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1. Chairman’s statement

I am pleased to present Northumbria Healthcare’s annual report for 2014/15, where we have had another busy and successful year.

Despite the challenges that the NHS faces, we continue to maintain a strong track record of financial performance and strive to deliver the very best quality of care to our patients.

We are consistently one of the top performing foundation trusts in England – something that our staff, council of governors and the board are extremely proud of. However, we are not complacent and have an open and honest culture where we are committed to continuous improvement and providing the highest quality of services to patients, every second of every day.

Quality is at the very heart of everything we do. To support this, we have developed and launched the trust’s new quality strategy, alongside staff and patient groups. This strategy sets out our long-term ambition, priorities and how we will support our staff to seek opportunities to make improvements to our patient care.

We were delighted that, once again, we have been recognised nationally and named as the best in the country for our work to improve patients’ experiences of receiving care in Northumberland and North Tyneside.

The accolade of ‘overall best trust’ was one of six awards that we won at the Patient Experience Network National Awards 2014. These awards recognise and celebrate the delivery of outstanding patient experience by healthcare organisations.

All of this is possible due to the professionalism, enthusiasm and sheer commitment of our staff and I would like to record my thanks to them all.

This commitment is reflected in the latest national staff survey results where we were the top trust in England for staff feeling able to contribute to improvements at work, working well as a team and having support from immediate managers. Our employees are also some of the most satisfied in the NHS, with 94 per cent feeling their role makes a difference to patients.

Our relationship with North Cumbria University Hospitals NHS Trust continues as an official ‘buddy’ trust whilst North Cumbria is in ‘special measures’. Every effort is being made to ensure the trust can come out of special measures as soon as possible for the benefit of patient care.

I would like to express my sincere thanks and gratitude to our council of governors for their commitment, hard work and continued support to help develop our future priorities and shape our services across Northumberland and North Tyneside. The council of governors - made up of stakeholders, elected staff and public governors - are an invaluable link between the trust, our members and the local communities we serve.

As we move ever closer to our new specialist emergency care hospital opening in Cramlington this June, it is imperative that our patients and the public understand where to go to access our services and our governors have played an integral part in helping us communicate this.
I would also like to thank my colleagues on the board of directors for their expertise, support and leadership during the year.

As we look ahead, we do not doubt that next year will be another very challenging one; however, we have strong foundations in place and will remain focused on delivering excellent services for our patients and service users.

Brian Flood

Chairman
29 May 2015
2. **Chief Executive’s statement**

I am pleased to confirm that 2014/15 has been another very successful year for the trust, as you will see within this report. Although this is usually the case, in my view, this performance is worthy of note as it was a very, very challenging year for the NHS.

We have seen provider organisations across the country, and regionally, start to struggle financially and with the delivery of some key standards. However, I am proud to say that our performance continued to be excellent, in spite of extreme pressure throughout the year.

The pressures on our emergency services were more severe last year than we have seen in many years, with a 34% increase in hospital admissions at peak times, mainly of very frail old people. I think the big difference this year was the length of time this pressure went on for, with our staff going the extra mile, day-after-day, for several months.

Throughout the year, and in spite of the above pressure, our overall performance continued to be amongst the best in England and we managed to maintain financial discipline and strength. More importantly, patient, and staff satisfaction were largely maintained throughout the year and our staff managed to make fantastic progress on our quality priorities – particularly sepsis where our improvements are starting to look really impressive and are saving lives.

There were many other achievements through the year, too many to mention here. However, I think our integration of hospital, community and adult social care and now, through Northumbria Primary Care, primary care make this a very special organisation. This integration has led us to be chosen as a Vanguard site and we are expecting great breakthrough improvements as part of this.

I write this just a few weeks before we open our new specialist emergency care hospital – The Northumbria. This represents the culmination of more than ten years’ work and will enable us to deliver a new standard in emergency care, and enable us to transform care throughout the organisation. It is natural that we may feel a little nervous ahead of this, but I know that our staff will embrace this in the usual way – the Northumbria way - and make this a huge success.

Finally, I would like to thank all of our staff, partners and governors for all they have achieved over this last year. This sort of performance is only possible when everyone pulls together and that has definitely been the case again this year.

Jim Mackey  
Chief Executive  
29 May 2015
3. Strategic report

Trust profile

Northumbria Healthcare NHS Foundation Trust received authorisation from Monitor on 1 August 2006 and has operated as a foundation trust since that date. Foundation trusts are membership-based, public benefit corporations. Members elect governors who, as a body, hold to account the board of directors for the management and performance of the trust.

We employ almost 9,500 members of staff, our annual budget is around £471 million and we provide services and care to a population of over half a million people across one of the largest geographical areas of any trust in England, stretching from Tyneside to the Scottish Borders across to Haltwhistle in the west.

We have three general hospitals: Hexham, Wansbeck and North Tyneside, and six community hospitals: Alnwick, Berwick, Blyth, Haltwhistle, The Whalton Unit in Morpeth and Rothbury, and outpatient and diagnostic centres at Sir GB Hunter in Wallsend and Morpeth NHS Centre. We rebuilt our community hospital in Haltwhistle replacing this with a new integrated health and social care scheme which opened this year. Our new specialist emergency care hospital in Cramlington – The Northumbria – will open in June 2015.

We deliver hospital services including accident and emergency, maternity care, children’s services, surgery, intensive care, and medicine. We also provide NHS care outside of hospital which is delivered from venues in local communities and in people’s homes - such services include community and district nursing, health visiting, rehabilitation, public health and sexual health services.

We manage adult social care services on behalf of Northumberland County Council, helping to ensure people move between hospital, community health and social care services easily and with continuity of care. We also give people greater choice and control over their care to help them to live independently at home and to avoid hospital admission where appropriate. Further detail on the trust’s business is detailed in the directors’ report.

We want to ensure we provide the best possible care to each and every patient. We also want to ensure our patients are valued and respected by staff and that they feel in control of their care and confident to make decisions. Patient experience is therefore a key priority for us so we have continued to expand our already extensive patient experience programme. This continues to drive up standards with 99 per cent of patients surveyed feeling they were treated with kindness and compassion. More information about patient experience, activity and care can be found in section 4, directors’ report and business review.

To achieve our vision of being the leader in providing high quality, safe and caring services, we recognise the importance of engaging with our stakeholders. Their contributions help us shape our strategic direction and are crucial to our success. Further detail on stakeholder engagement is covered in section 7 of this report - membership activity.
Northumbria Healthcare Facilities Management Ltd (NHFM Ltd) was established on 17 January 2012, and is a wholly owned subsidiary of the trust. It provides specialist project management services for large and small capital developments, estates maintenance services and Private Finance Initiative (PFI) contract compliance/monitoring services.

NHFM Ltd helps clients through the capital development process from concept through to final occupation. This includes developing initial briefings and options, securing appropriate sites and planning consents, appointing consultant designers and advisors, managing the detailed design process, appointing contractors, managing the construction process and getting clients into fully operational buildings. NHFM Ltd also provide maintenance services to ensure that premises are safe, comfortable and correctly meet the business needs of the client and comply with all statutory and/or mandatory requirements.

Over the last year, two major projects have been managed by NHFML Ltd; these are the build of the new specialist emergency care hospital at Cramlington and the completion of the new integrated health and social care scheme in Haltwhistle.

Northumbria Primary Care Ltd is a new company established to provide GPs with professional support in many of the corporate functions that come with running a GP practice. It is a wholly owned subsidiary of Northumbria Healthcare NHS Foundation Trust which will start trading on 1 April 2015. This will operate via a cost sharing group.

Financial performance

We recorded a surplus for the year of £1.8 million (£16.0 million in 2013/14) before ‘one off’ items, the largest arising from impairments of fixed assets arising from a full estate revaluation exercise and the release of unused provision arising from the termination notice of the Hexham PFI contract. We recorded a surplus for the year of £78,000 (deficit for the year of £51.9 million in 2013/14) including these ‘one off’ items.

Excluding the impact of the settlement of the PFI contract the group continued to generate cash from operations indicative of a continued strong operational performance. The impairments of fixed assets have no impact on the Groups cash flows or liquidity position.

Our surplus (before ‘one-off’ items) was in line with expectations and represented excellent performance given the continued levels of patient activity (table 1), the need to reduce costs and the continuing need to invest in services.

This reflects the strength of financial management and efficiency in the trust and enables us to continue to have an excellent rating for financial risk.
The trust ends the financial year on a strong note and we are positive about the future.

We strive to bring yet further improvements to our services to ensure excellent quality and patient-centred healthcare is delivered. This includes a bold and innovative strategic plan for the next ten years, the most significant elements of which are the opening of a specialist emergency care hospital, redevelopment of our community hospitals and improvements to North Tyneside and Wansbeck general hospitals.

There are some challenges and we have acknowledged the risks to achieving these plans but the board is confident that they will be properly managed and that we will continue to prosper. These challenges include: the continuing economic climate and implications on the public sector; changes in the non-elective elements of the tariff; issues in the management of demand; hospital acquired infections and the penalty regime linked to reductions in quality of service and the changes in legislation with the introduction of the Health and Social Care Act 2012.

We will deal with these issues through sound financial management and firm agreements with our commissioners. Substantial planning has already been undertaken to reduce costs and improve efficiency during the year and gains from these totalled £23 million, all whilst maintaining and delivering high quality care to our patients.

### Trust activity

Last year we:-

- Employed almost 9,500 members of staff (7613, whole time equivalents)
- Cared for around 71,000 patients and families on our wards
- Provided treatment to around 167,000 patients in our A&E departments and minor injuries units
- Performed almost 36,476 operations
- Treated almost 47,000 people using day-case procedures
- Carried out around 1.4 million appointments with patients outside of hospital
- Provided 78,000 face-to-face adult social care appointments including home visits

<table>
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<tr>
<th>Patient activity (by payment by results only)</th>
<th>Plan 2014/15</th>
<th>Outturn 2014/15</th>
<th>Outturn 2013/14</th>
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<td>Non-elective inpatient spells</td>
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<td>119,540</td>
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<tr>
<td>Outpatient follow-up</td>
<td>307,338</td>
<td>292,160</td>
<td>296,856</td>
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<td>Outpatient radiology</td>
<td>44,644</td>
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<td>Outpatient procedures</td>
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<tr>
<td>Diagnostic tests (direct access only)</td>
<td>2,231,105</td>
<td>2,343,056</td>
<td>2,285,125</td>
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<tr>
<td>A&amp;E attendances</td>
<td>165,471</td>
<td>166,101</td>
<td>163,833</td>
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Table 1: Patient activity
At the end of 2014/15, we employed 9,464 staff of which 756 were fixed term/temporary employees and 919 were bank staff (with 19% of the workforce being male and 81% of the workforce being female). Further detail regarding working with our staff and progress against our workforce strategy is provided in the directors’ report.

**Trust values**

The trust developed its values in conjunction with staff. The values are: putting patients first; providing safe and high quality care; ensuring responsibility and accountability; everyone’s contribution counts and respect. Excellent patient care can only be achieved with a strong workforce and Northumbria is privileged to attract, develop and retain the best people available in every aspect of service delivery to shape how we operate.

Honesty, integrity and openness have always been among our top priorities. Maintaining high ethical standards will continue to be a key part of how we do business and we take our obligations and responsibilities seriously, particularly taking into account the recommendations from the Francis report on Mid Staffordshire NHS Foundation Trust.

**Strategic direction and the business model**

The trust is one year into an ambitious programme of work which was outlined in the 2013/14 five-year strategic plan and reflected within the two-year operational plan. This work detailed comprehensively the trusts business model alongside articulating a clear future.

The board recommitted to this strategic plan in March 2015 alongside committing to additional priorities which included becoming a ‘vanguard’ site for NHS England’s NHS Five Year Forward View alongside placing a greater focus on population public health prevention. Key to the successful delivery of the strategic plan is the opening of the new Northumbria Specialist Emergency Care Hospital. The practical completion of the new hospital took place on the 31st March 2015 and is set to open in June 2015. This landmark hospital, the first of its kind dedicated to emergency care, will allow the trust to transform the model of care provided to patients living in North Tyneside and Northumberland.

Our core priorities and values continue to be the best in class for delivering high quality, safe, patient-centred healthcare through dedicated, caring and committed support teams and healthcare professionals. We have a number of clinical priorities that encompass safety and quality measures ranging from the delivery of integrated care between acute and community services and zero tolerance to hospital-acquired infections, to transformational strategic priorities. All of the above focus on delivering improved outcomes for the local population.

Northumbria Healthcare has continued to work with North Cumbria University Hospitals NHS Trust under the ‘buddy’ agreement arranged by the NHS Trust Development Authority (TDA). During this time, North Cumbria University Hospitals NHS Trust has continued to be a stand-alone statutory organisation in its own right. Any support provided by Northumbria Healthcare has been as a result of the ‘buddy’ contract.
Financially, our performance remains strong despite the health sector challenges all NHS organisations face. This has been as a result of prudent financial management and a clear financial strategic focus which has brought about innovative approaches which include the Hexham hospital PFI buy back, a scheme which will save the trust an estimated £3.5 million per year. This is just one example of many which has ensured our performance within this area. The position does however, remain challenging and generating the efficiencies required will increasingly become more difficult requiring innovative approaches into the longer-term. Further detail with regard to how the trust and directors have performed can be found in The NHS foundation trust code of Governance, Board Performance (Section 6) and the Quality Account appendix B.

We have maintained a consistently strong performance throughout the year for both finance and governance. The trust board continuously examines its approach to quality governance which is the combination of structures and processes to ensure the delivery of high quality care. Further detail with regard to performance throughout the year is provided in the directors’ report.

**Principal risks and uncertainties**

The trust has identified a clear risk mitigation strategy to deal with the externally volatile environment and we continue to engage with partners in the development of such plans. We continue to maintain a strong track record of delivery against our objectives, regulatory requirement and targets and as such remain confident in delivering these measures going forward.

In order to continue to deliver safe, high quality care, we will enhance our patient-focused and performance-driven culture. The trust’s culture has been built on trust, openness and empowerment with clear lines of accountability/responsibility that has helped the organisation to learn and improve over time.

The key risks for the trust continue to be the external financial environment which has the potential to result in a quality impact on services delivered by the trust. The trust, however, has a robust process in place to manage all cost reduction programmes within business units that ensures a quality impact assessment is undertaken with full clinical challenge in advance of the scheme being undertaken, and six months post-delivery of the significant scheme.

The Annual Governance Statement detailed in section 12, outlines the trust’s system for internal control which is designed to manage risk for the organisation.

**Environmental matters**

We are fully committed to the principles of sustainable development, low carbon economy and reductions in the consumption of finite natural resources. We recognise the impact of these issues on the economic and social development of local, national and international communities and are determined to play our part in meeting the requirements of the sustainability agenda. The trust continues to deliver a reduction on carbon emissions and met the Department of Health target to reduce energy/utility related carbon emissions one year ahead of schedule.
Statement of going concern

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

In summary

The Annual Report provides a comprehensive summary of the trust’s activities throughout 2014/15 including operational and financial performance. This includes information relating to; composition and performance of the board of directors, employees and council of governors, key areas of development of the past 12 months and key objectives and risks looking forward.

I hope you will agree after reading this Annual Report that Northumbria has had an outstanding year and I have been honored to work with people who truly are the best and brightest in our profession.

The strategic report was approved by the board of directors on 29 May 2015 and signed on its behalf by:

Jim Mackey
Chief Executive Office
29 May 2015
4. Directors’ report and business review

Directors’ statement

As directors, we take responsibility for the preparation of the Annual Report and Accounts. We consider the Annual Report and Accounts, taken as a whole, to be fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the trust’s performance, business model and strategy.

5. Operating and financial review

Our operational performance is measured against a series of national targets and performance against these targets is reported to Monitor, within the arrangements set by Monitor’s Risk Assessment Framework. We are also regulated by the Care Quality Commission, which assesses the trust against a set of national safety and quality outcomes on patient safety, clinical and cost effectiveness and governance, as well as a number of local safety and quality standards that are agreed with our commissioners North Tyneside Clinical Commissioning Group and Northumberland Clinical Commissioning Group.

Northumbria Specialist Emergency Care Hospital (NSECH)

The build of our new Northumbria Specialist Emergency Care Hospital in Cramlington is now complete and the trust took possession of this hospital during the financial year. We are preparing to open to patients in June 2015.

Much planning work has taken place to allow the safe transfer of services to the new hospital and to ensure this hospital can function well alongside our existing general hospitals.

The Northumbria Specialist Emergency Care Hospital will be the first purpose-built hospital of its kind in England to have this level of medical cover. It will have emergency care consultants working there 24 hours a day, seven days a week. Consultants in a broad range of conditions will also offer services seven days a week, speeding up specialist care for patients in order to maximise chances of survival and a good recovery.

There are benefits for our general hospitals too as separating serious emergencies from planned care will mean patients attending for planned operations, tests and outpatient clinic appointments won’t have their care affected by the need to prioritise seriously ill emergency patients. Our general hospitals will become centres of excellence for care and treatment that is planned. They will also continue to provide 24-hour walk-in services for urgent but less serious conditions.

Sale of Morpeth Cottage Hospital

We no longer deliver services from Morpeth Cottage Hospital having moved outpatient services to the new NHS Centre in Morpeth and inpatient elderly care to a ward named the Whalton Unit, inside of Helen McArdle Care Home on the Morpeth Cottage Hospital site.
As the hospital is no longer fit for purpose, the trust sold the hospital and its land to its neighbour, Helen McArdle Care. Helen McArdle Care is looking at plans to build a care village which will have various types of high quality accommodation for older people.

**North Cumbria acquisition**

We have maintained our commitment, via the current national ‘buddy’ arrangements, to work with North Cumbria University Hospitals NHS Trust and continue to provide support to North Cumbria colleagues.

**New integrated health and social care facility at Haltwhistle**

This year we opened the new Haltwhistle War Memorial Hospital, which is now an integrated health and social care facility built in partnership with Northumberland County Council.

It is one of the first facilities of its kind in the country as it provides hospital and social care support under one roof. The hospital is on the first floor of the development and has 15 beds arranged in two four-bed bays and seven single en-suite rooms. The social care facility has 12 purpose-designed extra-care flats on the ground floor called Greenholme Court. These are managed by Homes for Northumberland on behalf of Northumberland County Council.

**Care Quality Commission (CQC)**

The role of the Care Quality Commission (CQC) is to make sure health and social care services provide people with safe, effective, compassionate, high quality care. The CQC will assess services and the trust over five core domains which are safe, effective, caring, responsive and well-led.

They have a responsibility to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and this includes the publication of their findings to help people choose care. The CQC will look at outcomes and experiences of care and will involve people who use and provide services to focus on how care is delivered, including a method known as intelligence monitoring. For Northumbria, the December 2014 intelligence monitoring profile classified the trust in band 5 (second lowest risk category).

In 2014/15 there were no planned or unplanned CQC reviews and the safety and quality outcomes set by the CQC have all been fully met. Although the trust is fully aware of the changes to the CQC regulation process, it continues with its current systems of maintaining and ensuring on-going compliance with CQC standards.

**Service reviews**

During 2014/15, we have carried out service reviews in anaesthetics, child health, clinical biochemistry, child and adolescent mental health services, child safeguarding, community learning disability team, dental, diabetes, endoscopy, falls, gastro, haematology, histopathology, infection control, joint equipment loan service, microbiology, occupational therapies, pain service, pharmacy, psychiatry of old age service, physiotherapy, podiatry, sexual health, special care baby unit and urology.
Service reviews have involved critically examining the evidence that is available both in the form of regulatory compliance but also on specific outcomes and patient experience. The income generated by these reviews represents 18.2 per cent of the total income generated from the provision of health services by the trust for 2014/15.

**Regulatory ratings (financial risk, governance risk, quality risk)**

Our overall performance is reflected in the view taken by Monitor of the level of risk in the trust in the categories of finance and governance. Monitor has a statutory role to ensure the continued provision of key NHS services, as identified by commissioners.

The requirements of Monitor’s Risk Assessment Framework help them detect early signs of financial risk that could lead to a foundation trust’s failure and so threaten the continuity of the key services it provides. There are four rating categories for the financial risk rating ranging from 1, which represents the most serious risk, to 4, representing the least risk. The trust has maintained a risk rating of 4 since the implementation of the new regime.

NHS foundation trusts should be well-governed, which includes evidence of how trusts oversee care for patients, deliver national standards and remain efficient, effective and economic.

There are three categories to the new governance rating applicable to all NHS foundation trusts. Where there are no grounds for concern at a trust, they will be assigned a green rating. Where concern has been identified but the trust has not yet taken action, Monitor will provide a written description stating the issue and the action under consideration. Where enforcement action has already commenced, Monitor will assign a red rating.

Table 2, shows our risk ratings for the two categories of finance and governance, including the comparison between actual quarterly performance and the overall planned performance for the year.

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<td>Governance risk rating</td>
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<tr>
<td><strong>Under the Risk assessment framework</strong></td>
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*Table 2: Trust Risk Rating 2013/14 and 2014/15*

We have maintained a consistently strong performance throughout the year for both finance and governance. The board also examined its approach to quality governance which is the combination of structures and processes to ensure the delivery of high quality care.
Financial performance

We recorded a surplus for the year of £1.8 million (£16.0 million in 2013/14) before ‘one off’ items, the largest arising from impairments of fixed assets arising from a full estate revaluation exercise and the release of unused provision arising from the termination notice of the Hexham PFI contract. We recorded a surplus for the year of £78,000 (deficit for the year of £51.9 million in 2013/14) after taking these exceptional items into account.

Excluding the impact of the settlement of the PFI contract the group continued to generate cash from operations indicative of a continued strong operational performance. The impairments of fixed assets have no impact on the Groups cash flows or liquidity position.

Our surplus (before ‘one-off’ items) was in line with expectations and represented excellent performance given the continued levels of patient activity (table 3), the need to reduce costs and the continuing need to invest in services.

This reflects the strength of financial management and efficiency in the trust and enables us to continue to have an excellent rating for financial risk.

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</tr>
<tr>
<td>Outpatient radiology</td>
<td>44,644</td>
<td>51,838</td>
<td>58,982</td>
</tr>
<tr>
<td>Outpatient procedures</td>
<td>32,777</td>
<td>29,874</td>
<td>27,997</td>
</tr>
<tr>
<td>Diagnostic tests (direct access only)</td>
<td>2,231,105</td>
<td>2,343,056</td>
<td>2,285,125</td>
</tr>
<tr>
<td>A&amp;E attendances</td>
<td>165,471</td>
<td>166,101</td>
<td>163,833</td>
</tr>
</tbody>
</table>

Table 3: Patient activity

The trust ends the financial year on a strong note and we are positive about the future.

We strive to bring yet further improvements to our services to ensure excellent quality and patient-centred healthcare is delivered. This includes a bold and innovative strategic plan for the next ten years, the most significant element of which will be the opening of a specialist emergency care hospital, redevelopment of our community hospitals and improvements to North Tyneside and Wansbeck general hospitals.

There are some challenges and we have acknowledged the risks to achieving these plans but the board is confident that they will be properly managed and that we will continue to prosper. These challenges include: the continuing economic climate and implications on the public sector; changes in the non-elective elements of the tariff; issues in the management of demand; hospital acquired infections and the penalty regime linked to reductions in quality of service and the changes in legislation with the introduction of the Health and Social Care Act 2012.
We will deal with these issues through sound financial management and firm agreements with our commissioners. Substantial planning has already been undertaken to reduce costs and improve efficiency during the year and gains from these totaled £23 million, all whilst maintaining and delivering high quality care to our patients.

**High quality care**

This year, we were privileged to have our commitment to quality recognised with a number of achievements:

- British Medical Journal (BMJ) Award for surgical team of the year for ground-breaking web-based audio-visual link with Kilimanjaro Christian Medical Centre
- Rated 13th in the country in NHS England’s 2013 Inpatient Survey
- For the seventh consecutive year, named among 40 best performing NHS organisation in CHKS Top Hospitals programme 2014
- Pharmaceutical Care Awards 2014 audience choice award for the SHINE project which has enabled care home residents in North Tyneside to become more involved with decisions about their medication
- North Tyneside General Hospital rated top in the country by junior doctors training in trauma and orthopaedics in General Medical Council’s 2014 national training survey
- Health Education North East Allied Health Professionals Service Improvement Award for radiographer reporting service project
- Rated 6th in the country for cancer patient experience by Macmillan Cancer Support (named in the top 10 for the fourth consecutive year)
- Payroll World Awards for in-house payroll team and manager award for head of payroll Sue Childerstone. Sue also won professional of the year at the Pay and Benefits Awards 2015
- Nursing Times Award for primary mental health worker team for our approach to better support children and young people who self-harm in North Tyneside
- UK Clinical Pharmacy Association Patient Safety Award for pharmacist prescribing
- North East NHS Leadership Recognition Awards – won board leadership category and the trust’s equality and diversity lead, Patrick Price, was named leader of inclusivity
- NHS Employers Compassion in Practice Awards for Hip Qip
- Rated 11th in the country in The Care Quality Commission’s 2014 national A&E patient survey
- Named among Britain’s best employers for lesbian, gay and bisexual staff in Stonewall’s 2015 Workplace Equality Index, rising 50 places from 2014
- Named ‘overall best trust’ and awarded five other accolades at The Patient Experience Network National Awards 2014. The awards recognised our patient experience programme, leadership (professional and managerial), support for carers and work to introduce keyhole surgery in Kilimanjaro Medical Centre in Tanzania
- Recognised for efforts to improve staff health and wellbeing with a Silver Better Health at Work Award

In addition to these awards, the NHS staff survey results showed that our employees are among the most satisfied in the country with 94 per cent of staff feeling their role makes a difference
to patients. We recorded the best response rate in England at 82 per cent, with staff expressing extremely high levels of satisfaction in their job and in the quality of patient care they deliver.

We were also recognised for our work to integrate health and social care in one of the most rural counties in England by NHS England who chose us to lead nationally on transforming care for patients as a ‘vanguard’ site. This involves working with partners to deliver an integrated primary and acute care system for the county.

**Priorities for quality improvement in 2014/15**

The improvement priorities for 2014/15 are highlighted in table 4. These priorities were identified in collaboration with members of the public, staff, governors and key stakeholders. We take pride in using patient and service user feedback to support the quality improvements we wish to focus on.

The priorities were agreed in collaboration with clinicians who made recommendations to the board of directors and council of governors. They were categorised as either providing safer care, delivering more effective care, a better patient experience and a focus on culture in line with the NHS definition of quality.

**Improvement Priorities 2014/15**

<table>
<thead>
<tr>
<th>Safer Care (SC)</th>
<th>Effective Care (EC)</th>
<th>Patient Experience (PE)</th>
<th>Culture (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Improve our management of medicines in hospital</td>
<td>2. Understanding our hospital mortality through case note audit</td>
<td>2. Roll out a new metric for kindness and compassion in line with the Francis report</td>
<td></td>
</tr>
<tr>
<td>5. Dementia assessment</td>
<td>5. Helping our patients manage their long-term conditions – focus on respiratory conditions and alcohol abuse</td>
<td>5. Achieving national accreditation schemes – Bliss and Year of Care</td>
<td></td>
</tr>
<tr>
<td>6. Commence process to implement electronic prescribing</td>
<td>6. Development of community services in line with Better Care Fund to reduce admissions to hospitals</td>
<td>6. Friends and family test including staff experience</td>
<td></td>
</tr>
<tr>
<td>7. Embedding the World Health Organisation (WHO) checklist and debrief in theatres</td>
<td>7. Developing systems and processes for integrated working with nursing homes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 4: Improvement priorities 2014/15**
These priorities have been tracked monthly by the board and monitored in-depth by the trust’s committee structure with delegated responsibility to measure, monitor and scrutinise progress and performance. Each of the quality improvements, specific metrics and the achievement of each are described in detail in the Quality Account in appendix B.

### Complaints

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>2014/15 Outturn</th>
<th>2013/14 Outturn</th>
<th>2012/13 Outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td>New complaints received</td>
<td>no target</td>
<td>457</td>
<td>510</td>
<td>528</td>
</tr>
<tr>
<td>Acknowledge all complaints within 3 days of receipt</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Complaints closed</td>
<td>no target</td>
<td>491</td>
<td>525</td>
<td>592</td>
</tr>
<tr>
<td>Complaints closed within timescale agreed with complainant</td>
<td>95%</td>
<td>88%</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>Percentage of well-founded complaints</td>
<td>no target</td>
<td>62%¹</td>
<td>58%</td>
<td>52%</td>
</tr>
</tbody>
</table>

Note: ¹Based upon confirmed outcomes from complaints responded to during 2014/15

Table 5: Complaints

The trust recognises that in the majority of instances it is best to resolve issues as soon as possible. During the year, the trust’s complaints patient information leaflets and posters were updated, to encourage concerns to be raised immediately with the person in charge of a patient’s care. Alternatively contact details are provided for the PALS service, the on-call senior manager (available out of hours) and also the complaints team.

During 2014/15 there have been a number of national complaints publications from organisations such as The Patients Association, Parliamentary and Health Ombudsman and Healthwatch.

Each report continued to raise the profile of complaints within the NHS and proposed changes to existing systems or identified local best practice. As a response, the trust initiated a quality improvement project with the aim of conducting a comprehensive analysis of the current complaints system used within the trust to identify any further areas for improvement.

The project involved a range of interested parties, including patient stakeholders, staff who investigate complaints and PALS representatives. The project concluded in January 2015 with initial findings reported to the trust’s executive management team and an action plan agreed in March 2015.

### Ombudsman

During the 2014/15, the Parliamentary and Health Service Ombudsman (PHSO) investigated 14 complaints.

Of these, five have been concluded with one fully upheld, one partially upheld and three not upheld. Nine investigations remain on-going.

No recommendations were made for the partially upheld complaint, however in the case of the upheld complaint, the PHSO made three recommendations which included an apology to the complainant, a compensation payment for the injustice suffered and the development of an action plan to ensure that the identified failings are not repeated. The trust is in the process of addressing each of these recommendations.
Clinical audit

During 2014/15, 32 national clinical audits and two national confidential enquiries covered relevant health services that Northumbria Healthcare NHS Foundation Trust provides. During that period the trust participated in 97 per cent national clinical audits and 100 per cent of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Northumbria Healthcare NHS Foundation Trust participated in, and for which data collection was completed during 2014/15, are listed in table 6 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. We will support specialties to maximise their data completion rates when participating in national audits, and examine the reasons for any lower rates of attainment.

<table>
<thead>
<tr>
<th>National Audit</th>
<th>Sponsor</th>
<th>% Data Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute coronary syndrome or acute myocardial infarction</td>
<td>National Institute Cardiovascular Outcomes Research</td>
<td>100%</td>
</tr>
<tr>
<td>2. Bowel cancer</td>
<td>Health and Social Care Information Centre</td>
<td>100%</td>
</tr>
<tr>
<td>3. Cardiac rhythm management</td>
<td>National Institute Cardiovascular Outcomes Research</td>
<td>100%</td>
</tr>
<tr>
<td>4. Case mix programme</td>
<td>Intensive Care National Audit and Research Centre</td>
<td>100%</td>
</tr>
<tr>
<td>5. Diabetes (adult), includes National Diabetes Inpatient Audit</td>
<td>Health and Social Care Information Centre</td>
<td>100%</td>
</tr>
<tr>
<td>6. Diabetes (paediatric)</td>
<td>Royal College of Paediatrics and Child Health</td>
<td>100%</td>
</tr>
<tr>
<td>7. Elective surgery (National PROMs Programme)</td>
<td>Health and Social Care Information Centre</td>
<td>100%</td>
</tr>
<tr>
<td>8. Epilepsy 12 audit (childhood epilepsy)</td>
<td>The Royal College of Paediatrics and Child Health</td>
<td>100%</td>
</tr>
<tr>
<td>9. Falls and Fragility Fractures Audit Programme</td>
<td>Royal College of Physicians</td>
<td>100%</td>
</tr>
<tr>
<td>10. Fitting child (care in emergency departments)</td>
<td>The College of Emergency Medicine</td>
<td>100%</td>
</tr>
<tr>
<td>11. Gastrointestinal Haemorrhage Study</td>
<td>NCEPOD (National confidential enquiry into patient outcome and death)</td>
<td>81%</td>
</tr>
<tr>
<td>12. Inflammatory bowel disease (IBD)</td>
<td>Royal College of Physicians</td>
<td>100%</td>
</tr>
<tr>
<td>13. Lung cancer</td>
<td>Health and Social Care Information Centre</td>
<td>100%</td>
</tr>
<tr>
<td>14. Maternal, Newborn and Infant Clinical Outcome Review Programme</td>
<td>MBRRACE-UK, National Perinatal Epidemiology Unit</td>
<td>100%</td>
</tr>
<tr>
<td>15. Mental health (care in emergency departments)</td>
<td>The College of Emergency Medicine</td>
<td>30%</td>
</tr>
<tr>
<td>16. Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for People with Mental Illness</td>
<td>Centre for Mental Health and Risk, University of Manchester</td>
<td>100%</td>
</tr>
<tr>
<td>17. National Cardiac Arrest Audit</td>
<td>Intensive Care National Audit &amp; Research Centre</td>
<td>100%</td>
</tr>
<tr>
<td>18. National Comparative Audit of Blood Transfusion Prog.</td>
<td>NHS Blood and Transplant</td>
<td>100%</td>
</tr>
<tr>
<td>19. National Heart Failure Audit</td>
<td>National Institute for Cardiovascular Outcomes</td>
<td>100%</td>
</tr>
<tr>
<td>20. National Joint Registry</td>
<td>Healthcare Quality Improvement Partnership</td>
<td>100%</td>
</tr>
<tr>
<td>21. Neonatal intensive and special care</td>
<td>The Royal College of Paediatrics and Child Health</td>
<td>100%</td>
</tr>
<tr>
<td>22. Oesophago-gastric cancer</td>
<td>Royal College of Surgeons of England</td>
<td>100%</td>
</tr>
<tr>
<td>23. Older people (care in emergency departments)</td>
<td>The College of Emergency Medicine</td>
<td>70%</td>
</tr>
<tr>
<td>24. Pleural procedures</td>
<td>British Thoracic Society</td>
<td>100%</td>
</tr>
<tr>
<td>25. Sentinel Stroke National Audit programme</td>
<td>Royal College of Physicians</td>
<td>100%</td>
</tr>
<tr>
<td>26. Severe trauma</td>
<td>Trauma Audit &amp; Research Network</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 6: National clinical audits and national confidential enquiries
Patient experience

Patient experience is now recognised as a fundamental part of the quality of healthcare and, as such, is a key priority for us. We want to ensure that we provide the best possible care and outcomes for each and every patient and that everyone entering our hospitals feels welcomed and valued by well-trained and respected staff.

We want our patients to have information to make choices, feel confident and feel in control. We expect that they will be listened to and treated with honesty, respect and dignity at all times. We acknowledge that patients and their families are the experts in terms of their experience of our care. Really listening to what they have to tell us allows us to design the type of services that they need and will use.

Real-time programme

Over the last 12 months we have continued to make excellent progress in capturing the views of patients during their hospital stay and feeding this information back to clinical teams within 24 hours. This real-time activity increased by 40 per cent in 2014 and included maternity services. We also visited patients over the weekend and in the evenings to get a full picture of their care out of hours.

As part of this programme we now have face-to-face interviews with over 500 patients per month and we continue to focus on the measures that matter most to patients. A new domain for kindness and compassion was introduced in our real-time programme in April 2014.

During 2014 we also rated the timeliness of information provision as well as the appropriateness of the content.

We believe that this commitment is beginning to pay real dividends in our ability to respond to the needs of patients and families and deliver care of the highest standard. An independent team interviewed 6,489 patients during 2014 and these patients gave us the following feedback on key aspects of care:

- A score of 99% for patients who feel they have been treated with kindness and compassion
- 99% for being treated with respect and dignity at all times
- 98% for their relationships with our doctors and nurses
- 98% for maintaining excellent standards of cleanliness on the wards
- 97% for doing everything we can to manage pain
- 94% for involving patients in decisions about their care and treatment as much as they wanted to be

We want to do more to improve our scores for coordination and consistency of care (91 per cent) and communication about medicines and side effects (85 per cent).

As well as capturing people’s experiences on the day of discharge, we survey thousands of patients once they leave hospital to enable us to have a very balanced view of their experience of our care. We have used all feedback to target and improve essential aspects of our care that we know matter most.
The outpatient results continue to be outstanding. On average the trust is in the top 20 per cent of all trusts in England. It is in the top 20 per cent for 18 of the 19 most important questions to patients. The remaining question scores are above average. All hospital sites have an overall score in the national top 20 per cent. The overall score is 88.8 per cent, with the score for the top 20 per cent in England standing at 84.4 per cent. 98 per cent of patients rate the trust as excellent, very good or good.

The inpatient results for 2014 continue to be very good. The trust is in the top 20 per cent of all trusts on 16 of the 19 most important questions to patients. On the remaining three questions the trust is marginally outside the top 20 per cent and above the national average. The overall score for the trust on the key 19 questions is 84.5 per cent which is in the top 20 per cent of trusts (83.4 per cent). Overall, 95 per cent of patients rated their care as excellent, very good or good.

The emergency department results are very good. The trust remains in the top 20 per cent of all trusts in England on 21 of the 27 questions that are comparable with national data. The average score is 80 per cent. The top 20 per cent score for England is 78 per cent. This score has been consistently high in each quarter since April 2011. Average scores across the three sites are very similar; Hexham 83 per cent, North Tyneside 80 per cent, and Wansbeck 79 per cent.

**Experience of community care**

Being able to demonstrate consistently high performance across all our care settings is an important feature of a high performing organisation. To support this, a number of community experience surveys were conducted throughout 2014.

One of these surveys included the Adult Social Care Survey (ASCS) annual survey. This survey is overseen by the Health and Social Care Information Centre throughout England and Wales by local authorities with social services responsibility.

The questionnaire is made up of 23 questions to capture a range of information on service users’ circumstances and health; satisfaction with the support services they receive; quality of life; and surroundings.

The survey gathers information on how services affect the lives of users. Data also feeds into the national Adult Social Care Outcomes Framework (ASCOF) indicators.

We have shown good results in these areas:

- Performing above the average score of the North East region local authorities in seven out of seven ASCOF outcomes
- Achieving better results than the previous year for six out of six of the comparable ASCOF outcomes, such as, people feeling safe and having control over their daily life.
- Gaining an overall satisfaction rating with services of 93.6%
- Increasing the proportion of people who said they find it easy to find information about services increased by 9.3% - from 75.9% last year to 85.2% this year
- Improving quality of life with 93.8% of people saying care and support services did this
Patient Experience Network Awards – Trust of the Year 2014

The trust had its most successful year yet at the PENNA. Eleven Northumbria projects were shortlisted as national finalists across 16 categories – a fantastic achievement reflecting the diverse improvement work that is happening across hospital and community care. At the award ceremony in March 2015, Northumbria was named Trust of the Year as a result. The following projects and individuals were also named as outright winners in the following categories:

- Bringing care closer to home – Northumbria Healthcare International Partnerships
- Support for caregivers – Learning from Carers / Michelle O’Brien and Paul Paes
- Manager of the year – Kelly Angus (Human Resources)
- Professional of the year – Kim Minnis (matron, Hexham General Hospital)
- Measuring, reporting and acting – Northumbria Healthcare patient experience programme

The shared purpose project – dignity in practice was also a runner-up in the personalisation of care category.

Public information

We recognise that the provision of high quality information can improve the overall patient experience. Two patient information initiatives were completed and rolled out trust-wide to support this.

Patients and relatives told us they were confused by the number of different professionals involved in their care and identifying who was who on the wards as staff wear a variety of different coloured uniforms across the trust. To help address this large, wall-mounted boards showing the different staff uniforms have been produced and are now in patient areas.

A further initiative has been to make 12 standard items of patient information available in branded leaflet holders placed in key locations in our hospitals.

The use of new technologies is a key ambition of the Department of Health’s Information Strategy (2012). We are working towards achieving this to ensure that the patient information we develop is accessible electronically, and in alternative formats via our website. We have set a first year target of making 50% of trust registered information available electronically. We recognise that widening access to information supports patients to make informed decisions about their treatment and care, helps to ensure patients are properly prepared for procedures or operations and reminds patient and carers what they have been told about their treatment.

In the last year, over 30 items of patient information have been developed internally. This includes information developed by the admission avoidance team, community nursing service, dietetics, child health, endoscopy, pharmacy and occupational therapy.

The number of new, internally-developed leaflets has decreased slightly compared to last year as we are encouraging more use of resources available from well-respected external organisations. We keep a database of organisations whose information we trust and there are currently over 70 external organisations registered on this. The organisations, which are mainly third sector organisations, have all been audited and have robust systems for the development, review and archiving arrangements of their information.
Corporate social responsibility

Being socially responsible means organisations behave ethically and with sensitivity toward social, cultural, economic and environmental issues. The trust is committed to corporate social responsibility and two initiatives which have taken great strides forwards this year are:

- **Our community garden in the grounds of Wansbeck General Hospital.**
  Work started in April 2014 with partners to begin a new project to create a low maintenance community garden at Wansbeck General Hospital for the recreational, educational and, where appropriate, therapeutic use by hospital staff, visitors, patients, community groups and other interested individuals and groups. A number of activities were organised to support the development of the garden and staff, community groups, a local nursery and local schools have been involved. The development of the community garden will continue in the coming year.

- **Installation of foodbank collection points**
  It is estimated that over 500,000 people rely on food aid and we know the number of people using foodbanks is increasing. For this reason we have installed foodbank collection points at North Tyneside, Wansbeck and Hexham general hospitals, Blyth Community Hospital and Merley Croft in Morpeth. The donated food is collected and distributed by local foodbank organisations on behalf of the trust.

**Workforce**

At the end of 2014/15, we employed 9,464 staff of which 756 were fixed term/temporary staff and 919 were bank staff.

<table>
<thead>
<tr>
<th>Business Unit (Primary Assignments) as at 31-MAR-2015</th>
<th>Total</th>
<th>Headcount (Total number of staff in primary assignments)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Bank</td>
</tr>
<tr>
<td>319 CHI Child Health Directorate</td>
<td>549</td>
<td>0</td>
</tr>
<tr>
<td>319 CLI Clinical Support</td>
<td>600</td>
<td>2</td>
</tr>
<tr>
<td>319 COM Community Business Unit</td>
<td>1876</td>
<td>2</td>
</tr>
<tr>
<td>319 COR Corporate Services</td>
<td>855</td>
<td>3</td>
</tr>
<tr>
<td>319 MED Emergency Care and Medicine Business Unit</td>
<td>2271</td>
<td>2</td>
</tr>
<tr>
<td>319 SUR Emergency Surgery &amp; Elective Care Business Unit</td>
<td>1878</td>
<td>7</td>
</tr>
<tr>
<td>319 EST Estates and Facilities</td>
<td>532</td>
<td>0</td>
</tr>
<tr>
<td>319 Staff Bank</td>
<td>903</td>
<td>903</td>
</tr>
<tr>
<td>Trust Total</td>
<td>9464</td>
<td>919</td>
</tr>
</tbody>
</table>

*Table 7: Workforce as at March 2015*

**Gender Profile (Headcount) March 2015**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>81%</td>
</tr>
<tr>
<td>Female</td>
<td>19%</td>
</tr>
</tbody>
</table>

*Table 8: Gender profile - breakdown of the number of male and female employees as at 31 March 2015*
During 2014/15 we have had a significant drive to recruit apprentices in a wide variety of areas. We have been working in partnership with a number of key agencies in order to ensure that young people choose the trust as the local employer of choice and with a long-term career to live and train locally. This recruitment drive has significantly changed our age profile which is positive in terms of securing the supply of a longer-term workforce.

We continue to manage absence however this has been a demanding year. For 2014/15, the average number of days lost per employee due to sickness was 15 days compared to a total NHS average of 9.5 days. We continue to fare well in relation to regional benchmarking however with a consistent record of being second in the region with an annual average of 4.33% absence.

We have continued to build strong relationships with our trade union colleagues, working in partnership on key initiatives such as supporting and preparing our workforce as we undertake one of our largest major organisational change programmes to ensure that our workforce is ready for the opening of the Northumbria Specialist Emergency Care Hospital.

**Staff engagement**

There are significant arrangements in place to listen and consult with our employees and our strong partnership working arrangements continue to go from strength to strength. This involves senior managers meeting with staff representatives from a broad range of trade unions on a bi-monthly basis at a partnership meeting.

Issues regularly discussed in the last 12 months include our financial position, key staffing indicators such as sickness absence and labour turnover rates, staff survey results and associated action plans, key service developments such as the specialist emergency care hospital and key policies affecting staff. We have worked in partnership to review our health at work policy, with a view to streamlining bureaucracy but increasing effectiveness and support.

We have established a staff side and management sub-committee working in partnership on the consultation with staff for the new emergency care hospital and this is working well. We have completed on the implementation of the national negotiations on pay progression for agenda for change staff and introduced a new appraisal scheme which is more closely linked to what staff have told us they want from appraisal meetings.

Following participation in the NHS staff survey, the partnership meeting has taken an active role in supporting the on-going development of the action plan for the staff survey. How we engage and communicate with our workforce is a constant topic for the partnership meeting as well as the board of directors, and we continue to place an on-going emphasis on the communication between senior managers and employees and regularly receive feedback to ensure that this is as effective as it can be. Communication has been particularly strengthened with the continuing weekly staff briefings, quarterly newsletters, monthly team brief, chief executive roadshows and high impact internal campaigns. Over the next year we will be expanding our use of digital media in our employee communication with the launch of a new intranet site and increasing use of film content.
NHS staff survey

Approach to staff engagement and feedback arrangements in place

The national staff survey was published in February 2015. The staff response rate for the trust was 82 per cent for 2014/15 which was an increase from 78 per cent last year. For the fourth year running this was the highest response rate in the country for an acute trust. Overall the survey provides some excellent results however we will continue to focus on areas for improvement.

Staff engagement scores continue to rise within the organisation with a further increase in staff recommending the trust as a place to work or receive treatment. Most importantly, 76 per cent of our staff feel able to contribute to improvements at work which forms a core part of the trust’s ‘We’re Listening’ campaign to encourage ideas for continuous improvement from all areas of the organisation. This was the highest result for any acute trust which is excellent.

The friends and family test, which commenced at the end of April 2014, allowed us to monitor our staff engagement and enabled the trust to further learn from the feedback.

In comparison with the 2013 staff survey for the 29 key findings:

- 8 key finding have significantly improved (as detailed in table 9)
- 19 key findings have no significant change
- 0 key findings have significantly deteriorated
- 2 new key findings from last year (as detailed in table 10)

<table>
<thead>
<tr>
<th>8 Key Findings that have significantly improved</th>
<th>2014</th>
<th>Average for Acute Trusts 2014</th>
<th>Best Score Acute Trust 2014</th>
<th>Comparison with other Acute Trusts 2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF 2 % of staff agree their role makes a difference to patients</td>
<td>94</td>
<td>91</td>
<td>95</td>
<td>Best 20% of acute Trusts</td>
<td>91</td>
</tr>
<tr>
<td>KF 4 Effective Team Working</td>
<td>3.94</td>
<td>3.74</td>
<td>3.94</td>
<td>Best 20% of acute Trusts</td>
<td>3.81</td>
</tr>
<tr>
<td>KF 6 % of staff have received job relevant training, learning or development in the last 12 months</td>
<td>87</td>
<td>81</td>
<td>90</td>
<td>Best 20% of acute Trusts</td>
<td>81</td>
</tr>
<tr>
<td>KF 9 % of staff receiving support from immediate Managers</td>
<td>3.89</td>
<td>3.65</td>
<td>3.89</td>
<td>Best 20% of acute Trusts</td>
<td>3.77</td>
</tr>
<tr>
<td>KF 20 % of staff felt pressure in last 3 months to attend work when feeling unwell</td>
<td>17</td>
<td>26</td>
<td>17</td>
<td>Best 20% of acute Trusts</td>
<td>22</td>
</tr>
<tr>
<td>KF 21 % of staff report good communication between senior management and staff</td>
<td>40</td>
<td>30</td>
<td>46</td>
<td>Best 20% of acute Trusts</td>
<td>34</td>
</tr>
<tr>
<td>KF 23 Staff are experiencing job satisfaction</td>
<td>3.82</td>
<td>3.6</td>
<td>3.83</td>
<td>Best 20% of acute Trusts</td>
<td>3.73</td>
</tr>
<tr>
<td>KF 26 % of staff have received equality and diversity training in the last 12 months</td>
<td>66</td>
<td>63</td>
<td>85</td>
<td>Better than average</td>
<td>57</td>
</tr>
</tbody>
</table>

Table 9: Summary of results for the 8 key findings that have significantly improved in comparison to the 2013 National staff survey.

<table>
<thead>
<tr>
<th>2 Key Findings Introduced in 2014</th>
<th>2014</th>
<th>Average for Acute Trusts 2014</th>
<th>Best Score Acute Trust 2014</th>
<th>Comparison with other Acute Trusts 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF 15 % of staff agreeing they would feel secure raising concerns about unsafe clinical practice</td>
<td>78</td>
<td>67</td>
<td>80</td>
<td>Best 20% of acute Trusts</td>
</tr>
<tr>
<td>KF 29 % of staff agreeing feedback from patients/service users is used to make informed decisions in their directorate/dept</td>
<td>67</td>
<td>56</td>
<td>74</td>
<td>Best 20% of acute Trusts</td>
</tr>
</tbody>
</table>

Table 10: Summary of results for the 2 new key finding introduced into the 2014 National Staff Survey.
Rankings compared with other acute trusts:

- 25 key findings are best (highest/lowest) 20%
- 3 key findings are above/below (better than) average
- 1 key findings is average
- 0 Key findings are below average when compared with other acute trusts
- 0 Key findings are bottom 20% of acute trusts

Each year the trust produces an action plan which highlights improvements to be made in line with the staff survey response rates. This includes the bottom four ranking scores and findings that are reporting below 50 per cent where the higher the score is better. This is developed as a trust-wide action plan with individual business units taking responsibility for delivering the improvements.

**Action plan 2014/15 - areas for improvement**

Key improvement areas highlighted in table 12 show the progress we have made in the last year.

**Achievement against 2013 - action plan at a glance**

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF2</td>
<td>% of staff agree their role makes a difference to patients</td>
<td>91</td>
</tr>
<tr>
<td>KF6</td>
<td>% of staff have received job relevant training, learning or development in the last 12 months</td>
<td>81</td>
</tr>
<tr>
<td>KF8</td>
<td>% of staff who have had a well-structured appraisal</td>
<td>41</td>
</tr>
<tr>
<td>KF10</td>
<td>% of staff have received health &amp; safety training in last 12 months</td>
<td>78</td>
</tr>
<tr>
<td>KF 13</td>
<td>% of staff are reporting errors, near misses or incidents witnessed in the last month.</td>
<td>91</td>
</tr>
<tr>
<td>KF 21</td>
<td>% of staff report good communication between senior management and staff</td>
<td>34</td>
</tr>
<tr>
<td>KF 26</td>
<td>% of staff have received equality and diversity training in the last 12 months</td>
<td>57</td>
</tr>
</tbody>
</table>

Table 12: Performance against the key areas for improvement identified from 2013 results
Equality and diversity

This year we have had some significant successes with our approach to equality and diversity with the trust being ranked fourth amongst NHS organisations nationally and ranked 50th in the Stonewall Workplace Equality Index top 100 employers list.

We have continued with our strong partnership arrangement with Northumberland County Council and we have together set our strategic direction for equality and diversity within our respective organisations. We are utilising the partnership approach to ensure that we meet our legal requirements and use the skills and expertise of individuals within both organisations to ensure that we remain focussed on key issues which are important to our workforce and the population that we serve.

During 2014/15 we have:

- Further developed our partnership arrangement with Northumberland County Council
- Published equality information in line with the requirements of the Equality Act 2010
- Published an annual comprehensive equality and diversity report in line with statutory reporting requirements
- Developed our information systems to enable us to report on the Workforce Race Equality Scheme
- Improved information available to patients with learning disabilities
- Developed an equality and diversity allies programme with over 80 staff recruited to support our equality initiatives
- Achieved Stonewall recognition within the top 100 of the national Stonewall Workplace Equality Index, rising 50 places from last year’s position and being ranked fourth top healthcare organisation
- Encouraged staff to join support groups, including the Staff Disability Network and the LGBT network
- Developed values based recruitment questions which promote inclusivity for patients and staff and are reflective of the values that we wish our staff to work within
- Won two prestigious awards for our work on promoting equality and diversity

The challenges for 2015/16 are to continue work to embed equality and diversity in our service delivery. We will also continue to engage service managers in reporting and assessing their respective service users from an equalities perspective to try and better understand who is, and more importantly who is not, accessing our services and make subsequent adjustments where possible.
Health and wellbeing

The trust’s health and wellbeing programme has continued to engage staff in a number of topics. We have delivered campaigns on hydration, healthy eating, physical activity, mental wellbeing, alcohol and smoking and each has had an interactive element so that staff are supported to make lifestyle changes where appropriate. All of our campaigns are supported by volunteer health advocates – members of staff who have an interest in wellbeing and wish to support their colleagues in leading healthier lifestyles. To date, we have over 60 health advocates across the trust.

Feedback from employees continues to be very positive and this is reflected in the recent staff survey results. The perception of the trust supporting staff wellbeing has significantly improved and awareness of a number of initiatives has increased. We also invited all staff to complete a health and wellbeing survey in November 2014 and are now using the results to develop new initiatives.

We were awarded the silver level of the regional Better Health at Work Award in December 2014, with the assessors particularly impressed with the trust’s partnership working and model of delivery. We are now working towards the gold level of the award. We continue to be a Mindful Employer charter signatory.

Health and wellbeing roadshows, at which staff can receive healthy lifestyle information and free mini health MOTs, have continued to be popular. An increased number of fitness classes are available at several sites and we have established two running groups for employees. We are also continuing to review the food options available on site and are committed to improving the range of healthier options.

The trust’s work on staff health and wellbeing is recognised nationally and we have provided a case study for NHS Employers on our healthy weight initiatives, which is due to be published shortly. We have also presented at an NHS Employers event, a regional Time to Change conference and a local Better Health at Work Award good practice event.

Occupational health services

The occupational health service and staff psychology and counselling team have continued to provide a responsive triage service to staff on sick leave with mental health issues. This work has been recognised as an example of good practice by the General Medical Council (GMC).

The staff psychology and counselling service has continued to roll out resilience training for staff. This is proving to be a popular course and external evaluation of this has shown this to be very successful in terms of improving wellbeing and work performance. Similarly, external evaluation of the mediation service was very positive with researchers feeding back that the trust has a unique conflict resolution framework that should be shared with others as a model of best practice. The evaluation report will be published on the ACAS website later this year.
Participation in clinical research

2,420 patients were recruited in 2014/15 to participate in research following approval by the ethics committee. There were a total of 86 research studies.

The number of patients taking part in research within the trust continues to rise, with an increase of 57 per cent on the previous year. The majority of our clinical teams now regularly take part in research and we have also had an increase in the number of consultants developing their own research ideas and being awarded funding to carry out the research here in the trust.

The study which recruited the most patients in 2014/15 was developed by a consultant orthopaedic surgeon, the study continues and is focusing on indicators that might help us predict when a person could be at a higher risk than expected of developing an infection following joint replacement surgery.

We have also had a great many patients wishing to work with us on other studies, the areas generating most interest include:

- Parkinson’s disease – a study looking to understand the experience of people with Parkinson’s in institutional care and understanding the care needs of people with Parkinson’s.

- Stroke medicine – a number of studies have been on-going over the year, including Robot Assisted Training for the Upper Limb after Stroke (RATULS). This study featured on BBC Breakfast in July 2014 to showcase a major new national research programme using robot assisted training to help stroke patients regain movement in their affected arm.

- The NoAH study looking to develop a standardised way of ensuring that older people, who may need assistance following their stroke, are drinking enough fluids. Supported through funding from The Health Foundation.

- Respiratory medicine looking at ways to support patients with Chronic Obstructive Pulmonary Disease (COPD) to manage their condition at home, rather than in hospital, with the support of the hospital care team and social services. Supported through a grant from the Research for Patient Benefit (RfPB) funding stream.

The trust has also continued to develop its partnership with Synexus Ltd, a company responsible for running clinical trials on behalf of some of the world’s leading pharmaceutical companies. A new Synexus clinical trials centre, based at Hexham General Hospital, opened in July 2014 and a number of patients have been seen in the centre and taken part in trials since. A recent review of progress made to date has been very encouraging and we hope to continue the good work that has been started with what continues to be the first partnership of its kind, bringing the NHS and a clinical trials organisation together to deliver high quality clinical trials.
Sustainability and climate change

We are fully committed to the principles of sustainable development, the low-carbon economy and reductions in the consumption of finite natural resources. We recognise the impact of these issues on the economic and social development of local, national and international communities and are determined to play our part in meeting the requirements of the sustainability agenda.

The sustainability management and implementation group, established in 2009, continues to deliver a reduction in carbon emissions. The trust has met the Department of Health target to reduce its energy/utility related carbon emissions using a 2007 baseline. This target was met by the trust one year early and remains below that target. The group is working on plans to allow us to continue to meet the requirements of the climate change act and the Health and Social Care Carbon Reduction Plan suggested by the Sustainable Development Unit.

The trust continues to be a participant in the Carbon Reduction Commitment Energy Efficiency Scheme (CRC EES) having registered for phase 2 of the scheme to ensure legislative compliance. Phase 2 of the scheme has a significantly higher financial impact on the trust as the cost of carbon allowances rises from £12 per tonne to £15.60 per tonne.

The trust now generates over 0.5MWh of electricity from the PV arrays installed at North Tyneside and Wansbeck general hospitals and has now installed a significant number of LED lights throughout its hospitals. The trust has also invested in the installation of both a biodiesel CHP (combined heat and power) and a biomass boiler at the new specialist emergency care hospital, the CHP will generate green electricity for the hospital and combined with the biomass boiler will produce a significant proportion of the hospital’s heat with extremely low carbon emissions.

The trust aims for the hospital to achieve a BREEAM excellent score and is on line to achieve this.

The annual sustainability report advised that the targets for the reduction of emissions from both energy and waste streams have been met and a robust process to manage risk and slippage has been implemented. This group has provided annual reports to board covering the periods 2010/11, 2011/12, 2012/13, 2013/14.

The priorities to further reduce the carbon emissions include further improvement in the management of waste and delivering a 10 per cent reduction in carbon footprint by 2015 using a 2007 baseline.

The actions to achieve those priorities include:

- Further reducing waste by improving efficiency of consumption and action within the supply chain
- Improving the segregation of waste
- Increasing the recycling of waste
- Increasing the volumes of offensive waste and reducing high temperature waste
- Reducing the overall energy consumption by the implementation of energy efficiency
- Engaging staff to act in a more sustainable manner
- Exploring the use of renewable technologies as a longer-term strategy
- Travel planning and transport management
- Improving long term sustainable procurement, including engaging with the local suppliers
The trust continues to utilise its Salix spend to save funds and to utilise capital funding to invest in carbon reduction schemes.

Table 13 shows the status of sustainability projects, in terms of the completed projects within the reporting year and those that are currently being installed, and also the status of projects that have been identified and are in the process of being designed.

<table>
<thead>
<tr>
<th>Description</th>
<th>Investment Required</th>
<th>Business Case</th>
<th>Annual Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>Source</td>
<td>Approval</td>
</tr>
<tr>
<td>Awareness campaigns</td>
<td>£10,000.00</td>
<td>Revenue</td>
<td>yes</td>
</tr>
<tr>
<td>Annual BEMS setting review</td>
<td>£0.00</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Remove Wansbeck hospital portacabin</td>
<td>N/A</td>
<td>Capital</td>
<td>Yes</td>
</tr>
<tr>
<td>Wansbeck hospital energy centre inverter</td>
<td>£10,078.78</td>
<td>Salix</td>
<td>Jun-13</td>
</tr>
<tr>
<td>North Tyneside hospital office lighting Ph 1</td>
<td>£55,000.00</td>
<td>Salix</td>
<td>Sep-15</td>
</tr>
<tr>
<td>Wansbeck hospital office lighting</td>
<td>£55,000.00</td>
<td>Salix</td>
<td>Sep-15</td>
</tr>
<tr>
<td>Alnwick office lighting</td>
<td>£60,553.00</td>
<td>Salix</td>
<td>Dec-14</td>
</tr>
<tr>
<td>Lighting Controls (North Tyneside hospital)</td>
<td>£57,600.00</td>
<td>Salix</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Boiler controls (trust-wide)</td>
<td>£36,720.00</td>
<td>Salix</td>
<td>Mar-15</td>
</tr>
<tr>
<td>North Tyneside hospital IT training portacabin</td>
<td>N/A</td>
<td>Capital</td>
<td>Yes</td>
</tr>
<tr>
<td>Wansbeck hospital energy centre lights</td>
<td>£6,000.00</td>
<td>Salix</td>
<td>Yes</td>
</tr>
<tr>
<td>North Tyneside hospital Ward 24 LED lights</td>
<td>£13,662.00</td>
<td>Salix</td>
<td>Dec-14</td>
</tr>
<tr>
<td>Revise CHP export profiles</td>
<td>£0.00</td>
<td>N/A</td>
<td>Feb-15</td>
</tr>
</tbody>
</table>

Table 13: Carbon Reduction Schemes 2014 – 2015

Performance in this area over the past seven years is shown in the table 14. Overall, our performance is positive with an overall reduction in the levels of waste and increases in the amount of waste that is recycled. The reduction in the use of gas and electricity continues to reduce.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Non financial</td>
<td>22,817,022</td>
<td>23,133,968</td>
<td>24,091,271</td>
<td>23,535,899</td>
<td>23,181,428</td>
<td>22,967,875</td>
<td>22,539,808</td>
<td>21,116,259</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicators</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>2,673</th>
<th>75,121</th>
<th>515,255</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gas (kWh)</td>
<td>46,929,358</td>
<td>49,876,317</td>
<td>50,685,257</td>
<td>52,611,100</td>
<td>46,635,914</td>
<td>49,750,335</td>
<td>44,886,577</td>
<td>41,594,721</td>
</tr>
<tr>
<td>Oil (l)</td>
<td>15,261</td>
<td>15,261</td>
<td>15,261</td>
<td>16,953</td>
<td>17,277</td>
<td>15,421</td>
<td>171,953</td>
<td>39,815</td>
</tr>
<tr>
<td>Water (m³)</td>
<td>192,316</td>
<td>175,904</td>
<td>178,095</td>
<td>169,099</td>
<td>173,308</td>
<td>168,030</td>
<td>180,614</td>
<td>180,070</td>
</tr>
<tr>
<td>Sewerage (m³)</td>
<td>191,505</td>
<td>175,093</td>
<td>177,284</td>
<td>168,288</td>
<td>165,304</td>
<td>160,291</td>
<td>171,829</td>
<td>169,619</td>
</tr>
</tbody>
</table>

| Financial indicators (£) | Total energy expenditure | 2,879,439 | 4,766,534 | 3,975,470 | 3,337,948 | 4,343,622 | 4,437,378 | 4,372,750 | 4,022,476 |

| Non financial | Alternative treatment (tonnes) | 674 | 687 | 664 | 625 | 946 | 632 | 740 | 654 |

<table>
<thead>
<tr>
<th>Indicators</th>
<th>High temp treatment (tonnes)</th>
<th>28</th>
<th>37</th>
<th>16</th>
<th>40</th>
<th>42</th>
<th>25</th>
<th>26</th>
<th>66</th>
</tr>
</thead>
<tbody>
<tr>
<td>Landfill (tonnes)</td>
<td>1,221</td>
<td>934</td>
<td>912</td>
<td>753</td>
<td>755</td>
<td>797</td>
<td>812</td>
<td>970</td>
<td></td>
</tr>
<tr>
<td>Recycling (tonnes)</td>
<td>0</td>
<td>84</td>
<td>129</td>
<td>328</td>
<td>219</td>
<td>261</td>
<td>261</td>
<td>319</td>
<td>334</td>
</tr>
</tbody>
</table>

| Financial indicators (£) | Total waste expenditure | 373,209 | 488,140 | 474,990 | 560,048 | 486,093 | 518,557 | 555,774 | 556,836 |

Table 14: Waste management and energy performance 2014/15
6. The NHS foundation trust Code of Governance

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

The trust board and council of governors are committed to the principles of best practice and good corporate governance as detailed in the NHS Foundation Trust Code of Governance (the Code). The trust board regularly review metrics in relation to regulatory obligations, contractual obligations and additional internal performance targets/standards of the trust. To review the performance and effectiveness of the trust, a number of arrangements are in place including governance structures, policies and processes to ensure compliance with the code. These arrangements are set out in documents that include:

- The constitution of the trust
- Standing orders
- Standing financial instructions
- Schemes of delegation and decisions reserved to the board
- Terms of reference for the board of directors, council of governors and subcommittees.
- Role descriptions
- Codes of conduct for staff, directors and governors
- Annual declarations of interest

In accordance with the code, all directors and non-directors of the trust board scrutinise and constructively challenge the performance of the trust to drive improvement and achieve high quality safe care. The non-executive directors of the board are held to account by the council of governors who are responsible for ensuring that non-executive directors (individually and collectively) are exercising their duty in constructively challenging executive directors, developing strategic proposals and ensuring the on-going effectiveness and performance of the trust board.

The chairman of the trust ensures that the council of governors meet on a regular basis and are fully consulted on areas of potential development or change in a timely manner. Thus supporting the Governors to fulfil their role and discharge their duties of representing the interests of members within their constituencies to whom they are accountable.

NHS foundation trusts are required to provide (within their annual report) a specific set of disclosures in relation to the provisions within schedule A of the code of governance. Northumbria Healthcare is compliant with these provisions and in compliance with the code, a supporting explanation for each is provided within the table 15.
<table>
<thead>
<tr>
<th>Provision</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.1.1</td>
<td>The Board of directors and responsibilities (Section 6), details how the board of directors and the council of governors operate.</td>
</tr>
<tr>
<td>A.1.2</td>
<td>The Board of directors and responsibilities (Section 6, table 17), identifies the chairperson, the deputy chairperson, the chief executive and senior independent director. The table further details the meetings attended by the Board of directors and their attendance. Nomination, Remuneration &amp; Development Committee (Section 9), details the members and attendance of the Nomination committee meetings. Audit Committee (Section 10, table 26) details the members and attendance of the Audit committee.</td>
</tr>
<tr>
<td>A.5.3</td>
<td>Council of governors &amp; composition (Section 7, table 19), details the members of the council of governors, including the constituency they represent, election/appointment information, the duration of their appointments and the nominated lead governor.</td>
</tr>
<tr>
<td>FT ARM</td>
<td>The FT ARM requires an additional statement about the number of meetings of the council of governors and individual attendance by governors and directors.</td>
</tr>
<tr>
<td></td>
<td>- Attendance of Governors is detailed within the Council of governors &amp; composition (Section 7, table 19).</td>
</tr>
<tr>
<td></td>
<td>- Attendance of Directors is detailed within The Board of directors and responsibilities (Section 6, table 17).</td>
</tr>
<tr>
<td>B.1.1</td>
<td>The board of directors considers all non-executive directors of the Trust to be fully independent. Further detail is provided within The Board of directors and responsibilities (Section 6).</td>
</tr>
<tr>
<td>B.1.4</td>
<td>The skills, expertise and experience of each director of the Board is detailed within the annual report, The Board of directors and responsibilities (Section 6, table 17). A clear statement about the balance, completeness and appropriateness of the Board is available within Board composition and balance (Section 6).</td>
</tr>
<tr>
<td>FT ARM</td>
<td>The FT ARM requires the inclusion of the length of appointments of Non-executive directors. This is detailed in Board of directors and responsibilities (Section 6, table 17).</td>
</tr>
<tr>
<td>B.2.10</td>
<td>Nomination, Remuneration and Development committee (Section 9), describes the work of the nominations committee, including the process it has used in relation to board appointments.</td>
</tr>
<tr>
<td>FT ARM</td>
<td>The FT ARM requires the Trust to disclose the work of the nominations committee in relation to the appointment of the Chair. Nomination, Remuneration and Development Committee (Section 9), details the appointment process for the Chair during the 2014/15 period.</td>
</tr>
<tr>
<td>Provision</td>
<td>Compliance</td>
</tr>
<tr>
<td>-----------</td>
<td>------------</td>
</tr>
<tr>
<td>B.3.1</td>
<td>The Chairman of the Trust had no significant commitments to declare during 2014/15 as detailed in Board composition and balance (Section 6). Any change to commitments would be reported to the council of governors as they arise and would be subject to review within the nominations committee as appropriate.</td>
</tr>
<tr>
<td>B.5.6</td>
<td>The Membership strategy (Section 8) details the Governors and Trusts approach to gathering the opinion of the trust’s members, and the public.</td>
</tr>
<tr>
<td>FT ARM</td>
<td>The FT ARM requires the trust to declare where governors have exercised their power under paragraph 10C of schedule 7 the NHS Act 2006. During the period of 2014/15, governors have not exercised this power.</td>
</tr>
<tr>
<td>B.6.1</td>
<td>The Annual Governance Statement, Review of effectiveness (Section 12), details how the performance of the board and its committees has been conducted. The performance of the Board of directors and the chairperson is subject to an annual rigorous review as detailed in Nomination, Remuneration and Development Committee (Section 9).</td>
</tr>
<tr>
<td>B.6.2</td>
<td>The Audit Committee section of the report (Section 10), provides detail regarding the Board of Directors receipt of the KPMG report on the independent review of the Trust’s Quality Governance Assessment for Northumbria and North Cumbria on the 26th June 2015. Annual Governance Statement, Review of economy, efficiency and effectiveness of the use of resources (Section 12), declares that the Trust was assessed by external auditors KPMG under the Auditors Local Evaluation (ALE) which reviews internal control and value for money KPMG are the External Auditors of the Trust and are independent. In order to ensure that the independence and objectivity of the external auditor is not compromised by providing the trust with additional non-audit services, a policy has been agreed that requires the audit committee to approve the arrangements for all proposals to engage the external auditors on non-audit work. The auditors themselves also comply with the Ethical Standards of the Auditing Practices Board in this matter.</td>
</tr>
<tr>
<td>C.1.1</td>
<td>The director’s explanation of responsibility in relation to the preparation of the annual report and accounts is detailed in the Statement of the chief executive’s responsibilities as the accounting officer of Northumbria Healthcare NHS Foundation Trust (Section 13 &amp; 14) The Directors approach to quality governance is detailed in the Annual Governance Statement (Section 12)</td>
</tr>
<tr>
<td>C.2.1</td>
<td>Annual Governance Statement, Review of effectiveness (Section 12) details the review of effectiveness of the Trusts internal controls.</td>
</tr>
<tr>
<td>C.2.2</td>
<td>The Annual Governance Statement, Review of effectiveness (Section 12) details how the Trusts internal audit function is structured and the role that it performs.</td>
</tr>
</tbody>
</table>
Table 15: Demonstration of compliance

<table>
<thead>
<tr>
<th>Provision</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.3.5</td>
<td>The council of governors approved the appointment of the Trusts external Auditor KPMG LLP for a period of three years, plus a further two years subject to satisfactory performance, at the general meeting held 29 February 2012 as detailed in Audit Committee (Section 10).</td>
</tr>
<tr>
<td>C.3.9</td>
<td>Audit Committee, describes the work of the audit committee in discharging its responsibilities (Section 10).</td>
</tr>
<tr>
<td>D.1.3</td>
<td>Remuneration disclosures within the annual report comply with the code relating to the release of an executive director to serve elsewhere by including a statement relating to their retention of earnings. Further detail is provided within Remuneration report (Section 11).</td>
</tr>
<tr>
<td>E.1.4</td>
<td>Contact procedures for members who wish to communicate with Governors are available to members on the NHS foundation trust’s website. A dedicated email address is provided to support our members and the public to contact Trust governors. <a href="mailto:governors@northumbria.nhs.uk">governors@northumbria.nhs.uk</a></td>
</tr>
<tr>
<td>FT ARM</td>
<td>The FT ARM requires the annual report to provide further detail relating to membership including eligibility requirements, number of members and summary of the membership strategy. The information is detailed as required in membership activity &amp; membership strategy (Section 8).</td>
</tr>
<tr>
<td>FT ARM</td>
<td>The FT ARM (based on the FReM requirement) requires the trust to disclose details relating to the Governors and Directors declarations of interest. The Trust Constitution and Health and Social Care Act 2012 (Section 6) provides an explanation on how members of the public can gain access to the registers of interest.</td>
</tr>
<tr>
<td>E.1.5</td>
<td>Non-executive directors and executive directors of the trust board develop an understanding of the views of governors and members about the NHS foundation trust through attendance at Governors General meetings, development Meetings and sub committees.</td>
</tr>
<tr>
<td></td>
<td>Board of directors and responsibilities (Section 6), provides further detail relating to the relationship between Governors and Board members. Attendance of Board members at Governors General meetings is provided within (Section 6, table 17). Attendance at Council of Governors General meetings</td>
</tr>
<tr>
<td>E.1.6</td>
<td>The board of directors monitor the representation of the trusts membership in compliance with the code. This is detailed Membership activity. Membership analysis (Section 8).</td>
</tr>
</tbody>
</table>

Table 16: Explanation of noncompliance

The trust is compliant with the further provisions of the code that are applied on a comply or explain basis with the following exception:

<table>
<thead>
<tr>
<th>Provision</th>
<th>Explanation for non-compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.1.2</td>
<td>The number of executive directors exceeds the number of non-executive directors however; some executive directors have shared voting rights to ensure that there is a balance in the voting power of the two groups. The board considers all non-executive director members of the board to be independent. Further detail is available in Nomination, Remuneration and Development committee (Section 9).</td>
</tr>
</tbody>
</table>

Table 16: Explanation of noncompliance
Trust Constitution and Health and Social Care Act 2012

The trust’s constitution was amended in April 2013 to incorporate changes required as a result of the Health and Social Care Act 2012 (the Act). The Act, introduced fundamental changes to the way NHS foundation trusts are governed and managed. This included directors having a statutory responsibility to promote the success of the trust and maximise benefits for members as a whole, and the public. There were also express duties included that requires each director to avoid conflicts of interest. The annual declarations of interest for both the board of directors and council of governors alongside the trusts constitution are available on the trust’s website at www.northumbria.nhs.uk.

Board of directors and responsibilities

The board of directors is responsible for exercising all of the powers of the trust; however, has the option to delegate these powers to senior management and other committees. The board sets the strategic direction within the context of NHS priorities, allocates resources, monitors performance against organisational objectives, ensures that clinical services are safe, of a high quality, patient-focused and effective, ensures high standards of clinical and corporate governance and, along with the council of governors, engages members and stakeholders to ensure effective dialogue with the communities it serves.

The board is comprised of ten executive directors (comprising six voting rights), seven voting non-executive directors including a non-executive chairman. The chairman and non-executive directors are appointed by the council of governors via the nomination committee for terms of office of up to three years and may seek reappointment in line with the provisions set out in the Code of Governance. The annual declarations of interest for both the board of directors and council of governors are available on the trust’s website at www.northumbria.nhs.uk.

All of the non-executive directors are considered to be independent in character and in judgement. The executive directors are appointed on permanent contracts and all directors undertake an annual appraisal process to ensure that the focus of the board remains on the patient and delivering safe, high quality, patient-centred care. Additional assurance of independence and commitment for those non-executive directors serving longer than six years is achieved via a rigorous annual appraisal and review process in line with the recommendations outlined in the Code. A report of the nomination committee is detailed further in the report. The composition of the board over the year is set out in table 17 which also includes details of background, committee membership and attendance.
<table>
<thead>
<tr>
<th>Name and position</th>
<th>Background</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Executive Directors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jim Mackey</td>
<td><em>Member of the Chartered Institute of Public Finance</em></td>
<td>11</td>
</tr>
<tr>
<td><strong>Chief Executive</strong></td>
<td><em>Extensive background in public sector finance and general management</em></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><em>Exemplary leadership of the trust as Chief Executive since 2005</em></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Paul Dunn</td>
<td><em>Member of the Chartered Institute of Public Finance</em></td>
<td>8</td>
</tr>
<tr>
<td><strong>Executive Director of Finance</strong></td>
<td><em>Extensive experience in NHS finance</em></td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Birju Bartoli</td>
<td><em>Extensive experience in operational and strategic management</em></td>
<td>10</td>
</tr>
<tr>
<td><strong>Executive Director of Performance and Governance</strong></td>
<td><em>Bsc (Hons) Applied Biochemistry 1st class</em></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td><em>PhD in cancer research</em></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td><em>Health Management diploma/Reflective Practice in Healthcare diploma</em></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Ann Stringer (5)</td>
<td><em>BA (Hons) Sociology and Social Administration</em></td>
<td>8</td>
</tr>
<tr>
<td><strong>Executive Director of Human Resources and Organisational Development</strong></td>
<td><em>Extensive experience in HR management in both the public and private sectors</em></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Ann Wright (1) (3)</td>
<td><em>MBA, University of Durham Business School</em></td>
<td>10</td>
</tr>
<tr>
<td><strong>Executive Director of Operations</strong></td>
<td><em>Experience in operational and strategic management</em></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Rosemary Stephenson (1)</td>
<td><em>Registered General Nurse (RGN) with extensive experience as a Nursing Director</em></td>
<td>11</td>
</tr>
<tr>
<td><strong>Executive Director of Nursing</strong></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Richard Curless (1)</td>
<td><em>Consultant Physician (medicine for older people) with a special interest in stroke</em></td>
<td>7</td>
</tr>
<tr>
<td><strong>Divisional Medical Director</strong></td>
<td><em>Extensive experience as clinical lead for older people’s services and stroke Northumbria</em></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Daljit Lally (1)</td>
<td><em>MBA / BA (Hons) Business Studies (Finance Major)</em></td>
<td>6</td>
</tr>
<tr>
<td><strong>Executive Director of Community Services</strong></td>
<td><em>Registered General Nurse (RGN)</em></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td><em>Substantial clinical, operational and strategic management experience across the NHS, local government and private sectors</em></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>David Evans (2)</td>
<td><em>Consultant Obstetrician and Gynaecologist with extensive experience as a Medical Director</em></td>
<td>10</td>
</tr>
<tr>
<td><strong>Medical Director</strong></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Derek Thomson (2) (3) (5)</td>
<td><em>General Practitioner and Medical Director for long-term conditions</em></td>
<td>8</td>
</tr>
<tr>
<td><strong>Medical Director</strong></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Non-Executive Directors</td>
<td>Details</td>
<td>2014</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------</td>
<td>------</td>
</tr>
</tbody>
</table>
| Brian Flood | Chairman  
*Appointed until 31/12/15  
(2nd year – post 2nd term)* | BSc Eng (Hons), Postgraduate diploma in nuclear engineering  
Extensive experience in engineering and involvement in local government | 9* | N/A | N/A | 2* | 4 |
| Ian Swithenbank | Vice-Chairman/Senior Independent Director  
*Appointed until 31/12/15  
(3rd year – post 2nd term)* | Extensive experience in local government | 8 | 2 | 5 | 1* | 3 |
| Neil Mundy | Non-Executive Director  
*Appointed until 31/12/15  
(3rd year – post 2nd term)* | Extensive experience in financial management in both public and private sectors  
Member of the Chartered Institute of Public Finance and Accountancy  
Associate of the Institute of Revenues Rating and Valuation  
Diploma in Municipal Administration  
Fellow of the Royal Society of Arts | 11 | 8* | N/A | N/A | 3 |
| David Thompson | Non-Executive Director  
*Appointed until 31/12/15  
(3rd year – post 2nd term)* | BA (Hons) Geography  
MA in Applied Geography and Postgraduate diploma in Education  
Extensive experience in secondary education | 10 | 4 | 9 | N/A | 4 |
| Ian McMinn | Non-Executive Director  
*Appointed until 31/12/15  
(3rd year – post 2nd term)* | BSc (Hons) Mathematics, Postgraduate diploma in operational research  
Extensive experience in finance and performance review  
Extensive experience in public and voluntary sectors | 10 | 7 | 7* | N/A | 3 |
| John Marsden (4) | Non-Executive Director  
*Appointed until 30/04/17  
(2nd term)* | Master of Science in Social Planning  
Qualified social worker  
Former Chief Executive, North Yorkshire and North Tyneside | 11 | N/A | 9 | N/A | 3 |
| Peter Sanderson (4) (5) | Non-Executive Director  
*Appointed until 31/10/16  
(1st term)* | Retired GP, worked as a family doctor for 31 years  
RAF medical officer  
Secretary of Northumberland LMC and GP clinical advisor with the trust | 10 | 7 | 7 | N/A | 3 |

* Denotes Committee Chair  
(1) (2) Groupings for Shared Voting Rights  
(3) Directors of Pointnorth CIC Limited, a joint venture between the Trust and the Ponteland Medical Group  
(4) Non-Executive Directors for Northumbria Healthcare Facilities Management Ltd  
(5) Directors of Northumbria Primary Care Ltd.
Board performance

The board of directors ensures that adequate systems and processes are maintained to deliver the trust’s annual plan, deliver safe, high quality healthcare, measure and monitor the trust’s effectiveness and efficiency as well as seeking continuous improvement and innovation. The board delegates some of its powers to a committee of directors or to an executive director and these matters are set out in the trust’s scheme of delegation. Decision making for the operational running of the trust is delegated to the executive management team.

In response to the publication of the Francis Report in February 2013 on the Mid-Staffordshire NHS Foundation Trust public inquiry, the trust developed working groups comprising of board members, governors and members of staff. The working groups examined the key themes and recommendations and made a self-assessment against each element. The action plan continues to be reviewed on a quarterly basis by the trust board, the council of governors and via the quality review group (QRG) where Clinical Commissioning Group leads from both North Tyneside and Northumberland are members.

Following the introduction of a number of new standards that NHS boards need to comply with - these include duty of candour, the fit and proper person’s test and improving openness and transparency - the board has met and agreed an implementation plan linked to each of these new compliance standards and receive regular updates regarding progress.

Board composition and balance

Our board is satisfied that it has the appropriate balance of knowledge, skills and experience to enable it to carry out its duties effectively. This is supported by the council of governors which takes into consideration the collective performance of the board via the nomination committee.

Details of company directorships and other significant interests held by directors or governors which may conflict with their management responsibilities are registered and reviewed on an annual basis. The chairman has no other significant commitments to disclose. Registers are available from the trust secretary, North Tyneside General Hospital, Rake Lane, North Tyneside, NE29 8NH or via the website at www.northumbria.nhs.uk.

All members of the board are required to declare their interests on an on-going basis to ensure registered interests are up-to-date. The directors declare any interests before each trust board and committee meeting which may conflict with the business of the trust and excuse themselves from any discussion where such conflict may arise. The trust is satisfied with the independence of the board for the entire year.
7. Council of governors and composition

The composition of council of governors has 36 governor positions elected by members in the public constituency, 23 governor positions elected by the staff constituency, 11 governors appointed by local partner organisations and one governor position elected by the patient constituency.

Governors are elected to office for terms of up to three years and may seek re-election for further terms. During the year, elections to the public constituencies of Berwick upon Tweed, Blyth Valley, Hexham, North Shields and Wansbeck and staff constituencies of North Tyneside General Hospital, Wansbeck General Hospital and North Tyneside community were contested. Elections to the public constituency of Wallsend and the staff constituency of Northumberland community were uncontested. Currently, we do not have an elected patient governor as we have not reached the minimum number of patient members as stated in the trust’s constitution.

Details of the elections are shown in table 18.

<table>
<thead>
<tr>
<th>Constituency</th>
<th>No. to elect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public governor vacancies</td>
<td></td>
</tr>
<tr>
<td>Berwick upon Tweed</td>
<td>2</td>
</tr>
<tr>
<td>Blyth Valley</td>
<td>3</td>
</tr>
<tr>
<td>Hexham</td>
<td>3</td>
</tr>
<tr>
<td>North Shields</td>
<td>1</td>
</tr>
<tr>
<td>North West Tyneside</td>
<td>2</td>
</tr>
<tr>
<td>Wansbeck</td>
<td>2</td>
</tr>
<tr>
<td>Wallsend</td>
<td>2</td>
</tr>
<tr>
<td>Staff governor vacancies</td>
<td></td>
</tr>
<tr>
<td>Blyth</td>
<td>1</td>
</tr>
<tr>
<td>Morpeth</td>
<td>1</td>
</tr>
<tr>
<td>Wansbeck General Hospital</td>
<td>1</td>
</tr>
<tr>
<td>North Tyneside General Hospital</td>
<td>5</td>
</tr>
<tr>
<td>North Tyneside community</td>
<td>1</td>
</tr>
<tr>
<td>Northumberland community</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 18: Elections to the council of governors 2014/15

The council of governors is responsible for fulfilling its statutory duties of:

- Appointing, removing and deciding the terms of office and remuneration of the chairman and other non-executive directors
- Appointing or removing the trust’s external auditors
- Approving the appointment of the chief executive
- Receiving the trust’s annual report and accounts (including the auditor’s report)
- Contributing to the trust’s forward plans

Members of the council of governors who served during the year along with details of their appointments and attendance at meetings are shown in table 19.
A register is maintained of the interests of governors in companies or related parties that are likely to do, or may seek to do, business with us. This register is available for inspection by the public and anyone who wishes to inspect it should make an appointment to do so by contacting the Trust Secretary, Northumbria Healthcare NHS Foundation Trust, Northumbria House, Unit 7-8 Silver Fox Way, Cobalt Business Park, North Shields, NE27 0QJ.

For further information on membership or becoming a governor, contact the Foundation Team, Northumbria Healthcare NHS Foundation Trust, Northumbria House, Unit 7/8 Silver Fox Way, Cobalt Business Park, Newcastle upon Tyne, NE27 0QJ, tel: 0191 2031296 or via e-mail at foundation@nhct.nhs.uk

The council of governors carries out its formal business in a series of general meetings including the annual members’ meeting and there were four such meetings. All general meetings are open to our members and the general public. During the past year, the council has participated in the development of our Quality Account, safety and quality priorities and annual planning and has approved amendments to the council of governors’ terms of reference. Governors receive regular updates on the progress of the new Northumbria specialist emergency care hospital, the process for the acquisition of North Cumbria University Hospitals NHS Trust and the trust’s mortality figures.

The chief executive provides governors with regular updates on finance and performance and directors are invited to attend all meetings of the council of governors. The agenda ensures that governors are given full opportunity to question directors (including non-executive directors) on the performance of the trust and to engage with them in considering strategic issues. Governors have also allocated representatives from amongst the council of governors to sit on strategic, outward-facing board committees to provide a member perspective to proposed developments and initiatives.

In light of the trust’s on-going developments as part of the £200 million investment programme, it has been acknowledged that it is important to maintain governors’ involvement in the hospital re-developments. Regular updates on trust-wide developments are already provided at council of governors’ meetings and in addition discussed at monthly constituency meetings with the chairman. A separate governors’ focus group for the new specialist emergency care hospital continued with representation from across the constituencies. Through these mechanisms, governors are kept up-to-date with the latest developments and to ensure that they have the opportunity to influence the plans for the re-development of base sites and contribute a patient/public and staff perspective.

The chief executive has regular meetings with the staff governors whereby staff governors determine the agenda and items for discussion. Notes and action points from these sessions are fed into the executive team and responses and feedback are provided by the chief executive at subsequent sessions. This has helped to develop relationships between the board and staff governors as well as governors and staff members by enabling two-way feedback from board-to-ward.
### Composition and attendance of the council of governors 1st April 2014 – 31st March 2015

<table>
<thead>
<tr>
<th>Public governors</th>
<th>Detail of appointment</th>
<th>General meetings attended (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Berwick constituency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liz Veever</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>2 (out of 4)</td>
</tr>
<tr>
<td>Peter Herdman</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>3 (out of 4)</td>
</tr>
<tr>
<td>Anne-Marie Trevelyan</td>
<td>Elected 1/8/13 – 31/7/16</td>
<td>0 (out of 4)</td>
</tr>
<tr>
<td>Maureen Raper</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>2 (out of 4)</td>
</tr>
<tr>
<td>Linda Pepper</td>
<td>Elected 1/8/14 – 31/7/17</td>
<td>3 (out of 4)</td>
</tr>
<tr>
<td>Andrew Gray</td>
<td>Elected 1/8/14 – 31/7/17</td>
<td>2 (out of 2)</td>
</tr>
<tr>
<td><strong>Blyth Valley constituency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simpson Crawford</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>3 (out of 4)</td>
</tr>
<tr>
<td>Ken Patterson</td>
<td>Elected 1/8/14 – 31/7/17</td>
<td>2 (out of 4)</td>
</tr>
<tr>
<td>Bill Dowse</td>
<td>Elected 1/8/13 – 31/7/16</td>
<td>4 (out of 4)</td>
</tr>
<tr>
<td>Eric Young</td>
<td>Elected 1/8/13 – 31/7/16</td>
<td>3 (out of 4)</td>
</tr>
<tr>
<td>Joyce Middleton</td>
<td>Elected 1/8/11 – 31/7/14</td>
<td>2 (out of 2)</td>
</tr>
<tr>
<td>Sean Fahey</td>
<td>Elected 1/8/14 – 31/7/17</td>
<td>2 (out of 2)</td>
</tr>
<tr>
<td>Mavis Wilkinson-Hamilton</td>
<td>Elected 1/8/14 – 31/7/17</td>
<td>1 (out of 2)</td>
</tr>
<tr>
<td><strong>Wansbeck constituency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mike Elphick</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>4 (out of 4)</td>
</tr>
<tr>
<td>David Wilkinson</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>2 (out of 4)</td>
</tr>
<tr>
<td>Brian Kipling</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>2 (out of 4)</td>
</tr>
<tr>
<td>Pauline Greaves</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>1 (out of 4)</td>
</tr>
<tr>
<td>Eric Jones</td>
<td>Elected 1/8/14 – 31/7/17</td>
<td>3 (out of 4)</td>
</tr>
<tr>
<td>Julia Mann</td>
<td>Elected 1/8/14 – 31/7/17</td>
<td>2 (out of 4)</td>
</tr>
<tr>
<td><strong>Hexham constituency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Derek Bramley</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>4 (out of 4)</td>
</tr>
<tr>
<td>Graham Ridley</td>
<td>Elected 1/8/14 – 31/7/17</td>
<td>2 (out of 4)</td>
</tr>
<tr>
<td>Sheila Robson</td>
<td>Elected 1/8/14 – 31/7/17</td>
<td>4 (out of 4)</td>
</tr>
<tr>
<td>Stephen Prandle</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>3 (out of 4)</td>
</tr>
<tr>
<td>Senga Bond</td>
<td>Elected 1/8/11 – 31/7/14</td>
<td>2 (out of 2)</td>
</tr>
<tr>
<td>Ian Fell</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>3 (out of 4)</td>
</tr>
<tr>
<td>Isobel Johnson</td>
<td>Elected 1/8/14 – 31/7/17</td>
<td>1 (out of 2)</td>
</tr>
<tr>
<td><strong>North Shields constituency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stuart Arkley</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>4 (out of 4)</td>
</tr>
<tr>
<td>John Robson – Lead Governor</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>4 (out of 4)</td>
</tr>
<tr>
<td>Peter Blair</td>
<td>Elected 1/8/11 – 31/7/14</td>
<td>2 (out of 2)</td>
</tr>
<tr>
<td>Gill Close</td>
<td>Elected 1/8/14 – 31/7/17</td>
<td>2 (out of 2)</td>
</tr>
<tr>
<td><strong>North West Tyneside constituency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peter Latham</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>3 (out of 4)</td>
</tr>
<tr>
<td>Vacancy x 2</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Wallsend constituency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ian McKee</td>
<td>Elected 1/8/14 – 31/7/17</td>
<td>3 (out of 4)</td>
</tr>
<tr>
<td>Tony Turnbull</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>2 (out of 4)</td>
</tr>
<tr>
<td>Vacancy</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Whitley Bay constituency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>John Ross</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>3 (out of 4)</td>
</tr>
<tr>
<td>Heather Carr</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>3 (out of 4)</td>
</tr>
<tr>
<td>Eunice Weatherhead</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>3 (out of 4)</td>
</tr>
<tr>
<td>Staff governors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Alnwick Infirmary (Including Rothbury Community Hospital)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nicola Karolewski</td>
<td>Elected 1/8/13 – 31/7/16</td>
<td>2 (out of 4)</td>
</tr>
<tr>
<td><strong>Berwick Infirmary</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glynis Duff</td>
<td>Elected 1/8/13 – 31/7/16</td>
<td>2 (out of 4)</td>
</tr>
<tr>
<td><strong>Blyth Community Hospital</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vacancy</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td><strong>Morpeth Walton Unit and Health Centre</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vacancy</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td><strong>Hexham General Hospital (Including Haltwhistle)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dot Dickinson</td>
<td>Elected 1/8/11 – 31/7/14</td>
<td>0 (out of 2)</td>
</tr>
<tr>
<td>Anne Boulton</td>
<td>Elected 1/8/13 – 31/7/16</td>
<td>1 (out of 4)</td>
</tr>
<tr>
<td><strong>North Tyneside General Hospital (including Cobalt)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angela Moore</td>
<td>Elected 1/8/14 – 31/7/17</td>
<td>1 (out of 4)</td>
</tr>
<tr>
<td>Joanne Mackintosh</td>
<td>Elected 1/8/14 – 31/7/17</td>
<td>0 (out of 2)</td>
</tr>
<tr>
<td>Helen McKee</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>0 (out of 4)</td>
</tr>
<tr>
<td>Alison Bywater</td>
<td>Elected 1/8/11 – 31/7/14</td>
<td>2 (out of 2)</td>
</tr>
<tr>
<td>Ian Smallman</td>
<td>Elected 1/8/13 – 31/7/16</td>
<td>0 (out of 4)</td>
</tr>
<tr>
<td>Julie Hogarth</td>
<td>Elected 1/8/11 – 31/7/14</td>
<td>0 (out of 2)</td>
</tr>
<tr>
<td>Christine Houghton</td>
<td>Elected 1/8/14 – 31/7/17</td>
<td>1 (out of 4)</td>
</tr>
<tr>
<td>Rachel Lucas</td>
<td>Elected 1/8/14 – 31/7/17</td>
<td>0 (out of 2)</td>
</tr>
<tr>
<td>Kim Thompson</td>
<td>Elected 1/8/14 – 31/7/17</td>
<td>0 (out of 2)</td>
</tr>
<tr>
<td><strong>Wansbeck General Hospital</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peter Smith</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>3 (out of 4)</td>
</tr>
<tr>
<td>Jen Henderson</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>3 (out of 4)</td>
</tr>
<tr>
<td>Jennifer Cribbes</td>
<td>Elected 1/8/12 – 31/7/15</td>
<td>4 (out of 4)</td>
</tr>
<tr>
<td>Sean Brock</td>
<td>Elected 1/8/13 – 31/7/16</td>
<td>1 (out of 4)</td>
</tr>
<tr>
<td>Ruth Hibbert</td>
<td>Elected 1/8/11 – 31/7/14</td>
<td>0 (out of 2)</td>
</tr>
<tr>
<td>Lynn Turner</td>
<td>Elected 1/8/14 – 31/7/17</td>
<td>1 (out of 2)</td>
</tr>
<tr>
<td><strong>Northumberland community</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alice Whincup</td>
<td>Elected 1/8/11 – 31/7/14</td>
<td>1 (out of 2)</td>
</tr>
<tr>
<td>Jason Wilkes</td>
<td>Elected 1/8/11 – 31/7/14</td>
<td>3 (out of 4)</td>
</tr>
<tr>
<td>Kim Thompson</td>
<td>Elected 1/8/11 – 31/7/14</td>
<td>0 (out of 2)</td>
</tr>
<tr>
<td><strong>North Tyneside community</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joanne Mackintosh</td>
<td>Elected 1/8/11 – 31/7/14</td>
<td>1 (out of 2)</td>
</tr>
<tr>
<td>Tracy Scott</td>
<td>Elected 1/8/13 – 31/7/16 – <em>stood down August 14</em></td>
<td>0 (out of 2)</td>
</tr>
<tr>
<td>Kevin Smith</td>
<td>Elected 1/8/14 – 31/7/17</td>
<td>2 (out of 2)</td>
</tr>
<tr>
<td>Vacancy</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Appointed governors</strong></td>
<td>Attendance</td>
<td></td>
</tr>
<tr>
<td>North Tyneside CCG – vacancy</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Northumberland CCG – vacancy</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>North Tyneside Council - Muriel Green</td>
<td>0 (out of 4)</td>
<td></td>
</tr>
<tr>
<td>North Tyneside Council - Judith Wallace</td>
<td>2 (out of 4)</td>
<td></td>
</tr>
<tr>
<td>Northumberland County Council - Susan Dungworth - <em>changed in year</em></td>
<td>0 (out of 2)</td>
<td></td>
</tr>
<tr>
<td>Northumberland County Council - Scott Dickinson</td>
<td>0 (out of 2)</td>
<td></td>
</tr>
<tr>
<td>Northumberland County Council - Susan Davey</td>
<td>0 (out of 4)</td>
<td></td>
</tr>
<tr>
<td>University of Newcastle Medical School - Julia Newton</td>
<td>0 (out of 4)</td>
<td></td>
</tr>
<tr>
<td>University of Northumbria - Margaret Rowe</td>
<td>0 (out of 4)</td>
<td></td>
</tr>
<tr>
<td>North East Ambulance Service NHS Trust - Nichola Kenny</td>
<td>2 (out of 4)</td>
<td></td>
</tr>
<tr>
<td>Voluntary Services Organisation - Vacancy</td>
<td>n/a</td>
<td></td>
</tr>
</tbody>
</table>

*Table 19: Composition of the council of governors*
8. Membership activity

We draw our members from three membership constituencies – the public constituency, the staff constituency and the patient constituency. Membership of the public constituency is open to anyone over the age of 12 living in Northumberland and North Tyneside. The patient constituency is open to people who have been treated in one of our hospitals in the past year but are not resident in the immediate catchment area. As of 31 March 2015, there were 61,720 members in the public constituency and ten in the patient constituency as shown in the table 20.

<table>
<thead>
<tr>
<th>Northumbria Healthcare NHS Foundation Trust</th>
<th>Membership 2014/15</th>
<th>Membership 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members of constituency class</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Berwick upon Tweed</td>
<td>8,533</td>
<td>8,954</td>
</tr>
<tr>
<td>Blyth Valley</td>
<td>10,401</td>
<td>10,909</td>
</tr>
<tr>
<td>Hexham</td>
<td>8,672</td>
<td>9,083</td>
</tr>
<tr>
<td>Wansbeck</td>
<td>11,785</td>
<td>12,364</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>39,391</strong></td>
<td><strong>41,310</strong></td>
</tr>
<tr>
<td>North West Tyneside</td>
<td>2,083</td>
<td>2,202</td>
</tr>
<tr>
<td>Wallsend</td>
<td>4,303</td>
<td>4,530</td>
</tr>
<tr>
<td>North Shields</td>
<td>8,738</td>
<td>9,185</td>
</tr>
<tr>
<td>Whitley Bay</td>
<td>7,205</td>
<td>7,603</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22,329</strong></td>
<td><strong>23,520</strong></td>
</tr>
<tr>
<td>Sub total</td>
<td>61,720</td>
<td>64,830</td>
</tr>
<tr>
<td>Patient</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td><strong>61,730</strong></td>
<td><strong>64,855</strong></td>
</tr>
</tbody>
</table>

*Table 20: Public constituency membership 2014/15*

Throughout the year, the membership data is regularly cleansed to remove people who are now deceased or have moved out of the area. Members can also choose to opt out of being a member resulting in a further reduction in membership numbers.

**Staff membership**

Staff who are employed directly by us on permanent contracts automatically become members of the staff constituency unless they inform us that they do not wish to do so. At 31 March 2015, there were 9,392 members in the staff constituency as detailed in table 21.

<table>
<thead>
<tr>
<th>Staff constituency</th>
<th>Membership 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Tyneside General Hospital, Cobalt, Ash Court, GB Hunter</td>
<td>4,304</td>
</tr>
<tr>
<td>Wansbeck General Hospital</td>
<td>2,043</td>
</tr>
<tr>
<td>Hexham, Haltwhistle</td>
<td>575</td>
</tr>
<tr>
<td>Whalton Unit and NHS Centre (both in Morpeth)</td>
<td>75</td>
</tr>
<tr>
<td>Blyth Community Hospital</td>
<td>153</td>
</tr>
<tr>
<td>Alnwick, Rothbury</td>
<td>163</td>
</tr>
<tr>
<td>Berwick Infirmary</td>
<td>130</td>
</tr>
<tr>
<td>Northumberland community staff</td>
<td>1,345</td>
</tr>
<tr>
<td>North Tyneside community staff</td>
<td>545</td>
</tr>
<tr>
<td>Other</td>
<td>59</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9,392</strong></td>
</tr>
</tbody>
</table>

*Table 21: Staff membership 2014/15*
Membership analysis

The diversity of our public membership is broadly in line with that of the general population in the constituency area with eight per cent of the total population being members of the trust. We keep the position under review via the governors’ membership committee to further improve alignment. Table 22 below shows the public membership broken down into age, ethnicity and gender:

<table>
<thead>
<tr>
<th>Public and patient membership 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
</tr>
<tr>
<td>0 – 16</td>
</tr>
<tr>
<td>17 – 21</td>
</tr>
<tr>
<td>22 – 29</td>
</tr>
<tr>
<td>30-39</td>
</tr>
<tr>
<td>40 – 49</td>
</tr>
<tr>
<td>50 – 59</td>
</tr>
<tr>
<td>60 – 74</td>
</tr>
<tr>
<td>Over 75</td>
</tr>
<tr>
<td>Unknown/unspecified</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td>Mixed</td>
</tr>
<tr>
<td>Asian or Asian British</td>
</tr>
<tr>
<td>Black or Black British</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Not Stated</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Unspecified</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

Table 22: Patient and public constituency

Membership strategy

We continuously review our membership strategy to ensure that it is fit for purpose and delivers a highly-effective membership across the trust’s operating area.

The council of governors has delegated responsibility for leading the development and implementation of our membership strategy which also includes the development of a communications strategy to ensure two-way communications between the trust, governors and members. The membership strategy has three broad overarching objectives, to have:

- A membership that is representative and reflective of the communities served by the trust
- An informed membership by providing appropriate, accurate and timely information to our members and to assist them in making informed contributions
- An involved membership where as many members as possible are actively engaged in the development of the trust and its activities
To date a variety of methods have been used to communicate and engage with both governors and members including regular meetings, the website, dedicated governors’ site, members’ newsletter, a central telephone number, dedicated email addresses and engagement road shows across North Tyneside and Northumberland. Future activity will include:

- Reviewing the content of the annual members’ newsletter to ensure it is meaningful
- Sending out a members’ e-bulletin with relevant information using data on members’ interests we are collecting on an ongoing basis
- Promoting the use of dedicated email address – governors@northumbria.nhs.uk to contact local governors
- Use of internal communication mechanisms to promote the role of staff governor
- Opportunities to meet governors when possible
- Continuing to hold engagement road shows when appropriate
- Increased use of PR (local council magazines) and social media (twitter) as a way to engage
- Governor comments and compliments forms
- Continuing to collect information about members’ interests and activities to enable further segmentation of the membership and more meaningful engagement

**Stakeholder engagement**

To support us in our ambition to deliver best in class healthcare it is critical that there are robust mechanisms in place to communicate and engage with our stakeholders across the area it serves and a stakeholder engagement plan has been implemented. Our stakeholder engagement plan concentrates on how we will communicate and engage with our stakeholders at a corporate level about the trust’s strategic direction, corporate information and messages, any changes to healthcare services and the latest trust developments and news.

**Regular communication and engagement activities include:**

- Regular meetings with MPs
- Bi-monthly e-bulletin to all stakeholders including:
  - MPs
  - Leaders of local authorities
  - Chairs of overview and scrutiny committees
  - Partners of the health and wellbeing boards
  - Healthwatch
  - Clinical commissioning groups
  - Local NHS organisations
  - Councillors – local area forums
  - Universities
  - Local voluntary organisations
- Quarterly meetings of the stakeholder engagement forum to strengthen links with key voluntary and community groups
- Regular attendance at the local council overview and scrutiny committees
- Membership of the Northumberland and North Tyneside health and wellbeing boards
- Key member of the health and wellbeing communication and engagement task and finish group
- Fortnightly update to GPs
- Quality Account questionnaires distributed annually

Representatives from the trust attend local overview and scrutiny meetings at North Tyneside and Northumberland local authorities, providing detailed briefings as and when requested. This has included discussing the latest developments of the Northumbria Specialist Emergency Care Hospital, a briefing on health informatics, a presentation on what future clinical developments could mean for the NHS and the development of the trust’s Quality Account.

We continue to be an integral member of Northumberland and North Tyneside health and wellbeing boards and have been involved with the development of their strategies and work plans.

We send out a fortnightly e-bulletin to GPs and monitor readership statistics allowing us to ensure we keep this informative and interesting to the audience. A bi-monthly magazine-style, feature-led update has continued to give GPs more detailed information about our services.

The trust’s Excellence through Collaboration events for GPs, which provide training opportunities, information and updates about services, are very well attended. These events are strengthening the links between trust clinical staff and primary care. Event feedback has been excellent and is used to help shape subsequent events.

The GP app, named Ciix, continues to provide GPs with access to an online service directory with information on what clinics we run and how they can refer their patients in easily. This is now available in both IOS and Android versions. It contains speciality-specific information including locations and times of clinics, referral information, consultants/clinical staff details and information on rapid access clinics. It continues to be very popular with GPs and feedback received has been very positive.

**Engagement forum**

The engagement forum has now been up and running since 2012 and was established to strengthen partnership working with voluntary and community sector organisations and groups across North Tyneside and Northumberland. Healthwatch, Carers Northumberland and Carers North Tyneside, forums that represent people with disabilities, AGE UK Northumberland and AGE UK North Tyneside, women’s organisations, Alzheimer’s Society, British Red Cross, victim support organisations and PALS are all key members of the forum.

Four meetings have been held in the past year with topics for discussion including care of the dying, transport to and from hospital and the new Northumbria Specialist Emergency Care Hospital and what it will mean for patients.
Social media

Northumbria’s corporate social media feeds are a core mechanism for communicating messages and engaging with stakeholders. As well as Twitter and Facebook, the trust has a corporate YouTube account to share videos of work taking place. Facebook and Twitter have continued to grow in popularity with many members of staff now following the trust online and reporting to the team that they feel more up-to-date with news and developments.

At present our total engaged Twitter audience is 2,458 people, our Facebook audience is 4,644 people, we have 611 LinkedIn connections, 67 You Tube subscribers, 14 Pinterest followers, 59 Instagram followers and 18 Google+ followers - these numbers continue to steadily increase on a daily basis as more people see and share our stories online.

North Cumbria acquisition – membership activity and shadow council of governors

We continue to work closely with North Cumbria University Hospitals NHS Trust acting as an official ‘buddy’ trust. This ‘buddy’ arrangement has been in place since the publication of the Keogh Review findings in July 2013 when the North Cumbria Trust was placed into ‘special measures’ with the NHS Trust Development Authority (TDA) which is responsible for monitoring progress against key areas for improvement.

No acquisition can take place while a trust is in ‘special measures’ and collective efforts of all partners remain on ensuring the North Cumbria Trust can come out of special measures as soon as possible for the benefit of patient care. Until this happens, the acquisition process which began over three years ago remains paused.

As part of the initial acquisition process for North Cumbria University Hospitals NHS Trust, we have recruited public, staff and patient members and also held elections for a shadow council of governors. Details of the membership and shadow council of governor elections are outlined in tables 23 and 24.

| North Cumbria University Hospitals NHS Trust | Membership 2014/15 |
| Members of constituency class | |
| Copeland | 410 |
| Allerdale | 879 |
| Carlisle | 597 |
| Eden | 245 |
| Total | 2,131 |
| Patient | 842 |
| Grand total | 2,973 |

*Table 23: North Cumbria membership*
In the west there are membership constituencies of: four public, two staff and one patient constituency with 34 governor positions – 20 public, 10 staff and four patients. There are also seven co-opted governor places.

<table>
<thead>
<tr>
<th>Constituency</th>
<th>No. to Elect</th>
<th>Eligible voters</th>
<th>Number of votes cast</th>
<th>Turnout %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public governor vacancies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carlisle</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allerdale</td>
<td>1</td>
<td>857</td>
<td>227</td>
<td>26.5%</td>
</tr>
<tr>
<td>Copeland</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Staff governor vacancies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Table 24: North Cumbria shadow governor elections*

Vacancies for one staff governor in West Cumberland Hospital, one staff governor at Cumberland Infirmary, one in Eden and one in Copeland remain due to in-year resignations.
9. Nomination, Remuneration and Development Committee

The members of the nomination, remuneration and development committee consists of public and staff governors who have been formally nominated by the council of governors. The committee was chaired by the chairman of the trust, with the exception of instances where the appointment and performance of the chairman was scheduled to be discussed. On these occasions the senior independent director/vice chairman chaired the committee meeting. The committee invited the trust’s chief executive, executive director of human resources and organisational development and trust secretary (or deputy) to attend the committee meetings to provide advice and support as required.

The committee was responsible for taking forward recommendations to the council of governors concerning the re-appointment of the chairman and non-executive directors prior to the conclusion of their terms of office. In making a recommendation, the committee reviewed each individual’s annual review documentation to consider how they had performed as a non-executive director and further ruminate on the knowledge, skills and experience that they contribute to the trust board. As part of this process, the committee monitored the collective performance of the trust board and considered the balance between the need for continuity, and the need to progressively refresh the trust board as advised within the Monitor code of governance (the Code).

The committee recommended the re-appointment of non-executive directors beyond the initial six-year term for continuity due to the trust board having been refreshed in 2013 with the appointment of Peter Sanderson. In compliance with the code, the non-executive directors and chairman were subject to a formal rigorous review which included the following elements:

- A review of the appraisal documentation for the previous 12 months
- Confirmation from the chairman that he considers the non-executive directors to be independent
- Confirmation from the chief executive that he considers the non-executive directors to be independent and confirmation of continuing constructive challenge and scrutiny
- Review of appropriate board and subcommittee
- Review of the annual independent board effectiveness
- Review of 360 degree information from peers, colleagues and governors

During the 2014/15 period, the performance of the non-executive directors was appraised by the chairman with the senior independent director/vice chair having led the appraisal of the chairman. The committee considered the re-appointment of the chairman and four non-executive directors all who were scheduled to reach the end of their term on 31 December 2014. The committee recommended to the council of governors (recommendation subsequently approved) that the chairman and non-executive directors be re-appointed for a further 12-month term subject to an annual rigorous review, this being in accordance with the NHS Foundation Trust Code of Governance. The chairman re-appointed was Brian Flood, non-executive directors re-appointed were Ian Swithenbank, Neil Mundy, Ian McMinn and David Thompson. There were no changes to remuneration levels during the last year.
The committee met on three occasions during the period of the 1 April 2014 to the 31 March 2015 to address the re-appointment of the non-executive directors and chairman. The attendance of its members is detailed in the table 25 below.

<table>
<thead>
<tr>
<th>Governor</th>
<th>No. of meetings attended (3)</th>
<th>Governor</th>
<th>No. of meetings attended (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bill Dowse, public governor</td>
<td>1</td>
<td>Mike Elphick, public governor</td>
<td>1</td>
</tr>
<tr>
<td>Linda Pepper, public governor</td>
<td>3</td>
<td>Peter Latham, public governor</td>
<td>1</td>
</tr>
<tr>
<td>Senga Bond, public governor</td>
<td>1</td>
<td>Stuart Arkley, public governor</td>
<td>3</td>
</tr>
<tr>
<td>Pauline Greaves, public governor</td>
<td>2</td>
<td>Jo Mackintosh, staff governor</td>
<td>2</td>
</tr>
<tr>
<td>Peter Blair, public governor</td>
<td>2</td>
<td>Peter Smith, staff governor</td>
<td>1</td>
</tr>
<tr>
<td>Heather Carr, public governor</td>
<td>2</td>
<td>Jen Henderson, staff governor</td>
<td>2</td>
</tr>
<tr>
<td>Ian McKee, public governor</td>
<td>1</td>
<td>Alison Bywater, staff governor</td>
<td>2</td>
</tr>
<tr>
<td>John Robson, public governor</td>
<td>2</td>
<td>Eric Jones, public governor</td>
<td>2</td>
</tr>
</tbody>
</table>

*Table 25: Member attendance at Nomination Committee between the period 1 April 2014 – 31 March 2015*
10. Audit Committee

The audit committee is comprised of not less than three non-executive directors and is chaired by non-executive director Neil Mundy who is considered to have recent and relevant financial experience. The committee met on seven occasions during the year with the executive director of finance, other trust officers and our internal and external auditors in attendance. The attendance of members is shown in table 26.

<table>
<thead>
<tr>
<th>Member attendance</th>
<th>7/4/14</th>
<th>22/4/14</th>
<th>19/5/14</th>
<th>14/7/14</th>
<th>29/9/14</th>
<th>17/11/14</th>
<th>26/1/15</th>
<th>16/3/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neil Mundy</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Ian McMinn</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Ian Swithenbank</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>David Thompson</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Peter Sanderson</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Table 26: Membership and attendance For Audit Committee 1 April 2013 – 31 March 2015

The committee is responsible for providing our trust board with advice and recommendations on matters which include the effectiveness of the framework of controls in the trust, the adequacy of the arrangements for managing risk and how they are implemented, the adequacy of the plans of our auditors and how they perform against them, the impact of changes in accounting policy and the committee’s review of the annual accounts.

During 2014/15 the significant issues that the committee considered in relation to the financial statements, operations and compliance were the valuation of tangible fixed assets and the settlement of the PFI termination and associated provision. The impact of these issues were discussed by the committee and advice considered from external audit and external advisors. The committee has also reviewed other key risks including those in relation to the proposed acquisition of North Cumbria University Hospitals and the completion of the new specialist emergency care hospital at Cramlington.

In order to ensure that the independence and objectivity of the external auditor is not compromised by providing the trust with additional non-audit services we have agreed a policy that requires the audit committee to approve the arrangements for all proposals to engage the external auditors on non-audit work. The auditors themselves comply with the Ethical Standards of the Auditing Practices Board in this matter.

During the year, the external auditors undertook work in addition to the statutory financial statements audit, as follows:

- An Auditors Local Evaluation Assessment (ALE)
- Review of the Quality Account
- A review of the controls in place on the shared ledger system and business continuity arrangements. This is on behalf of a consortium which shares the fee
- Independent assessment of the trust’s quality governance self-assessment.
- VAT advice
- Certification to National Audit Office (NAO) of balances for Whole of Governments Accounts
The committee is content that the objectivity and independence of the auditor was not compromised by any of these additional assignments.

The duty to appoint the external auditors lies with the council of governors. A panel of governors, supported by trust officers and the chair of the audit committee is established to oversee the procurement of external audit services regarding the appointment and retention of the external auditor. The council of governors approved the appointment of KPMG LLP after a competitive tendering process for a period of three years from 2012/13.

Following the recommendation to appoint KPMG LLP for a period of three years, plus a further two years subject to satisfactory performance, the council of governors approved this recommendation at the general meeting held 29 February 2012.

The governors and external audit panel met on three occasions during 2014/2015 and received information and reports on the role, remit and responsibility of the audit committee, conduct of internal and external audit and local counter fraud service as well receiving regular assurance on the process of the acquisition of North Cumbria University Hospitals NHS Trust.
11. Remuneration report

The remuneration committee deals with the remuneration of the chief executive, the executive directors and other senior managers. The definition of senior managers is those persons having authority or responsibility for directing or controlling the major activities of the NHS body. The committee is chaired by Ian McMinn, non-executive director and all of the non-executive directors are members with the exception of the chair of the audit committee. It met on nine occasions during the year and the attendance of members is detailed in table 27. The chief executive and the executive director of human resources and organisational development attend the committee except when it is dealing with matters concerning them. In 2014/15 the committee did not receive advice or services from any person or director who was not a member of the committee that materially assisted the committee in their consideration of any matter.

<table>
<thead>
<tr>
<th>Attendance</th>
<th>24/04/14</th>
<th>26/06/14</th>
<th>16/07/14</th>
<th>25/09/14</th>
<th>15/10/14</th>
<th>27/11/14</th>
<th>06/01/15</th>
<th>22/01/15</th>
<th>26/02/15</th>
<th>26/03/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peter Sanderson</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Ian McMinn</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>John Marsden</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>David Thompson</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Ian Swindenbank</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

*Table 27: Remuneration committee attendance*

The committee undertakes periodic reviews of the salary levels of the chief executive and the executive directors taking account of our overall performance and that of individual directors, the awards to other staff groups, and the prevailing rate of awards in other similar organisations and published benchmark information. None of the remuneration is directly related to performance. The committee also has responsibility for reviewing the pay of senior managers and for the allocation of clinical excellence awards and optional points to eligible medical staff. The trust does not envisage making any salary payments in relation to performance and do not offer an incentivisation programme at present.

In compliance with the Monitor ARM, the Trust is required to present the following 3 tables (28, 29 & 30) in relation to off-payroll arrangements. The Trust can confirm that during 2014/15 there were no senior off-payroll engagements for more than £220 per day.

<table>
<thead>
<tr>
<th>No. of existing engagements as of 31 March 2015</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Of which...</td>
<td></td>
</tr>
<tr>
<td>No. that have existed for less than one year at time of reporting.</td>
<td>N/A</td>
</tr>
<tr>
<td>No. that have existed for between one and two years at time of reporting.</td>
<td>N/A</td>
</tr>
<tr>
<td>No. that have existed for between two and three years at time of reporting.</td>
<td>N/A</td>
</tr>
<tr>
<td>No. that have existed for between three and four years at time of reporting.</td>
<td>N/A</td>
</tr>
<tr>
<td>No. that have existed for four or more years at time of reporting.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Table 28 - all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last for longer than six months*
Table 29 - all new off-payroll engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015, for more than £220 per day and that last for longer than six month.

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations</td>
<td>N/A</td>
</tr>
<tr>
<td>No. for whom assurance has been requested</td>
<td>N/A</td>
</tr>
<tr>
<td>Of which...</td>
<td></td>
</tr>
<tr>
<td>No. for whom assurance has been received</td>
<td>N/A</td>
</tr>
<tr>
<td>No. for whom assurance has not been received</td>
<td>N/A</td>
</tr>
<tr>
<td>No. that have been terminated as a result of assurance not being received.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Table 30: off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2014 and 31 March 2015

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.</td>
<td>0</td>
</tr>
<tr>
<td>Number of individuals that have been deemed ‘board members and/or senior officials with significant financial responsibility’ during the financial year. This figure must include both off-payroll and on-payroll engagements.</td>
<td>0</td>
</tr>
</tbody>
</table>

All of the executive directors and senior managers are appointed on permanent, open-ended contracts with notice periods of three, six or twelve months depending on the individual contract. The contracts of employment make no special provisions regarding early termination or termination payments. Executive directors and senior managers are subject to the trust’s normal disciplinary processes and sanctions. Terminations resulting from redundancy and retirement are in accordance with the provisions of national terms and conditions and the NHS pension scheme.

The remuneration of the chairman and non-executive directors is determined by the council of governors on the basis of a recommendation from the nomination, remuneration and development committee. Levels of remuneration are set with reference to market rates using national benchmark data where appropriate. Non-executive directors are appointed for periods of up to three years and may apply for reappointment at the end of their term of office. They are not eligible to receive compensation for loss of office.

Details of directors’ remuneration and the cash equivalent transfer values of the pensions of the executive directors who are current members of the NHS Pension Scheme are shown in tables 31 and 32.

There were no payments made in the financial year to senior managers for loss of office or any payments of money or other assets to former senior managers.
<table>
<thead>
<tr>
<th>Executive directors</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Salary and fees (bands of £5,000)</td>
<td>* All taxable benefits (nearest £100)</td>
</tr>
<tr>
<td>Rosemary Stephenson</td>
<td>155-160</td>
<td>6,500</td>
</tr>
<tr>
<td>Paul Dunn</td>
<td>150-155</td>
<td>10,600</td>
</tr>
<tr>
<td>Ann Stringer</td>
<td>150-155</td>
<td>5,000</td>
</tr>
<tr>
<td>Ann Wright</td>
<td>155-160</td>
<td>5,100</td>
</tr>
<tr>
<td>Birju Bartoli</td>
<td>125-130</td>
<td>6,100</td>
</tr>
<tr>
<td>Richard Curless</td>
<td>190-195</td>
<td>11,700</td>
</tr>
<tr>
<td>Daljit Lally (50% joint role with Northumberland County Council)</td>
<td>60-65</td>
<td>3,000</td>
</tr>
<tr>
<td>David Evans</td>
<td>175-180</td>
<td>13,700</td>
</tr>
<tr>
<td>Derek Thomson</td>
<td>115-120</td>
<td>4,200</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Executive Directors</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brian Flood</td>
<td>50-55</td>
<td>2,800</td>
</tr>
<tr>
<td>Ian McMinn</td>
<td>15-20</td>
<td>0</td>
</tr>
<tr>
<td>Neil Mundy</td>
<td>15-20</td>
<td>0</td>
</tr>
<tr>
<td>Peter Sanderson</td>
<td>10-15</td>
<td>0</td>
</tr>
<tr>
<td>David Thompson</td>
<td>15-20</td>
<td>0</td>
</tr>
<tr>
<td>Ian Swithinbank</td>
<td>15-20</td>
<td>0</td>
</tr>
<tr>
<td>John Marsden</td>
<td>15-20</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 31: Details of directors’ remuneration

* All pension related benefits are calculated as the annual increase to the total sum of pension entitlement upon retirement age and the subsequent 20 years for average further life expectancy.

** Taxable benefits consist of leased cars used for business and private purposes and the taxable benefit of payments made for the reimbursement of business miles made in privately-owned vehicles. For the periods reported, no director (executive nor non-executive), received an annual performance-related bonus or long-term performance related bonus.
James Mackey left the NHS Pension Scheme on 1 October 2010; therefore in lieu of employer’s contributions to the scheme he received payments totaling the sum that the trust would have contributed to the NHS Pension Scheme during the period had he remained a member. As such the new arrangement did not increase the overall cost of his remuneration package, and is therefore displayed within all pension related benefits.

Remuneration details are also reported in the trust’s annual accounts.

For the 2014/15 financial year Ann Farrar was seconded to North Cumbria University Hospitals NHS Trust and performed the role of chief executive at this trust. From 1 April 2014, her salary and travel costs were recharged to North Cumbria University Hospital NHS Trust in line with an agreed amount. An element of cost has been retained by the trust equivalent to £21,000 for period to 31st March 2015 to reflect the requirement to keep up-to-date with Northumbria Healthcare, to attend meetings and so on as requested.

<table>
<thead>
<tr>
<th>Name</th>
<th>Real increase / (decrease) in pension at age 60 since 1 April 2014 (bands of £2,500)</th>
<th>Real increase / (decrease) in pension related lump sum at age 60 since 1 April 2014 (bands of £5,000)</th>
<th>Total accrued pension at age 60 at 31 March 2015 (bands of £5,000)</th>
<th>Lump sum at age 60 at 31 March 2015 (bands of £5,000)</th>
<th>Cash equivalent transfer value at 31 March 2015 £’000s</th>
<th>Real increase / (decrease) in cash equivalent transfer value £’000s</th>
<th>Cash equivalent transfer value at 31 March 2014 £’000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul Dunn</td>
<td>2.5 - 5</td>
<td>7.5 - 10</td>
<td>45 - 50</td>
<td>140 - 145</td>
<td>843</td>
<td>70</td>
<td>773</td>
</tr>
<tr>
<td>Ann Wright</td>
<td>0 - 2.5</td>
<td>2.5 - 5</td>
<td>55 - 60</td>
<td>170 - 175</td>
<td>1,150</td>
<td>63</td>
<td>1,087</td>
</tr>
<tr>
<td>Richard Curless</td>
<td>0 - 2.5</td>
<td>2.5 - 5</td>
<td>60 - 65</td>
<td>180 - 185</td>
<td>1,187</td>
<td>56</td>
<td>1,132</td>
</tr>
<tr>
<td>Ann Stringer</td>
<td>0 - 2.5</td>
<td>2.5 - 5</td>
<td>35 - 40</td>
<td>110 - 115</td>
<td>784</td>
<td>56</td>
<td>728</td>
</tr>
<tr>
<td>Birju Bartoli</td>
<td>2.5 - 5</td>
<td>12.5 - 15</td>
<td>20 - 25</td>
<td>60 - 65</td>
<td>287</td>
<td>69</td>
<td>218</td>
</tr>
<tr>
<td>Derek Thomson</td>
<td>2.5 - 5</td>
<td>10 - 12.5</td>
<td>25 - 30</td>
<td>75 - 80</td>
<td>546</td>
<td>92</td>
<td>454</td>
</tr>
</tbody>
</table>

Table 32: Directors’ pension values

As non-executive directors do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive directors.

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 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 in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures include the values of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines prescribed by the Institute and Faculty Actuaries.
The increase or decrease in CETV reflects the change in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

There is no CETV for members of the scheme who have attained the age of 60 years.

Expenses of the governors and the directors were mainly related to reimbursement for travel costs reflecting the large geographical spread of the organisation. In 2014/15 expenses were paid to governors of £9,568 (£10,118 in 2013/14) and directors of £20,914 (£36,408 in 13/14).

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation’s workforce.

The banded remuneration of the highest paid director in Northumbria Healthcare NHS Foundation Trust in the financial year 2014/15 was £220,000-225,000 (2013/14, £230,000-235,000), excluding a payment in lieu of pension. This was 9.34 times (2013/14, 8.86) the median remuneration of the workforce, which was £23,825 (2013/14, £25,952). The reduction in the trust median reflects the continued commitment to train and develop people through the on-going support of the apprentice scheme.

In 2014/15, 11 (2013/14, 6) employees received remuneration in excess of the highest-paid director, these were medical staff. Remuneration ranged from £5,338 to £371,254 (2013/14 £5,240-£404,547). The range of salaries is reflective of the wide variation of roles that exist within the trust from trainee positions to experienced medical staff. It also includes payments for work or duties undertaken outside of normal contracted hours.

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

Jim Mackey
Chief Executive
29 May 2015
12. Annual Governance Statement

1 April 2014 to 31 March 2015

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Northumbria Healthcare NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Northumbria Healthcare NHS Foundation Trust throughout the year ended 31 March 2015 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

The leadership and accountability arrangements for the chief executive officer, board of directors, business unit directors, clinical directors, general managers, department heads, operational service managers and all staff are set out in the trust’s Risk Management Strategy and Policy. In addition, there are clear terms of reference for the key committees involved with risk. The trust has appointed a senior independent director to be available to governors and members if they have concerns which contact through the normal channels of chairman, chief executive or finance director has failed to resolve or for which such contact is inappropriate.

The trust employs appropriately-qualified staff who specialise in risk management and health and safety matters. Risk management awareness and health and safety training is delivered to all new members of staff on the first day of employment and to existing staff through mandatory training programmes. There is also the facility for all staff to undertake further training in health and safety using e-learning. Relevant policies are specific as regards accountabilities and responsibilities for all staff groups. Systems and procedures are in place to support staff in managing risk and carrying out their duties. All job descriptions include specific reference to requirements regarding risk management, infection control and health and safety. Good practice in risk management, both within the trust and nationally, is shared across the trust through newsletters and periodic reports.
The risk and control framework

Risks are identified proactively through risk assessment processes, our quality management system which includes harm review and mortality reviews and reactively through the monitoring of key business objectives, incidents, complaints and claims. We also use the Monitor Quality Governance Assessment. These risks are evaluated through the use of a risk assessment matrix and controlled through a risk register system. All high risks are considered by the Assurance Committee, assessed for strategic impact and if appropriate added to the trust’s assurance framework. The trust’s assurance framework sets out the principal risks to deliver key priorities and objectives and these are confirmed by the trust board following the annual risk assessment to deliver our annual and five-year plans. The assurance framework identifies the assurances available to the trust board in relation to the achievement of the trust’s key priorities and objectives. The principal risks to the delivery of these objectives are mapped to key controls. The trust board requires the assurance that the assurance framework identifies, those actions required to address gaps in control and assurance, and the development and implementation of action plans. All risks will be managed and mitigated and outcomes will be assessed through the assurance framework process.

The trust identified a number of major risks during 2014/15;

- The economic climate with an anticipated reduction in funding of 15-20% over the next three years
- Acquisition of North Cumbria University Hospital Trust (NCUH), the trust was confirmed as the preferred bidder in January 2012. The original acquisition timescales have been delayed as a result of North Cumbria being placed into special measures following the outcome of Sir Bruce Keogh’s review into the quality of care and treatment provided by 14 hospital trusts in England. North Cumbria University Hospital acquisition cannot take place until the trust demonstrates sufficient improvement to be removed from this status. Northumbria has been formally identified as ‘buddy’ to North Cumbria University Hospital, providing peer support and advice to enable necessary improvements.

The significant clinical risks were;

- The trust experienced extremely high numbers of patients attending its accident and emergency (A&E) departments, especially during the winter months. This sustained level of activity put the achievement of the A&E four-hour wait target at risk and also led to an increase in the number of boarded patients. Through careful management and monitoring the trust was able to ensure adherence to the national four-hour wait target.
- European Working Time Directive especially in the surgical specialties. Locums are in place however the best long-term solution is permanent staff in posts.
- Northumbria Specialist Emergency Care Hospital - this is a significant capital development to improve emergency and children’s care. Monthly monitoring is in place to report progress to the trust board.
- MRSA at the beginning of the year the trust’s annual target was to have no MRSA bacteraemia cases, with a deminimus level of 6. At the end of March 2015 the trust had
been apportioned a total of three cases.

- **Clostridium Difficile** - our annual target for 2014/15 was to have no more than 30 cases of hospital acquired C. difficile. At the end of March 2015 the trust had reported 30 cases.

- **Surgical site infections** – the trust was identified as an outlier for the national average for knee and hip replacements. Root cause analyses of all infections have led to a number of clinical changes that were implemented with immediate effect. Actions continue to be monitored and reported to the trust board.

- **Pressure ulcers and falls** were identified from incident reporting as key areas for improvement during 2014/15. Action plans were introduced in the year to address these areas with an overall improvement in the rate of both hospital acquired pressure ulcers and falls with harm.

- The trust board also recognises that collectively the risks outlined above could present an overarching risk to the trust in terms of management capacity depending on the timing of major projects.

The safety and quality committee is a sub-committee of the trust board and is chaired by a non-executive director. This sub-committee, in conjunction with the trust board, has responsibility for producing the strategic safety and quality vision, strategic goals and an implementation plan by horizon scanning and learning from the best evidence available. The committee reports to the trust board through a quarterly report on progress with the strategic objectives and produces the draft annual Quality Account for consideration by the trust board.

There are robust arrangements in place to provide assurance on the quality of performance information. This is known as our data quality standards and these are reported quarterly to our safety and quality committee, information, management and technology committee and trust board. The trust is compliant with level 2 of the information governance standards. The trust has an information governance group and reports to the information, management and technology committee and to the trust board. Finally, there is an annual independent review by the trusts internal auditors which covers the performance information included as part of the Monitor governance declaration.

The trust has arrangements to monitor compliance with the Care Quality Commission (CQC) registration requirements through completion of provider compliance assessments for each of the 16 essential safety and quality standards. Each safety and quality standard has an executive director lead and evidence of compliance is provided to the assurance committee at quarterly intervals. Additionally, there is monitoring of the trust’s ‘Intelligent Monitoring Report’ produced by the CQC on a quarterly basis.

The trust is fully compliant with the registration requirements of the CQC. During 2014/15 the trust did not receive any inspections from the CQC in respect of the essential safety and quality standards.

Business unit operational boards, the health and safety steering group and the assurance committee play key roles in evaluating and prioritising risk. It is accepted that all risks cannot be eliminated. An acceptable risk is one which has been appropriately risk assessed and the risks reduced to the lowest possible level.
Incident reporting is openly encouraged and handled across the trust. The trust has fully endorsed this principle. All serious untoward incidents and significant learning events are investigated by a senior clinician and manager and reported to the appropriate business unit board to agree on the action plan and monitor implementation. In addition, the most serious incidents are reviewed by the trust’s safety panel, which provides independent scrutiny of incident investigations and monitoring of the completion of action plans arising from such investigations.

Trust-wide learning is agreed at our clinical policy group. All serious incidents are reported to the trust board including the appropriate immediate action plan and embedded action plan. Sharing the lessons learnt is by cascade via the clinical policy group via the management teams to the ward management team.

The trust has worked closely with partner organisations to explore, understand, quantify and minimise potential risks which may impact upon other organisations and public stakeholders. Issues identified through the trust’s risk management process that impact on partner organisations and public stakeholders will be discussed in the appropriate forum so that action can be agreed.

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

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

The trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation’s obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

The process to maintain and review the effectiveness of the system of internal control in relation to the Quality Account was fully considered by Audit Committee and subsequently by the trust board. The outcome was that we already have a strong and robust internal audit system to review our process for self-assessment against the CQC standards and this has been in place for three years.

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

The trust has robust arrangements in place for setting objectives and targets on a strategic and annual basis. These arrangements include ensuring the financial strategy is affordable, scrutiny of cost savings plans to ensure achievement, compliance with terms of authorisation and coordination of individual objectives with corporate objectives as identified in the Annual Plan.
Performance against objectives is monitored and actions identified through a number of channels:

- Approval of annual budget by the trust board.
- Monthly reporting to the trust board on key performance indicators covering finance, activity, patient safety and quality, human resources targets and information, management and technology bi-monthly.
- Monthly review of financial and performance targets by the finance investment and performance committee, which is a committee of the trust board.
- Weekly reporting to executive team on key influences on the trust’s financial position.
- Monthly reporting to business units through the budgetary control and risk system.
- Periodic performance management of business units by the executive team covering performance against key objectives.
- Quarterly reporting to Monitor and compliance with terms of authorisation.

The trust also participates in initiatives to ensure value for money for example:

- Subscribes to the Foundation Trust Network benchmarking organisation that provides comparative information analysis on productivity and clinical indicators for high risk specialties
- Participates in top performing national initiatives with the Institute of Innovation and Learning to learn best practice in international sites
- CQC information that identifies key performance indicators and measures these over time to focus attention on areas for improvement.
- Value for money is an important component of the internal and external audit plans that provides assurance to the trust of processes that are in place to ensure effective use of resources.

The trust has a standard assessment process for future business plans to ensure value for money and full appraisal processes are employed when considering the effect on the organisation. Procedures are in place to ensure all strategic decisions are considered at executive and board level.

The emphasis in internal audit work is providing assurances on internal controls, risk management and governance systems to the audit committee and to the trust board. Where scope for improvement in terms of value for money was identified during an internal audit review, appropriate recommendations were made and actions were agreed with management for implementation.

The trust follows best practice as recommended by the NHS Counter Fraud and Security Management Service and participates in the National Fraud Initiative led by the Audit Commission. Staff are trained in fraud awareness and the trust actively promotes the mechanism for staff to report any concerns about potential fraud or corruption. All concerns are investigated by the local counter fraud and security management specialist and the outcome of all investigations are reported to the audit committee.
The trust was also assessed by external auditors KPMG under the Auditors Local Evaluation (ALE) which reviews internal control and value for money. The overall assessment for 2013/14 was level 4 – performing strongly. All internal audit reviews of material financial systems during 2014/15 resulted in significant assurance.

Information governance

The trust has measures in place to ensure the security of its information resources and assets. The trust continues to achieve a high level of compliance to the standards in the NHS Information Governance Toolkit supported by audit giving significant assurance of compliance with standards. An action plan has been developed where gaps have been identified and this will be monitored by the Information, Management and Technology Committee. The trust reported five losses of data under the arrangements for reporting serious untoward incidents. One incident involved inappropriate access of confidential information and the others related to confidential information being disclosed in error. All incidents were reported to the Information Commissioner’s Office who was satisfied that no formation action was necessary and the cases were now closed.

Quality Account

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

The Quality Account represents a balanced view and there are appropriate controls in place to ensure the accuracy of the data. The following provides evidence of the steps in place to provide this assurance:

Governance and leadership

This is the sixth year of developing of Quality Accounts for Northumbria Healthcare NHS Foundation Trust. The trust has a quality management system in place based on the Institute of Medicine definition of quality. This quality management system ensures that a balanced scorecard of quality standards and indicators is considered by the trust board. Furthermore, the direction by the Department of Health medical director that boards of directors must review all their services over a reasonable period has placed a commitment on trust boards to review all services over a three-year period based on the three quality indicators that are safety, effectiveness of care and patient experience. Finally, the trust board has tested these outcomes with the views of staff and patients, general public and statutory bodies. This structure of engagement is described in the Quality Account. The responses were significant in number. These themes were considered by the trust board and they resonated with the views of our clinical policy group hence the priorities for future years.
Policies

The trust has put controls in place to ensure the quality of care provided and accuracy of the data used in the Quality Account. This is not an exhaustive list but key policies include:

- RMP 03 Reporting and management of incidents
- RMP 14 Complaints policy and procedure
- IG104 Records policy
- DQP01 Data quality policy
- IG105 Secure transfer of identifiable information

The trust has an extensive range of clinical governance policies and these are reviewed at appropriate intervals but no later than three years to ensure our operating policies reflect the best practice.

Systems and processes

There is a system and process to report the quality indicators for services from trust board to every level in the trust. Each service has a range of national quality indicators and these are extracted from the information centre data source and reported by service line to the trust board at monthly intervals. Any high risk issues (red rated) are considered by the finance, performance and investment committee and an appropriate action plan agreed.

Furthermore the clinical audit plan reports on the performance of the national and local clinical audits at quarterly intervals to the trust board and the Safety and Quality Committee highlight any high risk issues to the trust board with an appropriate action plan agreed. The internal and clinical audit plans are also aligned to the trust’s assurance framework.

Patient experience results have been developed at service line and services now have at least four years of information on the views of outpatients and inpatients, where appropriate.

This year, we have continued to develop our quality panels which provide the trust board with a detailed assessment of the quality, safety and leadership effectiveness for each of the services we offer.

This service line information sits alongside established patient experience data to allow for a comprehensive assessment of quality. These panels rely on a face-to-face assessment as well as analysis of a wide range of information gathered in advance including ward observation.

People and skills

The Quality Account describes the focus on people and skills in the trust. There are three key elements described. Firstly, the outcomes of services to patients are delivered by highly-qualified and skilled individuals. The trust has robust policies for the recruitment and the development of staff. Secondly, mandatory and statutory training of staff is a key performance indicator and this is also reported to the trust board at quarterly intervals. Thirdly, results of the 2014 NHS staff survey, which the Trust achieved the highest response
rate in the country of 82 per cent, show that the majority of our staff would recommend the
trust as a place to work or receive treatment, putting Northumbria Healthcare in the top 20
per cent of all NHS organisations nationally in 25 of the 29 elements. Overall, the survey
provides some excellent results however we will continue to focus on areas for
improvement.

Data use and reporting

Good quality information underpins the effective delivery of patient care and is essential if
improvements in quality of care are to be made. Improving data quality, which includes the
quality of ethnicity and other equality data, will thus improve patient care and improve value
for money. The trust was again shortlisted (i.e. was in the top three) for the data quality
prize in the 2014 CHKS awards. We have won the award twice, the last time being in 2013.

The trust was subject to a payment by results clinical coding audit by Monitor during January
2015, and 200 cases were audited. The results enable the trust to score itself at level 3 (the
highest possible score) for the appropriate information governance toolkit requirement. The
trust’s information governance assessment report overall score for 2014/15 was 94 per cent,
which was graded green, because for all requirements attainment level 2 or above was
achieved.

The trust has robust procedures to ensure that the quality and accuracy of elective waiting
time data reported is as high. There is detailed guidance followed by the analysts each
month in producing the elective waiting time data reports for NHS England and the trust
board.

The external audit of the quality account found issues with the referral to Treatment (RTT)
national priority indicator (18 week indicator). The Trust had not kept the supporting data
relating to April 2014 to January 2015 for the RTT indicator and was unable to recover the
required information from its Patient Administration System. The trust has since ensured
that this supporting data is collected and retained.

Review of effectiveness

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

The trust board supported by the Audit Committee and Assurance Committee has routinely
reviewed the trust’s system of internal control and governance framework, together with
the trust’s integrated approach to achieving compliance with the CQC essential safety and
quality outcomes. The assurance framework provides the trust board with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

The Audit Committee have provided the trust board with an independent and objective review of internal financial control within the trust by reflecting on the trust financial report to the trust board.

The Finance Investment and Performance Committee and Safety and Quality Committee provides the trust board with an integrated clinical governance report at quarterly intervals and the former subcommittee of the trust board ensures the quarterly compliance on governance issues are delivered and immediate action is taken should performance not be in line with the target set by the trust board.

Clinical audit is given a high importance in Northumbria. The annual clinical audit plan is agreed by the Safety and Quality Committee and the annual plan reflects the priorities of the trust board and the national best practice, for example, NICE clinical guidelines, national confidential enquiries, NHS frameworks, high level enquiries and other nationally agreed guidance is taken into account in the context of clinical services provided by the organisation. A quarterly review of progress against the plan is reported to the safety and quality committee and to the trust board via an integrated governance report. Any significant issues that emerge are reported to the trust board and a service improvement plan or trust wide quality improvement is approved.

Internal audit has reviewed and reported upon control, governance and risk management processes, based on an audit plan approved by the Audit Committee. The work included identifying and evaluating controls and testing their effectiveness, in accordance with NHS Internal audit standards. Where scope for improvement was found, recommendations were made and appropriate action plans agreed with management.

The head of internal audit opinion statement has been received on the effectiveness of the system of internal control giving significant assurance.

**Conclusion**

The overall opinion is that no significant internal control issues have been identified and therefore significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation’s objectives, and that controls are generally being applied consistently.

Signed

![Signature]

Jim Mackey
Chief Executive
29 May 2015
13. Directors disclosures in the public interest

Actions taken by the trust to maintain or develop the provision of information to, and consultation with, employees

The trust continues to work in partnership with staff side to ensure that employees are provided with sufficient information and are consulted with on key strategic and operational issues. This year the trust has undertaken a significant change management exercise in relation to the opening of the Northumbria Specialist Emergency Care Hospital in partnership with staff side and the consultation and information process has to date been a great success. The trust has an active Trust Partnership Committee of key management and staff side representatives who have continued to meet regularly over the last twelve months to discuss contemporary strategic issues and agree key communication messages to staff at all times.

The trust’s policies in relation to disabled employees and equal opportunities

The trust has a strong equality and diversity programme with a dedicated lead appointed within the trust. During 2014/15 the trust participated in the NHS Employers Equality Partners Programme and also made significant progress on its rating with the Stonewall Equality Index and also progressed its rating in the Healthcare Equality Index. The trust has active and well represented staff network groups for disabled and LGBT employees. These groups actively work with key strategic members of the trust to ensure that staff are listened to and that positive interventions to support these staff groups within the workplace take place. The trust has also won several awards for its work in relation to equality and diversity during 2014/15.

Information on health and safety performance and occupational health

The trust’s Health and Safety Committee continues to have strong representation from across the trust (including occupational health) with positive delivery of agreed objectives taking place during 2014/15. The trust’s occupational health and health psychology service have continued to strengthen their work on resilience and mental health and they have delivered ambitious programmes on mental health triage, bereavement pathway and musculoskeletal support for staff as key areas identified where progress can be made. Introduction of safety needles and an active project on needle stick injuries has been facilitated through collaborative working across areas of the trust.

Going Concern

After making enquiries, the directors reasonably expect that Northumbria NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Directors’ declaration on audit information

So far as the directors are aware, there is no relevant audit information of which the auditors are unaware and the directors have taken all steps that they ought to as directors in
order to make themselves aware of any relevant information and to ensure the auditors were aware of that information.

The directors consider the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary patients, regulators and stakeholders to assess the Trust’s performance, business model and strategy.

**Income disclosures**

In 14/15 the trust met its requirement that income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes as defined under section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

All net income from the provision of goods and services for other purposes has been reinvested by the trust into front line healthcare for the benefit of patients.

**Late payment interest**

Legislation is in force which requires trusts to pay interest to small companies if payment is not made within 30 days (Late payment of Commercial Debts (Interest) Act 1998). We were not required to make any such payment during the year.

**Better payment practice code**

The code provides that all payments due to our non-NHS suppliers and contractors are made within thirty days of the receipt of the goods or services unless other terms have been agreed. We are working towards full compliance with the code and, in particular, make payments to small and local businesses within ten days. No payments of interest have been paid under the Late Payment of Commercial Debts (interest) Act 1998.

**Statement of compliance with cost allocation and charging requirements**

We have complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance.

**Countering fraud and corruption**

We expect an absolute standard of honesty and integrity from those who manage our funds and assets. The trust board receive a presentation from the local counter fraud specialist on an annual basis. This gives the board an opportunity to endorse the commitment of the trust in relation to counter fraud. We are committed to the prevention of fraud and corruption and when it is suspected it is investigated thoroughly and appropriate action is taken. We follow best practice as recommended by the NHS Counter Fraud and Security Management Service and participate in the National Fraud Initiative led by the Audit Commission. We continue to train our staff in fraud awareness and to promote the mechanism for staff to report any concerns about potential fraud or corruption. All concerns are investigated by the local counter fraud and security management specialist and the outcome of all investigations are reported to the audit committee.
Consultations completed in the previous year, consultations in progress at the date of the report, or consultations planned for the coming year

None

Consultation with local groups and organisations, including the overview and scrutiny committees of local authorities covering the membership areas

Representatives from the trust attend local overview and scrutiny meetings at North Tyneside and Northumberland local authorities, providing detailed briefings as and when requested. This has included discussing the latest developments about the Northumbria Specialist Emergency Care Hospital, a briefing on health informatics, a presentation on what future clinical developments could mean for the NHS and the development of the trust’s Quality Account.

In addition, the trust’s engagement forum, which was established in 2012 to strengthen partnership working with voluntary and community sector organisations and groups across North Tyneside and Northumberland, continued to meet. During the year, there were four meetings with topics for discussion including care of the dying, transport to and from hospital and the new Northumbria Specialist Emergency Care Hospital and what it will mean for patients.

Any other public and patient involvement activities

The trust has stakeholder, governor and member engagement plans in place to support trust activity. This year, communication and engagement has concentrated on informing patients, members, governors, stakeholders and the public about the new specialist emergency care hospital in Cramlington, the new model of emergency care and how these changes affect their local general or community hospital. We also continue to involve everyone about their views on our priorities for the coming year as part of the annual planning process.
14. Statement of the chief executive's responsibilities as the accounting officer of Northumbria Healthcare NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by Monitor.

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

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

- Observe the accounts direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- 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 to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Jim Mackey
Chief Executive
29 May 2015
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Foreword to the accounts

Northumbria Healthcare NHS Foundation Trust

These accounts for the year ended 31st March 2015 have been prepared on a going concern basis by Northumbria Healthcare NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 in the form which Monitor, the Independent Regulator of the NHS Foundation Trust, has, with the approval of the Treasury, directed.

Signed

Jim Mackey
Chief Executive

Date 29th May 2015
Northumbria Healthcare NHS Foundation Trust – Annual Accounts 2014/15

Statement of the chief executive's responsibilities as the accounting officer of

Northumbria Healthcare NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by Monitor.

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

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

- Observe the accounts direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- 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 to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Jim Mackey
Chief Executive
29 May 2015
Annual Governance Statement
1 April 2014 to 31 March 2015

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Northumbria Healthcare NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Northumbria Healthcare NHS Foundation Trust throughout the year ended 31 March 2015 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

The leadership and accountability arrangements for the chief executive officer, board of directors, business unit directors, clinical directors, general managers, department heads, operational service managers and all staff are set out in the trust’s Risk Management Strategy and Policy. In addition, there are clear terms of reference for the key committees involved with risk. The trust has appointed a senior independent director to be available to governors and members if they have concerns which contact through the normal channels of chairman, chief executive or finance director has failed to resolve or for which such contact is inappropriate.

The trust employs appropriately-qualified staff who specialise in risk management and health and safety matters. Risk management awareness and health and safety training is delivered to all new members of staff on the first day of employment and to existing staff through mandatory training programmes. There is also the facility for all staff to undertake further training in health and safety using e-learning. Relevant policies are specific as regards accountabilities and responsibilities for all staff groups. Systems and procedures are in place to support staff in managing risk and carrying out their duties. All job descriptions include specific reference to requirements regarding risk management, infection control and health and safety. Good practice in risk management, both within the trust and nationally, is shared across the trust through newsletters and periodic reports.

The risk and control framework

Risks are identified proactively through risk assessment processes, our quality management system which includes harm review and mortality reviews and reactively through the monitoring of key business objectives, incidents, complaints and claims. We also use the Monitor Quality Governance Assessment. These risks are evaluated through the use of a risk assessment matrix and controlled through a risk register system. All high risks are considered by the Assurance Committee, assessed for strategic impact and if appropriate added to the trust’s assurance framework. The trust’s assurance framework sets out the principal risks to deliver key priorities and objectives and these are confirmed by the trust board following the annual risk assessment to deliver our annual and five-year plans. The assurance framework identifies the assurances available to the trust board in relation to the achievement of the trust’s key priorities and objectives. The principal risks to the delivery of these objectives are mapped to key controls. The trust board requires the assurance that the assurance framework identifies, those actions required to address gaps in control and assurance, and the development and implementation of action plans. All risks will be managed and mitigated and outcomes will be assessed through the assurance framework process.

The trust identified a number of major risks during 2014/15;
The economic climate with an anticipated reduction in funding of 15-20% over the next three years

Acquisition of North Cumbria University Hospital Trust (NCUH), the trust was confirmed as the preferred bidder in January 2012. The original acquisition timescales have been delayed as a result of North Cumbria being placed into special measures following the outcome of Sir Bruce Keogh’s review into the quality of care and treatment provided by 14 hospital trusts in England. North Cumbria University Hospital acquisition cannot take place until the trust demonstrates sufficient improvement to be removed from this status. Northumbria has been formally identified as ‘buddy’ to North Cumbria University Hospital, providing peer support and advice to enable necessary improvements.

The significant clinical risks were;

- The trust experienced extremely high numbers of patients attending its accident and emergency (A&E) departments, especially during the winter months. This sustained level of activity put the achievement of the A&E four-hour wait target at risk and also led to an increase in the number of boarded patients. Through careful management and monitoring the trust was able to ensure adherence to the national four-hour wait target.
- European Working Time Directive especially in the surgical specialties. Locums are in place however the best long-term solution is permanent staff in posts.
- Northumbria Specialist Emergency Care Hospital - this is a significant capital development to improve emergency and children’s care. Monthly monitoring is in place to report progress to the trust board.
- MRSA at the beginning of the year the trust’s annual target was to have no MRSA bacteraemia cases, with a deminimus level of 6. At the end of March 2015 the trust had been apportioned a total of three cases.
- Clostridium Difficile - our annual target for 2014/15 was to have no more than 30 cases of hospital acquired C.difficile. At the end of March 2015 the trust had reported 30 cases.
- Surgical site infections – the trust was identified as an outlier for the national average for knee and hip replacements. Root cause analyses of all infections have led to a number of clinical changes that were implemented with immediate effect. Actions continue to be monitored and reported to the trust board.
- Pressure ulcers and falls were identified from incident reporting as key areas for improvement during 2014/15. Action plans were introduced in the year to address these areas with an overall improvement in the rate of both hospital acquired pressure ulcers and falls with harm.
- The trust board also recognises that collectively the risks outlined above could present an overarching risk to the trust in terms of management capacity depending on the timing of major projects.

The safety and quality committee is a sub-committee of the trust board and is chaired by a non-executive director. This sub-committee, in conjunction with the trust board, has responsibility for producing the strategic safety and quality vision, strategic goals and an implementation plan by horizon scanning and learning from the best evidence available. The committee reports to the trust board through a quarterly report on progress with the strategic objectives and produces the draft annual Quality Account for consideration by the trust board.

There are robust arrangements in place to provide assurance on the quality of performance information. This is known as our data quality standards and these are reported quarterly to our safety and quality committee, information, management and technology committee and trust board. The trust is compliant with level 2 of the information governance standards. The trust has an information governance group and reports to the information, management and technology committee and to the trust board. Finally, there is an annual independent review by the trusts internal auditors which covers the performance information included as part of the Monitor governance declaration.

The trust has arrangements to monitor compliance with the Care Quality Commission (CQC) registration requirements through completion of provider compliance assessments for each of the 16 essential safety and quality standards. Each safety and quality standard has an executive director lead and evidence of compliance is provided to the assurance committee at quarterly intervals. Additionally, there is monitoring of the trust’s ‘Intelligent Monitoring Report’ produced by the CQC on a quarterly basis.

The trust is fully compliant with the registration requirements of the CQC. During 2014/15 the trust did not receive any inspections from the CQC in respect of the essential safety and quality standards.
Business unit operational boards, the health and safety steering group and the assurance committee play key roles in evaluating and prioritising risk. It is accepted that all risks cannot be eliminated. An acceptable risk is one which has been appropriately risk assessed and the risks reduced to the lowest possible level.

Incident reporting is openly encouraged and handled across the trust. The trust has fully endorsed this principle. All serious untoward incidents and significant learning events are investigated by a senior clinician and manager and reported to the appropriate business unit board to agree on the action plan and monitor implementation. In addition, the most serious incidents are reviewed by the trust’s safety panel, which provides independent scrutiny of incident investigations and monitoring of the completion of action plans arising from such investigations.

Trust-wide learning is agreed at our clinical policy group. All serious incidents are reported to the trust board including the appropriate immediate action plan and embedded action plan. Sharing the lessons learnt is by cascade via the clinical policy group via the management teams to the ward management team.

The trust has worked closely with partner organisations to explore, understand, quantify and minimise potential risks which may impact upon other organisations and public stakeholders. Issues identified through the trust’s risk management process that impact on partner organisations and public stakeholders will be discussed in the appropriate forum so that action can be agreed.

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

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

The trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation’s obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

The process to maintain and review the effectiveness of the system of internal control in relation to the Quality Account was fully considered by Audit Committee and subsequently by the trust board. The outcome was that we already have a strong and robust internal audit system to review our process for self-assessment against the CQC standards and this has been in place for three years.

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

The trust has robust arrangements in place for setting objectives and targets on a strategic and annual basis. These arrangements include ensuring the financial strategy is affordable, scrutiny of cost savings plans to ensure achievement, compliance with terms of authorisation and coordination of individual objectives with corporate objectives as identified in the Annual Plan.

Performance against objectives is monitored and actions identified through a number of channels:

- Approval of annual budget by the trust board.
- Monthly reporting to the trust board on key performance indicators covering finance, activity, patient safety and quality, human resources targets and information, management and technology bi-monthly.
- Monthly review of financial and performance targets by the finance investment and performance committee, which is a committee of the trust board.
- Weekly reporting to executive team on key influences on the trust’s financial position.
- Monthly reporting to business units through the budgetary control and risk system.
- Periodic performance management of business units by the executive team covering performance against key objectives.
- Quarterly reporting to Monitor and compliance with terms of authorisation.
The trust also participates in initiatives to ensure value for money for example:

- Subscribes to the Foundation Trust Network benchmarking organisation that provides comparative information analysis on productivity and clinical indicators for high risk specialties
- Participates in top performing national initiatives with the Institute of Innovation and Learning to learn best practice in international sites
- CQC information that identifies key performance indicators and measures these over time to focus attention on areas for improvement.
- Value for money is an important component of the internal and external audit plans that provides assurance to the trust of processes that are in place to ensure effective use of resources.

The trust has a standard assessment process for future business plans to ensure value for money and full appraisal processes are employed when considering the effect on the organisation. Procedures are in place to ensure all strategic decisions are considered at executive and board level.

The emphasis in internal audit work is providing assurances on internal controls, risk management and governance systems to the audit committee and to the trust board. Where scope for improvement in terms of value for money was identified during an internal audit review, appropriate recommendations were made and actions were agreed with management for implementation.

The trust follows best practice as recommended by the NHS Counter Fraud and Security Management Service and participates in the National Fraud Initiative led by the Audit Commission. Staff are trained in fraud awareness and the trust actively promotes the mechanism for staff to report any concerns about potential fraud or corruption. All concerns are investigated by the local counter fraud and security management specialist and the outcome of all investigations are reported to the audit committee.

The trust was also assessed by external auditors KPMG under the Auditors Local Evaluation (ALE) which reviews internal control and value for money. The overall assessment for 2013/14 was level 4 – performing strongly. All internal audit reviews of material financial systems during 2014/15 resulted in significant assurance.

**Information governance**

The trust has measures in place to ensure the security of its information resources and assets. The trust continues to achieve a high level of compliance to the standards in the NHS Information Governance Toolkit supported by audit giving significant assurance of compliance with standards. An action plan has been developed where gaps have been identified and this will be monitored by the Information, Management and Technology Committee. The trust reported five losses of data under the arrangements for reporting serious untoward incidents. One incident involved inappropriate access of confidential information and the others related to confidential information being disclosed in error. All incidents were reported to the Information Commissioner’s Office who was satisfied that no formation action was necessary and the cases were now closed.

**Quality Account**

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

The Quality Account represents a balanced view and there are appropriate controls in place to ensure the accuracy of the data. The following provides evidence of the steps in place to provide this assurance:

**Governance and leadership**

This is the sixth year of developing of Quality Accounts for Northumbria Healthcare NHS Foundation Trust. The trust has a quality management system in place based on the Institute of Medicine definition of quality. This quality management system ensures that a balanced scorecard of quality standards and indicators is considered by the trust board. Furthermore, the direction by the Department of Health medical director that boards of directors must review all their services over a reasonable period has placed a commitment on trust boards to review all services over a three-year period based on the three quality indicators that are safety, effectiveness of care and patient experience. Finally, the trust board has tested these outcomes
with the views of staff and patients, general public and statutory bodies. This structure of engagement is
described in the Quality Account. The responses were significant in number. These themes were considered
by the trust board and they resonated with the views of our clinical policy group hence the priorities for
future years.

Policies

The trust has put controls in place to ensure the quality of care provided and accuracy of the data used in
the Quality Account. This is not an exhaustive list but key policies include:

- RMP 03 Reporting and management of incidents
- RMP 14 Complaints policy and procedure
- IG104 Records policy
- DQP01 Data quality policy
- IG105 Secure transfer of identifiable information

The trust has an extensive range of clinical governance policies and these are reviewed at appropriate
intervals but no later than three years to ensure our operating policies reflect the best practice.

Systems and processes

There is a system and process to report the quality indicators for services from trust board to every level in
the trust. Each service has a range of national quality indicators and these are extracted from the
information centre data source and reported by service line to the trust board at monthly intervals. Any
high risk issues (red rated) are considered by the finance, performance and investment committee and an
appropriate action plan agreed.

Furthermore the clinical audit plan reports on the performance of the national and local clinical audits at
quarterly intervals to the trust board and the Safety and Quality Committee highlight any high risk issues to
the trust board with an appropriate action plan. The internal and clinical audit plans are also aligned to the
trust’s assurance framework.

Patient experience results have been developed at service line and services now have at least four years of
information on the views of outpatients and inpatients, where appropriate.

This year, we have continued to develop our quality panels which provide the trust board with a detailed
assessment of the quality, safety and leadership effectiveness for each of the services we offer.

This service line information sits alongside established patient experience data to allow for a comprehensive
assessment of quality. These panels rely on a face-to-face assessment as well as analysis of a wide range of
information gathered in advance including ward observation.

People and skills

The Quality Account describes the focus on people and skills in the trust. There are three key elements
described. Firstly, the outcomes of services to patients are delivered by highly-qualified and skilled
individuals. The trust has robust policies for the recruitment and the development of staff. Secondly,
mandatory and statutory training of staff is a key performance indicator and this is also reported to the trust
board at quarterly intervals. Thirdly, results of the 2014 NHS staff survey, which the Trust achieved the
highest response rate in the country of 82 per cent, show that the majority of our staff would recommend
the trust as a place to work or receive treatment, putting Northumbria Healthcare in the top 20 per cent of
all NHS organisations nationally in 25 of the 29 elements. Overall, the survey provides some excellent
results however we will continue to focus on areas for improvement.

Data use and reporting

Good quality information underpins the effective delivery of patient care and is essential if improvements in
quality of care are to be made. Improving data quality, which includes the quality of ethnicity and other
equality data, will thus improve patient care and improve value for money. The trust was again shortlisted
(i.e. was in the top three) for the data quality prize in the 2014 CHKS awards. We have won the award
twice, the last time being in 2013.
The trust was subject to a payment by results clinical coding audit by Monitor during January 2015, and 200 cases were audited. The results enable the trust to score itself at level 3 (the highest possible score) for the appropriate information governance toolkit requirement. The trust’s information governance assessment report overall score for 2014/15 was 94 per cent, which was graded green, because for all requirements attainment level 2 or above was achieved.

The trust has robust procedures to ensure that the quality and accuracy of elective waiting time data reported is as high. There is detailed guidance followed by the analysts each month in producing the elective waiting time data reports for NHS England and the trust board.

The external audit of the quality account found issues with the referral to Treatment (RTT) national priority indicator (18 week indicator). The Trust had not kept the supporting data relating to April 2014 to January 2015 for the RTT indicator and was unable to recover the required information from its Patient Administration System. The trust has since ensured that this supporting data is collected and retained.

Review of effectiveness

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

The trust board supported by the Audit Committee and Assurance Committee has routinely reviewed the trust’s system of internal control and governance framework, together with the trust’s integrated approach to achieving compliance with the CQC essential safety and quality outcomes. The assurance framework provides the trust board with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

The Audit Committee have provided the trust board with an independent and objective review of internal financial control within the trust by reflecting on the trust financial report to the trust board.

The Finance Investment and Performance Committee and Safety and Quality Committee provides the trust board with an integrated clinical governance report at quarterly intervals and the former subcommittee of the trust board ensures the quarterly compliance on governance issues are delivered and immediate action is taken should performance not be in line with the target set by the trust board.

Clinical audit is given a high importance in Northumbria. The annual clinical audit plan is agreed by the Safety and Quality Committee and the annual plan reflects the priorities of the trust board and the national best practice, for example, NICE clinical guidelines, national confidential enquiries, NHS frameworks, high level enquiries and other nationally agreed guidance is taken into account in the context of clinical services provided by the organisation. A quarterly review of progress against the plan is reported to the safety and quality committee and to the trust board via an integrated governance report. Any significant issues that emerge are reported to the trust board and a service improvement plan or trust wide quality improvement is approved.

Internal audit has reviewed and reported upon control, governance and risk management processes, based on an audit plan approved by the Audit Committee. The work included identifying and evaluating controls and testing their effectiveness, in accordance with NHS Internal audit standards. Where scope for improvement was found, recommendations were made and appropriate action plans agreed with management.

The head of internal audit opinion statement has been received on the effectiveness of the system of internal control giving significant assurance.
Conclusion

The overall opinion is that no significant internal control issues have been identified and therefore significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation’s objectives, and that controls are generally being applied consistently.

Signed

Jim Mackey
Chief Executive
29th May 2015
INDEPENDENT AUDITOR’S REPORT TO THE COUNCIL OF GOVERNORS OF NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST ONLY

Opinions and conclusions arising from our audit

1 Our opinion on the financial statements is unmodified

We have audited the financial statements of Northumbria Healthcare NHS Foundation Trust for the year ended 31 March 2015 set out on pages 1 to 39. In our opinion:

- the financial statements give a true and fair view of the state of the Group’s and the Trust’s affairs as at 31 March 2015 and of the Group’s and the Trust’s income and expenditure for the year then ended; and

- the financial statements have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

2 Our assessment of risks of material misstatement

In arriving at our audit opinion above on the financial statements the risks of material misstatement that had the greatest effect on our audit were as follows:

Valuation of land and buildings - £208 million

Refer to Annual Report page 56 (Audit Committee Report), Annual Accounts pages 8 and 9 (accounting policy) and pages 24 to 25 (financial disclosures).

The risk: Land and buildings are required to be maintained at up to date estimates of year-end market value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, the depreciated replacement cost of a modern equivalent asset that has the same service potential as the existing property (MEAV). There is significant judgment involved in determining the appropriate basis (EUV or MEAV) for each asset according to the degree of specialization, as well as over the assumptions made in arriving at the valuation and the condition of the asset. In particular the MEAV basis requires an assumption as to whether the replacement asset would be situated on the existing site or, if more appropriate, on an alternative site, with a potentially significant effect on the valuation. Further, replacement cost is decreased if VAT on replacement costs is recoverable due to the transfer of assets to a property management subsidiary and so an assumption is required as to whether recovery will be made.

As at 31 March 2015 the Group commissioned a revaluation of land and building by an external valuer. A full valuation was performed for assets not in the scope of the previous valuation (undertaken at 31 March 2014) totaling £87m and a “desk-top” revaluation without physical inspection for the remaining assets totaling £121m.

Our response: In this area our audit procedures included:

- assessing the competence, capability, objectivity and independence of the Group’s external valuer and considering the terms of engagement of, and the instructions issued to, the valuer for consistency with the requirements of the NHS Foundation Trust Annual Reporting Manual;

- critically assessing with the assistance of our own valuation specialists the appropriateness of the valuation bases and assumptions applied to a sample of higher value assets by reference to the RICS Valuation Professional Standards (Red Book);
confirming the source of the data used by the valuers in respect of build costs and assessing whether this is appropriate;

critically assessing, in the light of our knowledge of the Trust’s assets and changes in market conditions, whether any significant movements in values since the last valuation are appropriate;

critically reviewed the assumption that DRC should be net of VAT on the grounds that the Trust’s property is held by a subsidiary that can recover VAT on construction costs. We confirmed the tax status of the subsidiary by review of correspondence with HMRC; and

considering the adequacy of the disclosures about the key judgments and degree of estimation involved in arriving at the valuation and the related sensitivities.

Our application of materiality and an overview of the scope of our audit

The materiality for the financial statements was set at £5.67m, determined with reference to a benchmark of income from operations (of which it represents 1.22%). We consider income from operations to be more stable than a surplus related benchmark.

We report to the audit committee any corrected and uncorrected identified misstatements exceeding £250k, in addition to other identified misstatements that warrant reporting on qualitative grounds.

The Group has three reporting components and these were subject to audits for group reporting purposes performed by the Group audit team at the Group’s Head Office in Newcastle Upon Tyne. These audits covered 100% of group income, deficit for the year and total assets. The audits performed for group reporting purposes were all performed to materiality levels set individually for each component and ranged from £0.847m to £5.65m.

4 Our opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts is unmodified

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 2014/15; and

- the information given in the Strategic Report and the Directors’ Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

5 We have nothing to report in respect of the matters on which we are required to report by exception

Under ISAs (UK and Ireland) we are required to report to you if, based on the knowledge we acquired during our audit, we have identified other information in the annual report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.

In particular, we are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our audit and the directors’ statement that they consider that the annual report and accounts taken as a whole is fair, balanced and understandable and provides the
information necessary for patients, regulators and other stakeholders to assess the Group’s performance, business model and strategy; or

- the Annual Report does not appropriately address matters communicated by us to the audit committee.

Under the Audit Code for NHS Foundation Trusts we are required to report to you if in our opinion:

- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15, is misleading or is not consistent with our knowledge of the Group and other information of which we are aware from our audit of the financial statements.

- the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources

We have nothing to report in respect of the above responsibilities.

**Certificate of audit completion**

We certify that we have completed the audit of the accounts of Northumbria Healthcare NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Our certificate is qualified in accordance with paragraph 5.12 of the Audit Code as whilst we have issued a limited assurance opinion in relation to the content of the quality report and 62 day Cancer Waits, we have not issued an opinion in relation to the Trust’s other mandated indicator (18 week Referral to Treatment).

**Respective responsibilities of the accounting officer and auditor**

As described more fully in the Statement of Accounting Officer’s Responsibilities on page (i) the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors.

**Scope of an audit of financial statements performed in accordance with ISAs (UK and Ireland)**

A description of the scope of an audit of financial statements is provided on our website at [www.kpmg.com/uk/auditscopeother2014](http://www.kpmg.com/uk/auditscopeother2014). This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

**The purpose of our audit work and to whom we owe our responsibilities**

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

Paul Moran (Senior Statutory Auditor)
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
Quayside House,
110 Quayside,
Newcastle upon Tyne,
NE1 3DX

29 May 2015
### CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME

<table>
<thead>
<tr>
<th>Note</th>
<th>Group Year Ending 31 March</th>
<th>Foundation Trust Year Ending 31 March</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015 £000</td>
<td>2014 £000</td>
</tr>
<tr>
<td>Operating income</td>
<td>3</td>
<td>461,368</td>
</tr>
<tr>
<td>Operating expenses - termination of PFI contract</td>
<td>4.1</td>
<td>12,242</td>
</tr>
<tr>
<td>Operating expenses - other</td>
<td>4.1</td>
<td>(461,299)</td>
</tr>
<tr>
<td>Total Operating expenses</td>
<td>4</td>
<td>(449,057)</td>
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<tr>
<td>Total operating surplus / (deficit)</td>
<td></td>
<td>12,311</td>
</tr>
<tr>
<td>Finance Costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance income</td>
<td>5</td>
<td>295</td>
</tr>
<tr>
<td>Finance expense</td>
<td>6</td>
<td>(12,477)</td>
</tr>
<tr>
<td>Finance expense - unwinding of discount on provisions</td>
<td>24</td>
<td>(105)</td>
</tr>
<tr>
<td>Finance expense - unwinding of discount on creditors</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>PDC dividends payable</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Net Finance Costs</td>
<td></td>
<td>(12,287)</td>
</tr>
<tr>
<td>Movement in fair value of other investments</td>
<td>35</td>
<td>54</td>
</tr>
<tr>
<td>(Surplus) / deficit</td>
<td></td>
<td>78</td>
</tr>
<tr>
<td>Other comprehensive income / (expense)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impairments</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Revaluations</td>
<td>10</td>
<td>(344)</td>
</tr>
<tr>
<td>Total comprehensive income / (expense) for the year</td>
<td></td>
<td>(266)</td>
</tr>
</tbody>
</table>

#### Note: Allocation of surplus / (deficit) for the year:

<table>
<thead>
<tr>
<th>Note</th>
<th>Group Year Ending 31 March</th>
<th>Foundation Trust Year Ending 31 March</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015 £000</td>
<td>2014 £000</td>
</tr>
<tr>
<td>(a) (Surplus) / deficit for the period attributable to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) minority interest, and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) owners of the parent.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) Total comprehensive income / (expense) for the year attributable to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) minority interest, and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) owners of the parent.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The notes on pages 1 to 39 form part of these accounts. All income and expenditure is derived from continuing operations.
## STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2015 - GROUP AND TRUST

<table>
<thead>
<tr>
<th>Non-current assets</th>
<th>Note</th>
<th>Group 31 March 2015 £000</th>
<th>31 March 2014 £000</th>
<th>Foundation Trust 31 March 2015 £000</th>
<th>31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intangible assets</td>
<td>8.1</td>
<td>3,593</td>
<td>4,135</td>
<td>3,593</td>
<td>4,135</td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>10.1</td>
<td>237,727</td>
<td>223,046</td>
<td>233,913</td>
<td>174,732</td>
</tr>
<tr>
<td>Other Investments - subsidiaries</td>
<td>14</td>
<td>50</td>
<td>60</td>
<td>78,490</td>
<td>48,977</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>35</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Investments</td>
<td>35</td>
<td>637</td>
<td>583</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>16</td>
<td>1,080</td>
<td>550</td>
<td>1,080</td>
<td>550</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td></td>
<td><strong>243,087</strong></td>
<td><strong>228,374</strong></td>
<td><strong>317,076</strong></td>
<td><strong>228,394</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current assets</th>
<th></th>
<th><strong>79,920</strong></th>
<th><strong>192,744</strong></th>
<th><strong>80,059</strong></th>
<th><strong>189,088</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inventories</td>
<td>15</td>
<td>10,936</td>
<td>9,708</td>
<td>10,936</td>
<td>9,708</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>16</td>
<td>40,200</td>
<td>46,479</td>
<td>42,787</td>
<td>46,245</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>35</td>
<td>350</td>
<td>1,250</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Assets held for sale</td>
<td>12</td>
<td>2,885</td>
<td>0</td>
<td>2,885</td>
<td>0</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>26</td>
<td>25,549</td>
<td>135,307</td>
<td>23,451</td>
<td>133,135</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td></td>
<td><strong>79,920</strong></td>
<td><strong>192,744</strong></td>
<td><strong>80,059</strong></td>
<td><strong>189,088</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Liabilities</th>
<th></th>
<th><strong>62,894</strong></th>
<th><strong>188,344</strong></th>
<th><strong>63,956</strong></th>
<th><strong>186,913</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade and other payables</td>
<td>18</td>
<td>(46,794)</td>
<td>(52,537)</td>
<td>(44,725)</td>
<td>(46,640)</td>
</tr>
<tr>
<td>Interest bearing borrowings</td>
<td>20</td>
<td>(8,412)</td>
<td>(68,528)</td>
<td>(11,543)</td>
<td>(68,528)</td>
</tr>
<tr>
<td>Provisions</td>
<td>24</td>
<td>(438)</td>
<td>(54,729)</td>
<td>(438)</td>
<td>(54,729)</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>19</td>
<td>(7,250)</td>
<td>(12,550)</td>
<td>(7,250)</td>
<td>(17,016)</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td></td>
<td><strong>(62,894)</strong></td>
<td><strong>(188,344)</strong></td>
<td><strong>(63,956)</strong></td>
<td><strong>(186,913)</strong></td>
</tr>
<tr>
<td><strong>Total assets less current liabilities</strong></td>
<td></td>
<td><strong>260,113</strong></td>
<td><strong>232,774</strong></td>
<td><strong>333,179</strong></td>
<td><strong>230,569</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-current liabilities</th>
<th></th>
<th><strong>(223,335)</strong></th>
<th><strong>(197,628)</strong></th>
<th><strong>(296,281)</strong></th>
<th><strong>(197,628)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade and other payables</td>
<td>18</td>
<td>(7,065)</td>
<td>(3,870)</td>
<td>(4,865)</td>
<td>(3,870)</td>
</tr>
<tr>
<td>Other Liabilities</td>
<td>19</td>
<td>(2,092)</td>
<td>0</td>
<td>(2,092)</td>
<td>0</td>
</tr>
<tr>
<td>Interest bearing borrowings</td>
<td>20</td>
<td>(206,290)</td>
<td>(190,417)</td>
<td>(281,436)</td>
<td>(190,417)</td>
</tr>
<tr>
<td>Employee benefits</td>
<td>23</td>
<td>(1,080)</td>
<td>(550)</td>
<td>(1,080)</td>
<td>(550)</td>
</tr>
<tr>
<td>Provisions</td>
<td>24</td>
<td>(6,808)</td>
<td>(2,791)</td>
<td>(6,808)</td>
<td>(2,791)</td>
</tr>
<tr>
<td><strong>Total non-current liabilities</strong></td>
<td></td>
<td><strong>(223,335)</strong></td>
<td><strong>(197,628)</strong></td>
<td><strong>(296,281)</strong></td>
<td><strong>(197,628)</strong></td>
</tr>
<tr>
<td><strong>Total assets employed</strong></td>
<td></td>
<td><strong>36,778</strong></td>
<td><strong>35,146</strong></td>
<td><strong>36,898</strong></td>
<td><strong>32,941</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financed by taxpayer’s equity</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Public dividend capital</td>
<td></td>
<td>148,675</td>
<td>146,777</td>
<td>148,675</td>
<td>146,777</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>25</td>
<td>3,267</td>
<td>4,686</td>
<td>3,267</td>
<td>4,686</td>
</tr>
<tr>
<td>Charitable fund reserve</td>
<td>36</td>
<td>2,935</td>
<td>3,083</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Reserves</td>
<td></td>
<td>(551)</td>
<td>(551)</td>
<td>(551)</td>
<td>(551)</td>
</tr>
<tr>
<td>Income and expenditure reserve</td>
<td></td>
<td>(117,548)</td>
<td>(118,849)</td>
<td>(114,493)</td>
<td>(117,971)</td>
</tr>
<tr>
<td><strong>Total taxpayer’s equity</strong></td>
<td></td>
<td><strong>36,778</strong></td>
<td><strong>35,146</strong></td>
<td><strong>36,898</strong></td>
<td><strong>32,941</strong></td>
</tr>
</tbody>
</table>

The notes on pages 5 to 39 form part of these accounts.

The financial statements on pages 1 to 39 were approved by the Board on the 29th May 2015 and signed on its behalf by:

Jim Mackey
Chief Executive               Dated   29th May 2015
## STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

### Changes in Taxpayer’s Equity for the year ended 31 March 2015

<table>
<thead>
<tr>
<th>Group</th>
<th>Public Dividend Capital £000</th>
<th>Revaluation Reserve £000</th>
<th>Income and Expenditure Reserve £000</th>
<th>Charitable Fund Reserve £000</th>
<th>Other Reserve £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance as at 31 March 2014</td>
<td>146,777</td>
<td>4,686</td>
<td>(118,849)</td>
<td>3,083</td>
<td>(551)</td>
<td>35,146</td>
</tr>
<tr>
<td>PDC received</td>
<td>1,898</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,898</td>
</tr>
<tr>
<td>Total comprehensive income for the year; retained surplus / (deficit) for the year</td>
<td>0</td>
<td>0</td>
<td>155</td>
<td>(77)</td>
<td>0</td>
<td>78</td>
</tr>
<tr>
<td>Transfer between reserves</td>
<td>0</td>
<td>(1,075)</td>
<td>1,146</td>
<td>(71)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments</td>
<td>0</td>
<td>(500)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(500)</td>
</tr>
<tr>
<td>Revaluations - property, plant and equipment</td>
<td>0</td>
<td>156</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>156</td>
</tr>
<tr>
<td>Balance as at 31 March 2015</td>
<td>148,675</td>
<td>3,267</td>
<td>(117,548)</td>
<td>2,935</td>
<td>(551)</td>
<td>36,778</td>
</tr>
</tbody>
</table>

### Changes in Taxpayer’s Equity for the year ended 31 March 2014

<table>
<thead>
<tr>
<th>Group</th>
<th>Public Dividend Capital £000</th>
<th>Revaluation Reserve £000</th>
<th>Income and Expenditure Reserve £000</th>
<th>Charitable Fund Reserve £000</th>
<th>Other Reserve £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance as at 31 March 2013</td>
<td>146,314</td>
<td>3,308</td>
<td>(66,969)</td>
<td>2,925</td>
<td>(551)</td>
<td>85,027</td>
</tr>
<tr>
<td>PDC received</td>
<td>463</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>463</td>
</tr>
<tr>
<td>Total comprehensive income for the year; retained (deficit) / surplus for the year</td>
<td>0</td>
<td>0</td>
<td>52,100</td>
<td>158</td>
<td>0</td>
<td>(51,942)</td>
</tr>
<tr>
<td>Transfer between reserves</td>
<td>0</td>
<td>(220)</td>
<td>220</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Revaluations - property, plant and equipment</td>
<td>0</td>
<td>1,598</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,598</td>
</tr>
<tr>
<td>Balance as at 31 March 2014</td>
<td>146,777</td>
<td>4,686</td>
<td>(117,971)</td>
<td>0</td>
<td>(551)</td>
<td>32,941</td>
</tr>
</tbody>
</table>

### Changes in Taxpayer’s Equity for the year ended 31 March 2015

<table>
<thead>
<tr>
<th>Group</th>
<th>Public Dividend Capital £000</th>
<th>Revaluation Reserve £000</th>
<th>Income and Expenditure Reserve £000</th>
<th>Charitable Fund Reserve £000</th>
<th>Other Reserve £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance as at 31 March 2014</td>
<td>146,777</td>
<td>4,686</td>
<td>(117,971)</td>
<td>0</td>
<td>(551)</td>
<td>32,941</td>
</tr>
<tr>
<td>PDC received</td>
<td>1,898</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,898</td>
</tr>
<tr>
<td>Total comprehensive income for the year; retained deficit for the year</td>
<td>0</td>
<td>0</td>
<td>2,403</td>
<td>0</td>
<td>0</td>
<td>2,403</td>
</tr>
<tr>
<td>Transfer between reserves</td>
<td>0</td>
<td>(1,075)</td>
<td>1,075</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments</td>
<td>0</td>
<td>(500)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(500)</td>
</tr>
<tr>
<td>Revaluations - property, plant and equipment</td>
<td>0</td>
<td>156</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>156</td>
</tr>
<tr>
<td>Balance as at 31 March 2015</td>
<td>148,675</td>
<td>3,267</td>
<td>(114,493)</td>
<td>0</td>
<td>(551)</td>
<td>36,898</td>
</tr>
</tbody>
</table>

### Changes in Taxpayer’s Equity for the year ended 31 March 2014

<table>
<thead>
<tr>
<th>Group</th>
<th>Public Dividend Capital £000</th>
<th>Revaluation Reserve £000</th>
<th>Income and Expenditure Reserve £000</th>
<th>Charitable Fund Reserve £000</th>
<th>Other Reserve £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance as at 31 March 2013</td>
<td>146,314</td>
<td>3,308</td>
<td>(66,621)</td>
<td>0</td>
<td>(551)</td>
<td>82,450</td>
</tr>
<tr>
<td>PDC received</td>
<td>463</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>463</td>
</tr>
<tr>
<td>Total comprehensive income for the year; retained deficit for the year</td>
<td>0</td>
<td>0</td>
<td>(51,570)</td>
<td>0</td>
<td>0</td>
<td>(51,570)</td>
</tr>
<tr>
<td>Transfer between reserves</td>
<td>0</td>
<td>(220)</td>
<td>220</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Revaluations - property, plant and equipment</td>
<td>0</td>
<td>1,598</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,598</td>
</tr>
<tr>
<td>Balance as at 31 March 2014</td>
<td>146,777</td>
<td>4,686</td>
<td>(117,971)</td>
<td>0</td>
<td>(551)</td>
<td>32,941</td>
</tr>
</tbody>
</table>
## Statement of Cashflows

### Cash flows from operating activities

<table>
<thead>
<tr>
<th>Description</th>
<th>Group Year Ending 31 March 2014 £000</th>
<th>Group Year Ending 31 March 2015 £000</th>
<th>Foundation Trust Year Ending 31 March 2014 £000</th>
<th>Foundation Trust Year Ending 31 March 2015 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating surplus / (deficit) from continuing operations</td>
<td>12,311</td>
<td>(41,271)</td>
<td>12,542</td>
<td>(41,399)</td>
</tr>
<tr>
<td>Operating surplus / (deficit)</td>
<td>12,311</td>
<td>(41,271)</td>
<td>12,542</td>
<td>(41,399)</td>
</tr>
</tbody>
</table>

### Non-cash income and expenses

<table>
<thead>
<tr>
<th>Description</th>
<th>Group</th>
<th>Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depreciation and amortisation</td>
<td>8,347</td>
<td>8,347</td>
</tr>
<tr>
<td>Impairments</td>
<td>17,343</td>
<td>17,343</td>
</tr>
<tr>
<td>Reversal of impairments</td>
<td>(3,343)</td>
<td>(3,343)</td>
</tr>
<tr>
<td>Gain on disposals of property, plant and equipment</td>
<td>405</td>
<td>405</td>
</tr>
<tr>
<td>Unwinding of discount on creditors</td>
<td>0</td>
<td>(143)</td>
</tr>
<tr>
<td>Decrease / (increase) in trade and other receivables</td>
<td>5,647</td>
<td>(14,473)</td>
</tr>
<tr>
<td>Increase in inventories</td>
<td>(1,228)</td>
<td>(1,228)</td>
</tr>
<tr>
<td>Increase / (decrease) in trade and other payables</td>
<td>134</td>
<td>4,692</td>
</tr>
<tr>
<td>(Decrease) / increase in other liabilities</td>
<td>(3,208)</td>
<td>3,528</td>
</tr>
<tr>
<td>Increase on other financial assets / investments</td>
<td>954</td>
<td>0</td>
</tr>
<tr>
<td>Unwinding of discount provisions</td>
<td>(105)</td>
<td>39</td>
</tr>
<tr>
<td>Decrease / (increase) in provisions</td>
<td>(50,274)</td>
<td>50,648</td>
</tr>
<tr>
<td><strong>Net cash (absorbed) / generated from operating activities</strong></td>
<td>(13,017)</td>
<td>26,249</td>
</tr>
</tbody>
</table>

### Cash flows from investing activities

<table>
<thead>
<tr>
<th>Description</th>
<th>Group</th>
<th>Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest received</td>
<td>329</td>
<td>249</td>
</tr>
<tr>
<td>Investment in a subsidiary / joint venture</td>
<td>10</td>
<td>(33,979)</td>
</tr>
<tr>
<td>Amounts placed on short term deposits</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Amounts recovered on short term deposits</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Purchase of property, plant and equipment and intangible assets</td>
<td>(44,750)</td>
<td>(9,009)</td>
</tr>
<tr>
<td><strong>Net cash used in investing activities</strong></td>
<td>(44,411)</td>
<td>(63,380)</td>
</tr>
</tbody>
</table>

### Cash flows from financing activities

<table>
<thead>
<tr>
<th>Description</th>
<th>Group</th>
<th>Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>PDC received</td>
<td>1,898</td>
<td>1,898</td>
</tr>
<tr>
<td>PDC dividend received / (paid)</td>
<td>68</td>
<td>68</td>
</tr>
<tr>
<td>Loans repaid</td>
<td>(7,500)</td>
<td>(7,500)</td>
</tr>
<tr>
<td>Loans received</td>
<td>25,000</td>
<td>25,000</td>
</tr>
<tr>
<td>Interest paid on loans</td>
<td>(6,814)</td>
<td>(6,814)</td>
</tr>
<tr>
<td>Capital receipts</td>
<td>2,350</td>
<td>2,350</td>
</tr>
<tr>
<td>Payment of finance lease obligations - interest</td>
<td>(813)</td>
<td>(813)</td>
</tr>
<tr>
<td>Payment of Private Finance Initiative obligations - interest</td>
<td>(4,776)</td>
<td>(4,776)</td>
</tr>
<tr>
<td>Payment of finance lease obligations - capital</td>
<td>(705)</td>
<td>(705)</td>
</tr>
<tr>
<td>Payment of Private Finance Initiative obligations - capital</td>
<td>(61,038)</td>
<td>(61,038)</td>
</tr>
<tr>
<td><strong>Net cash (absorbed) / generated from financing activities</strong></td>
<td>(52,330)</td>
<td>(110,044)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Group</th>
<th>Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Decrease) / increase in cash and cash equivalents</td>
<td>(109,758)</td>
<td>(109,684)</td>
</tr>
<tr>
<td>Cash and cash equivalents at 1 April</td>
<td>135,307</td>
<td>133,135</td>
</tr>
<tr>
<td>Cash and cash equivalents at 31 March</td>
<td>26</td>
<td>23,451</td>
</tr>
</tbody>
</table>

---

Northumbria Healthcare NHS Foundation Trust

Annual Accounts 2014-15
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 (ARM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2014/15 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting Convention

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

1.2 Going Concern Basis

These accounts have been prepared on a going concern basis. This is based on financial projections taking into account the working capital position, agreed 2015/16 contractual income and expenditure plans. The Group recorded a surplus for the year and a reduction in cash of £110 million. However £99 million of this cash was used to repay in full the significant PFI contract on which the Trust served notice of termination at the end of the previous year. Excluding this termination, which is not a recurring item, the Group cash position only decreased by £11 million to £25 million.

After making enquiries the directors have a reasonable expectation that the Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason they continue to use the going concern basis in preparing this report.

1.3 Consolidation

The group financial statements consolidate the financial statements of the Trust and entities controlled by the Trust (its subsidiaries) and incorporate its share of the results of wholly and jointly controlled entities and associates using the equity method of accounting. The financial statements of the subsidiaries are prepared for the same reporting year as the Trust.

Subsidiary entities are those over which the Foundation Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines.

Where subsidiaries accounting policies are not aligned with those of the Foundation Trust (including where they report under UK GAAP) these amounts are adjusted during consolidation where differences are material.

All intragroup balances and transactions, including unrealised profits arising from the intragroup transactions, have been eliminated in full. Subsidiaries are consolidated from the date on which control is obtained by the group and cease to be consolidated from the date on which control is no longer held by the group.

Joint ventures are separate entities over which the trust has joint control with one or more parties. The meaning of control is the same as that for subsidiaries. Joint ventures are recognised in the trusts financial statements using the equity method. This investment is initially recognised at a cost.

Northumbria Healthcare Facilities Management Ltd. was incorporated on the 9th October 2012 and is a wholly owned subsidiary of Northumbria Healthcare NHS FT. The primary purpose of the company is design, project management and operation of specific capital schemes. Currently the largest contract is for the development of the site of the Northumbria Specialist Emergency Care Hospital in Cramlington and provision of services.

Northumbria Primary Care Limited is a new company established to provide GPs with professional support in many of the corporate functions that come with running a GP practice. It is a wholly owned subsidiary of Northumbria Healthcare NHS Foundation Trust which will start trading on 1 April 2015. This will operate via a cost sharing group.

Northumbria Healthcare NHS Foundation Trust is the corporate trustee to Northumbria Healthcare NHS Trust Charity NHS charitable fund. The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Foundation Trust has the power to govern the financial and operating policies of the charitable fund so as to obtain benefits from its activities for itself, its patients and its staff.
The charitable funds statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Generally Accepted Accounting Principles (UK GAAP). On consolidation, necessary adjustments are made to the charity’s assets, liabilities and transactions to:

- Recognise and measure them in accordance with the Foundation Trust’s accounting policies; and
- Eliminate intra-group transactions, balances gains and losses.

The summary Statement of Financial Activities and Statement of Financial Position of the Charitable Fund are presented in a note (note 35) to the accounts.

When 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 the charitable purposes and cannot itself be spent are accounted for as endowment funds. Other funds are classified as unrestricted funds. Unrestricted funds which the Trustees have chosen to earmark for set purposes are also classified as designated funds. In all other respects the accounting policies of the Charitable Fund are materially in line with those of the Foundation Trust.

1.4 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.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.5 Expenditure on Employee Benefits

Short-term Employee Benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying Scheme assets and liabilities. Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the Scheme is taken as equal to the contributions payable to the scheme for accounting period.

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

The Scheme is subject to a periodic full actuarial investigation the main purpose of which 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 last such investigation, on the conclusions of which scheme contribution rates are currently based, had an effective date of 31 March 2004 and covered the period 1 April 1999 to that date. It was published in December 2007. Between full actuarial valuations, the Government Actuary provides an update of the Scheme liabilities for FRS 17 purposes. The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary Report which forms part of the NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed can be viewed on the Business Service Authority - Pension Division website at www.nhsia.gov.uk.

The conclusion of the 2004 investigation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. This is after making some allowance for the one-off effects of pay modernisation, but before taking into account any of the scheme changes which came into effect on 1 April 2008. Taking into account the changes in the benefit and contribution structure effective from 1 April 2008, employer contributions could continue at the
existing rate of 14% of pensionable pay. On advice from the actuary scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008 employees paid contributions at the rate of 6% (manual staff 5%) of their pensionable pay. From 1 April 2008 employees have paid contributions according to a tiered scale from 5% up to 8.5% of their pensionable pay.

**Defined benefit plan – Northumberland County Council Local Government Pension Scheme**

A defined benefit plan is a post-employment benefit plan other than a defined contribution plan. The Trust’s net obligation in respect of this defined benefit pension plan is calculated by estimating the amount of future benefit that employees have earned in return for their service in the current and prior periods; that benefit is discounted to determine its present value, and the fair value of any plan assets (at bid price) are deducted. The liability discount rate is the yield at the balance sheet date on AA credit rated bonds denominated in the currency of, and having maturity dates approximating to the terms of the Trust’s obligations. The calculation is performed by a qualified actuary using the projected unit credit method. When the calculation results in a benefit to the Trust, the recognised asset is limited to the present value of benefits available in the form of any future refunds from the plan, reductions in future contributions to the plan or on settlement of the plan and takes into account the adverse effect of any minimum funding requirements.

The Trust's defined benefit obligations in respect of this scheme have been indemnified by Northumberland County Council. As a result of this indemnification, the Trust has a right of reimbursement for expenditures required to settle this defined benefit obligation. This right does not give rise to a plan asset and is therefore recognised as a separate non-current asset at fair value when recovery is virtually certain.

**1.6 Expenditure on other goods and services**

**Expenditure on other goods and services**

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

**Financing income and expenses**

Net financing costs comprise interest payable and interest receivable on funds invested. Interest income and interest payable is recognised in the statement of Comprehensive Income as it accrues, using the effective interest method.

**1.7 Property, Plant and Equipment**

**Recognition**

Property, Plant and Equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the items individually have a cost of at least £5,000 or form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control or form part of the initial setting up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

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

Land is not depreciated as it is expected to have an infinite life. Buildings have expected lives of between 23 and 83 years, and are depreciated evenly over the life of the buildings.

Equipment is generally depreciated on current cost evenly over the estimated life of the assets on the following basis:

- Short life medical and other equipment – 5 years
- Medium life medical equipment – 10 years
- Long life medical equipment – 15 years
- Short life engineering plant and equipment - 5 years
- Medium life engineering plant and equipment – 10 years
• Long life engineering plant and equipment – 15 years
• Office and IT equipment – 2 to 5 years
• Mainframe-type IT installations – 8 years
• PCs and printers – 2 years
• Furniture – 10 years
• Vehicles – 7 years

Where it is possible individual assets are depreciated on a specific estimate of the assets life.

**Measurement**

1. **Valuation**

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All land and buildings are measured subsequently at fair value as required by the ARM.

Property, plant and equipment are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs, such as installation, directly attributable to bringing them into working condition. The carrying values of property, plant and equipment are reviewed for impairment in periods if events or changes in circumstances that indicate the carrying value may not be recoverable. The costs arising from financing the construction of the fixed assets are not capitalised but are charged to the income and expenditure account in the year to which they relate.

All land and buildings are re-valued using professional valuations in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Revaluations are made with sufficient regularity to ensure that the carrying amount does not differ materially from that which would be determined using fair value at the end of the reporting period. The last asset valuations were undertaken in 2015 as at the prospective valuation date of 31 March 2015. The revaluation undertaken at that date was accounted for on 31 March 2015.

The valuation was carried out by DTZ, qualified valuers (MRICS), using the Modern Equivalent Asset Valuation (MEAV) technique and Depreciated Replacement Cost method for specialised operational property and existing use value for non-specialised operational property. The value of land for existing use purposes is assessed at existing user value. For non-operational properties including surplus land, the valuations are carried out at open market value. Additional alternative open market value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

Assets in the course of construction are valued at cost and are valued by professional valuers as part of the valuations when they are brought into use.

Residual interests in 'off-Statement of Financial Position' private finance initiative properties are included in assets under construction within property, plant and equipment at the amount of the unitary charge allocated for the acquisition of the residual with an adjustment. The adjustment is the net present value of the change in the fair value of the residual as estimated at the start of the contract and at the Statement of Financial Position date.

Operational equipment is valued at net current replacement cost. Equipment surplus to requirements is valued at net recoverable amount.

2. **Subsequent expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset’s carrying value. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

3. **Depreciation**

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.
4. 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/expense’.

5. 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/ reclassification of property, plant and equipment

Assets intended for disposal are reclassified as ‘Held for Sale’ once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as ‘Held for Sale’;
  - and the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged 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.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘Held for Sale’ and instead is retained as an operational asset and the asset’s economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation / grant is credited to the income statement at the same time, unless the donor imposes a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the financial donation/ grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury’s FReM, are accounted for as ‘on-Statement of Financial Position’ by the Trust. In accordance with IAS 17 the underlying assets are recognised as property, plant and equipment at their fair value together with an equivalent financial liability. Subsequently the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.
The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the implicit interest rate for the scheme.

The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

1.8 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

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments 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’.

Intangible assets held for sale are measured at the lower of their carrying amount or ‘fair value less costs to sell’.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.
1.9 Revenue government and other grants

Government grants are grants from government bodies other than income from primary care trusts or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of all consumable goods is charged to operating expenses at the time of purchase.

1.11 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust’s normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

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 cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as ‘Fair Value through Income and Expenditure’, Loans and receivables or ‘Available-for-sale financial assets’.

Financial liabilities are classified as ‘Fair value through Income and Expenditure’ or as ‘Other Financial liabilities’.

Financial assets and financial liabilities at ‘Fair Value through Statement of Comprehensive Income’

Financial assets and financial liabilities at ‘fair value through Statement of Comprehensive Income’ are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust’s loans and receivables comprise: current investments, cash and cash equivalents, NHS receivables, accrued income and ‘other receivables’.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

All ‘other financial liabilities’ are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial
Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs.

**Impairment of financial assets**

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at ‘fair value through comprehensive income’ are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced.

**1.12 Leases**

**Finance leases**

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation 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 inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. 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.

**Operating leases**

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

**Leases of land and buildings**

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Following the adoption of a change to IAS 17 leased land is assessed separately to determine if it is a finance or operating lease, depending upon the nature of the lease terms.

**Determining whether an arrangement contains a lease**

At inception of an arrangement, the Group determines whether such arrangement is or contains a lease. This will be the case if the following two criteria are met:

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

At inception or on reassessment of the arrangement, the Group separates payments and other consideration required by such an arrangement into those for the lease and those for other elements on the basis of relative fair values. If the Group concludes for a finance lease that it is impractical to separate the payments reliably, then an asset and a liability are recognised at an amount equal to the fair value of the underlying asset. Subsequent the liability is reduced as payments are made and an imputed finance costs on the liability is recognised using the Group’s incremental borrowing rate.

**1.13 Provisions**

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury’s’ discount rate of 1.3%(2013/14 1.8%) in real terms.
Clinical negligence costs risk pooling

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation 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 NHS Foundation Trust. For this reason, the total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed in Note 22 but it is not recognised in the NHS Foundation Trust’s accounts.

Non-clinical negligence costs risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any ‘excesses’ payable in respect of particular claims are charged to operating expenses when the liability arises.

1.14 Contingencies

Contingent assets (assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity’s control) are not recognised as assets, but are disclosed in Note 29 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised in the Statement of Financial Position, but are disclosed in Note 29, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity’s control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.15 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as PDC. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the value of all liabilities, except for (i) donated assets (ii) average daily cash balances held with the Government Banking Services and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility and iii) any PDC dividend balance receivable or payable. 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 average actual relevant net assets as set out in the ‘pre-audit’ version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.16 Value Added Tax

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.17 Corporation Tax

The Trust Board has reviewed the commercial activities of the Trust and consideration has been given to the implications of corporation tax. At this stage the Trust Board is satisfied that there are no corporation tax liabilities resulting from non-core activities. The Trust will continue to review commercial services in light of any potential changes in the scope of corporation tax.

Northumbria Healthcare NHS Foundation Trust is a Health Service Body within the meaning of s519A ICTA 1998 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is the power from the Treasury to disapply the exemption in relation to the specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988. Accordingly, the Trust is potentially within the scope of Corporation Tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits there from exceed £50,000 per annum.

Tax on the profit or loss for the year comprises current and deferred tax. Tax is recognised in the income statement except to the extent that it relates to items recognised directly in equity, in which case it is recognised in equity.
Current tax is the expected tax payable or receivable on the taxable income or loss for the year, using tax rates enacted or substantively enacted at the balance sheet date, and any adjustment to tax payable in respect of previous years. Deferred tax is provided on temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for taxation purposes. The following temporary differences are not provided for: the initial recognition of goodwill; the initial recognition of assets or liabilities that affect neither accounting nor taxable profit other than in a business combination, and differences relating to investments in subsidiaries to the extent that they will probably not reverse in the foreseeable future. The amount of deferred tax provided is based on the expected manner of realisation or settlement of the carrying amount of assets and liabilities, using tax rates enacted or substantively enacted at the Statement of Financial Position date.

A deferred tax asset is recognised only to the extent that it is probable that future taxable profits will be available against which the temporary difference can be utilised.

The Trust’s subsidiary Northumbria Healthcare Facilities Management may be subject to corporation tax on commercial activities in the future. In the current and prior years this subsidiary recorded a taxable loss.

1.18 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 at the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.19 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury’s Accounting Reporting Manual.

1.20 Accounting Standards, amendments and interpretations in issue but not yet effective or adopted.

The accounting standards, amendments and interpretations have been issued by the IASB and IFRIC which have not been applied to the Trust in these financial statements. Their adoption is not expected to have a material effect on the financial statements;

- IFRS 13 – ‘Fair Value Measurement’ (Adopted delayed by HM Treasury – to be adopted from 2015/16)
- IFRS 15 – ‘Revenue from contracts with customers’ (Not yet EU adopted, expected to be effective from 2017/18)
- IAS 19* – ‘Employer contributions to defined benefit scheme’ (Not yet EU adopted, effective from 2015/16)
- IAS 36* – ‘Recoverable amounts disclosures’ (To be adopted from 2015/16 and aligned with IFRS 13 adoption)
- IFRIC 21 – ‘Levies’ (Not yet adopted by HM Treasury, EU adopted in June 2014)
- Annual Improvements 2012 (Not yet EU adopted, expected to be effective from 2015/16)
- Annual Improvements 2013 (Not yet EU adopted, expected to be effective from 2015/16)
1.21 International Financial Reporting Standards Applied

The following accounting standards, amendment and interpretations became effective in the year and have been adopted by the Trust:

- Amendment to IAS 1 – Presentation of Financial Statements
- IAS 19 – Employee benefits (Revised)
- Amendments to IFRS 7 – Disclosures – Offsetting Financial Assets & Financial Liabilities
- IFRIC 13 – Fair Value Measurement
- IFRS 10 – Consolidated Financial Statements
- IFRS 11 – Joint Arrangements
- IFRS 12 – Disclosure of Interests in Other Entities
- IAS 27 – Separate Financial Statements
- IAS 28 – Associates and Joint Ventures
- IAS 32 – Financial Instruments

The adoption of the above has not had a significant impact on the Foundation Trust’s financial statements.

1.22 IAS 1 – critical accounting judgements or key estimation uncertainties

"Critical accounting judgements and key sources of estimation uncertainty and critical judgement”

In the application of the Trust’s accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from these estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- In the light of the currently depressed state of the UK property market, the Trust has conducted a review of land and buildings, using independent qualified valuers, and revaluations and impairments have been made where required (note 10.1).
- Provisions have been made in line with management’s best estimates and in line with IAS 37: Provisions, Contingent Liabilities and Contingent Assets (note 24).

The following are the key critical judgements in applying accounting policies that have the most significant effect on the amounts recognised in the consolidated and Trust financial statements:

- Accounting for arrangements containing a lease and lease classification (note 21)
1.23 Late Payment of Commercial Debt

Legislation is in force which requires Trust’s to pay interest to small companies if payment is not made within 30 days (Late payment of Commercial Debts (Interest) Act 1998). The Trust was not required to make any such payment during the year.

1.24 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accrual basis, including losses which would have been made good through insurance cover had the NHS Foundation Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.25 Prior Period Adjustments

There were no prior period adjustments.
2 Segmental Reporting

All of the activities of the Trust arise from a single business segment, the provision of healthcare, which is an aggregate of all the individual specialty components therein. Similarly, the large majority of the Trust’s revenue arises from within the UK Government. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust, together with the related supplies and overheads needed to establish this production. The business activities which earn and incur these expenses are of one broad nature and therefore, on this basis, one segment ‘Healthcare’ is deemed appropriate.

The operating results of the Foundation Trust are reviewed monthly or more frequently by the Trust’s chief operating decision maker which is the overall Foundation Trust Board and which includes professional Non-Executive Directors. The Trust Board review the financial position of the trust as a whole, rather than individual components included in the totals, in terms of allocating resources. This process implies a single operating segment of healthcare in its decision-making process. The finance report considered monthly by the Trust Board provides summary figures for the whole Trust together with graphical and bar charts relating to different total income activity levels and directorate expense budgets with their cost improvement positions. Likewise only the financial position and cashflow forecasts are considered for the whole Foundation Trust. The Board, as chief operating decision maker, therefore only considers one segment of healthcare in its decision-making process.

The single segment of ‘Healthcare’ has therefore been identified as being consistent with the core principle of IFRS8 which is to enable users of the financial statements to evaluate the nature of financial effects of business activities and economic environments.
### 3.1 Income from Activities - by Function

<table>
<thead>
<tr>
<th>Group</th>
<th>Year Ending 31 March 2015 £000</th>
<th>Year Ending 31 March 2014 £000</th>
<th>Year Ending 31 March 2015 £000</th>
<th>Year Ending 31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective income</td>
<td>63,275</td>
<td>62,008</td>
<td>63,275</td>
<td>62,008</td>
</tr>
<tr>
<td>Non elective income</td>
<td>92,942</td>
<td>92,772</td>
<td>92,942</td>
<td>92,772</td>
</tr>
<tr>
<td>Outpatient income</td>
<td>57,374</td>
<td>61,239</td>
<td>57,374</td>
<td>61,239</td>
</tr>
<tr>
<td>Other NHS clinical income</td>
<td>79,453</td>
<td>53,261</td>
<td>79,453</td>
<td>52,412</td>
</tr>
<tr>
<td>A&amp;E income</td>
<td>17,246</td>
<td>17,006</td>
<td>17,246</td>
<td>17,006</td>
</tr>
<tr>
<td>Income for Community services</td>
<td>94,902</td>
<td>105,966</td>
<td>94,902</td>
<td>105,966</td>
</tr>
<tr>
<td>Private patient &amp; overseas visitors income</td>
<td>124</td>
<td>125</td>
<td>124</td>
<td>125</td>
</tr>
<tr>
<td><strong>Total income by function</strong></td>
<td><strong>405,316</strong></td>
<td><strong>392,377</strong></td>
<td><strong>405,316</strong></td>
<td><strong>391,528</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 ('Protected Services'). All income from activities shown above is derived from the provision of protected services.

### 3.2 Private Patient Income

<table>
<thead>
<tr>
<th></th>
<th>Year Ending 31 March 2015 £000</th>
<th>Year Ending 31 March 2014 £000</th>
<th>Year Ending 31 March 2015 £000</th>
<th>Year Ending 31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private patient income</td>
<td>93</td>
<td>125</td>
<td>93</td>
<td>125</td>
</tr>
<tr>
<td><strong>Total patient related income</strong></td>
<td><strong>405,316</strong></td>
<td><strong>392,377</strong></td>
<td><strong>405,316</strong></td>
<td><strong>391,528</strong></td>
</tr>
<tr>
<td><strong>Proportion (as a percentage)</strong></td>
<td><strong>0.02%</strong></td>
<td><strong>0.03%</strong></td>
<td><strong>0.02%</strong></td>
<td><strong>0.03%</strong></td>
</tr>
</tbody>
</table>

Under its Terms of Authorisation the Trust must ensure that the proportion of patient related income derived from private patients does not exceed the proportion received as an NHS Trust in the base year, 2002/3, which was 0.09% of related income.

### 3.3 Income from Activities - by Source

<table>
<thead>
<tr>
<th>Group</th>
<th>Year Ending 31 March 2015 £000</th>
<th>Year Ending 31 March 2014 £000</th>
<th>Year Ending 31 March 2015 £000</th>
<th>Year Ending 31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Foundation Trusts</td>
<td>1,120</td>
<td>1,163</td>
<td>1,120</td>
<td>1,163</td>
</tr>
<tr>
<td>NHS Trusts</td>
<td>1,223</td>
<td>0</td>
<td>1,223</td>
<td>0</td>
</tr>
<tr>
<td>CCGs</td>
<td>370,577</td>
<td>360,507</td>
<td>370,577</td>
<td>360,507</td>
</tr>
<tr>
<td>Local Authorities</td>
<td>29,797</td>
<td>28,743</td>
<td>29,797</td>
<td>28,743</td>
</tr>
<tr>
<td>NHS Other</td>
<td>1,080</td>
<td>975</td>
<td>1,080</td>
<td>975</td>
</tr>
<tr>
<td>Non NHS : Overseas visitors</td>
<td>31</td>
<td>11</td>
<td>31</td>
<td>11</td>
</tr>
<tr>
<td>Non NHS : Private patients</td>
<td>93</td>
<td>125</td>
<td>93</td>
<td>125</td>
</tr>
<tr>
<td>NHS Injury Scheme *</td>
<td>994</td>
<td>853</td>
<td>994</td>
<td>853</td>
</tr>
<tr>
<td>Non NHS Other</td>
<td>219</td>
<td>0</td>
<td>219</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total income from activities</strong></td>
<td><strong>405,316</strong></td>
<td><strong>392,377</strong></td>
<td><strong>405,316</strong></td>
<td><strong>392,377</strong></td>
</tr>
</tbody>
</table>

*NHS Injury Scheme income (formerly known as Road Traffic Act income) is subject to a provision for doubtful debts of 18.5% of claims.

### 3.4 Other Operating Income

<table>
<thead>
<tr>
<th>Group</th>
<th>Year Ending 31 March 2015 £000</th>
<th>Year Ending 31 March 2014 £000</th>
<th>Year Ending 31 March 2015 £000</th>
<th>Year Ending 31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research and Development</td>
<td>2,747</td>
<td>2,261</td>
<td>2,747</td>
<td>2,261</td>
</tr>
<tr>
<td>Education and training</td>
<td>11,776</td>
<td>10,389</td>
<td>11,776</td>
<td>10,389</td>
</tr>
<tr>
<td>NHS charitable funds: income received</td>
<td>1,422</td>
<td>1,357</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Profit on disposal of asset</td>
<td>450</td>
<td>0</td>
<td>450</td>
<td>0</td>
</tr>
<tr>
<td>Reversal of Impairments</td>
<td>3,343</td>
<td>2,837</td>
<td>3,343</td>
<td>2,837</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>6,566</td>
<td>5,956</td>
<td>6,566</td>
<td>5,956</td>
</tr>
<tr>
<td>Other income</td>
<td>29,748</td>
<td>34,298</td>
<td>29,748</td>
<td>35,181</td>
</tr>
<tr>
<td><strong>Total other operating income</strong></td>
<td><strong>56,052</strong></td>
<td><strong>57,098</strong></td>
<td><strong>54,630</strong></td>
<td><strong>56,624</strong></td>
</tr>
</tbody>
</table>

**Total Income**

<table>
<thead>
<tr>
<th>Group</th>
<th>Year Ending 31 March 2015 £000</th>
<th>Year Ending 31 March 2014 £000</th>
<th>Year Ending 31 March 2015 £000</th>
<th>Year Ending 31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>461,368</td>
<td>449,475</td>
<td>459,946</td>
<td>449,001</td>
</tr>
</tbody>
</table>
During 2013/14 the Trust served termination notice on a PFI contract. The charge of £52,798,000 recognised in 2013/14 was the Trust's best estimate of the likely level of compensation payable. During 2014/15 the final level of compensation was agreed resulting in the provision release of £12,424,000 (see note 24). These accounts have been separately disclosed in the Consolidated Statement of Comprehensive Income due to their size and non-recurring nature.

Provisions for bad debts was made in 2012/13 due to the uncertainty of the likely payment of some debts owed by Primary Care Trusts that ceased to exist early in the 2013/14 financial year. In the event the majority of this debt was paid in full hence the bad debt provision was reduced in both 2014/15 and 2013/14 resulting in a credit to operating expenses.

The main component of other expenditure is expenses relating to the provision of on-site crèche facilities.
4.2.1 Operating Lease Rentals

<table>
<thead>
<tr>
<th></th>
<th>Group Year Ending 31 March 2015</th>
<th>£000</th>
<th>Group Year Ending 31 March 2014</th>
<th>£000</th>
<th>Foundation Trust Year Ending 31 March 2015</th>
<th>£000</th>
<th>Foundation Trust Year Ending 31 March 2014</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land and buildings</td>
<td>1,275</td>
<td>1,855</td>
<td>1,275</td>
<td>1,855</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plant and machinery</td>
<td>5,285</td>
<td>5,261</td>
<td>5,285</td>
<td>5,261</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total operating lease rentals</strong></td>
<td><strong>6,560</strong></td>
<td><strong>7,116</strong></td>
<td><strong>6,560</strong></td>
<td><strong>7,116</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.2.2 Operating Lease Commitments

<table>
<thead>
<tr>
<th>Land and buildings total commitments on leases expiring;</th>
<th>Year Ending 31 March 2015</th>
<th>£000</th>
<th>Year Ending 31 March 2014</th>
<th>£000</th>
<th>Year Ending 31 March 2015</th>
<th>£000</th>
<th>Year Ending 31 March 2014</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>within one year</td>
<td>1,284</td>
<td>1,275</td>
<td>1,284</td>
<td>1,275</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>between one and five years</td>
<td>5,076</td>
<td>5,135</td>
<td>5,076</td>
<td>5,135</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>after five years</td>
<td>11,093</td>
<td>12,319</td>
<td>11,093</td>
<td>12,319</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total commitments land and buildings</strong></td>
<td><strong>17,453</strong></td>
<td><strong>18,729</strong></td>
<td><strong>17,453</strong></td>
<td><strong>18,729</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plant and machinery total commitments on leases expiring;</th>
<th>Year Ending 31 March 2015</th>
<th>£000</th>
<th>Year Ending 31 March 2014</th>
<th>£000</th>
<th>Year Ending 31 March 2015</th>
<th>£000</th>
<th>Year Ending 31 March 2014</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>within one year</td>
<td>637</td>
<td>821</td>
<td>637</td>
<td>821</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>between one and five years</td>
<td>5,936</td>
<td>5,716</td>
<td>5,936</td>
<td>5,738</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total commitments plant and machinery</strong></td>
<td><strong>6,573</strong></td>
<td><strong>6,559</strong></td>
<td><strong>6,573</strong></td>
<td><strong>6,559</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Land and building leases comprise of clinical accommodation used for elderly medicine services adjacent to North Tyneside General Hospital.

Operating leases of less than five years refer to leasing agreements entered into for leased vehicles. All such leases are for a period of three years with three equal annual instalments payable. Costs are charged to operating expenses in the year in which payments are made.

4.3 Staff Costs and Numbers

<table>
<thead>
<tr>
<th>4.3.1 Staff Costs (Excluding Non-Executive Directors)</th>
<th>Year Ended 31 March 2015</th>
<th>£000</th>
<th>Permanently Employed</th>
<th>£000</th>
<th>Other</th>
<th>£000</th>
<th>Total</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and wages</td>
<td>240,398</td>
<td>232,550</td>
<td>7,848</td>
<td>232,521</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social security costs</td>
<td>18,681</td>
<td>18,075</td>
<td>606</td>
<td>18,335</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer contributions to NHS pensions</td>
<td>29,202</td>
<td>28,255</td>
<td>947</td>
<td>29,028</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency/contract staff</td>
<td>4,872</td>
<td>0</td>
<td>4,872</td>
<td>3,441</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Termination costs</td>
<td>591</td>
<td>591</td>
<td>0</td>
<td>149</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total staff costs</strong></td>
<td><strong>293,744</strong></td>
<td><strong>279,471</strong></td>
<td><strong>14,273</strong></td>
<td><strong>283,474</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Included in the above is £1,087,000 of salaries that the Group capitalised as tangible fixed assets (2013/14 - £1,094,000). This relates to staff employed to work on specific capital schemes.
### 4.3 Staff Costs and Numbers - continued

#### 4.3.2 Staff costs (excluding Non Executive Directors) - Foundation Trust £000

<table>
<thead>
<tr>
<th></th>
<th>Year Ended 31 March 2015</th>
<th>Permanently Employed £000</th>
<th>Other £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and wages</td>
<td>240,013</td>
<td>232,165</td>
<td>7,848</td>
<td>232,198</td>
</tr>
<tr>
<td>Social security costs</td>
<td>18,681</td>
<td>18,075</td>
<td>606</td>
<td>18,310</td>
</tr>
<tr>
<td>Employer contributions to NHS pensions</td>
<td>29,202</td>
<td>28,255</td>
<td>947</td>
<td>28,988</td>
</tr>
<tr>
<td>Agency/contract staff</td>
<td>4,872</td>
<td>0</td>
<td>4,872</td>
<td>3,441</td>
</tr>
<tr>
<td>Termination costs</td>
<td>591</td>
<td>591</td>
<td>0</td>
<td>149</td>
</tr>
<tr>
<td><strong>Total staff costs</strong></td>
<td><strong>293,359</strong></td>
<td><strong>279,086</strong></td>
<td><strong>14,273</strong></td>
<td><strong>283,086</strong></td>
</tr>
</tbody>
</table>

Included in the above is £702,000 of salaries that the Trust capitalised as tangible fixed assets (2013/14 - £706,000). This relates to staff employed to work on specific capital schemes.

#### 4.3.3 Staff Numbers (Whole Time Equivalents) - Group and Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>Year Ended 31 March 2015</th>
<th>Permanently Employed</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental</td>
<td>607</td>
<td>457</td>
<td>150</td>
<td>553</td>
</tr>
<tr>
<td>Administration and estates</td>
<td>1,856</td>
<td>1,856</td>
<td>0</td>
<td>1,744</td>
</tr>
<tr>
<td>Healthcare assistants &amp; other support staff</td>
<td>730</td>
<td>730</td>
<td>0</td>
<td>735</td>
</tr>
<tr>
<td>Nursing, midwifery &amp; health visiting staff</td>
<td>3,097</td>
<td>3,096</td>
<td>1</td>
<td>3,104</td>
</tr>
<tr>
<td>Scientific, therapeutic and technical staff</td>
<td>1,265</td>
<td>1,265</td>
<td>0</td>
<td>1,208</td>
</tr>
<tr>
<td>Agency staff</td>
<td>58</td>
<td>0</td>
<td>58</td>
<td>36</td>
</tr>
<tr>
<td><strong>Total whole time equivalents</strong></td>
<td><strong>7,613</strong></td>
<td><strong>7,404</strong></td>
<td><strong>209</strong></td>
<td><strong>7,380</strong></td>
</tr>
</tbody>
</table>

Staff numbers are for the ‘whole time equivalent’ as opposed to a head count basis i.e. two employees working half the number of standard hours for a full time employee are classed as one ‘whole time equivalent’. The totals are an average of whole time equivalents worked for the reporting period.

Other staff includes staff on secondment from other organisations and medical staff whose contract of employment is with the NHS England.

Of the above total whole time equivalent 7,396 are employed by the Foundation Trust and 8 by its wholly owned subsidiary, Northumbria Healthcare Facilities Management Limited making a Group total of 7,404.

#### 4.3.4 Staff Exit Packages

<table>
<thead>
<tr>
<th></th>
<th>Redundancy Payments</th>
<th>Other Departures Agreed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than £10,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Between £10,000 and £25,000</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Between £25,001 and £50,000</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Between £50,001 and £100,000</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Between £100,001 and £150,000</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Between £150,001 and £200,000</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total Number of exit packages by type</strong></td>
<td><strong>7</strong></td>
<td><strong>0</strong></td>
<td><strong>7</strong></td>
</tr>
<tr>
<td><strong>Total Resource cost £000’s</strong></td>
<td><strong>591</strong></td>
<td><strong>0</strong></td>
<td><strong>591</strong></td>
</tr>
</tbody>
</table>

#### 4.3.5 Employee Benefits

The Trust incurred no costs in providing employee benefits, other than pensions costs (note 24), in the year ended 31 March 2014 (previous year - Nil).

<table>
<thead>
<tr>
<th></th>
<th>Year Ended 31 March 2015</th>
<th>Year Ended 31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of early retirements agreed on the grounds</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>Estimated additional liabilities</td>
<td>629</td>
<td>1,138</td>
</tr>
</tbody>
</table>

The costs of these ill-health retirements will be borne by the NHS Pensions Agency.
### Executive Directors

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Year ended 31 March 2015</th>
<th>Year ended 31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jim Mackey</td>
<td>Chief Executive</td>
<td>Basic salary (Bands of £5000)</td>
<td>Benefits in kind (nearest £1000)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>220-225</td>
<td>10,600</td>
</tr>
<tr>
<td>Rosemary Stephenson</td>
<td>Director of Nursing &amp; Emergency Care</td>
<td>155-160</td>
<td>6,500</td>
</tr>
<tr>
<td>Paul Dunn</td>
<td>Director of Finance</td>
<td>150-155</td>
<td>10,600</td>
</tr>
<tr>
<td>Ann Wright</td>
<td>Director of Elective Care</td>
<td>155-160</td>
<td>5,000</td>
</tr>
<tr>
<td>Birju Bartoli</td>
<td>Director of Performance and Governance</td>
<td>125-130</td>
<td>6,100</td>
</tr>
<tr>
<td>Richard Curless</td>
<td>Salary - Director of Emergency Care</td>
<td>30-35</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Other Remuneration - payment for clinical duties</td>
<td>160-165</td>
<td>11,700</td>
</tr>
<tr>
<td>Ann Stringer</td>
<td>Director of Human Resources</td>
<td>150-155</td>
<td>5,000</td>
</tr>
<tr>
<td>Daljit Lally</td>
<td>Director of Community Services</td>
<td>60 - 65</td>
<td>3,000</td>
</tr>
<tr>
<td>David Evans</td>
<td>Salary - Medical Director, Family Care and Medicine</td>
<td>30-35</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Other Remuneration - payment for clinical duties</td>
<td>145-150</td>
<td>13,700</td>
</tr>
<tr>
<td>Derek Thomson</td>
<td>Salary - Medical Director, Community Services</td>
<td>20-25</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Other Remuneration - payment for clinical duties</td>
<td>95-100</td>
<td>4,300</td>
</tr>
</tbody>
</table>

### Non-executive Directors

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Year ended 31 March 2015</th>
<th>Year ended 31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brian Flood</td>
<td>Chairman</td>
<td>50-55</td>
<td>2,800</td>
</tr>
<tr>
<td>Ian McMinn</td>
<td>Non Executive Director</td>
<td>15-20</td>
<td>-</td>
</tr>
<tr>
<td>Neil Mundy</td>
<td>Non Executive Director</td>
<td>15-20</td>
<td>-</td>
</tr>
<tr>
<td>John Marsden</td>
<td>Non Executive Director</td>
<td>15-20</td>
<td>-</td>
</tr>
<tr>
<td>David Thompson</td>
<td>Non Executive Director</td>
<td>15-20</td>
<td>-</td>
</tr>
<tr>
<td>Ian Swithenbank</td>
<td>Non Executive Director</td>
<td>15-20</td>
<td>-</td>
</tr>
<tr>
<td>Peter Sanderson</td>
<td>Non Executive Director</td>
<td>10-15</td>
<td>-</td>
</tr>
</tbody>
</table>

Benefits in kind consist of the taxable benefit of leased cars used for business and private purposes and the taxable benefit of payments made for the reimbursement of business miles made in privately owned vehicles.

Jim Mackey left the NHS Pensions Scheme on 1 October 2010. In addition to basic salary disclosed above he also received, in lieu of employer’s contributions to the scheme, a taxable payment of £25,000 during 2014/15 (2013/14 - £25,000). This is the sum that the Trust would have contributed to the NHS Pension scheme had he remained a member and as such the arrangement did not increase the overall cost of his remuneration package.

Full details of Directors’ pensions benefits are reported in the Trust’s Remuneration Report contained within the Trust’s 2014/15 Annual Report.

The Director of Community Services is joint role shared between Northumbria Healthcare and Northumberland County Council. The costs included within the Trust’s accounts reflect only the Trust’s share of the post’s total costs. Accordingly the salary shown in the table above is only for payment received in respect of duties at Northumbria Healthcare NHS Foundation Trust.
5 Finance Income

<table>
<thead>
<tr>
<th></th>
<th>Group Year Ending 31 March 2015</th>
<th>£000</th>
<th>Group Year Ending 31 March 2014</th>
<th>£000</th>
<th>Foundation Trust Year Ending 31 March 2015</th>
<th>£000</th>
<th>Foundation Trust Year Ending 31 March 2014</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest on loans and receivables</td>
<td>266</td>
<td>119</td>
<td>2,586</td>
<td>119</td>
<td>2,586</td>
<td>985</td>
<td>985</td>
<td></td>
</tr>
<tr>
<td>Other investment income</td>
<td>29</td>
<td>69</td>
<td>0</td>
<td>866</td>
<td>0</td>
<td></td>
<td>866</td>
<td></td>
</tr>
<tr>
<td>Total finance income</td>
<td>295</td>
<td>188</td>
<td>2,586</td>
<td>985</td>
<td>2,586</td>
<td>985</td>
<td>985</td>
<td></td>
</tr>
</tbody>
</table>

6 Finance Cost

6.1 Finance Costs - Interest Expense

<table>
<thead>
<tr>
<th></th>
<th>Group Year Ending 31 March 2015</th>
<th>£000</th>
<th>Group Year Ending 31 March 2014</th>
<th>£000</th>
<th>Foundation Trust Year Ending 31 March 2015</th>
<th>£000</th>
<th>Foundation Trust Year Ending 31 March 2014</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loan from Foundation Trust Financing Facility</td>
<td>2,252</td>
<td>2,084</td>
<td>2,252</td>
<td>2,084</td>
<td>2,252</td>
<td>2,084</td>
<td>2,252</td>
<td>2,084</td>
</tr>
<tr>
<td>Other loans</td>
<td>4,657</td>
<td>39</td>
<td>4,657</td>
<td>39</td>
<td>4,657</td>
<td>39</td>
<td>4,657</td>
<td>39</td>
</tr>
<tr>
<td>Finance leases</td>
<td>792</td>
<td>812</td>
<td>792</td>
<td>812</td>
<td>792</td>
<td>812</td>
<td>792</td>
<td>812</td>
</tr>
<tr>
<td>Finance costs in PFI obligations</td>
<td>4,776</td>
<td>7,555</td>
<td>4,776</td>
<td>7,555</td>
<td>4,776</td>
<td>7,555</td>
<td>4,776</td>
<td>7,555</td>
</tr>
<tr>
<td>Total finance expenses</td>
<td>12,477</td>
<td>10,490</td>
<td>12,477</td>
<td>10,490</td>
<td>12,477</td>
<td>10,490</td>
<td>12,477</td>
<td>10,490</td>
</tr>
</tbody>
</table>

6.2 Finance cost - Impairment of Assets Property, Plant and Equipment

<table>
<thead>
<tr>
<th></th>
<th>Group Year Ending 31 March 2015</th>
<th>£000</th>
<th>Group Year Ending 31 March 2014</th>
<th>£000</th>
<th>Foundation Trust Year Ending 31 March 2015</th>
<th>£000</th>
<th>Foundation Trust Year Ending 31 March 2014</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net impairments due to changes in valuation</td>
<td>17,343</td>
<td>15,185</td>
<td>17,343</td>
<td>15,185</td>
<td>17,343</td>
<td>15,185</td>
<td>17,343</td>
<td>15,185</td>
</tr>
<tr>
<td>Total impairments charged to income</td>
<td>17,343</td>
<td>15,185</td>
<td>17,343</td>
<td>15,185</td>
<td>17,343</td>
<td>15,185</td>
<td>17,343</td>
<td>15,185</td>
</tr>
</tbody>
</table>

During 2014/15 and 2013/14 in addition to the above further impairments were charged to the revaluation reserve (note 10).

7 Taxation

UK corporation tax

<table>
<thead>
<tr>
<th></th>
<th>Group Year Ending 31 March 2015</th>
<th>£000</th>
<th>Group Year Ending 31 March 2014</th>
<th>£000</th>
<th>Foundation Trust Year Ending 31 March 2015</th>
<th>£000</th>
<th>Foundation Trust Year Ending 31 March 2014</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current tax payable</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total tax payable</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Northumbria Healthcare Facilities Management Limited is subject to corporation tax on commercial activities. No tax arises in the current or prior period.

8 Intangible Non-Current Assets

8.1 Purchased

<table>
<thead>
<tr>
<th></th>
<th>Group Year Ending 31 March 2015</th>
<th>£000</th>
<th>Group Year Ending 31 March 2014</th>
<th>£000</th>
<th>Foundation Trust Year Ending 31 March 2015</th>
<th>£000</th>
<th>Foundation Trust Year Ending 31 March 2014</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross cost at 1 April</td>
<td>5,537</td>
<td>2,424</td>
<td>5,537</td>
<td>2,424</td>
<td>5,537</td>
<td>2,424</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reclassifications from property, plant and equipment</td>
<td>170</td>
<td>1,949</td>
<td>170</td>
<td>1,949</td>
<td>170</td>
<td>1,949</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additions - purchases</td>
<td>76</td>
<td>1,164</td>
<td>76</td>
<td>1,164</td>
<td>76</td>
<td>1,164</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disposals</td>
<td>(112)</td>
<td>0</td>
<td>(112)</td>
<td>0</td>
<td>(112)</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross cost at 31 March</td>
<td>5,671</td>
<td>5,537</td>
<td>5,671</td>
<td>5,537</td>
<td>5,671</td>
<td>5,537</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

|                                |                                |      |                                |      |                                |      |                                |      |
| Amortisation at 1 April        | 1,402                           | 1,402| 1,402                           | 1,402| 1,402                                       | 1,402|
| Provided during the year       | 779                             | 513  | 779                             | 513  | 779                                         | 513  |
| Disposal                       | (103)                           | 0    | (103)                           | 0    | (103)                                       | 0    |
| Amortisation at 31 March       | 2,078                           | 1,402| 2,078                           | 1,402| 2,078                                       | 1,402|

|                                |                                |      |                                |      |                                |      |                                |      |
| Net book value                 |                                |      |                                |      |                                |      |                                |      |
| Purchased at 31 March 2014     | 4,135                           | 1,535| 4,135                           | 1,535| 4,135                                       | 1,535|
| Total at 1 April               | 4,135                           | 1,535| 4,135                           | 1,535| 4,135                                       | 1,535|

|                                |                                |      |                                |      |                                |      |                                |      |
| Net book value                 |                                |      |                                |      |                                |      |                                |      |
| Purchased at 31 March 2015     | 3,593                           | 4,135| 3,593                           | 4,135| 3,593                                       | 4,135|
| Total at 31 March              | 3,593                           | 4,135| 3,593                           | 4,135| 3,593                                       | 4,135|

All intangible non-current assets are software licences.

8.2 Intangible Non-Current Assets Acquired by Government Grant

None of the Trust’s intangible assets were acquired by government grant.

8.3 Economic Life of Non-Current Assets

The Trust’s intangible assets, software licences, have an expected minimum economic life of five years.

9 Surplus/Deficit Attributable to the Trust

The surplus for the Trust was £2,403,000 (2013/14 deficit of £51,570,000) and is included within the Statement of Comprehensive Income for the Group.
10 Tangible Non-Current Assets

10.1 Property Plant and Equipment at the 31 March 2015 Comprise the Following Elements;

<table>
<thead>
<tr>
<th>Group</th>
<th>Buildings excluding dwellings £000</th>
<th>Assets under construction £000</th>
<th>Dwellings £000</th>
<th>Plant &amp; 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>
</table>

**Cost or valuation at 1 April 2014**
19,626 243,006 70,209 6,277 51,226 50 16,431 2,977 409,802

**Additions - purchased**
0 35,084 4,530 0 2,055 0 722 0 42,391

**Additions - donated**
0 0 0 0 203 0 0 0 203

**Impairments charged to revaluation reserve**
(500) 0 0 0 0 0 0 (500)

**Reclassifications**
0 67,786 (68,554) 0 236 0 362 0 (170)

**Transfer to asset held for sale**
(2,885) 0 0 0 0 0 0 (2,885)

**Disposals**
(1,700) (548) 0 0 (2,048) 0 (1,792) (120) (6,208)

**Cost or valuation at 31 March 2015**
14,541 345,328 6,185 6,277 51,672 50 15,723 2,857 442,633

The Group and Foundation Trust’s land and buildings were revalued at 31 March 2015 by external valuers. Further information is included in note 1, accounting policies. As a result of this revaluation a net amount of £14,000,000 was charged to the income statement (being impairments of £17,343,000 less impairment reversals of £3,343,000). Assets under construction were not included in this revaluation.

Property plant and equipment at the 31 March 2014 comprised the following elements;

<table>
<thead>
<tr>
<th>Group</th>
<th>Buildings excluding dwellings £000</th>
<th>Assets under construction £000</th>
<th>Dwellings £000</th>
<th>Plant &amp; 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>
</table>

**Cost or valuation at 1 April 2013**
18,204 226,934 30,537 6,277 48,286 50 13,459 2,977 346,724

**Additions - purchased**
0 14,399 45,879 0 3,145 0 723 0 64,146

**Additions - donated**
0 0 0 0 0 0 0 0 33

**Revaluations**
1,422 0 0 0 0 0 0 0 1,422

**Reclassifications to intangible assets**
0 0 (1,949) 0 0 0 0 (1,949)

**Reclassifications**
0 1,673 (4,258) 0 336 0 2,249 0 0

**Disposals**
0 0 0 0 (574) 0 0 0 (574)

**Cost or valuation at 31 March 2014**
19,626 243,006 70,209 6,277 51,226 50 16,431 2,977 409,802

The Group and Foundation Trust’s land and buildings were revalued at 31 March 2014 by external valuers. Further information is included in note 1, accounting policies. As a result of this revaluation a net £15,185,000 was charged to the income statement (being impairments of £18,022,000 less impairment reversals of £2,837,000) and £1,598,000 was credited to the revaluation reserve. Assets under construction were not included in this revaluation.

The Group and Foundation Trust’s land and buildings were revalued at 31 March 2015 by external valuers. Further information is included in note 1, accounting policies. As a result of this revaluation a net amount of £14,000,000 was charged to the income statement (being impairments of £17,343,000 less impairment reversals of £3,343,000). Assets under construction were not included in this revaluation.

The Group and Foundation Trust’s land and buildings were revalued at 31 March 2014 by external valuers. Further information is included in note 1, accounting policies. As a result of this revaluation a net amount of £14,000,000 was charged to the income statement (being impairments of £17,343,000 less impairment reversals of £3,343,000). Assets under construction were not included in this revaluation.

The Group and Foundation Trust’s land and buildings were revalued at 31 March 2015 by external valuers. Further information is included in note 1, accounting policies. As a result of this revaluation a net amount of £14,000,000 was charged to the income statement (being impairments of £17,343,000 less impairment reversals of £3,343,000). Assets under construction were not included in this revaluation.

The Group and Foundation Trust’s land and buildings were revalued at 31 March 2015 by external valuers. Further information is included in note 1, accounting policies. As a result of this revaluation a net amount of £14,000,000 was charged to the income statement (being impairments of £17,343,000 less impairment reversals of £3,343,000). Assets under construction were not included in this revaluation.
10 Tangible Non-Current Assets

10.1 Property Plant and Equipment at the 31 March 2015 Comprise the Following Elements;

### Foundation Trust

<table>
<thead>
<tr>
<th>Land</th>
<th>Buildings excluding dwellings</th>
<th>Assets under construction</th>
<th>Dwellings</th>
<th>Plant &amp; Machinery</th>
<th>Transport Equipment</th>
<th>Information Technology</th>
<th>Furniture &amp; fittings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<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 2014</td>
<td>19,626</td>
<td>243,006</td>
<td>21,895</td>
<td>6,277</td>
<td>51,226</td>
<td>50</td>
<td>16,431</td>
<td>2,977</td>
</tr>
<tr>
<td>Additions - purchased</td>
<td>0</td>
<td>83,998</td>
<td>716</td>
<td>2,055</td>
<td>0</td>
<td>0</td>
<td>722</td>
<td>0</td>
</tr>
<tr>
<td>Additions - donated</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>203</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>203</td>
</tr>
<tr>
<td>Impairments charged to revaluation reserve</td>
<td>(500)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Transfer to assets held for sale</td>
<td>(2,885)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(2,885)</td>
</tr>
<tr>
<td>Reclassifications</td>
<td>0</td>
<td>19,472</td>
<td>(20,240)</td>
<td>0</td>
<td>236</td>
<td>0</td>
<td>362</td>
<td>0</td>
</tr>
<tr>
<td>Disposals</td>
<td>(1,700)</td>
<td>(548)</td>
<td>0</td>
<td>(2,048)</td>
<td>0</td>
<td>(1,792)</td>
<td>(120)</td>
<td>(6,208)</td>
</tr>
<tr>
<td>Cost or valuation at 31 March 2015</td>
<td>14,541</td>
<td>345,328</td>
<td>2,371</td>
<td>6,277</td>
<td>51,672</td>
<td>50</td>
<td>15,723</td>
<td>2,857</td>
</tr>
</tbody>
</table>

#### Accumulated depreciation and impairment at 1 April 2014

<table>
<thead>
<tr>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>5,731</td>
</tr>
<tr>
<td>130,298</td>
</tr>
<tr>
<td>99</td>
</tr>
<tr>
<td>5,087</td>
</tr>
<tr>
<td>31,024</td>
</tr>
<tr>
<td>46</td>
</tr>
<tr>
<td>12,267</td>
</tr>
<tr>
<td>2,204</td>
</tr>
<tr>
<td>186,756</td>
</tr>
</tbody>
</table>

Provided during the year 18,204

Reversal of impairments 0

Impairments 0

Revaluation surpluses 0

Disposals 0

Cost or valuation at 31 March 2015 5,731

Accumulated depreciation and impairment at 31 March 2015 14,541

#### Net book value (cost less accumulated depreciation)

<table>
<thead>
<tr>
<th>Purchased At 31 March 2015</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>7,897</td>
<td>188,130</td>
</tr>
<tr>
<td>2,272</td>
<td>0</td>
</tr>
<tr>
<td>16,966</td>
<td>3</td>
</tr>
<tr>
<td>4,137</td>
<td>591</td>
</tr>
<tr>
<td>219,996</td>
<td></td>
</tr>
</tbody>
</table>

Finance Leases 913

On Balance Sheet PFI contracts 0

Donated At 31 March 2015 0

Cost or valuation at 31 March 2015 8,810

Accumulated depreciation and impairment at 31 March 2015 5,731

Net book value at 31 March 2015 33,462

The Group and Foundation Trust’s land and buildings were revalued at 31 March 2015 by external valuers. Further information is included in note 1, accounting policies. As a result of this revaluation a net amount of £14,000,000 was charged to the income statement (being impairments of £17,343,000 less impairment reversals of £3,343,000). Assets under construction were not included in this revaluation.

Property plant and equipment at the 31 March 2014 comprised the following elements;

### Foundation Trust

<table>
<thead>
<tr>
<th>Land</th>
<th>Buildings excluding dwellings</th>
<th>Assets under construction</th>
<th>Dwellings</th>
<th>Plant &amp; Machinery</th>
<th>Transport Equipment</th>
<th>Information Technology</th>
<th>Furniture &amp; fittings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<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 2013</td>
<td>18,204</td>
<td>226,934</td>
<td>24,665</td>
<td>6,277</td>
<td>48,286</td>
<td>50</td>
<td>13,459</td>
<td>2,837</td>
</tr>
<tr>
<td>Additions - purchased</td>
<td>0</td>
<td>14,399</td>
<td>3,437</td>
<td>0</td>
<td>3,145</td>
<td>0</td>
<td>225</td>
<td>0</td>
</tr>
<tr>
<td>Additions - donated</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>33</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>33</td>
</tr>
<tr>
<td>Revaluations</td>
<td>1,422</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,422</td>
</tr>
<tr>
<td>Reclassifications to intangible assets</td>
<td>0</td>
<td>0</td>
<td>(1,949)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(1,949)</td>
</tr>
<tr>
<td>Reclassifications</td>
<td>0</td>
<td>1,673</td>
<td>(4,258)</td>
<td>0</td>
<td>336</td>
<td>0</td>
<td>2,249</td>
<td>0</td>
</tr>
<tr>
<td>Disposals</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(574)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(574)</td>
</tr>
<tr>
<td>Cost or valuation at 31 March 2014</td>
<td>19,626</td>
<td>243,006</td>
<td>21,895</td>
<td>6,277</td>
<td>51,226</td>
<td>50</td>
<td>16,431</td>
<td>2,977</td>
</tr>
</tbody>
</table>

Provided during the year 5,731

Reversal of impairments 0

Revaluation surpluses 0

Disposals 0

Cost or valuation at 31 March 2014 19,626

Accumulated depreciation and impairment at 1 April 2013 5,731

Net book value (cost less accumulated depreciation)

<table>
<thead>
<tr>
<th>Purchased At 31 March 2014</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>12,984</td>
<td>79,127</td>
</tr>
<tr>
<td>21,796</td>
<td>0</td>
</tr>
<tr>
<td>18,669</td>
<td>4</td>
</tr>
<tr>
<td>4,164</td>
<td>714</td>
</tr>
<tr>
<td>137,458</td>
<td></td>
</tr>
</tbody>
</table>

Finance Leases 913

On Balance Sheet PFI contracts 0

Donated At 31 March 2014 0

Cost or valuation at 31 March 2014 13,897

Accumulated depreciation and impairment at 31 March 2014 5,731

Net book value at 31 March 2014 27,405

The Group and Foundation Trust’s land and buildings were revalued at 31 March 2014 by external valuers. Further information is included in note 1, accounting policies. As a result of this revaluation a net amount of £15,185,000 was charged to the income statement (being impairments of £18,022,000 less impairment reversals of £2,837,000). Assets under construction were not included in this revaluation.
### 10.2 Assets Held at Open Market Value

<table>
<thead>
<tr>
<th></th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Land</strong></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>4,885</td>
</tr>
<tr>
<td><strong>Total open market value</strong></td>
<td>0</td>
<td>4,885</td>
</tr>
</tbody>
</table>

During the year land with an open market value of £2,885,000 was transferred to assets held for sale (Note 12). The remaining land held at open market value, £2,000,000 was disposed of during the year.

### 10.3 The Net Book Value of Land, Buildings and Dwellings at the Date of the Statement of Financial Position Comprises

<table>
<thead>
<tr>
<th></th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Freehold</strong></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td></td>
<td>111,198</td>
<td>92,214</td>
</tr>
<tr>
<td><strong>Leasehold</strong></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td></td>
<td>97,448</td>
<td>35,581</td>
</tr>
<tr>
<td><strong>Total net book value</strong></td>
<td>208,646</td>
<td>127,795</td>
</tr>
</tbody>
</table>

At 31 March 2015 the Group and Foundation Trust’s land and buildings were independently revalued as described in note Accounting policies section 7. The valuation was prepared in accordance with the terms of the Royal Institution of Chartered Surveyors’ Valuation Standards, 6th Edition, insofar as these terms are consistent with requirements of HM Treasury, the National Health Service and Monitor. The method of valuation is outlined in paragraph 5 of the section ‘valuation’ on page 8.

### 11.1 Net Book Value of Assets Held Under Finance Leases

<table>
<thead>
<tr>
<th></th>
<th>Cost or valuation at 1 April 2014</th>
<th>Revaluation surpluses</th>
<th>Impairments recognised in operating expenses</th>
<th>Accumulated depreciation at 31 March 2015</th>
<th>NBV total at 31 March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group</strong></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>55,853</td>
<td>156</td>
<td>18</td>
<td>19,415</td>
<td>98,088</td>
</tr>
<tr>
<td><strong>Land</strong></td>
<td>913</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>98,088</td>
</tr>
<tr>
<td><strong>Dwellings</strong></td>
<td>1,551</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>98,088</td>
</tr>
<tr>
<td><strong>Plant &amp; Machinery</strong></td>
<td>3,702</td>
<td>3,051</td>
<td>264</td>
<td>26,417</td>
<td>10,489</td>
</tr>
<tr>
<td><strong>Buildings</strong></td>
<td>84,920</td>
<td>16,210</td>
<td>710</td>
<td>15,928</td>
<td>10,489</td>
</tr>
<tr>
<td><strong>Excluding Dwellings</strong></td>
<td>84,920</td>
<td>16,210</td>
<td>710</td>
<td>15,928</td>
<td>10,489</td>
</tr>
<tr>
<td><strong>PFI arrangements</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

During the year land with an open market value of £2,885,000 was transferred to assets held for sale (Note 12). The remaining land held at open market value, £2,000,000 was disposed of during the year.
11.1 Net Book Value of Assets Held Under Finance Leases

<table>
<thead>
<tr>
<th>Net book value</th>
<th>NBV - Purchased at 1 April 2014</th>
<th>36,495</th>
<th>913</th>
<th>1,190</th>
<th>915</th>
<th>0</th>
<th>33,477</th>
</tr>
</thead>
<tbody>
<tr>
<td>NBV total at 1 April 2014</td>
<td>36,495</td>
<td>913</td>
<td>1,190</td>
<td>915</td>
<td>0</td>
<td>33,477</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Net book value</th>
<th>NBV - Purchased at 1 April 2015</th>
<th>176,365</th>
<th>913</th>
<th>1,115</th>
<th>651</th>
<th>163,197</th>
<th>10,489</th>
</tr>
</thead>
<tbody>
<tr>
<td>NBV total at 31 March 2015</td>
<td>176,365</td>
<td>913</td>
<td>1,115</td>
<td>651</td>
<td>163,197</td>
<td>10,489</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12 Assets Held for Sale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Land held for sale</strong></td>
</tr>
</tbody>
</table>

Assets held for sale comprises surplus land at North Tyneside General Hospital, £1,650,000, and surplus land at Wansbeck General Hospital, £1,235,000.
13 Group Investments

The Trust’s principal subsidiary undertakings included in the consolidation at 31 March 2015 are shown below. The accounting dates for the subsidiaries and joint ventures is 31 March.

<table>
<thead>
<tr>
<th>Name</th>
<th>Country of Incorporation</th>
<th>Beneficial Interest</th>
<th>Principal Activity</th>
<th>Undertaking Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northumbria Healthcare Facilities Management Limited</td>
<td>UK</td>
<td>100%</td>
<td>Design, project management and operation of capital schemes</td>
<td>Subsidiary</td>
</tr>
<tr>
<td>Pointnorth Community Interest Company</td>
<td>UK</td>
<td>50%</td>
<td>Provision of healthcare services</td>
<td>Joint venture</td>
</tr>
<tr>
<td>Community Services North East Limited</td>
<td>UK</td>
<td>50%</td>
<td>Provision of healthcare services</td>
<td>Joint venture</td>
</tr>
<tr>
<td>Northumbria Primary Care Limited</td>
<td>UK</td>
<td>100%</td>
<td>Provision of healthcare services</td>
<td>Subsidiary</td>
</tr>
<tr>
<td>Northumbria Primary Care Cost Sharing Group Limited</td>
<td>UK</td>
<td>100%</td>
<td>A cost sharing group</td>
<td>Subsidiary</td>
</tr>
</tbody>
</table>

Northumbria Healthcare Facilities Management Limited was incorporated on the 25th of January 2012 and is a wholly owned subsidiary of Northumbria Healthcare NHS Foundation Trust. The primary purpose of the company is the design, project management and operation of specific capital schemes. Currently the largest contract is for the development of the site of the Northumbria Specialist Emergency Care Hospital in Cramlington, Northumberland and the provision of associated services. The year end of this company is 31 March 2015.

The Trust holds a 50% share in Pointnorth Community Interest Company with the remaining investment being fully held by Ponteland Medical Group GP practice.

The Trust holds a 50% share in Community Services North East Limited with the remaining investment being fully held by Norprime Limited a subsidiary Monkseaton Medical Practice.

The Trust held no investments in property or assets at the 31 March 2015 (31 March 2014 - Nil).

14 Investments in Subsidiary and Joint Venture Operations

<table>
<thead>
<tr>
<th>Group</th>
<th>Current</th>
<th>Total £000</th>
<th>31 March 2015 £000</th>
<th>31 March 2015 £000</th>
<th>31 March 2015 £000</th>
<th>31 March 2015 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Investments in wholly owned subsidiaries</td>
<td>Loans to wholly owned subsidiaries</td>
<td>Jointly controlled entities</td>
<td>Loans to jointly controlled entities</td>
<td></td>
</tr>
<tr>
<td>At beginning of year</td>
<td>60</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>59</td>
<td></td>
</tr>
<tr>
<td>Additions</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Repayment of loan principal</td>
<td>(30)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(30)</td>
<td></td>
</tr>
<tr>
<td>Total investment</td>
<td>50</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>49</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group</th>
<th>Current</th>
<th>Total £000</th>
<th>31 March 2014 £000</th>
<th>31 March 2014 £000</th>
<th>31 March 2014 £000</th>
<th>31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Investments in wholly owned subsidiaries</td>
<td>Loans to wholly owned subsidiaries</td>
<td>Jointly controlled entities</td>
<td>Loans to jointly controlled entities</td>
<td></td>
</tr>
<tr>
<td>At beginning of year</td>
<td>78</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>Additions</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Repayment of loan principal</td>
<td>(18)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(18)</td>
<td></td>
</tr>
<tr>
<td>Total investment</td>
<td>60</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>59</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Foundation Trust</th>
<th>Current</th>
<th>Total £000</th>
<th>31 March 2015 £000</th>
<th>31 March 2015 £000</th>
<th>31 March 2015 £000</th>
<th>31 March 2015 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Investments in wholly owned subsidiaries</td>
<td>Loans to wholly owned subsidiaries</td>
<td>Jointly controlled entities</td>
<td>Loans to jointly controlled entities</td>
<td></td>
</tr>
<tr>
<td>At beginning of year</td>
<td>48,977</td>
<td>10,029</td>
<td>38,888</td>
<td>1</td>
<td>59</td>
<td></td>
</tr>
<tr>
<td>Additions</td>
<td>29,543</td>
<td>1,019</td>
<td>28,504</td>
<td>0</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Repayment of loan principal</td>
<td>(30)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(30)</td>
<td></td>
</tr>
<tr>
<td>Total investment</td>
<td>78,490</td>
<td>11,048</td>
<td>67,392</td>
<td>1</td>
<td>49</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Foundation Trust</th>
<th>Current</th>
<th>Total £000</th>
<th>31 March 2014 £000</th>
<th>31 March 2014 £000</th>
<th>31 March 2014 £000</th>
<th>31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Investments in wholly owned subsidiaries</td>
<td>Loans to wholly owned subsidiaries</td>
<td>Jointly controlled entities</td>
<td>Loans to jointly controlled entities</td>
<td></td>
</tr>
<tr>
<td>At beginning of year</td>
<td>4,377</td>
<td>851</td>
<td>3,448</td>
<td>1</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>Additions</td>
<td>44,618</td>
<td>9,178</td>
<td>35,440</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Repayment of loan principal</td>
<td>(18)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(18)</td>
<td></td>
</tr>
<tr>
<td>Total investment</td>
<td>48,977</td>
<td>10,029</td>
<td>38,888</td>
<td>1</td>
<td>59</td>
<td></td>
</tr>
</tbody>
</table>

The Group has accounted Northumbria Healthcare Facilities Management Limited as a subsidiary undertaking. Investments in other entities have been recorded at cost of investment on the grounds that they are not material in the context of the Group financial statements.
## 15 Inventories

<table>
<thead>
<tr>
<th></th>
<th>31 March 2015</th>
<th>31 March 2014</th>
<th>Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Theatre inventories</td>
<td>6,393</td>
<td>5,511</td>
<td>6,393</td>
</tr>
<tr>
<td>Drugs and medical gases</td>
<td>1,879</td>
<td>1,886</td>
<td>1,879</td>
</tr>
<tr>
<td>Medical supplies</td>
<td>1,794</td>
<td>1,430</td>
<td>1,794</td>
</tr>
<tr>
<td>Other inventories</td>
<td>870</td>
<td>881</td>
<td>870</td>
</tr>
<tr>
<td><strong>Total inventories</strong></td>
<td><strong>10,936</strong></td>
<td><strong>9,708</strong></td>
<td><strong>10,936</strong></td>
</tr>
</tbody>
</table>

## 16 Trade and Other Receivables

### 16.1 Trade and Other Receivables

<table>
<thead>
<tr>
<th></th>
<th>31 March 2015</th>
<th>31 March 2014</th>
<th>Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>NHS receivables - invoiced</td>
<td>18,252</td>
<td>20,423</td>
<td>18,252</td>
</tr>
<tr>
<td>NHS receivables - accrued</td>
<td>2,844</td>
<td>0</td>
<td>2,844</td>
</tr>
<tr>
<td>Provision for impaired receivables</td>
<td>(1,717)</td>
<td>(1,778)</td>
<td>(1,717)</td>
</tr>
<tr>
<td>Other receivables - related parties</td>
<td>1,527</td>
<td>1,967</td>
<td>1,140</td>
</tr>
<tr>
<td>Prepayments</td>
<td>7,854</td>
<td>7,291</td>
<td>7,854</td>
</tr>
<tr>
<td>Accrued Income</td>
<td>6,249</td>
<td>11,138</td>
<td>6,249</td>
</tr>
<tr>
<td>Interest receivable</td>
<td>15</td>
<td>40</td>
<td>3,211</td>
</tr>
<tr>
<td>PDC receivable</td>
<td>0</td>
<td>68</td>
<td>0</td>
</tr>
<tr>
<td>Other receivables</td>
<td>5,176</td>
<td>7,330</td>
<td>4,954</td>
</tr>
<tr>
<td><strong>Total current receivables</strong></td>
<td><strong>40,200</strong></td>
<td><strong>46,479</strong></td>
<td><strong>42,787</strong></td>
</tr>
</tbody>
</table>

### Non-current

- Other receivables - employee benefits reimbursement right: 1,080, 550, 1,080, 550
- **Total non current receivables**: 1,080, 550, 1,080, 550

### Total trade and other receivables

- **Total trade and other receivables**: 41,280, 47,029, 43,867, 46,795

Non-current receivables comprises:

£1,080,000 for the rights of re-imbursement of expenditure required to settle the Trust’s defined benefit obligation arising from membership of the Northumberland County Council Local Government Pension Scheme. These defined benefit obligations have been indemnified by Northumberland County Council as part of the agreement for the transfer of the provider business of Northumberland Care Trust and North Tyneside PCT to Northumbria Healthcare NHS Foundation Trust at April 2011. Further details are set out in note 23.

### 16.2 Age Profile of Impaired Receivables

<table>
<thead>
<tr>
<th>Ageing of Impaired Receivables</th>
<th>31 March 2015</th>
<th>31 March 2014</th>
<th>Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Within 30 days</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>30 - 60 days</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>60 - 90 days</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>90 - 180 days</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Over 180 days</td>
<td>1,717</td>
<td>1,778</td>
<td>1,717</td>
</tr>
<tr>
<td><strong>Total impaired receivables</strong></td>
<td><strong>1,717</strong></td>
<td><strong>1,778</strong></td>
<td><strong>1,717</strong></td>
</tr>
</tbody>
</table>

### 16.3 Ageing of Non-NHS, Non-Impaired Debtors Past their Due Date

<table>
<thead>
<tr>
<th>Ageing of Non-NHS, Non-Impaired Debtors Past their Due Date</th>
<th>31 March 2015</th>
<th>31 March 2014</th>
<th>Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Within 30 days</td>
<td>0</td>
<td>686</td>
<td>0</td>
</tr>
<tr>
<td>30 - 60 days</td>
<td>0</td>
<td>286</td>
<td>0</td>
</tr>
<tr>
<td>60 - 90 days</td>
<td>3,408</td>
<td>180</td>
<td>3,408</td>
</tr>
<tr>
<td>90 - 180 days</td>
<td>4,814</td>
<td>189</td>
<td>4,814</td>
</tr>
<tr>
<td>Over 180 days</td>
<td>904</td>
<td>0</td>
<td>904</td>
</tr>
<tr>
<td><strong>Total non-impaired past due date</strong></td>
<td><strong>9,126</strong></td>
<td><strong>1,341</strong></td>
<td><strong>9,126</strong></td>
</tr>
</tbody>
</table>

### 17 Other Assets Investments

No current asset investments were held at 31 March 2015 (31 March 2014 - Nil).
Northumbria Healthcare NHS Foundation Trust - Annual Accounts 2014-15

18 Trade and Other Payables

Payables at the Statement of Financial Position date are made up of:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS payables</td>
<td>£7,727</td>
<td>£3,440</td>
<td>£7,727</td>
<td>£3,440</td>
</tr>
<tr>
<td>Amount due to related parties</td>
<td>£9,344</td>
<td>£9,159</td>
<td>£9,344</td>
<td>£9,159</td>
</tr>
<tr>
<td>Trade payables - capital</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Accrual - capital</td>
<td>£2,089</td>
<td>£6,373</td>
<td>£389</td>
<td>£505</td>
</tr>
<tr>
<td>Other trade payables</td>
<td>£6,929</td>
<td>£8,775</td>
<td>£6,484</td>
<td>£8,775</td>
</tr>
<tr>
<td>Other payables</td>
<td>£1,168</td>
<td>£3,036</td>
<td>£1,253</td>
<td>£3,036</td>
</tr>
<tr>
<td>Accruals</td>
<td>£19,537</td>
<td>£21,754</td>
<td>£19,528</td>
<td>£21,725</td>
</tr>
<tr>
<td>Total current payables</td>
<td>£46,794</td>
<td>£52,537</td>
<td>£44,725</td>
<td>£46,640</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade payables - capital</td>
<td>2,200</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other payables</td>
<td>4,865</td>
<td>3,870</td>
<td>4,865</td>
<td>3,870</td>
</tr>
<tr>
<td>Total payables due after 1 year</td>
<td>£7,065</td>
<td>£3,870</td>
<td>£4,865</td>
<td>£3,870</td>
</tr>
</tbody>
</table>

| Total trade and other payables | £53,859 | £56,407 | £49,590 | £50,510 |

Other payables include: - £36,000 for payments due in future years under arrangements to buy out the liability for 78 early retirements (31 March 2014 - £37,000)

19 Other Liabilities

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deferred Income</td>
<td>£7,250</td>
<td>£12,550</td>
<td>£7,250</td>
<td>£12,550</td>
</tr>
<tr>
<td>Wholly owned subsidiary share capital</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total other current liabilities</td>
<td>£7,250</td>
<td>£12,550</td>
<td>£7,250</td>
<td>£17,016</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deferred Income</td>
<td>2,092</td>
<td>0</td>
<td>2,092</td>
<td>0</td>
</tr>
<tr>
<td>Total other current liabilities</td>
<td>2,092</td>
<td>0</td>
<td>2,092</td>
<td>0</td>
</tr>
</tbody>
</table>

20 Interest bearing borrowings

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Loans from Foundation Trust Financing Facility</td>
<td>£2,624</td>
<td>£2,624</td>
<td>£2,624</td>
<td>£2,624</td>
</tr>
<tr>
<td>Other term loan</td>
<td>£4,876</td>
<td>£4,376</td>
<td>£4,876</td>
<td>£4,376</td>
</tr>
<tr>
<td>Obligations under finance leases</td>
<td>£423</td>
<td>£486</td>
<td>£3,554</td>
<td>£486</td>
</tr>
<tr>
<td>Obligations under Private Finance Initiative contracts</td>
<td>£489</td>
<td>£61,042</td>
<td>£489</td>
<td>£61,042</td>
</tr>
<tr>
<td>Total current borrowings</td>
<td>£8,412</td>
<td>£68,528</td>
<td>£11,543</td>
<td>£68,528</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Loans from Foundation Trust Financing Facility</td>
<td>£53,112</td>
<td>£55,736</td>
<td>£53,112</td>
<td>£55,736</td>
</tr>
<tr>
<td>Other term loan</td>
<td>£126,548</td>
<td>£106,924</td>
<td>£126,548</td>
<td>£106,924</td>
</tr>
<tr>
<td>Obligations under finance leases</td>
<td>£6,293</td>
<td>£6,935</td>
<td>£81,439</td>
<td>£6,935</td>
</tr>
<tr>
<td>Obligations under Private Finance Initiative contracts</td>
<td>£20,337</td>
<td>£20,822</td>
<td>£20,337</td>
<td>£20,822</td>
</tr>
<tr>
<td>Total non current borrowings</td>
<td>£206,290</td>
<td>£190,417</td>
<td>£281,436</td>
<td>£190,417</td>
</tr>
</tbody>
</table>

On 31 March 2014 the Trust served termination notice on a PFI contract. This notice was contractually binding and required payment of the outstanding liability together with compensation within six months of the notice being served. For this reason the entire PFI obligation relating to this contract was classified as a current liability at the end of 2013/14. This has subsequently been paid during 2014/15 (see note 24 for details).

Further details of loans;

<table>
<thead>
<tr>
<th>Loan and purpose of loan</th>
<th>Amount of Loan</th>
<th>Due after 5 years</th>
<th>Year of Loan</th>
<th>Interest rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>From FTFF for build of Cramlington Emergency Care Hospital</td>
<td>£50,000,000</td>
<td>£31,040,000</td>
<td>2011/12</td>
<td>4.00% fixed</td>
</tr>
<tr>
<td>From FTFF for purchase of Northumbria House Cobalt Business Park</td>
<td>£12,600,000</td>
<td>£9,576,000</td>
<td>2013/14</td>
<td>3.34% fixed</td>
</tr>
<tr>
<td>From Northumberland County Council for the termination of Hexham PFI contract</td>
<td>£111,200,000</td>
<td>£84,982,000</td>
<td>2013/14</td>
<td>3.98% fixed</td>
</tr>
<tr>
<td>From Northumberland County Council for the redevelopment of Berwick Hospital</td>
<td>£25,000,000</td>
<td>£20,000,000</td>
<td>2014/15</td>
<td>3.21% fixed</td>
</tr>
</tbody>
</table>

All loans are repayable by 50 equal instalments over 25 years.
21 Finance Lease Obligations

21.2 Finance Lease Obligations - Group

The Group had the following material finance lease obligations under non-PFI finance lease arrangements;

1. Staff Residences - Land and Building at Wansbeck and North Tyneside Hospitals leased for a 25 year period beginning in 2005.
2. PACS - Radiology and IT equipment with associated network infrastructure - 15 year lease beginning in 2004.
3. Beds - Beds and specialised beds for all wards Trustwide under various 15 year leases ending in 2020.

<table>
<thead>
<tr>
<th></th>
<th>31 March 2015</th>
<th>31 March 2014</th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td></td>
<td>Present Value</td>
<td>Present Value</td>
<td>Present Value</td>
<td>Present Value</td>
</tr>
<tr>
<td>Gross lease liabilities</td>
<td>13,425</td>
<td>11,951</td>
<td>11,743</td>
<td>12,095</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of which liabilities are due:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- not later than one year;</td>
<td>1,274</td>
<td>1,215</td>
<td>1,274</td>
<td>1,215</td>
</tr>
<tr>
<td>- later than one year and not later than five years;</td>
<td>4,211</td>
<td>4,258</td>
<td>3,999</td>
<td>4,042</td>
</tr>
<tr>
<td>- later than five years.</td>
<td>7,940</td>
<td>8,476</td>
<td>6,472</td>
<td>6,838</td>
</tr>
<tr>
<td>Net lease liabilities</td>
<td>6,716</td>
<td>7,420</td>
<td>5,644</td>
<td>6,237</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of which lease liabilities due:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- not later than one year;</td>
<td>423</td>
<td>486</td>
<td>423</td>
<td>486</td>
</tr>
<tr>
<td>- later than one year and not later than five years;</td>
<td>1,466</td>
<td>1,799</td>
<td>1,400</td>
<td>1,708</td>
</tr>
<tr>
<td>- later than five years.</td>
<td>4,827</td>
<td>5,135</td>
<td>3,821</td>
<td>4,043</td>
</tr>
</tbody>
</table>

21.3 Finance Lease Obligations - Foundation Trust

The Trust had the following material finance lease obligations under non-PFI finance lease arrangements;

1. Staff Residences - Land and Building at Wansbeck and North Tyneside Hospitals leased for a 25 year period beginning in 2005.
2. PACS - Radiology and IT equipment with associated network infrastructure - 15 year lease beginning in 2004.
3. Beds - Beds and specialised beds for all wards Trustwide under various 15 year leases ending in 2020.
4. Emergency Care Hospital Cramlington (ECC)

During 2012 the Trust entered into an agreement with Northumbria Healthcare Facilities Management Limited (NHFML) to design, finance, construct and operate healthcare facilities and provide facility management services with respect to the new Emergency Care Centre. Practical completion was granted on 31 March 2015 therefore the Emergency Care Centre asset has been reflected in the balance sheet of the Trust together with an associated finance lease creditor payable to Northumbria Healthcare Facilities Management Limited.

The classification and recognition of this asset and liability is based on a detailed assessment of the risks and rewards of this 'operated healthcare services' arrangement. This in turn includes as assessment of whether the arrangement is an arrangement containing a lease, whether such a lease is a finance or operating lease, and consideration of the economic substance of this arrangement.

Although the arrangement is not in the legal form of a lease, the Trust concluded that the arrangement contains a lease of the ECC, and it is unlikely that any parties other than the Trust will receive more than an insignificant part of its use. The Trust have concluded that substantially all the risks and rewards incidental to the ownership of this asset have transferred to the Trust under this arrangement. The element of this arrangement is therefore classified as a finance lease.

<table>
<thead>
<tr>
<th></th>
<th>31 March 2015</th>
<th>31 March 2014</th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td></td>
<td>Present Value</td>
<td>Present Value</td>
<td>Present Value</td>
<td>Present Value</td>
</tr>
<tr>
<td>Gross lease liabilities</td>
<td>91,702</td>
<td>13,951</td>
<td>90,022</td>
<td>12,095</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of which liabilities are due:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- not later than one year;</td>
<td>4,405</td>
<td>1,215</td>
<td>4,405</td>
<td>1,215</td>
</tr>
<tr>
<td>- later than one year and not later than five years;</td>
<td>16,735</td>
<td>4,258</td>
<td>16,523</td>
<td>4,042</td>
</tr>
<tr>
<td>- later than five years.</td>
<td>70,562</td>
<td>8,476</td>
<td>69,094</td>
<td>6,838</td>
</tr>
<tr>
<td>Net lease liabilities</td>
<td>84,993</td>
<td>7,420</td>
<td>83,921</td>
<td>6,237</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of which lease liabilities due:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- not later than one year;</td>
<td>3,554</td>
<td>486</td>
<td>3,554</td>
<td>486</td>
</tr>
<tr>
<td>- later than one year and not later than five years;</td>
<td>13,990</td>
<td>1,799</td>
<td>13,924</td>
<td>1,708</td>
</tr>
<tr>
<td>- later than five years.</td>
<td>67,449</td>
<td>5,135</td>
<td>66,443</td>
<td>4,043</td>
</tr>
</tbody>
</table>

22 PFI Obligations - on Statement of Financial Position

The Group and Trust has the following finance lease obligations under PFI arrangements;

1. Wansbeck Hospital Phase II - The scheme is for the provision of Maternity, Gynaecology, Outpatients, Day Surgery and Child Health facilities and associated building maintenance.
2. Rothbury Community Hospital - The scheme is for the reprovision of a community hospital.

The Group and Trust is contracted to make the following payments for on Statement of Financial Position PFI obligations over the total periods of the contracts;

<table>
<thead>
<tr>
<th></th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Gross PFI obligations (including lifecycle expenditure payments)</td>
<td>57,192</td>
<td>212,323</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of which liabilities are due:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- not later than one year;</td>
<td>2,614</td>
<td>155,135</td>
</tr>
<tr>
<td>- later than one year and not later than five years;</td>
<td>11,137</td>
<td>10,861</td>
</tr>
<tr>
<td>- later than five years.</td>
<td>43,441</td>
<td>46,327</td>
</tr>
<tr>
<td>Lifecycle maintenance expenditure</td>
<td>(11,580)</td>
<td>(28,036)</td>
</tr>
<tr>
<td>Finance charges allocated to future periods</td>
<td>(24,786)</td>
<td>(302,423)</td>
</tr>
<tr>
<td>Total gross PFI obligations</td>
<td>20,826</td>
<td>81,864</td>
</tr>
</tbody>
</table>

Net PFI liabilities falling due;

<table>
<thead>
<tr>
<th></th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>- not later than one year;</td>
<td>489</td>
<td>61,042</td>
</tr>
<tr>
<td>- later than one year and not later than five years;</td>
<td>972</td>
<td>582</td>
</tr>
<tr>
<td>- later than five years.</td>
<td>19,365</td>
<td>20,240</td>
</tr>
<tr>
<td>Total net PFI liabilities</td>
<td>20,826</td>
<td>81,864</td>
</tr>
</tbody>
</table>

Gross PFI liabilities include £11,580,000 (2013/14 - £28,036,000) in respect of lifecycle maintenance expenditure on the PFI schemes. These are payments to replace components of the hospital infrastructure throughout the course of the PFI agreement.

31
Service charge element of PFI

In addition to the above obligations the Group and Trust is contracted to make following payments over the remaining life of the PFI agreements in respect of the service element of operating the PFI schemes. These payments are expensed in the period in which they are made and are excluded from the gross and net PFI liabilities shown above.

<table>
<thead>
<tr>
<th>Service charge commitment falling due;</th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>- not later than one year;</td>
<td>456</td>
<td>1,057</td>
</tr>
<tr>
<td>- later than one year and not later than five years;</td>
<td>1,931</td>
<td>1,888</td>
</tr>
<tr>
<td>- later than five years;</td>
<td>7,577</td>
<td>8,076</td>
</tr>
<tr>
<td>Total service charge element commitment</td>
<td>9,964</td>
<td>11,021</td>
</tr>
</tbody>
</table>

PFI Payment obligations

During the next year the Group and Trust is committed to make the following payments for on-Statement of Financial Position PFI obligations in respect of the non-service unitary charge. The amount to be paid in 2014/15 is shown against the period in which the contract expires.

<table>
<thead>
<tr>
<th>Period when contract expires:</th>
<th>31 March 2015</th>
<th>31 March 2015</th>
<th>31 March 2015</th>
<th>31 March 2015</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>- within 1 year;</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2,945</td>
</tr>
<tr>
<td>- within 2 to 5 years;</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- within 15 to 20 years;</td>
<td>3,071</td>
<td>2,584</td>
<td>487</td>
<td>2,512</td>
<td>5,457</td>
</tr>
<tr>
<td>- within 21 to 25 years</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total PFI payment obligations</td>
<td>3,071</td>
<td>2,584</td>
<td>487</td>
<td>2,512</td>
<td>5,457</td>
</tr>
</tbody>
</table>

23 Employee Benefits NHS Pension Scheme

As the Trust is unable to identify its share of the underlying scheme assets and liabilities this pension scheme is accounted for as if it were a defined contribution pension scheme and the pension cost for the period represents contributions payable to the scheme. The pension cost of this scheme is £29,966,000 (2013/14 £29,028,000).

Northumberland County Council Local Government Pension Scheme

On 1 April 2011 Northumbria Healthcare NHS Foundation Trust acquired the provider business of Northumberland Care Trust and North Tyneside PCT. As part of this transaction a of employees transferred to Northumbria Healthcare Foundation Trust ('the Trust') the Trust was admitted as a member of the Northumberland County Council Local Government Pension Scheme.

As part of the agreement for the transfer of this business Northumberland County Council agreed to indemnify the Trust for all future pension costs of the employees transferred, including all future contributions and any terminal value. The effect of this agreement is that the Trust is indemnified by Northumberland County Council against any gains and losses arising through membership of this pension scheme.

Although the Northumberland County Council Pension Scheme is a multi-employer scheme the Trust is able to identify its share of the assets and liabilities of this scheme and therefore is accounting for this scheme as a defined benefit scheme. This results in a net pension liability being included in these accounts as a non current liability which is offset by a non current asset representing the right of reimbursement from Northumberland County Council under the terms of the Transfer Agreement. As this reimbursement right does not give rise to a plan asset this has been recognised as a separate non current asset.

No amounts are included in the Consolidated Statement of Comprehensive Income in respect of this scheme due to the right of reimbursement from Northumberland County Council of all pension pension costs arising from this scheme. Without this reimbursement right there would be a net charge to the income statement of £350,000 (2013/14 £480,000) comprising;

<table>
<thead>
<tr>
<th>Group and Trust</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current service cost</td>
<td>340</td>
<td>390</td>
</tr>
<tr>
<td>Interest cost</td>
<td>790</td>
<td>870</td>
</tr>
<tr>
<td>Less: expected return on scheme assets</td>
<td>(780)</td>
<td>(780)</td>
</tr>
<tr>
<td>Net charge to income statement</td>
<td>350</td>
<td>480</td>
</tr>
</tbody>
</table>

The information below is in respect of the Group and Trust’s share of the assets and liabilities of this scheme;

<table>
<thead>
<tr>
<th>Group and Trust</th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present value of funded defined benefit obligations</td>
<td>(21,420)</td>
<td>(18,550)</td>
</tr>
<tr>
<td>Fair value of plan assets</td>
<td>20,340</td>
<td>18,000</td>
</tr>
<tr>
<td>Recognised liability for defined benefit obligation</td>
<td>(1,080)</td>
<td>(550)</td>
</tr>
<tr>
<td>Net Liability</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
The fair value of the plan assets and the return on those assets were as follows:

<table>
<thead>
<tr>
<th></th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equities</td>
<td>13,831</td>
<td>12,222</td>
</tr>
<tr>
<td>Government debt</td>
<td>3,560</td>
<td>3,078</td>
</tr>
<tr>
<td>Corporate bonds</td>
<td>1,790</td>
<td>1,710</td>
</tr>
<tr>
<td>Property</td>
<td>895</td>
<td>792</td>
</tr>
<tr>
<td>Other</td>
<td>264</td>
<td>198</td>
</tr>
<tr>
<td><strong>As at 31 March 2015</strong></td>
<td><strong>20,340</strong></td>
<td><strong>18,000</strong></td>
</tr>
<tr>
<td><strong>Actual return on plan assets</strong></td>
<td><strong>2,200</strong></td>
<td><strong>130</strong></td>
</tr>
</tbody>
</table>

The expected rates of return on plan assets are determined by reference to the historical returns, without adjustment, of the portfolio as a whole and not on the sum of the returns on individual asset categories.

Principal actuarial assumptions (expressed as weighted average) at the year end were as follows:

<table>
<thead>
<tr>
<th></th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount rate</td>
<td>3.20%</td>
<td>4.30%</td>
</tr>
<tr>
<td>Future salary increases</td>
<td>3.30%</td>
<td>3.80%</td>
</tr>
<tr>
<td>Rate of increase to pensions in payment</td>
<td>1.80%</td>
<td>2.30%</td>
</tr>
<tr>
<td>Rate of increase to deferred pensions</td>
<td>1.80%</td>
<td>2.30%</td>
</tr>
<tr>
<td>RPI inflation</td>
<td>2.90%</td>
<td>3.30%</td>
</tr>
<tr>
<td>CPI inflation</td>
<td>1.80%</td>
<td>2.30%</td>
</tr>
</tbody>
</table>

In valuing the liabilities of the pension fund at 31 March 2015, mortality assumptions have been made as indicated below.

The assumptions relating to longevity underlying the pension liabilities at the Statement of Financial Position date are based on standard actuarial mortality tables and include an allowance for future improvements in longevity. The assumptions are equivalent to expecting a 65-year old to live for a number of years as follows; Current pensioner aged 65: 22.9 years (male), 25.4 years (female).

History of plans
The history of plans for the current and prior periods are as follows:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Present value of the defined benefit obligation</td>
<td>20,340</td>
<td>18,000</td>
<td>17,680</td>
</tr>
<tr>
<td>Fair value of plan assets</td>
<td>(21,420)</td>
<td>(18,550)</td>
<td>(19,920)</td>
</tr>
<tr>
<td><strong>Gross deficit</strong></td>
<td>(1,080)</td>
<td>(550)</td>
<td>(2,240)</td>
</tr>
<tr>
<td>Right of reimbursement</td>
<td>1,080</td>
<td>550</td>
<td>2,240</td>
</tr>
<tr>
<td><strong>Net (deficit) / surplus</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
24 Provisions for Liabilities and Charges

<table>
<thead>
<tr>
<th>Group and Foundation Trust</th>
<th>Cost of PFI Termination (£000)</th>
<th>Pensions relating to ‘Other’ staff (£000)</th>
<th>Injury Benefit Allowance (£000)</th>
<th>Equal Value Claims (£000)</th>
<th>Public Liability Claims (£000)</th>
<th>NEP Termination Costs (£000)</th>
<th>Payroll Termination Costs (£000)</th>
<th>Total 2015 (£000)</th>
<th>Total 2014 (£000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>At 1 April</td>
<td>52,798</td>
<td>1,031</td>
<td>1,044</td>
<td>645</td>
<td>241</td>
<td>1,479</td>
<td>82</td>
<td>57,520</td>
<td>53,106</td>
</tr>
<tr>
<td>Arising during the period</td>
<td>0</td>
<td>85</td>
<td>265</td>
<td>2,500</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2,850</td>
<td>(889)</td>
</tr>
<tr>
<td>Reversed unused</td>
<td>(12,242)</td>
<td>0</td>
<td>0</td>
<td>(400)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(12,642)</td>
<td></td>
</tr>
<tr>
<td>Utilised during the period</td>
<td>(39,691)</td>
<td>(146)</td>
<td>(123)</td>
<td>(170)</td>
<td>0</td>
<td>(457)</td>
<td>0</td>
<td>(40,587)</td>
<td>(1,569)</td>
</tr>
<tr>
<td>Unwinding of discount</td>
<td>0</td>
<td>54</td>
<td>51</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>105</td>
<td>39</td>
</tr>
<tr>
<td>At 31 March</td>
<td>865</td>
<td>1,024</td>
<td>1,237</td>
<td>2,775</td>
<td>241</td>
<td>1,022</td>
<td>82</td>
<td>7,246</td>
<td>57,520</td>
</tr>
</tbody>
</table>

Expected timing of cashflows:

<table>
<thead>
<tr>
<th></th>
<th>Within 1 year</th>
<th>1 - 5 years</th>
<th>Over 5 years</th>
<th>At 31 March</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>2015</td>
<td>140</td>
<td>220</td>
<td>664</td>
<td>865</td>
</tr>
<tr>
<td>2014</td>
<td>120</td>
<td>480</td>
<td>637</td>
<td>1,024</td>
</tr>
<tr>
<td>2015</td>
<td>58</td>
<td>2,717</td>
<td>262</td>
<td>1,237</td>
</tr>
<tr>
<td>2014</td>
<td>20</td>
<td>181</td>
<td>40</td>
<td>2,775</td>
</tr>
<tr>
<td>2015</td>
<td>100</td>
<td>660</td>
<td>262</td>
<td>241</td>
</tr>
<tr>
<td>2014</td>
<td>0</td>
<td>82</td>
<td>0</td>
<td>1,022</td>
</tr>
<tr>
<td>2015</td>
<td>0</td>
<td>82</td>
<td>0</td>
<td>82</td>
</tr>
<tr>
<td>2014</td>
<td>438</td>
<td>5,205</td>
<td>1,603</td>
<td>7,246</td>
</tr>
</tbody>
</table>

On 31 March 2014 the Trust served notice that it was terminating one of its PFI schemes, the one associated with Hexham Hospital. The PFI agreement provides for the payment of compensation to the PFI provider. This compensation is calculated by reference to a formula which is subjective. As the serving of the notice was contractually binding a provision of £52,798,000 was made in the prior year accounts being the best estimate of the compensation which was payable. During the current year the Trust continued to engage with the PFI provider on the level of compensation payable. During the year an amount of £98,674,000 has been paid, being the original capital of £58,983,000 (note 20) plus compensation of £39,691,000. Other than a remaining balance of £865,000 for contingency sub-contractor and legal fees, this liability has been legally settled in full. This results in a provision release of £12,242,000 in the current year. This has been separately disclosed in the Consolidated Statement of Comprehensive Income as a non-recurring item.

The provision for ‘pensions relating to other staff’ is in respect of staff, other than Directors, who retired prior to 6 March 1995. Repayment is by quarterly instalments to the NHS Pensions Agency.

Payment of injury benefit allowances is made to former employees via the Pensions Agency on the same basis.

The Trust has received a large number of equal value pay claims. The provision is in respect of the estimated costs of reviewing and agreeing job description information for the claimant and their comparators in respect of these claims where the cost of these has been provided by independent advisors and is known with some degree of certainty.

Public liability claims are limited in value because the Trust insures against these claims, and clinical negligence claims, by payment to the NHS Litigation Authority. The NHSLA includes in its accounts at 31 March 2015 a provision for £68,911,522 in respect of clinical negligence claims made against the Trust - (31 March 2014 - £56,701,374).
25 Revaluation Reserve

<table>
<thead>
<tr>
<th></th>
<th>Group and Foundation Trust</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31 March 2015 £000</td>
<td>31 March 2014 £000</td>
<td></td>
</tr>
<tr>
<td>Revaluation reserve at 1 April</td>
<td>4,686</td>
<td>3,308</td>
<td></td>
</tr>
<tr>
<td>Revaluations</td>
<td>(344)</td>
<td>1,598</td>
<td></td>
</tr>
<tr>
<td>Transfer to Income and expenditure reserve</td>
<td>(1,075)</td>
<td>(220)</td>
<td></td>
</tr>
<tr>
<td>Revaluation reserve at 31 March</td>
<td>3,267</td>
<td>4,686</td>
<td></td>
</tr>
</tbody>
</table>

All balances in the revaluation reserve relate to property, plant and equipment. The revaluation reserve does not contain any revaluations in respect of intangible assets.

26 Cash and Cash Equivalents

<table>
<thead>
<tr>
<th></th>
<th>Group</th>
<th>Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year Ending 31 March 2015 £000</td>
<td>Year Ending 31 March 2014 £000</td>
</tr>
<tr>
<td>At 1 April</td>
<td>135,307</td>
<td>61,076</td>
</tr>
<tr>
<td>Net change in year</td>
<td>(109,758)</td>
<td>74,231</td>
</tr>
<tr>
<td>At 31 March</td>
<td>25,549</td>
<td>135,307</td>
</tr>
</tbody>
</table>

Analysed as:

- Cash at commercial banks and cash in hand: 2,052, 110, 136, 94
- Cash with the Government Banking Service: 23,492, 134,247, 23,310, 133,041
- Other cash equivalents: 5, 950, 5, 0

Cash and cash equivalents as in Statement of Financial Position and Statement of Cash Flows:

<table>
<thead>
<tr>
<th></th>
<th>Group</th>
<th>Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25,549</td>
<td>135,307</td>
</tr>
</tbody>
</table>

The Trust held £99,000 cash at bank and in hand at 31 March 2015, (31 March 2014 - £103,000) which relates to monies held by the Trust on behalf of patients. The money is held in a separate bank account and has been excluded from the cash and cash equivalent figure reported in the accounts.

27 Future Accounting period

27.1 Events after the Reporting Period

There were no events after the reporting period.

27.2 Contractual Capital Commitments

At the date of the Statement of Financial Position the Group was contractually committed to complete two capital schemes. The value of payments committed to be made for the schemes are £6,444,000. The schemes are the completion of the building of a specialist emergency care hospital at Cramlington, Northumberland (started in 2012/13) and the redevelopment of psychiatry of old age wards (POAS) at North Tyneside General Hospital.

Capital commitments at 31 March 2014 - £5,344,000.
Contingent liabilities at 31 March 2015 are in respect of contingent employer and public liability claims as advised by the NHSLA.

In addition to the above amounts and in common with many other NHS organisations, the Trust has received a number of equal value pay claims from current and former employees. The Trust is taking appropriate legal and professional advice on this matter and has been advised that the probability of success of the claims is not clear and at this stage it is not practicable to quantify any possible financial effect of these claims. For these reasons no provision for this issue is included in the financial statements other than a provision for associated legal and professional fees based on estimates which have been provided by independent advisors (note 25). It is not possible to predict when this issue may ultimately be resolved.

29 Related Party Transactions and Balances

Northumbria Healthcare NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Northumbria Healthcare.

The Department of Health is regarded as a related party. During the year Northumbria Healthcare NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department, namely:

<table>
<thead>
<tr>
<th>Income Year Ended 31 March 2015 £000</th>
<th>Expenditure Year Ended 31 March 2015 £000</th>
<th>Receivables Year Ended 31 March 2015 £000</th>
<th>Payables Year Ended 31 March 2015 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northumberland Clinical Commissioning Group</td>
<td>191,390</td>
<td>0</td>
<td>1,540</td>
</tr>
<tr>
<td>North Tyneside Clinical Commissioning Group</td>
<td>130,806</td>
<td>0</td>
<td>1,151</td>
</tr>
<tr>
<td>North Cumbria Clinical Commissioning Group</td>
<td>8,888</td>
<td>0</td>
<td>4,255</td>
</tr>
<tr>
<td>Gateshead Clinical Commissioning Group</td>
<td>1,516</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Newcastle Clinical Commissioning Group</td>
<td>3,328</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Clinical Commissioning Groups</td>
<td>4,073</td>
<td>0</td>
<td>1,031</td>
</tr>
<tr>
<td>NHS England</td>
<td>32,005</td>
<td>0</td>
<td>1,794</td>
</tr>
<tr>
<td>Health Education England</td>
<td>11,944</td>
<td>0</td>
<td>246</td>
</tr>
<tr>
<td>The NHS Litigation Authority</td>
<td>3</td>
<td>6,506</td>
<td>0</td>
</tr>
<tr>
<td>NHS Property Services</td>
<td>860</td>
<td>2,143</td>
<td>5,862</td>
</tr>
<tr>
<td>NHS Foundation Trusts</td>
<td>9,117</td>
<td>4,702</td>
<td>4,469</td>
</tr>
<tr>
<td>Other NHS organisations</td>
<td>11,034</td>
<td>446</td>
<td>298</td>
</tr>
<tr>
<td><strong>Total NHS organisations</strong></td>
<td><strong>404,964</strong></td>
<td><strong>13,797</strong></td>
<td><strong>20,646</strong></td>
</tr>
</tbody>
</table>

| Other related parties: | | | | |
| Department of Health | 1,609 | 0 | 450 | 0 |
| HMRC | 0 | 19,170 | 1,527 | 5,415 |
| NHS Pensions Agency | 0 | 29,966 | 0 | 3,939 |
| **Total other related parties** | **1,609** | **49,136** | **1,977** | **9,354** |

Northumberland County Council | 25,795 | 1,523 | 458 | 348 |
| North Tyneside County Council | 4,057 | 1,251 | 205 | 0 |
| Other local authorities | 127 | 0 | 539 | 0 |
| **Total local government** | **29,979** | **2,774** | **1,202** | **348** |
| **Total related parties** | **436,552** | **65,707** | **23,827** | **17,429** |

No amounts are due to be paid or received from the Department of Health in respect of dividends due on Public Dividend Capital (2013/14 £68,000 owed by the Department of Health in respect of dividends due on Public Dividend Capital).

The transactions with Northumberland County Council and North Tyneside Council were for income received in respect of joint enterprises and payments in respect of business rates and community charges.

30 Private Finance Initiative Schemes Deemed to be off Statement of Financial Position

The Group and the Trust had no PFI schemes deemed to be ‘off the Statement of Financial Position’ at 31 March 2015 (31 March 2014 - Nil).
31 Financial Instruments

IAS 32, Financial Instruments: Recognition and Measurement, requires disclosure of the role that financial instruments have had during the period or changing the risks an entity faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with local CCGs and the way those CCGs are financed, the NHS Trust is not exposed to the degree of financial risk experienced by business entities. Also financial instruments paly a much more limited role in creating or changing risk than would be typical of the listed companies to which IAS 32 mainly applies. Financial assets and liabilities are primarily generated by day-to-day operational activities and are not held to change the risks facing Foundation Trusts in undertaking their activities.

As allowed by IAS 32, receivables and payables that are due to mature or become payable within twelve months from the date of the Statement of Financial Position have been omitted from the currency profile.

Credit Risk
Credit risk is the risk of financial loss to the Trust if a customer or counterparty to a financial instrument fails to meet its contractual obligations, and arises principally from the Trust's receivables.

Exposure to credit risk
The carrying amount of financial assets represents the maximum credit exposure. Therefore, the maximum exposure to credit risk at the Statement of Financial Position was £61,320,000, note 32.2, (2013/14: £174,843,000) being the total of the carrying amount of financial assets.

Credit Quality of Financial Assets and Impairment Losses
The Trust did not incur any impairment of NHS or trade receivables during the year.

Liquidity Risk
The Trust's net operating costs are incurred under service agreements with the local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust largely finances capital expenditure through internally generated funds and from loans that can be taken out up to an agreed borrowing limit. The borrowing limit is based upon a risk rating determined by Monitor, the Independent Regulator for Foundation Trusts, and take into account the Trust's liquidity. The Trust is not therefore exposed to significant liquidity risk.

The following are the contractual maturities of financial liabilities, including estimated interest payments:

Market Risk
Market risk is the risk that changes in market prices such as foreign exchange rates and interest rates will affect the Trust's income or the value of its holdings of financial instruments.

Interest-Rate Risk
The only financial asset which carries risk is cash which is subject to floating rates of interest. It is estimated that a 1% change in interest rates would impact the statement by £300,000.

The Trusts loans, finance lease obligations and obligations under PFI contracts carry interest at fixed rates. The remainder of financial liabilities carry no interest.

There are no financial liabilities which carry a floating rate of interest.

The Trust is not therefore exposed to significant interest rate risk.

Foreign exchange risk
All financial assets and liabilities are recorded in sterling. Therefore the Trust has no exposure to foreign exchange risks.

31.1 Floating and Fixed Rate Financial Instruments

<table>
<thead>
<tr>
<th></th>
<th>Group Floating Rate</th>
<th>Foundation Trust Floating Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31 March 2015 £000</td>
<td>31 March 2014 £000</td>
</tr>
<tr>
<td>Financial assets denominated in £ sterling</td>
<td>25,549</td>
<td>135,307</td>
</tr>
<tr>
<td>Total gross financial assets at 31 March</td>
<td>25,549</td>
<td>135,307</td>
</tr>
</tbody>
</table>

There are no financial asset or liabilities held in currencies other than sterling. The remaining financial assets (as set out in note 32.2) do not carry interest.

31.2 Financial Assets by Category

<table>
<thead>
<tr>
<th>Assets as per Statement of Financial Position</th>
<th>Group</th>
<th>31 March 2015 £000</th>
<th>31 March 2014 £000</th>
<th>Foundation Trust</th>
<th>31 March 2015 £000</th>
<th>31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS receivables</td>
<td>21,096</td>
<td>20,423</td>
<td>21,096</td>
<td>20,423</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provision for irrecoverable debts</td>
<td>(1,717)</td>
<td>(1,778)</td>
<td>(1,717)</td>
<td>(1,778)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Investments</td>
<td>637</td>
<td>583</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other financial assets</td>
<td>350</td>
<td>1,250</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investments in joint controlled operations</td>
<td>0</td>
<td>0</td>
<td>78,490</td>
<td>48,977</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accrued income</td>
<td>6,264</td>
<td>11,178</td>
<td>9,460</td>
<td>12,012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other receivables</td>
<td>9,141</td>
<td>7,880</td>
<td>8,919</td>
<td>7,617</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>25,549</td>
<td>135,307</td>
<td>23,451</td>
<td>133,135</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>61,320</td>
<td>174,843</td>
<td>139,699</td>
<td>220,386</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

31.3 Financial Liabilities by Category

<table>
<thead>
<tr>
<th>Liabilities as per Statement of Financial Position</th>
<th>Group</th>
<th>31 March 2015 £000</th>
<th>31 March 2014 £000</th>
<th>Foundation Trust</th>
<th>31 March 2015 £000</th>
<th>31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loans from Foundation Trust Financing Facility</td>
<td>55,736</td>
<td>58,360</td>
<td>55,736</td>
<td>58,360</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other loans</td>
<td>131,424</td>
<td>111,300</td>
<td>131,424</td>
<td>111,300</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Payables</td>
<td>7,727</td>
<td>3,440</td>
<td>7,727</td>
<td>3,440</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obligations under finance leases</td>
<td>6,716</td>
<td>7,421</td>
<td>84,993</td>
<td>7,421</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obligations under PFI contracts</td>
<td>20,826</td>
<td>81,864</td>
<td>20,826</td>
<td>81,864</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>14,402</td>
<td>16,231</td>
<td>13,682</td>
<td>16,231</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>9,342</td>
<td>12,550</td>
<td>9,342</td>
<td>17,016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accruals</td>
<td>19,537</td>
<td>21,754</td>
<td>19,528</td>
<td>21,725</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital creditors and accruals</td>
<td>4,289</td>
<td>6,373</td>
<td>389</td>
<td>505</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions under contract</td>
<td>7,246</td>
<td>57,520</td>
<td>7,246</td>
<td>57,520</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>276,885</td>
<td>376,813</td>
<td>350,893</td>
<td>375,382</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
31.4 Fair Values of Financial Instruments

Trade and other receivables - The fair value of trade and other receivables is estimated as the present value of future cash flows, discounted at the market rate of interest at the date of the Statement of Financial Position if the effect is material.

Trade and other payables - The fair value of trade and other payables is estimated as the present value of future cash flows, discounted at the market rate of interest at the Statement of Financial Position date if the effect is material.

Cash and cash equivalents - The fair value of cash and cash equivalents is estimated as the carrying amount where the cash is repayable on demand. Where it is not repayable on demand then the fair value is estimated at the present value of future cash flows, discounted at the market rate of interest the Statement of Financial Position date.

31.5 Fair Values of Financial Assets

<table>
<thead>
<tr>
<th>Group</th>
<th>31 March 2015 Book Value</th>
<th>31 March 2015 Fair Value</th>
<th>31 March 2014 Book Value</th>
<th>31 March 2014 Fair Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS receivables</td>
<td>21,096 £000</td>
<td>21,096 £000</td>
<td>20,423 £000</td>
<td>20,423 £000</td>
</tr>
<tr>
<td>Provision for irrecoverable debts</td>
<td>(1,717) £000</td>
<td>(1,717) £000</td>
<td>(1,778) £000</td>
<td>(1,778) £000</td>
</tr>
<tr>
<td>Other Investments</td>
<td>637 £000</td>
<td>637 £000</td>
<td>583 £000</td>
<td>583 £000</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>350 £000</td>
<td>350 £000</td>
<td>1,250 £000</td>
<td>1,250 £000</td>
</tr>
<tr>
<td>Accrued income</td>
<td>6,264 £000</td>
<td>6,264 £000</td>
<td>11,178 £000</td>
<td>11,178 £000</td>
</tr>
<tr>
<td>Other receivables</td>
<td>9,141 £000</td>
<td>9,141 £000</td>
<td>7,880 £000</td>
<td>7,880 £000</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>25,549 £000</td>
<td>25,549 £000</td>
<td>135,307 £000</td>
<td>135,307 £000</td>
</tr>
<tr>
<td>Total financial assets</td>
<td>61,320 £000</td>
<td>61,320 £000</td>
<td>174,843 £000</td>
<td>174,843 £000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Foundation Trust</th>
<th>31 March 2015 Book Value</th>
<th>31 March 2015 Fair Value</th>
<th>31 March 2014 Book Value</th>
<th>31 March 2014 Fair Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS receivables</td>
<td>21,096 £000</td>
<td>21,096 £000</td>
<td>20,423 £000</td>
<td>20,423 £000</td>
</tr>
<tr>
<td>Provision for irrecoverable debts</td>
<td>(1,717) £000</td>
<td>(1,717) £000</td>
<td>(1,778) £000</td>
<td>(1,778) £000</td>
</tr>
<tr>
<td>Other Investments</td>
<td>0 £000</td>
<td>0 £000</td>
<td>0 £000</td>
<td>0 £000</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>0 £000</td>
<td>0 £000</td>
<td>0 £000</td>
<td>0 £000</td>
</tr>
<tr>
<td>Investments in joint controlled operations</td>
<td>78,490 £000</td>
<td>78,490 £000</td>
<td>48,977 £000</td>
<td>48,977 £000</td>
</tr>
<tr>
<td>Accrued income</td>
<td>9,460 £000</td>
<td>9,460 £000</td>
<td>12,012 £000</td>
<td>12,012 £000</td>
</tr>
<tr>
<td>Other receivables</td>
<td>8,919 £000</td>
<td>8,919 £000</td>
<td>133,135 £000</td>
<td>133,135 £000</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>23,451 £000</td>
<td>23,451 £000</td>
<td>133,135 £000</td>
<td>133,135 £000</td>
</tr>
<tr>
<td>Total financial assets</td>
<td>139,699 £000</td>
<td>139,699 £000</td>
<td>220,386 £000</td>
<td>220,386 £000</td>
</tr>
</tbody>
</table>

31.6 Fair values of Financial Liabilities

<table>
<thead>
<tr>
<th>Group</th>
<th>31 March 2015 Book Value</th>
<th>31 March 2015 Fair Value</th>
<th>31 March 2014 Book Value</th>
<th>31 March 2014 Fair Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loans from Foundation Trust Financing Facility</td>
<td>55,736 £000</td>
<td>55,736 £000</td>
<td>58,360 £000</td>
<td>58,360 £000</td>
</tr>
<tr>
<td>Other loans</td>
<td>131,424 £000</td>
<td>131,424 £000</td>
<td>111,300 £000</td>
<td>111,300 £000</td>
</tr>
<tr>
<td>NHS Payables</td>
<td>7,727 £000</td>
<td>7,727 £000</td>
<td>3,440 £000</td>
<td>3,440 £000</td>
</tr>
<tr>
<td>Obligations under finance leases</td>
<td>6,716 £000</td>
<td>6,716 £000</td>
<td>7,421 £000</td>
<td>7,421 £000</td>
</tr>
<tr>
<td>Obligations under PFI contracts</td>
<td>20,826 £000</td>
<td>20,826 £000</td>
<td>81,864 £000</td>
<td>81,864 £000</td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>14,042 £000</td>
<td>14,042 £000</td>
<td>16,231 £000</td>
<td>16,231 £000</td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>9,342 £000</td>
<td>9,342 £000</td>
<td>12,550 £000</td>
<td>12,550 £000</td>
</tr>
<tr>
<td>Accruals</td>
<td>19,528 £000</td>
<td>19,528 £000</td>
<td>21,725 £000</td>
<td>21,725 £000</td>
</tr>
<tr>
<td>Capital creditors and accruals</td>
<td>4,289 £000</td>
<td>4,289 £000</td>
<td>6,373 £000</td>
<td>6,373 £000</td>
</tr>
<tr>
<td>Provisions under contract</td>
<td>7,246 £000</td>
<td>7,246 £000</td>
<td>57,520 £000</td>
<td>57,520 £000</td>
</tr>
<tr>
<td>Total financial liabilities</td>
<td>276,885 £000</td>
<td>276,885 £000</td>
<td>376,813 £000</td>
<td>376,813 £000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Foundation Trust</th>
<th>31 March 2015 Book Value</th>
<th>31 March 2015 Fair Value</th>
<th>31 March 2014 Book Value</th>
<th>31 March 2014 Fair Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loans from Foundation Trust Financing Facility</td>
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<td>55,736 £000</td>
<td>58,360 £000</td>
<td>58,360 £000</td>
</tr>
<tr>
<td>Other loans</td>
<td>131,424 £000</td>
<td>131,424 £000</td>
<td>111,300 £000</td>
<td>111,300 £000</td>
</tr>
<tr>
<td>NHS Payables</td>
<td>7,727 £000</td>
<td>7,727 £000</td>
<td>3,440 £000</td>
<td>3,440 £000</td>
</tr>
<tr>
<td>Obligations under finance leases</td>
<td>84,993 £000</td>
<td>84,993 £000</td>
<td>7,421 £000</td>
<td>7,421 £000</td>
</tr>
<tr>
<td>Obligations under PFI contracts</td>
<td>20,826 £000</td>
<td>20,826 £000</td>
<td>81,864 £000</td>
<td>81,864 £000</td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>13,682 £000</td>
<td>13,682 £000</td>
<td>16,231 £000</td>
<td>16,231 £000</td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>9,342 £000</td>
<td>9,342 £000</td>
<td>17,016 £000</td>
<td>17,016 £000</td>
</tr>
<tr>
<td>Accruals</td>
<td>19,528 £000</td>
<td>19,528 £000</td>
<td>21,725 £000</td>
<td>21,725 £000</td>
</tr>
<tr>
<td>Capital creditors and accruals</td>
<td>4,289 £000</td>
<td>4,289 £000</td>
<td>6,373 £000</td>
<td>6,373 £000</td>
</tr>
<tr>
<td>Provisions under contract</td>
<td>7,246 £000</td>
<td>7,246 £000</td>
<td>57,520 £000</td>
<td>57,520 £000</td>
</tr>
<tr>
<td>Total financial liabilities</td>
<td>350,893 £000</td>
<td>350,893 £000</td>
<td>375,382 £000</td>
<td>375,382 £000</td>
</tr>
</tbody>
</table>
32 Losses and Special Payments

Losses and special payments are charged to the relevant headings on a cash basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks, with insurance premiums being included as normal revenue expenditure.

<table>
<thead>
<tr>
<th>Losses</th>
<th>Year Ended 31 March 2015</th>
<th>Year Ended 31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>Number</td>
</tr>
<tr>
<td>Cash Losses</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Fruitless payments and constructive losses</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bad debts and claims abandoned</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Overpayments of salaries</td>
<td>175,730</td>
<td>229</td>
</tr>
<tr>
<td>Stores Losses</td>
<td>58,926</td>
<td>24</td>
</tr>
<tr>
<td><strong>Total Losses</strong></td>
<td><strong>234,656</strong></td>
<td><strong>253</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Special Payments</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extra contractual payments</td>
<td>0</td>
<td>0</td>
<td>250,000</td>
<td>1</td>
</tr>
<tr>
<td>Extra-statutory and extra-regulatory payments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Compensation payments</td>
<td>179,843</td>
<td>37</td>
<td>29,174</td>
<td>13</td>
</tr>
<tr>
<td>Special Severance</td>
<td>0</td>
<td>0</td>
<td>9,745</td>
<td>1</td>
</tr>
<tr>
<td>Ex-gratia payments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total special payments</strong></td>
<td><strong>179,843</strong></td>
<td><strong>37</strong></td>
<td><strong>288,919</strong></td>
<td><strong>15</strong></td>
</tr>
<tr>
<td><strong>Total losses and special payments</strong></td>
<td><strong>414,499</strong></td>
<td><strong>290</strong></td>
<td><strong>431,883</strong></td>
<td><strong>333</strong></td>
</tr>
</tbody>
</table>

33 Pooled Budgets

The Group and Trust had no pooled budget projects during the twelve months to 31 March 2015 (2013/14 - Nil).

34 Other Financial Assets

The Group and Trust had no other financial assets at 31 March 2015 (31 March 2014 - Nil).

35 Charitable Fund Reserve

The Trust is the corporate trustee to Northumbria Healthcare NHS Trust Charitable Fund. The Trust has assessed its relationship to the charitable fund and determined to be a subsidiary, in accordance with IAS 27, because the Trust has the power to govern the financial and operating policies of the charitable fund so as to obtain benefits from its activities for itself, its patients or its staff. Prior to 2013/14, the Treasury has directed that IAS 27 should not be applied to NHS Charities and therefore the FT ARM did not require the Trust to consolidate the charitable fund.

The main financial statements disclose the Trust's financial position alongside that of the group (which comprises the Trust, subsidiary and charitable fund).

Northumbria Healthcare NHS Trust Charity - Summary statement of financial activities;

<table>
<thead>
<tr>
<th>Year Ended 31 March</th>
<th>Intra-group eliminations</th>
<th>Year Ended 31 March</th>
<th>Intra-group eliminations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td></td>
<td>£</td>
</tr>
<tr>
<td>Donated Income</td>
<td>493</td>
<td>0</td>
<td>489</td>
</tr>
<tr>
<td>Income from activities for generating funds</td>
<td>929</td>
<td>0</td>
<td>867</td>
</tr>
<tr>
<td>Investment income</td>
<td>29</td>
<td>0</td>
<td>69</td>
</tr>
<tr>
<td><strong>Total incoming resources</strong></td>
<td><strong>1,451</strong></td>
<td><strong>0</strong></td>
<td><strong>1,425</strong></td>
</tr>
<tr>
<td>Charitable expenditure</td>
<td>(904)</td>
<td>71</td>
<td>(548)</td>
</tr>
<tr>
<td>Trading expenses</td>
<td>(749)</td>
<td>0</td>
<td>(732)</td>
</tr>
<tr>
<td><strong>Total outgoing resources</strong></td>
<td><strong>(1,653)</strong></td>
<td><strong>71</strong></td>
<td><strong>(1,280)</strong></td>
</tr>
<tr>
<td>Unrealised gains / (losses) on investments</td>
<td>54</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td><strong>Net incoming resources</strong></td>
<td><strong>(148)</strong></td>
<td><strong>71</strong></td>
<td><strong>158</strong></td>
</tr>
</tbody>
</table>

Northumbria Healthcare NHS Trust Charity - Summary statement of financial position;

<table>
<thead>
<tr>
<th>Year Ended 31 March</th>
<th>Intra-group eliminations</th>
<th>Year Ended 31 March</th>
<th>Intra-group eliminations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td></td>
<td>£</td>
</tr>
<tr>
<td>Investments- Common investment funds</td>
<td>637</td>
<td>0</td>
<td>583</td>
</tr>
<tr>
<td>Receivables</td>
<td>51 (42)</td>
<td>124 (83)</td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cash</td>
<td>1,897</td>
<td>1,126</td>
<td>0</td>
</tr>
<tr>
<td>Other financial assets - fixed term deposits current</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other financial assets - fixed term deposits non current</td>
<td>350</td>
<td>1,250</td>
<td></td>
</tr>
<tr>
<td><strong>Total net assets</strong></td>
<td><strong>2,935</strong></td>
<td><strong>(42)</strong></td>
<td><strong>3,083</strong></td>
</tr>
<tr>
<td><strong>Unrestricted Funds</strong></td>
<td><strong>1,419</strong></td>
<td><strong>0</strong></td>
<td><strong>1,726</strong></td>
</tr>
<tr>
<td><strong>Restricted Funds</strong></td>
<td><strong>1,516</strong></td>
<td><strong>0</strong></td>
<td><strong>1,357</strong></td>
</tr>
<tr>
<td><strong>Total funds</strong></td>
<td><strong>2,935</strong></td>
<td><strong>(42)</strong></td>
<td><strong>3,083</strong></td>
</tr>
</tbody>
</table>

The total funds are represented in the group accounts as Charitable Funds Reserve.

An explanation of the distinction between unrestricted and restricted funds is provided in section 3 page 6 of accounting policies.
APPENDIX B

QUALITY ACCOUNT 2014/15
Quality Account
2014/15
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PART 1 – Statement on quality from the Chief Executive

I am pleased to introduce the 2014/15 Quality Account for Northumbria Healthcare NHS Foundation Trust. This document sets out how we, as an organisation, have delivered high quality care in hospitals, in the community and in people’s homes across Northumberland and North Tyneside.

It has been another excellent year for the Trust, albeit at times challenging, where quality has remained at the heart of everything we have done, and continue to do. To demonstrate the clear commitment we place on quality of care, we launched our Quality Strategy last September, the aim being to ensure that quality underpins every decision taken by every member of staff, and to help us provide the safest health and care services to our patients and service users.

Over the last year, a number of key pieces of work have taken place as part of our drive to continually improve quality. I’ve highlighted some of them below:

- We launched a major project to improve the management of patients with sepsis - one of our safer care priorities - with funding from The Health Foundation. A major strand of this work has been to raise awareness among our workforce of the signs and symptoms of infection, encouraging them to spot infection early so we can treat sepsis sooner. This has really struck a chord with our staff and colleagues have come forward to stand as sepsis champions.

- Medicines management continues to be a key priority for us so I am pleased to report that our project to review the medications of patients in care homes in North Tyneside, and involve patients and their relatives in decisions about their care, achieved such fantastic results. Patients, their carers, care home staff and local GPs saw the results first hand and this has brought national recognition for this work.

- We will continue to improve our medicines management in the year ahead and are looking forward to the introduction of e-prescribing and the improvements that will bring to patient safety.

- This year we rolled out our ‘15 steps’ programme across the Trust, both in and out of hours. This is an assessment programme which puts our patients first and views the ward and care environment from our patients’ perspective.

Teams of clinical and non-clinical staff undertake impromptu visits to our wards and departments right across the Trust and give feedback to frontline teams on their first impressions - within ‘15 steps’ of walking onto a ward. Following visits, ward staff are empowered and supported to make changes.

These visits have become a really important tool in our drive to improve the quality of patients’ experiences. They are also allowing our people to lead from the frontline, to take ownership of their own care environments and have pride in making sure that every single person who comes onto their ward receives a warm welcome.

Whereas safety and quality of our care are always our first priority, we fully understand that a patient’s care involves much more than this. This year we introduced a new measure in our comprehensive patient experience programme – kindness and compassion. This is in line with the Francis report and we have been extremely pleased with the results.
To raise awareness among our staff of the importance of compassionate care, this year we backed the national ‘Hello, My Name Is’ campaign which encourages staff to introduce themselves to patients before administering care. This is a small gesture that helps to make a personal connection between care professionals and patients.

It has been another productive year for our patient experience programme which involves listening to the views of 50,000 patients every year. We’ve extended our real-time questionnaire – where feedback goes to individual teams within 24 hours – to more areas, introduced the friends and family test to measure staff experience and once again triumphed at The Patient Experience Network Awards.

We were delighted to be named ‘overall best Trust’ and win five other awards, in recognition of our work to improve patients’ experiences across our services in hospital and in the community.

We are extremely proud of our culture where staff report incidents, no matter how small. This is vital for us to learn from them and in turn improve the quality of care we provide. It is for this reason that, in comparison to other Trusts, we have high reporting figures and we believe that this is testament to our effective safety culture.

We have performed strongly against the standards set by our independent regulator Monitor and are passionate about making sure our patients are seen quickly. This is especially important for patients who are suspected, or have been diagnosed, with cancer.

This year we opened our fifth oncology day unit at Alnwick Infirmary allowing us to provide more people with access to chemotherapy closer to their homes which we know is important to patients at such a difficult time. We work very hard to make the experience of our cancer patients as positive as it can be and were pleased our patients rated us in the top 10 Trusts in the country for cancer patient experience.

Like every Trust across the country, it has been a very busy winter with extremely high numbers of people attending A&E and very poorly people requiring admission to hospital. In the wake of this intense pressure, our teams have shown immense dedication and professionalism, continually striving to provide safe and high quality care at all times and treat patients as quickly as possible. Whilst it has been a challenging time, we are pleased that we are one of only a few Trusts in the country to meet the national four-hour A&E standard for quarters three and four. That’s testament to a very big team effort by all of our staff.

As can be seen, 2014/15 has been a great year for further improving quality. It’s the year we took possession of our new specialist emergency care hospital (The Northumbria) and we are really looking forward to when this hospital opens in June 2015. It is at this time that we can start delivering a new level of urgent and emergency care which will give patients the best chance of making a full recovery. We have an exciting year ahead with further improvements planned to allow us to continue on our improvement journey.

To the best of my knowledge, the information contained in this Quality Account is accurate.

Jim Mackey,
Chief Executive
Northumbria Healthcare NHS Foundation Trust
About the Trust

Northumbria Healthcare NHS Foundation Trust is proud to be one of the country’s top performing NHS Trusts. Health services in North Tyneside and health and social care services in Northumberland take care of the wellbeing of a population of around half a million people.

Hospital services are provided from three modern general hospitals in Hexham, North Tyneside and Wansbeck as well as community hospitals throughout Northumberland. The Trust also cares for people in their homes or as close to their homes as possible and provide services from facilities in local communities, such as health centres.

The Trust is committed to delivering services in first class facilities. It has built a new Northumbria Specialist Emergency Care Hospital which will open in June this year. It will have Emergency Care Consultants on duty 24/7 and specialists in a range of conditions also working there seven days a week. This hospital will be the first purpose built hospital of its kind in England to have this level of medical cover.

The Trust is investing in its general hospitals too to further improve facilities and services at North Tyneside and Wansbeck general hospitals once the new Northumbria Specialist Emergency Care Hospital has opened. This will include creating ward environments which have four bedded bays (instead of six) and increasing, where possible, the en-suite and single room facilities. The general hospitals will become centres of excellence for care and treatment that is planned and will also continue to provide 24 hour walk-in services for urgent but less serious conditions.

The Trust is partnered with Northumberland County Council to deliver an integrated health and social care facility at Haltwhistle to replace the war memorial hospital and to provide hospital and social care support under one roof. This facility opened in June 2014.

The Trust employs around 9,500 staff and in a year it:
- cares for over 68,000 patients and families on its wards
- provides treatment to around 167,000 patients in its A&E departments and minor injuries units
- performs almost 27,000 operations
- sees more than 45,000 people for day case procedures
- provides advice, information, support and services to over 16,000 people through adult social care, and care managers meet with over 1,500 people each week
- carries out around 1.4 million appointments with patients outside of hospital

The Trust’s plans to rebuild Berwick Infirmary continue to progress with archaeological digs taking place on the site before a planning application can be submitted.

Wherever possible the Trust supports communities to take positive steps to improve their health and prevent illness. It encourages the people it serves to stop smoking, increase physical activity, improve their diet and maintain positive mental health and offers services to support them to do this.

The Trust manages adult social care services on behalf of Northumberland County Council, helping to ensure people move between hospital, community health and social care services easily and with continuity of care. It also gives people greater choice and control over their care to help them to live independently at home and to avoid hospital admission where appropriate.

Patients, service users and their families are at the heart of everything the Trust does. It strives to ensure every patient and service user has an exceptional experience so seeks their views to allow these to truly shape the way it does things. The Trust has one of the most extensive patient experience programmes of any Trust in England and the results of this programme are made available to its patients and the public.
Excellent patient care could not be achieved without the Trust’s talented staff. It aims to attract, develop and retain the best people available in every area of the business and to do this the Trust knows it needs to be a great employer.

It provides a working environment that encourages development and values staff input, with opportunities for training and progression. It actively engages and communicates with its staff to make sure they are informed about what is going on in the Trust.

In addition to its staff, the Trust has around 800 volunteers who generously give their time to support the Trust and serve its patients and visitors. The volunteers bring genuine warmth to the hospitals and are an essential part of the Trust’s charity, Bright Northumbria. Donations to Bright make it possible for the Trust to fund the little extras that it knows can make a real difference to patients.

The generosity of Bright Northumbria also reaches across the world as, for over a decade, Bright has supported a ground-breaking partnership with Kilimanjaro Christian Medical Centre in northern Tanzania.

**Key Achievement**

**Bringing safer care closer to Tanzania**

The Trust’s work at Kilimanjaro Christian Medical Centre over the last ten years has transformed patients’ experience of surgery by introducing laparoscopic (keyhole) surgery to Tanzania.

To achieve this, as well as carrying out face-to-face training in Tanzania, a ground-breaking audio-visual link was set up to connect the theatres at Kilimanjaro hospital with surgeons at the Trust.

The Tanzanian surgeons have now performed over 500 successful laparoscopic procedures. This has improved the lives of Tanzanian people by:

- Reducing overcrowding on the wards as patients recover more quickly and go home sooner
- Less anaesthesia and reduced need for pain killers reduces the overall cost to the patient who has to pay for healthcare
- Fewer post-operative complications exist so people can get back to work earlier
- Reduced overcrowding and length of stay means patients are less likely to develop post-operative infections.
PART 2 – Priorities for improvement and statements of assurance from the Board

This section of the Quality Account describes the progress made against priority areas for improvement in the quality of health services identified in the 2013/14 Quality Account and the priorities identified for 2015/16. It includes why they were chosen, how the Trust intends to make the improvements, and how it plans to measure them. It also sets out a series of statements of assurance from the Board on key quality activities, and provides details of the Trust’s performance against core indicators.

Progress against the priorities in 2014/15

The Quality Account for 2013/14 outlined the Trust’s proposed quality improvements for the year ahead (2014/15). These priorities were identified as a result of engagement with patients, the public, staff, members, governors and external stakeholders through face-to-face meetings, social media, and online surveys. The results were put into groups and themes, and where possible, cross checked against quantitative data that the Trust holds within its quality and performance management system.

A similar process has been used to identify the quality priorities for 2015/16 – see page 44. The views were considered by the Clinical Policy Group who made recommendations to the Board of Directors that were categorised as either providing safer care, delivering more effective care or a better patient experience in line with the NHS definition of quality. These finalised priorities were also widely communicated to stakeholders, staff and members of the public. Table 1 lists what the priorities for 2014/15 were:

Table 1: Priorities for 2014/15

<table>
<thead>
<tr>
<th>Safer Care (SC)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Minimise hospital acquired infections – MRSA, C. difficile and surgical site infections</td>
<td></td>
</tr>
<tr>
<td>2. Improve the management of medicines in hospital</td>
<td></td>
</tr>
<tr>
<td>3. Managing patients with sepsis</td>
<td></td>
</tr>
<tr>
<td>4. Minimising hospital falls and pressure ulcers - using the safety thermometer data</td>
<td></td>
</tr>
<tr>
<td>5. Dementia assessment</td>
<td></td>
</tr>
<tr>
<td>6. Commence process to implement electronic prescribing</td>
<td></td>
</tr>
<tr>
<td>7. Embedding the World Health Organisation (WHO) checklist and debrief in theatres</td>
<td></td>
</tr>
<tr>
<td>8. 7 day consultant working in specific services</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Effective Care (EC)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prevention of hospital acquired pneumonia – roll out of 30° tilt programme on elderly care wards</td>
<td></td>
</tr>
<tr>
<td>2. Understanding hospital mortality through case note audit</td>
<td></td>
</tr>
<tr>
<td>3. Development of maternity, endoscopy and palliative care model of working for the future</td>
<td></td>
</tr>
<tr>
<td>4. Support to carers through dementia and end of life care</td>
<td></td>
</tr>
<tr>
<td>5. Helping patients manage their long term conditions – focus on respiratory conditions and alcohol abuse</td>
<td></td>
</tr>
<tr>
<td>6. Development of community services in line with Better Care Fund to reduce admissions to hospitals</td>
<td></td>
</tr>
<tr>
<td>7. Developing systems and processes for integrated working with nursing homes</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Experience (PE)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Roll out of 15 steps programme – ward-based assurance during out-of-hours periods</td>
<td></td>
</tr>
<tr>
<td>2. Roll out a new metric for kindness and compassion in line with the Francis report</td>
<td></td>
</tr>
<tr>
<td>3. Understanding patient experience findings on weekdays and weekends</td>
<td></td>
</tr>
<tr>
<td>4. Further roll-out of real time programme</td>
<td></td>
</tr>
<tr>
<td>5. Achieving national accreditation schemes – Bliss and Year of Care</td>
<td></td>
</tr>
<tr>
<td>6. Friends and family test including staff experience</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Culture (C)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Executive team and Non-Executive Director ‘walk-arounds’</td>
<td></td>
</tr>
</tbody>
</table>

Quality Account 2014/15 | 5
Trust performance

This section provides details on how the Trust has performed against its 2014/15 priorities. The results relate to the period April 2014 to March 2015 or the most recent available period.

Where available, comparative information is also given which may vary depending on the measure and may be the Trust’s 2013/14 outturn position, the national position or a regulatory target.

Safer Care (SC)

SC Priority 1: Minimise hospital acquired infections – MRSA, C. difficile and surgical site infections

The Trust’s first priority was to minimise hospital acquired infections including MRSA, C. difficile and surgical site infections.

MRSA is a form of bacterial infection that is resistant to a number of widely used antibiotics. It can lead to life threatening sepsis if it is not diagnosed early and treated effectively.

C. Difficile is a type of bacterial infection that affects the digestive system and can result in diarrhoea.

A surgical site infection (SSI) is an infection that occurs after surgery in the part of the body where the surgery took place.

Over the last year, the Trust has undertaken a range of initiatives to help reduce such infections including raising awareness amongst staff, and undertaking full root cause analysis for each identified case with actions being monitored via the SSI Working Group and Trauma and Orthopaedic Board.

Table 2 shows the performance on this:

Table 2: Performance against SC Priority 1: Minimise hospital acquired infections – MRSA, C. difficile and surgical site infections

<table>
<thead>
<tr>
<th>Measure</th>
<th>2014/15 Target</th>
<th>Trust performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA: No. of cases isolated &gt; 48 hours after admission</td>
<td>Less than 3 positive cases</td>
<td>3</td>
</tr>
<tr>
<td>C. difficile: No. of cases</td>
<td>Less than 30 cases</td>
<td>31</td>
</tr>
<tr>
<td>SSI all infections: hip replacement</td>
<td>JHI target: 1.6%</td>
<td>1.08%</td>
</tr>
<tr>
<td>SSI all infections: knee replacement</td>
<td>JHI target: 4.2%</td>
<td>0.74%</td>
</tr>
<tr>
<td>SSI all infections: fractured neck of femur</td>
<td>-</td>
<td>0.76%</td>
</tr>
<tr>
<td>SSI all infections: breast surgery</td>
<td>-</td>
<td>1.10%</td>
</tr>
</tbody>
</table>

Performance Key:  ✈ Better  ⇧ Same  ⇩ Worse

Note:
1 – Not all Trusts measure surgical site infection rates after discharge and for those that do, not all Trusts measure it in the same way. Journal articles have identified this point. Tanner et al (2013) demonstrated that: ‘nine Trusts (8%) used inpatient following up alone, 24 Trusts (22%) used inpatient and readmission follow-up alone and 73 Trusts (68%) used inpatient, readmission and post discharge follow up. Longest patient follow up was related to higher SSI rates. (Tanner, J., Padley, W., Kiernan, M., Leaper, D., Norrie, P. and Baggott, R. (2013) “A benchmark too far: findings from a national survey of surgical site infection surveillance”, Journal of Hospital Infection (JHI), Vol. 83, pp.87-91.)

2 – April 2014 to February 2015 figures
**SC Priority 2: Improve the management of medicines in hospital**

The second priority under safer care was to improve the management of medicines in the Trust’s hospitals.

In particular, the Trust wanted to reduce the number of patients who had a missed dose of medication and increase the number of patients who had their medications reviewed by pharmacy staff.

During the year, the service piloted new ways of working as part of the planning for the Northumbria Specialist Emergency Care Hospital, as a result we were unable to achieve all of our priorities. It is anticipated that there will be further refinements to working procedures once the new hospital opens.

Table 3 shows the performance in managing medicines against these key areas:

<table>
<thead>
<tr>
<th>Measure</th>
<th>2014/15 Target</th>
<th>Trust performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of patients who have had an omitted dose in the last 24 hours (excluding patient refused and valid clinical reason)</td>
<td>A reduction to 15.5% by Sept 2014 and to 10.3% by Mar 2015</td>
<td>New indicator</td>
</tr>
<tr>
<td>Proportion of patients with an omission of a critical medicine in the last 24 hours</td>
<td>A reduction to 3.5% by Sept 2014 and to 1.8% by Mar 2015</td>
<td>New indicator</td>
</tr>
<tr>
<td>Discharge medicine reconciliation rate by pharmacy staff</td>
<td>Reach 85% by Mar 2015</td>
<td>74%</td>
</tr>
</tbody>
</table>

Performance Key: ⬆ Better ▼ Same ▼ worse

Note: 1 – Position as at March 2015 2 – Position as at February 2015

**Key Achievement**

**Northumbria medicines project is top choice for national award enabling care home residents in North Tyneside to become more involved in decisions about their medication**

The project involved a team of various NHS professionals and care home nurses working with care home residents and their families to review the medication they are taking and make joint decisions about any changes.

This is the second award for the work – earlier this year it won a Patient Experience Network National Awards recognising the personalised care being delivered.

David Campbell, Chief Pharmacist and Clinical Director for medicines management at the Trust, said:

“We are very proud of this project and the amazing results it has had in terms of involving care home residents in decisions about their medication and reducing the amount of unnecessary medication that is being prescribed. It is also a great example of partnership working across the NHS involving hospital and care home staff and GPs working together to bring about real benefits for people living in care homes in North Tyneside.”

The project involved clinical pharmacists from the Trust reviewing the appropriateness of residents’ medications with findings discussed by a multidisciplinary team including the pharmacist and a care home nurse, with input from the resident and/or their family/advocate and, where possible, a GP.

The review process helped to reduce unnecessary prescribing across care homes – for the 422 residents reviewed, 1,346 changes to medications were made, the majority of which involved stopping medicines.
The third priority was around improving the management of patients with sepsis. Sepsis is a time-critical condition that can lead to organ damage, multi-organ failure, septic shock and eventually death. As a key component of the Quality Strategy, the Trust has a focused quality improvement project supported by The Health Foundation to reduce harm and mortality caused by sepsis.

The project aims to:

- reduce the number of sepsis related deaths by 30% in two years and reduce mortality in pneumonia by 50% in two years
- improve timely recognition of sepsis
- improve timely treatment of sepsis
- improve ‘sepsis 6’ compliance to 80% in two years

Sepsis 6 refers to a set of six clinical interventions that should be administered within the critical first hour.

The roll out process continues with new wards being adopted into the project every three months. Inclusion in the project requires four main elements:

- inducting champions to ensure consistency of message, education and implementation
- sharing resources for the education and communication strategies
- implementing evidence-based techniques
- daily data collection and weekly reporting

Table 4 shows the performance on compliance with the sepsis 6 tasks:

<table>
<thead>
<tr>
<th>Measure</th>
<th>2014/15 Target</th>
<th>Trust performance</th>
<th>2014/15 Performance against target</th>
</tr>
</thead>
</table>
| % of patients with suspected sepsis who receive bundle of 6 elements of care | 40% improvement on 14/15 Q1 baseline at the end of 2 years (baseline of 6%) | New indicator for 2014/15 | 44% |.

Performance Key: ↑ Better  ↔ Same  ↓ Worse

Key Achievement 🌟

**Focus on spotting the symptoms of sepsis Saving lives through early intervention**

In September 2014, the Trust launched a major campaign to raise awareness amongst staff of the symptoms of sepsis which is the body’s reaction to an infection. It means the body starts attacking its own organs and it accounts for 37,000 deaths each year. Dr Eliot Sykes, Consultant in Anaesthesia and Intensive Care who is leading the campaign explained:

“Sepsis is a key focus for the Trust as we strive to deliver safe and effective care to all our patients. With calls nationally for more to be done to reduce the number of deaths from sepsis we are proud to be leading the way on this important safety priority.”
SC Priority 4: Minimising hospital falls and pressure ulcers - using the safety thermometer data

Pressure ulcers and falls have been identified from incident reporting and safety thermometer data as key areas for improvement, and both feature as the Trust priorities for the year and also as CQUIN measures. Improvement plans, led by the Executive Director of Nursing, are in place and are regularly monitored by the Trust’s Safety and Quality Committee.

The NHS Safety Thermometer provides a 'temperature check' on harm that can be used alongside other measures of harm to measure local progress in providing a care environment that is free of harm for patients.

Table 5 lists the performance on reducing falls and pressure ulcers:

<table>
<thead>
<tr>
<th>Measure</th>
<th>2014/15 Target</th>
<th>Trust Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure Ulcers: % of patients with a pressure ulcer (grades 2, 3 &amp; 4)</td>
<td>20% improvement in year 1 and further 20% improvement in year 2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Falls: % of patients with a fall</td>
<td>20% improvement in year 1 and further 20% improvement in year 2</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

Performance against 2014 Performance Key: 🔺 Better  ◀ Same  ▼ Worse

SC Priority 5: Dementia assessment

Dementia is a term used to describe the symptoms that occur when the brain is affected by certain diseases or conditions. There are many different types of dementia although some are far more common than others such as Alzheimer’s disease. It is important that the Trust identifies people who have dementia or are at risk of having dementia when they come into its hospitals so that it can make sure they receive the right type of care and treatment.

In line with national standards, the Trust has identified targets around screening people aged over 75 years old for risk of dementia and for the onward referral of those identified as risk to specialist services.

Table 6 lists the performance on this:

<table>
<thead>
<tr>
<th>Measure</th>
<th>2014/15 Target</th>
<th>Trust performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014/15 Target</td>
<td>2013/14</td>
</tr>
<tr>
<td>% of all patients aged 75 and over who have been screened following admission to hospital, using the dementia screening question</td>
<td>Threshold is 90%</td>
<td>New indicator</td>
</tr>
<tr>
<td>% of all patients aged 75 and over who have been screened as at risk of dementia, who had a dementia risk assessment within 72 hours of admission, using the hospital dementia risk assessment tool</td>
<td>New indicator</td>
<td>97.4%¹</td>
</tr>
<tr>
<td>% of all patients aged 75 and over, identified as at risk of having dementia who are referred for specialist diagnosis</td>
<td>New indicator</td>
<td>No cases²</td>
</tr>
</tbody>
</table>

Performance Key: 🔺 Better  ◀ Same  ▼ Worse

Note: 1 – Position as at February 2015
SC Priority 6: Commence process to implement electronic prescribing

Medicines are at the heart of modern medicine; however, the systems for prescribing and administering them have largely remained unchanged for the last 40 years. Meanwhile, the medications that are used in services have increased rapidly in number and complexity.

Electronic prescribing (ePrescribing) systems, where the ordering, administration and supply of medicines is supported by electronic systems, offer the opportunity to help reduce such risks and the Trust has identified the implementation of this as a key priority.

The Trust aimed to have a tender process completed by the end of 2014/15.

The Trust issued an Official Journal of the European Union (OJEU) tender in December 2014, tender responses were assessed in February 2015 with a preferred supplier identified and contract issued in March 2015.

SC Priority 7: Embedding the World Health Organisation (WHO) checklist and debrief in theatres

The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases of perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.

Performance was adversely affected in 2014/15 due to changes with how the data was collected/submitted and also establishing a process to collect endoscopy data.

Table 7 lists the performance on the extent to which this checklist has been completed in operating theatres:

Table 7: Performance against SC Priority 7: WHO Checklist

<table>
<thead>
<tr>
<th>Measure</th>
<th>2014/15 Target</th>
<th>Trust performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients receiving surgery who, when audited, had WHO safer surgery checklist forms in notes</td>
<td>100% compliance</td>
<td>100%</td>
</tr>
<tr>
<td>% completeness of audited WHO safer surgery checklist forms (31 domains)</td>
<td>100% compliance</td>
<td>99.49%</td>
</tr>
</tbody>
</table>

Performance Key: ↑ Better ⇧ Same ⇦ Worse

SC Priority 8: 7 day consultant working in specific services

Patients need the NHS every day. Evidence shows that the limited availability of some hospital services at weekends can have a detrimental impact on outcomes for patients, including raising the risk of mortality. Therefore, the Trust identified 7 day consultant working in radiology as a key priority.

Currently, the Trust has consultant availability at weekends through the on call system and provides the full range of diagnostic imaging 7-days per week (MRI, ultrasound, CT and plain film x-ray). This has developed over the last year. From June 2015 the Trust will have a 7-day presence 8am-8pm.
Effective Care (EC)

**EC Priority 1: Prevention of hospital acquired pneumonia**

The first effective care priority was to prevent the incidence of hospital acquired pneumonia by rolling out an initiative to ensure that patients are appropriately positioned when in bed. Research has suggested that when patients’ beds are elevated at 30°, the risk of acquiring aspiration pneumonia is reduced.

The target was to ensure that at least 70% of eligible patients in elderly wards were correctly positioned in bed.

Table 8 shows the performance on this:

<table>
<thead>
<tr>
<th>Measure</th>
<th>2014/15 Target</th>
<th>Trust performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roll out of 30 degree tilt programme on elderly care wards</td>
<td>CQUIN - baseline 70%</td>
<td>New indicator 98%</td>
</tr>
</tbody>
</table>

**EC Priority 2: Understanding hospital mortality through case note audit**

The issue of hospital mortality is well-established as a top priority within the Trust. During 2014/15, weekly mortality audits have been undertaken to analyse and understand the reasons for deaths and to identify if anything could have been done differently to prevent them.

Reports are circulated monthly, summing up the findings, including details of anonymised cases with key learning points. The report also identifies examples of excellence.

The presence of clinical coders during the audit process generates further learning on all sides.

The Trust also continues to work with other North East Trusts (via the Regional Mortality Group it helped to establish) to share learning and develop common approaches for the audit methodology and case note documentation.

There were 1,328 patients’ case notes audited during April 2014 – March 2015.

**EC Priority 3: Development of maternity, endoscopy and palliative care model of working for the future**

The maternity service has continued to grow and develop during 2014/15. During the year there has been a particular emphasis on improving the ante and postnatal models of care with developments such as: continuing to encourage breast feeding uptake as recognised by achieving the WHO Baby Friendly Initiative Breast Feeding Stage 2; supporting high risk pregnancies through the establishment of a high risk midwifery post to support ante natal care for women with drug or substance misuse issues and implementing an MDT substance misuse pathway with integrated team members from health and social care; implementation of the smoking cessation baby clear risk perception programme for smoking mothers across all sites; and implementation of the Early Health Assessment Safeguarding Tool into maternity services. In addition to the developments in the community parts of the maternity pathway, there has also been a substantial amount of work carried out to improve patient experience. This has included the implementation of a real-time patient survey into maternity services and the introduction of an extended CQC quarterly patient survey which is sent to patients using all sites to gather feedback across the whole of the pregnancy pathway.
The Endoscopy Service has continued commitment to growth and service development. In 2014/15 this was demonstrated by investment in the workforce, and increasing specialist skills and staffing levels to meet the needs of a developing service.

May 2014 saw the roll out of the Bowel Cancer Screening Programme Bowel Scope – a national programme launched by Public Health England – currently supported by North Tyneside General Hospital Endoscopy Unit, but will extend to Wansbeck General Hospital in August 2015. The Units ensure that the environment is safe and have developed an Endoscopy Safety Checklist based on the WHO Safer Surgery Checklist and introduced pre-procedure “Time Out”.

The Trust, Marie Curie Cancer Care (MCCC) and Macmillan have developed a collaborative partnership that will deliver a comprehensive programme of improvement for end of life care throughout Northumberland and North Tyneside – across health and social care settings. Through the formal strategic alliance with MCCC and support from Macmillan, the Trust aims to deliver a model of care that will significantly improve patient outcomes.

**EC Priority 4: Support to carers through dementia and end of life care**

Caring for someone with dementia or a terminal illness can be stressful and difficult so it is important that services provide carers with the practical and emotional support they need.

In the last 12 months, the Trust has invested in improving dementia wards with new specialist equipment for therapeutic activities to promote social interaction.

It has introduced artwork in communal and patient rooms to make the clinical surroundings more familiar and less intimidating. During the year, it has also introduced a series of questions that carers are asked about how well they feel they are being supported.

The perceptions of carers are measured and reported to Commissioners. Table 9 shows the performance on this:

<table>
<thead>
<tr>
<th>Measure</th>
<th>2014/15 Target</th>
<th>Trust performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013/14</td>
<td>2014/15</td>
</tr>
<tr>
<td>Audit on care of the elderly wards</td>
<td>20% improvement on 13/14 baseline</td>
<td>New indicator</td>
</tr>
</tbody>
</table>

Performance Key: ⬆ Better    ⬇ Worse

Note: 1 – Position as at January 2015
Key Achievement  

**Speaking up about dementia as part of a national campaign**

As part of national dementia awareness week in May 2014, hospital wards across the Trust held a number of tea parties for elderly patients, their families and staff.

The tea parties tied in with the theme of the week, run by the Alzheimer’s Society, which was about ‘opening up’ about dementia as the sooner you know what you are dealing with, the sooner you can get on with your life and feel in control again.

Annie Laverty, Director of Patient Experience, said:

“We know that dementia affects so many people and yet people don’t always feel able to talk openly about how they are feeling or some of the challenges they face. Our tea parties are just one of the ways we encourage patients, their families and carers to talk to us and to highlight the range of support available to them.”

Caring for older people is a major priority for the Trust, not only in the services provided in its hospitals, but also in the community and in people’s homes.

In the last 12 months, the Trust has worked with partners to support social and leisure activities to help people living with dementia to stay healthy and active for as long as possible following a diagnosis.

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**EC Priority 5: Helping patients manage their long term conditions – focus on respiratory conditions and alcohol abuse**

As part of its role in supporting people with long term conditions, the Trust identified alcohol abuse and the management of respiratory conditions as key priority areas. These impact on large numbers of people in the Trust’s local population, and were set as CQUIN targets by Commissioners.

In relation to respiratory conditions, the Trust wanted to focus on improving the inhaler technique of its patients. During the year, it has been training its staff in how to support patients with this, and checking the quality of these interventions via a competency workbook.

At the end of Q4, 93% of identified staff had received the training with all of these staff having had their competency workbooks assessed.

In relation to alcohol abuse, the Trust has been focusing on improving the assessment and recording of alcohol status of patients attending gastroenterology and endoscopy outpatients, to ensure they are referred on if needed to the specialist help they may need. The Trust has again been training its staff and auditing the extent to which this is done. By the end of Q4 in 2014/15 86% of eligible patients had their alcohol status recorded.
EC Priority 6: Development of community services in line with Better Care Fund (BCF) to reduce admissions to hospitals

**Northumberland BCF Plan**

A revised version of the BCF was submitted on 28 November 2014, and confirmation that this had been approved without conditions was received on 19 December 2014.

The community social care schemes included in the plan are largely continuations of existing social care services. These would otherwise be at risk because of the impact of national austerity savings on local authority budgets. The community health schemes are also largely continuations of existing services, but in both cases continuing work is taking place to refocus services to achieve maximum impact in preventing avoidable acute admissions. This includes an integrated project focusing on enhanced support to care homes to reduce emergency admissions of residents who could be supported in the home, and the full year effects of further development of integrated Immediate Response and Hospital to Home teams including social care and community health staff.

A Section 75 partnership agreement will provide a governance framework for the BCF schemes, and discussions are continuing about the apportionment of financial risk.

**North Tyneside BCF Plan**

An update to the BCF plan was agreed by the Health and Wellbeing Board on 18th December and submitted to NHS England on December 19th. Notification was received from NHS England in January 2015 that the plan was fully approved.

Many of the BCF services are already operational, some with interim funding from winter planning / system resilience funds and include a range of initiatives relating to areas such as end of life care, falls, telecare, overnight home care and reablement.

The Clinical Commissioning Group (CCG) and the Council have been working on the Section 75 agreement, which provides the legal and financial framework for the management of the BCF through a pooled budget. This agreement states that responsibility for managing the risk of overspend lies with the Lead Commissioner for each BCF initiative.

The agreement establishes a Partnership Board to manage the fund, with representatives from the Council and the CCG, who are the formal parties to the agreement, in order to gain wider input from health and social care providers.

EC Priority 7: Developing systems and processes for integrated working with nursing homes

**Dedicated Community Matrons for nursing homes** have now been in place for 18 months. Their role has been to support and work together with independent providers. Together they have helped revise clinical policies, procedures and worked with managers of the homes regarding admission and discharge to hospital. Feedback from the providers and local GPs has been positive and it is has become part of the Northumberland Better Care Fund.

**Northumberland CCG** is looking at various data sets and will reporting on this with the Trust in 2015.

The introduction of hand held devices that allow a mobile technical solution for Consultants to view a patient within a nursing home setting will be launched in May 2015 in rural Northumberland.
Patient Experience (PE)

**PE Priority 1: Roll out of 15 steps programme – ward based assurance during out of hours periods**

The Trust identified continuing to roll out the 15 steps programme of safety and quality assessments as one of its 2014/15 priorities. The 15 steps assessments are unannounced visits of wards, clinics and services by a mixed team of clinical and non-clinical professionals. The visits aim to capture the initial impressions of care provision as well as a more detailed assessment of practice. They involve observing practice and interactions; gathering real-time feedback from patients, their families and staff; checking records, equipment and the environment. Verbal feedback is given the same or next day to allow services to make improvements quickly, followed by a formal report. During 2014/15, these assessment visits were extended to include ‘out of hours’ periods which include evenings and weekends, and over 50 visits were undertaken during the year.

> "The 15 step assessment opens up the opportunity for discussions among the team about quality improvement – Ward Manager"

**PE Priority 2: Roll out a new metric for kindness and compassion in line with the Francis report**

Kindness and compassion are fundamental to patient care and were highlighted in the 2013 Francis Report on the quality of care at Mid Staffordshire NHS Foundation Trust. During 2014/15 the Trust introduced a new patient experience measure which focused on this. Patients on the ward are asked the following question “Were you treated with kindness and compassion by the staff looking after you?” Patient responses are converted into a score out of 10 using a Likert scale. Figure 1 illustrates performance on this over the year, by site:

![Figure 1: Kindness and compassion aggregate scores 2014/15 by site (as at March 2015)](image)

**PE Priority 3: Understand patient experience findings on weekdays and weekends**

In order to find out if patient experience is different on weekends to weekdays, the Trust has been piloting patients’ out of hours experience. To date 25 wards across the Trust have received at least 2 visits for out of hour’s measurement of the patient experience.

**PE Priority 4: Further roll out of real time programme**

As part of its commitment to listening to the views of patients, the Trust prioritised the further roll-out of its real-time programme during 2014/15. The friends and family programme is now extended across all services and community through development of a telephone line and website managed externally by Patient Perspective.
Additional feedback was also received from users of Psychiatry of Old Age Services, Physiotherapy Services, and Anaesthetics for the first time. The Trust also developed a new feedback questionnaire for carers, and 15 individuals with learning disability contributed to a learning café event to develop an easy read version of the current 2 minutes of your time survey cards.

**Key Achievement**

### Northumbria Healthcare’s awards for patient experience

The Trust has once again been recognised nationally for its work to improve patients’ experiences of receiving care in Northumberland and North Tyneside.

The Trust was shortlisted in 10 of the 16 categories in The Patient Experience Network National Awards 2014 – the only awards which recognise and celebrate the delivery of outstanding patient experience by healthcare organisations – and won 6 of the categories including ‘Trust of the Year’.

Widely recognised as having one of the best patient experience programmes in the NHS, the nominations reflect the wide range of services provided by the Trust across hospital and community care in North Tyneside and hospital, community and adult social care in Northumberland.

Annie Laverty, Director of Patient Experience, said:

“Improving patients’ experiences of receiving their care with us is a key priority. As an organisation, we’re passionate about delivering patient-centred care and listening to our patients and their relatives so we can make things even better.”
**PE Priority 5: Achieving national accreditation schemes – Bliss and Year of care**

**Bliss**

The Bliss Family Friendly Accreditation Scheme recognises and rewards neonatal units across the country caring for premature and sick babies, where they deliver consistent high quality family-centred care. The scheme stems from the Bliss Baby Charter to help hospitals caring for premature and sick babies self-assess the quality of family-centred care they provide and identify areas for improvement.

Extensive research has shown that this family-centred approach is hugely beneficial to babies and parents. It can lower a baby’s stress levels, promote better health, shorten hospital stays and reduce hospital readmissions. It helps parents bond with their baby and improves their confidence as a parent.

The Trust has been awarded a pledge of improvement by BLISS following a visit to the neonatal units. They highlighted things the Trust does as best practice that have been introduced throughout the network and have suggested these for national implementation, such as the “parent passport” which is a detailed family care plan which accompanies babies as they are moved from unit to unit promoting continuity of care and good communication.

Bliss has advised the Trust to wait to submit its final application for accreditation until the Trust moves to the new Northumbria Specialist Emergency Care Hospital. The service therefore intends to submit its application once the service has relocated.

**Year of care**

Year of Care Partnerships continue to work with over 40 health communities and organisations across the UK to support the implementation of personalised care planning for people with long term conditions, and the Trust is a key partner.

During 2014/15, it has continued to influence policy and practice, including working with The Coalition for Collaborative Care, Think Local Act Personal and National Voices, and many others.

It has also been working with the British Heart Foundation to support their flagship programme implementing the House of Care model in cardiovascular disease, including training and supporting their exemplar sites in Scotland, Gateshead and Derbyshire.

The approach of the Year of Care Programme has recently been published in the British Medical Journal (BMJ 2015; 350:h181).

**PE Priority 6: Friends and family test including staff experience**

The Friends and Family Test is an important feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience.

It asks people if they would recommend the services they have used to their friends and family and offers a range of responses.

When combined with other follow-up questions, the test provides a way of highlighting both good and poor patient experience.

The target for 2014/15 was to implement the test for Trust staff. This has been rolled out across the different services and business units.

A priority was also to increase the response rate to the Friends and Family Test within in-patients (to over 30% by Q4) and A&E (to over 20% by Q4). The performance on this is shown in Table 10:
Table 10: Performance against EC Priority 6: Friends and family test including staff experience – response rate

<table>
<thead>
<tr>
<th>Measure</th>
<th>2014/15 Target</th>
<th>Trust performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2013/14</td>
</tr>
<tr>
<td>Response rate for in-patients</td>
<td>Over 30% by Q4</td>
<td>New indicator</td>
</tr>
<tr>
<td>Response rate for A&amp;E</td>
<td>Over 20% by Q4</td>
<td>New indicator</td>
</tr>
</tbody>
</table>

Performance Key:  Better  Same  Worse

Culture (C)

C Priority 1: Executive team and non-executive director ‘walk-abouts’

Each month members of the Executive and Non-Executive team undertake walk-abouts of wards and services across the different hospital sites. These walk-abouts provide the team with a good opportunity to informally observe and witness the quality of care and practice first hand, and the chance to talk to patients, relatives and staff about their experiences.

Walk-abouts have taken place each month as planned and have involved members of the Executive and Non-Executive team, with summary reports from these ‘walk-abouts’ presented to Trust Board.

“I get a real sense of the issues facing our front-line staff from the walk-abouts we do – Non-Executive Director”
Statements of assurance from the Board

Services and reviews

During 2014/15 Northumbria Healthcare NHS Foundation Trust provided and/or sub-contracted 40 relevant health services.

Northumbria Healthcare NHS Foundation Trust has reviewed all the data available to them on the quality of care in 26 of these relevant health services.

The income generated by the relevant health services reviewed in 2014/15 represents 18.2% of the total income generated from the provision of relevant health services by Northumbria Healthcare NHS Foundation Trust for 2014/15.

The Trust aims to ensure that its services continue to provide the best possible care. To help with this, the Trust has carried out a programme of specialty reviews using its Quality Panels.

The main purpose of these multi-disciplinary Quality Panels is to explore individual services with Clinical Directors and Management Leads, both in terms of their clinical outcomes and other qualitative measures such as patient experience.

They analyse the service and identify areas of good practice and those in need of improvement, and any gaps in knowledge.

Participation in clinical audit

National audits

During 2014/15, 32 national clinical audits and 2 National Confidential Enquiries covered relevant health services that Northumbria Healthcare NHS Foundation Trust provides. During that period Northumbria Healthcare NHS Foundation Trust participated in 97% national clinical audits and 100% National Confidential Enquiries of the national clinical audits and National Confidential Enquiries which it was eligible to participate in.

They take account of data and information such as compliance with NICE guidance, involvement in local and national audits, outcomes data such as waiting times and health status and CQUIN targets, complaints and compliments, and other patient feedback. Their role is to examine if services are: safe, effective, caring, responsive, and well-led.

During 2014/15, the specialties that were reviewed included:

- Anaesthetics
- Child Health (Acute)
- Clinical Biochemistry
- Dental
- Endoscopy
- Gastro
- Histopathology
- Joint Equipment and Loans Service
- Occupational Therapies
- Pharmacy
- POAS
- Sexual Health
- Speech and Language
- CAMHS
- Child Safeguarding
- Community Learning Disability Team
- Diabetes
- Falls
- Haematology
- Infection Control
- Microbiology
- Pain Service
- Physiotherapy
- Podiatry
- Special Care Baby Unit
- Urology

The national clinical audits and national confidential enquiries that Northumbria Healthcare NHS Foundation Trust was eligible to participate in during 2014/15 are as follows (in Table 11):
### Table 11: Eligible National Audits and National Confidential Enquiries 2014/15

<table>
<thead>
<tr>
<th>National Audit</th>
<th>Sponsor</th>
<th>Purpose of the audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute coronary syndrome or Acute myocardial infarction</td>
<td>National Institute for Cardiovascular Outcomes Research</td>
<td>To examine the quality of the management of heart attacks in hospital</td>
</tr>
<tr>
<td>2. Adult community acquired pneumonia</td>
<td>British Thoracic Society</td>
<td>To determine to what extent the British Thoracic Society guidelines on the management of adult community acquired pneumonia are being met</td>
</tr>
<tr>
<td>3. Bowel cancer</td>
<td>Health and Social Care Information Centre</td>
<td>Focuses on key patient outcomes after major surgery for colorectal cancer including mortality, length of stay, readmission rates and access to laparoscopic surgery</td>
</tr>
<tr>
<td>4. Cardiac Rhythm Management</td>
<td>National Institute for Cardiovascular Outcomes Research</td>
<td>To examine the volume and equity of provision of the major cardiac implantable device therapies for cardiac arrest and cardiac resynchronisation therapy for advanced heart failure</td>
</tr>
<tr>
<td>5. Case Mix Programme</td>
<td>Intensive Care National Audit &amp; Research Centre</td>
<td>To determine the quality of adult critical care against a range of quality indicators</td>
</tr>
<tr>
<td>6. Diabetes (Adult), includes National Diabetes Inpatient audit</td>
<td>Health and Social Care Information Centre</td>
<td>To provide a snapshot audit of diabetes inpatient care in England and Wales focusing on: minimising the risk of avoidable complications; harm resulting from the inpatient stay; and patient experience</td>
</tr>
<tr>
<td>7. Diabetes (Paediatric)</td>
<td>Royal College of Paediatrics and Child Health</td>
<td>Focuses on registrations, complications, care processes and treatment targets for children and young people with diabetes</td>
</tr>
<tr>
<td>8. Elective surgery (National PROMs Programme)</td>
<td>Health and Social Care Information Centre</td>
<td>Patient Reported Outcome Measures (PROMs) are a means of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. The PROMs programme covers four common elective surgical procedures: groin hernia operations, hip replacements, knee replacements and varicose vein operations</td>
</tr>
<tr>
<td>9. Epilepsy 12 audit (Childhood Epilepsy)</td>
<td>The Royal College of Paediatrics and Child Health</td>
<td>To facilitate health providers and commissioners to measure and improve quality of care and to contribute to the continuing improvement of outcomes for children and young people with seizures and epilepsies and their families</td>
</tr>
<tr>
<td>10. Falls and Fragility Fractures Audit Programme</td>
<td>Royal College of Physicians</td>
<td>To audit the care that patients with fragility fractures and inpatient falls receive in hospital and to facilitate quality improvement initiatives</td>
</tr>
<tr>
<td>11. Fitting child (care in emergency departments)</td>
<td>The College of Emergency Medicine</td>
<td>To identify current performance in emergency departments of initial management of children and young people who are having a seizure</td>
</tr>
<tr>
<td>12. Gastrointestinal Haemorrhage Study</td>
<td>NCEPOD (National confidential enquiry into patient outcome and death)</td>
<td>To identify the remediable factors in the quality of care provided to patients who are diagnosed with an upper or lower gastrointestinal haemorrhage</td>
</tr>
<tr>
<td>13. Inflammatory bowel disease (IBD)</td>
<td>Royal College of Physicians</td>
<td>To measure the efficacy, safety and appropriate use of biological therapies, in patients with IBD in the UK and to capture the views of patients on their quality of life at intervals during their treatment</td>
</tr>
<tr>
<td>14. Lung cancer</td>
<td>Health and Social Care Information Centre</td>
<td>To monitor the effectiveness of cancer services including patient experience of these</td>
</tr>
<tr>
<td>15. Maternal, Newborn and Infant Clinical Outcome Review Programme</td>
<td>MBRRACE-UK, National Perinatal Epidemiology Unit</td>
<td>To investigate the deaths of women and their babies during or after childbirth, and also cases where women and their babies survive serious illness during pregnancy or after childbirth</td>
</tr>
<tr>
<td>16. Mental health (care in emergency departments)</td>
<td>The College of Emergency Medicine</td>
<td>To identify current performance in emergency departments in relation to the mental health assessment by staff and the facilities where the patient was seen</td>
</tr>
<tr>
<td>National Audit</td>
<td>Sponsor</td>
<td>Purpose of the audit</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>17. Mental health clinical outcome review programme: National Confidential</td>
<td>Centre for Mental Health and Risk, University of Manchester</td>
<td>Examines suicide and homicide committed by people who have been in contact with</td>
</tr>
<tr>
<td>Inquiry into Suicide and Homicide for people with Mental Illness</td>
<td></td>
<td>secondary and specialist mental health services in the previous 12 months</td>
</tr>
<tr>
<td>18. National audit of Intermediate Care National Confidential Inquiry into</td>
<td>NHS Benchmarking Network</td>
<td>To take a whole system view of the effectiveness of intermediate care, to develop</td>
</tr>
<tr>
<td>Suicide and Homicide for people with Mental Illness</td>
<td></td>
<td>quality standards and patient outcome measures and to assess local performance against</td>
</tr>
<tr>
<td></td>
<td></td>
<td>the agreed, national standards</td>
</tr>
<tr>
<td>19. National Cardiac Arrest audit National Audit</td>
<td>Intensive Care National Audit &amp; Research Centre</td>
<td>To audit in-hospital cardiac arrests with a view to: improving patient outcomes;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>decreasing the incidence of avoidable cardiac arrests; decreasing the incidence of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>inappropriate resuscitation; and promoting the adoption and compliance with evidence-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>based practice</td>
</tr>
<tr>
<td>20. National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme</td>
<td>Royal College of Physicians</td>
<td>To drive improvements in the quality of care and services provided for COPD patients</td>
</tr>
<tr>
<td>21. National Comparative audit of Blood Transfusion programme</td>
<td>NHS Blood and Transplant</td>
<td>Comprises of three audits including: the use of Anti-D; audit of patient information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and consent; and management of patients in Neuro Critical Care Units. The Trust</td>
</tr>
<tr>
<td></td>
<td></td>
<td>participated in the first two audits</td>
</tr>
<tr>
<td>22. National emergency laparotomy audit</td>
<td>Royal College of Anaesthetists</td>
<td>To review the structure, process and outcome measures for patients undergoing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>emergency laparotomy</td>
</tr>
<tr>
<td>23. National Heart Failure audit</td>
<td>National Institute for Cardiovascular Outcomes Research</td>
<td>Focuses on the clinical practice and patient outcomes of acute patients discharged</td>
</tr>
<tr>
<td></td>
<td></td>
<td>from hospital with a primary diagnosis of heart failure</td>
</tr>
<tr>
<td>24. National Joint Registry</td>
<td>Healthcare Quality Improvement Partnership</td>
<td>To collect high quality and relevant data about joint replacement surgery in order</td>
</tr>
<tr>
<td></td>
<td></td>
<td>to provide an early warning of issues relating to patient safety</td>
</tr>
<tr>
<td>25. Neonatal intensive and special care</td>
<td>The Royal College of Paediatrics and Child Health</td>
<td>To assess whether babies admitted to neonatal intensive and special care units receive</td>
</tr>
<tr>
<td></td>
<td></td>
<td>consistent care and to identify areas for improvement in units</td>
</tr>
<tr>
<td>26. Non-invasive ventilation – adults</td>
<td>British Thoracic Society</td>
<td>To enable participating hospitals to review the composition and effectiveness of their</td>
</tr>
<tr>
<td></td>
<td></td>
<td>service, benchmarked against the collated national average</td>
</tr>
<tr>
<td>27. Oesophago-gastric cancer</td>
<td>Royal College of Surgeons of England</td>
<td>To investigate whether the care received by patients with oesophago-gastric cancer is</td>
</tr>
<tr>
<td></td>
<td></td>
<td>consistent with recommended practice</td>
</tr>
<tr>
<td>28. Older people (care in emergency departments)</td>
<td>The College of Emergency Medicine</td>
<td>To identify current performance in emergency departments in relation to the assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>of older people by staff, communication and documentation</td>
</tr>
<tr>
<td>29. Pleural procedures</td>
<td>British Thoracic Society</td>
<td>To establish current practice relating to chest drain insertion with a focus on</td>
</tr>
<tr>
<td></td>
<td></td>
<td>complication rates, respiratory team involvement, use of thoracic ultrasound,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>frequency of out of hours procedures and training</td>
</tr>
<tr>
<td>30. Prostate cancer</td>
<td>Royal College of Surgeons of England</td>
<td>To collect information about the diagnosis, management and treatment of every patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td>newly diagnosed with prostate cancer, and their outcomes</td>
</tr>
<tr>
<td>31. Rheumatoid and early inflammatory arthritis</td>
<td>Northgate Public Services</td>
<td>To examine the assessment and early secondary care management of all forms of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>peripheral joint early inflammatory arthritis in all NHS secondary care settings</td>
</tr>
<tr>
<td>32. Sentinel Stroke National audit Programme</td>
<td>Royal College of Physicians</td>
<td>To improve services, enable those who manage and pay for services to monitor how well</td>
</tr>
<tr>
<td></td>
<td></td>
<td>they are doing, and to empower patients, carers, stroke survivors and the wider public</td>
</tr>
<tr>
<td></td>
<td></td>
<td>to call for improvements</td>
</tr>
</tbody>
</table>
The national clinical audits and National Confidential Enquiries that Northumbria Healthcare NHS Foundation Trust participated in during 2014/15 are as follows (shown in Table 12):

Table 12: National Audits and National Confidential Enquiries the Trust participated in during 2014/15

<table>
<thead>
<tr>
<th>National Audit</th>
<th>Sponsor</th>
<th>Purpose of the audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>33. Sepsis study</td>
<td>NCEPOD (National confidential enquiry into patient outcome and death)</td>
<td>To identify and explore avoidable and remediable factors in the process of care for patients with known or suspected sepsis</td>
</tr>
<tr>
<td>34. Severe trauma</td>
<td>Trauma Audit &amp; Research Network</td>
<td>To improve emergency healthcare systems by collating and analysing trauma care</td>
</tr>
</tbody>
</table>

The national clinical audits and National Confidential Enquiries that Northumbria Healthcare NHS Foundation Trust participated in during 2014/15 are as follows (shown in Table 12):

Table 12: National Audits and National Confidential Enquiries the Trust participated in during 2014/15

<table>
<thead>
<tr>
<th>National Audit</th>
<th>Sponsor</th>
<th>Trust Participation 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute coronary syndrome or Acute myocardial infarction</td>
<td>National Institute for Cardiovascular Outcomes Research</td>
<td>✓</td>
</tr>
<tr>
<td>2. Adult community acquired pneumonia</td>
<td>British Thoracic Society</td>
<td>✓</td>
</tr>
<tr>
<td>3. Bowel cancer</td>
<td>Health and Social Care Information Centre</td>
<td></td>
</tr>
<tr>
<td>4. Cardiac Rhythm Management</td>
<td>National Institute for Cardiovascular Outcomes Research</td>
<td>✓</td>
</tr>
<tr>
<td>5. Case Mix Programme</td>
<td>Intensive Care National Audit &amp; Research Centre</td>
<td></td>
</tr>
<tr>
<td>6. Diabetes (Adult), includes National Diabetes Inpatient Audit</td>
<td>Health and Social Care Information Centre</td>
<td>✓</td>
</tr>
<tr>
<td>7. Diabetes (Paediatric)</td>
<td>Royal College of Paediatrics and Child Health</td>
<td>✓</td>
</tr>
<tr>
<td>8. Elective surgery (National PROMs Programme)</td>
<td>Health and Social Care Information Centre</td>
<td>✓</td>
</tr>
<tr>
<td>9. Epilepsy 12 audit (Childhood Epilepsy)</td>
<td>The Royal College of Paediatrics and Child Health</td>
<td></td>
</tr>
<tr>
<td>10. Falls and Fragility Fractures audit Programme</td>
<td>Royal College of Physicians</td>
<td>✓</td>
</tr>
<tr>
<td>11. Fitting child (care in emergency departments)</td>
<td>The College of Emergency Medicine</td>
<td>✓</td>
</tr>
<tr>
<td>12. Gastrointestinal Haemorrhage Study</td>
<td>NCEPOD (National confidential enquiry into patient outcome and death)</td>
<td>✓</td>
</tr>
<tr>
<td>13. Inflammatory bowel disease (IBD)</td>
<td>Royal College of Physicians</td>
<td>✓</td>
</tr>
<tr>
<td>14. Lung cancer</td>
<td>Health and Social Care Information Centre</td>
<td>✓</td>
</tr>
<tr>
<td>15. Maternal, Newborn and Infant Clinical Outcome Review Programme</td>
<td>MBRACE-UK, National Perinatal Epidemiology Unit</td>
<td></td>
</tr>
<tr>
<td>16. Mental health (care in emergency departments)</td>
<td>The College of Emergency Medicine</td>
<td></td>
</tr>
<tr>
<td>17. Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness</td>
<td>Centre for Mental Health and Risk, University of Manchester</td>
<td>✓</td>
</tr>
<tr>
<td>18. National Cardiac Arrest audit</td>
<td>Intensive Care National Audit &amp; Research Centre</td>
<td></td>
</tr>
<tr>
<td>19. National Chronic Obstructive Pulmonary Disease (COPD) audit programme</td>
<td>Royal College of Physicians</td>
<td>✓</td>
</tr>
<tr>
<td>20. National Comparative Audit of Blood Transfusion programme</td>
<td>NHS Blood and Transplant</td>
<td></td>
</tr>
</tbody>
</table>
Table 13: National Audits and National Confidential Enquiries that the Trust participated in and for which data collection was completed during 2014/15 - % of required cases submitted

<table>
<thead>
<tr>
<th>National Audit</th>
<th>Sponsor</th>
<th>% Data Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute coronary syndrome or Acute myocardial infarction</td>
<td>National Institute for Cardiovascular Outcomes Research</td>
<td>100%</td>
</tr>
<tr>
<td>2. Bowel cancer</td>
<td>Health and Social Care Information Centre</td>
<td>100%</td>
</tr>
<tr>
<td>3. Cardiac Rhythm Management</td>
<td>National Institute for Cardiovascular Outcomes Research</td>
<td>100%</td>
</tr>
<tr>
<td>4. Case Mix Programme</td>
<td>Intensive Care National Audit &amp; Research Centre</td>
<td>100%</td>
</tr>
<tr>
<td>5. Diabetes (Adult), includes National Diabetes Inpatient Audit</td>
<td>Health and Social Care Information Centre</td>
<td>100%</td>
</tr>
<tr>
<td>6. Diabetes (Paediatric)</td>
<td>Royal College of Paediatrics and Child Health</td>
<td>100%</td>
</tr>
<tr>
<td>7. Elective surgery (National PROMs Programme)</td>
<td>Health and Social Care Information Centre</td>
<td>100%</td>
</tr>
<tr>
<td>8. Epilepsy 12 audit (Childhood Epilepsy)</td>
<td>The Royal College of Paediatrics and Child Health</td>
<td>100%</td>
</tr>
<tr>
<td>9. Falls and Fragility Fractures audit Programme</td>
<td>Royal College of Physicians</td>
<td>100%</td>
</tr>
<tr>
<td>10. Fitting child (care in emergency departments)</td>
<td>The College of Emergency Medicine</td>
<td>75%</td>
</tr>
</tbody>
</table>
The reports of 30 national clinical audits were reviewed by the provider in 2014/15 and Northumbria Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Specialties to continue to scrutinise and share learning from all national audit reports, undertake self-assessments against any national recommendations, and produce action plans for improvement where any gaps or shortfalls are identified, which will then be followed up by the Clinical Audit Team.

- Ensure national audits are clearly identified within the Business Units’ annual Clinical Audit Plans which form part of the Trust’s overall Clinical Audit Programme.

- Support specialties to maximise their data completion rates when participating in national audits, and examine the reasons for any lower rates of attainment.

- Continue to report national audits to the Safety and Quality Committee and respective Business Unit Governance Groups and monitor and review compliance with National Confidential Enquiries.

Table 14 provides further detail about the improvement actions to be taken following the review of national audit reports during 2014/15:

<table>
<thead>
<tr>
<th>National Audit</th>
<th>Sponsor</th>
<th>% Data Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Gastrointestinal Haemorrhage Study</td>
<td>NCEPOD (National confidential enquiry into patient outcome and death)</td>
<td>81%</td>
</tr>
<tr>
<td>12. Inflammatory bowel disease (IBD)</td>
<td>Royal College of Physicians</td>
<td>100%</td>
</tr>
<tr>
<td>13. Lung cancer</td>
<td>Health and Social Care Information Centre</td>
<td>100%</td>
</tr>
<tr>
<td>14. Maternal, Newborn and Infant Clinical Outcome Review Programme</td>
<td>MBRRACE-UK, National Perinatal Epidemiology Unit</td>
<td>100%</td>
</tr>
<tr>
<td>15. Mental health (care in emergency departments)</td>
<td>The College of Emergency Medicine</td>
<td>30%</td>
</tr>
<tr>
<td>16. Mental health clinical outcome review programme: National Confidential</td>
<td>Centre for Mental Health and Risk, University of Manchester</td>
<td>100%</td>
</tr>
<tr>
<td>Inquiry into Suicide and Homicide for people with Mental Illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. National Cardiac Arrest audit</td>
<td>Intensive Care National Audit &amp; Research Centre</td>
<td>100%</td>
</tr>
<tr>
<td>18. National Comparative Audit of Blood Transfusion programme</td>
<td>NHS Blood and Transplant</td>
<td>100%</td>
</tr>
<tr>
<td>19. National Heart Failure audit</td>
<td>National Institute for Cardiovascular Outcomes Research</td>
<td>100%</td>
</tr>
<tr>
<td>20. National Joint Registry</td>
<td>Healthcare Quality Improvement Partnership</td>
<td>100%</td>
</tr>
<tr>
<td>21. Neonatal intensive and special care</td>
<td>The Royal College of Paediatrics and Child Health</td>
<td>100%</td>
</tr>
<tr>
<td>22. Oesophago-gastric cancer</td>
<td>Royal College of Surgeons of England</td>
<td>100%</td>
</tr>
<tr>
<td>23. Older people (care in emergency departments)</td>
<td>The College of Emergency Medicine</td>
<td>70%</td>
</tr>
<tr>
<td>24. Pleural procedures</td>
<td>British Thoracic Society</td>
<td>100%</td>
</tr>
<tr>
<td>25. Sentinel Stroke National audit programme</td>
<td>Royal College of Physicians</td>
<td>100%</td>
</tr>
<tr>
<td>26. Severe trauma</td>
<td>Trauma Audit &amp; Research Network</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit</td>
<td>Purpose of the audit</td>
<td>Quarter Reviewed</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
</tbody>
</table>
| 1. National Hip Fracture Database: National Report 2013 | The National Hip Fracture Database is a clinically led, web-based audit of hip fracture care and secondary prevention | Q1               | • Mortality is already under review with a monthly review of data and quarterly mortality root cause analyses  
• Inpatient falls are already under review from Falls team; data for definite inpatient hip fractures added to local data collection from April 2012. The Clinical Commissioners Group Outcome Indictors Set for 2014-15 will include markers of hip fracture care based on entry to the database  
• We need to continue entering data to database and check data remains robust |
| 2. Inpatient Diabetes                             | To provide a snapshot audit of diabetes inpatient care                               | Q1               | • Explore further by audit the number of medication errors and increase diabetes education to secondary care staff                                                                                     |
| 3. Trauma Audit and Research Network (TARN)       | To improve emergency healthcare systems by collating and analysing trauma care        | Q1               | • Receive quarterly reports from TARN to enable us to improve the standards of trauma care  
• Well established links with North East Ambulance Service and their Trauma Service team  
• ‘Nursing Knowledge in Trauma’ course running three times a year to improve trauma care provided and expands knowledge of A&E nursing staff  
• Quarterly multi-disciplinary trauma meetings held to discuss and improve standards of trauma care |
| 4. National Paediatric Asthma Audit 2013          | The audit collects basic demographic data and information on 4 domains in the management of acute wheezing/asthma in children: initial hospital assessment; initial hospital treatment; discharge planning and follow-up | Q1               | • Plans to further improve use of information leaflets and improve documentation of checking inhaler technique  
• This includes introduction of a specific asthma information leaflet and on-going use of a generic wheeze information leaflet. Action plan produced  
• To be taken forward as part of a Quality Improvement project before the next national data collection |
| 5. Combined Nuchal Translucency (Cycle 15)         | Provides an independent audit of laboratory data in a standardised and statistically valid way. The analyses help laboratories check their baseline median values, risk algorithm parameter values and population measures | Q1               | • All distribution plots were forwarded to the practicing sonographer. The reason for amber flags were analysed due to the bias being just outside the green range |
| 6. National Audit of Cardiac Rhythm Management Devices | The audit describes cardiac device implantation performance in each Local Area Team in England and Wales. The report places local performance within a national and international context. It compares UK rates with other European countries. | Q1               | • We have presented our implant numbers regionally at the network meetings along with complication rates and our service is seen as good. We have the only ICD / CRT service in the North which is not a tertiary centre, and has been scrutinised by the specialised commissioners |
| 7. National care of the dying audit for hospitals, England | The aim of the audit was to contribute to learning that can help to improve the care for dying patients and their relatives or carers in hospital settings. | Q1               | • Develop 7 day a week face-to-face specialist palliative care service  
• Mandatory education and training in care of the dying for all staff caring for dying patients  
• Local audit of care of the dying, including the assessment of the views of bereaved relatives, at least annually  
• Improve documentation to ensure decisions & discussions about recognition of dying, clinical assisted hydration and nutrition, spiritual needs with patients / family / carers are clearly evident, including reasons why discussions may not have taken place  
• Trust board to routinely discuss care of dying patients  
• Ensure that PRN (‘as needed’) medication for the 5 common symptoms of dying patients are prescribed |
<table>
<thead>
<tr>
<th>National Audit</th>
<th>Purpose of the audit</th>
<th>Quarter Reviewed</th>
<th>Improvement</th>
</tr>
</thead>
</table>
| 8. Sentinel Stroke National Audit     | SSNAP aims to measure the quality of stroke care along the patient pathway from initial admission, through all subsequent locations, up to and including 6 months assessment | Q2 & Q3          | • As always following release of the SSNAP quarterly report, individual teams at Hexham, North Tyneside and Wansbeck will study their results and produce an action plan for areas of future improvement. This is likely to focus on the following:  
  • Hexham – availability of Speech and Language Therapy and standards at discharge with respect to weighing patients and referring them to dietetics  
  • There is no Early Supported Discharge Team (ESDT) at Hexham  
  • North Tyneside – increasing the scanning rate within an hour of arrival and reducing door-to-needle times in thrombolysis  
  • Wansbeck – availability of Occupational Therapy and standards by discharge with respect to weighing patients and referring them to dietetics. Increasing the number of patients discharged with the assistance of the ESDT  
  • The Trust is asked consider the recurring themes in the SSNAP quarterly reports when planning future investment in the stroke service |
| 9. National Audit of Psychological Therapies | To improve the quality of NHS-funded psychological therapy provision for people with anxiety and depression | Q2               | • Awaiting close of consultation process. Specification to be revised with CCG. Service criteria to be revised and communicated to referrers  
  • Publicity information will need reviewed in light of current service restructure  
  • All vacant posts to be recruited and in post  
  • Waiting List Initiative  
  • Partnership working with Richmond Fellowship  
  • Development of 24/7 computerised support package  
  • Develop service user forums to inform future service developments  
  • ‘Consent to therapy’ forms to be developed and implemented for therapists and patients to use within therapy |
| 10. Oesophago-gastric cancer          | To measure quality of care received by patients with oesophago-gastric cancer          | Q2               | • Audit of admission and reasons for this to be undertaken to identify action to take to reduce admission rates |
| 11. National Cardiac Arrest Quarterly Report | To identify and foster improvements in the prevention, care delivery and outcome from cardiac arrest | Q2               | • The Trust have adopted the SBAR tool to use for all medical and nursing handovers, so it is hoped this will decrease the number of cardiac arrests at these times  
  • There are 5 patients from WGH that have had a predicted probability of survival of >50%, but did not survive. It is important to look at these individual records again in depth to establish why this is  
  • We currently look at other data for our local Trust cardiac arrest audit; this looks at the events that occur before a cardiac arrest, and we are able to identify patients that are potentially “failure to rescue”. These records are then highlighted and reported through the Datix system, and areas of improvement are directly fed back to the area of concern |
| 12. Elective Surgery (PROMs)         | Patient Reported Outcome Measures are a means of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. The PROMs programme covers four common elective surgical procedures: groin hernia operations, hip replacements, knee replacements and varicose vein operations | Q2               | • The issue with low compliance with PROMs core collection pre-op was known and was addressed around 18 months ago. An improvement programme was run changing contact centre procedures and feeding back monthly to pre-assessment staff – with the various sites individualised  
  • There has since been a 34.7% improvement in participation |
<table>
<thead>
<tr>
<th>National Audit</th>
<th>Purpose of the audit</th>
<th>Quarter Reviewed</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. National Gout Audit</td>
<td>To demonstrate the complexity of gout managed by rheumatologists, compare management with national guidelines, and help to establish the extent to which standard treatments are successfully employed and the need for newer treatments in clinics</td>
<td>Q2</td>
<td>• To continue working in same manner adhering to all guidelines and undertake all audits necessary to prove compliance</td>
</tr>
</tbody>
</table>
| 14. Management of Asthma in Children                                         | Collects basic demographic data and information on the management of acute wheezing/asthma in children including: initial hospital assessment; initial hospital treatment; discharge planning and follow-up | Q2               | • Documentation of peak flow – readings if done, and reason why if not (e.g. age)  
• Improvement in beta-2 agonist/ipratropium being given within 10mins of arrival (in moderate/severe asthma)  
• Improvement in appropriate discharge prescription of steroids                                                                 |
| 15. Severe Sepsis and septic shock audit 2013-2014                          | An audit of the treatment of severe sepsis and septic shock against the clinical national standards | Q2               | • This audit was carried out prior to the introduction of the in house infection screening tool so the results should show a significant improvement  
• Particular areas to look at further are: initial observation recording at NTGH; the use of lactate at NTGH and WGH; the use of high flow oxygen at WGH; timing of blood cultures and antibiotic delivery at WGH; and the monitoring of fluid balance at both sites  
• Most of this data is already available via the on-going sepsis audits; the plan is to re audit using the CEM data collection parameters to see which areas the introduction of infection screening tool has improved                                                                 |
| 16. National Audit of Inflammatory Bowel Disease (IBD)                       | To audit individual patient care and the provision and organisation of IBD service resources, and assess inpatient experience and patient-reported outcome measures | Q3               | • Increase current nursing personnel  
• IBD nurses to speak to Gastroenterology wards  
• Increase in funding required to meet this need  
• Need to establish efficiency of currently available databases before investing in another                                                      |
| 17. Combined Nuchal Translucency (Cycle 16)                                  | Provides an independent audit of laboratory data in a standardised and statistically valid way. The analyses help laboratories check their baseline median values, risk algorithm parameter values and population measures | Q3               | • On reviewing the national report the results showed all were green flagged or low amber which requires no intervention as these are now considered to be in the normal range. However one white flag showed up in results. The results were forwarded to practicing sonographers. The sonographer who showed a white flag was asked to monitor their numbers |
| 18. National Lung Cancer Audit Report 2014 – Mesothelioma                    | To summarise the key findings of the audit for patients who were first seen in secondary care for diagnosis and treatment of their mesothelioma between 2008 and 2012 inclusive | Q3               | • The Trust does not currently meet the 85% 'present at diagnosis' criteria but the development of specialist pleural clinics will enable this to improve for the future                                                                 |
| 19. UK inflammatory bowel disease (Ulcerative Colitis)                      | Publishes national and hospital-level findings on the quality of care provided to people admitted to hospital primarily for the treatment of ulcerative colitis | Q3               | • Plans in place to recruit 2 more nurses for Gastroenterology  
• Input into Junior Doctors education. IBD Nurse Specialist to inform Gastroenterology wards  
• Investment required from information technology                                                                                       |
<p>| 20. Pleural Procedures                                                       | To drive improvements in the quality of care and services provided for patients with respiratory conditions | Q3               | • Discussion at Ward 18 clinical governance meeting. Improve / update chest drain care plan                                                                                                                   |
| 21. On the right trach? A review of the care received by patients who underwent a tracheostomy | National Confidential Enquiry into Patient Outcome and Death: to help identify the difficulties in the pathway of care for patients with a tracheostomy and in various hospital settings | Q3               | • The Trust is compliant with the recommendations and no specific actions for improvement were identified                                                                                         |</p>
<table>
<thead>
<tr>
<th>National Audit</th>
<th>Purpose of the audit</th>
<th>Quarter Reviewed</th>
<th>Improvement</th>
</tr>
</thead>
</table>
| 22. Epilepsy 12 | To facilitate health providers and commissioners to measure and improve quality of care and to contribute to the continuing improvement of outcomes for children and young people with seizures and epilepsies and their families | Q4 | • To increase hours of working  
• Transition clinics to run quarterly  
• Identify appropriate patients and refer to paediatric neurologist for syndromic diagnosis  
• Ensure adherence with NICE guidelines for referral to appropriate and timely neuroimaging |
| 23. Lower Limb Amputation: Working Together (National Confidential Enquiry) | To explore remediable factors in the process of care of patients undergoing major lower limb amputation. | Q4 | • Planned amputations to be referred to Freeman hospital. Specialist diabetes team within Trust will assess and liaise with Freeman  
• Establish pathway for referral of acute diabetic feet to vascular service |
| 24. Maternal, infant and newborn clinical outcome review programme: Saving Lives, Improving Mothers’ Care | To investigate the deaths of women and their babies during or after childbirth, and also cases where women and their babies survive serious illness during pregnancy or after childbirth | Q4 | • The Trust is compliant with the recommendations and therefore no specific improvement actions have been identified |
| 25. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness | Examines suicide and homicide committed by people who have been in contact with secondary and specialist mental health services in the previous 12 months | Q4 | • No specific improvement actions have been identified as being required for the Trust as a result of this Inquiry |
| 26. National Neonatal Audit Programme | To assess whether babies admitted to neonatal intensive and special care units receive consistent care and to identify areas for improvement in units | Q4 | • Lead obstetrician to be emailed to remind obstetric staff to consider antenatal steroids  
• All babies admitted born 24-34+6 weeks will be monitored by SCBUBG (Special Care Baby Unit ‘Badger’ Group) who will inform Supervisor of Midwives who will report non-compliance with obstetrics and gynaecology (O&G) antenatal, intrapartum, postnatal guideline 6 and intrapartum guideline 13 to O&G CGG via Datix  
• SCBUBG will monitor this standard monthly to ensure all steroids given are recorded  
• Evidence of improvement will be included in annual report  
• SCBUBG will ensure this standard is monitored monthly to ensure database up to date  
• Deputy Manager will report NUTH non-compliance to Child Health Business Unit management on a case by case basis  
• SCBUBG will ensure this standard is monitored monthly to ensure database up to date  
• SCBUBG to monitor use of system and its users  
• Ward managers to determine pathway for managing staff who fail to use system appropriately |
<p>| 27. Paracetamol Overdose | This audit compares the treatment for paracetamol overdose against the clinical standards published by the College of Emergency Medicine | Q4 | • Toxic OD &gt;8hrs, low figures for treatment within 1 hour. Now highlighted on proforma. Take to senior nurses meeting, the need to flag from triage |
| 28. Audit of Anti-D Immunoglobulin Prophylaxis | Audits compliance against 4 key clinical standards pertaining to Anti-D Immunoglobulin Prophylaxis | Q4 | • Add reminder into the maternal antenatal screening guideline to obtain and document any previous screening performed for women transferring into the Trust |</p>
<table>
<thead>
<tr>
<th>National Audit</th>
<th>Purpose of the audit</th>
<th>Quarter Reviewed</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>29. Myocardial Ischaemia National Audit Project</td>
<td>To examine the quality of the management of heart attacks in hospital</td>
<td>Q4</td>
<td>• Highlights areas of good practice but also areas where organisational structure hampers performance in this national audit. Patients with NSTEMI (Non-ST-Elevation Myocardial Infarction) are not admitted directly to a cardiac ward and go to Medical Admissions Unit hence the low figures for percentage of patients admitted to a cardiac unit or cardiac ward. This will improve with the new emergency care set up being planned.</td>
</tr>
<tr>
<td>30. Adult National Diabetes Audit</td>
<td>To provide a snapshot audit of diabetes inpatient care in England and Wales focusing on: minimising the risk of avoidable complications; harm resulting from the inpatient stay; and patient experience</td>
<td>Q4</td>
<td>• The Trust is compliant in relation to the audit recommendations and therefore no specific actions for improvement were identified.</td>
</tr>
</tbody>
</table>

### Local audits

The reports of 273 local clinical audits were reviewed by the provider in 2014/15 and Northumbria Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Update clinical guidelines and protocols in those areas where audits identified that changes in practice were needed
- Ensure findings and actions from local audits are disseminated appropriately with all relevant stakeholders so that learning can be shared, and to promote the consistency of high quality of care across different sites
- Enhance patient information and engagement where audits have identified this is either lacking or in need of improvement
- Deliver training and education for staff in areas where new practice has been identified or where audits have highlighted that awareness and understanding of existing practices needs to be strengthened
- Undertake re-audits were appropriate to ensure that any changes have led to an improvement in practice
- Follow up the actions of audits identifying that improvements are required or where the results present a moderate or high risk to the Trust.

### Participation in clinical research

This section of the Quality Account describes the Trust’s participation in clinical research studies.

The number of patients receiving NHS services provided or subcontracted by Northumbria Healthcare NHS Foundation Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 1,672 in a total of 76 research studies. This is an increase on the number of patients recruited to studies in previous years and is in part due to clinical specialties, such as Orthopaedics, Cardiology and Haematology strengthening and developing their research activities alongside those already actively participating in research such as those in Elderly Medicine, Obstetrics and Gynaecology, Musculoskeletal Medicine and Respiratory Medicine.
Key Achievement

New hope for stroke survivors with NHS robot research

In July, Professor Helen Rodgers, Consultant Stroke Physician and Professor of Stroke Care at Newcastle University was interviewed on BBC Breakfast about the major new national research programme which uses robot assisted training to help stroke patients regain movement in their affected arm.

The research, led by the Trust’s stroke specialists, with researchers at Newcastle University and other UK institutions is funded by a £3 million research grant from the National Institute for Health research and will see NHS patients take part in the first and largest study of its kind in the UK.

North Tyneside hospital is one of four major study centres for the five-year clinical trial and is one of the first in the country to house the new state-of-the-art stroke ‘rehabilitation robots’ from the Massachusetts Institute of Technology in the US after investing over £250,000.

Key Achievement

Synexus and Northumbria Healthcare partnership takes a major step forward

In 2013, the Trust confirmed that it had signed a collaboration agreement with Synexus, a company responsible for running clinical trials on behalf of some of the world’s leading pharmaceutical companies, such as Pfizer and Glaxo Smith Kline. The partnership formed between the Trust and Synexus is very exciting for clinical research as it is the first of its kind between a private company and the NHS and potentially showcases a new way of supporting clinical research in the UK.

Speaking at the North East launch of the new centre at Hexham General Hospital in July 2014, Sarah Beeby, Synexus’ UK Managing Director, said,

“This is a very exciting partnership as it potentially signals a new way of working for the clinical trials sector that will enable UK patients to access new treatments and will also help ensure the UK clinical trials industry remains competitive on the global stage. This is ground-breaking and, we hope, the start of something that will replicate across the UK so that even more people can benefit”.

Results of an Ipsos Mori poll identified that 97% of the public believed that it is important for the NHS to support research into new treatments. The NHS Constitution makes the pledge to inform people of research studies they may be able to take part in. The partnership between Northumbria Healthcare and Synexus will help further translate this requirement into action. Professor Richard Walker, Clinical Director of Research and Development said,

“At Northumbria we believe everyone should be able to take part in appropriate clinical trials if they would like to. This partnership will provide us with the opportunities to work together to deliver clinical research studies relating to a variety of conditions and usually will focus on those conditions which affect large numbers of people”.

An event to showcase the partnership to the pharmaceutical industry was held in September in London. It was attended by the Minister for Life Sciences; the right honourable George Freeman, and also Dr Jonathan Sheffield, Chief Executive of the National Institute for Health Research Clinical Research Network and other senior members of the Trust and Synexus.
Goals agreed with commissioners (the CQUIN – Commissioning for Quality and Innovation Payment Framework)

A proportion of Northumbria Healthcare NHS Foundation Trust’s income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between Northumbria Healthcare NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2014/15 and for the following 12 month period are available electronically at www.northumbria.nhs.uk.

The Trust’s services earned 99.6% of available CQUIN monies as it delivered the quality improvements outlined below in Table 15:

Table 15: Trust performance against 2014/15 CQUIN targets (as at Q3)

<table>
<thead>
<tr>
<th>CQUIN Quality Improvement Target</th>
<th>% Achieved</th>
<th>2014/15 Forecast of Income Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Long term conditions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Alcohol related attendances (assessment &amp; referral into appropriate pathways)</td>
<td>100%</td>
<td>£600,000 (£300,000 each for parts 1 and 2)</td>
</tr>
<tr>
<td>2) Inhaler technique training: initial instruction and reinforcement to improve patient adherence to therapy</td>
<td>100%</td>
<td>£1,200,000 (£900,000 for part 1 and £300,000 for part 2)</td>
</tr>
<tr>
<td><strong>Sepsis:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Implementing sepsis bundle- Promote the compliance of the implementation of the Sepsis 6 bundle to clinically appropriate patients</td>
<td>100%</td>
<td>£1,500,000 (£750,000 each for parts 1 and 2)</td>
</tr>
<tr>
<td>2) Head of bed - Promote the compliance of the head of bed elevation by 30 degrees</td>
<td>100%</td>
<td>£900,000</td>
</tr>
<tr>
<td><strong>NHS Safety thermometer - Improvement goal specification:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Pressure ulcers: To achieve a 20% reduction in the prevalence of pressure ulcers (new PUs, category 2-4) on the identified wards by delivering pressure ulcer bundle compliance on 4 wards across the Trust</td>
<td>100%</td>
<td>£600,000 (£180,000 for part 1, £90,000 each for parts 2 &amp; 3, £240,000 for part 4)</td>
</tr>
<tr>
<td>2) Falls: To achieve a 20% reduction in the prevalence of falls resulting in harm on 6 identified wards by delivering falls bundle compliance</td>
<td>100%</td>
<td>£600,000 (£360,000 for part 1, £60,000 for parts 2, £180,000 for part 3)</td>
</tr>
<tr>
<td><strong>Communications – improved clinic letters turnaround time:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Improve the numbers of OP clinic letters that are communicated to GPs within 10 working days of OP clinic being attended</td>
<td>100%</td>
<td>£600,000 (£180,000 for part 1, £90,000 each for parts 2 &amp; 3, £240,000 for part 4)</td>
</tr>
<tr>
<td>2) Improve the quality and standardisation of communications between secondary and primary care clinicians following treatment, through the introduction of agreed standard templates for communication within respiratory, rheumatology, geriatrics, cardiology, gastroenterology and paediatrics</td>
<td>100%</td>
<td>£600,000 (£360,000 for part 1, £60,000 for parts 2, £180,000 for part 3)</td>
</tr>
<tr>
<td><strong>Friends and Family Test:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Implementation of Staff FFT</td>
<td>100%</td>
<td>£600,000 (£180,000 for part 1, £90,000 each for parts 2 &amp; 3, £240,000 for part 4)</td>
</tr>
<tr>
<td>2) Early implementation: Full delivery of FFT across outpatients and day cases</td>
<td>100%</td>
<td>£600,000 (£360,000 for part 1, £60,000 for parts 2, £180,000 for part 3)</td>
</tr>
<tr>
<td>3) Increased or maintained Response Rate</td>
<td>100%</td>
<td>£600,000 (£360,000 for part 1, £60,000 for parts 2, £180,000 for part 3)</td>
</tr>
<tr>
<td>4) Increased Response Rate in acute inpatient services</td>
<td>100%</td>
<td>£600,000 (£360,000 for part 1, £60,000 for parts 2, £180,000 for part 3)</td>
</tr>
<tr>
<td><strong>Dementia:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Find, assess, investigate and refer</td>
<td>100%</td>
<td>£600,000 (£360,000 for part 1, £60,000 for parts 2, £180,000 for part 3)</td>
</tr>
<tr>
<td>2) Clinical leadership</td>
<td>100%</td>
<td>£600,000 (£360,000 for part 1, £60,000 for parts 2, £180,000 for part 3)</td>
</tr>
<tr>
<td>3) Supporting carers</td>
<td>100%</td>
<td>£600,000 (£360,000 for part 1, £60,000 for parts 2, £180,000 for part 3)</td>
</tr>
<tr>
<td>CQUIN Quality Improvement Target</td>
<td>% Achieved</td>
<td>2014/15 Forecast of Income Earned</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td><strong>End of Life Care:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Increasing the proportion of cancer/end stage chronic disease patients with a recorded Emergency Health Care Plan</td>
<td>100%</td>
<td>£600,000</td>
</tr>
<tr>
<td>2) Increase the percentage of patients on the Palliative Care Units, discharged with a DNAR where capacity assessment (and Best Interest decision where appropriate) has been made, recorded in the discharge summary and reported back to primary care</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Acute Total:</strong></td>
<td>100%</td>
<td>£6,000,000</td>
</tr>
<tr>
<td><strong>Community Total:</strong></td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>Community Services (Northumberland and North Tyneside)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sepsis:</strong></td>
<td>100%</td>
<td>£231,891</td>
</tr>
<tr>
<td>1) Reducing long-term urethral catheter use in the community through regular review of need</td>
<td></td>
<td>(£118,958 – Northumberland; £112,933 – North Tyneside)</td>
</tr>
<tr>
<td>2) Engaging with nursing homes to encourage use of 30 degree head up, emergency healthcare plans and DNARs</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>COPD Self-management:</strong></td>
<td>100%</td>
<td>£173,919</td>
</tr>
<tr>
<td>1) To develop a systematic approach to providing advice to COPD patients on self-management of exacerbations.</td>
<td></td>
<td>(£89,219 – Northumberland; £84,700 – North Tyneside)</td>
</tr>
<tr>
<td>2) To ensure competency in inhaler technique and monitor interventions</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Alcohol Brief Intervention:</strong></td>
<td>100%</td>
<td>£115,945</td>
</tr>
<tr>
<td>1) Develop a systematic approach to delivering brief intervention on alcohol as part of the district nursing service assessment process</td>
<td></td>
<td>(£59,479 – Northumberland; £56,466 – North Tyneside)</td>
</tr>
<tr>
<td><strong>Patient Experience – Friends and Family Test (FFT):</strong></td>
<td>87.5%</td>
<td>£173,919</td>
</tr>
<tr>
<td>1) Early implementation of F&amp;F to staff</td>
<td></td>
<td>(£89,219 – Northumberland; £84,700 – North Tyneside)</td>
</tr>
<tr>
<td>2) Early implementation of F&amp;F to patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Phased Expansion of F&amp;F to patients (score and response rate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pressure Ulcer care in the community:</strong></td>
<td>100%</td>
<td>£173,919</td>
</tr>
<tr>
<td>1) Reduction in community-acquire pressure ulcers from baseline period</td>
<td></td>
<td>(£89,219 – Northumberland; £84,700 – North Tyneside)</td>
</tr>
<tr>
<td><strong>Dementia Assessment (Housebound):</strong></td>
<td>100%</td>
<td>£115,945</td>
</tr>
<tr>
<td>1) To increase screening of patients with suspected dementia by district nursing and community matrons using the 6 Item Cognitive Impairment Test</td>
<td></td>
<td>(£59,479 – Northumberland; £56,466 – North Tyneside)</td>
</tr>
<tr>
<td><strong>End of Life Care:</strong></td>
<td>100%</td>
<td>£173,919</td>
</tr>
<tr>
<td>1) To embed the assessment of nutritional needs into process for patients with Advanced Care Planning</td>
<td></td>
<td>(£89,219 – Northumberland; £84,700 – North Tyneside)</td>
</tr>
<tr>
<td><strong>Community Total:</strong></td>
<td>98%</td>
<td>£1,159,456</td>
</tr>
<tr>
<td><strong>Combined Acute and Community Total:</strong></td>
<td>99.6%</td>
<td>£7,159,456</td>
</tr>
</tbody>
</table>

The monetary total for income in 2014/15 conditional upon achieving quality improvement and innovation goals was £7,159,456 and a monetary total for the associated payment in 2013/14 was £7,962,135.

Note: Final Q4 payment is subject to official notification of payment from the Trust’s Commissioners.
Northumbria Healthcare NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is fully registered with no conditions. The CQC has not taken enforcement actions against Northumbria Healthcare NHS Foundation Trust during 2014/15.

Northumbria Healthcare NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

During 2014/15 the Trust received two Intelligent Monitoring Reports; these reports were developed to give the CQC inspectors a clear picture of the areas of care that need to be followed up within a NHS acute Trust or a specialist NHS Trust.

The system is built on a set of indicators that look at a range of information including patient experience, staff experience and performance.

Trusts have been categorised into one of six summary bands, with band 1 representing highest risk and band 6 the lowest risk.

The bands have been assigned based on the proportion of indicators that have been identified as ‘risk’ or elevated risk, or if there are known serious concerns with Trusts (for example Trusts in special measures) they are categorised as band 1.

Both of the Intelligent Monitoring Reports received by Northumbria Healthcare NHS Foundation Trust in 2014/15 placed the Trust in band 5, the second lowest risk category.

Data quality

Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made. Improving data quality, which includes the quality of ethnicity and other equality data, will thus improve patient care and increase value for money.

The Trust was again shortlisted (i.e. was in the top 3) for the data quality prize in the 2014 CHKS awards (CHKS is a leading provider of healthcare intelligence and quality improvement services).

It has won the award twice, the last time being in 2013.

The patient’s NHS number

A patient’s NHS number is a key identifier for patient records, and the National Patient Safety Agency has found that the largest single source of nationally reported patient safety incidents relates to the misidentification of patients. The work to ensure the completeness of this data item within the Trust means that its performance is above the national average.

Northumbria Healthcare NHS Foundation Trust submitted records during 2014/15 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episodes Statistics (HES) which are included in the latest published data.

The percentage of records in the published data which included the patient’s valid NHS number was (for April 2014 to January 2015):

- 99.6% for admitted patient care (national value is 99.2%)
- 99.6% for outpatient care (national value is 99.3%)
- 97.8% for accident and emergency care (national value is 95.2%).
Accurate recording of the patient’s GP practice is essential to enable the transfer of clinical information from the Trust to their GP.

Northumbria Healthcare NHS Foundation Trust submitted records during 2014/15 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

The percentage of records which included the patient’s valid General Medical Practice Code was (for April 2014 to January 2015):

- 100.0% for admitted patient care (national value is 99.9%)
- 99.8 % for outpatient care (national value is 99.9%)
- 100.0% for accident and emergency care (national value is 99.2%).

Information governance toolkit attainment levels

Northumbria Healthcare NHS Foundation Trust’s Information Governance Assessment Report overall score for 2014/15 was 94% and was graded green, because for all requirements attainment level 2 or above was achieved.

Clinical coding of admitted patients

Clinical coding translates the medical terminology, as written by the clinician to describe a patient’s diagnosis and treatment, into standard recognised codes.

The accuracy of this coding is a key indicator of the accuracy of the patient record.

Clinical codes can be used to identify specific groups of anonymised patients (for example, those who have had a stroke, or those who have had a hip replacement operation) so that indicators of quality can be produced to help the improvement process.

Northumbria Healthcare NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were (as shown in Table 16):

<table>
<thead>
<tr>
<th>Error</th>
<th>Error Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>200 episodes (180 spells)</td>
</tr>
<tr>
<td></td>
<td>% (numerator/denominator)</td>
</tr>
<tr>
<td>Primary diagnosis incorrect</td>
<td>4.5% (9/200)</td>
</tr>
<tr>
<td>Secondary diagnoses incorrect</td>
<td>1.4% (8/564)</td>
</tr>
<tr>
<td>Primary procedure incorrect</td>
<td>4.9% (6/123)</td>
</tr>
<tr>
<td>Secondary procedures incorrect</td>
<td>9.4% (16/170)</td>
</tr>
</tbody>
</table>

The results should not be extrapolated further than the actual sample audited.

The sample audited was made up of 100 episodes from HRG subchapter NZ from HRG chapter N (Obstetrics); and 100 episodes from HRG subchapter AA from HRG chapter A (Nervous system).
An internal audit was also carried out by the Trust’s internal Clinical Coding Auditor. This covered 200 episodes from the Paediatric and Obstetrics and Gynaecology specialties. The results from this audit are shown in Table 17. The results should not be extrapolated further than the actual sample audited.

### Actions to improve data quality

Data must be of the highest quality so that information held about an individual patient and used in their care is accurate. In addition, the summary information used by the Trust to measure service improvement, and by the public and patients to assess quality of services, also requires that data should be of the highest quality.

Northumbria Healthcare NHS Foundation Trust will be taking the following actions to further improve data quality:

- Taking forward the approach to reporting on and managing data governance begun during the last year.

### Complaints

The Trust values the contributions patients and their carers have made to its patient surveys, complaints and compliments.

Table 18 below provides a summary of the key complaints performance indicators monitored within the Trust:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>2014/15 Outturn</th>
<th>2013/14 Outturn</th>
<th>2012/13 Outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Complaints Received</td>
<td>no target</td>
<td>457</td>
<td>510</td>
<td>528</td>
</tr>
<tr>
<td>Acknowledge all complaints within 3 days of receipt</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Complaints closed</td>
<td>no target</td>
<td>491</td>
<td>525</td>
<td>592</td>
</tr>
<tr>
<td>Complaints closed within timescale agreed with complainant</td>
<td>95%</td>
<td>88%</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>Percentage of well–founded complaints</td>
<td>no target</td>
<td>62%*</td>
<td>58%</td>
<td>52%</td>
</tr>
</tbody>
</table>

Note: *Based upon confirmed outcomes from complaints responded to during 2014/15.
The total number of complaints received in 2014/15 is 457 which represents a decrease of 10% from the total received in the previous year.

The main themes resulting from complaints are detailed in Table 19 below:

<table>
<thead>
<tr>
<th>Themes</th>
<th>New Complaints Received</th>
<th>Percentage of Total New Complaints Received</th>
<th>Percentage well-founded¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and Treatment</td>
<td>236</td>
<td>52%</td>
<td>49%</td>
</tr>
<tr>
<td>Communications</td>
<td>116</td>
<td>25%</td>
<td>67%</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>57</td>
<td>12%</td>
<td>74%</td>
</tr>
</tbody>
</table>

Note: ¹ Based upon new complaints opened and responded to 2014/15

The Trust recognises that in the majority of instances it is best to resolve issues as soon as possible. During the year, the Trust’s complaints patient information leaflets and posters were updated, to encourage concerns to be raised immediately with the person in charge of a patient’s care. Alternatively contact details are provided for the PALS service, the on-call Senior Manager (available out of hours) and also the Complaints Team.

During 2014/15 there have been a number of national complaints publications from organisations such as The Patients Association, Parliamentary and Health Ombudsman and Healthwatch. Each report continued to raise the profile of complaints within the NHS and proposed changes to existing systems or identified local best practice. As a response, the Trust initiated a quality improvement project with the aim of conducting a comprehensive analysis of the current complaints system used within the Trust to identify any further areas for improvement.

The project involved a range of interested parties, including patient stakeholders, staff who investigate complaints and PALS representatives. The project concluded in January 2015 with initial findings reported to the Trust’s Executive Management Team and an action plan agreed in March 2015.

**Parliamentary and Health Service Ombudsman**

During the 2014/15, the Parliamentary and Health Service Ombudsman (PHSO) investigated fourteen complaints.

Of these, five have been concluded with one fully upheld, one partially upheld and three not upheld. Nine investigations remain on-going.

No recommendations were made for the partially upheld complaint, however in the case of the upheld complaint the PHSO made three recommendations which included an apology to the complainant, a compensation payment for the injustice suffered and the development of an action plan to ensure that the identified failings are not repeated. The Trust is in the process of addressing each of these recommendations.

**Staff reporting incidents**

The National Reporting and Learning Service (NRLS) recognise that organisations that report more incidents usually have better and more effective safety cultures. During 2014/15, a total of 16,958 incidents were reported by staff. Once reported each incident is investigated and remedial action taken where necessary.

To further encourage reporting, staff receive feedback on incidents reported. The top 3 types of incident reported in the Trust during 2014/15 are indicated in Table 20:
Table 20: Top 3 incident types reported by staff during 2014/15

<table>
<thead>
<tr>
<th>Themes</th>
<th>Number Reported</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident, Fall, Slip, Trip or Collision</td>
<td>3636</td>
<td>The most frequent issue is patient falls, minimising hospital falls included as a safer care priority for 2014/15 and 2015/16.</td>
</tr>
<tr>
<td>Pressure Ulcer</td>
<td>2623</td>
<td>The most frequent issue is pressure ulcer damage present on admission to the Trust. As with falls, minimisation of pressure ulcers was included as a safer care priority in 2014/15 and 2015/16. The most serious cases of Trust acquired pressure ulcers are subject to full root cause analysis.</td>
</tr>
<tr>
<td>Accident caused by some other means</td>
<td>628</td>
<td>Miscellaneous accidents that do not fit under a specific category</td>
</tr>
</tbody>
</table>

### Serious Untoward Incidents

Serious Untoward Incidents (SUIs) which occur within the Trust are reported to the Commissioners. After reporting the incident, a Root Cause Analysis (RCA) investigation is undertaken for each incident reported. An investigation report, including an action plan, is produced following the RCA investigation. This report is reviewed by the Trust’s Safety Panel, which consists of the Medical Director, Executive Director of Nursing and Executive Director of Performance and Governance.

Once approved the report is submitted to the Commissioners. Actions arising from the investigation continue to be monitored by the Safety Panel until they are completed.

In total, 108 SUIs were reported by the Trust in 2014/15. The top three most frequently reported are shown in Table 21 below:

Table 21: Top 3 Serious Incidents reported during 2014/15

<table>
<thead>
<tr>
<th>Themes</th>
<th>Number Reported</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td>65</td>
<td>National guidance to report all ‘falls with fracture’. Minimising hospital falls included as a safer care priority in 2014/15 and 2015/16.</td>
</tr>
<tr>
<td>Pressure Ulcers</td>
<td>9</td>
<td>National requirement to report all category 3 and 4 pressure ulcers. Minimising hospital pressure ulcers included as a safer care priority in 2014/15 and 2015/16.</td>
</tr>
</tbody>
</table>

### Never Events

Never Events are serious, largely preventable patient safety incidents that should not have occurred if the available preventative measures have been implemented. During the year 2014/15, one never event occurred within the Trust, this related to wrong site surgery.

Wrong site surgery is the most common type of never event reported within the NHS. The never event was thoroughly investigated and a detailed report and action plan produced. The action plan will be monitored by both the Trust’s Safety and Quality Committee and also the Trust Board until all actions are fully complete.
Reporting against core indicators

This section of the Quality Account provides comparisons of quality standards common to all providers.

The standards are set by the Department of Health and the information and data used is from the NHS Information Centre.

All data can be found at: https://indicators.ic.nhs.uk/webview.

The standards that are benchmarked are:

- Summary Hospital-level Mortality Indicator
- Patient Reported Outcome Measures
- Emergency readmissions within 28 days
- Responsiveness to the needs of patients
- Staff who would recommend the Trust to family or friends
- Venous thromboembolism risk assessment
- C.difficile
- Patient safety incidents

Summary Hospital-level Mortality Indicator (SHMI)

Table 22 presents the Trust’s performance against the SHMI. Northumbria Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has in place the right quality standards and culture to ensure it delivers safe and good quality care as evidenced by its performance on the metrics of: responsiveness to the personal needs of patients, and staff who would recommend the Trust to family or friends.

- The percentage of deaths coded with palliative care codes is greater than the national average because the Trust provides a dedicated palliative care service on all sites. This service scores very highly on the Trust’s internal patient experience measures.

Northumbria Healthcare NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by following a comprehensive process for monitoring within-hospital mortality.

This involves using several mortality measures, and then accessing the records of the patients in those groups for which a review is indicated because of the value of the measure.

For each review the Medical Director is provided with the full and final clinical coding information. This includes details of primary diagnosis, any co-morbidities and also any procedures performed.

The Medical Director reviews all of the information available through clinical coding for each case, and then will request any further information required to make a full assessment. This could involve a review of the case notes and a discussion with the clinical team.

By this process, the Medical Director is able to report to the Board as to whether any of the deaths identified fall outside those that would be expected, or are not clearly accountable by the fully coded diagnoses and procedures.

In addition the Trust has also established a weekly clinical case note review of all deaths to analyse whether any improvements in care could have been made.

The Trust also participates in a regional group that shares best practice with regard to monitoring hospital mortality.
Table 22: Performance against the summary hospital-level mortality indicator (SHMI) core quality indicators

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trust Value</td>
<td>National Average</td>
</tr>
<tr>
<td>The value and banding of the summary hospital-level mortality indicator ('SHMI')</td>
<td>1.07</td>
<td>1.0</td>
</tr>
<tr>
<td>% of patient deaths with palliative care coded at either diagnosis or specialty level</td>
<td>32.9</td>
<td>25.0</td>
</tr>
</tbody>
</table>

Key: ⬆ better than expected; ⇧ as expected; ⬇ worse than expected

Patient Reported Outcome Measures (PROMs)

Table 23 presents the Trust’s performance against the PROMs. Northumbria Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- Although the Trust performs surgery on a high number of patients, it does not receive feedback on the results of surgery from all of them so, in some procedures, the numbers of questionnaires returned are too low to obtain a score. In areas where the Trust received sufficient feedback it received high scores.

Northumbria Healthcare NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- Strengthening the service pre-operatively to ensure patients have higher blood counts before surgery and by changing the knee replacement implant to one that results in better functional output according to data from the National Joint Registry and patient related outcome measures project.

Table 23: Performance against the Patient Reported Outcome Measures (PROMs) core quality indicators

<table>
<thead>
<tr>
<th>Measure: EQ-5D index casemix adjusted health gain</th>
<th>April 2014 – September 2014</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groin hernia surgery</td>
<td>0.082</td>
<td>0.091</td>
</tr>
<tr>
<td>Varicose vein surgery</td>
<td>No data for NHCT</td>
<td>0.093</td>
</tr>
<tr>
<td>Hip replacement surgery (primary)</td>
<td>0.467</td>
<td>0.46</td>
</tr>
<tr>
<td>Hip replacement surgery (revision) Low numbers</td>
<td>0.283</td>
<td>0.305</td>
</tr>
<tr>
<td>Knee replacement surgery (primary)</td>
<td>0.35</td>
<td>0.336</td>
</tr>
<tr>
<td>Knee replacement surgery (revision) No data for NHCT</td>
<td>0.328</td>
<td>0.323</td>
</tr>
</tbody>
</table>

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Table 24 presents the Trust’s performance on emergency readmissions to hospital within 28 days. Northumbria Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- There was previously no alternative service provision for those patients that required ambulatory services resulting in these patients being admitted to hospital for short periods of time – impacting on readmission rates.

Northumbria Healthcare NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by introducing two new services:

- Discharge lounges: The discharge lounges help to standardise the discharge process. Staff in the lounges follow up patients who are at high risk of readmission and arrange further support if necessary.

The discharge lounges work in partnership with pharmacy to ensure that patients understand their medications, as confusion about medication can lead to unnecessary readmission.

- Ambulatory care: Provides timely, accessible, specialist assessment, in an ambulatory setting which can provide the crucial support needed for those working in primary and community care to be able to help patients remain at home, therefore avoiding unnecessary admission.

A similar unit exists for surgical patients – surgical assessment unit. However, these patients are counted as non-elective inpatient admissions and as such; there is no overall impact on emergency readmissions data.

Table 24: Performance on emergency readmissions to hospital within 28 days of discharge

<table>
<thead>
<tr>
<th>Measure</th>
<th>2011/12¹</th>
<th>Trust Value</th>
<th>National Average</th>
<th>National Min</th>
<th>National Max</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients aged 0-15</td>
<td>10.21</td>
<td>-</td>
<td>0.0</td>
<td>47.58</td>
<td></td>
<td>⇘</td>
</tr>
<tr>
<td>Patients aged 16 or over</td>
<td>12.60</td>
<td>11.45</td>
<td>0.0</td>
<td>79.52</td>
<td></td>
<td>⇘</td>
</tr>
</tbody>
</table>

Key:

- = better than expected; ⇘ as expected; ⇘ worse than expected

Note:

1 – No more recent data available from NHS Information Centre

Responsiveness to the personal needs of patients

Table 25 presents the Trust’s performance on the responsiveness to the personal needs of patients.

Northumbria Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust is continually responding to patient feedback and has an extensive programme to ensure that it captures feedback at different times of the patient journey.

- Real-time patient experience data captured during inpatients stay is communicated to all members of the clinical teams in a timely manner, often within 3 hours of speaking to patients thus ensuring improvement can be made quickly. It also allows staff to appreciate how their service is viewed. This capture of feedback of real-time patient experience has helped clinical teams remain responsive to inpatients personal needs.
Northumbria Healthcare NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- It continues to develop its patient experience programme for inpatient, outpatient and community services using different methods of data collection and ensuring that this is communicated to teams in a timely manner.

The Trust has also taken steps this year to further understand its patient experience data by collecting data on both weekdays and weekends.

Table 25: Performance on responsiveness to the personal needs of patients

<table>
<thead>
<tr>
<th>Measure</th>
<th>2013/14</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trust Value</td>
<td>National Average</td>
</tr>
<tr>
<td>Responsiveness to inpatients' personal needs</td>
<td>74.9</td>
<td>68.7</td>
</tr>
</tbody>
</table>

Key: ‡ better than expected; ‡‡ as expected; ‡§ worse than expected

Staff who would recommend the Trust to family or friends

Table 26 presents the Trust’s performance on staff who would recommend the Trust to family or friends. Northumbria Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has a highly engaged workforce that is fully committed to delivering high quality care. The response rate for the Trust for the staff survey is one of the highest in the country. Real time patient experience data is communicated to all members of the clinical teams in a timely manner ensuring improvements can be made quickly when required and demonstrating to staff how their services are viewed.

Northumbria Healthcare NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- It continues to develop its patient experience programme for inpatient, outpatient and community services using different methods of data collection and ensuring that this is communicated to teams in a timely manner.

- The Trust also continues to engage with staff through focus groups following the results of the staff survey and the Trust’s culture survey to identify where and how any improvements can be made.

Table 26: Performance on staff who would recommend the Trust to family or friends

<table>
<thead>
<tr>
<th>Measure</th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of staff employed by, or under contract to the Trust who would recommend it as a provider of care to their family</td>
<td>Trust Value</td>
<td>National Average</td>
</tr>
<tr>
<td></td>
<td>80%</td>
<td>67%</td>
</tr>
</tbody>
</table>

Key: ‡ better than expected; ‡‡ as expected; ‡§ worse than expected
Table 27 presents the Trust’s performance on VTE risk assessment. Northumbria Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust was able to meet the 95% metric in Q2 but not in Q3. This was related to incomplete documentation, although patients received appropriate care.

Northumbria Healthcare NHS Foundation Trust has taken the following action to improve this rate, and so the quality of its services:

- New documentation has been introduced that further simplifies the data collection process. The new documentation is currently still being embedded, so a further positive change in performance is expected is 2015/16.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Target: 95%</td>
<td>93.3%</td>
<td>93.5%</td>
<td>95%</td>
<td>94.7%</td>
<td>94.8%</td>
</tr>
<tr>
<td>Trust Value:</td>
<td>93.3%</td>
<td>93.5%</td>
<td>95%</td>
<td>94.7%</td>
<td>94.8%</td>
</tr>
<tr>
<td>National Average:</td>
<td>96.1%</td>
<td>96.2%</td>
<td>96.2%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>National Min:</td>
<td>74.6%</td>
<td>87.2%</td>
<td>86.4%</td>
<td>81.2%</td>
<td>74.9%</td>
</tr>
<tr>
<td>National Max:</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

| Status: | ↓ better than expected; ⇧ as expected; ⇩ worse than expected |

C. difficile

Table 28 presents the Trust’s performance on C. difficile. Northumbria Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has continued to refine its infection control practices by monitoring antibiotic usage, engaging a dedicated ‘deep clean’ team, strict cleaning regimes and ensuring where appropriate isolation of patients is undertaken. The Trust has a dedicated team of Infection Control Nurses who work seven days a week to provide support and advice to the wards.

Northumbria Healthcare NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- The Trust continues with all of the practices previously described. In addition it has developed a seven day microbiology service to ensure that C.difficile positive results are provided in a timely manner and can be acted on appropriately and consistently seven days a week.

<table>
<thead>
<tr>
<th>Measure: Trust apportioned rate of C. difficile infection for patients aged two years and over per 100,000 bed days</th>
<th>2013/14</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Value</td>
<td>9.7</td>
<td>15.6</td>
</tr>
<tr>
<td>National Average</td>
<td>14.7</td>
<td>17.3</td>
</tr>
<tr>
<td>National Min</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>National Max</td>
<td>37.1</td>
<td>31.2</td>
</tr>
</tbody>
</table>

| Status | ↑ better than expected; ⇧ as expected; ⇩ worse than expected |

Key:
Table 29 presents the Trust’s performance on patient safety incidents. Northumbria Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has an open culture and encourages all staff to highlight when and where incidents have occurred. The Trust recognises that in line with National Reporting and Learning System (NRLS) guidance, organisations can’t learn and improve if they don’t know what the problems are.

- The Trust continues to ensure that staff are engaged in the process and receive feedback on incidents reported at ward/department level.

Northumbria Healthcare NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- The Trust has worked to ensure that incidents are correctly classified, (using National Patient Safety Alert definitions), as severe harm or death.

Such incidents are fully investigated with any learning identified and resulting actions implemented.

Table 29: Performance on patient safety incidents

<table>
<thead>
<tr>
<th>Measure</th>
<th>Oct 13 – Mar 14</th>
<th></th>
<th></th>
<th></th>
<th>Status</th>
<th>Apr 13 – Sep 13</th>
<th></th>
<th></th>
<th></th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of incidents</td>
<td>Trust Value</td>
<td>National Average</td>
<td>National Min</td>
<td>National Max</td>
<td>Status</td>
<td>Trust Value</td>
<td>National Average</td>
<td>National Min</td>
<td>National Max</td>
<td>Status</td>
</tr>
<tr>
<td></td>
<td>5605</td>
<td>4493</td>
<td>787</td>
<td>8015</td>
<td>🟢</td>
<td>5377</td>
<td>4399</td>
<td>1967</td>
<td>7757</td>
<td>🟢</td>
</tr>
<tr>
<td>Rate per 100 admissions</td>
<td>9.91</td>
<td>7.25</td>
<td>1.72</td>
<td>12.46</td>
<td>📶</td>
<td>9.51</td>
<td>7.08</td>
<td>3.85</td>
<td>11.06</td>
<td>📶</td>
</tr>
<tr>
<td>Number of incidents resulting in severe harm or death</td>
<td>6</td>
<td>25</td>
<td>0</td>
<td>103</td>
<td>📶</td>
<td>55</td>
<td>27.7</td>
<td>2</td>
<td>87</td>
<td>📶</td>
</tr>
<tr>
<td>% of incidents resulting in severe harm or death</td>
<td>0.1%</td>
<td>0.6%</td>
<td>0.0%</td>
<td>2.6%</td>
<td>📶</td>
<td>1.0%</td>
<td>0.7%</td>
<td>0.1%</td>
<td>3.0%</td>
<td>📶</td>
</tr>
</tbody>
</table>

Key: 🟢 better than expected; 📶 as expected; 🟠 worse than expected

Note: National comparison relates to Trusts identified by the NRLS as ‘Large Acute Trust’
Priorities for 2015/16

Having looked back at the Trust’s performance over the last year, this section of the Quality Account is forward looking and details the safety and quality priorities that the Trust has decided on for 2015/16. The rational for including these priorities is based on a range of factors such as actual data from the previous year, or as a consequence of clinical or public request for the priority to be included.

These priorities for improvement in the quality of care were agreed following an extensive engagement process and used the intelligence and data the Trust has from its safety and quality outcomes (including serious incidents, case note reviews, reviewing mortality and harm, complaints, clinical audit, outcomes from Quality Panel reviews, patient and staff experience surveys, and best practice guidance such as from NICE and national audit).

The priorities selected fulfil at least one of the following criteria:

- The Trust is committed to an improvement in this area
- A known improvement strategy is already in place and will remain in place overtime
- Measures are either in place or in development
- It is possible to undertake historic or benchmark comparison.

The safety and quality priorities for 2015/16 are illustrated in Table 30 below – some of these are a continuation from the measure in 2014/15, where the Trust considers them to continue to be important and are keen to further improve on their position.

Table 30: Priorities 2015/16

<table>
<thead>
<tr>
<th>Safe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reduce hospital acquired infections – C.Difficile, MRSA and surgical site infections</td>
</tr>
<tr>
<td>2. Medicine optimisation in hospital – missed doses, medicine reconciliation on discharge</td>
</tr>
<tr>
<td>3. Improve the management of sepsis in hospital and community settings</td>
</tr>
<tr>
<td>4. Implementation of electronic prescribing</td>
</tr>
<tr>
<td>5. Reduction of falls and pressure ulcers</td>
</tr>
<tr>
<td>6. Safety checklist (WHO) – embedding the practice – theatres and endoscopy</td>
</tr>
<tr>
<td>7. Implementation of the Northumbria Specialist Emergency Care Hospital (NSECH) model and 7 day working</td>
</tr>
<tr>
<td>8. 7 day communication to GPs following outpatient attendance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>High Quality Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Opening of NSECH and the base sites in their new form</td>
</tr>
<tr>
<td>2. Understanding hospital mortality through case note audit</td>
</tr>
<tr>
<td>3. Delivery of a 7 day endoscopy service</td>
</tr>
<tr>
<td>4. Development of the maternity service</td>
</tr>
<tr>
<td>5. Development of the palliative care model</td>
</tr>
<tr>
<td>6. Collaboration with nursing homes to improve patient care</td>
</tr>
<tr>
<td>7. Integration of acute and community services to support patient flow and discharge</td>
</tr>
<tr>
<td>8. Management of chronic obstructive pulmonary disorder (COPD) patients on discharge</td>
</tr>
<tr>
<td>9. Management of acute kidney injury in line with national guidance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Embed kindness and compassion as an ‘always behaviour’</td>
</tr>
<tr>
<td>2. Pilot ‘Think Safe’ as part of regional patient safety collaborative initiative</td>
</tr>
<tr>
<td>3. Ensure complaints, experience and social media comments are triangulated quarterly</td>
</tr>
<tr>
<td>4. Recognition of dementia – supporting carers as part of this process</td>
</tr>
<tr>
<td>5. Benchmark patient emergency care experience pre and post NSECH</td>
</tr>
<tr>
<td>6. Education for those patients dependent on alcohol who access hospital emergency services</td>
</tr>
<tr>
<td>7. Use of the emergency hospital care record for palliative patients</td>
</tr>
</tbody>
</table>
The Trust has developed a robust system of performance management to ensure the delivery of the quality priorities. Each priority has a strategic goal and is measured by the clinical team and reported to the Council of Governors quarterly and monthly to the Board of Directors and Safety and Quality Committee.

There are a number of measures that the Trust will continue to monitor about the quality of services that do not appear within the safety and quality priorities list. These are measures that clinical teams have felt are important as a result of national direction, horizon scanning or from the Trust’s own performance dashboard. For example, mortality rates are tracked using a number of different statistical methods. The rates are benchmarked nationally and reported to the Board quarterly in line with updated data.

As a Trust and a provider of local health services, Northumbria Healthcare NHS Foundation Trust is committed to listening to patients and the public about the services provided and what is important to them when they use its services.

During 2014/15 the Trust has actively engaged with patients, staff and stakeholders to develop the safety and quality priorities for the year ahead so that it can continue to ensure that it delivers a high quality service to its local communities.

The themes emerging from this engagement were presented to the Council of Governors and Clinical Policy Group at the end of 2014 and then again to the Council of Governors in February 2015.

The final priorities were decided by the Council of Governors, Clinical Policy Group and the Board of Directors in 2015.
Part 3 – Other information

This part of the Quality Account provides more detail about the Trust’s performance during the last year against its priorities identified for 2014/15, and against other key indicators and targets. It also describes some of the key quality initiatives the Trust has undertaken during the year, including the work it has done on improving and monitoring patient and staff experience.

Key measures

This section provides an overview of quality of care offered by Northumbria Healthcare NHS Foundation Trust based on performance in 2014/15 against indicators selected by the board in consultation with stakeholders. For ease of reference the Board of Directors’ priorities were reported in Part 2. Table 31 below outlines three measures that were included as quality priorities in 2011/12, 2012/13, 2013/14 and 2014/15.

These will also be included in 2015/16 as key measures of safety. This demonstrates the improvement from previous years and the Board are committed to sustaining further improvement throughout the year.

All of these measures should be cross-referenced to Part 2 of the Quality Account.

Table 31: Key Measures (Note - 2014/15 performance as at Jan 2015)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Comparator</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>2011/12 2012/13 2013/14 2014/15</td>
</tr>
<tr>
<td>Patient Safety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Diff number of cases</td>
<td>National requirement</td>
<td>n/a</td>
<td>72 53 31 30</td>
</tr>
<tr>
<td>MRSA number of cases</td>
<td>National requirement</td>
<td>n/a</td>
<td>2 2 3 3</td>
</tr>
<tr>
<td>SSI rates (hips)</td>
<td>JHI</td>
<td>1.6%</td>
<td>1.1% 2.0% 1.08% 0.45%</td>
</tr>
<tr>
<td>SSI rate (knees)</td>
<td>JHI</td>
<td>4.2%</td>
<td>1.5% 1.5% 0.74% 0.79%</td>
</tr>
<tr>
<td>Clinical Effectiveness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serious harm: falls</td>
<td>Internal metric</td>
<td>27</td>
<td>61 64 65</td>
</tr>
<tr>
<td>Harm rate events per 1000 bed days</td>
<td>IHI Global Trigger Tool for reporting harm</td>
<td>n/a</td>
<td>38 36 34 34</td>
</tr>
<tr>
<td>Readmission rate within 30 days</td>
<td>National requirement</td>
<td>n/a</td>
<td>- 8.3% 8.1% 9.6%</td>
</tr>
<tr>
<td>Patient Experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Real time survey results (domain average)</td>
<td>Internal metric</td>
<td>n/a</td>
<td>9.27 9.40 9.52 9.54</td>
</tr>
<tr>
<td>National patient experience CQUIN composite score</td>
<td>National requirement</td>
<td>n/a</td>
<td>72.3 71.6 82.7 n/a</td>
</tr>
<tr>
<td>National in-patient (new indicator)</td>
<td>National requirement</td>
<td>n/a</td>
<td>- - - 84.5%</td>
</tr>
<tr>
<td>Component scores of real time in-patient experience</td>
<td>Internal metric</td>
<td>n/a</td>
<td>9.27 9.40 9.52 9.54</td>
</tr>
</tbody>
</table>

Note:
1 – Position as at January 2015
Monitor’s Compliance Framework

Monitor is an independent regulator of NHS Trusts. It requires that minimum standards are maintained and these are described in the Department of Health’s Operating Framework as the most significant priorities.

These are reported to the Board of Directors and to Monitor every quarter. Table 32 below summarises the strong performance during 2014/15 against the relevant indicators and performance thresholds set out in Monitor’s Risk Assessment Framework (2014):

### Table 32: Quarterly performance against Monitor’s Risk Assessment Framework (Note - Q4 as at Feb 2015)

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Target</th>
<th>2014/15 Quarterly Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Q4</td>
</tr>
<tr>
<td>Key:</td>
<td>target exceeded;</td>
<td>target met;</td>
<td>target not met;</td>
</tr>
<tr>
<td>1.</td>
<td>Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted</td>
<td>90%</td>
<td>☹ 90.1%</td>
</tr>
<tr>
<td>2.</td>
<td>Maximum time of 18 weeks from point of referral to treatment in aggregate – non admitted</td>
<td>95%</td>
<td>☀ 96.0%</td>
</tr>
<tr>
<td>3.</td>
<td>Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway</td>
<td>92%</td>
<td>☀ 92.0%</td>
</tr>
<tr>
<td>4.</td>
<td>A&amp;E: maximum waiting time of four hours from arrival to admission/transfer/discharge</td>
<td>95%</td>
<td>☀ 95.0%</td>
</tr>
<tr>
<td>5a.</td>
<td>All cancers: 62-day wait for first treatment from: urgent GP referral for suspected cancer</td>
<td>85%</td>
<td>☁ 88.0%</td>
</tr>
<tr>
<td>5b.</td>
<td>All cancers: 62-day wait for first treatment from: NHS Cancer Screening Service referral</td>
<td>90%</td>
<td>☐ 82.0%</td>
</tr>
<tr>
<td>6a.</td>
<td>All cancers: 31-day wait for second or subsequent treatment, comprising: surgery</td>
<td>94%</td>
<td>☁ 100%</td>
</tr>
<tr>
<td>6b.</td>
<td>All cancers: 31-day wait for second or subsequent treatment, comprising: anti-cancer drug treatments</td>
<td>98%</td>
<td>☁ 100%</td>
</tr>
<tr>
<td>6c.</td>
<td>All cancers: 31-day wait for second or subsequent treatment, comprising: radiotherapy</td>
<td>94%</td>
<td>N/A</td>
</tr>
<tr>
<td>7.</td>
<td>All cancers: 31-day wait from diagnosis to first treatment</td>
<td>96%</td>
<td>☁ 99.0%</td>
</tr>
<tr>
<td>8a.</td>
<td>Cancer: two week wait from referral to date first seen, comprising: all urgent referrals (cancer suspected)</td>
<td>93%</td>
<td>☁ 95.0%</td>
</tr>
<tr>
<td>8b.</td>
<td>Cancer: two week wait from referral to date first seen, comprising: for symptomatic breast patients (cancer not initially suspected)</td>
<td>93%</td>
<td>☐ 93.0%</td>
</tr>
<tr>
<td>9a.</td>
<td>Care Programme Approach (CPA) patients, comprising: receiving follow-up contact within seven days of discharge</td>
<td>95%</td>
<td>☁ 100%</td>
</tr>
<tr>
<td>9b.</td>
<td>Care Programme Approach (CPA) patients, comprising: having formal review within 12 months</td>
<td>95%</td>
<td>N/A</td>
</tr>
<tr>
<td>10.</td>
<td>Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams</td>
<td>95%</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### Area | Indicator | Target  | 2014/15 Quarterly Performance |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Q4</td>
</tr>
<tr>
<td>11.</td>
<td>Meeting commitment to serve new psychosis cases by early intervention teams</td>
<td>95%</td>
<td>N/A</td>
</tr>
<tr>
<td>12a.</td>
<td>Category A call – emergency response within 8 minutes, comprising: Red 1 calls</td>
<td>75%</td>
<td>N/A</td>
</tr>
<tr>
<td>12b.</td>
<td>Category A call – emergency response within 8 minutes, comprising: Red 2 calls</td>
<td>75%</td>
<td>N/A</td>
</tr>
<tr>
<td>13.</td>
<td>Category A call – ambulance vehicle arrives within 19 minutes</td>
<td>95%</td>
<td>N/A</td>
</tr>
<tr>
<td>14.</td>
<td>Clostridium (C.) difficile – meeting the C. difficile objective</td>
<td>No more than 30 cases in the year</td>
<td>30 (cumulative total)</td>
</tr>
<tr>
<td>16.</td>
<td>Minimising mental health delayed transfers of care</td>
<td>≤ 7.5%</td>
<td>↑ 0.0%</td>
</tr>
<tr>
<td>17.</td>
<td>Mental health data completeness: identifiers</td>
<td>97%</td>
<td>↑ 99.0%¹</td>
</tr>
<tr>
<td>18.</td>
<td>Mental health data completeness: outcomes for patients on CPA</td>
<td>50%</td>
<td>N/A</td>
</tr>
<tr>
<td>19.</td>
<td>Certification against compliance with requirements regarding access to health care for people with a learning disability</td>
<td>-</td>
<td>Achieved</td>
</tr>
<tr>
<td>20a.</td>
<td>Data completeness: community services, comprising: referral to treatment information</td>
<td>50%</td>
<td>↑ 98.8%</td>
</tr>
<tr>
<td>20b.</td>
<td>Data completeness: community services, comprising: referral information</td>
<td>50%</td>
<td>↑ 85.8%</td>
</tr>
<tr>
<td>20c.</td>
<td>Data completeness: community services, comprising: treatment activity information</td>
<td>50%</td>
<td>↑ 84.3%</td>
</tr>
</tbody>
</table>

Note: ¹ Position as at February 2015

---

**Patient experience – an update on performance during 2014/15**

This section of the Quality Account explains the approach the Trust takes to continually improve the experience of its patients, service users and their families. The Trust is widely recognised as having one of the best patient experience programmes in the whole NHS, and it uses a range of approaches to actively engage with the people who use the Trust’s services. Listening to the views of patients allows the Trust to design and deliver services that people really need and in the way they want them.

We really appreciate the time people take to share their views every year. We know that responding well to this feedback will take us a long way towards realising our ambition for delivering safe, caring and high quality care for all our patients.

- Annie Laverty, Director of Patient Experience
Friends and family test

This national test tells the Trust what proportion of the people using Trust services would be extremely likely or likely to recommend them to their friends and family. As already described in the previous section, increasing the response rate to this test was a key priority for the Trust and it has made good progress on this.

The latest friends and family test results where a comparison against a national average was possible were published in January 2015. Using this data 97% of patients overall would be extremely likely or likely to recommend the Trust. This is 3% above the national average of 94%.

Figure 2 illustrates the results during 2014/15:

![Friends and Family Test Results 2014/15](image)

Real time feedback

The real time surveys take place whilst patients are still in hospital. They ask for feedback on a range of areas such as respect and dignity, pain control, kindness and compassion, and staff approach.

Figure 3 shows the average scores received for each area of care over the year are generally consistently high, and Figure 4 shows the domain average for 2014:

![Real time feedback scores 2014/15 – average score per domain](image)
While overall performance is very good; month-on-month tracking of the domain average score showed a dip in the latter part of the year. The Trust’s data is sensitive enough to detect the challenges that were being experienced by ward teams during the busy winter months.

It also serves as an early warning system to avoid complacency about performance. The Trust has used the results to refresh an on-going campaign to improve communication about medicine and side effects.

**Patient perspective surveys**

These surveys are sent to out-patients and in-patients once they have returned home to gather their views and experiences of services.

An independent company approved by the Care Quality Commission evaluates the results for the Trust.

**In-patients**

Overall, the inpatient results for 2014/15 continue to be very good.

The Trust is in the top 20% of all Trusts on 16 of the 19 most important questions to patients. On the remaining 3 questions the Trust is marginally outside the top 20% and above the national average.

The overall score for the Trust on the key 19 questions is 84.5% which is in the top 20% of Trusts (83.4%).

Overall, 95% of patients rated their care as excellent, very good or good.

Results remain consistently good in these areas:

- Cleanliness
- Privacy
- Communication with doctors and nurses
- Pain management
- Information about surgery

There is room for improvement in these areas:

- Information on medication side-effects
- Nurse hand-washing

Results for day-case patients are better still than for inpatients, averaging 92.0%. 

---

**Figure 4: Real time feedback scores 2014 – Domain average score**

![Graph showing real time feedback scores from January 2014 to December 2014.](image)
Out-patients

The outpatient results continue to be outstanding. On average the Trust is in the top 20% of all Trusts in England. It is in the top 20% for 18 of the 19 most important questions to patients. The remaining question scores above average.

All sites have an overall score in the national top 20%. The overall score is 88.8%, with the score for the top 20% in England standing at 84.4%. The score is unchanged from 2013/14.

98% of patients rate the Trust as excellent, very good or good.

Overall results are particularly good in these areas:

- All aspects of communication between doctors and patients
- Cleanliness
- Discharge information
- Letters to GPs being copied to patients

Results could be improved as follows:

- Information about treatment – what would happen and risks and benefits.

Accident and Emergency

Overall, the Emergency Department results remain very good. The Trust remains in the top 20% of all Trusts in England on 21 of the 27 questions that are comparable with national data.

The average score is 80%. The top 20% score for England is 78%. This score has been consistently high in each quarter since April 2011.

Average scores across the three sites are very similar - Hexham 83%, North Tyneside 80%, Wansbeck 79%.

Overall, results are good in these areas:

- Communication with doctors and nurses
- Cleanliness of the department and toilets
- Privacy when being examined
- Planning for leaving hospital

There is room for improvement in these areas:

- Waiting times until triage
- Information to patients about how long they might wait.

Key Achievement

Northumbria Healthcare top for cancer experience

Patients’ experiences of receiving care for cancer in Northumberland and North Tyneside are among the best in the country. The Trust came sixth in a league table measuring patient experience across England, according to results released by Macmillan Cancer Support.

It is the fourth successive year that the Trust has been named in the top 10 for the survey. The league table compares the performance of hospitals across England based on measures of patients’ experiences while being treated in hospital such as: whether they felt supported in their care; and whether they felt they were treated with respect.

Gill Starkey, lead cancer nurse at Northumbria Healthcare NHS Foundation Trust, said:

“We are delighted that once again we have been named among the best in the country for cancer patient experience.”
Quality initiatives during 2014/15

Launch of the Trust’s Quality Strategy

In September 2014, the Trust launched its Quality Strategy which gives staff a clear focus and reflects the importance and commitment the Trust places on quality of care.

The Strategy aims to ensure that quality of care underpins every decision taken by every member of staff and to provide the safest health and care services to patients in hospital and in the community.

It also aims for the Trust to be recognised as a caring organisation locally, regionally and nationally and to attract, retain, support and train the best staff.

The key quality objectives for 2014-2019 are:

- To deliver a year-on-year reduction in mortality rates across all the hospital sites
- To deliver a 20% reduction in harm from pressure ulcers and falls in 2014/15
- To deliver a 30% improvement in sepsis mortality by 2016
- To maintain and, where possible, exceed the Trust’s national position for patient and staff experience
- To work with patients and families to revise the complaints strategy
- To maintain the Monitor financial risk rating of at least 3
- To ensure levels of preventable harm remain below the 5% national average

“In order to achieve this, the Trust will support 5 large key programmes of quality improvement each year, and deliver 20 executive sponsored projects linked to the annual priorities. The Trust will also support a large number of frontline-led improvement plans to support teams in putting their ideas into practice.”

“The aim of the strategy is to be clear about our longer-term ambition, priorities and, most importantly, how all staff can be supported and encouraged where they see an opportunity to make improvements for their patients

– Jim Mackey, Chief Executive

The Northumbria Improvement Way

The Northumbria Improvement Way has been designed to deliver the best possible quality improvement process. It helps us to meet our objectives and has become our standard way for teams to deliver quality improvement projects.

Our context
- Our values
- Our resources
- Our culture
- Our readiness

The Northumbria improvement Way aimed at
- Our staff
- Our teams
- Our leaders
- Our pathways
- Our improvement capability

Our outcomes
- High quality, safe and caring, health and care services
- 5 large key programmes
- 20 Executive sponsored projects of must-do’s informed by business unit priorities, CQUIN or as a response to stakeholders
- A large number of frontline led team-based improvement plans supported by safety and quality training days
Quality improvements during 2014/15

There are many examples of quality improvement initiatives that have been successfully delivered throughout the year resulting in improved quality of care for the people who use services. Examples of some of the work the Trust has done are given in the sections below, along with some of the Trust’s key achievements:

Key Achievement

**Immediate Response Teams rolled out across South East Northumberland**

During 2014/15 a new service providing urgent support for people in a time of crisis was rolled out across south east Northumberland following a successful pilot. The teams have been made possible through joint working across adult social care between the Trust and Northumberland County Council.

As part of this the Immediate Response Team provide support to enable people with a sudden illness, medical condition or change in circumstance who are at risk of hospital admission, to remain at home. The fully integrated team of community health and social care staff aim to make contact with the person in need within two hours of the first call for assistance. The team can provide equipment to help someone move around their house, arrange emergency short term care support to enable them to remain at home, and help people to regain their confidence and independence.

Key Achievement

**Northumbria Healthcare backs “Hello, My Name Is…” campaign**

As part of its commitment to further improve patients’ experiences, in October 2014, the Trust pledged its support to a major campaign which has become a social media phenomenon.

The Trust has rolled out the national “Hello, My Name Is…” campaign in its health and social care services which encourages all staff, regardless of role, to introduce themselves to patients and service users. It is recognised that this is a small gesture and personal touch that makes a significant difference to compassionate care.

To kick-start the campaign, “Hello, My Name Is…” founder Dr Kate Granger visited the Trust and delivered an inspirational speech to more than 100 nurses who care for patients on the frontline and have a mentoring role in teaching, guiding and inspiring other healthcare staff.

Dr Granger, a registrar from Yorkshire specialising in elderly medicine, who was diagnosed with terminal cancer, launched the campaign after a hospital stay last summer when she found that many staff did not introduce themselves before delivering care.

Rosemary Stephenson, the Trust’s Director of Nursing said:

“All of our staff do an amazing job delivering high quality, personalised care and this campaign complements all the work we’re doing to continuously improve the experiences of the patients in our care.”
**Key Achievement**

**Alnwick’s new oncology day unit opens** to enable patients to receive chemotherapy treatment in their own community.

In September 2014, the Trust opened its new state-of-the-art oncology day unit at Alnwick Infirmary, meaning patients will no longer need to travel out of the area for their treatment.

The purpose-built unit is based in the former Coquet Ward and the area has undergone a refurbishment of more than £200,000 to include the latest equipment and the best facilities for patients.

The new nurse-led service initially operates one day per week, with a view to extending to two days per week later in the year. Up until now, patients requiring chemotherapy and supportive treatments faced a journey out of the area to Wansbeck or North Tyneside general hospitals.

The Oncology Day Unit builds on the ambulatory care services already provided at Alnwick Infirmary which prevents patients having to travel to a general hospital for their treatment. These services enable patients to have certain treatments locally, such as blood transfusions and some other intravenous medications, without the need for an overnight stay in hospital or travelling further afield.

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**Key Achievement**

**New Haltwhistle hospital welcomes patients and staff**

In June 2014, the Trust opened the new Haltwhistle War Memorial Hospital as part of a £4.6million integrated health and social care scheme in the town.

The hospital is on the first floor of the development and has 15 beds. These are arranged in two four-bed bays and seven single en-suite rooms offering the utmost privacy and dignity, with one room adapted for bariatric patients.

The hospital team provides support and rehabilitation including occupational therapy and physiotherapy for elderly patients, palliative care for those approaching the end of life and a minor injuries service.

The scheme also has 12 purpose-designed extra-care flats on the ground floor called Greenholme Court which have been funded and developed by Northumberland County Council. These are now managed by Homes for Northumberland on behalf of the council. These offer the opportunity for couples and friends to stay together and receive individually-tailored levels of on-site care.
Key Achievement

National Award for approach to helping children who self-harm

In November 2014, the Trust’s Primary Mental Health Worker team, which supports children and young people who self-harm in North Tyneside, won a national Nursing Times Award which represents true excellence in nursing and patient care.

Judges praised the team’s approach and said it was an excellent model of effective and sustainable service delivery to improve patient care.

The team worked in partnership to form a project team with schools, Educational Psychology Services, the Community Learning Disability Service, Public Health School Nurses in mainstream and specials schools, North Tyneside Council and the charity Young Minds. The group developed training for educating staff to enable them to spot the early signs that a young person may be at risk of self-harm.

Theresa Maddison, Nurse Consultant at the Trust’s Child and Adolescent Mental Health Service, said:

“Across the country as many as one in 12 children and young people self-harm for a variety of reasons so this project was a welcome addition to our service in North Tyneside. It provided people who self-harm with effective and efficient care, as well as ensuring professionals working with children and young people feel more knowledgeable and supported.”

Key Achievement

Working in partnership with volunteers Singing Group for Patients with Dementia

Singing is a wonderful activity that can be a stimulating social activity for all those involved. In particular, music and singing can bring beneficial effects to those patients who suffer with dementia.

The power of the music and singing seems to unlock memories that may have seemed lost forever due to damage that dementia causes to the brain and this can provide a great deal of enjoyment and promote social engagement.

Staff on Ward 23 at North Tyneside Hospital have worked in partnership with volunteers to provide singing sessions for patients on the ward. Patients have enjoyed singing and playing percussion instruments in the day room. The songs have stimulated many memories and triggered conversations of dance halls and trips to the cinema in days gone by.

The sessions have been a huge success and enjoyed by all those who have attended. Relatives have commented on the positive effects that the sessions have had on their family members and patients have remembered the sessions the next day asking if they can sing again.
Workforce factors

The Trust’s staff are key to providing safe, effective and respectful care. The NHS staff survey provides the Trust with good information about how its staff feel about different aspects of their work and how well they are equipped to deliver high quality patient care.

This year’s survey was published in February 2015. The staff response rate was 82% which is one of the highest response rates in the country for acute Trusts.

Overall, the survey provides some excellent results however the Trust will continue to focus on areas for improvement. There are 29 key findings that are grouped under seven headings – the four staff pledges from the NHS Constitution plus three additional themes of staff satisfaction, equality and diversity and patient feedback.

Table 33 provides the results, and shows how the Trust compares with other acute Trusts. The key findings are shown as a percentage or rated between 1-5:

Table 33: NHS Staff Survey Results for 2014/15

<table>
<thead>
<tr>
<th>Pledge</th>
<th>Key Finding</th>
<th>National Average</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To provide all staff with clear roles and responsibilities and rewarding jobs</td>
<td>87% feel satisfied with the quality of work and patient care they deliver</td>
<td>77%</td>
<td>Best 20%</td>
</tr>
<tr>
<td></td>
<td>94% agree their role makes a difference to patients</td>
<td>91%</td>
<td>Best 20%</td>
</tr>
<tr>
<td></td>
<td>Work pressure felt by staff, 2.83</td>
<td>3.07</td>
<td>Best 20%</td>
</tr>
<tr>
<td></td>
<td>Effective Team Working, 3.94</td>
<td>3.74</td>
<td>Best 20%</td>
</tr>
<tr>
<td></td>
<td>66% of staff state they are working extra hours</td>
<td>71%</td>
<td>Best 20%</td>
</tr>
<tr>
<td>2. To provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed</td>
<td>87% of staff have received job relevant training, learning or development in the last 12 months</td>
<td>81%</td>
<td>Best 20%</td>
</tr>
<tr>
<td></td>
<td>90% of staff have been appraised in the last 12 months</td>
<td>85%</td>
<td>Best 20%</td>
</tr>
<tr>
<td></td>
<td>46% have a well-structured appraisal</td>
<td>38%</td>
<td>Best 20%</td>
</tr>
<tr>
<td></td>
<td>Staff receiving support from immediate managers, 3.89</td>
<td>3.65</td>
<td>Best 20%</td>
</tr>
<tr>
<td>3. To provide support and opportunities for staff to maintain their health, well-being and safety</td>
<td>82% of staff have received health &amp; safety training in last 12 months</td>
<td>77%</td>
<td>Better than average</td>
</tr>
<tr>
<td></td>
<td>32% of staff have suffered work related stress in last 12 months</td>
<td>37%</td>
<td>Best 20%</td>
</tr>
<tr>
<td></td>
<td>28% of staff witnessed potential harmful areas, near misses or incidents in the last month</td>
<td>34%</td>
<td>Best 20%</td>
</tr>
<tr>
<td></td>
<td>92% of staff are reporting errors, near misses or incidents witnessed in the last month</td>
<td>90%</td>
<td>Better than average</td>
</tr>
<tr>
<td></td>
<td>Staff who felt the incident reporting procedures were fair and effective, 3.68</td>
<td>3.54</td>
<td>Best 20%</td>
</tr>
<tr>
<td></td>
<td>78% of staff agreeing that they would feel secure raising concerns about unsafe clinical practice</td>
<td>67%</td>
<td>Best 20%</td>
</tr>
<tr>
<td></td>
<td>15% of staff have experienced physical violence from patients relatives or the public in the last 12 months</td>
<td>14%</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>2% of staff have experienced physical violence from staff in the last 12 months</td>
<td>3%</td>
<td>Best 20%</td>
</tr>
<tr>
<td></td>
<td>25% of staff have experienced harassment bullying or abuse from patients, relatives or the public in the last 12 months</td>
<td>29%</td>
<td>Best 20%</td>
</tr>
<tr>
<td></td>
<td>17% of staff have experienced harassment, bullying or abuse from staff in the last 12 months</td>
<td>23%</td>
<td>Best 20%</td>
</tr>
<tr>
<td></td>
<td>17% of staff felt pressure in last 3 months to attend work when feeling unwell</td>
<td>26%</td>
<td>Best 20%</td>
</tr>
</tbody>
</table>
To engage staff in decisions that affect them and the services they provide and empower them to put forward ways to deliver better and safer services

- 40% report good communication between senior management and staff
- 76% of staff feel able to contribute towards improvements at work

Additional theme: staff satisfaction

- Staff are experiencing job satisfaction, 3.82
- Staff would recommend the Trust as a place to work or receive care, 4.03
- Staff are motivated at work, 3.95

Additional theme: equality and diversity

- 66% of staff have received equality and diversity training in the last 12 months
- 94% of staff believed the Trust provides equal opportunities for career progression or promotion
- 7% of staff experiencing discrimination at work in the last 12 months

Additional theme: patient/service user experience feedback

- 67% of staff agreeing that feedback from patients/service users is used to make informed decisions in their directorate/department

Overall staff engagement

- Northumbria score was 3.93

Key Achievement

Northumbria NHS teams amongst happiest in England according to NHS Staff Survey

The Trust’s staff are some of the happiest in England, according to the national NHS Staff Survey for 2014 with 94 per cent of staff feeling their role makes a difference to patients.

The Trust recorded the best response rate in England at 82 per cent for the national survey, with staff expressing extremely high levels of satisfaction in their job and in the quality of patient care they deliver.

Out of all 287 NHS organisations which took part in the survey, the Trust was also the top Trust in England for staff feeling able to contribute to improvements at work, working well as a team and having support from immediate managers.

Jim Mackey, Chief Executive, said:

“We have placed great emphasis, over many years, on listening to our frontline teams and on creating a culture where each and every member of staff feels empowered to make a difference and has the support they need to continuously improve the care and experience we offer our patients. Listening to our teams will always be at the heart of our work and we look forward to building upon these results for many years to come.”

The annual NHS Staff Survey seeks the views of NHS staff working in England and is recognised as an important way of ensuring that the views of staff working in the NHS inform local improvements and that staff have their say in the delivery of high quality, safe and effective care.
**Key Achievement**

**Northumbria Healthcare named among country’s top employers for Lesbian, gay and bisexual staff**

The Trust was placed in Stonewall’s 2015 Workplace Equality Index which lists the top 100 employers in the country. Named in the top 100 employers for the first time in 2014, this year the Trust has risen a further 50 places, making the Trust the fourth highest ranking healthcare service taking part in the index.

In the last year, the Trust has promoted equality and diversity in a range of ways including taking part in NHS Equality, Diversity and Human Rights Week and Northern Pride Week, as well as supporting community groups in Northumberland by holding a workshop on funding opportunities, all of which involved members of the Trust’s lesbian gay bisexual and transgender staff network.

The index takes into account organisations’ policy and practice, staff training, engagement and communication, data collection, improving health of lesbian, gay and bisexual people and workplace equality.

Patrick Price, General Manager and the Trust’s Equality and Diversity and LGBT lead and champion, said:

“This represents a real breakthrough for the Trust and sends a very clear signal to our workforce and the wider community that we are committed to fair and equal treatment for all of our staff and patients regardless of their sexual orientation.”

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**Key Achievement**

**District Nurses awarded with the Queen’s Nurse titles for community nursing**

Two of the Trust’s District Nurses in North Tyneside have been awarded the title of Queen’s Nurses by a national body in recognition of their dedication to their community roles.

To qualify for the title, a Queen’s Nurse must demonstrate integrity, honesty and compassion, while delivering the highest quality care to the benefit of individuals, their families, carers, and their peers. Queen’s Nurses act as role models to their colleagues and demonstrate a commitment to learning and the development of community nursing.

Gill Brown is based at Monkseaton Medical Centre and Marine Avenue Medical Centre in Whitley Bay and has been a District Nurse for 26 years. She has seen the profession change for the better as nurses have wider skills. She highlighted the role community services are playing in improving care for patients and also partnership working between health professionals.

“Community care is huge and it has been on the agenda for so long. Working together is beneficial for everyone including the patients and also health professionals such as doctors and nurses in the hospitals. It is so important.”

Queen’s Nurses must be currently registered with the Nursing and Midwifery Council, with a minimum of three years’ community nursing or health visiting experience, and be currently working with people in their own homes or community-based settings.
Listening to the views of stakeholders to inform the Quality Account

There is a high expectation that Trusts should listen to the views of a wide range of stakeholders and that the Board of Directors would give careful consideration to these views when determining the quality improvement priorities.

The Trust wishes to acknowledge the views of all those involved and is grateful for their time and contribution.

Table 34 summarises the input the Trust has received from different stakeholders:

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Responses</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary groups</td>
<td>N/A</td>
<td>Volunteer attendance at the Stakeholder event held in February. Questionnaires completed by volunteers and incorporated into staff feedback</td>
</tr>
<tr>
<td>GP Practice Managers in Northumberland and North Tyneside</td>
<td>N/A</td>
<td>Questionnaires/surveys distributed to all GP practices in Northumberland and North Tyneside, feedback as part of the public feedback</td>
</tr>
<tr>
<td>Patient surveys</td>
<td>25,000</td>
<td>Detail in the Patient Experience section of this document</td>
</tr>
<tr>
<td>Complaints</td>
<td>457</td>
<td>The top three complaint types are aspects of care and treatment; communication; and privacy and dignity</td>
</tr>
<tr>
<td>Staff Foundation Trust Members</td>
<td>379</td>
<td>Minimise hospital acquired infections (for example MRSA, surgical site infection), minimise hospital falls and pressure ulcers (damage caused to the skin - breaking its integrity), managing patients with infection and ensuring that the appropriate treatment bundle is provided in a timely manner (spot sepsis campaign), develop community services to reduce admission to hospital and reduce hospital length of stay, support carers through dementia and end of life care by understanding their needs</td>
</tr>
<tr>
<td>Public Foundation Trust Members</td>
<td>757</td>
<td>Minimise hospital acquired infections (for example MRSA, surgical site infection), minimise hospital falls and pressure ulcers (damage caused to the skin - breaking its integrity), managing patients with infection and ensuring that the appropriate treatment bundle is provided in a timely manner (spot sepsis campaign), support carers through dementia and end of life care by understanding their needs, develop effective ways of working with and supporting nursing homes to help prevent unnecessary hospital attendances or admissions</td>
</tr>
</tbody>
</table>
Annex 1: Statements from Stakeholders

Statement on behalf of the Council of Governors

The Quality Account was circulated electronically and by post on the 27th April 2015 to key stakeholders. This formal response was received on the 20th of May 2015.

Council of Governors response to the Northumbria Healthcare NHS FT Quality Account 2014/15

Northumbria Healthcare NHS Foundation Trust actively engaged with Governors to produce the Quality Account and ensure that the views of our members had been incorporated. The safety and quality indicators set during the 2014/15 period provided clarity relating to expected standards that allowed us to monitor areas and fulfil our role in holding the Board to account.

Feedback on the Quality Account 2014 -2015 – content

As a Council, we were involved at each stage of the production of this report and have collectively sign up to the statement: “We have received briefings from the Chief Executive, Executive Director of Performance and Governance and other Trust representatives on frequent occasions throughout the year. This has involved detailed presentations relating to the Trusts priorities over the past year, and priorities for the Trust moving forward. Our questions and comments have been taken on board and we have received acceptable responses”.

We agreed that the priorities outlined in the report were ambitious and clearly written. Some of our comments related to the continuing scrutiny of services and significant challenges both in terms of last year’s performance and the situations experienced. The council of governors acknowledged the remarkable work of Northumbria staff who worked above and beyond their role to maintain high standards, and deliver quality safe care for our patients during periods of increased hospital attendances and subsequent significant pressure. The continuance to integrate services and focus on delivering a seamless patient pathway between community and acute services was emphasised.

In terms of significant issues going forward we were keen to continue a focus on patient experience and compassionate care and further support the Trusts adoption of the ‘Hello my names is’ campaign. We have continued to select a number of safety indicators moving forward including sepsis, falls, medicines management and pressure ulcers. We also continue to support the challenge with regard to the C. Diff target for next year.

Presentation of the Quality Account

We have no comments to make with regard to the presentation of the document and the council of governors therefore have no hesitation in commending this report and providing assurance that we will continue to hold the board to account in the coming year.

John Robson, Lead Governor
For and on behalf of
The Council of Governors
Northumbria Healthcare NHS Foundation Trust
20 May 2015
Ms Birju Bartoli
Executive Director: Performance and Governance
Northumbria Healthcare NHS Foundation Trust
North Shields
Rake Lane
NE29 8NH

Dear Ms Bartoli

NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST QUALITY ACCOUNT 2014/2015

Statement from Northumberland County Council’s Care and Wellbeing Overview and Scrutiny Committee

Members of the Care and Wellbeing Overview and Scrutiny Committee welcome the opportunity to discuss and scrutinise the information you have provided over the course of the past year, and to submit a commentary for inclusion in your Annual Quality Account for 2014/2015.

We have continued to engage with the Trust routinely on matters of mutual importance and we have had valuable discussions throughout the past year at the Committee’s monthly meetings, whose minutes are available on the Council’s website, including:

21 May 2014 Haltwhistle Integrated Scheme
24 September 2014 Minor Injuries Unit at Rothbury
10 December 2014 Innovation in Healthcare

As shown above, the Committee received presentations from the Trust on Innovation in Healthcare, and Care Quality Priorities and the drafting of the Quality Account itself.

Issues raised by our Members on 10 December 2014 received the following responses:

- Could the ongoing centralisation of some services as medical professionals became more specialised increase the danger from infections after surgery?
Germs were widespread and hospitals were clean but it was preferable to return home sooner than later. Infections could be easily avoided through a number of basic hygiene methods. Local hospitals could no longer provide all the services people needed, and the issue should not be about access to people's local hospital, but rather about access to the best possible health services.

- Specialised services at the main hospitals might be an improvement, but what about the availability of transport to get people to the right place for their treatment?

For transport in paramedic ambulances, people's treatment began before their journey did. Although it was now taken for granted, one of the most important new technologies for saving lives had been mobile phones. Being able to make contact and summon help this way had been transformational.

- There seemed to be a public relations issue about not every doctor being able to treat any condition. Providing specialisms at centralised facilities might be better but it did mean some patients needed to travel more.

Members were advised of public consultation organised to get this message across. Also, regarding the provision of ambulatory care, work was taking place to set up more units. Three thousand patients a month now received this service.

- A Member referred to a recent visit to the North Tyneside Palliative Care Unit and enquired about the future of palliative care.

Members were advised that more training was required for staff. Northumberland did not have its own facility. Also, regarding training generally, the medical workforce was changing and some areas were now under-subscribed, including the northern area's GP scheme. A substantial amount of the workforce would need to be replaced over time.

- A Member enquired about the future of treatment for minor injuries.

Members were advised that this service was being centralised to the new Accident and Emergency Hospital in Cramlington. Some diagnostic tests had previously only been available at the Freeman Hospital but many were now available at Wansbeck General Hospital, and waiting times were now shorter.

- Was the standard of care at weekends an issue?

A seven day service was delivered in which people were seen by a consultant. Some figures produced by external organisations were not reflective of the practice of NHS organisations, and issues raised in Northumberland were no different to those in other areas.

- Discharged patients having to wait a long time for the patient transport service to take them home was a concern.

Members were advised that such problems should not happen in Northumberland, however transport between distant areas of Northumberland would be looked at further.

Issues raised on 25 March 2015 received the following responses:

- A Member enquired about integration of acute and community services to support patient flow.

The intermediate response time was more about people being discharged from hospital who may need care rather than the admission process.
- Members enquired about the issue of ambulances waiting at hospitals

While this was not noted as a priority in the Quality Report it was addressed in a monthly performance report and was one of the matrixes worked on with NEAS. It was believed that delays could be reduced by changing the model of care. Baseline information had been collected this year and a report would be provided next year.

- Members enquired about a seven day service

Sundays were not popular and now that waiting times had been reduced people were being more selective. Members felt that it was about getting the message across and educating people to have confidence that the hospital was open for business seven days a week. Healthwatch Northumbria had been successful in getting the message out and there had been 600 comments that month, 80 per cent of which had indicated that people were happy with the service.

The Committee Chairman attended your Quality Account Stakeholder Event on 12 February 2015 and interacted with other partners in contributing to your draft proposals for areas to prioritise in 2015/2016.

From the information available to the Committee, including the final draft, we believe that the Quality Account is a fair and accurate reflection of the services provided by the Trust and reflects the priorities of the community. Members also support the priorities for improvement planned for 2015/2016.

Yours faithfully,

Paul Allen
Scrutiny Officer, for Chairman
Care and Wellbeing Overview and Scrutiny Committee

cc Daljit Lally, Executive Director: Wellbeing and Community Health
Statement on behalf of the Adult Social Care, Health and Wellbeing Sub-Committee, North Tyneside Council

The Quality Account was circulated electronically and by post on the 27th April 2015 to key stakeholders. This formal response was received on the 14th of May 2015.

As Chair of North Tyneside Council’s Adult Social Care, Health and Wellbeing Sub-committee, I welcome the opportunity to comment on the Trust’s draft Quality Account 2014/15.

The sub-committee have engaged with the Trust on a number of occasions during the past year to discuss and scrutinise important issues including:

**Northumbria Specialist Emergency Care Hospital (NSECH)**

The Medical Director attended the sub-committee meeting in February to give a comprehensive progress update on NSECH. Members appreciated the opportunity to ask questions in relation to access and public transport to the new site; communication and engagement plans with local residents; the future arrangements for maternity services; and the impact the opening of the new emergency care hospital will have on North Tyneside General Hospital. The Chair and Deputy Chair of the sub-committee also had an informative site visit to NSECH during the summer of 2014. The sub-committee look forward to receiving regular updates following the opening of NSECH.

**Electronic Discharge Summary Project**

The Director of Health Informatics provided an update report on the Electronic Discharge Summary Project for the sub-committee at the beginning of 2015. The sub-committee believes that the electronic discharge system is a key component to improve hospital discharge for patients and plans to monitor its progress over the coming year.

Following presentations from the Trust on its draft Quality Account 2014/15 and priorities for 2015/16, the sub-committee were pleased to learn that overall the Trust is performing well against its priorities, however expressed concern in relation to:

- **Performance against the summary hospital-level mortality indicators (SHMI),** which shows that the Trust has higher than average rates of death occurring in hospital or within 30 days of discharge. Whilst the sub-committee acknowledges the complexity around the analysis of this indicator and that the rates are within the expected range, they are pleased that all hospital deaths are reviewed and that this continues to be a top priority for the Trust.

- **The priority for 2015/16 to educate patients dependent on alcohol who access hospital emergency services.** Whilst the sub-committee recognises the importance of this, they are concerned about the extra pressure this will place on A&E.

In conclusion the Quality Account presents a fair and accurate reflection of the services provided by the Trust and the sub-committee supports the priorities for improvement in 2015/16.

**Councillor Alison Waggott-Fairley**
Chair of Adult Social Care, Health and Wellbeing Sub-committee
North Tyneside Council
Healthwatch North Tyneside acknowledge the importance that the Trust places on seeking the views of patients to improve performance of its services. We welcome the different methods that are used to obtain those views and the recognition of the need to communicate with the wide range of communities in North Tyneside.

We are pleased to see from this year’s Quality Account that the trust continues to obtain high scores for patient satisfaction in a number of areas, particularly those that relate to how patients are treated as individuals by members of the Trust’s staff (i.e. respect and dignity; kindness and compassion).

However, we made the point last year that the presentation of the statistics does not enable a clear view of how the different sites are performing. We are obviously interested in patient satisfaction at North Tyneside General Hospital (NTGH) and it would have been helpful to have had a breakdown for this site, as well as for the specialisms within the hospital. We hope this information can be made available to Healthwatch during this coming year.

In terms of out-patients, we are pleased to see that there has been an improvement in ‘Discharge Information’, although it is not clear whether this improvement relates to NTGH or to other sites within Northumbria. Once again, we would have liked to have had more information about the areas for improvement, how these have changed year on year and what action has been taken since the last Quality Account. We hope this will be addressed by the time of next year’s Quality Account.

We look forward to working closely with Northumbria Healthcare during this coming year to ensure that the widest possible range of views are obtained from all communities in North Tyneside on the Trust’s services. This will be particularly important in relation to the new hospital in Cramlington and the impact this will have on services elsewhere in the Trust’s area.

Peter Kenrick
Chair
Healthwatch North Tyneside
Members of our board have considered the quality account and have made the following comments.

We note that there have been improvements and good performance in a number of areas, such as pressure ulcers and falls, 15 Step Challenge inspections, support for people with dementia, improving medicines management, Friends and Family test, inclusion of carers in the end of life pathway, engaging with and responding to patients and clinical performance.

We feel there are some areas for improvement, particularly issues around discharge including medicines management, which need to be addressed. Staff communication with patients and involving carers in more service areas are also areas for improvement. We note that the level of founded complaints is up 6.8%. There are some issues identified in the quality account which may improve following the opening of NSECH.

Regarding progress against last year’s priorities, the Trust seems to be making good progress in most areas. It would be good to see the immediate response team being rolled out into other areas. We will be interested to see the impact of the new way of delivering emergency care on stroke patients which seems to be an area for improvement.

Regarding priorities for 2015/16, more information relating to discharge process, particularly around medication, would be helpful. More comment on the value and practical improvement in patient care through integration with adult social care would be helpful.
More involvement of carers across all services/domains would build on the good work in the previous year around dementia and end of life care pathway. It might be useful to have some information about how patient experience of emergency care and transfer back to base sites will be monitored and evaluated.

We would expect that performance against re-admissions within 28 days will reduce once the new way of delivering emergency care is established.

Overall the quality account reflects local priorities in Northumberland, however, narrative within the document does not reflect the rurality of the population or the role of community hospitals and their importance to patients particularly well.

Yours sincerely

Cynthia Atkin
Chair
Statement on behalf of North Tyneside and Northumberland Clinical Commissioning Groups

The Quality Account was circulated electronically and by post on the 27th April 2015 to key stakeholders. This formal response was received on the 22nd of May 2015.


The CCGs welcome the opportunity to review and comment on the Quality Accounts for Northumbria Healthcare NHS Foundation Trust for 2014/15 and would like to offer the following commentary.

North Tyneside and Northumberland Clinical Commissioning Groups (CCGs) aim to commission safe and effective services that provide a positive experience for patients and carers. Commissioners of health services have a duty to ensure that the services commissioned are of good quality. This responsibility is taken very seriously and considered to be an essential component of the commissioning function.

Throughout 2014/15 bi-monthly Quality Review Group meetings with representation from the CCG’s have taken place with Northumbria Healthcare NHS Foundation Trust. These are well established mechanisms to monitor the quality of the services provided and to encourage continuous quality improvement. Also, CCG attendance at the Trust’s Clinical Policy Group encourages a transparent monitoring of the Cost Improvement Plan process. The CCGs feel that these meetings have become a valuable forum through which both organisations can both gain assurance and work collaboratively to understand the quality systems in place within the Trust.

The CCGs recognises progress made towards the delivery of the 2014/15 priorities; The Trust has achieved 20 of the 22 agreed quality measures however with regard to the two priority areas where performance did not quite meet expected targets, the Trust should provide more detail in the quality account as to the reasons for this and also outline how this has this been resolved.

For example, on the issue of the overall failure to implement the World Health Organisation surgical safety checklists, the Trust should provide a more detailed narrative of the reasons for this and how the system has been further developed with the addition of endoscopy services to the process.

It should be acknowledged that a significant amount of work has been undertaken to understand the Trust’s mortality figures and the work being carried out within the Trust to measure and monitor these, and that this work is continuing.

We would like to congratulate the Trust on the national awards they have received, including the Nursing Times Approach to Children who Self-harm, Queens Nursing Award for Community Nursing and for achieving six of the Patient Experience Network Awards, one of which included Trust of the Year. This certainly is something to be proud of.
The Trust should be commended for the results of the NHS Staff Survey which demonstrated that Northumbria Healthcare NHS Foundation Trust were one of the top Trusts in England for staff feeling able to contribute to improvements at work, working well as a team and having support from immediate managers.

The CCGs would also like to commend the Trust for exceeding the Friends and Family Test inpatient and A&E response rate targets; as well as achieving consistently high scores for the number of patients who would recommend the Trust as a place to receive treatment.

The CCGs acknowledge the improvements made on reducing the overall number of pressure ulcers and falls during 2014/2015 however, it is a concern that the number of falls incidents where patients have experienced serious harm has shown a slight increase. Falls reduction continues to be a key priority in 2015/16 for the Trust and will be monitored via the quality review groups and CCG serious incident panels.

Whilst we would also like to recognise the Trust’s achievement in meeting the Clostridium Difficile target, the zero tolerance for MRSA bacteraemia has been exceeded for the second year. It is however encouraging that the Trust is undertaking a range of initiatives to help reduce hospital acquired infections and subsequent implementation of actions.

The CCG’s are assured that the Trust demonstrates a culture of improvement throughout the organisation, an example of which is the successful roll-out of the 15-Steps programme into weekend and evenings, alongside the executive and nonexecutive team walk-arounds. The quality account also provides assurance that the Trust is committed to improving clinical effectiveness by engaging with national quality improvement programmes, clinical audits and clinical research.

The CCGs have worked collaboratively and successfully with the Trust to develop the Commissioning for Quality & Innovation (CQUIN) scheme for 2015/16. There will be a continued focus on the further development and continuation of work regarding the identification and prevention of sepsis together with the improvement of communication links with primary care colleagues.

The CCGs welcome the specific priorities for 2015/16 which are highlighted within the report and consider that they are appropriate areas to target for continued improvement. They also link with the CCG commissioning priorities. It is noted that a number of these priorities have been rolled over or are stretched targets from the 2014/15 priorities, however, the CCGs are assured that these priorities were developed in conjunction with key stakeholder, including staff and patients.

It is felt overall that the report is well written and is reflective of quality activity and aspirations across the organisation for the forthcoming year. The CCG’s look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned in 2015/16.

Annie Topping
Director of Quality
NHS Northumberland CCG
22nd May 2015

Lesley Young Murphy
Executive Director of Nursing & Transformation
NHS North Tyneside CCG
22nd May 2015
Annex 2: Statement of Directors’ Responsibilities for the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS 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 2014/15 and supporting guidance;
- 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 2014 to May 2015
  - papers relating to Quality reported to the board over the period April 2014 to May 2015
  - feedback from commissioners dated 22/05/2015
  - feedback from governors dated 20/05/2015
  - feedback from local Healthwatch organisations dated 19/05/2015 and 28/5/2015
  - feedback from Overview and Scrutiny Committees dated 14/05/2015 and 18/05/2015
  - the Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 21/04/2015
  - the 2014 national patient survey
  - the 2014 national staff survey
  - the Head of Internal Audit’s annual opinion over the Trust’s control environment dated 20/05/2015
  - CQC Intelligent Monitoring Report dated July 2014 and December 2014
- 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 www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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

By order of the board

Chairman
Date: 29/05/15

Chief Executive
Date: 29/05/15
### Annex 3: Glossary of Terms

<table>
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<tr>
<th>Glossary</th>
<th>Description</th>
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<tr>
<td><strong>CCG</strong></td>
<td>Clinical Commissioning Group. CCGs are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. They are clinically led groups that include all of the GP groups in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients.</td>
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<tr>
<td><strong>CQC</strong></td>
<td>The Care Quality Commission (CQC) is the independent regulator of all health and adult social care in England. The aim being to make sure better care is provided for everyone, whether that’s in hospital, in care homes, in people’s own homes, or elsewhere.</td>
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<tr>
<td><strong>CQUIN – Commissioning for Quality and Innovation</strong></td>
<td>The CQUIN framework was introduced in April 2009 as a national framework for locally agreed quality improvement schemes. It enables commissioners to reward excellence by linking a proportion of English healthcare provider’s income to the achievement of local quality improvement goals.</td>
</tr>
<tr>
<td><strong>DATIX</strong></td>
<td>DATIX is an electronic risk management software system which promotes the reporting of incidents by allowing anyone with access to the Trust intranet to report directly into the software on easy-to-use-web pages. The system allows incident forms to be completed electronically by all staff.</td>
</tr>
<tr>
<td><strong>Monitor</strong></td>
<td>Monitor is the independent regulator of NHS foundation Trusts. Established in January 2004 to authorise and regulate NHS foundation Trusts it is independent of central government and directly accountable to Parliament.</td>
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<tr>
<td><strong>National Reporting and Learning System (NRLS)</strong></td>
<td>The NRLS was established in 2003. The system enables patient safety incident reports to be submitted to a national database. This data is then analysed to identify hazards, risks and opportunities to improve the safety of patient care.</td>
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<tr>
<td><strong>Near Miss</strong></td>
<td>An unplanned or uncontrolled event, which did not cause injury to persons or damage to property, but had the potential to do so.</td>
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<td><strong>NHS Safety Thermometer</strong></td>
<td>The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and “harm free” care. This tool measures four high-volume patient safety issues (pressure ulcers, falls in care, urinary infection (in patients with a catheter) and treatment for venous thromboembolism (Pulmonary embolus or deep vein thrombosis DVT).</td>
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<tr>
<td><strong>Quality Account</strong></td>
<td>Quality Accounts are annual reports to the public from providers of NHS healthcare that detail information about the quality of services they deliver.</td>
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<td><strong>Quality Report</strong></td>
<td>This is the same as the Quality Account but includes additional information required by the health care regulator Monitor for Foundation Trusts.</td>
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<tr>
<td><strong>Root Cause Analysis</strong></td>
<td>A collective term that describes a wide range of approaches, tools, and techniques used to uncover causes of problems.</td>
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<tr>
<td><strong>Section 75 Agreement</strong></td>
<td>Under Section 75 of the National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 SI 617, as amended, certain Local Authorities and NHS bodies are able to enter into partnership arrangements.</td>
</tr>
<tr>
<td><strong>Sepsis 6</strong></td>
<td>A set of six tasks including oxygen, cultures, antibiotics, fluids, lactate measurement and urine output monitoring to be instituted within one hour by non-specialist practitioners at the front line.</td>
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### Annex 4: Abbreviations

<table>
<thead>
<tr>
<th>Abbreviations</th>
<th>Description</th>
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<tbody>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Service</td>
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<td>CCGs</td>
<td>Clinical Commissioning Group</td>
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<td>C.diff</td>
<td>Clostridium difficile</td>
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<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<td>CT</td>
<td>Computerised tomography</td>
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<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
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<td>CQUIN</td>
<td>Commissioning for Quality and Innovation payment framework</td>
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<td>FFT</td>
<td>Friends and Family Test</td>
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<tr>
<td>FT</td>
<td>Foundation Trust</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>GMC</td>
<td>General Medical Council</td>
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<tr>
<td>HCAI</td>
<td>Healthcare Associated Infection</td>
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<tr>
<td>HGH</td>
<td>Hexham General Hospital</td>
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<td>HRG</td>
<td>Healthcare Resource Group</td>
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<tr>
<td>IBD</td>
<td>Inflammatory Bowel Disease</td>
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<tr>
<td>IPC</td>
<td>Infection Prevention and Control</td>
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<td>MDT</td>
<td>Multi-Disciplinary Team</td>
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<td>MRI</td>
<td>Magnetic resonance imaging</td>
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<tr>
<td>MRSA</td>
<td>Methicillin-resistant Staphylococcus aureus</td>
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<tr>
<td>N/A</td>
<td>Not Applicable</td>
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<tr>
<td>NCEPOD</td>
<td>National Confidential Enquiries into Patient Outcome and Death</td>
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<tr>
<td>NEWS</td>
<td>Northumbria Early Warning Score</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NICE</td>
<td>National Institute for health and care excellence</td>
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<tr>
<td>NSECH</td>
<td>Northumbria Specialist Emergency Care Hospital</td>
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<tr>
<td>NTGH</td>
<td>North Tyneside General Hospital</td>
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<tr>
<td>OJEU</td>
<td>Official Journal of the European Union</td>
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<tr>
<td>PALS</td>
<td>Patient Advice and Liaison Service</td>
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<td>POAS</td>
<td>Psychiatry of Old Age Service</td>
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<tr>
<td>PROMs</td>
<td>Patient Reported Outcome Measures</td>
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<tr>
<td>SHMI</td>
<td>Summary Hospital-level Mortality Indicator</td>
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<tr>
<td>SSI</td>
<td>Surgical Site Infection</td>
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<tr>
<td>SUIs</td>
<td>Serious Untoward Incidents</td>
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<tr>
<td>UTIs</td>
<td>Urinary tract infections</td>
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<tr>
<td>VTE</td>
<td>Venous thromboembolism</td>
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<tr>
<td>WGH</td>
<td>Wansbeck General Hospital</td>
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</table>
Annex 5: Feedback Form

We would like to hear your views about our Quality Account

Your feedback will give us an opportunity to include the initiatives you want to hear more about. The results of this feedback will contribute to the development of the Quality Account 2016/17. Please fill in the feedback form below, tear it off, and return to us, in the post, at the following FREEPOST address:

Patient Services and Quality Improvement - RTLL-KCYL-EYHL
Northumbria Healthcare NHS Foundation Trust
7-8 Silver Fox Way
Cobalt Business Park
Newcastle Upon Tyne NE27 0QJ

Or alternatively, you can email us at: Patient.Services@nhct.nhs.uk

Thank you for your time

Feedback Form (please tick the answers that are applicable to you)

What best describes you:
Patient ☐ Carer ☐ Member of public ☐ Staff ☐ Other ☐

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<th>Yes all of it</th>
<th>Most of it</th>
<th>None of it</th>
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<tr>
<td>Did you find the Quality Account easy to read?</td>
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<td>Did you find the content easy to understand?</td>
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<td>Did you feel the content was relevant to you?</td>
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<td>Would the content encourage you to use our services?</td>
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Are there any topics that you would like to see included in next year’s Quality Account?
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How do you feel we could improve our Quality Account?
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Alternative Formats

If you would like a copy of this information in large print, another language, audio tape or other format please call the Contact Centre on 0344 811 8118
APPENDIX C

EXTERNAL ASSURANCE - QUALITY ACCOUNT 2014/15
INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Northumbria Healthcare NHS Foundation Trust to perform an independent assurance engagement in respect of Northumbria Healthcare NHS Foundation Trust's Quality Report for the year ended 31 March 2015 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicator for the year ended 31 March 2015 subject to limited assurance is the following national priority indicator;

- Maximum waiting time of 62 days from urgent GP referral to first treatment of all cancers.

The scope of our review originally also covered the Referral to Treatment (RTT) national priority indicator. The Trust has not kept the supporting data relating to April 2014 to January 2015 for the RTT indicator and is unable to recover the required information from its Patient Administration System. As a consequence we are unable to conclude on the completeness and accuracy of the RTT indicator included in the published Quality Report and have excluded this indicator from the scope of our limited assurance review.

We refer to the remaining national priority indicator as the 'indicator'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2014/15 ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider 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.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the documents below:

- board minutes for the period April 2014 to May 2015;
- papers relating to quality reported to the board over the period April 2014 to May 2015;
- feedback from Commissioners, dated May 2015;
• feedback from governors, dated May 2015;
• feedback from local Healthwatch organisations, dated May 2015;
• feedback from Overview and Scrutiny Committee dated May 2015;
• the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2015;
• the 2014/15 national patient survey;
• the 2014/15 national staff survey;
• Care Quality Commission Intelligent Monitoring Report, dated December 2014;
• the Head of Internal Audit’s annual opinion over the trust’s control environment, dated 20 May 2015; and
• any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the ‘documents’). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Northumbria Healthcare NHS Foundation Trust as a body, to assist the Council of Governors in reporting the 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 2015, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Northumbria Healthcare NHS Foundation Trust for our work on this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

• evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
• making enquiries of management
• testing key management controls
• limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
• comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report.
• reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Northumbria Healthcare NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Quayside House
110 Quayside
Newcastle upon Tyne
NE1 3DX

29 May 2015