bacteremia and C. difficile 2010/11 - 2013/14

<table>
<thead>
<tr>
<th>Infection</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA bacteremia</td>
<td>8</td>
<td>7</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>C. difficile</td>
<td>150</td>
<td>101</td>
<td>76</td>
<td>75*</td>
</tr>
</tbody>
</table>

*This indicator has been subject to assurance by PricewaterhouseCoopers LLP.
Following each case of MRSA a rapid review and Post Infection Review form are completed. A Serious Infection Review Meeting (SIRM) is held and lessons learned are discussed and implemented. This information is collated in a quarterly report which is submitted to the Infection Prevention and Control Committee (IPCC) and disseminated to all Directorates, which facilitates the sharing of lessons learned and best practice.

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

one episode of diarrhoea (Bristol Stool Chart Type 5-7 or stool loose enough to take the shape of a container used to sample it) that is not attributable to any other cause, including medicines, and that occurs at the same time as a positive toxin assay and / or endoscopic evidence of pseudomembranous colitis (PMC). All NHS Trusts in England are required to participate in the Department of Health’s mandatory CDI reporting system and to report all cases of C. difficile toxin (CDT) positive diarrhoea in patients over 2 years of age.

All samples (hospital and wider community) which are type 5 – 7, are tested on all patients aged 65 years and above and on those aged less than 65 years if this is clinically indicated. Stool specimens are sent for toxin testing on the 2nd episode of Type 5 – 7 diarrhoea of unknown cause ensuring sufficient quantity is sent for testing, i.e. fills up to 1/5th of the container.

Specimens are not sent on the first episode of diarrhoea (unless clinically indicated or the patient is admitted due to diarrhoea of unknown cause, if this is the case, send specimen immediately).

Following each C. difficile case a Root Cause Analysis (RCA) is completed and the results compiled in a database.

An RCA is completed on all patients who are confirmed C. difficile positive >72 hours after admission or following contact with Trust acute services in the preceding 28 days. This is completed by the Matron (or Sister / Charge Nurse) and Doctor involved in the patients care supported by an IPC Nurse.

RCAs are discussed at the Trust Serious Infection Review Meeting (SIRM) at the discretion of the Director of Infection Prevention and Control, site Infection Prevention and Control Doctor and Matron for Infection Prevention and Control; cases will be reviewed within four weeks of occurrence. All cases where C. difficile is recorded on the patient’s death certificate will be required to attend SIRM. This information contributes to the production of the quarterly report to the Infection Prevention and Control Committee. Monthly C. difficile statistics are reported as a scorecard to the Trust Board.

Fifteen C. difficile cases were submitted to the Commissioners for appeals for this year. These were cases where it was felt that best practice was adhered to. Of these, 11 cases have been successfully upheld and therefore not included in the Trust’s C. difficile numbers in terms of the contract.

The graphs help to indicate the Trust position at the end of March 2014 and progress made over the year in respect of reducing the incidence of hospital acquired infections. Clinical Directors and Directorate Managers have produced Directorate HCAI action plans to clearly identify compliance and progress with the HCAI strategy, along with evidence. These plans have been reviewed by the IPC Operational Group and comments have been fed back to the Directorates.

The figures are reported to the Trust Board and Public Health England (PHE) on a monthly basis. The HCAI and C. difficile action plans have been reviewed by the Infection Prevention and Control Committee (IPCC). As a result, Infection Prevention & Control (IPC) is a standing agenda item at the Trust’s main forums and Directorate level communication and governance meetings.

The Serious Infection Review Meeting process has been revised to ensure all cases requiring review are presented within four weeks. Lessons learned are disseminated to clinical staff and work is ongoing to encompass IPC issues in a broader safety bulletin.

Antibiotic stewardship is a standing agenda item at the IPCC. Antibiotic champions will be appointed for each Directorate to lead on audit work. Pharmacy will undertake quarterly ward usage audits to demonstrate trends and will implement an annual Trust-wide prevalence audit.

The Trust recognises that the reduction in HCAIs must remain a Trust priority and has therefore decided to include it as a priority within the Quality Report in 2014/15.

Graph 1 - Trust acquired MRSA bacteraemia rates April 2007- March 2014

Graph 2 - Trust acquired C. difficile rates April 2007- March 2014
Priority 2 – Safety Thermometer

In accordance with the Safety Thermometer to prevent avoidable harm, disability or death from:

- Falls
- Pressure Ulcers
- Catheter related urinary tract infections (UTIs)
- Venous thromboembolism (VTE)

Graph 3 shows a comparison of the Trust position for harm free care for the period July 2012- March 2014. The Trust only started to submit data to the Health and Social Care Information Centre in July 2012 and therefore does not have 12 months of data for 2012/13.

Graph 3 - Trust position for harm free care period April 2012- March 2014

The following funnel plots illustrate the Trust position in relation to harm free care and the four harms reported in March 2014.

Funnel Plot 1 - National harm free care March 2014

Funnel plot for HFC all harms

Funnel Plot 2 - National pressure ulcer harm March 2014

Funnel Plot for pressure ulcer prevalence

Funnel Plot 3 - National Falls from harm March 2014

Funnel plot for falls with harm

Funnel Plot 4 - National catheter with UTIs March 2014

Funnel Plot for catheters with UTI
As part of The Trust’s commitment to feeding back learning from incidents the key messages from a review of falls incidents graded moderate and above found the following:

Who is most at risk?

- Patients aged 65 years and over are at highest risk of falling and patients aged 85 and over are at highest risk of injury from a fall
- The Care of the Elderly/Medicine Directorate has the highest number of at risk patients and the highest number of falls
- Patients who report having had a previous fall are at high risk of falling as an in-patient
- Patients who demonstrate confusion and reduced mobility are at highest risk of falling and suffering injury.

Falls

The Trust reported 3023 patient falls in 2013/14, this was a slight increase in the total number of 2829 reported in 2012/13. A total of 85 patient falls resulted in injury graded moderate or above in 2013/14 which is a rise in the 76 reported in 2012/13. However the rate of patient falls per 1,000 bed days has shown to be below the national average as measured in the National Inpatient Falls 2010/11 Royal College of Physicians Audit which was 6.8 and based on the median for acute hospitals. Graph 4 shows this comparison.

Graph 4 - Rate of patient falls per 1,000 bed days 2012/13- 2013/14

New cutting edge pioneering healthcare continues to be delivered at the Trust
When and where are people most at risk?

There is a definitive peak in injurious falls in the early hours of the morning, particularly between 05:00 and 06:00.

- At times of increased activity on the wards there is also a peak of injurious falls, but less falls during visiting times
- Patients most frequently fall in bays and cubicles. Falls in bathrooms/toilets have reduced but are still significant.

What is currently being done well?

- Confused patients falling in bathrooms/toilets has reduced but the need to individually assess each patient’s risk of being left alone in these areas still remains paramount
- Significantly, serious harm from falls has reduced but the population of highest risk patients is expected to rise each year. It is therefore essential that each individual’s falls prevention measures are put in place and that these are continuously assessed throughout admission.

What has been done recently to prevent harm from falls?

- The Falls Care Bundle is now established as the Trust Falls Risk Assessment Tool. This is based on NICE guidelines and is a multifactorial risk assessment and intervention tool designed to reduce falls and harm from falls
- The FOCUS Chart is being used on all adult in-patient wards to reinforce patient safety checks at regular intervals throughout the day and night. This specifically starts at 05:00 in response to findings that there is a peak of injurious falls between 05:00 and 06:00
- As part of The Trust’s ‘No Falls On My Patch’ Campaign all in-patient falls graded as moderate and above (according to The Trust Risk Matrix) are investigated through a Root Cause Analysis process. These are reviewed regularly to analyse common themes and identify any areas of learning and implementation of change in practice.

Pressure Ulcers

Pressure ulcers are deemed to be largely preventable and they have become a key quality issue for the NHS. Pressure ulcers are said to be a “harm” caused to the patient, which implies neglect in care by the provider. The published results of the Safety Thermometer data does influence public perception of the quality of care delivered by the Trust.

It is important to stress that the best strategy for pressure ulcer prevention is turning patients as often as possible, at times hourly turns are necessary: this is time consuming for staff on the ward and a change of ward routine is necessary to embed this practice. Therapy mattresses, heel booties and other equipment are great adjuncts but never replace good turning practices.