Freeman Hospital  
High Heaton,  
Newcastle upon Tyne.  
NE7 7DN  
Telephone (0191) 233 6161  
Fax (0191) 213 1968

Newcastle Hospitals Community Health  
Benfield Road,  
Newcastle upon Tyne.  
NE6 4PF  
Telephone (0191) 275 5110

The Dental Hospital  
Richardson Road,  
Newcastle upon Tyne.  
NE2 4AZ  
Telephone (0191) 233 6161  
Fax (0191) 282 4671

Northern Genetics Service  
Institute of Human Genetics,  
International Centre for Life,  
Central Parkway,  
Newcastle upon Tyne.  
NE1 4EP  
Telephone (0191) 241 8600  
Fax (0191) 241 8799

Campus for Ageing & Vitality  
(former Newcastle General Hospital site)  
Westgate Road,  
Newcastle upon Tyne.  
NE4 6BE  
Telephone (0191) 233 6161

Royal Victoria Infirmary  
Queen Victoria Road,  
Newcastle upon Tyne.  
NE1 4LP  
Telephone (0191) 233 6161  
Fax (0191) 201 0155

Northern Centre for Cancer Care  
Freeman Hospital,  
High Heaton,  
Newcastle upon Tyne.  
NE7 7DN  
Telephone (0191) 233 6161  
Fax (0191) 213 1968

Newcastle Fertility Centre  
Biosciences Centre,  
International Centre for Life,  
Times Square,  
Newcastle upon Tyne.  
NE1 4EP  
Telephone (0191) 219 4740  
Fax (0191) 219 4747
Developing our staff

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Our partners

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The organisation

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Annual Report & Accounts 2010/11

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Year in Brief

...proud to be amongst the very best of NHS providers of service

### Income & Expenditure 2010/11

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<th>£000</th>
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<tbody>
<tr>
<td>Income</td>
<td>778,686</td>
</tr>
<tr>
<td>Expenditure</td>
<td>(748,225)</td>
</tr>
<tr>
<td><strong>Operating Surplus</strong></td>
<td><strong>30,461</strong></td>
</tr>
<tr>
<td>Net Finance Costs</td>
<td>(30,337)</td>
</tr>
<tr>
<td><strong>Surplus for the year (before exceptional items):</strong></td>
<td><strong>124</strong></td>
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</table>

### Financial Risk Ratios 2010/11

*Monitor applies a rating system from 1 to 5, where higher numbers are better*

<table>
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<th>Ratio</th>
<th>Rating</th>
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<tbody>
<tr>
<td>EBITDA Margin</td>
<td>3</td>
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<tr>
<td>EBITDA % Plan Achieved</td>
<td>4</td>
</tr>
<tr>
<td>Return on Assets</td>
<td>2</td>
</tr>
<tr>
<td>I &amp; E Surplus Margin</td>
<td>2</td>
</tr>
<tr>
<td>Liquidity Ratio</td>
<td>3</td>
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<tr>
<td><strong>Overall:</strong></td>
<td><strong>3</strong></td>
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Note: *EBITA = Earnings before Interest, Depreciation and Amortisation*

### Key Patient Activity 2010/11

<table>
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<tr>
<th>Activity</th>
<th>Percentage</th>
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<tr>
<td>Day Case FCEs *</td>
<td>46.1 %</td>
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<tr>
<td>Elective Inpatient FCEs</td>
<td>14.6%</td>
</tr>
<tr>
<td>Non-elective Inpatient FCEs</td>
<td>39.3%</td>
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</tbody>
</table>

*FCE = Finished Consultant Episode*
Percentage Income by Commissioner:

- Newcastle PCT 31%
- North Tyneside PCT 29%
- Other Commissioners 19%

Income by Activity Type (£,000,000):

- Specialised Services £233
- Elective Services £163
- Non-Elective Services £147
- Outpatients £95
- A&E £7
- Private (Non NHS) Patients £4
- Other £2
Chairman’s Statement
The Newcastle upon Tyne Hospitals can once again with pride reflect upon a most successful and productive year. All our key clinical performance targets were met and we finished the year in a strong financial position. The Accident & Emergency Department together with other specialist regional services including Neurosciences, Children & Infection Diseases successfully moved from the Newcastle General Hospital to the RVI and this hospital together with the Freeman continues to enjoy a first class and enviable reputation. Innovation too was a clear achievement and our key partners are highlighted with some measure of pride in the Annual Review. They are to be commended for working with us and in certain respects showing such tenacity when sharing common purpose.

The year saw a shift in emphasis, much it must be said as a consequence of national policy which served to endorse our ambition to bring about more effective and efficient continuity of care and treatment of patients between home and hospital settings. Our ‘Better Together’ manifesto, which was so proactively promoted by the Council of Governors, began to move from ambition into reality. The very platform that gave us the strength and purpose in putting the patient first was that of being an NHS Foundation. This forward looking approach resulted in the acquisition of Community Services that had operated under the aegis of the NHS North of Tyne, marking an important stage in the continuing evolution of the Foundation Trust as a public benefit corporation. All of this enables us to provide clinical services to our patients in their homes, in the community and in our hospitals. What we have been striving to achieve is being about demonstrable benefit to patients who only have one organisation responsible for their care and treatment pathway. We believe the aim is to bring about efficient and effective use of resources irrespective of bureaucratic boundaries. It is this integrated approach to the care of our patients that we wish to further develop.

Whilst we continue to be very successful we are very mindful of the significant challenges that we face in the future as a result of the Coalition Government’s reforms to the NHS and the significant efficiency savings that the government is demanding of us. In our case this amounts to £37m a year for the next 3 years. I am confident however that we are well placed to meet these challenges.

In supporting the main thrust of the Coalition Government’s proposals we hope that one of their objectives of significantly reducing the bureaucracy that is inherent in the current system and encircles and hinders providers is achieved. We very much hope that the new organisational tiers that are beginning to emerge are very mindful of this. What we do know is that Foundation Trusts are the most successful component of our NHS and are openly accountable in the public interest. Monitor, the Independent Regulator of NHS Foundation Trusts has played a most fundamental role in bringing about demonstrable and sustained improvements. We can only hope that the new measures being introduced do not in any way diminish the role and responsibilities of the Independent Regulator.

I would like to pay tribute to the Board, our Governors and our loyal workforce who have contributed so much to the continuing success of the organisation.

We are very blessed to have staff that are dedicated, committed and hard working. The skills and expertise that they bring ensures that our patients receive the highest quality of clinical care and support. In these challenging times where innovation and professionalism are so imperative I must pay tribute to the people who really ‘make it happen’ - the staff providing the hands on care and all the supporting services which help to make us so successful.

The Council of Governors also deserve a very special mention. NHS Foundation Trusts have distinct accountability via public membership and the Governors play a pivotal role in holding the Board of Directors to account, unlike the governance model in all other NHS bodies, statutory and non statutory and no matter how these organisations are configured. The contribution made to the esteem and strategic direction of the organisation is also to be commended as an exemplar of constructive commitment. This tends to be an unsung achievement in today’s NHS.

Kingsley W Smith OBE DL
Chairman
Service Portfolio

Cancer Services
Comprehensive Non Surgical Oncology services including Radiotherapy and Chemotherapy
Palliative care
Macmillan Cancer Information Centre
Clinical Trials Centre
Sir Bobby Robson Foundation

Cardiothoracic Services
Adult and Paediatric Cardiology
Adult and Paediatric Respiratory Medicine
Adult and Paediatric Cardiothoracic Surgery
Adult and Paediatric Cardiopulmonary Transplantation
Electrophysiology
Pacing and defibrillator implantation
Angioplasty
Thoracic Surgery
Pulmonary hypertension
Sleep investigation
Neonatal and Paediatric extra corporeal membrane oxygenation
Cardiothoracic Anaesthesia
Primary Pulmonary Hypertension
Cardiothoracic Intensive Care

Children’s Services
Paediatric Medicine
Paediatric and Neonatal Surgery
Paediatric Oncology including Neuro-oncology
Paediatric Nephrology
Paediatric Respiratory Medicine
Paediatric Rheumatology
Paediatric Gastroenterology
Paediatric Continence and Stomacare
Forensic Paediatrics
Paediatric Endocrinology
Paediatric metabolic disease
Paediatric Intensive Care
Paediatric Immunology and Infectious Diseases including Severe Combined Immunodeficiency Syndrome
Paediatric Neurology and Neurosurgery
Paediatric Bone Marrow Transplantation

Clinical Support Services
Physiotherapy
Occupational Therapy
Dietetics
Speech Therapy
Chiroprapy
Pharmacy
Psychology

Dental Services
(Dedicated Dental Hospital and School)
Restorative Dentistry
Oral Surgery
Oral Medicine
Oral and Maxillo Facial Surgery
Paediatric Dentistry
Orthodontics
Specialist Radiology
Prosthodontics
Periodontology
Dental Sedation
Dental Emergency Clinic
Undergraduate training
Postgraduate training
Training of dental care professionals

Dermatology Services
Dermatology outpatients clinics
Dermatology outpatient treatments including Phototherapy and vascular laser treatment
Dedicated in-patient services
Dermatological Surgery including MohS
Paediatric Dermatology
Phototesting

Elderly Care Services
Acute Elderly Care
Cardiovascular investigation unit
Elderly rehabilitation including Stroke
Continuing care
Day hospital
Respite care
Intermediate care
Integrated falls services

Genetics Services
Clinical Genetics
Cytogenetics
Molecular Diagnostic Genetics

Diagnostic Service for Rare Neuromuscular Diseases
Genetics Knowledge Park

Mitochondrial DNA Laboratory

Internal Medicine Services
Emergency Admissions
General Medicine
Endocrinology
Diabetes
Cystic fibrosis
Respiratory Medicine
Acute Stroke Medicine
Auto-immune gut disorder
Gastroenterology
Cardiology
Clinical Immunology and Allergy
Infectious Diseases and Tropical Medicine (including high security isolation unit)
Hepatology
Clinical Pharmacology and Poisons Information Service
Accident and Emergency Services
Urgent Care Services
Walk in Centres

Laboratory Medicine
Clinical Biochemistry
Maternal serum screening
Clinical Haematology and blood transfusion
Microbiology and Infection Control
Cellular Pathology (including Neuropathology)
Muscle and Nerve Biopsy Service
Immunology
Open access service
Cytology
Virology

Musculoskeletal Services
Trauma
Adult Orthopaedics
Paediatric Orthopaedics
Rheumatology
Metabolic Bone Disease Services
Bone tumour services
Specialist spinal surgery
Neuroscience Services
Neurosurgery
Neurology
Epilepsy Services
Neurovascular Service
Neurophysiology
Neuroradiology

Deep Brain Stimulation Centre

Ophthalmology Services
Cataract service
Glaucome service
Adult and Paediatric Strabismus (squint) services
Oculoplastics including socket service
Multidisciplinary Thyroid orbital service
Vitreoretinal surgery
Corneal service including transplantation
Eye casualty services
Optometry and Orthoptic clinics
Nurse-led pre-admission assessment clinics
Dedicated separate adult and paediatric daycase facilities
Medical photography
Tertiary centre for Photodynamic therapy for age-related maculopathy
Rehabilitation officer for newly registered blind and partially sighted patients

Otolaryngology, Head and Neck
Ear, Nose and Throat
Head and Neck Surgery
Audiology and Hearing Aid Services
Otology implant services

Peri-Operative and Critical Care Services
Anaesthetics
Theatres
Resuscitation
Intensive Care
Chronic and Acute pain management
High dependency care
Recovery
Multi-specialty day unit
Home ventilation service
Critical Care Outreach service

Plastic and Reconstructive Surgery Services
General Plastic and Reconstructive Surgery
Vascular laser treatments
Cleft lip and palate surgery
Burns
Hand surgery
Head and Neck Surgery (with ENT)
Breast reconstructive surgery
Paediatric plastic surgery

Radiology
General X-ray
Contrast Studies
Interventional Radiology
Magnetic Resonance Imaging
Computed Tomography
Ultrasound
Ward Imaging

Regional Medical Physics
Nuclear Medicine
Radiotherapy Physics and Technology
Physiological measurement
Critical Care physics
Bone mineral measurement
Audiological science
Vascular Ultrasound
Photomedicine
Clinical instrumentation
Radiation protection
Ultrasound quality assurance
Audiometer calibration and repair
Technical Aid service
Rehabilitation engineering and mobility
Clinical and scientific computing equipment development and calibration
Bioengineering

Renal Services
Acute Nephrology
Haemodialysis
Specialist hypertension services
Transplantation
Continuing care and support

Specialist Haematology Services
Haemato-oncology
Haemophilia
Bone marrow transplantation
Thrombophilia
Community Anti-coagulant service
DVT service

Surgical Services
General Surgery
Upper gastro-intestinal services
Vascular Surgery
Colorectal Surgery
Endocrine Surgery

Liver Transplantation
Renal Transplantation
Pancreas and Islet Transplantation

Hepatobiliary and Pancreatic Surgery
Breast care services
Disablement services
Endoscopy
Pre-admission clinics

Urology Services
General and Specialised Urological Surgery
General Urology
Uro-oncology
Laparoscopy
Incontinence
Reconstruction
Urodynamics
Surgical Andrology
Endourology and Lithotripsy

Womens Services
Gynaecology including Urogynaecology and Colposcopy
Obstetrics
Fetal Medicine
Reproductive Medicine
Neonatal Medicine Intensive Care and Special Care
Family planning services
Community midwifery
Maternity
Midwife/obstetric ultrasound and screening
Specialist services (multidisciplinary) for pregnant women with substance misuse problems
Specialist services (multidisciplinary) for twins and multiples
Termination of Pregnancy service
Bereavement counselling

Note: Excludes Newcastle Community Health Services which were acquired in April 2011
Review of the Year 2010/2011

How we did
The vision of the CQC is of high quality patient centred health and social care which helps people and their carers make informed choices about care, and responds to individual needs. It has a range of enforcement powers to ensure that health care providers deliver the highest quality of care.

We want to work with the CQC to ensure that the care we provide is safe and patients get the right clinical outcomes. The CQC wants us to ensure that using our services is a good experience for the people who use them, their carers and their families.

The CQC has a five-year strategy which outlines its approach to gathering information on organisations, using patients’ expertise and working closely with hospitals and other providers. It will focus on care rather than processes with an aim that actions of the CQC will be based on the views of the patients.

Registration

The CQC views registration as key to the regulation process. All organisations wishing to provide health and social care are required to register with the CQC. The Trust successfully registered in 2010 for a fee of £75,000 which was based on its annual turnover, and remains registered without conditions. Registration means that people can expect services to meet essential standards of quality and safety.

There are sixteen standards which the Trust must comply with covering a range of patient centred outcomes in areas such as patient involvement, personalised care, nutrition, staffing, safeguarding and safety.

Assurance

The CQC intends to “regulate in partnership” with organisations such as ourselves, other hospital trusts and care homes. It wants to us to work with it to ensure that the care we provide helps to prevent illness, and promotes healthy, independent living. It also wants to satisfy itself that care is available to those who need it when they need it and that it provides good value for money.

The Trust has developed an assurance process to ensure that it complies with the essential standards. Each of the sixteen key outcomes of the essential standards of quality and safety has been allocated an operational and an executive lead. Compliance is overseen for each standard by a designated Trust committee, the chair of which must sign-off a statement of assurance, which in turn must demonstrate compliance. A process of ongoing review has been implemented to take into account new evidence and changes in practice.

There are sixteen standards which the Trust must comply with covering a range of patient centred outcomes in areas such as patient involvement, personalised care, nutrition, staffing, safeguarding and safety

Compliance

The CQC continuously monitors compliance with the essential standards. It gathers information from a variety of sources including patients and their carers, public representative groups, peer reviews, the Department of Health and from other organisations and regulators. Much of the evidence the CQC collects is included in a Quality and Risk Profile (QRP) on each organisation which is updated and published monthly.

The first QRP for this Trust was published in September 2010. It is intended that the QRPs will be made available to the general public in due course.

The monthly QRP contains details of all the information the CQC has collected about the Trust from a variety of sources and an estimate of risk based on whether each item of information is “better” or “worse” than expected. It enables the CQC to identify any potential areas of risk. To date the Trust has not had any outcomes of the essential standards identified as high risk.

The CQC also undertakes unannounced inspections of hospitals and other care providers. It does this in a targeted way and will generally undertake inspections if it has concerns about a particular provider’s compliance with one or more of the standards or concerns about patient safety. These concerns may be based on feedback from patients, their relatives or a range of other sources, often contained within the QRP. The CQC also undertake inspections as part of a planned review of a particular standard with Inspectors observing care being delivered and talking to patients, their relatives and carers. The CQC did not undertake an unannounced inspection of this Trust during 2010-2011.

If the CQC has concerns that a provider is not meeting essential standards of quality and safety they will act quickly using their range of enforcement powers.
Review of the Year 2010/2011

Summary of Service Statistics

Photograph by Lee Dobson
Inpatient and Daycase activity

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<tbody>
<tr>
<td>Non-elective Inpatient FCES</td>
<td>65,391</td>
<td>66,778</td>
<td>68,253</td>
<td>70,988</td>
<td>76,051</td>
<td>83,231</td>
</tr>
<tr>
<td>Elective Inpatient FCES</td>
<td>36,724</td>
<td>36,724</td>
<td>38,851</td>
<td>38,814</td>
<td>37,148</td>
<td>30,904</td>
</tr>
<tr>
<td>Day Case FCES</td>
<td>75,237</td>
<td>74,210</td>
<td>78,289</td>
<td>82,248</td>
<td>83,771</td>
<td>97,584</td>
</tr>
<tr>
<td><strong>Total FCES</strong></td>
<td>176,352</td>
<td>177,712</td>
<td>185,393</td>
<td>192,050</td>
<td>196,970</td>
<td>211,719</td>
</tr>
</tbody>
</table>

% Elective FCES undertaken as daycases

- 68% 67% 67% 68% 69.3% 75.9%

Average Length of stay

- 4.73 4.34 4.16 4.08 4.35 4.08

Average % Occupancy

- 82% 81% 79% 78% 78% 80%

OP Activity

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<tbody>
<tr>
<td>New outpatient attendances</td>
<td>201,211</td>
<td>205,486</td>
<td>217,750</td>
<td>230,955</td>
<td>254,588</td>
<td>280,083</td>
</tr>
<tr>
<td>Review outpatient attendances</td>
<td>589,139</td>
<td>597,491</td>
<td>606,990</td>
<td>638,410</td>
<td>653,418</td>
<td>665,403</td>
</tr>
<tr>
<td><strong>Total outpatient attendances</strong></td>
<td>790,350</td>
<td>802,977</td>
<td>824,740</td>
<td>869,365</td>
<td>908,006</td>
<td>945,486</td>
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Diagnostic services

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<tbody>
<tr>
<td>Laboratory requests</td>
<td>2,219,108</td>
<td>2,295,099</td>
<td>2,289,628</td>
<td>2,490,628</td>
<td>2,772,824</td>
<td>2,759,575</td>
</tr>
<tr>
<td>Radiological examinations</td>
<td>372,804</td>
<td>394,004</td>
<td>410,238</td>
<td>434,264</td>
<td>441,361</td>
<td>463,614</td>
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Accident & Emergency

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<tbody>
<tr>
<td>A&amp;E attendances</td>
<td>96,633</td>
<td>96,901</td>
<td>93,709</td>
<td>92,872</td>
<td>91,382</td>
<td>103,489</td>
</tr>
<tr>
<td>Walk in centre attendances</td>
<td>37,084</td>
<td>36,543</td>
<td>37,885</td>
<td>38,316</td>
<td>36,115</td>
<td>28,252</td>
</tr>
<tr>
<td><strong>Total attendances</strong></td>
<td>133,717</td>
<td>133,444</td>
<td>131,594</td>
<td>131,188</td>
<td>127,497</td>
<td>131,741</td>
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Surgery

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<tbody>
<tr>
<td>Cardiopulmonary transplants</td>
<td>65</td>
<td>73</td>
<td>74</td>
<td>78</td>
<td>78</td>
<td>82</td>
</tr>
<tr>
<td>Liver transplants</td>
<td>32</td>
<td>37</td>
<td>21</td>
<td>43</td>
<td>34</td>
<td>35</td>
</tr>
<tr>
<td>Renal transplants</td>
<td>100</td>
<td>86</td>
<td>108</td>
<td>98</td>
<td>123</td>
<td>139</td>
</tr>
<tr>
<td>Bone marrow transplants</td>
<td>73</td>
<td>76</td>
<td>68</td>
<td>99</td>
<td>131</td>
<td>176</td>
</tr>
<tr>
<td>Heart Operations (CABGs &amp; PCI)</td>
<td>2,443</td>
<td>2,479</td>
<td>2,519</td>
<td>3,249</td>
<td>3,248</td>
<td>3,206</td>
</tr>
<tr>
<td>Joint Replacements (Hips &amp; Knees)</td>
<td>811</td>
<td>897</td>
<td>998</td>
<td>1,024</td>
<td>1,110</td>
<td>1,385</td>
</tr>
<tr>
<td>Cataracts</td>
<td>7,181</td>
<td>7,615</td>
<td>7,365</td>
<td>7,787</td>
<td>8,174</td>
<td>8,023</td>
</tr>
</tbody>
</table>

Reproductive Medicine - Centre for Life

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>No of IVF treatments started</td>
<td>559</td>
<td>504</td>
<td>729</td>
<td>779</td>
<td>982</td>
<td>843</td>
</tr>
<tr>
<td>Live birth rate per cycle started</td>
<td>28.3%</td>
<td>27.0%</td>
<td>23.6%</td>
<td>27.8%</td>
<td>24.9%</td>
<td>26.4%</td>
</tr>
</tbody>
</table>

Other key statistics

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total no of renal dialysis sessions</td>
<td>35,886</td>
<td>37,760</td>
<td>37,995</td>
<td>41,702</td>
<td>43,774</td>
<td>44,227</td>
</tr>
<tr>
<td>Total no births</td>
<td>5,364</td>
<td>5,630</td>
<td>6,228</td>
<td>6,301</td>
<td>6,683</td>
<td>7,062</td>
</tr>
<tr>
<td>No of bed days for elderly long term care</td>
<td>26,184</td>
<td>25,855</td>
<td>23,891</td>
<td>24,555</td>
<td>25,591</td>
<td>19,726</td>
</tr>
<tr>
<td>Total no of ward attenders*</td>
<td>12,379</td>
<td>12,796</td>
<td>13,769</td>
<td>15,405</td>
<td>8,885</td>
<td>n/a</td>
</tr>
<tr>
<td>Day hospital attendances</td>
<td>3,581</td>
<td>3,947</td>
<td>3,366</td>
<td>3,710</td>
<td>3,124</td>
<td>3,617</td>
</tr>
<tr>
<td>Disablement service attendances</td>
<td>7,946</td>
<td>7,758</td>
<td>7,288</td>
<td>7,502</td>
<td>7,268</td>
<td>6,529</td>
</tr>
</tbody>
</table>

* this classification of attendance was not used in 2010/11
Performance Review of the Year 2010/2011
The Trust operated Legally Binding Contracts (LBCs) with six clusters of Primary Care Organisations (PCOs) during 2010/11 (NHS North of Tyne; Durham; Tees; NHS North Cumbria; South of Tyne & Wear; and North Yorkshire & York) as well as Service Level Agreements (SLAs) with two Scottish Health Boards (Borders and Dumfries & Galloway). LBCs were also in place with the North East Specialised Commissioning Group with regard to a range of Specialist Services, which included Neurosciences; Renal Dialysis; Cystic Fibrosis; Burns; and a number of other services. In addition the National Commissioning Group (NCG) commissioned a range of nationally designated services such as transplantation.

The skills and expertise that we bring ensures our patients receive the highest quality of clinical care and support.
The following are based on the national peer group sourced from CHKS based on April 2010-March 2011 activity:

**Mortality rate compared to average**

**Readmission Rate Histogram (within 30 days)**

**Mortality Histogram**

The following is from the CHKS Top 40 Hospitals peer group based on January - December 2010 activity

**Rates of emergency readmission following an acute Myocardial Infarctions (AMI)**

**Peer distribution: Rate of emergency readmission to hospital following AMI within 28 days**
Achieving Waiting Times and National Targets

18 Week Referral to Treatment Target
We continued to achieve the 18 week targets for admitted and non admitted patients across every specialty and for direct access Audiology during the year.

Cancer Waiting Times
2010 saw the introduction of new extended targets. We can report that excellent performance was again sustained in relation to cancer targets for 2010/11. The progress made in this area, which represents a very tangible improvement in services for patients.

As a tertiary centre, we receive many referrals for patients with complex cancers who have already been seen in other hospitals before reaching us. The 62 day target has remained a challenge but the following exhibit shows that performance has been sustained. Late referrals continue to be significant and work is ongoing with the North of England Cancer Network and the referring Trusts out with Newcastle to improve the pathways of those patients who require urgent assessment.

Within the Trust, pathways and processes have again been reviewed which led to a range of enhancements across clinical care and treatment pathways.

6 Week Diagnostic Target
We are pleased to report that no one was waiting more than 6 weeks for diagnostic tests throughout the whole of the year.
Accident & Emergency

Is Moving...

From midnight on 16th/17th November 2010, Newcastle’s Emergency Department will move from Newcastle General Hospital to

The Royal Victoria Infirmary

It’s easy to reach and conveniently located at:

The Royal Victoria Infirmary, Richardson Road, Newcastle upon Tyne NE1 4LP

You’ll be able to reach the new A&E via Richardson Road, as the specialist unit will be located just along from the Leazes Wing entrance. You’ll also find parking for emergency requirements only.

Royal Victoria Infirmary

Key:
- Dental Hospital
- Claremont Wing
- Multi-storey Car Park
- Leazes Wing
- New Victoria Wing
- Peacock Hall / Crawford House

From 17th November, there will no longer be Accident & Emergency facilities at Newcastle General Hospital, but a brand new, specialist Emergency Department at the Royal Victoria Infirmary (RVI)

For further information visit www.newcastle-hospitals.org.uk
A&E Waiting Times

The Care Quality Commission national A&E waiting time target of 98% was achieved and for the 12 month period ending March 2011 was 98.1%. A comparative review of attendances to the Emergency Department (ED) and Walk In Centre showed a 4% increase during the full 12 month period in comparison to the previous year. Following the move of ED from the Newcastle General Hospital to the Royal Victoria Infirmary (RVI) in November 2010, the main ED and Minor Injury Unit (MIU) at the RVI have seen a real increase in attendances. The most notable increase was in December when the number of attendances rose by an average of 71 attendances per day compared to the previous December. The number of patients waiting over 4 hours increased significantly during the second half of the year, rising in October and remaining elevated during the Winter months. December was particularly busy and the severe weather conditions, high level of attendances and increase in patients with flu like symptoms affected performance. The predominant reasons for breaches included those arising out of clinical need and patients waiting to be seen. A weekly multi disciplinary conference was put into place to improve all patient flows in ED and across all other Trust wide emergency presentation pathways. During quarter 4, despite encountering a 23% increase in ED attendances compared to quarter 3, as a result of the unstinting efforts of clinical and operational staff, the Trust achieved an exemplary 98.9% against the 4-hour waiting time standard.

![A&E Waiting Time Performance 2010/11](image_from_source)
Providing top quality care

Coronary heart disease accounts for about one in five deaths in men and one in six deaths in women. In addition, the British Heart Foundation estimate that there are over 1 million men living in the UK who have or have had angina (heart-related chest pain), and over 840,000 women.

There are now 105 PCI centres in the United Kingdom.

Centre size: there is evidence that suggests improved outcomes for patients being treated in higher volume PCI centres, particularly those that perform at least 400 procedures pa. This forms part of the recommendations of the Joint Working Group on PCI of BCIS and the British Cardiovascular Society. In 2009 20% of PCI units were performing 400 or less cases pa, but the majority of these were new units undertaking a gradually increasing volume of work.

Percutaneous coronary intervention (PCI) is a rapidly evolving technique used to treat patients whose coronary arteries - which supply the heart with blood - are narrowed or blocked. The procedure works by mechanically improving blood flow to the heart. First, the doctor uses x-ray images of the heart arteries to make the position and shape of any narrowing or blockages visible (a ‘coronary angiogram’). If the clinical circumstances and the angiogram findings suggest that something needs to be done to physically modify the blood flow to the heart, then the majority of patients are treated by PCI (a minority treated by coronary artery bypass surgery). A small balloon is inserted which, when inflated, squashes the fatty tissue out of the way and widens the artery. In most cases a ‘stent’ is then implanted - a metal mesh that stays permanently in place to keep the artery wall open. Treatment thus aims to prevent the arteries blocking (which might cause a heart attack) and improve flow to the heart muscle to alleviate the symptoms of angina.
Any delay in the performance of a PCI is associated with a worse outcome for the patient. There are 2 important procedural measures. The patient call for help to time of PCI treatment (call-to-balloon time) measures the entire process of care, and the time a patient arrives at a PCI centre to the time of PCI treatment (door-to-balloon time) which assesses how quickly the PCI unit can respond to the emergency. There are two routes into a PCI centre for emergency PCI. One where an ambulance brings the patient directly to that centre, and the other, where a patient first presents to a hospital that is not capable of performing PCI and is then transferred to the PCI centre (interhospital transfer). The transfer process engenders additional delays. A strategy to try to avoid interhospital transfers is likely to result in quicker and therefore better treatment.

Ensuring prompt treatment in Greater Tyneside

Call to balloon time (CTB): percentage of patient treated within 150 minutes of calling for help

Door to balloon time (DTB): percentage of patient treated within 90 minutes of arriving at a PCI centre
How do we compare?

For the 11th consecutive year the Trust has won the prestigious CHKS Top 40 Hospitals Award and is one of only five Trusts in the country to do so. The CHKS Top Hospitals Programme celebrates excellence across the UK and is now in its eleventh year. Awards are based on the evaluation of 21 key performance indicators covering safety, clinical effectiveness, health outcomes, efficiency, patient experience and quality of care.

James Coles, Director of Research, CHKS explains: “Hospitals are accountable to their patients, their families and their local communities to provide a safe environment and high standards of patient care. Our award winners this year show a commitment to driving improvement and engendering a culture of excellence throughout their organisations”.

![Image from source](image.png)

![Image from source](image.png)

![Image from source](image.png)
Senior Medical Staff Productivity

The Trust participates in a programme which addresses medical productivity. This is facilitated by Civil Eyes Research Ltd., a leading benchmarking organisation. Civil Eyes enables clinicians and managers to understand information about quality and productivity within health services. Some 20 teaching hospitals across the UK have joined together to focus on productivity issues. For the second year running, the exhibit following shows that arising out of contractual Programmed Activities (PAs), Newcastle Consultants spend 83% of their time devoted to Direct Clinical Care (DCC), the highest amongst the peer group.

![Proportion of Direct Clinical Care Programmed Activity per Consultant](source: Civil Eyes 2010/11)
Length of stay and day case rates

The Trust has shorter average length of stay in compassion with peer hospitals of similar size and similar specialty casemix whilst risk adjusted length of stay contrasts favourably with peers. We recognise that there is scope for further reduction in length of stay and actions are being taken to bring about further improvement.

Day case rates are significantly better than peer hospitals highlighting that wherever possible patients are safely and appropriately discharged home the same day as their procedure.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Newcastle Hospitals</th>
<th>Peer (all)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day cases</td>
<td>76.3%</td>
<td>69.3%</td>
</tr>
<tr>
<td>Risk Adjusted Length of Stay (lower than 100 = better than expected)</td>
<td>88</td>
<td>87</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>2.6 days</td>
<td>3.0 days</td>
</tr>
</tbody>
</table>

Source CHKS 2011
Hospitals are accountable to their patients, families and local communities to provide a safe environment and high standards of patient care

Newcastle achieves and sustains such standards
Review of the Year 2010/2011

National Sentinel Stroke Organisational Audit 2010

The National Sentinel Stroke Audit is a national audit which, at a specific point in time, identifies levels of practice and service provision across the country for stroke patients and allows benchmarking between trusts. Higher scores are better.

The National Sentinel Stroke Audit 2010, published by the Royal College of Physicians, provides a methodical evidence based scrutiny of 58 features scored within 8 domains - all of distinct relevance and bearing to the quality of care and treatment of stroke. Below are the findings for NuTH and other Trusts in the North East of England.

Overall Scores for Organisation of Stroke Care in the North East
(National Stroke Audit October 2010)
Choose and Book

In terms of the number of bookings received through the national Choose and Book system, the Trust consistently has the highest number of commitments.

### Top ten in the country - March 2011

<table>
<thead>
<tr>
<th>Trust</th>
<th>Bookings</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Newcastle upon Tyne Hospitals NHS Foundation Trust</td>
<td>8,493</td>
</tr>
<tr>
<td>Gloucestershire Hospitals NHS Foundation Trust</td>
<td>7,365</td>
</tr>
<tr>
<td>Norfolk &amp; Norwich University Hospitals NHS Foundation Trust</td>
<td>6,692</td>
</tr>
<tr>
<td>United Lincolnshire Hospitals NHS Trust</td>
<td>6,690</td>
</tr>
<tr>
<td>Hull &amp; East Yorkshire Hospitals NHS Trust</td>
<td>6,259</td>
</tr>
<tr>
<td>County Durham &amp; Darlington NHS Foundation Trust</td>
<td>6,005</td>
</tr>
<tr>
<td>Nottingham University Hospitals NHS Trust</td>
<td>5,869</td>
</tr>
<tr>
<td>Barking, Havering &amp; Redbridge Hospitals NHS Trust</td>
<td>5,810</td>
</tr>
<tr>
<td>Doncaster &amp; Bassetlaw Hospitals NHS Foundation Trust</td>
<td>5,720</td>
</tr>
<tr>
<td>Plymouth Hospitals NHS Trust</td>
<td>5,707</td>
</tr>
</tbody>
</table>

### North East - March 2011

<table>
<thead>
<tr>
<th>Trust</th>
<th>Bookings</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Newcastle upon Tyne Hospitals NHS Foundation Trust</td>
<td>8,493</td>
</tr>
<tr>
<td>County Durham &amp; Darlington NHS Foundation Trust</td>
<td>6,005</td>
</tr>
<tr>
<td>City Hospitals Sunderland NHS Foundation Trust</td>
<td>5,516</td>
</tr>
<tr>
<td>South Tees Hospitals NHS Foundation Trust</td>
<td>5,457</td>
</tr>
<tr>
<td>Northumbria Healthcare NHS Foundation Trust</td>
<td>3,083</td>
</tr>
<tr>
<td>Gateshead Health NHS Foundation Trust</td>
<td>2,520</td>
</tr>
<tr>
<td>North Tees &amp; Hartlepool NHS Foundation Trust</td>
<td>2,174</td>
</tr>
<tr>
<td>South Tyneside NHS Foundation Trust</td>
<td>1,739</td>
</tr>
</tbody>
</table>
Complaints

The cornerstone of our grievances handling strategy is to ensure we learn lessons from complaints and concerns no matter what the prevailing circumstances to address those areas where improvement is called for. This is not just in terms of written complaints, but also in respect of all comments, and concerns received via the Trust’s web site and telephone calls to the Patient Relations Department.

There were 571 complaints received from service users during the year, and which included queries relating to clinical treatment, waiting times and delays, attitude of staff and communication issues.

In addition, some 649 patient related enquiries (PRES) were received by the Patient Relations Department staff which identified issues that had the potential to develop into a formal complaint or grievance if left unresolved. Of the 649 PRES raised, only 5% of the issues highlighted progressed to a formal complaint or grievance. The majority of these potential complaints were resolved by the Patient Relations Department or by staff at Ward or department level, often with the involvement of the appropriate Matron or Consultant.

Some 66% of complaints related to all aspects of clinical treatment and which was an increase of 9% on the previous year. Complaints relating to appointment delays and cancellations decreased by 4%. There was a pleasing decrease of 5% in complaints relating to the perceived attitude of staff, and a 4% reduction in complaints relating to appointment delays and cancellations. However, complaints involving communication shortcomings remained static at 8%, and which demonstrates the need for further improvement in this area where called for. Other categories of complaint remained similar to the previous year.

<table>
<thead>
<tr>
<th>Category</th>
<th>% of Total</th>
<th>Change on previous year</th>
</tr>
</thead>
<tbody>
<tr>
<td>All aspects of clinical treatment</td>
<td>66%</td>
<td>+ 9%</td>
</tr>
<tr>
<td>Appointment delays/cancellation both inpatient &amp; outpatient</td>
<td>8%</td>
<td>- 4%</td>
</tr>
<tr>
<td>Communication/information both written &amp; oral</td>
<td>8%</td>
<td>-</td>
</tr>
<tr>
<td>Perceived attitude of staff</td>
<td>9%</td>
<td>- 5%</td>
</tr>
<tr>
<td>Admission, discharge and transfer arrangements</td>
<td>3%</td>
<td>-1%</td>
</tr>
<tr>
<td>Personal records</td>
<td>2%</td>
<td>+1%</td>
</tr>
<tr>
<td>Hotel Services (including food)</td>
<td>&lt;1%</td>
<td>-</td>
</tr>
<tr>
<td>Failure to follow procedures</td>
<td>&lt;1%</td>
<td>-</td>
</tr>
<tr>
<td>Aids, appliances, equipment/premises</td>
<td>&lt;1%</td>
<td>-</td>
</tr>
<tr>
<td>Patient privacy &amp; dignity</td>
<td>&lt;1%</td>
<td>-</td>
</tr>
<tr>
<td>Transport</td>
<td>&lt;1%</td>
<td>-</td>
</tr>
<tr>
<td>Policy &amp; Commercial decision</td>
<td>1%</td>
<td>-</td>
</tr>
<tr>
<td>Consent to treatment</td>
<td>&lt;1%</td>
<td>-</td>
</tr>
<tr>
<td>Mortuary &amp; Post Mortem procedures</td>
<td>&lt;1%</td>
<td>-</td>
</tr>
<tr>
<td>Other categories</td>
<td>&lt;1%</td>
<td>-</td>
</tr>
</tbody>
</table>
The percentage of complaints resolved within the negotiated timescale 97% (97% in 2009/10) continues to demonstrate good performance year on year. Our overall performance in respect of complaint handling, learning from complaints, and the outcome of reviews performed by the Parliamentary and Health Services Ombudsman (PHSO), continues to be closely scrutinised on a monthly basis by the Trust Complaints Panel. The panel includes membership from Executive and non Executive Directors and three elected Public Governors of the Trust.

Of the 20 requests made to the PHSO during the period (25 in 2009/10), one was upheld and two cases were referred back to the Trust for further information to be supplied to the complainant. The Trust continues to endeavour to ensure good feedback of learning points from complaints to Directorates and Departments, so that changes in policy and protocols and other practical improvements can be followed up to ensure these are achieved and the “loop closed”.

Examples of some of the improvements made to services and which arose from or associated with a complaint include:

- **Pharmacy.** Procedures relating to dispensing of adjusted dosage Methotrexate prescriptions, including storage and collection, were improved in the light of a complainant’s experience.
- **Children’s Services.** Processes revised to improve open access for children following a previous admission.
- **Northern Centre for Cancer Care.** Improved visual communication introduced in clinics for patients attending for chemotherapy.
- **Older Peoples Medicine.** Information Leaflet produced to provide advice for patients and relatives this includes details of meal times, provision of hot beverages, advice regarding suitability and storage of patients own food and arrangements for visitors to assist relatives at meal times.
- **Plastic Surgery.** A DVD has been produced by the Trust to provide information on mastectomies and reconstructive techniques so that patients can be made more aware of what is involved in their surgery and the post operative outcomes.
- **Womens Services.** Following receipt of a complaint in respect of a possible breach of privacy & dignity during examination the Directorate have reviewed their practice regarding chaperoning, and also the provision of appropriate gowns, to ensure these are always checked and available prior to commencement of clinic.
- **Rehabilitation.** Following receipt of a complaint a review of the referral system between Fracture Clinic and Physiotherapy Departments has resulted in reduced patient waiting time and improved transfer of clinical information.
The Picker Institute, on behalf of the Care Quality Commission, conducts an annual survey of the experiences of inpatients in hospitals around the country.

The findings of the National Inpatient Survey 2010 outlined here enable comparison to be made with results of the previous Inpatient Surveys. The purpose of the survey is to understand what patients think of healthcare services provided by the Trust. A standard postal survey was sent to a random sample of 850 patients discharged from the Trust in July 2010. A response rate of 51% was achieved (416 responses). This should be seen in the context of overall activity within the Trust as, during the year 2009-2010, a total of 196,970 inpatients (day case, elective and non-elective) were cared for in the Trust.

The results highlight many positive aspects of the patient experience. The majority of patients reported that:

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall: rating of care was good/excellent</td>
<td>92%</td>
</tr>
<tr>
<td>Overall: doctors and nurses worked well together</td>
<td>94%</td>
</tr>
<tr>
<td>Doctors: always had the confidence and trust</td>
<td>87%</td>
</tr>
<tr>
<td>Hospital: room or ward was very/fairly clean</td>
<td>98%</td>
</tr>
<tr>
<td>Hospital: toilets and bathrooms were very/fairly clean</td>
<td>96%</td>
</tr>
<tr>
<td>Hospital: hand-wash gels visible and available for patients and visitors to use</td>
<td>95%</td>
</tr>
<tr>
<td>Care: always enough privacy when being examined or treated</td>
<td>90%</td>
</tr>
<tr>
<td>Surgery: risks and benefits clearly explained</td>
<td>84%</td>
</tr>
</tbody>
</table>

These results 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 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.
The Inpatient Survey is 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 is slipping, or improvements have arisen. A total of 86 questions were used in both the 2009 and 2010 Surveys. Compared with the 2009 Survey, the Trust was:

- **Significantly better on 7 questions**
- **Significantly worse on 0 questions**
- **The scores showed no significant difference on 79 questions**

The questions where the Trust has improved significantly are (lower scores are better):  

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital: bothered by noise at night from other patients</td>
<td>38 %</td>
<td>31 %</td>
</tr>
<tr>
<td>Hospital: room or ward not very or not at all clean</td>
<td>3 %</td>
<td>1 %</td>
</tr>
<tr>
<td>Hospital: toilets not very or not at all clean</td>
<td>5 %</td>
<td>2 %</td>
</tr>
<tr>
<td>Discharge: not fully told of danger signals to look for</td>
<td>43 %</td>
<td>35 %</td>
</tr>
<tr>
<td>Discharge: family not given enough information to help</td>
<td>54 %</td>
<td>45 %</td>
</tr>
<tr>
<td>Discharge: did not receive copies of letters sent between hospital doctors and GP</td>
<td>31 %</td>
<td>20 %</td>
</tr>
<tr>
<td>Overall: no posters/leaflets seen explaining how to complain about care</td>
<td>37 %</td>
<td>29 %</td>
</tr>
</tbody>
</table>

The questions where more than 50% of respondents reported room for improvement are listed below:

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge: delayed by 1 hour or more</td>
<td>85 %</td>
<td>84 %</td>
</tr>
<tr>
<td>Overall: not asked to give views on quality of care</td>
<td>81 %</td>
<td>78 %</td>
</tr>
<tr>
<td>Overall: not given enough information on how to complain</td>
<td>[77] %</td>
<td>83 %</td>
</tr>
<tr>
<td>Hospital: nowhere to keep personal belongings safely</td>
<td>70 %</td>
<td>63 %</td>
</tr>
<tr>
<td>Planned admission: not given choice of admission date</td>
<td>68 %</td>
<td>62 %</td>
</tr>
<tr>
<td>Discharge: not told how long delay in discharge would be</td>
<td>68 %</td>
<td>65 %</td>
</tr>
<tr>
<td>Planned admission: not offered a choice of hospitals</td>
<td>66 %</td>
<td>60 %</td>
</tr>
<tr>
<td>Hospital: didn’t get enough information about Ward routines</td>
<td>53 %</td>
<td>58 %</td>
</tr>
</tbody>
</table>

...most patients are highly appreciative of the care that they receive

These results were encouraging to note as the actions identified following the 2009 Survey related to improving the information and advice given at discharge. As a consequence of the 2009 Survey, actions identified in collaboration with staff and patient representatives, included:

- **A review of discharge information to ensure roles and responsibilities are clearly outlined to improve the patient’s expectation of what will happen on the day of discharge**
- **A review of discharge aftercare information available to ensure the patient and/or their carer have the information they need regarding what to watch for and who to contact for further advice after leaving hospital. This review will ensure aftercare information is available for at least the top five procedures for each Department and Clinical Directorate.**
- **A re-launch of the discharge fold-out cards to ensure patients have the information they need following discharge e.g. contact details and names of relevant staff.**
The results show that the Trust performs better than average in each of the five questions related to the COUIN measure. The Patient, Carer and Public Involvement Committee has reviewed the findings of the latest Inpatient Survey to further inform an action plan. This task also brings about the involvement of the Council of Governors, Community Advisory Panel and Patient Advice & 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 NHS Trusts using the Picker Institute) it is of note that for 49 questions, we were assessed as better than in the previous year. In the 5 questions used to assess the Trust performance for the COUIN measure of ‘improving responsiveness to personal needs of patients’, the Trust performs better than average.

* The results will be standardised by age, gender and admission method when published by the CQC and used within the COUIN payment framework. These problem scores give an indication of Trust performance.

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<table>
<thead>
<tr>
<th>Lower scores are better</th>
<th>2009</th>
<th>2010</th>
<th>Average</th>
</tr>
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<tbody>
<tr>
<td>Care: wanted to be more involved in decisions</td>
<td>36 %</td>
<td>39 %</td>
<td>46 %</td>
</tr>
<tr>
<td>Care: could not always find staff member to discuss concerns with</td>
<td>53 %</td>
<td>48 %</td>
<td>57 %</td>
</tr>
<tr>
<td>Care: not always enough privacy when discussing condition or treatment</td>
<td>27 %</td>
<td>26 %</td>
<td>28 %</td>
</tr>
<tr>
<td>Discharge: not fully told side-effects of medications</td>
<td>39 %</td>
<td>41 %</td>
<td>46 %</td>
</tr>
<tr>
<td>Discharge: not told who to contact if worried</td>
<td>15 %</td>
<td>16 %</td>
<td>21 %</td>
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Review of the Year 2010/2011

How we do it

Keeping you safe
Providing a clean and high quality environment in which to deliver excellence in health care is a fundamental aspect of the Trust’s service provision. A clean, well maintained environment is essential for the delivery of safe patient care and clinical practice. This supports the infection prevention and control strategy in order to reduce the risk to patients from Health Care Associated Infection (HCAI). All patients, staff and members of the public can be confident that the service provided is safe being delivered in an environment that inspires confidence through excellent standards of cleanliness and estates maintenance.

The Trust can report that, once again, it has been successful in meeting its obligations with regard to infection prevention and control standards and targets, and was able to report full compliance with the standards set by the Care Quality Commission (CQC), and the NHS Litigation Authority (NHSLA). In addition, the national, and local Commissioner’s targets were all achieved.

There has been a significant reduction in the number of MRSA bacteraemias. The Department of Health’s target of 12 bacteraemias (2010/11) has been comprehensively met with only 8 bacteraemias. This should be seen as a major success; however the target set for 2011/12 is 6, there is clearly no room for complacency reinforcing the ongoing need to continue with all campaigns.
The Department of Health Clostridium Difficile target of 296 was also comprehensively achieved with 150 cases being reported during 2010/11. Local surveillance data indicates a significant reduction in cases of hospital acquired Clostridium Difficile throughout the organisation. Directorates with the highest risk group of patients have demonstrated commitment to make substantial improvement in healthcare practice.

The Newcastle upon Tyne Hospitals recognise that the effective prevention and control of Healthcare Associated Infection is essential to patient and staff safety. The over-riding principle in our delivery of care is to treat patients to the standard they would expect for their own family or loved ones.

As expected, frequent cases of Norovirus have been identified throughout the year however a major outbreak has been avoided. Good anticipation, re-enforcement of the relevant policy and heightened sensitivity amongst ward staff and the Patient Services Coordinators to potential cases has been effective. Whilst wards have been temporarily closed to admission to reduce cross-infection, the nature of the populations of the wards concerned has not often led to significant reduction in bed days.

The Influenza A (H1N1) pandemic was officially declared over by the World Health Organisation in August 2010. Over the 2010/11 winter season the pandemic H1N1 virus replaced previously circulating strains as the predominant seasonal Influenza strain. Influenza admissions peaked over the Christmas and New Year period, with more patients admitted to the Trust with confirmed Influenza during winter 2010/11, than during winter 2009/10 (pandemic year). The increased influenza activity this year coincided with the annual paediatric epidemic of Respiratory Syncytial Virus.

The IPC team was again active in providing advice relating to the care of patients with Influenza infection and overseeing fit testing of masks in appropriate clinical areas; this was also delivered by a cascade training approach.
A staff vaccination campaign was held with over 50% staff coming forward for Influenza vaccination. This was one of the highest rates achieved in the region.

The Trust has a defined Healthcare Acquired Infections, Prevention and Control Strategy, and the principal objective of the strategy is to set out the Board level agreement in terms of infection prevention and control. It also seeks to provide the Board of Directors with assurance that appropriate structures and processes are in place to minimise the risks of HCAI to patients, staff and visitors. The Nursing & Patient Services Director and Director of Infection Prevention and Control (DIPC) are responsible for the monthly update provided to the Trust Board.

The aims of the strategy are to ensure that:

- Robust infection prevention and control has a positive effect on the quality of care, safety and wellbeing of patients, staff, volunteers and visitors, and on the business, performance and reputation of the Trust.
- The organisation recognises infection prevention and control, and wider infection control issues, as a key element of clinical and non-clinical governance.
- Infection prevention and control systems and processes are embedded across clinical directorates and in corporate services including business planning, service development, financial planning, project and programme management and education.
- The organisation adopts a coordinated and multi-disciplinary approach in managing infection prevention and control through a systematic process of identification, analysis, learning, and management of risk. This approach extends to partnership working with other providers and Commissioners.
- The Trust strives to be amongst its best performing peers nationally and does not exceed national and local targets in relation to MRSA and Clostridium Difficile (C. Difficile).

A detailed Clinical Assurance Tool (CAT) has been introduced within the Newcastle Hospitals as a Trust wide tool to provide continuing clinical assurance to the Trust Board and an overview of performance for each ward and directorate. The aim of the CAT is to identify, measure and demonstrate compliance with the published documents and national drivers such as the Chief Nursing Officer’s High Impact Actions for Nurses and Midwives, The Department of Health’s Saving Lives programme, as well as providing useful data to support, verify and offer assurance for inspectorates including CQC and NHS LA. During the forthcoming year this will be reported by Matron, as a subset of Directorate reports. Its use across the Trust provides Board level assurance across all IPC measures and environmental cleanliness standards, providing robust and meaningful data to clinicians and care leaders.

This tool will replace the Ward Accreditation Tool (WAT) which was developed in 2008 to provide assurance across a range of cleanliness and infection prevention control measures.

The current Ward Accreditation Tool was developed to underpin Saving Lives and environmental standards and has been very successful in raising the bar and defining and measuring standards across the Trust in a systematic and robust process. To date, 55 wards/Departments have been accredited with the majority of the remainder being eligible. The monthly audits are reviewed by the Infection Prevention and Control Operational Group and presented to the Infection Prevention and Control Committee for information every month. Action plans are sought where areas of concern are identified with the Matron providing assurance on a solution.

The annual 2011 Patient Environment Action Team (PEAT) programme commenced in January 2011. All sites with 10 or more inpatient beds are eligible for inclusion, and as in previous years, all sites undergo a self assessment using the standard assessment form produced by the National Patient Safety Agency (NPSA).

The Trust’s assessment took place during February 2011. Trusts are required to assess either 25% of their site or a minimum of 10 Wards whichever is the greater.

The PEAT assessment is carried out from the patient’s perspective, involving members of the public and/or patients is an important part of the PEAT process as it allows Trusts to be able to demonstrate a commitment to the principles of public/patient involvement and provides an opportunity for members of the local community to have increased confidence in the process.

Members of the Trust’s Community Advisory Panel participated in the assessment for the Newcastle Hospitals.

### All patients, staff and members of the public can be confident that the service provided is safe being delivered in an environment that inspires confidence through excellent standards of cleanliness and estates maintenance

For the Trust the PEAT results were ‘excellent’ in all categories ie.

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<tr>
<th></th>
<th>Environment Score</th>
<th>Food Score</th>
<th>Privacy &amp; Dignity Score</th>
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<tbody>
<tr>
<td>Freeman Hospital</td>
<td>Excellent</td>
<td>Excellent</td>
<td>Excellent</td>
</tr>
<tr>
<td>Royal Victoria Infirmary</td>
<td>Excellent</td>
<td>Excellent</td>
<td>Excellent</td>
</tr>
<tr>
<td>Walkergate Hospital</td>
<td>Excellent</td>
<td>Excellent</td>
<td>Excellent</td>
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</table>
The Department of Health’s Saving Lives programme, was introduced in the Trust in 2008 with the intention of reducing healthcare acquired infection, and embedding a culture of best practice across all disciplines. This demonstrated great success and, therefore, in March 2010, the Saving Lives Steering Group was reconvened with the aim of:

- Revisiting Saving Lives material, identifying gaps and developing work streams for completion.
- Refreshing and re-launching educational material.
- Reviewing and re-launching supporting documentation.

Action plans to embed Saving Lives throughout the Trust will be developed to assure sustainability.

As with the previous Saving Lives Campaign, leads were identified for each of the high impact interventions (HIIs). Each of these leads convened a sub group to take forward the work. The new Steering Group did not move away from the core principles which had enabled the previous campaign to be successful, but built upon and developed this ensuring that practice was supported by evidence.

This has been most effective, and over the last 12 months many changes and updates have been made to all of the work streams, not least of which is the introduction of Aseptic Non-Touch Technique (ANTT) as a principle to underpin Asepsis.

Saving Lives is to be re-launched formally at the IPC Education Forum on 20th May at will be an agenda item at all of the main forums throughout June 2011.

New photographic step by step guidelines for commonly performed Aseptic procedures will be available in clinical areas to enable application of ANTT to practice. Additionally high impact interventions which don’t relate directly to Asepsia will have an updated ‘bubble’ diagram. All of these will be available at ward and department level.

A new Saving Lives webpage will be re-launched in May/June 2011 and a new e-learning package has been developed.

All members of staff in the Trust are required to adhere to and practice good hand hygiene technique. All members of staff are also expected to comply with the ‘5 Moments for Hand Hygiene’. This is vital to ensure a safe environment for patients, visitors and staff by reducing the transmission of potentially harmful micro-organisms.

An extensive hand hygiene audit programme, which monitors adherence to Bare Below the Elbow (BBE), opportunity and technique has continued to demonstrate sustained improvement and compliance. Hand hygiene ‘opportunity’ audits continue with monthly ‘by exception’ reports to IPCOG and IPCC by the Head of Nursing (RVI). More recently, the hand hygiene audit tool has been revised and the audit process is now incorporated into CAT and results are to be reported via the monthly Trust scorecard.

Hand hygiene with soap and water is essential for patients symptomatic of diarrhoea. In October 2010 additional hand washing posters were introduced in Older Peoples Medicine and Medicine to raise awareness and encourage all staff and visitors to wash their hands when leaving single room accommodation. A simple questionnaire was devised to assess the effectiveness of the posters and analysis indicated increased compliance with hand hygiene practices. These posters have also been placed in all public toilets throughout the Trust.

There are plans for the coming year to review the current Hand Hygiene Policy, including an escalation procedure, and to refresh the hand hygiene promotional material for patients, visitors and staff.

Infection prevention and control continues to be given the highest priority in the organization, and is underpinned by a robust, extensive and challenging audit and inspection programme, providing continued assurance in the delivery of safe care to our patients and service users.
By contrast, we justify our promise of ‘Healthcare at its very best’ because our doctors, nurses and resources really are good enough to give you the ‘very best’. Similarly, promising ‘a personal touch’ reflects our great respect for the ‘person inside each patient’. This is all because we recruit, train and retain the best staff in all fields. As a result:

- We have Clinical Teams led by ‘world class’ Consultants, recognised by their peers as being amongst the very best in the field.
- Our research output is respected across the world. Most is done in partnership with the Universities of Newcastle and Northumbria, who both enjoy high reputations for doing good research. The opportunity of engaging in world class research is one of the reasons why we attract world class staff.
- We treat more conditions than any other healthcare provider in the North East.
- One of the leading ‘Trauma Centres’ in the country.
- Our nurses are rated as amongst the best in the country. We also enjoy one of the lowest rates of healthcare professional turnover.

This is not one of those promises which sound good but mean little!
Maintaining such standards requires a committed staff, proud to work for the Trust. The Trust in turn must provide a stable and supportive working environment, in which staff are encouraged to:

- do their jobs conscientiously without undue fear of insecurity.
- develop a mutually supportive culture which encourages synergy and helps improve productivity, recognising that needs are unlikely to diminish while the availability of resources will.
- help develop successful new income generating opportunities engendering a commitment, a ‘can/will do’ culture and more flexible working practices.

It has taken many people many years to make Newcastle upon Tyne the Centre for Excellent Patient Care it now is. It is up to us to build on that foundation and be proud to continue to promise our patients Healthcare at its very best - with a personal touch.
Clinical Governance

Clinical Governance is the principal process through which organisations strive continuously to improve the quality of patient care. It is also essential to enable the NHS to maintain high standards. All health organisations have a statutory duty to seek quality improvement by setting standards against which their performance can be judged.

Clinical Governance encompasses a variety of principles, commonly referred to as the ‘seven pillars’. These comprise:

- risk management
- clinical audit
- staff management
- patients’ experience and involvement
- use of information
- education and training
- clinical effectiveness.

The Trust has continued to work with a small group of other Foundation Trusts, under the aegis of Monitor, the Independent Regulator, in defining and measuring a series of parameters to assess the quality of care we deliver. These centre around three domains: patient safety, clinical effectiveness and the patient experience. The Trust Board receives a report each month in which these parameters are measured and any trends analysed.

More than 40,000 MRSA screening swabs per month are now analysed in the Microbiology Department

Risk Management

In respect to patient safety the list of ‘never events’ has been expanded this year in accordance with recommendations from the Department of Health. Work has been undertaken to ensure that the Trust has clearly defined processes to minimise the risk of any of these occurring.

The National initiative to ensure that all patients admitted for procedures are screened to identify risk factors for venous thrombosis is in place. Audits of all patients suffering hospital acquired thrombosis have been implemented and reviews of practice arise from these.

Work to reduce the risk of healthcare acquired infection (HCAI) within the Trust continues. The Ward accreditation tool has been replaced by the Clinical Assurance Tool in all clinical areas to drive up further standards in relation to hand hygiene, environmental cleanliness and aseptic technique. The Trust has participated actively in the ‘Matching Michigan’ project to ensure that the care of central venous catheters is optimised in all our critical care units. All appropriate patients coming into hospital are screened for nasal, throat and skin colonisation with methicillin resistant staphylococcus aureus (MRSA). More than 40,000 MRSA screening swabs per month are now analysed in the Trust’s Microbiology Department. Every patient who develops an MRSA bacteraemia or any other serious infection has a detailed ‘root cause analysis’ with the aim of identifying the source of infection. The case is reviewed in detail by senior members of the clinical team, together with the Medical Director, Nursing and Patient Services Director and Director of Infection Prevention and Control. The Trust has also been working proactively with colleagues in the community to try to reduce the level of MRSA skin colonisation in patients in high risk environments, such as nursing and care homes. These measures have resulted in a further reduction in the incidence of MRSA bacteraemias among the Trust’s patients in the last year. Further measures to reduce the incidence of C.Difficile infection have also been implemented and the number of patients suffering this has also significantly reduced in the last year. The Trust regards MRSA bacteraemias and rates of C.Difficile infection as simply being ‘markers’ of its overall ability to minimise the risk of all HCAI. Stringent external targets for both C.Difficile and MRSA bacteraemia rates have been set for the next year with the aim of continuing to drive down rates of all forms of HCAI. Mandatory surveillance of surgical site continues to show very low rates of infection in patients undergoing hip and knee replacement.
Clinical Audit

The Trust has an active programme of clinical audit, which is the process by which the quality of local care is compared with exemplar standards. Each Clinical Directorate has an audit lead, who is responsible for identifying topics for audit. Priority is given to the comparison of standards of care within the Trust against external benchmarks, such as guidelines from the National Institute for Health and Clinical Excellence (NICE) and standards set by NCEPOD. Increasing emphasis is placed on re-audit after an interval to ensure that lessons have been learned from initial examinations and that corrective actions have been put in place.

Staff Management

A programme of work to introduce enhanced appraisal for all medical staff has been ongoing throughout the last year. These appraisals will form the basis of the process of revalidation, which all medical staff will have to undergo over a continuous rolling five yearly cycle to retain their license to practice. Revalidation is an extension of good processes of clinical governance through which all doctors will need to demonstrate that they are: practicing safely, keeping up to date and communicating effectively with colleagues and with patients. All staff groups are subject to annual appraisal and performance review. These assessments include confirmation of the individual’s completion of statutory and mandatory training as well as evidence of their Continuing Professional Development. The Trust has an active programme to promote equality and diversity and to support minority groups. In response to significant increases in workload additional Consultant staff have been recruited in a number of Departments including Anaesthesia and Accident and Emergency. A number of training schemes have been introduced to provide groups of nursing staff with specialist skills.

Patient Experience and Involvement

Active participation by patients in the running of the Trust is sought through the Patient and Public Involvement Forum. Many of the Directorates have conducted patient satisfaction surveys through the year. In the main these have demonstrated high levels of satisfaction with the services provided. Where deficiencies or problems have been identified these have led to corrective action. The Council of Governors has received a number of presentations in year in the course of which the Trust’s strategic development plans have been outlined and Governors’ approval sought. Governors sit as members on a number of the Trust’s committees, including the Clinical Governance and Quality Committee and the Complaints Review Panel. At this meeting, which is attended by both the Nursing and Patient Services and Medical Directors, every complaint received by the Trust in the previous month is reviewed. Annually, representatives from each Directorate attend the panel and all complaints received about the Directorate within the previous year are reviewed. The aims of this meeting are to ensure appropriate action has been taken when complaints occur and to seek to identify recurring themes contributing to patient dissatisfaction. The Trust is developing further questionnaires for patients after discharge and also those attending outpatients, asking them to rate the quality of their overall experience. Work to collect real time patient feedback continues.

The MAGIC project, funded by the Health Foundation and undertaken in conjunction with the Institute of Health and Society at Newcastle University has continued through the year. This is looking at the best way of implementing the principals of shared decision making into routine clinical practice. The three specific projects include:

1. The choice between mastectomy and breast conserving surgery in patients with early breast cancer
2. Choice between elective caesarean section and attempted vaginal birth in women who have previously undergone caesarean section
3. Choice between self monitoring, drug treatment and surgery in men presenting with lower urinary tract symptoms
Use of Information

The Trust benchmarks its performance against similar organisations using data provided by CHKS, Dr Foster, the National Audit Office and other such sources including the Care Quality Commission.

All diagnostic imaging studies within the Trust are stored in digital format on the picture archiving system. The previous system had come to the end of its planned life and an upgraded system has been seamlessly introduced with a significant improvement in performance and reliability. The elements of the previous system which had been customized to facilitate the Trust’s specialized practice have been retained in the process. Formal procurement of a longer term replacement system is about to commence.

A system of sharing images through a web based portal enables the results of imaging investigations performed in other Trusts to be directly available to our staff, with appropriate security measures. This facilitates the provision of second opinions on complicated cases from specialists within the Trust and ensures that, when patients are transferred from other hospitals, there is no need to repeat previously performed investigations.

The roll out of our electronic patient record this year has continued. Many of the initial issues associated with the PAS system have been overcome and the remainder are being addressed by the introduction of a major upgrade to the system in the Autumn of 2011. Introduction of the clinical systems has been successful. ePrescribing has been introduced in all parts of the Trust where adults are treated and is ongoing in paediatrics. Handwritten prescriptions for in-patients are therefore a thing of the past. Ordering and communications software now allows investigations on in-patients to be ordered electronically and results are available online as soon as the investigation has been performed and reported. Future plans include the introduction of theatre scheduling and the roll out of orders and communications to out-patient practice.

Anonymised information regarding all patients treated in our critical care units is contributed to the Intensive Care National Audit and Research Centre. This allows us to monitor performance against a variety of benchmarks. In general the Trust’s critical care areas evaluate very favourably against other units and Trusts.
An in-house software solution ‘InTime’ to facilitate the timely transmission of discharge information to General Practitioners has been introduced. This enables discharge summaries to be transmitted electronically to GPs at the time of the patient leaving hospital. This has corrected a significant source of dissatisfaction amongst General Practitioners which has been an ongoing issue for some years.

In the Perioperative Directorates an electronic rostering system has been successfully introduced and has assisted with increasing efficiency of the service both in the utilisation of Consultant staff time and in ensuring that trainees are allocated to the activities which they require from an educational standpoint.

New National standards have resulted in a programme of work to ensure that the Trust is compliant with the requirements of the Information Governance toolkit.

The Trust has been fully licensed in respect to standards of tissue retention and storage in accordance with the requirements of the Human Tissue Authority. Various inspections have been undertaken in respect to the HTA licences this year and no major deficiencies have been identified.

Feedback from those attending courses in the Newcastle Surgical Training Centre remains very positive. The participants in these courses include postgraduate trainees and established Consultants from other Trusts who come to learn new techniques of minimally invasive surgery.

The simulation centre is now very active. It is used to train staff from a variety of disciplines in a number of different scenarios. These range from basic techniques of resuscitation through basic and advanced airway skills and on to the management of rare but life threatening emergencies. Great emphasis is placed not only on individual learning but also on the ability to work effectively in a team.

Education and Training

The Trust operates active undergraduate training programmes for doctors, dentists, nurses and various groups of therapists. It acts as a training institution for clinical scientists and other allied health professionals.

Postgraduate studies continue in many disciplines across the Trust for staff in training grades. A continuing challenge for the forthcoming year is to demonstrate compliance with externally defined and assessed standards in postgraduate education and training.

There are ongoing continuous professional development programmes for all groups of permanent staff. Increasingly rigorous standards for statutory and mandatory training for all staff have also been met.

Clinical Effectiveness

The Trust seeks to ensure that all treatments offered are supported by a clear evidence base derived from research and ongoing clinical evaluation. Before new treatments or procedures are implemented approval needs to be obtained - from the Drug and Therapeutics Committee for medicinal treatments and from the Clinical Governance Committee for new procedures - such as new operations or interventional radiological techniques. The person seeking to introduce the new treatment has to make an application to one of these two committees indicating what the treatment involves, what the evidence is for its efficacy and in what way the new treatment is superior to conventional therapy. Consideration is also given to the information which patients must be given if they are to be administered a new treatment and to the process of informed consent for such treatment. The respective clinical practitioner needs to demonstrate that they have had the necessary training and have acquired the appropriate skills for it to be safely undertaken. An audit of outcomes and results is usually required with a report back to the Clinical Governance Committee. Only after all of these conditions have been met are practitioners allowed to proceed.

The Trust also has a large portfolio of research activity. Much of this is undertaken in a collaborative fashion with Newcastle University under the banner of Newcastle Biomedicine - which is a partnership between the Trust and the University. Directors of the Trust and those of equivalent status in the University sit on a joint executive which oversees the collaboration. Research funding is derived from The NHS Research and Development budget, via commercially sponsored studies and from many external grant giving and funding sources.

It is only possible for the Trust to achieve continuing success in terms of Clinical Governance and, in particular, to strive continuously to improve the quality of patient care with the active support and high professional standards of all colleagues within the Trust and also our external advisors and collaborators. I am extremely grateful for the continuing support of colleagues from all disciplines in moving forward actively with the clinical governance agenda.

Timothy J. Walls
Medical Director
Clinical Effectiveness & Audit

A review of reports from previous years reveals certain recurring themes. Firstly, the continual and ever-widening demands placed on the Clinical Governance and Risk Department (CGARD); secondly, the continuing proliferation of national guidance, and thirdly, the development of Directorate audit reporting.

Unsurprisingly, these themes are yet again reflected in the activities of the past year. CGARD remains very busy, with virtually no spare capacity for personal audit projects, which are now essentially the responsibility of clinical staff. Once regarded as an optional extra, audit is now a mandatory activity for trainee medical staff - all Royal Colleges require regular audit projects to be part of their training portfolios. Consultants too, when revalidation is finally introduced, will have to demonstrate regular participation in audit, although the frequency, and the exact definition of ‘participation’, remains to be clarified. There should be no lack of opportunity, however - this year there has been a greater emphasis than ever before on participation in national audits, with over 50 such projects now included within the Trust’s Quality Account.

This brings me to national guidelines more generally. The National Institute for Health and Clinical Excellence (NICE) has produced - and continues to produce - yet another new range of guidelines. These ‘Quality Standards’ (QSTs) are defined as ‘a set of specific, concise statements that act as markers of high-quality, cost-effective patient care... and address three dimensions of quality: clinical effectiveness, patient safety and patient experience’. There are approximately 150 QSTs planned, all of which will presumably have to be implemented and monitored. As I have noted in a previous report (2006), such extensive guidance, while well-intentioned, can place a heavy burden on healthcare institutions in terms of its implementation and compliance monitoring, especially in a large organisation. The value of central micro-management may also be questioned, especially as it does not guarantee a high standard of care - witness the Mid Staffordshire Trust debacle.

Another type of guidance that has recently been introduced is Medical Technology guidelines (MTGs). As the name suggests, these are concerned with specific technologies for the management of specific conditions, such as MTG 002: Moor LD12 Burns Imager, a device using laser technology to assess burns. These guidelines too come within the purview of the Clinical Effectiveness Audit and Guidelines Committee (CEAG).

On a more positive note, the Trust was successful in being assessed at Level 3 (the highest) for its Risk Management Standards by the NHS Litigation Authority. This achievement was strongly supported by the work of the staff in CGARD, and its significance lies in the reduction of the premium paid by the Trust to insure against clinical negligence claims.

The routine work of the CEAG Committee continues much as before, with monthly meetings to monitor the implementation of new guidance and to receive annual reports from all Directorates on their audit and associated activities. These reports are now expected to follow a strict format, partly to ensure that key matters are included, partly to facilitate their inclusion in other reports, and partly to curb the occasional overly loquacious reporter! However, earlier this year, in addition to its regular meetings, the Committee had to hold several extra sessions to accommodate the workload. Membership of the Committee has inevitably...
fluctuated somewhat over the year, but perhaps the biggest changes will be associated with the merger last year of Newcastle Hospitals Community Health Trust with Newcastle upon Tyne Hospitals NHS Foundation Trust, with all the implications this will have for audit activity, policies and guidelines, etc. We are currently looking to extend the membership of the Committee, to reflect its additional responsibilities consequent upon this expansion of the Trust.

In previous reports, I have mentioned audit competitions held within the Trust - the Sharing Good Practice Awards, and the (separate) competition for F1 and F2 (junior) doctors, introduced in July 2007. Sadly, the Sharing Good Practice Awards were discontinued in 2009, but the F1/F2 competition continues to thrive, with a very high standard of projects being entered. Not only does the competition encourage excellence, but success provides a valuable addition to the trainee’s curriculum vitae.

Finally, as always, I should like to place on public record my appreciation of the work done by my colleagues in CGARD, and particularly of the guidance and support they provide me. The fact that I say much the same thing every year in no way detracts from its truth - I could not wish for better colleagues.

Dr Ian R Fletcher
Consultant Anaesthetist, Chairman, Clinical Effectiveness Audit and Guidelines Committee
Improving your care

Newcastle Birthing Centre - opened 2011
Nursing - Improving patient care

...we work to develop partnerships and improve Patient Pathways across Acute and Community Services

Building on Firm Foundations - Nursing and Midwifery in the Newcastle Hospitals

Moving on from last year’s achievements within Nursing and Midwifery, many of the themes detailed in the Trust Nursing and Midwifery Strategy: Proud of Nursing and Midwifery in Newcastle, have been developed further, and new initiatives added, highlighting that any strategy has to be progressive, and flexible, to meet the ever changing demands of the role.

During the year, a Clinical Assurance Toolkit was developed and piloted, and April 2011 saw its rollout across all wards and departments. This toolkit measures resources (staffing levels, budget position); environmental standards of cleanliness; assurance around key nursing assessments (nutrition, end of life care, falls); and clinical measures (early recognition of the deteriorating patient, High Impact Interventions). It is an invaluable tool to support the Trust in identifying, measuring, and demonstrating compliance with, published documents and national drivers. This is reported on a monthly basis to the Trust Board, and to Matrons and Ward Sisters and Charge Nurses, providing Assurance from 'The Board to the Ward' regarding standards of Nursing practice throughout the Trust.

National initiatives, including the High Impact Actions for Nursing and Midwifery, and revised benchmarks for Essence of Care, have also given impetus to ensuring that quality and innovation remain firmly at the forefront of our focus for the year to come.

The Senior Nursing Team led the refresh and re-launch of the Saving Lives campaign which, this year, also includes the introduction of Aseptic Non Touch Technique (ANTT), a nationally recognised, evidence based, approach to asepsis. A high priority, for the coming year, will be to extend rollout to include community services, and ensure that this becomes firmly embedded in practice.

The Trust continues to build on a range of educational programmes designed to support staff development, and enhance the quality of patient care. Aimed at staff from bands 2 to 8a these include bespoke, in-house, development programmes, and mandatory education programmes such as MEWS (Modified Early Warning Score) and Falls Prevention. A range of Masterclasses has been provided, on a monthly basis, to meet the development needs of Matrons, and a programme entitled ‘Patients are People’ is available to every member of staff, encouraging the very highest standards of customer focussed care.

Working with our partners in Higher Education, representatives from the Trust are actively involved in post-qualifying education programmes, both as learners and in support of module deliveries. For example, a number of staff are currently supporting the development of new pre-registration nursing and midwifery programmes. A Preceptorship Programme commenced during the year, for newly registered nurses, encouraging critical reflection, and is accredited at degree level by Northumbria University.

For the second year in succession, PhDs have been awarded, to both a Midwife and a Nurse. A further six staff are currently enrolled on PhD programmes.

A new, three year, Nursing and Midwifery research strategy: Action For All (2011-2014) has been developed, and includes objectives relating to the promotion of primary research, as well as maximising evidence into practice. This will serve to increase nursing and midwifery research activity and capacity across the organisation.

Whilst new initiatives are encouraged, and welcomed, we must not allow existing, and proven, measures to be the ‘poor relations’, and a number of these measures, to encourage staff engagement at all levels, remain in place, and continue to be effective. These include the quarterly Nursing and Midwifery newsletter, both Senior Nurse and Matrons’ Forum, as well as the recently established Engagement Forum for nurses and midwives from bands 2 to 5.

The Annual Nursing and Midwifery Achievement Awards provide a way to recognise the nurses and midwives, and the methods by which they develop, and enhance, the service provided to our patients. The overall winner this year has worked with children from the Teenage Cancer Unit, at the Great North Children’s Hospital, to develop a ‘Welcome to the Teenage unit’ DVD.

Three other applicants were highly commended, and their work included, a) improving the patient journey when having a liver biopsy, b) a novel initiative for collaborative education to increase cancer prevention awareness in young people, and c) on-going initiatives to improve nutrition and hydration for in-patients.

This broad spectrum of initiatives illustrated the wide range of impact of Nurses on the patient experience.

The 13th Annual Nursing & Midwifery conference was held this year at Northumbria University’s new School of Law and Business Studies. With excellent facilities, and the highest ever attendance (over 300 delegates). The event continues to be one
Two Midwives from Newcastle have won one of the UK’s top midwifery prizes at the Royal College of Midwives (RCM) Annual Awards. Christine Watson and Sallyanne Stroyan, from the Newcastle upon Tyne Hospitals NHS Foundation Trust, received the Award for Development of Services Addressing Inequalities in Health at the Ninth Royal College of Midwives Annual Midwifery Awards at a ceremony on 19th January 2011, at the Royal Garden Hotel, Kensington, London.

Christine and Sallyanne developed a service to detect pregnancies at risk of haemoglobinopathy, which includes conditions such as sickle cell disease and thalassaemia.

The Midwives started their haemoglobinopathy specialist Midwife clinic in May 2008. The service is based on close co-operation with other colleagues such as consultant Obstetricians and Neonatal and Paediatric Services. It enables early access to screening services particularly for women of black and ethnic minority backgrounds who are particularly vulnerable to these conditions. It also provides and supports a seamless service during pregnancy and for the newborn infant.

Early detection of these diseases enables women and their partners to make informed choices regarding their pregnancy. In the long-term it gives parents access to specialist services should they need them, such as specialist paediatric clinics. It is hoped that information sharing amongst communities will also spread the message around screening and the help and support available, as well as increasing knowledge of other healthcare professionals such as Health Visitors and GPs.

Cathy Warwick, General Secretary of the Royal College of Midwives, said: “This award highlights the important, innovative and pioneering work being done by Christine and Sallyanne, and demonstrates the value of midwifery care. It is important for people to know that midwifery practice does not stand still. When midwives are given the resources, support and freedom to develop their work, the result is better services, better care and better outcomes for mothers, babies and their families.”

Chris Wilkinson, Head of Midwifery and Directorate Manager of Women’s Services here in Newcastle explains: “This the second year running in which midwives from the RVI have won first prize at the Annual RCM midwifery awards - last year our midwives secured first place for the fantastic work they have undertaken with bereavement services - the National Maternity Support foundation Award for Excellence in Bereavement Care - Jakes charity. I am absolutely delighted our service has been recognised again this year for another field of excellence - both Sallyanne and Christine have been dedicated to improve the service for parents and their families to ensure support and improved health outcomes.”
NORTH East doctors have devised a pioneering life-saving device for premature babies.

The appliance, Safe Place, helps doctors position neonatal intravenous catheters in premature babies using Electrocardiogram recordings (ECG).

Developed by the Regional Medical Physics Department and Special Care Baby Unit at Newcastle Hospitals NHS Foundation Trust, the new neonatal device aims to increase the accuracy and reliability of positioning tips of intravenous feeding tubes to give babies medication and food.

It is the first time this has been done and it is hoped the instrument will greatly reduce the risk and harm to the baby. Alan Fenton, Consultant Neonatologist at the Special Care Baby Unit at Newcasles Royal Victoria Infirmary, said: Inserting very fine intravenous tubes for giving drugs and food is a routine part of looking after very tiny babies often weighing less than 1kg. It is crucial that the end of the tube sits in a large vein but is away from the heart to avoid potentially fatal complications. Presently this is done using a series of rules of measurements followed by an X-ray, but as you can imagine such small tubes are often hard to visualise on X-ray. However, by using a high quality ECG reading obtained through the tube using Safe Place we are able to place the end of the tube more accurately and in time may reduce the need for X-ray in these vulnerable patients.

NHs Innovations North, based in Sunderland, has been involved in the development of the device and has helped Newcastle Hospitals NHS Foundation Trust licence Safe Place to company Vygon UK and has assisted in the identification of suitable manufacturing partners in the region.

Mark Smith, Business Development Manager at Vygon UK, said: As providers of healthcare and medical products worldwide, this was an opportunity that we couldn’t miss out on, particularly with the massive benefits this will have to the lives of such tiny babies. Being involved in this unique device has enabled us to not only work with the clinical experts at Newcastle Hospitals but also to capitalize on the wealth of manufacturing expertise in the North East.

We are grateful for the help and support received from NHs Innovations North in helping us to make this project a success.

Safe Place is being manufactured by Summit 1 Technology, an electronic manufacturing service based in Jarrow, and Classic Industries Europe, injection moulding specialists.

John Tweedlie, managing director at Summit 1 EMS Ltd said: We are really pleased that we can help in the manufacture of this device.

This is a great opportunity for us to enter a new market and we are extremely positive and passionate about making this device a success. We look forward to seeing the difference that this can make to babies lives.

March 2011 by Helen Rae, The Journal
of the highlights of the year, and seven concurrent sessions, presented by staff from within the Trust, provided an excellent vehicle for sharing best practice. The combination of national keynote speakers, this year from the Nursing & Midwifery Council and the Yorkshire & Humber Strategic Health Authority, as well as the very personal story of a carer, meant the programme had wide appeal and thought provoking content.

Over 20 high quality posters describing the innovative work that is carried out by nurses and midwives across the Trust were displayed at the conference with a prize awarded for the poster judged by a peer group, to be the best.

The establishment of Sharing Best Practice study days provides an opportunity to introduce staff to new and, on-going, initiatives, as well as both local and national examples of good practice, and ways of implementing evidence from research into practice.

This year, a number of national awards were won by nurses and midwives in the Trust;

- The Children’s Community Nursing Team won the Health Service Journal’s ‘Best Practice’ Award in the category ‘Enhancing quality and efficiency in services for children and young people’.
- Two Midwives won a Royal College of Midwives award for their work to develop a more streamlined patient experience for families at risk of having a child with a haemoglobinopathy.
- A Nurse Specialist, from NCCC, was awarded the British Journal of Nursing Oncology, Nurse of the Year Award, for work that she has been doing with women with breast cancer over many years.

The Government’s commitment to eliminate mixed sex accommodation is a commitment the Trust has also embraced. Patients’ perception of their care is very important and, through the Clinical Assurance Toolkit, we now ask over 500 patients a month about their views in relation to mixed sex accommodation, whether they feel they have been involved in decisions about their care, and if they feel they have been treated with dignity and respect. The results of this information are available to Matrons and Ward Sisters each month, and mean that, as an organisation, we can respond very quickly to patient concerns.

The Trust remains committed to working, within an inter-agency framework, to protect vulnerable adults from harm, and to ensure best practice is delivered as guided by National Policy. To this
end, the Adult Safeguarding Team has increased in size over the year, and now has, in post, a Nurse Specialist, a dedicated Training Officer (shared with Children’s Safeguarding), a Learning Disability Nurse Specialist, and a Mental Capacity Act/Deprivation of Liberty Lead, demonstrating the recognition being given by the Trust to these complex areas of work.

We continue to listen to, and work closely with, service users and other agencies. This year, two particular examples of this are worthy of note;

» *The Journey* is a very personal story of a teenager who sustained 90% burns following an incident at a friend’s house whilst playing with matches. A documentary style film, which was produced by Tyne and Wear Fire Education Department, in collaboration with staff from the Burns Unit at the RVI, was shown in all secondary schools in the Tyne and Wear area, highlighting the devastating consequences of playing with fire.

» *Feeling Whole Again* is again a DVD, this time about Breast Reconstruction. The project was commissioned by the Breast Reconstruction Team, and funded by Newcastle Healthcare Charity, utilising money which was raised by patients and others to support ladies undergoing the breast reconstruction journey. It was created in response to a demand from patients for a visual information tool that they could take away and watch in their own homes.

Building upon work already underway, the Trust has taken its responsibilities for people with Learning Disabilities very seriously. In June 2010, Trust Board signed up to MENCAP’s ‘Getting it right’ charter, and the Learning Disability Specialist Nurse has undertaken a significant amount of work, with colleagues throughout the region, to develop Care Pathways for this very vulnerable group of people. In addition, a close relationship has been developed with a drama group, whose members all have a Learning Disability, and their attendance, as an integral part of the ‘Patients are People’ programme, provides a stimulating and thought provoking focus for the day’s activity.

In retrospect a busy year - in prospect an even busier one, as we work to develop partnerships and improve Patient Pathways across Acute and Community Services since the successful transfer of Community Services to the management of Newcastle Hospitals, thus establishing the brand of Newcastle Hospitals Community Health.
Installation of Fine Art Wall Hanging to Celebrate 50th Anniversary of the RVI Nurses’ League

The RVI Nurses’ League held a reception on 5th May to celebrate the installation of a fine art wall hanging which was commissioned to mark the 50th Anniversary of the league in 2009.

The wall hanging was created to have visual impact within the spacious Atrium of the New Victoria Wing of the RVI and measures an impressive 3 metres wide by 1 metre high!

Patricia Winksell, a local embroiderer of considerable skill and reputation, created the wall hanging.

The commission was made possible due to donations from members of the League, League funds and supplemented with generous donations from the Trustees of the Newcastle Healthcare Charity and the School of Health Community and Education Studies, Northumbria University.

Filipina Nurses - 10 Years of Excellent Service

It is ten years since the Trust embarked on a major project to actively recruit nurses from the Philippines to help meet the Trust’s need for qualified Nurses. This anniversary was marked with a celebratory mass and party held on the 30th July 2011 which brought colleagues from across the Trust together with the original project leads, Miss Mary Pitt, Mrs Frances Blackburn, and many family members.

Over 40 of the original group of 50 Nurses who joined the Trust ten years ago continue to work within the Trust which is a real testament to them, the Trust, and to Newcastle where they have made their homes.

The Trust is very proud to have this strong association with the Filipino nursing community and many of their families who work within the Trust. The contribution of these staff to the Trust’s delivery of high standards of care and services is recognized by colleagues throughout the organisation.
Our Learning Disability Conference 2011

“The health and strength of a society can be measured by how well it cares for its most vulnerable members”

(Health Care for All, 2008)

Learning Disabilities Week got off to an excellent start, with a conference introduced by our Chief Executive, who is passionate about making health services more accessible to those with a learning disability.

The Conference focused on living with learning disabilities, everyday issues, hospital admission and making a difference, which was underpinned by ‘Death by Indifference’ and ‘6 Lives’, the Ombudsman’s report into failures in care of those with learning disabilities.

This was presented in a unique way by the Twisting Ducks Theatre Company, providing visual, engaging theatre relating to the experiences of people with learning disabilities.

All participants across acute and community services worked together to share good practice and identify areas for improvement. Ideas and action points were formulated to take positive steps forward, bridging the gap between acute and community services.

As a result of the conference, further awareness and education is being undertaken within medical teams across the Trust.

We would like to extend a very big thank you to all those involved.
Spotlight falls on disability equality

A GROUP of unlikely theatrical entrepreneurs are shining a light on the problems faced by people with learning difficulties and teaching the world to be a more understanding place. And they’re having great fun doing it. MIKE KELLY reports.

People with learning difficulties can be characterised as finding it difficult to communicate, form friendships and being a little taciturn. Try telling that to the members of The Twisting Ducks Theatre Company - if you can get a word in edgeways that is.

The eight-strong group are a lively bunch and they’re still coming down off the high of their ‘Big Launch’ earlier this month at the People’s Theatre in Newcastle. There they staged a series of performances for the public and health professionals about issues affecting the lives of people with learning difficulties.

While the initial start-up benefited from a grant from the Big Lottery Fund and it has been named one of the Lord Mayor of Newcastle’s chosen charities for the year, the group is to be self-financing in the future, contracted to do stage performances mostly as a teaching tool for those who deal with people with learning difficulties.

It has opened doors for the members and such is the interest in their initiative they are planning to launch a ‘performance academy’ in the future where people who want to emulate them can start their own group.

So how did it all come about?

The origins of the company go back three years when members of the group met while on a City Learning funded course for people with learning difficulties. Jay Hare who is now project co-ordinator for The Twisting Ducks took drama classes there which many of the current members took part in but wanted to take the skills they were being taught a stage further.

Jay said: “The idea was to get people together who enjoyed it and wanted it as a career route. They wanted a direction and they decided to form an issues-based theatre company.”

The name The Twisting Ducks was literally pulled out of a hat. Words were written on paper and placed into two hats then plucked out randomly until a name that caught their imagination was found.

“It could have been knitting with noodles,” said Marc McAndrew and the group laughed in unison.

Marc, along with Alan Cuthbertson, Fiona Mothersole, Sameena Varris, Alex Dougherty, Kylie Wightman, Martin Roberts and Zoe Cullen are the members of the group. Ranging in age from Kylei and Zoe who are 22, to Fiona who is 38, they meet on Mondays and Tuesdays at Westgate Community College in Newcastle with Jay and project support worker Ani Sherab.

They discuss ideas and “workshop them”, turning them into scripts. The end result for their big launch was performances inc-luding What’s Up Duck? based around health, and Person First about equality and diversity.

They deal with matters as simple as a visit to a GP for health problems from the perspective of a person with learning difficulties to show how baffling it can be, to personal relationships. While giving an insight into how their thought processes differ from those without learning difficulties, it also highlights prejudices or misconceptions which they have all faced when coming face-to-face with health professionals who mean well but aren’t on their wavelength.

Rather than being preachy and dry, they got their message across in a series of vignettes involving music and humour. The end result is entertaining, educational and informative.

As Bill Norman, valuing people co-ordinator at Newcastle City Council put it: “Their shows put the message of disability equality better than a thousand reports ever could.” And they’re having fun doing it.

Fiona said: “It’s the golden opportunity of our lives” and Alex quickly chips in: “We’re going to have a heck of a time.”

Not surprisingly other people with learning difficulties are keen to have a heck of a time too.

Jay said: “We’ve been inundated with people wanting to join. A lot of them look at The Twisting Ducks and find it quite inspiring but we can’t take any more people on. Then one of The Twisting Ducks came up with starting up a performance academy.”

It will involve singing and drama coaches while the group continues to expand its interest in film and media. The plan is for 10-week block courses starting in January. Groups can also buy the plays and mus-scale already written by The Twisting Ducks or commission them to write new ones which can be specifically geared to the needs of the purchaser.

There is a veiled criticism among members of the group about what was on offer to them before The Twisting Ducks to keep those with learning difficulties occupied. Too much sitting around, nothing really planned. And that could get worse if and when day centres close in the forthcoming cutbacks. The memory acts as a stimulus to them.

Alex, an ebullient character, said: “You don’t want to waste your time watching EastEnders. This is much more exciting. I love performing and getting the message across.”

Marc added: “It’s a fantastic opportunity for someone with a learning disability. If you go out into the world and see how many people with a learning disability have nothing to do. We’re full up now but they can form their own group. If they don’t, they don’t know what they’re missing.”

For the time being at least the future for The Twisting Ducks looks good. As the nation lives under the shadow of Government cuts it is helping itself both with the ongoing contract it has for performances with the Newcastle NHS Foundation Trust.

Its Chief Executive Sir Len Fenwick, one of the country’s longest serving health officials, was in the audience for The Twisting Duck’s big launch.

He said: “In many ways they were highly professional and it was impressive. Not just health workers but all parts of society could learn from them in terms of listening and taking that little bit of extra time to understand, super-port and encourage and to be able to adjust. The Twisting Ducks have a broad message to give not just in the field of learning disabilities.”

It seems the group could have tapped into something bigger than they thought.

Ani Sherab who has been with the group since the start is justifiably proud of their achievements. She said: “I look back to those first early performances and it is remarkable how far everybody has come in those three years.”

Asked about The Twisting Ducks mean to them, the group’s ans-wers are variations on similar themes to each member – independence, satisfaction and camaraderie.

As Sameena puts it: “It means everything to me and there’s nowhere else I’d rather be. When my mother asks who my best friend is I say I don’t have one best friend. They are all my best friends.”

To find out more about the company, visit its website: www.thetwistingducks.co.uk

The Journal, September 2010
The Royal Victoria Infirmary which opened in 1906, has seen extensive redevelopment to bring about ‘best in class’ specialist teaching hospital infrastructure.

A seven year investment programme shall come to fruition in 2012.

In the late Autumn of 2010 the range of facilities encompassing Emergency Medicine in its widest context enabled the closure and transfer of Acute Services from Newcastle General Hospital.

The Edwardian heritage has not been forgotten with investment in the Listed Buildings, complementary design features and the development of the Civic Centre adjacent to the Peacock Hall and St Lukes Chapel.
Review of the Year 2010/2011

A corner in the Percy Ward

The Royal Victoria Infirmary, Newcastle-on-Tyne, 1906

Source: Royal Victoria Infirmary Annual Report

The Royal Victoria Infirmary, Newcastle-upon-Tyne, 1906

Source: Royal Victoria Infirmary Annual Report
District ambulances bringing patients to the Infirmary, 1927

Peacock Hall, 2010
The Great North Children’s Hospital came into full operation in November 2010. It is where our child healthcare experts provide joined up, seamless pathways of care, all under one roof.

This new £100 million facility offers the very highest level of care. Part of the ongoing transformation of the Newcastle Hospitals, this stunning building is already a beacon of excellence for the care and treatment of children from throughout the North East and beyond.

With its circular, copper-clad exterior the building is sure to be as iconic a landmark as the Tyne Bridge and its neighbour, St James’ Park. Inside, the hospital is equally dramatic with a spectacular six-storey central atrium, coloured, curved corridors and multi-coloured windows combining to create a real sense of space and light.

This is a hospital designed to look as little like a hospital as possible. It’s a nurturing environment, a place where children and their parents can feel more at ease, however long their stay. Staffed by world-class doctors and nursing staff using the very latest equipment and medical techniques, we are caring for young people with a huge variety of conditions.

I wish hospital was not boring
However, all of our patients will definitely have one thing in common. Being in hospital is not top of their list of things to do! That’s why we’ve included a 50-seat cinema that screens the very latest films, while the designers of our new ‘penthouse’ area at the children’s hospital should have a good idea of what teenagers want - they’re teenagers themselves. And because we know that kids of all ages need their own space, three out of four of the hospital’s 245 beds are in private ensuite rooms. The bathrooms and sleeping area for parents are all part of a very distinctive environment to create privacy and positively enhance the experience and well being for patients, their families and friends.

**The Services and Facilities include:**

- Spacious and airy environment for our inpatients - there are 246 beds - with 75% of these being single rooms with ensuite facilities.
- The purpose built Teenage Cancer Unit with its ‘Penthouse’.
- A centralised Children’s Outpatient Department.
- Five dedicated paediatric operating theatre suites and two of these are state of the art laparoscopic theatres.
- First class facilities to allow parents to stay overnight.
- An ‘Amazing Interactives’ 3D system. The Burns and Plastic Surgery unit is the first to benefit - this system aids distraction therapy (and gives fun) to children.
- MediCinema - a new 50 seat cinema to benefit children - blockbuster movies can be viewed with nursing staff, family members and carers in attendance.
- The Bridges School within The Great North Children’s Hospital provides accommodation, a classroom and ‘breakout’ space to support education of children within the hospital environment.
- Our CANi Nursing Team - this Community Acute Nursing Initiative is an award winning outreach team which helps support early discharge in children by offering nursing care and support in the local community.
- Radio Lollipop studio - tremendous fun and entertainment! … amongst many other facilities.

*This is a hospital designed to look as little like a hospital as possible*
As of April 2011 the Royal Victoria Infirmary became a Major Trauma Centre (MTC). This will serve as the hub of a major trauma network supported by Trauma Units in Tyne & Wear and North Cumbria.

The development of major trauma networks is a major step forward in the improvement in outcomes for injured patients in the UK. Reports from NCEPOD, the National Audit Office and Royal Colleges in recent years had highlighted fragmented delivery and poor outcomes in the management of major trauma. A growing awareness of needless loss of life in the relatively young at-risk population and associated disability and consequent long-term costs to the health economy as a whole has resulted in a Department of Health initiative to improve the care of patients with major trauma. Professor Keith Willett has been appointed as National Clinical Director for Trauma with clear direction that health regions need to develop major trauma systems and that these should be established from April 2011 and fully commissioned from April 2012. We received a visit at the RVI from Professor Willett in May and were able to demonstrate the considerable progress made here in Newcastle upon Tyne and our associated Trauma Units towards a fully functional major trauma network.

There will be two networks in the North East of England within a Northern Trauma System - Tyne and Wear with the RVI, Newcastle at its hub and Tees Valley based around James Cook University Hospital, Middlesbrough. Both will be serviced by the North East Ambulance Service and the Great North Air Ambulance Service. Both of these pre-hospital services will be adopting a new triage system to identify potential major trauma patients that should be transferred directly to a MTC. Although our status as Major Trauma Centre went live in April 2011 and we already have improved transfer protocols into Newcastle from our local trauma Units, it will not be until next April 2012 when the triage system is up
and running that the major impact on the RVI will be felt.

The key principle in the establishment of major trauma networks is the direct delivery of patients to the facility with the specialised services to provide definitive care. This changes the current philosophy of delivery to the nearest facility irrespective of its ability to meet the needs of that particular patient. The ‘London Trauma System’ has been a pathfinder for this approach to major trauma and early indications have confirmed improved care of patients with major trauma and improved outcomes in terms of both disability and mortality.

The Trust expects a significant additional volume of seriously ill trauma patients to come through its doors, which in turn will impact on many of our surgical specialties and critical care facilities as we strive to provide continued quality of care to these extra patients. During the latter part of 2011 we will be recruiting additional specialist medical and nursing staff to support this new approach to trauma. We also recognise management of the acute phase of injury, whilst of vital importance, is only part of the story - it is successful rehabilitation of the survivors of trauma that determines return to families and productive lives. To this end the Trust will be exploring exciting possibilities in the development of rehabilitation services in the North East, building on existing expertise.

There are challenging times ahead for the Trust but this is again an opportunity for the Trust to reaffirm our status as a leading centre of excellence with specialist management of complex trauma.
We have laid down the gauntlet for other national and international centres to follow suit.

Institute of Transplantation

One year on and the vision of the Institute of Transplantation has become a reality. As September approaches, the final touches are being made to the building that will change forever, the way we deliver transplant services in Newcastle. Since the last annual report, transplant clinicians and research scientists working within our Foundation Trust and Newcastle University have begun to collaborate to generate advances in both clinical service and translational science that meets the current and future needs of our patients. It has been extremely heartening to see how transplant professionals in Newcastle have embraced this project over the last year. With the strong support from the Trust behind us, we have demonstrated our resolve in meeting the challenge laid down by the Department of Health to enhance the national programme, and have laid down the gauntlet for other national and international centres to follow suit.
Success of teenager’s stopgap surgery gives hope to thousands of patients

The heart girl who could herald the end of transplants

By: Aine Simms

Institute of Transplantation entrance - construction completion imminent

August 2011
A comprehensive research and development strategy for the Institute has now been developed, some of which has already been funded nationally by the National Institute for Health Research and internationally by the European Union. Our R&D strategy will provide a comprehensive portfolio across all organ specialties that will improve our understanding of such events as graft rejection and improved measurements of clinical outcomes as well as focusing on novel approaches to ‘re-condition’ previously unusable organs to both increase the number of suitable donor organs and improve their clinical outcomes. Over the last year, besides ‘traditional’ organ transplantation, we have made significant progress in the field of cell transplantation and have made some exciting links with our stem cell scientists. In addition, The Institute is committed to providing opportunities for education and training and we are well underway with developing a comprehensive programme including a Newcastle University accredited qualification, which we will start to deliver early in 2012.

Developing the Institute has allowed health professionals in Newcastle to think ‘outside the box’ and develop new and innovative ways of delivering a service that has traditionally been very demanding and costly and in light of the NHS reforms this has come at a most opportune time. From changing the way we deliver an ‘on-call’ service to developing a digital strategy to educate the general population. This is one of the most exciting projects we have been involved in and once again demonstrates the vision of The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Professor D M Manas, 
Director

Professor P Corris, 
Deputy Director

Professor A Fisher, 
Academic Director
Dear Newcastle upon Tyne Hospitals NHS Foundation Trust,

My daughter Eve was having a day off school due to a minor illness when she suddenly collapsed and was rushed to the Royal Victoria Infirmary. Eve had experienced a massive bleed to the brain with no apparent cause leaving me feeling helpless and very worried.

Eve’s mother and her husband joined me immediately at the hospital to spend what would be an incredibly difficult first night at the hospital. In the panic we had left basic necessities behind and had to make the unpleasant decision to leave Eve’s bedside to return home to collect what would be needed for our stay. Every mile of that journey felt like an eternity and I couldn’t wait to be back at my daughter’s side.

I never wanted to be that far from my daughter’s side again and therefore when we were directed to The Sick Children’s Trust’s Crawford House by a social worker from the hospital it felt like an incredible weight had been lifted from our shoulders. We were able to stay in this ‘Home from Home’ knowing that we were only ever a couple of minutes from Eve’s bedside and it was fantastic to know that the practical needs of having a place to eat, sleep and wash were no longer a concern.

The house was also brilliant for my youngest daughter Mia, who instantly felt at home in Crawford House. In other foreign places, such as hotels, Mia has felt unsure of herself and required frequent reassurance; however this friendly environment with incredibly approachable staff clearly made her feel safe. Knowing that Mia was comfortable was another thing off our minds during this stressful time.

The doctors explained that it was also very beneficial to meet other residents in the communal dining room. Everyone is going through similar circumstances and can empathise with our situation. Occasionally people talked to each other about their children but everyone was also sensitive to each other and respected that sometimes people need to just sit quietly.

Eve has now been moved from the Paediatric Intensive Care Unit to the neuro-ward. A stent has drained fluid in her brain and she has been more responsive since; opening her eyes, making sounds and trying to move her arms. Without the continuing support from Crawford House, this whole experience would be significantly worse.

Eve is still very poorly and therefore it is comforting to know that if I did need to draw on Crawford House again, the staff involved would do all they could to accommodate me. I truly believe that family is the best medicine and cannot thank The Sick Children’s Trust enough for giving us the opportunity to be as close to our daughter as possible in her greatest time of need.

Ian, Eve’s dad

Dear Newcastle upon Tyne Hospitals NHS Foundation Trust,

Our Son Robin was only three years old when he was diagnosed with Chronic Granulomatous Disorder which affected his immune system and we were told he would need a bone marrow transplant.

The doctors explained that they would need to transfer him to the Great North Children’s Hospital in Newcastle from our local hospital in County Down in Northern Ireland and the recovery time could take up to six months. When we heard this we panicked as we didn’t know anyone in Newcastle and the thought of racking up hotel bills for this length of time was terrifying, never mind how we would stay together as a family with our daughter Lucy, who was only seven weeks old.

We all initially came over in November one week so the hospital could undertake Robin’s pre transplant test but he took ill unexpectedly whilst we were in the UK and we had to extend our stay, so we stayed in hospital accommodation but after three weeks we had to move out of there as they needed the house. This was when we moved into The Sick Children’s Trust Crawford House.

At first we were a bit apprehensive as the hospital accommodation wasn’t that great but when we arrived at the ‘Home from Home’ and we saw how lovely it was we were blown away. It was just so clean and welcoming. The relief of knowing we could stay there free of charge whilst Robin was recovering in hospital lifted the stress of the situation and meant we could focus all our attention on our son.

Staying at Crawford House made the whole experience of Robin’s illness much easier to cope with. We were only a minutes walk from his ward, we had somewhere to go and make meals together and a lovely room where we could all get a good night sleep so we were fresh to face a new day in the hospital. It wasn’t our home but was definitely the next best thing.

We stayed at Crawford House for six months and we really appreciated the gift of staying there as it made the bad times that little bit easier to cope with.

Leah Calvert, Robin’s mum
Maggie’s Cancer Caring Centres

Maggie’s North East is being developed at the Freeman Hospital to provide a welcoming and supportive environment where people affected by cancer can drop in to receive help and advice from healthcare professionals.

There is to be complimentary support to the Northern Centre for Cancer Care. It is being developed in partnership with the Maggie’s Cancer Caring Centre, which now has a network of centres in Scotland, Cheltenham and London, with more planned in Nottingham and Aberdeen as well as at Newcastle.

The aim of the Maggie’s Centres is to help people with cancer to be as healthy in mind and body as possible and to enable them to make their own contribution to their medical treatment and recovery. Maggie’s programme of support allows anyone affected by cancer - patients, carers, families and friends - to address all aspects of living with cancer. They can share their experiences with others in similar situations and, with professional help, learn more about the medical realities of their disease. The friendly and welcoming environment of the centres invites people to take time out and gives them a non-institutional place where they can feel relaxed and supported.
The progress made in this period has been supported by a new governance and reporting structure within the ISSB; enhanced engagement with front-line clinical staff through the ISSB Clinical Advisory Group and the Clinical Informatics Committee; alignment of the information systems strategy with front-line clinical care and with the Trust’s business needs; the establishment of a Project Portfolio, prioritised in line with the Trust’s overall strategy; and the implementation of standardised project management processes. This organisational development over the course of 2010 has been possible through the hard work of the Director of Information Technology; the Head of Programmes; the Head of Clinical Informatics and Business Intelligence; the Chair of the Clinical Informatics Committee, and the Chair of its precursor, the eRecord Programme Board; a significant number of medical and nursing staff through their support of the ISSB, clinical sub-committees, and project supervision; and through the active support of the Trust Executive. These organisational developments have underpinned the effective implementation of an aligned, prioritised information systems strategy for the benefit of front-line care and in support of the Trust’s business needs.

There have been significant tangible, objective outcomes as a result of the re-aligned information systems strategy. Some of the key developments are summarised below, and relate to Direct Patient Care; Patient Experience; Primary Care Integration; Business Support; and IT Infrastructure Renewal.

The individual projects in each of these categories that have been delivered or significantly developed or refined in 2010 - 2011 are shown below:
Direct Patient Care

There has been significant embedding and refinement of the Trust’s implementation of Cerner Millennium over the course of 2010 - 2011, consisting of the following aspects. The Patient Administration System implemented in 2009 has been significantly refined, with significant benefits for clinic and theatre administration, patient bookings, correspondence, and case note tracking. The administrative processes have been optimised over this period, primarily through the work of the Clinical Informatics team. There has been effective implementation of inpatient Investigation Ordering and Results, supporting direct patient care by facilitating the investigation and tracking of results of diagnostic tests. Over 2010 - 2011, there has been successful implementation of Inpatient e-Prescribing, with resulting improvements in medication tracking and administration. There has also been significant progress towards the development of a Paperless Electronic Record, with partial development within Accident and Emergency, as part of the process of moving towards a more general paperless electronic patient record within the Trust. An innovative Patient Tracker Board has also been implemented and refined within Accident and Emergency supporting the real-time monitoring of treatment progress within the Department. These first components of the Trust’s Cerner Millennium programme have laid the foundation for further development of the system in 2011 - 2012, with progressing of the Theatre Management System, Outpatient Ordering, and Message Centre (to facilitate patient referral and treatment tracking as an integral part of the drive towards a paperless electronic record) all planned for the coming year.

There has also been significant progress in the optimisation of the PACS imaging system. The governance and forward development of the system has been re-enthroned within the Trust’s ISSB governance structure, and a process of PACS optimisation over the course of late 2010 - 2011 is well underway. This has resulted in significant improvements in functionality and system stability, with improved clinical care as a result.

Patient Experience

There have been significant developments to improve the quality of care experienced by patients and relatives, over and above projects delivering Direct Clinical Care support. These include the implementation of Patient Contact - a system supporting direct communication with patients by telephone and text to improve the quality of contact with the Trust, and Clinical Assurance Toolkit - a system optimising aspects of direct patient experience on the ward, including infection control and cleanliness; with development planned for Self Service Check-In in 2011 - 2012 - to improve patient and relative waiting times in outpatient clinics.

Primary Care Integration

Information systems have been developed to support integration of clinical care information with Primary Care. This year has seen the implementation of GP Messaging for Pathology Results - allowing primary care clinicians to access pathology results directly from the Trust’s systems; and of GP Messaging for Discharge Summaries - consisting of electronic transfer of clinical discharge information to clinicians in primary care. Both developments have been well received by local GP’s, and have directly improved the quality of patient care at the Primary Care - Secondary Care interface. Further development of GP Messaging for Radiology Results is in progress for 2011 - 2012.

Another key ongoing project relates to the integration of information systems in support of Transforming Community Services - to facilitate the integration of Primary Care and Secondary Care services. Two-way communication between the Trust information systems and Primary Care systems is in active development, and has been made functional with the emergency admission areas. Further development is in planning for 2011 - 2012.

Business Support

There has been on-going development of information systems to support the Trust’s business needs. Version 2010 Upgrade is central to this, ongoing over 2010 - 2011 and due for completion this autumn, and will provide the ability to clearly track the Trust’s performance towards 18-week referral-to-treatment targets, supporting the provision of high quality, timely clinical care. Patient Level Costing has also been under development over 2010 - 2011 and is nearing completion, and this will provide a clear view of the costs and associated income associated with a broad range of clinical activity. There has been significant work on Choose and Book, and the Trust is now recognised as a leading performer nationally as a provider of online patient appointing. There has also been a large amount of work completed in 2010 - 2011 with respect to Electronic Document Management, including the completion of a pilot and the initiation of a planning framework, in support of a move towards replacing the existing paper record with an electronic repository. The Electronic Staff Record has also been successfully implemented, which ensures that required training and staff documentation is appropriately up-to-date, in support of the provision of high quality clinical care.

IT Infrastructure Renewal

The Trust has been supported in the implementation of its information systems strategy by the renewal of key elements of the IT infrastructure over the course of 2010 - 2011. This has included the implementation of an enhanced Disaster Recovery System, to ensure business continuity; Network Upgrade, remedying areas of structural weakness; Storage Upgrade, improving the overall performance and resilience of the Trust’s networks; and Anti-Virus Renewal, to optimise protection of the Trust’s information systems. There has also been a concomitant process of organisational restructuring and renewal within IT, to optimise the internal governance and functioning of Trust IT, and to improve the service delivered to front-line staff, for example through the Service Desk.

In conclusion, a significant number of key developments have been effectively implemented over 2010 - 2011 as part of the Trust’s information systems strategy, in support of the provision of the highest quality of patient care, with a further programme of intense activity planned for the period 2011 - 2012.

Dr Daniel Birchall
Chair, Information Systems Strategy Board
The Trust has continued to increase its research activity in the context of the Government’s Plan for Growth, highlighting the key role of health research in the national economy as well as in improving health and care. The National Institute for Health Research (NIHR) in the Department of Health is responsible for overseeing health research in the NHS and provides the majority of health research funding received by the Trust.

In 2010-11 the Trust approved 325 new studies, a 40% increase on studies approved in 2009-10. The Trust’s major focus is supporting research on the national NIHR Portfolio of research studies. Last year the Trust approved more NIHR portfolio studies and commercial studies than any other Trust in England. Reflecting the increase in our research portfolio the number of Trust patients participating in research studies continued to increase with over 14,000 patients entering trials and studies. The Trust makes a major contribution to national NIHR research studies, accounting for 2% of national patient recruitment. In four research areas the Trust contributed more than 10% of national recruitment: dental and oral health, metabolic and endocrine, nervous system disorders, urology and urogynaecology. The Trust maintained its position as the sixth highest recruiting Trust nationally. Close working with the Northumberland Tyne and Wear Comprehensive Local research Network and local cancer, dementia and neurodegenerative diseases, diabetes, stroke networks has been key in achieving this level of research activity. The Trust, in collaboration with Northumbria Healthcare Trust, was one of only eight Trusts awarded three years’ funding to establish a hyperacutec stroke research centre (HSRC). The HSRC will build on the service improvement in acute stroke care to develop advanced brain imaging and neurointerventional care to evaluate promising new treatments for hyperacute stroke such as clot retrieval devices.

Alongside Newcastle University, the Trust has identified six research priority areas (respiratory, cardiovascular, child health, clinical oncology, elderly care, respiratory, transplantation) for investment and development in the immediate future. The Trust will build on the considerable investment already made in these areas to deliver high quality clinical research that will translate into future benefits for Newcastle patients.

As a consequence of the national Plan for Growth NIHR has placed considerable investment in the development of translational research partnerships involving NHS Trusts and Universities with the life sciences industry to undertake early and exploratory development of new drugs, devices and other interventions to improve patient outcomes. The Trust, in partnership with Newcastle University, continues to be a leading UK centre for early translational research. Newcastle is one of nine centres participating in the Office of Life Sciences Joint and Inflammatory Diseases Therapeutic Cluster developing innovative new treatments for patients with rheumatoid arthritis and other inflammatory conditions.

A major achievement in 2011 was successful renewal of the Biomedical Research Centre (BRC) for Ageing and Age related disease and award of a Biomedical Research Unit (BRU) in Lewy Body Dementia, with a combined funding amount of £21 million over 5 years. Newcastle was one of only two Trusts outside the ‘Golden Triangle’ of London, Cambridge, and Oxford to receive Biomedical Research Centre funding and this reflects recognition by NIHR of the world class research into ageing and chronic disease undertaken by the Trust (in partnership with Northumberland Tyne and Wear Mental Health NHS Trust) and Newcastle University. Chief Medical Officer, Professor Dame Sally Davies said:

“The National Institute for Health Research centres and units announced today have been selected because of the world class quality of their translational research. By focussing on translational research across a wide range of diseases, the centres and units will help pull new scientific discoveries into benefits for NHS patients. I believe they will make a significant impact on the health of the population.”

On the day following the announcement of the BRC and BRU awards the Secretary of State for Health, the Rt. Hon Andrew Lansley, CBE, MP visited the Campus for Ageing and Vitality, during which time he met patients with Lewy body dementia in the Clinical Ageing Research Unit, saw work being undertaken in the Newcastle Brain Tissue Resource, and was shown around the Biomedical Research Building which is still under construction.

This year the dental research group won a prestigious medical futures innovations award for their development of a technique to reduce discomfort from dental injections. Later this year, a dedicated Dental Clinical Research Facility will open in the Dental Hospital at the RVI. This will provide first class, dedicated facilities for conducting clinical trials in dentistry, and is supported by research laboratories specialising in microbiology, molecular analytical techniques, fluoride research and materials sciences.

Recent research achievements that have had a major impact on patient care include the following:

- Newcastle investigators have made key discoveries in how to treat non-alcoholic fatty liver disease showing that exercise may reverse the early stages of the disease by reducing liver fat. Ongoing research funded by the Medical Research Council is determining whether scarring of the liver may be prevented by angiotensin receptor blockers usually used for lowering blood pressure in hypertension.
The Newcastle stroke team developed the Face Arm Speech Test initially used by UK ambulance services to identify patients with stroke and facilitate transport to hospitals with stroke teams and facilities to deliver clot busting treatment. The Test was used by the Department of Health in a highly effective campaign to increase public awareness of stroke and has had a major impact on public and professional awareness of stroke symptoms.

The lung transplantation research team has developed a new clinical programme of ex-vivo lung perfusion (EVLP) with funding support from the UK Cystic Fibrosis Trust. EVLP is a novel technique to improve the condition of donor lungs that cannot currently be used thus increasing the supply of donor lungs suitable for transplant and enabling more patients to be offered life saving lung transplants. Their work has allowed 7 patients to receive donor lungs successfully that would not have previously been transplanted. This important advance is now being tested in other transplant centres across the UK in an NIHR funded trial led by Newcastle clinicians team.

The thyroid surgical team have shown that using a Harmonic Scalpel can dramatically improve transformed the way thyroid surgery is done in the UK. One third of all cases in the UK are now operated using this technique with better outcomes and quicker discharge from hospital. Safe and effective haemostasis in surgery is clearly essential, and in the neck where risks of airway compromise are also present any new technology that purports to offer advantages must be rigorously evaluated. We describe our experience with the use of the Harmonic Scalpel (Ethicon UK) in thyroidectomy. A retrospective clinical review of 183 patients undergoing hemi or total thyroidectomies from 12 months prior to using the harmonic scalpel (2003; n=77) and 12 months ‘beyond the learning curve’ (2006; n=106). The results demonstrate that, once past the learning curve, the use of the harmonic scalpel during thyroidectomy significantly reduces operative time and postoperative hypocalcaemia, and is as safe as conventional surgery with regard to voice change and bleeding.

At a time when the NHS faces considerable pressures and challenges the stability of national funding for research from NIHR offers real opportunities to advance care and improve patient outcomes. The Trust’s research activity has undergone considerable expansion in the last 5 years and our close partnership with Newcastle University makes Newcastle one of the leading centres in the UK for medical research. For the future the Trust aims to be at the forefront of evaluating innovative new therapies for patients and ensuring our patients are able to benefit from new therapies that are shown to be effective through the research that we lead.

Professor Gary A Ford, Clinical Director, R&D

...we are one of only two Trusts outside the “Golden Triangle” of London, Cambridge, and Oxford to be awarded Biomedical Research Centre Status and funding.
Our major investment plan will set the scene for Newcastle to become nationally and internationally renowned as a leader in Ageing and Health - one of the four Newcastle Science City themes.

Working in close partnership, The Newcastle upon Tyne Hospitals NHS Foundation Trust, Newcastle University and major retail provider Tesco aim to create the UK’s very first Campus for Ageing and Vitality.

Unique collaborations between research, healthcare, business and retail will enable Newcastle to build upon its already well established reputation as Europe’s premier centre for age-related research - enhancing its international standing as a world leader in the field of ageing and vitality and helping people to select healthier lifestyles leading to prolonged independence as we age.

Working together with the public and a variety of partners, we aim to:

- comprehensively understand the fundamentals of the ageing process
- identify ways in which we can all reach older age as healthily as possible
- combat age-related diseases especially those which are known to be degenerative and debilitating
- translate these exciting findings into every day life through the commercial development of products and services aimed at healthy living and supporting those disadvantaged by ageing

The Campus for Ageing and Vitality shall bring many benefits to the West End of Newcastle including the creation of a substantial number of new jobs and significant commercial opportunities. It will play a major role in helping to revive and reinvigorate the surrounding neighbourhood.

This is an outstanding opportunity to look at how people age, at our choices and behaviours, and at the support we need as we age.

The resultant findings can then be transferred into real benefits, not just for the elderly of today, but for all of us as we grow older.

The masterplan driving this major regeneration scheme revolves around four key components:

- Academic Quarter
- Business and Engagement Quarter
- Healthcare Quarter
- Retail Quarter

The interaction between these four quarters is absolutely essential to create a successful synergistic relationship that will ensure the ‘whole’ is greater than the sum of the parts and determining this centre of excellence as an internationally recognised leader in its field.

Benefits of New Centre

Extended Hours
One Stop Care
Service Synergy
Closer to Home
Excellent Access
Multi-agency approach
Reducing health inequalities
Improving access to healthcare

Andrrew Lansley MP Secretary of State for Health accompanied by Professor Chris Day and Sir Leonard Fenwick at the Campus
The Academic Quarter

The Institute for Ageing and Health was the first of Newcastle’s research institutes, founded on cross-disciplinary collaboration between basic and social scientists, and clinicians, primarily in the field of brain ageing and dementia. Its scope has since expanded to include world class exploration of the biology and other aspects of ageing.

The Institute is widely recognised as the National and European leader in the ageing field with a scope of world class research across a broad range of disciplines associated with ageing.

One of the key goals of the Institute is to translate scientific advances into direct benefits for patients and this has lead to Newcastle being nationally designated as a Biomedical Research Centre (BRC) focusing on Ageing and Chronic Disease.

The BRC also involves other University Research Institutes and is a key component of Newcastle Biomedicine - a progressive collaboration between Newcastle University and the Newcastle Hospitals tasked with tackling major challenges in healthcare.

Furthermore, two of the five national Clinical Research Network (CRN) Coordinating Centres - for Stroke and Dementia & Neurodegenerative Diseases - are also based in Newcastle.

The principles on which the business and engagement quarter will be founded are already emerging strongly in the academic quarter at the north end of the site. Close to £40m of investment over the past 10 years has seen the emergence of a complex of synergistic research facilities including:
- Magnetic Resonance Imaging
- Clinical research and trials facilities
- Biogerontology and pathology laboratories
- Systems biology
- Newcastle brain tissue resource

The latest capital investment in the site has been the Biomedical Research Centre Building, which, when completed in October this year, will serve as the headquarters of Newcastle Biomedical Research, as well as uniting much of the research complex into a single facility. The new building is a significant investment and an exciting multi-user model.

Clinical services will be provided on the ground floor through innovative multi-disciplinary clinics, which seek to meet the needs of older people who tend to have multiple conditions that would benefit from more holistic management than is often achieved in conventional clinics.

These clinics will be highly complementary to the existing clinical trials facilities of the adjoining Clinical Ageing Research Unit, and will facilitate cross referral between clinics and trials.

Additional laboratory space on the first floor will allow for the expansion of the basic science of ageing on the Campus, with particular emphasis on nutrition and on the development of biomarkers of ageing.

The new building provides 3 new laboratories, larger than those available in the existing facilities, which will be directly linked to the laboratory spaces in the existing Henry Wellcome Laboratories and Edwardson Building.

On the 2nd floor, Newcastle University’s Changing Age for Business programme will provide space for regional small and medium sized businesses wishing to work closely with the University and Newcastle Biomedicine in projects related to ageing and demographic change.

A number of new and established businesses have already expressed an interest in occupying space in the building and their presence will strengthen the process of businesses, healthcare, public and academics working together to innovate products and services for our ageing society.
The Newcastle upon Tyne Hospitals NHS Foundation Trust have been providing patient-centred healthcare to communities in the North East of England and beyond for over 250 years. The Trust is one of the largest in the UK, offering a wider range of specialist services than any other.

In 2011 for the 11th consecutive year The Newcastle upon Tyne Hospitals NHS Foundation Trust won the prestigious CHKSTop Hospital award and was one of only five trusts in the UK to do so.

This work has already supported the development of a number of new businesses, as well as new products and services, many of which anticipate an ongoing relationship with Newcastle University or Newcastle Biomedicine and a prolonged future on the Campus.

Changing Age for Business works closely with the University’s VOICE North group, who provide a public voice into innovation projects related to ageing within the University and industry through participation in inclusive design, focus groups, trials and testing.

Changing Age for Business provides a single entry point for businesses seeking to engage with the University’s knowledge base in ageing and vitality, and is already working with 50 businesses to identify, shape and deliver projects.

The Business and Engagement Quarter will be the home for the unique partnership formed between The Newcastle upon Tyne Hospitals NHS Foundation Trust and Newcastle University. The result of this unique partnership is Newcastle Biomedicine - a partnership focused on transforming health through collaboration and a sound commercial approach.

The academic quarter continues to be the headquarters of strategically important groups for the University and Newcastle biomedicine and to produce research of an internationally excellent quality. We now see evidence that this research is being put to good use to develop real benefits for society, nationally and internationally but with Newcastle first.

The Campus will not only maintain Newcastle’s position at the forefront of research in ageing within Europe, but further extend that reputation into the fields of business and innovation.

Existing developments

University investment of over £30m in the Campus has already generated a group of high quality facilities to attract other activity to the site, such as:

- Clinical research facilities in the Wolfson Research Centre, contiguos with the NHS Centre for the Health of the Elderly
- State of the art Ageing Research Laboratories in the Henry Wellcome Laboratories and Edwarsdon Building
- Research imaging facilities in the Newcastle Magnetic Resonance Centre, supporting investigations into diabetes, stroke and dementias, amongst other conditions
- Special facilities for the conduct of clinical trials involving older people in the Clinical Ageing Research Unit

This clutch of complementary research facilities is an embryonic representation of the wider aspiration for the Campus as a driver of innovation in healthy ageing, and an important and an important reason for others to locate here.

The Business and Engagement Quarter

The Newcastle upon Tyne Hospitals NHS Foundation Trust have been providing patient-centred healthcare to communities in the North East of England and beyond for over 250 years.

The Trust is one of the largest in the UK, offering a wider range of specialist services than any other.

In 2011 for the 11th consecutive year The Newcastle upon Tyne Hospitals NHS Foundation Trust won the prestigious CHKSTop Hospital award and was one of only five trusts in the UK to do so.

From newborn babies to the elderly and infirm, our aim is to deliver leading-edge healthcare with a personal touch.

The Business and Engagement Quarter will be the home for the unique partnership formed between The Newcastle upon Tyne Hospitals NHS Foundation Trust and Newcastle University. The result of this unique partnership is Newcastle Biomedicine - a partnership focused on transforming health through collaboration and a sound commercial approach.

The strengths and benefits of both organisations are encapsulated in the Newcastle Biomedicine partnership, enabling speedy routes to markets for commercially viable products and services that can really make a difference.

By working with regionally-based industry we aim to develop a fully integrated, collaborative Business and Engagement Quarter which would open up a diverse range of development opportunities for commercial enterprises.

In order to meet the many challenges for delivering improved health and wellbeing to a population that is growing older, the connections between clinicians, academics and industry must be strong and dynamic.

The business and engagement quarter will offer an environment that facilitates collaborative working, with access to the users of products and services at the core. All too often, their knowledge and needs can be neglected, resulting in solutions that are not appropriate and consequently are commercially unsuccessful or fail to achieve their intended purpose.

Newcastle Biomedicine - an effective collaboration between Newcastle University and the Newcastle Hospitals in teaching, research and innovation, is currently expanding its business development and commercial capacity.

The Business and Engagement Quarter and the increased collaboration with industry that it will bring shall be a catalyst to innovation and enterprise, not only increasing the flow of commercial developments out of Newcastle Biomedicine but, through the sharing of knowledge of clinical and social challenges and of applicable technology and understanding, allow researchers and industry to develop solutions based on real needs from the coal face.
The objectives of the Business and Engagement Quarter are closely aligned with the economic goals of:

- Encouraging more businesses to locate in the area
- Helping existing businesses grow
- Stimulating new business start-ups

The resulting benefits to the local economy of more jobs and economic growth in Newcastle being welcomed by all.

The opportunities for industry will include:

- Nutrition and lifestyle
- Assistive technology and telecare
- Pharmaceuticals
- Diagnosis and monitoring
- Systems biology and biomarkers

The infrastructure to support this will be centred on a collection of complementary facilities including:

- Bioscience incubator (Business centre)
- Technology development centre
- Research and innovation care home
- Teaching and engagement centre

The interrelated nature of these activities and the interaction with the other elements of the campus will result in significant synergies which will enable new developments to progress at pace.

The Already award-winning Newcastle upon Tyne Hospitals NHS Foundation Trust and Newcastle University spin out company Limbs Alive has staked a claim on a campus location. Founder and Director Prof. Janet Eyre said “The concept for the whole campus is groundbreaking and I am delighted that Limbs Alive is first in line for space in the business centre. For any small business operating in this sector it brings a unique opportunity that will ultimately benefit the patient. As the development takes shape I am certain there will be a very long line of businesses seeking to follow our lead.”

Limbs Alive brings a unique opportunity that will ultimately benefit the patient

**Limbs Alive Ltd**

Stroke frequently damages the area of the brain controlling movement. As a consequence, worldwide, millions of people have weakness down one side of their body. This has a major impact on their lives because everyday activities require two hands. The brain can relearn control of the weak arm, but this needs frequent therapy over many months. There are not enough therapists to provide this on a one to one basis and fewer than 20% of patients regain independence after a stroke.

Award winners Limbs Alive Ltd have developed a library of video games to be played at home, which provide highly motivating therapy for relearning arm and hand movements. Programs are currently being developed to analyse information about patients’ performance of arm and hand movements during the video games in order to provide feedback to the patient and their therapist via the internet. This will enable effective rehabilitation of arm and hand movements to be delivered at home at times and places to suit patients, whilst still maintaining expert supervision from a therapist. The need for hospital visits will be greatly reduced, patients will have the opportunity to undertake more frequent therapy sessions, therapists will be able to supervise more patients and patients should regain greater independence.

**Awarded overall Best NHS Innovation 2011** at the prestigious Medical Futures Awards Ceremony, 6th June 2011, London

*Left to right: Rory Bremner & Emma Sands (Hosts), Janice Pearce, Professor Janet Eyre (Limbs Alive), Professor Bruce Keogh KBE (NHS Medical Director) and Nina Wadia*
Review of the Year 2010/2011

Newcastle upon Tyne Hospitals NHS Foundation Trust are committed to continuing to provide high quality healthcare, closer to home, for the people living in West End of Newcastle. The development at Brighton Grove as part of the Campus will enable us to achieve this.

The Brighton Grove Health, Wellbeing and Walk-in Centre

The centre will provide a modern, purpose built, high quality environment that underpins the delivery of an enhanced model of patient care.

The new Brighton Grove facility will act as the main point of health service delivery on the Campus for Ageing and Vitality. Development of this facility has been driven by the requirement to achieve the following:

- A reduction in health inequalities in the west
- Good patient access and choice in this area of the city
- Integrated or streamlined healthcare provision (across hospital and community services) to improve the patient experience
- A further shift in Trust focus from delivering unplanned activity to anticipatory / preventative care
- The best possible use of the Trust’s overall estate and facilities
- Overall operational efficiency
- Maximum value for money in a highly challenging economic environment

The Trust has chosen to develop services on the former General Hospital site, as opposed to elsewhere in the west of the city, for the following reasons:

- Through sale of land to Tesco, an opportunity exists to develop a vibrant, modern new building, which can be purpose built and geared towards the needs of modern service delivery for many years to come
- The Newcastle Hospitals have an established track record within the locality as a provider of high quality services. As such, the Trust already has well developed relationships with partner statutory agencies, the voluntary sector and the local community
- Patients are familiar with the site and are used to accessing services in this location
- There are excellent bus transport links to and from the site with all areas of the city
- Enormous potential exists to develop links with other sections of the Campus for Ageing and Vitality. The campus will support a wide and varied range of activities which will be of benefit to patients. Examples include a translational research unit, a centre for assistive technologies, a Medical Research Council supported project focused around the benefits of exercise in the aged as well as the existing Centre for Ageing Research Unit and a range of other academic and research facilities
- The Campus for Ageing and Vitality and Brighton Grove, as a key part of this, will serve to support the regeneration agenda in the west of the city by providing jobs and income within the local economy
- There is adequate space for parking for patients
- Good physical access to the building will be available with easy escalator and lift access from parking areas
- The development will be next to other busy amenities including local shopping outlets which enhances patient convenience

The Brighton Grove facility will offer the following:

- One stop care - assessment, diagnosis and treatment in one visit
- Integrated care
Emphasis on preventative/anticipatory care - minimizing the need for non-elective intervention

Emphasis on managing older people - with links to the wider Campus

Centre of Excellence for the management of long term conditions such as Diabetes, Heart Failure and Chronic Respiratory Disease.

Wrap around ‘enabling’ or support services - like Diagnostics, Rehabilitation and Social Care, Strong service synergy - Integrating the range of services offered, further supporting the ‘One Stop’ and ‘Integrated Care’ ethos

Flexible, good access - extended opening hours and easy to get to

There has been a collaborative approach to service planning and whilst the overall plan is still evolving, key pillars include:

A Community Clinic Suite offering services across a wide range of specialties: Ophthalmology, ENT, Musculoskeletal Services, Older Peoples Medicine and Women’s Health

The clinic suite will incorporate a Long Term Conditions Unit providing integrated care for patients with conditions such as Diabetes, Heart and Chest Disease as well as a Clinical Skills Development Unit for hospital and community based staff

A Nutritional Unit offering clinical care, teaching, consultancy and advisory services, will develop academic links with Newcastle University

Walk in Services will include offering a Minor Ailments and Injuries Service plus other potential ‘rapid response’ services to support admission avoidance where appropriate

There has been a collaborative approach to service planning and whilst the overall plan is still evolving, key pillars include:

A Diagnostic, Investigative, Screening and Monitoring Unit will offer Radiology, Audiology, Cardiac ECHO and ECG, a Gait Laboratory Assessment facility plus Pre Admission Assessment and Screening

Other support services to include Phlebotomy, Rehabilitation, Loan Equipment, Wheelchair Services and a variety of patient education programmes including those which promote selfmanagement

Underpinning these pillars are a range of support services:

Flexible, good access - extended opening hours and easy to get to

The current building design includes a three storey scheme with a modern and attractive design. It offers excellent access for patients directly from Westgate Road, as well as the north south ‘linear park’ (the area between Tesco and Brighton Grove).

The Retail Quarter

A ground breaking partnership has been struck up with Tesco, one of the UK’s most successful, major retailers. The site presents the opportunity to develop a significant Regeneration Partnership Store. The Tesco Regeneration Partnership schemes match up the needs of local communities with development programmes that create local jobs and services whilst ensuring value and quality for all customers.

Close working between all the Campus for Ageing and Vitality partners has shaped the design process resulting in some innovative and forward thinking ideas for this Tesco store in the West End.

The new Tesco store will provide ample free parking for customers including dedicated spaces for disabled customers and parents with young children. An atrium entrance will give travelator access to the shopping area and café facility.

Specialist, integrated services including an Integrated Balance & Dizziness Assessment Service, Integrated Spinal Management, a Multidisciplinary Pain Management Service and Amputee Assessment and Rehabilitation

Other treatment and advisory services with some available on a drop-in basis such as Continence, DVT Clinics and aspects of Mental Health

Job Opportunities

The store will be a regeneration store meaning that at least half of the full and part time jobs created will be given to long term unemployed local people. Training from basic retail skills through to graduate is provided as well as pre employment support. Tesco employees enjoy among the best rates of pay and benefits in the industry.

Being a Green Grocer

The store will be packed full of green design features to make sure it has a lower environmental impact, including timber cladding, roof vents and rainwater harvesting. Tesco want to make it easier for customers to do the same by supporting greener, more sustainable choices, such as giving extra Clubcard points to customers who reuse their carrier bags. Through this greener living initiative Tesco is changing the way it transports goods by introducing a range of measures including battery powered home delivery vans.
Following an extensive visit to Newcastle by a large delegation of senior Panasonic managers in February 2010, encouraging progress can be reported regarding Newcastle Hospitals relationship with Panasonic. Following further discussions in Newcastle during the summer of 2010, Mr Kingsley Smith, the Trust Chairman, travelled to Japan in November 2010 to cement this relationship by signing a Memorandum of Understanding with Panasonic Corporation Director Teruhisa Noro. The Memorandum of Understanding details a commitment from both organisations to work collaboratively for mutual benefit.
Panasonic Healthcare has an excellent appreciation of the increasing demands on society and healthcare providers globally to provide effective and increasingly efficient services to the public. By combining Panasonic’s electronic and bio-related technologies and fostering close relationships with end users and opinion leaders within Newcastle Hospitals NHS Foundation Trust, the Trust and Panasonic are seeking to develop and advance technology. Several areas are being considered where the application of technology could make a real difference to patients’ experience and include:

- The introduction of greater automation of hospital processes. Panasonic have an extensive R & D programme looking at how robotics and other technical solutions can make processes more efficient and effective.
- Panasonic are a manufacturer of hearing aids and have been looking at new developments for the UK market with audiologists in Newcastle.
- The use of leading edge audio visual equipment on operating theatres which supports minimally invasive surgery as well as enabling live links to be made with teaching facilities remote from the theatre.

Developments in these areas will have a real benefit to all involved and the wider healthcare market. Evaluation and development of key projects is currently underway and decisions as to which projects will be progressed will be made over the following months.
During the year much time has been spent listening to local people about how they would like these centres to develop having now become successfully established within their locality.

The staff are now working with local health agencies and voluntary sector staff to provide health and lifestyle clinics on both sites to benefit patients in both localities.

Always treated respectfully and everything explained thoroughly

Survey shows high levels of satisfaction

Both Health Centres scored highly in the latest General Practitioner Assessment Questionnaire, which is carried out every year in all GP surgeries.

At both Battle Hill and Ponteland Road, there was high patients’ satisfaction with our opening hours, satisfaction with receptionists, phoning through to the practice, and availability of any doctor.

Dr Tony Thick, Clinical Director, said, “We’re delighted that our patients rate us so highly. We believe that we do offer high quality services and excellent staff at the centre, and this confirms that our patients do have a good experience. We will of course be looking to improve still further and are keen to get patients views on a regular basis to help us do this.”

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<thead>
<tr>
<th>Battle Hill</th>
<th>National average</th>
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<tr>
<td>Satisfaction with receptionists</td>
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<td>Phoning through to doctor for advice</td>
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<tr>
<td>Continuity of care</td>
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<table>
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<tr>
<th>Ponteland Road</th>
<th>National average</th>
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</thead>
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<td>72</td>
</tr>
<tr>
<td>Continuity of care</td>
<td>73</td>
</tr>
</tbody>
</table>
I’m registered with Battle Hill Health Centre. I have a condition called Fibromyalgia. It’s a common condition characterized by long-term pain and tender points in joints, muscles, tendons, and other soft tissues. Fibromyalgia has also been linked to fatigue, morning stiffness, sleep problems, headaches, numbness in hands and feet, and depression. The list goes on and on. I have had to try different medications, which I seem to be very sensitive to.

I am lucky that I have found a doctor that I can sit and talk to or should I say moan to! They are very supportive in my choices of how I’m trying to handle my condition.

As I work full time I am glad we have Battle Hill Health Centre as it gives me the choice of seeing a doctor or nurse after 6 o’clock and I have always found them to be very pleasant and professional as are the reception staff. I would like to take this opportunity to thank all the people working there for giving a good service to Battle Hill and the surrounding area.

Liz

I am living and working in London. On a visit to Newcastle to visit my parents I was concerned when I became aware of a lump in my groin. This was on a Saturday morning. I contacted Battle Hill and was given an appointment with a GP at 4pm on that day. I was thoroughly examined and given the opportunity to look at my options by a truly superb GP, Dr Williams. We agreed she would inform my GP in London and would advise her of the consultation and the need for an urgent appointment.

When I contacted my surgery on the Monday morning I was given an appointment that day. By the time I saw my GP, Dr Williams had been in contact and I was fast tracked to my local hospital to continue investigations.

I can’t thank Dr Williams and her staff enough for their professionalism, speed and support which began with the ability to book a GP appointment on a Saturday afternoon.

Ruth
Sixty five year old Daniel reckons registering with a doctor at Ponteland Road was the ‘best move’ he’s ever made.

Since signing up in November 2009, Daniel has been impressed with the quality of care, and helpfulness of staff at the surgery. Daniel says, “The staff are all really friendly and it’s wonderful being able to see a doctor any day of the week. I’ve always managed to get an appointment and the doctors really listen to you. Being open seven days a week is fantastic.”

In fact Daniel has been so happy with our services that he has recommended us to friends and family - and his sister is also now registered with us!

I injured my leg playing Rugby one weekend. I couldn’t get an appointment with my GP. I went to the Walk In centre at Ponteland Road. When I arrived I completed the forms and had no sooner sat down than I was called through and I was treated by an extremely efficient and professional nurse practitioner. It was brilliant.

Anon

Supporting patient choice

Working with Newcastle Hospitals we are able to provide a range of specialist services at Battle Hill and Ponteland Road Health Centres. The Consultants and their teams offer clinics at both centres and at the RVI and Freeman Hospital.

This enables patients to be able to choose where they want to be seen and also offers staff opportunities for development. The clinics on site include:

- Hepatology
- Glaucoma
- Plastic surgery
- Renal
- Dermatology
- Gynaecology
- Ophthalmology
- ENT

There is work being done to bring more services from the RVI and Freeman Hospitals into the community to benefit patients. Ponteland Road and Battle Hill Health Centres are working with staff in the hospitals to ensure services that would benefit patients in both localities are considered.

Our work does not just relate to how quickly we treat our patients but we also work to improve our patient’s health. To do this we are beginning to work in partnership with agencies that can offer healthy lifestyle education and support to patients and to involve and train our staff in this valuable area of work.

Easy to access, plenty of parking spaces. Good facilities.
**Staff**

Mark Paterson, 35, started working in the NHS as a porter in 1995 and had a number of different jobs over the following years including a post as a Radiographic Assistant. In 2001 Mark qualified as a Radiographer and took up a post within the Trust where he has worked since. Mark now works each morning in the RVI and each afternoon in Battle Hill Health Centre.

“I wanted to work at the centre as the role provides me with a greater control over my work, and I can spend more time with patients. I also have a greater degree of autonomy within the role and this keeps me learning and developing my skills. I get to see a wide range of patients and my workload varies greatly each day. I might see an elderly patient with a long standing chest problem one minute and see a young child that has trapped their fingers the next.”

Mark, who lives in Fenham with wife Katie, is a keen cyclist and runs the Trust’s cycling club. He says, “Another advantage to my job is that I get to cycle every day between the RVI and Battle Hill, a round trip of 13.5 miles, which is great.”

“I run one of a number of clinics at the Battle Hill Health Centre in Wallsend - an approach which fully supports our patient-centred ‘Better Together’ initiative. These clinics are really popular with the local residents because they are so convenient with excellent parking and are an excellent example of how we are developing joined-up patient pathways between primary and secondary care”.

**Specialist centred ENT assessment in our local health centres**
Pharmacy has embedded a number of new working practices into its services, most notably electronic prescribing, medicines reconciliation, support for rapid discharge and improved communication with GPs.

**Electronic Prescribing**

Electronic prescribing is now live on all adult in-patient wards. It has dramatically changed the way the hospital supplies medicines to patients and information to GPs. The system allows pharmacy to give medication advice to staff when needed, to monitor prescriptions immediately and to gather information. This has benefitted doctors and nurses, made the checking and supply of prescriptions to wards more efficient and supports the electronic transfer of discharge summaries to local GPs four hours after a patient leaves hospital. The information gathered is clear, legible and in a consistent format, which improves communication.

The pharmacy department plans to develop the system and add in further warnings and alerts to assist clinical staff, expanding the range of prescribing advice for certain medication types. This will have benefits to individual patients and to the Trust as a whole. An example would be a focus on antibiotic prescribing to improve patient treatment and contribute to infection control.
Newcastle Specials

Newcastle Specials continue to go from strength to strength, producing safer, cost-effective ready to use injectable medicines and also over labelled medicines to support rapid discharge. This success has enabled an expansion into providing special medicines for other NHS organisations across the UK. We continue to secure re-investment and which in turn brings about a flourishing and innovative enterprise.

...focus on antibiotic prescribing to improve patient treatment and contribute to infection control

Quality and Cost Improvement

The Pharmacy department is continually looking for ways to improve the quality of services provided, in addition to ensuring that best value is achieved. The Pharmacy medicines procurement team have been particularly successful this year in getting the best prices for the medicines we buy, generating a significant saving for the Trust.

Specific groups of patients now receive supplies of their regular medicines delivered straight to their homes, co-ordinated by our Home Delivery team. This avoids the need for some of our regular patients to travel to hospital, simply to collect their medicines.

The senior pharmacy team have been working with colleagues in primary care particularly GPs and Pharmacists to explore areas where the care of patients can be improved through the optimal use of medicines.

Neil Watson
Clinical Director of Pharmacy and Medicines Management
As part of the national drive to 'Transform Community Services' (TCS) The Newcastle upon Tyne Hospitals NHS Foundation Trust worked in partnership to produce the ‘Better Together’ vision which describes the objective of serving seamless, integrated care for patients. This vision is supporting the delivery following the transfer, on 1 April, of community health services from Newcastle Primary Care Trust, which has led to the establishment of ‘Newcastle Hospitals Community Health’.

Newcastle Hospitals Community Health is the key provider of community health services to the city’s 273,000 residents. These include:

- Belsay Day Unit
- CHEST team - support for people with chronic obstructive pulmonary disease
- Cherryburn Stroke Unit
- Chlamydia screening
- Community TB service
- Community cardiology
- Community rehabilitation services
- Community resource team for the elderly
- Continence service
- Continuing care
- Core health improvement
- Cragside (inpatient rehabilitation ward)
- Diabetes service
- District nursing
- Domiciliary physiotherapy
- Falls prevention
- Funded nursing care
- Health psychology team
- Health visiting
- Loan equipment
- Molineux Street NHS Walk-in Centre
- Nurse practitioners
- Nursing care assessment team
- Occupational health
- Occupational therapy
- Orthoptic screening
- Phlebotomy (blood testing) service
- Physiotherapy
- Podiatry
- Primary care mental health and psychology service
- Primary care response team
- Rehabilitation and intermediate care
- Safeguarding
- School nursing
- Sexual health
- Sexual relationship and education - ‘Teenage Kicks’
- Specialist palliative care
- Speech and language therapy
- Stoma services
- Stop smoking
- Stroke discharge team
- Tissue viability nurse
- Wallington Ward (inpatient rehabilitation)
- Wellbeing and weight management

Our vision is to bring safe and effective care to patients closer to and in their own homes
Community Services have a track record of delivering excellent services with staff who are experts in their chosen field. The staff are fully committed to the Trust’s vision of being at the forefront of service change delivery to bring safe and effective care to patients closer to and in their own homes.

This report highlights just a few examples of where community services have excelled during 2010/11 and identifies other areas which are being developed. As part of TCS there are also further opportunities for the development of seamless, integrated care for patients.

Newcastle City Loan Equipment Service

Newcastle City Loan Equipment Service is an example of successful joint working between Newcastle City Council and Newcastle Hospitals Community Health. It is the main provider of timely health and social care equipment to people living in their own homes. The service supports both chronic and end of life care at home, hospital discharge, reablement, accident/injury prevention and carer support.

Throughout the year the service performed exceptionally well with an average performance Indicator outturn of 99.40%. The service also exceeded the national target of 70% for recycled equipment, by achieving an impressive rate of 87%.

The patient survey conducted in September 2010 identified 99.59% of people were happy with the service delivery and 98.37% were happy with the equipment that was provided.

Children and Family

The ‘Solihull approach’, an integrated psychotherapeutic and behavioural model for health visitors and other professionals working with children and families to address parenting skills for young children, has been adopted by Health Visitors working in Newcastle. 142 staff across the children workforce have been trained to ensure that there is a consistent approach with parents. The implementation has evaluated positively from the staff and has supported an improvement and confidence in practice. The parent’s perceptions of the practice are now being evaluated. The next phase is the roll out to the school health advisor service to ensure there is a joined up approach across the children’s workforce.

The school health service has also started a piece of work with the transformation team using the ‘Productive Community Series’ methodology to ensure that they have maximised their efficiency. The teams as part of this process are reshaping to reflect school pyramids.
Our Community Services have a track record of delivering excellent services with staff who are experts in their chosen field

Specialist Palliative Care Team

The team were successful in gaining funding to support training of non qualified staff across health and social care in the management and support of end of life care. This accredited training has evaluated extremely positively with large numbers of staffing taking part.

Last year saw the development of the Macmillan Support Service which brought together a range of services provided by volunteers to support individuals and their carers during the pathway of their palliative illness. New funding from Macmillan is supporting the development of bereavement and befriending service for Newcastle residents.

Primary Care Response, Orthopaedic Discharge and Supported Discharge Teams

Last year has seen these teams integrate to provide a more joint up approach to supporting admission avoidance and supported early discharge, through proactive working with the acute wards and medical admission the teams are supporting this important agenda and ensuring patients have the right support to keep them at home.

Community Nursing (District Nursing)

The Implementation of a new IT electronic record ‘SystmOne’ was a major milestone for the service last year. All teams both in and out of hours are now using the system which is supporting more robust data collection demonstrating the outputs of the service and better work force planning. The system was invaluable in the winter months identifying workload in the bad weather and being able to ensure all patients were seen in a timely way.

Sexual Health Services

New Croft House Sexual Health Centre continues to develop and increase its patient numbers, with the introduction of walk in and booked appointments within the same clinical session the service is now accessed by on average 750 patients per week. The centre achieved the national ‘You’re Welcome’ accreditation in March 2011. You’re Welcome quality criteria
sets out principles that identify how health services (including non-NHS provision) can ensure that they are young people friendly. Responding to patient demand a new Young Persons clinic was introduced in February held on a Wednesday evening, providing sexual health and contraceptive advice along with information around teenage pregnancy. The young people attending the clinic were consulted with prior to its introduction around the venue, name, staffing and layout of the session. To date the response and attendance at the clinic have been very positive.

**Diabetes Service**

The Newcastle Diabetes Centre introduced SystmOne IT system into the service in February 2011. This allowed the service to become paper light with patient records and information stored within the IT system. This has led to a significant increase in the efficiency of the administration processes within the service increasing the level of service to patients within this excellent and expanding service. The Newcastle Diabetes Centre will be relocating in August 2011, remaining within the Centre for Aging and Vitality site but improving the layout and patient flow within the centre.

**Podiatry Services**

The Newcastle podiatry service provides foot care, including a range of specialist areas of podiatry, to the population of Newcastle who are registered to a Newcastle General Practitioner and have been assessed as having a clinical need. During 2010-11 the podiatry department completed 42,825 community contacts; 1,830 contacts for biomechanics and 6,144 within the diabetes centre, which meant that the podiatry department achieved an average of 4,233 patient contacts per month through 2010/11.

The diabetes foot care training for primary care staff has continued for 2010/11, this programme has trained and supported practice staff to assess the foot health of patients with diabetes as per NICE guidelines, allowing patients with diabetes with a low risk of foot ulceration over the coming year to be managed within their own GP practice. To date this training has been delivered to 130 primary care staff and has raised awareness of the importance of foot care to prevent amputation, as well as improving communication.

**The Year Ahead**

So much to do as we continue integrating community services, embedding robust information technology governance and ensuring standards that meet expectations. Community services will continue to provide excellent health services ensuring quality and value for money focussed on patients needs to achieve good clinical outcomes. We will also ensure services are efficient as possible through transforming and redesigning pathways, working in partnership with GPs, the local authority and other stakeholders.
There has been a wealth of clinical evidence for many years that specialist clinical services, such as stroke, trauma and heart surgery, should be concentrated in fewer centres. This would allow the latest equipment to be sited with a critical mass of expert clinicians who regularly manage these challenging clinical problems, and are backed by the most up-to-date research. The greater volumes of patients mean doctors are better at spotting problems and treating them quickly. Survival and recovery rates would improve markedly with many lives saved. As techniques and technology have developed over recent years, speciality rather than proximity has become the key for patient safety. So increased patient safety and improved care must be the major drivers of any recon-figuration.

Patients may indeed have to travel further for some specialist care, but if it is significantly better care then we believe that centralisation is justified. However, at the same time there is also strong evidence to support a large amount of more routine care, currently taking place in hospitals, being carried out closer to where patients live in the community with GPs playing a crucial role in the delivery of services.

Delivering this requires strong leadership and brave decision-making from doctors, managers and politicians. Simply condemning change as bad and defending the status quo as ideal is not serving the interests of patients.

Signed by all the Presidents of the following organisations at the time: Academy of Medical Royal Colleges, Royal College of Physicians, Royal College General Practitioners, NHS Confederation, Royal College Obstetricians and Gynaecologists, Royal College of Paediatrics & Child Health, Royal College of Psychiatrists, Royal College of Anaesthetists, Royal College of Radiologists, Royal College of Ophthalmologists, Faculty of Public Health Medicine, Faculty of Pharmaceutical Medicine, Faculty of Occupational Health.
Newcastle Hospitals underwent an assessment visit in May 2010. The assessment visits influence whether a service is likely to remain as one of the new, larger centres. When measured against the new standards, Newcastle scored 7th out of 11 centres, this was higher than the other two hospitals in the northern region.

On 16th February 2011, a meeting of the Joint Committee of PCTs (JCPCs) was convended to approve the options that would be put out to consultation. A four month consultation period was then launched, which finishes at the start of July 2011. Four reconfiguration options have been proposed, resulting in either 6 or 7 centres. Freeman Hospital features in the three top-scoring options being consulted upon and the preferred option.

Newcastle Hospitals are extremely proud of the Freeman Hospital’s Paediatric Cardiothoracic Unit. The Trust has invested significantly in the unit and will continue to do so, keeping pace with technology with exciting developments such as the new PICU, improved ward infrastructure incorporating a new HDU and the superb charitable funded parents’ and carers’ accommodation, soon to be built on the Freeman Hospital site.

We are one of only two centres in the UK providing national heart and lung transplant services, and one of three providing ECMO. It is these expertise and support systems that allow the Freeman Hospital to undertake high-risk paediatric surgery, with excellent outcomes.

The Trust unreservedly supports the aims of the national review and welcomes the opportunity to drive up standards of care by ensuring we have the right staffing levels, with the right skills, working within the right infrastructure. The Trust is working through plans to expand its paediatric heart surgery services, but we strongly believe that with the infrastructure available and positive staff attitudes, Freeman Hospital will continue being a centre of national excellence long into the future.

The NHS Management Board has asked the National Commissioners to examine the way that children's heart surgery services are provided in England, with a view to reconfiguration of services. The likely outcome of the review will be fewer centres, each treating children from a larger catchment area. Services have been assessed against a set of new national Standards, through a combination of submitted information, evidence gathering and site visits.

The Children's Heart Unit Fund plays an invaluable and vital role in enabling the unit to remain at the forefront of the treatment and care of children with heart problems.
TRIUMPHANT charity champions Ivan Hollingsworth and Ben Shephard ran into the sea at Tynemouth to mark the end of an epic 280-mile mission.

Whitley Bay father Ivan, 35, and his TV presenter friend – together with a core group of fellow athletes – have cycled to Whitehaven and run back in a multi-marathon charity drive to raise funds for the Freeman Hospital’s Children’s Heart Unit.

Sebastian, one of the core group, has followed his father in a support car during the challenge, with Ivan wearing a different superhero costume each day on the five-marathon run back.

Ivan said: “The superhero costumes are my way of trying to symbolise what I think of children like Seb and the others in the unit.”

Ben joked that won’t be up for any more sporting challenges this year, having used up all his energy over the last week.

He said: “If Ivan calls me in the next six months I’ll kill him. Seriously, I’ll kill him.”

The total raised at the finish yesterday stood at £94,500, but they hope to reach £120,000 after their annual ball tonight at Close House Hotel in Northumberland.
Millionaire on a mission to help hospital that saved his baby daughter

‘You can have all the money and power in the world, but you can’t put a value on life’

By RUTH LEACOMBE

IT WAS December 2004 and little Alice was just nine months old when her heart gave up the ghost. Her heart had stopped beating for three minutes and it was her life support machine that whisked her back to life. Alice was a fitting name: it is an old English nickname for the devil, meaning ‘of evil’. To her parents, John and Helen Freeman, it was neither. It was a name of hope and love.

The parents, who were both河水 doctors, had been close to giving up hope for their baby. Alice was born 13 weeks early with a heart defect called hypoplastic left heart syndrome, which meant she had only half a heart. She was operated on five times and could only live for 30 minutes after each operation. The mechanical heart support machine that kept her alive saved her life, but it was anything but the cure.

Today the Freemans’ heart-ache is history. Alice’s heart is now normal and she is healthy. She is such a positive little girl and she is just the miracle that they needed. The Freemans have now made it their mission to raise £5 million to fund the new Freeman Cardiac Centre at the Freeman Hospital.

Helen said: ‘You can have all the money and power in the world, but you can’t put a value on life. It was one of the most tense moments of my life. When it went you breathed a sigh of relief, but when it dropped you began to panic.’

The centre will provide a one-stop shop for children suffering from heart disease. Helen said: ‘The centre will bring children together, enabling us to provide facilities for child and adult patients. Many young children are now living longer and this will help the children.’

Tiny miracles make Freeman a world leader

The Freeman Hospital in Newcastle upon Tyne has been named the ‘world’s best children’s cardiac centre’ by the British Cardiovascular Society. The Freeman centre has been named the world leader in the field of children’s heart surgery. The Freeman Hospital is one of the few hospitals in the UK that performs both adult and children’s cardiac surgery.

Dr. John and Helen Freeman, who founded the Freeman Hospital, said: ‘It is an honour to be one of the leading centres in the world for children’s cardiac surgery. We are proud to be able to provide the best possible care for children with heart problems.’

The Freeman Hospital is a leading centre for children’s cardiac surgery and is one of just a few hospitals in the UK that perform both adult and children’s cardiac surgery. It was established in 1969 and was one of the first centres in the world to perform cardiac surgery on children. It has since become a world leader in the field of children’s cardiac surgery.

Dr. John Freeman, who is the director of the Freeman Hospital, said: ‘We are proud to be able to provide the best possible care for children with heart problems. We have a team of experienced and dedicated doctors and nurses who work tirelessly to ensure that our patients receive the best possible care.’

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Dr. John Freeman, who is the director of the Freeman Hospital, said: ‘We are proud to be able to provide the best possible care for children with heart problems. We have a team of experienced and dedicated doctors and nurses who work tirelessly to ensure that our patients receive the best possible care.’
Better Together

The Trust has continued to work closely with Primary Care Professionals and Newcastle City Council during 2010/11 to deliver the vision for joined up care.

Our Vision

Better Together means...

Creating fully integrated care pathways

Delivery of a more responsive local health service

Dissolving artificial boundaries

Patients cared for by one organisation, from home to hospital and back again

Patients receiving the right care, in the right place, at the right time, from the right person

How are we achieving this?

Some examples

ENT Services in conjunction with primary care have developed shared clinical guidelines ensuring patients receive the right care at the right time in the right place.

Ophthalmology & ENT Services are participating in a Choose and Book pilot with the CareFirst Clinical Commissioning Group in North Tyneside.

Seeking innovative ways to reduce and avoid admissions has remained a key theme in the joint work between the Trust, primary care and Newcastle City Council and a number of initiatives were progressed during 2010/11, including:

- the production of bulletin for all GPs highlighting the specialist urgent and open access clinics the Trust provides
- a dedicated telephone service for emergency admission opinion (currently for Newcastle GPs only) which has resulted in avoided admissions
- a workshop was held by the Trust bringing together healthcare professionals from primary, secondary and social care to focus on reducing emergency admissions
- reviewing discharge arrangements

Improving pathways for patients with long term conditions such as Diabetes and Chronic Obstructive Pulmonary Disease (COPD), for example, establishing a COPD exacerbation service in Newcastle supporting patients, their carers and primary care professionals.
Care Closer to Home

Promoted by the Council of Governors, our ‘Better Together’ strategy is about developing truly integrated models of joined-up care and providing traditionally hospital-based services in community settings closer to home. For example:

<table>
<thead>
<tr>
<th>Osteoporosis Screening Service - identifying patients at high risk of osteoporosis and providing treatment where appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newcastle Bridges Intermediate Musculoskeletal Assessment and Treatment Service (IMAT). Two of the Trust’s Orthopaedic Surgeons are providing sessional input to this community-based pilot which aims to ensure more care and treatment closer to home and reduce reliance on hospital-based treatment.</td>
</tr>
<tr>
<td>Provision of specialist nursing into a project being delivered by Prospect Medical Group in Newcastle to improve care for patients with long term conditions</td>
</tr>
<tr>
<td>A GP child health update event took place at the Great North Children’s Hospital with over 50 GPs from North of Tyne attending.</td>
</tr>
<tr>
<td>Hearty Lives - a partnership with Healthworks, the British Heart Foundation and Newcastle GPs aimed at improving access to services and supporting positive lifestyle changes.</td>
</tr>
<tr>
<td>Deep Venous Thrombosis (DVT) - developing a primary care pathway for DVT in Newcastle</td>
</tr>
<tr>
<td>Improving Access for ECGs - in collaboration with Newcastle TyneHealth Clinical Commissioning Group a specialist reporting service has been developed.</td>
</tr>
</tbody>
</table>

Haematology Outreach Clinical Nurse Specialist

This innovative service has been established to reduce quality of life and reduce hospital visits for haematology oncology patients. Home-based reviews, venepuncture and supervision and administration of treatment are undertaken all within the patient’s own home. Hospital visits have been reduced without compromising quality and standards of care.

The Newcastle Childrens Community Nursing Team

The Childrens Community Nursing Team was established to support children who are still receiving treatment or require clinical monitoring to have this done at home instead of staying in hospital. This initiative has reduced lengths of stay, saving significant bed days and been well received by the children and their families.

ENT services are being delivered in an increasing number of community venues across Tyne and Wear including Northumberland, South of Tyne and Co.Durham.

Specialist outreach provision has increased at the Battlehill Healthcentre, Wallsend and Ponteland Road Healthcentre, Cowgate/Blakelaw.

Providing clinics in GP practices - the Trust is providing more Consultant-led clinics in practices across the region including, Cramlington, Blyth, Gateshead, Consett and Co.Durham.

“Engaging with like minded clinicians at Newcastle Hospitals has enabled us to make things happen quickly towards delivery of a vision for shared and joined up care, ultimately improving healthcare provision in Newcastle. Their forward thinking, outward facing approach to collaborating with GP colleagues - working together as one NHS family team - means that patients really do receive high quality, safe care, in and outside of hospital.”

Dr Mike Scott and Dr Steve Turley, Newcastle GPs
Walkergate Healthcare and Diagnostic Facility

Following a protracted period of discussion and consultation with Commissioners, our plans for a new scheme on the Walkergate Hospital site have finally come to fruition.

The Walkergate Healthcare & Diagnostic Centre is now under construction and will be operational in the early spring of 2012. The new facility will offer core and enhanced GP services, which will be provided by the longstanding team at Heaton Medical Centre, who are relocating from their current facilities at 37a Heaton Road. A range of Newcastle Hospitals ‘outreach clinics’ will also be provided as well as Trust Radiology Services and a Community Pharmacy / retail outlet.

From the Trust’s point of view this facility is about taking services closer to patients and so we will be offering a range of clinics that are currently only available at our main hospital sites. Detailed service plans are still being developed but will include e.g. ENT, Audiology and Hearing Aid Repair Services, Outpatient Clinics for Older People, Services for patients with Back Pain and Arthritis, follow up clinics for patients who have had Hip and Knee replacement surgery, Women’s Health clinics and some Children’s Services.

As well as delivering care closer to patients, the new unit will provide opportunities for Primary and Secondary Care teams to work closely together to, where possible, streamline the pathway of care for patients.

The purpose built facility will benefit from excellent parking and we are also undertaking work with local partners with the aim of influencing current transport provision in the east of the city.

Alongside Brighton Grove in the west of the city, this facility will play a key role in delivering healthcare services to residents in the east of Newcastle.
Developing our staff
Human Resources

More than 1000 staff participate in the travel scheme

The HR Department continues to support the Trust achieve its strategy and objectives, and change remains a major activity for the function.

Focus continues to improve service delivery, and there have been a number of achievements, in particular:

- The introduction of new recruitment processes for non medical staff, including the identification of service key performance indicators. One particularly successful development was a centralised approach for Domestic, Healthcare Assistant and junior Administrative posts.
- The introduction of e-CRB checking resulting in a reduced turnaround time enabling the Trust to secure the appointment of staff sooner through a more efficient service.
- The introduction of the ‘Long Service Award’ Scheme to recognise the loyalty and commitment of staff who had been continuously employed by the Newcastle upon Tyne Hospitals NHS Foundation Trust and contribute to the delivery of high quality healthcare. 141 staff benefitted from the award - 109 staff received 25 year awards and 32 staff 35 year. These awards have been well received and much appreciated by those who have benefited from them.
- Under ‘Improving Working Lives’ there has been a significant investment in improving infrastructure for cyclists. The Trust was very pleased to receive funding from the Cycle England Project, and this has facilitated investment in a new bike compound on the RVI site and a second under construction at Freeman Hospital. In addition, a cycling web page is being is being developed to provide easy access to information on a range of cycling related matters. The Trust also offers a travel scheme to all staff through which travel passes can be purchased at discounted rates. Currently over 1000 staff participate in the travel scheme. Further the Trust hosts an annual event at both sites to promote staff benefits and engage with staff to ensure they can take advantage of the range of options.
- Volunteering in the Trust remains an area which requires proactive support. Responsibility for the coordination of volunteering has been transferred into HR, and new developments include a centralised volunteer recruitment process supported by a robust training and induction package. The Trust continues to recruit volunteers into many areas including meeting and greeting, mealtim support and administration and will continue to work collaboratively with volunteering organisations to actively promote and support volunteering across all areas.
- The Manager Self Service (MSS) module from the national Electronic Staff Record (ESR) system was also introduced across the Trust. This reduces the need for manual reporting, and enables managers to view, report and manage key areas such as absence, establishment control, staff turnover, training spend and competencies enabling quicker decision making related to staff resources.

Dee Fawcett
Director of Human Resources

The Trust hosts an annual event at both sites to promote staff benefits and engage with staff to ensure they can take advantage of the range of options.
Tom Chambers, Strictly Come Dancing Champion 2008 giving our staff a lift!
Equality, Diversity and Human Rights
Equality and Diversity is led at Board level by the Executive Director of Nursing and Patient Services, and a Non Executive Director Champion. Performance is monitored via the Board and the North East Strategic Health Authority. Within the organisation, an integrated approach has been adopted to facilitate engagement and participation, through the Involvement and Equalities Steering Group and the Equality, Diversity and Human Rights Working Group.

The Trust is committed to creating an environment where all who use our premises are treated with dignity and respect, where every employee is treated fairly and valued equally

The Trust believes that in order to continuously deliver high quality services it must recruit, develop and retain a workforce which is valued and whose diversity reflects the communities it serves. It must also ensure that all who use its services feel they are welcomed into the Trust, where they can be confident they are getting the best possible treatment from skilled, caring and responsive staff.

The Trust is committed to creating an environment where all who use its premises are treated with dignity and respect, where every employee is treated fairly and valued equally, and no employee, potential employee, employees of other organisations, contractors or agency employees, volunteers, visitors or patients receive less favourable treatment on the grounds of their age, disability, race, nationality, ethnic or national origin, gender, religion, beliefs, sexual orientation, domestic circumstances, social and employment status, HIV status, gender reassignment, political affiliation, or staff organisation/trade union membership. To underpin this philosophy, and continue to raise awareness, E & D training for staff has been revised to include an introduction to human rights. This training now forms part of both Trust induction and mandatory training requirements.

It should be noted that the Trust has an all encompassing approach to Equality and Diversity, in that both staffing and service issues are seen as integrated with each other to ensure the Trust provides the highest quality services to its users by ensuring staff are trained and involved at all levels.

The Trust is compliant with the relevant publication duties.

Leadership, corporate and governance arrangements demonstrate the continuing commitment to challenging discrimination, promoting equality and respecting human rights.

The impact and effect of policies, procedures and functions on communities and minority groups is understood as Equality Impact Assessments are completed as standard practice, and published on the website.

The Trust actively engages in partnership working, consultation and involvement, particularly in challenging discrimination, promoting equality and respecting human rights.

The Trust aims to be representative in its workforce and training and enables staff to challenge discrimination, promote equality and respect human rights. This is monitored via the Trust’s mandatory training policy.

The Trust uses patient and staff equality monitoring data, reporting and publishing to identify potential discrimination, to promote equality and to respect human rights.

The Trust uses complaints and other sources of feedback to identify ways to challenge discrimination, promote equality and respect human rights. This is monitored primarily via the complaints procedures.

The Trust has reviewed and implemented a Single Equality Scheme in partnership with the Strategic Health Authority, which monitors the Trust’s performance in relation to the Scheme.

The Trust has also paid due regard to the Equality Act which was enacted by the House of Commons and passed into law in October 2010. All relevant polices were reviewed and amended as required to ensure compliance with the Act.

Workforce statistics related to E & D are reported to the Board of Directorson a quarterly basis.
The Trust has increased its provision of a number of programmes and introduced new developments aligned to the Trust annual plan and service priorities and the priority of supporting a safe, skilled and competent workforce.

There has been a significant improvement in compliance with mandatory training. This achievement was facilitated by the increase in the range of e learning packages designed by our staff, reducing time away from service to ensure compliance with training requirements.

Education and Training

2010/11 has continued to be a busy year for the Trust Education and Training service, facilitating the support of ongoing education, training and development across the whole workforce. As a teaching hospital the Trust aims to support ongoing development to enable all staff to maintain their expertise and support the delivery of excellence in patient care and associated support services.
The Trust maintained its focus on maximising workforce capacity and capability across the multi professional workforce, particularly in terms of leadership and management skills. Staff development courses increased in both volume and range almost doubling the uptake from the previous year. Ways of learning have been expanded, and a new e learning route has been designed to complement the existing staff development courses including equality and diversity, recruitment and selection.

New leadership development activities including coaching skills for line managers, providing access to 1:1 coaching to improve individual performance/effectiveness and a ‘Ward Sister Development Programme’ were introduced and have received excellent feedback. An ‘Induction for Managers’ programme has also been implemented and overall the internal leadership development activity increased by 85% from 2009/10. Further, over 30 multi professional senior clinical and non clinical managers were able to attend external Senior Leadership development the output of which included each person undertaking a service improvement project. This development activity included programmes provided by the North East Leadership Academy (NELA). The Trust also enables staff to maintain their continuing professional development (CPD) requirements through a wide range of learning development activities both internally and supporting around 4,500 external study leave applications.

The new multi professional simulation training facility (Sim North East) continues to develop and saw a 61% increase in the number of courses run, examples include:

- Advanced ventilation skills
- Anaphylaxis training
- Early recognition of acutely ill children
- MEWS training (Medical Early Warning Score)

The centre also hosted a Neuro Endovascular course, in partnership with industry, using an advanced simulator for teaching endo vascular techniques. In addition to the clinical programmes, the centre has designed and delivered an introduction to simulation instruction programme as part of its strategy to continue to develop staff that can use this approach to teaching delivery.

The Trust also continues its commitment to the non-professionally qualified workforce through a range of programmes including:

- A revised Health Care Assistant Development programme, with 32 staff attending in 2010/11
- Introduced the BICS, national vocational qualification for our domestic services staff
- Established accreditation for Information Technology NVQs
- Created a validated internal NVO for laboratory staff in house, with 100% timely achievement of the awards for individuals

The Trust is also working in partnership with ‘Unison’ through Bridges for Learning and the Open University to improve access to adult learning for a range of staff, developing numeracy and literacy skills, supporting people in development which helps them both at work and at home.

Ensuring the value of ensuring the patient is at the centre of every thing we do was supported by a number of initiatives including an innovative way of working with a local theatre company ‘Twisting Ducks’. The company comprising of actors who are adults with learning difficulties, was exclusively commissioned to design and deliver a ‘Patients as People’ programme, through the use of drama and anonymous real situations to support the objective of reviewing and improving the patient experience.

The education and training service continues to work on developing the business of education and in particular, external relationships with our local schools and universities. The Trust enabled 170 young people from local schools to access careers insight and work experience programmes, including observing clinical staff in practice and simulation training in the Trust simulation centre. Simulation courses in response to GP needs have been developed and provision for primary care will continue in collaboration with relevant partners.

The integration of community services within the Trust opens a number of opportunities for joint learning and development and facilitating new ways of working to improve patient care.

The coming year will continue to see developments in the way education and training is commissioned and provided at a national and local level as a result of proposals in ‘Liberating the NHS: Developing the Healthcare Workforce’. The Trust has participated in the Government consultation, and the proposals will potentially provide the Trust with greater accountability and responsibility for commissioning education and training for all parts of the workforce.

Karen Giles
Head of Education and Development
Medical Education 2010-11

August 2010 saw BBC 3 on the wards filming some of our new F1 and F2 doctors as they started their NHS employment.

The objective of the BBC programme team was to make a programme that provided alternative role models for young people targeted at the audience which usually tunes in to BBC3 at 9pm. A small group of final year students and F1 doctors had volunteered for the project and after screen testing and some careful heart searching a final group was selected for live filming as they worked in various sites across the trust. The trust and the doctors had the opportunity to see and comment on the programmes but final editorial responsibility remained with the BBC. Many people were very curious to see the finished result.

The series proved to be the most successful programme ever shown on BBC 3 attracting audience viewing figures more than three times greater than usual suggesting that it reached an interested audience who wanted to know more about health care and the people who work in it. The trainees who took part in the filming were supported by their educational supervisors and they also had regular contact with the education team in the Trust. None of us predicted the extent to which there would be comments both professional and very personal and sometimes downright rude from so many people on all aspects of their role in various web based social networking forums. It is to the credit of the trainees and the teams they work with that they have continued to develop as successful foundation trainees within the programme.

Exposing our services and our trainees in this way was not a decision taken lightly but we had considerable confidence that our undergraduate and foundation programme training was at least as good as any elsewhere and better than most and we had a support infrastructure of team work and collaboration that would identify and work to rectify any issues at an early stage. The trainees made the most difficult decision when they decided to take part in the programme to allow their first actions - successes and failures as newly qualified F1 and F2 doctors to be filmed and broadcast widely. I think we could all empathise with the venfion that can’t be sited or the workload that just sometimes seems to be too much and an official view that working times must be adhered to. It begs the question as to how should we best prepare our enthusiastic medical student recruits for the reality of shift working, routine paperwork and unexpected outcomes? We will be asking the BBC for some of their material but this is no substitute for real experiential learning as a final year student within a team to ensure that the core tasks and responsibilities are understood and mastered. It was pleasing to note that six 1 hour slots were condensed to a prime time 1 hour broadcast on BBC1.

The (GMC) document on ‘Tomorrow’s Doctors 2009’ highlights the need to ensure that students are properly prepared for the role of an F1 doctor by recommending the use of student assistanships meaning ‘a period during which a student acts as assistant to a junior doctor, with defined duties under appropriate supervision’. But how is this different to what our students are already doing when on attachment in our wards and clinics? Perhaps we all need to focus on our roles as trainers in this area - the NHS has to sustain its own workforce and it is vital that everyone participates to some extent in teaching and training to ensure that we develop and sustain the correct skills and attitudes in our students and trainees. One day they will become our colleagues and be the provider of care for us and our families - what better incentive could there be? Within the Trust the undergraduate education team is considering this issue carefully as we don’t want to just change a name without modifying the experience that is delivered and to date the experience for Newcastle medical students based in the hospitals of the North East has always had a strong experiential element to it. The challenge for us now is to ensure that our final year students are ready for practice.

At the Tyne Base undergraduate teachers away day the innovations being developed by Dr Gill Vance and her team were shared with an interested audience of teachers. This includes the use of a simulated environment to allow students and trainees to work in a realistic setting with a real clinical problem which is safe and where no harm can come to patients or themselves. This innovation has received very positive feedback from students and Dr Vance and her team are working to collect more data to establish a robust evidence base for its continued place in undergraduate training. A similar approach within the shadowing week was highlighted as notable practice in the GMC report on training in the Northern Deanery and thanks are due to Jon Hanson and Simon Warne for continuing to develop the role of simulation in healthcare training across the trust.

The focus on workforce issues has been strong during 2010-11 with the proposal in the White Paper to transfer responsibility for commissioning healthcare education to local skills networks with direct involvement of employers to ensure that workforce development is appropriate to patient and population need. Recruitment to postgraduate training posts in all areas in the North East continues to be challenging. We need to import more graduates than we produce and while the ‘Live and Train’ branding provided by the SHA and the Deanery have helped we need to continue to ensure that we can offer training opportunities that are recognized to be of high quality. Trainees are more selective about where they choose to go and can now access information on aspects of training quality from several sources. The GMC trainee survey (previously known as the PMETB trainee survey) provides data on their web site http://www.gmc-uk.org/education/surveys.asp by deanery, programme and provider. While we might have issues with the questions asked and the interpretation of the data acquired it remains the biggest national comparative source of information and as such has
significant value. As the largest local education provider in the North East we need to ensure that all programmes in our trust develop a good reputation and are perceived by trainees to be of the highest calibre. The trainer survey has now also been published (same website address) and provides feedback from Deanery and by Trust. One of the questions this asks is if trainers have been selected for the role and what training they have received. Response to this highlights the variation across trusts, specialties, schools and deaneries and in how time for training is recognized. This will be a major focus of the work for the new education team in the coming year. The team has undergone change in the last year - both Mike Clarke and John Hanley have taken on new challenges but I’d like to acknowledge the huge contribution they both made to supporting and developing medical education in the trust. We welcome Mike McKean (Paediatrics) and John Davison (Older Peoples Medicine) to the team as Assistant Directors of Medical Education.

The structure of managing medical education and training in the trust has also changed in the last year and Clinical Directors were asked to nominate a single representative from each directorate to attend the trust medical and dental education group which meets on alternate months. This has proved to be a very successful forum thanks to the enthusiasm with which members participate to share good ideas and to identify solutions for the generic issues which are difficult for all. The issues raised should then be discussed within each directorate to ensure that the business of education and training is recognized as being a major strand in the Trust’s activity portfolio and key to our ongoing success. The contribution by all involved in educating our staff remains outstanding and the Trust is immensely grateful for the immense care, enthusiasm and commitment they make to educating the next generation of medical staff.

The cast of seven junior doctors were a combination of F1s and F2s. They were selected by our team to give a mix of personalities, ages, gender and clinical disciplines: A&E, Emergency Admissions Unit, Plastic Surgery, Paediatrics, Respiratory, Gastroenterology.

We were told that the first three months working on the Wards, is the sharpest learning curve in a doctor’s career. We were privileged to be welcomed into their world at a vulnerable and challenging time. What we learnt is that doctors aren’t born, they are supported, guided and shaped along the way by the nursing teams, registrars and consultants. At the end of that journey they emerge confident and accomplished Clinical Practitioners.

We hope the series highlighted the dedication and strength of character involved in becoming a doctor. Thank you Newcastle - you can be justly proud of where and who you are.

Jo Bishop
Series Editor

Dr Sheila Macphail
Assistant Medical Director

A student assistantship is a type of clinical placement. It should be designed to increase the preparedness of the medical student to start practice as an F1. Although some direct care of patients is implicit and necessary, it is primarily an educational experience which should provide a number of hands-on learning experiences that allow the medical student to gain experience of working within clinical settings and practice clinical skills.

GMC Tomorrow’s Doctors 2009 Supplementary Advice

BBC Three was keen to make a series about young people starting work for the first time, something that its young audience could closely relate to: finding your feet on your first day, wanting to make your mark, but terrified of the responsibility.

What could be more compelling than a first job that really is dealing with life and death!
Review of the Year 2010/2011

The organisation
A leading NHS Foundation Trust year on year
NHS foundation trusts are at the core of the move from a centrally managed NHS to a healthcare system which is responsive both to the needs of the patient and the wishes of the local community. NHS foundation trusts have been given significant freedoms. While they remain public institutions, NHS foundation trusts are not subject to direction by the Secretary of State or the performance management requirements of the Department of Health. They set their own strategies and make their own decisions within the framework of their contracts with their purchasers. They have an independent council of governors which appoints the chairman and other non-executive directors, and which also approves the appointment of the chief executive. They can borrow commercially, retain surpluses and invest to serve local needs.

These freedoms create a significant opportunity to continue to reshape and improve the delivery of healthcare in England. NHS foundation trusts can invest in new patient care facilities, enter partnerships with primary care trusts ("PCTs") to manage chronic disease better or develop long term care facilities. They can form partnerships with the private sector, alliances with other hospitals or specialise in selected services. They can acquire or merge with other service providers. They can also innovate and bring to England models of care that have worked in other countries. They can set local targets in consultation with their members or in contracts with commissioners. In all of these areas, NHS foundation trusts are free to determine how they can most effectively improve patient services through innovation, investment and engagement locally with key stakeholders.

These freedoms also carry important responsibilities. The board of directors of each NHS foundation trust ("the board") is accountable for its success or failure. They must ensure that NHS foundation trusts operate effectively, efficiently and economically. While NHS foundation trusts can retain surpluses, they can also fail.

Monitor’s Compliance Framework is designed to enable NHS foundation trusts to innovate, respond to local wishes and provide better healthcare. Monitor will maintain an environment conducive to innovation by focusing on providing a regulatory platform that ensures NHS foundation trusts maintain their viability: staying solvent, governing themselves effectively within their constitution, engaging with patients, service users and commissioners, providing all the services that they are required to deliver by law, and complying with the other conditions set out in their Authorisation.
NHS Foundation Trusts can invest in new patient care facilities, enter partnerships with Primary Care Trusts (PCTs) to manage chronic disease better or develop long term care facilities

5. Monitor’s view is that a successful NHS foundation trust will be legally constituted in accordance with the National Health Service Act 2006 (‘the Act’) and be compliant at all times with their Terms of Authorisation, including being financially sustainable. It will also decide on the appropriate balance between investment in current provision and innovation to enable continuing improvement in services for patients and service users.

6. A successful NHS foundation trust can expect to be given considerable latitude to exercise its freedoms. Financially secure NHS foundation trusts will be given an increased ability to borrow. Monitor will not involve itself in determining healthcare strategy or operational policies in NHS foundation trusts.

7. Monitor takes a proportionate regulatory approach. For successful and well governed NHS foundation trusts, the regulatory regime will require very limited generation of additional information and only infrequent contact with Monitor. However, where NHS foundation trusts are experiencing major financial or service problems, oversight will be more intensive and Monitor will intervene rapidly to ensure services to patients are safeguarded. The legislation gives Monitor extensive powers to intervene in the event that an NHS foundation trust is failing to comply with its Authorisation.

8. Effective self-governance is therefore essential. The board takes primary responsibility for compliance with the Authorisation. The chairman of an NHS foundation trust should ensure that the board monitors the performance of the NHS foundation trust in an effective way and satisfies itself that appropriate action is taken to remedy problems as they arise. The Compliance Framework is largely aimed at satisfying Monitor that boards and chairs are receiving independent assurance where appropriate and are discharging their responsibilities effectively.

9. In contrast, councils of governors are expected to focus less on compliance and more on ensuring NHS foundation trusts respond to the needs and preferences of stakeholders, especially local communities. Governors’ statutory roles include:
   - Appointing, removing and deciding the terms of office of the chair and other non-executive directors, and approving the appointment of the chief executive;
   - Appointing and removing the auditor;
   - Reviewing the annual accounts, auditor’s report and annual report at a general meeting; and
   - Expressing a view on the board’s forward plans for the NHS foundation trust.

10. Monitor expects that NHS foundation trusts, and their stakeholders as represented through the council of governors and other mechanisms, will also set their own aspirations for innovation, including determining the balance between investment in current provision and innovation through the development of new services.

The following principles shape Monitor’s approach to regulation:

- **Self-regulation**: Boards of directors are responsible for ensuring that NHS foundation trusts comply with their Authorisation and statutory obligations at all times;

- **Proportionality**: Monitor takes a risk-based approach to regulation, intervening only when necessary. The intensity of its monitoring of an NHS foundation trust is guided by the risk of a significant breach of their Authorisation;

- **Transparency**: Monitor will use a transparent method for assessing risks to compliance, as set out in the compliance framework;

- **Trust-based approach**: Monitor expects NHS foundation trusts to disclose issues speedily and candidly. Monitor will seek to provide collaborative support in resolving issues before considering intervention;

- **Confidentiality**: Monitor will not, unless it has a statutory obligation to do so, disclose confidential information without prior agreement;

- **Minimal duplication of regulation**: Monitor will not usually act where other bodies have a lead regulatory role unless they have exhausted their powers and an NHS foundation trust still risks a breach of their Authorisation; and

- **Minimal information requirements**: Monitor aims to minimise the information requirements it places on NHS foundation trusts. Its requirements should in any case be a sub-set of the information which a board requires to discharge its functions effectively.
Foundation Trusts - Overview

The first ten NHS Foundation Trusts were authorised in April 2004. Since then, a further 128 have been established, bringing the total (as at August 2011) to some 138, of which 97 are acute services providers, nine of them in the North East. The Trust received its Authorisation on 1st June 2006.

Monitor asks Foundation Trusts to assess their own compliance with the terms of their authorisation, as part of its risk based approach to regulation. NHS Foundation Trusts submit an annual plan, quarterly and ad hoc reports to Monitor. Using this information, Monitor assigns annual and quarterly risk ratings, monitors actual performance against plans, and identifies any steps that need to be taken to address problems.

Monitor publishes quarterly reports covering the performance and risk ratings for NHS Foundation Trusts. These provide a summary of the performance of the foundation trust sector, and also give individual NHS Foundation Trusts the opportunity to understand their own performance in relation to other foundation trusts.

The quarterly reports are a vital part of Monitor’s annual reporting cycle, along with the publication each year of NHS Foundation Trusts Consolidated Accounts.

The foundation trust directory (http://www.monitor-nhsft.gov.uk/home/about-nhs-foundation-trusts/nhs-foundation-trust-directory) shows the current governance and financial risk ratings for each foundation trust. The risk ratings page shows the ratings for all foundation trusts.

At the end of 2010/11 trading year, the Trust was rated by Monitor as follows:

<table>
<thead>
<tr>
<th>Risk ratings (using a 1 to 5 scale, where 5 is lowest risk)</th>
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<tbody>
<tr>
<td>Financial</td>
<td>3 (annual plan originally 4 but revised with Monitor’s agreement to 3 to reflect deferral of PFI support monies into 2011/12)</td>
</tr>
<tr>
<td>Governance</td>
<td>Green (annual plan Green)</td>
</tr>
<tr>
<td>Mandatory Services</td>
<td>Green (annual plan Green)</td>
</tr>
</tbody>
</table>

Liquidity Rating of 3, reflecting 23.5 days of operating cash.
The role and purpose of Governor Groups

The Governors of the Trust have the specific role, both as individuals and as the Council of Governors, to hold the Board of Directors to account for its planning and delivery of patient services and for maintaining financial strength and organisational sustainability.

Not only do Governors bring their own skills and experience to this role but, in the process of fulfilling their responsibilities, they are informed by the views and opinions of the members whom they represent. The Governors are, then, able to assist the Executive through contribution to strategic thinking, advice and through monitoring of service delivery. Carrying out such a role requires an understanding of a complex and sophisticated business, commitment to its purpose and core values, and time and energy. The Governors’ Working Groups exist to enable Governors to carry out this role.

The Governors’ Working Groups

All public Governors are members of a Working Group, of which there are four:
- Business Development Group
- Quality of Patient Experience Group
- Membership and Community Relations Group
- Nominations Committee

The Business Development Group

The aim and objectives of this Group focus on ensuring that the Trust Board takes appropriate action on direction, purpose and financial strength to maintain future sustainability.

The scope of its work covers the scrutiny of operational issues by means of contribution to the strategic three year business plan, monitoring of the achievement of the previous year’s plan through visits to wards and departments and communication of plan priorities to members and gaining views for future plans, along with scrutiny of financial performance reports, examination of the final accounts and receipt of the external auditors’ management letter.

This Group also holds the statutory responsibility of recommending to the Council the appointment or removal of the external auditor which it carries out in full, along with the Trust’s Audit Committee.

The Quality of Patient Experience Group

The aim and objectives of this Group centre around ensuring that the Trust Board maintains the highest level of quality in patient care through achieving targets in areas such as infection prevention and control, patient safety and service improvement and in striving to improve the quality of patient experience.

The Group closely monitors patient experience on selected wards, analyses information from sources such as complaints, progresses specific quality based projects and regularly scrutinises the Trust’s Quality Account.

The Membership and Community Relations Group

This Group’s aim and objectives are based on representing, understanding and responding to the needs of members, the public and users, all of which are essential to the successful work of all Governors. The Group contributes to ensuring that members are aware of the Trust’s services and to obtaining their views on those services.

Work also covers building external links with existing bodies, forging relationships and encouraging governor/member two way communication, mounting member engagement events, and contributing to the Members’ Newsletter. The Group is also involved in growing and strengthening the membership base.

The Nominations Committee

Governors also have a statutory responsibility to recommend the appointment (and potential removal) of the Non Executive Directors of the Trust, including the Chairman.

The Nominations Committee has its aim and objectives related to sourcing and recruiting the most suitable candidates for the roles. Members of the Committee are involved in the full recruitment process and establish the conditions of appointment for each Non Executive Director. In conjunction with the Senior Independent Director in the case of the Chairman and the Chairman and Board in the case of other NEDs, they then play a significant part in the annual assessments of NED performance.

During the last 12 months the Committee advertised, shortlisted and interviewed a number of candidates to fill two vacant positions as Non-Executive Directors to the Board. Following its recommendations the Council approved the selection and appointed Ms Sokhjinder Kler and Dr Bryan Dobson to fill these positions.

Two Non-Executive Directors were reappointed, following reports from the Chairman and the Board and satisfactory assessments from the Directors. Once again Council endorsed the recommendations and so Mrs Hilary Parker and Mr John Kirkby were re-appointed.

The second annual assessment of the Chairman was undertaken and the Committee joined the Senior Independent Director in appraising the Chairman. As a result of this process he was given another 12 month extension to take him to September 2012.

The four Group Chairmen coordinate the work of the Groups, which cooperate together on certain activities, and the full Council is made aware of and is able to debate and comment on matters before any decision or resolution is made. Governors are thus enabled, both individually and as a Council, to hold the Board of Directors to account.
The Trust is committed to involving patient, carers and the public at all levels in order to ensure that services are planned around the needs of patients and that year on year improvements in the patient experience are achieved.

In 2010-11, key achievements in support of the patient, carer and public involvement agenda included:

**The development of a Patient, Carer and Public Involvement (PCPI) Strategy and action plan 2011-14** -
The new PCPI Strategy and action plan covers the objectives, actions and expected results (required to achieve individual and collective involvement at three levels:  
1. Information provision  
2. Feedback on trust services  
3. Influencing planning and decisions about services

The strategy will be continually reviewed and monitored to maintain this as a dynamic tool develop and capture the Trusts PCPI achievements. We will work with staff, patients, carers and associated groups to achieve the strategy objectives in order to make real improvements to the patient experience with demonstrable results.

**Strengthening the role of the Patient, Carer and Public Involvement (PCPI) Group** -
This Group brings together Trust clinicians, corporate staff and representatives from various involvement mechanisms within and out with the Trust i.e. Local Involvement Network (LINK), Patient Advice and Liaison Service (PALS), Community Advisory Panel (CAP) and Council of Governors. The PCPI Group will monitor the PCPI Strategy and associated work.

**The Community Advisory Panel continues to work with the Trust to provide a valuable patient perspective** -
The Panel are a group of volunteers with experiences as patients or carers within the Trust. They continue to work with us as ‘a critical friend’ on various projects, committees and training programmes including a review of the bereavement process, regular food tasting visits, involvement in cleanliness inspections and observational audits. Further details of the Panel’s work in 2010-11 can be found on page 132.

**Strengthening the Patient Advice and Liaison Service (PALS)** with the opening of a PALS office in the New Victoria Wing. Patients and visitors can simply drop-in for information and advice or use a freephone to get in touch with the service from other areas. PALS Volunteers also visit wards and departments to talk to patients about their experience in hospital and raise awareness of the PALS service.

**Ensuring patient, carer and public involvement in the provision of patient information** -
Through the continued work of the Patient Information Review Panel, the department was successful in providing assurance regarding the patient information process to support the Trust in achieving level 3 NHSLA accreditation. The Panel continue to benefit from service user representation in order to comment on the readability of internally produced patient information leaflets.

**Understanding the patient experience through the feedback obtained in the Trust**
In order to gain an understanding of the key issues and themes surrounding the patient experience, information from various feedback mechanisms is collected on a Patient Experience Database. This includes feedback from the following mechanisms:

- Details of Patient Advice and Liaison Service (PALS) contacts
- Details of Complaints received
- Comments and Suggestions made on the feedback forms in public areas of the Trust
- Feedback from PALS volunteers
- Comments and feedback received into the trust website
- Comments placed on the NHS Choices website

The patient feedback we receive is reviewed by the Patient, Carer and Public Involvement (PCPI) Group and circulated to directorate managers, matrons and heads of nursing for information, action and feedback where applicable. This feedback is shared with staff in their areas of responsibility in order to raise overall awareness of the issues that matter to patients.

**Undertaking patient surveys as part of the NHS Patient Survey Programme**
The Trust is committed to taking part in the national patient survey programme (managed by the Care Quality Commission) which is intended to be a mechanism for making the NHS more patient focused and provides a quantifiable way of achieving this. The 2010-11 national survey programme for acute trusts consisted of a repeat of the Acute Inpatient survey and a survey of Maternity Patients. The following section outlines the key findings from the two surveys carried out in 2010-11.
The 2010 national inpatient survey highlighted the many positive aspects of the patient experience. The majority of patients reported that:

| Overall: | rating of care was good/excellent | 92% |
| Overall: | doctors and nurses worked well together | 94% |
| Doctors: | always had the confidence and trust | 87% |
| Hospital: | room or ward was very/fairly clean | 98% |
| Hospital: | toilets and bathrooms were very/fairly clean | 96% |
| Hospital: | hand-wash gels visible and available for patients and visitors to use | 95% |
| Care: | always enough privacy when being examined or treated | 90% |
| Surgery: | risks and benefits clearly explained | 84% |

Compared to the 2009 survey, it is encouraging to note that the Trust has improved significantly in seven areas:

| Hospital: | bothered by noise at night from other patients |
| Hospital: | room or ward not very or not at all clean |
| Hospital: | toilets not very or not at all clean |
| Discharge: | not fully told of the danger signals to look for |
| Discharge: | family not given enough information to help |
| Discharge: | did not receive copies of letters sent between hospital doctors and GP |
| Overall: | no posters/leaflets seen explaining how to complain about care |

“The staff and doctors were fantastic. Their quick actions and response saved my life. I have no complaints only admiration.”
The whole hospital stay was excellent. The staff were all friendly & kind. Nothing was too much trouble. Everyone was pleasant courteous & respectful...

How do we compare?

The Care Quality Commission (CQC) produce a benchmark report for each acute Trust which contains standardised results displayed against those from all other Trusts. Their report identifies whether the Trust score is in the top 20%, mid 60% or lowest 20% of all Trusts’ scores.

The benchmark report of the results produced by the CQC shows that this Trust:

- Was in the best performing 20% of Trusts in 49 out of 64 questions and scored the highest score of all trusts for the question - ‘Did you see any posters or leaflets on the ward asking patients and visitors to wash their hands or to use the handwash gels?’
- Was in the intermediate 60% of Trusts in 14 questions
- Was in the worst performing 20% of Trusts for just one question (choice of admission date).

The CQC also produce information for their website for the public which shows how the Trust did against other trusts in the inpatient survey.

The following table shows the score for each section of the Survey and the category awarded:

<table>
<thead>
<tr>
<th>Section heading</th>
<th>Score out of 10 for this Trust</th>
<th>How this score compares with other Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Emergency / A&amp;E Department, answered by emergency patients only</td>
<td>7.76</td>
<td>About the same</td>
</tr>
<tr>
<td>Waiting lists and planned admissions, answered by those referred to hospital</td>
<td>6.74</td>
<td>About the same</td>
</tr>
<tr>
<td>Waiting to get to a bed on a Ward</td>
<td>8.46</td>
<td>About the same</td>
</tr>
<tr>
<td>The Hospital and Ward</td>
<td>8.47</td>
<td>Better</td>
</tr>
<tr>
<td>Doctors</td>
<td>8.96</td>
<td>Better</td>
</tr>
<tr>
<td>Nurses</td>
<td>8.73</td>
<td>About the same</td>
</tr>
<tr>
<td>Care and treatment</td>
<td>7.79</td>
<td>About the same</td>
</tr>
<tr>
<td>Operations and procedures, answered by patients who had an operation or procedure</td>
<td>8.73</td>
<td>Better</td>
</tr>
<tr>
<td>Leaving Hospital</td>
<td>7.38</td>
<td>About the same</td>
</tr>
<tr>
<td>Overall views and experiences</td>
<td>6.94</td>
<td>Better</td>
</tr>
</tbody>
</table>

All treatment and care at the Freeman Hospital and RVI was excellent. I cannot praise both hospitals enough. If I were a multi-millionaire I could not have received better quality of care.
Excellent quality of care was given to me and my baby

Maternity Survey 2010

The purpose of the Survey is to understand what maternity patients think of healthcare services provided by the Trust. A postal questionnaire was sent to all women who had a live birth at the RVI Maternity Unit between 1 and 28 February 2010. A total of 492 patients were sent a questionnaire. To put the results into context, the Trust reported 6,683 total births in 2009/10. These were 250 respondents.

| Overall rating of care during pregnancy is excellent, very good or good | 94% |
| Overall rating of care during labour and birth is excellent, very good or good | 92% |
| Overall rating of care after the birth is excellent, very good or good | 90% |

How do we compare?

The Care Quality Commission (CQC) produce a benchmark report for each acute trust which contains standardised results displayed against those from all other trusts. Their report identifies whether the trust score is in the top 20%, mid 60% or lowest 20% of all trusts’ scores.

The benchmark report of the results of the Maternity Survey produced by the CQC shows that this Trust:

- Was in the best performing 20% of Trusts in 4 out of 19 questions
- Was in the intermediate 60% of Trusts in 15 questions

The following table shows the score for each section of the Survey and the category awarded:

<table>
<thead>
<tr>
<th>Section heading</th>
<th>Score out of 10 for this Trust</th>
<th>How this score compares with other Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care during pregnancy (antenatal care)</td>
<td>8.5</td>
<td>About the same</td>
</tr>
<tr>
<td>Labour and birth</td>
<td>7.5</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>8.8</td>
<td>About the same</td>
</tr>
<tr>
<td>Care in hospital after the birth (postnatal care)</td>
<td>7.3</td>
<td>About the same</td>
</tr>
<tr>
<td>Feeding the baby during the first few days</td>
<td>6.3</td>
<td>About the same</td>
</tr>
</tbody>
</table>

Representatives from Women’s Services participated in a planning workshop and have developed an action plan in response to the findings of the survey. Actions planned and taken include:

- Review of information given to women at various stages of pregnancy and in the postnatal period.
- Discussion of need for postnatal six week check with women as part of discharge process.
- Training for staff in breastfeeding to ensure consistent advice and support provided.
- Introduction of nursery nurses solely for skin to skin and breastfeeding support on delivery suite and postnatal wards.

I gave birth to both of my children in the RVI and on both occasions could not praise the staff highly enough. They were friendly, warm and helpful and the standard of care given was excellent at every stage of my pregnancy and labour...
Making Good Decisions In Collaboration (MAGIC) with patients

Engaging patients in decisions about their own treatment options is increasingly seen as an imperative for modern health care, with major benefits for both patients and health care, but implementation in routine practice is challenging.

MAGIC is a collaboration between The Newcastle upon Tyne Hospitals NHS Foundation Trust, the Newcastle University Institute of Health and Society, Cardiff and Vale Health Board, and Cardiff University Department of Primary Care & Public Health.

The project was awarded an 18 month, £750,000 grant by The Health Foundation to develop a generalisable approach to the implementation of shared decision making in practice.

The MAGIC Framework: Action learning with indicator feedback, located in a social marketing context and supported by organisational level leadership
Key elements of the project are:

- effective engagement of multidisciplinary clinical teams through clinical champions, skills development, trained facilitators, and embedding change into clinical pathways and practice
- raising the profile of knowledge and understanding of shared decision making across the participant organisations using a social marketing approach
- drawing upon what we know works in change management and professional behaviour change, whilst testing some additional innovative elements.
- Our targets include both specific choices supported by decision-specific Decision Support as well as implementation across specialty groups supported by generic Decision Support tools.
- a focus on tackling barriers and embracing facilitators to implementation of Shared Decision Making
- rapid action learning and feedback (implementation monitoring)
- patient and public engagement.

As well as contributing to practical knowledge and understanding of relevance to the wider NHS, the outputs of this work will also be of considerable international interest. Involvement of the Trust in this high profile collaboration and national initiative puts it at the leading edge of development of implementation of shared decision making, with an opportunity to set the agenda in this area for some years to come.

Making Good Decisions In Collaboration with Patients

Who decides about your healthcare?

There is often more than one way to improve or treat health problems. We want to help you to understand your choices, and support you to make better decisions about your healthcare.

What is shared decision making?

Shared decision making is a process where you can expect:
- Support to understand the choices available.
- That your clinician will understand what is important to you.
- That your clinician team will work with you to decide which treatment option is best for you.

What is the MAGIC Programme?

Through shared decision making, MAGIC is working to find the best ways of making sure that patients are involved as much as they would like to be in decisions about their healthcare. For more information, ask a member of the team looking after you.

www.magicsdm.co.uk

Ask 3 Questions

If there is a DECISION to be made about your healthcare today, make sure you get the answers to these 3 questions:

What are my options?

What are the possible benefits and risks of those options?

How can we make a decision together that is right for me?
The Newcastle upon Tyne Hospitals NHS Foundation Trust

Healthcare at its very best
with a personal touch
Our latest edition?

There is now a Dedicated Telephone Service for Emergency Admission Opinion for GP's in Newcastle

0191 282 1524
The Community Advisory Panel of the Newcastle upon Tyne Hospitals NHS Foundation Trust is a group of volunteers who have been or are patients or carers in the Trust. They come from various backgrounds and all share an interest in improving healthcare. The Panel first came into being in 2002 to work with the Trust in order to improve the patient experience by getting involved in various activities, projects and committees and to provide the patient or carer perspective on many issues.

The Panel, which is a non-statutory group of 12 volunteers, is always aiming to recruit new members to supplement the skills and experiences of the current membership. Although dedicated to doing its best to represent patients and carers in their relationship with the Trust, it does not take on the complaints of individuals. The background and expertise of the members being so varied are assets which enable it to approach its role in the knowledge that the widest and best possible coverage is applied in a fair and impartial manner.

In 2006 the members developed a publication known as a ‘Customer Care Charter’ and it was revised in 2009 to reflect changes as seemed appropriate. It was distributed throughout the 4 hospitals which comprised the Trust, and with amendments where necessary remains in constant use. The Charter acts as a reminder of good practice and outlines basic expectations about the way in which all service users can expect to be treated. It is recognised that patients, carers and visitors should act with the same respect for staff. The Charter is used in the ‘Patients are People’ training programme and should be given to all staff at induction.

The Panel holds a formal monthly meeting where a Senior Trust Manager, who may be one of the following, The Chairman, the Director of Nursing, Trust Secretary present updates on matters concerning the most recent Board meeting of the Trust and which are of interest to the Panel. Others may attend to introduce topics or make requests for the Panel to carry out surveys on behalf of the Trust. This personal contact allows pertinent questions to be made directly and to receive answers at the time. Concerns and suggestions can be transmitted clearly and without ambiguity and the answers received in the same fashion. The system works very well to the benefit of all.

In addition to the formal meetings, a number of informal meetings take place throughout the year. At these, Heads of Departments are invited to address the Panel on their specific responsibilities and answer questions on points raised by the Panel. This often results in specific requests for the panel members to undertake tasks of an identified nature and to prepare a report for the department concerned on the patient experience within that department.

Heads of Departments on the other hand, frequently approach the Panel and ask if they can come and talk and gain the opinion...
of the Panel on a project they are involved in or about to undertake. This form of contact ensures the Panel, as well as being made aware of new and proposed developments within a department, is given an opportunity for a significant input on behalf of patients and carers at the early stages. All work undertaken by the Panel relates strictly to the Patient Experience.

Throughout the last year, the Panel has been involved in fewer projects than previous years but on a wide variety of issues involving suggestions to benefit patients, carers and the Trust. The Panel is pleased when it see the improvements introduced as a direct result of its involvement.

Some projects, in which the Panel has been or is continually involved, include:

- Electing a member of the Panel as its representative on the Council of Governors of the NHS Foundation Trust.
- Continued presence on a number of other Trust Committees, including the ‘Volunteers in the NHS’, PEAT, and PEAG.
- Taking part in a number of staff further training and development programmes by introducing the Panel initiative - the Customer Care Charter, attendance at ‘Being with Patient’ days.
- Menu revision/ food tasting on a monthly basis.
- Nutritional Steering Group.
- Making a presentation at ‘The NHS Graduate Managers Scheme North East Local Induction Programme’ in Newcastle 2010 regarding ‘The Patient Experience’ plus an overview of The Community Advisory Panel. This resulted in one of the students, Miss Emma Norris requesting more information and permission to attend meetings. Emma attended a number of meetings and took part in a survey on 2 occasions.
- As part of cleanliness audits of wards and departments under the Patient Environment and Action Team and inspections including Annual PEAT Assessments, and Peer Inspections.
- Assisted with advice specific to access and availability of service in relation to wheelchair users.
- Played a large part in the rewriting of the Patient Information Booklet.
- Regular review of Patient Leaflets.
- Volunteers in the NHS.
- Review of patient gowns.
- Observational audits - staff in public places.

Although the tasks which the Panel undertook were less in number, the amount of work involved represented a lot of time and commitment. We are grateful therefore that this has been acknowledged accordingly and has realised real benefits to patients, carers and staff.

A commentary based on the above examples was forwarded to the Care Quality Commission.

Alf Brown, Chairman
April 2011
The Trust has become one of a select group of hospitals from across the world which forms an international patient safety movement

Care Quality Commission and NHSLA Standards

Two major sets of quality standards by which the Trust is independently measured are the Care Quality Commission’s ‘Outcomes’ and the NHS Litigation Authority (NHSLA) Risk Management Standards.

Throughout 2010/11 the Trust also monitored compliance with key national standards and performance indicators to ensure that the excellent ratings achieved in past years were maintained.

The Trust is currently rated at Level 3 for the NHSLA Risk Management Standard for General Acute Services and holds Level 3 (the highest attainable) for the Clinical Negligence Scheme for Trusts (CNST) for Maternity Services. A review assessment of the latter is scheduled for Autumn 2011.

Incident Reporting

The Trust uses a transparent and accessible approach to incident reporting, via the Datix system, which offers a web-based system for reporting, analysis and control. This system facilitates a quick and comprehensive analysis of all reported incidents, in addition to underpinning reporting in to the National Patient Safety Agency (NPSA) via the National Reporting & Learning System.

Datix also supports the corporate Risk Register, which again uses a web-based system which is designed for ease of use and which is monitored by the Corporate Governance Committee.

Quality Indicators

As part of the continuing commitment to Risk Management and all this entails, the Trust uses several indicators which have been prioritised for improvement. As ever, the past year has seen a focus on minimisation of the incidence of healthcare associated infection and in particular MRSA bacteraemia and Clostridium difficile (C. diff). Several workstreams ran throughout the year, including continued implementation of specific care bundles as part of the “Saving Lives” campaign; and the Ward Accreditation scheme for clinical practice standards and cleanliness supported the reduction of these infections such that the Trust surpassed all applicable national and locally imposed standards and targets. Continued commitment to further reduction in such infections remains an overriding priority for the year ahead.

A further indicator of patient safety is the hospital standardised mortality ratio, which is a calculation of the expected number of deaths against the actual number. The calculation adjusts for factors which may affect mortality, such as age, sex, diagnosis and admission status and produces a summary estimate of hospital mortality relative to the national pattern. A figure of 100 represents results directly in line with expectations, a higher represents a high mortality rate and a low figures a lower mortality rate than expected. The current calculation of 89 is favourable and does place the Trust amongst the most effective providers in England. It is anticipated that a new national indicator will be launched in Autumn 2011 which will enable more meaningful comparisons to be drawn between Trusts.

We were proud to have been one of the eight pilot Trusts which worked with Monitor (the independent regulator of NHS Foundation Trusts) and McKinsey & Co in 2009/10 to develop Quality Accounts, which are now mandatory for all Trusts. Priorities for 2010/11 were to:

- reduce the rate of hospital acquired infection by 25%  
- reduce the incidence of patient falls by 10% and the number of incidents resulting in major or catastrophic occurrences by 10%  
- reduce the Trust Hospital Standardised Mortality Ratio (HSMR) to less than or equal to 75  
- ensure that all patients have their concerns addressed and are treated with dignity and respect, and to increase the proportion of patients who rate their overall experience as very good or excellent  
- reduce the number of sharps and needle-stick injuries by 10%.

You can find out how we did in detail in the chapter on the Quality Account pages 230 - 250.
The Newcastle upon Tyne Hospitals NHS Foundation Trust and its predecessor bodies have been providing patient-centred healthcare to communities in the North East of England and beyond for over 250 years.

As one of the largest NHS trusts in the UK, we offer the widest range of specialist services of any Trust in the UK. From newborn babies to the elderly and infirm, our aim is to deliver leading-edge healthcare of the highest quality but with a personal touch.

...we are committed to providing patients with the highest quality of healthcare

Our Vision for Quality

We put our patients at the heart of everything we do, working for them in a sensitive and compassionate manner whilst protecting their safety and dignity. The Newcastle upon Tyne Hospitals NHS Foundation Trust is committed to providing patients with the highest quality of healthcare and to be the most prolific and innovative Trust in moving the frontiers of excellence in all that we do for the benefit of people everywhere.

We aim to:

- put patients at the centre of all we do, by providing the highest quality clinical care in our hospitals, associated locations and the local community we serve
- provide the highest quality support services to patients
- work in partnership with Newcastle University Faculty of Medical Sciences; the School of Biomedical Sciences; the Institute of Health and Society; and others to be nationally and internationally respected for our successful clinical research and development programme which leads to benefits in healthcare and for patients
- promote healthy living and lifestyles through our own activities and in collaboration with partners in primary and social care and in statutory, voluntary and academic agencies
- ensure value for money and effectively deploy the freedoms of being a public benefit corporation to explore the service portfolio and partnerships and to exploit our strengths and specialisms to the full, including through vertical integration and expansion where it is appropriate
- ensure effective corporate and clinical leadership while maintaining the highest standards of ethics and governance
- ensure a full appreciation throughout the organisation of the changing environment of competition, risk, regulation, patient choice and the economic environment
- recruit and retain the best staff
- promote effectively and generate a clear understanding of the services we provide.

In developing these aims we endeavor to measure quality and clinical effectiveness throughout the organisation by monitoring activity regularly to understand where improvement is necessary and that it is happening.

We recognise the role of Clinicians as leaders and work with the Clinical Policy Group and also the Clinical Governance and Quality Committee to ensure that essential standards are consistently achieved.

We embrace opportunities to be innovative and enhance quality and safety for patients and our staff. All of this activity is supported by an established governance system with an emphasis on honest and open communication.
Queen Victoria Road ‘side entrance’ to the New Victoria Wing atrium
Newcastle University Armstrong Building in the background
Initiatives in Quality

The challenges facing the public sector and the NHS are significant and the need for efficiency and innovation is greater than ever before. We are meeting this challenge across a range of initiatives and investment programmes. The transformation to help us deliver even better health care in the future is well underway.

In the Autumn of 2010 we relocated our Emergency Department from the Newcastle General Hospital (NGH) site to the new purpose built facility at the Royal Victoria Infirmary (RVI). This department is one of the busiest in the country, dealing with over 75,000 patients every year. Thanks to the commitment of our staff and cooperation of partner organisations and patients the relocation was very successful. Simultaneously we re-located Trauma Services and the Regional Neurosciences Centre to the RVI. These completed a series of moves planned as part of the Transforming Newcastle Hospitals Investment Programme (commenced 2006) and, with effect from 1st April 2011, gave us Level 1 Trauma Care. This major reconfiguration, which involved the closure of Acute Services at Newcastle General Hospital was brought about smoothly and uneventfully due to the dedication and expertise of our staff and also that of the North East Ambulance Service.

We are recognised nationally as a centre of healthcare excellence - more than 30% of our patients come from outside of Tyne & Wear. We also treat complex cases referred to us by other hospitals from throughout the UK, from Southern Ireland, from various other countries in Europe including Iceland and from as far afield as the USA and the Middle East.

We focus upon continuous improvement in the pursuit of excellence whilst seeking and embracing new opportunities and innovations to develop and enhance our clinical services.

We value the contribution of staff, volunteers, members, governors and other partners and stakeholders, trusting each other, working collaboratively and professionally and being committed to the development and improvement of skills.

We are delighted that, on 31st March 2011, we eventually reached agreement with NHS North of Tyne (representing the three local Primary Care Trusts) to become the provider organisation for community services in the Newcastle area. This initiative complements the Trust manifesto ‘Better Together—Vision for Shared Care’, in which we seek, once and for all in the local setting, to bring about a cohesive, vertically integrated, pathway of care for patients from home to hospital and home again.

Quality Improvements

The following are examples of Quality Improvement in 2010/2011:

- The Trust has developed ‘In Time’, an internal system facilitating the electronic generation of interim discharge summaries. This system is accessible from all inpatient and day case units within the Trust. A discharge letter is sent to GPs within 24 hours of discharge and initial audit results have shown significant improvement in the quality and timeliness of the correspondence to GP Practices.
- During 2010/11 there was a significant reduction in the number of MRSA bacteraemias acquired in the Trust. The Trust’s internal target of 12 was achieved, with only 8 bacteraemias being confirmed in the year. The Trust is also compliant with the MRSA mandatory screening targets. Furthermore there has been a significant decrease in the rate of C. diff, with 150 cases in 2010/11, in comparison with 304 cases in 2009/10. This has been achieved through good and effective collaboration between staff and the application of consistent and rigorous standards.
- Development of specialist service for Haemoglobinopathy.
- National Stroke Sentinel Audit reports Newcastle upon Tyne Hospitals with best overall score in the North East Region for quality of care and treatment of stroke.
- The introduction of a haematology outreach service run the by nurse specialist team.
- Development of an electronic learning package which demonstrates benefit of assessment of venous thromboembolism (VTE) which has resulted in over 90% of inpatients now being assessed for VTE and all potential cases of VTE being analysed by a defined root cause analysis mechanism.
- Publication of bone marrow transplantation survival rates (2002 - 2007) indicate that survival is better in the NuTH patients than the national average.
- The Great North Childrens Hospital won the “You’re Welcome” award.
- 75% of relevant wards now using the Liverpool Care Pathway approach to management and care of the dying patient.
- The Nursing and Patient Services Team developed a Clinical Assurance Toolkit to audit and monitor quality of care.
- Reduction in length of time from diagnosis of HIV to improvement in blood count results which effectiveness of treatment.
- Extensive participation in National Clinical Audit and National Confidential Enquiries.
- All new in-patients including those referred for surgery, and out-patients are asked about their smoking status and have this status recorded. As a proactive public health initiative the Trust aims to give brief advice and offer a referral to NHS Stop Smoking Services. At the start of 2010 an initial audit to determine what our compliance was with offering referrals, indicated that we did this in 53.6% of instances. At the end of the year we have shown a great improvement by increasing the number of referrals we offer to the stop smoking service to 80.1%.
- Professor Steele, Dean of the Dental School has received an Honorary FDS from the Edinburgh College in recognition for his contribution to Dentistry.
Increase in the number of patients placed on the National Kidney Transplant Waiting List and the number of patients transferred to the Newcastle Live Renal Donor Waiting List

The Great North Childrens Hospital Research Unit has been established to support and develop good clinical research

The National Annual (CQC) Survey of the views of adult inpatients considers the experiences of people who have been admitted to hospital and had at least one overnight stay. The questions in the Survey cover the issues that patients consider important in their care. The Survey offers an insight into experiences and this information is used in the assessment of NHS Trusts by the CQC.

The summary of results identifies whether the trust score is in the top 20%, mid 60% or lowest 20% of all trusts’ scores.

The report indicates that the Trust:

- is in the best performing 20% of Trusts in 49 out of 64 questions and scored the highest score of all Trusts for the question 'Did you see any posters or leaflets on the ward asking patients and visitors to wash their hands or to use the handwash gels?'
- is in the intermediate 60% of Trusts for 14 questions
- is in the worst performing 20% of Trusts for just one question (choice of admission date)

The Trust Hospital Standardised Mortality Ratio (HSMR) has been monitored monthly by the Board of Directors. The ratio has ranged during the year between 80.3 and 89.87 which means that we are in a very favourable position with the lowest ratio in the region and one of the lowest nationally.

The CQC also published the results of a Survey of Maternity Services provided by Trusts in England in December 2010. The Survey was undertaken collaboratively with the Picker Institute and indicates how each Trust scored on a number of questions compared to national average responses. There were 250 respondents from this Trust which is a response rate of 52%. The percentage of women who had previously given birth was 48% with the rest being first time mothers. The highest percentage of respondents were aged 35 and over.

The results were in five broad areas:

- Care during pregnancy (Antenatal care)
- Labour and birth
- Staff during labour and birth
- Care in hospital after the birth (Postnatal care)
- Feeding the baby during the first few days.

The Survey results indicated that the Trust achieved satisfactory responses for patient satisfaction for this sample of patients with no results in the bottom 20% and two in the top 20% giving an overall score which matched national expectations for Trust performance.

The Directorate of Women’s Services have achieved and increase in the number of pregnant women who are referred to smoking cessation and receive a brief intervention.

We strive to promote a quality focused culture and use our Leadership Walkabouts to ensure that members of the Board of Directors are able to hear first hand of any challenges facing clinical staff and to further develop our philosophy of supporting frontline clinicians to provide the highest possible standards of patient safety and good quality care.
We can boast another highly successful year for Newcastle Medical School. Once again this was due in no small part to the invaluable synergies between the Faculty and The Newcastle upon Tyne Hospitals NHS Foundation Trust. The past year has seen us further develop an effective working relationship between the organisations acting de facto as an Academic Health Science Centre.

This will be even further stimulated by the recent national recognition of our standing through substantial funding for our Biomedical Research Centre and new Biomedical Research Unit (see below). Of importance for this relationship is our heavy focus on research that benefits patients in the short or medium term although we continue to have very successful groups that concentrate on more basic science that feeds into this translational domain. We firmly believe that there is a virtuous cycle. Investment and achievement in medical research and innovation leads to better service delivery and patient care, enhancing the reputation of Newcastle as a centre of excellence. This in turn can lead to increased referrals and commissioning, ‘growing the business’ and in turn recruitment of new specialist staff that can further enhance both the clinical services and medical research.

The Joint Business Executive that was formed more than one year ago has enabled us to move forward very effectively in identifying and promoting medical innovations that can have an immediate impact on patients. Of note, in the 2011 Medical Futures Award, two of the six national winners came from Newcastle - the best dental innovation to Dr John Meechan for his Smart dental system for reduced dental pain and best NHS innovation to Professor Janet Eyre and colleagues for her programme ‘Limbs Alive’.

The recently formed Joint Education Executive has been exploring the development of a range of new courses, some of which would be credit bearing, others stand-alone continuing professional development modules. Newcastle led the successful bid for Department of Health funding as part of the Modernising Scientific Careers in the areas of Gastrointestinal and Cardiovascular Physiology and in Medical Physics. This has been done in partnership with other agencies in the North East and puts us in an almost unique position to develop training in these disciplines which will lead to Masters level qualifications.
Research Highlights

We have highlighted in previous years that the Faculty has deliberately focused on a number of key areas that tackle the big health questions of the 21st century. We have concentrated heavily on ageing and this theme being adopted as the first societal challenge for the University - Changing Age. Over the past year we have seen a large number of projects and activities addressing this challenge, which included the generation of a charter for older persons. The PR company that supported this campaign won a national award for their work on this topic.

Of particular note has been our recent award from the National Institute of Health Research for £21 million over the next five years to support our Biomedical Research Centre in Ageing and Chronic Disease and to develop a new Biomedical Research Unit focused on dementia, particularly that associated with Lewy Bodies and Parkinson’s disease. The award was made to the joint partnership between the Faculty and Trust and we were delighted to receive double the financial support that had been expected for the Biomedical Research Centre (the only award nationally that saw such a dramatic increase). The Biomedical Research Unit for dementia is one of only four that have been set up to tackle this important set of disorders. The Biomedical Research Centre will focus on three principal areas - the ageing brain, the ageing body (liver, cardiovascular and metabolic) and the ageing limbs. There are however, cross cutting themes which include medical treatments in the elderly and genetic aspects.

Much work has been done over the past six months developing a future joint research strategy. In addition to the themes that run through the BRC and BRU, we have identified a number of priority areas for investment where research and innovation could ‘grow the business’ of both organisations. This includes developments in respiratory medicine, elderly care, transplantation, radiotherapy, cardiovascular disease and child health.

Principal investigators in the Faculty have again secured outstanding amounts of grant income. Professor Christine Harrison and colleagues secured more than £3 million for leukaemia research. Professor Martin Embley secured funding from European Research Councils for £2 million as part of a senior investigator award. Other large awards include a £2.7 million MRC grant as part of an MRC/ABBPI Inflammation initiative to Professor John Isaacs; a Cancer Research UK Programme Grant to Professor Josef Vormoor and colleagues; and an EU FP7 on biosensors to Professor Calum McNeil and colleagues. Substantial funding was also secured to extend the successful clinical trial in traumatic intracerebral bleeding (STITCH2).

Other notable esteem indicators included the award to a research team in the Northern Institute for Cancer Research of the first CRUK Translational Team Prize. Four of our senior staff (Professors Burn, Ferrier, Turnbull and Walker) became NIHR senior investigators and three were admitted to the Academy of Medical Sciences (Professors Newell, Griffiths and Embley). Professor Tom Kirkwood was awarded the Longevity prize of the Ipsen Foundation in recognition of his research in the field of the biology of longevity; this is the highest international award in this area. Professor David Burn was awarded the William Farr medal for 2012 in recognition of his research into Parkinson’s Disease and neurodegenerative disorders. The Pro Vice Chancellor (Professor Chris Day) was appointed to Council of the MRC and as chair of the main medical panel for the Research Excellence Framework 2014. Professors Burt and Walls were appointed as panel members. Professor David Jones was appointed chair of the NIHR Biomedical Research Centre National Training Forum.

Newcastle led the successful bid for Department of Health funding as part of the Modernising Scientific Careers in the areas of Gastrointestinal and Cardiovascular Physiology and in Medical Physics

Clinical Research Platforms

We continue to improve the facilities available for undertaking high quality research in the Faculty and Trust. The Campus for Ageing and Vitality continues to expand with the new Biomedical Research Centre building well under construction. The Wellcome Trust awarded a sum of £5.8 million towards an extension of the Henry Wellcome Building at the front of the Medical School to house translational studies in neuroscience. Research facilities will form part of the new Transplantation centre soon to be opened on the Freeman Hospital site and over the past year we have seen significant investment in facilities for Bio banking to provide safe, secure and ethically sound storage of tissue samples for use in translational research. There has also been the development of an Exercise Laboratory and a recent award from Arthritis Research UK to establish a Tissue engineering centre which will co-ordinate work to be carried out with partners in York, Aberdeen and Keele.
The Dental School

The Dental School (part of the University Faculty of Medicine) and the Dental Directorate continue to progress and to cooperate to provide outstanding education and clinical services; increasingly the relationship between the two organisations is critical if we are to continue to do this in uncertain times. With ‘Service Increment for Teaching’ (SfT) funding to support under-graduate education accounting for a large proportion of directorate income, changes in SfT and/or changes in higher education sector funding can have direct impact on the ability of both organisations to operate. The most immediate changes are in the higher education sector. The introduction by universities of increased student fees from 2012 has exercised the minds of both school and directorate over the last year. We will be entering a highly competitive phase when it comes to attracting students but are well placed to compete.

We depend on filling our student places with good quality students to maintain Newcastle’s global reputation in dental education. That means our clinical and other facilities and our teaching have to be of the highest quality. Autumn 2010 saw the opening of a completely refurbished ‘Conservatory 2’ clinic on level 6 of the dental hospital. This 22 unit clinic allows two full groups of students to be accommodated simultaneously at high specification dental chairs. With very efficient use of existing space. A third of the units have operating microscopes for complex and detailed clinical work, particularly valuable in endodontic training. No other UK school is as well equipped. The rolling programme of refurbishment in the hospital since it opened in 1978 has been critical to our current status. Student recruitment has also been very high and extremely competitive. From the autumn 2010 admissions almost three-quarters of the students to whom places were offered had put us as first choice (typically most student will have 2 or 3 offers). This popularity causes us a problem as we are overquota and controlling our intake in the face of unprecedented demand prior to the introduction of high fees is now extremely difficult.

Once a part of the school our new students will be taught to use new treatment planning strategies introduced in the last year which align with clinical developments in wider NHS primary care. Our ratings in league tables and independent assessments continue to be excellent.

On research, the aim of our clinical research in the Directorate and School is to continue to recruit patients to studies on the NIHR portfolio. This depends also on appropriate facilities. A specialist dental Clinical Research Facility, planned 2 years ago is not yet open, but the final plans were approved, building work is underway and it should soon be open for business. One of our senior clinical academics, Dr John Meechan, honorary consultant in oral surgery, won the highly prestigious overall title at the Medical Innovations award for his invention of a novel, ‘painless’ dental anaesthetic cartridge. This was the culmination of many years of research here in the Dental Directorate and School and attracted extensive media coverage.

We are currently recruiting new consultant staff to fill important vacancies whilst also exploring new ways of diversifying our clinical and educational activities. Some real challenges and uncertainties lie ahead, and there may be some very difficult decisions to be made but the Directorate and School are well placed to weather these.

Newcastle Medical School remains one of the foremost centres in the UK for training undergraduate medical and dental students. Recent results from the 2010 National Student Survey (NSS) saw us continue to be in the top elite institutions, coming 4th in Medicine and 3rd in Dentistry. Overall, the University came 10th out of almost 160 institutions in the country. This excellent result will be of immense importance in the years to come where we will see the impact of increased student fees and a greater focus on student choice. Our graduates continue to bring us pride with continued highly creditable success rates in postgraduate examinations after qualification.

Our branch campus in Malaysia continues to go from strength to strength. The very first intake of 24 students have now completed their first 2 years in Newcastle and return to South Malaysia to move on to their clinical years. From September first year students will start their studies in Johor Bahru. We are delighted that we are able to attract excellent students to the programme and this unique development is the envy of many other UK institutions. This development on that site provides an opportunity to deliver other programmes such as courses in Biomedical Sciences in the future.

We have maintained our very strong reputation and outstanding performance in training clinical academics. We have had a particularly good year for our clinical academic trainees securing NIHR fellowships to undertake PhD programmes. The Wellcome Trust funded clinical PhD programme on Translational Medicine and Clinical Pharmacology is seen to be arguably the most successful of its type in the UK and puts Newcastle in a strong position for further investment in this area.

The future

There have clearly been major changes (with more to come) to public spending in England and Wales. The whole basis of funding higher education and commissioning health services is undergoing radical change and, of course, this brings with it significant risks. Nonetheless we have seen unprecedented investment in medical research and by continuing to work effectively between the Faculty and The Newcastle upon Tyne Hospitals NHS Foundation Trust we believe that we are in a very strong position to reap the benefits of this Government’s belief in the importance of translational medicine and continue to be at the leading edge of medical and dental education. We need to make the most of the virtuous cycle we referred to above.

Professor Alastair D Burt
Dean of Clinical Medicine, Faculty of Medical Sciences
Professor Christopher P Day
Pro Vice Chancellor, Faculty of Medical Sciences
Newcastle Biomedicine

Newcastle Biomedicine is a virtuous circle: excellence in research is rooted in excellence in healthcare, creating an environment for further research excellence and leading to healthcare provision

Sir Leonard Fenwick, Chief Executive

We are a world leading collaboration of research scientists, engineers, medical doctors and teaching professionals who deliver undergraduate and postgraduate teaching in medicine, dentistry and health sciences.

We are a recognised national centre of excellence which brings together internationally respected research in clinical care, basic science and engineering in an innovative environment. We excel in tackling challenges in health and healthcare.

Our key areas of focus include ageing, stem cells, cancer, cell biology, genetics, drug development, medicine in society, and neuroscience.

Newcastle Biomedicine joins Newcastle University with The Newcastle upon Hospitals NHS Foundation Trust and further embraces other academic institutions and NHS hospitals in the North East of England.

In essence Newcastle Biomedicine is at the forefront of the Translational Medicine revolution. Its principal aim is to translate scientific advances made in the Faculties at Newcastle University into direct benefits for patients being treated in our partner NHS Trusts.

This strategy has already led to major advances in the healthcare of patients within the region, as well as nationally and internationally and I am delighted to say that our research excellence has been recognised at various levels nationally and internationally.

Professor Christopher Day
Director, Newcastle Biomedicine
Northumbria University

It goes without saying that the past twelve months have been rather challenging for the NHS, as well as for higher education institutions.
...our commitment to increasingly innovative and flexible methods of delivering education to the healthcare workforce is one of our major achievements.

As educators of future health professionals, the School of Health, Community and Education Studies at Northumbria University understands that in order to meet the increasing demand placed upon The Newcastle upon Tyne Hospitals NHS Foundation Trust by the Health and Social Care Bill, Government targets and changing population needs, staff have to be resilient, highly skilled and fully equipped to meet the testing times ahead.

Northumbria University has always worked closely with the Trust to train highly able, confident and caring health professionals who can meet, and exceed, these increasingly complex requirements and as we embark on a strategic review of our Pre-registration Health Curriculum, the relationship between our two great organisations has never been stronger.

In May 2012, Midwifery, Nursing, Occupational Therapy, Operating Department Practice and Physiotherapy programmes will all be re-validated to ensure our curricula reflect the diverse requirements of service providers and users. We are currently working closely with colleagues across all professional groups to engage in an open and extensive dialogue with all stakeholders. The focus of our priorities are to continue to provide a positive learning experience for students and staff and to ensure a thorough integration into the communities of practice required to deliver safe and effective evidence-based health services. We are confident that May 2012 will bring a re-validated Pre-registration Health framework, developed in partnership with local and national services to produce autonomous practitioners who are competent, confident and compassionate in the professional judgments required of them.

We are delighted that the past twelve months has seen another steady rise in the level and quality of applications that we are receiving for our Pre-registration programmes. This is testimony to the fact that our health-related programmes, delivered at Undergraduate and Postgraduate levels, remain at the cutting edge of learning and teaching philosophies nationally. In addition, our continued commitment to maintaining our state-of-the-art Clinical Skills facilities has seen us invest significantly in equipment and we are planning a further £500,000 in additional Clinical Skills developments for the next cycle.

The core research focus of the School remains unchanged with professional engagement, service-user involvement and health service developments being at the heart of our ethos. Bucking a national trend, demand for our Postgraduate programmes is continuing with Postgraduate research degree applications increasing at a School level by 49% between 2010 and 2011.

It is the relevance to clinical practice and drive to be at the cutting edge of research-informed teaching, in programmes such as our new Master of Clinical Practice (Advanced Critical Care Practice) that keeps Northumbria at the forefront of high quality healthcare delivery. This new award, which incorporates the Postgraduate Certificate Clinical Practice (Advanced Critical Care Practice) and Postgraduate Certificate in Advanced Clinical Skills, has been created in direct response to variations in recruitment and retention patterns, the impact of the Working Time Directive, and the increasing complexity of care pathways. With many critical care units having introduced new roles or have extended the scope of practice of nurses, technicians, physiotherapists and clinical pharmacists, entrants will be recruited from adult critical care posts with the potential to add paediatric and neonatal critical care posts at a later date. As further emphasis of our collaboration, the Trust is also committing to the supervision of the trainees in placement by qualified medical staff and this is important because of the significant focus on developing competence within this curriculum.

The University’s ongoing commitment to increasingly innovative and flexible methods of delivering education to the healthcare workforce is one of our major achievements. Few institutions are as competent delivering work-based learning as Northumbria, and one of the most exciting recent developments in this area are the ongoing discussions with the Trust to offer a structured leadership and management framework. Designed to enhance and develop promising individuals, this ‘Talent Management’ scheme will assist senior staff to spot, capture and develop talent across the Trust.

On a more personal level, Northumbria University was delighted to recognise the outstanding contributions of Sir Leonard Fenwick who has striven to bring about and sustain ever improving healthcare for the people of the North East, by awarding him an Honorary Degree. Speaking after the ceremony, Sir Leonard said:

“Northumbria University is a pivotal part of the health picture in the North East and an essential ingredient in innovative and safe healthcare provision. There’s a tremendous interaction between the Health Service and Northumbria University that’s resulted in a virtual circle of training and continuing professional development."

Northumbria University is privileged to have such a truly collaborative relationship with The Newcastle upon Tyne Hospitals NHS Foundation Trust. Our collective commitment to the training and continual development of staff to meet the challenges we undoubtedly face is inspiring and encouraging to our staff, students and stakeholders. Although the next year will undeniably be the most challenging yet, we have never been better placed to rise to them and sustain our platform of success.

Professor Kath McCourt FRCN,
Dean of the School of Health,
Community and Education Studies,
Northumbria University
Review of the Year 2010/2011

Experiencing the Great North Children's Hospital

Photograph by Lee Dobson
Supporters & Volunteers

We are grateful to the many individuals and organisations who support much of what we do

There are more than 700 volunteers providing a direct commitment in one way or another throughout our hospital sites.

Freeman Hospital
New CT Scanner part funded from a generous donation of £280,000 by WRVS
These are some of the voluntary and charitable fundraising groups with whom we are proud to be associated. There are many others and a host of individuals - a huge thank you to all concerned.
Meet a new North East icon.

It seems just like yesterday, that under the direction of Sir Leonard Fenwick, Chief Executive, his hospital staff and the Cancer Charity Daft as a Brush held a preliminary meeting to plan and organise the first pilot scheme to transport, free of charge, cancer outpatients that require chemotherapy and/or radiotherapy treatment at the Freeman Hospital.

The philosophy of Daft as a Brush might seem ‘old fashioned’ but providing a bespoke patient service is all we do. The success to date has only been made possible by the staff of the Freeman Hospital who have been super, plus the team of incredible Daft as a Brush volunteers.

After completing many patient journeys throughout the region, the satisfaction Daft as a Brush receives from cancer patients on the completion of their treatment and journeys is unbelievable.

Many thanks to ALL those people who have made possible this outstanding success.

Kind regards

Brian Burnie, Trustee
Volunteers Needed
for this fantastic CANCER CHARITY

The charitable trust (number 328432) was set up and established in 1989 by Brian Burnie. The involvement in charitable work goes back to the late 1960’s assisting a variety of good causes throughout the region. Today, Daft as a Brush Cancer Patient Care provides staffed custom made vehicles to transport outpatients, free of charge, to and from Hospital who are undergoing Chemotherapy and / or Radiotherapy cancer treatment.

Be a part of the journey to Recovery

We’re looking for volunteers to assist in the following:
- Chauffeurs - Driving the Daft as a Brush ambulances
- Companions - Helping and assisting in the ambulances
- Fundraiser / Events Co-ordinator etc.

Our offices can be found between the Vivienne Westwood shop and the Newcastle Building Society Branch.
3-5 Hood Street, 1st Floor, Grainger Chambers,
Newcastle upon Tyne, NE1 6JQ.

Download an application form at www.daftasabrush.org.uk
Or, telephone: (0191) 23 28 999, Fax (0191) 23 28 241
Email: info@daftasabrush.org.uk

Thank you
...working for patients in a sensitive and compassionate manner whilst protecting their safety and dignity

The Trust’s Quality Account highlights the ways in which we all work to meet its aim of delivering ‘leading-edge Healthcare of the Highest Quality but with a personal touch’.

These are a few of the ways in which the Chaplaincy Department contributed to this overall aim:

1. Patients at the heart of everything we do, working for them in a sensitive and compassionate manner whilst protecting their safety and dignity:
   
   Chaplains continue to provide a 24 hour on-call service to the Trust, allowing patients (and staff) to access appropriate support from the department when needed. Calls and referrals are for:
   
   ‘Spiritual Support’
   as people try to make sense of the situations in which they find themselves and the implications of their diagnosis.
   
   ‘Religious Support’
   as people look to draw upon the resources of their Faith by accessing appropriate rites and rituals that give expression to what they believe and help with their coping.

   These requests are met by providing:
   
   - trained and competent Chaplains to listen and counsel in both formal and informal ways,
   - access to appropriate facilities and rituals which are sensitive to the needs of all faiths or none,
   - staff support, training and education to enable appropriate and sensitive care to be offered by all staff to patients.

   The Department has moved to be part of the Patient Services Directorate this year which has enabled further development of the Multi-disciplinary way of working that has been the focus of previous years and opens up the possibilities of more co-ordinated working in the future.

2. Value the contribution of Staff and Volunteers and manage resources in a co-ordinated way
   
   The Chaplaincy has always worked with volunteers to support their work. Dedicated volunteer from local faith communities offer patient support on the wards, supporting patients in accessing opportunities for worship by bringing them to and from the wards and by looking after the Chapel and the flower arranging that adds to people sense of wellbeing as well as being a focus for the books of remembrance.
   
   The Department has a high profile as a Centre for Excellence through it’s involvement in the Centre for Chaplaincy Studies based in Cardiff University, the National Multi-Faith Group for Health Care Chaplaincy, the College of Health Care Chaplains as well as it’s links with student education and placements through Northumbria and Durham University.

   It is currently involved in Research into Bereavement support, the changing role of Healthcare Chaplains and ethical issue’s involved in with-holding and withdrawing treatment as part of it’s commitment to continuous improvement and development.

   Rev’d Nigel M. Goodfellow
   Head of Chaplaincy

3. Be a Centre of Excellence and focus on continuous improvement in pursuit of excellence
   
   The Chaplaincy has always worked with volunteers to support their work. Dedicated volunteer from local faith communities offer patient support on the wards, supporting patients in accessing opportunities for worship by bringing them to and from the wards and by looking after the Chapel and the flower arranging that adds to people sense of wellbeing as well as being a focus for the books of remembrance.

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   Rev’d Nigel M. Goodfellow
   Head of Chaplaincy

...we provide staff support, training and education to enable appropriate and sensitive care to all patients
The number of charitable funds seeking to create and build their own brand is increasing progressively. This in turn will help attract those patients, family, staff and companies who have special reason to support our Hospital services. This year newly created brands for charitable funds have been the Children’s Head Injury Fund (CHIEF) and the DREAME Fund.

The Children’s Head Injury Fund (CHIEF)

With a national and international reputation for quality, research and innovation the Newcastle Paediatric Neurorehabilitation team are excited about their recent move to The Great North Childrens Hospital at the Royal Victoria Infirmary. The Children’s Head Injury Fund (CHIEF) will help enhance facilities and specialist equipment to allow children to make the best recoveries possible after experiencing ‘Acquired Brain Injury (ABI)’ - from stroke, meningitis, a brain tumour or a severe accident.

David Ryan Equipment and Medical Education Fund (DREAME)

The DREAME Fund originally the MAGIC Fund, was founded by the late Dr. David Ryan and following David’s death a decision was taken to rename the charity as the DREAME Fund (David Ryan Equipment and Medical Education Fund). The fund supports the work of the Freeman Hospital Integrated Critical Care Unit (ICCU). Excellent patient care provided to the patients during the operative period by Anaesthetists, Surgeons and Operating Theatre staff on ICCU at the Freeman Hospital is comparable to anywhere in the world.

Working in collaboration with Potts Print (UK) we can now offer to assist with a free service to create a brand identity which will be attractive to potential donors, foster and maintain their loyalty and ultimately increase charitable revenue. As you can see from the following pages many charitable funds are now reaping the benefits of creating awareness in the community through this medium. An increase in funds and awareness can help to shape future planning.

Finally on behalf of the Trustees I would like to thank everyone person who has supported the charitable funds of the Newcastle upon Tyne Hospitals NHS Foundation Trust and kindly ask for their continued support to create world class facilities.

Please get in touch if you require any help and advice with regard to fundraising and rest assured your efforts are greatly appreciated.

Pauline Buglass
Head of Fundraising
Tel: 0191 213 7235
Email: Pauline.Buglass@nuth.nhs.uk

During the past year the diversity, expansion and development of the charitable work taking place across Newcastle upon Tyne Hospitals has advanced in leaps and bounds to complement and enhance NHS resources. Newcastle Upon Tyne Hospitals NHS Charity and the Newcastle Healthcare Charity hold and administer monies donated to the NHS for the Hospitals for which they have been appointed, in accordance with the wishes of the donor. There are currently approximately 500 charitable funds.
Kind hearted, Roly Sanderson, an electrical craftsman, at Rio Tinto Alcan’s Lynemouth Power Station has raised an astonishing £8,315 for charity.

The money will go towards The Great North Children’s Hospital, a new facility based at the Royal Victoria Infirmary Hospital (RVH), in Newcastle which opened its doors to patients in November 2010.

The hospital offers the highest level of care to all youngsters, from toddlers to teenagers and brings a number of specialist treatments such as a Paediatric Rheumatology Services under one roof.

Roly raised the money by completing his 26th consecutive Great North Run. The world famous half marathon, which starts in Newcastle and ends in South Shields, now attracts over 54,000 runners, many of whom raise money for numerous charities across the country.

Roly was delighted when he recently met with Pauline Buglass, the head of fundraising for Newcastle Hospitals to hand over the money and check out the new facilities.

He said: “I decided to run for The Great North Children’s Hospital, because it’s a very good cause, providing comfort for many ill children, young people and their families from across the North East.

“Facilities such as the Paediatric Intensive Care Unit is fantastic, providing specialist treatments for children suffering from kidney failure, meningitis or head injuries.

“The hospital building is very modern, and does not look like your typical hospital, it has vibrant multi-coloured windows and curved corridors making it spacious and very light. I was delighted to find a cinema inside, a lovely way for children and families to relax together, away from a hospital environment.

“I would like to take this opportunity to thank my friends and colleagues who supported me, hopefully they will dig deep into their pockets when I run again this year.”

Roly completed his last run in an astonishing 1 hour and 39 minutes. In the past 26 years, he has raised over £127,000 for a number of local charities.

Pauline Buglass, of Newcastle Hospitals, said: “I was astounded at the amount raised by Roly, his generosity is helping us to create a world class hospital for children in the North of England.

“On behalf of the hospital, patients and parents, I would like to thank him for his kindness and support.”

Vaun Campbell, works director at Lynemouth Power Station, said: “We’d like to congratulate Roly once again for this fantastic achievement.

“To take on the challenge of one half marathon is hard enough, but Roly somehow finds the strength to take part each year and continues to raise vital funds for good causes throughout the region.

“Everyone at Lynemouth is incredibly proud of his efforts and we wish him all the best for his 27th Great North Run this September!”
In November 2009 Mark Dransfield set himself and Sanderson Arcade in Morpeth the challenge to raise £30,000 to provide 3D Sensory Equipment for the Great North Children’s Hospital.

After some dedicated fundraising driven by Mark and Debbie Anderson Centre Manager for the Sanderson Arcade Morpeth, Northumberland on 20th April 2011, a cheque for £30,534.09 was presented to ITV’s Philippa Tomson who was involved with the fundraising at the Arcade.

Managing Director of Dransfield Properties, Mark Dransfield, said: “When I heard about The Children’s Foundation and the work it does to help children in the North East I was deeply moved and determined to raise enough money to buy 3D sensory equipment. Everyone involved with the fundraising has really pulled together and are looking forward to seeing it in use at the Great North Children’s Hospital.”
Walk in the Park 2010

helping local children is a walk in the park!

Three-year-old Patrick Skinner from Whitley Bay has already been through an awful lot in his short life. The brave youngster has fought leukaemia, heart failure and recovered from a heart transplant.

Patrick’s treatment all took place within the Newcastle upon Tyne Hospitals NHS Foundation Trust at both the Royal Victoria Infirmary (RVI) and Freeman Hospital - and parents Devon Higgins and Kevin Skinner are very appreciative of the excellent care he received.

Dad Kevin, a structural engineer, has undertaken a number of physical challenges to raise money for Children’s Ward 4 at the RVI and the Children’s Heart Transplant Fund at the Freeman. These have included the Coast to Coast Cycle Ride and climbing Ben Nevis, Scafell Pike and Mount Snowdon in just 24 hours, however his next charity activity is one which even young Patrick can join in.

Patrick, Devon and Kevin joining in the Walk in the Park 2010 to raise funds for the Great North Children’s Hospital Appeal.

The Walk in the Park, sponsored by Northumbrian Water, is a five mile stroll around historic Leazes Park.

Kevin says: “The Great North Children’s Hospital is doing a fantastic job helping to make visits to hospital easier for children and their parents.

“Nobody expects to see their children go through the kind of problems which Patrick has. The chemotherapy he needed to fight leukaemia caused his heart to fail on Christmas Eve 2008 after he’d been in remission for just three weeks. There was only a one in 500 chance of that happening so it was a huge shock. He then spent the next three months in hospital with a double Berlin Heart to keep him alive.

“To see him so active now is amazing and we are very grateful for the care he has received.”

The popular Walk has previously been started by Sir Bobby Robson, Tyne Tees weather reporter Philippa Tomson and entrepreneur Duncan Bannatyne. Held annually in Leazes Park, Newcastle.
A Big thank you to Barry Speker OBE for his support over the years...

Freeman Cardio and Education Fund

A Charity Chinese banquet was held at The Palace Garden Chinese Restaurant on the initiative of the owners Mr and Mrs Peter Cheng. They wished to raise money to show their thanks to Dr Azfar Zaman and his team at the Regional Cardiothoracic Centre at Freeman Hospital where Mrs Cheng has been a patient. The event was organised by Barry Speker OBE, Alison Barrett, Amie Leung, Ada Tsow, Yanhong Bi, Kamber Kimti and Stan and Tony Rutter. The magnificent sum of over £10,000 was raised.
Now in its 13th year the event, which as usual was sponsored by Samuel Phillips Law Firm, has since its inception contributed considerably to the Charlie Bear cause.

The 2010 winning team was from Keenan Processing and the runners up were Ortho Clinical Diagnostics.

Prizes were presented by David Allison Chief Operating Officer of the Newcastle Hospitals and Barry Speker, Senior partner at Samuel Phillips Law Firm.

Once again the day was hugely successful and raised over £4,400, bringing the total raised by the event in its 13 year history to £120,000.
Programme of Events June 2010 - June 2011

**June 2010**
- **Blaydon Race**
  Members of the Newcastle Magnetic Resonance team competed in the Blaydon Race to raise funds for the Charlie Crowe Scanner Appeal.

**July 2010**
- **Tynedale Shadows Summer Festival**
  Brian Bowman of the Tynedale Shadows Guitar Club held an fundraising music festival at the Federation Breweries in aid of the appeal.

**August 2010**
- **Hadrian Wall Walk**
  Mrs Margaret George and her friends walked Hadrian’s Wall from Bowness-on-Solway to Wallsend in support of the Scanner Appeal.

**September 2010**
- **City of Newcastle Golf Club**
  The Ladies team from the City of Newcastle Golf Club chose to support the Charlie Crowe Scanner Appeal as their charity of the year.

**October 2010**
- **Dobbies Garden Centre**
  The staff from Dobbies Garden Centre in Birtley held a fundraising evening in support of the Charlie Crowe Appeal.

**November 2010**
- **Ruby Wedding Donation**
  Mr and Mrs Cartner held a Ruby Wedding Celebration of which all their guests donated money to our appeal.

**December 2010**
- **Christmas Coffee Morning**
  The Mr Centre held a Christmas Coffee Morning supported by Starbucks; all proceeds went to the appeal.
  - Also in December: Civic Reception
  - As our appeal was a chosen charity of the Lord Mayor in her year of office, she hosted a Black and White Ball which was held in the Civic Centre.

**January 2011**
- **Fiona Phillips Endorses the Charlie Crowe Appeal on our Website.**

**March 2011**
- **Tynedale Shadows Musical Evening**
  Brian Bowman of the Tynedale Shadows Guitar Club held another social evening in support of the Charlie Crowe Appeal.

**April 2011**
- **Whitley Bay Football Club Fundraising Evening**
  Alan Pardew the NUFC Manager brought along a signed Newcastle shirt which was auctioned and monies donated to Charlie Crowe Appeal. Many thanks to Whitley Bay FC for being a wonderful host.

**June 2011**
- **Ponteland Rotary Luncheon**
  Professor Ray Taylor Director of the Newcastle Magnetic Resonance Centre was invited to give a talk at a Rotarian Lunch. The president of the Rotary Club kindly donated a cheque to the Charlie Crowe Appeal.
Blaydon Race Reception

Samuel Phillips Law Firm recently hosted a reception for personnel from the Newcastle upon Tyne Hospitals NHS Foundation Trust. This coincided with the annual Blaydon Race, as a number of runners from the Newcastle Hospitals were taking part. Samuel Phillips office premises - Gibb Chambers - are associated with the Blaydon Race.

Some went to the Infirmary and some to Dr Gibbs
And some to the dispensary to mend their broken ribs

The evening raised funds for the Charlie Crowe Scanner Appeal in support of the MRI Resonance Centre based at the Campus for Ageing & Vitality. More than 100 people attended the reception.
Notable events that took place during the year included:-

1. **Progressive dinner**  
   **May 2010**

   After a gap of 4 years, the Progressive Dinner returned as a Charlie Bear for Cancer Care fundraiser. A number of restaurants on the Quayside lent their support & the event was well attended.

   On the night, 40 guests gathered at the Copthorne Hotel & enjoyed a sparkling wine reception, Canapés were served and music was provided by Elliott Park a young pianist from the Royal Grammar School. The diners then moved on to the Malmaison Hotel for starters, followed by a visit to the Vermont Hotel for the main course. The evening was completed with dessert at the Gusto restaurant where a raffle and auction were held.

   Transport for the diners was provided by 5 Star Taxis and the event raised the magnificent sum of £3345.

2. **Malmaison Hotel Abseil**  
   **4th July 2010**

   Supporters took a leap of faith and abseiled down the side of the Malmaison Hotel. The event raised £1140.

3. **Lanchester EP School Events**

   Throughout the year, pupils at Lanchester EP School raised money for Charlie Bear in the name of David Dawson, one of their students who received treatment at NCCC.

   Davis became a huge Charlie Bear fan whilst attending for his treatment, and he enlisted the help of the staff and the other pupils at the school, holding ‘bakeathons’ and selling the results, they made donations instead of sending Christmas cards, held games in school and organised a Fantasy football competition during the World Cup.

4. **Great North Run**  
   **19th September 2010**

   A number of participants in the GNR did so in the Charlie Bear cause, and it is hoped that participation by Charlie’s supporters will become an annual event. 2010’s efforts raised the fantastic sum of £7,443.

5. **Christmas Fair and Auction**

   This now well established annual event raised over £4500 for the Charlie Bear cause.

6. **Million Metre Row Durham School Boat Club**  
   **11th December 2010**

   This event took place in the Durham School Boat Club House Common Room from 9.30 - 6.30, raising £1060.

7. **Charlie Bear was Whickham School’s Charity of the Year for 2010**

   Events held by the school included a Variety Show which ran for three nights, highlighting the many talents of their students, bag packing at local supermarkets, an X-Factor competition won by Sam Watson a year 7 pupil, a Sumo Wrestling competition and the proceeds from tuck shops biscuits sales.

   Year 12 pupils, tutors and the sixth form team helped organise the events that took place, and one of the teachers Mr Thompson raised £200 being sponsored to run to school every day.

   On the final day of fundraising, students and staff paid to dress up in costumes with a Pyjamas and Teddies theme.

   The events the school held across the year raised the amazing sum of £9892.95 which included a generous £750 from Barclays Bank.

8. **Sir John Halls ‘Box of Tricks’**

   Sir John Hall generously allowed Charlie Bear to auction the use of his private box at St James Park for the match against Bolton, Sir John, who acted as host on the day, is a former patient and has kindly agreed to be a patron of Charlie Bear for Cancer Care.

   The successful bid of £1400 was entered by Mr John McGowan,
who kindly donated the use of the box back to the charity and as a result a group of young people affected by cancer were invited to watch the game and sample the atmosphere and hospitality on offer.

Cory Davison, aged six, of Blyth, was joined by his dad Steven who said: “He is a massive Newcastle fan and he was just thrilled, it is a once in a lifetime opportunity. Sir John was fantastic, a true gent”.

Sir John said “It has been tremendous. When I was in the Freeman with prostate cancer I met some children having treatment and I was impressed and humbled by what they were going through and they did it with a brave face”.

9. Hall of Fame Award April 2011

Michael Ready is a young cancer sufferer who was nominated by Charlie Bear and won the Journal Great North Run Hall of Fame Award for his bravery and the money he has helped raise.

Michael of Lobley Hill was diagnosed with Hodgkin’s Lymphoma in 2009 and faced a gruelling regime of radiotherapy and chemotherapy to help save his life. Despite this and determined to help others in a similar situation, he threw himself into raising as much money as possible for Charlie Bear. The funds he helped raise as with all donations and money raised were used for the benefit of patients affected by cancer attending NCCC for their care and/or treatment.

Michael’s mother Lynn, a financial PA said “Michael has been through hell and back in the last year. He is happy to be alive. The Great North Run has been a goal of his and his training is to help raise his fitness levels again”.

Michael is the second nominee from Charlie Bear for Cancer Care to win this prestigious award.

10. Charlie Bear recruits his first Nurse

As part of the continuing drive to offer the best and most comprehensive care to it’s patients, services at NCCC have been boosted by the recruitment of the first Charlie Bear Specialist Nurse to ensure continuity of care and advice to patients with on going longer term problems related to Breast Cancer.

This is the charity’s first clinical appointment, and the post holder; Karen Verrill has proved an invaluable addition to the staff and the services available at NCCC.

11. Charlie Bear helps to update Radiotherapy DVD

As part of the comprehensive suite of information available to patients and carers, the Information & Support Centre at NCCC, is now, courtesy of Charlie Bear, able to offer patients and carers a new and updated DVD outlining the undertaking of a course of radiotherapy.

This replaces an outdated version that was made prior to the transfer of the service to Freeman Hospital. The DVD is narrated by Colin Briggs of BBC North East, himself a former patient and as well as describing the process involved in undergoing a course of radiotherapy, it describes the experience from a patients point of view. A number of former patients, including Sir John Hall, give their impressions and share their experience whilst they underwent radiotherapy at NCCC.
The Grafters Club has had a very busy year. The club has grown to 70 members who partake in the activities and trips that are organised to bring the children and families together who have suffered a burn injury.

Living with scars is a challenge and this is often the only time the children get the opportunity to meet others who have had a similar experience. Our trips allow the children to meet new challenges, share coping strategies, gain confidence and build their self esteem.

The Club took 22 children to an activity weekend at Kingswood near Hexham in May which was a great success. This was followed up with 150 people (30 families) on a day trip to Flamingo Land.
P&G (Procter & Gamble) has donated £8,000 to a charity close to one of its employee’s hearts.

Ray Murray, who works at P&G’s Seaton Delaval site, is the proud father of two-year-old twin girls and nominated the region’s only charity that celebrates multiple births – More than One - to receive the donation after the charity supported his family during the birth of his baby daughters.

More Than One, based at the RVI, was set up in 2007 to bring together families who are expecting, or have had, multiple births. The charity aims to raise awareness of the work of The Women’s Services Directorate at the RVI and raise funds towards purchasing equipment and teaching materials to help with the safe delivery of multiple birth babies.

The money - which was raised by more than 400 of Ray’s colleagues as part of the company’s Community Matters Programme - contributed to buying two double heart monitors and two breast pumps for the charity. Other donations were received from Buckland Trust which donated £2,000 and Terry Mann who donated £5,000 following the arrival of twin grandchildren.

Ray said: “As a father of twins I know firsthand how valuable the expertise is at the RVI. It can be a very daunting time for families but More than One is very supportive and tells you everything you can expect throughout the pregnancy, during labour and even two years later! The network my family has gained at the RVI is invaluable and I hope the donation from P&G leads to the charity supporting more families like they supported us.”

Sandra Bosman, specialist midwife for multiples, founder of More Than One and Mamas and Papas Midwife of the Year 2007, was very grateful for the donation. She said: “We are delighted with P&G’s gift, as a small charity we are always very pleased when someone thinks of us. I started More than One because multiples are often looked at with fear and trepidation – we encourage families to embrace the experience and celebrate being different.”

More than One will be celebrating its 5th annual event at Leazes Park, Newcastle on 4 September. For more information, and tickets, visit www.morethan1.org.uk
Most of the patients had been diagnosed with breast cancer and underwent reconstruction either at the same time or after their surgery to remove the cancer. A significant minority were known to be at a genetic risk of developing breast cancer and had opted for risk reducing breast surgery. In both groups the decision to undergo complex reconstruction, in addition, was a very difficult one to make.

Now an informative new dvd, suggested and presented by patients who have been through the process themselves, has been created to help other women thinking about undergoing breast reconstruction.

Funded through the Newcastle Healthcare Charity, Feeling Whole Again is a two part dvd available through the Plastic Surgery Breast Nurse Specialists at the RVI.

It is a step-by-step journey through breast reconstruction at the RVI covering potential issues and concerns, detailing the different reconstruction options available and introducing the expert medical team who will help throughout the process.

For the benefit of women who are unsure how their reconstructed breasts could look, the dvd also features a number of patients showing the final results of their surgery.

Sue Keeton, Senior Breast Reconstruction Nurse Specialist, explains: “It was a brave decision for our patients to be filmed - some of them half undressed - for this dvd: but, it was also typical of them to take up this challenge on behalf of other women who may be considering this surgery.

“We work within a very supportive environment and many of our patients are involved, long after their own surgery is complete, in offering women attending our Breast Reconstruction Support Group the benefit of their own experiences.

“When the dvd was first suggested to us we thought it was a wonderful idea and thanks to donations to the Newcastle Healthcare Charity we were able to set the wheels in motion”.

The dvd is available to all women seeking breast reconstruction surgery at the RVI. Further details about where to access this and other information can be obtained by contacting the Plastic Surgery Breast Nurse Specialists at the hospital on 0191 282 0194.
An event to launch and raise money for the newly named DREAME fund, proved to be a success as over £5000 was raised over the course of an evening at the South Northumberland Cricket Club.

The DREAME fund (David Ryan Equipment and Medical Education, previously known as MAGIC) is a charity set up to raise funds for the Integrated Critical Care Unit at the Freeman Hospital.

The black tie event held recently in memory of the Unit’s founder, the late Dr David Ryan, included a dinner dance and games as well as a charity auction to help raise funds.

The location chosen for the event was particularly poignant, being the cricket club where Dr Ryan used to be a long term member. As well as being a Consultant in Anaesthesia and Intensive Care Medicine, Dr Ryan had a keen interest in cricket and helped establish and coach junior cricket at the club in South Northumberland in the 1980s and early 1990s.

Dr Joe Cosgrove, Consultant in Anaesthesia and Critical Care, and organiser of the event explains: “We wanted to hold a ball to launch the new name for the fund and the Cricket club seemed an ideal location for it. The events from the evening were a real success in celebrating David’s contributions to Critical care but also to his input to the world of Junior Cricket in Northumberland.

As part of the evening, a number of paintings were auctioned which were donated by artists from Northumberland and County Durham. These included many from the Northumbrian and Teesdale Artists Networks such as Leigh Lambert, Martin Tallantyre, Jackie Lyness, Ray Landon and Peter Podmore (who also used to coach cricket with Dr Ryan at the cricket club).

Joe continues: “I’ve been taken aback by people’s generosity and can’t thank the artists who have donated their wonderful work to the charity enough for their continued support.”
The New castle H ealthcare C harity

The economic downturn and the potential effect on charitable giving posed serious questions for the charity at the start of the 2010/11 financial year and produced an initial degree of caution in managing the investment portfolio and agreeing long term commitments. Thankfully the early predictions of poor investment performance and sizeable reductions in income streams did not materialise to any great extent and the Trustee’s were heartened by the fact that income of £1.5m was only 4% down on the previous financial year. Unrealised gains on investments also produced a further £646k, which whilst modest, was both acceptable and gratifying.

Review of the Year 2010/2011

These results owe much to the generosity of our local population and the careful management of our investment portfolio, which has enabled us to continue supporting health care services throughout the region at a similar level as previous years. Despite the prevailing economic conditions, grants and commitments to the NHS (1.6m) actually increased by 1% on the previous financial year.

The major grant awards to the Newcastle Hospitals reflected the progress made in the Transforming the Newcastle Hospitals programme. The opening of the new Victoria Wing and the Great North Children’s Hospital, on the Royal Victoria Infirmary site, amalgamated a range of services previously delivered by Newcastle General Hospital and enabled Service Managers to gauge what further enhancements were then required. Consequently many of the grants made by the charity were aimed at complementing the brand new facilities with equipment of equal quality.

The Children’s Services Directorate was the largest beneficiary, receiving seven awards totalling £221k and covered such diverse projects as producing a visual and artistic programme for the Great North Children’s Hospital to providing interactive equipment designed to entertain and distract children during treatment procedures. Support for high quality medical equipment was also combined with grants to Radio Lollipop and the Clown Doctors Service.

The very successful Tynesight charitable fund, which supports the Ophthalmology Directorate at the RVI, continues to attract substantial financial support, which it translates into high levels of state-of-the-art equipment. Four awards totalling £145k included a Heidelberg OCT machine for detecting and monitoring glaucoma, diabetic retinopathy and age-related macular regeneration and a Quantel Aviso ultrasound scanner used to diagnose congenital anomalies and iris and ciliary body tumours.

Three awards totalling £147k were made to the Directorate of Medicine including an EBUS scope (Respiratory Medicine) which is used primarily as an investigative tool for lung cancer patients and avoids the need for investigative surgery. Similarly the purchase of a Halo Generator Ablation system, used primarily in Barrett’s Oesophagus disease, incorporates an endoscopic technique, which is designed to avoid the need for specialist surgery. Such awards are made with the specific aim of reducing the need for invasive surgery, minimising discomfort for patients and speeding up the recovery process.

Major grants totalling £128k were also made to the Department of Surgery (radio-guided equipment), Specialist Haematology and Cancer Services (pre-assessment nursing post, infusion pumps & support for the arts and complimentary therapy services), Maternity Services (fetal monitors), Neurology (ward furnishings & support for complimentary therapy services) and Peri-Operative & Critical Care (echocardiograph machines). The wide range of awards is designed with the intention of providing enhancements and improvements to patient care throughout the Newcastle hospitals.

Whilst the primary focus is on providing patient benefit the charity are mindful of the support needed by staff in delivering these services and this prompted a three-year award (£87k) to support on-line medical and research journals which can be accessed by staff throughout the NHS Trust. The charity (in conjunction with the Newcastle Hospitals NHS Charity) also continued its support for the provision of a Christmas meal for all staff within the Trust as a token of appreciation for their hard work and commitment.

Supporting medical research has been a long-standing commitment of the charity and seventeen awards were made during the year, totalling £344k. The awards are designed to pump-prime research projects, usually for one year, which allows the researchers to build up data with a view to attracting substantial funding for future years.

During the year it became clear that the Newcastle Hospitals no longer needed use of the charity’s properties for staff accommodation however there was an urgent need to increase parental accommodation primarily for the SCIDS and Paediatric Intensive Care Units. Following discussion with the Trust the
The charity decided to sell 1 & 9 North Terrace with a view to ring-fencing the proceeds to assist with the provision of the parental accommodation on the RVI site. At the time of this report, firm offers had been received for both properties and the sales were progressing.

The charity’s policy of working in partnership with independent charities with similar aims has resulted in closer co-operation and better use of charitable funds and in some cases such charities have opted to come under the umbrella of Newcastle Healthcare Charity to maximise benefits and reduce administrative costs. During the year the Trustee’s were delighted to accept administrative control of the previously independent Children’s Head Injury & Equipment charity. This has allowed the previous Trustees to work alongside ourselves in promoting the service and increase the exposure to the general public and has resulted in a substantial increase in the level of support. This model, which incorporates trust and co-operation, is something that we are keen to extend and at the time of writing a further independent charity of long standing has indicated their willingness to amalgamate their funds under the Newcastle Healthcare Charity umbrella, subject to Charity Commission agreement.

I would like to take this opportunity to relay the gratitude of my Trustees to everyone who has supported the Newcastle Healthcare Charity, both in the past but particularly during the 2010/11 financial year. Such support has allowed us to commit almost £12 million to NHS projects over the last six years and we remain fully committed in our efforts to provide continued support to enhance and improve services across the region.

We are also indebted to individuals who have provided bequests to the charity (almost £3.9 million over the last six years) and in doing so provide a fitting and lasting memory to those individuals and ensure that future generations will benefit from this ultimate act of kindness.

Finally, I would like to pay tribute to Margaret Carter who stood down as a Trustee during 2010 following ten years unbroken service with the charity. As a local Councillor and former Mayor of Newcastle upon Tyne, Margaret reflected the needs of our local population and was a loyal, dedicated Trustee of the charity and her input will be missed.

Ken Grey
Chairman

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**Society of Indian Doctors (Cleveland)**

The Society of Indian Doctors (Cleveland) presented a cheque for £9000.00 to Dr Roderick Skinner representing the Children’s Cancer Ward at the Great North Children’s Hospital, Newcastle upon Tyne. This contribution was made in support of their efforts in providing intensive care and treatment for children and young people (0-19 years) with all forms of cancer as the regional centre for the whole of North East England.

Inspired by the successful treatment of a local boy Amaan Ali, the Society of Indian Doctors (Cleveland) and Mr Mourzzam Ali (Amaan’s father) organized a Charity Ball on 29th January 2011 at the Tall Trees Hotel in Yarm. This ‘Hollywood meets Bollywood’ themed Black Tie event was attended by 360 people who donated generously for this worthy cause. They enjoyed stage performances by Desi Naach (Bollywood Dances), a live band ‘Synergy’ playing hits from the 60’s to the latest and Bollywood & Bhangra music played by DJ MIB. There was a sumptuous three course Indian meal to add to the Bollywood touch.
It has been another incredible year for the Sir Bobby Robson Foundation. This remarkable charity, launched by Sir Bobby in March 2008, has now raised over £3.5 million to fight cancer and continues to grow thanks to wonderful ongoing support from fundraisers and people kindly making donations.

Sir Bobby’s wife, Lady Elsie, and three sons Paul, Andrew and Mark are very involved and the charity is also represented by dedicated Patrons including Sunderland AFC chairman Niall Quinn, Newcastle United legend Alan Shearer, Middlesbrough chairman Steve Gibson and Sir Bobby’s Ipswich Town captain Mick Mills.

Lady Elsie Robson, said:

“The commitment shown by fundraisers is simply incredible. I’m extremely grateful to everyone who has organised or supported an event for us and to everyone who has made a donation.

I know my husband would be very proud to see what we’ve been able to achieve together through the charity he launched. He believed in the Sir Bobby Robson Foundation whole-heartedly and that together we will help the experts beat cancer.

I find it very touching that so many other people also share his faith.”

Valued Support from Fund-Raisers Builds Every Year

For the second year, staff and students from South Tyneside College raised money by rowing the eight miles from Newcastle to South Shields.

For the third time, men’s, women’s and junior five-a-side football teams from across the region, including Middlesbrough Ladies FC pictured here, played in the Robson 5s tournament in Newcastle.

A group of Middlesbrough fans raised over £10,000 playing at match at the Riverside Stadium. This is the third year they have supported the charity.
A Quiet Area for Cancer Patients

A useful new patient facility has opened at the Northern Centre for Cancer Care thanks to joint funding from the Sir Bobby Robson Foundation and Macmillan Cancer Support.

The new ‘quiet area’ is benefiting visitors and patients who come to the Freeman Hospital from across the region for specialist cancer treatment.

Tucked away in a peaceful corner, it is a comfortable space to relax between appointments with books and a television and it is also stocked with useful information about cancer.

Lady Elsie officially opened the quiet area alongside Maureen Rutter, Macmillan Cancer Support Director, and Sir Leonard Fenwick, Chief Executive.

Lady Elsie said: “I’m very proud to see this wonderful new facility open. As someone who spent a great deal of time in various hospitals while my husband received treatment I can appreciate the value of quiet space such as this. I hope the new quiet area provides a relaxing space for visitors to the hospital for many years to come.”

The funding provided by Macmillan Cancer Support was raised by former Newcastle United goalkeeper Shay Given.

Significant Investment in Cancer Research

The Sir Bobby Robson Foundation has made a very significant investment of more than £0.5 million to purchase an ultra-compact cyclotron, which will help with the diagnosis and treatment of cancer.

Only the second of its type in the world, it will be the first in Europe, and we shall help in the development of new cancer treatments to save lives.

The cyclotron will be housed in a newly built ‘specialist environment’ in the School of Chemistry at Newcastle University. This is a requirement when making agents that will be administered to patients and the University is funding this aspect of the project.

The cyclotron works by creating radioactive tracers which are given to patients who then undergo scans. The resulting information then helps doctors to understand where the disease is in each patient, how serious the disease is and whether new treatments are getting into the tumours at the right dose.

Herbie Newell, Professor of Cancer Therapeutics at the Northern Institute for Cancer Research, Newcastle University, explains: “This is a piece of equipment which will help us enormously in our fight against cancer.

It is a really powerful technology which will allow us to assess which patients are most likely to benefit from particular types of drug or radiation therapy, and whether the treatments are working. It will especially help us with our research into new and better ways of treating cancer.

As well as being valuable in diagnosing certain cancers, neurological and cardiac diseases, it can also help to show where drugs are going in the body. For individual patients it will help us work out whether drugs are working or if a different approach to treatment might be better.”
Leukaemia Laboratory Equipment

A £20,000 contribution from the Sir Bobby Robson Foundation is helping further research into leukaemia.

Funding from the charity to the Leukaemia Research Cytogenetics Group has purchased an Olympus BHX6 fluorescence microscope, which is connected to a highly sophisticated image analysis system.

Christine Harrison, Professor of Childhood Cancer Cytogenetics at the Northern Institute for Cancer Research, Newcastle University, said:

“This top of the range microscope is an important piece of equipment for us.

Although our research is focussed on leukaemia, the techniques we’re using, and the use of the microscope, will be of great value to other researchers within the Northern Institute for Cancer Research.

We’re grateful to everyone who has raised money in aid of the Sir Bobby Robson Foundation for helping to make this purchase happen.”

The research of the Leukaemia Research Cytogenetics Group involves the study of chromosomes in the bone marrow cells of patients with leukaemia. Abnormalities of these chromosomes indicate the type of leukaemia that each patient has, and more importantly, they provide an indication of how the patient will respond to treatment.

This feature helps form decisions regarding patient treatment according to their abnormality, which ensures that they are given the most appropriate therapy and increase survival rates.

Lady Elsie officially presented the microscope with help from Joseph Green from South Shields who is currently fighting leukaemia.

New Research Posts

Two new clinical research posts, a doctor and nurse, at the Sir Bobby Robson Cancer Trials Research Centre are now being funded through the Sir Bobby Robson Foundation.

Dr Peter Stephens and nurse Lindsey Mills have joined the 16 strong clinical research team working with patients who have elected to undergo trials of new cancer drugs.

Both posts are trainee clinical trials positions and Professor Ruth Plummer, director of the Sir Bobby Robson Centre, is very pleased to be investing in the future of cancer research as well as gaining two talented and enthusiastic new medical staff.

Professor Plummer said: “We have a wonderful, professional and dedicated medical team at the Sir Bobby Robson Centre and it is a great bonus that the Foundation has funded these training posts, allowing us to invest for the future in training new research staff.

Bringing new talent into a team and being able to develop this is something which matters as much in a research team as it does in a football team.

The Sir Bobby Robson Centre continues to grow as Sir Bobby would have wished, with increasing numbers of patients treated each year. Since we opened over two years ago more than one thousand patients have been treated here on clinical trials, with over 300 of these participating in the earliest trials of new treatments”.

BBC Radio 5 live from the Sir Bobby Robson Centre

RBC Radio 5 live broadcast live from the Sir Bobby Robson Cancer Trials Research Centre as part of its Septemberfest festival.

The two hour national radio show, hosted by Gabby Logan, focussed on the pioneering cancer research being done at the Sir Bobby Centre and the ongoing work of the Sir Bobby Robson Foundation.

Interviewees included Lady Elsie and her sons, Alan Shearer, who is a patron of Sir Bobby’s charity, and Newcastle United goalkeeper Steve Harper.

Sir Bobby Robson Centre patients, staff and fund-raisers for the Foundation also contributed to the programme which paid tribute to Sir Bobby and the incredible legacy he left for cancer patients in the north east and Cumbria.

Gabby Logan explained: “What a truly inspiring and magical place and Sir Bobby Robson’s presence loomed large all afternoon. It was a joy to meet the patients, nurses and Professor Plummer here and I hope the Foundation’s fund-raising goes from strength to strength.”
Wonderful Fundraising

Once again, fund-raisers continue to surprise and impress with their incredible imagination and commitment. Everyone involved with the Sir Bobby Robson Foundation is very grateful and here is just a small selection of the wonderful activities undertaken in the past year.

Help from famous names and high profile Patrons help to keep the charity in the public eye but it is the sheer volume of donations and fund-raising events which enables the Sir Bobby Robson Foundation to continue its work.

In the last year, snooker legends Jimmy White and Tony Drago played a match at Newcastle’s Labour Club in front of an enthusiastic crowd. This is the second year Jimmy has travelled to the north east to help the charity.

The Tyneside Irish Society raised over £4,000 through its Emerald Ball at St James’ Park, while the 2 Toots Scooter Club rode out in the rain to remember veteran scooter rider Kenny ‘Jasper’ Crown.

The dvd ‘A Knight to Remember’ continues to sell and has already raised an amazing £95,000 and a group of cyclists undertook a coast to coast with a difference starting in Chile and ending in Argentina.

A fund-raising darts marathon was held in memory of Dot Severn and her daughter, Sue Bowes. It is pictured here with Newcastle United footballers Jose Enrique (left) and Fabricio Coloccini.

Football fans from across the region and beyond came together for the third Robson 5s five-a-side tournament and East Coast made a very generous donation to the charity and named a train ‘Sir Bobby Robson.’

Northumbria University students staged ‘A Questoon of Sport’ at St James’ Park, their own version of the popular television quiz show, while Middlesbrough fans played a match at the Riverside which raised more than £10,000.

Local band the Longsands released their version of Tyneside anthem the Blaydon Races and Newcastle councillor Dipu Ahad was sponsored to climb to Everest base camp.

Fans of Sunderland AFC and Newcastle United played each other to raise funds for the Sir Bobby Robson Foundation in memory of Jamie Wright from South Shields.

Foottballers Fabricio Coloccini Jose Enrique visited Cramlington Social Club to support the Ladiea Darts Team which had raised money to remember Dot Severn through a 10 hour darts marathon and Sunderland AFC chairman Niall Quinn visited Barclays bank staff in Sunderland to wish them well as they raised money with a wide variety of activities.

In Billingham a pie and pea supper in memory of Pamela Mason- Pooley raised over £4,000 and the first Sir Bobby Robson Foundation Celebrity Golf Day organised by the Robson family generated phenomenal support at beautiful Rockcliffe Hall Hotel, Durham, from all of the charity’s Patrons and football clubs from across the region.

Lady Elsie with Yarm’s Paul Robinson

Lady Elsie enjoyed meeting the ladies of Durham’s Inner Wheel Club at their annual Inter Club Meeting and she also met Paul Robinson from Yarm who had cycled his BMX across Britain in memory of his father.

Councillor Dipu Ahad preparing to climb to Everest base camp using the University of Northumbria’s environmental chamber
Newcastle Hospitals is an integral part of city life. I value the economic contribution the Trust and University Faculty of Medicine bring to the city. Not only through the many staff directly employed, but also in the large number of construction and other jobs flowing from the ‘Transforming our Hospitals’ programme and developments like the Institute of Transplantation at the Freeman - the first of its kind in the UK. The reputation of the Trust and Faculty see the city benefit greatly from large numbers of students who spend locally and help foster international, community and business relations. The city is proud we can retain many of the graduates too, enhancing the skilled labour force.

I am also pleased to see the clinical reputation of the Trust maintained this year and was happy to support them as part of the national review of children’s congenital heart surgery. The Trust has worked well with Councillors (including through scrutiny) and shared information, as requested, with communities.

This is a period of significant change in health. Despite the Coalition’s much vaunted ‘listening exercise’, proposals in the Health and Social Care Bill remain broadly the same. Over the next few years we will see a lot of organisational change, including more freedom for Foundation Trusts and local Health and Wellbeing Boards being established to plan local services. The Bill sees the Council taking on a stronger leadership role in promoting partnership working, integrating services in health, social care and public health and we fully intend to work with...
all providers, like Newcastle Hospitals, to secure the best of services for local people. Regardless of the Bill, my cabinet colleagues and I had already prioritised the reduction of health inequalities by taking a fresh look at the wider determinants of health. We will also be establishing a Future Needs Assessment to be the foundation of all council policy formulation. We look forward to working with Trust colleagues on their evidence base of what works for patients and what more could be done.

On a day-to-day basis the Council and Trust work well together at key points in the lives of families. We have avoided, for example, the problems of so called ‘bed blocking’ which is beginning to be seen elsewhere. In Newcastle our well-established multi-disciplinary teams provide support to patients on discharge and recently our re-ablement service has ensured local people are getting more intense support if they need it. I look forward to further developing our integrated services offer with the Trust particularly as they have, since April 2011, taken on community-based services previously provided by the Newcastle Primary Care Trust.

Councillor Nick Forbes
Leader, Newcastle City Council

The reputation of the Trust and Faculty see the city benefit greatly from large numbers of students who spend locally and help foster international, community and business relations
Despite the challenges of an increasingly difficult economic environment and a period of significant change in the NHS, Newcastle Hospitals has continued to excel – putting patients at the very heart of its plans to provide healthcare of the highest possible standard.

There have been several important developments during the year. Most importantly the trust carried out a lot of preparatory work to enable it to take over the management and delivery of community health services as from 1 April 2011. This involved the transfer of over 1300 community based staff from Newcastle Primary Care Trust.

Community and hospital based services have come together in a move that will undoubtedly help improve the quality, efficiency and sustainability of services and create a more seamless pathway of care for patients in the city of Newcastle upon Tyne.
Work has also continued to develop the Trust’s state-of-the-art facilities with the New Victoria Wing at the Royal Victoria Infirmary now fully operational and the relocation of the national Severe Combined Immunodeficiency Syndrome Unit into the Great North Children’s Hospital which all in all is a world class facility available to children from across the North East and beyond.

The Institute of Transplantation at the Freeman Hospital is also nearing completion and will again provide another world class facility for Newcastle, firmly positioning the North East as a centre of excellence in the field of transplantation. A timely achievement as the Trust this year celebrates over 40 years of transplant success.

Of course, none of these exciting developments would be possible without the continued hard work and commitment of every single member of staff at Newcastle Hospitals, who along with Trust Governors and the public membership can be justifiably proud of their organisation’s performance.

Looking ahead, the NHS must continue to deliver quality and efficiency improvements and with a history of strong leadership, excellent performance and dedicated staff, Newcastle Hospitals is very well placed to meet this challenge.

David Stout OBE
NHS North East
**Medical Physics**
Professor Alan Murray
Clinical Director until January 2011
retired July 2011
Dr Callcott
Clinical Director from February 2011
Mr Gordon Kirkup
Dietary Manager until July 2011

**Musculoskeletal Services**
Dr Lesley J Kay
Clinical Director
Maiza Bayley
Dietary Manager from September 2011
Mr Ben Richards
Dietary Manager from July 2010

**Metabolic Bone Disease:**
Dr Terry Aspray
from March 2011
Dr Wendy M Carr
Professor Roger M Francis
repeated February 2011

**Orthopaedic & Trauma Surgery:**
Mr John R Andrews
Mr William H Blues
Mr Nigel T Brewster
Mr Peter J Briggs
Mr Jonathan Corkish
Mr Antoine de Gheldere
from July 2010
Professor David J Deehan
Mr Paul V Pearson
Mr David Fender
Mr Craig G Gerrard
Mr Mike J Gibson
Mr Andrew C Gray
Mr Munawar A Hashmi
Mr Philip D Herman
Mr Jim P Holland
Professor Andrew W McCozie
Miss Shona A Murray
Mr Paul L Sandersen
Malik S Siddique
Mr Paul R Stuart
Mr Richard N Villar
Mr David J Weir
Mr John R Williams
Mr Peter Watlock

**Rheumatology:**
Dr Fraser N Birell
Professor Helen E Foster
Mr Paul J M Irwine
Dr Bridget Griffiths

**Neurology:**
Dr Matthew L Grove
Professor John D Issacs
Dr Sherina Jashid
from July 2011
Dr Dina Jayachandran
from April 2010
Dr Lesley J Kay
Dr Alice Lorentz
from October 2011
Dr Andrea Myers
Dr Wai P Ng
Dr Pamela Peterson
Dr Philip N Pratt
Dr Richard J Reece
Dr Martin P Ryseu
Dr David J Walker

**Neurosciences**
Dr Anil R Ghokh
Clinical Director
Mrs Rebecca Mercer
Dietary Manager

**NEUROPHYSIOLOGY:**
Dr Kirttie Anderson
Professor David Bates
repeated April 2010
Professor David J Burn
Professor Paul P Chinnery
Dr Peter G Cleland
Dr Paul J Dorman
Dr Martin E Duddy
Dr Paul Goldsmith
Dr Grainne Gorman
Dr Laura A Graham
Professor Timothy D Griffiths
Dr Joe V Guedes
Dr Yvonne M Hart
from April 2010
Dr Rita Horvath
from December 2010
Dr Margaret J Jackson
Dr Richard E Jones
Dr James A L Miller
Dr Philip P Nichols
Professor Helen Rodgers
Dr Andrew M Schaefer
Dr Osheek A Seidi
Professor Douglass M Turnbull
from Tim J Wallis
Dr Naomi M Warren
from January 2011
Dr Tim J Williams

**NEURODIAGNOSIS:**
Dr H Ming Lai
Dr Ian J Schofield
Dr Roger G Whittaker

**Ophthalmology:**
Dr Daniel Burchill
Dr David J A Butteries
Dr Anil R Ghokhar
Dr Vijay J Jayakrishnan
Dr Dip Mitra
Dr Zoe C Morris
from September 2010

**Neurosurgery:**
Prof Param S Bhatharhi
Mr Peter J Crawford
repeated April 2011
Mr John S Crossman
Mr Christopher J Gerber
from May 2011
Mr Alastair J Jenkins
Professor A M Abdelwahed
Mr Patrick Mitchell
Mr Justin J Nissen
Mr Nicholas Ross
Mr Robin P Sengupta
Mr Nick V Todd
from October 2011
Dr Guy A Wynne-Jones

**Oncology**
Dr Hamish R Paterson

**Plastic Surgery/Ophthalmology/Dermatology**
Mr Richard H Miller
Clinical Director (of Plastic Surgery/Ophthalmology) until May 2010
Dr Janet McLelland
Clinical Director (of Dermatology) until May 2010
Dr Janet McLelland
Clinical Director (of Plastic Surgery/Ophthalmology/Dermatology) from June 2010

**Review of the Year 2010/2011**
Mr Peter Worlock
Mr David J Weir
Mr Andrew C Gray
Mr Tony Currie
Mr Mohammed A M R Elbadawy
Mr Carol Gray
from August 2011
Mr John Hill
Mr Wolfgang Lassing
Mr Ian J M Johnson
Mr David Meikle
Mr Vinodh Paleri
Mr Arunesh Sil
from May 2011

**Otolaryngology, Head & Neck Surgery**
Mr Sean Carne
Clinical Director
Mrs Jean Appelgard
Dietary Manager
Mr Sean Carne
Mr Mohamed A E M R Elbadawy
Mr Carol Gray
from August 2011
Mr John Hill
Mr Wolfgang Lassing
Mr Ian J M Johnson
Mr David Meikle
Mr Vinodh Paleri
Mr Arunesh Sil
from May 2011

**Peri-Operative & Critical Care Services**
FREEMAN:
Dr Philip J M Bayly
Clinical Director
until November 2010
Dr Karen J Beacham
Clinical Director
from December 2010
Miss Kath Martin
Dietary Director
from April 2011
Mr Andrew Watson
Dietary Director
from February 2011
Dr Vicky J Addison
Dr Heather Allen
Dr Helen L Anderson
Dr Phil J M Bayly
Dr Karen J Beacham
Dr Geoff Bedford
Dr Jim H Carter
Dr Ahmad D Chishti
Dr Joe F Coagrove
Dr David M Creasy
Dr Neeraj R K Siddique
from April 2010

**Paediatric Surgery**
Mr David P Carr
Clinical Director (of Plastic Surgery/Ophthalmology/Dermatology) until May 2010
Dr Janet McLelland
Clinical Director (of Dermatology) until May 2010
Dr Janet McLelland
Clinical Director (of Plastic Surgery/Ophthalmology/Dermatology) from June 2010
Mrs Sue Cook
Acting Manager (of Plastic Surgery/Ophthalmology/Dermatology) until May 2010
Mrs Margaret Gray
Dietary Manager (of Ophthalmology) until May 2010
Mrs Margaret Gray
Dietary Manager (of Plastic Surgery/Ophthalmology/Dermatology) from June 2010

**DERMATOLOGY:**
Dr Rupert M Barry
repeated June 2011
Dr Hilary G Benbow
Dr Anne-Marie Egeset
from April 2011
Professor Peter M Farr
Dr Ben S Frankel
from March 2011
Dr Kate S Gittins
Dr Philip J Hampton
Dr James Lamptey
Dr Clifford M Lawrence
repeated December 2010
Dr Suzy N Leech
Dr Janet McLelland
Dr Lucinda McWhor
Dr From May 2011
Dr Muzaffar A Md Hanifat
Dr Simon J Worrall
Dr Christopher R Murray
from April 2011
Professor Nick J Reynolds
Dr Caroline Sharp
Dr Kate A Short
Dr E Lucy Speight
Dr Aileen B Taylor

**OPTOMETRY:**
Dr Imran Ashqad
Mr Eric A Barnes
Mr Michael K Birch
Mr Andrew C Browning
Mr Tuij T Changlani
Dr Lucy O Clarke
from February 2011
Mr Mike P Clarke
Dr David G Cottrell
Miss Mags R Dayan
Miss A Jane Dickenson
Mr Francesco C D Figueredo
Mr Paul G Griffiths
Mr Rajen Gupta
Dr Sat J Palota
Ms Zoe K Johnson
Dr Rajeev Kak
Mr Christopher C R Neoh
Dr Ranjeet P Pandit
Mrs Neeta Raychaudhuri

**Microbiology:**
Dr Patricia J Cleave
Dr Angela Gallonary
repeated March 2011
Professor F Kate Gould
Dr Ali B Hames
from May 2010
Dr Shan Mannal
Dr Samuel E Moses
from April 2010
Mr Manjuha Narayanan
Dr Tamin F B W neatly
Dr Muhammad Raiza
Dr Julie Samuel
from September 2011
Dr Jayanta Sarma
Dr David Tate
from January 2011

**Pathology:**
Dr Dafydd P Jones
Professor A M Abdelwahed
Dr Brendan P Johnstone
Dr Richard J Reece
Dr Martin P Ryseu
Dr David J Walker

**Dermatology:**
Dr Alistair J Jenkins
Professor A M Abdelwahed
Mr Patrick Mitchell
Mr Justin J Nissen
Mr Nicholas Ross
Mr Robin P Sengupta
Mr Nick V Todd
from October 2011
Dr Guy A Wynne-Jones

**Occupational Health**
Dr Hamish R Paterson

**Plastic Surgery/Ophthalmology/Dermatology**
Mr Richard H Miller
Clinical Director (of Plastic Surgery/Ophthalmology) until May 2010
Dr Janet McLelland
Clinical Director (of Dermatology) until May 2010
Dr Janet McLelland
Clinical Director (of Plastic Surgery/Ophthalmology/Dermatology) from June 2010

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Dietary Manager until July 2011

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Mr William H Blues
Mr Nigel T Brewster
Mr Peter J Briggs
Mr Jonathan Corkish
Mr Antoine de Gheldere
from July 2010
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Mr Paul V Pearson
Mr David Fender
Mr Craig G Gerrard
Mr Mike J Gibson
Mr Andrew C Gray
Mr Munawar A Hashmi
Mr Philip D Herman
Mr Jim P Holland
Professor Andrew W McCozie
Miss Shona A Murray
Mr Paul L Sandersen
Malik S Siddique
Mr Paul R Stuart
Mr Richard N Villar
Mr David J Weir
Mr John R Williams
Mr Peter Watlock

**Rheumatology:**
Dr Fraser N Birell
Professor Helen E Foster
Mr Paul J M Irwine
Dr Bridget Griffiths

Dr Manoj Valappil
Dr Katherine E Walton
Dr Shelia Waugh

**Neuropathology:**
Dr Abhijit R Joshi
from April 2010
Dr Tuomo M Pohjolakki

**Oral Pathology:**
Dr G Mac Robinson

**Infection Control & Preventive Medicine**
Dr Alistair G Gascoigne
Director until August 2011
Dr D Ashley Price
Director from September 2011
Professor F Kate Gould
Dr Marijunga Nanayanan
Dr Mohammad Raza

**Clinical Biochemistry:**
Dr Harish K Datta
Dr David McClure
repeated March 2011
Dr R Desmout G Neely
Dr Hilary J Worrell
repeated April 2011

**Cytology:**
Dr Sarah J Johnson
Dr Viney Wadehra

**Haematology:**
Dr Peter J Casey
Professor Matthew P Collin
Dr Jane S Conn
Professor Andrew G Hall
Dr John P Hanley
Professor Graham H Jackson
Dr Gail L Jones
Dr Patrick J L Kesterven
Dr Anni L Letensad
Dr Tobias P Morene
from October 2010
Dr Sneema Nair
from November 2010
Professor Stephen G O’Brien
Professor Stephen J Proctor
Dr Suthir S Ramasinghe
from April 2011
Dr Kate L Talks
Dr Jonathan P Wallace
Dr Chris Williams

**Microbiology:**
Dr Victoria J Cleave
Dr Angela Gallonary
repeated March 2011
Professor F Kate Gould
Dr Ali B Hames
from May 2010
Dr Shan Mannal
Dr Samuel E Moses
from April 2010
Mr Manjuha Narayanan
Dr Tamin F B W neatly
Dr Muhammad Raiza
Dr Julie Samuel
from September 2011
Dr Jayanta Sarma
Dr David Tate
from January 2011

Presented to Parliament pursuant to Schedule 7, paragraph 25(4) of the National Health Service Act 2006
Our Vision
To be ‘the health service for Newcastle’ and a leading national healthcare provider

Aims
- To put patients at the centre of all we do, providing the safest and highest quality health care
- To be the healthcare provider for Newcastle and a national specialist centre
- In partnership with Newcastle University Faculty of Medical Sciences and others to be nationally and internationally respected for our successful clinical research and development programme which leads to benefits in healthcare and for patients
- To maintain financial viability and stability
- To promote healthy living and lifestyles

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

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.
Chief Executive’s Statement

Our fifth year as an NHS Foundation Trust has served to demonstrate what a successful NHS Foundation Trust can bring about.

A service portfolio encompassing local, regional and national commitments has gone from strength to strength. The scope of innovation and an enhanced infrastructure, whether it be a local Health Centre or the most sophisticated centre offering advanced treatment technology, is our raison d’être. Quality of outcome and satisfaction in meeting the expectation of the patients we serve is the overriding consideration in all that we do.

Newcastle Hospitals are, when reflecting upon a plethora of benchmarks and standards, proud to be amongst the very best of NHS providers of service. Having said that we can always do better and our skilled and highly committed workforce is determined to do so.

The economic downturn is an understood and very real challenge for a public benefit corporation to effectively and openly address. The year has involved a series of actions being taken by the Board of Directors to not only sustain but enhance our reputation as a robust going concern.

The following milestones are also of such significance that it would be remiss not to highlight these:

- Closure of Newcastle General Hospital as part of Year 5 of the Transforming Newcastle Hospitals Investment Programme and as a consequence the refreshed presentation of state of the art infrastructure at the Royal Victoria Infirmary
Quality of outcome and satisfaction in meeting the expectation of the patients we serve is the overriding consideration in all that we do

- ‘Go Live’ of the Newcastle eRecord - a national first
- Significant momentum in the renaissance of the Newcastle General Hospital site as the Campus for Ageing & Vitality
- The envisaged change that shall be brought by the Health & Social Care Bill will we believe serve to reinforce and recognise excellence
- The Council of Governors manifesto ‘Better Together’ gaining acceptance as the platform to bring much needed change in the organisation and delivery of Community Health Services.
- Our partnership working with Newcastle University in our joint venture ‘Newcastle Biomedicine’.

In line with extant practice we shall publish a detailed ‘Review of the Year 2010/11’ including the Annual Report & Accounts, which shall serve to inform the Annual General Meeting scheduled for 28th September 2011.

Sir Leonard Fenwick
Chief Executive
2 June 2011
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 Primary Care Organisations 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 1.15 million patient contacts, comprised of 114,000 inpatients, 97,500 daycases and 945,500 outpatients. There were 7,062 births under our care. More than 131,000 people attended for urgent or emergency care in our Accident & Emergency Department and Walk-In Centres. We carried out 256 organ transplants, over 3,200 heart operations and replaced 1,385 joints.

Business Review

All in all, another satisfactory trading year can be advised of with the platform established to enter into our sixth 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 98.7% against a target of 98%.

(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 2011, the position was 93.3% and 96.8% respectively.

Within the 18 week referral to treatment target, the milestones for diagnostic assessment, outpatients and inpatients were all fully met throughout the year.

(iii) Cancer Waiting Times (31 and 62 days)

Targets fully met. Against a target of 98% in relation to 31 days (from referral to subsequent drug treatment) and 85% in relation to 62 days the end of year position was 99.2% and 88.6% respectively. Against a screening target of 90% within 62 days, the Trust achieved 98.4%.

b) Care Quality Commission (CQC) Annual Performance Ratings

The Care Quality Commission discontinued the national performance ratings in 2010. In the last year in which ratings were available, the Trust achieved ‘Excellent’ for both Quality of Care and Use of Resources, the same as in the previous year.

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 2010/11 originally predicted a Financial Risk Ratio (FRR) for the year of 4, with a ‘Green’ rating for both Governance and Mandatory Services. With the agreement of Monitor, this was revised to a FRR of 3 for Quarters 3 and 4, to reflect a deliberately planned reduction in Earnings Before Interest, Tax and Amortisation (EBITDA) in order to allow deferral of PFI support income into the 2011/12 financial year.

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. For Mandatory Services, a ‘Green’ rating shows compliance with all of Monitor’s requirements, while ‘Amber’ indicates a breach of one requirement and ‘Red’ a breach of two or more requirements.

<table>
<thead>
<tr>
<th></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>3</td>
</tr>
<tr>
<td>Governance</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
</tr>
<tr>
<td>Mandatory Services</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
</tr>
</tbody>
</table>

For MRSA bacteraemias, against a target for the year of no more than 12 cases the Trust had just 8 cases

The membership of the Board of Directors in the course of the year can be found below in the chapter entitled ‘Board of Directors’.
d) **Other Indicative Measures of Quality in the National Setting**

(i) **CHKS 2010 Top 40 Hospitals Programme**

Named as one of 4 trusts within the CHKS Top 40 for an eleventh consecutive year.

(ii) **National Inpatient Survey 2010 - (Adult Inpatients)**

The results highlighted many positive aspects of the patient experience. The majority of patients reported that:

- Overall: rating of care was good/excellent 92%
- Overall: doctors and nurses worked well together 94%
- Doctors: always had the confidence and trust 87%
- Hospital: room or ward was very/fairly clean 98%
- Hospital: toilets and bathrooms were very/fairly clean 96%
- Hospital: hand-wash gels visible and available for patients and visitors to use 95%
- Care: always enough privacy when being examined or treated 90%
- Surgery: risks and benefits clearly explained 84%

The Inpatient survey is currently repeated on an annual basis. The 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 86 questions were used in both the 2009 and 2010 surveys. Compared to the 2009 survey, the Trust is significantly better on 7 questions, significantly worse on 0 questions, and the scores show no significant difference on 79 questions.

The questions where the Trust has improved significantly are (lower scores are better):

<table>
<thead>
<tr>
<th>Question</th>
<th>Average</th>
<th>Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital: bothered by noise at night from other patients</td>
<td>38 %</td>
<td>31 %</td>
</tr>
<tr>
<td>Hospital: room or ward not very or not at all clean</td>
<td>3 %</td>
<td>1 %</td>
</tr>
<tr>
<td>Hospital: toilets not very or not at all clean</td>
<td>5 %</td>
<td>2 %</td>
</tr>
<tr>
<td>Discharge: not fully told of danger signals to look for</td>
<td>43 %</td>
<td>35 %</td>
</tr>
<tr>
<td>Discharge: family not given enough information to help</td>
<td>54 %</td>
<td>45 %</td>
</tr>
<tr>
<td>Discharge: did not receive copies of letters sent between hospital doctors and GP</td>
<td>31 %</td>
<td>20 %</td>
</tr>
<tr>
<td>Overall: no posters/leaflets seen explaining how to complain about care</td>
<td>37 %</td>
<td>29 %</td>
</tr>
</tbody>
</table>

(iii) **National Staff Survey 2010**

The findings of the survey were summarised and presented in the form of 38 key findings which were structured around the four pledges to staff in the NHS Constitution, which was published in January 2009 as follows:

- **Pledge 1:** To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.
- **Pledge 2:** To provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed.
- **Pledge 3:** To provide support and opportunities for staff to maintain their health, well-being and safety.
- **Pledge 4:** To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

<table>
<thead>
<tr>
<th>Year</th>
<th>Response Rate</th>
<th>Trust</th>
<th>National Average</th>
<th>Trust</th>
<th>National Average</th>
<th>Improvement on last year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009/10</td>
<td>49%</td>
<td></td>
<td>55%</td>
<td></td>
<td></td>
<td>53%</td>
</tr>
<tr>
<td>2010/11</td>
<td>53%</td>
<td></td>
<td></td>
<td>51%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The results highlight many positive aspects of staff experience. The overall indicator of staff engagement shows the following score:

- Overall: rating of staff engagement 3.64

This score is higher than the average for acute trusts which was 3.62. Possible scores range from 1 to 5, with 1 indicating staff are poorly engaged (with their work, team and Trust) and 5 indicating highly engaged.

We can always do better and our skilled and highly committed workforce is determined to do so

The top four ranking scores percentage of staff (average for acute trusts shown in brackets) highlighting the key findings for which the Trust compares most favourably with other acute Trusts in England:

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receiving health and safety training in last 12 months</td>
<td>93%</td>
<td>(80%)</td>
</tr>
<tr>
<td>Receiving equality and diversity training in last 12 months</td>
<td>76%</td>
<td>(41%)</td>
</tr>
<tr>
<td>Saying hand washing materials are always available</td>
<td>74%</td>
<td>(67%)</td>
</tr>
<tr>
<td>Witnessing potentially harmful errors and near misses or incidents in the last month (Lower score better)</td>
<td>31%</td>
<td>(37%)</td>
</tr>
</tbody>
</table>

These are very encouraging scores and of particular note is the response in regard to hand washing materials. This is very clearly aligned to the key Trust objective of promoting infection control.

The bottom four ranking scores (average for acute trusts shown in brackets) where the Trust compared least favourably with other acute Trusts, were:

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff using flexible working options</td>
<td>56%</td>
<td>(63%)</td>
</tr>
<tr>
<td>Trust commitment to work-life balance</td>
<td>3.24</td>
<td>(3.38)</td>
</tr>
<tr>
<td>Support of immediate line managers</td>
<td>3.50</td>
<td>(3.61)</td>
</tr>
<tr>
<td>Staff job satisfaction</td>
<td>3.41</td>
<td>(3.48)</td>
</tr>
</tbody>
</table>

While such scores are disappointing, it is of note that within the question set the first question asked related to ‘flexitime’. It is relevant to note that while the Trust does have a Flexible Working policy which is utilised by a significant number of staff across a range of options, the policy does not provide the choice of formal ‘flexitime’ working arrangements. These are however available at a local, operational level within many departments in the Trust.
Comparison to previous survey

**Improved Staff Experience**

This section highlights the four Key Findings where staff experiences have improved the most since the 2009 survey. This summary is very encouraging, in particular the improvement in staff receiving appraisals and personal development plans. The score for the 2009 staff survey is shown in brackets.

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>2011</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff appraised with PDP in last 12 months</td>
<td>63%</td>
<td>(46%)</td>
</tr>
<tr>
<td>Percentage of staff appraised in the last 12 months</td>
<td>78%</td>
<td>(61%)</td>
</tr>
<tr>
<td>Percentage of staff having equality and diversity training in last 12 months</td>
<td>76%</td>
<td>(52%)</td>
</tr>
<tr>
<td>Impact of health and well being on ability to perform work or daily activities (Lower score better)</td>
<td>1.52</td>
<td>(1.56)</td>
</tr>
</tbody>
</table>

**Deteriorating Staff Experience**

This section highlights the Key Finding that has deteriorated at the Trust since the 2009 survey.

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>2011</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work pressure felt by staff</td>
<td>3.07</td>
<td>(2.96)</td>
</tr>
</tbody>
</table>

As an observation, this is the only area where staff experience has deteriorated from the previous year’s survey, and compared to other acute Trusts is better than average. This may not be greatly surprising in view of the current economic climate and the challenges the Trust faces in respect of meeting a range of demands. The CQC suggests such factors could be used as the starting point for any local improvement action an employer may wish to take.

An action plan has been developed to address these areas in the course of 2011.

e) **Caseload Trends and Throughput (Using FCEs)**

   (i) **Overall Activity**
   - In patient and day case elective activity = 6.52% (7,869 patients)
   - Non elective inpatients = 9.44% (7,180 patients)
   - New outpatients = 10% (25,495 patients)
   - All outpatients = 4.1% (37,480 patients)
   - A&E and Walk in Centre activity = 3.3% (4,244 patients)

   (ii) **Key Specialty Trends**
   - Liver transplants ↑ 3% (1 patient)
   - Bone marrow transplants ↑ 34.3% (45 patients)
   - Heart operations (CABGs and PCIs) ↓ 1.3% (42 patients)
   - Cataracts ↓ 1.8% (151 patients)
   - Number of IVF cycles started ↓ 14.1% (139 patients)
   - Number of renal dialysis sessions ↑ 1.0% (453 sessions)
   - Births ↑ 5.7% (379 deliveries)

(f) **Key Indicators**

For MRSA bacteraemias, against a target for the year of no more than 12 cases the Trust had just 8 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 two health centres in partnership with local GPs, one at Ponteland Road, Newcastle, the other at Battle Hill, 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 2010/11.

The Trust also holds shares in and is represented on the Boards of NewGene Limited, which markets novel genetic tests to other NHS bodies; and Pulse Diagnostics Limited, which is seeking to commercialise an invention for the non-invasive detection of Peripheral Vascular Disease.

**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 satisfactory (at 3 out of 5, where 5 is lowest risk), all key financial targets were met and a modest 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.

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). The Board ensures compliance with the Terms of Authorisation, the NHS 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 committees 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 governor members or 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 organisational benefits to be had from the Newcastle eRecord project. Growth rates 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, MRSA bacteraemia and achievement of the 18 Weeks Referral to Treatment target. All of these targets were met
- Continuing uncertainty about the allocation of funding streams relating to Education and Training, compounded by the difficulties arising from the amalgamation of these streams into a single, bundled, sum and hence concealing the breakdown into the original three streams for service costs underpinning training (SIFT), multi- professional education and training (MPET) and non-medical education and training (NMET)
- Planning for the economic downturn generally and the Unitary Payment for TNH specifically, while maintaining financial strength

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
Delivering the Joint Venture with UPMC and maximising the benefits arising out of the Newcastle Electronic Record

Implementation of government policy on Equitable Access and ‘vertical integration’, where proposals to provide care in community settings could, if not delivered by the Trust itself, result in disinvestment and loss of income. In fact, the Trust has been very successful in establishing two healthcare centres in partnership with local GPs under the Equitable Access programme.

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</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin and Clerical</td>
<td>2159</td>
<td>18.92%</td>
</tr>
<tr>
<td>Allied Health</td>
<td>714</td>
<td>6.26%</td>
</tr>
<tr>
<td>Ancillary</td>
<td>1058</td>
<td>9.27%</td>
</tr>
<tr>
<td>Building and Maintenance</td>
<td>101</td>
<td>0.89%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>1011</td>
<td>8.86%</td>
</tr>
<tr>
<td>Nursing and Midwifery - Qualified</td>
<td>3717</td>
<td>32.57%</td>
</tr>
<tr>
<td>Nursing and Midwifery - Unqualified</td>
<td>1023</td>
<td>8.96%</td>
</tr>
<tr>
<td>Professional and Technical/Scientific</td>
<td>1629</td>
<td>14.27%</td>
</tr>
<tr>
<td><strong>Trust Total</strong></td>
<td><strong>11412</strong></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>7592</td>
<td>66.53%</td>
</tr>
<tr>
<td>Part Time</td>
<td>3820</td>
<td>33.47%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>8769</td>
<td>76.84%</td>
</tr>
<tr>
<td>Male</td>
<td>2643</td>
<td>23.16%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disabled</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>3707</td>
<td>32.48%</td>
</tr>
<tr>
<td>Not recorded</td>
<td>7605</td>
<td>66.64%</td>
</tr>
<tr>
<td>Yes</td>
<td>100</td>
<td>0.88%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>389</td>
<td>3.41%</td>
</tr>
<tr>
<td>Black</td>
<td>78</td>
<td>0.68%</td>
</tr>
<tr>
<td>Chinese</td>
<td>41</td>
<td>0.36%</td>
</tr>
<tr>
<td>Mixed</td>
<td>47</td>
<td>0.41%</td>
</tr>
<tr>
<td>Not known</td>
<td>445</td>
<td>3.90%</td>
</tr>
<tr>
<td>Other</td>
<td>304</td>
<td>2.66%</td>
</tr>
<tr>
<td>White</td>
<td>10108</td>
<td>88.57%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>15-24</td>
<td>801</td>
<td>7.02%</td>
</tr>
<tr>
<td>25-34</td>
<td>2628</td>
<td>23.03%</td>
</tr>
<tr>
<td>35-44</td>
<td>3004</td>
<td>26.32%</td>
</tr>
<tr>
<td>45-54</td>
<td>3378</td>
<td>29.60%</td>
</tr>
<tr>
<td>55-64</td>
<td>1520</td>
<td>13.32%</td>
</tr>
<tr>
<td>65-74</td>
<td>81</td>
<td>0.71%</td>
</tr>
</tbody>
</table>
Sickness Absence Data

The table below shows on a quarter by quarter basis the sickness absence rates in 2010/11 as a percentage of total staff, for each staff group:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Apr 10 to Jun 10</th>
<th>Jul 10 to Sep 10</th>
<th>Oct 10 to Dec 10</th>
<th>Jan 11 to Mar 11</th>
<th>Apr 10 to Mar 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin and Clerical</td>
<td>3.28%</td>
<td>3.11%</td>
<td>3.69%</td>
<td>3.44%</td>
<td>3.38%</td>
</tr>
<tr>
<td>Allied Health Professions</td>
<td>2.68%</td>
<td>2.27%</td>
<td>3.07%</td>
<td>2.54%</td>
<td>2.64%</td>
</tr>
<tr>
<td>Ancillary</td>
<td>5.89%</td>
<td>5.84%</td>
<td>5.76%</td>
<td>6.24%</td>
<td>5.93%</td>
</tr>
<tr>
<td>Building and Maintenance</td>
<td>3.00%</td>
<td>4.35%</td>
<td>4.18%</td>
<td>4.44%</td>
<td>3.99%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>1.01%</td>
<td>0.86%</td>
<td>0.91%</td>
<td>1.07%</td>
<td>0.96%</td>
</tr>
<tr>
<td>Nursing and Midwifery - Qualified</td>
<td>4.03%</td>
<td>3.68%</td>
<td>4.29%</td>
<td>4.59%</td>
<td>4.15%</td>
</tr>
<tr>
<td>Nursing and Midwifery - Unqualified</td>
<td>5.30%</td>
<td>6.59%</td>
<td>6.94%</td>
<td>6.84%</td>
<td>6.42%</td>
</tr>
<tr>
<td>Professional and Technical</td>
<td>3.06%</td>
<td>2.68%</td>
<td>3.47%</td>
<td>3.13%</td>
<td>3.08%</td>
</tr>
<tr>
<td><strong>Trust Total</strong></td>
<td><strong>3.64%</strong></td>
<td><strong>3.52%</strong></td>
<td><strong>4.03%</strong></td>
<td><strong>4.05%</strong></td>
<td><strong>3.81%</strong></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.
Informing Our Staff

The Trust is committed to engaging with staff at all levels and has various forums and groups including the Trust Consultative Group, Employment Partnership Forum, Policies and Procedures group, Equality and Diversity group and SHA networking groups, which all have management and staff side membership, where discussions concerning strategic and other Trust matters take place in partnership.

The Trust holds monthly communications meetings which heads of departments and senior managers attend. Minutes of these meetings are available for all staff and information is cascaded through departmental heads to staff in all directorates and departments.

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 weekly 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 10. 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 childcare 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, and this also enables discussion about professional developments, priorities, and the development of nursing and nursing practice.

A Nurses in Specialist Roles meeting takes place on a quarterly basis, 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.

During 2010 an additional ‘Nursing Staff Engagement Forum’ has been established, in line with the Trust’s Nursing Strategy (Proud of Nursing and Midwifery in Newcastle – A Strategy for Success 2010-13) for all Nursing staff below band 7. This provides a forum for presentation and discussion of key issues that are important to staff at Ward level, and ensures awareness of these issues at a senior level in the organisation.

A Nursing and Midwifery Newsletter (N&M News) is produced bimonthly, and also the regular quarterly Infection Prevention and Control Newsletter for all staff.

The Trust’s annual Nursing and Midwifery Conference is now in its thirteenth year, and is a well established event in the Trust’s Calendar. The event, which allows the sharing of best practice and networking, is well attended and evaluated.

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.

Involving Our Staff

The Trust Consultative Group is the primary forum through which the Board seeks the views of staff, via their representatives, when making decisions likely to affect their interests. The Consultative Group 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.
Sustainability / Climate Change

The Board is conscious of the role of the Trust as a major employer in the North East and of the consequent impact made upon the environment. In this regard, the major operational sites all receive their electrical supplies from Combined Heat and Power engines which are certified to be of such efficiency that they are not liable for the Climate Change Levy. The Trust has a full-time Energy Manager and designated ‘energy champions’ in every work area. There is an active ‘green transport’ policy, aimed at encouraging staff and visitors to use public transport where possible, or to cycle to work. Newcastle Hospitals is a member of the Carbon Trust.

The Department of Health released ‘Saving Carbon, Improving Health’ in May 2008. This was in essence the response to the emerging Climate Change Bill and the targets set by the global Kyoto Treaty of 1997. There were several suggested targets, which need to be satisfied by all NHS bodies, and these included:

- **2009** All NHS organisations to have a Board-approved carbon management plan (CMP). The Trust has signed up to the NHS Carbon Management Programme and the CMP was endorsed in September 2009.
- **2010** All NHS bodies to have a Board-approved sustainable travel plan (the Trust has had this in place for four years).
- **2010** All Trusts to reduce ‘greenhouse gas’ emissions by 15% based on 2000 emissions. An energy management strategy has been developed in order to achieve this.
- **2012** NHS to recycle 75% of its waste. A Waste Management Officer was appointed in anticipation of the target and efforts to encourage recycling of both ‘commercial’ and ‘domestic’ materials have been stepped up.
- **2015** All new buildings to be low carbon. Design standards and specifications have been redrafted to enable this.
Waste Management

Successful tender for new Trust-wide all inclusive non-clinical waste contract (SITA UK).

- Cost savings (based on 2009-10 waste services) in excess of £120,000 per year.
- All “black bag” waste diverted from landfill and now goes to Energy from Waste facility (reducing our environmental impact and saving CO₂).
- All brand new waste compaction and baling equipment provided and fully maintained.

Increased recycling rates

- Cardboard bale production has more than doubled (no increase in waste, just better segregation). Each bale makes the Trust £20 and saves us £30 in putting the cardboard into the general waste (£50 per bale!)
- Mixed recycling has been introduced to office areas at RVI and will continue into clinical areas of the RVI. Recycling is free. The more recycling we take out of the black bag waste stream the more we save.

Shredding our confidential waste with Shred-It meant that we saved over 1,500 trees from destruction in 10/11.

- Shred-It send the shredded paper off to UK paper mills who use it in paper production, reducing the need for paper from felled trees.

Battery Recycling Trust-wide

- Introduced last year. Small 5L tubs in waste battery producing areas. Free service sourced by Waste Officer - previously at cost.

Fluorescent Tube Recycling

- Recycling at cost for years. Approximately 3,000 tubes per year at each site (£8,000 total in 2009-10). Free service now used, sourced by Waste Officer in 2010.

Waste Electrical and Electronic Equipment (WEEE) Recycling

- Mandatory recycling since 2007, but at cost of £20-30,000 per year. Free service in use from late 2010, sourced by Waste Officer.
- Using Sharpsmart Reusable Containers - saving CO₂
- The Trust uses the Sharpsmart reusable sharps disposal system instead of the traditional one-use disposable boxes. This is much more environmentally friendly and saves us over 300 tonnes of CO₂ each year (due to the reuse of the container and the reduction in weight of waste sent for incineration).

Maternity Glass Recycling at RVI

- Introduced in April 2011. 52,000 small glass bottles from post-natal baby feed now recycled each year.
**Energy Management**

- Commissioned checking and maintenance of all steam traps in Trust retained Estate (saves energy).
- Track Energy Markets on a weekly basis to ensure Trust get the best deal possible on gas prices for Combined Heat & Power (CHP).
- Re-lagging large stretches of chilled water pipework to reduce thermal bridges (saves energy).
- Long-term plans to renew the Building Management System at both RVI/Freeman Hospital. Potential for 5%+ savings on annual bill.
- Received VAT back from energy provided to PFI building. Worth approximately £350,000 per year (backdated to last year).
- Working on PFI energy consumption targets (not currently achieving contractual usage).

**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 one 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 11,000 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.

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

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

(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 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 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 2010/11 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 January 2011, 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.

During the period 1st April 2010 to 31st March 2011, there were 11 ordinary meetings of the Board of Directors and one extraordinary meeting.
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 Date</th>
<th>Background</th>
<th>Ordinary meetings</th>
<th>Extra-ordinary meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr D Allison, Chief Operating Officer (COO)</td>
<td>Appointed 1st May 2007 (as Business &amp; Development Director; appointed COO from 1st November 2009)</td>
<td>Commercial and Regional Development Agency background</td>
<td>10</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Professor P H Baylis, Non-Executive, Senior</td>
<td>Independent Director and Deputy Chairman: Appointed 1st June 2006, term expired 31st May 2008; re-appointed 19th January 2009 for three years</td>
<td>Former Pro Vice Chancellor, Faculty of Medical Sciences, University of Newcastle upon Tyne</td>
<td>10</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Professor C P Day, Non-Executive</td>
<td>Appointed 1st April 2008 (term of office up to 5 years at discretion of University of Newcastle upon Tyne)</td>
<td>Pro Vice Chancellor, Faculty of Medical Sciences, University of Newcastle upon Tyne</td>
<td>8</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Dr B C Dobson, Non-Executive</td>
<td>Appointed 1st October 2010 for three years</td>
<td>International Chemical Industries background</td>
<td>6 (of 6)</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Mrs P Dodds, Non-Executive</td>
<td>Appointed 1st June 2006, term expired 30th October 2008 but extended by Council of Governors; retired 31st October 2010</td>
<td>Retired Civil Service Personnel Manager</td>
<td>7 (of 7)</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Mrs A Dragone, Finance Director</td>
<td>Appointed 9th March 2009</td>
<td>Career NHS Accountant and Finance Manager</td>
<td>10</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Councillor D Faulkner, Non-Executive</td>
<td>(from 1st September 2006); stepped down 21st September 2010</td>
<td>Local Authority Councillor/Deputy Leader, Newcastle City Council</td>
<td>3 (of 4)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Sir Leonard Fenwick, Chief Executive</td>
<td>Career NHS Manager</td>
<td>10</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr J Kirkby, Non-Executive</td>
<td>Appointed 1st June 2008 for three years</td>
<td>Retired Public Sector Accountant</td>
<td>10</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Ms S Kler, Non-Executive</td>
<td>Appointed 1st November 2010 for three years</td>
<td>Housing Association and Primary Care Trust background</td>
<td>4 (of 5)</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Mrs H Lamont, Nursing and Patient Services Director</td>
<td>(appointed 1st April 2009)</td>
<td>Career NHS Nurse and Manager</td>
<td>10</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Mrs H A Parker, Non-Executive</td>
<td>Appointed 1st June 2006, term expired 31st May 2008; re-appointed 1st June 2008 for three years</td>
<td>Commercial Property Lawyer</td>
<td>8</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Mr K W Smith, 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)</td>
<td>Former Treasurer then Chief Executive of Durham County Council; Adviser to global Japanese company NSK</td>
<td>11</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Mrs S Stewart, Non-Executive</td>
<td>Appointed 19th January 2009 for three years; resigned 31st May 2010</td>
<td>Independent Marketing and Communications Consultant</td>
<td>1 (of 2)</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Dr T J Walls, Medical Director</td>
<td>Appointed 1st April 2006</td>
<td>Consultant Neurologist, former Clinical Director - Neurosciences</td>
<td>11</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Mr E Weir, Non-Executive</td>
<td>Appointed 1st October 2010 (term of office annual, renewal at discretion of Newcastle City Council)</td>
<td>Director of Adult and Culture Services, Newcastle City Council</td>
<td>4 (of 5)</td>
<td>n/a</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 2010/11, the Committee was chaired by Mr J Kirkby. 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 Trust and its auditors.

Five meetings, including one extraordinary meeting, were held between 1st April 2010 and 31st March 2011 and attendance was as follows:

<table>
<thead>
<tr>
<th></th>
<th>Ordinary</th>
<th>Extraordinary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor P H Baylis, Non-Executive Director</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Mr J Kirkby, Non-Executive Director (Committee Chair)</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Mrs H A Parker, Non-Executive Director</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. The Council of Governors approved a 12-month extension to that contract on 20th May 2010.

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**Actively pursuing the Equality, Diversity and Human Rights Agenda also helps to address inequalities by ensuring inclusive approaches to recruitment and employment**
The Trust has a total of 37 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 the Quality, Innovation, Productivity and Prevention (QIPP) initiative and the proposal by Northumbria Healthcare NHS Foundation Trust to build a Specialist Emergency Care Hospital on the outskirts of Cramlington, a few minutes drive from the Trauma Centre at the Royal Victoria Infirmary, Newcastle.

In the course of May 2010 elections were held, for those Governorships where the three-year terms of office were due to expire by 31st May 2010 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. These were reflected in the restructuring of the work of Governor interest groups, which were reformed into the following Working Groups, each 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.

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.

There was significant and productive engagement in a special meeting in August 2010, at which Governors considered the NHS White Paper and its implications for the Trust.

Governors also continued the programme of 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:

- Walkergate Hospital
- Royal Victoria Infirmary:
  - Dermatology services
  - Women’s services
- Freeman Hospital:
  - Renal & Urology services

The Patients’ Food Tasting Panel continued its sterling work and visited patient care areas at Newcastle General Hospital, Freeman Hospital, the Royal Victoria Infirmary and Walkergate Hospital, 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, Headquarters Office, 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 of Directors engages with the membership through mail-outs or mass emailings. In the past year there was significant interest in the NHS White Paper, in the latest phases of the Transforming Newcastle Hospitals Investment Programme, including the opening of the Great North Children’s Hospital; and in the acquisition of the Community Health Services for Newcastle.
There was significant and productive engagement in a special meeting in August 2010, at which Governors considered the NHS White Paper and implications for the Trust

Governor Elections

In the course of 2010/11 there was a round of elections occasioned by the expiry of original terms of office and some resignations. Elections were held as follows:

<table>
<thead>
<tr>
<th>May 2010</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3 seats in Public Constituency 1 (Newcastle upon Tyne)</td>
<td>2 candidates stood and were returned unopposed</td>
</tr>
<tr>
<td>3 seats in Public Constituency 2 (Northumberland Tyne &amp; Wear exc. Newcastle)</td>
<td>8 candidates stood</td>
</tr>
<tr>
<td>Two existing governors were re-elected (Mrs H S Abrahams, Mrs G Haigh)</td>
<td>Turnout 41%</td>
</tr>
</tbody>
</table>

1 vacancy carried forward to the 2011 elections.

In the Staff elections, Mr R Nuttall was returned unopposed in the Ancillary & Estates Constituency and Miss E Houliston was returned unopposed in the Volunteers Constituency.
Governors by Constituency (number of Council of Governors meetings attended shown in brackets)

### Constituency 1

**Newcastle upon Tyne**

**Elected Public Governors**
- Ms Y Cookson (1 of 5)
- Dr J Court (1 of 6)
- Mrs J Donnelly (6 of 6)
- Mr E Green (to 31st May 2010) (0 of 1)
- Ms S Harvey (6 of 6)
- Miss G Jones (5 of 5)
- Professor J Potts (6 of 6)
- Mrs E Randall (to 31st May 2010) (1 of 1)
- Dr G Sanders (3 of 6)
- Mrs S A Webster (2 of 6)

### Constituency 2

**Former Northumberland, Tyne and Wear Strategic Health Authority area (excluding Newcastle)**

**Elected Public Governors**
- Mrs H S Abrahams (4 of 5)
- Professor F Arthur (5 of 6)
- Mr P Atkinson (5 of 6)
- Mrs G Haigh (3 of 6)
- Mrs M A Hargreave (6 of 6)
- Mr M J R Harvey (6 of 6)
- Ms V Hayden (3 of 5)
- Mrs N Kenny (to 31st May 2010) (1 of 1)
- Mr P Ramsden (5 of 6)
- Mrs D Staley-Bush (3 of 6)
- Mr C Venables (4 of 6)

### Constituency 3

**Former County Durham & Tees Valley Strategic Health Authority area and former Cumbria & Lancashire Strategic Health Authority area and beyond**

**Elected Public Governors**
- Mr J Bedlington (5 of 6)
- Dr A G M Johnson (4 of 6)
- Dr L N S Murthy (6 of 6)
- Revd Dr M Saunders (4 of 6)

### Elected Staff Governors

**Medical and Dental**
- Mr A Welch (3 of 6)

**Nursing and Midwifery**
- Ms E Coghill (5 of 6)
- Mrs B Crittenden (0 of 6)

**Health Professions Council**
- Dr M Holliday (4 of 6)

**Administrative & Clerical, Management and Hospital Chaplains**
- Mr P Brigham (2 of 6)

**Ancillary and Estates**
- Mr R Nuttall (5 of 5)

**Volunteers**
- Miss E Houliston (5 of 5)

### Appointed Governors

**Newcastle Primary Care Trust (PCT)**
- Ms G Tiller, Chair of NHS North of Tyne (3 of 6)

**PCTs within Northumberland, Tyne & Wear SHA other than Newcastle PCT**
- Dr M Prentice, Chair of Professional Executive Committee, Gateshead PCT (0 of 6)

**PCTs within County Durham and Tees Valley/Cumbria and Lancashire SHA**
- Mrs Pat Taylor, Co Durham PCT (0 of 6)

**Newcastle City Council**
- Councillor E Langfield (0 of 6)

**University of Newcastle upon Tyne**
- Professor A Burt, Dean of Clinical Medicine (1 of 6)

**University of Northumbria at Newcastle**
- Professor A Wathey, Vice Chancellor and Chief Executive (1 of 6)

**Trust Community Advisory Panel**
- Mrs M Hallam (2 of 6)

**North East Assembly (abolished September 2010)**
- Mr P Briggs (2 of 2)

**Pentagon Partnership (community and voluntary sector)**
- Mr R Venus (4 of 6)
Nominations Committee

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 Jane Donnelly (Chair of the Committee), Mr M J Harvey, Professor J Potts, Revd Dr M Saunders) and supported by Trust officers. Attendance is set out in the table below.

<table>
<thead>
<tr>
<th>Name</th>
<th>Number of meetings attended (out of 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs Jane Donnelly</td>
<td>3</td>
</tr>
<tr>
<td>Mr M J Harvey</td>
<td>3</td>
</tr>
<tr>
<td>Professor J Potts</td>
<td>3</td>
</tr>
<tr>
<td>Revd Dr M Saunders</td>
<td>3</td>
</tr>
<tr>
<td>Mr D Allison, Chief Operating Officer</td>
<td>2</td>
</tr>
<tr>
<td>Mrs A Dragone, Finance Director</td>
<td>2</td>
</tr>
<tr>
<td>Sir Leonard Fenwick, Chief Executive</td>
<td>2</td>
</tr>
</tbody>
</table>

There were three meetings of the Committee in the period 1st April 2010 to 31st March 2011 and the Committee recommended to the Council of Governors the reappointment of the Chairman, Mr KW Smith, for a second term of up to three years (subject to annual review). Following open external advert, the Nominations Committee also recommended to the Council of Governors the appointment of two Non-Executive Directors, Dr B C Dobson and Ms S Kler.
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.

Membership continued to be disappointingly static between 1st April 2010 and 31st March 2011. The target for membership recruitment for the year end was 10,000 public members and at the end of the year the figure for registered public members had fallen from 6,134 to 5,908. It is thought that this decline reflects the demographic skewing towards the older end of the age range. Staff membership stood at just over 3,200. Full details are set out in the table opposite.

 Whilst the membership is relatively balanced from a gender mix perspective, with a male to female ratio of 47.6%: 52.4%, representation from ethnic minority members of the local population (at 4.0%) and the under 21 age group (0.3%) would benefit from targeted recruitment.

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 very few new Members recruited - 246 in the course of 2010/11 but some 472 members were lost in the same period.

The newly formed Membership and Community Relations Working Group has set about developing a revised strategy, with an array of new approaches to increasing the number and also the ethnic and age diversity of Members. The Council of Governors acknowledged the challenges of increasing the Membership and endorsed revised targets for 2011/12 at its November 2010 meeting, of a further 2,215 public and 250 staff, giving a new overall figure of 11,750.

The twice-yearly newsletter for Members facilitated a ‘sign one up!’ campaign, encouraging every member to sign up a family member, colleague or relative. The newsletter will continue to be a key recruiting tool. The Chairman challenged Governors to ‘do their bit’ and promote Membership and offered an incentive to the Governor who had created the largest number of new Members by December 2010. Mr Atkinson took the prize, with 61 new Members.

The first event for Members and the public was held on 31st March 2011 and proved to be a great success, with attendance over-subscribed and several dozen new Members signed up at the event. Existing communications networks across the region with which governors are engaged, particularly charities related to patient care, will also be used as conduits for further promotion.

The Membership application form has been made available at public-facing locations throughout the Trust and the web address for online sign-up (www.nhs-membership.co.uk/nutt) is now 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 or Director 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 was launched in early Summer 2010 and will be revised following the Spring 2011 elections. In addition, Members can use the “General Enquiries” page of the website, which is monitored daily.
The Membership and Community Relations Working Group has set about developing a revised strategy, with an array of new approaches to increasing the number and also the ethnic and age diversity of Members.

Membership Report, 1st April 2010 to 31st March 2011

<table>
<thead>
<tr>
<th>Public Constituencies</th>
<th>Eligible Population</th>
<th>Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>As at 1st April 2010</td>
<td>Total = 6,134</td>
<td></td>
</tr>
<tr>
<td>Newcastle</td>
<td>2,694</td>
<td></td>
</tr>
<tr>
<td>Northumberland etc</td>
<td>2,432</td>
<td></td>
</tr>
<tr>
<td>Co Durham etc</td>
<td>1,008</td>
<td></td>
</tr>
<tr>
<td>New Members</td>
<td>246</td>
<td></td>
</tr>
<tr>
<td>Members leaving</td>
<td>472</td>
<td></td>
</tr>
<tr>
<td>At year end (31st March 2011)</td>
<td>5,908</td>
<td>1,378,853</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff Constituencies</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>As at 1st April 2010</td>
<td>3,170</td>
<td></td>
</tr>
<tr>
<td>New Members</td>
<td>209</td>
<td></td>
</tr>
<tr>
<td>Members leaving</td>
<td>157</td>
<td></td>
</tr>
<tr>
<td>At year end (31 March 2011)</td>
<td>3,222</td>
<td>11,412</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>
<th>Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-16</td>
<td>Not applicable - minimum age = 18</td>
<td></td>
</tr>
<tr>
<td>17-21</td>
<td>18</td>
<td>73,795</td>
</tr>
<tr>
<td>22+</td>
<td>5,259</td>
<td>1,305,058</td>
</tr>
</tbody>
</table>

Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Eligible Population</th>
<th>Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>5,517</td>
<td>1,342,787</td>
</tr>
<tr>
<td>Mixed</td>
<td>24</td>
<td>7,080</td>
</tr>
<tr>
<td>Asian</td>
<td>170</td>
<td>20,644</td>
</tr>
<tr>
<td>Black</td>
<td>34</td>
<td>2,406</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>6,873</td>
</tr>
</tbody>
</table>

Socio-Economic Groupings

<table>
<thead>
<tr>
<th>Socio-Economic Groupings</th>
<th>Eligible Population</th>
<th>Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC1</td>
<td>3,903</td>
<td>477,330</td>
</tr>
<tr>
<td>C2</td>
<td>1,014</td>
<td>168,577</td>
</tr>
<tr>
<td>D</td>
<td>155</td>
<td>218,698</td>
</tr>
<tr>
<td>E</td>
<td>776</td>
<td>226,586</td>
</tr>
</tbody>
</table>

Gender Analysis

<table>
<thead>
<tr>
<th>Gender</th>
<th>Eligible Population</th>
<th>Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>2,797 (47.6%)</td>
<td>668,532</td>
</tr>
<tr>
<td>Female</td>
<td>3,077 (52.4%)</td>
<td>711,073</td>
</tr>
</tbody>
</table>
1. Financial Performance

The Trust continues to demonstrate a strong financial base and a surplus of £124,000 and a ‘Financial Risk Rating’ of ‘3’ was reported for 2010/11.

The financial stability of the Trust does stand it in good stead to address the impact of economic downturn in the funding of public services and all that entails. There remains an underlying strength and hence the opportunity for capital investment to progress further innovation and in particular to derive the benefits which are available from the integration of community services.

2. Income

The presenting caseload exceeded contracts to the value of almost £15 million. The greatest proportion of this increased demand is driven by patients in the North East locality who exercise patient choice, and this is undoubtedly driven by quality of patient care and outcome considerations. However there are also increasing proportions of activity from patients outside of the local catchment area, in many cases testimony to the skill and reputation of Newcastle Hospitals and the skilled and specialist workforce.

Further specialist services continue to develop in scope and volume. In particular this year brought exceptionally
high levels of service requirement in areas as diverse as Bone Marrow Transplant; Ventricular Assist Devices (VADs); and Infectious Diseases. The Trust also received additional Department of Health funding to assist in dealing with the impact of influenza pressures in year.

It is to be noted that the level of private non NHS fee paying patient income was £4.2 million. This is 0.6% of total patient care income and hence well within the regulated upper limit of 1.2%.

3. Expenditure

As highlighted in previous years nationally determined pay awards and enhanced conditions of service proved to be inflationary on the Trust and have placed pressure on the cost base. Whilst every endeavour has been taken to exercise constraint in staff expenditure this has always been done with full regard for clinical safety and treatment outcomes.

We continue to challenge ways of working, managing down the value of premium payments required to ensure the delivery of waiting times and access targets, and driving productivity gains in the clinical workforce. This will be an on-going focus in 2011/12.

Given the economic environment some reduction in the number of established posts is contemplated and wherever possible this will be achieved via natural wastage.

Non pay expenditure reflected the volume of patient activity and the distinctly enhanced investment in programmes designed to reduce the risk of healthcare acquired infection. As a Foundation Trust this has all been brought about without external financial support.

Non-recurrent and unplanned income gains have provided for investment opportunity and enabled additional expenditure in the estate and IT infrastructure to address the future needs of the organisation.

4. Capital Expenditure Plans

Capital expenditure in 2010/11 exceeded £45.8 million.

A number of major strategic building projects progressed towards completion during this financial year. Most significant was the Institute of Transplantation (overall value £30 million). This is due for occupation in late 2011 and will fulfil the ambition to provide a world class infrastructure here in the North East serving local and national catchments, all of this being in line with the Department of Health determination to increase transplantation uptake by no less than 50%. Other key developments saw the building of a Midwifery Led Unit and a contribution to the building of the Biomedical Research Centre, a venture in partnership with the University of Newcastle on the Campus for Aging and Vitality which is focused on translating research into practice, predominantly in the field of Elderly Care.

Planning was also approved for the building of a primary care partnership facility at Walkergate Hospital and this is a further opportunity for the Trust to invest in the primary care infrastructure supporting the ‘Better together’ philosophy. This aims to develop the interface and integrate working relationships with primary care practices and also to provide a range of diagnostic facilities for patients in the east of the City.

There was further investment in the organisational infrastructure, including ward refurbishments and upgrades. A major refurbishment of the Dental Conservation clinic (£1.08m) was completed as well as the purchase of a wide range of clinical care and treatment technologies, both new and replacement.

The overall strategic intention of our 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 £30.6 million with £27 million of new savings identified on a recurrent basis. This exceeded planned expectations.

As we look to the future the requirement for sustained and demanding efficiencies will be a challenge to all public bodies. This national efficiency agenda has served to focus the organisational effort. Given the economics of the NHS and the anticipation of minimal growth the expectation is that a much higher proportion of the future savings requirement must come from reductions to the cost base and productivity gains rather than from contributions and economies which arise from income growth and a more pro-active trading.

In this environment 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 the commitment and understanding that is being shown.

Efforts to eliminate waste and to make savings in areas which do not have a detrimental impact on the direct delivery of patient care and treatment continue to be first and foremost in the minds of healthcare professionals. Savings continue to be provided from on-going tendering and procurement rationalisation; staffing reviews; and a wide range of smaller opportunities delivered at ward and department level are the focus of very detailed attention.

6. The Balance Sheet

In common with other NHS bodies the assets of the Trust were re-valued on 31st March 2011 to reflect a change in the national building cost index. The effect of this re-
valuation was to increase asset values by a net £7,562k with the impact of this reflecting predominantly in the Revaluation Reserve. This is material and equates to a 1.26% increase in the value of closing assets.

The closing year end cash balances at 31st March 2011 were £53.9 million. This balance provides strength and resilience as we move into a more uncertain NHS economy.

In conclusion 2010/11 was a year of expansion and income growth in a very difficult financial environment. This necessitated tight cost control and the delivery of a demanding efficiency programme structured to enhance productivity and ensure value for money.

7. Operational Future

The medium term financial environment is less than certain. As a Foundation Trust there is no choice but to meet the challenge of reduced income whilst continuing to deliver improved quality, and ensure compliance with contractual commitments and financial targets.

In addition to the expectation of the most challenging efficiency requirement ever in the history of the NHS and the additional constraint on Tariff payment mechanisms in relation to the 30% emergency Tariff and non-payment of emergency re-admissions, there is an expectation that an increasing percentage of the annual income uplift will come to be based on the delivery of quality objectives and indicators. Further the indication that a rising proportion of the income will be offered non recurrently brings a distinct challenge.

The more effective engagement of the GP commissioner is welcomed and seen as an opportunity to enhance the benefits of Vertical Integration and the engagement in community services.

We remain focused on financial stability and a business model which anticipates vibrant growth, increased market share and a truly effective partnership with primary care. Following the acquisition of Newcastle Community Services from 1st April 2011 (value £52m) we are well placed to thrive in this area.

There are a number of issues which require the on-going focus of the Trust.

The opportunity for Vertical Integration and all this entails is of great interest to this Trust and one which we have pursued with enthusiasm. We have gained experience at first hand of the primary care delivery setting through two successful ‘Equitable Access’ initiatives and in pursing a working partnership with Newcastle City Council should provide the platform to bring about genuinely ‘joined up’ service delivery.

In relation to Education and Training funding there is fundamental concern that Department of Health and SHA reviews of training levies shall result in funding reductions from 2011/12 onwards. Such an imposed funding loss will prove to be highly problematical to accommodate without adverse knock on consequences for the Trust hence every endeavour will need to be taken to secure legally binding contracts that embrace all aspects of MPET.

In terms of NHS Research and Development (R&D) funding streams, in conjunction with Newcastle University we are actively seeking to be more successful and grow output including relevant translational research. The knock on consequence for the Trust/Faculty of Medical Sciences will be an escalating cost improvement requirement.

8. In Summary

The Trust continues to deliver to all financial targets and this is testimony to the enormous efforts we have made in the past few years to improve operational efficiency and 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 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 remains confident of maintaining the long established record of sound financial management and provision of a service portfolio with esteem.
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.

**Chairman and Non-Executive Directors**

**Chairman**  
Mr K W Smith  
None

**Non-Executive Directors**

Professor P H Baylis  
None

Professor C P Day  
Pro Vice Chancellor, Faculty of Medical Science, University of Newcastle upon Tyne  
Council Member, Academy of Medical Sciences, Medical Research Council  
Trustee, Alcohol Education and Research Council  
Executive, Medical Schools Council

Dr B C Dobson  
None

Mrs P M Dodds  
None

Councillor D Faulkner  
None

Mr J Kirkby  
None

Ms S Kler  
None

Mrs H A Parker  
Member of Sintons Limited Liability Partnership (Solicitors)  
Chair of Three Rivers Housing Association Ltd

Mrs S Stewart  
None

Mr E Weir  
Director, Adult & Culture Services, Newcastle City Council

**Executive Directors**

Sir Leonard Fenwick CBE  
Chairman and Trustee, St Mary Magdalen & Holy Jesus Trust  
Chief Executive  
Chairman and Trustee, Freemen of the City of Newcastle upon Tyne  
Director, Newcastle NE1 Limited

Mr D Allison  
Chairman, NewGene Limited (55% owned by Trust)  
Chief Operating Officer  
Director, Freeman Clinics Limited (80% owned by Trust)  
Executive Director, Pulse Diagnostics Limited (Trust is a majority shareholder)

Mrs A Dragone  
Director, Freeman Clinics Limited (80% owned by Trust)  
Finance Director  
Director, NewGene Limited  
Secretary, Newcastle Healthcare Charity

Mrs H Lamont  
Trustee, Heath Committee  
Nursing & Patient Services Director

Dr T J Walls  
Director, Freeman Clinics Limited (80% owned by Trust)  
Medical Director  
Director, Crossco (1080) Limited (dormant company)
Statement of Chief Executive’s Responsibilities as Accounting Officer of The Newcastle upon Tyne Hospitals NHS Foundation Trust

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 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 Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts (‘Monitor’).

Under the 2006 Act, 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; and
- Prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the 2006 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
2 June 2011
Annual Governance Statement

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.

1. Scope of responsibility

The Board of Directors is accountable for internal control. As Accounting Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation’s policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation’s assets for which I am personally responsible as set out in the Accounting Officer Memorandum. This Statement on Internal Control (SIC) covers the period 1st April 2010 to 31st March 2011, i.e. for the fourth full financial year in which the Trust has been licensed as an NHS Foundation Trust and thus subject to the requirements of the regulatory regime of Monitor, the Independent Regulator of NHS Foundation Trusts.

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.

The Trust works as required with the Strategic Health Authority (SHA) for the North East and with organisations such as the NHS North of Tyne Commissioning Board (albeit a non-statutory body) and the Department of Health National Commissioning Group to agree objectives and targets. These are monitored through the Performance Assessment Framework and by Monitor.

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 directly accountable 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.

The risks are shared with and informed by the joint planning and governance arrangements with respective commissioners, as well as Monitor, the North East SHA, the Department of Health and a substantial range of external agencies and regulatory bodies.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control has been in place in The Newcastle upon Tyne Hospitals NHS Foundation Trust for the period commencing 1st April 2010 and up to the date of approval of the Annual Report and Accounts for financial year 2010/11.

3. Capacity to handle risk

As Accounting Officer and Chief Executive I have overall

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2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the organisation’s policies, aims and objectives,
- 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 period commencing 1st April 2010 and up to the date of approval of the Annual Report and Accounts for financial year 2010/11.

3. Capacity to handle risk

As Accounting Officer and Chief Executive I have overall
responsible for Risk Management and actively promote good practice across the organisation.

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.
- 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 financial issues.
- The Trust Secretary has responsibility for non-clinical governance matters, including information governance in his role as Senior Information Risk Owner.
- The Chief Operating Officer, in liaison with the Medical Director, has responsibility for the implementation and further development of Risk Management in relation to business continuity, fire, security and related operational and organisational issues.
- 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 organisation of the Corporate Governance Committee, responsible for overseeing and co-ordinating activities within the various Risk Management working groups.

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, an Investment Committee was established, with a remit to ensure that business cases for significant developments were robust, addressed key risks explicitly and would deliver a satisfactory rate of return on the investment made.

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/or 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.

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.

4. The risk and control framework

The Newcastle upon Tyne Hospitals NHS Foundation 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 web-site.

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 into 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.
Wherever possible, opportunities are taken to learn lessons from adverse events and near misses

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.

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 has identified five 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:

- Planned maintenance reporting - this will now rest with the Capital Management Group
- CRB checks for Volunteers - procedures have been reviewed by HR
- Software licensing - an inventory of software in use has been developed and mapped to licenses held
- Physical verification of assets and inventory - a significant exercise was undertaken in Winter 2010 and all items valued at ≥£5,000 identified and checked against inventory
- eRecord audit capability - the solution to this lies in the impending upgrade to PAS version 2010.01.

In addition, the Head of Internal Audit Opinion for 2010/11 did identify the following areas of limited assurance, for all of which robust action plans for remediation and improvement have been put in place:

**Financial**

- Capital – appropriate levels of authorisation for any project overspends

**Non Financial**

- Records Management - the need for a revised and refreshed policy for non-clinical records

**IM&T**

- eRecord Security - automated audit of user login not yet available
- Firewalls/Wireless Network – audit and change control mechanisms to be improved
- Network Continuous Testing - automated antivirus updates instigated; back up restores to be improved; dormant/terminated user accounts to be cleansed
- Disaster Recovery / Business Continuity - dedicated staff resources; Staff awareness and training; completion, maintenance and testing of business impact assessments, business continuity plans and risk assessments.

The Trust did not need to declare any Serious Untoward Incidents with regard to patient confidentiality or data losses in the course of 2010/11.

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

5. Information Governance

**Information Governance Toolkit** - In 2010/11 the Trust achieved an overall rating of 58%, a change of -20% from the Trust’s rating in 2009/10 (78%). However, Version 8 of the Toolkit has more and tighter standards than Version 7 and hence direct comparisons are not valid. Further development of the Information Governance structure within the Trust,
enhancing staff training and understanding of Information Governance and mapping and understanding data flows within the organisation and to external bodies, has been undertaken. In order to satisfy Monitor’s requirements, a Level 2 rating (≥ 50%) needs to be achieved.

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 to Connecting for Health on its achievement of the standards set out in the Information Governance Toolkit. This information is used by Connecting for Health, the Care Quality Commission and the NHS Litigation Authority. Compliance with the IG Toolkit is a requirement for ongoing NHSLA Risk Management standards accreditation and Care Quality Commission assessments of Trust performance.

**Information Governance** - following from the HMRC data loss in late 2007, the NHS was required to carry out a review of data flows across and through the NHS. The Trust provided assurances to Monitor and provided information to the SHA. In the course of 2008/09, an Information Governance Committee was established, in the light of the recommendations contained in the NHS Chief Executive’s letter of October 2008. This Committee reports to the Audit Committee and its minutes are received by the Board of Directors. The key purpose of the Committee was to provide the Board of Directors with appropriate assurance of compliance with the applicable legislation covering information governance matters. The Committee met four times in 2010/11 and with the purpose of highlighting any risk areas and consequent mitigation plans across all operational areas of the Trust which handle data.

The Trust Secretary has been designated by the Board as the Senior Information Risk Owner. In November and December 2009 a comprehensive and cross-cutting review of Information Governance arrangements across the Trust was conducted by an independent, external body. The report on key findings was presented in January 2010 and the Board of Directors briefed in February 2010. This review underpinned the action plan for 2010/11 and the Information Governance Committee took oversight of implementation of the key actions.

**Implementation of Security Software** - the Trust has completed the implementation of Single Sign-on software 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.

**6. 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. Further, the Board affirms that key controls are in place to prepare and publish a Quality Report, as required by the Department of Health. Indeed, the Trust has been a pioneer in this field, participating in the original pathfinding project overseen by Monitor.

The Department of Health also now requires all Trusts to report on implementation of the NHS Carbon Management Plan. Organisations that met the criteria to participate have, from April 2010, to monitor emissions from energy use, report these emissions annually, and purchase and surrender a corresponding number of carbon emission allowances on a cap and trade basis. The Trust has put the appropriate mechanisms in place to fulfill these obligations.

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 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 these legal requirements in the NHS Foundation Trust Annual Reporting Manual. Measures are 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 and these are described in detail in the “Quality” section below.

**7. Review of effectiveness**

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 by the programme of reviews undertaken by Internal and External Auditors; Monitoring of actions related to previous Controls Assurance assessments; the Clinical Audit programme; Care Quality Commission and Strategic Health Authority monitoring of Clinical Governance development; Risk Management assessments by the Clinical Negligence Scheme for Trusts; external benchmarking processes; and a range of inspections by professional bodies and agencies.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors and its sub-committees, including the Audit Committee and Corporate Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The effectiveness of the system of internal control has been maintained and reviewed by the Board of Directors via its sub-committees and individual management responsibilities at Director and Senior Manager level. I am satisfied that this SIC describes a system and approach which remained robust for the period from 1st April 2010 to 31st March 2011 and supports...
preparation of the annual accounts on a going concern basis. Regular reports have been received from sub-committees or individual officers in relation to all of the key risks. Annual reports have been received by the Board of Directors relating to all important areas of activity, and ad hoc reports in-year wherever these were required.

Clinical governance and processes to ensure quality of patient care are overseen by the Clinical Governance and Quality Committee, under the leadership of the Medical Director. Minutes of this Committee were received by the Board of Directors, together with ad hoc reports on specific issues as necessary. An annual report summarises the most significant issues in this area.

The Medical Director had delegated lead responsibility for Risk Management across the Trust. Practical support and co-ordination was provided by the Clinical Governance and Risk Department. Individual Directors and Senior Managers are empowered to assess and manage risks within their own areas of responsibility, linking in closely with the wider Trust processes. Significant support was provided via training, advice and guidance documentation, to enable senior personnel to effectively fulfil this function.

An analysis of controls and assurances in relation to key organisational risks has been undertaken via the Assurance Framework. Underpinning this, the Trust Risk Register has been further developed, to provide a detailed assessment of specific risks in all departments and key functions. The Corporate Governance Committee scrutinised these processes and advised the Board of Directors in relation to the most significant risk and control issues arising from the Assurance Framework and Risk Register. Regular reports from the Corporate Governance Committee have highlighted emerging and developing risks.

In addition to the above processes, the Complaints Panel maintained an overview of the management of complaints, incidents and litigation 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 former Annual Health Check and Clinical Negligence Scheme for Trusts) and informal processes, including those facilitated by the Department of Health, Strategic Health Authority, National Patient Safety Agency, Care Quality Commission, and National Audit Office.

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
2 June 2011
The Newcastle upon Tyne Hospitals NHS Foundation Trust (NuTH) and its predecessor bodies have been providing patient-centred healthcare to communities in the North East of England and beyond for over 250 years.

As one of the largest NHS trusts in the UK, we offer the widest range of specialist services of any Trust in the UK. From newborn babies to the elderly and infirm, our aim is to deliver leading-edge healthcare of the highest quality but with a personal touch.

We put our patients at the heart of everything we do, working for them in a sensitive and compassionate manner whilst protecting their safety and dignity. We value the contribution of staff, volunteers, members, governors and other partners and stakeholders, trusting each other, working collaboratively and professionally and being committed to the development and improvement of skills. We focus upon continuous improvement in the pursuit of excellence whilst seeking and embracing new opportunities and innovations to develop and enhance our clinical services. We manage our resources in a co-ordinated way, with an emphasis on delivering care of the highest quality which is sustainable and delivers the best value in the use of exchequer and non-exchequer funding.

In the Autumn of 2010 we relocated our Emergency Department from the Newcastle General Hospital (NGH) site to the new purpose built facility at the Royal Victoria Infirmary (RVI). This department is one of the busiest in the country, dealing with over 75,000 patients every year. Thanks to the commitment of our staff and cooperation of partner organisations and patients the relocation was very successful. Simultaneously we re-located our Trauma services and the Regional Neurosciences Centre to the RVI. These completed a series of moves planned as part of the Transforming the Newcastle Hospitals Investment Programme (commenced 2006) and, with effect from 1st April 2011, gave us the specialty/sub-specialty reconfiguration necessary to provide Level 1 Trauma Care there. This major reconfiguration, which involved the closure of Acute Services at NGH was brought about smoothly and uneventfully due to the dedication and expertise of our staff.

We are recognised nationally as a centre of healthcare excellence - more than 30% of our patients come from outside of Tyne & Wear. We also treat complex cases referred to us by other hospitals from throughout the UK, from Southern Ireland, from various other countries in Europe including Iceland and from as far afield as the USA and the Middle East.

We are delighted that, on the 31st March 2011, we reached agreement with NHS North of Tyne (representing the three local Primary Care Trusts) to become the provider organisation for community services in the Newcastle area. This initiative complements the Trust manifesto ‘Better Together Vision for Shared Care’, in which we seek, once and for all in the local setting, to bring about a cohesive, vertically integrated, pathway of care for patients from home to hospital and home again. This Quality Account serves to demonstrate our commitment to delivering care of the highest quality. Aspects of our performance in 2010/11 are highlighted together with the priorities for 2011/12.

Sir Leonard Fenwick
Chief Executive
2 June 2011
Statement of assurance from the Board of Directors and Review of the Trust’s position and status on Quality

We aim to put quality at the heart of everything we do and to constantly strive for improvement by monitoring effectiveness. High level parameters of quality and safety have been reported monthly to the Board and Clinical Policy Group, bi-monthly to the Clinical Governance and Quality Committee and to the Council of Governors at each meeting by the Quality & Performance Account. The Quality & Performance Account reports information under the headings of Patient Safety, Clinical Outcomes and Clinical Effectiveness, all of which feature factors relating to the patient experience. Activity is monitored in respect to quality priorities and safety indicators by exception and performance is compared with local and national standards. Leadership walkabouts, coordinated by the Director - Quality and Effectiveness, involving Executive and Non-Executive Directors and members of the Medical Director’s and Director of Nursing and Patient Services’ teams have been regularly conducted in a variety of departments.

Feedback and, where necessary, reports on improvement actions are provided to the Corporate Governance Committee.

2010/11 Performance

Key National Priorities

An overview of performance in 2010/11 against the key national priorities from the Department of Health’s Operating Framework is set out here, addressing the following:

- Improving cleanliness and reducing healthcare-associated infections (HCAIs);
- Improving access;
- Keeping adults and children well, improving health and reducing health inequalities;
- Improving patient experience, staff satisfaction and engagement; and
- Preparing to respond in a state of emergency, such as an outbreak of a new pandemic.

Improving cleanliness and reducing healthcare-associated infections (HCAIs) continues to be of the utmost importance to the Trust as can be evidenced by our continued improved performance in the reduction of hospital acquired infections which is highlighted in this report with significant improvements in the rate of both MRSA and C. difficile during this financial year.

Improved access means more than simply reduced waiting times but encompasses a new approach to delivery of service to patients with an emphasis on flexibility and choice. This has been achieved by proactive and innovative developments in a wide range of trust services which have resulted in improved performance in this area.

The Trust has taken every opportunity to promote health for adults and children whilst reducing health inequalities in the community. This is particularly demonstrated by the community services delivered by the Freeman Clinics and further opportunities will be available in the coming year with the new Newcastle Hospitals Community Services.

The Trust Hospital Standardised Mortality Ratio (HSMR) has been monitored monthly by the Board of Directors. The ratio has ranged during the year between 80.3 and 89.87

Improving patient experience and staff satisfaction is an ongoing process. The latest staff survey has shown some areas of improvement and as outlined above the Trust actions are being planned to further improve staff satisfaction. Developments within the Trust to improve the patient experience include a real time patient feedback project to promote immediate feedback from patients following an episode of care and monitoring of patient comments made on NHS Choices so that appropriate action may be taken.
Trust preparation to be able to effectively respond in the event of an emergency has been reviewed throughout the year for both major incident planning and business continuity with the formation of steering groups and the undertaking of exercises to test policies and procedures. Directorate based business continuity plans have been formulated and have been externally audited to ensure their robustness. Considerable preparations were made for a potential flu pandemic including ensuring accurate and up to date information was available at all times. An extensive programme of staff immunisation was undertaken with large numbers of staff being protected in this way.

Quality Priorities for 2010/2011

Priority 1 - Reduce rate of hospital acquired infection by 25%

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>MRSA bacteraemia</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>MRSA colonisation in hospital</td>
<td>402</td>
<td>236</td>
</tr>
<tr>
<td>C. difficile</td>
<td>304</td>
<td>150</td>
</tr>
</tbody>
</table>

There has been a significant reduction in the number of MRSA bacteraemias acquired in the Trust. The Trust’s internal target of 12 has been fully met, with only 8 bacteraemias being confirmed. The Trust is compliant with the MRSA mandatory screening targets.

There has been a significant decrease in the rate of C. difficile in 2010/11 at 150 cases, in comparison with the 2009/10 total of 304. This has been achieved through the diligence and hard work of staff and exceeds our own internal stretch target of 296 cases.

Priority 2 - Reduce incidence of patient falls by 10% and the number of incidents resulting in major or catastrophic occurrences by 10%.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Patient Falls</td>
<td>2649</td>
<td>2727</td>
</tr>
</tbody>
</table>

Whilst it is disappointing that we have been unable to demonstrate a sustained reduction in the total number of falls related incidents a wide variety of measures aiming at reducing falls have been implemented in year and the final quarter of 2010/11 did see the lowest reported number of falls incidents. The Trust has implemented a variety of initiatives, as recommended by the National Patient Safety Agency (2007) and the Patient Safety First Campaign (2009), These include:

- a new falls assessment and intervention tool which has been modified following a trial period and which was fully implemented by the summer of 2010
- the production of a comprehensive training package
- the development and approval of the Management and Prevention of Slips, Trips and Falls policy and development of the Falls Reduction Strategy
- the successful application for funding to undertake a study relating to the use of slip resistant footwear in the Internal Medicine and Elderly Care Directorate

Evidence from the Patient Safety First Campaign (2009), suggests that any initiatives on patient falls can create increased awareness that leads to better reporting and therefore an apparent increase in falls incidents. Any such apparent increase in falls is most likely to be seen in the category of insignificant falls as these are the most commonly unreported incidents. This may explain our current position as the actual number of falls reported has increased although we can demonstrate a small reduction in harm.

Quality Priorities for 2010/2011

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Number of Patient Falls Incidents graded as minor or above</td>
<td>1473</td>
<td>1314</td>
</tr>
<tr>
<td></td>
<td>56%</td>
<td>49%</td>
</tr>
<tr>
<td>Number of patient falls incidents graded as insignificant</td>
<td>1176</td>
<td>1413</td>
</tr>
<tr>
<td></td>
<td>44%</td>
<td>51%</td>
</tr>
</tbody>
</table>
Priority 3 - Reduce the Trust Hospital Standardised Mortality Ratio (HSMR) to less than or equal to 75.

The Trust HSMR has been monitored monthly by the Board of Directors. The ratio has ranged during the year between 80.3 and 89.87. Although we are disappointed that we have been unable to reduce the HSMR the Trust is in a very favourable position and has one of the lowest ratios when compared with other hospitals both locally and nationally, although there has been a slight increase during the year.

We recognise that we set a challenging target for 2010/11. It has been very difficult to monitor trend in HSMR over time as the calculations were rebased in mid year resulting in a sudden upward shift in the ratio. The table below, sourced from the NHS Choices website, illustrates how NuTH compares with other acute hospitals in the region. Our overall mortality rate is indicated as being well below the National average in the ‘dr foster® Hospital Guide 2010’.

We aim to put quality at the heart of everything we do and to constantly strive for improvement by monitoring effectiveness

Priority 4 - To ensure that all patients have their concerns addressed and are treated with dignity and respect. To increase the proportion of patients who rate their overall experience as very good or excellent.

The National Annual (CQC) Survey of the views of adult inpatients considers the experiences of people who have been admitted to hospital and had at least one overnight stay. The questions in the survey cover the issues that patients consider important in their care. The survey offers an insight into their experiences and this information is used in the assessment of NHS trusts by the CQC.

The summary of results identifies whether the trust score is in the top 20%, mid 60% or lowest 20% of all trusts’ scores.

The report indicates that the Trust:

- is in the best performing 20% of Trusts in 49 out of 64 questions and scored the highest score of all Trusts for the question ‘Did you see any posters or leaflets on the ward asking patients and visitors to wash their hands or to use the handwash gels?’
- is in the intermediate 60% of Trusts for 14 questions
- is in the worst performing 20% of Trusts for just one question (choice of admission date).
The CQC also published the results of a Survey of Maternity Services provided by Trusts in England in December 2010. The survey was undertaken collaboratively with the Picker Institute and indicates how each trust scored on a number of questions compared to national average responses.

Women were eligible to participate in the survey if they had had a live birth between 1-28 February 2010 and were aged 16 years or older. The survey involved 142 NHS acute trusts and two primary care trusts and received responses from more than 25,000 women.

There were 250 respondents from this Trust which is a response rate of 52%. The percentage of women who had previously given birth was 48% with the rest being first time mothers. The highest percentage of respondents were aged 35 and over.

The results were in five broad areas:
- Care during pregnancy (Antenatal care)
- Labour and birth
- Staff during labour and birth
- Care in hospital after the birth (Postnatal care)
- Feeding the baby during the first few days.

The survey results showed that the Trust achieved satisfactory responses for patient satisfaction for this sample of patients with no results in the bottom 20% and two in the top 20% giving an overall score which matched national expectations for Trust performance.

The Trust is in the best performing 20% of Trusts in 49 out of 64 questions and scored the highest score of all Trusts for the question ‘Did you see any posters or leaflets on the ward asking patients and visitors to wash their hands or to use the handwash gels?’
Real Time Patient Feedback Initiative

The Trust is keen to establish a system for real-time patient feedback in all departments and is currently considering a suitable mechanism for this system within the Out patient department setting.

A pilot of this initiative has commenced in two outpatient clinics (General Outpatients and Musculoskeletal) at the Freeman Hospital, by means of touch screen kiosks. A third clinic (ENT, also in Freeman Hospital) was also included but the survey response collection for this clinic is online using a link from the NUTH website.

Priority 5 - Reduce the number of sharps and needle-stick injuries by 10%.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Needlestick Injuries</td>
<td>334</td>
<td>298</td>
</tr>
</tbody>
</table>

The Sharps and Needlestick Injury Prevention Group continues to meet monthly to co-ordinate actions to reduce sharps and needlestick injuries. Although we have met our proposed 10% reduction we will continue to closely monitor the number of incidents in relation to Sharps and Needlestick injury.

The following initiatives have been undertaken to bring about this reduction in incidents:

- introduction of medical devices including safety cannulas, retractable needles and mobile sharps containers
- sharps disposal at the point of care reinforced
- ‘Your Sharp, Your Responsibility’ campaign posters
- A Sharps Prevention week initiative.

The number of sharps and needlestick incidents will continue to be reported monthly in the Quality & Performance Account.

In addition to the priorities highlighted above, other patient safety, clinical outcome and clinical effectiveness parameters are monitored regularly by the Board of Directors, Council of Governors, Clinical Policy Group and Clinical Governance and Quality Committee.

Priorities for 2011/12

Following discussion with the Board of Directors, the Clinical Policy Group, the Council of Governors (on behalf of the Membership which respective governors represent and including the public) and Departmental/Directorate Governance leads the following priorities for 2011/12 have been agreed. These priorities either continue the key themes from 2010/11, or represent those areas which have come to the fore in the public eye, through national consideration.

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 less than 6
- reducing hospital acquired infections related to *Clostridium difficile* (*C.diff.*) to less than 155 cases in the next year.

Reducing HCAI remains one of our highest priorities. Measures to achieve this include providing a clean and safe environment for patients, their relatives and our staff. Healthcare Acquired Infections are caused by a wide range of micro-organisms and, as the term suggests, are associated with medical care and treatment. Numbers of MRSA bacteraemias and *C.Diff.* infections are markers of how effective our infection prevention and control measures are. Reducing the numbers of patients suffering those form of infections indicates that we have good processes in place to minimise the risk of all forms of HCAI.

In hospital we use antibiotics according to well–established guidelines - sometimes to prevent infection (before and after some operations) and sometimes to treat a known infection.
A new falls reduction taskforce has been established

Utilising the expertise of our microbiologists and infection control teams enables us to use the right antibiotics at the right time to ensure they help patients when they need them.

Activity related to reduction of infections will continue to be monitored by the Infection Prevention and Control Committee which includes representation from the Council of Governors. In the near future, it will include colleagues from Newcastle Hospitals Community Health, enabling us to seek to reduce HCAI not only within the hospitals but also in the community.

**Monitoring, Measurement & Reporting**

- reports to the Infection Prevention & Control Committee, Clinical Governance & Quality Committee, Board of Directors and Council of Governors, showing numbers of MRSA bacteraemias and *C.Diff* infections and monthly trends; compliance rates with mandatory screening

**Board Sponsor**

Mrs Helen Lamont, Nursing and Patient Services Director

**Implementation Lead**

Dr Alistair Gascoigne, Director of Infection Prevention and Control
Priority 2 - To demonstrate a reduction in the level of harm caused by patient safety incidents associated with slips, trips and falls, by reducing incidents graded as minor or above by 5% when compared with the severity of incidents reported in 2010/11.

The most frequently reported patient safety incidents are due to falls. Elderly patients are particularly at risk of falls and consequent harm. A proportion of these falls result in major or catastrophic consequences for the patient. The aim of this priority is to reduce the severity of harm resulting from a fall. A new falls reduction taskforce has been established to develop and monitor processes to reduce the incidence and severity of inpatient falls.

Clinical Effectiveness

Priority 3 - To reduce avoidable death, disability and chronic ill health from venous thromboembolism (VTE) by:

- implementing and auditing compliance with the VTE assessment tool
- refining and enhancing the Trust’s VTE prevention policy
- achieving at least 95% compliance with VTE assessment for inpatients.

Venous thromboembolism (VTE) is a condition which strikes rapidly and often silently to cause death or long term problems such as swollen limbs, varicose veins or chronic limb ulcers. In many instances these complications are avoidable. A range of measures to prevent VTE in hospitals have therefore been mandated nationally. One of these is the monitoring and reporting of VTE Risk assessment compliance. A national goal on VTE risk assessment is included within provider CQUIN schemes for 2011-12 to support the work on VTE prevention, linking payment to healthcare providers to achievement of at least 95% of appropriate adult patients being risk assessed for VTE on admission to hospital.

Priority 4 - To implement an Early Warning Score System (this will ensure early recognition and a timely response to effectively manage patients at risk of deterioration in their condition).

Any patient in hospital may become acutely ill. However, the recognition of acute illness is sometimes delayed and its subsequent management may lead to late referral and avoidable admissions to critical care. The implementation of an Early Warning Score System (EWSS) will ensure early recognition and a timely response to effectively manage patients at risk of deterioration in their condition. In turn this will lead to patients receiving ‘the right care at the right time’ and promote clearer decision making and clinical outcomes.

In 2011/2012 we will develop and implement systems to ensure that Early Warning Scores are recorded and actions taken to reduce undetected clinical deterioration.
We believe that patients deserve a service that is individualised, person centred and where staff have a real understanding of what reasonable adjustments are needed to ensure care is safe, equitable and productive.

Priority 5 - To monitor and improve the patient experience by:

- development of pathways specifically for patients with learning difficulties
- enabling responsiveness to the personal needs of patients by evaluating the inpatient experience, based on the Care Quality Commission (CQC) National inpatient survey
- evaluating the outpatient and community patient experience from local surveys.

We believe that patients deserve a service that is individualised, person centred and where staff have a real understanding of what reasonable adjustments are needed to ensure care is safe, equitable and productive. We will strive to improve the care and health outcomes specifically of people with learning disabilities by using reasonable adjustments through the implementation of learning disability care pathways.

Whilst we will monitor responses to all aspects of the National Inpatient Surveys, we will focus specifically on achieving improvements in the scores of the following 5 questions from the CQC adult inpatient survey.

- Were you as involved as you wanted to be (in decisions about your care and treatment)?
- Did you find someone to talk to about worries and fears?
- Were you given enough privacy?
- Were you told about medication side effects to watch for?
- Were you told who to contact if you were worried?

Monitoring, Measurement & Reporting
Review of national inpatient survey; review of local patient experience surveys

Board Sponsor
Mrs Helen Lamont, Nursing & Patient Services Director

Implementation Lead
Mrs Francis Blackburn, Head of Nursing, Freeman and Walkergate Hospitals
Mrs Christine Eddy, Head of Patient Services

Priority 6 - To develop and implement improved pathways and provision of facilities for patients with physical and sensory impairments by:

- enhancing the working relationship with the local representative groups as a source of guidance and advice in relation to any work undertaken
- undertaking a patient experience rolling programme of surveys to review services provided in selected departments across the Trust
- enabling responsiveness to the personal needs of these patients by evaluating patient experience, based on the feedback from the local representative groups.

Monitoring, Measurement & Reporting
Review of local patient experience surveys and other feedback as described

Board Sponsor
Mrs Helen Lamont, Nursing & Patient Services Director

Implementation Lead
Mrs Diane Palmer, Director - Quality and Effectiveness
Representatives of the Council of Governors

Service Provision and Quality of Care
During 2010/11 the Newcastle upon Tyne Hospitals NHS Foundation Trust provided and/or sub-contracted 21 NHS services.

The Newcastle upon Tyne NHS Foundation Trust has reviewed data available to it on the quality of care in all 21 of these NHS services.

The income generated by the NHS services reviewed in 2010/11 represents 100 per cent of the total income generated from the provision of NHS services by the Newcastle upon Tyne NHS Foundation Trust for 2010/11.
Clinical Audits and Enquiries

During 2010/11 52 national clinical audits and six national confidential enquiries covered NHS services that Newcastle Hospitals provides.

During 2010/11 Newcastle Hospitals participated in 84.6% (44) of the 52 national clinical audits and 100% of the six national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Newcastle Hospitals was eligible to participate in during 2010/11 and did participate in were as follows:

<table>
<thead>
<tr>
<th>National Audit issue</th>
<th>Sponsor / Audit</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perinatal mortality</td>
<td>CEMACE</td>
<td>Trust is compliant.</td>
</tr>
<tr>
<td>Neonatal intensive and special care</td>
<td>NNAP</td>
<td>The NNAP dataset and metric definitions require further refinement before the RVI can properly be benchmarked against other services.</td>
</tr>
<tr>
<td>Paediatric pneumonia</td>
<td>British Thoracic Society</td>
<td>No results date yet issued.</td>
</tr>
<tr>
<td>Paediatric fever</td>
<td>College of Emergency Medicine</td>
<td>Results of audit are expected in November 2011.</td>
</tr>
<tr>
<td>Paediatric intensive care</td>
<td>PICANet</td>
<td>Trust is compliant although results not available until November 2011.</td>
</tr>
<tr>
<td>Diabetes</td>
<td>RCPH National Paediatric Diabetes Audit</td>
<td>Audit largely records national figures for HbA1c.</td>
</tr>
<tr>
<td>Emergency use of oxygen</td>
<td>British Thoracic Society</td>
<td>There are certain issues requiring improvement. The original plan was to use ePrescribing for oxygen however it does not work for insulin or warfarin where feedback between a measurement and the prescription is needed so it is not likely to work for oxygen. Suggestions have been drawn up for a paper prescribing record but are yet to be finalised and will require CRAC approval.</td>
</tr>
<tr>
<td>Adult community acquired pneumonia</td>
<td>British Thoracic Society</td>
<td>Work being undertaken to reduce time to CXR (liaising with Radiology) and this is being reaudited locally.</td>
</tr>
<tr>
<td>Non invasive ventilation (NIV) - adults</td>
<td>British Thoracic Society</td>
<td>Awaiting outcome</td>
</tr>
<tr>
<td>Pleural procedures</td>
<td>British Thoracic Society</td>
<td>Trustwide training package in place and ongoing training for medical and nursing staff with plans to roll this out on ESR.</td>
</tr>
<tr>
<td>Vital signs in majors</td>
<td>College of Emergency Medicine</td>
<td>Results of audit are expected in November 2011.</td>
</tr>
<tr>
<td>Adult critical care</td>
<td>Case Mix Programme</td>
<td>Trust is compliant.</td>
</tr>
<tr>
<td>Potential donor audit</td>
<td>NHS Blood &amp; Transplant</td>
<td>The Trust has complied with the audit since it commenced in 2003.</td>
</tr>
<tr>
<td>Diabetes</td>
<td>National Clinical Audit Support Programme</td>
<td>Results of audit are expected in April / May 2011.</td>
</tr>
<tr>
<td>Heavy menstrual bleeding</td>
<td>RCOG National audit of HMB</td>
<td>Audit only recently commenced. Trust is one of the first nationally with the audit in place.</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>National Pain Audit</td>
<td>Phase 2 and Phase 3 to commence during 2011/12.</td>
</tr>
<tr>
<td>Ulcerative colitis &amp; Crohn’s disease</td>
<td>National IBD Audit</td>
<td>A date for publication of the results has yet to be identified.</td>
</tr>
<tr>
<td>Parkinson’s disease</td>
<td>National Parkinson’s audit</td>
<td>Awaiting outcome</td>
</tr>
<tr>
<td>COPD</td>
<td>British Thoracic Society / European Audit</td>
<td>Results of audit are expected in July 2011.</td>
</tr>
<tr>
<td>Adult asthma</td>
<td>British Thoracic Society</td>
<td>The Trust is better, or on a par, with national figures in most respects. There are two areas where Trust could do better. The first is in initial recording of peak flow (a measure of severity of attack) where Trust fell a little below national average. The second was recording checks of inhaler technique.</td>
</tr>
<tr>
<td>National Audit issue</td>
<td>Sponsor / Audit</td>
<td>Outcome</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------</td>
<td>---------</td>
</tr>
<tr>
<td>Bronchiectasis</td>
<td>British Thoracic Society</td>
<td>Trust performed very well. The areas where Trust scored less well reflected local guidelines prior to National Guidelines e.g. Trust checks aspergillus precipitins rather than RAST.</td>
</tr>
<tr>
<td>Hip, knee and ankle replacements</td>
<td>National Joint Registry</td>
<td>Results of audit are still awaited. No date of issue yet identified.</td>
</tr>
<tr>
<td>Elective surgery</td>
<td>National PROMs Programme</td>
<td>In the main, patients report a positive health gain from undergoing one of the four procedures in the Trust. Awaiting outcome</td>
</tr>
<tr>
<td>Cardiotoracic transplantation</td>
<td>NHSBT UK Transplant Surgery</td>
<td>Awaiting outcome</td>
</tr>
<tr>
<td>Liver transplantation</td>
<td>NHSBT UK Transplant Registry</td>
<td>Trust is compliant.</td>
</tr>
<tr>
<td>Coronary angioplasty</td>
<td>NICOR Adult Cardiac interventions audit</td>
<td>Trust continues to perform well with next results due November 2011.</td>
</tr>
<tr>
<td>Peripheral vascular surgery</td>
<td>VSGBI Vascular Surgery Database</td>
<td>Trust is compliant.</td>
</tr>
<tr>
<td>Carotid interventions</td>
<td>Carotid Interventions Audit</td>
<td>Vascular Surgery achieved 100% data entry.</td>
</tr>
<tr>
<td>CAGB and valvular surgery</td>
<td>Adult cardiac surgery audit</td>
<td>Trust is compliant.</td>
</tr>
<tr>
<td>Familial hypercholesterolaemia</td>
<td>National Clinical Audit of Mgmt of FH</td>
<td>Adult clinic is above median on most measures.</td>
</tr>
<tr>
<td>Acute Myocardial Infarction and other ACS</td>
<td>MINAP</td>
<td>No results date yet issued.</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>National Clinical Audit Support Programme</td>
<td>No results date yet identified.</td>
</tr>
<tr>
<td>Pulmonary hypertension</td>
<td>Pulmonary hypertension Audit</td>
<td>No results date yet issued.</td>
</tr>
<tr>
<td>Stroke care</td>
<td>National Sentinel Stroke Audit</td>
<td>Results of audit are expected at end of financial year.</td>
</tr>
<tr>
<td>Renal replacement therapy</td>
<td>Renal Registry</td>
<td>No results date yet issued but compliant in previous audit.</td>
</tr>
<tr>
<td>Renal transplantation</td>
<td>NHSBT UK Transplant Registry</td>
<td>No results date yet issued but compliant in previous audit.</td>
</tr>
<tr>
<td>Patient Transport</td>
<td>National Kidney Care Audit</td>
<td>Results of audit are expected in June 2011.</td>
</tr>
<tr>
<td>Renal colic</td>
<td>College of Emergency Medicine</td>
<td>Results of audit are expected in November 2011.</td>
</tr>
<tr>
<td>Lung Cancer (LUCADA)</td>
<td>National Clinical Audit Support Programme</td>
<td>Results of audit are expected in December 2011.</td>
</tr>
<tr>
<td>Bowel Cancer (NBOCAP)</td>
<td>National Clinical Audit Support Programme</td>
<td>Results of audit are expected in November 2011.</td>
</tr>
<tr>
<td>Head and neck cancer (DAHNO)</td>
<td>National Clinical Audit Support Programme</td>
<td>Results of audit are expected in May / June 2011</td>
</tr>
<tr>
<td>Hip fracture</td>
<td>National Hip Fracture Database</td>
<td>Results of audit are expected in June 2011.</td>
</tr>
<tr>
<td>Severe trauma</td>
<td>Trauma Audit &amp; Research Network</td>
<td>Data completion rates have improved.</td>
</tr>
<tr>
<td>Falls and non-hip fractures</td>
<td>National Falls and Bone Health Audit</td>
<td>No results date yet issued.</td>
</tr>
<tr>
<td>O neg blood use</td>
<td>National Comparative Audit of Blood Transfusion</td>
<td>Results of audit are awaited.</td>
</tr>
<tr>
<td>Dementia audit</td>
<td></td>
<td>The Trust performed well above average in the core audit. A number of service areas were identified for improvement and an action plan has been developed to address these issues.</td>
</tr>
</tbody>
</table>
The national clinical audits and national confidential enquiries that Newcastle Hospitals participated in, and for which data collection was completed during 2010/11, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

<table>
<thead>
<tr>
<th>National Audit issue</th>
<th>Sponsor / Audit</th>
<th>Percentage Data completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perinatal mortality</td>
<td>CEMACE</td>
<td>100%</td>
</tr>
<tr>
<td>Neonatal intensive and special care</td>
<td>NNAP</td>
<td>100%</td>
</tr>
<tr>
<td>Paediatric pneumonia</td>
<td>British Thoracic Society</td>
<td>100%</td>
</tr>
<tr>
<td>Paediatric fever</td>
<td>College of Emergency Medicine</td>
<td>Data collection ongoing although expected to achieve BAEM deadline</td>
</tr>
<tr>
<td>Paediatric intensive care</td>
<td>PICANet</td>
<td>100%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>RCPH National Paediatric Diabetes Audit</td>
<td>100%</td>
</tr>
<tr>
<td>Emergency use of oxygen</td>
<td>British Thoracic Society</td>
<td>100%</td>
</tr>
<tr>
<td>Adult community acquired pneumonia</td>
<td>British Thoracic Society</td>
<td>80%</td>
</tr>
<tr>
<td>Non invasive ventilation (NIV) - adults</td>
<td>British Thoracic Society</td>
<td>100% by the completion deadline</td>
</tr>
<tr>
<td>Pleural procedures</td>
<td>British Thoracic Society</td>
<td>100%</td>
</tr>
<tr>
<td>Vital signs in majors</td>
<td>College of Emergency Medicine</td>
<td>Data collection ongoing although expected to achieve 100% by BAEM deadline.</td>
</tr>
<tr>
<td>Adult critical care</td>
<td>Case Mix Programme</td>
<td>100%</td>
</tr>
<tr>
<td>Potential donor audit</td>
<td>NHS Blood &amp; Transplant</td>
<td>100%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>National Clinical Audit Support Programme</td>
<td>100%</td>
</tr>
<tr>
<td>Heavy menstrual bleeding</td>
<td>RCOG National audit of HMB</td>
<td>N/A</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>National Pain Audit</td>
<td>100% for Phase 1.</td>
</tr>
<tr>
<td>Ulcerative colitis &amp; Crohn’s disease</td>
<td>National IBD Audit</td>
<td>100%</td>
</tr>
<tr>
<td>Parkinson’s disease</td>
<td>National Parkinson’s audit</td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td>British Thoracic Society / European Audit</td>
<td>100%</td>
</tr>
<tr>
<td>Adult asthma</td>
<td>British Thoracic Society</td>
<td>100%</td>
</tr>
<tr>
<td>Bronchiectasis</td>
<td>British Thoracic Society</td>
<td>100%</td>
</tr>
<tr>
<td>Hip, knee and ankle replacements</td>
<td>National Joint Registry</td>
<td>94.5%</td>
</tr>
<tr>
<td>Elective surgery</td>
<td>National PROMs Programme</td>
<td>All procedures participation rate 78.9% (headline participation rate of 65.1%)</td>
</tr>
<tr>
<td>Cardiothoracic transplantation</td>
<td>NHSBT UK Transplant Surgery</td>
<td></td>
</tr>
<tr>
<td>Liver transplantation</td>
<td>NHSBT UK Transplant Registry</td>
<td>100%</td>
</tr>
<tr>
<td>Coronary angioplasty</td>
<td>NICOR Adult Cardiac interventions audit</td>
<td>100%</td>
</tr>
<tr>
<td>Peripheral vascular surgery</td>
<td>VSGBI Vascular Surgery Database</td>
<td>100%</td>
</tr>
<tr>
<td>Carotid interventions</td>
<td>Carotid Interventions Audit</td>
<td>85%</td>
</tr>
</tbody>
</table>

We will monitor responses to all aspects of the National Inpatient Surveys.
The reports of 52 national clinical audits were reviewed by the provider in 2010/11 and Newcastle Hospitals intends to take the following actions to improve the quality of healthcare provided.

The Clinical Effectiveness, Audit and Clinical Guidelines Committee receives a quarterly report on the Trust’s performance in relation to participation in the NICE Programme. On an annual basis the Committee receives a report on the projects in which the Trust participates and requires the lead clinician of each audit programme to identify any potential risk, and where there are concerns action plans will be monitored on a three monthly basis.

<table>
<thead>
<tr>
<th>National Audit Issue</th>
<th>Sponsor / Audit</th>
<th>Percentage Data completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>CABG and valvular surgery</td>
<td>Adult cardiac surgery audit</td>
<td>100%</td>
</tr>
<tr>
<td>Familial hypercholesterolaemia</td>
<td>National Clinical Audit of Mgmt of FH</td>
<td>100%</td>
</tr>
<tr>
<td>Acute Myocardial Infarction and other ACS</td>
<td>MINAP</td>
<td>Data collection closed 31 May 2011</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>National Clinical Audit Support Programme</td>
<td>100%</td>
</tr>
<tr>
<td>Pulmonary hypertension</td>
<td>Pulmonary hypertension Audit</td>
<td>100%</td>
</tr>
<tr>
<td>Acute stroke</td>
<td>SINAP</td>
<td>N/A</td>
</tr>
<tr>
<td>Stroke care</td>
<td>National Sentinel Stroke Audit</td>
<td>100%</td>
</tr>
<tr>
<td>Renal replacement therapy</td>
<td>Renal Registry</td>
<td>98%</td>
</tr>
<tr>
<td>Renal transplantation</td>
<td>NHSBT UK Transplant Registry</td>
<td>100%</td>
</tr>
<tr>
<td>Patient Transport</td>
<td>National Kidney Care Audit</td>
<td>95%</td>
</tr>
<tr>
<td>Renal colic</td>
<td>College of Emergency Medicine</td>
<td>Data collection ongoing although expected to achieve 100% by BAEM deadline</td>
</tr>
<tr>
<td>Lung Cancer (LUCADA)</td>
<td>National Clinical Audit Support Programme</td>
<td>100%</td>
</tr>
<tr>
<td>Bowel Cancer (NBOCAP)</td>
<td>National Clinical Audit Support Programme</td>
<td>100%</td>
</tr>
<tr>
<td>Head and neck cancer (DAHNO)</td>
<td>National Clinical Audit Support Programme</td>
<td>98%</td>
</tr>
<tr>
<td>Hip fracture</td>
<td>National Hip Fracture Database</td>
<td>100%</td>
</tr>
<tr>
<td>Severe trauma</td>
<td>Trauma Audit &amp; Research Network</td>
<td>57.9%</td>
</tr>
<tr>
<td>Falls and non-hip fractures</td>
<td>National Falls and Bone Health Audit</td>
<td>100%</td>
</tr>
<tr>
<td>O neg blood use</td>
<td>National Comparative Audit of Blood Transfusion</td>
<td>100%</td>
</tr>
<tr>
<td>Dementia audit</td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

The reports of 52 national clinical audits were reviewed by the provider in 2010/11 and Newcastle Hospitals intends to take the following actions to improve the quality of healthcare provided.

The Clinical Effectiveness, Audit and Clinical Guidelines Committee receives a quarterly report on the Trust’s performance in relation to participation in the NICE Programme. On an annual basis the Committee receives a report on the projects in which the Trust participates and requires the lead clinician of each audit programme to identify any potential risk, and where there are concerns action plans will be monitored on a three monthly basis.

Following audit work being undertaken and performance being monitored by internal and external agencies some examples of changes in practice include:

1. The Trust has developed ‘In Time’, an internal system facilitating the electronic generation of interim discharge summaries. This system is accessible from all inpatient and day case units within the Trust. A discharge letter is sent to GPs within 24 hours of discharge and initial audit results have shown significant improvement in the quality and timeliness of the correspondence to GP Practices.

2. All new in patients including those referred for surgery, and out patients are asked about their smoking status and have this status recorded. As a proactive public health initiative the Trust aims to give brief advice and offer a referral to NHS Stop Smoking Services. At the start of 2010 an initial audit to determine what our compliance was...
with offering referrals indicated that we did this in 53.6% of instances. At the end of the year we have shown a great improvement by increasing the number of referrals we offer to the Stop Smoking Service to 80.1%.

The reports of 322 local clinical audits were reviewed by the provider in 2010/11 and Newcastle Hospitals intends to take the following actions to improve the quality of healthcare provided:

- Each Clinical Directorate will produce a report which contains audit activity broken down by national and local priority, results will be reported with details of changes in practice and improvement. All local audit activity will be monitored by the Clinical Effectiveness, Audit and Clinical Guidelines Committee on an annual basis.

The number of patients receiving NHS services provided or subcontracted by Newcastle Hospitals that were recruited during the period to participate in research approved by a research ethics committee was 14,188.

### CQUIN

A proportion of Newcastle Hospitals income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between Newcastle Hospitals and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2010/11 and for the following 12 month period are available online at: [http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275](http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275)

The total sum of income in 2010/11 conditional upon achieving quality improvement and innovation goals was £7.4 million of baseline income and all of this sum was received for 2010/11.

### Care Quality Commission

The Newcastle upon Tyne Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is Registered Without Conditions. The Newcastle upon Tyne Hospitals NHS Foundation Trust is registered to deliver care from nine separate locations with a range of regulated activities on each site.

The Care Quality Commission has not taken enforcement action against The Newcastle upon Tyne Hospitals NHS Foundation Trust during 2010/11.

The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

### Hospital Episode Statistics

The Newcastle upon Tyne Hospitals NHS Foundation Trust submitted records during 2010/2011 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are reported in the latest published data. The percentage of accurate records in the published data is indicated in the table below.

The Newcastle upon Tyne Hospitals NHS Foundation Trust Clinical Informatics & Business Intelligence

**NHS Number and GP Code % validity**

For data during the time period 01.04.2010 - 31.03.2011

Data taken from SUS for data submitted as at 19.04.2011

<table>
<thead>
<tr>
<th>Dataset</th>
<th>Number of records submitted to SUS</th>
<th>Blank</th>
<th>Non Blank</th>
<th>% Valid NHS Number</th>
<th>Unknown/Not registered</th>
<th>Valid GP</th>
<th>% Valid GP from total records submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>84118</td>
<td>13689</td>
<td>70429</td>
<td>83.7%</td>
<td>6300</td>
<td>77818</td>
<td>92.5%</td>
</tr>
<tr>
<td>IP</td>
<td>227051</td>
<td>11435</td>
<td>215616</td>
<td>95.0%</td>
<td>3379</td>
<td>223672</td>
<td>98.5%</td>
</tr>
<tr>
<td>OP</td>
<td>1434382</td>
<td>46544</td>
<td>1387838</td>
<td>96.8%</td>
<td>17859</td>
<td>1416523</td>
<td>98.8%</td>
</tr>
</tbody>
</table>
The Newcastle upon Tyne Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2010/11 was 58% and was graded red. An action plan to improve this is in place and progress is being monitored by the Information Governance Committee.

The Information Governance Team will produce a full risk report for all the mapped data flows. Each mapped flow will be assigned to the Information Asset Owner (IAO), or if there is no IAO for a particular area, the Information Governance Working Group will undertake a review.

The IAOs or Information Asset Administrator will then review the risk scores and include any mitigation and present a revised risk score back to the IG team. Agreed High and Moderate risks will be entered into the Trust Risk Register (Datix) and will then be managed and reported through the Trust Risk process. The deadline for this part of the Programme is 30th June 2011. Management of the risks once agreed and entered will be owned by the IAO and review dates and actions will be monitored.

The Newcastle upon Tyne Hospitals NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the 2009/10 year by the Audit Commission and the error rates reported in the latest published audit (September 2010) for that period for diagnoses and treatment coding were 3.7%. Audit data for diagnostic and treatment coding accuracy for 2010/11 is awaited. The results should not be extrapolated further than the actual sample audited, which covered the following services:

**National Theme**  General Medicine

**Local Themes**

- Gynaecology
- HRG chapter CZ (Mouth Head Neck and Ears Procedures and Disorders)
- HRG chapter FZ (Digestive System Procedures and Disorders)
Part 3: Other Information

<table>
<thead>
<tr>
<th>Indicators for 2010/11</th>
<th>2010/11 Threshold</th>
<th>2010/11 Achievement</th>
<th>2009/10 comparator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient safety</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td>296</td>
<td>150</td>
<td>304</td>
</tr>
<tr>
<td>MRSA bacteraemias</td>
<td>12</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Screening all elective in-patients for MRSA</td>
<td>100%</td>
<td>100%</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Patient falls</td>
<td>10% reduction on previous year</td>
<td>2,727</td>
<td>2,649</td>
</tr>
<tr>
<td>Needlestick injuries</td>
<td>10% reduction on previous year</td>
<td>298</td>
<td>334</td>
</tr>
<tr>
<td><strong>Clinical effectiveness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All cancers: 31-day wait for second or subsequent treatment comprising either:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>94%</td>
<td>98.8%</td>
<td>98.3% overall in 2009/10</td>
</tr>
<tr>
<td>Anti cancer drug treatments</td>
<td>98%</td>
<td>99.7%</td>
<td></td>
</tr>
<tr>
<td>Radiotherapy</td>
<td>94%</td>
<td>98.9%</td>
<td></td>
</tr>
<tr>
<td>All cancers: 62-day wait for first treatment, comprising either:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>From urgent GP referral to treatment</td>
<td>85%</td>
<td>89.2%</td>
<td>90.0%</td>
</tr>
<tr>
<td>From consultant screening service referral</td>
<td>90%</td>
<td>97.8%</td>
<td>100.0%</td>
</tr>
<tr>
<td>All cancers: 31-day wait from diagnosis to first treatment</td>
<td>96%</td>
<td>99.2%</td>
<td>99.5%</td>
</tr>
<tr>
<td>Cancer: two week wait from referral to date first seen, comprising either:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All cancers</td>
<td>93%</td>
<td>96.0%</td>
<td>95.4%</td>
</tr>
<tr>
<td>For symptomatic breast patients (cancer not initially suspected)</td>
<td>93%</td>
<td>97.9%</td>
<td>n/a for 2009/10</td>
</tr>
<tr>
<td>People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)</td>
<td>68%</td>
<td>n/a</td>
<td>n/a in 2009/10</td>
</tr>
<tr>
<td><strong>Patient experience</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum waiting time of 18 weeks from point of referral to treatment in aggregate and by specialty for admitted patients</td>
<td>90%</td>
<td>94.0%</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>Maximum waiting time of 18 weeks from point of referral to treatment in aggregate and by specialty for non-admitted patients</td>
<td>95%</td>
<td>96.7%</td>
<td>&gt;95%</td>
</tr>
<tr>
<td>Maximum waiting time of four hours in A&amp;E from arrival to admission, transfer or discharge</td>
<td>98%</td>
<td>98.7%</td>
<td>98.7%</td>
</tr>
</tbody>
</table>

The selection of these indicators for 2010/11 was based upon national requirements, and discussion with the Board of Directors, the Clinical Policy Group, the Council of Governors (on behalf of the Membership which respective governors represent and including the public) and Departmental/ Directorate Governance leads.
Data for all of the above indicators is extracted from the relevant internal systems used by the Trust to provide the inputs to the monthly reports to the Board and its standing committees (where applicable) and to national recording systems, e.g. the Health Protection Agency for healthcare associated infection data. All indicators are reported in line with the applicable national definitions.

The only updates from the prior year are any new indicators for 2010/11 and these are indicated above where appropriate. Certain indicators have been disaggregated in 2010/11 and hence direct comparison with the previous year is not possible. The table above includes the most relevant comparative data.

Part 2 above provides an overview of performance in the year against the key national priorities set out in the NHS Operating Framework 2010/11 and consistent with the priorities of the Trust, as set out in the table above.

In relation to patients with learning disabilities, the Trust certifies that:

a. The Trust has a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients

b. the Trust provides readily available and comprehensible information to patients with learning disabilities about treatment options, complaints procedures and appointments

c. the Trust has protocols in place to provide suitable support for family carers who support patients with learning disabilities

d. the Trust has protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff

e. the Trust has protocols in place to encourage representation of people with learning disabilities and their family carers

f. the Trust has protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports.
Annex: Statements from Primary Care Trusts, Local Involvement Networks and Overview and Scrutiny Committees

**PCTs**

NHS North of Tyne welcomes the opportunity to comment upon the Newcastle upon Tyne Hospitals NHS Foundation Trust draft Quality Account 2010/11.

It is a clear and well-structured document that presents a balanced summary of Trust performance against key quality indicators, identifying both areas of high achievement and areas for further development. There is perhaps greater opportunity for the use of benchmarking data and national comparisons, and evidence of continued improvement over time through presentation of historical data.

Many positive improvements have been made, particularly reduction in the levels of Clostridium Difficile, an important patient safety issue. We would welcome further benchmarking regarding the mortality rate and inclusion in the report of comparative post surgery mortality data.

The development of a system for real-time patient feedback is to be supported. The report would benefit from evidence of the process for taking on board feedback from users, staff and your stakeholders, and the link to the quality priorities for 2011/12. We welcome the improvement of services for people with learning disabilities in the coming year, an agreed priority for the north east.

We are particularly supportive of the smoking cessation initiatives and the link to the CQUIN agreement, which could have a large quality impact on patient outcomes post operatively. With the management of the smoking cessation team transferring to the Trust from 1 April 2011, we look forward to significant improvement in the service delivery.

In terms of data quality, we would welcome sight of your action plan to improve your Information Governance Assessment Score of 58% in 2010/11. The quality of data submitted through the Secondary Uses Service is noted, which will be further enhanced in relation to completeness in 2011/12.

In terms of future partnership working, we hope it will be possible for greater involvement of our GP consortia in your quality assurance processes, for example, the quality walkabout visits to hospital wards and departments.

Overall NHS North of Tyne is satisfied that the draft document contains accurate data and information. We look forward to continuing the well established clinical partnership working to drive up quality and innovation for our population in 2011/12.

**LiNks**

Newcastle LINk thanks NUTH for giving an opportunity to be involved in the development of their Quality Account and ensuring this response is incorporated into the final Quality Account. The LINk held a meeting to consider the Quality Account on 26 May 2011 and also considered it at its Executive Board meeting on 17 May. This response is framed from these meetings and other comments that have been received independently.

**Involvement and engagement**

Newcastle LINk would welcome future discussions with NUTH regarding the indicators in the document. It would like to offer the following feedback about the draft document it received:

- The Abbreviations and Glossary of Terms should come at the beginning of the document.
- Some of the graphs are complex and difficult to read/understand.
- The use of background colours makes some of the text difficult to read.
- NUTH should consider seeking advice with regard to making the document accessible for people with visual and other impairments.

The Department of Health have set the 30 day consultation period for Quality Accounts. Newcastle LINk can respond to 3 separate Quality Accounts in its locality and to make it easier it would help if all 3 NHS Trusts could consider co-ordinating their 30 day period into the same 30 calendar days.

**Many positive improvements have been made, particularly reduction in the levels of Clostridium difficile, an important patient safety issue**

Chris Reed  Vida Morris
Chief Executive  Associate Director of 
Nursing and Patient Safety
Patient Experience

Newcastle LINk welcomes the pilot for people with learning disabilities and would like to see this rolled out to other groups e.g. for people with physical disabilities, older people and those with mental health issues (MH). In terms of MH the LINk wonders whether there is a flagging system whereby NUTH staff can be alerted to the fact that a patient has a MH issues besides the presenting medical issue. This may provide useful information, for example, the patient’s psychiatric medication that they will require in their hospital stay.

Review of priorities for 2010 / 2011

Priority 1 - Reduction in rate of hospital acquired infections

There has been progress in this area which should be complimented. Specifically the 50% reduction in CDiff cases is recognised by Newcastle LINk as a real achievement.

Priority 2 - Reduce incidence of patient falls

The LINk is disappointed to see this has risen, but recognises that falls graded as minor or above have reduced and that the increase in ‘insignificant’ falls may be due to an increased awareness and better reporting. A LINk suggestion would be if figures for any falls graded as ‘severe’ could be given as it is felt that ‘minor or above’ is too broad.

Newcastle LINk wonders whether a poster could be displayed at all ward nursing stations to continue falls awareness beyond the week in September.

Priority 3 - Reduce the trust hospital Standardised Mortality Ratio

The LINk felt that this was presented in a too difficult and complex manner. However, the fact that NUTH was best for the region will give local people confidence.

The LINk would welcome clarification of what ‘HSMR’ is and how it is calculated as it is difficult to comment on the figures with the level of explanation given.

Priority 4 - To ensure all patients are treated with dignity and respect

Newcastle LINk would like more detail on comparisons with other trusts - ‘Better’ or ‘About the same’ was felt not to be sufficient.

As NUTH scored in the top 20% for 49/64 questions and performed very well, it would be useful to see what these questions were.

The fact that NUTH scored best for hand hygiene is viewed positively with LINk members suggesting that staff at NUTH set a good example including non clinical staff such as porters.

In terms of patient satisfaction with anaesthetic care the LINk required more detail in order to comment fully e.g. does this include pre-operative interactions as well as post-operative?

It would be in NUTH’s interest to give more information about this as they have performed well. The LINk would also be interested in a comparison between in patient and day patient experiences.

The LINk welcomes the real time patient feedback and looks forward to using this tool with inpatients as well. Information on how many people have used this would be useful to include in the Quality Account.

Priority 5 - Needle-stick injuries

The LINk is pleased to see a reduction in these incidents and is looking forward to seeing how the initiatives listed will further reduce the number of these incidents.

Overview of monthly board assurance 2010 / 2011

NUTH should be complimented on the reduction in the number of near misses for incorrect transfusions. The LINk would be interested to know why CNST figures have risen steadily over the four quarters and is disappointed to see that Choose and Book is not performing as expected.

Quality improvements

The LINk is pleased that NUTH is performing the best in the region according to the National Sentinel Stroke Organisational Audit 2010. This reassures people that they will receive prompt care and treatment. The LINk would, however, like to see details of the features used for scoring in this audit.

The Bone Marrow Rates diagrams are, however, difficult to understand and not easy to read.

The LINk would like to praise the RVI maternity team for their RCM Award.

Participation in National Clinical Audits and National Confidential Enquiries

The LINk notes that 3 Audits relating to mental health (MH) were all considered “Not Applicable” (Depression and Anxiety, Prescribing in MH services and National Audit of schizophrenia). Newcastle LINk understands that the reason for this may be that they are only applicable to specialist Mental Health Trusts. The LINk would ask, however, whether there is a possibility of NUTH opting to carry out these MH-related audits as an example of all-round, holistic healthcare monitoring?

Key National Priorities

NUTH are achieving most of the targets which the LINk views as positive.

Workforce factors

The reduction in loss of work days by a third is important for service provision and supports the use of the measures introduced.
Governors

The following statement was produced on behalf of the Council of Governors by the governors’ Quality of Patient Experience (QPE) working group:

“This document is very comprehensive and easy to read - I have recommended it is a reference document for all Governors, as it covers all aspects of how the Trust is ensuring the highest quality standards in QPE. The Working Group welcomes the inclusion of Priority 6 ‘to consider the pathways and provision of facilities for patients with physical and sensory impairments’ in response to suggestions from the QPE Working group’.

Overview and Scrutiny Committee

Newcastle Scrutiny Councillors are happy to endorse priorities in the Trust’s draft Quality Account 2010/11. In delivering those ambitions, the Council is keen to work with the Trust in areas of joint interest; particularly where change benefits Newcastle residents. Challenging financial times, plus NHS re-organisation, emphasise the need for joined-up and integrated working.

The experience of Scrutiny Councillors, 2010/11, is NUTH demonstrates a strong cultural commitment to transparency in planning service change. NUTH’s Chair and Chief Executive made time to discuss vision and values, a site visit to the RVI was held and open reporting has been exhibited at all times.

The Trust provides readily available and comprehensible information to patients with learning disabilities

The Trust has protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010-11;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2010 to June 2011
  - Papers relating to Quality reported to the Board over the period April 2010 to June 2011
  - Feedback from the commissioners dated 17/06/2011
  - Feedback from governors dated 31/05/2011
  - Feedback from LINks dated 31/05/2011
  - The trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 11/06/2010,
  - The 2010 national patient survey dated 07/02/2011
  - The 2010 national staff survey dated 11/03/2011
  - The Head of Internal Audit’s annual opinion over the trust’s control environment dated 01/06/2011
  - CQC quality and risk profiles dated 06/04/2011

- the Quality Report presents a balanced picture of the NHS foundation trust’s performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review, and the Quality Report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Accounts regulations) (published at http://www.monitor-nhsft.gov.uk/home/our-publications/browse-categoryguidance-foundation-trusts/mandatory-guidance/nhs-foundation-t-3 as well as the standards to support data quality for the preparation of the Quality Report (available at http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category-guidance-foundation-trusts/mandatory-guidance/nhs-foundation-t-3)

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

Kingsley W Smith
Chairman

Sir Leonard Fenwick
Chief Executive

27 June 2011
We have been engaged by the Council of Governors of The Newcastle upon Tyne Hospitals NHS Foundation Trust (‘the Trust’) to perform an independent assurance engagement in respect of the content of The Newcastle upon Tyne Hospitals NHS Foundation Trust’s Quality Report for the year ended 31 March 2011 (the ‘Quality Report’).

**Scope and subject matter**

We read the Quality Report and considered whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual*, and consider the implications for our report if we become aware of any material omissions.

**Respective responsibilities of the Directors and auditors**

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual 2010/11* issued by the Independent Regulator of NHS Foundation Trusts (‘Monitor’).

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that the content of the Quality Report is not in accordance with the *NHS Foundation Trust Annual Reporting Manual* or is inconsistent with the documents.

We read the other information contained in the Quality Report and considered whether it is inconsistent with:

- Board minutes for the period April 2010 to June 2011
- Papers relating to quality reported to the Board over the period April 2010 to June 2011
- Feedback from the commissioners dated 17/06/2011
- Feedback from governors dated 31/05/2011
- Feedback from LINKS dated 31/05/2011
- The Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Compliance Regulations 2009, dated 11/06/2010;
- The 2010 national patient survey 07/02/2011;
- The 2010 national staff survey 11/03/2011;
- The Head of Internal Audit’s annual opinion over the Trust’s controls environment dated 01/06/2011; and
- COC quality and risk profiles dated 06/04/2011.

We considered the implications for our report if we became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the “documents”). Our responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Council of Governors of The Newcastle upon Tyne Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting The Newcastle upon Tyne Hospitals NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and The Newcastle upon Tyne...
Reducing HCAI remains one of our highest priorities. Measures to achieve this include providing a clean and safe environment.

Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

**Assurance work performed**

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

- Making enquiries of management;
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- Reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

**Limitations**

It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

**Conclusion**

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the *NHS Foundation Trust Annual Reporting Manual*.

PricewaterhouseCoopers LLP
Chartered Accountants
Newcastle
27 June 2011
Audit & Controls

Quality of outcome and satisfaction in meeting the expectation of the patients we serve is the overriding consideration in all that we do

Investment Manager
CCLA Investment Management Ltd
The Charities Official Investment Fund (COIF)

Banker
HSBC

External Auditor
PricewaterhouseCoopers LLP

Payroll
North of Tyne Payroll Service (a consortium serving local Primary Care Organisations and NHS Trusts)

Internal Auditor
Northumbria Internal Audit and Counter Fraud Service (a consortium serving local Primary Care Organisations and NHS Trusts)

Legal Advisers
Samuel Phillips Law Firm
Dickinson Dees Law Firm
Ward Hadaway
Sintons LLP
The principal objective of the Independent Auditor was to carry out an audit in accordance with paragraph 24(s) of Schedule 7 of the National Health Service Act 2006 and the requirements of the Audit Code issued by Monitor - the Independent Regulator of NHS Foundation Trusts - which by necessity ensures compliance with International Standards for Audit (UK & Ireland) issues by the Auditing Practice Board. This required an opinion on the Annual Accounts and a review of arrangements for legality; financial standing; internal financial control; and standards of financial conduct, including fraud and corruption.

The Audit Committee met on a regular basis to assess a range of studies and work programmes including detailed value for money scrutinies. The internal and external auditors attended all meetings of the Audit Committee and on each occasion there was the opportunity to meet privately with the Non-Executive Director membership. The auditors also had unrestricted access to the Audit Committee, its Chairman and individual members.

Sound corporate governance and all that entails was an overriding priority. This included review and audit of established counter-fraud and corruption policies, reported to the Audit Committee by the Internal Auditors in the context of the national Fraud Awareness Review.

Better Payments Practice Code
The Trust is required to pay trade creditors in accordance with the national Better Payments Practice Code and government Accounting Rules which require that:

- Bills are paid within 30 days, unless covered by other agreed payment terms
- Disputes and complaints are handled by a nominated officer
- Payment terms are agreed with all traders prior to commencement of contracts
- Payment terms are not varied without prior agreement with traders
- A clear policy of paying bills in accordance with contracts exists.

Any complaints received from traders regarding payment were recorded, investigated and the appropriate action taken where called for. Details of compliance with the Code are given in Note 6.1 to the Accounts.

Code of Governance
In the course of the year, the Board reviewed and considered Monitor’s ‘NHS Foundation Trust Code of Governance’ and considered that it complied with all recommended practice, including the identification of a senior independent director (SID) in January 2009 by the Nominations Committee of the Council of Governors, when Professor P H Baylis was identified as the SID.

Specifically, the Board conducted a review of the effectiveness of the Trust’s system of internal controls. The Annual Governance Statement sets out the details of this - see page 223.

The year has involved a series of actions being taken by the Board of Directors to not only sustain but enhance our reputation as a robust going concern.
Annual Accounts

The Newcastle upon Tyne Hospitals
NHS Foundation Trust Annual Accounts 2010/2011
Foreword to the Accounts
The Newcastle upon Tyne Hospitals NHS Foundation Trust

The accounts for the year ended 31 March 2011 are set out on the following pages and comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers’ Equity, the Statement of Cash Flows and the Notes to the Accounts.

The accounts have been prepared by The Newcastle upon Tyne Hospitals NHS Foundation Trust in accordance with Schedule 7, Paragraphs 24 and 25, of the National Health Services Act 2006, in the form which Monitor, the independent regulator of NHS Foundation Trusts has, with the approval of HM Treasury, directed.

The accounts for the year ended 31 March 2011 have been prepared under International Financial Reporting Standards, in accordance with HM Treasury directions. The Statement of Comprehensive Income has been presented in three columns for consistency with the prior year and to better present the Income & Expenditure of the Trust (as shown in column 1) before the financial impact of asset revaluation exercises which have taken place during the year (column 2). The final result for the year is as presented in column 3.

Sir Leonard Fenwick
Chief Executive
2 June 2011
Independent Auditors’ Report
to the Council of Governors of The Newcastle upon Tyne Hospitals NHS Foundation Trust

We have audited the financial statements of The Newcastle upon Tyne Hospitals NHS Foundation Trust for the year ended 31 March 2011 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers’ Equity and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual issued by the Independent Regulator of NHS Foundation Trusts (‘Monitor’).

Respective responsibilities of Directors and auditors
As explained more fully in the Directors’ Responsibilities Statement the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with the NHS Act 2006, the Audit Code for NHS Foundation Trusts issued by Monitor and International Standards on Auditing (ISAs) (UK and Ireland). Those standards require us to comply with the Auditing Practices Board’s Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Council of Governors of The Newcastle upon Tyne Hospitals NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Scope of the audit of the financial statements
An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the NHS Foundation Trust’s circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the NHS Foundation Trust; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report and Accounts to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements
In our opinion the financial statements:
- give a true and fair view, in accordance with the NHS Foundation Trust Annual Reporting Manual, of the state of the NHS Foundation Trust’s affairs as at 31 March 2011 and of its income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual.
Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion

- the part of the Directors’ Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual; and
- the information given in the Directors’ Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if:

- in our opinion the Statement on Internal Control does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Accounting Officer’s Statement on Internal Control addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
- we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- we have qualified our report on any aspects of the Quality Report.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Janet Eilbeck
(Senior Statutory Auditor)
For and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Newcastle upon Tyne
27 June 2011

Notes:

(a) The maintenance and integrity of the Trust’s website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

(b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.
Statement of Comprehensive Income
for the year ended 31 March 2011

<table>
<thead>
<tr>
<th>Note</th>
<th>2010/11 Before Exceptional Items * £000</th>
<th>2010/11 Exceptional Items * £000</th>
<th>2010/11 Total £000</th>
<th>2009/10 Before Exceptional Items * £000</th>
<th>2009/10 Exceptional Items * £000</th>
<th>2009/10 Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>652,806</td>
<td>0</td>
<td>652,806</td>
<td>613,313</td>
<td>0</td>
<td>613,313</td>
</tr>
<tr>
<td>4</td>
<td>125,880</td>
<td>4,771</td>
<td>130,651</td>
<td>129,260</td>
<td>0</td>
<td>129,260</td>
</tr>
<tr>
<td>5</td>
<td>(748,225)</td>
<td>(8,238)</td>
<td>(756,463)</td>
<td>(703,999)</td>
<td>(68,806)</td>
<td>(772,805)</td>
</tr>
<tr>
<td>6</td>
<td>30,461</td>
<td>(3,467)</td>
<td>26,994</td>
<td>38,574</td>
<td>(68,806)</td>
<td>(30,232)</td>
</tr>
<tr>
<td>7</td>
<td>0</td>
<td>455</td>
<td>455</td>
<td>325</td>
<td>0</td>
<td>325</td>
</tr>
<tr>
<td>8</td>
<td>(20,496)</td>
<td>0</td>
<td>(20,496)</td>
<td>(18,284)</td>
<td>0</td>
<td>(18,284)</td>
</tr>
<tr>
<td>22</td>
<td>(67)</td>
<td>0</td>
<td>(67)</td>
<td>(104)</td>
<td>0</td>
<td>(104)</td>
</tr>
<tr>
<td>9</td>
<td>(10,229)</td>
<td>0</td>
<td>(10,229)</td>
<td>(11,516)</td>
<td>0</td>
<td>(11,516)</td>
</tr>
<tr>
<td>12</td>
<td>(30,337)</td>
<td>0</td>
<td>(30,337)</td>
<td>(29,579)</td>
<td>0</td>
<td>(29,579)</td>
</tr>
</tbody>
</table>

SURPLUS / (DEFICIT) FOR THE YEAR

<table>
<thead>
<tr>
<th></th>
<th>2010/11</th>
<th>2010/11</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(3,467)</td>
<td>(3,343)</td>
<td>(59,811)</td>
</tr>
<tr>
<td></td>
<td>8,995</td>
<td>(68,806)</td>
<td></td>
</tr>
<tr>
<td>SURPLUS / (DEFICIT) FOR THE YEAR</td>
<td>124</td>
<td>(3,467)</td>
<td>(3,343)</td>
</tr>
</tbody>
</table>

Other Comprehensive Income & Expense:**

- Impairments 12.1
  - Increase in the donated asset reserve due to receipt of donated assets 12.1
  - Revaluation gains / (losses) on property, plant and equipment SOCITE 12.1

Other recognised gains

TOTAL COMPREHENSIVE INCOME & EXPENSE FOR THE YEAR

<table>
<thead>
<tr>
<th></th>
<th>2010/11</th>
<th>2010/11</th>
<th>2010/11</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>75</td>
<td>7,563</td>
<td>7,638</td>
<td>8,494</td>
</tr>
<tr>
<td></td>
<td>(70,104)</td>
<td>(78,598)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* An Income & Expenditure surplus of £124k (2009/10 £8,995k) is reported, before exceptional items. A net charge of £3,467k (2009/10 charge of £68,806k) is made to the Statement of Comprehensive Income as an exceptional item. This results from the impact of current market conditions on the valuation of Trust properties and the impairment of assets during the year. The adjustment has no impact on the cash flows of the Trust. Note 12.1.1 refers.

** Other Comprehensive Income & Expense relates to items which have been charged directly to Reserves in the Statement of Financial Position, not to in-year results. The Statement of Changes in Taxpayers’ Equity on page 263 refers to this.

*** The prior year figures have been restated to reflect a change in accounting policy with regard to asset impairments, as detailed in note 12.1.2.
## Statement of Financial Position as at 31 March 2011

<table>
<thead>
<tr>
<th>Non-Current Assets</th>
<th>31 March 2011 £000</th>
<th>Restated 31 March 2010 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intangible assets</td>
<td>2,689</td>
<td>3,030</td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>604,162</td>
<td>574,874</td>
</tr>
<tr>
<td>Investments in subsidiaries and joint ventures</td>
<td>130</td>
<td>130</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>1,700</td>
<td>550</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td><strong>608,681</strong></td>
<td><strong>578,584</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Assets</th>
<th>31 March 2011 £000</th>
<th>Restated 31 March 2010 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inventories</td>
<td>16,481</td>
<td>16,073</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>44,758</td>
<td>48,977</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>3,175</td>
<td>1,854</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>53,953</td>
<td>51,749</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td><strong>118,367</strong></td>
<td><strong>118,653</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Liabilities</th>
<th>31 March 2011 £000</th>
<th>Restated 31 March 2010 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade and other payables</td>
<td>(71,395)</td>
<td>(66,093)</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>(21,668)</td>
<td>(14,530)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>(6,587)</td>
<td>(5,478)</td>
</tr>
<tr>
<td>Provisions</td>
<td>(1,760)</td>
<td>(1,381)</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td><strong>(101,410)</strong></td>
<td><strong>(89,482)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Current Liabilities</th>
<th>31 March 2011 £000</th>
<th>Restated 31 March 2010 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade and other payables</td>
<td>(839)</td>
<td>(1,226)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>(255,118)</td>
<td>(255,698)</td>
</tr>
<tr>
<td>Provisions</td>
<td>(20,368)</td>
<td>(10,756)</td>
</tr>
<tr>
<td><strong>Total non-current liabilities</strong></td>
<td><strong>(276,325)</strong></td>
<td><strong>(267,680)</strong></td>
</tr>
</tbody>
</table>

**Total Assets Employed**

<table>
<thead>
<tr>
<th>31 March 2011 £000</th>
<th>Restated 31 March 2010 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>349,313</td>
<td>340,075</td>
</tr>
</tbody>
</table>

**Taxpayers’ Equity:**

<table>
<thead>
<tr>
<th>31 March 2011 £000</th>
<th>Restated 31 March 2010 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public dividend capital</td>
<td>223,984</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>130,872</td>
</tr>
<tr>
<td>Donated asset reserve</td>
<td>18,225</td>
</tr>
<tr>
<td>Income and expenditure reserve</td>
<td>(23,768)</td>
</tr>
</tbody>
</table>

**Total Taxpayers’ Equity**

<table>
<thead>
<tr>
<th>31 March 2011 £000</th>
<th>Restated 31 March 2010 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>349,313</td>
<td>340,075</td>
</tr>
</tbody>
</table>

The financial statements on pages 261 to 308 were approved by the Board on 1 June 2011 and signed on its behalf by:

Sir Leonard Fenwick, Chief Executive
2 June 2011
### Statement of changes in Taxpayers’ Equity for the year ended 31 March 2011

<table>
<thead>
<tr>
<th>Note</th>
<th>Taxpayers’ equity at 1 April 2010</th>
<th>Total Taxpayers’ Equity £000</th>
<th>Public dividend capital * £000</th>
<th>Revaluation reserve * £000</th>
<th>Donated asset reserve * £000</th>
<th>Income and expenditure reserve * £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>340,075</td>
<td>222,384</td>
<td>125,796</td>
<td>17,479</td>
<td>(25,584)</td>
</tr>
</tbody>
</table>

**Total Comprehensive income for 2010/11:**

- **(Deficit) for the year**
  - SOCI 3,343
  - Impairments 5,373
  - Revaluation gains on property, plant and equipment 16,403
  - Increase in donated asset reserve due to receipt of donated assets 1,606
  - (Reduction) in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets (1,655)

**Public dividend capital received** 1,600

**Other movements on reserves **

<table>
<thead>
<tr>
<th>Note</th>
<th>Taxpayers’ equity at 31 March 2011</th>
<th>Total Taxpayers’ Equity £000</th>
<th>Public dividend capital £000</th>
<th>Revaluation reserve £000</th>
<th>Donated asset reserve £000</th>
<th>Restated Income and expenditure reserve £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>349,313</td>
<td>223,984</td>
<td>130,872</td>
<td>18,225</td>
<td>(23,768)</td>
<td></td>
</tr>
</tbody>
</table>

**Taxpayers’ equity at 1 April 2009**

<table>
<thead>
<tr>
<th>Note</th>
<th>Taxpayers’ equity at 1 April 2009</th>
<th>Total Taxpayers’ Equity £000</th>
<th>Public dividend capital £000</th>
<th>Revaluation reserve £000</th>
<th>Donated asset reserve £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>400,179</td>
<td>212,384</td>
<td>145,827</td>
<td>21,880</td>
<td>20,088</td>
</tr>
</tbody>
</table>

**Total Comprehensive income for 2009/10:**

- **(Deficit) for the year**
  - As previously stated 46,125
  - Prior period adjustment - change of accounting policy *** 13,686
  - Restated SOCI 59,811

**Revaluation losses and impairment losses on property, plant and equipment:**

- As previously stated 19,587
- Prior period adjustment - change of accounting policy *** 13,686

**Increase in donated asset reserve due to receipt of donated assets** 1,450

**Public dividend capital received** 10,000

**Transfer in respect of impairment due to loss of economic benefit *****

<table>
<thead>
<tr>
<th>Note</th>
<th>Taxpayers’ equity at 31 March 2010</th>
<th>Total Taxpayers’ Equity £000</th>
<th>Public dividend capital £000</th>
<th>Revaluation reserve £000</th>
<th>Donated asset reserve £000</th>
<th>Income and expenditure reserve £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>340,075</td>
<td>222,384</td>
<td>125,796</td>
<td>17,479</td>
<td>(25,584)</td>
<td></td>
</tr>
</tbody>
</table>

**Reserves:**

- **Public dividend capital represents, in substance, the Secretary of State for Health’s ‘equity’ investment in the Trust.**
- **The revaluation reserve is used to record revaluation gains/losses and impairments/reversals on property, plant and equipment that are recognised in Other Comprehensive Income.**
- **The donated asset reserve is used to record transactions in respect of donated assets and is operated to ensure that there is no net cost or credit recognised in the Trust’s surplus/deficit for the year. At all times the balance on the donated asset reserve matches the carrying value of the Trust’s donated assets.**
- **The Trust’s surplus or deficit for the year is recognised in the Income and Expenditure reserve.**

**Note:**

- **The movement between the revaluation reserve and Income and Expenditure reserve of £5.15m (2009/10 £5.1m net) relates to the removal of remaining balances on the revaluation reserve for buildings impaired during the year.**
- **The prior period adjustment has resulted from a change in accounting policy as required by the HM Treasury FrER. Impairments which result from the consumption of economic benefits are now charged to operating expenses, regardless of whether there is an available Revaluation Reserve balance. To ensure compliance with IAS 16, Property, Plant & Equipment, an equal and opposite transfer has been made between the revaluation reserve and the income and expenditure reserve in the 2009/10 Statement of changes in Taxpayers’ Equity.**
Statement of Cash Flows
for the year ended 31 March 2011

<table>
<thead>
<tr>
<th>Note</th>
<th>2010/11 £000</th>
<th>2009/10 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash flows from operating activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net cash generated from operating activities</td>
<td>24</td>
<td>73,960</td>
</tr>
<tr>
<td><strong>Cash flows from investing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest received</td>
<td></td>
<td>460</td>
</tr>
<tr>
<td>Payments to acquire financial assets</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Payments to acquire intangible assets</td>
<td></td>
<td>(149)</td>
</tr>
<tr>
<td>Payments to acquire property, plant and equipment</td>
<td></td>
<td>(45,600)</td>
</tr>
<tr>
<td>Sales of property, plant and equipment</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td><strong>Net cash (used in) investing activities</strong></td>
<td></td>
<td>(45,279)</td>
</tr>
<tr>
<td><strong>Cash flows from financing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital received</td>
<td></td>
<td>1,600</td>
</tr>
<tr>
<td>Loans received</td>
<td>21</td>
<td>5,232</td>
</tr>
<tr>
<td>Capital element of finance lease rental payments</td>
<td></td>
<td>(783)</td>
</tr>
<tr>
<td>Capital element of private finance initiative obligations</td>
<td></td>
<td>(3,920)</td>
</tr>
<tr>
<td>Interest paid</td>
<td></td>
<td>(341)</td>
</tr>
<tr>
<td>Interest element of finance lease rental payments</td>
<td></td>
<td>(193)</td>
</tr>
<tr>
<td>Interest element of private finance initiative obligations</td>
<td></td>
<td>(19,901)</td>
</tr>
<tr>
<td>Public dividend capital dividend paid</td>
<td></td>
<td>(8,171)</td>
</tr>
<tr>
<td>Cash flows (used in) other financing activities</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td><strong>Net cash (used in) financing activities</strong></td>
<td></td>
<td>(26,477)</td>
</tr>
<tr>
<td><strong>Increase/(Decrease) in cash and cash equivalents</strong></td>
<td>2,204</td>
<td>(10,066)</td>
</tr>
<tr>
<td>Cash and cash equivalents at 1 April</td>
<td></td>
<td>51,749</td>
</tr>
<tr>
<td><strong>Cash and cash equivalents at 31 March</strong></td>
<td>17</td>
<td>53,953</td>
</tr>
</tbody>
</table>
1 ACCOUNTING POLICIES AND OTHER INFORMATION

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual (FT ARM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2010/11 issued by Monitor. The accounting policies contained in that manual follow EU endorsed International Financial Reporting Standards (IFRS), International Financial Reporting Interpretations Committee statements (IFRICs) and HM Treasury’s Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts, as amended for the change in accounting policy as noted below.

Change in accounting policies

The accounting policy on the impairment of fixed assets has been changed. IAS 36, *Impairment of Assets*, is adapted for use in the public sector by HM Treasury, and Foundation Trusts are required under the FT ARM to follow the adapted guidance. Impairments which result from the consumption of economic benefits are now charged to operating expenses regardless of whether there is an available revaluation reserve balance. A prior year adjustment has been made to reflect this change, details of which can be found in the relevant notes.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention as modified by the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities. NHS foundation trusts, in compliance with the FT ARM, are not required to comply with IAS 16 regarding the disclosure of historical cost carrying amounts.

Critical accounting judgements and key sources of estimation in applying the Trust’s accounting policies

The preparation of the financial statements requires the use of certain critical accounting estimates and also requires the Trust directors and senior managers to exercise their judgement in the process of applying the Trust’s accounting policies.

The directors and senior managers make estimates and assumptions concerning the future. As a result the accounting estimates may not equal the related actual results. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year are discussed below:

a) **Incomplete patient spells at the year end:**

   The Trust prepares an estimate of income generated for incomplete in-patient spells at the year end. This estimate is based on an equivalent month end date occurring earlier in the year to provide a basis for calculation.

b) **Legal claims:**

   Legal claims are based upon professional assessments, which are uncertain to the extent that they are an estimate of the likely outcome of individual cases.

c) **Indices:**

   The valuation of land and buildings is based on building cost indices provided by and used by the District valuer in his valuation work. These indices are based on an indication of trend of accepted tender prices within the construction industry as applied to the Public Sector.

d) **Private Finance Initiative (PFI) schemes:**

   As part of the Transforming Newcastle Hospitals PFI scheme, the Trust is required to pay the operator for Lifecycle replacement assets. A judgement has been made that payment for these assets is accounted for in equal annual instalments over the period of the scheme, rather than when payments are made. This results in a prepayment for assets being established in the early years of the scheme, which is used in later years when the asset replacement occurs.

1.2 Basis of preparation

The financial statements are those of the Trust and contain information about the Trust as a single entity. The Newcastle upon Tyne Hospitals NHS Charity would qualify as a subsidiary under the requirements of IAS 27. However, the results of the Newcastle upon Tyne Hospitals NHS Charity have not been consolidated within these accounts, in accordance with the dispensation obtained by Monitor from HM Treasury for the years ended 31 March 2011 and 31 March 2010. Consolidated financial statements have not been prepared to incorporate the results of subsidiaries and joint ventures detailed in note 13, on the grounds of immateriality.

1.3 Income

Income in respect of services provided is recognised when, and to the extent that performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.
1.3 Income (continued)

The Trust follows the Department of Health’s Payment by Results (PbR) methodology in the form of its contracts with NHS commissioners.

For partially completed patient spells, which commenced prior to the financial year end and for which date of discharge is not known, the income relating to the activity is accrued. The accrued income is calculated based on the length of stay in the financial year multiplied by a standard income per day differentiated by speciality.

For patient income where the spell has been completed, the accrual is based on the days in the financial year multiplied by the relevant tariff.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met and is measured as the sums due under the sale contract.

Income in respect of the NHS Injury Compensation Scheme is recognised in accordance with standard guidance, when the Trust receives confirmation from the Compensation Recovery Unit that a patient has lodged a claim.

Research and development income is recognised when the conditions attached to the grant or payment are met.

Education and training income is recognised either in equal instalments over the financial year or if the income can be identified with specific expenditure, in line with this expenditure.

1.4 Expenditure on goods and services

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

1.5 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust’s business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Expenditure on research is not capitalised, it is written off to the statement of comprehensive income in the period to which it relates.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- The project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- The Trust intends to complete the asset and sell or use it;
- The Trust has the ability to sell or use the asset;
- How the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- Adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- The Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software and software licences, is capitalised as an intangible asset when expenditure of at least £5,000 is incurred.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. (See 1.6 below)

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery, normally between 5-10 years.

Intangible assets under development are not amortised

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if it is capable of being used for a period which exceeds one financial year, it is probable that future economic benefits will flow to, or service potential be supplied to the Trust, the cost of the item can be measured reliably and it is held for use in delivering services or for administrative purposes.
1.6 Property, plant and equipment (continued)

Also the assets:

a. individually have a cost of at least £5,000; or

b. form a group of assets which collectively have a cost of at least £5,000, and individually have a cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

c. form part of the initial setting-up cost of a new building, or refurbishment of a ward or unit, and their individual cost exceeds £250.

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

Measurement

Valuation

All property, plant and equipment is measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Property, plant and equipment (excluding specialised land and buildings) - On initial recognition they are measured at cost, including any costs, such as installation, directly attributable to bringing them into working condition.

Subsequently they are measured at fair value which is the lower of replacement cost and recoverable amount. Any costs arising from financing the construction of the property, plant and equipment are not capitalised but are charged to the statement of comprehensive income in the year to which they relate.

Non-specialised operational buildings are valued on an existing use basis.

Specialised land and buildings - Specialised operational buildings are measured on a modern equivalent asset basis. For non-operational buildings, including surplus land, the valuations are carried out at open market value.

All land and buildings are valued on a frequent basis to ensure that the fair value is not materially misstated. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The latest asset valuation exercise concluded as at 31 March 2011 when the district valuer prepared an updated valuation.

Property in the course of construction is carried at cost. Cost includes professional fees but not borrowing costs, which are recognised as an expense immediately, as allowed by IAS 23 for assets held at fair value. Property in the course of construction once brought into use is valued by professional valuers as part of the standard valuation process.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition. The carrying amount of the part replaced is derecognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive income in the period in which it is incurred.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where and to the extent that they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

Other impairments are treated as revaluation losses. Reversals of “other impairments” are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as ‘Held for sale’ once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;

- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
1.6 Property, plant and equipment (continued)

- an active programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as ‘Held for sale’; and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued, except where the ‘fair value less costs to sell’ falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits which is normally on a straight line basis. The useful economic lives and hence depreciation rates for equipment assets are determined by staff within the Medical Electronics department. Freehold land is considered to have an infinite life and is not depreciated.

Property in the course of construction and payments on account are not depreciated until the property is brought into use. Property, plant and equipment which has been reclassified as ‘Held for Sale’ ceases to be depreciated upon reclassification.

Buildings, installations and fittings are depreciated on their modern equivalent asset value over the estimated remaining life of the asset as assessed by the Trust’s professional valuers. Assets capitalised under finance leases are depreciated over the primary lease term or the life of the asset if it reverts to the Trust at the end of the lease period.

Equipment is depreciated on fair value evenly over the estimated life of the asset. Asset lives fall into the following ranges:

- Land - Not Depreciated
- Buildings excluding dwellings - 1 to 90 years
- Dwellings - 27 to 43 years
- Assets under construction - Not Depreciated
- Plant and machinery - 1 to 32 years
- Transport equipment - 7 years
- Information technology - 5 to 10 years
- Furniture and fittings - 5 to 15 years

Donated assets

Donated non-current assets are capitalised at their fair value on receipt and this same value is credited to the donated asset reserve. Donated non-current assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the statement of comprehensive income. Similarly, any impairment on donated assets charged to the statement of comprehensive income is matched by a transfer from the Donated Asset Reserve. On sale of donated assets, the net book value is transferred from the donated asset reserve to the income and expenditure reserve.

1.7 Government grants

Government grants are grants from government bodies other than income from primary care trusts or NHS trusts for the provision of services. Grants from the Department of Health are accounted for as government grants, as are grants from the Big Lottery Fund. Where the government grant is used to fund revenue expenditure it is taken to the statement of comprehensive income to match that expenditure. Where the grant is used to fund capital expenditure, the grant is held within other liabilities and released to operating income over the life of the asset, in a manner consistent with the depreciation charge for that asset.

1.8 Private Finance Initiative (PFI) transactions

HM Treasury has determined that the Trust shall account for infrastructure PFI schemes where the Trust controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12, Service Concession Agreements. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) payment for the fair value of services received
b) payment for the PFI asset, including finance costs
c) payment for the replacement of components of the asset during the contract (lifecycle replacement)

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within ‘operating expenses’. Finance interest and contingent rent in relation to services received are recorded under Finance expense-financial liabilities in the Statement of Comprehensive Income.
1.8 Private Finance Initiative (PFI) transactions

(continued)

PFI asset
The PFI assets are recognised as property, plant and equipment when the unitary payment becomes payable. The assets are measured at fair value which is kept up to date in accordance with the Trust’s approach for each relevant class of asset in accordance with the principles of IAS 16, Property, Plant and Equipment.

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17, Leases.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the lease liability for the period, and is charged to ‘Finance Costs’ within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase which is due to inflation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as contingent finance cost in the statement of comprehensive income.

Lifecycle replacement
An amount is set aside from the unitary payment each year into a Lifecycle Replacement prepayment to reflect the fact that the Trust is effectively pre-funding some elements of future lifecycle replacement by the operator.

When the operator replaces a capital asset, the fair value of this replacement item is recognised as property, plant and equipment.

Where the item was planned for replacement and therefore its value is being funded through the unitary payment, the lifecycle prepayment is reduced by the amount of the fair value.

The prepayment is reviewed annually to ensure that its carrying amount will be realised through future lifecycle components to be provided by the operator. Any unrecoverable balance is written out of the prepayment and charged to operating expenses.

Where the lifecycle item was not planned for replacement during the contract it is effectively being provided free of charge to the Trust. A deferred income balance is therefore recognised instead and this is released to operating income over the life of the replacement component.

Other assets contributed by the Trust to the operator
Assets contributed (e.g. cash payments) by the trust to the operator before the asset is brought into use, which are intended to defray the operator’s capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.9 Non-current assets held for sale
The Trust has no non-current assets classified as held for sale.

1.10 The Trust as a lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to finance costs in the statement of comprehensive income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease.

Leases of land and buildings
Where a lease is for land and buildings, the land and building components are separated and the classification for each is assessed separately.

1.11 The Trust as a lessor

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Assets leased to others are accounted for in accordance with the accounting policy for property, plant and equipment.
1.12 Inventories

Inventories are valued at cost, by reference to supplier information on a first-in first-out basis. This is considered to be a reasonable approximation to fair value due to the high turnover of inventory.

Provision is made for obsolete and defective stock whenever evidence exists that a provision is required.

1.13 Cash and cash equivalents

Cash and cash equivalents include cash in hand, deposits held at call with banks and other short term highly liquid investments with original maturities of three months or less. Cash and bank balances are recorded at the current values of these balances in the Trust’s cash book. Interest earned on bank accounts is recorded as ‘finance income’ in the period to which it relates. Bank charges are recorded as operating expenditure in the periods to which they relate.

As the Trust has no bank overdrafts there is no difference between the amount disclosed as cash and cash equivalents in the statement of financial position and in the statement of cash flows.

1.14 Provisions

The Trust recognises a provision where it has a present legal obligation or constructive obligation of uncertain timing or amount and where a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury’s discount rate of 2.2% in real terms, except for the injury benefit provision which uses the HM Treasury’s pension discount rate of 2.9% in real terms.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed in note 22.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHSLA and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any ‘excesses’ payable in respect of specific claims, are charged to operating expenses as and when the liability arises.

1.15 Contingent liabilities

Contingent liabilities are not recognised in the accounts but are disclosed in note 27, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

a. Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events, not wholly within the Trust’s control, or

b. Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise, or for which the amount of the obligation cannot be measured with sufficient reliability.

1.16 Expenditure on employee benefits

Short term employee benefits

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

Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme (the scheme). Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the Trust of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

Employers pension cost contributions are charged to operating expenses as and when they become due.

1.17 Value added tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.18 Corporation tax

Foundation Trusts are exempt from corporation tax on their principal health care income under section 519A Income and Corporation Taxes Act 1988. In determining
1.18 Corporation tax (continued)
whether other income may be taxable, a three-stage test must be employed which asks whether the activity is an authorised activity related to the provision of core healthcare, whether the activity is actually or potentially in competition with the private sector, and whether the annual profits of the activity are in excess of £50,000 per trading activity. The Trust does not have any corporation tax liability in the current or prior year.

1.19 Foreign exchange
The functional and presentational currency of the Trust is sterling.
A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.
The Trust has no monetary assets or liabilities denominated in a foreign currency at the Statement of Financial Position date.

1.20 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of the HM Treasury Financial Reporting Manual.

1.21 Public Dividend Capital (PDC) and PDC Dividend
Public dividend capital (PDC) represents taxpayers’ equity in the Trust. PDC is recorded at the value received. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.
A charge reflecting the cost of capital utilised by the Trust is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Service and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “draft” (unaudited) annual accounts. The dividend thus calculated is not revised should any adjustments to net assets occur as a result of the audit of the annual accounts. However any movement in net assets would be reflected in the calculation for the following year.

1.22 Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with general payments. They are divided into different categories, which govern the way in which each individual case is handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, (excluding any provisions in relation to such payments), including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.23 Financial assets and financial liabilities
Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust’s normal purchase, sale or usage requirements, are recognised when and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.
Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above.
All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.
Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised as Loans and receivables. Financial liabilities are classified as Other Financial liabilities.

Loans and receivables
The Trust’s loans and receivables comprise: cash and cash equivalents and trade and other receivables. Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in non-current and current assets.

Other financial liabilities
The Trust’s other financial liabilities comprise: trade and other payables, other liabilities, finance lease obligations, PFI obligations, other borrowings and provisions under contract.
1.23 Financial assets and financial liabilities (continued)

Other financial liabilities (continued)

All other financial liabilities are recognised initially at cost, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest rate method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as non-current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest rate method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

The Trust considers that all of its financial assets are ‘loans and receivables’ and all of its financial liabilities are included at cost. The Fair Value of financial assets and liabilities is considered to be approximately the same as the carrying value.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses are recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

An asset’s carrying value is either written down or a provision made on a judgement basis, based upon past experience. Once it has been established that an amount provided for will not be recovered, this amount is written off against the carrying amount of the financial asset.

1.26 EU Emissions Trading Scheme

EU Emission Trading Scheme allowances, granted by DEFRA at 1 January each year, are treated as current asset investments. The same accounting treatment is accorded to credits purchased to cover the excess of actual emissions to allowances. A deferred income balance, equal and opposite to the allowances received, is released progressively each year to the Statement of Comprehensive Income. The costs of actual emissions are charged to the Statement of Comprehensive Income, and a provision is set aside. The provision is cleared when the allowances and credits are surrendered at the end of the term covered by the scheme. All Statement of Financial Position entries are valued at fair value at the end of each financial year.

The Carbon Reduction Commitment scheme became operational on 1 April 2010, but for data collection and registration purposes only. The purchase and surrender of allowances is due to commence from 2011/12.

1.27 Accounting standards that have been issued but have not yet been adopted

The standards which have been released but which are not mandatory in the 2010/11 accounts, and which have not been adopted early, are set out below:

- IFRS 9, Financial Instruments - This is a new standard which will eventually replace IAS 39, Financial Instruments: Recognition and Measurement. At the present time it is not clear when this standard will be applied because the EU has delayed its endorsement.

- IAS 24 (Revised), Related Party Transactions - This standard seeks to reduce the extent of disclosures required by government entities whose transactions are principally with other government entities, and is due for adoption in 2011/12. This may relieve NHS bodies from providing some related party disclosures with other entities within the Whole of Government Accounts boundary.

The following changes to the HM Treasury FReM are potentially applicable to NHS bodies from 2011/12:

- Treatment of Grants Received - Under the new approach, grants received towards the cost of an asset are
1.27 Accounting standards that have been issued but have not yet been adopted (continued)

recognised in income unless the funder imposes a condition on the grant e.g. that it must be used to fund the construction or acquisition of an asset. If there are no conditions, or once all conditions have been met, the grant is recognised in full within income. If adopted, the impact is likely to be an increase in volatility in annual results where capital grants are received or released once conditions have been met. When the change is applied, existing government grants deferred are likely to be released to the Income and Expenditure Reserve.

Donated Assets - The new approach for donated assets is effectively the same as treatment of grants received, above. Where donations are received without conditions, or where conditions have been met, they should be recognised in income. If brought into effect it would result in most, or all, donations being reflected in income in the year of receipt which could lead to greater volatility in the annual result. The existing donated asset reserve would be transferred to the Income and Expenditure Reserve and, where it includes an element of asset revaluation, to the revaluation reserve.

1.28 Investments in subsidiaries and joint ventures

Subsidiary entities are those over which the Trust has the power to exercise control so as to gain economic benefit or other benefits. A joint venture is a contractual arrangement whereby the Trust and other parties undertake an economic activity that is subject to joint control. Joint venture arrangements that involve the establishment of a separate entity in which each venturer has an interest is referred to as a jointly controlled entity.

The Trust consolidates the results of investments in subsidiaries and joint ventures where results are material to the Trust financial position.
2. SEGMENTAL ANALYSIS

The Trust has determined that the Chief Operating decision maker is the Board of Directors, on the basis that all strategic decisions are made by the Board. Segmental information is not provided to the Board of Directors and therefore it has been determined that there is only one business segment, that of Healthcare.

There are no differences between the figures reported to the Board in April 2011 and those included within these financial statements.

The Trust conducts the majority of its business with Health Bodies in England. Transactions with entities in Scotland, Ireland and Wales are conducted in the same manner as those within England.

The Trust generates its income predominantly from the provision of secondary care services. Organisations which contribute 10% or more of the Trust’s income are set out in the table below. Further information can be found in note 28, Related Party Transactions.

<table>
<thead>
<tr>
<th></th>
<th>2010/11</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Newcastle PCT</td>
<td>31</td>
<td>32</td>
</tr>
<tr>
<td>North Tyneside PCT</td>
<td>29</td>
<td>30</td>
</tr>
<tr>
<td>Northumberland Care Trust</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>North East Strategic Health Authority</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

The following is an analysis of the financial information provided to the Board of Directors in relation to the years ended 31 March 2011 and 31 March 2010.

<table>
<thead>
<tr>
<th></th>
<th>2010/11</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Operating income</td>
<td>780,944</td>
<td>742,572</td>
</tr>
<tr>
<td>Operating expenditure</td>
<td>(725,114)</td>
<td>(677,539)</td>
</tr>
<tr>
<td>Earnings before interest, tax, depreciation and amortisation</td>
<td>55,830</td>
<td>65,033</td>
</tr>
<tr>
<td>Non-operating income</td>
<td>455</td>
<td>325</td>
</tr>
<tr>
<td>Non-operating expenditure</td>
<td>(56,162)</td>
<td>(56,363)</td>
</tr>
<tr>
<td>Surplus for the year excluding impairments</td>
<td>123</td>
<td>8,995</td>
</tr>
<tr>
<td>Impairments</td>
<td>3,467</td>
<td>56,120</td>
</tr>
<tr>
<td>Surplus / (Deficit) for the year after impairments</td>
<td>(3,344)</td>
<td>(46,125)</td>
</tr>
</tbody>
</table>

Differences between the amounts presented to the Board in April 2011 and those included within these financial statements are purely presentational and relate to the earlier timing of information provided to the Board.

The prior year figures are those which were reported to the Board in April 2010. Due to the prior year adjustment regarding impairments, as detailed in the accounting policies and the SOCI, the figures previously reported to Board differ to the restated figures per the 2010/11 accounts.
3. OPERATING INCOME

3.1 Activity income analysed by activity

<table>
<thead>
<tr>
<th></th>
<th>2010/11 £000</th>
<th>2009/10 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective income</td>
<td>163,183</td>
<td>152,997</td>
</tr>
<tr>
<td>Non elective income</td>
<td>146,982</td>
<td>143,330</td>
</tr>
<tr>
<td>Outpatient income</td>
<td>96,430</td>
<td>65,870</td>
</tr>
<tr>
<td>A &amp; E income</td>
<td>7,505</td>
<td>6,808</td>
</tr>
<tr>
<td>Other NHS clinical income</td>
<td>233,238</td>
<td>218,057</td>
</tr>
<tr>
<td>Private patient income</td>
<td>4,217</td>
<td>3,838</td>
</tr>
<tr>
<td>Non-protected clinical income</td>
<td>2,251</td>
<td>2,413</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>652,806</strong></td>
<td><strong>613,313</strong></td>
</tr>
</tbody>
</table>

The Trust’s Terms of Authorisation set out the mandatory goods and services that the Trust is required to provide. All of the income from activities shown above, excluding private patient income and non-protected clinical income, is derived from the provision of mandatory services.

* Other NHS clinical income consists primarily of income received outside of the Payment by Results payment mechanism, e.g., specialised services and locally commissioned services. Payment by Results covers a significant volume of mainstream NHS activity and is primarily based on a specific tariff for a unit of activity, but does not cover specialised activity or locally commissioned activity.

** Non-protected clinical income relates to the NHS Injury Compensation Scheme and overseas patients.

3.1.1 Private patient income

<table>
<thead>
<tr>
<th></th>
<th>2010/11 £000</th>
<th>2009/10 £000</th>
<th>2002/03 (Base Year) £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private patient income</td>
<td>4,217</td>
<td>3,838</td>
<td>4,033</td>
</tr>
<tr>
<td><strong>Total patient related income</strong></td>
<td><strong>652,806</strong></td>
<td><strong>613,313</strong></td>
<td><strong>334,065</strong></td>
</tr>
<tr>
<td>Proportion (as percentage)</td>
<td>0.6%</td>
<td>0.6%</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

Section 44 of the National Health Services Act 2006 requires that the proportion of private patient income to the total patient related income of NHS Foundation Trusts should not exceed its proportion whilst the body was an NHS Trust in 2002/03. The Trust has met this requirement.
3. OPERATING INCOME (CONTINUED)

3.2 Activity income analysed by source

<table>
<thead>
<tr>
<th>Source</th>
<th>2010/11 £000</th>
<th>2009/10 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Foundation Trusts</td>
<td>676</td>
<td>517</td>
</tr>
<tr>
<td>NHS Trusts</td>
<td>17</td>
<td>116</td>
</tr>
<tr>
<td>Strategic Health Authorities</td>
<td>28,678</td>
<td>28,332</td>
</tr>
<tr>
<td>Primary Care Trusts</td>
<td>607,929</td>
<td>571,498</td>
</tr>
<tr>
<td>Local Authorities</td>
<td>551</td>
<td>562</td>
</tr>
<tr>
<td>Department of Health</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>NHS Other *</td>
<td>3,577</td>
<td>1,963</td>
</tr>
<tr>
<td>Non NHS (including non-English NHS):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Private Patients</td>
<td>4,217</td>
<td>3,838</td>
</tr>
<tr>
<td>- Overseas patients (non-reciprocal)</td>
<td>45</td>
<td>63</td>
</tr>
<tr>
<td>- NHS Injury Scheme (formerly RTA) **</td>
<td>2,206</td>
<td>2,350</td>
</tr>
<tr>
<td>- Other ***</td>
<td>4,910</td>
<td>4,071</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>652,806</strong></td>
<td><strong>613,313</strong></td>
</tr>
</tbody>
</table>

*NHS Other income relates primarily to specialist activity such as transplant related income.

**NHS Injury Compensation Scheme income is subject to a provision for doubtful debts to reflect expected rates of collection. The provision is based on the value of debts not recovered in previous years which is assessed at 11%. Any movement in year is adjusted against the receivable balance in the Statement of Financial Position.

***Non-NHS other income relates primarily to healthcare activity income from Scottish, Welsh and Irish health bodies.

4. OTHER OPERATING INCOME

<table>
<thead>
<tr>
<th>Source</th>
<th>2010/11 £000</th>
<th>2009/10 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research and development</td>
<td>17,543</td>
<td>15,508</td>
</tr>
<tr>
<td>Education and training</td>
<td>62,379</td>
<td>62,735</td>
</tr>
<tr>
<td>Transfers from donated asset reserve in respect of depreciation and disposal of donated assets</td>
<td>1,638</td>
<td>1,977</td>
</tr>
<tr>
<td>Non-patient care services to other bodies *</td>
<td>17,957</td>
<td>24,622</td>
</tr>
<tr>
<td>Reversal of impairments **</td>
<td>4,771</td>
<td>0</td>
</tr>
<tr>
<td>Other income ***</td>
<td>26,363</td>
<td>24,418</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>130,651</strong></td>
<td><strong>129,260</strong></td>
</tr>
</tbody>
</table>

*Non-patient care services to other bodies includes the provision of Estates services and the hosting of Regional Medical Physics.

**Further detail regarding the reversal of impairments can be found in note 12.

***Other income includes Department of Health funding for clinical excellence awards, clinical test income, lease rental income, car parking receipts and catering and nursery income. Also included is £76k (2009/10 £22k) government grant income. Grant income relates to specific pieces of property, plant and equipment and is released to income over the life of the assets.
4. OTHER OPERATING INCOME (CONTINUED)

4.1 Operating lease income

<table>
<thead>
<tr>
<th></th>
<th>2010/11</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rents recognised within other income in the year</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>560</td>
<td>412</td>
</tr>
</tbody>
</table>

**Future minimum lease payments due**

- not later than one year
  - 556
- later than one year and not later than five years
  - 916

**Total**

- 1,472
- 1,898

The Trust acts as lessor of certain buildings and office accommodation, principally for Healthcare purposes. The leases are all for a period of five years or less.

5. OPERATING EXPENSES

5.1 Operating expenses comprise:

<table>
<thead>
<tr>
<th>Description</th>
<th>2010/11</th>
<th>Restated 2009/10</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services from NHS Foundation Trusts</td>
<td>5,352</td>
<td>7,117</td>
<td></td>
</tr>
<tr>
<td>Services from NHS Trusts</td>
<td>1,011</td>
<td>999</td>
<td></td>
</tr>
<tr>
<td>Services from other NHS bodies</td>
<td>4,265</td>
<td>5,002</td>
<td></td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>6,460</td>
<td>4,668</td>
<td></td>
</tr>
<tr>
<td>Employee expenses - executive directors</td>
<td>1,049</td>
<td>1,066</td>
<td></td>
</tr>
<tr>
<td>Employee expenses - non-executive directors</td>
<td>133</td>
<td>144</td>
<td></td>
</tr>
<tr>
<td>Employee expenses - staff</td>
<td>437,339</td>
<td>423,604</td>
<td></td>
</tr>
<tr>
<td>Drugs costs</td>
<td>83,475</td>
<td>78,341</td>
<td></td>
</tr>
<tr>
<td>Supplies and services - clinical (excluding drugs costs)</td>
<td>92,534</td>
<td>87,705</td>
<td></td>
</tr>
<tr>
<td>Supplies and services - general</td>
<td>8,499</td>
<td>7,927</td>
<td></td>
</tr>
<tr>
<td>Establishment</td>
<td>7,673</td>
<td>7,709</td>
<td></td>
</tr>
<tr>
<td>Research and development (non-NHS only)</td>
<td>1,921</td>
<td>699</td>
<td></td>
</tr>
<tr>
<td>Transport</td>
<td>2,528</td>
<td>1,935</td>
<td></td>
</tr>
<tr>
<td>Premises</td>
<td>47,894</td>
<td>33,525</td>
<td></td>
</tr>
<tr>
<td>Bad debt expense</td>
<td>1,691</td>
<td>529</td>
<td></td>
</tr>
<tr>
<td>Depreciation on property, plant and equipment (note 12)</td>
<td>24,879</td>
<td>26,185</td>
<td></td>
</tr>
<tr>
<td>Amortisation on intangible assets (note 11)</td>
<td>490</td>
<td>277</td>
<td></td>
</tr>
<tr>
<td>Impairments of property, plant and equipment (note 12) *</td>
<td>8,238</td>
<td>68,806</td>
<td></td>
</tr>
<tr>
<td>Auditor’s remuneration - Statutory audit fee</td>
<td>97</td>
<td>83</td>
<td></td>
</tr>
<tr>
<td>Auditor’s remuneration - Further assurance services</td>
<td>22</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Auditor’s remuneration - Other services</td>
<td>73</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>NHSLA insurance premium</td>
<td>8,696</td>
<td>7,116</td>
<td></td>
</tr>
<tr>
<td>Loss on disposal of land and buildings</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Loss on disposal of other property, plant and equipment</td>
<td>576</td>
<td>211</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>11,568</td>
<td>9,140</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>756,463</td>
<td>772,805</td>
<td></td>
</tr>
</tbody>
</table>

* Impairments of property, plant and equipment in 2009/10 have been restated to reflect a change in accounting policy, as detailed in note 12.1.2.
5. OPERATING EXPENSES (CONTINUED)

5.2 Auditor’s remuneration

Statutory auditor’s remuneration of £97k is inclusive of non-recoverable VAT.

Other auditor’s remuneration of £73k includes a due diligence report on Transforming Community Services (TCS) £30k, a review of the PFI contract £20k, Quality Accounts services £18k and other services £5k. (2009/10: £17k for Information Governance review). Further information on the TCS transaction can be found in note 26, Events after the Reporting Date.

The Trust approved the principal terms of engagement with its auditor, PricewaterhouseCoopers LLP, on 21 November 2007, covering the period of PricewaterhouseCoopers LLP’s engagement as auditor. The terms include a limitation on their liability to pay damages for losses arising as a direct result of breach of contract or negligence, of £1m.

5.3 Operating leases

Arrangements containing an operating lease:

<table>
<thead>
<tr>
<th></th>
<th>2010/11</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum lease rentals</td>
<td>2,138</td>
<td>1,829</td>
</tr>
</tbody>
</table>

Future minimum lease payments due

<table>
<thead>
<tr>
<th></th>
<th>2010/11</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>- not later than one year</td>
<td>2,157</td>
<td>1,234</td>
</tr>
<tr>
<td>- later than one year and not later than five years</td>
<td>3,461</td>
<td>1,519</td>
</tr>
<tr>
<td>- later than five years</td>
<td>806</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6,424</td>
<td>2,753</td>
</tr>
</tbody>
</table>

The Trust leases certain buildings and equipment under operating leases where financial assessment has provided evidence that leasing provides better value for money than outright purchase. Operating leases for buildings are predominantly for residential and office space. Significant equipment operating leases relate to managed service contracts, as detailed below:

**Picture Archiving and Communication System (PACS)**

The PACS contract is for a period of 3 years and expires in September 2013. The provision of the service has been assessed as an operating lease under the requirements of IAS 17, Leases.

**Laboratory managed equipment services contract**

The Trust entered into a managed services contract with Roche Diagnostics Limited from 1 April 2010 for a period of 10 years for laboratory services. The provision of the equipment under this contract has been assessed as an operating lease under the requirements of IAS 17, Leases.
5. OPERATING EXPENSES (CONTINUED)

5.4 Salary and pension entitlements of senior managers

a) Remuneration excluding employer’s national insurance and pension costs

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>2010/11</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary (bands of £5,000) £000</td>
<td>Other Remuneration (bands of £5,000) £000</td>
</tr>
<tr>
<td>Chairman Mr K W Smith</td>
<td>50 - 55</td>
<td>50 - 55</td>
</tr>
<tr>
<td>Chief Executive Sir Leonard Fenwick</td>
<td>230 - 235</td>
<td>230 - 235</td>
</tr>
<tr>
<td>Finance Director Mrs A Dragone</td>
<td>155 - 160</td>
<td>155 - 160</td>
</tr>
<tr>
<td>Chief Operating Officer Mr D Allison *</td>
<td>170 - 175</td>
<td>160 - 165</td>
</tr>
<tr>
<td>Nursing &amp; Patient Services Director Mrs H Lamont</td>
<td>140 - 145</td>
<td>140 - 145</td>
</tr>
<tr>
<td>Medical Director Dr T J Walls **</td>
<td>150 - 155</td>
<td>150 - 155</td>
</tr>
<tr>
<td>Non Executive Director Professor P H Baylis</td>
<td>10 - 15</td>
<td>10 - 15</td>
</tr>
<tr>
<td>Non Executive Director Professor C P Day</td>
<td>10 - 15</td>
<td>10 - 15</td>
</tr>
<tr>
<td>Non Executive Director Mrs P Dodds (to 31 Oct-10)</td>
<td>5 - 10</td>
<td>10 - 15</td>
</tr>
<tr>
<td>Non Executive Director Mr J Kirkby</td>
<td>15 - 20</td>
<td>15 - 20</td>
</tr>
<tr>
<td>Non Executive Director Mrs H A Parker</td>
<td>10 - 15</td>
<td>10 - 15</td>
</tr>
<tr>
<td>Non Executive Director Mrs S Stewart (to 31-May-10)</td>
<td>0 - 5</td>
<td>10 - 15</td>
</tr>
<tr>
<td>Non Executive Director Councillor David Faulkner (to 21-Sep-10)</td>
<td>5 - 10</td>
<td>10 - 15</td>
</tr>
<tr>
<td>Non Executive Director Dr B Dobson (from 1-Oct-10)</td>
<td>5 - 10</td>
<td>0</td>
</tr>
<tr>
<td>Non Executive Director Mr E Weir (from 1-Dec-10)</td>
<td>0 - 5</td>
<td>0</td>
</tr>
<tr>
<td>Non Executive Director Ms S Kler (from 1-Nov-10)</td>
<td>0 - 5</td>
<td>0</td>
</tr>
</tbody>
</table>

* 2009/10 benefits in kind relate to inherited lease car commitments that were term-limited and which were transferred to the Trust from a previous employer on appointment.

** Other Remuneration for Dr T J Walls relates to remuneration for clinical duties.
5. OPERATING EXPENSES (CONTINUED)

5.4 Salary and pension entitlements of senior managers (continued)

b) Pension Benefits

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>Real increase in pension at aged 60</th>
<th>Total accrued pension at age 60 at 31 March 2011</th>
<th>Real increase in pension lump sum at aged 60</th>
<th>Lump sum at age 60 related to accrued pension at 31 March 2011</th>
<th>Cash Equivalent Transfer Value at 31 March 2011</th>
<th>Cash Equivalent Transfer Value at 31 March 2010</th>
<th>Real increase / (decrease) in Cash Equivalent Transfer Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive Sir Leonard Fenwick</td>
<td>(0 - 2.5)</td>
<td>120 - 122.5</td>
<td>0 - 2.5</td>
<td>345 - 347.5</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Finance Director Mrs A Dragone</td>
<td>2.5 - 5</td>
<td>45 - 47.5</td>
<td>7.5 - 10</td>
<td>140 - 142.5</td>
<td>676</td>
<td>729</td>
<td>(53)</td>
</tr>
<tr>
<td>Chief Operating Officer Mr D Allison</td>
<td>2.5 - 5</td>
<td>7.5 - 10</td>
<td>7.5 - 10</td>
<td>25 - 27.5</td>
<td>118</td>
<td>90</td>
<td>28</td>
</tr>
<tr>
<td>Nursing &amp; Patient Services Director Mrs H Lamont</td>
<td>7.5 - 10</td>
<td>60 - 62.5</td>
<td>25 - 27.5</td>
<td>182.5 - 185</td>
<td>1,232</td>
<td>1,154</td>
<td>78</td>
</tr>
<tr>
<td>Medical Director Dr T J Walls</td>
<td>2.5 - 5</td>
<td>90 - 92.5</td>
<td>7.5 - 10</td>
<td>275 - 277.5</td>
<td>2,015</td>
<td>2,096</td>
<td>(81)</td>
</tr>
</tbody>
</table>

The financial information disclosed in the table above is derived from information provided to the Trust from the NHS Pensions Agency. Whilst the Trust accepts responsibility for the values shown, the Trust is reliant upon the NHS Pensions Agency for the accuracy of the information provided to the Trust and is unable to audit the figures. The figures are therefore shown in good faith as an accurate reflection of the directors’ pension information.

Cash Equivalent Transfer Values

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

Real Increase / (decrease) in CETV

This reflects the increase or decrease in CETV, taking account the increase or decrease in accrued pension due to inflation and contributions paid by the employer during the year. Common market valuation factors are used for the start and end of the period. An apportionment of the real increase or decrease between employer and employee contributions is made, based on an assessment of their relative percentage contributions to the NHS Pension Scheme.

The up-rating (annual increase) of public sector pensions was changed, with effect from April 2011, from the Retail Prices Index (RPI) to the Consumer Prices Index (CPI). As a result, the Government Actuaries Department undertook a review of all transfer factors. The new CETV factors have been used in the calculations and are lower than the previous factors used. As a result, the value of some CETVs have fallen since 31 March 2010. The level of CETV increase or decrease is dependant on the age of a director and is also influenced by salary increases or decreases in year.
5. OPERATING EXPENSES (CONTINUED)

5.5. Staff costs and numbers

5.5.1 Staff costs

<table>
<thead>
<tr>
<th></th>
<th>2010/11</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wages and salaries</td>
<td>330,637</td>
<td>319,303</td>
</tr>
<tr>
<td>Social security costs</td>
<td>24,750</td>
<td>24,281</td>
</tr>
<tr>
<td>Employer contributions to NHS Business Services Authority - Pensions Division</td>
<td>38,055</td>
<td>36,640</td>
</tr>
<tr>
<td>Other pension costs to NHS Business Services Authority - Pensions Division</td>
<td>79</td>
<td>78</td>
</tr>
<tr>
<td>Agency and contract staff *</td>
<td>44,867</td>
<td>44,368</td>
</tr>
<tr>
<td></td>
<td><strong>438,388</strong></td>
<td><strong>424,670</strong></td>
</tr>
</tbody>
</table>

* Included within agency and contract staff is £28,763k (2009/10 £27,049k) related to recharges of junior doctors in training from County Durham & Darlington NHS Foundation Trust, the host body.

5.5.2 Average number of persons employed

<table>
<thead>
<tr>
<th></th>
<th>2010/11</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental staff</td>
<td>1,491</td>
<td>1,474</td>
</tr>
<tr>
<td>Administration and estatea staff</td>
<td>1,915</td>
<td>1,869</td>
</tr>
<tr>
<td>Healthcare assistants and other support staff</td>
<td>1,629</td>
<td>1,655</td>
</tr>
<tr>
<td>Nursing, midwifery and health visiting staff</td>
<td>3,263</td>
<td>3,193</td>
</tr>
<tr>
<td>Nursing, midwifery and health visiting learners</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Scientific, therapeutic and technical staff</td>
<td>2,028</td>
<td>1,984</td>
</tr>
<tr>
<td>Social care staff</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>Bank, contract and agency staff *</td>
<td>373</td>
<td>354</td>
</tr>
<tr>
<td></td>
<td><strong>10,729</strong></td>
<td><strong>10,562</strong></td>
</tr>
</tbody>
</table>

* Includes The Newcastle upon Tyne Hospitals NHS Foundation Trust in-house nurse and clerical bank staff.

5.5.3 Retirements due to ill-health

During 2010/11 there were 18 (2009/10: 10) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £1,167k (2009/10: £534k). The cost of these ill-health retirements will be borne by the NHS Pensions Agency.
6. BETTER PAYMENT PRACTICE CODE

6.1 Better Payment Practice Code - measure of compliance

<table>
<thead>
<tr>
<th></th>
<th>2010/11 Number</th>
<th>2010/11 Value £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Non-NHS trade invoices paid in the year</td>
<td>189,936</td>
<td>321,516</td>
</tr>
<tr>
<td>Total Non-NHS trade invoices paid within target</td>
<td>175,536</td>
<td>293,859</td>
</tr>
<tr>
<td>Percentage of Non-NHS trade invoices paid within target</td>
<td>92%</td>
<td>91%</td>
</tr>
<tr>
<td>Total NHS trade invoices paid in the year</td>
<td>6,206</td>
<td>92,514</td>
</tr>
<tr>
<td>Total NHS trade invoices paid within target</td>
<td>5,216</td>
<td>79,697</td>
</tr>
<tr>
<td>Percentage of NHS trade invoices paid within target</td>
<td>84%</td>
<td>86%</td>
</tr>
</tbody>
</table>

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

No payments were made under this legislation during the financial year (2009/10 £Nil).

7. FINANCE INCOME

<table>
<thead>
<tr>
<th></th>
<th>2010/11</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other loans and receivables</td>
<td>455</td>
<td>325</td>
</tr>
</tbody>
</table>

Finance income relates to interest received on short term deposits and other bank accounts.

8. FINANCE EXPENSE - INTEREST PAYABLE

<table>
<thead>
<tr>
<th></th>
<th>2010/11</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>PFI Interest</td>
<td>19,899</td>
<td>17,894</td>
</tr>
<tr>
<td>Finance leases</td>
<td>193</td>
<td>268</td>
</tr>
<tr>
<td>Loan interest</td>
<td>332</td>
<td>36</td>
</tr>
<tr>
<td>Other</td>
<td>72</td>
<td>86</td>
</tr>
<tr>
<td>Total</td>
<td>20,496</td>
<td>18,284</td>
</tr>
</tbody>
</table>

Other finance costs relate to interest in connection with a commercial agreement.
9. **PDC DIVIDENDS PAYABLE**

The Trust is required to pay a dividend to the Department of Health equal to 3.5% of the average of opening and closing net relevant assets for the year. As set out in the Foundation Trust Annual Reporting Manual, the calculation of the dividend excludes donated assets and cash held with the Government Banking Service.

10. **IMPAIRMENT OF ASSETS CHARGED TO STATEMENT OF COMPREHENSIVE INCOME**

<table>
<thead>
<tr>
<th></th>
<th>2010/11 £000</th>
<th>2009/10 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss or damage from normal operations</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Loss as a result of catastrophe</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Abandonment of assets in course of construction</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unforeseen obsolescence</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Over specification of assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other *</td>
<td>3,757</td>
<td>23,083</td>
</tr>
<tr>
<td>Changes in market price</td>
<td>4,481</td>
<td>45,723</td>
</tr>
<tr>
<td>Reversal of prior year impairments</td>
<td>(4,771)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3,467</td>
<td>68,806</td>
</tr>
</tbody>
</table>

* Other impairments are due to loss of economic benefit from buildings declared surplus when operations have been transferred to other Trust facilities.
11. INTANGIBLE ASSETS

<table>
<thead>
<tr>
<th>Software and software licences (purchased)</th>
<th>Assets under development</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Cost at 1 April 2010</td>
<td>4,018</td>
<td>0</td>
</tr>
<tr>
<td>Reclassifications</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Additions purchased</td>
<td>103</td>
<td>46</td>
</tr>
<tr>
<td>Disposals</td>
<td>(6)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Gross cost at 31 March 2011</strong></td>
<td><strong>4,115</strong></td>
<td><strong>46</strong></td>
</tr>
<tr>
<td>Accumulated amortisation at 1 April 2010</td>
<td>988</td>
<td>0</td>
</tr>
<tr>
<td>Provided during the year</td>
<td>490</td>
<td>0</td>
</tr>
<tr>
<td>Disposals</td>
<td>(6)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Accumulated amortisation at 31 March 2011</strong></td>
<td><strong>1,472</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><strong>Net book value</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchased</td>
<td>2,643</td>
<td>46</td>
</tr>
<tr>
<td>Donated</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total at 31 March 2011</strong></td>
<td><strong>2,643</strong></td>
<td><strong>46</strong></td>
</tr>
<tr>
<td>Cost at 1 April 2009</td>
<td>1,785</td>
<td>0</td>
</tr>
<tr>
<td>Reclassifications</td>
<td>406</td>
<td>0</td>
</tr>
<tr>
<td>Additions purchased</td>
<td>1,827</td>
<td>0</td>
</tr>
<tr>
<td><strong>Gross cost at 31 March 2010</strong></td>
<td><strong>4,018</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td>Accumulated amortisation at 1 April 2009</td>
<td>711</td>
<td>0</td>
</tr>
<tr>
<td>Provided during the year</td>
<td>277</td>
<td>0</td>
</tr>
<tr>
<td><strong>Accumulated amortisation at 31 March 2010</strong></td>
<td><strong>988</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><strong>Net book value</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchased</td>
<td>3,030</td>
<td>0</td>
</tr>
<tr>
<td>Donated</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total at 31 March 2010</strong></td>
<td><strong>3,030</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><strong>Net book value at 1 April 2009</strong></td>
<td><strong>1,074</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

The Trust does not hold any donated intangible assets (31 March 2010 £Nil) and has no intangibles funded by government grant (31 March 2010 £Nil)

Reclassifications

The reclassification of £Nil (2009/10 £406k) relates to software licences purchased as part of items of equipment, transferred from Property, Plant & Equipment when they become operational. An equal and opposite reclassification is shown within note 12, Property, Plant & Equipment.

Revaluations

At the year end a review was carried out to determine if the fair value of Intangible Assets was still appropriately stated. No adjustment to fair value was deemed necessary.
### 12. PROPERTY, PLANT AND EQUIPMENT

#### 12.1 Property, plant and equipment at the balance sheet date comprise the following elements:

##### 12.1.1 2010/11 Financial Year

<table>
<thead>
<tr>
<th></th>
<th>Land £000</th>
<th>Buildings excluding dwellings £000</th>
<th>Dwellings £000</th>
<th>Assets under construction &amp; payments on account £000</th>
<th>Plant and Machinery £000</th>
<th>Transport Equipment £000</th>
<th>Information Technology £000</th>
<th>Furniture &amp; fittings £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost or valuation at 1 April 2010</strong></td>
<td>83,913</td>
<td>409,261</td>
<td>828</td>
<td>25,596</td>
<td>137,280</td>
<td>431</td>
<td>16,340</td>
<td>807</td>
<td>674,456</td>
</tr>
<tr>
<td>Additions purchased</td>
<td>0</td>
<td>7,019</td>
<td>0</td>
<td>29,997</td>
<td>8,044</td>
<td>0</td>
<td>594</td>
<td>6</td>
<td>45,600</td>
</tr>
<tr>
<td>Additions donated</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,653</td>
<td>0</td>
<td>153</td>
<td>0</td>
<td>1,606</td>
</tr>
<tr>
<td>Reclassifications *</td>
<td>0</td>
<td>13,943</td>
<td>0</td>
<td>(14,616)</td>
<td>613</td>
<td>0</td>
<td>60</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Revaluations**</td>
<td>1,238</td>
<td>399</td>
<td>428</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2,115</td>
</tr>
<tr>
<td>Impairments**</td>
<td>(1,565)</td>
<td>(3,788)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(5,373)</td>
</tr>
<tr>
<td>Disposals</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(224)</td>
<td>(14,067)</td>
<td>0</td>
<td>(744)</td>
<td>(58)</td>
<td>(15,193)</td>
</tr>
<tr>
<td><strong>Cost or valuation at 31 March 2011</strong></td>
<td>83,616</td>
<td>426,834</td>
<td>1,256</td>
<td>40,653</td>
<td>133,323</td>
<td>431</td>
<td>16,343</td>
<td>755</td>
<td>703,211</td>
</tr>
<tr>
<td>Depreciation at 1 April 2010</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>88,155</td>
<td>366</td>
<td>10,319</td>
<td>742</td>
<td>99,582</td>
</tr>
<tr>
<td>Provided during the year</td>
<td>0</td>
<td>14,273</td>
<td>19</td>
<td>0</td>
<td>8,716</td>
<td>22</td>
<td>1,836</td>
<td>13</td>
<td>24,879</td>
</tr>
<tr>
<td>Impairments**</td>
<td>181</td>
<td>3,060</td>
<td>226</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3,467</td>
</tr>
<tr>
<td>Revaluation surpluses**</td>
<td>0</td>
<td>(14,269)</td>
<td>(19)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(14,288)</td>
</tr>
<tr>
<td>Disposals</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(13,789)</td>
<td>0</td>
<td>(744)</td>
<td>(58)</td>
<td>(14,591)</td>
<td></td>
</tr>
<tr>
<td><strong>Depreciation at 31 March 2011</strong></td>
<td>181</td>
<td>3,064</td>
<td>226</td>
<td>0</td>
<td>83,082</td>
<td>388</td>
<td>11,411</td>
<td>697</td>
<td>99,049</td>
</tr>
</tbody>
</table>

#### Net book value

- Purchased at 1 April 2010 | 83,913 | 397,187 | 828 | 25,596 | 44,064 | 65 | 5,683 | 59 | 557,395 |
- Donated at 1 April 2010 | 0 | 12,074 | 0 | 0 | 5,061 | 0 | 338 | 6 | 17,479 |
| **Total at 1 April 2010** | 83,913 | 409,261 | 828 | 25,596 | 49,125 | 65 | 6,021 | 65 | 574,874 |
- Purchased at 31 March 2011 | 83,435 | 411,446 | 1,030 | 40,653 | 44,767 | 43 | 4,510 | 53 | 585,937 |
- Donated at 31 March 2011 | 0 | 12,324 | 0 | 0 | 5,474 | 0 | 422 | 5 | 18,225 |
| **Total at 31 March 2011** | 83,435 | 423,770 | 1,030 | 40,653 | 50,241 | 43 | 4,932 | 58 | 604,162 |

#### Property, plant and equipment financing

- Owned | 83,435 | 190,210 | 1,000 | 40,653 | 44,767 | 43 | 4,510 | 53 | 364,701 |
- Finance leased | 0 | 3,652 | 0 | 0 | 0 | 0 | 0 | 0 | 3,652 |
- PFI | 0 | 217,584 | 0 | 0 | 0 | 0 | 0 | 0 | 217,584 |
- Donated | 0 | 12,324 | 0 | 0 | 5,474 | 0 | 422 | 5 | 18,225 |
| **Total at 31 March 2011** | 83,435 | 423,770 | 1,030 | 40,653 | 50,241 | 43 | 4,932 | 58 | 604,162 |

* Reclassifications
The reclassifications relate to transfers from assets under construction to other asset categories once the project to which they relate has been completed.

** Impairments and revaluations
During 2010/11 the following revaluations took place which resulted in impairments recognised in operating expenses, reversal of prior year impairments and impairments charged to the revaluation and donated asset reserves:

- £4,655k charged to operating expenses and £5,159k charged to the revaluation reserve relating to buildings demolished or identified as surplus across all sites. The buildings which have not been demolished are not held for sale.

- £897k credited to operating expenses and £3,852k to revaluation reserve in relation to the re-instatement of a building at the NGH site previously declared as surplus and subsequently identified as being required for operational purposes.

- A valuation of the Trust’s estate was carried out as at 31 March 2011 by a qualified valuer within the Valuation Office Agency. The valuation was based on both national and regional Building Cost Indices. Both indices increased during 2010/11 leading to an overall increase in asset values of £7,562k. The valuation resulted in the following income, expenditure and reserve movements:

  i) a £4,480k charge to operating expenses as impairments in year;
  ii) a £4,771k credit to operating income as a reversal of prior year impairments;
  iii) a net £6,383k increase in revaluation reserve (consisting of a £11,756k increase and £5,373k impairment);
  iv) a £795k credit to the donated asset reserve.

The revaluation was accounted for as at 31 March 2011 and accumulated depreciation and asset lives adjusted accordingly.

- Reconciliation of impairments and revaluations to amounts disclosed in table above:

  **Cost or valuation:**
  - Revaluations, £2,115k: made up of £11,756k (c iii), £3,852k (b), £795k (c iv), less revaluation surpluses £14,288k in depreciation section.
  - Impairments £(5,373k): made up of £5,373k (c iii).

  **Depreciation:**
  - Impairments £3,467k: made up of £4,655k (a), £4,480k (c i), less £897k (b), less £4,771k (c ii).

  Note that the £5,159k in point a) relates to a transfer between the Revaluation and I&E reserve as detailed in the “Other movements on reserves” in the SOCITE.
12. PROPERTY, PLANT AND EQUIPMENT (CONTINUED)

12.1 Property, plant and equipment at the balance sheet date comprise the following elements (continued):

12.1.2 2009/10 Financial Year

|                          | Cost or valuation at 1 April 2009 | Buildings excluding dwellings | Dwellings | Assets under construction & payments on account | Plant and Machinery | Transport Equipment | Information Technology | Furniture & fittings | Total/
<table>
<thead>
<tr>
<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></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Cost or valuation at 1 April 2009</td>
<td>77,826</td>
<td>422,190</td>
<td>874</td>
<td>9,849</td>
<td>125,570</td>
<td>438</td>
<td>15,344</td>
<td>821</td>
<td>652,912</td>
</tr>
<tr>
<td>Additions purchased</td>
<td>0</td>
<td>96,008</td>
<td>1</td>
<td>21,566</td>
<td>12,535</td>
<td>0</td>
<td>596</td>
<td>0</td>
<td>130,735</td>
</tr>
<tr>
<td>Additions donated</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,327</td>
<td>0</td>
<td>123</td>
<td>0</td>
<td>0</td>
<td>1,450</td>
</tr>
<tr>
<td>Reclassifications *</td>
<td>0</td>
<td>2,255</td>
<td>0</td>
<td>(4,236)</td>
<td>1,236</td>
<td>0</td>
<td>339</td>
<td>0</td>
<td>(406)</td>
</tr>
<tr>
<td>Reclassification from non current assets held for sale</td>
<td>5,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5,000</td>
</tr>
<tr>
<td>Impairments recognised in operating expenses **</td>
<td>0</td>
<td>(68,806)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(68,806)</td>
</tr>
<tr>
<td>Revaluation charged to revaluation and donated asset reserves and depreciation eliminated on revaluation **</td>
<td>1,087</td>
<td>(42,396)</td>
<td>(47)</td>
<td>(1,455)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(42,801)</td>
</tr>
<tr>
<td>Disposals</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(158)</td>
<td>(3,388)</td>
<td>(7)</td>
<td>(61)</td>
<td>(14)</td>
<td>(3,628)</td>
</tr>
<tr>
<td>Cost or valuation at 31 March 2010</td>
<td>83,913</td>
<td>409,261</td>
<td>828</td>
<td>25,596</td>
<td>137,280</td>
<td>431</td>
<td>16,340</td>
<td>807</td>
<td>674,456</td>
</tr>
<tr>
<td>Depreciation at 1 April 2009</td>
<td>0</td>
<td>17,115</td>
<td>19</td>
<td>0</td>
<td>82,936</td>
<td>343</td>
<td>8,598</td>
<td>743</td>
<td>109,754</td>
</tr>
<tr>
<td>Provided during the year</td>
<td>0</td>
<td>15,887</td>
<td>19</td>
<td>0</td>
<td>8,481</td>
<td>25</td>
<td>1,782</td>
<td>13</td>
<td>26,187</td>
</tr>
<tr>
<td>Depreciation eliminated on revaluation</td>
<td>0</td>
<td>(32,982)</td>
<td>(38)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(33,339)</td>
</tr>
<tr>
<td>Disposals</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(158)</td>
<td>(3,388)</td>
<td>(7)</td>
<td>(61)</td>
<td>(14)</td>
<td>(3,628)</td>
</tr>
<tr>
<td>Depreciation at 31 March 2010</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>88,155</td>
<td>366</td>
<td>10,319</td>
<td>742</td>
<td>99,582</td>
<td>543,158</td>
</tr>
</tbody>
</table>

** Reclassifications
The reclassifications of £406k relate to software purchased as part of items of equipment, transferred to Intangible Assets when they become operational. An equal and opposite reclassification is shown within note 11, Intangible Assets. Reclassifications also include transfers from assets under construction to other asset categories once the project to which they relate to has been completed.

** Impairments
During 2009/10 the following revaluations took place which resulted in impairments recognised in operating expenses and impairments charged to the revaluation and donated asset reserves:

a) £5,397k charged to operating expenses and £8,610k charged to the revaluation reserve relating to buildings demolished or identified as surplus, as part of the Transforming Newcastle Hospitals PFI scheme. These buildings were primarily related to activities which are now being carried out in the new Victoria Wing Levels 4-6 and the Great North Children’s Hospital. The buildings which were not demolished were not held for sale.

b) A formal valuation of the Trust’s estate was carried out as at 31 March 2010 by a qualified valuer within the Valuation Office Agency. The valuation was based on both national and regional Building Cost Indices. Both indices fell significantly during 2009/10 due to the economic climate, leading to a significant fall in asset values which resulted in £45,723k charged to operating expenses, £10,795k to the revaluation reserve and £3,891k to the donated asset reserve. Where buildings had previously been revalued any balance included in the revaluation reserve was utilised before any charge to the statement of comprehensive income. This revaluation was accounted for as at 31 March 2010 and accumulated depreciation and asset lives adjusted accordingly.

As a result of a change in accounting policy relating to impairments, an adjustment has been made as a prior period adjustment. For buildings excluding dwellings, impairments recognised in operating expenses have been increased by £13,686k to £68,806k, and revaluation charged to revaluation reserve has been reduced by £13,686k to £42,386k.
12. PROPERTY, PLANT AND EQUIPMENT (CONTINUED)

12.2 Analysis of tangible fixed assets

<table>
<thead>
<tr>
<th></th>
<th>Land £000</th>
<th>Buildings excluding dwellings £000</th>
<th>Dwellings £000</th>
<th>Assets under construction &amp; payments on account £000</th>
<th>Plant and Machinery £000</th>
<th>Transport Equipment £000</th>
<th>Information Technology £000</th>
<th>Furniture &amp; fittings £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total at 31 March 2011</strong></td>
<td>83,435</td>
<td>423,770</td>
<td>1,030</td>
<td>40,653</td>
<td>50,241</td>
<td>43</td>
<td>4,932</td>
<td>58</td>
<td>604,162</td>
</tr>
</tbody>
</table>

- Protected assets at 31 March 2011: 52,995 380,016 360 0 0 0 0 0 433,371
- Unprotected assets at 31 March 2011: 30,440 43,754 670 40,653 50,241 43 4,932 58 170,791

Net book value

12.3 Assets held at open market value

Of the closing balance at 31 March 2011, £14.9m (2009/10: £14.4m) related to land and dwellings valued at open market value.
12. PROPERTY, PLANT AND EQUIPMENT \((CONTINUED)\)

12.4 Net book value of land, buildings and dwellings

<table>
<thead>
<tr>
<th></th>
<th>31 March 2011</th>
<th>31 March 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Protected £000</td>
<td>Unprotected £000</td>
</tr>
<tr>
<td>Freehold</td>
<td>433,371</td>
<td>74,864</td>
</tr>
</tbody>
</table>

12.5 Analysis of assets held under finance leases and PFI contracts

<table>
<thead>
<tr>
<th></th>
<th>Finance leases £000</th>
<th>PFI arrangements £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost at 1 April 2010</td>
<td>3,664</td>
<td>218,675</td>
<td>222,339</td>
</tr>
<tr>
<td>Additions</td>
<td>0</td>
<td>198</td>
<td>198</td>
</tr>
<tr>
<td>Revaluation</td>
<td>(12)</td>
<td>(1,285)</td>
<td>(1,297)</td>
</tr>
<tr>
<td><strong>Cost at 31 March 2011</strong></td>
<td><strong>3,652</strong></td>
<td><strong>217,588</strong></td>
<td><strong>221,240</strong></td>
</tr>
<tr>
<td>Depreciation at 1 April 2010</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Provided during the year</td>
<td>136</td>
<td>4,971</td>
<td>5,107</td>
</tr>
<tr>
<td>Depreciation eliminated on revaluation</td>
<td>(136)</td>
<td>(4,967)</td>
<td>(5,103)</td>
</tr>
<tr>
<td><strong>Depreciation at 31 March 2011</strong></td>
<td><strong>0</strong></td>
<td><strong>4</strong></td>
<td><strong>4</strong></td>
</tr>
<tr>
<td><strong>Net book value at 31 March 2011</strong></td>
<td><strong>3,652</strong></td>
<td><strong>217,584</strong></td>
<td><strong>221,236</strong></td>
</tr>
</tbody>
</table>

|                     | 3,416               | 174,352               | 177,768    |
| Additions           | 0                   | 89,496                | 89,496     |
| Impairments         | 248                 | (45,173)              | (44,925)   |
| **Cost at 31 March 2010** | **3,664**             | **218,675**            | **222,339** |
| Depreciation at 1 April 2009 | 118           | 4,984                | 5,102      |
| Provided during the year | 157           | 5,421                | 5,578      |
| Impairments         | (275)              | (10,405)              | (10,680)   |
| **Depreciation at 31 March 2010** | **0**             | **0**                  | **0**      |
| **Net book value at 31 March 2010** | **3,664**         | **218,675**           | **222,339** |

The Trust has one finance lease which relates to the Multi-Storey car park at the Royal Victoria Infirmary site. The lease expires in 2012 when the building reverts to the Trust.

The PFI arrangements relate to the Transforming Newcastle Hospitals scheme and the Boiler Houses at the RVI and Freeman sites. See note 21 for further information.
## INVESTMENTS IN SUBSIDIARIES AND JOINT VENTURES

<table>
<thead>
<tr>
<th></th>
<th>2010/11 £000</th>
<th>2009/10 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost at 1 April</td>
<td>130</td>
<td>50</td>
</tr>
<tr>
<td>Additions</td>
<td>0</td>
<td>80</td>
</tr>
<tr>
<td><strong>Cost at 31 March</strong></td>
<td><strong>130</strong></td>
<td><strong>130</strong></td>
</tr>
<tr>
<td>Impairment at 1 April</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairment in year</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Provision at 31 March</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><strong>Net book value</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total at 1 April</td>
<td>130</td>
<td>50</td>
</tr>
<tr>
<td><strong>Net book value</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total at 31 March</td>
<td>130</td>
<td>130</td>
</tr>
</tbody>
</table>

The investments relate to the shareholdings detailed below. The investments in companies which would qualify as subsidiaries have not been consolidated into these accounts on the basis of immateriality.

Freeman Clinics Limited, a company incorporated in the UK for the purpose of providing primary care services - the Trust holds 80% of the ordinary share capital of the company, the Trust’s investment all being in ordinary shares at a cost of £80k. The company commenced trading in July 2009.

Newgene Limited - The Trust owns 55% of the £100 ordinary share capital of Newgene Limited, a company incorporated in the UK for the purpose of providing DNA diagnostics and rapid DNA sequencing services.

Limbs Alive Limited - The Trust owns 24.5% of the ordinary share capital of Limbs Alive Limited, a company incorporated on 21 July 2010 for the development of interactive software, primarily for the therapy of medical disorders in children, in particular for movement disorders such as stroke and cerebral palsy. The company has not yet commenced trading.

Pulse Diagnostics Limited, a company incorporated in the UK for the purpose of developing a method of measuring and analysing pulse wave data for application in early detection of Peripheral Vascular Disease - at 31 March 2011, the Trust held 52.9% of the total share capital of the company (86% of the ordinary shares), the Trust’s investment all being in ordinary shares. The cost of this investment is £50k. The company has not yet commenced trading.

The Trust also has shareholdings in the following dormant companies:

Crossco (1080) Limited - The Trust owns 50% of the £100 ordinary share capital of Crossco (1080) Limited, a company incorporated in the UK for the purpose of exploitation of software rights. The company has not commenced trading.

Norprime (Wallsend) Limited - The Trust owns 100% of the £1 ordinary share capital of Norprime (Wallsend) Limited, a company incorporated in the UK for general commercial activities. The company has not commenced trading.

The directors believe that the carrying value of the investments is supported by their underlying net assets.
14. INVENTORIES

<table>
<thead>
<tr>
<th></th>
<th>31 March 2011</th>
<th>31 March 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raw materials and consumables</td>
<td>£16,481</td>
<td>£16,073</td>
</tr>
<tr>
<td>Inventories recognised in expenses</td>
<td>£182,978</td>
<td>£175,533</td>
</tr>
</tbody>
</table>

15. TRADE AND OTHER RECEIVABLES

15.1 Analysis of trade and other receivables

<table>
<thead>
<tr>
<th></th>
<th>31 March 2011</th>
<th>31 March 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS trade receivables</td>
<td>£8,974</td>
<td>£16,039</td>
</tr>
<tr>
<td>Non-NHS trade receivables</td>
<td>£7,067</td>
<td>£4,659</td>
</tr>
<tr>
<td>Provision for impaired receivables</td>
<td>(£1,667)</td>
<td>(£1,276)</td>
</tr>
<tr>
<td>Other receivables with related parties *</td>
<td>£1,893</td>
<td>£225</td>
</tr>
<tr>
<td>Prepayments</td>
<td>£6,926</td>
<td>£5,765</td>
</tr>
<tr>
<td>PFI prepayment</td>
<td>£203</td>
<td>0</td>
</tr>
<tr>
<td>Accrued income</td>
<td>£15,325</td>
<td>£15,388</td>
</tr>
<tr>
<td>PDC receivable</td>
<td>0</td>
<td>£2,034</td>
</tr>
<tr>
<td>Other receivables</td>
<td>£6,037</td>
<td>£6,143</td>
</tr>
<tr>
<td>Sub total</td>
<td>£44,758</td>
<td>£48,977</td>
</tr>
</tbody>
</table>

| Non-current            |               |               |
| PFI prepayment         | £1,700        | 0             |
| Other receivables      | £600          | £550          |
| Provision for impaired receivables | (£600) | 0 |
| Sub total              | £1,700        | £550          |

Total trade and other receivables £46,458 £49,527

* From 2011/12, the accounts of Foundation Trusts will be consolidated into the Department of Health Resource Accounts. From 2010/11, in preparation for this exercise, a number of bodies within the Whole of Government have been reclassified as related parties, including the Health Protection Agency, Her Majesty’s Revenue & Customs (HMRC), the Department of Health and Irish Health Bodies. 2009/10 balances included amounts owed from Charitable Funds only.
15. **TRADE AND OTHER RECEIVABLES (CONTINUED)**

15.2 Provision for impaired trade receivables (provision for doubtful debts)

<table>
<thead>
<tr>
<th></th>
<th>31 March 2011</th>
<th>31 March 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>£000</strong></td>
<td><strong>£000</strong></td>
<td><strong>£000</strong></td>
</tr>
<tr>
<td>At start of year</td>
<td>1,276</td>
<td>1,366</td>
</tr>
<tr>
<td>Increase in provision</td>
<td>2,156</td>
<td>1,276</td>
</tr>
<tr>
<td>Amounts utilised</td>
<td>(700)</td>
<td>(619)</td>
</tr>
<tr>
<td>Unused amounts reversed</td>
<td>(465)</td>
<td>(747)</td>
</tr>
<tr>
<td><strong>At 31 March</strong></td>
<td>2,267</td>
<td>1,276</td>
</tr>
</tbody>
</table>

Included within the above is an amount of £463k (2009/10: £327k) relating to the Road Traffic Accident provision which is classified as a non-financial asset.

15.3 Analysis of provision for impaired trade receivables (provision for doubtful debts)

<table>
<thead>
<tr>
<th></th>
<th>31 March 2011</th>
<th>31 March 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>£000</strong></td>
<td><strong>£000</strong></td>
<td><strong>£000</strong></td>
</tr>
<tr>
<td><strong>Ageing of impaired trade receivables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to three months</td>
<td>577</td>
<td>155</td>
</tr>
<tr>
<td>In three to six months</td>
<td>110</td>
<td>237</td>
</tr>
<tr>
<td>Over six months</td>
<td>1,580</td>
<td>884</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,267</td>
<td>1,276</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>31 March 2011</th>
<th>31 March 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>£000</strong></td>
<td><strong>£000</strong></td>
<td><strong>£000</strong></td>
</tr>
<tr>
<td><strong>Ageing of non-impaired trade receivables past their due date</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to three months</td>
<td>2,251</td>
<td>2,928</td>
</tr>
<tr>
<td>In three to six months</td>
<td>660</td>
<td>1,536</td>
</tr>
<tr>
<td>Over six months *</td>
<td>3,544</td>
<td>3,167</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6,455</td>
<td>7,631</td>
</tr>
</tbody>
</table>

* Non-impaired debtors over six months old include Road Traffic Accident debts. The Trust does not hold any collateral over these balances.

16. **OTHER FINANCIAL ASSETS**

<table>
<thead>
<tr>
<th></th>
<th>31 March 2011</th>
<th>31 March 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>£000</strong></td>
<td><strong>£000</strong></td>
<td><strong>£000</strong></td>
</tr>
<tr>
<td>Loans and receivables - EU emissions scheme</td>
<td>3,175</td>
<td>1,854</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3,175</td>
<td>1,854</td>
</tr>
</tbody>
</table>
17. CASH AND CASH EQUIVALENTS

<table>
<thead>
<tr>
<th></th>
<th>31 March 2011</th>
<th>31 March 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Balance at 1 April</td>
<td>51,749</td>
<td>61,815</td>
</tr>
<tr>
<td>Net change in year</td>
<td>2,204</td>
<td>(10,066)</td>
</tr>
<tr>
<td>Balance at 31 March</td>
<td>53,953</td>
<td>51,749</td>
</tr>
</tbody>
</table>

**Made up of:**

- Cash at commercial banks and in hand: 1,434 5,102
- Cash with the Government Banking Service: 52,519 16,647
- Other current investments: 0 30,000

**Cash and cash equivalents as per statement of financial position:**

53,953 51,749

There is no difference between cash and cash equivalents as detailed above and cash and cash equivalents in the Statement of Cash Flows.

18. TRADE AND OTHER PAYABLES

<table>
<thead>
<tr>
<th></th>
<th>31 March 2011</th>
<th>31 March 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Current</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receipts in advance</td>
<td>12,646</td>
<td>10,784</td>
</tr>
<tr>
<td>NHS payables</td>
<td>5,258</td>
<td>3,108</td>
</tr>
<tr>
<td>Amounts due to other related parties *</td>
<td>5,526</td>
<td>0</td>
</tr>
<tr>
<td>Other payables</td>
<td>15,494</td>
<td>17,031</td>
</tr>
<tr>
<td>Accruals</td>
<td>28,447</td>
<td>22,028</td>
</tr>
<tr>
<td>Trade payables - capital</td>
<td>4,000</td>
<td>6,836</td>
</tr>
<tr>
<td>Other trade payables *</td>
<td>0</td>
<td>8,306</td>
</tr>
<tr>
<td>PDC payable</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td><strong>Sub total</strong></td>
<td>71,395</td>
<td>68,093</td>
</tr>
<tr>
<td><strong>Non current</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>839</td>
<td>1,226</td>
</tr>
<tr>
<td><strong>Sub total</strong></td>
<td>839</td>
<td>1,226</td>
</tr>
</tbody>
</table>

**Total trade and other payables:**

72,234 69,319

* From 2011/12, the accounts of Foundation Trusts will be consolidated into the Department of Health Resource Accounts. From 2010/11, in preparation for this exercise, a number of bodies within the Whole of Government have been reclassified as related parties, including HMRC. 2009/10 amounts owed to HMRC were included within other trade payables.
19. OTHER LIABILITIES

<table>
<thead>
<tr>
<th></th>
<th>31 March 2011 £000</th>
<th>31 March 2010 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deferred income</td>
<td>20,916</td>
<td>13,703</td>
</tr>
<tr>
<td>Deferred government grant</td>
<td>752</td>
<td>827</td>
</tr>
<tr>
<td><strong>Total other liabilities</strong></td>
<td><strong>21,668</strong></td>
<td><strong>14,530</strong></td>
</tr>
</tbody>
</table>

20. PRUDENTIAL BORROWING LIMIT

The Trust is required to comply and remain within the Prudential Borrowing Limit (PBL) as determined by Monitor, the Independent Regulator of Foundation Trusts. The PBL is the limit that Monitor calculates that the Trust could permanently borrow and service from its resources should it require access to additional funds for investment. The PBL is made up of 2 elements:

- the maximum cumulative amount of long-term borrowing, set by reference to the 5 ratio tests set out in Monitor’s Prudential Borrowing Code. The maximum sum is then capped based on Monitor’s risk assessment of the Trust as described under Monitor’s Compliance Framework. The financial risk rating set under the Compliance Framework determines one of the ratios and therefore can impact upon the long term borrowing limit.

- the amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the independent Regulator of Foundation Trusts, at www.monitor-nhsft.gov.uk.

The Trust’s prudential borrowing limit was reduced by £59.9m to £327m for 2010/11. The Trust’s 2009/10 Prudential Borrowing Limit was set at the maximum level based on Monitor’s assessment which takes into account the maximum borrowing required for the Trust’s PFI schemes and other long term borrowing. The 2010/11 Prudential Borrowing Limit only allows for the borrowing required in the 2010/11 year for those items and it is made up as follows:

**Prudential Borrowing Limit**

<table>
<thead>
<tr>
<th></th>
<th>31 March 2011 £000</th>
<th>31 March 2010 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum cumulative long term borrowing</td>
<td>277,000</td>
<td>336,900</td>
</tr>
<tr>
<td>Approved working capital facility</td>
<td>50,000</td>
<td>50,000</td>
</tr>
<tr>
<td><strong>Total prudential borrowing limit</strong></td>
<td><strong>327,000</strong></td>
<td><strong>386,900</strong></td>
</tr>
</tbody>
</table>

**Borrowings under the PBL**

<table>
<thead>
<tr>
<th></th>
<th>31 March 2011 £000</th>
<th>31 March 2010 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borrowings at 1 April</td>
<td>261,176</td>
<td>173,361</td>
</tr>
<tr>
<td>Net actual borrowing in year</td>
<td>529</td>
<td>87,815</td>
</tr>
<tr>
<td><strong>Borrowings at 31 March</strong></td>
<td><strong>261,705</strong></td>
<td><strong>261,176</strong></td>
</tr>
</tbody>
</table>

The prior year figures have been updated to reflect the fact that borrowings for the purposes of the PBL relate to both current and non-current borrowings.
20. **PRUDENTIAL BORROWING LIMIT (CONTINUED)**

The Trust had no borrowings during the year under its working capital facility (2009/10: £Nil).

The Trust’s key financial ratios are set out below:

### 2010/11 Financial Ratios

<table>
<thead>
<tr>
<th>Ratio</th>
<th>Actual Ratio</th>
<th>Approved PBL Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Dividend Cover</td>
<td>3</td>
<td>&gt; 1 x</td>
</tr>
<tr>
<td>Minimum Interest Cover</td>
<td>3</td>
<td>&gt; 2 x</td>
</tr>
<tr>
<td>Minimum Debt Service Cover</td>
<td>2</td>
<td>&gt; 1.5 x</td>
</tr>
<tr>
<td>Maximum Debt Service to Revenue</td>
<td>3%</td>
<td>&lt; 10%</td>
</tr>
</tbody>
</table>

### 2009/10 Financial Ratios

<table>
<thead>
<tr>
<th>Ratio</th>
<th>Actual Ratio</th>
<th>Approved PBL Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Dividend Cover</td>
<td>4</td>
<td>&gt; 1 x</td>
</tr>
<tr>
<td>Minimum Interest Cover</td>
<td>4</td>
<td>&gt; 2 x</td>
</tr>
<tr>
<td>Minimum Debt Service Cover</td>
<td>3</td>
<td>&gt; 1.5 x</td>
</tr>
<tr>
<td>Maximum Debt Service to Revenue</td>
<td>3%</td>
<td>&lt; 10%</td>
</tr>
</tbody>
</table>

21. **BORROWINGS**

21.1 **Total Borrowings**

<table>
<thead>
<tr>
<th></th>
<th>31 March 2011</th>
<th>31 March 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-current</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Loan from Foundation Trust Financing Facility</td>
<td>10,959</td>
<td>7,477</td>
</tr>
<tr>
<td>Obligations under finance lease agreements</td>
<td>561</td>
<td>1,274</td>
</tr>
<tr>
<td>Obligations under PFI agreements</td>
<td>243,598</td>
<td>246,947</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>255,118</td>
<td>255,698</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>31 March 2011</th>
<th>31 March 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Loan from Foundation Trust Financing Facility</td>
<td>1,750</td>
<td>0</td>
</tr>
<tr>
<td>Obligations under finance lease agreements</td>
<td>902</td>
<td>972</td>
</tr>
<tr>
<td>Obligations under PFI agreements</td>
<td>3,935</td>
<td>4,506</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6,587</td>
<td>5,478</td>
</tr>
</tbody>
</table>

**Total borrowings**

|                        | 261,705      | 261,176      |
21. **BORROWINGS (CONTINUED)**

21.2 Loans

<table>
<thead>
<tr>
<th></th>
<th>31 March 2011</th>
<th>31 March 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Non-current</td>
<td>10,959</td>
<td>7,477</td>
</tr>
<tr>
<td>Current</td>
<td>1,750</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total loans</strong></td>
<td><strong>12,709</strong></td>
<td><strong>7,477</strong></td>
</tr>
</tbody>
</table>

During 2009/10 the Trust entered into a loan agreement with the Foundation Trust Financing Facility. The maximum loan amount is £28m which can be drawn down as required. The loan bears interest at a fixed rate of 2.92%. Repayments on the loan commence in December 2011 and are payable in sixteen equal six monthly instalments. The loan is held at fair value through profit or loss, as amortised value is not materially different.

21.3 Obligations under finance leases

<table>
<thead>
<tr>
<th>Minimum lease payments:</th>
<th>31 March 2011</th>
<th>31 March 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Gross lease liabilities which are due:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not later than one year</td>
<td>1,020</td>
<td>972</td>
</tr>
<tr>
<td>Later than one year and not later than five years</td>
<td>605</td>
<td>1,629</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,625</strong></td>
<td><strong>2,601</strong></td>
</tr>
<tr>
<td>Finance charges allocated to future periods</td>
<td>(162)</td>
<td>(355)</td>
</tr>
<tr>
<td><strong>Net finance lease obligations</strong></td>
<td><strong>1,463</strong></td>
<td><strong>2,246</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Net finance lease obligations which are due:</th>
<th>31 March 2011</th>
<th>31 March 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not later than one year</td>
<td>902</td>
<td>779</td>
</tr>
<tr>
<td>Later than one year and not later than five years</td>
<td>561</td>
<td>1,467</td>
</tr>
<tr>
<td><strong>Present value of minimum lease payments</strong></td>
<td><strong>1,463</strong></td>
<td><strong>2,246</strong></td>
</tr>
</tbody>
</table>

The Finance Lease held by the Trust relates to the multi-storey car park at the RVI site. The agreement expires in 2012 when the car park will revert to the Trust.
21. BORROWINGS (CONTINUED)

21.4 Obligations under PFI arrangements

<table>
<thead>
<tr>
<th></th>
<th>31 March 2011</th>
<th>31 March 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Gross liabilities which are due:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not later than one year</td>
<td>20,490</td>
<td>19,971</td>
</tr>
<tr>
<td>Later than one year and not later than five years</td>
<td>77,517</td>
<td>84,062</td>
</tr>
<tr>
<td>Later than five years</td>
<td>472,611</td>
<td>457,547</td>
</tr>
<tr>
<td>Sub-total</td>
<td>570,618</td>
<td>561,580</td>
</tr>
<tr>
<td>Finance charges allocated to future periods</td>
<td>(323,085)</td>
<td>(310,126)</td>
</tr>
<tr>
<td>Net PFI obligations</td>
<td>247,533</td>
<td>251,454</td>
</tr>
</tbody>
</table>

Net PFI obligations which are due:

<table>
<thead>
<tr>
<th></th>
<th>31 March 2011</th>
<th>31 March 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not later than one year</td>
<td>3,935</td>
<td>4,507</td>
</tr>
<tr>
<td>Later than one year and not later than five years</td>
<td>16,882</td>
<td>16,466</td>
</tr>
<tr>
<td>Later than five years</td>
<td>226,716</td>
<td>230,481</td>
</tr>
<tr>
<td></td>
<td>247,533</td>
<td>251,454</td>
</tr>
</tbody>
</table>

21.5 PFI schemes

The Trust has three PFI schemes which are included within the Statement of Financial position.

The Trust has determined that in accordance with the relevant accounting standards, it should recognise an asset of the relevant buildings as an item of property, plant and equipment and a corresponding finance lease liability. This then requires the trust to apportion the Unitary Payment for accounting purposes only into the following components: (a) a finance lease rental/asset financing component; (b) a services component and (c) a component in respect of funding for the replacement of parts of the asset over the life of the contract (lifecycle replacement).

Transforming Newcastle Hospitals (TNH) PFI scheme:

- Capitalised value to 31 March 2011: £252.7m
- Contract Start date: May 2005
- Contract End date: May 2043

The Transforming Newcastle Hospitals PFI scheme, for a major service configuration at the Freeman Hospital and Royal Victoria Infirmary, reached financial close on 27 April 2005. As at 31 March 2011, there are two remaining elements of the scheme to be completed. These are due for completion by January 2013.

The capital construction cost for the TNH scheme is £295m, excluding VAT, rolled up interest and financing costs. The initial Unitary Payment became payable from April 2005, when the scheme became partly operational (Freeman Multi-Storey Car Park). Construction of the Freeman Multi-Storey Car Park commenced prior to contract completion and was subsequently incorporated into the scheme. The District valuer has prepared a Modern Equivalent Asset valuation for the separate elements of the scheme and this value is used when capitalising the assets.
21. BORROWINGS (CONTINUED)

21.5 PFI schemes (continued)

The Trust pays the operator a monthly Unitary Payment covering the provision of the assets and services. These cash flows can vary due to the following factors:

a) The Unitary payment is adjusted each year for the effects of price changes by applying changes in the RPI to the whole Unitary Payment.

b) The contract provides for the Trust to deduct amounts from the Unitary Payment to the extent that any part of the buildings are unavailable for use, or if services are not provided to the standards set out in the contract.

The operator is responsible for ensuring the buildings remain in the required condition over the life of the contract, undertaking property maintenance and replacement of components of assets when required. The contract does not include the provision of any "soft" facilities management provision, eg security, cleaning or portering.

At the completion of the PFI contract the buildings will revert to the Trust at no additional cost. There is no option in the contract for its extension.

RVI Boiler House PFI scheme:

Capitalised value £5.7m
Contract Start date October 2002
Contract End date June 2023

The RVI Boiler House PFI scheme is for the provision of energy through the RVI Boiler House. The scheme commenced on 22 December 2000, with the Trust paying the PFI contractor to run the transferred plant.

The Unitary Payment became payable from October 2002 when the PFI scheme became fully operational.

Freeman Boiler House PFI scheme:

Capitalised value £5.4m
Contract Start date December 1997
Contract End date June 2027

The Freeman Boiler House PFI scheme covers two stages, both for the upgrade of facilities and the provision of energy through the Freeman boiler house. The first stage became operational on 1 December 1997 and the second on 1 January 2008.

21.6 Minimum amounts payable under PFI contracts

Maturity analysis of unitary payments

The Trust is committed to make the following Unitary Payments over the remaining period of the PFI schemes:

<table>
<thead>
<tr>
<th></th>
<th>31 March 2011</th>
<th>31 March 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Not later than one year</td>
<td>33,271</td>
<td>31,351</td>
</tr>
<tr>
<td>Later than one year and not later than five years</td>
<td>148,063</td>
<td>138,293</td>
</tr>
<tr>
<td>Later than five years</td>
<td>1,372,580</td>
<td>1,371,840</td>
</tr>
<tr>
<td></td>
<td>1,553,914</td>
<td>1,541,484</td>
</tr>
</tbody>
</table>

The amounts shown not later than one year include an actual inflation rate change of 5.5%. Other amounts are shown inclusive of an anticipated annual inflation rate of 2.5% as per the contract. The actual inflation rate incorporated into the Unitary Payment is based on the Retail Price Index (RPI) issued in the February preceding the financial year, therefore the figures above will vary depending on the actual rate.
21. **BORROWINGS (CONTINUED)**

21.7 **Asset financing component of PFI schemes**

<table>
<thead>
<tr>
<th></th>
<th>Gross payments</th>
<th>Present value of payments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31 March</td>
<td>31 March</td>
</tr>
<tr>
<td></td>
<td>2011</td>
<td>2010</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Not later than one year</td>
<td>20,490</td>
<td>19,971</td>
</tr>
<tr>
<td>Later than one year and not later than five years</td>
<td>77,517</td>
<td>84,062</td>
</tr>
<tr>
<td>Later than five years</td>
<td>472,611</td>
<td>457,547</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td><strong>570,618</strong></td>
<td><strong>561,580</strong></td>
</tr>
</tbody>
</table>

Less: finance cost attributable to future periods 

|                                | (323,085)      | (310,126)                |

**Total** 

|                                | **247,533**    | **251,454**              |

The RPI indexation increase which would be applied to the lease element of the unitary payment is not included in payments detailed above. Instead, and in accordance with IAS17, the RPI indexation amount is treated as contingent rent when paid and, because in substance it is part of the cost of financing, it is treated and disclosed as a finance cost.

During 2010/11 £3,282k was expensed as a contingent finance cost (2009/10: £2,389k).

21.8 **Services component of PFI schemes**

|                                | Gross payments | 31 March       | 31 March       |
|                                |                | 2011           | 2010           |
|                                |                | £000           | £000           |
| Not later than one year        | 5,587          | 5,226          |
| Later than one year and not later than five years | 23,788 | 22,106 |
| Later than five years          | 152,764        | 153,878        |
| **Total**                      | **182,139**    | **181,210**    |

The services component excludes the impact of inflation but includes the additional charges to be incurred on the handover of the final two stages of the scheme, as the Trust is contractually committed to these phases (see note 25).

The amount charged to operating expenses during the year in respect of services was £5,434k (2009/10: £4,638k).

The actual amounts paid vary to forecast due to inflation, contract variations and credits received for service failures.
21. **BORROWINGS (CONTINUED)**

21.9 **Lifecycle replacement component of PFI schemes**

<table>
<thead>
<tr>
<th></th>
<th>Gross payments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31 March</td>
</tr>
<tr>
<td></td>
<td>2011</td>
</tr>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Not later than one year</td>
<td>2,102</td>
</tr>
<tr>
<td>Later than one year and not later than five years</td>
<td>8,408</td>
</tr>
<tr>
<td>Later than five years</td>
<td>56,823</td>
</tr>
<tr>
<td></td>
<td><strong>67,333</strong></td>
</tr>
</tbody>
</table>

The lifecycle component excludes the impact of inflation but includes the additional charges to be incurred on the handover of the final two stages of the scheme, as the Trust is contractually committed to these phases (see note 25).

22. **PROVISIONS**

|                    | 31 March       | 31 March       |
|--------------------|----------------|
|                    | 2011           | 2010           |
| £000               | £000           |
| Pensions           | 1,368          | 1,439          |
| Legal claims       | 11,466         | 7,593          |
| Other              | 9,294          | 3,105          |
| Total              | **22,128**     | **12,137**     |

**Analysed by:**

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Non-current</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1,760</td>
<td>20,368</td>
<td>22,128</td>
</tr>
<tr>
<td></td>
<td>1,381</td>
<td>10,756</td>
<td>12,137</td>
</tr>
</tbody>
</table>

**Movement in year:**

<table>
<thead>
<tr>
<th></th>
<th>Pensions £000</th>
<th>Legal claims £000</th>
<th>Other £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>At 1 April 2010</strong></td>
<td>1,439</td>
<td>7,594</td>
<td>3,104</td>
<td><strong>12,137</strong></td>
</tr>
<tr>
<td>Change in discount rate</td>
<td>(113)</td>
<td>0</td>
<td>0</td>
<td>(113)</td>
</tr>
<tr>
<td>Arising during year</td>
<td>89</td>
<td>4,432</td>
<td>6,566</td>
<td><strong>11,087</strong></td>
</tr>
<tr>
<td>Utilised during year</td>
<td>(79)</td>
<td>(492)</td>
<td>(376)</td>
<td>(947)</td>
</tr>
<tr>
<td>Reversed unused</td>
<td>7</td>
<td>(96)</td>
<td>0</td>
<td>(103)</td>
</tr>
<tr>
<td>Unwinding of discount *</td>
<td>39</td>
<td>28</td>
<td>0</td>
<td><strong>67</strong></td>
</tr>
<tr>
<td><strong>At 31 March 2011</strong></td>
<td><strong>1,368</strong></td>
<td><strong>11,466</strong></td>
<td><strong>9,294</strong></td>
<td><strong>22,128</strong></td>
</tr>
</tbody>
</table>

* Unwinding of discount relates to the inflation effect on existing provisions of their payment in the future.

Pensions - relates to sums payable to former employees having retired prematurely due to injury at work. The outstanding liability is based upon current and expected benefits advised by the NHS Pensions Agency and the computed life expectancies of pension recipients.
22. PROVISIONS (CONTINUED)

Legal Claims - based upon professional assessments, which are uncertain to the extent that they are an estimate of the likely outcome of individual cases. Due dates of settlement of claims are based upon estimates supplied by the NHS Litigation Authority and/or Legal Advisers.

Other - relates primarily to building related provisions resulting from the ongoing development of the Royal Victoria Infirmary (RVI) and Newcastle General Hospital sites. Timing of payments is based upon work programme estimates. Additionally, a sum has been set aside to cover the Trust’s liability under the European Union Emissions Trading Scheme, due to carbon emissions from Energy Centres at the RVI and Freeman hospitals. This provision is due for settlement in 2013.

The Trust has an insurance arrangement through the NHS Litigation Authority in respect of clinical negligence, with liabilities covered by an annual insurance premium payment. Excluded from this note therefore is a sum of £53.3m (2009/10 £51.8m) which is included within the provisions of the NHS Litigation Authority in respect of clinical negligence liabilities of the Trust.

Where it is not considered probable that a payment will be made, provisions are included within note 27, Contingent Liabilities.

23. REVALUATION RESERVE

<table>
<thead>
<tr>
<th>Description</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revaluation reserve at 1 April 2010</td>
<td>125,796</td>
</tr>
<tr>
<td>Impairments</td>
<td>(5,373)</td>
</tr>
<tr>
<td>Revaluations</td>
<td>15,608</td>
</tr>
<tr>
<td>Asset disposals</td>
<td>0</td>
</tr>
<tr>
<td>Other recognised gains and losses</td>
<td>0</td>
</tr>
<tr>
<td>Other reserve movements</td>
<td>(5,159)</td>
</tr>
<tr>
<td><strong>Revaluation reserve at 31 March 2011</strong></td>
<td>130,872</td>
</tr>
</tbody>
</table>

Restated £000

<table>
<thead>
<tr>
<th>Description</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revaluation reserve at 1 April 2009</td>
<td>145,827</td>
</tr>
<tr>
<td>Impairments</td>
<td>0</td>
</tr>
<tr>
<td>Revaluations - as previously stated</td>
<td>(19,587)</td>
</tr>
<tr>
<td>Prior period adjustment - change of accounting policy</td>
<td>13,686</td>
</tr>
<tr>
<td>Revaluations - restated</td>
<td>(5,901)</td>
</tr>
<tr>
<td>Other recognised gains and losses</td>
<td>0</td>
</tr>
<tr>
<td>Other reserve movements</td>
<td>(444)</td>
</tr>
<tr>
<td>Transfer in respect of impairment due to loss of economic benefit</td>
<td>(13,686)</td>
</tr>
<tr>
<td><strong>Revaluation reserve at 31 March 2010</strong></td>
<td>125,796</td>
</tr>
</tbody>
</table>

The prior period adjustment is due to the change in accounting policy as detailed in note 12.1.2.
24. NOTES TO THE CASH FLOW STATEMENT

24.1 Reconciliation of operating surplus to net cash flow from operating activities

<table>
<thead>
<tr>
<th></th>
<th>2010/11 £000</th>
<th>Restated 2009/10 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total operating surplus/(deficit)</td>
<td>26,994</td>
<td>(30,232)</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>25,369</td>
<td>26,462</td>
</tr>
<tr>
<td>Impairments</td>
<td>8,238</td>
<td>68,806</td>
</tr>
<tr>
<td>Reversal of impairments</td>
<td>(4,770)</td>
<td>0</td>
</tr>
<tr>
<td>Transfer from donated asset reserve</td>
<td>(1,654)</td>
<td>(1,960)</td>
</tr>
<tr>
<td>(Increase) in inventories</td>
<td>(408)</td>
<td>(2,117)</td>
</tr>
<tr>
<td>Decrease/(Increase) in trade and other receivables</td>
<td>3,069</td>
<td>(6,065)</td>
</tr>
<tr>
<td>Increase/(Decrease) in trade and other payables</td>
<td>2,915</td>
<td>(818)</td>
</tr>
<tr>
<td>Increase in Other Liabilities</td>
<td>7,137</td>
<td>3,023</td>
</tr>
<tr>
<td>Increase/(Decrease) in provisions</td>
<td>9,991</td>
<td>(1,980)</td>
</tr>
<tr>
<td>Other movements in operating cash flows</td>
<td>(2,921)</td>
<td>1,023</td>
</tr>
<tr>
<td><strong>Net cash generated from operating activities</strong></td>
<td><strong>73,960</strong></td>
<td><strong>56,142</strong></td>
</tr>
</tbody>
</table>

The prior year figures have been restated in accordance with the FT ARM relating to the treatment of impairments. Total operating deficit has increased by £13,686k and impairments have increased by £13,686k.

24.2 Property, plant and equipment additions

No additions to property, plant and equipment (2009/10: £89.5m) were financed during the year as part of the PFI scheme.

25. CONTRACTUAL CAPITAL COMMITMENTS

Commitments under capital expenditure contracts at 31 March 2011 were £37.2m (2009/10: £55.9m).

26. EVENTS AFTER THE REPORTING DATE

On 1st April 2011 the Trust acquired part of the Community Care functions from Newcastle Primary Care Trust. The total value of the acquisition was £54.487m. The Trust has entered into an occupation licence for the use of relevant assets and equipment.

The acquisition has resulted from the Department of Health Transforming Community Services programme.

The Trust did not acquire responsibility for any of the assets or liabilities of the former Newcastle PCT body.

There were no other events after the reporting date which are required to be incorporated into the accounts in 2010/11 (2009/10: £nil).
27. CONTINGENT LIABILITIES

<table>
<thead>
<tr>
<th></th>
<th>31 March 2011</th>
<th>31 March 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross value of contingent liabilities</td>
<td>(89) £000</td>
<td>(6,541) £000</td>
</tr>
<tr>
<td>Amounts recoverable</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net value of contingent liabilities</td>
<td>(89) £000</td>
<td>(6,541) £000</td>
</tr>
</tbody>
</table>

Contingent liabilities relate to £89k employer’s liability (2009/10: £69k) and £Nil other legal claims (2009/10: £6,472k).

28. RELATED PARTY TRANSACTIONS

28.1 Ultimate parent

The Newcastle upon Tyne Hospitals NHS Foundation Trust is a public benefit corporation established under the National Health Service Act 2006. Monitor, the Independent Regulator for NHS Foundation Trusts, has the power to control the Trust within the meaning of IAS27 ‘Consolidated and Separate Financial Statements’ and therefore can be considered as the Trust’s parent. Monitor does not prepare group accounts but does prepare separate NHS Foundation Trust Consolidated Accounts. The NHS FT Consolidated Accounts are included within the Whole of Government Accounts. Monitor is accountable to the Secretary of State for Health. The Trust’s ultimate parent is therefore HM Government.

28.2 Whole of Government Accounts Bodies

All government bodies which fall within the Whole of Government accounts boundary are regarded as related parties because they are all under the common control of HM Government and Parliament. This includes for example all NHS bodies, all local authorities and central government bodies.

Significant transactions and balances with other NHS bodies are detailed below:

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Payables</td>
<td>Receivables</td>
<td>Income</td>
<td>Expenditure</td>
<td>Payables</td>
<td>Receivables</td>
<td>Income</td>
<td>Expenditure</td>
<td>Payables</td>
</tr>
<tr>
<td>Newcastle PCT</td>
<td>25</td>
<td>6,844</td>
<td>204,221</td>
<td>780</td>
<td>127</td>
<td>5,209</td>
<td>197,137</td>
<td>2,603</td>
</tr>
<tr>
<td>North Tyneside PCT</td>
<td>556</td>
<td>3,944</td>
<td>191,504</td>
<td>2,256</td>
<td>182</td>
<td>4,022</td>
<td>181,365</td>
<td>611</td>
</tr>
<tr>
<td>Northumberland Care PCT</td>
<td>2,752</td>
<td>0</td>
<td>74,301</td>
<td>46</td>
<td>116</td>
<td>0</td>
<td>71,973</td>
<td>16</td>
</tr>
<tr>
<td>North East Strategic Health Authority</td>
<td>14</td>
<td>99</td>
<td>63,334</td>
<td>67</td>
<td>4</td>
<td>662</td>
<td>63,705</td>
<td>9</td>
</tr>
<tr>
<td>Gateshead PCT</td>
<td>0</td>
<td>397</td>
<td>43,871</td>
<td>358</td>
<td>0</td>
<td>73</td>
<td>39,207</td>
<td>0</td>
</tr>
<tr>
<td>County Durham PCT</td>
<td>0</td>
<td>718</td>
<td>30,926</td>
<td>0</td>
<td>0</td>
<td>692</td>
<td>28,264</td>
<td>0</td>
</tr>
<tr>
<td>London Strategic Health Authority</td>
<td>0</td>
<td>43</td>
<td>28,811</td>
<td>0</td>
<td>0</td>
<td>5,103</td>
<td>28,148</td>
<td>0</td>
</tr>
<tr>
<td>Sunderland Teaching PCT</td>
<td>0</td>
<td>555</td>
<td>20,507</td>
<td>0</td>
<td>0</td>
<td>235</td>
<td>18,895</td>
<td>430</td>
</tr>
<tr>
<td>Cumbria PCT</td>
<td>0</td>
<td>2,409</td>
<td>21,096</td>
<td>0</td>
<td>0</td>
<td>2,631</td>
<td>18,729</td>
<td>5</td>
</tr>
<tr>
<td>South Tyneside PCT</td>
<td>0</td>
<td>283</td>
<td>17,814</td>
<td>1</td>
<td>0</td>
<td>1,128</td>
<td>15,882</td>
<td>30</td>
</tr>
<tr>
<td>NHS Business Services Authority</td>
<td>533</td>
<td>0</td>
<td>0</td>
<td>19,752</td>
<td>531</td>
<td>0</td>
<td>229</td>
<td>18,778</td>
</tr>
<tr>
<td>NHS Pension Scheme (Employers)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>57,332</td>
<td>19</td>
<td>0</td>
<td>0</td>
<td>36,640</td>
</tr>
</tbody>
</table>

None of the receivable or payable balances are secured. Amounts are usually due within 30 days and will be settled in cash.
28. RELATED PARTY TRANSACTIONS (CONTINUED)

28.3 Charitable funds
The Trust receives revenue and capital payments from a number of charitable funds, including the Newcastle upon Tyne Hospitals NHS Charity, for which the Trust acts as ‘Corporate Trustee’. The accounts of the Newcastle upon Tyne Hospitals NHS Charity are included in the Trust’s Annual Report and Accounts. Income received in 2010/11 was £1,081k (2009/10: £1,000k) and the year-end receivable balance was £358k (2009/10: £200k).

28.4 Directors
A Non-Executive Director, Mrs H A Parker, is a member of Sintons LLP solicitors. During the year the Trust used Sintons to provide legal advice in relation to a specific project. The legal services were provided on commercial terms and on an arm’s length basis.

During the year the Trust had a Director in common with the University of Newcastle Upon Tyne (Professor C P Day). Transactions with the University were both financial and non financial, and were at arms length relating principally to income received of £5.1m (2009/10: £5.4m) and payments made of £11.3m (2009/10: £11.0m) in relation to staff who work across both organisations. The year end payable balance was £398k (2009/10 £77k) and the receivable balance was £879k (2009/10 £653k).

28.5 Remuneration of key management personnel
The remuneration of the executive directors, who are the key management personnel of the Trust, is set out below in aggregate for each of the categories specified in IAS 24 Related Party Disclosures. Further information about the remuneration of individual directors is provided in Note 5.4 (a).

2010/11 2009/10
£000 £000
Short term employee benefits 918 943
Pension contributions 131 123

1,049 1,066

There were no amounts owing to Key Management Personnel at the beginning or end of the financial year.
29. **FINANCIAL INSTRUMENTS AND RISK MANAGEMENT**

Financial instruments are defined in IAS32: Financial instruments: Presentation, as ‘any contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity’. Financial instruments are identified as financial assets, financial liabilities or equity instruments and accounted for on the appropriate line of the statement of financial position.

IFRS7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the continuing service-provider relationship that the Trust has with local Primary Care Trusts and the way those Primary Care Trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which the financial reporting standards mainly apply. Financial assets and liabilities are generated by day-to-day operational activities rather than being held in order to change the risks facing the Trust.

The Trust’s treasury management operations are carried out by the finance department, within parameters defined formally within the Trust’s standing financial instructions and policies agreed by the board of directors.

IFRS7 also requires disclosures relating to the risks associated with financial instruments. There are three types of risk:

**Credit Risk**

Credit risk is the risk that one party to a financial instrument will cause a financial loss for the other party by failing to discharge an obligation. For the Trust, credit risk arises mainly from NHS and other receivable balances. Credit risk is mitigated as a substantial part of the Trust’s activity is carried out with other Health Bodies. For other transactions specific checks are made regarding credit worthiness before the Trust enters into any new contracts. The Trust manages this risk by regular review of aged debtor balances, prompt follow up on those which are overdue and provides for any deemed to be impaired. Once the balance is determined to be irrecoverable the amount is written off.

Of the Trust’s cash and cash equivalents balance at the year end, 97% was held with the Government Banking Service and the remaining 3% with the Trust’s banker, HSBC. The credit risk arising, i.e., that the banks may default on repayment, is considered to be low, due to the following:

- The Government Banking Service is operated by HM Government and is therefore considered to have zero risk.
- HSBC is credit rated as AA long term and A-1+ short term (Standard & Poor’s) and therefore the risk is considered insignificant.

The Trust held no short term deposits at the year end. During the year the Trust has held on average £23.75m on short term deposit with four commercial banks. These are interest bearing accounts. The credit risk arising i.e. that these banks may default on repayment is considered to be low, due to the following:

The banks are rated as either A-1+ or A-1 short term (Standard & Poor’s) and therefore the risk is considered insignificant.

An analysis of aged and impaired receivables is given in note 15.

The credit risk associated with all other financial instruments is considered to be low. The Trust’s maximum exposure to credit risk at the balance sheet date is £90.5m (2009/10: £91.1m). There are no amounts held as collateral against these balances.

There are no financial assets that would otherwise be past due or impaired whose terms have been renegotiated.

**Liquidity risk**

Liquidity risk is the risk that the Trust will encounter difficulty in meeting obligations associated with financial liabilities. The Trust’s net operating costs are incurred under three-year service agreement contracts with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust receives such income month by month, based on a contracted annual level of activity, with quarterly corrections made to adjust for actual activity carried out and resultant income due.

The Trust largely finances its capital expenditure from internally generated resources. Funds have also been made available from Government, in the form of additional Public Dividend Capital, to progress specific capital schemes. In addition, the Trust can borrow from commercial sources to finance capital schemes. Such financing would be drawn down to match the spend profile of the scheme concerned and the Trust is not, therefore, exposed to significant liquidity risk in this area.

The Trust has a loan agreement with the Foundation Trust Financing Facility with an outstanding balance at 31 March 2011 of £12,709k. Further details can be found in note 21 to the accounts. An extended five year plan was prepared and submitted to Monitor prior to this loan being authorised.
29. **FINANCIAL INSTRUMENTS AND RISK MANAGEMENT (CONTINUED)**

To alleviate the risk of any cash shortfall resulting from the timing of revenue or capital receipts and payments, at 31 March 2011 the Trust had in place a £45m (2009/10: £35m) working capital facility with a commercial bank, as required by the Trust’s Terms of Authorisation. The Trust has not drawn on this facility.

The Trust is also subject to liquidity risk in relation to the long term PFI contracts into which it has entered. The maturity analysis for payments under these schemes can be found in note 21. Expenditure savings have been identified to mitigate the liquidity risk of the PFI contracts. Prior to the contract being entered into the scheme was reviewed by HM Treasury and, subsequently, by Monitor when the Trust was applying for Foundation Trust status.

**Market Risk - Interest-rate risk**

Interest rate risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in market interest rates.

Of the Trust’s cash and cash equivalents 100% attract variable rates. As the variable rates are based on base rate less either 0.25% or 0.05%, any reduction would have an immaterial impact on cash flow and hence interest rate risk on these financial assets is deemed to be immaterial.

Within trade and other receivables falling due after more than one year is a loan to a company of which the Trust owns 50%. This loan bears interest at base rate +1%. As the base rate at 31 March 2011 was 0.5%, any reduction in market rate would not have a material impact on future cash flows.

The Trust has a loan agreement with the Foundation Trust Financing Facility. This loan bears interest at a fixed rate of 2.92%.

The Trust’s finance lease and PFI arrangements are on fixed interest terms.

Other than as described above, none of the other remaining Trust financial assets or liabilities carry interest rates which vary with market rates and therefore interest rate risk is not deemed material and a sensitivity analysis is not considered necessary.
30. FINANCIAL ASSETS AND LIABILITIES

30.1 Financial assets by category

<table>
<thead>
<tr>
<th></th>
<th>31 March 2011</th>
<th>31 March 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Loans and receivables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables excluding non-financial assets</td>
<td>33,420</td>
<td>37,541</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>3,175</td>
<td>1,854</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>53,953</td>
<td>51,749</td>
</tr>
<tr>
<td><strong>Total at 31 March</strong></td>
<td>90,548</td>
<td>91,144</td>
</tr>
</tbody>
</table>

Fair value is not considered significantly different from book value.

30.2 Financial liabilities by category

<table>
<thead>
<tr>
<th></th>
<th>31 March 2011</th>
<th>31 March 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Borrowings excluding Finance lease and PFI liabilities</td>
<td>12,709</td>
<td>7,477</td>
</tr>
<tr>
<td>Trade and other payables excluding non financial assets</td>
<td>54,049</td>
<td>50,231</td>
</tr>
<tr>
<td>Finance lease obligations</td>
<td>1,463</td>
<td>1,274</td>
</tr>
<tr>
<td>Provisions under contract</td>
<td>22,128</td>
<td>12,137</td>
</tr>
<tr>
<td>PFI finance lease obligations</td>
<td>247,533</td>
<td>246,947</td>
</tr>
<tr>
<td><strong>Total at 31 March</strong></td>
<td>337,882</td>
<td>318,066</td>
</tr>
</tbody>
</table>

Fair value is not considered significantly different from book value.
31. THIRD PARTY ASSETS
The Trust held £13k cash at bank and in hand at 31 March 2011 (2009/10: £13k), which relates to monies held by the Trust on behalf of patients. These monies have not been included in the cash at bank and in hand figure reported in the accounts.

32. LOSSES AND SPECIAL PAYMENTS
There were 407 cases of losses and special payments totaling £846k during the year (2009/10: 325 cases totaling £833k). No cases (2009/10: none) were estimated to have cost the Trust over £100k.

33. RETIREMENT BENEFIT SCHEME
The Trust is a member of the NHS Pensions Scheme which covers past and present employees. The scheme is not designed to be run in a way that would enable the NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore the scheme is accounted for as if it were a defined contribution scheme: the cost to the Trust of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The Scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The latest published valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date and was published in December 2007. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had, up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, the Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme liabilities.

b) Accounting valuation
A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions
In 2008-09 the NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

Annual Pensions
The Scheme is a ‘final salary’ scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as ‘pension commutation’.
33. RETIREMENT BENEFIT SCHEME (CONTINUED)

c) Scheme provisions (continued)

Pensions Indexation
Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Lump Sum Allowance
A lump sum is payable on retirement which is normally three times the annual pension payment.

Ill-Health Retirement
Early payment of a pension, with enhancement in certain circumstances, is available to members of the Scheme who are permanently incapable of fulfilling their duties or regular employment effectively through illness or infirmity.

Death Benefits
A death gratuity of twice their final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Additional Voluntary Contributions (AVCs)
Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Transfer between Funds
Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved Benefits
Where a scheme member ceases NHS employment with more than two years service they can preserve their accrued NHS pension for payment when they reach retirement age.

Compensation for Early Retirement
Where a member of the Scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer’s cost.
This part of the Annual Report is unaudited.

DIRECTORS’ REMUNERATION

Full details are given in the Remuneration Report on page 279 of the Accounts.

TERMS OF SERVICE AND REMUNERATION COMMITTEE

The Committee is responsible for determining all elements of Executive Director remuneration as well as the discretionary points payment awards to the senior medical staff. The Committee meets annually.

Membership of the Committee

Membership of the Terms of Service and Remuneration Committee is made up of the Chairman (Mr K W Smith) and two Non-Executive Directors (Mrs H A Parker and Dr B C Dobson). The Chief Executive (Sir Leonard Fenwick) and the HR Director (Mrs D Fawcett) are also in attendance. There was one meeting of the Committee in 2010/11, which was attended by all members as described above.

Base salary - individual base salaries are reviewed annually and take into account the overall performance of the organisation and any responsibility changes in the context of comparable organisations and the direction being taken by the NHS overall. For Executive Directors, account is taken of the Department of Health guidance on Very Senior Managers Pay.

Executive Directors are subject to individual performance review, conducted by the Chairman and nominated Non-Executive Directors annually. Performance is evaluated in the context of national performance targets and the Annual Health Check. Where applicable, there is some benchmarking or comparison with other NHS Foundation Trusts. The Terms of Service and Remuneration Committee oversees the remuneration for Executive Directors. None of the Executive Directors has a service contract and there are no special provisions for early termination of contract - standard NHS terms apply.

The Chairman and Non-Executive Directors received a fee determined by the Council of Governors.

Other Benefits - as outlined in Note 5.4 to the Accounts.

Pensions - all Executive Directors participate in the NHS Superannuation Scheme.

Service as a Non-Executive Director is not pensionable.

Date of the contracts, notice and termination periods

All Executive Directors have a substantive Contract of Employment with agreed notice periods of between 3 and 6 months. No termination payments were made in the course of 2010/11.

Remuneration and performance conditions

In reviewing the annual salary of Directors, the Committee takes into consideration a number of factors including the overall performance of the organisation as and effective and efficient trading entity, the delivery of agreed corporate objectives for the year and the pattern of remuneration amongst NHS Foundation Trusts and the wider NHS.

The Medical Director’s salary is in accordance with the terms and conditions of the National Health Service Consultant Contract plus a responsibility allowance payable for the duration of office.

There are no special contractual compensation issues for the early termination of Executive Director contracts.

All Executive Directors are subject to performance review and this is undertaken by the Chairman and the Chief Executive. Directors’ salaries have no component of performance-related pay.

The remuneration for Non-Executive Directors was reaffirmed by the Council of Governors at a meeting held on 17th January 2008. The level of remuneration is paid for a minimum of two and a half days per month for Non-Executive Directors.

A table showing the remuneration of Directors and Non-Executive Directors can be seen in Note 5.4 to the Accounts. This is the only audited section of this report.

Sir Leonard Fenwick
Chief Executive
2 June 2011
Structure, Governance and Management

The Charity was formed by a Declaration of Trust dated 16 July 1996 as The Freeman Group of Hospitals NHS Charity which was amended by a Supplemental Deed dated 17 March 1999 to the Newcastle upon Tyne Hospitals NHS Charity, Registration Number 1057213.

Trustee

The Board of Directors of the Newcastle upon Tyne Hospitals NHS Foundation Trust acts as the ‘Corporate Trustee’. The Funds are administered by a Standing Committee of the Trust Board and Council of Governors known as the Trust (Charitable) Funds Committee which meets quarterly with other meetings convened as and when necessary. Members of the Trust Board are remunerated by the NHS Trust and Committee members receive no remuneration or expenses from the Charity.

Trust (Charitable) Funds Committee

Non Executive Directors (appointed by the Council of Governors)
- Mrs H Parker (Chairman)
- Professor P Baylis
- Ms S Kler

Executive Directors
- Sir L R Fenwick (Chief Executive)
- Dr T Walls (Medical Director)
- Mrs A Dragone (Finance Director)

Elected Public Governors
- Dr L Murthy
- Mrs M A Hargreave

Induction of committee members is provided by a detailed information pack containing relevant Charity Commission guidance and information specific to the Charity; on going training is provided as required and the Charity subscribe to the Governance publication (Essential Information for Effective Trustees) to supplement Trustee awareness. Guidance is also supplied by the Healthcare Financial Managers Association (HFMA) and the Association of NHS Charities.

Charity Structure

The Charity comprises of a General Purposes Fund (known as the Umbrella Fund), with an additional seventeen subsidiary funds (largely reflecting clinical specialties), which are registered with the Charity Commission. Operationally the subsidiary funds are further subdivided to reflect the wishes of respective donors and the proposed utilisation, and at 31st March 2011 there were 195 sub, i.e. individual, Funds.

Funds have designated advisers to whom balances are communicated on a quarterly basis. The Funds are administered in accordance with Financial Procedure Notes communicated to Fund Advisers by a charity specific information pack and seminars. Adherence to the procedures is monitored by Internal Audit, the Trust’s Audit Committee and ultimately by the Trust Board as part of the structured controls assurance within the Trust.

PRINCIPAL PROFESSIONAL ADVISORS

Investment Managers  CCLA Investment Management Ltd, 80 Cheapside, London EC2V 6DZ
Bankers  HSBC PLC, 110 Grey Street, Newcastle upon Tyne NE1 6JG
External Auditors  PricewaterhouseCoopers LLP, 89 Sandyford Road, Newcastle upon Tyne, NE1 8HW
Internal Audit  Northumbria Internal Audit, 3 North Terrace, Newcastle upon Tyne NE2 4AD

Management

A dedicated team provides administration, financial and fundraising support within the Trust; the Charity does not directly employ any members of staff. The Newcastle upon Tyne Hospitals NHS Foundation Trust issues contracts of employment and recharges the Charity for costs incurred in relation to both staffing and related non-pay expenditure.

Official Charity Address:
Charitable Funds Office
Room 203, Cheviot Court
Freeman Hospital, High Heaton
Newcastle upon Tyne, NE7 7DN
Telephone: 0191 223 1434 (General Enquiries) 0191 213 7236 (Fundraising Manager)
Website: www.newcastle-hospitals.org.uk/charity-matters.aspx

Grant Access and Evaluation

The majority of expenditure applications are initiated by Fund advisers and are subject to an approval process identified as part of The Newcastle upon Tyne Hospitals NHS Foundation Trust’s overall Scheme of Delegation and Corporate Governance procedures. The application process uses a standard application form, and for applications over £1,000 there is a requirement to...
demonstrate the appropriateness of the potential spend from charitable funds. This ensures that no expenditure is incurred by the Charity that should have been funded from revenue sources.

Under the Trust Scheme of Delegation, the Head of Charitable Funds can approve applications up to £1,000. Applications between £1,000 - £5,000 require the approval of the Chief Executive and over £5,000, the Chair of the Trust (Charitable) Funds Committee also has to give approval.

Most of the applications over £5,000 are formally discussed at the Trust (Charitable) Funds Committee to allow full consideration of their appropriateness with regard to the objectives of the charity, relative priority to other applications and the guideline expenditure targets established by the Reserves Policy. Any applications over £1,000 approved outside of the formal meetings are reported to the Committee to ensure that there is full accountability.

The exceptions to this are the dedicated Research Funds for which the Joint Research Executive Scientific Committee (advising both the Newcastle upon Tyne Hospitals Charity and The Newcastle Healthcare Charity respectively) considers applications for research projects and makes recommendations to the Trust (Charitable) Funds Committee and the Charlie Bear for Cancer Care Fund which is administered by a Sub-Committee and which reports to the Trust (Charitable) Funds Committee. The Sir Bobby Robson Foundation Committee comprising members of the late Sir Bobby’s family and including Executive and non-Executive Trust (Charitable) Funds Committee members, meet regularly to discuss and recommend projects which accord with the Foundation’s Constitution.

The Joint Research Executive Scientific Committee is made up of leading consultants and physicians. This Committee carries out a peer review of all research grant applications and considers the suitability, value and quality of the research and the qualifications and academic standing of the researchers.

**Risk Management**

The Corporate Trustee considers the Charity has the necessary practices currently in place to assess Governance, Operational, Financial, External and Compliance risks. These have been identified in a Risk Management Schedule specific to the Charitable Funds, which is presented annually to the Corporate Trustee i.e. the Trust Board. This Schedule identifies risk areas, the potential impact of these risks and the steps taken to mitigate the risks to the Charity. The Trust (Charitable) Funds Committee review the schedule on a regular basis. Working practices and procedures conform to the Charity Commission’s guidelines and are subject to scrutiny by Internal and External Audit.

**Reserves Policy and Spending Targets**

The Trustee operates a Reserves Policy which is largely designed to provide an appropriate level of support to Newcastle upon Tyne Hospitals, across the largest funds within each of the 17 sub-registrations, which are mainly by specialty and the General Purposes Fund.

In formulating the policy it is hoped that the current level of funds can be replenished over a 3-4 year period. A guideline expenditure level is set each year, generally at 30% of the market value of existing funds. These targets are guidelines only which address the need to spend at least a proportion of the fund in each financial year.

During 2010-11 guideline expenditure targets for non-research based grants (excluding the Sir Bobby Robson Foundation) were set at £1.1m and the level of commitments made against this target was £444k. The under-performance was reflective of the caution exercised by the Charity in committing to large scale projects whilst providing a window of opportunity to allow the funds to regenerate.

The Trustee has different criteria for research funds which allow funds to be spent on the following basis, in a particular financial year. The spending target for Research in 2010/11 was initially £445,000 and the performance against this target was £177,000, a take up of 40%. Whilst this is relatively low, the reality is that demand for grants vastly exceeds supply and this is often inhibited by the small number of specialty research funds which are capable of funding yearly projects. The declining level of available research funding is a cause for concern and the position will continue to be reviewed during 2011-12.

**Investment Policy Statement**

Of the eighteen registered Funds only one, the Charlie Bear for Cancer Fund, is reliant on proactive fundraising and because it expends resources significantly faster than the other Funds it is invested via the money market. The Sir Bobby Robson Foundation was established on the same basis, ie, funds are invested via the money market as it is expected that the funds will be expended in the shorter, rather than the longer term. The low returns on such funds and the high volume of support for the Sir Bobby Robson Foundation prompted a part reinvestment of the Foundation’s funds with Yorkshire Bank. In the case of the other Funds the majority of assets held which are not required to meet outstanding liabilities continue to be invested via the Charities Official Investment Fund (COIF), the majority being held in a diversified Common Investment Fund with a portfolio chosen by the manager,
CCLA Investment Management Ltd, and comprising equities, property and cash. The equities comprise shareholdings in public companies with stock market quotations; however the portfolio refrains from the direct investment in companies that derive a substantial amount of their profit from investment in tobacco.

The investment objective for the fund is to provide an average return over a business cycle of inflation plus 5%, whilst maintaining income in real terms. The Responsible Investment Policy of CCLA has three strands:

1. Engagement on issues of corporate social responsibility with a view to optimising long term economic returns.
2. Engagement on corporate governance including proxy voting on issues to protect and enhance shareholder value.
3. Setting appropriate constraints on investment and exposure to activities considered unacceptable by an independent Board.

The current benchmark used as a comparator is the WM Company CFS Universe. This benchmark is under review, as there are some differences in asset allocation between the CCLA fund and the WM Universe.

The review of the charity’s Investment advisors was postponed to allow a further review of the CCLA performance during 2010-11. Whilst the overall position improved in line with the Stock Market stabilisation, the position will be given further consideration during 2011-12. The Committee are of the opinion that alternative advisors should be given an opportunity to review the portfolio and tender for the position of Investment Advisors during 2011-12.

Newcastle Healthcare Charity

There are additional Trust (Charitable) Funds for the benefit of the Royal Victoria Infirmary, Newcastle General Hospital and Walkergate Hospital and which form part of The Newcastle upon Tyne Hospitals NHS Foundation Trust. These funds are held by the Newcastle Healthcare Charity, a separate registered charity, and are not the subject of either this Report or accompanying Accounts. The Newcastle Healthcare Charity has provided a Statement and this is included within the Review of the Year, which supplements the full text of the Foundation Trust’s annual accounts.

Objectives and Activities

“For any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by the Newcastle upon Tyne Hospitals NHS Foundation Trust”

The Charity’s aim is to complement NHS resources in The Newcastle upon Tyne Hospitals NHS Foundation Trust to increase patient comfort and enhance facilities for both patients and staff. By complementing NHS resources the Charity enables the Trust to be on the leading edge of both specialised service provision and clinical, scientific and technological developments in the field of health and the promotion of Newcastle’s national and international reputation as a leading academic centre by supporting research.

The Charity

- Purchases service-enhancing equipment enabling medical treatments to be improved.
- Improves amenities for patients so the time spent in hospital is more comfortable.
- Enhances facilities for staff so improving working lives.
- Funds research and development activities which ultimately improve patient care.

These aims and objectives are deemed to satisfy the public benefit guidance issued by the Charity Commission.

Achievements and Performance

During 2010-11 the Trustee agreed commitments (exclusive of research awards) of £1,412,000.

This comprised larger applications as detailed below and many smaller applications, which are designed to support and enhance patient and staff welfare.

The Charlie Bear Shop (opened in May 2009) continues to flourish and generated a net income of almost £34k in support of cancer patients attending the Northern Centre for Cancer Care. The shop also provides a welcome diversion for patients and visitors attending the Centre.
<table>
<thead>
<tr>
<th><strong>£500k+</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer (Sir Bobby Robson Foundation)</td>
<td>Cyclotron Machine</td>
<td>£625,000</td>
</tr>
<tr>
<td><strong>£50k - £100k</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiothoracic</td>
<td>Endobronchial Scope</td>
<td>£87,000</td>
</tr>
<tr>
<td>Cardiothoracic</td>
<td>2 x Pulmonary Function Plethsmographs</td>
<td>£60,240</td>
</tr>
<tr>
<td>Cardiothoracic</td>
<td>2 x Genius Thermometers</td>
<td>£50,000</td>
</tr>
<tr>
<td>Cancer (Sir Bobby Robson Foundation)</td>
<td>Contribution to Cell Sorter</td>
<td>£50,000</td>
</tr>
<tr>
<td><strong>£10 - £50k</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer (NCCC)</td>
<td>Clinical Trials Associate posts</td>
<td>£37,272</td>
</tr>
<tr>
<td>Ward 36</td>
<td>28 x Infusion Pumps</td>
<td>£32,859</td>
</tr>
<tr>
<td>Cancer Research &amp; Education Fund</td>
<td>Data Manager &amp; Health Care Asst Posts</td>
<td>£31,135</td>
</tr>
<tr>
<td>General Fund</td>
<td>Staff Christmas Meals</td>
<td>£24,285</td>
</tr>
<tr>
<td>Ward 4</td>
<td>Ward 4 refurbishment</td>
<td>£21,888</td>
</tr>
<tr>
<td>Cancer (Sir Bobby Robson Foundation)</td>
<td>Contribution to Maggie Centre</td>
<td>£20,000</td>
</tr>
<tr>
<td>Ward 6A Renal Transplant</td>
<td>Haemochron Analyser &amp; Bladder Scanner</td>
<td>£17,352</td>
</tr>
<tr>
<td>PICU</td>
<td>Aquarius Dialysis Machine</td>
<td>£14,000</td>
</tr>
<tr>
<td>Cancer (Charlie Bear)</td>
<td>Support for Complimentary Therapy service</td>
<td>£12,500</td>
</tr>
<tr>
<td>Haematology/Transplantation</td>
<td>Cardio exercising Study</td>
<td>£10,000</td>
</tr>
<tr>
<td><strong>£5k - £10k</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardio Education &amp; Research</td>
<td>Atlantis SR Pro Systems</td>
<td>£8,995</td>
</tr>
<tr>
<td>Child/Adult Cardiothoracic</td>
<td>Luxtec PAL Headlight camera</td>
<td>£8,000</td>
</tr>
<tr>
<td>Ward 19</td>
<td>Bladder Scanner</td>
<td>£7,990</td>
</tr>
<tr>
<td>Cancer (Sir Bobby Robson Foundation)</td>
<td>Arjo Sara Plus Hoist</td>
<td>£7,712</td>
</tr>
<tr>
<td>Cancer (Charlie Bear)</td>
<td>Immobilisation Equipment</td>
<td>£6,751</td>
</tr>
<tr>
<td>M.A.G.I.C Appeal (ICU)</td>
<td>Sonosite –M Turbo System</td>
<td>£6,842</td>
</tr>
<tr>
<td>Medical Oncology Research Day Unit</td>
<td>Support for Complementary Therapy service</td>
<td>£6,250</td>
</tr>
<tr>
<td>Walkergate Hospital</td>
<td>31 x televisions/Board Games</td>
<td>£5,399</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>£1,151,470</strong></td>
</tr>
</tbody>
</table>
Research & Development

The Joint Research Executive Scientific Committee reviewed many research projects during 2010/11 and the following grant awards were made:

<table>
<thead>
<tr>
<th>Principal Investigator</th>
<th>Title of Project</th>
<th>Amount Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr A Zaman</td>
<td>Assessment of quality and quantity of thrombus in patients with subclinical hypothyroidism.</td>
<td>£7,910</td>
</tr>
<tr>
<td>Dr D Kavanagh</td>
<td>The role of thrombomodulin in atypical haemolytic uraemic syndrome</td>
<td>£35,689</td>
</tr>
<tr>
<td>Dr B Stenberg</td>
<td>3D Contrast enhanced ultrasound in perfusion studies in early renal transplants.</td>
<td>£5,200</td>
</tr>
<tr>
<td>Dr L Armstrong</td>
<td>Establishment of induced pluripotent stem cell derived cardiomyocyte lines for the investigation of hypoplastic left heart syndrome.</td>
<td>£49,981</td>
</tr>
<tr>
<td>Prof I Spyridopoulos</td>
<td>Role of T-cells in infarct inflammation and repair after myocardial infarction</td>
<td>£36,673</td>
</tr>
<tr>
<td>Prof D Elliot</td>
<td>Investigating the role of a novel androgen-regulated isoform of the tuberous sclerosis 2 tumour suppressor protein in prostate cancer cells.</td>
<td>£39,536</td>
</tr>
<tr>
<td>Prof J Loughlin</td>
<td>Exomic analysis of rare monogenic disorders to identify causal mutations –a pilot study.</td>
<td>£9,920</td>
</tr>
<tr>
<td>Prof R Charnley</td>
<td>Evaluation of imaging and histology in pancreatic cancer patients.</td>
<td>£21,660</td>
</tr>
</tbody>
</table>

|                                                   |                                                                 | £208,569       |

Fundraising

The Charity utilises the services of a Trust Fundraising Manager, in a collaborative agreement with Newcastle Healthcare Charity. This provides an assurance that any fundraising activity carried out in the Charity’s name, and approved via the Charitable Funds Office, is appropriately managed with regard to adherence to Trust policy, Charity Commission and Institute of Fundraising guidelines.

A highlight of fundraising activities is incorporated in the full text of the Foundation Trust’s annual accounts.

Financial Review 2010/11

Income in the year decreased by £144,000 to £2,026,000. This decrease is largely due to the prevailing social and economic downturn and whilst not unexpected, the charity is heartened by the continuing high levels of support from the general public.

The income position is inconsistent in that certain categories actually rose (legacy income £67k, grants £6k and retail sales £20k) whilst donations decreased by £94k and fundraising income showed a downturn of £151k.
Overall the position was considered to be relatively healthy considering the prevailing circumstances that the charity sector is currently experiencing.

**Expenditure in the year was £1,604,000.** The increase in expenditure of £164,000 was as a result of a number of sizeable commitments in the Cardiothoracic Directorate combined with commitments of almost £700k from the Sir Bobby Robson Foundation, the largest of which was £625k towards the purchase and installation of a Cyclotron machine for use in the Northern Centre for Cancer Care.

Grants were awarded for both patient education and welfare (£205k) and staff education and welfare (£54k). The majority of awards for patient/staff welfare and amenities involves are under £5k but which, in total, make a substantial contribution to enhancing the patient experience and raising standards and quality of service delivery. The expenditure on patient welfare includes the provision of quality furniture and furnishings aimed at raising the patient environment. Additionally the provision of comforts, ward decoration and gifts is designed at raising spirits and morale during a period of hospital confinement.

As might be expected, the largest range of grants (£927k) is concentrated on providing new and innovative equipment over and above that available to the NHS. As well as enhancing the quality of service the equipment is designed to provide speedier diagnosis and delivery of treatment and continues to raise the high standards provided by the Newcastle upon Tyne Hospitals.

The charity continues to support the training and development of staff members through the attendance at conferences and advanced training courses aimed at increasing the awareness of changes in current practice and new developments in their field of expertise. This knowledge can then be cascaded and adapted with a view to raising the quality of care and delivery.

The charity awarded eight grants totalling £209k in support of medical research, following peer review and recommendation from the Joint Research Executive Scientific Committee. The awards are designed to pump prime more expansive research which will enable the researcher to develop and extend the line of research by obtaining large scale funding. Improving the ultimate standard of care and treatment of patients is a key factor in the decision making process.

Cost of generating funds in 2010/11 decreased by £32k. The drop in expenditure is largely due to the extensive branding and...
promotion costs associated with Charlie Bear for Cancer Care programme during 2009/10 which was a one-off commitment and not repeated during 2010/11. The costs relating to promoting and delivering fundraising events has reduced (£5k) and similarly the purchase of items for resale has also reduced by £6k. The costs of bought-in services (representing salary and overhead charges levied by the Newcastle upon Tyne Hospitals NHS Foundation Trust) increased by £7k.

The Sir Bobby Robson Foundation incurred public relations and costs relating to fundraising events totalling £27k. The income generated during the same period amounted to £983k.

The market value of Funds held at 31 March 2011 was £7,985,000, representing an increase of £598k since the previous year-end. Income exceeded expenditure by £422k and investments gains accounted for a further £176k.

Future Plans

“We will continue to enhance the services provided by The Newcastle upon Tyne Hospitals NHS Foundation Trust.”

The Charitable Funds Committee continue to monitor income levels with a view to aligning with related grant activity and ensuring that the optimum use is made of its charitable funds. In view of the prevailing economic conditions, a reduction in charitable giving is likely and a degree of caution will be exercised during 2011/12 when reviewing commitments and making new grants. The Committee is heartened however by continuing high levels of support received from the general public and the esteem in which the Newcastle Hospitals is perceived. Such goodwill will hopefully mitigate the anticipated decline in charitable support. The Committee will continue to engage with Fund Advisers and Service Areas with a view to aligning objectives with available charitable support.

Statement of Trustee’s Responsibilities

The law applicable to charities in England and Wales requires the trustee to prepare financial statements for each financial year which give a true and fair view of the charity’s financial activities during the year and of its financial position at the end of the year. In preparing financial statements giving a true and fair view, the trustee should follow best practice and:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable accounting standards and statements of recommended practice have been followed, subject to any departures disclosed and explained in the financial statements; and;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in operation.

The Trustee is responsible for keeping accounting records which disclose with reasonable accuracy the financial position of the charity and which enables them to ascertain the financial position of the charity and which enables them to ensure that the financial statements comply with the Charities Act 1993, the Charity (Accounts and Reports) Regulations and the provisions of the trust deed.

The Trustee is responsible for safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Provision of Information to Auditors

The Trustee at the date of approval of this report confirms that so far as they are aware, there is no relevant audit information of which the charity’s auditors are unaware; and they have taken all the steps that they ought to have taken as a trustee in order to make themselves aware of any relevant audit information and to establish that the charity’s auditors are aware of that information.

Summary

The members of the Committee on behalf of the Trust wish to record their gratitude to the volunteers, other individuals, families and organisations that have contributed so generously to the Charitable Funds in the form of donations, legacies and fundraising events. The efforts of these people have hugely contributed to the quality of care offered by The Newcastle upon Tyne Hospitals NHS Foundation Trust.
Respective responsibilities of trustees and auditors

As explained more fully in the Trustees’ Responsibilities Statement, the trustees are responsible for the preparation of financial statements which give a true and fair view.

We have been appointed as auditors under section 43 of the Charities Act 1993 and report in accordance with regulations made under section 44 of that Act. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board’s Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the charity’s trustees as a body in accordance with Regulation 27 of The Charities (Accounts and Reports) Regulations 2008 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the charity’s circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the trustees; and the overall presentation of the financial statements. In addition, we read all the financial and nonfinancial information in the Report of The Newcastle upon Tyne Hospitals NHS Charity to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the charity’s affairs as at 31 March 2011, and of its incoming resources and application of resources and cash flows, for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Charities Act 1993.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Charities Act 1993 requires us to report to you if, in our opinion:

- the information given in the Report of The Newcastle upon Tyne Hospitals NHS Charity is inconsistent in any material respect with the financial statements; or
- sufficient accounting records have not been kept; or
- the financial statements are not in agreement with the accounting records and returns; or
- we have not received all the information and explanations we require for our audit.

PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Newcastle upon Tyne

6 June 2011

PricewaterhouseCoopers LLP is eligible to act as an auditor in terms of section 1212 of the Companies Act 2006

Notes:

a) The maintenance and integrity of the website of The Newcastle upon Tyne Hospitals NHS Foundation Trust is the responsibility of the trustee; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.
Statement of Financial Activities
for the year ended 31 March 2011

<table>
<thead>
<tr>
<th>NOTE</th>
<th>2010-2011 Unrestricted £000</th>
<th>2010-2011 Restricted £000</th>
<th>2010-2011 Total £000</th>
<th>2009-2010 Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INCOMING RESOURCES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incoming Resources from Generated Funds:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary Income:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Donations</td>
<td>3</td>
<td>8</td>
<td>242</td>
<td>250</td>
</tr>
<tr>
<td>Legacies</td>
<td>4</td>
<td>8</td>
<td>421</td>
<td>429</td>
</tr>
<tr>
<td>Activities for generating funds:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fundraising Events</td>
<td>0</td>
<td>995</td>
<td>995</td>
<td>1,146</td>
</tr>
<tr>
<td>Fundraising Sales</td>
<td>6</td>
<td>0</td>
<td>64</td>
<td>64</td>
</tr>
<tr>
<td>Investment Income</td>
<td>11</td>
<td>53</td>
<td>229</td>
<td>282</td>
</tr>
</tbody>
</table>

| Incoming Resources from Charitable Activities |                             |                           |                      |                      |
| Grants Received | 0 | 6 | 6 | 0 |

| Total Incoming Resources | 69 | 1,957 | 2,026 | 2,170 |

| RESOURCES EXPENDED | 7-10 |                             |                           |                      |                      |
| Costs of generating funds: |                             |                           |                      |                      |
| Fundraising Office | 0 | 64 | 64 | 85 |
| Fundraising Events | 0 | 30 | 30 | 35 |
| Fundraising Sales | 6 | 0 | 14 | 14 | 20 |
| Investment Management | 0 | 1 | 1 | 1 |
| Charitable Activities: |                             |                           |                      |                      |
| Purchase of new Equipment | 0 | 927 | 927 | 257 |
| Patient Education and Welfare | 10 | 195 | 205 | 190 |
| Medical Research | (12) | 286 | 274 | 600 |
| Staff Education and Welfare | 6 | 48 | 54 | 212 |
| Governance Costs | 0 | 35 | 35 | 40 |
| Total Resources Expended | 4 | 1,600 | 1,604 | 1,440 |

| Net Incoming / (Outgoing) Resources before transfers | 65 | 357 | 422 | 730 |

| Gains / (Losses) on Investment Assets |                             |                           |                      |                      |
| Unrealised Gains / (Losses) on Investment Assets | 3 | 173 | 176 | 1,270 |

| Net Movement in Funds | 68 | 530 | 598 | 2,000 |
| Fund balances brought forward at 1 April 2010 | 94 | 7,293 | 7,387 | 5,387 |
| Fund balances carried forward at 31 March 2011 | 14 | 7,823 | 7,985 | 7,387 |
# Balance Sheet

as at 31 March 2011

<table>
<thead>
<tr>
<th></th>
<th>NOTE</th>
<th>2010-2011 Unrestricted £000</th>
<th>2010-2011 Restricted £000</th>
<th>2010-2011 Total £000</th>
<th>2009-2010 Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fixed Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investments</td>
<td>11</td>
<td>136</td>
<td>7,729</td>
<td>7,865</td>
<td>7,679</td>
</tr>
<tr>
<td><strong>Total Fixed Assets</strong></td>
<td></td>
<td>136</td>
<td>7,729</td>
<td>7,865</td>
<td>7,679</td>
</tr>
<tr>
<td><strong>Current Asset</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stocks</td>
<td></td>
<td></td>
<td>0</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Debtors</td>
<td>12</td>
<td>1</td>
<td>82</td>
<td>83</td>
<td>96</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>0</td>
<td>24</td>
<td>24</td>
<td>24</td>
<td>98</td>
</tr>
<tr>
<td>Short term Investments and Deposits</td>
<td>25</td>
<td>1,635</td>
<td>1,660</td>
<td>636</td>
<td></td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>26</td>
<td>1,760</td>
<td>1,786</td>
<td>837</td>
<td></td>
</tr>
<tr>
<td><strong>Creditors: Amounts falling due within one year</strong></td>
<td>13</td>
<td>0</td>
<td>1,646</td>
<td>1,646</td>
<td>1,057</td>
</tr>
<tr>
<td><strong>Net Current Assets</strong></td>
<td></td>
<td>26</td>
<td>114</td>
<td>140</td>
<td>(220)</td>
</tr>
<tr>
<td><strong>Total assets less current liabilities</strong></td>
<td>162</td>
<td>7,843</td>
<td>8,005</td>
<td>7,459</td>
<td></td>
</tr>
<tr>
<td><strong>Creditors:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amounts falling due after more than one year</td>
<td>13</td>
<td>0</td>
<td>20</td>
<td>20</td>
<td>72</td>
</tr>
<tr>
<td><strong>Net  Assets</strong></td>
<td></td>
<td>162</td>
<td>7,823</td>
<td>7,985</td>
<td>7,387</td>
</tr>
<tr>
<td><strong>Total Funds</strong></td>
<td></td>
<td>162</td>
<td>7,823</td>
<td>7,985</td>
<td>7,387</td>
</tr>
</tbody>
</table>

The financial statements were approved by the Trust (Charitable)Funds Committee and signed by:

H Parker  
Non Executive Director  
2 June 2011
Notes to the Accounts
for the year ended 31 March 2011

1 ACCOUNTING POLICIES

(a) Basis of preparation
The financial statements have been prepared under the historic cost convention (with the exception of investments which are included at market value) and in accordance with applicable United Kingdom Accounting Standards, Accounting and Reporting by Charities: Statement of Recommended Practice (SORP 2005) issued in March 2005 and the Charities Act 1993.

(b) Funds structure
Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund. Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment funds. Other funds are classified as unrestricted funds. Funds which are not legally restricted but which the Trustees have chosen to earmark for set purposes are designated funds. The major fund held within these categories is disclosed in note 14.

(c) Incoming resources
All incoming resources are included in full in the Statement of Financial Activities as soon as the following three factors can be met:

i) entitlement - arises when a particular resource is receivable or the charity’s right becomes legally enforceable;

ii) certainty - when there is reasonable certainty that the incoming resource will be received;

iii) measurement - when the monetary value of the incoming resources can be measured with sufficient reliability.

(d) Incoming resources from legacies
Legacies are accounted for as incoming resources once the receipt of the legacy becomes reasonably certain. This will be once confirmation has been received from the representatives of the estate that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled.

(e) Resources expended
The funds held on trust accounts are prepared in accordance with the accruals concept. All expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party.

Grants payable are payments, made to third parties (including NHS bodies) in the furtherance of the funds held on Trust’s charitable objectives wholly or mainly for the service provided by the Newcastle upon Tyne Hospitals NHS Foundation Trust (patient welfare, staff welfare, equipment and research). They are accounted for on an accruals basis where the conditions for their payment have been met or where a third party has a reasonable expectation that they will receive the grant.

(f) Allocation of overhead and support costs
Support costs and overhead charges from The Newcastle upon Tyne Hospitals NHS Foundation Trust are allocated as direct costs or apportioned on an appropriate basis. The cost attributable to Charitable Activities is then apportioned across those activities in proportion to total spend.

(g) Costs of generating funds
The costs of generating funds are the costs associated with generating income for funds held on Trust. These are the charity’s Fundraising manager and costs relating specifically to the Charlie Bear fund and Sir Bobby Robson Foundation. There are no direct investment management costs, as the costs relating to CCLA for their management of COIF units are absorbed by the overall fund, of which the charity holds a share.

(h) Governance costs
Governance costs are those costs incurred in the governance of the charity, including statutory audit.

(i) Fixed asset investments
Investments are shown at market value as at the balance sheet date. The Statement of Financial Activities includes any net gains and losses arising on revaluation and disposals throughout the year.

(j) Realised gains and losses
All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sale proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later).

(k) Pooling Scheme
There is no official pooling scheme operated for investments.

(l) Stock
Stock is valued at the lower of cost and net realisable value.

2. RELATED PARTY TRANSACTIONS

The Trust Board of The Newcastle upon Tyne Hospitals NHS Foundation Trust acts as corporate trustee for The Newcastle upon Tyne Hospitals NHS Charity. The charitable trust has made revenue and capital payments to The Newcastle upon Tyne Hospitals NHS Foundation Trust. During the year none of the members of the Corporate Trustee Board, key management staff or parties related to them has undertaken any material transactions with the Newcastle upon Tyne Hospitals NHS Charity.
3 DONATIONS

<table>
<thead>
<tr>
<th>Department</th>
<th>2010-2011 £000</th>
<th>2009-2010 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Purposes</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Patients' Welfare</td>
<td>58</td>
<td>106</td>
</tr>
<tr>
<td>Staff Training and Education</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>General Research Purposes</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Cardiothoracic</td>
<td>36</td>
<td>65</td>
</tr>
<tr>
<td>Medicine</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Surgery</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Ear, Nose and Throat</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Urology</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pathology</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Cancer</td>
<td>9</td>
<td>64</td>
</tr>
<tr>
<td>Anaesthesia</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Renal</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Charlie Bear</td>
<td>104</td>
<td>46</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>250</strong></td>
<td><strong>344</strong></td>
</tr>
</tbody>
</table>

4 LEGACIES

<table>
<thead>
<tr>
<th>Department</th>
<th>2010-2011 £000</th>
<th>2009-2010 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Purposes</td>
<td>8</td>
<td>59</td>
</tr>
<tr>
<td>Patients' Welfare</td>
<td>12</td>
<td>127</td>
</tr>
<tr>
<td>Staff Training and Education</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>General Research Purposes</td>
<td>47</td>
<td>12</td>
</tr>
<tr>
<td>Cardiothoracic</td>
<td>68</td>
<td>4</td>
</tr>
<tr>
<td>Surgery</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Urology</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pathology</td>
<td>0</td>
<td>69</td>
</tr>
<tr>
<td>Cancer</td>
<td>108</td>
<td>2</td>
</tr>
<tr>
<td>Anaesthesia</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Renal</td>
<td>181</td>
<td>80</td>
</tr>
<tr>
<td>Charlie Bear</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>429</strong></td>
<td><strong>362</strong></td>
</tr>
</tbody>
</table>
5. **GRANTS**

A grant of £6,000 was received from Siemens Ltd in support of the costs of a patient information DVD (Charlie Bear for Cancer Care Fund).

6. **FUNDRAISING SALES**

Fundraising sales relates to the stall operated by the Charlie Bear fund at the Northern Centre for Cancer Treatment. This is run by volunteers and overseen by the Charlie Bear Assistant.

7. **ALLOCATION OF OVERHEAD AND SUPPORT COSTS**

Support and overhead costs have been analysed to identify:

- Governance Costs: Apportioned across all funds in proportion to market value as at 30.9.2010
- Costs of Generating Funds: Apportioned across all funds in proportion to market value as at 30.9.2010
- Costs in Support of Charitable Activities: Apportioned across all relevant funds in proportion to the costs of grants made in support of charitable activities

The apportionments excluded any costs which were directly attributable to the Charlie Bear Fund.

<table>
<thead>
<tr>
<th>2010-2011</th>
<th>2010-2011</th>
<th>2010-2011</th>
<th>2010-2011</th>
<th>2009-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance Costs</td>
<td>Costs of Generating Funds</td>
<td>Costs in Support of Charitable Activities</td>
<td>Total</td>
<td>Total</td>
</tr>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Auditors’ Remuneration - Audit Fee</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Bought-in services from NHS</td>
<td>25</td>
<td>60</td>
<td>57</td>
<td>142</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>49</td>
<td>0</td>
<td>53</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35</strong></td>
<td><strong>109</strong></td>
<td><strong>57</strong></td>
<td><strong>201</strong></td>
</tr>
</tbody>
</table>

Bought-in services from NHS includes Internal Audit and a recharge from The Newcastle upon Tyne Hospitals NHS Foundation Trust for finance support and overheads.

8. **ANALYSIS OF CHARITABLE EXPENDITURE**

<table>
<thead>
<tr>
<th>2010-2011</th>
<th>2010-2011</th>
<th>2010-2011</th>
<th>2009-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grant Funded Activities</td>
<td>Support Costs</td>
<td>Total</td>
<td>Total</td>
</tr>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Purchase of new Equipment</td>
<td>910</td>
<td>17</td>
<td>927</td>
</tr>
<tr>
<td>Patient Education and Welfare</td>
<td>193</td>
<td>12</td>
<td>205</td>
</tr>
<tr>
<td>Medical Research</td>
<td>252</td>
<td>22</td>
<td>274</td>
</tr>
<tr>
<td>Staff Education and Welfare</td>
<td>48</td>
<td>6</td>
<td>54</td>
</tr>
<tr>
<td><strong>Total Grants Payable</strong></td>
<td><strong>1,403</strong></td>
<td><strong>57</strong></td>
<td><strong>1,460</strong></td>
</tr>
</tbody>
</table>
9. ANALYSIS OF GRANTS

All grants are made directly to The Newcastle upon Tyne Hospitals NHS Foundation Trust via a scheme of delegation operated by the corporate trustee. All grant funded activity is managed by fund holders in accordance with standing orders and financial instructions.

10. ANALYSIS OF STAFF COSTS/PENSION CONTRIBUTIONS

There are no staff employed directly by the charity therefore there have been no pension contributions made in the period.

11. FIXED ASSET INVESTMENTS

a) Movement in Fixed Asset Investments

<table>
<thead>
<tr>
<th></th>
<th>2010-2011</th>
<th>2009-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Market Value at 1 April 2010</td>
<td>7,679</td>
<td>6,395</td>
</tr>
<tr>
<td>Add Acquisitions at Cost</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Net Gain / (Loss) on Revaluation</td>
<td>176</td>
<td>1,270</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Market Value at 31 March 2011</td>
<td>7,865</td>
<td>7,679</td>
</tr>
<tr>
<td>Historic Cost at 31 March 2011</td>
<td>4,259</td>
<td>4,249</td>
</tr>
</tbody>
</table>

b) Fixed Asset Investment

<table>
<thead>
<tr>
<th></th>
<th>2010-2011</th>
<th>2010-2011</th>
<th>2010-2011</th>
<th>2010-2011</th>
<th>2009-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Held in UK</td>
<td>Held Outside UK</td>
<td>Total</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td></td>
</tr>
<tr>
<td>Investments in a Common Deposit Fund or Common Investment Fund</td>
<td>602,505</td>
<td>6,113</td>
<td>0</td>
<td>6,113</td>
<td>5,936</td>
</tr>
<tr>
<td>Cash Held as part of the Investment Portfolio (see Note A)</td>
<td>0</td>
<td>1,752</td>
<td>0</td>
<td>1,752</td>
<td>1,743</td>
</tr>
<tr>
<td>Total</td>
<td>602,505</td>
<td>7,865</td>
<td>0</td>
<td>7,865</td>
<td>7,679</td>
</tr>
</tbody>
</table>

c) Analysis of Gross Income from Investments

<table>
<thead>
<tr>
<th></th>
<th>2010-2011</th>
<th>2010-2011</th>
<th>2010-2011</th>
<th>2009-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Held in UK</td>
<td>Held Outside UK</td>
<td>Total</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Investments in a common Deposit Fund or common Investment Fund</td>
<td>268</td>
<td>0</td>
<td>268</td>
<td>260</td>
</tr>
<tr>
<td>Cash Held as part of the Investment Portfolio *</td>
<td>9</td>
<td>0</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Other Investments</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Total Market Value of Fixed Asset Investments</td>
<td>282</td>
<td>0</td>
<td>282</td>
<td>274</td>
</tr>
</tbody>
</table>

* Interest is paid directly into the COIF Deposit Account for re-investment
12. ANALYSIS OF DEBTORS

<table>
<thead>
<tr>
<th></th>
<th>2010-2011 £000</th>
<th>2009-2010 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amounts falling due within one year:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accrued Income</td>
<td>83</td>
<td>53</td>
</tr>
<tr>
<td>Other Debtors</td>
<td>0</td>
<td>43</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>83</strong></td>
<td><strong>96</strong></td>
</tr>
</tbody>
</table>

13. ANALYSIS OF CREDITORS

<table>
<thead>
<tr>
<th></th>
<th>2010-2011 £000</th>
<th>2009-2010 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amounts falling due within one year:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade Creditors *</td>
<td>329</td>
<td>220</td>
</tr>
<tr>
<td>Accruals #</td>
<td>1,317</td>
<td>837</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,646</strong></td>
<td><strong>1,057</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2010-2011 £000</th>
<th>2009-2010 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amounts falling due after more than one year:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accruals #</td>
<td>20</td>
<td>72</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
<td><strong>72</strong></td>
</tr>
</tbody>
</table>

* Trade Creditors represents the amount owed to a related party - The Newcastle upon Tyne Hospitals NHS Foundation Trust, for costs incurred on behalf of the charity in the furtherance of the charity’s objects.

# Accruals of £625k (2009-2010 £908k) have been included in the above figures which the Trustee considers to be a legal or constructive obligation because of ongoing or future schemes agreed with the Trust (see Annual Report for details).
## 14. ANALYSIS OF CHARITABLE FUNDS

### RESTRICTED FUNDS

<table>
<thead>
<tr>
<th>Fund</th>
<th>Balance 1 April 2010 £000</th>
<th>Incoming Resources £000</th>
<th>Resources Expended £000</th>
<th>Transfers £000</th>
<th>Gains and Losses £000</th>
<th>Balance 31 March 2011 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients’ Welfare</td>
<td>1,177</td>
<td>131</td>
<td>(186)</td>
<td>0</td>
<td>26</td>
<td>1,148</td>
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<tr>
<td>Staff Training and Education</td>
<td>88</td>
<td>7</td>
<td>(3)</td>
<td>0</td>
<td>2</td>
<td>94</td>
</tr>
<tr>
<td>General Research Purposes</td>
<td>785</td>
<td>91</td>
<td>(211)</td>
<td>0</td>
<td>23</td>
<td>688</td>
</tr>
<tr>
<td>Cardiothoracic</td>
<td>1,558</td>
<td>208</td>
<td>(222)</td>
<td>0</td>
<td>58</td>
<td>1,602</td>
</tr>
<tr>
<td>Medicine</td>
<td>189</td>
<td>4</td>
<td>8</td>
<td>0</td>
<td>2</td>
<td>203</td>
</tr>
<tr>
<td>Surgery</td>
<td>345</td>
<td>19</td>
<td>(28)</td>
<td>0</td>
<td>10</td>
<td>346</td>
</tr>
<tr>
<td>Ear, Nose and Throat</td>
<td>222</td>
<td>8</td>
<td>(2)</td>
<td>0</td>
<td>5</td>
<td>233</td>
</tr>
<tr>
<td>Urology</td>
<td>252</td>
<td>15</td>
<td>(2)</td>
<td>0</td>
<td>11</td>
<td>276</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>50</td>
<td>3</td>
<td>(11)</td>
<td>0</td>
<td>1</td>
<td>43</td>
</tr>
<tr>
<td>Pathology</td>
<td>84</td>
<td>3</td>
<td>(12)</td>
<td>0</td>
<td>2</td>
<td>77</td>
</tr>
<tr>
<td>Cancer (see Note D)</td>
<td>1,925</td>
<td>1,033</td>
<td>(794)</td>
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<td>20</td>
<td>2,184</td>
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<tr>
<td>Chapel Fund</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Anaesthesia</td>
<td>117</td>
<td>19</td>
<td>(13)</td>
<td>0</td>
<td>2</td>
<td>125</td>
</tr>
<tr>
<td>Renal</td>
<td>245</td>
<td>194</td>
<td>(3)</td>
<td>0</td>
<td>5</td>
<td>441</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>173</td>
<td>8</td>
<td>(3)</td>
<td>0</td>
<td>6</td>
<td>184</td>
</tr>
<tr>
<td>Charlie Bear (see Note A)</td>
<td>80</td>
<td>214</td>
<td>(118)</td>
<td>0</td>
<td>0</td>
<td>176</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7,293</strong></td>
<td><strong>1,957</strong></td>
<td><strong>(1,600)</strong></td>
<td><strong>0</strong></td>
<td><strong>173</strong></td>
<td><strong>7,823</strong></td>
</tr>
</tbody>
</table>

### UNRESTRICTED FUNDS

<table>
<thead>
<tr>
<th>Fund</th>
<th>Balance 1 April 2010 £000</th>
<th>Incoming Resources £000</th>
<th>Resources Expended £000</th>
<th>Transfers £000</th>
<th>Gains and Losses £000</th>
<th>Balance 31 March 2011 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Purposes</td>
<td>94</td>
<td>69</td>
<td>(4)</td>
<td>0</td>
<td>3</td>
<td>162</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>94</strong></td>
<td><strong>69</strong></td>
<td><strong>(4)</strong></td>
<td><strong>0</strong></td>
<td><strong>3</strong></td>
<td><strong>162</strong></td>
</tr>
</tbody>
</table>

### TOTAL FUNDS

<table>
<thead>
<tr>
<th>Fund</th>
<th>Balance 1 April 2010 £000</th>
<th>Incoming Resources £000</th>
<th>Resources Expended £000</th>
<th>Transfers £000</th>
<th>Gains and Losses £000</th>
<th>Balance 31 March 2011 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td><strong>7,387</strong></td>
<td><strong>2,026</strong></td>
<td><strong>(1,604)</strong></td>
<td><strong>0</strong></td>
<td><strong>176</strong></td>
<td><strong>7,985</strong></td>
</tr>
</tbody>
</table>

**Notes:**

**A** - Charlie Bear expends resources significantly faster than the other funds. Therefore, it is invested via the money market and not via the Charities Official Investment Fund (COIF); investment gains are not applicable.

**B** - No endowment funds are held.

**C** - Funds are shown at Market Value as at 31.3.2011

**D** - This registration includes the Sir Bobby Robson Foundation which is invested via the money market, not the Charities Official Investment Fund; investment gains are not applicable.
15. **TRUSTEES & CONNECTED PARTY TRANSACTIONS**

There were no expenses or remuneration paid to the Trustees during the year (2009-10 NIL).

15.1 There were no transactions with Trustees or connected persons for the year to 31st March 2011 (2009-10 NIL).

15.2 No indemnity insurance was provided to the Trustees in the year to 31st March 2011 (2009-10 NIL).

15.3 There were no loans or guarantees secured against assets of the Charity in the year to 31st March 2011 (2009-10 NIL).

15.4 Related Party Transactions:

During the year none of the members of the Trust (Charitable) Funds Committee or members of the key management staff or parties related to them has undertaken any material transactions with Newcastle upon Tyne Hospitals NHS Charity.

During the financial year payments of £1.08 million were made to the Newcastle upon Tyne Hospitals NHS Foundation Trust in respect of grants made to the Trust. A further sum of £0.3 million was due for payment at 31st March 2011.

The charges made by Newcastle upon Tyne Hospitals NHS Foundation Trust (£110k) for administrative support and overheads, include the provision of staff and office accommodation, which enables the charity to fulfil its statutory duties and provide support for the day-to-day running of the charity (£106k 2009/10).
Freeman Hospital
Main entrance reception
Meetings in public

The Council of Governors meets at 2-00pm on the third Thursday of alternate months, at the Freeman Hospital. These meetings are open to the public. Details may be found on the website at www.newcastle-hospitals.org.uk/about-us/council-of-governors-papers.aspx

Annual General Meeting

The Trust’s Annual General Meeting is held each year on the fourth Wednesday of September at 6-00pm in the Education Centre, Freeman Hospital, Newcastle upon Tyne.

Feedback

Whether it be a complaint or a compliment or simply an enquiry, we do want to hear from you. There are Suggestion Boxes around our sites, or any member of staff would be happy to listen. Alternatively, contact:

Sir Leonard Fenwick
Chief Executive

The Newcastle upon Tyne Hospitals
NHS Foundation Trust
Freeman Hospital
High Heaton
Newcastle upon Tyne NE7 7DN
Telephone: (0191) 233 6161
Fax: (0191) 213 1968

Openness and Accountability

Information

The Trust is keen to share information and wherever possible respond positively to requests for detail relating to the performance of the organisation and how it operates. The Council of Governors papers are published routinely on the website and the Trust has a detailed Publication Scheme under the Freedom of Information Act, which makes a significant volume of information readily available, including via the website.
Charitable Fundraising

We are extremely grateful for all the help and support that our hospitals receive from the general public and the local business community. The goodwill that is generated by our hospitals and staff is most gratifying. We are consistently approached by members of the public offering their support, or seeking our advice.
There are many ways to help the Newcastle Hospitals and we have listed here the most common forms of support. We are keen to protect both the hospitals’ good name and integrity as well as those individuals who offer support and we therefore ask that anyone wishing to fundraise in our name seeks permission before the fundraising commences. Help and support is available from the Charity Fund Office and a letter of authorisation will be issued to the fundraiser.

**Donation**

Single or periodic donations are the most common form of contribution and cheques can be made payable to ‘The Newcastle upon Tyne Hospitals NHS Charity (no. 1057213)’ or ‘Newcastle Healthcare Charity (no. 502473)’.

All donations should be sent to:

Charity Fund Office  
Room 203  
Cheviot Court  
Freeman Hospital  
High Heaton  
Newcastle upon Tyne  
NE7 7DN

Standing Order forms are available on request from the same address.

**Payroll giving**

Individuals can elect to make donations to a charity of their choice by having an agreed sum deducted from their salary (weekly/monthly/annually). The effect of this is twofold: the charity receives both the donation and also the tax that would have been deducted on that particular sum. Thus a donation of £50 is increased to £64.10, with the donor only paying the agreed sum of £50 and HM Revenue and Customs providing the difference. Ask your employer for details.

**Share giving**

Gifts of shares and securities can be transferred to the hospital charities and at the same time offer tax relief for the donor at the date of the transfer. This has become an increasingly popular form of charitable giving and allows individuals to benefit charities, often with minimal impact on income, in a simple and effective manner.

**Fundraising**

Helping the hospitals in this way can be fun and at the same time generate vital funds for the local hospitals. It is important that fundraisers are aware of local regulations and what is considered acceptable practice. The Charity Fund team will offer advice and support and arrange a letter of authorisation for those involved. Sponsorship forms are available on request.

**Gift aid**

Any donation made to a registered charity can be increased by 28% by using the Gift Aid Scheme. Anyone who pays income tax (or capital gains tax) can elect to have their donation “Gift Aided” and this will allow the Trust’s charities to recover the tax paid on the contribution. A gift of £250 will be increased to £320 using the Gift Aid Scheme, with the extra £70 coming from HM Revenue and Customs and if the donor pays higher rate tax the personal liability will be reduced by £64.

**Legacy**

After providing for their family, many people make a gift to their local hospitals in recognition of personal treatment or that provided to a loved one or friend. Help maintain and improve the healthcare for future generations by remembering your local hospital in your Will.

**Matched giving**

Many local businesses support charities by matching any fundraising efforts by their own staff. This in effect doubles any money raised by those individuals and is an excellent way of inspiring and increasing contributions.

**Help and advice**

For further information, help and advice, please contact:

Charity Fund Office,  
Room 203,  
Cheviot Court,  
Freeman Hospital,  
High Heaton,  
Newcastle upon Tyne  
NE7 7DN

Tel: 0191 223 1434  
Email: Charity.Matters@nuth.nhs.uk  
Website: www.newcastle-hospitals.org.uk

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We are recognised nationally as a centre of healthcare excellence - more than 30% of our patients come from outside of Tyne & Wear.
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0845 375 1875 www.potts.co.uk

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It has been printed using an alcohol-free process, with a water-based varnish and vegetable-based printing inks, which are non-hazardous
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