NHS
South Tees Hospitals
NHS Foundation Trust

South Tees Hospitals NHS Foundation Trust

Annual Report and Accounts

1 April 2018 to 31 March 2019

Excellence in Patient Outcome and Experience

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Presented to Parliament pursuant to
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National Health Service Act 2006

Contents

1 Performance Report

The purpose of the performance report is to provide an overview of South Tees Hospitals NHS Foundation Trust (the Trust), its purpose and a glimpse of its history. The Chief Executive's and Chairman's perspective is included together with the key issues and associated risks to the delivery of our objectives.


CHILDREN'S WARD

Introduction to South Tees Hospitals NHS Foundation Trust

South Tees Hospitals NHS Foundation Trust is a statutory body which became a public benefit corporation on 1 April 1992. We are the largest hospital Trust in the Tees Valley and our core purpose is to provide acute and community services with the highest quality of patient care and experience.

Our Trust is one of the largest employers in the Tees Valley. We have a total of 994 beds provided from the James Cook University Hospital in Middlesbrough and the Friarage Hospital in Northallerton with over 1.5m patient contacts per year, with an additional 1.2m patient contacts with our community services. We are a Major Trauma Centre, Regional Cancer Centre and a Tertiary Centre with particular expertise in heart and lung disease, neurosciences, children's and maternity services, renal medicine, cancer services and spinal injuries.

We are registered with the Care Quality Commission with our last inspection providing a 'Good' rating.

We are committed to providing patients with the very best care across all of our services.

In addition, we provide care in our local communities and in people's homes including community and district nursing and services from the following hospital sites:

- Redcar Primary Care Hospital
- East Cleveland Primary Care Hospital in Brotton
- Friary Community Hospital in Richmond

We are recognised as one of the best performing and most innovative organisations in the NHS. We are a major employer within our local area and a key system leader within the health and social care system that serves our communities.

Our Trust is a leading partner in the Academic Health Science Network (AHSN) and member of the Clinical Research Network for the North East and North Cumbria, which aims to recognise the brilliant ideas originating from the region's health service, turning them into treatments, accessible technologies and medicines to enable patients to benefit from better healthcare.

We recognise that patient experience is a fundamental component of quality healthcare, with our aim to provide the best possible care for each and every one of our patients.

We expect at all times that all of our patients will be listened to and treated with honesty, dignity and respect. We appreciate that patients and their families are the experts in terms of their experience of our care, and we aim to listen closely to what they have to tell us to enable our services to meet their current and future needs.

Overview by the Chairman and Chief Executive

We are pleased to present this report which gives us the opportunity to highlight some of our key achievements, along with some of the challenges that we've faced. It provides a review of our business including a balanced comprehensive analysis of developments and operational and financial performance.

2018/19 nationally was one of unprecedented levels of demand for many NHS services, with continued levels of major financial deficit across the NHS.

Over the last 12 months, we have made significant improvements in our operational performance which were supported and managed alongside an extremely challenging financial climate. We delivered £38.7million of productivity and efficiency savings in 2018/19, £12.3 million ahead of our plan. At the year-end, the Trust reported an £7.9 million deficit Control Total excluding Provider Sustainability Funding (PSF). The overall deficit for the year was £30.9m after impairments of £50.6m

This strong financial performance is the first time in four years that the trust has achieved its control total, resulting in additional funding being secured via provider sustainability funding of £23.4 million, which will improve our cash position.

Although we have delivered circa £128m in productivity savings over the last four years, we remain focussed on improving our patient outcomes and experience as well as our financial sustainability.

Working collaboratively with our commissioners across the health economy, during 2018/19, we signed aligned incentive contracts with our CCG commissioners, providing a stable platform on which to plan and transform services and their delivery for our patients.

Over the last 12 months we have continued to make significant improvements in our delivery of patient care with the support of our operational and financial performance.

The Trust has made significant improvements in relation to Clostridium difficile infections, achieving our lowest ever recorded number of trust apportioned cases. During 2018/19 we saw the number of patient falls reported across our health services reduce to 4.8 per 1000 bed days, an 11.7% reduction on the previous year.

In terms of our performance against the four hour Accident and Emergency standard, we are ranked as one of the top performing Trusts in the country, achieving 95.24% against the 95% target, despite an overall increase in demand of 5%.

Demand for our cancer services during 2018/19 increased by 16% across all areas, resulting in our cancer performance falling behind the target of 85% to 82.65%.

We launched our Medical Examiner service – the only one in the region – which continues to provide an improved experience for patients' families.

Our flu champions vaccinated 80.4% of frontline healthcare staff in the Trust this year. This was the highest number at the Trust.

In 2018/19, the Trust was inspected by the Care Quality Commission and at the time of this report, was awaiting the CQCs final report.

Research is an important element of the Trust's business and is key to ensuring that the care the Trust provides is keeping pace with developments in practice and technological advancements. In 2018/19 we sustained our previous highest ever levels of recruitment which included:

- 3,718 patients recruited into clinical research trials, in line with last year's highest ever levels of recruitment (3,728)
- Recruited to 196 different clinical trials in 24 clinical specialisms, ranking 3rd in the region, in the top 11% of NHS Trusts nationally and in the top 25% of Acute Trusts
- 257 of these patients were recruited into 33 commercial clinical trials in 12 clinical specialisms.

The Trust is the award holder for several on-going multi-centre National Institute for Health Research (NIHR) grant funded projects, providing support in sponsorship, study co-ordination/management and research delivery. Six further successful NIHR grant funding applications were recorded in 2018/19, supplementing the existing NIHR grants, co-ordinated by the research and development team.

This year we embarked on an exciting strategic partnership with our two neighbouring acute trusts to form the 'Durham Tees Valley Research Alliance'. This created a single research and development service to offer patients increased opportunities to participate in research, as well as standardise research and development study set up across the Durham Tees Valley.

Throughout 2018/19 the Trust has used its Assurance Framework to ensure risks to the delivery of our principle objectives were identified, controls and assurances were assessed, and action plans were delivered and implemented as appropriate. This system of oversight of significant risks is maintained by the Board of Directors with Centres and divisional leaders ensuring actions are prioritised.

South Tees Hospitals NHS Foundation Trust

We employ around 8,700 staff, of whom 82% are female and 54% of staff work part time and our staff turnover was 11.8%. One third of our staff are qualified nurses which equates to 58% of our overall pay expenditure. Our workforce is our greatest asset and is clearly a key contributor to the Trust's achievements in that they consistently deliver a high quality service and patient centred care to the population we serve. Our award-winning teams continue to provide first class treatment. In 2018/19, our teams delivered success and achievements including:

Doors open to **£10million** cancer centre

The first patients were treated in The Sir Robert Ogden Macmillan Centre at the Friarage Hospital. The Centre was developed in partnership with Macmillan, Sir Robert and Lady Ogden and Interserve which is the main building contractor engaged by the Trust.

The centre officially opened its doors on 11 December 2018 and demonstrates the Trust's long-term commitment to delivering clinically safe and sustainable services to the people of Hambleton, Richmondshire, Whitby and the surrounding area.

Recognition as **'veteran aware'** Trust

As part of the commemoration to mark the 100th anniversary of the end of the First World War, the Trust was accredited as 'veteran aware'. This mark of distinction means that patients who have served in the UK armed forces will be cared for by frontline staff who have received training and education on their specific needs, such as mental health and who can signpost them to local support services.

New technique treats spinal fractures within an hour

The James Cook spinal surgery unit became the first in the region to use a one-step technique to fix spinal fractures. The advanced procedure uses a special instrument to insert multiple screws into the back to stablise the spine. The procedure takes just one hour and most patients are then well enough to go home the next day.

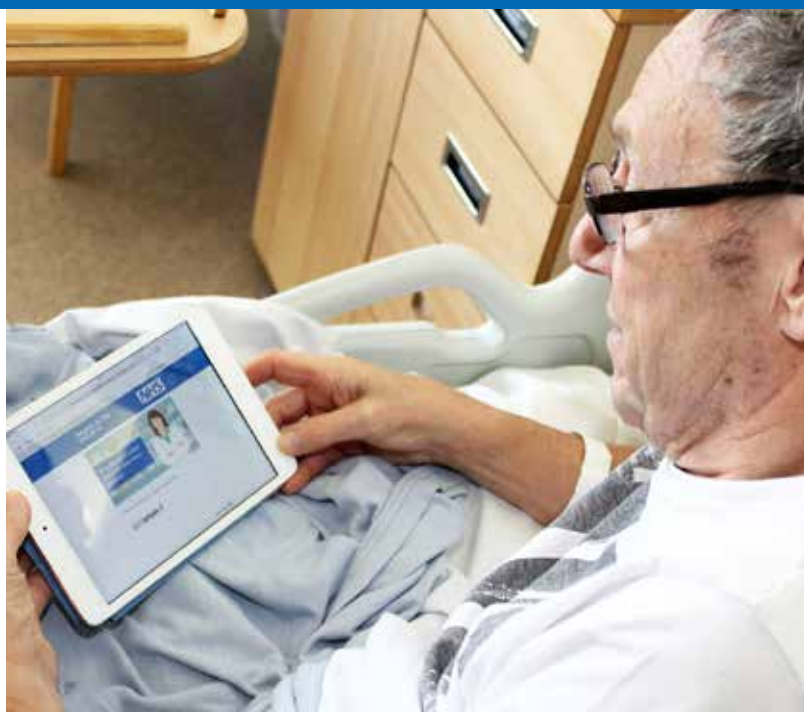
Celebrating 25 years of cardiothoracic surgery on Teesside

Previous and current staff celebrated 25 years of cardiothoracic surgery being carried out on Teesside. Since the unit began operating in 1993, 33,000 operations have been carried out, with patients now benefitting from world-renowned surgery, including cutting edge robotic surgery and minimally invasive procedures. Doctors have seen significant changes over the 25 years, with patients who are older, with more complex conditions, but who now benefit from the latest research and trials, with technology meaning that they can have their operations and go home sooner. The team reached a special milestone after implanting its 10,000th pacemaker in 2018. The celebrations also recognised the work of the South Cleveland Heart Fund, which has raised over £2.5million, with all funds supporting the unit.

Patient centred visiting introduced

We extended ward visiting hours across all our sites from 1 October, 2018 to enable family and friends to see patients at any time during the day. The more flexible and patient centred approach welcomes visitors at a time that the patient wants and needs.

Free WiFi introduced at James Cook and Friarage Hospitals



We introduced free WiFi for patients, visitors and staff at both James Cook and Friarage Hospitals. The service was set up in response to national patient feedback asking for free WiFi service to be made available in NHS locations. The service allows patients and the public to download health apps, browse the internet and access healthcare information.

Trust prepares for **smokefree** sites

The Trust prepared to go smokefree by 1 April 2019, following up on our commitment to the NHS smokefree pledge we signed in 2017.

While the Trust's hospital sites are already designated as no smoking areas, we led a public health campaign and committed to routinely offer smoking cessation advice to patients in all clinical areas and Nicotine Replacement Therapy (NRT) to all inpatients. We systematically record the smoking status of all patients, with an opt-out approach to referrals for specialist advice and support. We provided smoking cessation training for staff, provide improved stop smoking support for staff, ensure NRT is easily accessible via onsite or nearby pharmacies and promoted smokefree entrances and exits across all hospital sites, ready for our launch.

70 YEARS OF THE NHS 1948 - 2018

We marked the 70th anniversary of the National Health Service, with activities across the Trust. We showcased our innovations in a specially commissioned news programme which highlighted the innovative work across our Trust, how we have revolutionised urgent and emergency care procedures, and how we are speeding the treatment of those with cancer and providing patients with the best outcome.

Centre of excellence for blood cancer treatment

The myeloma service at James Cook was accredited as a centre of excellence, recognising our commitment to providing superior treatment to myeloma patients, which is the third most common type of blood cancer. The team were recognised by patients as delivering care that was 'second to none', and staff were supportive and caring.

Freedom to Speak Up roles expanded

We appointed two new freedom to speak up guardians and trained a number of new champions across the Trust as part of our work to support staff who want to raise concerns. Building on our existing whistleblowing policy, we launched an online reporting tool, alongside the appointment of champions and guardians, to provide staff with the tools they need to speak up.

Urgent temporary changes at the Friarage Hospital

We introduced a number of temporary urgent changes to some services at the Friarage Hospital in Northallerton from 27 March, 2019 to ensure we continued to provide safe services. The changes were as a result of a shortage of critical care staff. This has resulted in the accident and emergency service temporarily changing to an Urgent Treatment Centre, although the majority of patients currently treated at A&E at the Friarage will still be treated in the Urgent Treatment Centre. Patients requiring critical care are being cared for at The James Cook University Hospital or Darlington Memorial Hospital. Very few patients will be affected by these changes, with nearly 9 out of 10 patients continuing to receive their treatment at the Friarage. We are working with the Clinical Commissioning Group to deliver a full public consultation in 2019, in order to agree the longer term sustainable future service model for the Friarage.

Cardiac team at the Friarage named **team of the year**

The cardiac rhythm management service at the Friarage was named team of the year in the Arrhythmia Alliance Excellence in Practice Awards for the work they have done in introducing rapid access to the service, remote patient monitoring clinics and a range of other initiatives that were recognised for making an outstanding contribution to patient care.

Friarage hosts undergraduate students

Two groups of students from Imperial College London were based at the Friarage Hospital as part of their undergraduate studies. They were able to experience community and rural medicine and healthcare in a rural setting, as they experienced the delivery of health services in North Yorkshire.

New state-of-the-art eye scanner at the Friarage

Leading-edge imaging technology is now being used, thanks to the Friends of the Friarage, to speed up diagnosis of eye conditions such as age-related macular degeneration and diabetic eye problems at the earliest possible stage. The Heidelberg machine uses imaging techniques to scan the back of the eye, producing highly detailed images, as well as scanning other parts of the eye. Staff working in the ophthalmology service have found the technology has revolutionised the way they work and the service they can provide to patients.

New blackout service opened at the Friarage Hospital

A new service at the Friarage Hospital was launched for those patients who suffer from blackouts and often find themselves facing numerous medical appointments and tests to find the exact cause of the problem. The new service aims to provide a faster diagnosis as patients are assessed by a range of specialists in one place.

New radiotherapy machine treating patients **three times faster**

Cancer patients at the Trust are now benefiting from a leading edge radiotherapy machine which can deliver treatment up to three times faster than conventional methods. The new linear accelerator (linac) has advanced 4D image guidance systems which provide extremely accurate treatment delivery and minimal side effects for our patients.

Triple recognition for infectious diseases research team

Our infectious diseases research team were recognised through three awards. The team have increased their involvement in HIV and infection studies, as well as antibiotics and vaccine trials. One project, developed with GPs and Teesside University, has involved a software application to improve testing for HIV and viral hepatitis, which is undergoing testing in GP surgeries, and the innovation won the Medipex NHS Innovation Award for Primary Care. The team's work on blood borne virus application also saw the team recognised through a Bright Ideas in Health Award for development of an innovative device or technology.

The Royal College of Physicians and Clinical Research Network also recognised their research activity.

UroRadiology star named Nurse of the Year

Advanced nurse practitioner in radiology, Helen Scullion, was recognised by the Nursing Times, and awarded the national title of 'nurse of the year' for the work she has done to instigate and complete specialist training to enable her to carry out interventional work. These tasks were previously only conducted by consultants to help patients get the right follow up care without any delays and reduce the number of patients re-admitted.

£1m investment in the Learning, Research and Innovation centre and undergraduate medical programme

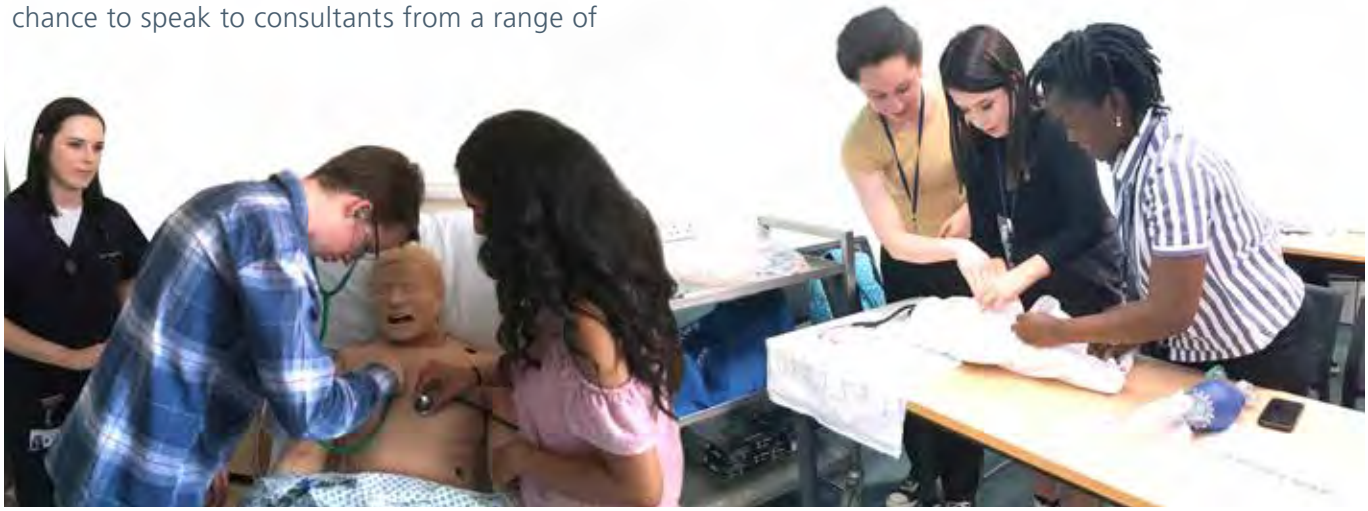
We announced a £1million programme of investment, in partnership with Newcastle University, in our academic facilities at the Learning, Research and Innovation centre at James Cook to support the growth of the undergraduate medical programme across the Tees Valley, with work beginning in 2019.

Shh... Sleep helps healing campaign launched

We launched a campaign in December 2018 to help reduce noise levels on our wards at night. The campaign follows feedback from our 1,000 Voices patient survey, which identified that noise at night as the main area that could be improved. The campaign urges both staff and patients to dim the lights and keep noise to a minimum between 11pm and 6am and wards across all hospitals joined the campaign.

Residential course for 'wannabe' doctors

James Cook University Hospital hosted a residential course for future doctors from lowincome backgrounds, the only such course in the country. The week-long programme featured live theatre lectures, practical workshops and the chance to speak to consultants from a range of specialties in a unique career carousel event. The course was organised by the Trust in partnership with the Social Mobility Foundation to support high achieving students from low-income backgrounds.



The Heart team **medical mission** to Ghana

A team of consultants from the heart and lung surgery team at the Trust gave up their own time to take part in a life-saving mission to Ghana. Having raised £30,000 to fund equipment and medical supplies, surgeons, cardiologists, intensive care practitioners, anaesthetists and a heart bypass technician spent a week at the Komfo Anokye Teaching Hospital in Ghana in February 2019 performing life-saving surgery on patients, whilst also teaching staff at the hospital. The team are already planning another trip to Ghana later in 2019.

Treat as One mental health awareness pledge

We launched our 'Treat as One' campaign to increase staff awareness of mental health, introducing compulsory mental health training for staff, ensuring everyone has a basic understanding. The pledge means that patients with potential or pre-existing mental health disorders will have their holistic health needs assessed and treated appropriately by skilled staff.

Recognition for **putting care needs first**

Our nursing and therapeutic care teams won a national award in recognition for their use of an IT system, HealthRoster, to directly allocate staff to a ward, supporting patients who require one to one care very quickly. The award was given in the Allocate Awards 2018, and the team were praised for providing the best possible outcomes for patients.

It has been a challenging year for the NHS and we have no doubt that the challenges will continue in the year ahead but we are confident we will continue to succeed with the commitment, hard work and support from our workforce. This will help drive forward continuous improvements, building on our strong foundations to deliver excellent services for each and every one of our patients that we serve.

Signed:

Date: 20 June 2019

Siobhan McArdle
Chief Executive & Accounting Officer

Signed:

Date: 20 June 2019

Alan Downey
Chairman

OUR MISSION

The Trust's mission is to provide seamless, high quality, safe healthcare for all.

OUR VISION

Our vision is to be recognised nationally for excellence in quality, patient safety, patient experience, social engagement and continuous improvement.

OUR VALUES

Putting patients at the centre of everything we do;

Supporting, respecting and valuing each other;

Continuously improving quality;

Using our resources to the benefit of the wider community.

OUR STRATEGIC OBJECTIVES

We have five strategic objectives to help us deliver our mission, vision and values which include:

We will deliver excellence in patient outcomes and experience

We will deliver excellence in employee experience to be seen as an employer of choice

We will drive operational performance to deliver responsive, cost effective care

We will deliver long-term financial sustainability to invest in our future

We will develop clinical and commercial strategies to ensure our long term sustainability

Supporting our five strategic objectives are a number of enabling strategies.

Enabling Strategies

Our enabling strategies are used as a mechanism to achieve our five strategic objectives and include such strategies as Cancer, Services for the Frail Elderly, Children and Young People, End of Life, and Trauma services.

Delivery of our 2018/19 Annual Plan

The purpose of this strategic report is to help inform readers of the accounts to help them assess how well the directors have performed during 2018/19 to promote the success of our Trust.

We developed key objectives and key performance indicators (KPIs) to monitor delivery of five strategic objectives.

At every Board meeting strategic and operational progress is monitored through the use of the Chief Executive's report and the Integrated Performance report covering quality, safety, performance and finance. In addition there are detailed monthly reports that include finance and activity; safer staffing, learning from deaths and healthcare associated infections.

In 2018/19, the Trust's Annual Plan was communicated and understood at all levels throughout the Trust. Key objectives were agreed with each Centre and division.

This section of the report aims to provide a detailed analysis of performance in relation to each strategic priority, including achievements, challenges and mitigating actions taken.


PORTLAND
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We will deliver excellence in patient outcomes and experience

1.1 Delivering Safer Care
1.2 Improving Clinical Outcomes
1.3 Improving Patient Experience

Throughout the year we worked hard to deliver excellence in patient outcomes and experience with detailed evidence found within the Quality Report appended to this report.

A summary of patient outcomes and experience include:

- Reducing the numbers of Trust apportioned Clostridium difficile infections, with 41 cases against an upper threshold of 54
- A reduction of 11.7% in the number of patient falls on the previous year
- Implementing the new measurement of pressure ulcers with the re-launch of our tissue viability strategy, to reduce incidences
- Collaborative working with care homes and social care to improve education on continence and urinary catheter care funded by the Better Care Fund
- Development of criteria led discharge, following recognition of our project making the most progress
- Introduced our medical examiner service to provide an improved experience for patients' families
- Improved our performance on patient experience on in-patient wards
- Patient safety and incident reporting part of the new induction for all new employees
- Introduction of patient centred visiting, with visitors welcome at any time during daytime hours, across all hospitals
- Improved opportunities for patient feedback and improved communication on opportunities for patient feedback.

Patient feedback and complaints process

We launched our patient experience strategy in 2018/19 and all patient experience feedback is reviewed to identify themes and action points and share with the Board. Each ward now has a board explaining to patients, visitors and staff the process for escalating concerns and includes patient facing reports on our performance.

Patient experience facilitators actively encourage patients to discuss any issues relating to their medical care with staff or act on their behalf. We have undertaken a review of our patient leaflets, making them easily accessible on our wards. Each and every patient, relative, carer feedback or complaint we receive we are committed to responding to with the aim of improving our services and sharing of best practice. We have a Patient Advisory Liaison Service (PALS) which provides an accessible service and handles all feedback including complaints and concerns sensitively.

In 2018/19 we received the following number of compliments, PALS contacts and complaints:

2518 PALS contacts

379 complaints

261 compliments

Further details on the Trust's compliments, PALS contacts and complaints can be found within the Quality Report.

1,000 voices patient experience programme

We continue to develop our '1000 voices' programme to ensure that patient experience and feedback are at the heart of service development and quality improvement. We capture real time data at ward level, including friends and family test data. Our facilitators spoke with 4,383 patients during 2018/19 and we have seen improvements across the 10 domains covered by the programme.

We are going to expand this work to ensure we hear feedback from 'hard to reach' groups. We are also introducing a new IT system to improve response rates and work with partners to capture feedback from patients who have a mental health diagnosis, working closely with the Treat As One working group.

Patient Care Environment

Patient-led Assessment of Care Environment (PLACE) puts patients views at the centre of the process with assessments carried out throughout our premises covering: privacy and dignity; cleanliness; general building maintenance; food and dementia. We then identify how well we are doing through the evaluation of these assessments and compare ourselves against other hospitals nationally. The Trust's performance against the national average can be found in the table below:

	Overall Trust score (2018/19)	Overall Trust score (2017/18)	National average (2018/19)	National average (2017/18)
Cleanliness	98.64%	99.21%	98.47%	98.38%
Food	84.82%	91.96%	90.17%	89.68%
Organisation food	93.99%	94.29%	89.97%	88.80%
Ward food	84.26%	91.61%	90.52%	90.19%
Privacy, dignity and wellbeing	88.70%	86.70%	84.16%	83.68%
Condition, appearance and maintenance	96.44%	96.51%	94.33%	94.02%
Dementia	85.02%	85.01%	78.89%	76.71%
Disability	91.79%	86.31%	84.19%	82.56%

Cyber Security

The Trust was not directly affected by the global cyber-attack on 12 May 2017. We put in place precautionary actions following this incident to safeguard our infrastructure and we continue to build on the work undertaken to-date, audit recommendations and national expectations related to IT/Cyber security.

Five strategic themes have been identified which are planned to be delivered through an action plan which will be monitored through the Trust's governance structure and escalated to senior management review where appropriate.

The five themes include:

- Governance and assurance
- Training and awareness
- Policies and standard operating procedures
- Improvement to technology and IT related processes
- Review of resources

The cyber risks that the Trust is exposed to are managed via the Trust risk register and risk management process and are reviewed regularly to ensure they remain accurately scored and updated with the latest issues.

A number of investments, totalling £500,000 were made during the past year to improve our Cyber security and a number of additional key business cases are under development to support the Trust's progress through the identified five themes as listed above. A significant investment in these areas is required. NHS Digital and the Nation Cyber Security Centre have recently established a Cyber Associates Network which the Trust has joined. This route is seen as a key driver to provide regular updates, events, knowledge sharing and training support to organisations.

Cyber-attacks remain one of the biggest risks to any organisation who hold sensitive data or have a reliance on electronic systems. The learning/experience of large scale attacks has demonstrated that preparation, user awareness and understanding of the risks posed to an organisation are all part of the key defence that organisations should be performing as business as usual in the current climate.

Health and safety

Health and safety is integral to everything that we do. We have in place a defined health and safety management and leadership structure with great emphasis on proactive health and safety management which is clearly explained within the Health and Safety Policy.

We will deliver excellence in employee experience to be seen as an employer of choice

2.1 Identifying and Attracting the Right Workforce
2.2 Engaging and Retaining People
2.3 Rewarding and Recognising High Performance
2.4 Developing and Delivering Our Workforce of the Future

We take employee experience seriously and have worked to be seen as an employer of choice throughout the year which has included:

- Workforce plans in place to address current and future professional and location needs which are monitored by the Workforce Assurance Committee
- Targeted recruitment and retention activity for key staff groups, with a focus on reward, recognition and responsibility
- Pay spend matches planned budgets;
- Agency staff levels and pay consistently maintained within NHS Improvement's target
- Mandatory training and appraisals targets closely monitored against action plans
- Development of our Health and Wellbeing strategy with a focus on mental health
- Developed our apprenticeships across a range of vocational areas
- Re-established our equality, diversity and inclusion network to promote inclusivity.

We will drive operational performance to deliver responsive, cost effective care

3.1 Delivering operational excellence

We measure performance according to the delivery of objectives which are aligned in our Annual Plan which sets the vision for the year and the key objectives that we are committed to. Our Annual Plan is split between the core areas of: operations (activity planning), quality, workforce and finance. During 2018/19 our four priority areas 'must dos' for the Trust to deliver were:

- Clostridium difficile objective
- Cancer 62 day wait for first treatment from urgent referral
- 18 week referral to treatment time; and
- 4 hour maximum wait in Accident and Emergency from arrival to admission, transfer or discharge

Clostridium difficile

The lowest ever level of Clostridium difficile infection was reported across the Trust in 2018/19, with 41 trust attributed cases against an upper threshold of 54.

We continue to remain vigilant and are focused on implementing exemplary infection control practices across all areas to ensure the incidence of Clostridium difficile remain low. Further details are provided within the Quality Report.

Cancer (62 day wait)

Our overall performance was 82.65% against an 85% target. We continued to hold weekly performance meetings with service managers and relevant clinical and support staff to prioritise and progress cancer patients and rapidly reduce time between referral and treatment.

18 week referral to treatment

We achieved a performance of 89.49% against a target of 92% for patients treated within 18 weeks of referral. We have ensured that our waiting list at March 2019 did not exceed that of March 2018 in terms of numbers of patients. We are committed to reducing overall waits for all our patients and ensuring patient experience and outcomes will improve as a result of overall waiting time.

4 hour maximum wait in Accident and Emergency

In terms of our performance against the four hour Accident and Emergency standard, we successfully achieved this 95% target, delivering 95.24% and are ranked as one of the top performing Trusts in the country despite an overall increase in demand of 5%.

Our performance against these key healthcare targets is listed below:

	13/14	14/15	15/16	16/17	17/18	18/19	18/19 Target
Safety							
Clostridium (c.) difficile – meeting the C.difficile objective	57	76	61	43	48	41	54
All cancers: 62 day wait for first treatment from:							
Urgent GP referral for suspected cancer	84.70%	85.30%	79.10%	81.10%	85.44%	82.65%	85%
NHS Cancer Screening Service Referral	94.80%	92.60%	89.80%	89.00%	94.55%	87.14%	90%
18 weeks referral to treatment time (RTT)							
Incomplete pathways	95.20%	95.70%	93.20%	92.20%	91.45%	89.49%	92%
Accident & Emergency							
4 hour maximum wait in A&E from arrival to admission, transfer or discharge	96.70%	94.90%	95.80%	95.33%	95.68%	95.24%	95%
Diagnostic Waits							
Patients waiting 6 weeks or less for a diagnostic test	99.60%	98.70%	98.82%	99.15%	97.46%	98.26%	99%

Winter Planning

Effective winter planning and surge management remained a key priority during the year. The Trust has in place a rehearsed winter and surge plan which is tested year on year with unexpected challenges which the Trust reflects upon to develop future plans whilst working collaboratively with its commissioners and key stakeholders.

The Trust is required to report to its regulator each year on its winter plans with a national drive to ensure additional assurance in the system for emergency departments and system resilience, with Accident and Emergency Delivery Boards having responsibility for co-ordinating capacity and operational plans across the health and social care system.

We will deliver long-term sustainability to invest in our future

4.1 Restructure Debt

The Trust has not restructured debt during 2018/19.

During the year the Trust repaid debt of £9.8m, and borrowed an additional £9.0m. The additional borrowing relates to Provider Sustainability Funding (PSF) due in the fourth quarter of 2018/19.

All the year-end borrowing of £55.0m becomes repayable during 2019/20. The Trust is currently in dialogue with NHSI over the extension of these loans.

4.2 Deliver Operational Financial Performance

The Trust was required to operate at a deficit Control Total of £10.1m during 2018/19 prior to the receipt of PSF. The Trust would then achieve a surplus Control Total of £3.8m with the inclusion of (£13.9 million) PSF, if the financial target was achieved

The Trust secured a deficit Control Total of £7.9m before the receipt of PSF, representing an over achievement of £2.2 million against the original plan.

As a result of both achieving the Control Total (financial plan) and the over achievement (£2.2m) the Trust became eligible for additional PSF. The Trust received PSF totalling £23.4m, representing original PSF of £13.9m and bonus PSF of £9.5m.

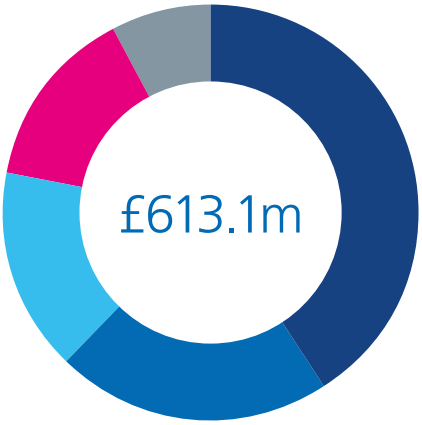
The Trust therefore returned a surplus Control Total of £15.5m consisting of the underlying deficit of £7.9m and PSF of £23.4m.

The Trust's £15.5m surplus Control Total, excludes impairments, donations towards capital expenditure and depreciation on donated assets. The Trust's actual deficit, as reported in the accounts, amounted to £31.5m including impairments, donations and depreciation on donated assets. On a Group basis the surplus Control Total was £16.1m and the actual deficit was £30.9m.

Comprehensive Income Performance

Trust only	Plan £m	Actual £m	Variance £m
Clinical income	543.1	545.2	2.1
Non-clinical income	40.7	44.5	3.8
Transition support	13.9	23.4	9.5
Total income	**597.7**	**613.1**	**15.4**
Pay spend	(346.4)	(357.4)	(11.0)
Non-pay spend	(236.0)	(240.2)	(4.2)
Impairments	(8.2)	(50.7)	(42.5)
Total spend before dividend and interest	**(590.6)**	**(648.3)**	**(57.7)**
Operating surplus/(deficit)	**7.1**	**(35.2)**	**(42.3)**
Profit on sale of assets	11.4	20.7	9.3
Dividend, interest and finance costs	(19.1)	(17.0)	2.1
(Deficit) for the year	**(0.6)**	**(31.5)**	**(30.9)**

The Trust secured income of £613.1 million, split over the below categories:

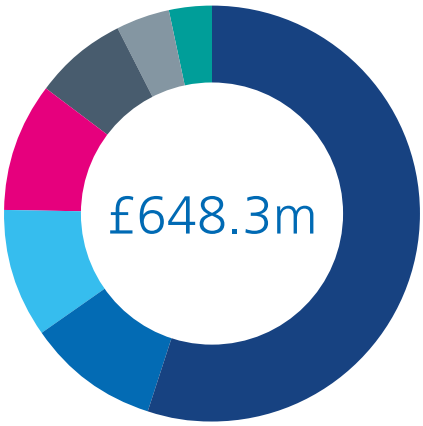


	£m
Other clinical income	251.0
Non-elective patient activity	132.0
Outpatient and A&E	95.7
Elective patient activity	88.3
Community Services	46.1
Total	**613.1**

The largest proportion of the Trust's income is generated from patient related activities which represent 89% of the total income. The majority of this is derived from contracts with the Trust's clinical commissioners.

Education and training income accounts for a further 2.8% and Provider Sustainability Funding, a further 3.8%.

Analysis of Trust expenditure



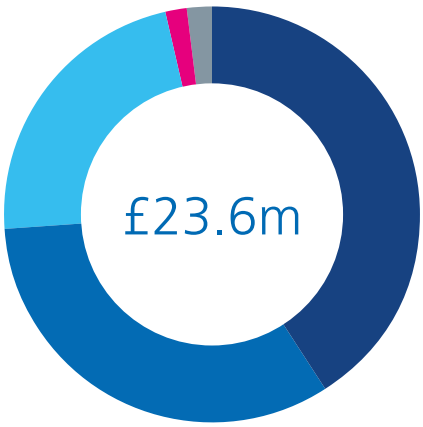
	£m
Pay	358.7
Other clinical supplies	67.4
Drugs	64.3
Depreciation, amortisation and impairment	63.9
Other	46.8
Premises	26.1
Service element of the PFI	21.1
Total	**648.3**

The largest proportion of the Trust's expenditure relates to staff, accounting for 55% of operating expenses with depreciation, amortisation and impairments, clinical supplies and drugs each accounting for a further 10%.

Capital Expenditure

The Trust has a rolling capital programme to maintain and develop its capital infrastructure. In 2018/19, the Trust invested £23.6m of capital expenditure to enhance and expand the asset base. The main areas of expenditure are detailed below:

Analysis of Trust Capital Scheme Expenditure



	£m
PFI lifecycle	9.7
Cancer Centre development	7.8
Wifi in Secondary Care	5.3
Cancer Transformation	0.4
Medical equipment and IT infrastructure replacements	0.4
Total	**23.6**

The programme of capital expenditure was mainly funded by depreciation. The Wifi in secondary care and Cancer Transformation were funded by the Department of Health via the issue of additional Public Dividend Capital and the Cancer Centre development was funded by contributions from Macmillan.

The Trust plans to continue to invest in new assets in 2019/20 including:

- Continued refurbishment of the Learning, Research and Innovation Centre
- Development of the estate, renewal of medical equipment and IT upgrades

Liquid Assets

Group cash holdings amounted to £7.3 million at 31 March 2019. This is a decrease from last year and the balance is held to cover outstanding commitments in April 2019.

Sustainability

Sustainability means, among other things, spending public money well, understanding and implementing the efficient use of natural resources and the building of healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health in the immediate and long term even in the context of the rising cost of natural resources; by demonstrating that we consider social and environmental impacts, and ensuring that the legal requirements in the Public Services (Social Value) Act (2012) are met.

As a public sector body we acknowledge our responsibility towards creating a sustainable future, we achieve that by delivering awareness campaigns to promote the benefits of sustainability to our staff and interested parties, whilst seeking continuous improvement. We are maintaining our ISO14001:2015 environmental management standard status and working closely with external agencies, sharing best practices and widening our network of expertise.

To that end we remain committed to improving the environment not only as a Trust but with our partners in Teesside and North Yorkshire communities. This is demonstrated in our mission statement:

'South Tees Hospitals NHS Foundation Trust is one of the largest Trusts in the North of England and as such is one of the principal healthcare providers and employers. To that end it is imperative that the Trust accepts its responsibility towards the environmental impact it creates by reacting to climate change, and exploiting every opportunity to improve social, economic, and environmental sustainability. As a Trust we have a moral duty of care to ensure we function in the best interests of the local community and as so improve the health and wellbeing of all.'

To achieve this we will continue to improve as a health care organisation, whilst enhancing the workplace for our staff, increasing business opportunities and reducing our carbon footprint. This is all in the context of fulfilling our commitment to delivering high quality care across the Trust.

Sustainability Initiatives

- During 2019 we are looking at increasing the number of our electric charging points at the James Cook site. These have proved to be very popular amongst staff and have assisted in reducing our carbon footprint.
- We have made contact with the Industry Nature Conservation Association (INCA) in order to develop a strategy to encourage wildlife and green spaces at James Cook. This will lead to the establishment of short (20 minute) walks around the site for staff, patients and visitors.
- Work is being undertaken to look at the feasibility of anaerobic digestion at the Friarage Hospital. This could see waste food, currently going to waste, being collected and taken away to be processed into energy for homes and fertiliser for farmers.
- The Friarage has a new domestic waste disposal contract in place which gives us the opportunity for widespread recycling initiatives. This is potentially income generating for the Trust once handling and transport costs are taken in to account. We are also looking at other waste streams such as cardboard, plastics and scrap metal initially and then moving into areas such as Theatres for more specialist recyclable waste streams.

Clinical Waste

The recent national clinical waste issue due to a main waste contractor ceasing trading had an impact on the Trust. However, front line services were maintained and still remain unaffected. Numerous contingencies were put in place well before the contracted service stopped and these interim measures were effective. Whilst the transition to a new service provider is still settling in we are close to having what we consider a normal service. It is anticipated that over the next few months any teething issues will be addressed.

As a result of the impact of this issue we have seen improvements such as establishing an 'in-house' clinical waste service for patients who have their treatment at home. This helped to give the patient a better service and the Trust control over the effective use of resources. It is hoped to take this a stage further later this year by having the waste cardboard and plastic drums collected and brought back to the Friarage Hospital site for recycling.

Energy

Energy usage forms an important part of everyday life within the NHS. In line with our sustainability plan we are committed to reduce our energy usage and carbon emissions. On-going Invest to Save schemes are in place at the Trust to replace conventional lighting with more efficient LED lighting complemented by automatic controls. This is apparent in areas such as the bridge entrance corridor on the James Cook Hospital site which has recently benefited from a lighting upgrade. In addition, all new and lifecycle/upgrading works are complemented with LED lighting, including the Macmillan Centre at the Friarage site and the ward refurbishments at the James Cook site.

Following the decision by the Trust, in principle, to be included in the Middlesbrough District Energy Network, a project led by Tees Valley Combined Authority (TVCA) is well underway to provide detailed information for the design of a new Energy Centre on the James Cook University site. Phase one of this work will be completed by October 2019.

The following chart shows the main consumption figures for Energy on the James Cook and Friarage sites:

The consumption figures show that as a Trust we are managing our Energy consumption. Although this is the case, unit costs are increasing, mainly due the commodity price of each unit of energy increasing but also non-commodity charges and levies are placed on energy costs by the Government. To demonstrate this, although the electricity consumption at the James Cook site decreased by 0.5% against the previous financial year, the cost of energy showed an 11% increase.

The Trust is required by the Environment Agency to partake in the European Union Emissions Trading System (EU ETS), which aims to encourage the reduction of Carbon Emissions. Due to EU exit negotiations, the future of EU ETS is currently uncertain. If the UK is to remain a participant in EU ETS, Phase IV of the scheme is due to begin in January 2021. We will continue to monitor the situation in order to plan for any changes in legislation.

Energy Centre Usage	Site	2018/2019	2017/2018	Variance	Variance %
KWH	JCUH*	43,867,111	43,434,909	432,202	▼ 1%
KWH	FHN*	9,680,506	9,048,792	631,714	▼ 6.7%
Electricity					
KWH	JCUH	25988275.6	25858567	129708.6	▼ 0.5%
KWH	FHN	4636814.3	4564119.8	28032.78	▼ 1.6%

*The James Cook University Hospital, JCUH and Friarage Hospital Northallerton, FHN

We will develop clinical and commercial strategies to ensure our long term sustainability

Integrated Care System

The Trust continues to be an active partner in the development of the Integrated Care System (ICS) which was previously named Sustainability and Transformation Partnerships (STP) with the work ongoing with providers of health and social care; local commissioners; local authorities and specialist commissioners.

The Trust is part of the South Integrated Care Partnership (ICP) which is working with County Durham and Darlington NHS Foundation Trust and North Tees and Hartlepool NHS Foundation Trusts. During 2018/19 the South Integrated Care Partnership partners have been taking forward and building upon the work of the Better Health Programme, and other programmes over recent years to develop proposals for sustainable hospital services in this area. This next phase is the development of the clinical strategy for hospital services for the South of the North East and North Cumbria region.

The clinical strategy for hospital services is a programme of service model development where clinical leaders are developing better ways and new ideas to organise health and care services to help solve some of these challenges, by joining up processes to 'do once' and deliver more with the same resources.

They are also taking into account clinical priorities set out by clinical networks across Northern England such as the Northern Trauma Network, the North East Urgent and Emergency Care Network and the Northern England Neonatal Network, and the work of Local Maternity Systems (LMS).

The first phase of the clinical strategy is looking at the future delivery of a number of key hospital services which are a priority for change - Urgent and Emergency Care, Women's and Children's services (Maternity services , Obstetrics, Gynaecology, Neonatal intensive care and Paediatric services), Frailty and Stroke services, and elective (non-urgent, planned) care for spinal, breast and urology services.

Strategies

We have developed five strategic plans to support our strategic objectives which included: Cancer Services; Services for the Frail Elderly; Trauma Services; End of Life Care; Children and Young People.

Sir Robert Ogden Cancer Centre

Work on our new multi-million pound cancer centre which will expand services at the Friarage Hospital in Northallerton was completed and opened in December 2018. The centre, the Sir Robert Ogden Macmillan Centre, is jointly funded by the North Yorkshire based philanthropist, Macmillan and the Trust.

This new facility is an important part of the development of cancer services at the Friarage, which will help us to ensure the highest quality of care is provided for our patients in a dedicated environment.

Teaching and training

We continue to build our reputation as a leading regional and national provider of health care related education. We have increased the range of staff delivering extended roles and expanded our interdisciplinary learning.

The Medical Education strategy, launched in October 2018, aims to provide an educational environment which facilitates the delivery of excellent clinical care, with trainee focussed high quality training within an inclusive and supportive culture. The strategic goals focus on Undergraduate (medical students, Newcastle University) and Postgraduate medical education (trainee doctors) but the principles are either directly applicable to or have resonance with nursing and our many allied health professionals.

Our Library and Knowledge Service has again achieved 100% compliance with the Library Quality Assurance Framework (LQAF) and won a bid for improving the infrastructure for the library.

Undergraduate education

We continue to host the Tees base for Newcastle University students and, with a £1million investment to refurbish our facilities at James Cook, we are preparing to host 4th year students from September 2020. Work has started to improve the learning environment and improve and expand our simulation facilities.

Following a successful partnership with North Yorkshire GPs, we secured the Hull York Medical School Longitudinal Clerkship for 4th year students, which will involve spending one year at the Friarage and with local GPs, which will help our promotion and recruitment of staff in North Yorkshire.

Postgraduate education

We continue to support the training and development of doctors and continue our strong military medical and nurse training presence linked with the Joint Hospital Group North.

We have retained our position in the top national quartile (46th) for GMC survey results and been highlighted in other surveys for our excellent supervision and support of our training doctors. Educationally, we were the best performing large acute hospital Trust in the region.

Our regional review by the GMC in late 2018 highlighted the excellent consultant support to doctors in training, our positive learning culture and the very high quality of the majority of our induction programmes.

We continue to increase the volume of our simulation activity, supported by investment in our anaesthetic/critical care educational infrastructure by Health Education England North East and Cumbria.

Our hospital is one of the flagship centres for providing the Practical Assessment of Clinical Examination (PACES) exam, on behalf of the Membership of the Royal Colleges of Physicians of the United Kingdom MRCP (UK), and in the last three years, the number of candidates taking the exam has increased by as much as 50%.

Academia and Research

We are committed to the development and delivery of high quality research. In 2018/19 we were the second largest recruiter in the North East in 'complexity-adjusted' recruitment and recruited to the second highest number of clinical research studies in the North East. We are aligning our research strategy with North Tees and Country Durham and Darlington NHS Foundation Trusts within a newly developed Durham and Tees Valley Research Alliance (DTVRA). This will provide greater opportunities and access to research for our patients and realise efficiencies across the organisations, enabling us to offer a greater range of research opportunities to a larger number of patient groups across the Tees Valley.

We work with a range of partners including the Academic Health Science Network (AHSN) and the Local Clinical Research Network (LCRN) for the North East and North Cumbria. We have built on existing university collaborations providing support for our researchers and innovators, allowing them to secure funding for a range of projects that have benefitted our patients. We continue to work within the Northern Health Science Alliance (NHSA) which links eight universities and eight NHS teaching trusts with the AHSN, covering a population of over 15 million people.

This initiative brings together research, health science innovation and commercialisation to provide benefits for researchers, universities, hospitals, patients as well as commercial partners. We are also part of the National Institute for Health Research's Applied Research Collaborations (ARC), which drives research and turns findings into practice.

Over the next 5 years our ambition is to grow the research currently undertaken in the trust, with exciting projects such as the DVTRA supporting the expansion of our research portfolio and academic reputation. The trust aspires to be a leading regional and national provider of safe, innovative, high quality care that is underpinned by a research-led clinical evidence base.

Innovation

Throughout the year our innovation team have worked with the Teesside Health Innovation Partnership and commercial partners on projects that will allow the ideas originating from the trust's healthcare teams to be transformed in to treatments, technologies and medicines for our patients.

In 2018/19, we were part of innovation partnerships awarded grants with an overall value of €3.9m from European Union's Horizon 2020 fund.

Trust Charity

We would like to take this opportunity to thank all of our charity partners, our volunteers, our carers, our staff and our local communities for their continued support!

By organising some amazing fundraising events, giving donations, competing in some spectacular and testing activities and giving up valuable spare time you've allowed us to enhance the services and environment of the Trust and supported our mission.

Our patients, their friends, family and relatives, as well as our staff, our charity partners and members of the public come together to support us with all this effort. We are delighted to report that in 2018/19 our voluntary donations were £630,000 showing a 2% increase on last year. Investment income remains largely similar at £194,000.

Last year we were able to make a difference to patients by spending almost £100,000, on their welfare and improving the clinical environment, this is an increase of £40,000 on the previous year. We have supported the purchase of 100 pieces of medical equipment at a cost of £700,000, as well as improving patient experience by providing free TV on a number of wards and adding those extra personal touches to many day and waiting rooms. Investment in our people to enhance education and development was £112,000 and this continues to be a key priority.

The total income was £1,670,000 in 2018/19, a reduction of £84,000 when compared with the last financial year. This is largely due to a £206,000 reduction in legacy income, partially offset by an increase in grant income of £98,000.

Following an external review, we are delighted to report that we are performing within the top 25% of charities associated with NHS Trusts of a similar size. This ranks us fourth highest income generators with some of the lowest costs of all the charities in this group.

We have some exciting new strategic growth plans for the coming year. We will review, streamline and enhance our processes, increase our presence and profile with some corporate partnership working; and we will continue to work closely with our teams, our charity friend organisations and our supporters.

Investments

There are no significant differences between the carrying amount and the market value of the Trust's investment holdings.

Insurance cover

The Trust has not arranged specific insurance to cover the risk of legal action against its directors over and above what is covered by the NHS Litigation Authority.

2018/19 Consultations

The Trust did not undertake any public consultations during 2018/19. We are committed to working in partnership with stakeholders within our health economy and the Board aims to work at creating and maintaining good relationships and recognises the importance of engagement.

During 2018/19, the Trust worked closely with its local commissioners, local authorities, local Trusts, local networks, Newcastle University and Teesside University, the Health and Wellbeing Board, Overview and Scrutiny Committee as well as other partners to develop an integrated health service to meet the needs of the patients. In addition regular meetings have taken place with Members of Parliament who represent the Trust's catchment areas.

Overseas operations

The Trust has no overseas operational activity and has received no commercial income from overseas activity during the year.

Better Payment Practice Code

Unless other terms are agreed, we are required to pay our creditors within 30 days of the receipt of goods or a valid invoice, whichever is later. This is to ensure that we comply with the Better Payment Practice Code. The Trust's performance against this metric is shown as follows:

Non NHS	NHS
Target: 95%	Target: 95%
Result by number: 59%	Result by number: 77%
Result by value: 71%	Result by value: 72%

The relatively small number and high value of NHS invoices means that a small number of late paid NHS invoices can result in dramatic shifts in the percentage paid on time. A detailed breakdown of the figures is shown below:

	2018/19		2017/18	
	Number	£000	Number	£000
Total non NHS trade invoices paid in the year	78,590	301,820	90,150	275,430
Total non NHS trade invoices paid within target	46,620	213,538	24,259	137,082
% of non NHS trade invoices paid within target	59%	71%	27%	50%
Total NHS trade invoices paid in the year	3,340	13,080	2,000	19,090
Total NHS trade invoices paid within target	2,569	9,372	904	11,910
% of NHS trade invoices paid within target	77%	72%	45%	62%

Interest paid under the Late Payment of Commercial Debts (Interest) Act 1998 amounted to £26,458.

Annual Accounts

A full set of accounts has been prepared on a going concern basis and will be submitted to Parliament with the Annual Report by 19 July 2019. The accounts included within the Annual Report were prepared under schedule 7 of the National Health Service Act 2006 (paragraphs 24 and 25) and in accordance with directions given by NHS Improvement.

For the purpose of the Annual Report, the Trust is referred to as a separate entity with the exception of any reference to Group information which includes South Tees Hospitals Charity and Associated Fund. The Trust formed the South Tees Institute of Learning, Research and Innovation Limited Liability Partnership and South Tees Healthcare Management Limited and the transactions of these companies have not been consolidated within the Accounts on the basis of materiality.

Performance Analysis

Strategic direction (looking forward)

Looking ahead to 2019/20 we have developed an Annual Plan to build on our strategic objectives whilst incorporating the Five Year Forward View and NHS Mandate.

The Executive Directors have prepared the 2019/20 budget following robust analysis of the key operational priorities and risks.

Our budget planning assumptions included identifying additional savings opportunities whilst negotiating with NHS Improvement on the level of Control Total for 2019/20. Following this review the Chief Executive and the Executive Team identified productivity and efficiency initiatives (£26.8m net) to address the Trust's financial gap. These productivity and efficiency plans were presented and approved by the Finance and Investment Committee with the Board accepting the revised Control Total offer from NHS Improvement for 2019/20.

The Trust is working within the South ICP to deliver a further £20m of additional productivity and efficiency savings, in order to achieve the Trust's financial targets. The total required system targets across the Tees Valley equates to £62m.

The Board prepared budgets on the basis of the delivery of financial targets to place the Trust on a sustainable financial footing whilst ensuring the delivery of associated operational performance targets.

At the same time as working hard to achieve financial stability, the Board will continue to focus on the quality of the services we deliver, on developing and retaining a high-quality workforce and on playing a leading role in the wider health and social care system to which we belong.

Quality continues to drive our strategy. Our Executive Medical Directors and Director of Nursing and Quality promote a quality-focused culture throughout the Trust. Our patient safety priorities will include improved recognition and reporting of patient safety issues, developing our patient experience programme and improving clinical effectiveness by ensuring patients have a safe, effective and timely discharge. We are driving standardisation through our operational processes and implementing new operating standards for all our clinical services, underpinned by clear and consistent performance and quality measures.

Through the delivery of our medical education strategy we will be expanding our undergraduate and post graduate training facilities welcoming more students to our Trust. The newly developed Durham and Tees Valley Research Alliance (DTVRA) will provide greater opportunities and access to research for our patients.

We are an important part of a wider health and social care economy. We will continue to be an active partner in the development of the South Integrated Care Partnership to develop and deliver clinical strategies for hospital services, developing better ways and new ideas to provide patient care across the Tees Valley. We are therefore playing a key role in pushing for efficiency gains and quality improvements.

Counter fraud

We have established an anti-fraud service which is provided by Audit One. Our local counter fraud service works in line with standards issued for providers by NHS Protect relating to fraud, bribery and corruption.

Audit One lead on delivering a proactive and reactive programme of work with the Counter Fraud team who prepare a risk based plan each year based on risks identified locally, nationally and those arising from the NHS Protect quality assessment process. Work completed by our Internal Audit team provides assurance over the key financial controls and highlights any areas where the Trust may be exposed to the risk of fraud.

Going concern

The Trust has prepared its 2018/19 Annual Accounts on a Going Concern basis. 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.

The day to day operations of the Trust are funded from agreed contracts with NHS commissioners. The uncertainty in the current economic climate has been in part mitigated by agreeing contracts with Clinical Commissioning Groups and NHS England for a further year and these payments provide a reliable stream of funding reducing the Trust's exposure to liquidity and financing problems.

The Trust's budget and expenditure plans have been prepared using national guidance on tariff and inflationary factors with income based on agreements with Commissioners. These plans outlined a surplus control total in 2018/19 of £3.8m, including Provider Sustainability Funding (PSF).

The Trust has set challenging efficiency targets in 2018/19 which included a Cost Improvement Plan of £35.6m. In 2019/20 the target has initially been set at £33.2m and the Trust believes that this forward plan provides a challenging but realistic assessment of the Trust's position.

The Trust has historically received support through the Department of Health from 2014/15 through to 2017/18. The Trust has utilised Interim Revenue Support during 2018/19 in the form of short term borrowing to cover PSF. During the year the Group received new loans of £9.0m and made loan repayments of £9.8m. The Trust delivered its Control Total in 2018/19 and received confirmation that Incentive and Bonus PSF amounting to £9.5m will be paid to the Trust in 2019. The Trust has not included a requirement for Interim Revenue Support in the 2019/20 Annual Plan submission but is in discussions with NHS Improvement over the submission of a request for Capital Support to cover essential replacements and loan repayments of £55.0m which fall due for repayment in 2019/20. The operational stability of the Trust is dependent on the Trust achieving the 2019/20 Efficiency Plan and the Trust believes that this Plan is challenging but realistic.

Notwithstanding the above the Group recorded a deficit for the year of £30.9m and showed a reduction in cash and cash equivalents of £2.6m. The balance sheet shows net current liabilities of £0.6m which includes aggregate loans from the Department of Health and Social Care (DHSC) totalling £55.0m repayable in 2019/20. The Group is forecasting a deficit of £0.6m for the year ending March 2020 and will require on-going loan support from DHSC together with non-repayment of current funding in order to meet the future financial obligations of the group.

The Group has not been notified by any relevant national body of any intention to dissolve the Group or to transfer services to another public sector body. Based on recent discussions and past experience the Trust believes that the loans of £55.0m from DHSC will not be required to be repaid when they fall due for payment and that they will continue to be made available to the Group or replaced by new funding. The Group also believes that if further funding support is required in 2019/20 this will be made available. As with any Trust placing reliance on the DHSC for financial support, the directors acknowledge that there can be no certainty that this support will continue although, at the date of approval of these financial statements, they have no reason to believe that it will not do so.

Based on the above factors the Directors believe that it remains appropriate to prepare the financial statements on a going concern basis. However, the above factors give rise to a material uncertainty which may cast doubt on the Group's and the Trust's ability to continue as a going concern and, therefore, to continue to realising its assets and discharging its liabilities in the normal course of business. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate.

2 Accountability Report


THE SIR ROBERT OGDEN
WE ARE MACMILLAN. CANCER SUPPORT

Director's Report

It is the responsibility of the Directors of South Tees Hospitals NHS Foundation Trust (STHFT) to prepare the Annual Report and Accounts. The Board of Directors considers that the Annual Report and Accounts taken as a whole are fair, balanced and understandable, providing the information necessary for the public, patients, regulators and other stakeholders to assess STHFT's performance, business model and strategy.

Every NHS Foundation Trust has its own governance structure. The basic governance structure of a NHS Foundation Trust includes:

- Membership
- Council of Governors
- Board of Directors

This structure is well developed at STHFT, and can be found within STHFT's Constitution at: www.southtees.nhs.uk

STHFT is headed by a Board of Directors with responsibility for the exercise of the powers and the performance of the NHS Foundation Trust. In addition to the basic governance structure, STHFT makes use of its Board Committees and Executive Groups which comprise of directors and senior managers as a practical way of dealing with specific issues.

Signed:

Date: 20 June 2019

Siobhan McArdle
Chief Executive & Accounting Officer

Signed:

Date: 20 June 2019

Alan Downey
Chairman

Foundation Trust Membership

We involve our Governors who represent the members from STHFT's constituent areas in developing our forward plans. By involving Governors in designing services and improving care we ensure that the views of local people are being heard and we enhance the experience of patients, carers, visitors and staff.

On 1 April 1992 our original membership was established and since then we have worked to maintain and engage with our representative membership. During 2018/19 we established a Membership and Engagement Committee to help further improve our member engagement. This Committee has approved a Membership and Engagement Strategy which will support STHFT's overarching Communication and Engagement Strategy. Engaging with members and the public ensures that the views of local people and those further afield are taken into account; this helps to improve the experience of our patients, visitors and staff.

Most recently a Governor Task and Finish Group was established which reviewed STHFT's Constitution and made recommendations to the Council of Governors concerning changes to meet legal and regulatory requirements as well as changes to membership constituent areas.

Our membership consists of public and staff and is described in more detail below:

Public members

We have 4,721 public members covering Middlesbrough, Redcar and Cleveland, Hambleton and Richmondshire and the remainder of the United Kingdom.

A member of the public who is 16 years of age or over and lives within STHFT's public constituent areas or who has been a patient and/or carer within the last 10 years can become a member of our Trust for one of the following areas:

- Middlesbrough
- Redcar and Cleveland
- Hambleton and Richmondshire
- Rest of England
- Patient and/or Carer

Staff members

When joining STHFT a staff member on a contract of more than 12 months automatically becomes a member unless they choose to opt out. This staff constituency also includes: Endeavour SCH Plc; Sovereign Hospital Services replaced by Serco during the year; Middlesbrough Council Hospital Social Work Team; and Cambridge Perfusion Services.

The tables below provide details of STHFT's membership:

Constituency	Actual 31 March 2019	Actual 31 March 2018
Staff	8,655	8,953

Public Constituency	Actual 31 March 2019	Actual 31 March 2018
Middlesbrough	1,288	1,319
Redcar and Cleveland	1,309	1,333
Hambleton and Richmondshire	1,264	1,269
Rest of England	290	313
Patient and/or Carers	570	574

Public membership Age (years)	Number of members (31 March 2019)	Eligible membership
16-21	14	24,715
22-65	1,575	199,603
66+	2,408	113,885
Unknown	724	-

We communicate and engage with our members, patients, carers and volunteers by a variety of ways, these include:

- Membership and Staff newsletter
- STHFT website
- Local media
- Annual Members meetings

As part of the on-going work across the Tees Valley we have worked closely with our partnership organisations, including Middlesbrough Council, Redcar and Cleveland Council, North Yorkshire Council, South Tees CCG, Richmondshire and Whitby CCG, Durham University, Newcastle University, Teesside University, Healthwatch and many other organisations across the third sector. We have plans to engage further with all our membership and key stakeholders.

Further information on membership and how to communicate with Governors can be found on our website: www.southtees.nhs.uk/about/membership or email: stees.foundation.trust@nhs.net

Council of Governors

Our Council of Governors has a membership of 33; five represent Middlesbrough; five Redcar and Cleveland; five Hambleton and Richmondshire; one Rest of England; two Patient and/or Carers; three staff; and 12 represent our partner organisations.

The Council of Governors directly represents members of the public, staff, and other stakeholders and forms an integral part of our governance structure.

The Council of Governors has a number of statutory duties. The Governors appoint the Non-executive Directors, including the Chairman, to STHFT's Board of Directors. They also have a key role in holding Non-executive Directors individually and collectively to account for the performance of the Board whilst representing the interests of STHFT's members.

The Council of Governors collectively has responsibility for supporting STHFT in taking account of the views of its members when developing forward plans and services. Our Governors were engaged with the formation of STHFT's operational plan for 2019/20 and continued to form part of the Friarage Hospital working group which has been looking at the services provided at the Friarage Hospital.

Other statutory duties of the Council of Governors include:

- Appointment and removal of the Chairman and other Non-executive Directors
- Approving the appointment of the Chief Executive
- Deciding the remuneration of the Chairman and Non-executive Directors
- Appointment and removal of STHFT's External Auditors
- Receiving STHFT's Annual Report and Annual Accounts
- As necessary make recommendations and/or approving revisions to STHFT's Constitution
- Approval of significant transactions;
- Approval of an application by the Foundation Trust to enter into a merger, acquisition, separation or dissolution
- Review of STHFT's membership and engagement arrangements

There were a number of changes to the Council of Governors during 2018/19 including elections that were held. Details of the composition and changes that occurred are described in the following table:

Governor	Constituency	Term of Office	Number of Terms	Term due to end/ended	Council of Governor Meeting Attendance
Public Elected Governors					
Ann Arundale	Middlesbrough	3 years	1	30.11.19	9/9
Rebecca Hodgson	Middlesbrough	3 years	1	30.11.19	5/9
Jean Milburn	Middlesbrough	3 years	1	31.03.21	9/9
Carolyn Newton	Middlesbrough	3 years	2	30.11.19	5/9
Alison Munkley	Middlesbrough	3 years	1	31.03.21	5/9
Barbara Hewitt	Redcar and Cleveland	3 years	1	31.03.21	7/9
[1]	Redcar and Cleveland	3 years	1	12.03.19	2/9
Allan Jackson	Redcar and Cleveland	3 years	1	31.03.18	7/9
John Race	Redcar and Cleveland	3 years	2	31.03.18	8/9
Plym Auty	Hambleton and Richmondshire	3 years	3	31.03.21	9/9
Janet Crampton	Hambleton and Richmondshire	3 years	2	31.11.19	5/9
David Hall	Hambleton and Richmondshire	3 years	1	31.03.21	9/9
Graham Lane	Hambleton and Richmondshire	3 years	1	31.03.20	5/9
Mike Holmes	Hambleton and Richmondshire	3 years	1	30.11.19	7/9
Angela Seward	Rest of England	3 years	2	30.11.19	9/9
[2]	Patient/Carer	3 years	1	12.07.18	1/1
Tink Wedgewood-Jones	Patient/Carer	3 years	1	31.03.21	7/9
Staff Elected Governors					
Stuart Finn	3 years	1	31.03.19	5/9	
Jonathan Broughton	3 years	2	31.03.19	8/9	
[3]	3 years	1	20.06.18	2/2	

Under Article 21 of the General Data Protection Regulation the names have been excluded for 1-3 above

[1] left the Trust 12 March 2019
[2] resigned 12 July 2018
[3] left the Trust 20 June 2018

Appointed/Partnership Governors

Governor	Partner Organisation	Date appointed	Council of Governor meeting attendance
Abigail Barron[1]	Hambleton, Richmondshire and Whitby CCG	March 2017	5/9
Erik Scollay	Middlesbrough Council	January 2017	2/9
Cllr Caroline Dickinson	North Yorkshire Council	July 2017	8/9
Lynn Pallister	Redcar and Cleveland Council	October 2015	1/9
Dr Adetayo Kasim	Durham University	April 2017	5/9
Dr Stephen Jones	Newcastle University	January 2016	7/9
Anne Binks	Teesside University	December 2015	4/9
Julia Bracknall	Carer Organisation	April 2018	8/9

[1] Left Hambleton, Richmondshire and Whitby CCG in March 2019 and appointed governor term ended

Governor Elections

During 2018/19 there were no Governor elections held. Elections to fill the 6 Governor vacancies (3 staff; 2 Redcar and Cleveland; and 1 Patient and Carer vacancies) are due to be completed by the end of May 2019.

Council of Governor Meetings

From 1 April 2018, the Council of Governors met on 9 occasions which included five meetings held in public and five meetings held in private:

- 8 May 2018
- 10 July 2018
- 9 October 2018
- 11 December 2018
- 12 March 2019

Council of Governor Committees

The Council of Governors delegates some of its powers to Committees of Governors and these matters are described within STHFT's Constitution which includes the Nomination Committee.

Further details on the workings of the Nomination Committee can be found within the Remuneration Report.

The Council of Governors established other groups including the Membership and Engagement Committee as mentioned previously in this section of the report, Annual Operating Plan Group, the Constitution Working Group, Quality Account Group, Smoke Free Working Group, Governors Friarage Working Group with representation on the Friarage Clinical Steering Group. Governors also participated in PLACE assessments and Governor Drop-in sessions across out-patient departments.

The Annual Operating Plan Group met to consider STHFT's Operational Plans and review the development of the 2019/20 Operational Plan prior to its approval by the Board and submission to STHFT's regulator, NHS Improvement.

Governor training and development

During the year Governors have been provided with access to a range of training and development opportunities to further support them in their role. These included inductions and learning and educational sessions held prior to Council of Governor meetings. A number of our Governors including our Lead Governor attended a NHS Providers training event, after which they shared their learning with fellow Governors at the March 2019 Council of Governor meeting.

There are a number of ways members of STHFT and members of the public can communicate with the Council of Governors:

Telephone: 01642 854151
Email: stees.foundation.trust@nhs.net

Write to your Governor at:
Membership Office
STHFT
The Murray Building
James Cook University Hospital
Marton Road
Middlesbrough
TS4 3BW

The Board of Directors relationship with the Council of Governors

The Board of Directors and Council of Governors seek to work together effectively in their respective roles. During the year, the Lead Governor has worked closely with the Chairman and Company Secretary to review all relevant issues which are taken into consideration to produce agendas for meetings of the Council of Governors. The Executive and Non-executive Directors were invited to attend meetings as observers and take part when required.

STHFT's Governors are encouraged to attend the Board meetings held in public to gain a broader understanding of discussion taking place at Board level, to observe the decision making processes and to understand how Non-executive Directors challenge and support Executive Directors.

Declaration of Interests of the Council of Governors

All Governors are required to comply with the Council of Governors Code of Conduct which includes a requirement to declare any interests that may result in a potential conflict in their role as Governor of STHFT. At every meeting of the Council of Governors there is a standing agenda item which requires Governors to make known any interest in relation to agenda items and any changes to their declared interests.

The Register of Governor's interests is held by the Company Secretary and is available for public inspection via the following address:

Membership Office
STHFT
The Murray Building
James Cook University Hospital
Marton Road
Middlesbrough
TS4 3BW

Board of Directors

The Board of Directors operates to the highest corporate governance standards. It is a unitary Board with collective responsibility for all areas of performance of STHFT, including clinical, operational and financial performance, governance and management.

The Board is legally accountable for the services provided by STHFT and has the following key responsibilities:

- Setting the strategic direction of STHFT whilst taking into account the views of the Council of Governors'
- Ensuring adequate systems and processes are in place to deliver STHFT's Annual Operational Plan
- Ensuring that services provided are safe, and clean, and that personal care is provided to patients
- Ensuring robust governance systems and processes are in place supported by an effective assurance framework that supports sound systems of internal control;
- Ensuring rigorous performance management to ensure STHFT achieves local and national targets
- Measuring and monitoring STHFT's efficiency and effectiveness
- Continuous improvement;
- Exercising its powers established under statue, as described in STHFT's Constitution which is available at: www.southtees.nhs.uk

The Board of Directors has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. It has also resolved that some powers are delegated to a Committee of Directors. The powers and decisions of the Board and the Council of Governors are set out in the Standing Orders, Reservation of Powers to the Board and Scheme of Delegation.

Further details on the workings of the Statutory Board Committees (Remuneration Committee and Audit Committee) can be found within the Remuneration Report. In addition to the Statutory Board Committees, STHFT has additional Executive Operational Groups which were reviewed as part of the independent Well-led review.

The Board ensures that the interests of patients and the local community are represented by working groups in place within and outside of STHFT. These are in addition to the Council of Governor Committee structure.

Board composition and balance

The Board consists of individuals with an 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 assesses the Board's performance.

Board of Director Meetings

The Board held five of its meetings in public and resolved that, due to the confidential nature of business to be discussed, a further 13 meetings should be held in private.

All Board members have annual performance appraisals. The Chairman carries out the appraisals for Non-executive Directors and the Chief Executive. The Senior Independent Director carries out the annual performance appraisal for the Chairman: in order to gather input into the Chairman's appraisal she meets with Governors, the Non-executive Directors, and meets separately with the Chief Executive.

The collective performance of the Board is evaluated through discussions and evaluation at Board development sessions, through review of the Board Assurance Framework and through independent reviews such as the independent well-led review of Board governance. The outcome of the re-review resulted in improvements which are explained in the Annual Governance Statement.

Board of Directors Profiles

Non-executive Directors

Mr Alan Downey
Chairman

Alan began his career as a Civil Servant in 1981, gaining experience in a wide range of policy areas and working closely with Ministers. He left the Civil Service in 1989 to join KPMG as a management consultant and was promoted to partner in 1997. Over his 25 year career with KPMG he held various Board level positions including Chief Operating Officer of the company's UK consulting business and Chair of KPMG's public sector practices across Europe, the Middle East and Africa. Following his retirement from KPMG in June 2014 he was for four years a Non-executive Director at South London and Maudsley NHS Foundation Trust and for three years a member of the Charity Commission's Audit and Risk Committee.

Appointed as Chair Designate from 1 January 2018 and
Chairman from 1 April 2018 for a three year term

Mrs Amanda Hullick
Non-executive Director/Deputy Chair

Amanda commenced as a Non-executive Director at the Trust in September 2014 after an international career in human resources and organisational development. Amanda worked at a senior level in a number of major private companies including Shell, ICI and Rolls Royce. In the public sector Amanda worked for British Rail and was instrumental in the work carried out to privatise the national rail service. Amanda is Australian by birth, married with two children and lives in York.

Appointed 1 September 2014 for a three year term
Reappointed 1 September 2017 for a further three year term
Acting Chair from 14 December 2016 to 31 March 2018 to cover during the Chair's absence.

Mrs Maureen Rutter
Non-executive Director/ Senior Independent Director

Maureen is a registered nurse with an MBA and post graduate qualifications in teaching and palliative care. Following working in the NHS for 25 years Maureen worked in the voluntary sector as a Director of Macmillan Cancer Support responsible for East Midlands and the North of England and later Direct Services UK wide. Maureen was an appointed Governor of the Trust prior to her becoming a Non-executive Director of the Trust.

Appointed 2 September 2013 for a three year term
Re-appointed 1 September 2016 for a further three year term
Acting Deputy Chair from 14 December 2016 to 31 March 2018

Non-executive Directors

Mr Richard Carter-Ferris

Non-executive Director

Richard is a Chartered Accountant and an experienced finance professional having worked at a senior level in a number of large businesses. Richard's previous roles included Director of Internal Audit at Asda Wal Mart, Global Financial Controller for GE Plastics, Finance Director of National Express East Coast and Finance Director of Vantage Airport Group. He is a self-employed consultant proving financial and non-executive support to a range of clients.

Appointed 1 August 2015 for a three year term

Reappointed 1 August 2018 for a further three year term

David Heslop

Non-executive Director

David has decades of experience developed in the finance and insurance industry. David became Director for the Teachers' Pension Scheme at Capita in 2015. Prior to joining Capita, David was a Chief Operating Officer for the Pension Protection Fund and had a 20 year career at Aviva, one of the UK's largest insurance and savings groups. David read statistics at City University and is a Fellow of the Royal Statistic Society and the Institute of Actuaries.

Appointed 1 August 2015 for a three year term

Reappointed 1 August 2018 for a further three year term

Jake Tompkins

Non-executive Director

Jake has worked in the subsea construction industry for nearly 20 years, providing services internationally to major operators and contractors. In 2008 Jake established Darlington based Modus Seabed Intervention, now one of the subsea sectors leading providers of autonomous and remotely operated vehicle services. Jake has a particular focus on technology and innovation and is a Non-executive director for a number of private, public and third sector organisations.

Appointed 1 December 2016 for a three year term (left the Trust on 1 April 2019)

Non-executive Directors

Mike Ducker

Non-executive Director

Mike has over 30 years' experience in the petrochemicals manufacturing industry on Teesside with ICI, Huntsman and SABIC. Mike has worked across a broad range of functions from operations to human resources within the Tees Valley, and spent 10 years as the Chairman of the SABIC UK Pension Fund. He is a trustee of two UK charities, and an advisor to the UK Government on chemicals sector resilience. Mike lives near Thirsk, North Yorkshire.

Appointed 1 February 2018
for a three year term

Debbie Reape

Non-executive Director

Debbie is a registered general nurse and a registered sick children nurse who has worked in the NHS for 38 years in a number of senior nursing and management roles. Debbie joined the Trust as a Non-executive director following on from her retirement in 2017 from Northumbria Healthcare NHS Foundation Trust where her last role was as Executive Director of Nursing. Debbie lives in Newcastle Upon Tyne and has one son.

Appointed 1 November 2018
for a three year term

Executive Directors

Siobhan McArdle

Chief Executive and Accountable Officer

Siobhan was previously the Trust's Director of Transformation from April 2015. Prior to that Siobhan worked as a management consultant working nationally and internationally on strategy development, performance improvement , turnaround and transformational change in partnership with large global corporate organisations, high growth SMEs and public sector organisations including the NHS.

Appointed Interim Chief Executive on 1 October 2015

Appointed Chief Executive on 1 April 2016

Adrian Clements

Deputy Chief Executive/ Medical Director for Urgent and Emergency Care

Adrian commenced as a Consultant in Accident and Emergency Medicine in March 2001 and has served as Clinical Director for nine years before commencing the role of Medical Director for Urgent and Emergency Care on 1 April 2016.

Appointed voting director on 1 April 2016

Commenced as Deputy Chief Executive on 1 December 2017

Gill Hunt

Director of Nursing and Quality

Gill was appointed as the director of nursing / director of infection prevention and control in November 2015 having previously had the role of deputy director of nursing within the Trust. With 29 years' experience in the NHS, Gill has held a number of senior nursing and management posts in the region and is also currently the Board lead for safeguarding.

Appointed voting director as Director of Nursing on 26 November 2015

Executive Directors

David Chadwick

Medical Director for Planned Care

David has worked as a Consultant Urologist in the Trust for over 20 years and is the Clinical Lead for Prostate Cancer and Robotic Surgery. David's previous roles included Clinical Director of Urology and Chief of Service for the Surgical Services Centre.

Appointed voting director on 1 April 2016

Sath Nag

Medical Director for Community Care

Sath is a Consultant in Acute Medicine, Diabetes and Endocrinology. Sath has held previous posts of Deputy Medical Director and Clinical Director for the Diabetes and Endocrine Directorate.

Appointed voting director on 3 May 2016

Andrew Owens

Medical Director for Corporate Clinical Centre Board

Andrew was appointed Consultant Cardiac Surgeon at South Tees in 2002 and has served as Clinical Director for Cardiothoracic Surgery and Director of R&D. He holds a substantive academic position at the Institute of Genetic Medicine in Newcastle University and has previously been an executive member of the Society for Cardiothoracic Surgery in UK and Ireland and the NIHR Clinical Research Network North East and North Cumbria.

Appointed voting director on 1 November 2018 following the Board restructure.

Executive Directors

Steven Mason

Director of Finance

Steven is a qualified Chartered Certified Accountant and has 35 years' experience of working mainly in health and local government. Prior to joining the Trust Steven was Chief Executive and Director of Finance at Northumberland County Council. Steven formerly had been Chief Executive and Director of Finance at North Durham Hospital and Deputy Finance Director at the Royal Victoria Infirmary.

Appointed voting director from 1 October 2017

Board of Director Attendance

Non-executive Directors		Board Attendance 2018/19
Alan Downey	Chair Designate from 1.01.18 to commencing as Chairman on 1.04.18	16/18
Amanda Hullick	Vice Chair/Non-executive Director (Acting Chair from 14.12.16 - 31.03.18)	18/18
Maureen Rutter	Senior Independent Director/Non-executive Director	17/18
Richard Carter-Ferris	Non-executive Director	14/18
David Heslop	Non-executive Director	17/18
Jake Tompkins	Non-executive Director	3/18
Mike Ducker	Non-executive Director	13/18
Debbie Reape[1]	Non-executive Director	5/7

[1]Debbie Reape appointed 1 November 2018

Independence of Non-executive Directors

The Board of Directors determine whether each Non-executive Director is independent in character and judgement and whether there are any relationships or circumstances which are likely to affect, or could affect, the Director's judgement. None of the current Non-executive Directors have served more than six years at STHFT and they have been members only of the Board and Board Committees and have not been members of STHFT's management or executive groups and therefore have retained significant independence from operational management of STHFT. Further details on Directors' independence can be found within the Foundation Trust Code of Governance section of this report.

Executive Directors		Board Attendance 2018/19
Siobhan McArdle	Chief Executive	16/18
Adrian Clements	Deputy Chief Executive	16/18
Steven Mason	Director of Finance	14/18
Gill Hunt	Director of Nursing	16/18
David Chadwick	Medical Director for Planned Care	17/18
Sath Nag	Medical Director for Community Care	15/18
Andrew Owens[1]	Medical Director for Corporate Clinical Support Services	6/7

[1]Andrew Owens appointed as a voting member from 1 November 2018

NHS Improvement's Well-led Framework

During 2016/17 the Board commissioned an independent Well-led Review. Since that time STHFT has made significant improvements to its Board governance. This resulted in NHS Improvement removing the enforcement for Board governance and Clostridium difficile with a compliance certificate issued by NHS Improvement in October 2017; and a revised enforcement undertaking issued to supersede the previous undertaking relating to financial sustainability. Further plans to ensure STHFT meets NHS Improvement's Well-led framework is included within the Annual Governance Statement.

Declaration of Interests of the Board of Directors

An annual review of the Board of Director's Register takes place alongside the annual review of the Fit and Proper Person Regulation assessment. This is in addition to any changes to Directors interests declared at the next routine meeting following the change to their interests. During the year STHFT put in place a revised policy for the collection of interests which includes the Board of Directors and all decision making staff.

The Board of Directors has a standing agenda item which requires Executive and Non-executive Directors to declare any interest in relation to agenda items and any changes to their declared interests.

The Register of Board interests is available for public inspection via STHFT's website or from the following address:

Company Secretary
STHFT
The Murray Building
James Cook University Hospital
Marton Road
Middlesbrough, TS4 3B

Statutory statement required within the Directors Report

STHFT has complied with the cost allocation and charging requirements set out in the HM Treasury and Office of Public Sector Information guidance.

A statement describing adoption of the Better Practice Code is included within the Annual Accounts. Income disclosures as requested by Section 43 2(A) of the NHS Act 2006 are included within the financial performance section of the Performance Report.

All Directors of STHFT have undertaken to abide by the provisions of the Code of Conduct for Board level Directors; this includes ensuring that, at the time that this Annual Report is approved:

- So far as each Director is aware, there is no relevant audit information of which the Trust's auditor is unaware; and
- Each Director has taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

The provisions of the Code of Conduct also require each Director to confirm, they have undertaken all the steps that they ought to have taken as a Director in order to do the things mentioned above and:

- Made such enquiries of their fellow Directors and of the company's auditors for that purpose; and
- Taken such other steps (if any) for that purpose, as are required by their duty as a Director of the company to exercise reasonable care, skill and diligence.

Annual Remuneration Report

Annual Statement on Remuneration

We present to you the Directors' Remuneration Report for the financial year 2018/19.

The Nomination Committee is established by the Council of Governors to deal with Non-executive Directors remuneration and terms of office.

The Remuneration Committee is established by the Board of Directors and deals with the remuneration and terms of service for the Executive Directors and any other such senior managers.

The Remuneration Report includes the following:

- Senior Managers' Remuneration policy
- The Annual Report on Remuneration including Directors' service contract details and Governance requirements including Committee membership; attendance and business conducted during 2018/19

Major Decisions on Remuneration in 2018/19:

STHFT's Remuneration and Nomination Committees both aim to ensure that Executive and Non-executive Directors' remuneration is set appropriately. The Remuneration Committee takes into account relevant market conditions to ensure Executive Directors are appropriately rewarded for their performance against goals and objectives linked directly to STHFT's objectives and that their pay is reasonable and comparable to other Executive Director pay.

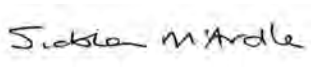
After careful consideration of national guidance, benchmarking and satisfactory appraisals, these Committees decide what level of increase in remuneration is appropriate to ensure any increase is fair and reflects benchmarking of Executive and Non-executive pay across the NHS.

During 2018/19 the Committees:

- Approved the appointment of Debbie Reape as a Non-executive Director from 1 November 2019
- Reviewed the remuneration for Non-executive Director positions and approved an increase to the Senior Independent Director position to reflect the additional duties this role covers;
- Approved the revised Board structure
- Set and reviewed the Chief Executive's and Executive Directors objectives and performance;
- Received senior manager appointment and termination updates
- Approved the Chief Executive and Senior Leadership Remuneration Review which resulted in additional payments made to the Chief Executive and Director of Nursing and Quality;
- Approved the appointment and remuneration for the Director of Finance

The Nomination and Remuneration Committees fulfil their responsibilities and report to either the Board of Directors or the Council of Governors.

Signed:



Date: 20 June 2019

Siobhan McArdle
Chief Executive &
Accounting Officer

Signed:

Date: 20 June 2019

Alan Downey
Chairman

Nomination Committee

The Council of Governors established the Nomination Committee for matters relating to the appointment and terms of office of Non-executive Directors including the Chairman. Attendance during 2018/19 is found below:

Alan Downey, Chair of the Committee	2/2
Angela Seward, Lead Governor	2/2
David Hall, Public Governor	2/2
Jon Broughton, Staff Governor	1/2
Mike Holmes, Public Governor	1/2
Paul Crawshaw, Healthwatch Governor	1/2

The Senior Independent Director is invited to the Committee to provide support and advice along with the Director of Human Resources and Company Secretary. At times when the Chairman's terms of office or performance appraisal is being considered the Chair would withdraw from the meeting.

During 2018/19 the Council of Governors through the Nomination Committee agreed and had oversight on the following:

- Approved the appointment of Debbie Reape as Non-executive Director from 1 November 2018
- Approved an additional one year term of office for Maureen Rutter
- Approved an increase for the Senior Independent Director position to reflect the additional duties of the role to commence from 1 April 2019
- Approved an external search consultancy to support the recruitment to the Non-executive Director vacancy
- Approved succession plans for Non-executive Director positions

Non-executive Directors can be terminated from office on resolution made by the Council of Governors in accordance with STHFT's Constitution.

Remuneration Committee

The Board of Directors established the Remuneration Committee which is responsible for matters relating to the remuneration of Executive Directors, including the Chief Executive and very senior managers. Attendance during 2018/19 is found below:

Alan Downey[1], Chairman	4/4
Amanda Hullick[2], Deputy Chair Non-executive Director	4/4
Richard Carter-Ferris	4/4
Maureen Rutter	4/4
David Heslop	3/4
Jake Tompkins	1/4
Mike Ducker	2/4
Debbie Reape	1/1

[1] Alan Downey, Chaired 1 out of 4 meetings
[2] Amanda Hullick Chaired 3 out of 4 meetings

The Chief Executive and Director of Human Resources are invited to attend meetings to provide advice.

During 2018/19 the Remuneration Committee:

- Reviewed Chief Executive and Executive Director pay against independent national benchmarking
- Agreed the Chief Executive's objectives, salary and allowances with a contracted salary in the range of £235,000 to £240,000. An additional payment of £52,873 was made in 2018/19, over and above base salary. This was to honour an historic commitment, made at the time of appointment to the role, relating to time worked over and above contracted hours.
- Approved the appointment and remuneration for the Director of Finance
- Approved a salary increase for the Director of Nursing and Quality;
- Approved the Board revised structure increasing the number of voting Medical Directors from three to four
- Reviewed senior management remuneration and succession planning arrangements
- Established senior roles of Chief Operating Officer and Transformation Director
- Noted the proposed changes to the Freedom to Speak Up Guardian roles
- Reviewed the outcome of the LCEA process and agreed to transfer oversight to the Workforce Committee

In 2018/19 STHFT received independent local and national benchmarking information on Executive Director pay to market test remuneration levels (including those that are remunerated above the Prime Minister's salary). The Committee was assured that salaries above the threshold displayed within the Remuneration table within the Accountability Report are reasonable and comparable to other Executive Director pay.

Only members of the Nomination and Remuneration Committees are eligible to attend meetings. However, other members of the Board can be invited to attend to offer advice and to support the working of the Committees. These Committees may also invite individuals to attend, as and when required to receive specialist and/or independent advice on any matter relevant to their roles and functions.

Senior Managers' Remuneration Policy

The Chief Executive and Executive Directors receive a fixed salary which is reviewed annually and determined by independent benchmarking against NHS organisations throughout the country with the use of NHS Provider benchmarking information, NHS Annual Reports and Accounts and knowledge of job descriptions, person specifications and market pay. Executive Directors are substantive employees and their contacts can be terminated by either party giving notice ranging between three and nine months. For the purpose of this Remuneration Report only voting members of the Board are considered as 'senior managers'.

Service Contracts

The Chief Executive and Executive Director contracts contain between a three month and nine month notice period. Non-executive Directors serve for three year terms of office and serve a maximum of six years subject to satisfactory performance (with additional years approved subject to satisfactory performance on an annual basis).

The Council of Governors consider and set terms of office for Non-executive Directors beyond that to meet the needs of STHFT whilst taking into account NHS Improvement's guidance. Further details on each of the Non-executive Directors can be found in the Director's Report within this Annual Report.

Senior Manager Remuneration and Benefits

The authority and responsibility for controlling major activities is retained by the statutory Board of Directors who has voting rights. This includes the voting Executive and voting Non-executive Directors (including the Chairman).

Pension arrangements for the Chief Executive and Executive Directors are in accordance with reference to the NHS Pension Scheme, the Accounting Policies for Pensions and relevant benefits are set out in the following tables:

Figures below are for the 12 month period from 1 April 2018 to 31 March 2019 for comparison purposes a table showing figures for the prior year is also included.

Directors' costs table 2018/19

	2018/19					
Names and title	Salary & fees (in bands of £5k) £000	Taxable benefits (total to the nearest £100) £00	Performance-related bonuses (in bands of £5k) £000	Long-term performance related bonuses (in bands of £5k) £000	All pension related benefits (in bands of 2.5k) £000	Total £000
Mike Reynolds[1] Non-executive Director	-	-	-	-	-	-
David Heslop Non-executive Director	15-20	-	-	-	-	15-20
Hugh Lang[2] Non-executive Director	-	-	-	-	-	-
Richard Carter-Ferris Non-executive Director	15-20	-	-	-	-	15-20
Amanda Hullick Deputy Chair and Non-executive Director	20-25	-	-	-	-	20-25
Maureen Rutter Senior Independent Director and Non-executive Director	15-20	-	-	-	-	15-20
Siobhan McArdle[3] Chief Executive	290-295	-	-	-	92.5-95	385-390
Steven Mason[4] Director of Finance	180-185	-	-	-	-	180-185
Rob Cooper Acting Director of Finance	-	-	-	-	-	-
Ruth James Director of Quality and Performance and Patient Experience	-	-	-	-	-	-
Gill Hunt Director of Nursing	135-140	-	-	-	115-117.5	250-255
David Chadwick Medical Director – Specialist and Planned Care	235-240	2	-	-	25-27.5	265-270
Adrian Clements Deputy Chief Executive and Medical Director – Urgent and Emergency Care	270-275	2	-	-	82.5-85	355-360
Simon Kendall Medical Director – Clinical Diagnostic/Support Services	-	-	-	-	-	-
Andrew Owens[5] Medical Director – Corporate Clinical Support Services	100-105	-	-	-	37.5-40	135-140
Sath Nag Medical Director – Community Care	240-245	-	-	-	62.5-65	305-310
Mike Stewart Medical Director – Specialist Care	-	-	-	-	-	
Jake Tompkins Non-Executive Director	10-15	-	-	-	-	10-15
Alan Downey Chairman	50-55	-	-	-	-	50-55
Debbie Reape[6] Non-executive Director	5-10	-	-	-	-	5-10
Mike Ducker Non-executive Director	15-20	-	-	-	-	15-20
Band of Highest Paid Director's Total Remuneration in £000s (excluding redundancy payments and payments in lieu of notice)	290-295					

[1] Non-executive Director appointed on 1 August 2015 left the Trust on 31 August 2017;

[2] Non-executive Director appointed 10 January 2011 left the Trust on 31 December 2017;

[3] Contracted salary is in the range of £235,000 to £240,000. An additional payment of £52,873 was made in 2018/19, over and above base salary. This was to honour an historic commitment, made at the time of appointment to the role, relating to time worked over and above contracted hours.

[4] Appointed as the substantive Director of Finance from 26 June 2018;

[5] Andrew Owens Medical Director for Corporate Clinical Support Services was appointed as a voting member of the Board from 1 November 2018;

[6] Debbie Reape was appointed to the role of Non-executive Director from 1 November 2018.

Figures below are for the 12 month period from 1 April 2017 to 31 March 2018

	2017-18					
Names and title	Salary & fees (in bands of £5k) £000	Taxable benefits (total to the nearest £100) £00	Performance related bonuses (in bands of £5k) £000	Long-term performance related bonuses (in bands of £5k) £000	All pension-related benefits (in bands of 2.5k) £000	Total £000
Mike Reynolds[1] Non-executive Director	5-10	-	-	-	-	5-10
Hugh Lang[2] Non-executive Director	10-15	-	-	-	-	10-15
David Heslop Non-executive Director	10-15	-	-	-	-	10-15
Richard Carter-Ferris Non-executive Director	15-20	-	-	-	-	15-20
Amanda Hullick Acting Chairman and Non-Executive Director	50-55	-	-	-	-	50-55
Maureen Rutter Acting Deputy Chairman and Senior Independent Director	20-25	-	-	-	-	20-25
Rob Cooper[3] Acting Director of Finance	90-95	-	-	-	-	90-95
Steven Mason[4] Acting Director of Finance	100-105	-	-	-	32.5-35	135-140
Adrian Clements[5] Deputy Chief Executive and Medical Director – Urgent and Emergency Care	230-235	2	-	-	90-92.5	325-330
Mike Stewart[6] Medical Director – Specialist Care	160-165	-	-	-	-**	160-165
Simon Kendal[7] Medical Director – Clinical Diagnostic/ Support Services	175-180	-	-	-	-	175-180
Ruth James[8] Director of Quality and Performance and Patient Experience	295-300	-	-	-	125-127.5	425-430
Alan Downey[9] Chair Designate	10-15	-	-	-	-	10-15
Mike Ducker[10] Non-executive Director	0-5	-	-	-	-	0-5
Gill Hunt Director of Nursing	125-130	-	-	-	25-27.5	150-155
Siobhan McArdle Chief Executive	230-235	-	-	-	87.5-90	320-325
David Chadwick Medical Director – Planned Care	225-230	2	-	-	87.5-90	315-320
Sath Nag Medical Director – Community Care	235-240	-	-	-	52.5-55	290-295
Jake Tompkins Non-Executive Director	10-15	-	-	-	-	10-15
Band of Highest Paid Director's Total Remuneration in £000s (excluding redundancy payments and payments in lieu of notice)	235-240 (please note the salary for Medical Directors is in accordance with the NHS Consultant Contract plus a Board responsibility allowance)					

The figures for Taxable Benefits relate to lease cars.

* In accordance with NHS Improvement's NHS Foundation Trust Annual Reporting Manual s2.36, disclosure is now shown where one or more senior managers are paid more than £150,000 (currently equating to the Prime Minister's managerial and parliamentary salary). Every salary approved by the remuneration committee has been appropriately externally benchmarked and salary levels set to ensure we are attracting the right skills and competencies.

** In accordance with NHS Improvement's NHS Foundation Trust Annual Reporting Manual s2.46, where the calculations for Pension-Related Benefits result in a negative value the result should be reported as zero.

The information included above for pension benefits has been supplied by NHS Pensions and one concern has been raised with NHS Pensions on the information provided. STHFT Is now awaiting a response.

The median total remuneration is a calculation based on Trust employees as at 31 March 2019. This number includes locum staff and STHFT's in-house nurse and clerical bank staff but excludes external agency staff.

Any part time employee numbers are pro-rated to provide whole time equivalents.

*** under Article 21 of the General Data Protection Regulation individuals listed in the remuneration tables above with financial information aligned to them have granted the Trust their permission for the information about them to be published.

[1] Non-executive Director appointed on 1 August 2015 left the Trust on 31 August 2017;

[2] Non-executive Director appointed 10 January 2011 left the Trust on 31 December 2017;

[3] Interim Director of Finance commenced as voting director on 1 April 2017, leaving the Trust on 30 September 2017

[4] Steven Mason was appointed on 1 September 2017 as Interim Director of Finance with effect from 1 October 2017;

[5] Adrian Clements was appointed to Deputy Chief Executive from 1 December 2017; and the Remuneration Committee approved the additional remuneration for the Deputy Chief Executive with effect from 1 December 2017;

[6] Medical Director (Specialist Care) stepped down from the Board on 31 December 2017;

[7] Medical Director (Clinical Diagnostic and Support Services) appointed voting member on 1 April 2016 and following a Board restructure became a non-voting member of the Board from 1 January 2018;

[8] Director of Quality and Performance was appointed as a voting director from 23 February 2015, stood down from the Board on 31 December 2017 and left the Trust on 31 March 2018;

[9] Alan Downey was appointed to the role of Chair Designate from 1 January 2018 and Chairman from 1 April 2018;

[10] Mike Ducker was appointed to the role of Non-executive Director from 1 February 2018.

**** A statutory redundancy payment was made to Director of Finance who left the Trust on 31 December 2017 amounting to £82,725 (in addition legal fees of £12,274.99 were paid on behalf of the former Director of Finance).

Pension Information

	Real increase in pension at pension age	Real increase to pension lump sum at pension age	Total accrued pension at pension age at 31 March 2019	Lump sum at pension age related to accrued pension at 31 March 2019	Cash equivalent transfer value at 1 April 2019	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2018	Employer's contribution to stakeholder pension
Executive Directors	Bands of £2,500	Bands of £2,500	Bands of £5,000	Bands of £5,000	£000s	£000s	£000s	£000s
Gill Hunt (*) Director of Nursing	5-7.5	10 – 12.5	50-55	150-155	1,039	180	839	0
Siobhan McArdle (*) Chief Executive	2.5-5	0	15-20	0	216	41	140	0
David Chadwick (*) Medical Director Planned and Specialist Care	0-2.5	2.5-5	80-85	250-255	2,068	165	1,875	0
Adrian Clements (*) Deputy Chief Executive and Medical Director Urgent & Emergency Care	2.5-5	0	70-75	175-180	1,377	151	1,181	0
Sath Nag Medical Director Community Care	2.5-5	0-2.5	40-45	90-95	707	97	589	0
Andrew Owens Medical Director Corporate Clinical Support Services	0-2.5	0	45-50	110-115	905	99	790	0

(*) NHS Pensions have, in some cases, amended the comparative information at 31 March 2018. The revised values have been used when preparing the above tables.

Notes to Senior Managers remuneration and Pension benefits

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

The CETV figures, and from 2004-2005 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV reflects the increase in CETV effectively funded by the employer. It excludes the increase in accrued pensions 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 this period.

Fair Pay Multiple

As a NHS Foundation Trust, the Trust is required to disclose the relationship between the remuneration of the highest paid Executive Director in their organisation and the median remuneration of the organisation's workforce (this excludes one-off severance payments and pension related benefits). For this Trust, Executive Directors are deemed those with voting rights on the Board, as disclosed in the salary table above. In 2018/19 the highest paid director in the Trust is the Chief Executive (in 2017/18 the highest paid director was the Medical Director of Community Care).

The banded remuneration of the highest paid director at the Trust in 2018/2019 was £292,500 (2017/2018 £238,208). This was 12.5 times (2017/2018 11.0 times) the median remuneration of the workforce, which was £23,351 (2017/2018 £21,719).

This exercise has included all staff employed by the Trust during the financial period, regardless of whether they were still employed at 31 March 2019. The remuneration figures used are based on the cost of the whole time equivalent of all staff identified as part of this exercise.

In 2018/2019, no employees received remuneration in excess of the highest paid director (six employees in 2017/2018). Remuneration ranged from £17,460 to £294,947 (2017/2018 £15,404 to £273,998). 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.

The starting point for the ranges for the financial periods is based on the minimum agenda for change pay scales. Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The banded remuneration of the Chief Executive and the median remuneration of the workforce are as follows:

	2018/19 £	2017/18 £
Medium remuneration	23,351	21,719
Banded remuneration of highest paid director	292,500	238,208
Ratio between median remuneration and mid-point of the banded remuneration of the highest paid director	12.5	11.0

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.

Expenditure on consultancy

In 2018/19, expenditure on consultancy was £2.060 million (2017/18 £1.710 million). Consultancy expenditure in the year related mainly to support in developing and delivering the Trust's Financial Improvement Programme.

Staff exit packages

In 2018/19, the Trust agreed an exit package with 34 members of staff (these are in comparison to 14 exit packages agreed in 2017/18) which cost £1.024 million (2017/18 cost was £0.572 million).

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	10	2	12
£10,000 - £25,000	5	1	6
£25,001 - £50,000	9	2	11
£50,001- £100,000	3	2	5
£100,001 - £150,000	0	0	0
£150,000- £200,000	0	0	0
Total number of exit packages by type	27[1]	7	34
Total resource cost £m	0.767	0.257	1.024

Other departures	Agreement Number	Agreement Amount (£)
Voluntary redundancies including early retirement	6	213
Mutually agreed resignations (MARS) contractual costs	1	44
Contractual payment in Lieu of Notice	0	0
Exit Payment following Employment Tribunal or Court Order	0	0
Non-contractual payments requiring HMT approval	0	0
Total	7	257
(0f which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary)	0	0

[1] There were a total of 27 compulsory redundancies arising from restructuring exercises undertaken during the year within corporate services (finance, human resources, communications, south tees charities, transformation and resolution centre)

Governors' expenses

In accordance with STHFT's Constitution Governors are eligible to claim expenses for travel at rates determined by STHFT. Out of the Council of Governor membership there were 7 Governors who claimed expenses which totalled £2,278.

Directors' expenses

In 2018/19, there were 7 individuals who held the office of Director at STHFT with a total of £1,479 in expenses paid to 4 of those Directors. All costs paid related to the reimbursement of travel and subsistence costs and course expenses. Details of remuneration and benefits in kind can be found within the Remuneration table.

Analysis of staff costs

Details of the costs of our workforce are available within Note 5, page 20 of the Financial Statements. The note includes information to support employee expenses and details of monthly average of people employed by STHFT.

Off-payroll engagements

Executive Director approval is required for all off-payroll engagements and STHFT reports to NHS Improvement as required in line with national requirements. Board approval via recommendations from the Remuneration Committee is required by any off-payroll Board member engagement.

Off-payroll engagements as of 31 March 2018, for more than £245 per day and that last for longer than six months	
Number of existing engagements as of 31 March 2019 of which:	0
Number that have existed for less than one year at time of reporting	0
Number that have existed for between one and two years at time of reporting	0
Number that have existed for between two and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting	0

All new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months:	
Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019 of which:	0
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to Trust) and are on STHFT's payroll	0
Number reassessed for consistency/ assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Any off-payroll engagements of Board members, and/ or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019:	
Number of off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, during the financial year	0
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	0

The Audit Committee

STHFT has established an Audit Committee which plays a key role by critically reviewing and reporting on the adequacy and effectiveness of systems of integrated governance, risk management, and internal control that supports the achievement of STHFT's objectives. It also plays a pivotal role in supporting STHFT's Board of Directors.

In carrying out its work, the Audit Committee primarily utilises the work of internal and external audit. It receives assurance from the views of other external agencies such as the Care Quality Commission and NHS Improvement.

In December 2018 the Terms of Reference of the Audit Committee were revised to align with updated regulatory requirements and strengthen the effectiveness of the Committee. The Audit Committee now incorporates a wider clinical governance focus with a Non-executive Director with clinical experience joining the membership and the Director of Nursing and Quality attending meetings; and clinical assurance reports/clinical audit being integral to its function. The Audit Committee plans to strengthen its clinical governance focus further going forward into 2019/20.

Audit Committee membership includes three Non-executive Directors and is chaired by Richard Carter-Ferris, Non-executive Director. There is an open invitation for all other Non-executive Directors to attend Audit Committee meetings (the Chair of STHFT is not a member of the Audit Committee).

Attendance during 2018/19 was as follows:	
Richard Carter-Ferris	5/5
Amanda Hullick	4/5
Debbie Reape*	1/1

*commenced as Audit Committee member from 1 November 2018

Meetings were attended by the Director of Finance, Director of Nursing and Quality, Company Secretary, Internal and External Audit teams.

During 2018/19, the Audit Committee undertook an annual self-assessment against the HFMA standards for Audit Committees. It was identified that there were no significant issues that needed to be addressed.

The performance of STHFT's external auditors (KPMG) was assessed during the year against the auditing standards. There were no conflicts of interest that needed to be addressed by the Auditor or the Audit Committee during the year.

The Audit Committee met its responsibilities during 2018/19 by:

- Monitoring the integrity of the activities and performance of STHFT and any formal announcement relating to STHFT's financial performance
- Reviewed PFI lifecycle, Gross Internal Area review, and Sale and Leaseback transactions
- Monitoring all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the CQC/NHS Improvement Well-led requirements), together with any accompanying Head of Internal Audit statement, External Audit Opinion or other appropriate independent assurances, prior to endorsement by the Board
- Reviewed STHFT's standing orders, financial instructions and scheme of delegation
- Reviewed the policies and procedures for all work related to fraud and corruption as set out in the Secretary of State's Directions and as required by the Counter Fraud and Security Management Service
- Reviewed the schedule of losses and compensations, the annual fraud report and provided assurance to the Board following each of its meetings.

The Audit Committee considered the risks associated with the year-end financial statements. These risks included valuation and impairment of property valuations should exclude VAT, revenue recognition and the preparation of the financial statements on a going concern basis (further information is included in the Accounts). Consideration of each of these risks included an assessment of the appropriate accounting treatment and the associated disclosures. In making these judgements the Audit Committee took into account the findings of the External Auditor, KPMG LLP.

In the review of internal audit and management assurance reports, Audit Committee identified significant fragility of the IM&T infrastructure, alongside the need to develop digital technology solutions. Further to this the Finance and Investment Committee and Board reviewed and supported a priority investment case for an Electronic Patient Record solution (subject to capital funding availability) to stabilise and transform the IM&T infrastructure.

Internal Audit

STHFT has an internal audit function provided by PwC which reviews, appraises and reports on the extent of compliance with, and the financial effect of relevant policies, plans and procedures, the adequacy and application of financial and other related management controls, the suitability of financial and other related management data, the extent to which STHFT's assets and interest are accounted for and safeguarded against any loss arising from fraud, bribery, corruption and other offences, waste, extravagance, inefficient administration and poor value for money or other causes.

The Head of Internal Audit attends Audit Committee meetings and has the right of access to all Audit Committee members, the Chair and Chief Executive. At the beginning of the financial year a programme of work is agreed with the internal auditors and progress is reported against the programme at each meeting.

The agreement with PwC complies with the guidance on reporting contained within the NHS Internal Audit Standards.

Counter fraud

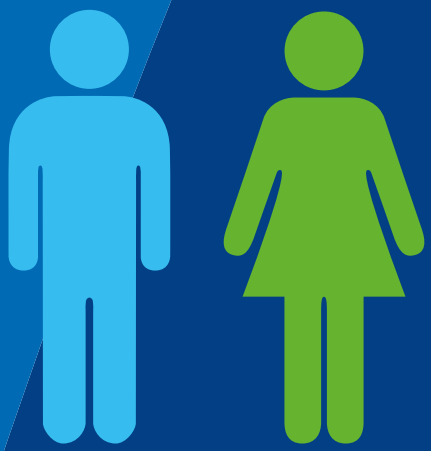
The Trust has in place an anti-fraud service which is provided by Audit One which works in line with standards issued for providers by NHS Protect relating to fraud, bribery and corruption.

Audit One lead on delivering a proactive and reactive programme of work with the Counter Fraud team who prepare a risk based plan each year based on risks identified locally, nationally and those arising from the NHS Protect quality assessment process. Work completed by our Internal Audit team provides assurance over the key financial controls and highlights any areas where the Trust may be exposed to the risk of fraud.

Charitable Funds Committee

A Charitable Funds Committee has been established with responsibility for the on-going management of charitable funds on behalf of the Corporate Trustees.

Staff Report



Our vision is to be recognised nationally for excellence in quality, patient safety, patient experience, social engagement and continuous improvement. To achieve our vision we have to deliver excellence in employee experience to be seen as an employer of choice.

Our workforce includes a broad range of clinically registered professions and support roles and we value everyone for the part they play in delivering high quality care to our patients through our one team approach.

We continue to drive innovation in service delivery which in turn is driving high performance at a time when many organisations are struggling financially and in terms of performance. Human Resources has a key role to play in supporting our people to recognise and reward achievements at a Trust, local, regional and national level, using our knowledge and experience to help shape health and social care policy and process.

By Staff Group

	Headcount		FTE	
	2018/19	2017/18	2018/19	2017/18
Bank	**126**	197	**0.00**	0.00
Fixed Term Temp	**510**	491	**458.11**	434.76
Locum	**46**	45	**3.47**	1.47
Permanent	**7973**	8220	**6941.61**	7063.29
Total	**8655**	8953	**7403.19**	7499.52

Age

	Headcount		FTE	
	2018/19	2017/18	2018/19	2017/18
16-20	**42**	55	**36.57**	49.89
21-25	**538**	590	**499.61**	548.63
26-30	**994**	978	**884.31**	869.17
31-35	**1013**	1008	**877.00**	849.52
36-40	**1070**	1142	**911.75**	937.94
41-45	**1046**	1108	**902.30**	928.41
46-50	**1218**	1301	**1066.52**	1102.07
51-55	**1192**	1270	**1038.23**	1087.49
56-60	**978**	953	**796.33**	760.7
61-65	**442**	427	**321.00**	301.82
66-70	**90**	90	**55.93**	51.47
71 & above	**32**	31	**13.65**	12.42
Total	**8655**	8953	**7403.20**	7499.53

Ethnicity

	Headcount 2018/19	Headcount 2017/18	FTE 2018/19	FTE 2017/18
Asian	**420**	395	**375.13**	347.24
Black	**77**	59	**67.73**	51.8
Mixed	**75**	78	**68.18**	69.85
Not Stated	**557**	596	**463.29**	489.3
Other	**141**	131	**125.59**	115.64
Undefined	**14**	1	**10.19**	0
White	**7371**	7693	**6293.08**	6425.7
Total	**8655**	8953	**7403.19**	7499.53

Gender

	Headcount 2018/19	Headcount 2017/18	FTE 2018/19	FTE 2017/18
Female	**7052**	7310	**5962.41**	6053.71
Male	**1603**	1643	**1440.78**	1445.82
Total	**8655**	8953	**7403.19**	7499.53

Gender Profile

The breakdown below includes information about staff at the end of the year in terms of male and female staff, Directors, other managers and employees

Female

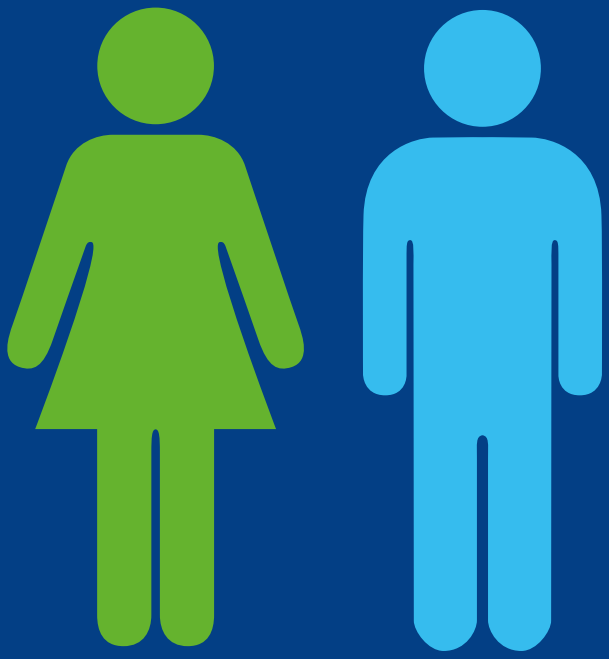
7052

Directors (Including CEO)

2

Senior Managers

5



Male

1603

Directors (Including CEO)

5

Senior Managers

10

* The above figures are taken in accordance with the Occupation Code guidance – 'senior managers' are classed as voting members of the Board and exclude those who retired or left the organisation during 2018/2019.

Health and Wellbeing

We have taken an integrated approach to promote health and wellbeing, working with a range of partners to help people make healthier choices and to address the social factors that affect people's health.

There are many factors that can affect staff wellbeing and partly this can be attributed to the fact that work can often be physically, emotionally and psychologically demanding. In addition, for many of our staff, our services operate for 24 hours a day, 365 days of the year.

Ensuring our staff has access to services to support their health and wellbeing is a key initiative we are proud to provide.

Mental Health accounts for 23% of all ill health in England and affects more than 1 in 4 of the population at any one time. As a Trust we recognise that good mental health is linked to good physical health and education and this has been a key focus during 2018/19.

As part of our Health and Wellbeing Strategy staff have access to excellent occupational health and wellbeing services, with a specific focus on mental health.

As a Trust our aims for 2018/2019 included:

- To achieve an 80% flu vaccination rate for our staff
- To develop a new Health and Wellbeing Strategy that links with our sickness absence key reasons and provides tangible supportive outcomes
- To support our staff and to ensure all staff challenge negative attitudes that impacts the lives of those experiencing mental health problems
- To provide access to services to improve the musculoskeletal wellbeing of our staff

Some of the key outcomes and improvements made during the 2018/19 are listed below:

- Functional Rehabilitation Sessions – to enable staff to perform the manual handling tasks required by their role under the supervision and guidance of a manual handling advisor.
- Postural Fitness Class - to support staff who are suffering with musculoskeletal symptoms predominately to their neck and/or shoulder(s) that are affecting or affected by their habitual postures at work
- Spinal Rehabilitation Programme - for staff with acute or chronic low back pain.
- Resilience, stress management and relaxation workshops
- We are working in collaboration with partner agencies to provide support to individuals who are experiencing difficulties at work due to depression, anxiety, stress and/or other mental health conditions
- STHFT has signed up to Time to Change which is a growing social movement working to change the way we all think and act about mental health problems

Flu

Our Flu campaign has been the most successful on record, 80.4% of all staff were vaccinated.

Nationally STHFT were recognised and shortlisted for most improved Trust and flu fighter champion of the year at the NHS Annual Flu Fighter Awards.

Sickness Absence

Fair and appropriate sickness absence management systems are a key aspect of staff health and wellbeing. In order for our trust to be able to provide safe, effective and efficient patient care we need a healthy workforce.

We continue to focus on sickness absence and in addition we have made significant improvements in ensuring short term sickness absences are managed in accordance with the sickness absence policy.

The Occupational Health team continues to work in conjunction with the operational HR teams and managers to provide appropriate interventions to support staff through their absence and expedite a return to work.

The HR team has relocated and is closely aligned to the departments across STHFT, supporting line managers in the management and rehabilitation of staff currently absent from work through sickness.

In 2018/2019 the average sickness absence rate for STHFT was 4.69% which is an increase of 0.46% on the previous year. We have had a particularly challenging winter period which saw sickness absence rates increase to a high of 5.51% in January 2019.

Junior Doctors

Implementation of the 2016 Doctors in Training Contract has continued throughout 2018/2019.

STHFT now has a total of 254 doctors in training on the 2016 contract which accounts for 68% of all funded training posts. The remaining 32% are doctors who were employed on run-through contracts by the Lead Employer Trust prior to the introduction of the 2016 contract. It is expected that all doctors in training will be on the 2016 Terms and Conditions by 2022.

The Junior Doctor Forum has continued to meet quarterly. Attendance has increased due to combining the forum meetings with existing training sessions for junior doctors.

As part of the new contract, doctors in training are able to submit 'exception reports' in real time where they have worked additional hours to their rota or have missed educational sessions due to staffing levels. Exception reporting continues to be at a low level in comparison with other Trusts. There were 74 exception reports raised in total during 2018/2019. The Guardian of Safeworking recently ran a series of briefing sessions for Consultants regarding the contract and the importance of encouraging exception reporting. These were well attended. The Guardian also encourages Doctors in Training to submit reports via the Junior Doctor Forum.

The vacancy rate for junior doctors for the 2018/2019 financial year was 8.4% which is lower than the previous financial year (10%).

Vacancies have been actively recruited to throughout the year and are also covered via a variety of methods including internal locum, use of the master vendor agency HCL or by redesign of rotas where possible to accommodate lower number of doctors. In August 2018, STHFT introduced rotational Trust Doctor posts which mirror Core Medical and Core Surgical training rotations. These posts were successfully recruited to and are currently being advertised ready for the new intake of doctors in August 2019. Some specialties have also appointed advanced nurse practitioners (ANP) to work on rotas alongside the junior doctors (for example neonates, paediatrics and cover of palliative care beds).

STHFT is a part of the regional junior doctor bank run by Liaison on behalf of the Lead Employer Trust. We continue to have a high success rate in covering short term absences of 95%, plus out of hour's shifts for longer term vacancies via our own internal bank plus the regional bank. The regional bank has given STHFT access to a small, additional pool of doctors – i.e. LET employed doctors who work in other Trusts/GP surgeries.

Developing a sustainable workforce

Recent publication of figures show that there has been a 96% reduction in the number of nurse applications from EU countries and a 15.8% increase in the overall number of vacancies in the NHS in the last year.

In order to address these challenges, make better use of our most valuable resource and develop a long-term sustainable workforce we have focussed on our people in terms of reward, recognition and responsibility. These include:

- Improving retention through increased employee capability and accountability with initiatives including ward manager development programme, administration and clerical development workshops, specifically targeted HR refresher training and external leadership provision through Ashridge
- Providing more flexible training pathways and investing in continuing professional development
- Changing skill mix to release the full potential of staff and deliver more patient-focused care, through continuous review of our resourcing models
- Improving our approach to workforce planning, with a focus on developing a deep understanding of the skills gap in the current workforce and how to bridge that gap
- Making better use of information technology to support more flexible working and improve productivity

The Learning and Development Team continue to widen the accessibility of learning and development through the apprenticeship levy offering new starters and staff a vocational route to progress within the organisation.

We have 252 active apprenticeships currently and are actively recruiting to apprenticeship roles. Included are the Advanced Clinical Practitioners, Nursing Associates as well as Health Care Support and Business Administration.

We continue to offer graduates, through the Graduate Management Scheme, the opportunities to develop knowledge and skills operationally and strategically within their chosen field.

There remains a proactive approach to Continuing Workforce development which is available to all staff and focuses on professional development to meet service need. There has been over 400 staff who have accessed modules and master classes through the CWD portfolio to build on clinical skills from September 2018.

In house training is core to the learning and development agenda focusing on leadership and technical skills, allowing staff to develop key skills fundamental to their roles.

1326 staff members have accessed a variety of internal leadership and technical sessions and training from our corporate trainer in 18/19.

Recruitment

The NHS employs over a million staff with half of the growth in the NHS among professionally qualified staff. The highest rate of growth in 2018 was service doctors, scientific, therapeutic and technical staff all of which grew by 3% or more.

Recruitment and retention of talented staff remains a challenge in key areas. Specific areas identified are Anaesthetists, Critical Care Consultants, Acute Medical Physicians, Radiologists and Neuroradiology Interventionists. We continue to hold nurse recruitment days and these have been successful with 311 new nurse appoints during 2018/19.

As a Trust we continue to strive to be innovative in our recruitment approach in order to attract the best talent. During the year we held a number of targeted recruitment campaigns which included:

- Headhunting approach
- Strengthened our relationship with key master vendor clients.
- Social media campaign – via LinkedIn, Indeed, Facebook and Twitter.
- Open days –targeting registered, student nurses and return to practice nurses.
- Continue our international recruitment campaign for nurses – and we have welcomed 21 nurses from the Philippines.
- Attendance at the BMA Careers fair in London in October

Employee Self Service

As part of our on-going commitment to staff to improve accessibility to their personal data we rolled out an Employee Self Service (ESS) in all areas across STHFT which allows employees to:

- View payslips online
- View their P60s (up to three years' history) and pension statements
- Change personal details such as address, contact numbers and banking details
- Access their personal details at home via a PC, smartphone or tablet

Day Nursery

Playdays Nursery is an excellent onsite facility, offering quality and flexible childcare for our staff's children whilst they are at work. It was awarded a 'good' rating following our recent Ofsted inspection.

Nursery fees are competitive in comparison to other local nurseries. It is considered a valuable service for our staff and our nursery continues to grow and offer our staff the flexibility and assurance that their children are being cared for to a high standard.

Equality, Diversity and Inclusion

We continue our commitment to ensure all staff are free from discrimination, feel equally supported in career progression and opportunities and report the same levels of satisfaction with their role at STHFT.

The overall workforce has reduced from 8,590 in our 2018 report to 8,469 (a 1.41% decrease), however, despite the reduction in headcount, there has been an increase in the number of staff declaring that they are from a BME background (618 in 2018 to 683 in 2019).

The Equality, Diversity and Inclusion network group has been re-established. This is an exciting time for us to really promote inclusive behaviour by ensuring that all our staff are aware of the effects of their behaviour on others and are equipped to challenge and report inappropriate behaviour when they experience or witness it.

Diversity network groups, focusing on specific staff groups, are being set up to provide a forum for individuals to come together, to share ideas, raise awareness of challenges and provide support to each other. The network groups identified so far are:

- Lesbian, Gay, Bisexual and Transgender Networks
- Black Asian Minority Ethnic Network
- Disability and Long Term Health Network
- Mental Health Network
- Faith Network

One initiative underway is the 'Rainbow Badge Initiative' which gives healthcare staff a way to show that their place of work offers open, non-judgemental and inclusive care for all who identify as (lesbian, gay, bisexual, transgender+, (LGBT+). The + simply means inclusive of all identities, regardless of how people define themselves.

We continue to follow to the duties of the Equality Act 2010, which legally protects people from discrimination in the workplace and in wider society, and the Public Sector Equality Duty.

This includes:

- the production of annual workforce and patient monitoring reports
- compliance with the Workforce Race Equality Standard
- use of the Equality Delivery System (2) to identify our Equality and Diversity priorities
- production and publication of our Gender Pay Gap report
- staff mandatory training in equality and diversity

All our policies are developed in partnership with trade union colleagues and are applied consistently to ensure fair and open recruitment of people with protected characterises, as well as ensuring that staff with disabilities can access appropriate training and development, promotional opportunities, and flexible working arrangements.

Gender

	Headcount 2018/19	Headcount 2017/18	FTE 2018/19	FTE 2017/18
Female	**7052**	7310	**5962.41**	6053.71
Male	**1603**	1643	**1440.78**	1445.82
Total	**8655**	8953	**7403.19**	7499.53

Religious Belief

	Headcount 2018/19	Headcount 2016/17	FTE 2018/19	FTE 2016/17
Atheism	**811**	706	**732.5753**	507.85
Buddhism	**21**	18	**18.74**	10.7
Christianity	**3702**	3800	**3207.48**	2993.13
Do not wish to disclose	**3260**	3574	**2688.05**	3322.28
Hinduism	**74**	66	**64.37**	35.72
Islam	**167**	134	**148.41**	69.57
Judaism	**2**	1	**2**	0.75
Other	**583**	619	**514.85**	469.93
Sikhism	**11**	11	**10.36**	8.21
Undefined	**24**	24	**16.33**	7.22
Total	**8655**	8953	**7403.19**	7425.36

Sexual Orientation

	Headcount		FTE	
	2018/19	2016/17	2018/19	2016/17
Bisexual	**23**	19	**19.97**	15.79
Do not wish to disclose	**3099**	3414	**2549**	2764.92
Gay	**69**	68	**66.01**	65.36
Heterosexual	**5437**	5428	**4750.13**	4641.18
Lesbian	**4**	0	**3.60**	0
Undefined	**23**	24	**14.53**	12.28
Total	**8655**	8953	**7403.19**	7499.53

Disabled

	Headcount		FTE	
	2018/19	2016/17	2018/19	2016/17
No	**5086**	5062	**4395.26**	4288.98
Not Declared	**3327**	3652	**2793**	3004.28
Undefined	**16**	12	**10.90**	7.92
Yes	**220**	220	**198.03**	191.34
Prefer Not to Answer	**6**	7	**6.00**	7
Total	**8655**	8953	**7403.19**	7499.52

Relationships with Trade Unions

We continue to develop our partnership with Trades Union colleagues, with a partnership agreement supports consultation in relation to key changes in our HR policies as well as any significant matters affecting STHFT.

The investments we have made in our trade union relationships have resulted in innovative ways of developing solutions within a challenging environment, with both sides recognising that their interests are mutually compatible with the aim of preserve jobs and the quality of services.

Employment Policies

The Joint Partnership Committee consists of Trust management side and staff side representatives working in partnership to ensure that policies and procedures are fit for purpose, reflective of any changes to employment law and support equality and diversity within the workplace.

In 2018/2019, the Joint Partnership Committee (JPC) approved 14 policies which were then ratified by Operational Management Board. These included:

- Disclosure & Barring Policy
- Healthcare Professionals Alert Notices Guidance
- Professional Registration Policy
- Mandatory Training
- Job Evaluation Policy
- Stress Policy
- Alcohol, Drugs & Other Substances Policy
- Notice Periods
- Fit & Proper Persons Procedure
- Pay Protection
- Standards of Business Conduct
- Long Service
- Code of Conduct
- Induction Policy


Suzanne
Allday

National NHS Staff Survey Results 2018

Staff Survey Report 2018

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 2018 survey among trust staff was 33% (2017: 33%).

Scores for each indicator together with that of the survey benchmarking

Group – Combined acute and community Trusts are presented below.

	2018/19		2017/18		2016/17	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Group
Equality, diversity and inclusion	9.3	9.2	9.2	9.5	9.3	9.6
Health and wellbeing	5.6	5.9	5.9	6.0	5.7	6.1
Immediate managers	6.6	6.8	6.8	6.8	6.6	6.8
Morale	5.8	6.2	N/A	N/A	N/A	N/A
Quality of appraisals	4.5	5.4	4.9	5.3	4.8	5.4
Quality of care	7.4	7.4	7.7	7.5	7.5	7.5
Safe environment – bullying and harassment	8.1	8.1	8.1	8.1	8.4	8.2
Safe environment – violence	9.5	9.5	9.3	9.5	9.6	9.5
Safety culture	6.3	6.7	6.4	6.7	6.6	6.7
Staff engagement	6.6	7.0	6.8	7.0	6.9	7.0

Key Areas of Focus for 2019

Equality & Diversity	**Improve the experience for staff with mental health problems by working in partnership with external organisations – signed up to Time to Change Employers Pledge.** Staff networks are being developed to support staff with protected characteristics.
Violence, Harassment & Bullying	**Work with NHS Improvement as pilot organisation for tackling bullying.** An education programme developed for all staff to heighten awareness of bullying and negative behaviours, what bullying is and is not, how those behaviours sit with Trust values and how staff should respond when they are recipients of such behaviour.
Quality of Appraisal	**Undertake staff development and review refresher training with managers.** Implement an SDR checklist for Managers to include key learning from the survey results.
Safety Culture	**Process to be developed to ensure that feedback is provided to staff regarding changes/lessons learned.** Ensure improvements are publicised.
Health and Wellbeing	**Develop a Health & Wellbeing strategy for 2019** Develop a detailed action plan and delivery against target.
Morale	**Develop and deliver the Ward to Board programme – increase visibility of Senior Leaders.** Develop a Trust retention strategy.
Staff Engagement	**Develop a staff engagement strategy for 2019.** Recognise and celebrate success.
Immediate Managers	**Review values and define the supporting behaviours required to deliver our vision.** Develop a culture of engaging leadership, strong management and effective communication.
Quality of Care	**Promote a culture of personal accountability and pride in the quality of care we deliver.** Promote a renewed focus on 'back to basics' that enables the delivery of high quality care. Develop a culture of effective team working and communication across all staff groups.

NHS Trust Code of Governance

We have applied the principles of the NHS Foundation Trust Code of Governance (2006) which was updated in July 2014.

The Board has in place governance policies and procedures that reflect the principles of the NHS Foundation Trust Code of Governance which includes the following:

- Standing Orders of the Board and Council of Governors, Scheme of Delegation, and Standing Financial Instructions
- Good quality performance reports are presented to the Board that meet STHFT's regulators requirements for quality, operational and financial performance
- Induction programme for Executive and Non-executive Directors
- At least half of the Board excluding the Chairman comprises independent Non-executive Directors
- Non-executive Directors have regular meetings with the Chairman
- Agreed the recruitment process for Non-executive Directors
- Induction programme for Governors is in place
- A Non-executive Director covers the Senior Independent Director role
- Register of Board and Governor interests is in place and publicly available
- Appraisal process is in place for Non-executive Directors and the Chair
- Records of attendance are maintained for the Board of Directors and Council of Governors meetings
- Indemnity insurance is in place to cover any such risks if they arise in respect of legal action against Directors
- Process to raise any serious concerns and resolving disagreements between the Council of Governors and the Board is in place
- Lead Governor in place who actively undertakes the role
- Private meetings are held with the Chair and Governors to discuss strategic and operational matters
- An assurance reporting process is in place with the Chief Executive and supporting Directors presenting on quality, operational and financial performance as well as strategic developments at Council of Governors meetings
- Embedded Council of Governors structure in place
- Terms of Reference for the Remuneration Committees are in place for the Board
- Recruitment process in place for Non-executive Director positions
- Board evaluation has taken place throughout the year with a development plan in place
- Well-led Board governance review undertaken by independent company within the last two years
- Code of Conduct is in place for the Board and Council of Governors
- Going Concern Report is undertaken annually
- Audit Committee provides robust arrangements
- Council of Governors led appointment process for the appointment of external auditors and approved any extensions
- Standard of Business Conduct (Conflict of Interest) Policy and Plan is in place
- Freedom to Speak Up Policy and Counter Fraud Policy and Plan are in place

STHFT has applied the principles of the NHS Foundation Trust Code of Governance on a comply and 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 following STHFT complied with the Code during 2018/19 with the exception of:

A5.8 Policy for Governor engagement with the Board for circumstances when they have concerns

The Board recognises it does not have a defined policy in place but it does have strong working processes for Governors to raise concerns through regular meetings with the Chairman, the Lead Governor, Senior Independent Director and Company Secretary.

Application of the Modern Slavery Act

The Modern Slavery and Human Trafficking Act 2015 Act established a duty for commercial organisations to prepare an annual slavery and human trafficking statement to include the steps the organisation has taken during the year to ensure that slavery and human trafficking is not taking place in any of its supply chains or in any part of its own business.

Our Trust is the largest in the Tees Valley and we are fully aware of the responsibilities it bears towards patients, employees and the local community. Our senior procurement team regularly monitor and review its supply base and are all suitably qualified and uphold to the Chartered Institute of Purchasing and Supply code of conduct.

All members of our staff have a personal responsibility for the successful prevention of slavery and human trafficking with the procurement department taking lead responsibility for the supply chain.

Quality and Clinical Governance

The Care Quality Commission (CQC) has a role to ensure that health and social care services that are provided are done so safely, effectively, compassionately, and are of the highest quality. The CQC is responsible for monitoring, inspecting and regulating services to ensure they meet core standards of quality and safety and publish their findings to help people choose their care provider. The CQC carried out a Comprehensive Inspection in 2016 and published their report on 28 October 2016 rating STHFT as 'Good'. In January and February 2019 the CQC carried out a further inspection and a draft report has been received at STHFT to check for factual accuracy. At the time of writing this report the final report has not been received.

NHS Improvement's Single Oversight Framework

Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

The Trust is currently in segment 3 – 'Mandated Support' which includes segmentation support for providers within this segment as described below:

"Providers receiving mandated support for significant concerns: there is actual or suspected breach of licence, and a Regional Support Group has agreed to seek formal undertakings from the provider or the Provider Regulation Committee has agreed to impose regulatory requirements."

The primary concern previously for the Trust in this context was the requirement to achieve the Trust financial Control Total. In 2018/19 the Trust has achieved the Control total. The Trust has made representations to NHS Improvement to request being taken out of enforcement on the basis of the achievement of the Control Total.

This segmentation information is the Trust's position as at 31 March 2019. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

Finance and Use of Resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2018/19 scores				2017/18 scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	4	4	4	4	4	4	4	4
	Liquidity	4	2	3	2	3	4	4	4
Financial efficiency	I&E margin	1	3	4	4	4	3	4	4
Financial controls	Distance from financial plan	1	1	1	1	4	1	1	1
	Agency spend	1	1	1	1	1	1	1	1
Overall scoring		3	3	3	3	3	3	3	3

Accounting Officer's Responsibilities

Statement of the Chief Executive's Responsibilities as the Accounting Officer of South Tees Hospitals NHS Foundation Trust (STHFT)

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 NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require STHFT to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of STHFT and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

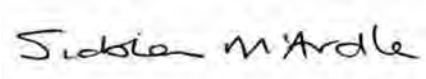
In preparing the accounts, the Accounting Officer is required to comply with requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, 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 (and the Department of Health and Social Care Group Accounting 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
- Confirm that the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess STHFT's performance, business model and strategy; and
- Prepare the financial statements on a going concern basis

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of STHFT and to enable her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of STHFT 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 the NHS Foundation Trust Accounting Officer Memorandum.

Signed:



Date: 20 June 2019

Siobhan McArdle
Chief Executive & Accounting Officer

Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS 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 Trust Accountable 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 South Tees Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in South Tees Hospitals NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As the Chief Executive, I am responsible for overseeing risk management across all organisational, financial and clinical activities. I am the Chair of the Executive Risk Group which reports to the Risk Committee. The Executive Risk Group has overall responsibility for risk management, including the development and implementation of the assurance framework and risk management strategy; overseeing the Trust's Single Oversight Framework; and reviewing quality and patient safety assurance and risk registers.

The Trust has a risk management strategy and policy in place which is consistent with best practice and Department of Health guidance. During 2018/19 the Trust's strengthened its risk management processes with the implementation of a risk escalation framework and the redevelopment of its assurance framework to ensure that risk assessment is an integral part of all clinical, managerial and financial processes. Training is provided for risk assessment and incident investigation and delivered at appropriate levels in relation to job role and duties.

An important enabler to fulfilling this responsibility has been the establishment of the Risk Validation Group during the year to strengthen the Trust's capacity to handle risk and its purposeful interaction with the Executive Risk Group/Risk Committee and the Trust's Audit Committee. Audit Committee provides a key forum through which the Trust's Non-executive Directors bring independent judgement to bear on issues of risk management and performance. In quarter 3 of 2018/19 the Audit Committee's Terms of Reference were updated to strengthen its effectiveness to include clinical oversight. The constructive interface between the Audit Committee and Executive Risk Group/Risk Committee supports the effectiveness of the Trust's internal control.

Risk and control framework

Risk management requires participation, commitment and collaboration from all staff. The process starts with the systematic identification of risks via structured risk assessments. Identified risks are then included on risk registers.

These risks are then analysed to determine their relative importance using a risk scoring matrix. Low scoring risks are managed by the area in which they are found whilst higher scoring risks are managed at progressively higher levels within the Trust.

Achieving control of the higher scoring risks is given priority over lower scoring risks. Risk control measures are identified and implemented to reduce the potential of harm.

The potential consequence and likelihood of the risk occurring are scored with the effectiveness of existing control measures. The total sum of these scores determines the level in the Trust at which the risk is reported and monitored to ensure effective mitigation.

Each Centre Board has in place risk registers which are overseen by the Risk Validation Group, Executive Risk Group and Risk Committee. It directs management focus to the mitigation of significant risks. The specific group related significant risks inform the Board Assurance Framework which in turn informs the Board agenda.

Risks are identified proactively through this risk assessment process from Board, Board Committees, Operational Management Board and across all Centres, wards, departments and directorates. The Trust's quality management system includes harm and morality reviews and quality is managed reactively through the monitoring of key objectives, incidents, complaints and claims.

South Tees Hospitals NHS Foundation Trust seeks to reduce risk as far as possible; however, it is understood that delivering healthcare carries inherent risks that cannot be eradicated completely. The Trust therefore pursues assurance that controls continue to be operated for risks that cannot be reduced any further. On this basis, risks are tolerated in line with an organisational risk appetite.

The Trust's Assurance Framework is based on the following key areas:

- Clearly defined principle objectives agreed with stakeholders together with clear lines of responsibility and accountability;
- Clearly defined principle risks to the achievement of these objectives together with assessment of their potential impact and likelihood;
- Key controls by which these risks can be managed, including involvement of stakeholders in agreeing controls where risks impact on them;
- Management and independent assurance that risks are being managed effectively;
- Board level reports that identify risks are being reasonably managed and objectives being met, together with gaps in assurances and gaps in control of risk;
- Board level action plans which ensure the delivery of objectives, control of risk and improvement in assurances.

The workplan of Committees and the Assurance Framework are linked in order that the Board is assured that there is an aligned independent and executive focus on strategic risk and assurance. Routine referral of items that are known issues exist between Committees to ensuring a respective understanding of risk and assurance. The Internal Audit Corporate Governance Review 2018/19 confirmed that the review of Board Committee functions are structured to meet NHS requirements to support assurance and accountability to the Board.

The Board of Directors receives summary reports following every Board Committee and Operational Management Board meeting via the Chair's Logs. Risks are also retrospectively identified through adverse incident reporting, receipt and response to complaints and claims, patient surveys and feedback and concerns raised by the Coroner.

The Trust has two Freedom to Speak Up Guardians (FTSUG) to act in a genuinely independent and impartial capacity to support staff who raise concerns. The FTSUGs are supported by a number of Freedom to Speak Up Champions who are in place across the Trust. The FTSUGs have access to the Chief Executive and Chairman and the Trust's nominated Executive Director and Non-executive Director for Freedom to Speak Up. The Board nominated the Senior Independent Director as the Trust's nominated Non-executive Director for Freedom to Speak Up. A bi-annual report of all concerns raised and themes is produced for the Board with summary information escalated through the risk management processes as appropriate.

During 2018/19 the Trust ensured on-going assessment of all of the following in-year and future significant risks:

- Delivery of a sustainable future at the Friarage Hospital, Northallerton;
- Under-reporting of incidents;
- Delivery of control total'
- Delivery of cost improvement programme;
- Development of an IT strategy and IT infrastructure fit for current and future needs;
- Estate strategy and management of PFI contract;
- Capital solutions for major strategic programmes;
- Compliance with access standards;
- Clinical staffing establishments.

These conditions are detailed within the Corporate Governance Statement, the validity of which is assured by the Audit Committee.

The Trust commissioned an independent Well-led Governance review in 2017 and since that time the Trust has made significant improvements with regard to Board governance and rates of Clostridium difficile infection. As a result of that NHS Improvement considered the Trust to be fully compliant with its licence for Board Governance and Clostridium difficile. A compliance certificate was issued by NHS Improvement in October 2017 and a revised enforcement undertaking was issued to supersede the previous undertaking in relation to financial suitability.

The Trust is fully compliant with the CQC registration requirements. The last Comprehensive Inspection report was published on 28 October 2016 rating the Trust as 'Good'. In January and February 2019 the CQC carried out a further inspection of core services and the 'well-led' key question. The draft report has been received at STHFT to check for factual accuracy. At the time of writing this report the final report from the CQC has not been received, we anticipate receiving it in the coming weeks. Areas of focus and future work include:

- Effectively managing the increasing demand for critical care services whilst maintaining safe staffing in line with national guidance
- Improving compliance with mandatory training and rates of appraisals
- Continuing to focus on the reduction of avoidable harm
- Improving rates of incident reporting, investigation and subsequent learning across the organisation to support an open safety culture
- Focussing on staff engagement

As a provider of NHS services under the licence of the CQC the Trust must comply with the requirements of the NHS provider licence which forms the legal basis for NHS Improvement's oversight for NHS Foundation Trusts.

Developing workforce safeguards

The Trust is working towards the recommendations for Developing Workforce Safeguards by expanding the current reporting of biannual nursing and midwifery staffing to the Board to cover Theatres and Accident and Emergency in 2019. We are working closely with our Allied Health Professionals colleagues to include all staff groups and will produce joint papers where appropriate to do so. Community nursing and Out Patient Department reviews will follow in 2020 using the evidence based tools which currently exist.

The Trust currently uses Allocate SafeCare to review nurse staffing at least twice a day and has included the paediatric and Neonatal Unit to allow their teams to use the system effectively. Staff are redeployed to meet patient need and this detail is reported through the monthly safe staffing paper to Board. Our external bank is provided by NHS Professionals and we will be creating a bank collaborative with North Tees Hospitals in June 2019 to widen the pool of staff to fill vacant shifts and maintain our minimal use of nursing agency.

Quality impact assessments (QIA) for all new roles and skill mix changes, such as the introduction of the Registered Nursing Associate role will be assessed via our QIA process, which is led by the Director of Nursing and Quality and Medical Director.

We have worked with Allocate software to complete an 'E-rostering Levels of Attainment' self-assessment and are currently working through the action plan to raise the levels across all staff groups. The Director of Nursing and Quality will be chairing a Workforce Assurance Group, reporting to the Workforce Committee and escalating / reporting to Board as required.

The Director of Nursing and Quality has sponsored the Assistant Director of Nursing Workforce to attend the CNO Safe Staffing Fellowship Programme starting in May 2019 and will mentor her throughout the programme to ensure any learning is embedded within the organisation.

NHS Improvement Developing Workforce Safeguards (Oct 2018) states the need for effective workforce plans to be formulated by multi-disciplinary teams and considering the whole workforce required to deliver the activity. To support the development of these safeguards operationally teams of Healthcare Professionals (AHP's, Scientists and Pharmacists) have commenced a review of available evidence in line with professional judgement to outline the staffing levels required to support positive outcomes for our patients. This work will support the development of safe and sustainable staffing levels across the professional groups to give a view of the whole workforce required to deliver activity as required. A strategy for the healthcare professionals workforce will support wider trust strategy and integrate with Nursing and Midwifery. Operationally models will be developed and built in to e–rostering systems where appropriate to allow effective monitoring and highlight areas of positive attainment and areas for improvement.

The Trust has fully implemented Allocate's e-Job Plan system to facilitate efficient planning for deployment of senior medical staff.

In line with the 2016 junior doctors' contract, the Trust has appointed a Guardian of Safe Working who reports quarterly to the Workforce Committee and to the Trust Board. This individual has established a programme of refresher sessions for Clinical and Educational Supervisors. A Junior Doctors Forum was established as per the contract terms and conditions; all doctors who have moved onto the new contract to date are sent regular reminders about the forum and to increase engagement it was agreed with junior doctor forum representatives to add the meeting onto the Foundation Programme generic skills teaching days. Higher trainees have also been invited to attend and further discussion is planned with the forum to find ways to continue to improve engagement. To further support development of the safeguards for this group of staff a review of the Royal College of Physicians Guidance on Safe Medical Staffing (2018) is underway with the Medical Directors.

The Trust is part of a regional collaborative bank for junior medical grade staff as well as having our own local bank of doctors. The Trust also has a master vendor arrangement for agency doctors via HCL.

For junior grade medical staff, fill rates via bank are high with minimal agency usage. Agency usage for senior grade doctors is reviewed on a regular basis with a view to moving long term agency locums onto substantive contracts with the Trust.

Register of Interests - the Trust has in place a register of interests for decision making staff. A revised policy was approved within the past twelve months, and the Trust is working towards meeting the requirements of the NHS England/ Improvement 'Managing Conflicts of Interest in the NHS 'guidance.

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 Trust's obligations under equality, diversity and human rights legislation are complied with.

The Trust has undertaken risk assessments and has a sustainable development management plan in place with takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The financial plan is approved by the Board of Directors and submitted to NHS Improvement our independent regulator (in exercising its powers conferred by Monitor). This plan includes forward projections and is monitored by the Finance and Investment Committee with key performance indicators and financial sustainability metrics also reviewed monthly by the Operational Management Board and the Board of Directors at each of its meetings.

The Trust was set a challenging financial plan for 2018/19 which required the Trust to operate at a deficit of £10.1m before the receipt of Provider Sustainability Funding (PSF). The receipt of PSF of £13.9m would then result in a surplus of £3.8m. In order to achieve the planned financial performance the Trust was required to achieve a productivity and efficiency programme of £35.6m.

The Trust achieved the required level of financial performance and operated at an underlying deficit of £7.9m throughout 2018/19. The Trust delivered a total productivity and efficiency programme of £38.7m, split between recurrent £14.3m and non-recurrent measures of £24.4m.

As a consequence the Trust was not only eligible for core PSF but achieved bonus PSF of £9.5 million. The Trust therefore achieved an underlying performance of £15.5m, consisting of an underlying deficit of £7.9m and PSF of £23.4m.

The Trust's deficit within the annual accounts of £31.5m reconciles to the underlying deficit of £7.9m by the inclusion of PSF £23.4m, impairment of assets £50.6m, donations towards capital expenditure £4.7m and depreciation on donated assets £1.0m.

The Trust and Endeavour (PFI Provider) have worked closely throughout 2018/19 to collectively understand the position of the life cycle programme and reconcile the respective accounting within each organisation. The Trust recognises the importance of facilitating future life cycle capital works in order to minimise the extent of any prepayment.

The Trust continues to face a challenging financial agenda, and is actively working across the Southern ICP System with parties to address the financial challenges of the Tees Valley.

The lack of available capital funding represents a major risk to the Trust given a prolonged period of reduced capital expenditure. The Trust is seeking emergency capital funding via NHS Improvement and reviewing/prioritising all capital expenditure bids to minimise clinical and organisational risk.

The Trust has £55m Department of Health loans which are due for repayment in 2019/20. The Trust is dependent on continuing ongoing support in order to meet our financial obligations. It is anticipated the loans will be renewed but the Trust has not received formal notification that this will be the case.

Financial governance arrangements are managed within the corporate governance framework which includes Standing Orders, Standing Financial Instructions and a Scheme of Delegation. Financial governance is supported by internal and external audit to ensure economic, efficient and effective use of resources and monitored by the Audit Committee.

The Corporate Governance Structure, Board Committee Terms of Referenced, Standing Orders and Standing Financial Instructions were reviewed during the year to ensure the governance framework reflects the organisation of the Trust and maintains internal control.

During 2017/18 (the previous year), the Interim Director of Finance requested a change to the Internal Audit Programme to include a review of the key financial processes in place at the Trust to provide assurance on the financial control framework. The audits undertaken included: Procurements and Accounts Payable, Income Generation and Recording and Accounts Receivable, Financial Management and Month End Processing. The audit reports included a total of 19 recommendations of which four were classified high, 10 medium and five low. These findings were consistent with the Interim Director of Finance's views which initiated a targeted programme of action.

The high priority recommendations related to:

- Private Patient Income;
- Journal Entry;
- Aged Creditors;
- Contract Renewal.

As a direct result of these audit findings, the overall Internal Audit opinion in 2017/18 changed from 'generally satisfactory with some improvements required' to 'substantial improvement required'.

The Interim Director of Finance advised the Board that the recommendations related to discreet parts of the system. He was satisfied that these issues are discreet and that the issues and the aggregate of these issues are sufficiently covered by other controls within the Finance and Procurement Departments. The Board determined that these issues do not, in aggregate, represent a critical risk to the overall financial control framework of the Trust. The areas highlighted have now been addressed, and accepted by the Trust's internal auditors, PwC. The Trust has also strengthened the process to follow up internal audit recommendations. The internal auditor's opinion for 2018/19 has returned to 'generally satisfactory with some improvements required'.

Centres and corporate departments are responsible for the delivery of financial and other performance targets via a performance management framework which incorporates service reviews with the Executive Directors.

The changes made to the Board during 2018/19 included the substantive appointment of Steven Mason as Director of Finance from June 2018, the appointment of Debbie Reape as Non-executive Director from 1 November 2018 and following a change to medical director portfolios, Professor Andrew Owens, Medical Director (Corporate Clinical Support Services) was made a voting member of the Board from 1 November 2018.

All changes were approved by the Nomination and Remuneration Committees and endorsed by the Council of Governors and Board of Directors.

Information Governance

Information Governance is assessed as part of a process using the new Data Security and Protection (DSP) Toolkit, which replaces the Information Governance toolkit reporting function and is based upon the National Data Guardians 10 Data Security Standards. The content of the DSP Toolkit has significantly been changed and updated to include more assurance around technical aspects of cyber security and information security compliance.

DPST also differs from the previous IG Toolkit which assessed performance against three levels (1, 2 and 3). The DSPT no longer includes levels and instead requires compliance with assertions and (mandatory) evidence items. These include a total of 40 assertions and 100 pieces of mandatory evidence. A status update received in early March 2019 from NHS Digital offers organisations that may be non-compliant on some areas of the toolkit, the option to upload a detailed action plan as an addition to its evidence submission. This will help mitigate those areas of risk where it has been highlighted that evidence within certain standards may be currently lacking. The Trust has currently provided 78 of 100 mandatory evidence items and has therefore received the status of "Standards Not Met". The remaining 22 items are included within a detailed action plan which has been approved by the Trust's SIRO for completion by the end of June 2019. We are awaiting confirmation from NHS Digital that this action plan is agreed and our assessment status will then change to "Standards not met (action plan agreed)".

The Trust's Risk Register is updated with identified information risks. As part of the national requirements, the Trust's information incidents are assessed and reported to NHS Digital via the Data Security and Protection Incident Reporting Tool. In 2018/2019, the Trust reported five reportable data breach incidents to the Information Commissioner's Office.

The five reportable data breach/incidents were reported through the DSP Toolkit in 2018/2019. These related to inappropriate disclosure of patient information (wrong address). All incidents were fully investigated and actions were taken to reduce the risk of re-occurrence; the Information Commissioner's Office has closed four of the incidents and no formal action was taken.

The Trust's Internal Auditors, PricewaterhouseCoopers (PWC), have performed an internal audit review on compliance with the DSPT standards and the final report has been received by the Audit Committee which includes areas of risk associated with:

- IG training compliance
- Access control issues
- Patching implementation
- Supplier GDPR compliance review

The Trust was not directly affected by the global cyber-attack on 12 May 2017. However, the Trust continues to build on the work undertaken to-date, audit recommendations and national expectations related to IT/Cyber security. Five strategic themes have been identified and will be delivered with the support of an action plan, monitored through the Trust's corporate meeting structure and escalated for senior management review where appropriate to cover:

- Governance and assurance
- Training and awareness
- Policies and standard operating procedures
- Improvement to technology and IT related processes
- Review of resources

The cyber risks that the Trust is exposed to are managed through the Trust's risk management framework. Risks are included on the risk register and are reviewed regularly to ensure they remain accurately scored and updated with the latest issues.

A number of investments, totalling £500,000 were made during the past year to improve our Cyber security and a number of additional key business cases are under development to support the Trust in its progress through the identified themes above.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations 2010 (as amended) to prepare Quality Accounts each financial year.

The development of the Quality Report included a range of information obtained via feedback from staff, patients, governors and external stakeholders to identify the priorities for quality improvement. The Annual Quality Report is supported internally through the Board Assurance Framework. The Board has a dedicated Quality Assurance Committee and all data and information is reviewed through this Committee. The Board regularly reviews quality improvement against set targets and identified projects. This Committee is chaired by a Non-executive Director and provides assurances to the Board in relation to the Trust's compliance against the CQC registration requirements.

Significant progress was made to reduce Clostridium difficile infection across the Trust and in 2018/19 we reported our lowest ever number of Trust apportioned cases a figure of 41, which was well below the upper threshold of 54.

The burden of gram negative blood stream infections (GNBSI) particularly E.coli is challenging and requires reliable auditing to establish the potential multiple causes of Gram negative blood stream infections (GNBSI). The Trust has identified this as a quality priority for 2019/20, with a review and refresh of the system wide GNBSI action plan being undertaken during April 2019.

In January 2017, the Trust launched our '1000 voices' project to ensure that patient experience and feedback are at the heart of service development and quality improvement. The 1000 voices programme continues to be promoted within the Trust and provides 'real time' data to wards on the patient's experience. The real time facilitators spoke with 4383 patients during 2018/19.

Since the programme began there has been a slow rise in the domain scores with improvements across the board. The programme is now embedded into the culture of patient experience in the inpatient environment.

Hospital numbers are recorded for patients who take part in the survey to allow the team to look at the experiences of patients across the Trust in groups such as age, ethnicity, service and procedure rather than just the snapshot of an individual ward. The Patient Experience team has worked closely with the Treat as One (TAO) working group to be able to demonstrate the experience of those patients with mental health conditions. This has been the first step in the Patient Experience Programme utilising the hospital information collected from patients. This has helped to inform the work undertaken by the group and assist in feeding into the TAO strategy.

The introduction of the online Meridian system in Quarter 1 2019/20 will give us the facility to reach more patients and will also enhance the 1000 voices programme and allow us to obtain information from 'hard to reach' groups.

The Trust has seen the results of its 15th national survey of adult inpatients in 2018. With 546 surveys returned completed, the Trust had a response rate of 46.3. The Trust achieved an average score of 80% which is higher than last year. The Trust scored in the top 20% of Trusts on 38 questions and the bottom 20% on one question.

During 2018/19 the Trust:

- Delivered an 11.7% reduction in falls compared with 2017/18 and achievement of the target of <5 per 1000 bed days with an average for the year of 4.8 per 1000 bed days
- Participation in a criteria led discharge national collaborative led by NHS Improvement to provide patients with a quicker and more efficient discharge process
- The Trust's response to deaths in care has been strengthened through the introduction of the Medical Examiner Service in May 2018. We are the first Trust in the north east to implement this and are sharing our knowledge and experience with local Trusts.

With a focus on improving medication safety, the organisation achieved a reduction in omitted doses, and in particular for critical medicines.

The agreed quality priorities for 2019/2020 include:

Patient Safety

- Improve recognition and reporting of patient safety incidents and ensure lessons learnt are embedded across the organisation (including pressure ulcers and medication safety)
- Reduce harm from health care associated infection with a focus on gram-negative bacterial bloodstream infections
- Reduce the occurrence of 'Never Events' and ensure there is a focus on safe surgical practice

Clinical Effectiveness

- Ensure patients have a safe, effective and timely discharge
- Ensure there is recognition and appropriate management of patients who are clinically deteriorating, including compliance with the escalation pathway
- Ensure that patients' pain is managed appropriately and effectively
- Agree and implement the 'End of Life Care' Strategy

Patient Experience

- Develop the patient experience programme using the Meridian system to increase patient feedback including 'hard to reach' groups
- Review the way complaints are investigated and standardise complaint responses
- Improve the Out-patient Department experience (via Governor drop-ins, secret shopper and better communication via all channels)

Each priority has an executive lead, who is responsible for securing improvements in line with agreed deliverables.

During 2018/19, the Trust directed internal audit to review the process for recording and reporting the (18 week) Referral to Treatment (RTT) consultant led elective waiting times. This formed part of a wider validation programme of the RTT process undertaken by the Trust earlier in the year. The internal audit corroborated the key areas of focus identified, which prompted changes to the reporting mechanism. Targeted training and awareness sessions were also undertaken to address highlighted risks to the quality and accuracy of the data. Additional weekly and monthly data quality reports have been put into place which target known areas of concern, with compliance issues raised daily through performance monitoring.

In November 2018, The North of England Commissioning Support Unit (NECS) was also commissioned to undertake a validation exercise on behalf of the Trust on the data that is used to report RTT compliance. This presented the ideal opportunity to provide assurance via a "critical friend" and to ensure that highlighted issues were being addressed and improvements made. A site visit from the NHS Improvements Elective Intensive Support Team, and review of the Trust Access Policy and proposed improvement programme, provided the opportunity to engage with key stakeholders within the RTT process and provided further assurance, guidance and support.

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, executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Quality Assurance Committee, Finance and Investment Committee, Risk Committee, Executive Risk Group and Operational Management Board and a plan to address weaknesses and ensure continuous improvement of the systems in place.

The Board Assurance Framework provides me with an opinion about the effectiveness of the assurance framework and the internal controls that manage the risks to the organisation achieving its principle objectives. Internal audit provides me with an opinion on the effectiveness of the assurance framework and internal controls reviewed as part of the internal audit plan. Work undertaken by internal audit is reviewed by the Board Committees, including the Audit Committee. During 2018/19, the Trust directed internal audit to review all aspects of IT and information governance (including DSP toolkit compliance, cyber security, IT strategy and data quality), corporate governance, Emergency preparedness and Business Continuity, key financial systems and controls, and consultant contracts. The Trust continued to embed its approach to counter fraud including a number of investigations.

The outcome of these Audits has resulted in the overall opinion as mentioned above. This position was discussed by the Audit Committee at its meeting held on 23 May 2018 and the Board on 28 May 2018. It was determined that the Trust has risk management processes in place to manage and mitigate these risks including the Board Assurance Framework and Risk Registers which are reviewed by the Risk Committee, Executive Risk Group, Board Committees and Operational Management Board with significant risks detailed within the Chief Executive's Report and Integrated Performance Report presented to the Board at each of its meetings. This provides me and the Board with evidence of the effectiveness of controls in place to manage risks to achieve the Trust's principal objectives.

The Trust commissioned an independent Well-led Review in 2017 and since that time the Trust has made significant improvements with regard to Board governance and Clostridium difficile. As a result of that NHS Improvement considered the Trust to be fully compliant with its licence for Board Governance and Clostridium difficile. A compliance certificate was issued by NHS Improvement in October 2017 and a revised enforcement undertaking was issued to supersede the previous undertaking in relation to financial suitability.

My review is also informed by the external audit opinion, inspections carried out by the CQC and other external agencies and visits of accreditation. In assessing and managing risks, the Trust has well established processes to ensure the effectiveness of the systems of internal control. The Trust has assessed compliance with the NHS Foundation Trust condition 4 (FT governance). The Audit Committee reviewed the assessment at its meeting on 23 May 2018 and confirmed no material risk had been identified. The Trust believes that effective systems and processes are in place to maintain and monitor the following conditions:

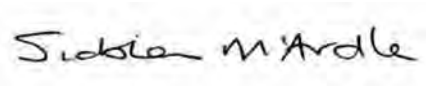
- the effectiveness of governance structures;
- the responsibility of Directors and Committees;
- reporting lines and accountabilities between the Board, its Committees and the executive team;
- the submission of timely and accurate information to assess risks to compliance with the Trust's licence;
- the degree and rigour of oversight the Board has over the Trust's performance.

These conditions are detailed further within the Corporate Governance Statement; the validity of this is assured by the Audit Committee.

Conclusion

The Board believes it has effective governance assurance systems in place and is continuing to strengthen and improve upon these. The control issues identified within 2017/18 have been addressed, and this is reflected in the 2018/19 Internal Audit opinion. This framework enables identification of issues and control risks and is designed to manage organisational objectives and minimise the Trust's exposure to risk. Internal and external audit reviews, audits, inspections and the Trust's governance systems are all part of the overall process to identify risks. When identified these risks are reported through the Trust's Assurance Framework and Risk Registers and managed and improved upon within the overall framework of the Trust.

Signed:



Date: 20 June 2019

Siobhan McArdle
Chief Executive & Accounting Officer

KPMG

Independent auditor's report

to the Council of Governors of South Tees Hospitals NHS Foundation Trust

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of South Tees Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2019 which comprise the Group and Trust Statements of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Equity, Group and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

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 2019 and of the Group's and Trust's income and expenditure for the year then ended; and
- the Group's and the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2018/19 and the Department of Health and Social Care Group Accounting Manual 2018/19.

Overview		
Materiality: Group financial statements as a whole	£10.4m (2018:£8.0m) 1.7% (2018: 1.3%) of Operating Income	
Coverage	100% (2018:100%) of Operating Income	
Risks of material misstatement		**vs 2018**
Event driven	**New:** Material uncertainty relating to going concern	▲
Recurring risks	Valuation of land and buildings	◄►
	New: Recoverability of PFI prepayment	▲

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Group and Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

2. Material uncertainty relating to going concern

	The risk	Our response
Going concern We draw attention to note 1.3.1 to the financial statements which indicates that the Group's outturn position for the current year was a deficit of £30.9m. Furthermore the Group has £55.0m of borrowings with the Department of Health and Social Care (DHSC) which fall due for payment in full in March 2020. The Group is also forecasting a deficit of £0.6 million for the year ending 31 March 2020 and on this basis will require ongoing revenue loan support from the DHSC, together with non-repayment of current funding in order to meet the future financial obligations of the Group. The Group does not have alternative funds from which to settle these future repayment obligations. Furthermore the Group has not been notified by any relevant national body of any intention to dissolve the Group or to transfer services to another public sector entity. The directors acknowledge that there can be no certainty that this financial support from DHSC will continue although, at the date of approval of these financial statements, they have no reason to believe that it will not do so. These events and conditions, along with the other matters explained in note 1.3.1, constitute a material uncertainty that may cast significant doubt on the Group's and the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.	**Disclosure quality:** There is little judgement involved in the directors' conclusion that the risks and circumstances described in note 1.3.1 to the financial statements represent a material uncertainty over the ability of the Group and Trust to continue as a going concern for a period of at least one year from the date of approval of the financial statements. However, clear and full disclosure of the facts and the directors' rationale for the use of the going concern basis of preparation, including that there is a related material uncertainty, is a key financial statement disclosure and so was the focus of our audit in this area. Auditing standards require this to be reported as a key audit matter.	Our procedures included: — **Our NHS experience:** We assessed the likelihood of DHSC not demanding repayment of existing loans in the 12 month period under assessment. — **Historical comparisons:** We assessed the Group's performance in meeting its financial targets set in the 2018/19 financial plan, including Control Total, Efficiency Plan and Cost Improvement Programme. — **Assessing transparency:** We assessed the completeness and accuracy of the matters disclosed in the going concern disclosure with reference to our audit findings. We further assessed whether the going concern disclosure was consistent with our understanding and that the material uncertainty was clearly disclosed by; — Using our professional judgement to determine whether the basis of preparation note adequately describes the challenges facing the Trust; — Agreeing the financial balances disclosed in note 1.3.1 back to the Trust's financial statements for 2018/19 and the financial plan for 2019/20; and — Confirming the terms and classifications of the loans and considering the timing of future repayments.

3. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on:the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows:

All of these key audit matters relate to the Group and the Trust.

	The risk	Our response
Valuation of land and buildings £170 million; (2018: £203 million) *Refer to pages 60-61 Audit Committee Report, Accounts Section 1.7 of Note 1 to the Accounts (accounting policy) and Note 9 of the Accounts (financial disclosures).*	**Subjective valuation:** Land and buildings are required to be maintained at up to date estimates of current value in existing use (EUV). For specialised assets where no market value is readily ascertainable, EUV is the depreciated replacement cost of a modern equivalent asset that has the same service potential as the existing property (DRC). There is significant judgement involved in determining the appropriate basis (EUV or DRC) for each asset according to the degree of specialisation, as well as over the assumptions made in arriving at the valuation. The DRC 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. Furthermore, replacement cost is decreased if VAT on replacement costs is deemed to be recoverable. The majority of the Trust estate is held under PFI arrangements under which the VAT on construction costs is recoverable. The valuer has provided DRC valuations net of VAT on the assumption that replacement assets would be provided using the existing PFI arrangements or through a facilities management company. This has a material impact on the valuation. The valuation is undertaken by an external expert engaged by the Group. The valuation utilises data provided by the Group's Estates Department. The Group's external valuers performed a full valuation, supported by inspection, as at January 2017 and February 2019 and indexed this to determine the valuation as at 31 March 2019. There is a risk that the valuation is not applied to the financial statement balances appropriately to recognise the valuation gains and impairment losses in line with the requirements of the Department of Health Group Accounting Manual 2018/19. The effect of these matter is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole, and possibly many times that amount.	Our procedures included: — **Assessing valuer's credentials:** We assessed the competence, capability, objectivity and independence of the Trust's external valuer and considered the terms of engagement of, and the instructions issued to, the valuer for consistency with the requirements of the NHS Group Accounting Manual; — **Methodology choice:** We assessed the appropriateness of the valuation basis and assumptions applied by the valuers; — **Test of detail:** We tested the accuracy of the estate base data provided to the external valuer to complete the valuation to ensure it accurately reflected the Trust's estate; — **Historic comparisons:** We considered the Group's history of VAT recovery through its PFI arrangement and the existing and future plans for its commercial activities and assessed the consistency of this judgement with the evidence presented; — **Accounting analysis:** We undertook work to understand the basis upon which any movements in the valuation of land and buildings had been classified and treated in the financial statements and determined whether they comply with the requirements of the DHSC Group Accounting manual 2018/19. — **Assessing transparency:** We considered the adequacy of the disclosures about the key judgements and degree of estimation involved in arriving at the valuation and the related sensitivities.

3. Key audit matters: our assessment of risks of material misstatement (continued)

	The risk	Our response
Recoverability of PFI Prepayment £24.5 million; (2018: £23.9 million) *Refer to pages 60-61 Audit Committee Report, Accounts Section 1.12 of Note 1 to the Accounts (accounting policy) and Note 17 of the Accounts (financial disclosures).*	**Subjective estimate:** The Trust entered into a PFI contract in 2003 (and expiring in 2033) under which the PFI operator is required to build and to maintain the majority of the Trust's estate. In line with DHSC guidance the Trust recognises both the PFI property asset and the corresponding liabilities on balance sheet and splits the unitary payments into payments for services, payments for the asset and lifecycle payments. As is the norm for lifecycle replacement under a PFI scheme, the timing of the actual lifecycle expenditure incurred by the operator is different to the profile of the planned expenditure in the financial model. The Trust has recognised a prepayment of £24.5m representing deferred purchased lifecycle which will be incurred later than originally planned. When the lifecycle replacement is actually received this prepayment will be derecognised and new items recognised as property, plant and equipment. To the extent that any planned expenditure is considered to be no longer needed then the prepayment should be expensed to the Income Statement. There is a risk that the prepayment could include amounts for planned lifecycle expenditure which is no longer expected to be incurred and therefore that the prepayment should be impaired.	Our procedures included: – **Tests of details:** We have reconciled the accounting entries back to the PFI model established on inception of the PFI contract and agreed current year payments back to invoice and cash. – **Enquires with PFI operator:** We have inspected correspondence and agreements between the Trust and the PFI operator which set out details of expenditure deferred to date together with the latest estimates of total expected lifecycle expenditure over the entire agreement. – **Test of detail:** We have performed a comparison between original agreed works per the contract, actual work to date and agreed deferred work. We have also compared the levels of total expected lifecycle expenditure with payments to date and future payments to be made. From this we have assessed the carrying value of the prepayment to the estimated level of future lifecycle costs deferred and the need for any provision against the prepayment.

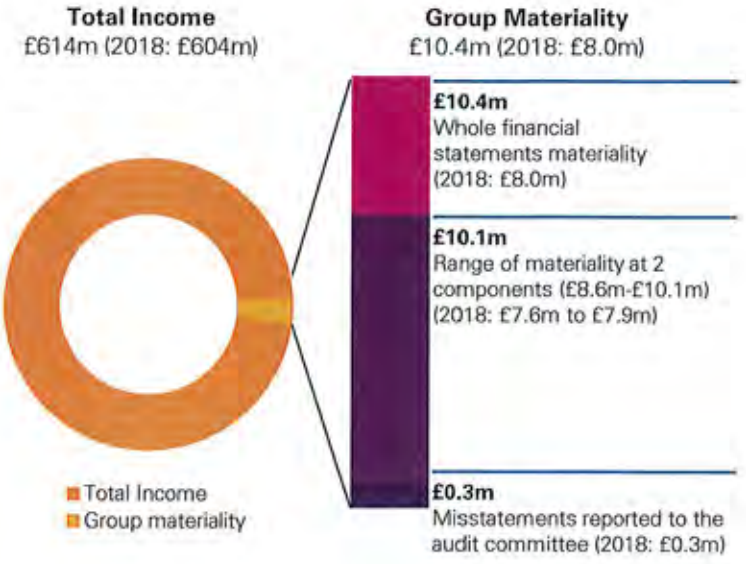
4. Our application of materiality and an overview of the scope of our audit

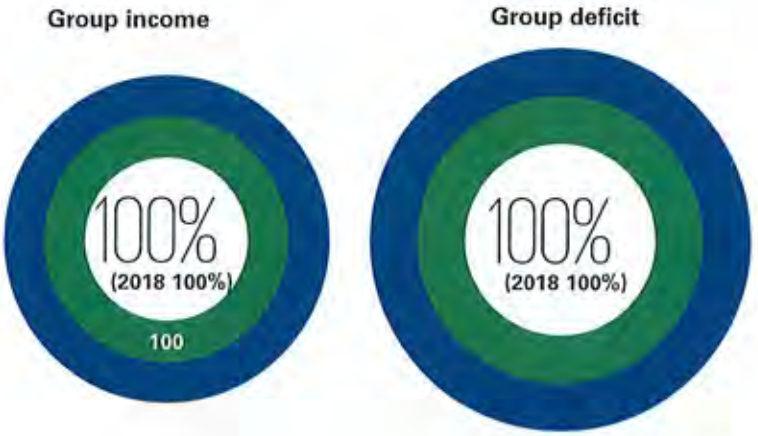
Materiality for the Group financial statements as a whole was set at £10.4 million (2018: £8.0 million), determined with reference to a benchmark of operating income (of which it represents approximately 1.7% (2017/18: 1.3%)). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

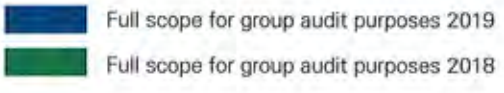
Materiality for the parent Trust's financial statements as a whole was set at £10.1 million (2018: £7.9 million), determined with reference to a benchmark of operating income (of which it represents approximately 1.7% (2017/18: 1.3%)).

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.3 million (2018: £0.3 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

The Group's two (2018: two) reporting components, were subject to full scope audits for Group purposes. The Group audit team carried out all of the work on the 2 components. The components within the scope of our work accounted for the percentages illustrated opposite.







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5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

Corporate governance disclosures

We are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Group's position and performance, business model and strategy; or
- the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or
- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19, 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.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page X, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group and parent Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and parent Trust without the transfer of their services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

Our conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources is adverse

Under the Code of Audit Practice we are required to report if the Trust has not made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

Adverse conclusion

As a result of the matters outlined in the basis for adverse conclusion paragraph below, we are unable to satisfy ourselves that in all significant respects South Tees Hospitals NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2019.

Basis for adverse conclusion

- In July 2014 NHS Improvement issued a notice of enforcement undertakings. NHS Improvement concluded that the Trust had failed to establish and effectively implement systems or processes to ensure compliance with its duty to operate efficiently, economically and effectively. The Trust remained subject to this enforcement notice at 31 March 2019.
- The Group is reliant on non-payment and the renewal of borrowings of £55.0m which fall due for payment during the 2019/20 year. The Group deficit for the year was £30.9m (2017/18: £9.6m).

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources..

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out below together with the findings from the work we carried out on each area.

Significant Risk	Description	Work carried out and judgements
Enforcement Undertakings	In July 2014 NHS Improvement (NHSI) issued a notice of enforcement undertakings. NHSI concluded that the Trust had failed to establish and effectively implement systems or processes to ensure compliance with its duty to operate effectively, economically and efficiently. The two elements that led to this conclusion related to financial sustainability and board governance. The Trust remains subject to this enforcement action.	Our work included: — We reviewed correspondence with NHSI and obtained documentation on the enforcement undertakings. **Our findings on this risk area:** — As a result of the enforcement undertakings we concluded that the Trust does not have adequate arrangements in place for planning its finances effectively to support the sustainable delivery of its strategic priorities and maintaining statutory functions, or for acting in the public interest, through demonstrating and applying the principles and values of sounds governance.
Financial Sustainability and Internal Control	The agreed plan for the financial year 2018/19 was a overall deficit of £1.0m, the actual outturn was a deficit of £30.9m. The Trust's planned control total for 2018/19 was a surplus of £3.8m including Provider Sustainability Fund (PSF). Excluding PSF the Trust's planned control total was a deficit of £10.1m. The Trust reported a control total surplus of £15.5m including PSF and a deficit of £7.9m excluding PSF, the overall deficit for the year was £30.9m. The Trust has submitted its annual plan for the 2019/20 financial year based on the achievement of an overall deficit of £0.6m, a control total surplus (including PSF) of £3.2m and control total deficit (excluding PSF) of £7.3m. The trust has borrowings of £55.0m which will require refinancing in the coming year with no arrangements in place to repay these borrowings.	Our work included: — An assessment of the process for forecasting and monitoring cash levels and the associated financial controls; — A review of correspondence with the main Clinical Commission Groups from which the Trust receives income; — An assessment of the Trust's funding arrangements and consideration of current borrowing facilities and the need to agree the non-payment and renewal of these borrowing facilities within the 2019/20 financial year together with any additional borrowing needs. **Our findings on this risk area:** — The Trust did achieve its Control total in the 2018/19 financial year but recorded a deficit for the year of £30.9m and continues to be reliant on further borrowing to meet its short term funding requirements. — Due to the significant financial challenges facing the Trust we determined that financial sustainability and the adequacy of internal control represented significant risks to our value for money conclusion. — As a result of the above we concluded that the Trust does not have adequate arrangements in place for planning its finances effectively to support the sustainable delivery of its strategic priorities and maintaining a sound system of internal control.

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 and the terms of our engagement by the Trust. 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 the further matters we are required to state to them in accordance with the terms agreed with the Trust, 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.

KPMG

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of South Tees Hospitals NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Paul Moran
for and on behalf of KPMG LLP (Statutory Auditor)
Chartered Accountants
Quayside House
110 Quayside
Newcastle upon Tyne
NE1 3DX
26 June 2019

3 Quality Report 2018 – 2019

Contents


Theatre Manager
Friarage Hospital

Part One
Statement on quality from the Chief Executive

I am delighted to introduce the 2018/2019 Quality Report as Chief Executive of South Tees Hospitals NHS Foundation Trust.

Patient safety and quality remains integral to everything we do and we are committed to ensuring our resources are used effectively in order to provide safe services and deliver high standards of care for our patients. This report outlines achievements and successes against our quality priorities over the past 12 months and also our quality priorities for 2019/20.

Infection prevention and control has remained a focus for 2018/19. The Trust continued to be below the threshold for trust attributed cases of Clostridium difficile, with an end of year total of 41. This was well below the target of 54 and is the lowest ever recorded number of trust apportioned cases.

Reducing gram negative blood stream infections (GNBSI) is a national priority with the stated aim of a 50% reduction in healthcare associated GNBSI by 2021. The burden, particularly of E.coli, is challenging and requires reliable auditing to establish the potential multiple causes of the GNBSIs. The Trust has identified this as a quality priority for the second year in a row, with a review and refresh of the system wide GNBSI action plan being undertaken during April 2019.

There has been a sustained focus on reducing falls during 2018/19 and this has included interventions such as improvements to signage, continence and delirium care planning, medication reviews and interventions to prevent muscle loss, specifically for older and frail patients. The Trust was successful in achieving its target of below 5 per 1000 bed days with an average of 4.8 per 1000 bed days, representing an 11.7% decrease in falls compared with 2017/18.

Securing a reduction in pressure ulcers remains an area of challenge for the trust, most notably due to the changes to the definitions and reporting processes following the publication of NHS Improvement Guidance. A full refresh of pressure ulcer prevention strategies is taking place across the whole organisation during April 2019 and securing reductions in avoidable harm in this area remains a key focus.

The 1000 voices programme continues to be promoted within the Trust and provides 'real time' data to wards on the patient's experience. The real time facilitators spoke with 4383 patients during 2018/19.

The Family and Friends Test (FFT) response rates are lower than the national average and we are continuing to try different methodologies to improve this. The introduction of the online Meridian system in Q1 19/20 will give us the facility to reach more patients and will also enhance the 1000 Voices Programme and allow us to obtain information from 'hard to reach' groups.

The Trust's response to deaths in care has been strengthened through the introduction of Medical Examiners (ME) in May 2018. We are proud of this achievement as we are the first organisation in the North East to establish this service and we are sharing our knowledge and experience with other trusts in the area. Our aim is that all deaths (not referred to the Coroner in acute hospitals) in the Trust will receive a first level review. Currently about 70% of deaths receive a first level review with around 15% of those requiring a full case record review (second stage).

The development of criteria led discharge (CLD) is intended to provide patients with a quicker and more efficient discharge process, respond to patient needs, and reduce discharge delays and to make best use of nurse, allied health professional and junior doctors' skills. The Trust has participated in an NHS Improvement national collaborative project to implement this and the project ran from October 2018 to March 2019. South Tees was awarded the peer prize for the Trust as it has demonstrated the most progress. This will remain a priority for 2019/20.

Operationally, our other key quality measures, which directly link to the outcomes and experience of our patients, were:

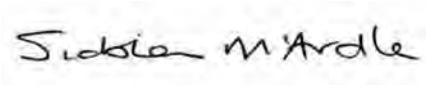
- 4 hour Accident and Emergency waiting time target - our year-end performance was 95.24% against a target of 95% and we are incredibly proud of meeting this target again.
- 62-day cancer wait target for first definitive treatment for all cancers – our indicative year-end performance was 82.65% against a target of 85%. This is an area of significant concern for the organisation and action plans are in place both within the organisation and working with referring partners to improve this.
- Referral to Treatment (RTT) 18-week target – our year-end performance was 89.49% which is below the national target of 92%, however our waiting list size has not grown in comparison to 2017/18.

Despite challenging financial and operational pressures on our services, and the NHS as a whole, we have seen some significant improvements this year which we are immensely proud of.

We continue to promote a quality focused and honest and open culture throughout our organisation to ensure we deliver excellence in both patient outcome and experience. Reporting of incidents and ensuring that lessons learnt are shared across the Organisation will remain a focus, with the Trust committed to delivering 'harm free' patient care. The evolving Clinical Intelligence Unit will be a key enabler to support the organisation to drive service improvements, providing detailed analysis and triangulation of a number of data sources including patient outcome and experience.

To the best of my knowledge, the information contained in this Quality Account is accurate.

Signed:



Date: 20 June 2019

Siobhan McArdle
Chief Executive & Accounting Officer

Part Two Priorities for Improvement and Statements of Assurance from the Board


Freedom to Speak Up
Freedom to Speak Up Guardian

Priorities for improvement

Review of progress with the 2018/19 quality priorities

In last year's Quality Account we identified the following as our quality priorities:

Safety

- Improving medication safety
- Improving incident reporting (to drive safety culture)
- Reducing harm from HCAI with a focus on E-coli

Outcomes

- Strengthening mortality process
- Improving early review of emergency patients by a consultant across the week
- Ensuring safe and effective discharge

Patient Experience

- Develop and implement the patient experience strategy
- Improving the care of patients with mental health concerns and those in vulnerable groups through a holistic and collaborative approach
- Improving communication with our patients and particularly focusing on reducing the amount of conflicting information patients receive

The following section summarises the progress made against the goals identified for each priority.

Patient Safety

Priority: Improving Medication Safety

Goals:

- To increase the percentage of medicines reconciliation within 24 hours. Target 70% by Q4.
- To continue to ensure the omitted doses of the Trust remain below 5% consistently including critical medicines. Maintain omitted doses of critical medicines below 2%.

How will we do this?

Implement medication safety dashboards in all inpatient areas in Q1. Provide education and training to ensure staff are aware of metrics on a monthly basis. Ensure performance and learning is embedded in multi-professional ward safety huddles.

- Review the pharmacy workforce model to improve the productivity and efficiency of staffing levels to increase medicines reconciliation, a restructure of staff to allow more medicines management technicians has occurred and will go live in Q2. A weekend service will be implemented in the Acute Admission units in Q2
- Implement a pilot of automated medicines cabinets in the Emergency Department and Critical Care areas at the James Cook University Hospital, if successful to create a business case for further areas with high omitted doses
- Ambition to procure and implement an Electronic Prescribing system during 2018/19 (as part of an Electronic Patient Record) as a key enabler to improving medication safety

Achievements and challenges of 2018/19 goals

To increase the percentage of medicines reconciliation within 24 hours (target of 70% by Q4)

Medicines reconciliation is the process of ensuring that an accurate record is taken of the patient's medication prior to admission to hospital, to ensure the prescriber has a complete record from which appropriate decisions to continue or stop treatment are made. This is completed using various sources - patient, carer, GP surgery, repeat prescription forms, summary care records or MAR (Medicine Administration Record) charts. It is usually undertaken by a pharmacist or medicine management trained technician. The process ensures a reduction in prescribing errors leading to safe and effective prescribing and administration of routine medications for all patients admitted to hospital.

See table and graph of medicines reconciliation figures across the organisation in the past 11 months:

Apr-18	20.0%
May-18	32.7%
Jun-18	41.9%
Jul-18	45.8%
Aug-18	47.0%
Sep-18	51.3%
Oct-18	67.6%
Nov-18	59.0%
Dec-18	58.5%
Jan-19	46.9%
Feb-19	37.4%
Mar-19	43.4%

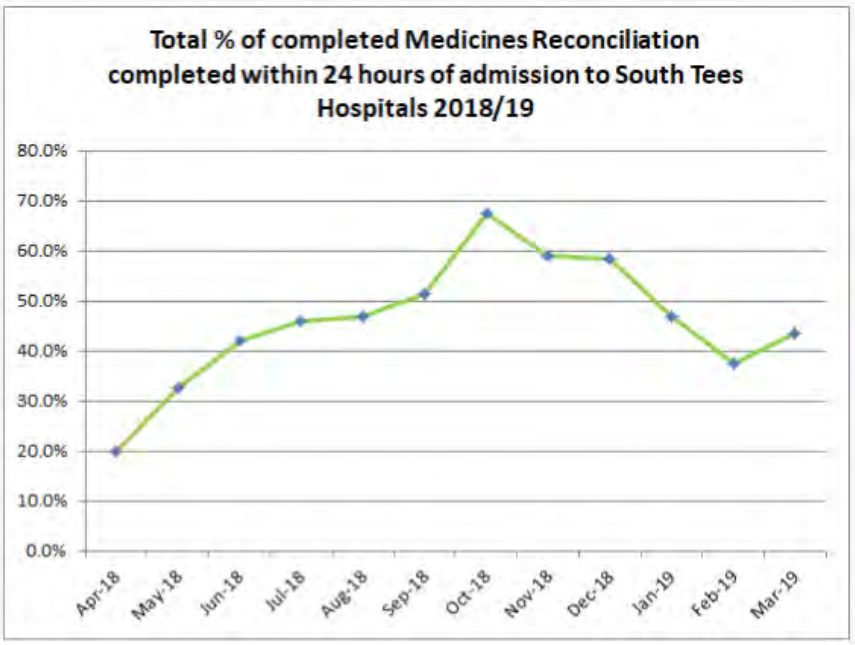


Figure 1: Medicines reconciliation 18/19

The medicines reconciliation results showed a steady incline from April to October 2018, where results steadily improved to a maximum of 67% in October 2018, reflecting the implementation of the previous year's goals.

While the proportion of medicines reconciliation completed within the first twenty four hours of admission has reduced from 67.6% to 37.4% in the past 4 months, the total number of completed medicines reconciliation has reduced only from 87.1% to 71.2%. This is likely to be due to pharmacy teams undertaking medicines reconciliation later, due to increased patient throughput. Additionally, other ward-based activity is noted to be buoyant; e.g. ward-based dispensing, pre-screening of discharge prescriptions and patient counselling, while the number of pharmacist clinical reviews has increased overall despite the apparent reduction in medicines reconciliation. This suggests that teams are seeing a greater number of patients overall, though the proportion reviewed within the first twenty four hours of admission has fallen. See below for details of plans in place to address this.

The medication safety dashboards have been successfully implemented in all areas across the organisation in 2018/19. These have been a useful tool to share, promote and improve upon monthly metrics of both medicines reconciliation and omitted doses in each individual area. Further promotion, education and training for nursing staff on the dashboards is planned for 2019/20, to ensure these priorities are embedded within the wards and departments across the organisation.

To ensure that omitted doses across the Trust maintain below 5% for all medicines and below 2% for critical medicines

Omitted doses are any medications that are prescribed for, but not administered to a patient. This may be for a variety of reasons including the medication being unavailable, the route of administration not being available (e.g. patient nil by mouth) or the patient refusing medication. Critical medicines are those that pose a higher risk if omitted or not administered on time, for example, insulin, Parkinson medication and anticoagulants (to help prevent blood clots).

Table 1 and Figure 2 show the figures for omitted doses for the past 11 months:

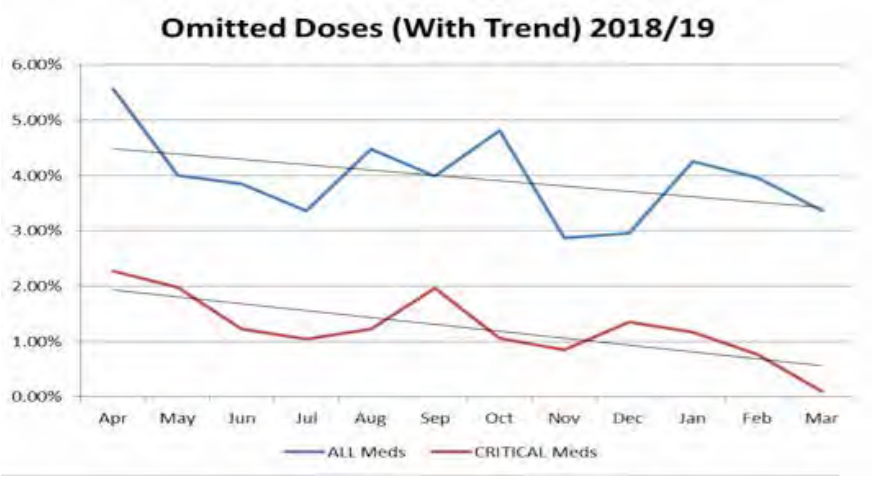


Figure 2: Omitted doses 2018/19

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
ALL Meds	5.56%	4.00%	3.84%	3.36%	4.47%	3.99%	4.81%	2.88%	2.95%	4.25%	3.95%	3.36%
CRITICAL Meds	2.27%	1.98%	1.23%	1.04%	1.22%	1.97%	1.07%	0.85%	1.35%	1.18%	0.77%	0.10%

Table 1: Omitted Doses per Month

As the information demonstrates, the Trust was successful in achieving this goal.

The continual monitoring of omitted doses on a monthly basis has maintained focus on this issue. While conducting the audit the pharmacy team investigate the reason(s) for the omission and highlight to the ward team solutions to prevent this, i.e. pharmacy ordering process, accurate documentation, helping to prevent reoccurrence by education. The results are fed back to the wards by the pharmacy teams. This audit is also included on the ward monthly medicine management dashboard, feeding back the results in real time.

Plans to further achieve set goals

In relation to further improving medicines reconciliation and omitted doses targets, the following planned actions have not yet been actioned:

- Implement a pilot of automated medicines cabinets in the Emergency Department and Critical Care areas at the James Cook University Hospital, if successful create a business case to roll this out in other areas with high omitted doses.
- Ambition to procure and implement an Electronic Prescribing system during 2018/19 (as part of an Electronic Patient Record) as a key enabler to improving medication safety.

A business case for the automated medicines cabinets has been approved, with planned implementation of the first two cabinets in Q2 of 2019/20 and implementation of a further 15 cabinets by Q4. The implementation of these cabinets raises the potential for omitted doses figures to be further decreased, by ensuring prompt and effective medication ordering from pharmacy, to ensure suitable and consistent stock levels of medication in the ward areas to allow timely administration.

Progress has been made with the procurement of an Electronic Prescribing system as part of an Electronic Patient Record, and this project is continuing. There is currently no agreed date for implementation of this but the aim is to initiate this within two years. There is a multi-disciplinary group involved in this project which has Board support. Until both of these actions are implemented, interim measures to improve medicines reconciliation figures include:

1. Optimisation of workforce skill mix.
2. Deployment of four lap-tops to the clinical teams to facilitate access to the Summary Care Record for medicines reconciliation.
3. Implementation of more robust data collection by teams to ensure consistent data collection via the eCamis whiteboards, once operational in all areas of the trust. The eCamis whiteboards are interactive whiteboards that allow staff to electronically update which patients have had medicines reconciliation completed in real time.
4. Senior pharmacy team reviewing and promoting the Zephyr SCR (Summary Care Record) data-transformation tool to reduce time taken on transcription of SCR information into the notes implemented by Q2. A re-design of the standard document that it produces to fit what we would need has been completed.

A clinical weekend service is additionally planned to be implemented in the acute admission units at James Cook University Hospital by Q4, which will further contribute to improving medicines reconciliation figures.

Interim measures to improve and maintain a low rate of omitted doses are to include:

1. Continued feedback of omitted dose audit results to relevant care centre directorate meetings by the relevant lead pharmacist.
2. The standards for completion of the medication charts (by prescribers and nursing staff) will be reinforced by the Acting Chief Pharmacist and via the Safer Medication Practice Group (SMPG).

Plans for Further Medication Safety Improvements in 2019/2020

1. To effectively prioritise medicines reconciliations for high risk patients.

The implementation of prioritisation tools for pharmacy staff/nursing staff is aimed at ensuring effective prioritisation of high risk patients for medicines reconciliation. This is planned to be implemented by Q2.

2. To implement biannual pharmacy-led medicines assurance rounds for all wards and departments across the organisation.

These medicines assurance rounds are aimed at ensuring that all wards and departments are safely and securely storing and using medications, in line with the Trusts Medicines Policy (G34). Pharmacy-led medicine's assurance rounds are planned to be completed in Q1 and Q3 (in addition to the adapted NHS protect security audit that is routinely conducted in Q2 and Q4).

Safety

Priority: Improving incident reporting to drive a safety culture

Goals:

- To improve the safety culture within the organisation by encouraging staff to report incidents and near misses and improve feedback of lessons learnt.
- Quarter on quarter increase in incident reporting.
- Increased feedback of lessons learnt at ward, centre and Trust level.

How will we do this?

- Education and awareness training
- Survey of staff to identify barriers to reporting
- Improve near miss reporting
- Review incident reporting form
- Review feedback process to reporters of incidents
- Streamline final approval process
- Streamline root cause analysis process for falls and pressure ulcers

Progress

The Trust corporate induction programme of face to face training has commenced in March 2019 and this includes a presentation on patient safety and the importance of incident reporting including near miss reporting, as well as an interactive teaching session on how to report an Incident.

On average, 1,350 incidents are reported each month which equates to 44 incidents on each day of each month. Near miss reporting has improved by almost 50% from 600 in 2017/18 to 874 in 2018/19. Improved descriptors on Datix, the risk management software used within the Trust, may have enhanced reporters understanding of what constitutes a near miss.

		Q1 Apr to Jun				Q2 Jul to Sep				Q3 Oct to Dec				Q4 Jan to Mar					
		Apr 2018	May 2018	June 2018	Q1	Jul 2018	Aug 2018	Sep 2018	Q2	Oct 2018	Nov 2018	Dec 2018	Q3	Jan 2019	Feb 2019	Mar 2019	Q4	2018 /19	2017 /18 YTD
Incidents	Total number of incidents	1086	1191	1068	3345	1086	1125	1066	3277	1216	1162	1181	3559	1313	1166	1149	3628	18809	13886
	Incidents graded as moderate or above	25	38	32	95	30	35	23	88	29	22	19	70	23	34	36	93	346	275
	Incidents graded as moderate and above %	2.3%	3.2%	3.0%	2.8%	2.8%	3.1%	2.2%	2.7%	2.4%	1.9%	1.6%	2.0%	1.8%	2.9%	3.1%	2.6%	2.5%	2.0

Table 2: Incidents Reported per quarter in 2018/19

Table 2 demonstrates that in Q1 a total of 3345 incidents were reported, 3277 incidents were reported in Q2, 3559 in Q3 and 3628 in Q4. A total of 13809 incidents were reported in 2018/19 compared with 2017/18 when 13886 incidents were reported, this represents a very slight decrease.

Work is currently taking place to review the functionality of Datix to facilitate incident reporting and improve the process so it is less laborious. Voice recognition and other methods of utilising Datix are currently being explored with the aim of increasing incident reporting by making it easier to report an incident.

The Datix incident report form has been reviewed and work is continuing to refine this. The pressure ulcer reporting form has been incorporated into the general Incident reporting form (it was previously a separate form) with all sections streamlined and corresponding with the Root Cause Analysis (RCA) paperwork. Incidents are now sub-categorised and graded by the reporter allowing for meaningful data to be pulled on submission and harm events to be alerted through appropriately.

Incidents that are overdue are reviewed on a weekly basis as part of the Executive-led Patient Safety Wall and work continues to streamline this process with the Quality Business Partners (QBP). A weekly review of open harm events with QBPs and the patient safety team will commence with the aim of closing down incidents within the week that they are reported.

A process to support the early identification and investigation of patient harm events has been introduced with director level colleagues along with clinicians involved in the patient's care dialling in to decision-making MDT's. The patient safety team review all harm events graded as moderate and above on a daily basis and encourage early investigation and feedback to establish any trust-wide actions required.

A revised Investigation template has been launched trust-wide to replace the Root Cause Analysis template. Our commissioners have approved this streamlined tool and we hope to extend this to pressure ulcers and falls Serious Incidents (SI's) over the coming months. The reviewed action plan allows for actions that would prevent the event and actions that are incidental to be tracked in one document.

The quality performance ward dashboards include a list of safety alerts which have been distributed in the previous month – many of which have been developed following an Incident. A Patient Safety Sub Group was established in Q2 18/19 with a key focus on Trust wide learning.

Safety

Priority: Reducing harm from healthcare associated infections with a focus on gram negative bacteraemia

Goals:

- To reduce the incidence of E.coli blood stream infections.
- To improve continence care within the acute hospital for frail/older people and increase the number of patients with a urinary catheter who have a pathway in place.

How will we do this?

- Review the contributory factors leading to an E.coli blood stream infection by individual case review to inform action planning across the health economy, from Q1.
- Work with local nursing homes to improve education and training in continence management and urinary catheter care.
- Develop and implement guidance for the treatment of urinary tract infection in the frail / older people.
- Reduce the number of urinary catheters inserted in the hospital setting.
- Implement urinary catheter pathway across the hospital and community setting.
- Be an active partner in the Tees wide Infection Prevention and Control Collaborative developing and implementing strategies to improve hydration in older people.

How will we know how we have done?

- Number of Trust assigned E.coli cases
- Number of urinary catheters inserted
- Number of patients with a urinary catheter who have a pathway in place

Progress:

Review the contributory factors leading to an E.coli blood stream infection by individual case review to inform action planning across the health economy, from Q1.

In February 2018 dedicated Infection Prevention and Control (IPC) time was identified to collect and analyse data to enable a thematic analysis and identification of the key contributory factors for GNSBI (Gram-negative bacterial blood stream infections). IPC conducted robust surveillance monitoring of GNBSI across the health economy, including completion of mandatory data entry to Public Health England Data Capture System (DCS). Urinary tract infections were agreed as the focus.

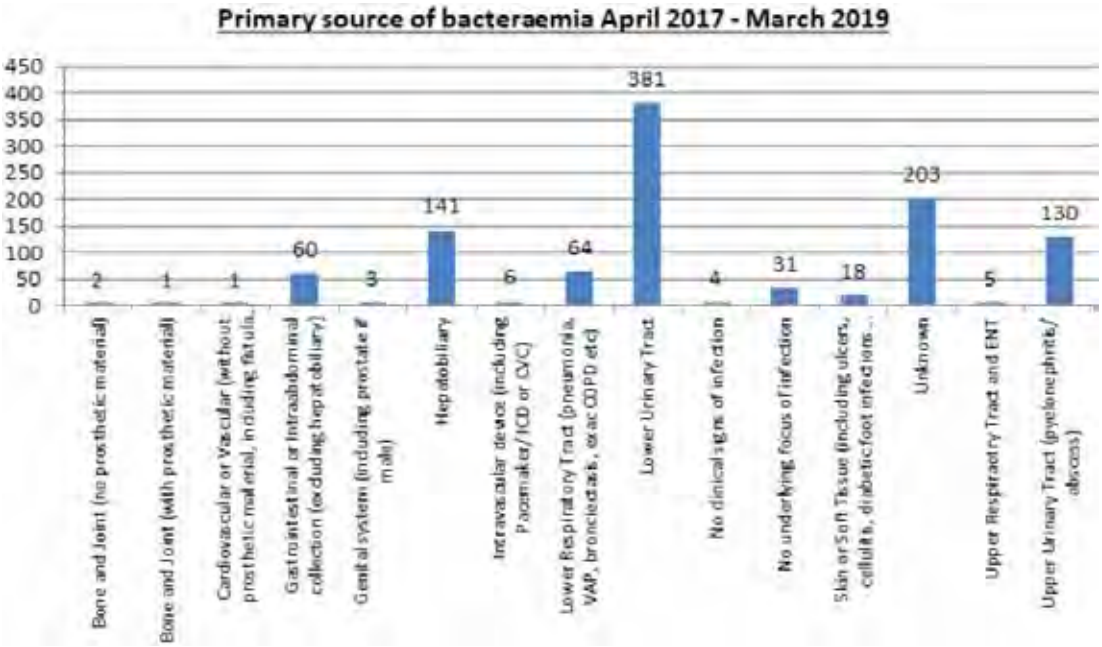


Figure 3: Primary source of E.coli bacteraemia April 2017 – March 2019

Work with local nursing homes to improve education and training in continence management and urinary catheter care.

An IPC Post has been established funded by Better Care specifically linking Care Homes with Health and Social Care and acute trusts for South Tees Hospitals NHS Foundation Trust with part of the aim of delivering education to care homes around continence and urinary catheter care. Funding for the post has been secured for a further 12 months until April 2020. Teaching resources were made available on South Tees internet and intranet in January 2018, informing staff of appropriate catheter care and providing contact numbers for professional advice. The resources were also available to prompt healthcare staff in planning, reviewing and removing catheters prior to discharge. Physical copies of the resources were provided to all care homes as a collaborative and aligned care home support service. In collaboration with CCG's Quality leads and social care colleagues, training needs across localities involved public campaigns engaging with Public Health and Primary Care and utilising different media platforms.

Develop and implement guidance for the treatment of urinary tract infection in the frail /older people.

South Tees Hospitals NHS Foundation Trust achieved the national CQUIN (Commissioning for Quality and Innovation) for reduction in antibiotic prescribing for urinary tract infections (UTI's) from 1st April 2017 to 31st March 2018. Phase two is the development of urinary tract infection guidance; this is currently in draft form with an anticipated launch date of September 2019. This work is being led by the Clinical Lead for Frailty as part of our wider delirium prevention work for older adults.

In addition, the Trust nursing and continence assessment has been amended to reflect Public Health England guidance advising that health professionals stop performing urine dipsticks in patients over 65 years old with a suspected UTI. The changes to both documents focus on symptoms of a UTI and complement the draft treatment guidance. Both are scheduled for launch Trust-wide in April 2019 following a trial within our older peoples' wards.

Reduce the number of urinary catheters inserted in the hospital and community setting setting

Development and launch of continence clinical guidance and product guide including continence formulary review at regional level commenced in April 2018 and is currently in progress. This was to look at standardising all continence products. In December 2018 a six monthly point prevalence audit of 105 local care homes demonstrated an overall reduction of 15% in urinary catheters since June 2017 (figure 4). (NB This data is produced 6 monthly with the next data being published in June this year).

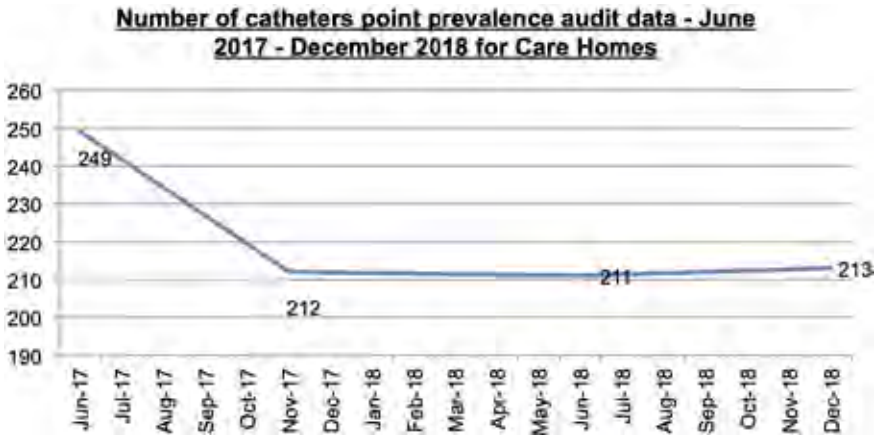


Figure 4. Point prevalence audit of urinary catheters in care homes

Within the Trust, processes for reviewing catheterisation in the Accident and Emergency department post discharge following acute retention were implemented through improving patient care delivery and follow-up services. Training was provided in care homes, to care home providers and GP practices regarding patients who were being discharged from the acute hospital setting with catheters to ensure robust communication of follow-up care where necessary.

Implement urinary catheter pathway across the hospital and community setting

Urinary catheter pathways were trialled from January 2018 and launched at South Tees Hospitals NHS Foundation Trust in June 2018 in collaboration with the IPN (Infection and Prevention Nurse) working in the community funded by Better Care. A community urinary catheter pathway was created and embedded into System One (community database) for primary care in June 2018.

Be an active partner in the Tees wide Infection Prevention and Control Collaborative developing and implementing strategies to improve hydration in older people.

Following analysis of E.coli bacteraemia data by the Infection Prevention team to identify potential themes/trends and extrapolating unique data from HCAI (Healthcare Acquired Infections) DCS, urinary tract infections (UTI's) were agreed as the focus. As a potential cause of UTI, hydration was acknowledged as a priority in the prevention and management of UTIs in older people. Urine colour charts and fluid matrix (Figure 5) were launched in March 2018 as part of this work and more initiatives are planned for 2019/2020.

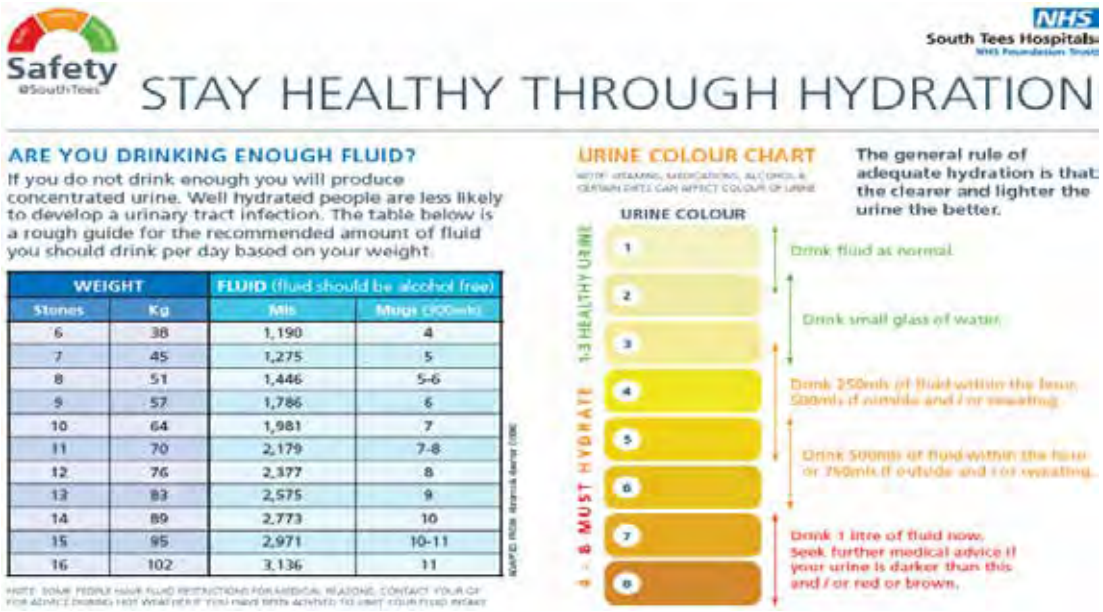


Figure 5: Urine colour chart and fluid matrix

Number of Trust assigned and non-Trust assigned GNBSI for 2018/19

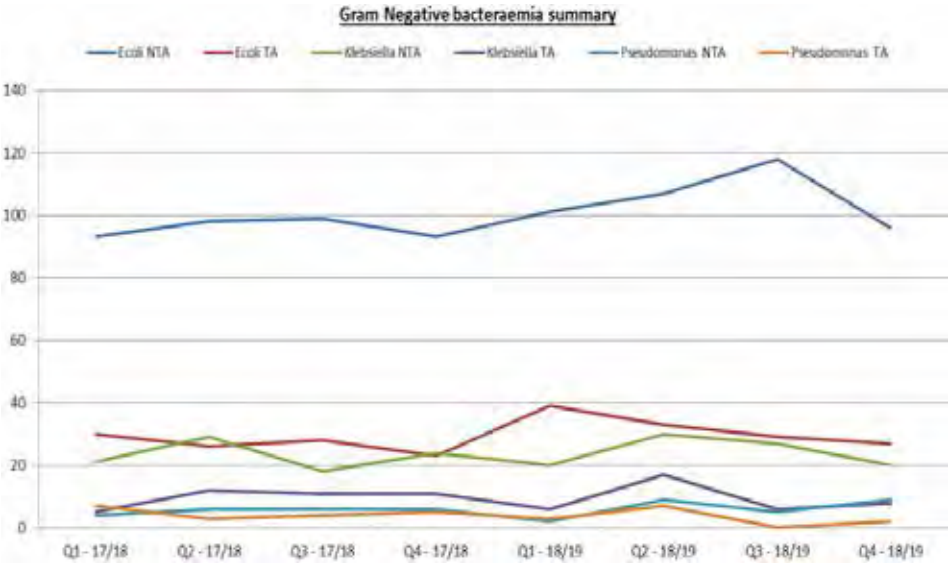


Figure 6: Gram Negative bacteraemia summary 2018/19

The data above highlights the burden of E.coli bacteraemia in the community, however figures in Q4 show a reduction in numbers for both Trust and non-Trust attributed GNBSI.

Number of urinary catheters inserted

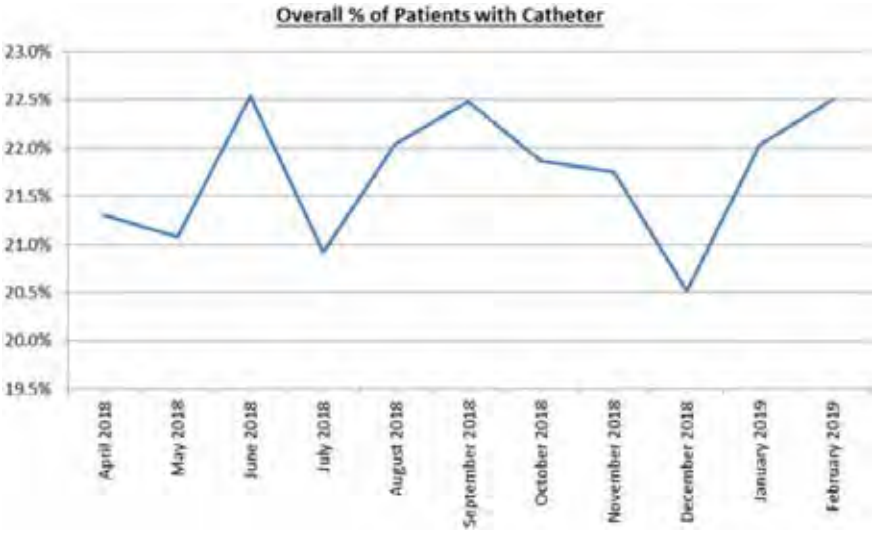


Figure 7: Overall percentage of patients with catheters

Safety thermometer data demonstrating numbers of patients with catheters in situ from April 2018 to December 2018 showed a decline in catheters and then a slight increase to February 2019. This data includes patients who have been admitted with catheters. Point prevalence audit from July 2018 to October 2018 of SystmOne demonstrated that over 95% of urinary catheters were originally inserted in the acute hospital setting, highlighting the need for robust review of catheters in situ in an inpatient setting and promoting prompts for early removal, which remains a key focus.

Number of patients with a urinary catheter who have a pathway in place

The use of the catheter pathway for patients who have urinary catheters is yet to be measured. This is planned for May 2019 to allow full implementation of the pathway.

Outcomes

Priority: Strengthening the mortality review process

Goals: to strengthen arrangements for learning from deaths in care in the Trust.

- A Medical Examiner (ME) Service will be implemented and lessons learnt and actions taken identified.
- Learning from Deaths dashboard published quarterly in public Board papers reporting deaths, number reviewed or investigated and proportion judged to be due to problems in care. Report of themes identified and actions taken to address concerns.
- Audit of the medical examiner processes by Internal Audit team.

How will we do this?

- Establish a Medical Examiner (ME) Service in Q1. This includes discussing all deaths with bereaved families, attending teams and reviewing healthcare records.
- Review in more detail all deaths identified by Medical Examiners.
- Where appropriate ensure deaths are investigated thoroughly

Progress

The Trust's response to deaths in care has been strengthened through the introduction of Medical Examiners (ME) in May 2018. Medical Examiners review the death at time of death certification or referral to Coroners. Their work includes contact with the team that cared for the patient at time of death, review of case records and contact with the family to see if they have any questions or concerns (Diagram 1).

Diagram 1: Medical Examiner Review Process

They provide a relatively simple "1st Stage" case note review, talk to the clinical team that was looking after the patient at their time of death and speak with the bereaved family. If that process detects any concerns then a "2nd Stage" case record review is undertaken (there are also cases that automatically get a 2nd stage review, even if there are no ME concerns – these include patients with learning disabilities, serious mental illnesses, where an incident has been reported etc.). About 1-15% of deaths get a 2nd stage review. In a small number of cases (about 10 a year) a Serious Incident may have occurred (usually reported through the incident reporting system) and these will all receive a detailed investigation.

The service is fully operational at James Cook University Hospital (JCUH) and improvements to the service at the Friarage were introduced in February 2019. Once this is fully established the aim is that all deaths (not referred to the Coroner in acute hospitals) in the Trust will receive a first level review. The service has developed since its introduction in May 2018 with 70% of deaths in March 2019 receiving a first level review and 15% of those requiring a second stage review.

The Medical Examiner processes are continuously audited to determine how many deaths have the involvement of Medical Examiners in the process of issuing the Medical Certificate of Cause of Death, have a documented '1st stage' case record review and how many are referred for '2nd stage' case record review.

A dashboard is published through the Board on a quarterly basis. This details the number of deaths, the number that have been reviewed or investigated and the number judged to have a greater than 50:50 chance of being preventable. These figures are also reported for patients with a learning disability or a serious mental illness.

Since the Medical Examiner service began 926 deaths have been subject to a first review of which 173 were recommended for the full second stage review. Fifty six have so far had a second stage review and 89 have had a specialty review entered onto the system. In addition a further 201 deaths have been excluded from needing a 2nd stage review following a positive 1st stage review and no further factors (age, mental health coding, HSMR alert etc.) coming into play.

The focus for next year will be in strengthening the ME Service, considering how it might take on out of hospital deaths not referred to the Coroners. It is anticipated that there will be some national guidance regarding this in the next financial year and engagement work around this will take place. We are also sharing with other Trusts how we have set the service up (since we are the first in the region to have an ME service) and all other trusts will need to set these up. We have shared at regional and national conferences and had site visits from Gateshead and North Tees. County Durham and Darlington NHS Trust is coming for a visit and we've had discussions with Northumbria, Newcastle and North Cumbria. We are also regular attendees at the Regional Mortality Group.

Outcomes

Priority: Improving the early review of emergency patients by a Consultant across the week

Goals: To increase the percentage of emergency patients seen by an appropriate Consultant within 14 hours.

- Improved compliance in second audit of 2018/19

How will we do this?

- Participate in the six monthly national audits
- Develop specialty specific action plans

Progress

The Trust is continuing to work towards implementing the four priority seven day clinical standards as part of the work to ensure emergency patients are reviewed by a consultant early in the process. The Trust is compliant with two of the four core standards and compliance with these is outlined below, along with actions the Trust is taking to address issues identified and to work towards full compliance.

Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

Results from the National Spring Audit 2018 showed that Weekday Compliance was 62.6% and Weekend Compliance was 69.5%. Total compliance with the standard was 64.5%.

Detailed breakdown of time periods of review showed that compliance with the standard was highest at 83% for patients admitted between 2200 and 0900 hrs. Compliance with the four hour standard dropped to 46% for patients admitted between 1700-2200 hrs. Further analysis showed that the mean and median times from admission to Consultant assessment were 10 hours 25 minutes and 10 hours 18 minutes respectively.

Action plan to improve compliance with Standard 2:

Extending Consultant presence on the Acute Medical units to 2200 hours will improve compliance with this standard but implementation of this has been affected by critical Consultant workforce pressures in Acute Medicine. South Tees does not have an electronic patient record and we have highlighted issues with medical record keeping with deficiencies in the documentation of date and time of Consultant review. This has affected the validity of the results from the Spring Audit in 2018.

The Acute Assessment Unit at South Tees has Specialist Trainees in acute medicine on the regional training programme who conduct supervised ward rounds as part of their training. All patients reviewed by trainee registrars are subsequently reviewed by a Consultant and a rubber stamp entry confirming date and time of review has been introduced. This ensures that trainees operate within a robust framework of supervision and this model of working will be presented to the Trust Board as part of Board Assurance that is currently mandated.

- Implement and embed twice daily (0900 and 1600 hours) and rolling ward rounds in clinical areas with existing Consultant of the week system.
- Implement evening trauma ward round at 2000 hours.
- Pilot Consultant led 'Rapid assessment on admission' in Acute Admissions Unit.
- Prioritise review of patients admitted between 1700-2200 hours

As part of Board Assurance, a retrospective audit of the above standard will be conducted to include unselected non-elective admissions from 15-21 April 2019.

The following areas in the Trust will be audited for compliance against standards 2 and 8 as part of the Board Assurance Process. This data will be uploaded to NHS Improvement for the June 2019 submission.

- Acute Medicine
- Paediatrics
- Cardiology including CCU (Coronary Care Unit)
- Stroke Medicine
- General Medicine to include the following specialities-Diabetes/Infectious Diseases/Care of the Elderly/Respiratory Medicine
- Acute General Surgery
- Trauma and Orthopaedics

Clinical standard 8: All patients with high dependency needs should be seen and reviewed by a Consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

Data from the spring 2018 audit showed that the overall proportion of patients who required twice daily Consultant reviews and were reviewed twice by Consultant was 10 %. The percentage receiving required twice daily reviews was 0% for weekday and 33% for the weekend.

The data collected is at variance with actual practice as it is standard policy that all patients in ITU and HDU are seen at least twice daily and a formal handover occurs twice daily. Similarly all new admissions and acutely unwell patients on the Acute Assessment units are seen throughout the day on 'rolling' ward rounds. This enables prompt Consultant review and intervention.

The overall proportion of patients who required a daily Consultant review and were reviewed by a Consultant was 68%. The percentage receiving required once daily reviews was 71% for weekday and 57% for the weekend. All new admissions and patients who are acutely unwell are reviewed by a Consultant over the weekend.

We need to document and highlight more clearly the patients who are on a criteria led discharge pathway who do not require a daily Consultant review. All medical outliers are reviewed daily.

Action plan to improve compliance with Standard 8:

- Embed Directorate and ward specific measures to ensure that patients receive Consultant or delegated competent decision maker review daily.
- All patients on the AMU (Acute Medical Assessment unit), SAU (Surgical Assessment unit) and ICU (Intensive Care unit) and other high dependency areas to be seen and reviewed by a Consultant twice daily or on rolling ward rounds.
- Once transferred from the acute area of the hospital to a general ward patients to be reviewed during a Consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.
- Inpatients not in high dependency areas to be reviewed daily by a competent decision-maker. (This can be delegated by Consultants on a named patient basis based on specific criteria included in the Seven Day Services Clinical Standards guidance (September 2017)).

Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology.

The Trust is fully compliant with Standard 5. South Tees is a tertiary Cardiothoracic Centre and out of hours echocardiography (ECG) is performed by the on-call Cardiology Specialist Trainee if clinically indicated.

Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. These interventions include:

- Critical care
- Interventional radiology
- Interventional endoscopy
- Emergency general surgery
- Emergency renal replacement therapy
- Urgent radiotherapy
- Stroke thrombolysis percutaneous coronary intervention
- Cardiac pacing (either temporary via internal wire or permanent)

South Tees is compliant in all areas apart from interventional radiology (IR) which has current Consultant workforce pressures. There are three current Interventional Radiologists in South Tees who provide a one in three cover for interventional radiology services. Work is underway to develop a regional strategy by engaging with Newcastle Hospitals NHS Foundation Trust as the other tertiary provider in the region to provide IR services in collaboration.

Outcomes

Priority: Ensuring safe and effective discharge

Goals: To ensure safe and effective discharge for our patients.

- Decreasing trend in incidents, complaints, PALS (Patient Advice and Liaison Service) enquiries and GP alerts.
- Improved patient flow measured by increased numbers of patients discharged before 12 with no associated quality concerns.

How will we do this?

- By end of Q1 develop and pilot a discharge care plan (currently a checklist on discharge) on five inpatient wards where prevalence of incidents and complaints are higher. This will be rolled out across the organisation by the end of Q3 and evaluated in Q4.
- Ensure all incidents and complaints relating to discharge are reviewed and relevant actions put in place in a new 'Discharge working group' to commence in May 2018.
- In Q1 develop and pilot a 'criteria led discharge' tool to enable a safe and efficient process in defined patient groups.

Progress

A discharge care plan has been piloted on the medical wards at James Cook University Hospital from April 2018 to present. Feedback has been sought from staff and amendments made accordingly. This care plan will now form part of a new nursing documentation booklet for inpatient wards to be launched in May 2019. The key concept of the discharge care plan is that it prompts staff to plan and make effective arrangements for discharge in a timely manner from the point of admission rather than waiting until the point of discharge. In addition to the pilot of the care plan, mandatory workshops were held for all inpatient ward managers to update them on current discharge processes, resources available in relation to discharge and learning from incidents. Social care colleagues were also invited and attended the workshops to promote integrated and safer working processes.

An 'Improving Discharge Working Group' has been established and the first meeting took place in May 2018 and membership of the group includes acute and community nursing staff, allied health professionals, local authority staff and representatives from the Care Commissioning Groups including Safeguarding. Part of the remit of this group is to review any safeguarding alerts that have been raised by care homes in relation to discharge from the Trust and ensure this feedback was received by the relevant ward staff and appropriate actions put in place.

There is now increased engagement with care homes by the Lead Nurse for Discharge and the Lead Nurse for Frailty both regularly attending the care home forums and offering points of contact and escalation if care home staff have any concerns about the discharge of one of our patients to them.

The development of criteria led discharge (CLD) is intended to provide patients with a quicker and more efficient discharge process, respond to patient needs, and reduce discharge delays and to make best use of nurse, allied health professional and junior doctors' skills. The named Consultant continues to have ownership of patient pathways and remains the senior decision maker with CLD offering the opportunity to clearly document what criteria is to be met prior to discharge that enables other appropriate healthcare professionals to discharge the patient.

South Tees has participated in an NHS Improvement national collaborative project to implement CLD in acute Trusts. This project ran from October 2018 to March 2019. South Tees was awarded the peer prize for the Trust that has demonstrated the most progress. Twelve Trusts from across the country participated. Two wards participated in a pilot of CLD and chose specific patient pathways;

- Respiratory (ward 9): asthma, bronchiectasis and lung biopsy.
- Vascular (ward 5): carotid endarterectomy.

'Plan, Do, Study, Act (PDSA) cycle improvement methodology was utilised to engage staff and agree the process. CLD was then trialled in January and February 2019. Of the 20 patients admitted across the three pathways in the respiratory service, 18 were discharged using CLD. One patient who was not discharged using CLD became clinically unwell and therefore came off the pathway. The second patient was a missed opportunity for CLD. Of the 12 patients admitted onto the vascular pathway in this time period, all 12 patents were discharged using CLD. On-going plans for 2019/20 include increasing the number of pathways using CLD on the respiratory and vascular wards and implementing CLD in the colorectal directorate.

There has been an approximate 11% reduction in Datix incidents relating to discharge from 2017/18 to 2018/19. The key theme is around discharge arrangements and this will continue to be a focus for improvement.

There has been an approximate 2% reduction in PALS enquiries and complaints relating to discharge. Numbers across the individual categories are low but demonstrate an on-going need to focus on communication and on-going support for patients on discharge.

With regard to safeguarding alerts raised by care homes; of the 19* alerts raised in 2017/18, three were substantiated. Of the 21* raised in 2018/19, none have been substantiated (*indicative as a small number of cases still remain open to investigation). The key theme in these alerts relates to discharge medications. Initiatives to improve medicines reconciliation, ward base checking processes and patient information remain a current focus.

Our rate of discharges before midday in 2018/19 has been between 14%-19% against a Trust target of 35%. We have however been placing emphasis on reducing the overall length of stay meaning patients may be going home earlier than previously expected. The average length of stay for our adult inpatient wards demonstrates a downward trend (Figure 8), although, it is challenging to demonstrate the length of stay detail for such a large organisation. Where increased focus on length of stay and discharge has occurred however, for example the respiratory and vascular wards piloting CLD, both demonstrate a significant decrease in their overall length of stay (Figure 9).

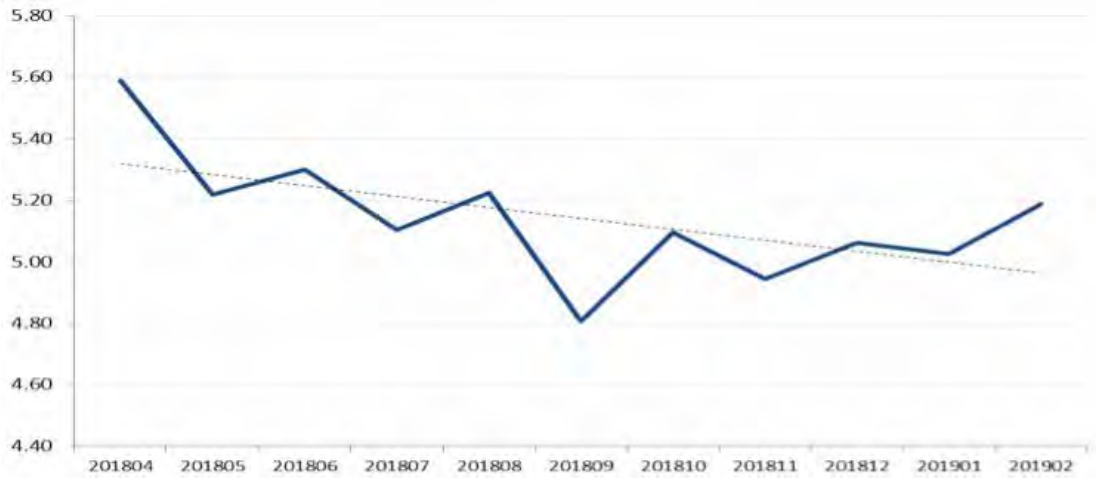


Figure 8: Average length of stay, adult inpatient wards, James Cook University Hospital

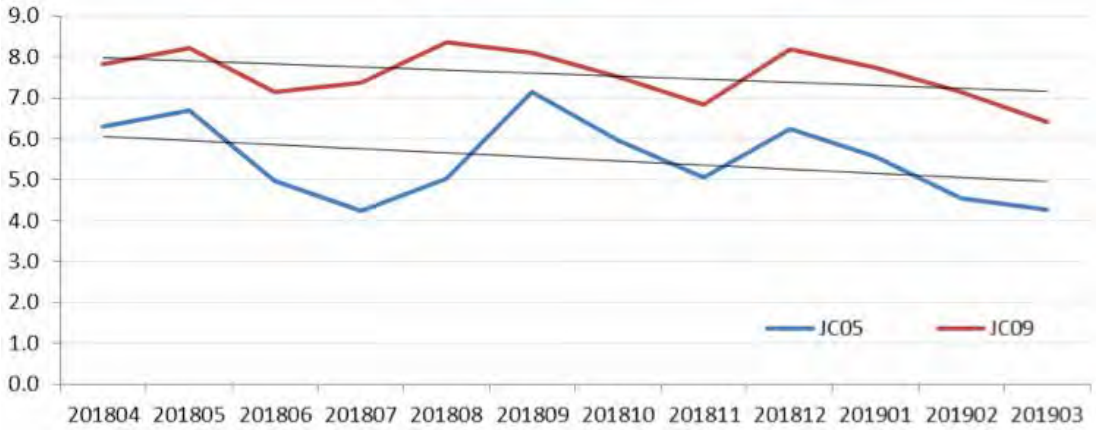


Figure 9: Average length of stay by days for wards 5 and 9, James Cook University

Patient Experience

Priority: Develop and implement the Patient Experience Strategy

- Launch the Patient Experience Strategy in Q1
- Develop mechanisms for service improvement and organisational learning
- Ensure the patient voice is evident from ward to Board

How will we know how we have done?

- Patient experience captured across the full patient pathway
- Strategic and operational groups in place and effective
- Centre governance meeting minutes

Progress

The Trust launched the "Delivering Excellence in Patient Experience" plan in 2018/19. Three key work streams were identified; developing an organisational culture, proactively seeking and acting upon the views of service users and delivering the strategy.

All patient experience feedback is reviewed in order to identify themes and action points across the Trust. This is presented at Trust public board meetings where patient's stories are also shared.

Ward boards are now in place explaining to patients, visitors and staff the escalation process for concerns, starting at ward level. The ward boards include patient facing reports for the 'Real Time' survey and are updated on a monthly basis. Further work will take place throughout 2019/20 to ensure staff at ward-level have the skills and knowledge and are confident in being able to address concerns and resolve these at an early stage. Work is also underway with the Quality Business Partners to identify themes and trends relating to PALS concerns to allow for a 'deep dive' into these areas to see what can be done to address these locally. This work will ensure concerns are managed effectively and resolved locally preventing where possible escalation to a formal complaint.

The Trust is looking to increase 'Real Time' feedback with the introduction of a new IT survey system (Meridian) being implemented in May 2019, which will enable the Trust to collect feedback from more inpatients. It is also anticipated that this will facilitate feedback from harder to reach groups, such as patients with a mental health diagnosis.

We actively liaise with our facilities management partner Serco, sharing feedback monthly with a view to improving and enhancing the patient experience as and where issues are identified.

A further initiative currently being developed is the introduction of a 'secret shopper' feedback mechanism. This will expand on the current work undertaken by the Council of Governors who currently visit outpatient departments to talk to patients about their experiences. A written report from these visits is produced and an action plan developed to address issues identified. Further work is planned to strengthen this process and ensure that where actions have been identified there is evidence to substantiate that the actions have been implemented.

The Trust will continue to focus on enhancing patient experience during 2019/20 and a Patient Experience Sub-Group has been developed to lead on issues identified relating to the patient experience and to target service improvement initiatives where necessary.

Patient Experience

Priority: Improving communication with our patients particularly focussing on reducing the amount of conflicting information patients receive

Why we chose this priority:

It has been recognised through the analysis of complaints and real time patient experience feedback that there are some occasions where patients do not understand some of the medical information that they have been given or feel that they do not understand their plan of care.

How will we do this?

- Triangulate existing sources of patient feedback to understand where further work is required and the areas of good practice
- Empower patients to seek clarification from medical staff
- Provide education and awareness for medical staff using patient feed back
- Review of communication during ward rounds
- Review of how board round decisions are communicated to patients
- Review of visiting hours
- Pilot ward manager / matron ward rounds

How will we know how we have done?

- Improvement in scores in the Co-ordination and Consistency domain in 1000 voices programme

Who will this be reported to?

- Patient Experience Sub Group
- Quality Assurance Committee

Progress

Trends from both complaints and patient experience feedback are reported on and fed back to clinical teams to discuss and share practice and reports are produced and discussed at clinical team meetings. This allows issues requiring further work to be addressed as well as highlighting good practice. Further work is planned during 2019/20 to ensure that good practice is shared across the Trust resulting in shared learning and where improvements are required these are addressed and wards/departments scoring highly will share their experiences.

Patients are very much encouraged and empowered to seek clarification from medical staff on their medical care and treatment at all times. The patient experience facilitators actively encourage patients to discuss any issues relating to their medical care and if the patient does not feel able to approach medical staff directly, they will approach medical staff on the patient's behalf (with the consent of the patient) should the patient prefer this option.

The Trust has completed a review of all of the patient information leaflets and made these increasingly accessible at ward level.

The 'Consistency and Co-ordination' domain is part of the 'real time' patient feedback information collected monthly and the scores for this domain during the year are shown in Figure 10. The score for this domain was at its lowest at 9.15 in April 2018 where there were some low scores in paediatrics which improved to 9.56 the following month and this has been sustained generally throughout the year. The reports from the 'real time' are shared with ward staff and discussed at ward level.

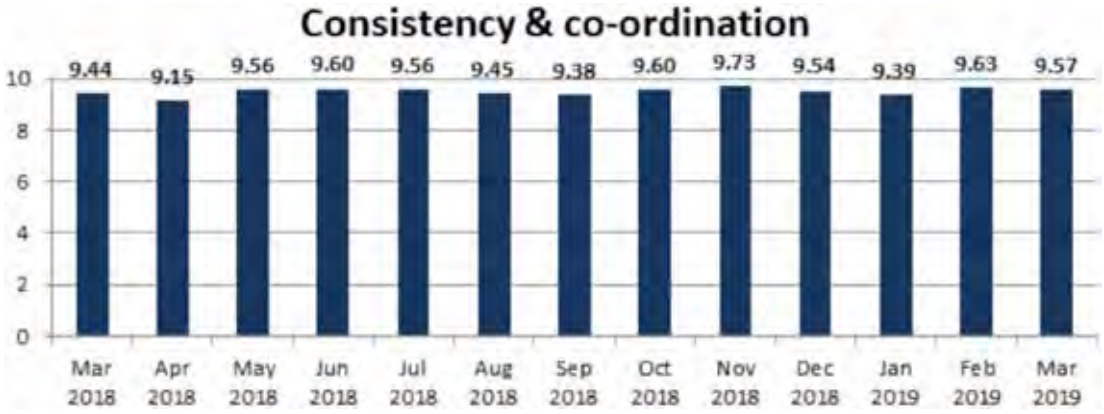


Figure 10: Consistency and Co-ordination scores 2018/19

In addition, ward patient experience notice boards provide information for patients and staff on how to manage concerns and how to escalate these where necessary and to whom. Inpatients contacting the PALS service are encouraged to speak to the medical staff directly however PALS will offer to do this on behalf of the patient if this is their preference.

The Trust launched person-centred visiting in October 2018. Visitors are now welcome across all hospitals at any time during daytime hours, providing this is what the patient wants and needs. A formal evaluation of this is due to take place in May 2019 and will include analysis of patient and carer feedback.

It is planned to introduce matron/manager ward rounds during 2019/20 and these will be piloted in Q1 of 2019/20. It is well recognised that patients and relatives often do not want to take up the time of doctors by asking questions, therefore, the ward round will consist of the Matron taking a proactive approach to asking patients and relatives a range of questions about their care that includes if there is anything about their care delivery or plans they have been told by the medical team that they do not understand.

Further initiatives planned for Q1 2019/20 include a new Clinical Director forum chaired by the Chief Executive where operational and quality related issues that are specific to the medical staff can be discussed and improvement plans put in place as required. Communication with patients and relatives will be a key topic.

Patient Experience

Priority: Improving the care of patients with mental health issues through a holistic and collaborate approach

How will we do this?

- A robust targeted plan will be in place and by April 2018 e-learning 'Mental Health Awareness' will be established as a mandatory component of clinical education for all clinical staff that interact with patients. 40% compliance will be achieved by end of 2018/19 and 95% compliance by 2019/20.
- A minimum of three clinical directorates with defined groups of patients will perform mental health screening as part of their clinical assessment processes. In turn we will expect to see an increase in referral to community psychological therapy organisations.
- Completion of a successful pilot and evidence of service improvement initiatives in the pilot areas.

Progress

A 'Treat as One' strategy has been developed. The proactive approach of the Trust to 'Treat as One' attracted positive interest from neighbouring trusts and in September 2018 a regional 'Treat as One' Group was established with the aim of standardising aspects of practice and optimising resource to ensure effective care for our patients with mental health disorders. The regional group will meet on a quarterly basis. Progress against the three Trust specific measures of success are detailed below:

1. A robust targeted plan will be in place and by April 2018 e-learning 'Mental Health Awareness' will be established as a mandatory component of clinical education for all clinical staff that interact with patients. 40% compliance will be achieved by end of 2018/19 and 95% compliance by 2019/20.

At the time of writing this report compliance with completion of the eLearning awareness module is 78%. This level of training is referred to as 'Tier 1', achieving a level of awareness for all staff to enable staff to start thinking a little more about mental health and regarding South Tees as an organisation that is committed to both mental and physical health needs. A target of 90% has been set for 2019/20.

For 2019/20, the plan is to run a number of workshops addressing 'Unconscious Bias'. Developing insight about the influence of bias on how we communicate and make decisions is required for practitioners who are likely to come into contact with and care for patients with mental health needs – 'Tier 2'.

Tier 3 is the very specific training need of staff who would be involved in the diagnosis, treatment and referral of patients with mental health needs and this tier is in development as part of the regional programme.

2. A minimum of three clinical directorates with defined groups of patients will perform mental health screening as part of their clinical assessment processes. In turn we will expect to see an increase in referral to community psychological therapy organisations.

Two clinical specialties have participated in a pilot for routine depression screening for patients with chronic physical health problems in order to identify individuals who may benefit from further assessment and treatment: heart failure outpatients and inpatient gastroenterology. Two further specialties are commencing pilots in April 2019, renal (haemodialysis) and oral and maxillofacial surgery.

The screening comprises of two initial depression identification questions, if the answer to one or both is yes then a more detailed PHQ9 (depression test questionnaire) screening tool is used. Dependent on the score, patients either need no further treatment for mental health or, would be advised for onward self-referral to Improving Access to Psychological Therapy (IAPT) 'talking therapies' in the community or referred to their GP for consideration of antidepressant medications.

Heart failure: patients were screened if the nurse specialist picked up nonverbal cues from the patient's general demeanour or if the patient stated that they felt low in mood. Ten patients have been screened between June 2018 and February 2019. None of the sample required emergency interventions, all were either referred onto their GP to consider antidepressants and/or helpline numbers were provided for the talking therapy services. Patient feedback included being surprised by the results as the patients had not considered they were depressed. Many were thankful there was someone taking an interest in their mental wellbeing. The plan for 2019/20 is to continue screening and increase the audit detail to enable service development if required.

Gastroenterology: A pilot project over a two week period (6/8/2018-15/8/2018) was performed in which all new patients admitted during this time were screened. Nineteen patients were screened during this two week time frame, 13 patients answered "No" to both Depression Identification Questions. Six patients answered "Yes" to one or both of the Depression Identification Questions. These six patients proceeded to PHQ9 assessment. Four patients were referred on to talking therapies and their GP informed. Two patients expressed suicidal thoughts and were referred to psychiatric liaison. We would not have known about how these patients were feeling if we had not screened them. The plan for 2019/20 is for the leadership team in gastroenterology to work with clinical psychology to develop psychological support pathways for the inpatient service aligned with improved IAPTS commissioning plans.

As described above, two successful pilots have been performed. We have been working with one of the current IAPT providers (Insight) to look at how we might develop joint pathways of care between South Tees Foundation Trust Clinical Psychology and IAPT so that our hospital patients receive the appropriate psychological support in a co-ordinated manner. Although the formal expansion of the IAPT contract has been deferred until 2020, the Trust is continuing with this pathway work so that we are in a position to fully implement the pathways when the new IAPT contract commences. The plan for 2019/20 is for the Trust Lead for Clinical Psychology to liaise with specific service areas to develop further pathways. These new pathways can then be deployed within the existing contractual framework (i.e. we will be making referrals to an IAPT provider, but within a collaborative decision-making framework and with better communication as the patients go through the pathway).

3. Completion of a successful pilot and evidence of service improvement initiatives in the pilot areas.

The experiences of patients with mental health disorders in our hospital has been collected by cross referencing the hospital numbers of patients who have been questioned as part of the Trust 1000 Voices patient experience programme and mental health HRG (clinical coding) codes. In this way patients with known mental health disorders were identified and their specific feedback analysed. Patients were questioned under 10 domain headings including 'kindness, 'involvement' and 'consistency and coordination' and each domain is scored out of 10. The data of 25-45 patients per month has been analysed since September 2018 and every month the domain score average is greater than 9.5. Patient feedback is excellent however we recognise the limitations of this methodology as we are not asking questions about mental health specifically, only ensuring that their overall stay with us has been satisfactory and that they have been treated well We have therefore designed a specific survey for patients with mental health disorders to enable meaningful data collection that can inform service improvements and education programmes. The survey is currently being piloted with service users before a wider roll out in May 2019.

2019 – 2020 Quality Priorities

The Quality Account priorities are a sub-set of the Quality Improvement objectives within the Trust's annual plan. In order to select priorities for 2019/20 a full review of trends in incidents, complaints, PALS, claims and patient feedback was conducted. In addition to this a review of national requirements, CQC concerns, CCG concerns and contractual requirements identified further areas of concern. A Quality Indicators Working Group was established with a number of Governors as part of the process of agreeing organisational priorities.

The Board of Directors have agreed the following as quality priorities for 2019/20 for inclusion in the Quality Account.

Patient Safety

Improve recognition and reporting of patient safety incidents and ensure lessons learnt are embedded across the organisation (including pressure ulcers and medication safety)

Reduce harm from HCAI (Healthcare Acquired Infections) with a focus on Gram-negative bacterial bloodstream infections

Reduce the occurrence of 'Never Events' and ensure there is a focus on safe surgical practice

Clinical Effectiveness

Ensure patients have a safe, effective and timely discharge

Ensure there is recognition and appropriate management of patients who are clinically deteriorating, including compliance with the escalation pathway

Ensure that patients' pain is managed appropriately and effectively in the patient setting

Ensure that patients who are at the end of life and their families receive high quality care in their preferred place

Patient Experience

Develop the Patient Experience Programme using the Meridian System to increase patient feedback including 'hard to reach' Groups

Review the way complaints are investigated and standardise complaint responses

Improve the Outpatients Department (OPD) Patient Experience

Patient Safety

Priority: Improve recognition and reporting of patient safety incidents and ensure lessons learnt are embedded across the organisation (including pressure ulcers and medication safety).

Rationale

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. Reporting incidents supports the NHS to learn from mistakes and to take action to keep patients safe.

The fair or just treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. This allows us to have open, honest and transparent communication with our patients and their families.

Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated. We recognise feedback is a valuable contribution to the development of better quality healthcare and are therefore committed to identifying lessons learned from incidents and near misses to ensure services across our organisation can be improved.

Actions

A robust incident reporting action plan will be developed describing specific actions which will include:

- Completion of a comprehensive review of incident management process including discussing with staff at all levels and all staff groups to understand barriers to reporting by end Q1 2019/20.
- Undertake review of different reporting mediums offered by our current software provider, Datix by end Q2 2019/20.
- Review of the 'Incident Reporting Policy (G60) to ensure that it reflects agreed processes as well as best practice by end Q1 2019/20.
- Develop and implement a standardised incident report form on Datix for use across the Trust as well as short forms that can feed into the main system by end Q2 2019/20.
- All new starters receive a session on incident reporting at Trust Induction (March) evaluate effectiveness in Q2.
- Focused work on wards/departments to ensure staff have the skills and knowledge to recognise, report and investigate incidents in a timely manner. A work program will be developed to support this by end Q1 2019/20.
- Outstanding incidents are reviewed on a weekly basis as part of the Patient Safety wall.
- A weekly review of open harm events with QBP's (Quality Business Partners) and patient safety will commence with the aim of closing down incidents within the week that they are reported. This will be fully embedded across all centres by end Q2 2019/20.
- Lesson of the Month is agreed at Patient Safety Sub Group and shared via relevant groups and forums to enable organisational learning and displayed in ward boards.

Measures of success:

- Approval of the revised 'Incident Reporting' Policy
- Implementation of improved system for reporting incidents
- Increase in the number of Incidents reported – including Near Miss reporting in groups of historically "low reporting" staff
- Serious Incidents will be identified and reported to our commissioners within the mandated timeframes
- Development of standardised incident report form
- Establishment of a Datix user group, terms of reference and minutes of meetings.
- Implement Datix champions in all staff groups

Patient Safety

Priority: Reduce harm from HCAI (Healthcare Acquired Infections) with a focus on Gram-negative bacterial bloodstream infections

Rationale

Gram negative bacteria include Escherichia coli (E.Coli), Klebsiella and pseudomonas[1]. Reducing gram negative blood stream infections (GNBSI) is a national priority with the stated aim of a 50% reduction in healthcare associated GNBSI by 2021. The burden particularly of E.coli is challenging and requires reliable auditing to establish the potential multiple causes of the GNBSIs. E.coli figures for 2018/19 did not show any reduction compared to 2017/18 (Figure 11).

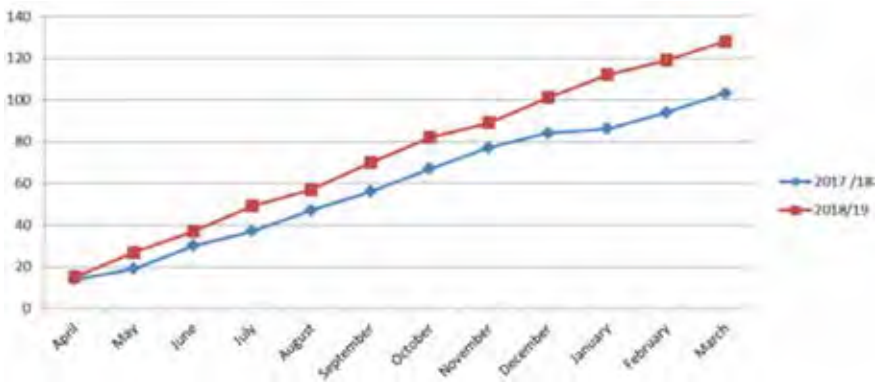


Figure 11: Trust attributed E.Coli bacteraemia cases for 2017/18 and 2018/19

[1]Gram-negative bacteria are bacteria that do not retain the crystal violet stain used in the gram-staining method of bacterial differentiation

The majority of GNSBI originate in the community particularly E.Coli. The number of cases of hospital acquired Klebsiella and Pseudomonas infections are relatively low. These cases are associated with the specific risk factor of multiple invasive devices such as central lines and endotracheal tubes and therefore more likely to be found in patients in the critical care environments prompting a focus on this for 2019/20;

In the wider patient population, common invasive devices such as prolonged use of urinary catheters are associated with a high risk of developing gram negative urine infection and progression to GNBSI, specifically E.Coli. A reduction in the number of catheters inserted and reducing the numbers of days a catheter is in situ may help reduce the number of urine and blood stream infections

The burden of E.coli bacteraemia remains a concern in the community as demonstrated by the small percentage in critical care (Table 5) and the rest of the Trust.

Aseptic Non-Touch Technique (ANTT) is an important resource for minimising contamination during invasive procedures and subsequent acquisition of GNBSI. Our approach to ANTT was reviewed and refreshed in March 2019 with the aim of rolling out training to all clinical staff.

Actions:

A robust GNSBI action plan will be put in place by the end of April 2019 highlighting specific actions which will include:

1. Pilot of a 'blue pillow' project in critical care areas which will ensure that dedicated pillows for the patient's head are distinguished from other pillows used for positioning patients. Blue pillow cases for every head in a critical care bed will be used starting from 29th April 2019 with the aim of reducing contamination of lines and reduce avoidable GNBSI.
2. Train a minimum of 90% of clinical staff in ANTT by the end of 2019/20.
3. Develop and implement a urinary catheter management education program aimed at reducing the amount of catheters inserted and prompting removal at the earliest possible opportunity. Education for staff, patients and carers will also include proactive approaches to hydration and optimised hygiene requirements for patients with catheters in situ. A training plan with associated trajectories will be initiated by end Q1 2019/20.
4. A minimum of five GNBSI retrospective case reviews per month reviewed by the Lead Infection Prevention and Control Nurse to start to identify causes and common themes in order to make targeted efforts in reducing GNBSI overall.

Measures of success:

- Reduction in the rate of klebsiella and pseudomonas blood stream infections in high risk areas.
- 90% of clinical staff will be trained in ANTT by end Q4.
- Reduction in the rate of urinary catheters in situ to 21% or less by end Q4.

Patient Safety

Priority: Reduce the occurrence of 'Never Events' and ensure there is a focus on safe surgical practice

Rationale

Never Events are considered unacceptable and eminently preventable. Harm free compassionate care in the operating theatre should be a fundamental element of the Trust's operating theatres vision. All healthcare staff involved in clinical practice in a patients' theatre journey have a common goal which is to prevent harm and deliver safe patient care to the highest standards. Although Never Events are rare, two recent events both occurring in the operating theatres on the James Cook Hospital site have identified several factors that contributed to these Never Events in December 2018 and January 2019.

Following the detailed investigation reports it is apparent that work is required to strengthen the use of the World Health Organisation (WHO) Theatre Checklist to ensure effective team communication, verification of the correct operation and correct site surgery. As a result the Time Out Checklist needs to be underpinned by standards and training, it requires full engagement from all disciplines in the theatre multi-disciplinary team as it will not work in isolation.

A review of the contributing human factors identified that there are team factors to be taken into account and addressed, including leadership, culture and behaviours as well as clarity of individual roles and accountability in relation to the 'Time out'.

Staff should feel empowered to use the 'Stop' phrase to raise concerns. All theatres now have a 'STOP, I am not happy' phrase visible within each operating theatre. A 'Sign out' phase has been included on the swab count board to ensure compliance by the theatre scrub team. Incident forms also need to be completed as soon as an error is detected. Staff allocation has now been amended to clearly identify the lead in each theatre on a daily basis and that the Safer Surgery SOP/LocSSIP (Local Safety Standard for Invasive Procedures) needs to be available in each theatre and the Safer Surgery Policy also requires review.

Actions

All of the above and compliance with all aspects of safer surgery processes should be therefore reassessed across all staff groups through the establishment of an MDT (multi-disciplinary team) Safer Surgery Group to formulate the required actions and learning to improve safer surgery compliance. The following lessons learned have identified the following:

- Ensure everyone is aware who is the senior theatre team member and who is in charge day to day.
- Operating surgeon responsibility – the operating surgeon should always perform the safer surgery 'Time out'. 100% compliance with formal time out/sign out.
- Concerns should be raised or escalated immediately to senior theatre staff so that a timely decision can be made and guidance given.
- The introduction of a 'nurse educator role' within theatres similar to ICU (intensive care unit) is currently being explored since this is currently lacking and would provide some assurance that all staff are trained appropriately to their roles.
- All new members of staff from the MDT should have completed their local induction (inclusive of safer surgery presentation) – this could be overseen by the above Nurse Educator for Anaesthesia.
- Promoting an open and honest culture of reporting incidents when errors have been identified
- In addition, through the establishment of the MDT Safer Surgery Group, there should be a renewed focus on the safety critical sign out process in accordance with existing Trust LocSSIP standards of practice. The team should also be focused on the 'Sign Out' phase which should be fully observed and performed after the final count is performed and before the patient is woken from anaesthesia with all medical staff present. This is included in the Trust's annual audit plan. The observational audit is undertaken weekly in one theatre, and all theatres are covered within the audit throughout the year.

Measures of success

- Zero tolerance with Never Events
- 100% compliance with required time-outs
- 100% compliance with completion of the WHO Surgical Checklist
- 100% compliance with the 'Sign Out' process
- LocSSIP's available and embedded in all areas

Clinical Effectiveness

Priority: Ensure patients have a safe, effective and timely discharge

Rationale

Unnecessarily prolonged stays in hospital are bad for patients. Tackling long stays in hospital will reduce the risk of patient harm, disability and unwarranted cost. Congestive hospitals struggle to deliver the best care, reduced bed occupancy through improved flow greatly improves the working and care environment. (NHS Improvement 2018)

Every day in hospital is a precious day away from home. We want to embed a home first mind set across our health and social care system, the aim is to do everything we can so that our patients, especially older people, can continue to enjoy their lives in their own home environments. For the few that cannot go home from hospital we should endeavour to minimise delays as patients move to a location most suited to meeting their needs.

Patients with a length of stay over seven days are defined as 'stranded' and patients with a length of stay over twenty one days are defined as 'long stay' patients.

A 'delayed transfer of care' (DToC) occurs when a patient is ready to leave a hospital or similar care provider but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice.

The benefits of reducing the time that a patient occupies an acute hospital bed are clear, but achieving this has proven difficult, particularly in the winter period. Long stay patients account for about 8% of overnight admissions generally and have an average length of stay of 40 days nationally (NHS Improvement).

The term 'patient flow' refers to the ability of a health care system to manage patients effectively and with minimal delays as they move through stages of care. The consequences of poor flow are known:

- ED becomes crowded, stressful and unsafe.
- Patients are admitted as outliers to areas that are not best suited to manage their care.
- Ambulatory care services may fill with patients waiting for ward admission.
- In patients are shuffled between wards to make capacity for newcomers.
- Staff are over stretched and routine activity slowed down dramatically.
- Clinical outcomes are measurably worse, particularly for frail older people who may suffer more harm events and may decondition due to the extended stay in hospital beds.
- Patient and carers time is wasted due to delays and slow care process and their experience is adversely affected.

Reasons for delays relate very much to the communication and interface between the acute provider and social or continuing health care. Delays can also be classified using a national 'Clinical Utilisation Review' (CUR) tool which measures and monitors patient need for an acute bed. The main delay categories associated with 'CUR not met' are:

- Awaiting assessments
- Medications and intravenous therapies
- Access to diagnostics
- Access to therapies

The average CUR 'not met' in the acute setting in 2018/19 was 34.0%.

These delays can be compounded if internal processes are not robust, specifically our Model Ward approach based on SAFER principles (NHSI, 2017):

S	**Senior review**. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.
A	**All patients** will have an expected discharge date and clinical criteria for discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.
F	**Flow of patients** will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10 am.
E	**Early discharge**. 33% of patients will be discharged from base inpatient wards before midday.
R	**Review**. A systematic multi-disciplinary team review of patients with extended lengths of stay (>7 days – 'stranded patients') with a clear 'home first' mindset.

The CUR 'not met' reasons, the need to further embed SAFER principles along with the need for optimal communication with local authority and clinical commissioning group colleagues form the basis of the improvement action required:

Actions

- Implement the use of the discharge care plan as part of the new nursing documentation pack on all adult in patient wards by end May 2019.
- Regular review of delayed discharge and length of stay metrics and associated actions put in place. This will take place operationally at a weekly 'discharge wall' and strategically at a monthly meeting attended by key staff members of the acute Trust, local authorities and the CCG.
- Increase focus on the increasing population of frail patients; pilots of multidisciplinary frailty team approaches to planning transfers and discharge.
- Implement criteria led discharge on three wards by the end of Q2 and eight wards by the end of Q4.
- Implement a robust model of working for the Patient Resource and Flow Team by end Q2.
- Ensure improvement plans in place for CUR 'not met' categories are in place by end Q2 (Awaiting assessments, medications and intravenous therapies, access to diagnostics, access to therapies).
- Embedded frailty screening for all people aged over 65 within all admission routes to enable earlier targeted assessment and intervention by end Q3.
- Implement engagement program with Clinical Directors (CD) to optimise the use of SAFER principles via a new CD forum by end Q2.

Measures of success

- Decreasing rate of delayed transfers of care to below the 3.5% upper threshold.
- Decreasing average length of stay in the acute setting – individual directorates to set own targets by end Q2 relative to baseline to achieve either top quartile or top decile against national benchmarks.
- Decreased number of discharge related PALS and patient complaints.
- Improving trend of discharges before 12 midday, towards the Trust target of 35% by the end of Q4 with a stepped target of 25%.
- Set baseline and improvement trajectories for decreasing length of stay in patients with clinical frailty by end Q1.
- Decreasing levels of harm in patients with frailty. Baseline and improvement targets to be set by end Q2 and monitored via Datix and the frailty dashboard.

Clinical Effectiveness

Priority: Ensure there is recognition and appropriate management of patients who are clinically deteriorating, including compliance with the escalation pathway

Rationale

Early recognition of patients who are deteriorating is essential to enable appropriate intervention and prevent further deterioration to the point of requiring resuscitation and avoidable admission to a Critical Care unit. Early recognition aims to reduce the risk of patients needing to stay longer in hospital, not recovering fully or dying.

The Trust has utilised an electronic system to record physiological observations since October 2014.

VitalPAC is a suite of platforms that focuses on timely and appropriate physiological observations using the NEWS 2 model.

There are four modules in the suite:

VitalPAC Nurse

ipad based, used by nursing staff to record and monitor NEWS on adult wards.

VitalPAC Ward

ipad based, used by all clinicians to retrieve individual observations, and gain an overview of patient scores on the ward.

VitalPAC Clinical

Similar to VitalPAC Ward, but browser based, and uses individual log in for clinicians to view current and historic data, and other areas in the hospital

VitalPAC Administrator

Allows administration of users and devices.

There is a general recognition that the acuity of patients in hospital is relatively higher than in previous years. Despite this, over the last five years the Trust has seen an increase in compliance of frequency of observations, appropriateness of observation interval, and night time observations. This has been demonstrated by annual point prevalence studies and compliance indicators displayed in real-time on the devices. Figure 12 demonstrates high compliance in 2019.

Datix reports are completed for incidents that relate directly or indirectly to lack of recognition or appropriate escalation regardless of whether the patient came to any harm to enable trend analysis and on-going learning. In 2018/19, 119 Datix reports were submitted which is an increase from 79 in 2017/18.

The Trust has taken a proactive approach to increase incident reporting around patient safety, however this is still an increase that we would not want to see continue.

Recognition of the deteriorating patient educational initiatives and associated technology now encompass specific conditions that are life threatening if not recognised and treated early, specifically, sepsis and acute kidney injury. Enhanced education and continued investment in VitalPAC technology form the basis of plans for 2019/20.

Point prevalence 2019 observation interval appropriate

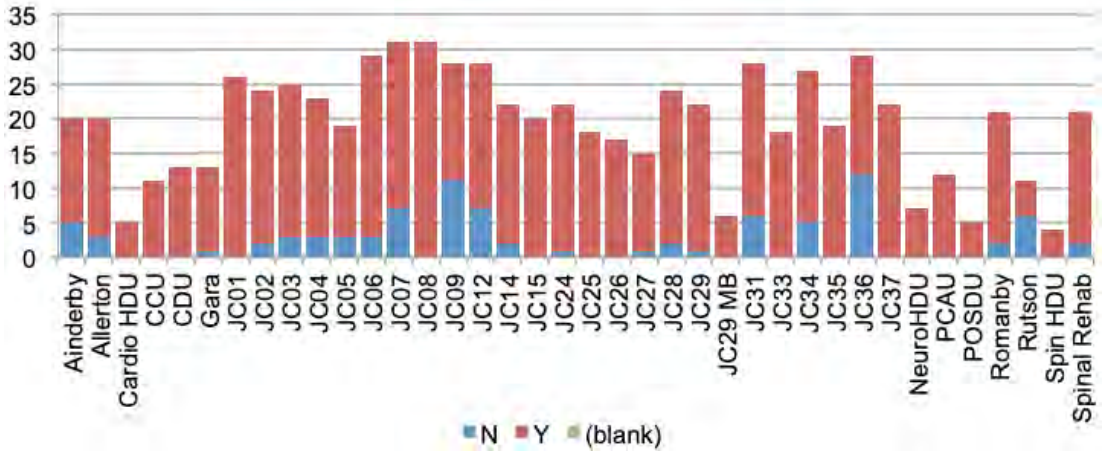


Figure 12: Point prevalence of physiological observational interval appropriateness (Y= Yes N = No)

Goal

To maintain compliance and monitor frequency and appropriateness of observations across the Trust.

Actions

- NEWS 2 was successfully implemented in Nov 2018, which also sees the implementation of VitalPACs business intelligence (BI) reporting suite. We are expecting this to be fully functional by the end of May 2019, as all IT pre-requisites for the application are currently being implemented and we are completing the training programme.
- Test the fluid balance module, and providing we have satisfactory result we will produce a rollout plan for 2019.
- Develop and implement an educational programme for staff when testing of fluid balance is complete.
- Present to Ward Managers and senior teams for best ways to use the BI dashboard.
- Continue to review all avoidable admissions to critical care to enable on-going learning from ward teams.

Measures of success

- Increasing compliance with fluid balance completion. Baselines and improvement trajectories to be set on roll out as the currently system is paper based and will not provide a comparable baseline.
- Ability to produce monthly compliance reports to allow direct feedback to wards and centres.
- No increase in Datix incidents relating to non-recognition or escalation of the deteriorating patient. As we have encouraged staff to increase reporting of incidents it is challenging to set a reduction target however this will be reviewed on a monthly basis.

Clinical Effectiveness

Priority: Ensure that patients' pain is managed appropriately and effectively in the patient setting

Rationale

Good pain management improves patient experience and outcomes. It is a marker of good care and clinical effectiveness in all age groups.

In older adults and those with clinical frailty pain can be a contributing factor to delirium. Development of delirium frequently impacts on length of stay and contributes to delayed transfers of care (DToCs) and patient harm.

Effective pain management is reliant on:

- Timely and appropriate prescribing
- Regular assessment of pain using an appropriate and validated tool
- Safe administration
- Evaluation of analgesia using an appropriate and validated tool

Our patient experience '1000 Voices' domain score remains over 9/10 for the question 'Do you think staff did everything they could to help control your pain'.

Figure 13 shows however that we do still record some negative comments about pain management in the 1000 Voices data collection and our retrospective audits of pain evaluation demonstrate that improvements can be made evaluating the use of analgesia. In addition we received 37 formal complaints from patients relating directly or partially to pain management in 2018/19, a slight decrease from 43 in 2017/18.

Themes identified from complaints included:

- Staff failing to recognise the patient was in pain
- Unnecessary pain due to delays/failure of treatment/surgery
- Incorrect/lack of prescribed pain relief

Actions

- Review referral process for the pain team to ensure service meets clinical need – by end Q1.
- Undertake a centre / ward level training needs analysis to identify training needs in relation to pain by end Q2.
- Respond and focus training activity of the pain team in response to training needs analysis.
- Integrate pain management training within preceptorship training – by end Q2.
- Increase focus on the use of specialist guidance such as older adults prescribing guidance. This includes correct use of pain assessment chart.
- Explore opportunities to integrate pain assessment and evaluation within VitalPAC.
- Implementation of the Meridian system in May 19 will facilitate triangulation of patient experience data with quality indicator compliance.

Measures of success

- 25% Improvement in audit data relating to pain administration evaluation within monthly quality indicators.
- Demonstrable improved compliance with prescribing guidance - baselines and improvement trajectories to be set by end Q1.
- Improved training data by centre and ward for registered nurses, nursing associate and assistant practitioners.
- Reduced incidence of negative comments relating to pain management within 1000 voices.
- Minimum of 10% reduction in the number of complaints relating to pain management in the inpatient setting by end Q4.

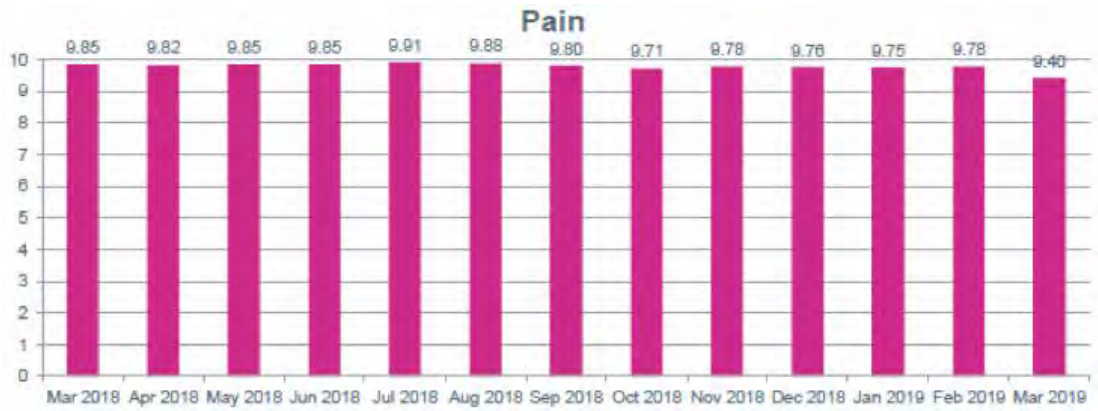


Figure 13: '1000 Voices' patient experience domain score trend for pain management

Clinical Effectiveness

Priority: Ensure that patients who are at the end of life and their families receive high quality care in their preferred place.

Rationale

South Tees Hospitals NHS Foundation Trust places great emphasis upon preventing avoidable deaths however when preventing death is no longer an option we will continue to treat and support our patients throughout their last months and weeks of life.

To achieve our strategy we have been guided by three key national documents:

Ambitions for Palliative and End of Life Care- a framework for local action 2015-2020 (National Palliative and End of Life Care Partnership: 2015) and *One Chance to get it right* (Leadership Alliance for the Care of Dying People: 2014) and the *NHS Long Term Plan* (2019).

The ambitions document proposes 6 ambitions. The trust is committed to ensuring that as an organisation that we make the ambitions a reality, through strong leadership commitment and empowerment. The six ambitions are:

- Each person is seen as an individual
- Each person has fair access to care
- Maximising comfort and well being
- Care is coordinated
- All staff members are prepared to care
- Each community is prepared to help

The One Chance to get it right document describes five priorities of care for patients who are in the last days of life. These priorities are:

- **Recognise:** this possibility that the person may die within the next few days or hours and that this is recognised and communicated clearly, decisions made and actions taken in accordance with the persons wishes and needs, and these are regularly reviewed and decisions revised accordingly.
- **Communicate:** sensitive communication takes place between staff and the dying person, and those identified as important to them.
- **Involve:** the dying person and those important to them are involved in decisions about their treatment and care to the extent that the dying person wants.
- **Support:** the needs of the family and others identified as important to the dying person are actively explored, respected and met as far as possible.
- **Plan & Do:** an individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed coordinated and delivered with compassion.

In order to achieve our ambitions and to embed the principles outlined by the Leadership Alliance there are five foundations to be successful in our vision:

1. **Personalised care planning:** Everyone approaching the end of life should be offered the chance to create a personalised care plan, including an opportunity to record wishes, preferences and goals.
2. **Involving and supporting** those who are important to the dying person, ensuring that feedback is built in to improving our services.
3. **Education and training**. Every professional needs to be confident and competent to provide good end of life care.
4. **24/7 access**. Every person at the end of life should have access to 24/7 services as needed as standard.
5. **Leadership**. Strong leadership with local partners and commissioners to provide care which is suited to the needs of the population.

Actions

The below actions form the basis of a robust work programme with associated objectives and improvement trajectories which will be put in place by the end of life strategy group by end Q2. Each sub action will be assigned its own baseline and improvement target where applicable.

- Strengthening our skills in honest and well informed conversations regarding death, dying and bereavement by delivering training to our clinical teams.
- Embedding the work around the "Deciding Rights Initiative" and tools to support advance care planning in order to meet the patients' priorities for their care (www.northerncanceralliance.nhs.uk).
- Embed the individualised care planning for everyone receiving end of life care in our services.
- We will work with our local partners to ensure access to the best clinical care and that care can be delivered in an environment which best meets the patients' needs.
- We will work with patients and those important to them in preparation for bereavement, signposting to appropriate bereavement services.
- Using all data sources to better understand our services and to identify gaps in our care.
- We will work in partnership with our commissioners in order to provide care which is suited to our population.
- We will participate in national and regional audit activity in order to demonstrate we are providing good care but also to use the data to further develop and improve our services.
- Patients dying in hospital will do so with as much comfort and dignity as possible with those who choose around them. The Trust has an open visiting policy and families are supported to stay with patients. Comfort packs are in place to support families which include information, toiletries, free car parking and provision of light refreshments. This work will be built upon and embedded across all hospital sites.
- Ensure that the facilities and the environment to meet the needs of patients and those close to them are appropriate. This also includes care to the bereaved provided through the bereavement and mortuary services. In order to achieve this vision the Trust has participated in a programme delivered by hospice UK and the NHS Emergency Care Improvement Programme (Fresh Eyes Approach). Work will commence on this in May/June 2019.
- Building upon existing services which provide 24/7 support to ensure that care can be provided in a timely manner.
- Expanding the specialist palliative care team service to become a seven day service which includes the opportunity for face to face assessments.
- Identify patients earlier in the acute inpatient setting who would potentially benefit from assessment from the Specialist Palliative Care Team by undertaking scoping work with the Critical Care Outreach Team and front of house services.
- Increase the number of patients who are in the last days of life who are assessed by the Specialist Palliative Care Team.

- Gather feedback from families regarding the care which was received in the patients last days of life.
- Working with care homes within our localities to improve advance planning and care to patients within these settings.
- Clear leadership and executive support for end of life care.
- Clear signposting to locally and nationally relevant services for patients and their families.
- Ensuring that the intranet is current and either provides the resources which staff need to deliver evidenced based end of life care or signposts them to such sources of support.
- Trust development of electronic patient record which will ensure the seamless transfer of care and patient information across all care settings.
- Promoting a culture that care of the dying is everyone's responsibility.
- Ensure that effective specialist leadership is in place, led by the Medical Directors and Director of Nursing to instil the Trust vision and ambitions for end of life care at all levels across the organisation.
- Delivery of core end of life care education to all staff using the 'End of Life Care for All' modules within the e-Learning for Health Programme, preceptorship and Trust induction programme.
- Further develop palliative care link nurses to become champions for end of life care within ward areas and community nursing teams, ensuring this role is recognised in Personal Development Plans for staff and in annual appraisals, and alongside clinical supervision.
- Working with partners in raising the profile of end of life care in our communities; building on work which is undertaken by organisations such as Dying Matters.

Measures of success

- Have a robust system in place for identifying complaints that relate directly to end of life care (currently challenging to track as may not always be identified as main category) and set improvement trajectory by end Q2.
- Define baseline of number of dying patients assessed by the Specialist Palliative Care Team by the end of Q1 and set increasing targets for Q2, Q3 and Q4.
- Have a system in place to gather specific feedback on the patients and family's experience of end of life care provided by the Trust by end Q2 (current system focusses on the bereavement service at the point of registration of death).
- Participation in the National Audit of Care at the End of Life(NACEL) will demonstrate improvements in the documented evidence of individualised care planning.
- The environment in which care is provided to the dying in the acute hospitals will improve. This will include bereavement and mortuary services.
- Expansion of the Specialist Palliative Care Team to provide face to face assessments 7 days a week and reach groups of patients who currently do not receive consistent access to assessments.
- Demonstrable increasing use of Internet and intranet websites that provide guidance for staff and patients/families regarding end of life care.
- The Trust will have a range of polices to support staff in the provision of palliative and end of life care.
- All staff employed by the Trust will have access to training in end of life care.
- Trust participation in "dying matters" week and general awareness raising of end of life care.

Patient Experience

Priority: Develop the Patient Experience Programme using the Meridian System to increase patient feedback including 'hard to reach' Groups

Rationale

The Trust is committed to ensuring that patients have a positive experience of the Trust and patient feedback is obtained to inform service improvements.

The 1000 Voices programme has allowed for the capture of 'real time' data at ward level and includes FFT feedback. The 'real time' data provides feedback on issues identified for improvement. It has been recognised that further work is needed to expand on the work that is currently taking place to ensure feedback from 'hard to reach' groups is captured.

FFT data shows that patients are generally satisfied with the care they receive however the Trust response rates are very low and well below the national average.

Actions

A robust Patient Experience action plan will be developed by the end of May 2019 highlighting specific actions which will include:

- Implementation of the Meridian IT system across the Trust
- Use Meridian to increase the FFT response rates
- Use of Meridian to increase the reporting of 'real time' feedback specifically within inpatients
- Re-launch the FFT programme within Outpatients
- Implement a system to identify specific 'hard to reach' groups utilising Meridian
- Use of the Patient Experience Facilitators to facilitate feedback from the 'hard to reach groups
- Work with TEWV (Tees, Esk and Wear Valley) mental health services to capture feedback from patients who have mental health diagnosis in the acute setting
- Implementation of a feedback questionnaire following closure of complaints to identify service improvements
- Review of processes in the Trust to gain patient feedback in relation to Trust and local objectives
- More focused work and triangulation of available data to inform a robust programme to support service improvement
- Ensure the Patient Experience Subgroup sets the strategic direction for patient experience

Measures of success

- Roll out of Meridian with increased responses (Q1)
- Increased FFT reporting to a statistically significant number of responses
- Utilisation of patient/service users in the core construction of any evaluative and improvement initiatives
- Demonstrable evidence of improvement initiatives as a result of patient feedback
- FFT Programme implemented in OPD and increase response rates including A&E
- Feedback obtained from identified 'hard to reach' groups
- Improve patient experience for patients with mental health diagnosis
- Feedback from complaints closure survey
- Increase the number of 'real time' feedback responses to 800 a month across inpatient areas (currently c360)
- Established and effective Patient Experience Subgroup and service user forum (Q1)

Patient Experience

Priority: Review the way complaints are investigated and standardise complaint responses

Rationale

Our values are to deliver high quality care that puts the patient and their families first and to have open, honest and transparent communication with patients at all times. It is our belief that everyone has a right to have their views heard, acted upon and resolved quickly and professionally. This reflects our behavioural standards, in that we want our patients and their families to feel safe, cared for and confident in their treatment.

Our staff will ensure patients and their families and carers who give any type of feedback regarding their treatment will receive and be treated according to their clinical needs and their care will not be compromised in any way. Equally, families and carers will not be treated in a negative way because they have raised concerns or made a complaint.

The patient remains the focus of the complaints process and the Trust aims to ensure that concerns and complaints are handled thoroughly without delay and with the aim of satisfying the complainant whilst being fair and open with all those involved. We recognise feedback is a valuable contribution to the development of better quality healthcare and are therefore committed to identifying lessons learned from complaints so that services across our organisation can be improved.

Actions

A robust complaints management action plan will be developed by the end of May 2019 highlighting specific actions which will include:

- Completion of a comprehensive review of the complaints management process to agree and clarify roles and responsibilities.
- Review of the 'Receiving Patient Feedback and Handling Patient Complaints' Policy (G01) to ensure that it reflects agreed processes as well as best practice.
- Develop and implement a standardised complaint response template for use across the Trust.
- Develop a quality assurance process for reviewing a proportion of complaint responses to ensure they conform to agreed standards.
- Ensure national guidance is reviewed and considered as part of the continued development of the complaints management service.
- Focused work on wards/departments to ensure staff are equipped with the skills and knowledge to manage complaints at an early stage and resolved locally where possible, prior to escalation to PALS or a formal complaint.
- Ensure complaints are closed within the agreed timescales.

Measures of success

- Approval of the revised 'Patient Feedback and Handling Patient Complaints' Policy
- Development of standard response template letter for complaint responses
- Development of a quality assurance process for reviewing complaint responses
- Reduction in the number of formal complaints
- 5% reduction in the number of re-opened complaints – baseline 2018/19 (12%)
- Increase in the percentage of complaints closed within the agreed timescales – target 80% - stretch target 85%

Patient Experience

Priority: Improve the Outpatients Department (OPD) Patient Experience

Rationale

The Trust is committed to ensuring that when patients attend for an outpatient appointment they have a positive experience.

Investigation of PALS data demonstrated that a significant amount of contacts were with regard to outpatient appointments (21%), with patients unsure of when their appointment was and unable to contact the relevant department, or in some cases unsure of what their appointment was for.

Actions

A robust patient experience action plan will be developed by the end of June 2019 highlighting specific actions which will include:

- Review of communication letters to patients to ensure adequate and effective communication, this will include information relating to accessible information and asking patients if they would like the information in another format. This review will consider the information sent pre-appointment, information provided during appointments and post-appointment follow up.
- Strengthen the governor 'drop-in' programme to ensure that robust action plans are put in place to address issues identified during their visits and ensure that there is evidence that actions have been completed within agreed timescales. Feedback will be provided quarterly to the Quality Assurance Committee (QAC) and the Council of Governors to provide assurance that actions identified have been implemented.
- Ensure there are robust systems in place to respond to patient feedback relating to outpatient appointments.
- Implementation of a 'secret shopper' initiative within OPD's to inform future improvement work.
- Re-launch the FFT programme within Outpatients.

Measures of success

- Completion of baseline assessment of information communicated to patients relating to outpatients appointments.
- Programme of Governor's drop in sessions and evidence of actions taken following these visits.
- Implementation of the 'secret shopper' initiative across the Trust.
- Reduction in the number of PALS queries relating to OPD appointments.
- Introduction of FFT within Outpatients.

Statements of Assurance from the Board

Statements of Assurance from the Board

Review of services

During 2017/18, South Tees Hospitals NHS Foundation Trust provided and/or sub-contracted 75 relevant health services.

South Tees Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 75 of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 99.5% of the total income generated from the provision of relevant health services by the South Tees Hospitals NHS Foundation Trust for 2018/19.

Participation in clinical audit

The Trust has a well-structured clinical audit programme which is regularly reviewed to ensure it reflects the needs of our acute and community services. We know that high quality clinical audit enhances patient care and safety, and provides assurance of continuous quality improvement.

During 2018/19, 62 national clinical audits and 8 national confidential enquiries covered relevant health services that STHFT provides.

During 2018/19, the Trust participated in 96.7% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the South Tees Hospitals NHS Foundation Trust was eligible to participate in, and for which data collection was completed during 2018/19 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

Title	Eligible	Participated	% cases
Adult Cardiac Surgery	✓	✓	100%
Adult Community Acquired Pneumonia – British Thoracic Society (BTS)	✓	✓	Ongoing
The British Association of Urological Surgeons (BAUS) Urology Audit – Cystectomy	✓	✓	100%
BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)	✓	✓	100%
BAUS Urology Audit – Nephrectomy	✓	✓	100%
BAUS Urology Audit – Percutaneous Nephrolithotomy (PCNL)	✓	✓	100%
BAUS Urology Audit – Radical Prostatectomy	✓	✓	100%
Cardiac Rhythm Management (CRM)	✓	✓	100%
Case Mix Programme (CMP)	✓	✓	100%
Elective Surgery (National Patient Reported Outcome Measures (PROMs) Programme)*	✓	✓	115.6% *
Falls and Fragility Fractures Audit Programme (FFFAP)	✓	✓	Ongoing
Feverish Children (care in emergency departments)	✓	✓	100%
Inflammatory Bowel Disease programme (IBD) / IBD Registry **	✓	✘	N/A
Intensive Care National Audit and Research Centre (ICNARC)	✓	✓	100%
Learning Disability Mortality Review Programme (LeDeR)	✓	✓	100%

Title	Eligible	Participated	% cases
Major Trauma Audit	✓	✓	100%
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	✓	✓	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	✓	✓	100%
Myocardial Ischaemia National Audit Project (MINAP)	✓	✓	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme -COPD Best Practice Tariff	✓	✓	JCUH – 31% FHN – 32%
National Asthma and COPD Audit Programme - Asthma	✓	✓	Ongoing
National Audit of Breast Cancer in Older People	✓	✓	100%
National Audit of Cardiac Rehabilitation	✓	✓	100%
National Audit of Care at the End of Life (NACEL)	✓	✓	100%
National Audit of Dementia (NAD)	✓	✓	100%
National Audit of Percutaneous Coronary Interventions (PCI)	✓	✓	100%
National Audit of Seizures and Epilepsies in Children and Young People	✓	✓	100%
National Bariatric Surgery Registry (NBSR)	✓	✓	100%
National Bowel Cancer Audit (NBOCA)	✓	✓	100%
National Cardiac Arrest Audit (NCAA)	✓	✓	100%
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	✓	✓	Ongoing
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	✓	✓	Ongoing
National Comparative Audit of Blood Transfusion Programme	✓	✓	100%
National Diabetes Core Audit ***	✓	✘	N/A
National Pregnancy in Diabetes Audit	✓	✓	Not Known
National Diabetes Foot Care Audit	✓	✓	100%
National Diabetes In Patient Audit (NaDIA)	✓	✓	100%
National Diabetes Transition Audit	✓	✓	100%
National Diabetes HARMS Audit	✓	✓	100%
National Emergency Laparotomy Audit (NELA)	✓	✓	47%
National Heart Failure Audit	✓	✓	87%
National Joint Registry (NJR) – Friarage Hospital (FHN)	✓	✓	96.4%
National Joint Registry (NJR) – James Cook University Hospital (JCUH)	✓	✓	96.3%
National Lung Cancer Audit (NLCA)	✓	✓	100%
National Maternity and Perinatal Audit (NMPA)	✓	✓	100%
National Mortality Case Record Review Programme	✓	✓	66%
National Neonatal Audit Programme (NNAP)	✓	✓	100%
Title	Eligible	Participated	% cases

National Oesophago-gastric Cancer (NAOGC)	✓	✓	100%
National Ophthalmology Audit	✓	✓	56.2%
National Paediatric Diabetes Audit (NPDA)	✓	✓	100%
National Prostate Cancer Audit	✓	✓	100%
National Vascular Registry- Abdominal Aortic Aneurysm	✓	✓	92%
National Vascular Registry - Carotid Endarterectomy	✓	✓	78%
Neurosurgical National Audit Programme	✓	✓	100%
Non-Invasive Ventilation – Adults British Thoracic Society	✓	✓	Ongoing
Paediatric Intensive Care (PICANet)	✓	✓	100%
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Sepsis Screening	✓	✓	100%
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) IV Antibiotics within 1 hour	✓	✓	84.8%
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours	✓	✓	83%
Sentinel Stroke National Audit programme (SSNAP)	✓	✓	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	✓	✓	100%
Seven Day Hospital Services	✓	✓	100%
Surgical Site Infection Surveillance Service	✓	✓	100%
UK Cystic Fibrosis Registry	✓	✓	98%
Vital Signs in Adults (care in emergency departments)	✓	✓	100%
Venous thromboembolism (VTE) risk in lower limb immobilisation (care in emergency departments)	✓	✓	100%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Acute Bowel Obstruction	✓	✓	Ongoing
NCEPOD Long term Ventilation	✓	✓	Not Yet Started
NCEPOD Acute Heart Failure	✓	✓	100%
NCEPOD Cancer in Teens and Young Adults	✓	✓	100%
NCEPOD Child Health Clinical Outcome Review Programme Chronic Neurodisability	✓	✓	70%
NCEPOD Child Health Clinical Outcome Review Programme Adolescent Mental Health	✓	✓	82%
NCEPOD Peri-operative Diabetes	✓	✓	67%
NCEPOD Pulmonary Embolism	✓	✓	100%

Table 6: National Clinical Audits

* PROMS data could include patients from out of area who have been subcontracted to South Tees for their surgical procedure therefore the percentage of patients is showing as greater than 100%.
** Inflammatory Bowel Disease programme /IBD Registry - waiting for an IBD database to facilitate submission of data.
*** National Diabetes Core Audit – waiting for electronic patient record to facilitate submission of data.

The reports of 10 national clinical audits were reviewed the provider in 2018/19 and South Tees Hospitals Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Title of Audit	Actions
Adult cardiac surgery (ACS)	Good practice regarding reduction of wait time for cardiac surgery shared in National Cardiac Audit Programme (NCAP) report. All post-operative Cerebrovascular accident (CVA) cases to be re-examined by Surgeon Lead for further clinical scrutiny. Review of post-operative bleeding to be conducted using six months of cases.
Intensive Care National Audit and Research Centre (ICNARC) Cardiac Intensive Care unit	Infection rates particularly to continue to be closely monitored. All mortality cases reviewed by Anaesthetists each month with the aim of identifying learning points in the care for service improvement.
National Audit of Cardiac Rehabilitation (NACR)	Development of an in-house database to be able to collect and submit more comprehensive and timely data. This is with the aim of securing British Association for cardiovascular Prevention and Rehabilitation (BACPR) certification as recommended in the national audit. Also all patients now complete a comprehensive pre and post rehabilitation assessment, this was a recommendation in the recent NACR quality and outcomes report 2018.
Learning Disability Mortality Reviews (LeDeR)	There are currently three LeDER reviewers who have completed the training within the Trust.
Seven Day Hospital Services (7DS)	There are four core clinical standards and the Trust is fully compliant with two of the four: **Clinical Standard 2: Emergency Admissions seen and have thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission** – Weekday Compliance is 62.6% and Weekend Compliance is 69.5%. Total compliance with the standard is 64.5%. Extending Consultant presence on the Acute Medical Units to 2200 hours will improve compliance with this standard but implementation of this has been affected by critical Consultant workforce pressures in Acute Medicine. **Clinical Standard 5: Access to diagnostic tests** – The Trust is fully compliant with this standard. **Clinical Standard 6: Access to consultant-directed interventions** The Trust is compliant in all areas apart from interventional radiology (IR), which has current Consultant workforce pressures. There are plans to engage with Newcastle as the other tertiary provider in the region to provide IR services in collaboration. **Clinical Standard 8: Ongoing review by Consultant twice daily if high dependency patients, daily for others.** The Trust is not currently compliant with this. For patients who require twice daily Consultant reviews, the data collected is at variance with actual practice as it is standard policy that all patients in ITU (Intensive Therapy Unit) and HDU (High dependency Unit) are seen at least twice daily and a formal handover occurs twice daily. Similarly all new admissions and acutely unwell patients on the Acute Assessment Units are seen throughout the day on 'rolling' ward rounds. This enables prompt Consultant review and intervention. The overall proportion of patients who required a daily Consultant review and were reviewed by a consultant was 68%. The percentage receiving required once daily reviews was 71% for weekday and 57% for weekend. All new admissions and patients who are acutely unwell are reviewed by a Consultant over the weekend. Further actions have been identified and are being implemented to address this. There is more information on implementation of Seven Day Services in the main body of the report.

Title of Audit	Actions
The National Audit of Care at the End of Life (NACEL)	Improve documentation of specific aspects of care proposed and discussed at end of life, review of the templates used for documentation of the medical team plans and related communication for the dying person in conjunction with the North of England Cancer Network (NECN) review. Gather the perceptions of the bereaved about the care delivered to their deceased family member. Explore the possibility of assessing this through more formally documented feedback from next of kin that is already obtained by the Medical Examiners or via an annual survey of the experience of bereaved people. Provide mandatory/priority training to all staff related to end of life care, this is currently underway as a priority item of the End of Life Strategic Group work plan. Provide opportunity for face to face assessment of the dying patient 9-5 seven days per week by Specialist Palliative Care Team, currently underway as a priority item of service development for the Integrated Specialist Palliative Care service. Provide opportunity for communication skills training for staff; explore the potential for this through the Education group of the Integrated Specialist Palliative Care Team.
(NCEPOD) Perioperative Diabetes Management - 'Highs and Lows'	Write a new peri-operative guideline including all current guidance – specifically identifying high risk patients, change to HbA1c targets, and identification of diabetes mellitus patients, National Early Warning Score (NEWS – this is a tool used to detect the deteriorating patient) and paper records.
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Sepsis Training in Community hospitals – targeting wards that are not compliant with escalation processes. Continuing with Sepsis champion launch days. The team is attending regional Sepsis nurse meeting for Haematology and attended the Rapid Response Conference in Manchester and presented the Sepsis Champions Competency poster. Sepsis Commissioning for Quality and Innovation (CQUIN) and teaching continues throughout the hospital as well as teaching on the Foundation doctor (FY1) study day in July 2018- acutely ill patient Acute Illness Management (AIM) course. Training continues to be delivered in the community. Sepsis CQUIN recommended introduction of NEWS2 and this was implemented within the Trust in October 2018. In September 2018 a stand was set up in the hospital's atrium to promote World Sepsis Day and raise awareness.
Sentinel Stroke National Audit programme (SSNAP)	SSNAP score improved with the Trust overall scoring A for compliance in six domains, B in three domains and B/C in one domain (SSNAP scoring consists of 44 key indicators; these are grouped into 10 domains which are scored A-E. Domains are graded from A to E, with A being the very best standard of care). The number of stroke beds on Zetland Ward has been expanded to 15 (from 12) and updated guidance uploaded onto the Trust's intranet.
Surgical Site Infection Surveillance Service	No actions required.

Table 7: Actions from National Clinical Audits

Local Clinical Audits

The reports of local clinical audits reviewed by South Tees NHS Hospitals Foundation Trust in 2018/2019 are shown below, and the Trust intends to take the following actions to improve the quality of healthcare provided.

Title	Actions
Pressure Ulcer Management	Length of stay reduced initially but has increased slightly; the past four years represent a shift towards reduced readmissions but increased length of stay suggesting increased complexity of pressure ulcers. Improving care planning and efficiency with Decision Support Tools, STs, long waiting lists with plastic surgery; working to improve patient compliance Look at people with Spinal Cord Injuries admitted to other departments in the hospital for pressure sore management
Temporary pacing wires usage post cardiac surgery	Pacing wires to be checked for every patient on the ward round and discussed as appropriate. Electrocardiogram (ECG) findings to be written in the medical notes and the ECG filed in the notes. It should also be written clearly in the medical notes whether pacing or sensing and the clinical reason for pacing.
How effective are the surgical interventions for complications of mid-urethral tape procedures	Ensure new patients referred to Urogynaecology clinic complete an electronic patient questionnaire (ePAQ-PF) before attending or at appointment. Ensure this is also ticked on the pre-operative high vigilance form, which is reviewed in MDT prior to surgery. As part of the post-operative documentation, upload details of the procedure onto the British Society of Urogynaecology (BSUG) database. All post-operative complications to be uploaded contemporaneously as and when patients are seen in clinic.
Compliance to Sepsis 6	Devising a centre report to be sent out to each centre highlighting the results and therefore gaining an insight into how compliance can be increased for each individual area through feedback and discussion. More training dates to be arranged. Sepsis competencies to be extended to Paediatrics, Out Patient Departments (OPD's), Community, Allied Professionals (AP's) and Health Care Assistants (HCA's). The Trust is going to purchase a vital Pac sepsis module – this is an electronic screening treatment record.
Re-audit, the use of blood test within the emergency department	Our interventions have successfully reduced over-investigation within our department and have developed a greater understanding of the utility of Clotting screen, D-Dimer, Troponin I and Amylase. To maintain this standard of practice, we need to continue educational processes both formally at induction and informally during day to day practice. We also need to ensure that our requesting interface is optimised to facilitate the user to correctly select appropriate investigations. This model could be replicated and used in other Emergency Departments within the Trust and the region.
Cochlear Implant Audit	Audit shows compliance therefore no further action required.

To measure success of achieving community therapy KPI (Key performance indicator) 6	The rapid response service and the community therapy referral form have both been reviewed and re-launched.
Title	**Actions**
Wound Assessment Audit (CQUIN – Commissioning for Quality and Innovation)	Undertake a GAP analysis of the current SystmOne (electronic patient record system) template for wound care against the Minimum Data Set requirements. Undertake a review of the Wound Care Plan on SystmOne. Provide training to staff groups. Roll out of New Wound Care Plan Template. Evaluate completion of new template and identify further training requirements. Establish internal monthly snapshot audits to ensure full roll out has been successful. Establish improvement trajectory.
Management of Gestational Diabetes in women with previous history	No actions required.
Audit of infrainguinal graft surveillance/patency	Perioperative angiogram / immediate post-operative duplex to be performed Using a classification and regression tree to make graft surveillance more efficient
Re-audit Urinary Tract Infection in Pregnancy	Increase awareness of the right choice of antibiotics by presenting at team briefs in the Maternity Assessment Unit (MAU). Improve awareness of repeat sample after completing antibiotics by prompt added to stickers to document that this advice has been given.
Venous Thromboembolism (VTE) in neurosurgical patients	Re-emphasise the importance of VTE completion. Presentation of Re-Audit results showing improvement and re-emphasising need at Journal Club. Need to update VTE when Tinzaparin is being started or stopped- Person prescribing or stopping Tinzaparin is responsible for updating VTE. Mechanical prophylaxis prescribed upon completion of VTE assessment - inform Neurology cross cover when covering ward 24.
NICE TA513 – Obinutuzumab for untreated advanced follicular lymphoma (six month audit)	Low patient numbers but good compliance. No concerns identified.
Deep vein thrombosis (DVT) service audit	To improve Wells scoring (the Wells score is used to identify a patient's risk of developing DVT) and D-dimer utilisation by education and review/reinforcement of protocol, use of an aide memoire or proforma.
Long term Urinary Catheters Documentation Audit (Re-audit of 6036)	Review of SystmOne template to improve community nursing record keeping for patients with a long term urinary catheter.

Table 8: Local Clinical Audits

Clinical Effectiveness

Clinical Research

Clinical research is a national and Trust priority. South Tees NHS Foundation Trust is part of the Clinical Research Network North East and North Cumbria (CRN NENC). There is a clear link between research activity, clinical effectiveness and improved patient experience. A recent large-scale study demonstrated that patients cared for in NHS hospitals that have a high level of participation in clinical research have lower mortality rates and improved clinical outcomes. This effect was not just limited to those people who took part in the trials, but was significant across the entire patient population. It is therefore important that the Trust continually develops clinical research, bringing new therapies and new treatments to the people of Teesside and the wider population.

The Trust's active engagement in research is reflected by the high number of research studies being undertaken.

In 2017/18 the Trust recruited 3732 patients enrolled in 206 different research studies. In 2018/19 the Trust recruited 3691 patients enrolled in 196 different research studies. While the overall number of recruits marginally decreased when using this measure, when the figures are adjusted by the NIHR (National Institute for Health Research) to reflect the 'complexity' of the research then recruitment at South Tees Hospitals increased 13% year-on-year. In addition South Tees Hospitals contributed a higher proportion of the patients that were recruited to research in the North East and North Cumbria region.

The Trust is routinely meeting the NIHR target deadlines (40 days from receiving a complete research application) for setting up new trials to help ensure that there are minimal avoidable delays to research activity and income. In order to continue improving the support available for clinical research delivery the Trust previously established a Clinical Research Lead position and individual Research Nurse Team Leads as part of a restructure. The Trust is creating a formal research alliance with two other NHS Trusts (North Tees and Hartlepool Hospitals NHS Foundation Trust and County Durham and Darlington NHS Foundation Trust) in order to increase patient opportunities to participate in research.

The Trust continues to successfully deliver major NIHR grant-funded trials and this year has been awarded other commercial research grants.

The Trust has received accolades from the NIHR for achieving global, European and UK first patient recruits for several commercial trials. Income directly related to trust sponsored research grew by 53% between 2017/18 and 2018/19.

Patient Engagement

We routinely appoint patient representatives to the steering committees of our NIHR grant funded studies and carry out other patient and public involvement activity for individual trials, for instance focus group sessions.

The Trust has appointed several members of the public as Research Patient Ambassadors to act as advocates and provide guidance from a patient perspective on the Trust's research activities.

Goals agreed with commissioners – use of the CQUIN payment framework

A proportion of the South Tees Hospitals NHS Foundation Trust's income in 2018/19 is conditional on achieving quality improvement and innovation goals agreed between South Tees Hospitals 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 2018/19 and for the following 12 month period are available on request from the Quality Assurance Team, South Tees Hospitals NHS Foundation Trust, The James Cook University Hospital, Marton Road Middlesbrough TS4 3BW or via email stees.qualityassurance@nhs.net

The table below demonstrated the income conditional upon achievement of the CQUIN measures and the payment received by the Trust for the last 2 financial years.

	Income conditional upon achievement of the CQUIN measures	Payment received by the Trust
2017/18	£9.98m	£8.95m
*2018/19	£11.08m	tbc

Table 9: CQUIN Income

Care Quality Commission Registration

South Tees Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'Registered without conditions'.

The Care Quality Commission has not taken enforcement action against South Tees Hospitals NHS Foundation Trust during 2018/19.

CQC Rating

The Care Quality Commission inspected the Trust in June 2016 and published its findings in October 2016. The ratings matrix can be found below:

Overall Good		
	Safe	Good ●
	Effective	Good ●
	Caring	Good ●
	Responsive	Good ●
	well-led	Good ●

Overview and CQC inspection ratings

This inspection was a focused re-inspection and our rating improved from requires improvement to good.

All services and domains were rated as good, with Maternity and Gynaecology receiving a rating of outstanding for the Well Led domain and Community Services receiving an outstanding rating for the Caring domain. There were no requirement notices issued as a result of this report.

South Tees Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

In January 2019 the Trust received an 'unannounced inspection' starting at the Friarage Hospital, the core services of Medical Care, Surgery and Urgent and Emergency services were inspected on both acute sites. In February 2019 the CQC returned to undertake a 'Well Led' inspection across the Trust. As well as inspecting this key question within each service level inspection, the CQC also assess this separately at a trust-wide level for NHS Trusts and Foundation Trusts approximately annually. During February unannounced inspections of both critical care and diagnostic imaging were also undertaken.

The draft report has been received at STHFT to check for factual accuracy. At the time of writing the final report has not been received, we anticipate receiving it in the coming weeks. Areas of focus and future work include:

- Effectively managing the increasing demand for critical care services whilst maintaining safe staffing in line with national guidance
- Improving compliance with mandatory training and rates of appraisals
- Continuing to focus on the reduction of avoidable harm
- Improving rates of incident reporting, investigation and subsequent learning across the organisation to support an open safety culture
- Focussing on staff engagement

NHS number and general medical practice code validity

South Tees Hospitals NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode 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:

✓	99.87% for admitted patient care;
✓	99.96% for outpatient care; and
✓	99.35% for accident and emergency care.

Included the patient's valid General Medical Practice Code was:

✓	99.99% for admitted patient care;
✓	99.99% for outpatient care; and
✓	99.96% for accident and emergency care.

Information Governance (IG) toolkit attainment levels

Information Governance is assessed as part of a process using the new Data Security and Protection (DPST) Toolkit, which replaces the older IG toolkit reporting function and is based upon the National Data Guardians 10 Data Security Standards. The content of the DSP Toolkit has significantly changed; it has been significantly updated to include more assurance around technical aspects of cyber security and information security compliance.

DPST also differs from the previous IG Toolkit which assessed performance against three levels (1, 2 and 3). The DSPT does not include levels and instead requires compliance with assertions and (mandatory) evidence items.[1] These include a total of 40 assertions and 100 pieces of mandatory evidence. A status update received in Early March 2019, from NHS Digital offers organisations that consider they may be non-compliant on some areas of the toolkit, the option to upload a detailed action plan as an addition to its evidence submission. This will help mitigate those areas of risk where it has been highlighted that evidence within certain standards may be currently lacking.

South Tees NHS Foundation Trust has submitted a return for the Data Security and Protection Toolkit V1 2018/2019 and is awaiting formal publication by NHS Digital. Of the 100 mandated requirements the Trust has met 78 and this indicates a "Standards Not Met" status. An improvement plan has been developed and is currently being implemented with a completion date of 30 September 2019. The plan has been submitted to NHS Digital and it is anticipated that once reviewed the South Tees NHS Foundation Trust published status will be updated to "standards not met (improvement plan in place)". Implementation is being monitored by Informatics Strategy Steering Committee and reported to the Trusts Senior Information Risk Owner (SIRO) on a monthly basis.

Clinical coding

South Tees Hospitals NHS Foundation Trust was not subject to a Payment by Results clinical coding audit during 2018/19 by the Audit Commission.

Learning from Deaths

During 2018/19, 1,847 patients of South Tees Hospitals NHS Foundation Trust died. This comprised the number of deaths which occurred in each quarter of that reporting period:

442 in the first quarter;

438 in the second quarter;

436 in the third quarter;

531 in the fourth quarter.

[1]Some evidence items will not be required where an organisation uses NHSmail, or has in place an existing relevant standard (Cyber Essentials PLUS, ISO 27001).

By 31st March 2019, 150 case record reviews and 39 investigations have been carried out in relation to 1,847 deaths above.

In 29 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

12 in the first quarter;
9 in the second quarter;
6 in the third quarter;
2* in the fourth quarter.

*This figure is accurate at the time of this report and the low number for Q4 relates to timely provision of notes to the ME Service. Since there has usually been an incident reported and an investigation, the patient case notes are usually in high demand across several parts of the organisation and therefore the review cannot be carried out until these have been received.

Seven deaths, representing 0.4% of the patient deaths during the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: -

2, representing 0.5% for the first quarter;
4, representing 0.9% for the second quarter;
0, representing 0.0% for the third quarter;
1, representing 0.2% for the fourth quarter.

These numbers have been estimated using an adapted version of the Preventable Incident, Survival and Mortality Study (PRISM) methodology. The Trust established a Medical Examiner Service in May 2018. Approximately 80% of deaths (those not referred for Coronial investigation) will be scrutinised by Medical Examiners. Anywhere there may be a problem in care (or meet specific criteria) is reviewed by a central team led by Respiratory medicine and Renal consultants. Each review results in 2 grades, one for quality of care and one for preventability of the death.

The reviews highlighted the following learning points and recommendations:

- ✓ Elevated NEWS scores should be escalated appropriately with timely Consultant review and treatment plan.
- ✓ "The care was fine up until the day of discharge… when despite having bloods requested by the registrar at ward round which came back very abnormal, they were either not seen or not acted upon before the patient was discharged. Investigations need to be reviewed, acted upon and if necessary escalated."
- ✓ "No documentation of medication on arrival, no medicines reconciliation. As a consequence this lady's insulin was omitted"

255 case record reviews and 9 investigations were completed after 31/03/2018 which related to deaths which took place before the start of the reporting period.

One death representing 0.05% of the patient deaths before the reporting period, was judged to be more likely than not to have been due to the problems in the care provided to the patient. This number has been estimated using an adapted version of the Preventable Incident, Survival and Mortality Study (PRISM) methodology. Deaths are reviewed by a central team led by Respiratory and Renal Consultants. Each review results in two grades, one for quality of care and one for preventability of the death.

Staff who 'Speak Up' (including whistleblowers)

Following the Mid Staffordshire NHS Foundation Trust Public Inquiry Sir Robert Francis QC made recommendations designed to make the culture of the NHS patient focused, open and transparent – one in which patients are always put first and their safety and the quality of their treatment are the priority.

There was an increasing recognition of the contribution staff can make to patient care through speaking up however there was a continuing problem with regard to the treatment of staff who raise genuine concerns about safety and other matters of public interest, and the handling of those concerns.

The review highlighted a number of people who reported victimisation or fear of speaking up which is unacceptable.

Sir Robert Francis concluded "Each time someone is deterred from speaking up, an opportunity to improve patient safety is missed". Every organisation needs to foster a culture of safety and learning in which all staff feel safe to raise a concern. "We need to get away from the culture of blame, and the fear that it generates, to one which celebrates openness and commitment to safety and improvement".

Figure 14: Process for managing concerns reported through 'Freedom to Speak Up'

In light of the recommendations outlined above the Trust introduced a new 'Freedom to Speak Up (FTSU) Raising Concerns (Whistleblowing)' Policy in 2016 and employed the services of an independent impartial service 'SeeHearSpeakUp' to manage concerns that were raised. It became clear however that more needed to be done to support staff who had concerns to feel able to raise those concerns.

The Trust has now appointed two new 'Freedom to Speak Up Guardians', Helen Smithies (Assistant Director of Nursing) and Laura Mills (Head of Facilities), both have been with the organisation for many years and will be known to many staff. Supported by an Executive and Non-Executive Director leads they have developed a new policy, attended national training and developed a network of 35 champions. FTSU awareness has been incorporated into the new Trust induction.

Use the new reporting tool that has been developed which enables staff to report concerns in a number of ways:

Anonymous notification – no one, including the guardians, knows your name. It is important when making an anonymous notification to provide sufficient details to allow for an investigation – for example, which area, ward or department you are referring to. The lack of identification means feedback cannot be given to an anonymous referrer.

Confidential notification – the guardians know your name but will not disclose it to anyone else. This allows the guardians to gather any missing or unclear information and to provide feedback following the investigation.

Open notification – you have agreed to your name being shared with the investigators. You will also be able to be provided with feedback.

In addition to the reporting tool staff are able to report their concerns in person to the Guardians or champions within the Trust. There is also a dedicated email account for staff to use.

Feedback to Staff

Staff receive feedback either by email or face to face depending on their preference, provided they have passed on their details and not reported their concerns anonymously. Staff are also asked to report detriment and this is monitored by the Guardians and reported back to the national office.

Further work is planned during 2019/20 to strengthen these processes and continue to promote the service.

Number of Concerns Reported

Data is only available from January 2019 when the Trust took over providing this service internally. Since that time there have been 7 concerns reported, 3 of these have been closed and 4 are ongoing. One of the incidents related to a small team of staff. Due to the small number of reported concerns no themes were identified however next year, as the service continues to be promoted, it is anticipated that analysis of the data will allow themes and trends to be identified.

Reporting against core indicators

In addition to the progress with our locally identified quality priorities and our performance against national performance targets, we also monitor measures from the NHS Outcomes Framework. The data reported below is data that is publicly available from NHS Digital; we have included benchmarking data where this is available. The most recently available data from NHS Digital has been used however, it should be noted that due to the nature of some of the measures and the data collection systems, the time period reported for some of the measures may be some time in the past.

The NHS Outcome Framework has five domains within which are grouped together measures for monitoring progress. The Quality Account regulations require a selection of these to be included in this report and these are described below under the heading of the relevant domain.

Domain 1
Preventing people from dying prematurely

Summary Hospital Level Mortality Indicator (SHMI)

Figure 15: Summary Hospital Level Mortality Indicator (SHMI) (Data source: NHS Digital)

South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: the Trust experiences approximately as many deaths as would be expected, given the patients it serves and the range of services it delivers. Thus the SHMI is approximately 100 (i.e. observed and expected mortality rates are approximately the same). The categorisation of the SHMI into band 2 means that the mortality is within the expected range.

% of patient deaths with palliative care coded at either diagnosis or specialty level

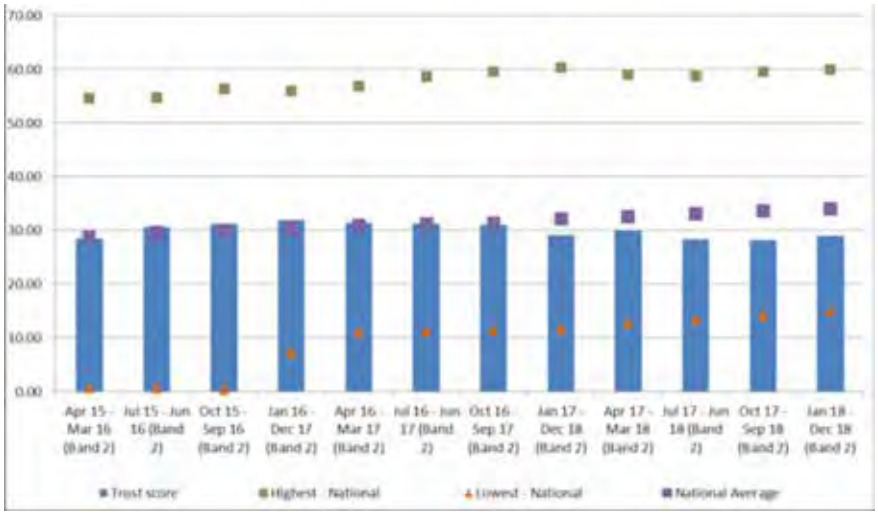


Figure 16: Percentage of Patient Deaths with Palliative Care Coded (Data source: NHS Digital)

The percentage of patient deaths with specialist palliative care coding has fallen a little behind the national average and in the period Jan 2018 to Dec 2018 was 29.0% compared to 34.0%. Work is underway to explore this in more depth and to develop an action plan to address issues identified.

The Trust is taking the following actions to improve the indicators and therefore the quality of its services; in 2018 the Trust re-organised some of its governance committees and established a Patient Safety Sub Group to coordinate hospital safety monitoring and improvement activity. This includes reviewing the range of statistics available to monitor hospital mortality, establishing the Medical Examiner Service (the first in the North East), overseeing a weekly clinical review of hospital deaths so that common themes can be identified and lessons can be learnt to improve the quality of its services. Whilst improvements in the processes for identifying patients and recording the input of the Specialist Palliative Care Team (SPCT) into the care of individual patients has been difficult to maintain, further work in this area is on-going.

The Trust has implemented quality improvements that might reasonably be expected to impact on mortality indicators. These include improving identification and management of deteriorating patients (the electronically recorded Early Warning Score has been updated in line with national guidance including in the electronic patient record in the Emergency Departments and Acute Assessment Units), identifying and managing patients with sepsis, prevention of falls, further reductions in infections and medication errors as well as the implementation of innovations as recommended by NICE guidance and national audits like the National Emergency Laparotomy Audit.

Domain 2
Enhancing quality of life for people with long-term conditions

No applicable indicators

Domain 3
Helping people to recover from episodes of ill health or following injury

Patient Reported Outcome Measures (PROMs)

PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected from patients through PROMs questionnaires before and after a healthcare procedure and provides an indication of the outcomes or quality of care delivered to NHS patients (HSCIC website http://www.hscic.gov.uk/proms). The score reported is an adjusted health gain score based on case mix, a higher number indicates a better health gain.

Hip replacement patient reported outcome measures – health gain score

Figure 17: Hip Replacement PROMS

Knee replacement patient reported outcome measures – health gain score

Figure 18: Knee Replacement PROMS (Data source: NHS Digital)

South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: the specialist review and pre-assessment process ensures that patients are offered the procedure likely to deliver the most benefit and best outcome. The health gain scores for hip replacements and knee replacements are in line with the national average.

The Trust has taken the following actions to improve these scores, and therefore the quality of its services: providing regular feedback of the scores to clinical teams and benchmarking performance across the NHS and other hospitals in the North East, through a regular report produced by the North East Quality Observatory Service (NEQOS), to ensure the quality of services is maintained.

Re-admission within 28 days

Emergency re-admission within 28 days of discharge (age 16 and over)

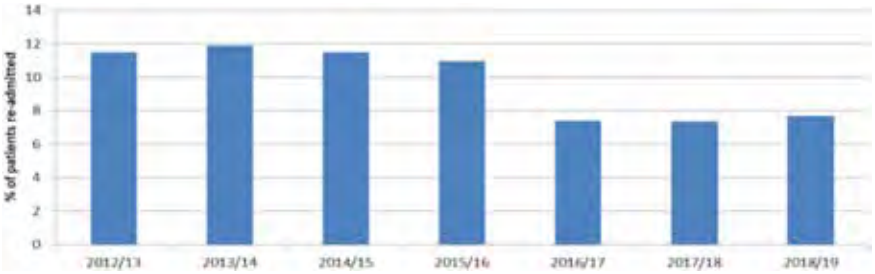


Figure 19: Emergency Readmissions Aged 16 and over

Emergency re-admission within 28 days of discharge (age 0-15)

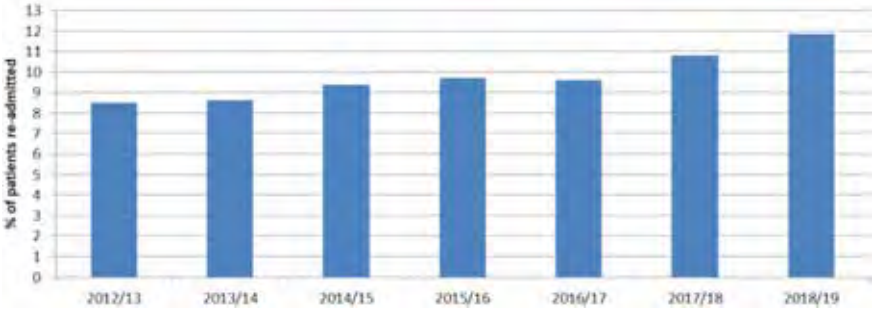


Figure 20: Emergency Readmissions Aged under 16 (Data source: Local patient administration system)

South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: the percentage of re-admissions for patients aged over 16 remained at around 11% between 2013/13 and 2015/16, before falling in 2016/17. The reduced figure has been sustained in 2017/18 and 2018/19.

The percentage of re-admission for children aged 0 to 15 years increased gradually between 2013/13 and 2018/19. The paediatric service has an open access day unit facility where children that have had a recent acute admission or a long term chronic condition can return if they deteriorate.

The South Tees Hospitals NHS Foundation Trust intends to take the following actions to improve these percentages, and the quality of our services: there has been considerable work undertaken in individual pathways, for example alcohol dependency, pain management and Chronic Obstructive Pulmonary Disease (COPD). The rapid response service and the Integrated Community Care Team will support those patients at high risk of re-admission.

Domain 4
Ensuring people have a positive experience of care

Responsiveness to the personal needs (National Inpatient Survey)

Figure 21: Responsiveness to Personal Needs (Data source: NHS Digital

South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: the Trust clinical standards focus on delivering care in a sensitive and person-centred way.

The Trust score for 2017/18 (which is the most recent data) was 72 which was higher than the national average of 68.6.

The Trust intends to take the following actions to improve this data and the quality of its services. The Trust continues to collect 'real time' patient experience data and this programme will be further expanded during 2018/19 with the roll out of the Meridian system. This provides immediate feedback to the wards thereby enabling staff to recognise and respond to patient queries and concerns immediately.

Staff who would recommend the Trust as a provider of care to their family and friends

% of staff that would recommend the trust as a provider of care to their family and friends

Figure 22: Percentage of Staff who would recommend the Trust (Data source: NHS Digital)

The South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; the Trust scores have been consistent over the last 5 years.

The South Tees Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage and thereby the quality of its services. It continues to work with staff to improve the quality of care provided to patients. In addition the Trust promotes the achievements of staff in delivering high quality care through regular staff bulletins, staff briefings and providing other opportunities for staff feedback.

Domain 5
Treating and caring for people in a safe environment and protecting them from avoidable harm

Patients that were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.

The South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; the Trust monitors compliance on a monthly basis and has achieved the required standard.

The South Tees Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services; the completion of a VTE risk assessment is monitored monthly through audit to ensure that the actions required following assessment are completed as well as recording that the assessment has taken place. Issues identified from the audit are further investigated and actions put in place to address any areas of concern.

% of patients risk assessed for venous thromboembolism

Figure 23: Percentage of Patients assessed for VTE (Data source: NHS Digital)

Clostridium difficile (C.difficile) Infections

Rate of C.difficile per 100,000 bed days amongst patients age 2 or over

Figure 24: Rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over. (Data source: NHS Digital)

The South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; the Trust is committed to driving down healthcare acquired infections, and achieved its lowest ever incidence Clostridium difficile infections in 2018/19, although this data is not available nationally as yet.

The South Tees Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services; the Trust has a comprehensive action plan for the prevention of trust-attributed Clostridium difficile infections which is monitored through the Infection Prevention Action Group. In addition to this all trust-attributed cases have a full root cause analysis and are reviewed at a panel chaired by the Director of Infection Prevention and Control or her deputy.

Rate of patient safety incidents reported within the Trust and the number and percentage of such patient safety incidents that resulted in severe harm or death

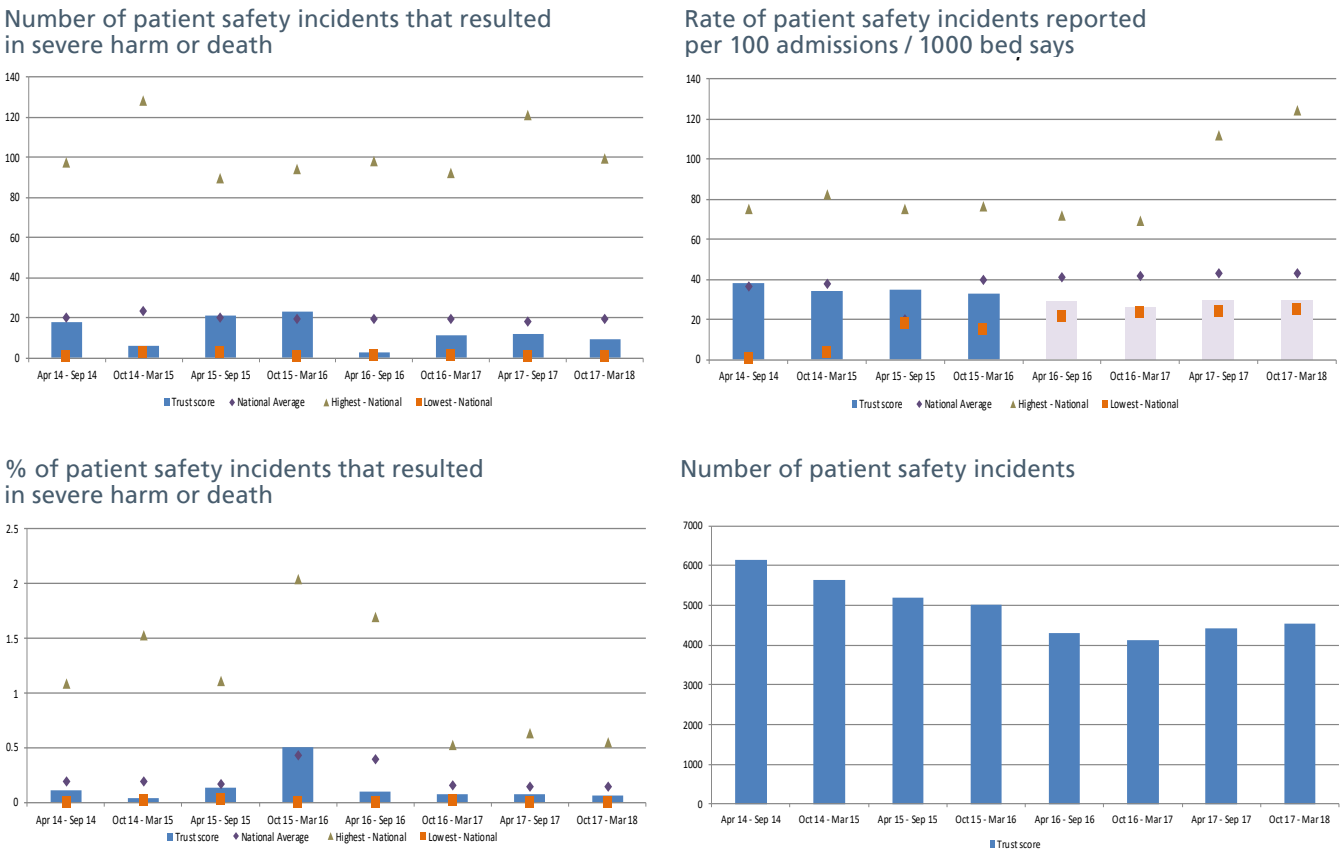


Figure 25: Rate of Patient Safety Incidents Reported (Data source: NHS Digital)

The indicator for patient safety incidents has changed from incidents per 100 admissions shown in blue above to that per 1000 bed days shown in light purple.

South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; the Trust has recognised that the rate of incidents and the number of incidents reported has fallen.

Incident reporting was identified as a Quality Priority for 2018/19 and further information on the action taken to improve incident reporting is described in this section of the report. Further work is taking place to explore ways of improving the incident reporting process and the Trust is currently exploring ways of making incident reporting easier, via the use of voice recognition software and other technology that should facilitate this process.

Each indicator is governed by standard national definitions.

Part Three Other information

An overview of the quality of care based on performance in 2018/19 against indicators

This section of the quality account contains a review of our quality performance during 2018/19. It also includes comments on the development and content of the quality account provided by a range of external stakeholders.

We are continuously exploring new ways of improving quality and safety, making innovative use of the data collected.

Information about quality of care is collated in the form of a dashboard at ward, clinical centre and Trust level, and is reviewed monthly. This information is shared with the Board of Directors, Board of Governors, senior clinicians and managers to provide assurance the Trust is on track to deliver its key targets.

The following section reviews the work of a range of quality work streams during 2018/19; these have been selected as the key indicators by the Board that demonstrate the quality of care provided by this organisation.

Patient Safety

Pressure Ulcers

Pressure ulcers are a key indicator of the quality and experience of patient care. Despite progress since 2012 in the management of pressure ulcers they remain a significant healthcare problem.

In the NHS in England, 24,674 patients were reported to have developed a new pressure ulcer between April 2015 and March 2016, and treating pressure damage costs the NHS more than £3.8 million every day. (NHS Improvement 2018)

We know that many pressure ulcers are preventable, so when they do occur they can have a profound impact on the overall wellbeing of patients and can be both painful and debilitating (Moore et al 2009). Preventing these will improve care for all vulnerable patients.

During 2018/19 the Trust continued to focus on reducing the number of pressure ulcers in both the acute and community settings. In December, the Trust adopted the NHS Improvement revised definition and measurement for pressure ulcers. These recommendations stipulated how to measure and record pressure ulcers to ensure a more consistent approach is taken across hospitals in England. This will allow comparisons between hospitals, something which has previously not been possible as many hospitals measured pressure ulcers differently.

The Trust re-launched its tissue viability strategy to ensure it aligns with current guidance and directs initiatives aimed at reducing the incidence of pressure ulcers.

The incident reporting form for pressure ulcers has been strengthened to capture relevant information to enable ward managers and clinical matrons to ensure trends and themes are identified and that these then inform further improvement work.

The safety@stees collaborative, a safety focused monthly meeting, includes pressure ulcers as a standing agenda item and provides a regular opportunity to monitor performance and share good practice. More detailed analysis is conducted by wards teams and actions are monitored through the clinical standards meeting. Where additional support, expert advice or training is required, the tissue viability team provide this to our clinical staff, both on wards and within the patient's own home.

Falls

In addition to the work described earlier in the report, there has been successful collaborative working and targeted interventions across the Trust which has led to a sustained reduction in falls. During 2018/19 there has been a sustained focus on reducing falls and this has included interventions such as improvements to signage, continence and delirium care planning, medication reviews and interventions to prevent muscle loss, specifically for older and frail patients.

Falls are reported via the incident reporting system and the reporting form for falls has been strengthened to enable more detailed reporting and identification of trends and themes to inform further improvement initiatives. Through analysis of incident data environmental issues such as light levels, weight of doors and toilet seat height identified as issues have all been addressed to reduce the incidence of falls.

The safety@stees collaborative meeting includes falls as a standing agenda item and provides a regular opportunity to monitor performance and share good practice. More detailed analysis is conducted by each ward and actions are monitored through our clinical standards meeting.

Ongoing interventions include monitoring the completion of the Trust's fall's assessment to ensure individual patient's risks are being addressed. Examples include conducting a review of medicines where necessary and ensuring appropriate footwear is worn. There is also a system for flagging patients identified at risk of falling and these patients are discussed at ward rounds and this is highlighted on the patient boards.

Duty of candour

Central to the Trust's strategy to improve patient safety is its commitment to improving communication between healthcare professionals and patients and/or carers when a patient is harmed as a result of a patient safety incident. This communication is known as 'Being Open' and involves apologising and explaining what happened. It ensures communication is open, honest and occurs as soon as possible following an incident. 'Being Open' about what happened and discussing incidents promptly, fully and compassionately can help patients cope better with the after-effects. Incidents can also incur extra costs through litigation and further treatment; openness and honesty can help prevent such events becoming formal complaints and litigation claims. 'Being Open' is a process rather than a one off event. The Duty of Candour is the statutory and regulatory requirement of the 'Being Open' process and applies when a patient safety incident results in moderate harm, major (severe) harm or death.

The Trust's process to discharge its Duty of Candour is described in the 'Being Open' policy which is available to all staff. An overview of Duty of Candour is included in the Trust's Induction programme. In addition the incident reporting system and investigation documentation includes prompts to ensure the Duty of Candour requirements are considered. An audit of incidents with a severity graded as moderate or greater was undertaken in December 2018 and showed that Duty of Candour had been discharged in all cases.

Clinical Effectiveness

Dying in hospital – mortality

Hospital mortality rates; how many people die in different hospitals as a proportion of the number of people who are admitted to the hospital, are not easy to compare across the NHS. Simply knowing how many people died at each hospital would be misleading as hospitals see different numbers of patients and provide different services to patients with different levels of risk. However, for an individual hospital or Trust it is important to monitor a number of measures of mortality as collectively they can provide alerts about the quality of care provided in the organisation.

The basic measure is to monitor the proportion of people who die in hospital and this number, known as the unadjusted mortality rate, is monitored on a weekly basis. Risk adjusted measures can take account of the different levels of risk to some extent. They are calculated by estimating the risk of death for each patient with specific medical conditions and comparing the actual death rate with the total estimated rate that can be expected from the predicted risks.

Mortality statistics are reported to the Trust Board on a quarterly basis and have been since 2008. These include the number of deaths, the unadjusted mortality rate and the Summary Hospital-level Mortality Indicator (SHMI), the NHS's official risk-adjusted mortality metric.

Mortality rate April 2005 – February 2018

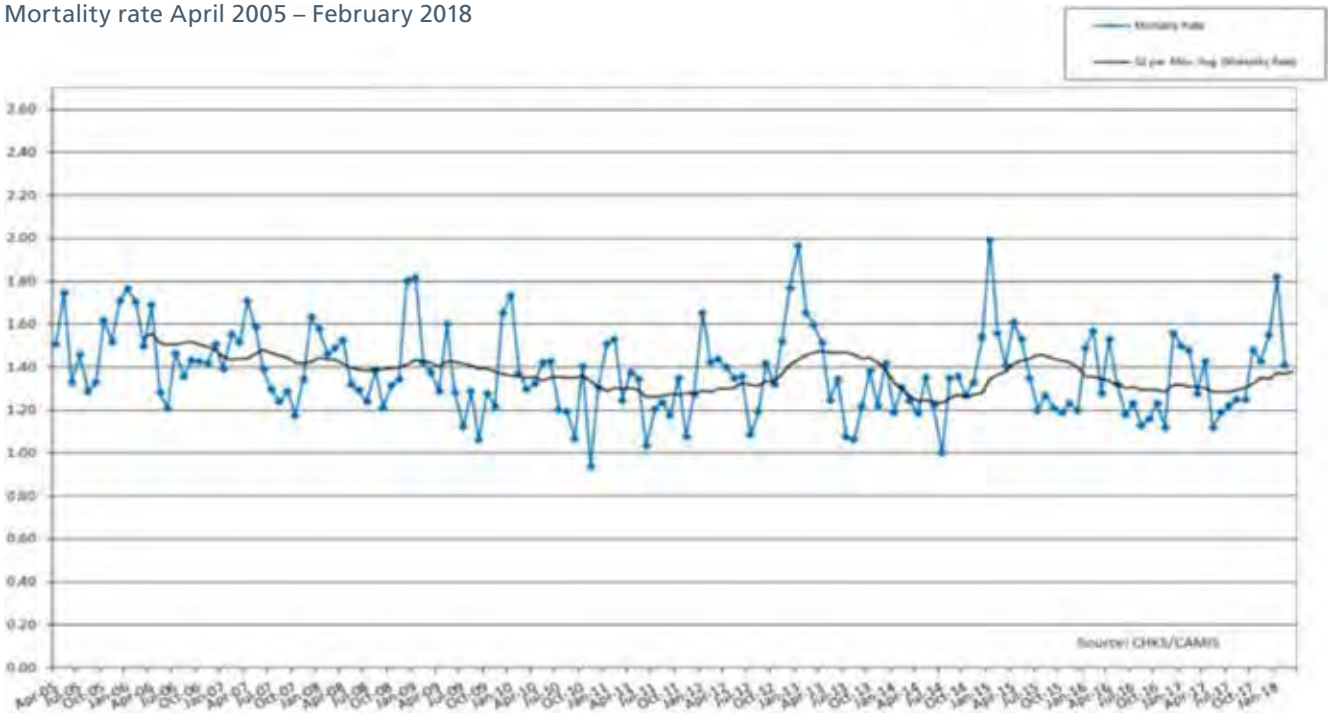


Figure 26 Unadjusted Mortality Rate April 2005 – Feb 2018 (including rolling 12 month averages) (Source: CHKS/CAMIS)

Unadjusted mortality measures the number of deaths as a percentage of patient inpatient and day case spells, excluding well babies (less than 28 days old). It is most useful for seeing the pattern of deaths through time. Looking at the trend from April 2005 – February 2018 it can be seen that a winter peak is experienced in most years, especially in 2013, 2015 and 2017. The peak in January 2015 in particular was severe but of short duration and reflects the amount of respiratory infections in the community. The peak between October 2017 and January 2018 again reflects the amount and severity of respiratory infections including influenza in the community, as primary causes of death and underlying other conditions such as sepsis, renal failure and other acute medical conditions. The winter peak for 2018-19 was relatively low.

SHMI with banding using 95% control limits and with adjustment for over-dispersion

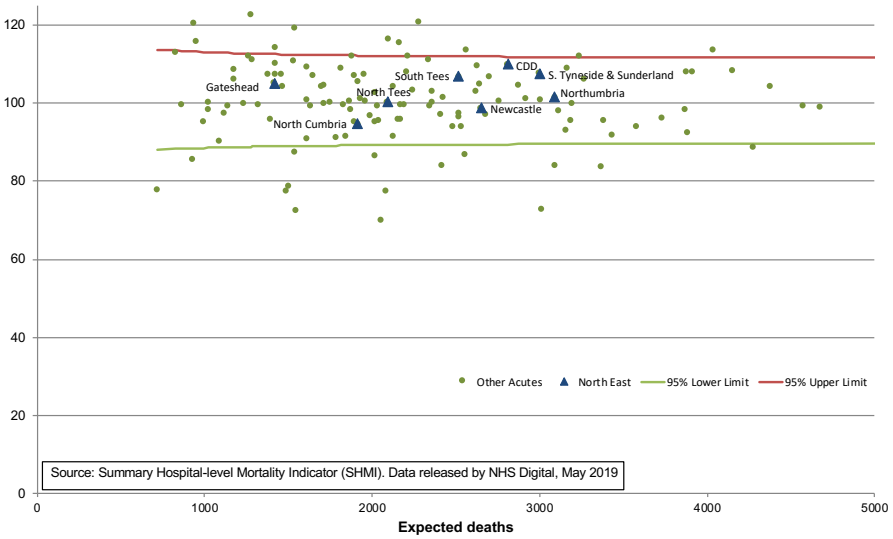


Figure 27: SHMI with 95% Control Limits and with adjustment for over-dispersion for January 2018 – December 2018 (Source: SHMI Data Release NHS Digital May 2019)

The Summary Hospital-level Mortality Indicator (SHMI) is designed to allow comparison between Trusts across the NHS. It includes deaths in hospital as well as deaths within 30 days of discharge from hospital. The SHMI for the Trust has been 'as expected' (i.e. within the amount of variation that can be anticipated by chance) in all data releases to date and the SHMI is currently 109 (Jul 2017 – Jun 2018). This means that the number of deaths in hospital or within 30 days of discharge from hospital is a little higher than the number expected using a statistical model.

SHMI and unadjusted mortality rate for South Tees

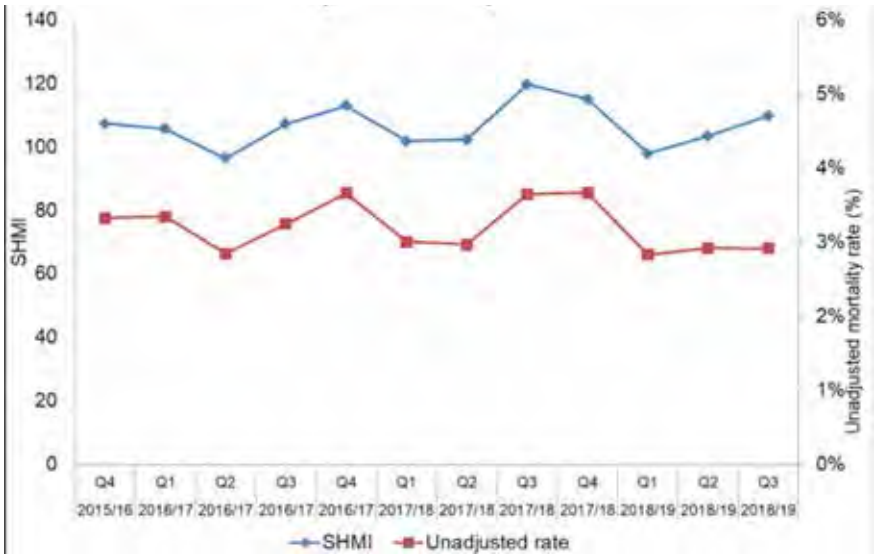


Figure 28: SHMI and Unadjusted Mortality Rate for South Tees (Source: Data extracted from HED May 2019)

The SHMI is monitored on a quarterly basis and broadly reflects the unadjusted rate for deaths included in the SHMI.

Re-admissions

30 day readmission rate following an unplanned admission (PbR) January 2015 – October 2018

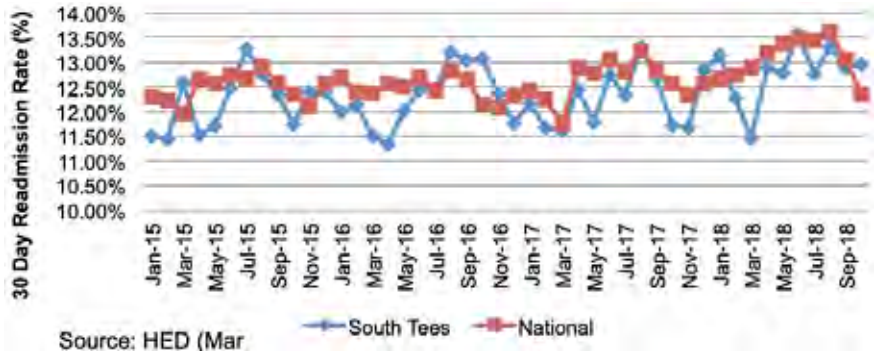


Figure 29: 30 day readmission rate following an unplanned readmission (Payment by Results)

Over the period illustrated, 30 day readmissions for the Trust has averaged 12.58% compared to the national average of 12.68%. For some patients this further admission is not linked to their recent hospital stay but for others, they have returned to hospital because of complications after their discharge. These complications may be related to their needs not being adequately established at pre-assessment, through to acquiring an infection during their hospital stay or due to their rehabilitation not progressing as planned. The graph demonstrates that the re-admission rate has stayed static over the period reported.

There has been considerable work undertaken in individual pathways, for example alcohol dependency, pain management and Chronic Obstructive Pulmonary Disease (COPD). The Rapid Response Service and the Integrated Community Care team will support those patients at high risk of re-admission.

Nutrition and hydration – getting the balance right

It is nationally recognised that today, an unacceptable number of people are becoming malnourished when they are in hospital. They become malnourished because their appetite or food intake is reduced due to their illness, the impact of treatment or interventions that they are receiving, or they don't get the right food that they can eat or the help they need to eat it. Being malnourished increases the risk of infection and also increases the length of time it will take them to recover.

The Trust has a proactive and organised approach to combating malnutrition, overseen by the Food and Drink Strategy Assurance Board, and its importance is recognised as a key priority for the organisation. The Trust aims to:

- ✓ Ensure all patients are screened to assess their risk of malnutrition and that this information is appropriately acted upon
- ✓ Ensure we meet the needs of patients who require help with eating or drinking
- ✓ Provide choices of food and drink for people to meet their diverse needs making sure the food and drink we provide is nutritionally balanced and supports their recovery.

Patients are assessed on admission using the Malnutrition Universal Screening Tool (MUST), which is a validated screening tool to detect malnutrition in adult patients. The following graph demonstrates compliance with using the tool and taking the appropriate actions.

Compliance with MUST assessments

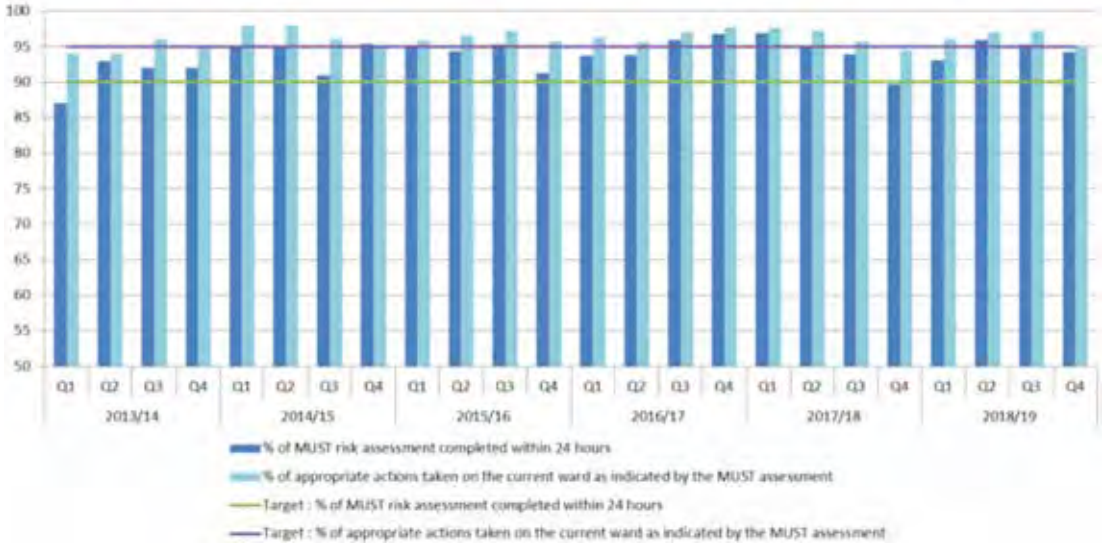


Figure 30: Compliance with Must Assessments (Data source: Local audit)

Compliance is monitored via ward managers monthly audits and the clinical assurance rounds, and where issues are highlighted targeted training is arranged locally.

MUST Screening Tool

The screening tool that we use to identify patients at risk of malnutrition has recently been revised and updated as part of the overall review of the nursing care pathway documentation. This is due to be re-launched across the Trust in May 2019.

International Dysphagia Diet Standardised Initiative (IDDSI) Implementation

An important piece of work for the Trust this year has been the implementation of the new IDDSI ('International Dysphagia Diet Standardisation Initiative) Framework. The IDDSI Framework is an internationally agreed framework that has been developed for a number of reasons but most importantly for patient safety. There have been a number of serious choking incidents related to poor understanding of previous terminology that was used for dysphagia, and particularly around the term 'soft diet'. IDDSI promotes patient safety through using the same definition to describe the different levels of dysphagia - for all ages and care settings across the world.

Dysphagia describes eating, drinking and swallowing difficulties. Treating dysphagia depends on what underlying condition (s) a person may have. If dysphagia is not treated appropriately, it can result in choking, pneumonia, chest infections, dehydration, malnutrition and weight loss. One of the ways in which dysphagia is managed is by modifying the texture of someone's food and/or increasing the thickness of their fluids.

Over the past year a multi-disciplinary group has led the implementation of this framework – introducing the new descriptors for fluids in June 2018 and the new descriptors for food texture levels from December 2018. This has involved a significant amount of work and collaboration to raise awareness, provide training, update documentation, change menus and develop information resources for patients, carers and care providers.

Nutrition and Dysphagia training in Care Homes

Delivery of the' nutrition and dysphagia' strand of the Better Care Fund (BCF) project (initially commenced in April 2017) has continued during 2018/19.

The BCF project aims to reduce the number of acute hospital admissions by up skilling staff in nursing/care homes across South Tees to more effectively identify and manage residents' nutrition and dysphagia related problems. Care home staff have been provided with delivered training sessions, along with provision of supporting educational resources on 'managing malnutrition' and 'managing residents with swallowing problems'. Key outcomes of the project this year have been:

- ✓ Care staff's confidence and knowledge has improved across all domains measured and improvement in completion rate and accuracy of MUST (Malnutrition Universal Screening Tool) scores following training.
- ✓ A re-audit of care home care plans has shown use of correct terminology when documenting swallowing recommendations has increased from 56% at first audit to 78% for fluid consistency and 74% at first audit to 89% currently for food textures.
- ✓ A cost saving of £19,155.36 was made through review of residents on supplements not actively under the care of a dietician.
- ✓ 100% of staff who attended the Phase 1 training rated it as good or excellent (84% excellent, 16% good)
- ✓ A workbook which covers the content of the basic training has been developed that managers or clinical leads can use with new or existing care staff. A 'MUST' competency pack has also been put together for senior and nursing staff.
- ✓ Telephone triage of Speech & Language Therapy referrals resulted in identification of 66 patients who required a high priority appointment (potentially preventing health deterioration and subsequent admission to hospital) and avoided the need for 65 face to face visits by discussion at the triage stage.
- ✓ Implementation of the IDDSI framework (International Dysphagia Diet Standardisation Initiative) for dysphagia descriptors.

Nutrition Training

Nutrition Training is a regular item on the Preceptorship, Frailty and Community Care Centre training programmes for nursing and AHP (Allied health professionals) staff, and as part of the junior doctors' programme and registrar training.

Seven Day Services

The government launched the seven day services programme to ensure that patients that are admitted as an emergency receive high quality consistent care, whatever day they enter hospital. Ten clinical standards were identified initially with four priority standards for implementation by 2020.

These four standards mean that emergency patients:

a) don't wait longer than 14 hours to initial consultant review

b) get access to diagnostic tests with a 24-hour turnaround time - for urgent requests, this drops to 12 hours and for critical patients, one hour

c) get access to specialist, consultant-directed interventions

d) with high-dependency care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds

The Trust is compliant with standards b - c, and is therefore focussing on increasing compliance with the initial consultant review within 14 hours.

For patients who require twice daily consultant reviews, the data collected is at variance with actual practice as it is standard policy that all patients in ITU (Intensive Therapy Unit) and HDU (High dependency Unit) are seen at least twice daily and a formal handover occurs twice daily. Similarly all new admissions and acutely unwell patients on the Acute Assessment Units are seen throughout the day on 'rolling' ward rounds. This enables prompt Consultant review and intervention.

Since this was identified as a quality priority for the Trust for 2018/19 further information including actions being taken to address the issues are described in Section 2.

NHS Doctors and Dentists in Training

Schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 requires: "a consolidated annual report on rota gaps and the plan for improvement to reduce these gaps" and NHSI has requested that there should be a statement in the Trust's Quality Account regarding this.

As a Trust we have had to fill 45 doctors training posts during 2018/19, with a fall in the overall trainee vacancy rate from 10% to 6.4% by December 2018. The medical rota team successfully filled approximately 95% of all junior doctor locum shifts each month with the majority (91%) being filled by internal locum cover as opposed to agency. The contract for the regional locum bank (Flexishift) hosted by the Lead Employer Trust has been extended following a successful pilot.

Areas also often adjust rotas to accommodate vacancies. In some areas, A&E for example, gaps are covered by supernumerary military doctors, in other areas advanced nurse practitioners have been utilised to cover the work of absent trainees. The Trust starts to recruit to potential vacant jobs in April, which is before the national job offers are released to candidates. Using our educational intelligence we can forecast where we will have vacant posts and by working with our 37 educational leads we have created and mirrored non-training posts that are both attractive and of educational value to candidates. We are also reviewing the workforce planning of all areas, with a focus on those with hard to fill roles/ gaps, to explore more sustainable solutions with advanced nurse practitioner and/or other non-training grade roles. We have a 100% fill rate for FY1 posts for 19/20, dependent upon exam success, we believe this is a reflection of our GMC survey which placed the Trust in the top 10 nationally for FY1 overall satisfaction.

In line with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 we have established a Guardian of Safe Working (GOSW), reporting quarterly to the Board and Workforce Committee, and established a junior doctors' forum. We have had one GOSW fine issued to date. This was due to a breach of the 72 hour absolute weekly maximum in cardiology, mitigations were put in place to prevent this occurring in the future.

Patient Experience

The Trust uses a number of sources to understand the patient experience in the organisation, and as discussed earlier in the report, the trust has implemented the 'real time' patient experience programme across all inpatient wards.

Complaints and PALS

In addition to this, we analyse our complaints, Patient Advice and Liaison (PALs) enquiries/concerns and compliments to understand the experience of our patients, with a view to continually improving this.

	2017/18	2018/19				
	Total	Q1	Q2	Q3	Q4	Total
Number of Formal Complaints	387	90	91	83	115	379
Number of PALs	2113	665	675	588	590	2518
Number of Compliments	316	81	45	54	81	261

Table 10: Number of Complaints and PALS Received during 2018/19 (Source: Datix)

The table above shows that there has been a slight decrease in the number of complaints reported during 2018/19 from the previous year. There has however been a significant increase in the number of PALS received during 2018/19. There were 2518 PALS received in 2018/19 compared with 2113 in 2017/18 which represents an increase of almost 20%. The number of compliments logged has decreased however not all compliments will be formally logged on Datix, as many will be received at ward/department level.

Trust received complaints per spell – 24 month period

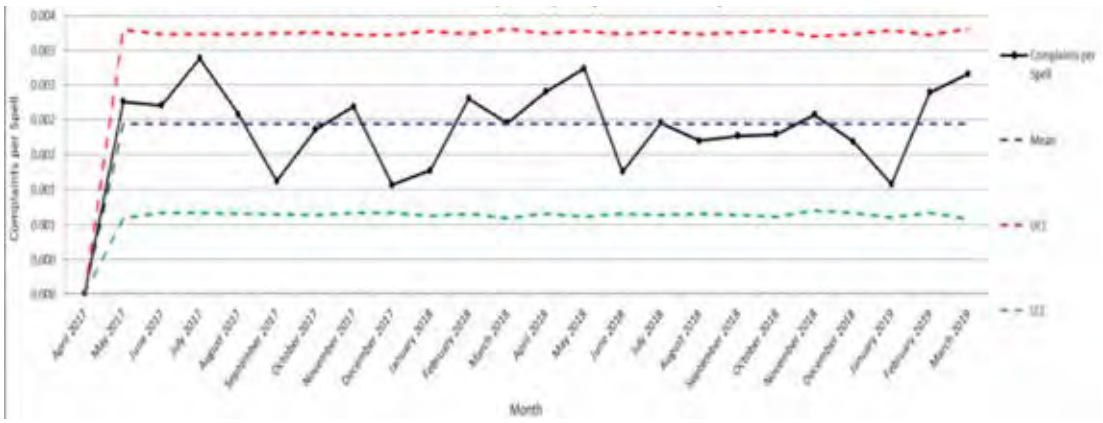


Figure 31: Complaints Received Over a 24 Month Period

The number of complaints received has increased in the last quarter however this is within normal variation. There were 37 complaints received in January, 37 in February and a slight increase to 41 in March.

Friends and Family Test (FFT)

The Trust continues to deliver the Friends and Family Test in line with national guidance. Patients attending as inpatients or maternity are offered a card before discharge to complete. The Trust performs well against national data with the percentage of patients that are very likely or likely to recommend, with performance generally in line or higher than the national average.

Response rates are however lower than the national average and the Trust continues to try different methodologies to improve this. The introduction of the online Meridian system in Q1 19/20 will give us the facility to reach more patients. In addition to this programme the Trust 'real time' programme also capture this information alongside the FFT information.

Detailed information is shown in the table below.

	Apr-18				May-18				Jun-18			
	Response Rate		% likely to recommend		Response Rate		% likely to recommend		Response Rate		% likely to recommend	
	Trust	England	Trust	England	Trust	England	Trust	England	Trust	England	Trust	England
Inpatient	8%	24%	99%	96%	5%	25%	97%	96%	5%	25%	99%	96%
A&E	7%	13%	94%	87%	4%	12%	97%	87%	1%	13%	98%	87%
Antenatal			-	97%			-	95%			-	95%
Birth	5%	23%	100%	97%	1%	22%	99%	97%	2%	21%	100%	97%
Postnatal ward			100%	95%			-	95%			80%	95%
Post natal			-	98%			-	98%			-	98%
Outpatient			94%	94%			93%	93%			98%	93%
Community			97%	96%			95%	96%			100%	96%
	Jul-18				**Aug-18**				**Sep-18**			
	Response Rate		% likely to recommend		Response Rate		% likely to recommend		Response Rate		% likely to recommend	
	Trust	England	Trust	England	Trust	England	Trust	England	Trust	England	Trust	England
Inpatient	5%	25%	98%	96%	5%	25%	98%	96%	6%	24%	98%	96%
A&E	0%	13%	100%	87%	-	13%	-	88%	-	12%	-	86%
Antenatal			-	95%			-	95%			-	95%
Birth	-	21%	-	97%	1%	20%	-	97%	8%	20%	97%	96%
Postnatal ward			-	95%			-	95%			100%	94%
Post natal			-	98%			-	98%			-	98%
Outpatient			98%	94%			100%	93%			100%	93%
Community			-	-			88%	97%			97%	96%
	Oct-18				**Nov-18**				**Dec-18**			
	Response Rate		% likely to recommend		Response Rate		% likely to recommend		Response Rate		% likely to recommend	
Inpatient	Trust	England	Trust	England	Trust	England	Trust	England	Trust	England	Trust	England
A&E	3%	25%	100%	96%	3%	24%	100%	95%	4%	22%	99%	96%
Antenatal	-	12%	-	87%	0%	12%	100%	87%	0%	11%	100%	86%
Birth			-	95%			*	95%			-	95%
Postnatal ward	1%	21%	*	97%	2%	21%	100%	97%	*	18%	*	97%
Post natal			*	95%			100%	95%			*	95%
Outpatient			-	98%			-	97%			-	98%
Community			100%	94%			100%	94%			-	94%
			*	96%			100%	96%			98%	96%
	Jan-19				**Feb-19**							
	Response Rate		% likely to recommend		Response Rate		% likely to recommend					
Inpatient	Trust	England	Trust	England	Trust	England	Trust	England				
A&E	2%	24%	97%	95%	5%	24%	98%	96%				
Antenatal	0%	12%	92%	86%	0%	12%	*	85%				
Birth			-	96%			-	95%				
Postnatal ward	8%	22%	100%	97%	1%	22%	*	97%				
Post natal			96%	95%			*	95%				
Outpatient			*	98%			*	98%				
Community			100%	94%			100%	94%				
			100%	96%			93%	96%				

Table 11: Family and Friends Test Data By Month Data source: NHS England

Listening to and acting on complaints and concerns

The Trust values all feedback received; negative or positive. The following goals were set in order to improve the experience and satisfaction of service users who provide feedback.

Our goals:

- ✓ Map current patient and carer engagement activities and identify gaps to inform the development of a patient and carer engagement strategy
- ✓ Sustain and continue to improve the timeliness of responding to formal complaints, with 80% receiving a response within 25 working days
- ✓ Improve the quality of first responses and the take up of local resolution meetings with the aim of reducing "re-opened" complaints
- ✓ Survey of those who have been involved in the complaint handling process to identify further opportunities for improvement
- ✓ Publish information on complaints and actions taken on the Trust internet site
- ✓ Improving the quality of our responses through training in letter writing skills

Progress to date:

Following a number of changes that were implemented in 2018/19 there has been a sustained improvement with 87.5% of complaint responses being issued within the required timeframe in March 2019 which has exceeded our target of 80% by Quarter 4 2018.

The Trust use a web based "Datix" module to record and track complaints. This provides corporate and centre colleagues with a single system for the tracking of complaints. It also allows all correspondence to be linked to the complaint record making it easier to advise complainants on current progress/status. The Trust has a standard that complaints will be responded to within 25 days and this is extended to 40 days if the complaint is particularly complex. The time frame for response is determined by the complexity of the complaint or if a meeting has been arranged outside of the original deadline date and this has been agreed with the complainant.

Complaint training is delivered by the corporate training department and during 2018/19 there has been five sessions delivered to a total of 70 delegates. The session aims to reflect on what the staff believe is a good customer experience, a good letter, how we set the tone of South Tees through our correspondence, where we get it wrong and considerations around how we are going to get it right.

New fields have been included within Datix to identify the reasons for re-opened complaints to enable the Trust to identify common themes and act to reduce the re-open rate. This is being reviewed as part of the current review of the Trust's 'Receiving Patient Feedback and Handling Patient Complaints' Policy.

The Trust has introduced new consent process documentation for complaints, which has been adopted by some of the regional complaints forum teams.

Further actions planned for the coming months include:

- ✓ Review and update the Trust wide 'Receiving Patient Feedback and Handling Patient Complaints' Policy (GO1)
- ✓ Review the definition of a 're-opened' complaint to enable clearer reporting
- ✓ Work to maintain and improve the response rates for formal complaints
- ✓ Corporate complaints management is part of the regional complaints managers' forum to learn from and share experiences of complaints handling and best practice.
- ✓ A satisfaction survey link will be added to each response letter and made available via the Trust website, in Quarter 2, to ask about the complainants experience of the complaints process and how we can improve the service

National Patient Surveys

National Inpatient Survey

The national survey of patients seen in July 2017 showed that a total of 546 surveys were returned completed therefore the Trust had a response rate of 46.3%.

The Trust scored an average score of 80% which is higher than in 2016.

The Trust scored in the top 20% of Trusts on 38 questions and the bottom 20% of Trusts on 1 question: Provision of written or printed information about medicines.

Areas of strength are:

- ✓ Waiting times
- ✓ Environment – managing noise at night; privacy
- ✓ Staff and care – positive views of doctors and nurses and decisions about care; communications, explanations, information giving; involvement in decisions about care and discharge planning; emotional support; pain management
- ✓ Provision of verbal information about medicines, enabling patients to manage their medicines brought in from home

Cancer Inpatient Survey

The national survey is conducted on an annual basis and includes all adult patients (aged 16 and over), with a confirmed primary diagnosis of cancer, who have been admitted to hospital as inpatients for cancer related treatment, or who were seen as day case patients for cancer related treatment, and have been discharged between the months of April, May or June 2017.

The survey is conducted by Quality Health on behalf of NHS England and the results of the 2017 survey were published in September 2018. A summary of the results for South Tees, which includes the Friarage Hospital, Northallerton and the James Cook University Hospital, is described as follows:

8.9	The average rating given by respondents when asked to rate their overall care on a scale of zero (very poor) to 10 (very good)
80%	of respondents said that they were definitely involved as much as they wanted to be in decisions about their care and treatment
92%	said they were given the name of a Clinical Nurse Specialist who would support them through their treatment; this was the Trust's biggest improvement on previous years and well above the national average
91%	of respondents said that it had been 'quite easy' or 'very easy' to contact their Clinical Nurse Specialist
86%	of respondents said that, overall, they were always treated with dignity and respect while they were in hospital
93%	of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital
60%	of respondents said they thought the GPs and nurses at their general practice definitely did everything they could to support them while they were having cancer treatment.

The results have been discussed internally and action plans developed to address specific issues identified.

Full national results and other reports are available at www.ncpes.co.uk.

National Maternity Survey 2018

144 women who gave birth during February 2018 within the organisation responded to the National Maternity Survey.

South Tees Hospitals NHS Foundation Trust performed 'about the same' as most trusts in the survey on 40 questions and 'better' than most other trusts in the survey on 11 questions. With a statistically significant improvement in three questions compared to 2017 and deteriorating in 1, 'were you given enough information about your own physical recovery after the birth?'

An action plan has been developed to secure and sustain improvements.

National NHS Staff Survey, 2018

Each year NHS staff are invited to take part in the NHS Staff Survey, the largest survey of staff opinion in the UK. It gathers views on staff experience at work around key areas, which include:

- ✓ Appraisal and Development
- ✓ Health and Wellbeing
- ✓ Staff Engagement and Involvement
- ✓ Raising Concerns

While results are primarily intended for NHS organisations to review and make improvements where necessary, the Care Quality Commission will use them to monitor on-going compliance with essential standards of quality and safety and the survey also supports accountability to the Secretary of State for Health for the delivery of the NHS Constitution.

A sample survey was carried out from October to December 2018. The survey was sent to a sample of 1247 staff with a response rate of 33% (413 members of staff).

Key findings were as follows:

Equality, Diversity and Inclusion

Question	Improvement/ deterioration	2017	2018	National Average 2018
Does your organisation act fairly with regard to career progression /promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	Improvement	85.7%	87.7%	85.5%
In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?	Improvement	5.2%	4.9%	5.2%
In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?	Improvement	6.1%	4.5%	7.0%
Has your employer made adequate adjustment(s) to enable you to carry out your work?	Deterioration	79.0%	74.8%	73.3%

Violence, Harassment & Bullying

Question	Improvement/ deterioration	2017	2018	National Average 2018
In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?	Improvement	17.6%	13.2%	12.6%
In the last 12 months how many times have you personally experienced physical violence at work from managers?	Improvement	0.9%	0.4%	0.5%
In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?	Improvement	2.1%	1.6%	1.5%
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?	Deterioration	27.5%	27.8%	25.8%
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?	Deterioration	8.3%	9.9%	12.1%
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?	Improvement	21.8%	18.2%	18.4%

Quality of Appraisals

Question	Improvement/ deterioration	2017	2018	National Average 2018
It helped me to improve how I do my job	Deterioration	19.5%	14.2%	21.5%
It helped me agree clear objectives for my work	Deterioration	32.6%	27.2%	33.3%
It left me feeling that my work is valued by my organisation	Deterioration	26.3%	24.8%	31.1%
The values of my organisation were discussed as part of the appraisal process	Deterioration	22.5%	19.4%	35.2%

Health & Wellbeing

Question	Improvement/ deterioration	2017	2018	National Average 2018
The opportunities for flexible working patterns	Improvement	47.7%	47.8%	52.8%
Does your organisation take positive action on health and well-being?	Deterioration	25.8%	15.9%	27.8%
In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?	Deterioration	25.4%	30.0%	27.4%
During the last 12 months have you felt unwell as a result of work related stress?	Deterioration	36.9%	40.1%	38.8%
In the last three months have you ever come to work despite not feeling well enough to perform your duties?	Improvement	56.0%	53.6%	56.3%

Staff Engagement

Question	Improvement/ deterioration	2017	2018	National Average 2018
Motivation				
I look forward to going to work	Deterioration	53.6%	50.8%	59.3%
I am enthusiastic about my job	Deterioration	73.6%	67.7%	74.8%
Time passes quickly when I am working	Deterioration	76.2%	75.6%	77.6%
Improvements/ suggestions				
There are frequent opportunities for me to show initiative in my role	Deterioration	69.9%	68.5%	73.4%
I am able to make suggestions to improve the work of my team / department	Deterioration	74.6%	73.8%	75.2%
I am able to make improvements happen in my area of work	Deterioration	53.8%	50.2%	56.5%
Recommendation of the organisation as a place to work/ receive treatment				
Care of patients / service users is my organisation's top priority	Deterioration	66.3%	59.9%	76.5%
I would recommend my organisation as a place to work	Deterioration	54.2%	47.2%	61.1%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	Improvement	69.9%	70.2%	69.9%

Immediate Managers

Question	Improvement/ deterioration	2017	2018	National Average 2018
The support I get from my immediate manager	Deterioration	69.1%	63.3%	70.0%
My immediate manager gives me clear feedback on my work	Deterioration	60.6%	55.4%	61.1%
My immediate manager asks for my opinion before making decisions that affect my work	Deterioration	52.8%	50.8%	54.6%
My immediate manager takes a positive interest in my health and well-being	Deterioration	67.7%	62.1%	67.8%
My immediate manager values my work	Deterioration	71.5%	67.7%	71.9%
My manager supported me to receive this training, learning or development	Improvement	47.6%	51.6%	54.3%

Safety Culture

Question	Improvement/ deterioration	2017	2018	National Average 2018
My organisation treats staff who are involved in an error, near miss or incident fairly	Improvement	49.2%	50.0%	59.0%
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again	Deterioration	67.1%	62.9%	70.0%
We are given feedback about changes made in response to reported errors, near misses and incidents	Deterioration	55.2%	51.7%	58.9%
I would feel secure raising concerns about unsafe clinical practice	Improvement	65.6%	65.8%	70.3%
I am confident that my organisation would address my concern	Deterioration	54.0%	49.9%	58.0%
My organisation acts on concerns raised by patients / service users	Deterioration	68.2%	59.6%	73.1%

Quality of care

Question	Improvement/ deterioration	2017	2018	National Average 2018
I am satisfied with the quality of care I give to patients / service users	Deterioration	83.4%	79.0%	80.5%
I feel that my role makes a difference to patients / service users	Deterioration	91.0%	89.8%	89.4%
I am able to deliver the care I aspire to	Deterioration	71.0%	64.7%	67.3%

Morale

Question	Improvement/ deterioration	2017	2018	National Average 2018
I am involved in deciding on changes introduced that affect my work area / team / department	Deterioration	51.5%	44.3%	53.1%
I receive the respect I deserve from my colleagues at work	No 2017 data		74.1%	72.1%
I have unrealistic time pressures	No 2017 data		21.6%	22.5%
I have a choice in deciding how to do my work	No 2017 data		49.6%	56.3%
Relationships at work are strained	No 2017 data		41.5%	45.8%
My immediate manager encourages me at work	No 2017 data		61.4%	68.8%
I often think about leaving this organisation	No 2017 data		37.3%	28.8%
will probably look for a job at a new organisation in the next 12 months	No 2017 data		21.3%	20.7%
As soon as I can find another job, I will leave this organisation	No 2017 data		18.4%	14.7%

Key Areas of Focus for 2019/20

Staff Engagement Strategy

- ✓ Develop our South Tees identity and create a sense of pride and belonging in our organisation
- ✓ Review our values and define the supporting behaviours required to deliver our vision whilst holding each other to account
- ✓ Develop our employer offer and employee experience to enable us to recruit and retain the best
- ✓ Develop a culture of engaging leadership, strong management, effective communication and collective responsibility
- ✓ Develop a mindset of transformation and service improvement to drive our organisation forward
- ✓ Recognise and celebrate success and ensure our people feel valued

Development Programmes

- ✓ Tipping Point and 7 Levers of Change
- ✓ Strategic Planning and Thinking
- ✓ Transformational change management and service improvement
- ✓ Operational Excellence
- ✓ Financial Management for Non-financial Managers
- ✓ Negotiation and Conflict Management/ Resolution
- ✓ Data analytics and machine based learning
- ✓ Clinical Intelligence
- ✓ Business Intelligence

Health and Wellbeing Strategy

- ✓ Create a safe and healthy working environment where staff have access to good occupational health and wellbeing services.
- ✓ Promote good practice in physical, emotional and psychological health activities.
- ✓ Encourage and support staff to develop and maintain a healthy lifestyle and act as role models to both colleagues and patients.
- ✓ Support people with manageable health problems or disabilities to maintain access to or regain work.
- ✓ Improve staff satisfaction, recruitment and retention.
- ✓ Ensure senior level ownership of health and wellbeing.
- ✓ Enhance South Tees Hospitals NHS Foundation Trust reputation as a good place to work.
- ✓ Clearly evaluate and measure improvements and the outcomes of staff health and wellbeing.
- ✓ Ensure managers are equipped with the necessary support to implement the health and wellbeing strategy

Equality, Diversity and Inclusion

- ✓ Dedicated focus group has been newly formed.
- ✓ Sub Groups/networks being developed for all protected characteristics.
- ✓ Undertake a random sample to review our recruitment and selection and HR processes.
- ✓ Improve the experience for staff with mental health problems by working in partnership with external organisations.
- ✓ Publish regular awareness bulletins for staff highlighting significant feasts and seasons for different faith and belief communities.
- ✓ Promoting inclusive behaviour by ensuring that all our staff are aware of the effects of their behaviour on others and are equipped to challenge and report inappropriate behaviour when they experience or witness it.
- ✓ We will invite staff who have protected characteristics to reverse mentor senior managers and executives to allow them "to walk a mile in our shoes", and act as role models.

Tackling Bullying

- ✓ Working with NHS Improvement as pilot organisation for tackling bullying
- ✓ Dedicated focus group newly formed to address Trust wide issues
- ✓ A Behavioural Standards Policy or Framework is created which clarifies the expected standards of behaviour of all staff and is drawn from the Trust values, professional codes of conduct and bullying and harassment negative behaviours.
- ✓ A Trust review of the structure, training and use of workplace investigators.
- ✓ An education programme should be put in place for all staff to heighten awareness of bullying and negative behaviours, what bullying is and is not, how those behaviours sit with Trust values and how staff should respond when they are recipients of such behaviour.
- ✓ Data monitoring and analysis to be highlighted to the Workforce Committee with an action plan in place.

Performance against key national priorities

Our performance against these key healthcare targets is listed below:

	13/14	14/15	15/16	16/17	17/18	18/19	18/19 Target
Safety							
Clostridium (c.) difficile – meeting the C.difficile objective	57	76	61	43	48	41	54
All cancers: 62 day wait for first treatment from:							
Urgent GP referral for suspected cancer	84.70%	85.30%	79.10%	81.10%	85.44%	82.65%	85%
NHS Cancer Screening Service Referral	94.80%	92.60%	89.80%	89.00%	94.55%	87.14%	90%
18 weeks referral to treatment time (RTT)							
Incomplete pathways	95.20%	95.70%	93.20%	92.20%	91.45%	89.49%	92%
Accident & Emergency							
4 hour maximum wait in A&E from arrival to admission, transfer or discharge	96.70%	94.90%	95.80%	95.33%	95.68%	95.24%	95%
Diagnostic Waits							
Patients waiting 6 weeks or less for a diagnostic test	99.60%	98.70%	98.82%	99.15%	97.46%	98.26%	99%

Table 12: Performance against National Priorities

Additional Quality Improvement Achievements

Awards and Things to Celebrate

A number of teams and services have achieved recognition in the last few months, with the Heart Rhythm Congress recognising the work of the cardiology team at the Friarage, the e-roster team and therapeutic care team winning an Allocate Award for 'putting care needs first', the Better Health Awards recognising the Parkinson Advanced Symptoms Unit for 'driving prevention and early intervention' and Bright Ideas in Health awarding our infectious diseases team recognition for their blood borne virus test.

Helen Scullion was also awarded 'Nurse of the Year' by the Nursing Times.

We also became a 'Veteran Aware' Trust, introduced patient-centred visiting, launched our campaign 'Sleep Helps Healing' in response to patient feedback about noise at night and supported 'Stop Pressure Ulcer' day.

We have had the formal opening of the Sir Robert Ogden Macmillan Cancer Centre at the Friarage Hospital, with patients receiving treatment from 3rd December. This is a great opportunity to demonstrate the excellent patient care that we provide, in these fabulous surroundings, as well as our continuing commitment to the people of Northallerton and the surrounding area.

Listening and Improving

1000 Voices Patient Experience Programme

The 1000 Voices Programme is the umbrella term for the Patient Experience work undertaken by the Trust, the goal of which is to obtain feedback from 1000 patients per month. Currently there are 3 main work streams capturing patient data; Real time, Friends and Family Test (FFT) and Governor Drop Ins.

Real Time

All 24 hour stay wards are included in the programme and Patient Experience Facilitators visit wards each month using a structured questionnaire (based on the National Inpatient Survey) to talk to patients about their experience in hospital. They capture the survey responses and the patients' comments and this is used to feedback any immediate issues to senior staff on the ward, followed by a report within 24 hours of the visit. Comments are individually themed using a set framework and this is presented graphically to allow the identification of trends and themes at ward, centre and Trust level.

The questionnaire provides feedback across 10 domains as well as an overall score.

- ✓ Consistency and Co-ordination
- ✓ Doctors
- ✓ Nurses
- ✓ Cleanliness
- ✓ Medication
- ✓ Kindness and compassion
- ✓ Dignity
- ✓ Involvement
- ✓ Pain control
- ✓ Noise at night

The roll out of the Real time inpatient data collection programme was completed in August 2017 with all 24 hour stay inpatient areas incorporated. Due to the patient makeup of some wards, visits by members of the patient experience team were not viable; as such a new version of the data collection tool was developed. This simplified version of the survey removed some of the domains to allow for the survey to be completed by a relative or carer. The domains removed were; noise at night, medication and pain management since these cannot be reliably answered by a carer or relative if the patient is unconscious. These surveys were then employed on wards where obtaining consistent numbers of patients to speak with was difficult; ICU (Intensive Care Unit), Neuro HDU (High Dependency Unit) and PICU, (Paediatric Intensive Care Unit). Further roll out of these to other hard to reach inpatient areas is currently underway.

The real time facilitators spoke with 4383 patients during 2018/19. Since the programme began there has been a slow rise in the domain scores with improvements across the board. The programme is now embedded into the culture of patient experience in the inpatient environment.

Hospital numbers are recorded for patients who take part in the survey and allow the team to look at the experiences of patients across the Trust in groups such as age, ethnicity, service and procedure rather than just the snapshot of an individual ward.

The Patient Experience team has worked closely with the Treat As One (TAO) working group to be able to demonstrate the experience of those patients with mental health conditions. This has been the first step in the Patient Experience Programme utilising the hospital information collected from patients. As such, the Patient Experience team has been able to cross reference the scores given by patients providing survey responses with a diagnosis of a mental health condition to provide a monthly report to the TAO Group. This has helped to inform the work undertaken by the group and assist in feeding into the TAO strategy.

Friends and Family Test (FFT)

This is a nationally mandated programme developed by NHS England. At the point of discharge, all patients are offered the opportunity to complete a FFT survey. Similarly following an appointment at Outpatients or Urgent Care departments an FFT survey is offered for patients to complete. The survey comprises of two questions:

1. How likely are you to recommend our ward/ department to friends and family if they needed care or treatment?
2. What was good about your care, and what could be improved?

These paper surveys are collected by the Patient Experience Team and the data collated and analysed to produce reports. This data is also shared nationally. Currently the Trust is performing better than the national average for the percentage of satisfaction scores however the response rates for the Trust are poor with 6792 surveys completed in 2018/2019. With plans to utilise a new IT system (Meridian) and returning to text and email surveys it is hoped that the response rate will increase significantly during 2019/20.

Governor Drop In

This programme is focused on the outpatient departments of the Trust. Each month two of the public governors visit an outpatient department and record observations on first impressions as well as surveying patients regarding the department, staff and the information provided in appointment letters. Following these observations and surveys, the Governors' meet with the clinic manager to discuss their findings and also to understand the staff views on the department including their successes and challenges. A full report is produced with an action plan to be taken forward by the manager and the senior team. This process will be strengthened during 2019/20 and progress with action plans monitored via the Patient Experience sub-group with a quarterly update to the Council of Governors.

2019/2020 Goals

- ✓ Incorporate patient feedback leaflets in all areas of the Trust to increase feedback rates
- ✓ Utilise new systems to improve FFT response rates to at least 24% (the national rate for inpatients)
- ✓ Develop a 'secret shopper' programme
- ✓ Develop more regular and in depth feedback mechanisms for outpatient areas
- ✓ Set up a Trust wide 'user group' incorporating representatives from patient groups across the Trust
- ✓ Develop methods to target 'hard to reach' patient groups for in depth feedback


One Heart


OMATOM

Annex 1: Statements from Clinical Commissioning Groups and Healthwatch

Statement from the Chairman of the North Yorkshire County Council Scrutiny of Health Committee

Over the past 12 months, the North Yorkshire Scrutiny of Health Committee has continued to work with the South Tees Hospitals NHS Foundation Trust to better understand the financial, workforce and clinical pressures within the local health system and the measures that have been put in place to respond to them.

The Scrutiny of Health Committee has scrutinised changes to critical care at the Friarage Hospital in Northallerton and will be undertaking scrutiny of proposed new models of delivery of that service in 2019/20. Members of the committee have also been involved, through the DDTHRW Joint Health Overview and Scrutiny Committee, in the scrutiny of the Integrated Care System and how the James Cook, the Friarage and Darlington Memorial hospitals could work more closely together to deliver services in the north of the county. The scrutiny process has been actively supported by the Trust, which has enabled the committee to gain a fuller understanding of what the level of need is in the county and how best it can be responded to.

The NHS nationally, regionally and locally is undergoing a sustained period of change both planned and reactive. The Scrutiny of Health Committee is committed to maintaining a system-wide view of services that helps to ensure people are not disadvantaged in accessing services by virtue of where they live in the county.

Over the next year, the Scrutiny of Health Committee looks forward to working with health commissioners and providers on the development of integrated and sustainable systems of care in rural areas.

County Councillor Jim Clark
Chairman, North Yorkshire Scrutiny of Health Committee
3 May 2019

Healthwatch Middlesbrough and Healthwatch Redcar and Cleveland Response to the Quality Accounts

Pg 4 Also, the pilot of the development of criteria led discharge (CLD) in respiratory and vascular wards to provide patients with a quicker and more efficient discharge process should, when adopted more widely, by helping reduce length of stay further reduce risk of HAI.

Pg 37 The section concerning the reduction of harm from HCAI with a focus on Gram-negative bacterial bloodstream infections points out that lower urinary tract infection is the largest cause of bacteraemia in patients. It is an accepted fact that the likelihood of urinary tract infection is related to the duration of urinary catheter insertion. To try and reduce this cause of bacteraemia the Trust plans to implement a urinary catheter pathway education programme across the hospital and community setting. The review of catheters in situ and the promotion of prompts for early removal have been part of infection prevention and control (IPC) teaching for some considerable time. The fact that urinary catheter pathways have only recently been introduced prompts us to ask if the reason for not doing so before has been due to a lack of available IPC staff in post and, whether the IPC department will now have sufficient manpower to undertake the planned programme of work suggested in your quality account. Healthwatch South Tees is certainly pleased to see IPC nurse provision for care homes in the community to deliver education on continence and catheter care which should enhance the quality of community care and hopes that it will be possible to maintain this post beyond April 2020.

Pg 39 With regard to reducing the occurrence of 'Never Events' and ensuring there is a focus on safe surgical practice, the WHO theatre checklist was first published in 2008 and has been widely used in hospitals in both high income countries and in developing countries, including a hospital in Malawi in receipt of occasional periods of training delivered by volunteer staff from The James Cook University Hospital. Although the Trust quality account reports a low incidence of such events, it was something of a surprise to find that the WHO checklist is only now being introduced into South Tees Hospitals Trust theatres.

Pg 60 With regard to the four core clinical standards mentioned in Seven Day Hospital Services, we look forward to seeing compliance with clinical standards 2 and 8 in future reports.

The report states that there has been considerable work undertaken in individual care pathways and that the Rapid Response Service and the Integrated Community Care team will support those patients at high risk of re-admission. From patient comments to Healthwatch, this is needed because of the often poor support provided by primary care.

Pg 61 Outside of the Trust hospitals environment, it was pleasing to note the introduction of sepsis training in community hospitals, particularly "targeting those wards that are not compliant with the escalation processes". This is so important in reducing mortality in this condition.

Pg 64 Given the stated "clear link between research activity, clinical effectiveness and improved patient experience", it was pleasing to see so much Trust participation in clinical audit, particularly those regarding the management of serious infection, such as sepsis, and those involving the review of antibiotic prescriptions during the management of these conditions in an effort to avoid the development of antibiotic resistance. However, apart from the introduction of the CQUIN for a reduction of antibiotic prescribing for UTIs, it was disappointing to note that there was nothing else in the Quality Account report on compliance with the Trust's Antimicrobials Drugs Guide, given the wide (over?) use of antibiotics in any health care setting.

Pg 93 The low response rates in the section on Patient Experience might, as stated in the report, suggest a bias in the results obtained and may therefore not reflect a true picture of how service users view service provision. Healthwatch South Tees looks forward to seeing the Trust target of 800 responses a month being met in next year's Quality Account. We note that again in this year's Quality Account there is no mention of bed occupancy which, when more than 85% can impact on quality of care. Although, given the workload imposed on the Trust, it is difficult to imagine what might be done to reduce this, surely it might be worth flagging up excessive occupancy rates to demonstrate the pressures the Trust is working under.

Kind regards
Lisa Bosomworth
Healthwatch South Tees Development & Delivery Manager

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SOUTH TEES NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of South Tees NHS Foundation Trust to perform an independent assurance engagement in respect of South Tees NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge;
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers;

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2018/19* ('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:

- Board minutes and papers for the period April 2018 to May 2019
- Papers relating to Quality reported to the Board over the period April 2018 to May 2019
- Feedback from the NHS South Tees Clinical Commissioning Group requested 30/04/2019
- Feedback from the NHS Hambleton, Richmond and Whitby Clinical Commissioning Group requested 30/04/19
- Feedback from Health watch North Yorkshire requested 30/04/2019
- Feedback from North Yorkshire Scrutiny of Health Committee requested 30/04/2019
- Feedback from the Governors dated 07/05/2019
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated, 27/07/2018
- The 2018 national staff survey 26/02/2019
- The 2017 national patient survey dated 01/07/2018
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 29/05/2018

- CQC inspection report dated October 2016
- 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 South Tees 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 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. 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 South Tees NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can 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* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by South Tees 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 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
Quayside House
110 Quayside
Newcastle upon Tyne
NE1 3DX

26 June 2019

Annex 2: Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement 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.

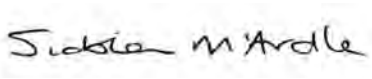
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 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 2018 to May 2019
- Papers relating to Quality reported to the Board over the period April 2018 to May 2019
- Feedback from the NHS South Tees Clinical Commissioning Group requested 30/04/2019
- Feedback from the NHS Hambleton, Richmond and Whitby Clinical Commissioning Group requested 30/04/19
- Feedback from Healthwatch Tees dated 21/05/2018
- Feedback from Healthwatch North Yorkshire requested 30/04/2019
- Feedback from North Yorkshire Scrutiny of Health Committee requested 30/04/2019
- Feedback from the Governors dated 07/05/2019
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated, 27/07/2018
- The 2018 national staff survey 26/02/2019
- The 2017 national patient survey dated 01/07/2018
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 29/05/2018
- CQC inspection report dated October 2016
- 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 NHS Improvement's annual reporting manual (which incorporates the Quality Accounts regulations) (published at www.monitor-hsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

Signed:



Date: 20 June 2019

Siobhan McArdle
Chief Executive & Accounting Officer

Signed:

Date: 20 June 2019

Alan Downey
Chairman

Annex 3: How to provide feedback on the account

We welcome feedback on this report and suggestions for the content of future reports.

If you wish to comment please go to the Quality Accounts page on the Trust website (www.southtees.nhs.uk).

Annex 4: Glossary of terms

18 Week RTT (Referral to Treatment)

This refers to the right to start your consultant-led treatment within a maximum of 18 weeks from referral, unless you choose to wait longer, or it is clinically appropriate that you wait longer. The Trust monitors this monthly.

A&E

Accident and emergency (usually refers to a hospital casualty department) where patients attend for assessment.

Acute

A condition of short duration that starts quickly and has severe symptoms.

Allied Health Professional (AHP)

Professionals (other than nurses) who work in health care teams to make the health care system function by providing a range of diagnostic, technical, therapeutic and direct patient care and support services that are critical to the other health professionals they work with and the patients they serve.

Aseptic Non Touch Technique (ANTT)

The Aseptic Non Touch Technique (ANTT®) is the standard intravenous technique used for the accessing of all venous access devices regardless of whether they are peripherally or centrally inserted.

Assurance

Confidence, based on sufficient evidence that internal controls are in place, operating effectively and objectives are being achieved.

Better Care Fund (BCF)

The national fund was set up to support moving resources into social care and community services and to support the avoidance of admissions to hospital.

Board of Directors (of Trust)

The role of the Trust's board is to take corporate responsibility for the organisation's strategies and actions. The chair and non-executive directors are lay people drawn from the local community and accountable to the Council of Governors. The chief executive is responsible for ensuring that the board is empowered to govern the organisation and to deliver its objectives.

Care Quality Commission

The Care Quality Commission (CQC) replaced the Healthcare Commission, Mental Health Act Commission and the Commission for Social Care Inspection in April 2009. The CQC is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. Visit: www.cqc.org.uk

Clinical audit

Clinical audit measures the quality of care and services against agreed standards and suggests or makes improvements where necessary.

Clinical Commissioning Group (CCG)

These 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 Practitioner groups in their geographical area with the aim of giving GPs and other clinicians the power to influence commissioning decisions for their patients. These organisations are overseen by NHS England and manage primary care commissioning, including holding the NHS Contracts for GP practices.

CUR (Clinical Utilisation Review)

The CUR is a clinical decision support tool that enables clinicians to make impartial and objective, evidence-based assessments of whether patients are receiving the right care, at the right place, at the right time and for the right duration. It improves patient flow across the health economy

Clinician

Professionally qualified staff providing clinical care to patients.

Commissioners

Commissioners are responsible for ensuring adequate services are available for their local population by assessing needs and purchasing services. Clinical Commissioning Groups are the key organisations responsible for commissioning healthcare services for their area. They commission services (including acute care, primary care and mental healthcare) for the whole of their population, with a view to improving their population's health.

Commissioning for Quality and Innovation (CQUIN)

'High Quality Care for All' document included a commitment to make a proportion of providers' income conditional on quality and innovation, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Consultant

Senior physician or surgeon advising on the treatment of a patient.

Council of Governors

The Governors help to ensure that the trust delivers services which meet the needs of patients, carers, staff and local stakeholders.

Criteria Led Discharge (CLD)

The lead clinician for a patient's care identifies the clinical criteria for their discharge. These criteria are discussed with the patient and the multi-disciplinary team and are recorded. A competent member of the multi-disciplinary team then discharges the patient when the clinical criteria for discharge have been met.

Datix

IT system that records healthcare risk management, incidents and complaints.

Daycase

Patient who is admitted to hospital for an elective procedure and is discharged without an overnight stay.

Department of Health

The Department of Health is a department of the UK government but with responsibility for government policy for England alone on health, social care and the NHS.

Duty of Candour

The duty of candour is a statutory (legal) duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. It applies to all health and social care organisations registered with the regulator, the Care Quality Commission (CQC) in England.

Echocardiogram (ECG)

An echocardiogram is a test that uses ultrasound to evaluate your heart muscle and heart valves.

Elective

A planned episode of care, usually involving a day case or inpatient procedure.

Electronic Patient Record

Digital based notes record system which replaces a paper based recording system. This allows easier storage, retrieval and modifications to patient records.

Electronic Prescribing System

Allows prescriptions to be transmitted and populated electronically, replacing paper and faxed prescriptions.

Emergency

An urgent unplanned episode of care.

Escherichia coli (E. Coli)

E. Coli is a Gram-negative, facultative anaerobe, rod-shaped, coliform bacterium of the genus Escherichia that is commonly found in the lower intestine of warm-blooded organisms.

Falls

A fall is defined as an unintentional/unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level.

Finished Consultant Episode

An NHS term for a consultant episode which has ended due to discharge, transfer or death. A consultant episode is the time a patient spends in the continuous care of one consultant using hospital site or care home bed(s) of one health care provider or, in the case of shared care, in the care of two or more consultants.

Foundation Trust

A type of NHS Trust in England that has been created to devolve decision-making from central government control to local organisations and communities so they are more responsive to the needs and wishes of their local people. NHS foundation Trust's provide and develop healthcare according to core NHS principles – free care, based on need and not on ability to pay. NHS Foundation Trusts have members drawn from patients, the public and staff, and are governed by a Board of Governors comprising people elected from and by the membership base.

Gastroenterology

The branch of medicine that deals with disorders of the stomach and intestines.

Governance

A mechanism to provide accountability for the ways an organisation manages itself.

GNBSI (Gram negative blood stream Infections)

A group of blood stream infections that include Escherichia coli (E.Coli), Klebsiella spp. and Pseudomonas aeruginosa.

HCAI

Health care associated infections. These are infections that are acquired as a result of healthcare interventions. There are a number of factors that can increase the risk of acquiring an infection, but high standards of infection control practice minimise the risk of occurrence.

Healthcare Quality Improvement Partnership

The Healthcare Quality Improvement Partnership was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales. It is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and national voices.

Healthwatch

Healthwatch are the national consumer champion in health and care. They have been given significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.

Hospital Episode Statistics (HES)

Hospital Episode Statistics is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere.

Hospital Standardised Mortality Ratio (HSMR)

This is a standardised tool for measuring mortality and is calculated using the ratio of observed (O) to expected (E) deaths. The observed number of deaths for a hospital is the sum of the actual number of deaths in that hospital.

HSMR (Hospital Standardised Mortality Ratio)

This is a scoring system that works by taking a hospital's crude mortality rate and adjusting it for a variety of factors – population size, age profile, level of poverty, range of treatments and operations provided, etc. It is possible to calculate two scores – the mortality rate that would be expected for any given hospital and its actual observed rate.

IAPT (Improving Access to Psychological Therapies)

Services that provide evidence based treatments for people with mental health issues, for example anxiety and depression.

Inpatient

Patient requiring an overnight stay in hospital.

Interventional Endoscopy

Is a minimally invasive procedure that involves the use of a thin, flexible tube (or scope) that is equipped with a camera and light at its tip.

Interventional Radiology (IR)

Interventional Radiology (IR) refers to a range of techniques which rely on the use radiological image guidance (x-ray fluoroscopy, ultrasound, computed tomography [CT] or magnetic resonance imaging [MRI]) to precisely target therapy. Most IR treatments are minimally invasive alternatives to open and laparoscopic (keyhole) surgery. As many IR procedures start with passing a needle through the skin to the target it is sometimes called pinhole surgery.

LocSSIP (Local Safety Standards for Invasive Procedures)

These are local processes/procedures in place to reduce the number of patient safety incidents related to invasive procedures, in which surgical 'Never Events' can occur.

Malnutrition Universal Screening Tool (MUST)

'MUST' is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan. It is used in hospitals, community and other care settings and can be used by all care workers.

MAR (Medicine Administration Record)

A report that serves as a legal record of the medicines administered to a patient by a health care professional.

Medical Examiners

Review the death at time of death certification or referral to Coroners. Their work includes contact with the team that cared for the patient at time of death, review of case records and contact with the family to see if they have any questions or concerns.

Meridian

IT programme that facilitates data collection surveys and audits.

Multidisciplinary Team (MDT)

A multidisciplinary team is a group of health care workers who are members of different disciplines (professions e.g. doctors, nurses, physiotherapists etc.), each providing specific services to the patient.

National Institute for Health Research (NIHR)

The NIHR (National Institute for Health Research) funds health and care research and translate discoveries into practical products, treatments, devices and procedures, involving patients and the public in all our work. NIHR ensure the NHS is able to support the research of other funders to encourage broader investment in, and economic growth from, health research. NIHR work with charities and the life sciences industry to help patients gain earlier access to breakthrough treatments, and train and develop researchers to keep the nation at the forefront of international research.

National Institute for Health and Clinical Excellence (NICE)

The National Institute for Health and Clinical Excellence is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. Visit: www.nice.org.uk

NCEPOD

National Confidential Enquiry into Patient Outcome and Death. The website for more information is http://www.ncepod.org.uk

National Patient Survey Programme

The National Patient Survey Programme, coordinated by the Care Quality Commission, gathers feedback from patients on different aspects of their experience of recently received care, across a variety of services/settings.

NHS Improvement (NHSI)

NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. It supports providers to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

NEQOS (North East Quality Observatory Service)

Provides quality measurement for NHS organisations in the north east (and beyond), using high quality expert intelligence in order to secure continually improving outcomes for patients.

NEWS2

This is the latest version of the National Early Warning Score (NEWS), first produced in 2012 and updated in December 2017, which advocates a system to standardise the assessment and response to acute illness.

Overview and Scrutiny Committees

Since January 2003, every local authority with responsibilities for social services (150 in all) has had the power to scrutinise local health services. Overview and scrutiny committees take on the role of scrutiny of the NHS – not just major changes but the ongoing operation and planning of services. They bring democratic accountability into healthcare decisions and make the NHS more publicly accountable and responsive to local communities.

PALS (Patient Advice and Liaison Service)

A service that offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

Patient Reported Outcome Measures (PROMs)

PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected from patients through PROMs questionnaires before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients.

Payment by Results

Is a system of paying NHS healthcare providers a standard national price or tariff for each patient seen or treated.

Plan Do Study Act (PDSA)

This is model for improvement that provides a framework for developing, testing and implementing changes leading to improvement. It is based in scientific method. The use of PDSA cycles enables changes to be tested on a small scale, building on the learning from these test cycles in a structured way before wholesale implementation. This gives stakeholders the opportunity to see if the proposed change will succeed and is a powerful tool for learning from ideas that do and don't work. This way, the process of change is safer and less disruptive for patients and staff.

Pressure Ulcer

A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful.

Providers

Providers are the organisations that provide relevant health services, for example NHS Trust's and their private or voluntary sector equivalents.

Regulations

Regulations are a type of secondary legislation made by an executive authority under powers given to them by primary legislation in order to implement and administer the requirements of that primary legislation.

Research

Clinical research and clinical trials are an everyday part of the NHS. The people who do research are mostly the same doctors and other health professionals who treat people. A clinical trial is a particular type of research that tests one treatment against another. It may involve either patients or people in good health, or both.

Risk

The possibility of suffering some form of loss or damage or the possibility that objectives will not be achieved.

Risk Assessment

The identification and analysis of relevant risks to the achievement of objectives.

RCA (Root Cause Analysis)

Is a systematic process for identifying "root causes" of problems or events including serious incidents to prevent a recurrence.

Secondary Uses Service (SUS)

The Secondary Uses Service is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.

Service user

An individual who uses a health care service, including those who are not in need of treatment, such as blood donors, carers or those using screening services.

Summary Hospital-level Mortality Index (SHMI)

The Summary Hospital-level Indicator (SHMI) reports mortality at Trust level across the NHS in England using standard and transparent methodology. It looks at deaths following hospital treatment which take place in or out of hospital for 30 days following discharge and is based on all conditions.

South Tees Hospitals NHS Foundation Trust

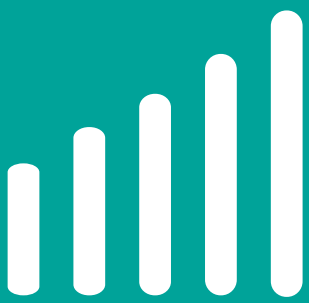
Includes The Friarage Hospital (FHN) and James Cook University Hospital (JCUH) and community services in Hambleton, Richmondshire, Middlesbrough, Redcar and Cleveland.

Ultrasound

Ultrasound is a type of scan that uses sound waves to produce images of the inside of your body. It's used to detect changes in the appearance, size or outline of organs, tissues and vessels, or to detect abnormal masses, such as tumours.

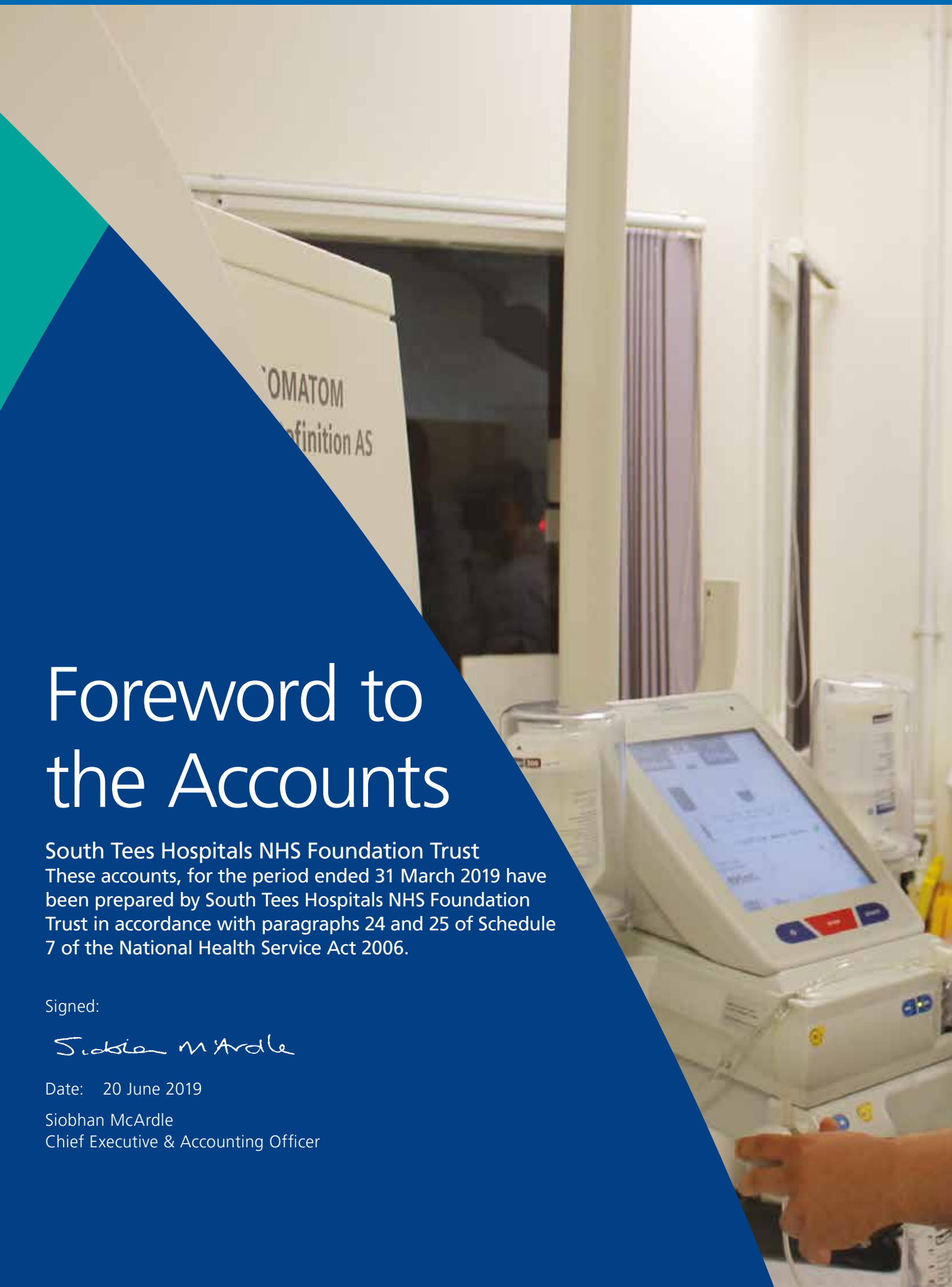
Urinary Catheter

A urinary catheter is a latex, polyurethane or silicone tube that is inserted in to the patient's bladder via the urethra to allow urine to drain freely from the bladder for collection.



4 Annual Accounts

For the year 1 April 2018
to 31 March 2019



Foreword to the Accounts

South Tees Hospitals NHS Foundation Trust

These accounts, for the period ended 31 March 2019 have been prepared by South Tees Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006.

Signed:

Siobhan McArdle

Date: 20 June 2019

Siobhan McArdle
Chief Executive & Accounting Officer


Abbott

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2019

		Group		Trust	
		2018/19	2017/18	**2018/19**	2017/18
	NOTE	**£000**	£000	**£000**	£000
Operating income	3	**614,031**	604,025	**613,149**	603,488
Operating expenses	4	**(649,430)**	(594,381)	**(648,293)**	(593,365)
OPERATING SURPLUS / (DEFICIT)		(35,399)	9,644	(35,144)	10,123
FINANCE COSTS:					
Finance income	7	**370**	238	**136**	44
Finance costs - financial liabilities	8.1	**(17,178)**	(17,709)	**(17,178)**	(17,709)
Finance costs - unwinding of discount on provisions	23	**(8)**	(15)	**(8)**	(15)
PDC dividends payable		**(2)**	(1,320)	**(2)**	(1,320)
NET FINANCE COSTS		(16,818)	(18,806)	(17,052)	(19,000)
Gain / (Loss) on disposal of assets	8.3	**20,720**	(484)	**20,720**	(484)
Movement in fair value of other investments	14	**584**	40	**0**	0
DEFICIT FOR THE YEAR		(30,913)	(9,606)	(31,476)	(9,361)
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	8.2	**(5,171)**	(10,557)	**(5,171)**	(10,557)
Revaluation gains on property, plant and equipment	8.2	**9,299**	11,873	**9,299**	11,873
Other reserve movements		**0**	49	**0**	0
TOTAL OTHER COMPREHENSIVE INCOME		4,128	1,365	4,128	1,316
TOTAL COMPREHENSIVE (EXPENSE)		(26,785)	(8,241)	(27,348)	(8,045)

The notes on pages 5 to 42 form part of these accounts. The reconciliation below provides further detail to support the references to the Control Total as detailed within the Annual Report.

Analysis of the deficit for the year		Group		Trust	
		2018/19	2017/18	**2018/19**	2017/18
	Note	**£000**	£000	**£000**	£000
(Deficit) for the financial period		**(30,913)**	(9,606)	**(31,476)**	(9,361)
Net impairment of property, plant, equipment and intangible assets	4.1	**50,643**	7,556	**50,643**	7,556
Capital donations, donated asset depreciation and CQUIN risk reserve		**(3,655)**	(4,375)	**(3,655)**	(4,375)
Surplus/ (Deficit) for the financial period before impairments, capital donations and depreciation on donated assets (reconciliation to the Trust NHSI Control Total)		**16,075**	(6,425)	**15,512**	(6,180)

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2019

		Group		Trust	
		31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	Note	**£000**	£000	**£000**	£000
Non-current assets					
Property, plant and equipment	9	**211,583**	254,192	**211,583**	254,192
Intangible assets	10	**4,158**	3,998	**4,158**	3,998
Trade and other receivables	17	**1,682**	1,556	**1,682**	1,556
Other investments	14	**5,885**	5,420	**0**	0
Total non-current assets		**223,308**	265,166	**217,423**	259,746
Current assets					
Inventories	15	**12,366**	11,651	**12,366**	11,647
Trade and other receivables	17	**101,109**	84,910	**100,253**	85,565
Cash and cash equivalents	16	**7,350**	9,988	**6,091**	8,213
Total current assets		**120,825**	106,549	**118,710**	105,425
Total assets		**344,133**	371,715	**336,133**	365,171
Current liabilities					
Trade and other payables	18	**(63,258)**	(60,896)	**(62,090)**	(60,621)
Borrowings	19	**(57,538)**	(15,188)	**(57,538)**	(15,188)
Provisions	23	**(653)**	(666)	**(653)**	(666)
Total current liabilities		**(121,449)**	(76,750)	**(120,281)**	(76,475)
Total assets less current liabilities		**222,684**	294,965	**215,852**	288,696
Non-current liabilities					
Borrowings	19	**(175,961)**	(222,144)	**(175,961)**	(222,144)
Provisions	23	**(788)**	(918)	**(788)**	(918)
Total non-current liabilities		**(176,749)**	(223,062)	**(176,749)**	(223,062)
Total assets employed		**45,935**	71,903	**39,103**	65,634
Financed by taxpayers' equity:					
Public dividend capital		**161,609**	160,748	**161,609**	160,748
Income and expenditure reserve		**(185,322)**	(155,395)	**(185,322)**	(155,395)
Revaluation reserve		**36,340**	33,805	**36,340**	33,805
Other reserves		**26,476**	26,476	**26,476**	26,476
Others' equity					
Charitable fund reserve	13	**6,832**	6,269	**0**	0
Total taxpayers' equity		**45,935**	71,903	**39,103**	65,634

The notes on pages 5 to 42 form part of these accounts.

The financial statements on pages 1 to 42 were approved by the Board on 28 May 2019 and signed on its behalf by:

Signed: Steven P Mason (Director of Finance) Date: 20 June 2019

Signed: Siobhan McArdle (Chief Executive) Date: 20 June 2019

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2019

	Public Dividend Capital (PDC)	Income and Expenditure Reserve	Revaluation Reserve	Other reserves	Trust total	Charitable funds reserve	Group total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017	158,962	(146,217)	32,672	26,476	71,893	6,465	78,358
Changes in taxpayers' equity for 2017/18							
(Deficit) for the year	0	(9,361)	0	0	(9,361)	(245)	(9,606)
Revaluation gains and impairment losses on property, plant and equipment.	0	0	1,316	0	1,316	0	1,316
Total comprehensive (expense) / income for the year	0	(9,361)	1,316	0	(8,045)	(245)	(8,290)
Public dividend capital received	1,786	0	0	0	1,786	0	1,786
PDC adjustment for cash impact of legacy transfer	0	0	0	0	0	0	0
Other transfers between reserves	0	183	(183)	0	0	49	49
Taxpayers' equity at 31 March 2018	160,748	(155,395)	33,805	26,476	65,634	6,269	71,903
Taxpayers' equity at 1 April 2018	160,748	(155,395)	33,805	26,476	65,634	6,269	71,903
Impact of implementing IFRS9 on opening reserves	0	(44)	0	0	(44)	0	(44)
Changes in taxpayers' equity for 2018/19							
(Deficit)/Surplus for the year	0	(31,476)	0	0	(31,476)	563	(30,913)
Revaluation gains and impairment losses on property, plant and equipment.	0	0	4,128	0	4,128	0	4,128
Total comprehensive expense for the year	0	(31,476)	4,128	0	(27,348)	563	(26,785)
Public dividend capital received	1,164	0	0	0	1,164	0	1,164
Public dividend capital repaid	(303)	0	0	0	(303)	0	(303)
Other transfers between reserves	0	1,593	(1,593)	0	0	0	0
Taxpayers' equity at 31 March 2019	161,609	(185,322)	36,340	26,476	39,103	6,832	45,935

Note: Additional PDC received by the Trust during the year related to funding from the Department of Health for investment in Radiotherpy, Wi-fi, Pharmacy and Information Technology. The amount shown as 'Other Reserves' represents the value of assets transferred to South Tees Hospitals NHS Foundation Trust following the acquisition of the former Northallerton Health Services NHS Trust, over and above the value of Public Dividend Capital repayable on dissolution of that Trust.

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2019

		Group		Trust	
		2018/19	2017/18	**2018/19**	2017/18
	NOTE	**£000**	£000	**£000**	£000
Cash flows from operating activities					
Operating (deficit)/ surplus from continuing operations		**(35,399)**	9,644	**(35,144)**	10,123
Non-cash income and expense					
Depreciation and amortisation	4	**13,216**	13,376	**13,216**	13,376
Net impairments	4	**50,643**	7,556	**50,643**	7,556
(Increase) in trade and other receivables		**(25,623)**	(26,262)	**(24,938)**	(26,587)
(Increase) in inventories	15	**(715)**	(173)	**(715)**	(169)
Increase/ (decrease) in trade and other payables		**1,051**	(2,316)	**1,348**	(1,645)
(Decrease)/ increase in provisions	23	**(142)**	20	**(142)**	20
Other movements in operating cash flows		**836**	(476)	**115**	100
Net cash generated from operations		**3,867**	**1,369**	**4,383**	**2,774**
Cash flows from investing activities					
Interest received	7	**136**	238	**136**	44
Purchase of intangible assets	10	**(1,069)**	(1,496)	**(1,069)**	(1,496)
Purchase of property, plant and equipment	9	**(11,960)**	(21,980)	**(11,960)**	(21,980)
Sales of property, plant and equipment		**26,848**	0	**26,848**	0
Net cash used in investing activities		**13,955**	(23,238)	**13,955**	(23,432)
Cash flows from financing activities					
Public dividend capital received		**1,164**	1,786	**1,164**	1,786
Public dividend capital repaid		**(303)**	0	**(303)**	0
Loans received		**9,014**	54,949	**9,014**	54,949
Loans repaid		**(9,845)**	(8,601)	**(9,845)**	(8,601)
Capital element of finance lease rental payments		**(1,149)**	(1,026)	**(1,149)**	(1,026)
Capital element of private finance initiative obligations		**(2,171)**	(3,286)	**(2,171)**	(3,286)
Interest on loans	8	**(3,009)**	(2,758)	**(3,009)**	(2,758)
Interest element of finance leases	8	**(514)**	(820)	**(514)**	(820)
Interest element of private finance initiative obligations	8	**(13,618)**	(14,050)	**(13,618)**	(14,050)
PDC dividend paid		**(29)**	(1,895)	**(29)**	(1,895)
Net cash used in financing activities		**(20,460)**	24,299	**(20,460)**	24,299
Decrease in cash and cash equivalents		**(2,638)**	2,430	**(2,122)**	3,641
Cash and cash equivalents at 1 April		**9,988**	7,558	**8,213**	4,572
Cash and cash equivalents at 31 March	16	**7,350**	9,988	**6,091**	8,213

NOTES TO THE ACCOUNTS

1. Accounting policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS Foundation Trusts under the NHS Act 2006. NHS Improvement has directed that the accounts of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (DHSC GAM), which shall be agreed with the Secretary of State. Consequently, the following accounts have been prepared in accordance with the DHSC GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. Where the NHS Foundation Trust Annual Reporting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently during the financial year when 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 and certain financial assets and financial liabilities.

1.2 Basis of consolidation

The Trust is the corporate trustee to South Tees Hospitals Charity and Associated Funds which is registered with the Charity Commission, registration number 1056061. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary as the Trust has the power to govern the financial and operating policies of the charitable fund to obtain benefits from its activities for the Trust, its patients and its staff.

The charitable fund's statutory accounts are prepared to 31 March and in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, adjustments have been made to the charity's income, expenditure, assets and liabilities to:

- recognise and measure them in accordance with the Trust's accounting policies; and
- eliminate in full all intra-group transactions and balances.

During 2016/17 the Trust formed the South Tees Institute of Learning, Research and Innovation LLP and South Tees Healthcare Management Limited. The financial year end of both companies is 31 May 2018 and this will be the second year end for both companies. Operations will begin in 2019/20 and due to the limited transactions of these companies in 2018/19 these companies have not been consolidated on the basis of materiality.

1.2.1 Alignment to accounting policies

The accounting policies and accounts of the charitable fund have been reviewed and are consistent with those of the Trust apart from the charitable fund's accounting policies on funds and investments. Details of the accounting policies that are different and have been aligned to those of the trust are outlined below:

Fund balances

Funds held by the charitable fund can be both restricted and un-restricted. Donations come in for specific funds and each fund has its own objectives/purpose. If a general donation is made and no specific fund is identified then the monies will be paid into the General Purpose Fund, which is used to benefit patients and staff of the Group and Trust. Funds specific to wards or departments are held as un-restricted designated funds. Legacies and donations received for a specific purpose or 'trust' are recorded and accounted for as restricted funds.

Investments

Investments are stated at market value as at the balance sheet date. The Consolidated Statement of Financial Position includes the net gains and losses arising on revaluation and disposals throughout the year.

At the financial reporting date, the Trust does not have any other interests in organisations that would classify as a subsidiary. Further information covering the nature and value of the consolidation of the charitable fund is included in Note 13 to the Accounts.

1.3 Critical accounting judgements and key sources of estimation in applying the Trust's accounting policies

In the application of the Group and 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 those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised.

The estimates and assumptions that have a significant risk of causing a material adjustment to the accounts are highlighted below:

a) Incomplete inpatient and critical care spells – the Group and Trust prepares an estimate of income generated for incomplete spells at the year end. This estimate is based on an equivalent month end date and partially coded data to provide a basis for calculation.

b) Asset valuation and indices – the valuation of land and buildings is based on building cost indices and location factors provided by and used by Cushman and Wakefield in their valuation work. These indices are based on an indication of trend of accepted tender prices within the construction industry as applied to the Public Sector.

c) Basis of PP&E valuation - Specialised property is valued at depreciated replacement cost. The cost of VAT has been excluded from the full trust estate specialised property valuations from 1 April 2014. The Trust estate is predominently PFI assets. This significant managment judgement was made on the basis that:

   (i) the majority of the James Cook Hospital is currently under a PFI arrangement and the Trust recovers the VAT on the Unitary Payment. When the Trust recognised the property as an asset in 2009/10 in its first IFRS-based accounts it appropriately excluded VAT from the initial measurement of FV.

   (ii) The majority of non-PFI assets relate to the Friarage Hospital, which transferred to the Trust in 2006. The Friarage Hospital would have formed part of the PFI development if it had been part of the Trusts assets at the date of the development.

   (iii) The Trust considers that when, in the future, it procures a significant replacement of its estate, it would do so through a PFI arrangement and expects to recover the VAT on the PFI payments.

   (iv) The Trust has set up a subsidiary undertaking and taken appropriate guidance that this entity will be able to recover VAT on capital projects.

d) Basis of asset impairments – an assessment is made each year as to whether an asset has suffered an impairment loss.

e) Private Finance Initiative (PFI) schemes – as part of the South Tees Hospitals PFI scheme, the Group and Trust is required to pay the operator for lifecycle replacement assets. A judgement has been made that payment for the assets is accounted for in line with the operator's model over the life of the scheme. Where there is a variation between the model and the timing of actual asset replacement, the variation is dealt with as a prepayment. The prepayment is reversed at the point when asset replacement occurs. This requires an ongoing assessment as to whether the prepayment is fully recoverable or whether it requires impairment.

1.3.1 Going concern

The day to day operations of the Trust are funded from agreed contracts with NHS commissioners.The uncertainty in the current economic climate has been in part mitigated by agreeing contracts with Clinical Commissioning Groups and NHS England for a further year and these payments provide a reliable stream of funding reducing the Trust's exposure to liquidity and financing problems.

The Trust's budget and expenditure plans have been prepared using national guidance on tariff and inflationary factors with income based on agreements with Commissioners. These plans outlined a surplus control total in 2018/19 of £3.8 million, including Provider Sustainability Funding (PSF).

The Trust has set challenging efficiency targets in 2018/19 which included a Cost Improvement Plan of £35.6 million. In 2019/20 the target has initially been set at £33.2 million and the Trust believes that this forward plan provides a challenging but realistic assessment of the Trust's position.

The Trust has historically received support through the Department of Health from 2014/15 through to 2017/18. The Trust has utilised Interim Revenue Support during 2018/19 in the form of short term borrowing to cover PSF. During the year the Group received new loans of £9.0m and made loan repayments of £9.8m. The Trust delivered its Control Total in 2018/19 and received confirmation that Incentive and Bonus PSF amounting to £9.5 million will be paid to the Trust in 2019. The Trust has not included a requirement for Interim Revenue Support in the 2019/20 Annual Plan submission but is in discussions with NHS Improvement over the submission of a request for Capital Support to cover essential replacements and loan repayments of £55.0m which fall due for repayment in 2019/20. The operational stability of the Trust is dependent on the Trust achieving the 2019/20 Efficiency Plan and the Trust believes that this Plan is challenging but realistic.

Notwithstanding the above the Trust recorded a deficit for the year of £30.9m and showed a reduction in cash and cash equivalents of £2.6m. The balance sheet shows net current liabilities of £0.6m which includes aggregate loans from the Department of Health and Social Care (DHSC) totalling £55.0m repayable in 2019/20. The Group is forecasting a deficit of £0.6m for the year ending March 2020 and will require ongoing loan support from DHSC together with non-repayment of current funding in order to meet the future financial obligations of the group.

The Group has not been notified by any relevant national body of any intention to dissolve the Group or to transfer services to another public sector body. Based on recent discussions and past experience the Trust believes that the loans of £55.0m from DHSC will not be required to be repaid when they fall due for payment and that they will continue to be made available to the Group or replaced by new funding. The Group also believes that if further funding support is required in 2019/20 this will be made available. As with any Trust placing reliance on the DHSC for financial support, the directors acknowledge that there can be no certainty that this support will continue although, at the date of approval of these financial statements, they have no reason to believe that it will not do so.

Based on the above factors the Directors believe that it remains appropriate to prepare the financial statements on a going concern basis. However the above factors give rise to a material uncertainty which may cast doubt on the Group's and the Trust's ability to continue as a going concern and, therefore, to continue to realising its assets and discharging its liabilities in the normal course of business. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate.

1.3.2 Key sources of estimation uncertainty

The amounts included within Provisions, Note 23, are based upon advice from relevant external bodies, including the NHS Litigation Authority and NHS Pensions Agency.

On 31 March 2019 Land and Buildings were revalued using the Modern Equivalent Valuation methodology by Cushman and Wakefield (who is an appropriately qualified member of the Royal Institute of Chartered Surveyors). From 1 April 2014 these valuations did not include VAT (note 1.3).

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset or liability recorded in note 9.

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 Group and Trust is contracts with commissioners in respect of healthcare services.

Income relating to inpatient and critical care spells that are part-completed at the year end are apportioned across the financial years as follows:

- Inpatient spells are apportioned on the basis of the average month end value of the part completed spells; and
- Critical care is valued by applying local tariffs agreed with commissioners to estimate the level of income due to be recognised at the point of discharge.

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

The Group and Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Group and Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Research and development income is recognised when the conditions attached to the grant are met. Education and training income is recognised either in equal instalments over the financial year or if the income can be identified with specific expenditure, in line with the expenditure.

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 under the sale contract.

The value of the benefit received when the Trust accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.5 Employee benefits

1.5.1 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 accounts to the extent that employees are permitted to carry forward leave into the following period.

1.5.2 Pension costs

NHS Pension Scheme

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

Employer's pension cost contributions are charged to operating expenses as and when they become due.

For early retirements, other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to operating expenses at the time the Group and Trust commits itself to the retirement, regardless of the method of payment.

1.6 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 and inventories unused at the end of the financial year.

1.7 Property, plant and equipment

1.7.1 Recognition

Property, plant and equipment is capitalised if:

- 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 will be supplied to, the Group and Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably;
- the item has a cost of at least £5,000; and
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significant cost and different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.7.2 Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value. Land and buildings used for the Group and Trust's services or for administrative purposes are stated in the Statement of Financial Position at their re-valued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings (dwellings) – market value for existing use; or
- Specialised buildings – depreciated replacement cost.

A standard approach to depreciated replacement cost valuations has been adopted based on HM Treasury guidance and the concept of Modern Equivalent Asset (MEA) Valuations. The valuation included in the Statement of Financial Position at 31 March 2019 is based on an alternative site MEA valuation, undertaken specifically in accordance with the HM Treasury guidance which states that such valuations are an option if the Group and Trust's service requirements can be met from the alternative site. The valuation has been adjusted from 1 April 2014 to exclude VAT in line with existing VAT regulations on recovery from the cost of construction (in line with the existing PFI arrangement on the James Cook Site).

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

Professional valuations are carried out by Cushman and Wakefield. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. Asset lives were reviewed by Cushman and Wakefield as at 1 April 2016.

1.7.3 Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component will flow to the Truat or Group and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is written off. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.7.4 Depreciation

Freehold land is considered to have an infinite life and is not depreciated. Otherwise, depreciation is charged to write off the costs or valuation of property, plant and equipment on a straight line basis over their remaining useful economic lives, in a manner consistent with the consumption of economic or service delivery benefits.

The estimated useful life of an asset is the period over which the Group and Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Group and Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of their estimated useful lives or the lease term. See note 9.4 for further information on asset lives.

1.7.5 Revaluation gains and losses

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation impairment previously 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".

1.7.6 Impairments

In accordance with the Department of Health group Accounting Manual, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenses to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

1.8 Intangible assets

1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of being sold separately from the rest of the Group and Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Group and Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000 and where the asset has a life of 1 year or more.

1.8.2 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.

1.8.3 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.

Intangible assets are subsequently measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating.

Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

An intangible asset which are surplus with no plan to bring it back into use is valued at fair value under IFRS 13, it it does not meet the requirements of IAS 40 or IFRS 5.

1.8 Intangible assets (continued)

1.8.4 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 Donated, government grant and other funded assets

Donated and grant funded non-current assets are capitalised at their fair value on receipt. These are valued, depreciated and impaired as described above for purchased assets. The donation/grant is credited to income at the same time that the asset is capitalised, unless the donor has imposed a condition that the future economic benefits embodied in the grant/donation are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met. The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.10 Revenue government and other grants

Government grants are grants from government bodies other than revenue from NHS bodies for the provision of services. Grants from the Department of Health, including those from the Big Lottery Fund, are accounted for as Government Grants. Where the Government Grant is used to fund revenue expenditure, it is taken to the Statement of Comprehensive Income to match the expenditure.

1.11 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee and all other leases are classified as operating leases.

1.11.1 Finance lease

Where substantially all risks and rewards of ownership of a leased asset are borne by the Group and Trust, the asset along with the corresponding liability is recorded at the commencement of the lease as property, plant and equipment. The value that both are recognised at 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 annual rental is split between the repayment of the liability and a finance cost to achieve a constant rate of finance over the life of the lease. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

1.11.2 Operating leases

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

1.11.3 Leases of Land and Buildings

Where a lease is for land and buildings, the land and building components are separated and assessed as to whether they are operating or finance leases.

1.12 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, as interpreted in HM Treasury's Financial Reporting Manual and following the principles of the requirements of IFRIC 12. The PFI asset is recognised as an item of property, plant and equipment at its fair value together with a financial liability to pay for it in accordance with IAS 17.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;

b) Payment for the PFI asset, including finance costs; and

c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

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

1.12.1 Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.12.2 PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequent measurements to fair value are kept up to date in accordance with the Group and Trust's approach for each relevant class of asset in line with the principles of IAS 16.

1.12.3 PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

1.12.4 Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Group and Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a liability or prepayment will be recognised.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.12.5 Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Group Statement of Financial Position.

1.12.6 Other assets contributed by the Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the Group and Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, were recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset was made available to the Trust, the prepayment was treated as an initial payment towards the finance lease liability and was set against the carrying value of the liability.

1.13 Inventories

Inventories are valued at either current or net realisable value using the weighted average cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

Provision is made for obsolete, slow moving and defective stock whenever evidence exists that a provision is required.

1.14 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.15 Provisions

Provisions are recognised when the Group and Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Group and Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision in the Statement of Financial Position is the best estimate of the expenditure required to settle the obligation, taking into account the risks and uncertainties. Where the effect of the time value of money is significant, the estimated risk adjusted cash flows required to settle the obligation are discounted using 3 real time HM Treasury discount rates that range from 0.76% in the short term to 1.99% for long term cash flow expectations. This excludes early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 0.29% in real terms (2017/18 0.10%).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

1.15.1 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Group and Trust pays an annual contribution to the NHSLA which, in return, settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Group and Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Group and Trust is disclosed at Note 22 but is not recognised in the Group and Trust's accounts. Since financial responsibility for clinical negligence cases transferred to the NHSLA at 1 April 2002, the only charge to operating expenditure in relation to clinical negligence in 2018/19 relates to the contribution to the Clinical Negligence Scheme for Trusts.

1.15.2 Non-clinical risk pooling

The Group and Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Group and 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 as and when they become due.

1.16 Carbon Reduction Commitment Energy Efficiency (CRC) Scheme

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Group and Trust is registered with the CRC scheme and has surrendered to the Government an allowance for every tonne of CO2 emitted during the year. The Group and Trust has accounted for the purchase of the allowances from government, their subsequent actual surrender and has recognised a liability, in settlement of the obligation amounting to £15.60 per tonne of CO2 emissions.

1.17 Financial Instruments and financial liabilities

1.17.1 Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items, which are entered into in accordance with the Group's normal purchase, sale or usage requirements. They are recognised when the Group becomes party to the financial instrument contract or when performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques

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 are described in policy 1.11.1.

1.17.2 De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Group has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.17.3 Classification and measurement

The Group currently holds financial assets 'at fair value through income and expenditure' in the form of Investments. Other financial assets are held at amortised costs. The Group does not hold any financial liabilities 'at fair value through income and expenditure' or any 'available for sale' financial assets that would require a fair value calculation and adjustment to the income statement.

1.17.4 Loans and receivables

Loans and receivables are non-derivative financial assets and liabilities with fixed or determinable payments which are not quoted in an active market. They are included in current assets and non-current and current liabilites. After initial recognition, they are measured at amortised cost, less any impairment. The Group's outstanding NHS borrowings, NHS and non-NHS receivables balances, accrued income and cash and cash equivalents have been classified as financial instruments and further information is available in Note 24.

1.17.5 Financial liabilities

All other financial liabilities, after initial recognition, are measured at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. The Group's outstanding NHS and non-NHS payables balances have been classified as financial instruments and further information is available in Note 24.

Loans from the Department of Health are recognised at historical cost. The Group does hold instruments that would fall into this category in the form of finance leases and the PFI Scheme (see Accounting Policy 1.11 and 1.12 for further information).

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment is not capitalised as part of the cost of those assets.

1.17.6 Impairment of financial assets

At the end of the reporting period, the Group assesses whether any financial assets carried at amortised cost should be impaired. Financial assets are impaired and recognised as a loss allowance representing expected credit losses on the financial instrument if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset which has an impact on the estimated future cash flows of the asset.

The Trust has adopted the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition, and otherwise at an amount equal to 12-month expected credit losses. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the creation of a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.18 Value Added Tax

Most of the activities of the Group 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.

1.19 Foreign currencies

The Group's functional currency and presentational currency is sterling. A transaction which is denominated in a foreign currency is translated into sterling at the spot exchange rate ruling on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Group's income or expense in the period in which they arise.

1.20 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Group and Trust has no beneficial interest in them. However, details of third party assets are disclosed in Note 27 to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.21 Public Dividend Capital (PDC) and PDC dividend

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. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32 and 39.

An annual charge, reflecting the cost of capital utilised by the Group and Trust, is payable to the Department of Health as PDC dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets, average daily cash balances held with the Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health, the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.22 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.23 Accounting standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following IFRS Standards and interpretations to be adopted in 2018/19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019/20, and the government implementation date for IFRS17 still subject to HM Treasury consideration.

- IFRS 14 Regulatory Deferral Accounts (Not yet EU endorsed);
- IFRS 16 Leases (application required for accounting periods beginning on or after 1 January 2019);
- IFRS 17 Insurance Contracts (application required for accounting periods beginning on or after 1 January 2021);
- IFRIC 23 Uncertainty over Income Tax Treatments (application required for accounting periods beginning on or after 1 January 2019).

The Trust is reviewing its position on the introduction of IFRS16. The impact on the Trust is yet to be determined.

1.24 Accounting standards issued that have been adopted early

There have not been any accounting standards issued with an effective date of 1 April, 2019, that have been adopted early.

1.25 Segmental reporting

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision maker. The chief operating decision maker, who makes the strategic decisions, is responsible for allocating resources and assessing performance of the operating segments, has been identified as the Board.

2. Operating segments

The Group received £543.141 million under contracts with commissioners during the year (£544.199 million in 2017/18) from Clinical Commissioning Groups and NHS England, which equates to 89% (90% in 2017/18) of total Trust income. There were no other significant external customers amounting to more than 11% of total income.

The Group has reviewed the process of reporting the financial performance at a trust wide level to the Board. Only limited divisional information is reported and this is similar in the nature of the products and services provided, the nature of the production process, the type of class of customer for the product or service, the method used to provide our services and the nature of the regulatory environment.

The Board is the chief decision making body within the Group and receives monthly updates on the financial position. These reports provide a global update on the Group's actual position compared to plan on expenditure, income, current surplus/deficit and progress on capital investment. The current position on cash balances is reported in conjunction with an updated risk rating. The figures reported to the Board are consistent with those included within these accounts.

On the basis of the information provided to the Board it has been determined that there is only one operating segment, that of healthcare.

3. Operating income

3.1 Income from activities by classification

	Group		Trust	
	2018/19	2017/18	**2018/19**	2017/18
	£000	£000	**£000**	£000
Elective income	**88,283**	98,790	**88,283**	98,790
Non elective income	**132,041**	125,979	**132,041**	125,979
First outpatient income	**26,098**	26,431	**26,098**	26,431
Follow up outpatient income	**51,686**	51,656	**51,686**	51,656
Other NHS clinical income	**175,693**	182,070	**175,693**	182,070
Accident and emergency income	**17,935**	18,149	**17,935**	18,149
Community services	**46,107**	43,098	**46,107**	43,098
Private patient income	**935**	1,153	**935**	1,153
AfC Pay Award	**6,329**	0	**6,329**	0
Other non-protected clinical income	**97**	267	**97**	267
Total income from activities	**545,204**	547,593	**545,204**	547,593
Research and development	**5,050**	4,699	**5,050**	4,699
Education and training	**17,466**	15,840	**17,466**	15,840
Charitable and other contributions to expenditure	**4,827**	3,943	**4,827**	3,943
Non-patient care services to other bodies	**3,126**	3,547	**3,126**	3,547
Provider Sustainability Fund/Sustainability and Transformation Fund income	**23,367**	12,343	**23,367**	12,343
Charitable Fund – incoming resources	**882**	537	**0**	0
Other income*	**14,109**	15,523	**14,109**	15,523
	68,827	56,432	**67,945**	55,895
Total income from continuing operations	**614,031**	604,025	**613,149**	603,488

*Other income includes consideration arising from car parking charges £3.172 million (2017/18 £2.755 million), income in respect of recovered staff costs £ 0.530 million (2017/18 £0.581 million), estate recharges £1.120 million (2017/18 £1.087 million), clinical excellence awards £1.356 million (2017/18 £1.349 million), staff accommodation £1.139 million (2017/18 £1.089 million), clinical tests £0.464 million (2017/18 £0.509 million), creche services £0.653 million (2017/18 £0.669 million) and catering £0.257 million (2017/18 £0.250 million).

Under the Terms of Authorisation the Group's total activity income from Commissioner Requested Services amounts to £543.147 million (2017/18 £544.301 million). All other activity income relates to Non-Commissioner Requested Services.

3.2 Income from activities by source

	2018/19	2017/18
	£000	£000
Group and Trust		
NHS foundation trusts	**6**	43
Clinical Commissioning Groups and NHS England	**536,812**	544,199
Department of Health and Social Care	**6,329**	0
NHS other	**0**	59
Non-NHS - overseas patients (non-reciprocal) (*)	**97**	267
Non-NHS - private patients	**935**	1,153
Non-NHS - other	**226**	150
NHS Injury Scheme	**799**	1,722
Total income from activities	**545,204**	547,593

(*) Cash payments received in year from overseas visitors, where patients are charged directly by the Trust, and relating to invoices raised in the current and prior years amounted to £0.056 million (£0.044 million in 2017/18). Additions to the provision for the impairment of receivables amounted to £0.150 million (£0.370 million increase in 2016/17) and the Trust did not write off any charges in year (no write offs in 2017/18).

Injury cost recovery is subject to a provision for impairment of receivables of 21.89% (2017/18 22.84%) to reflect expected rates of collection.

4. Operating expenses

4.1 Operating expenses comprise

	Group		Trust	
	2018/19	2017/18	**2018/19**	2017/18
	£000	£000	**£000**	£000
Services from NHS Foundation Trusts	**4,871**	4,771	**4,871**	4,771
Services from NHS Trusts,CCGs and NHS England	**204**	193	**204**	193
Services from other NHS bodies	**1**	33	**1**	33
Purchase of healthcare from non NHS bodies	**6,321**	5,767	**6,321**	5,767
Employee expenses - executive directors	**1,545**	2,458	**1,545**	2,458
Employee expenses - non-executive directors	**164**	172	**164**	172
Employee expenses - staff (*)	**356,171**	353,760	**356,171**	353,760
Employee expenses - charitable fund	**396**	231	**0**	0
Drug costs	**64,274**	61,858	**64,274**	61,858
Supplies and services - clinical	**67,368**	61,067	**67,368**	61,067
Supplies and services - general	**3,787**	29,715	**3,787**	29,715
Research and development	**580**	155	**580**	155
Establishment	**2,950**	2,264	**2,950**	2,264
Transport	**4,386**	4,733	**4,386**	4,733
Premises	**47,187**	24,017	**47,187**	24,017
(Decrease)/increase in provision for impairment of receivables	**(83)**	492	**(83)**	492
Increase/(decrease) in other provisions	**158**	216	**158**	216
Change in provisions discount rate	**(18)**	16	**(18)**	16
Inventories written down	**81**	67	**81**	67
Depreciation of property, plant and equipment	**12,307**	12,639	**12,307**	12,639
Amortisation of intangible assets	**909**	737	**909**	737
Net impairments of property, plant and equipment	**50,643**	7,496	**50,643**	7,496
Impairments of intangible assets	**0**	60	**0**	60
Audit fees audit services – statutory audit	**55**	55	**55**	55
audit services – charitable fund	**3**	3	**0**	0
Audit related assurance services	**12**	12	**12**	12
Clinical negligence	**17,530**	14,461	**17,530**	14,461
Legal fees	**144**	190	**144**	190
Consultancy costs	**2,060**	1,710	**2,060**	1,710
Internal audit costs	**133**	161	**133**	161
Training, courses and conferences	**1,020**	923	**1,020**	923
Patient travel	**0**	76	**0**	76
Redundancy (*)	**1,024**	657	**1,024**	657
Other services	**1,215**	1,196	**1,215**	1,196
Hospitality	**28**	35	**28**	35
Insurance	**362**	349	**362**	349
Losses, ex gratia and special payments	**258**	302	**258**	302
Other resources expended - charitable fund	**738**	782	**0**	0
Other	**646**	552	**646**	552
	649,430	594,381	**648,293**	593,365

(*) within operating expenses costs arising from redundancy of £1.024 million (2017/18 £0.657 million) related to restructuring expenses incurred to facilitate transformational change.

4.2 Limitation on external auditors' liability

The Companies (Disclosure of Auditor Remuneration and Liability Limitations Agreements) Regulations 2008 (SI 489/2008), requires disclosure of the limitation of the external auditors' liability. The limitation amounts to £1.000 million, as stated within the external auditors' engagement letter, dated 9 March 2018.

4.3 Operating Leases

4.3.1 Arrangements containing an operating lease

Significant operating lease arrangements include photocopiers and the lease of software for use by the Group and Trust. The terms of the leases range from 1 to 3 years.

Payments recognised as an expense	**2018/19**	2017/18
	£000	£000
Group and Trust		
Minimum lease payments	**560**	734
	560	734

Total future minimum lease payments	**2018/19**	2017/18
	£000	£000
Payable:		
Not later than one year	**576**	648
Between one and five years	**1,143**	36
Total	**1,719**	684

5. Employee expenses and numbers

5.1 Employee expenses (including Executive Directors' costs)

Group and Trust	**2018/19**			2017/18
	Total	**Permanently employed**	**Other**	Total
	£000	**£000**	**£000**	£000
Salaries and wages	**288,856**	**285,394**	**3,462**	288,099
Social security costs	**27,091**	**27,091**	**0**	27,067
Pension costs - defined contribution plans employer contributions to NHS Pensions	**32,058**	**32,058**	**0**	31,956
Termination benefits	**1,024**	**1,024**	**0**	657
Agency/contract staff	**10,114**	**0**	**10,114**	9,382
Charitable fund staff	**396**	**396**	**0**	231
Total staff costs	**359,539**	**345,963**	**13,576**	357,392
Costs capitalised as part of assets	**(403)**	**(403)**	**0**	(286)
Total staff costs excluding capitalised costs	**359,136**	**345,560**	**13,576**	357,106

The executive costs covers 9 directors (2017/18, 13) and consists of salaries amounting to £1.545 million (2017/18 £2.027 million), employers NI contributions £0.167 million (2017/18 £0.261 million) and employers superannuation contributions £0.117 million (2017/18 £0.170 million). Included within these values the highest paid director receives a salary amounting to £0.274 million (2017/18 £0.239 million), employers NI contributions £0.037 million (2017/18 £0.032 million) and £0.32 million for employers superannuation contributions (2016/17 £nil). For further information on Directors' remuneration and pension benefits please refer to the Remuneration Report in the Trust's Annual Report.

5.2 Monthly average number of people employed

Group and Trust	2018/19 Total	2018/19 Permanently Employed	2018/19 Other	2017/18 Total
	Number	Number	Number	Number
Medical and dental	**1,055**	**1,055**	**0**	901
Administration and estates	**1,303**	**1,303**	**0**	1,384
Healthcare assistants and other support staff	**369**	**369**	**0**	682
Nursing, midwifery and health visiting staff	**2,417**	**2,417**	**0**	2,482
Nursing, midwifery and health visiting learners	**1,262**	**1,262**	**0**	1,233
Scientific, therapeutic and technical staff	**1,174**	**1,174**	**0**	1,117
Total	**7,580**	**7,580**	**0**	7,799
Number of staff (WTE) engaged in capital projects (included above)	**7**			8

Note: the figures represent the Whole Time Equivalent as opposed to the number of employees.

5. Employee expenses and numbers

5.3 Staff exit packages

Exit package cost band	2018/19			2017/18		
Group and Trust	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
< £10,000	**10**	**2**	**12**	0	2	2
£10,000 to £25,000	**5**	**1**	**6**	2	2	4
£25,001 to £50,000	**9**	**2**	**11**	1	3	4
£50,001 to £100,000	**3**	**2**	**5**	2	1	3
£100,001 to £150,000	**0**	**0**	**0**	0	0	0
£150,001 to £200,000	**0**	**0**	**0**	1	0	1
> £200,001	**0**	**0**	**0**	0	0	0
Total number of exit packages by type	**27**	**7**	**34**	6	8	14
Total resource cost £000	**767**	**257**	**1,024**	359	213	572

Redundancy and other departure costs have been paid in accordance with NHS Agenda for Change terms and conditions. Exit costs are accounted for in full in the year of departure. Where the Group has agreed to early retirements, the additional costs are met by the Group and not by the NHS Pension Scheme. Ill health retirement costs are met by the NHS Pension scheme and are not included in the table.

5.4 Exit packages: non-compulsory departure payments

	2018/19 Agreements	2018/19 Total value of agreements	2017/18 Agreements	2017/18 Total value of agreements
	number	£000	number	£000
Voluntary redundancies including early retirement contractual costs	6	213	8	213
Mutually agreed resignations (MARS) contactual costs	1	44	0	0
Total	**7**	**257**	8	213

5.5 Retirements due to ill-health

During 2018/19 there were 5 (2017/18, 6) early retirements from South Tees Hospitals NHS Foundation Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £0.157 million (2017/18, £0.355 million). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

6. Pension costs

Past and present employees are covered by the provisions of the 2 NHS Pensions Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State for Health 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 each scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the accounts do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that the period between formal valuations shall be four years, with approximate assessments in intervening years. An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period.

This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on the valuation data as at 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme (England and Wales) Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. The list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained.

Annual pensions

The scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and the best of the last 3 years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Pensions indexation

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in the Consumer Price Index (CPI) in the twelve months ending 30 September in the previous calendar year.

Ill-health retirement

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity.

Early retirements other than ill-health

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Death benefits

A death gratuity of twice their final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Additional Voluntary Contributions (AVCs)

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVCs run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Other pension funds

Where the organisation has employees who are members of other schemes, disclosures will be required in respect of them too. Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

7. Finance income

	GROUP		TRUST	
	2018/19	2017/18	**2018/19**	2017/18
	£000	£000	**£000**	£000
Interest on bank accounts	**136**	44	**136**	44
Charitable fund - investment income	**234**	194	**0**	0
	370	238	**136**	44

8. Finance costs

8.1 Finance costs - interest expenses

	2018/19	2017/18
Group and Trust	**£000**	£000
Loans from Department of Health:		
- Capital loans	**916**	895
- Revenue support	**793**	401
- Revolving working capital facilites	**1,311**	1,462
Finance leases	**514**	820
Interest on late payment of commercial debts	**26**	81
Finance costs in PFI obligations		
- Main finance cost	**7,898**	8,136
- Contingent finance costs	**5,720**	5,914
Total	**17,178**	17,709

8.2 Impairment of assets (property, plant and equipment)

	2018/19	2017/18
Group and Trust	**£000**	£000
Income and Expenditure:		
Impairment of PPE	**65,942**	10,052
Impairment of intangible assets	**0**	60
Reversal of impairments of PPE	**(15,299)**	(2,556)
Other Comprehensive Income:		
Revaluation losses	**5,171**	10,557
Revaluation gain	**(9,299)**	(11,873)
Total	**46,515**	6,240

Further information on impairments is available within Note 9.3 to the Accounts.

8.3 Gains on disposal of assets

	2018/19	**2017/18**
Group and Trust	**£000**	**£000**
Gains on disposal of land and buildings	20,784	0
Losses on disposal of property, plant and equipment	(64)	(484)
Total	20,720	(484)

9. Property, plant and equipment

9.1 Property, plant and equipment comprise the following:

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2018	3,966	333,835	1,266	10,720	89,910	52	21,583	2,484	463,816
Additions purchased	0	0	0	13,375	3,605	11	520	22	17,533
Additions leased	0	0	0	0	147	0	0	0	147
Additions donated and government granted	0	0	0	4,230	518	0	79	0	4,827
Reclassifications from assets under construction	0	22,458	0	(25,287)	1,844	0	985	0	0
Disposals	(634)	(5,572)	0	0	(650)	0	0	0	(6,856)
Impairments charged to the revaluation reserve	0	(5,171)	0	0	0	0	0	0	(5,171)
Revaluation surpluses credited to revaluation reserve	54	9,245	0	0	0	0	0	0	9,299
Cost or valuation at 31 March 2019	3,386	354,795	1,266	3,038	95,374	63	23,167	2,506	483,595
Accumulated depreciation at 1 April 2018	0	135,518	311	118	55,779	51	15,557	2,290	209,624
Disposals	0	0	0	0	(562)	0	0	0	(562)
Impairments	1,251	64,331	360	0	0	0	0	0	65,942
Reversal of impairments	(15)	(15,257)	(27)	0	0	0	0	0	(15,299)
Provided during the year	0	2,628	12	0	7,909	1	1,697	60	12,307
Accumulated depreciation at 31 March 2019	**1,236**	**187,220**	**656**	**118**	**63,126**	**52**	**17,254**	**2,350**	**272,012**
Net book value at 1 April 2018									
Owned	3,966	17,842	955	7,843	29,067	0	5,361	177	65,211
Private Finance Initiative	0	175,575	0	0	0	0	0	0	175,575
Finance Lease	0	280	0	0	1,728	0	502	0	2,510
Government granted	0	811	0	376	571	0	117	0	1,875
Donated	0	3,809	0	2,383	2,765	1	46	17	9,021
Net book value total at 1 April 2018	**3,966**	**198,317**	**955**	**10,602**	**34,131**	**1**	**6,026**	**194**	**254,192**
Net book value at 31 March 2019									
Owned	2,150	20,555	610	2,504	27,874	10	5,664	147	59,514
Private Finance Initiative	0	139,961	0	47	0	0	0	0	140,008
Finance Lease	0	200	0	0	1,219	0	109	0	1,528
Government granted	0	799	0	0	420	0	25	0	1,244
Donated	0	6,060	0	369	2,735	1	115	9	9,289
Net book value total at 31 March 2019	**2,150**	**167,575**	**610**	**2,920**	**32,248**	**11**	**5,913**	**156**	**211,583**

9.2 Prior year - Property, plant and equipment comprise the following:

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	3,966	326,260	1,255	9,504	85,806	52	20,555	2,419	449,817
Additions purchased	0	5,476	0	2,628	2,837	0	675	65	11,681
Additions leased	0	0	0	0	464	0	0	0	464
Additions donated and government granted	0	0	0	253	1,651	0	14	0	1,918
Reclassifications from assets under construction	0	794	0	(1,665)	532	0	339	0	0
Disposals	0	0	0	0	(1,380)	0	0	0	(1,380)
Revaluation losses charged to revaluation reserve	0	(10,557)	0	0	0	0	0	0	(10,557)
Revaluation surpluses credted to revaluation reserve	0	11,862	11	0	0	0	0	0	11,873
Cost or valuation at 31 March 2018	**3,966**	**333,835**	**1,266**	**10,720**	**89,910**	**52**	**21,583**	**2,484**	**463,816**
Accumulated depreciation at 1 April 2017	0	125,339	91	118	48,849	51	13,713	2,224	190,385
Disposals	0	0	0	0	(896)	0	0	0	(896)
Impairments	0	9,589	197	0	65	0	201	0	10,052
Reversal of impairments	0	(2,556)	0	0	0	0	0	0	(2,556)
Provided during the year	0	3,146	23	0	7,761	0	1,643	66	12,639
Accumulated depreciation at 31 March 2018	**0**	**135,518**	**311**	**118**	**55,779**	**51**	**15,557**	**2,290**	**209,624**
Net book value at 1 April 2017									
Owned	3,966	19,680	1,164	6,675	32,790	0	5,644	172	70,091
Private Finance Initiative	0	177,397	0	1,010	0	0	0	0	178,407
Finance Lease	0	360	0	0	1,861	0	895	0	3,116
Government granted	0	782	0	0	740	0	262	0	1,784
Donated	0	2,702	0	1,701	1,566	1	41	23	6,034
Net book value total at 1 April 2017	**3,966**	**200,921**	**1,164**	**9,386**	**36,957**	**1**	**6,842**	**195**	**259,432**
Net book value at 31 March 2018									
Owned	3,966	17,842	955	7,843	29,067	0	5,361	177	65,211
Private Finance Initiative	0	175,575	0	0	0	0	0	0	175,575
Finance Lease	0	280	0	0	1,728	0	502	0	2,510
Government granted	0	811	0	376	571	0	117	0	1,875
Donated	0	3,809	0	2,383	2,765	1	46	17	9,021
Net book value total at 31 March 2018	**3,966**	**198,317**	**955**	**10,602**	**34,131**	**1**	**6,026**	**194**	**254,192**

9.3 Property, plant and equipment – revaluation

During 2018/19 the Trust undertook a review of the Gross Internal Area (GIA) of both the James Cook and Friarage Hospital sites. The review, in line Modern Equivalent Asset guidance critically evaluated the area requirement of the Trust and the revised GIA requirement over both sites which amounted to 117,908 square metres, a reduction of 31,116 square metres. An updated valuation was provided by Mr J. Stevenson, a Royal Institute of Chartered Surveyors (RICS) qualified valuer, from Cushman and Wakefield and the review resulted in an adjustment to the valuation of £35.3 million, This included an impairment of £51.1 million, offset by a revaluation increase amounting to £15.8 million and the update was introduced with effect from 1 April 2018.

A revaluation exercise was undertaken as at 31 March, 2019 on the Group and Trust's owned land and buildings by Cushman and Wakefield. The exercise was undertaken in accordance with the HM Treasury's Modern Equivalent Asset (MEA) recommendation adjusting the valuation undertaken at 31 March and 1 April 2018, for average movements in building cost indices over a 2 period and location factors over a 5 year period.

The exercise at 31 March, 2019, identified a revaluation increase of £9.3 million over the James Cook and Friarage sites. The resulting impairments and changes in valuation on both exercises are summarised in Note 8.2.

9.4 Economic lives of property, plant and equipment

The economic asset lives are as follows:

	Min life Years	Max life Years
Buildings excluding dwellings	22	90
Dwellings	47	47
Plant and machinery	8	15
Transport equipment	7	7
Information technology	5	7
Furniture and fittings	5	7

This represents the current range of asset lives relating to these assets.

9.5 Capital management

The Trust's capital programme is approved on an annual basis via the Senior Leadership Team and Finance Investment Committee with final approval through the Board of Directors. The full plan is included in the Annual Plan submitted to NHS Improvement. The capital programme for the year amounted to £22.9 million and included essential investment on the medical equipment and Information Technology replacement programmes, lifecycle works under the PFI contract and the Cancer Centre at the Friarage Hospital.

9.6 Donated assets

There are no restrictions or conditions imposed by the donor on the use of a donated assets reported within the Trust's Statement of Financial Position.

10. Intangible assets

10.1 Intangible assets

2018/19:	Computer software purchased	Assets under construction	Total
Group and Trust	£000	£000	£000
Gross cost at 1 April 2018	7,452	972	8,424
Additions purchased	362	707	1,069
Reclassifications from assets under constuction	1,679	(1,679)	0
Gross cost at 31 March 2019	**9,493**	**0**	**9,493**
Accumulated amortisation at 1 April 2018	4,426	0	4,426
Provided during the year	909	0	909
Accumulated amortisation at 31 March 2019	**5,335**	**0**	**5,335**
Net book value at 1 April 2018			
Purchased	2,379	596	2,975
Donated	647	376	1,023
Net book value total at 1 April 2018	**3,026**	**972**	**3,998**
Net book value at 31 March 2019			
Purchased	3,531	0	3,531
Donated	627	0	627
Net book value total at 31 March 2019	**4,158**	**0**	**4,158**

10.2 Prior year Intangible assets

2017/18:	Computer software purchased	Assets under construction	Total
Group and Trust	£000	£000	£000
Gross cost at 1 April 2017	6,640	288	6,928
Additions purchased	696	385	1,081
Additions donated	39	376	415
Reclassifications from assets under constuction	77	(77)	0
Gross cost at 31 March 2018	**7,452**	**972**	**8,424**
Accumulated amortisation at 1 April 2017	3,629	0	3,629
Impairments charged to operating expenses	60	0	60
Provided during the year	737	0	737
Accumulated amortisation at 31 March 2018	**4,426**	**0**	**4,426**
Net book value at 1 April 2017			
Purchased	2,244	288	2,532
Donated	767	0	767
Net book value total at 1 April 2017	**3,011**	**288**	**3,299**
Net book value at 31 March 2018			
Purchased	2,379	596	2,975
Donated	647	376	1,023
Net book value total at 31 March 2018	**3,026**	**972**	**3,998**

10.3. Intangible assets - asset lives

Each class of intangible asset has a finite remaining life as detailed below:

Economic lives of assets	Min life Years	Max life Years
Computer software	5	5

This represents the current range of asset lives relating to these assets.

11. Assets held under finance leases

11.1 Assets held under finance leases comprise of the following:

2018/19:	Buildings excluding dwellings	Plant and machinery	Information technology	PFI	Total
Group and Trust	£000	£000	£000	£000	£000
Cost or valuation at 31 March 2019	10,053	9,095	2,658	179,458	201,264
Accumulated depreciation at 31 March 2019	9,853	7,876	2,549	39,450	59,728
Net book value at 1 April 2018					
Finance lease	280	1,728	502	0	2,510
PFI	0	0	0	175,575	175,575
Net book value total at 1 April 2018	280	1,728	502	175,575	178,085
Net book value at 31 March 2019					
Finance lease	200	1,219	109	0	1,528
PFI	0	0	0	140,008	140,008
Net book value total at 31 March 2019	200	1,219	109	140,008	141,536

11.2 Prior year assets held under finance leases:

2017/18:	Buildings excluding dwellings	Plant and machinery	Information technology	PFI	Total
Group and Trust	£000	£000	£000	£000	£000
Cost or valuation at 31 March 2018	10,053	8,948	2,658	212,940	234,599
Accumulated depreciation at 31 March 2018	9,773	7,220	2,156	37,365	56,514
Net book value at 1 April 2017					
Finance lease	360	1,861	895	0	3,116
PFI	0	0	0	178,407	178,407
Net book value total at 1 April 2017	360	1,861	895	178,407	181,523
Net book value at 31 March 2018					
Finance lease	280	1,728	502	0	2,510
PFI	0	0	0	175,575	175,575
Net book value total at 31 March 2018	280	1,728	502	175,575	178,085

12. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these accounts:

Group and Trust	31 March 2019	31 March 2018
	£000	£000
Property, plant and equipment	**1,067**	376
Intangible assets	**0**	17
Total	**1,067**	393

13. Subsidiaries and consolidation of charitable funds

The Trust's principal subsidiary undertaking, South Tees Hospitals Charity and Associated Funds, is included in the consolidation at 31 March 2019. The accounting date of the financial statements for the charitable fund is in line with the Trust date of 31 March 2019. The South Tees Institute of Learning, Research and Innovation LLP and South Tees Healthcare Management Limited both have financial year ends of 31 May 2019. The transactions of these companies in 2018/19 have not been consolidated on the basis of materiality. Key financial information for the charitable fund is provided as follows:

13.1 Reserves

	31 March 2019	31 March 2018
	£000	£000
Restricted funds	**63**	90
Unrestricted funds	**6,769**	6,179
Total	**6,832**	6,269

Funds specific to wards or departments are held as un-restricted designated funds. Legacies and donations received for a specific purpose or 'trust' are recorded and accounted for as restricted funds. Further information covering the nature of the restricted and unrestricted funds is available within Accounting Policy 1.2.

13.2 Aggregated amounts relating to the charitable fund

	31 March 2019	31 March 2018
	£000	£000
Summary Statement of Financial Position:		
Non-current assets	**5,885**	5,420
Current assets	**2,412**	2,215
Current liabilities	**(1,465)**	(1,366)
Net assets	**6,832**	6,269
Reserves	**6,832**	6,269
Summary Statement of Financial Activities:		
Income	**1,819**	1,638
Expenditure	**(1,799)**	(1,923)
Total	**20**	(285)
Net realised gains on investment assets and other reserve movements.	**584**	40
Net movement in funds	**604**	(245)

In 2018/19 eliminations consisted of a £0.703 million adjustment to income and expenditure for capital transactions (£0.907 million in 2017/18) and adjustments to working capital amounted to £0.297 million (£0.982 million in 2017/18).

The above summary statements have initially been presented before group eliminations with an explanation to reconcile to the amounts included within the consolidated statements. As per accounting policy 1.2 the accounts of the charitable fund has been consolidated in full after the elimination of intra group transactions and balances.

14. Other investments

The investment portfolio of the charitable fund is managed by Barclays Wealth. Cash funds are held outside the portfolio by the fund to deal with short term cash flow issues.

	31 March 2019	31 March 2018
	£000	£000
Market value brought forward	**5,420**	5,917
Additions	**1,345**	1,629
Disposals	**(1,464)**	(2,166)
Fair value (losses) / gains	**584**	40
Market value at 31 March	**5,885**	5,420
Investments held		
Bonds	**791**	600
Equities	**4,236**	4,278
Alternative assets	**563**	522
Other holdings	**295**	20
	5,885	5,420

15. Inventories

15.1 Inventories

	Group		Trust	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
Group and Trust	**£000**	£000	**£000**	£000
Drugs	**3,738**	3,172	**3,738**	3,172
Consumables	**8,628**	8,468	**8,628**	8,464
Energy	**0**	11	**0**	11
Total	**12,366**	11,651	**12,366**	11,647

15.2 Inventories recognised in expenses

	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
Group and Trust	**£000**	£000	**£000**	£000
Inventories recognised as an expense	**125,970**	122,898	**125,970**	122,896
Write-down of inventories recognised as an expense	**81**	67	**81**	67
Total	**126,051**	122,965	**126,051**	122,963

16. Cash and cash equivalents

	Group		Trust	
Group and Trust	**31 March 2019**	31 March 2018	**31 March 2019**	31 March 2018
	£000	£000	**£000**	£000
At 1 April	**9,988**	7,558	**8,213**	4,572
Net change in year	**(2,638)**	2,430	**(2,122)**	3,641
Balance at 31 March	**7,350**	9,988	**6,091**	8,213
Broken down to:				
Cash with the Government Banking Service	**6,041**	8,070	**6,041**	8,070
Commercial banks and in hand	**1,309**	1,918	**50**	143
Cash and cash equivalents as in statement of cash flows	**7,350**	9,988	**6,091**	8,213

17. Trade and other receivables

17.1 Trade and other receivables

	Group		Trust	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
Group and Trust	**£000**	£000	**£000**	£000
Current				
Contract receivables invoiced	**33,008**	0	**33,008**	0
Contract receivables not yet invoiced	**26,056**	0	**25,200**	0
NHS receivables	**0**	5,621	**0**	5,621
Other receivables with related parties	**0**	115	**0**	115
Capital receivables	**166**	1,353	**166**	1,353
Other trade receivables	**2,323**	7,228	**2,323**	8,210
VAT	**2,029**	3,750	**2,029**	3,750
Accrued income	**0**	29,873	**0**	29,546
PDC dividend receivable	**1,298**	923	**1,298**	923
Allowance for impaired contract receivables	**(641)**	0	**(641)**	0
Provision for the impairment of receivables	**0**	(878)	**0**	(878)
Prepayments*	**36,870**	36,925	**36,870**	36,925
Total	**101,109**	84,910	**100,253**	85,565
Non-current				
Contract receivables not yet invoiced	**3,353**	0	**3,353**	0
Allowance for impaired contract receivables	**(1,671)**	0	**(1,671)**	0
Other receivables	**0**	3,115	**0**	3,115
Provision for the impairment of receivables	**0**	(1,559)	**0**	(1,559)
Total	**1,682**	1,556	**1,682**	1,556

*Included in prepayments is £24.493 million (2018 £23.932 million) in respect of prepaid PFI lifecycle costs relating to the James Cook PFI scheme. This contract was entered into in 2003 and expires in 2033. Under this contract the PFI operator is required to build and to maintain the majority of the Trust's estate. As is the norm for lifecycle replacement under a PFI scheme, the timing of the actual expenditure incurred by the operator is different to the profile of the planned expenditure in the financial model and this has resulted in the Group and Trust recognising a prepayment for the payment in advance of the lifecycle work being undertaken. When the replacement expenditure is received the prepayment will be derecognised and new items of property plan and equipment will be recognised.

The great majority of trade is with Clinical Commissioning Groups and NHS England, as commissioners for NHS patient care services. As these NHS bodies are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary.

Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

17.2 Allowance for credit losses

	31 March 2019	31 March 2018
	£000	£000
Balance at 1 April	**2,437**	1,945
Impact of IFRS9 implementation on 1 April	**44**	0
Utilisation of allowances	**(86)**	0
Reversal of allowances	**(278)**	0
Increase in provision	**195**	492
Balance at 31 March	**2,312**	2,437

The provision relates to outstanding Compensation Recovery Unit debts concerning Road Traffic Accidents (21.89% provision created on all outstanding debt), and provisions on non-NHS debtors (providing between 10 and 100% dependant on the type of debt) that includes provisions for individual invoices in dispute and in formal recovery . The Group does not hold any collateral in support of these debts.

18. Trade and other payables

	Group		Trust	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	£000	£000	**£000**	£000
Current				
Interest payable	**0**	160	**0**	160
NHS payables	**5,835**	13,322	**5,835**	13,322
Amounts due to other related parties	**920**	162	**920**	162
Other trade payables - revenue	**35,994**	28,590	**35,994**	28,590
Other trade payables - capital	**1,524**	1,243	**1,524**	1,243
Taxes payable (VAT, Income Tax and Social Security)	**6,953**	6,832	**6,953**	6,832
Accruals	**2,666**	4,196	**1,498**	3,921
Receipts in advance	**3,545**	1,973	**3,545**	1,973
Other payables	**5,821**	4,418	**5,821**	4,418
Total current trade and other payables	**63,258**	60,896	**62,090**	60,621

Other payables includes £4.495 million for outstanding pensions contributions (31 March 2018, £4.367 million).

19. Borrowings

Group and Trust	**31 March 2019**	31 March 2018
	£000	£000
Current		
Loans from Department of Health		
- Capital loans	**5,413**	5,369
- Revenue support	**13,927**	6,600
- Revolving working capital facilities	**35,685**	0
Obligations under:		
Finance leases	**607**	1,048
Private finance initiative contracts	**1,906**	2,171
Total current borrowings	**57,538**	15,188
Non-current		
Loans from Foundation Trust Financing Facility		
- Capital loans	**37,131**	42,500
- Revenue support	**42,939**	41,125
- Revolving working capital facilites	**0**	40,161
Obligations:		
Finance leases	**923**	1,484
Private finance initiative contracts	**94,968**	96,874
Total non-current borrowings	**175,961**	222,144

The loans from the Foundation Trust Financing Facility covers periods ranging from 3 to 25 years and loan rate payment terms range from 0.77% to 3.84%. The loans are not secured against Trust assets.

20. Finance lease obligations

Significant contractual arrangements have been reviewed to assess compliance with IAS 17. Those identified as finance lease obligations include the Group and Trust's equipment agreements and Managed Service Contracts for Energy Management and the Picture Archiving and Communications System. The term of leases range from 5 to 15 years in line with the economic lives of the individual assets.

Minimum lease payments outstanding on the lease agreements amount to £2.058 million (£3.490 million as at 31 March 2018). The Present Value of minimum lease payments included on the Group and Trust's Statement of Financial Position amounts to £1.530 million (£2.532 million at 31 March 2018), with the variance of £0.958 million (£0.528 million at 31 March 2018) relating to future finance charges on the agreements. The values disclosed do not include any liabilities relating to the private finance initiative.

Amounts payable under finance leases:	Minimum lease payments	
Group and Trust	**31 March 2019**	31 March 2018
	£000	£000
Within one year	**867**	1,492
Between one and five years	**1,191**	1,998
Less: finance charges allocated to future years	**(528)**	(958)
Present value of minimum lease payments	**1,530**	2,532
Net lease liabilities		
Not later than one year	**607**	1,048
Later than one year and not later than five years	**923**	1,484
	1,530	2,532

Note: the Group and Trust does not offer any leases as a Lessor and does not recover any rental income through such arrangements.

21. Private finance Initiative contracts

21.1 PFI schemes on Statement of Financial Position

The scheme was for the development of the James Cook University Hospital (JCUH) site resulting in the rationalisation of four existing sites into one. Services at Middlesbrough General Hospital, North Riding Infirmary and West Lane Hospital transferred to JCUH upon completion of the scheme in August 2003.

The scheme comprised 60,000m2 of new build with 11,000m2 of refurbishment, with an approximate capital cost of £157 million. Upon completion of the scheme the Trust granted a head lease with associated rights to Endeavour SCH Plc for a period of 30 years. Endeavour maintain the site, providing facilities management services via Serco Group plc (formerly Sovereign Healthcare), and grant an underlease with associated rights to the Trust for the use of the buildings. The Trust makes a unitary payment, quarterly in advance, to Endeavour SCH Plc for use of the building and associated facilities management services that amounts to approximately £52.118 million per annum excluding VAT. An element of the payment is also set aside to fund lifecycle expenditure amounting to £9.727 million. In return the Trust receives guaranteed income of approximately £0.290 million in respect of mall retail units, laundry and catering income. Responsibility for the collection of car parking income transferred back to the Trust from 1 April 2014.

The annual service fee is indexed linked in line with the 12 month rolling average of retail price indices (CHAW) as at January of each year, for the following contract year. The availability fee is uplifted in line with RPI twice a year based upon the published CHAW indices for March (effective from 1 April) and September (effective from 1 October).

The soft services element of the facilities management service is subject to market testing or benchmarking every 5 years, although the Trust has the option to extend this period by a further 12 months. The hard service element of the service is subject to benchmarking every 10 years.

Upon the Contract Period Expiry Date the Trust has a number of options ("the Expiry Options"):

- to extend the agreement on terms to be agreed with the concessionaire;
- to re-tender for the provision of services;
- to leave the hospital and terminate the underlease; and
- to remain in the hospital and assume responsibility for the provision of services.

Under the control test of IFRIC 12, the asset has been treated as an asset of the Trust. The substance of the contract is that the Trust has a finance lease and payments to the contractor comprise 2 elements; an imputed finance lease charge and service charges.

Total imputed finance lease obligations for on-Statement of Financial Position PFI contracts due:

	31 March 2019	31 March 2018
Group and Trust	**£000**	£000
Not later than one year	**9,638**	10,069
Later than one year, not later than five years	**39,613**	39,520
Later than five years	**122,964**	132,695
Sub total	**172,215**	182,284
Less: interest element	**(75,341)**	(83,239)
Total	**96,874**	99,045
Net PFI liabilities		
Not later than one year;	**1,906**	2,171
Later than one year and not later than five years;	**10,638**	9,748
Later than five years	**84,330**	87,126
	96,874	99,045

21.2 Charges to expenditure

The total charged in the year to expenditure in respect of the service element of on-Statement of Financial Position PFI contracts was £21.103 million (2017/18 £26.244 million).

The Trust is committed to the following annual charges:

	31 March 2019	31 March 2018
Group and Trust	**£000**	£000
Not later than one year	**27,268**	25,272
Later than one year, not later than five years	**116,062**	107,566
Later than five years	**321,677**	334,176
Total	**465,007**	467,014

21.3 Total concession arrangement charges

The Trust is committed to the following annual charges in respect of the PFI.

	31 March 2019	31 March 2018
Group and Trust	**£000**	£000
Not later than one year	**55,035**	52,161
Later than one year, not later than five years	**236,100**	225,247
Later than five years	**665,450**	713,261
Total	**956,585**	990,669

21.4 Total unitary payment charge on PFI scheme

The unitary payment paid in year to the service concession operator is made up as follows:

	31 March 2019	31 March 2018
Group and Trust	**£000**	£000
Interest charge	**7,898**	8,136
Repayment of finance lease liability	**2,171**	3,286
Service element	**21,103**	26,244
Capital lifecycle maintenance	**9,726**	6,804
Contingent finance costs	**5,720**	5,914
Total	**46,618**	50,384

22. Reconciliation of Liabilities arising from financing activities

The total outstanding liability from financing is detailed below:

	DHSC Loans	Finance Leases	PFI	Total
Group and Trust	£000	£000	£000	£000
Carrying value at 1 April 2018	**135,755**	**2,532**	**99,045**	**237,332**
Impact of applying IFRS 9 at 1 April	160	0	0	160
Cash movements:				
Financing cash flows - principal	(831)	(1,149)	(2,171)	(4,151)
Financing cash flows - interest	(3,009)	(514)	(7,898)	(11,421)
Additions	0	147	0	147
Interest charge arising in year	3,020	514	7,898	11,432
Carrying value at 31 March 2019	**135,095**	**1,530**	**96,874**	**233,499**

23. Provisions

	Current		Non-current	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
Group and Trust	**£000**	£000	**£000**	£000
Pensions relating to staff	**108**	116	**379**	468
Legal claims	**545**	550	**409**	450
Total	**653**	666	**788**	918

	Pensions relating to staff	Legal claims	Total
Group and Trust	£000	£000	£000
At 1 April 2018	584	1,000	1,584
Arising during the year	30	137	167
Changes in discount rate	(8)	(10)	(18)
Utilised during the year	(117)	(174)	(291)
Reversed unused	(9)	0	(9)
Unwinding of discount	7	1	8
At 31 March 2018	487	954	1,441
Expected timing of cash flows:			
– not later than one year;	108	545	653
– later than one year and not later than five years;	254	118	372
– later than five years.	125	291	416
Total	487	954	1,441

Pensions relating to staff

The amounts relate to sums payable to former employees who have retired prematurely. The outstanding liability is based on actuarial guidance from the NHS Pension Agency using computed life expectancies for the pension recipients. Variations in life expectancy will impact on these figures and the timings of payments. There is no contingent liability associated with this provision.

Legal claims

The timings and amounts within the provision are based upon the NHS Litigation Authority's assessment of probabilities in line with IAS 37 guidance. The provision relates to employer and public liability claims with the Group and Trust raised by staff and patients. This provision also includes injury benefit claims made by NHS employees with the level of awards determined by the NHS Pension Agency. The discounted provision is based on notifications received from the agency.

£270.210 million is included in the provisions of the NHS Litigation Authority at 31 March 2019, in respect of clinical negligence liabilities of the Group and Trust (2017/18 £280.138 million). This is not provided for within these financial statements.

24. Financial instruments

24.1 Financial assets

	Group		Trust	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	£000	£000	**£000**	£000
Financial Assets held at amortised cost				
Receivables excluding non financial assets with DHSC and other bodies	**62,594**	44,193	**61,441**	43,866
Cash and cash equivalents at bank and in hand	**7,350**	9,988	**6,091**	8,213
Assets at fair value through income and expenditure				
Investments	**5,885**	5,420	**0**	0
Total	**75,829**	59,601	**67,532**	52,079

24.2 Financial liabilities

	Group		Trust	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	£000	£000	**£000**	£000
Financial Liabilities held at amortised cost				
DHSC loans	**(135,095)**	(135,755)	**(135,095)**	(135,755)
Obligations under finance leases	**(1,530)**	(2,532)	**(1,530)**	(2,532)
Obligations under PFI contracts	**(96,874)**	(99,045)	**(96,874)**	(99,045)
Trade and other payables excluding non financial liabilities with DHSC and other bodies	**(52,609)**	(51,816)	**(51,441)**	(51,541)
Total	**(286,108)**	(289,148)	**(284,940)**	(288,873)

24.3 Maturity of financial liabilities

	Group		Trust	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	£000	£000	**£000**	£000
In one year or less	**(110,148)**	(67,002)	**(108,980)**	(66,727)
In more than one year but not more than two years	**(43,373)**	(55,196)	**(43,373)**	(55,196)
In more than two years but not more than five years	**(23,412)**	(54,781)	**(23,412)**	(54,781)
In more than five years	**(109,175)**	(112,169)	**(109,175)**	(112,169)
Total	**(286,108)**	(289,148)	**(284,940)**	(288,873)

24.4 Fair values of financial instruments

The fair values of financial instruments are considered to be materially similar to the book values.

24.5 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the NHS Foundation Trust has with Clinical Commissioning Groups and NHS England and the way that these are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Group has limited powers to invest surplus funds and can only borrow to the Prudential Borrowing Limit approved by Monitor. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Group in undertaking its activities.

The Group's treasury management operations are carried out by the finance department, within parameters defined formally within the Group's Treasury Management Policy and Standing Financial Instructions agreed by the Board. A key theme of the Group's strategic direction is business stability which means achieving target levels of financial surplus to enable investment. To support this target, the key objectives of the Treasury Management Policy include the achievement of a competitive return on surplus cash balances, ensure competitively priced funds are available to the Group when required and effectively identifying and managing financial risk.

Currency risk

The Group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Group has no overseas operations. The Group therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Group and Trust borrows from government for capital expenditure, subject to affordability. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Group and Trust therefore has low exposure to interest rate fluctuations.

The Trust is exposed to interest rate risk on the PFI scheme due to the linkage of the availablity payment to RPI which impacts on contingent rent, PFI lifecycle and non-operating expenditure.

Credit risk

The majority of the Group's income comes from contracts with other public sector bodies, the Group has low exposure to credit risk. The maximum exposures as at 31 March 2019 are in receivables from customers, as disclosed in Note 17.

The financial instruments utilised by the Group and Trust are deemed to be minimum risk; in relation to borrowing the Group and Trust has utilised the NHS Financing Facility with debt repayments linked to the economic life of the assets. In relation to investments, the Group and Trust only uses United Kingdom based financial institutions, investing a maximum of £4.000 million with one organisation for a period not exceeding 3 months. This is in line with Monitor guidance and investments are based on approved counterparty listings, supplied by Sector Treasury Services Ltd, and based on the ratings of leading credit rating agencies. Group treasury activity is subject to review by the Group's internal auditors.

Liquidity risk

The Group's operating costs are incurred under contracts with Clinical Commissioning Groups and NHS England, which are financed from resources voted annually by Parliament . The Group and Trust funds its capital expenditure from funds obtained within its prudential borrowing limit and does not have any flexibility to vary principal or interest payments on any of its fixed term liabilities, including those relating to the PFI contract. This inability to vary its long term debt repayments introduces an element of risk into the medium term financial planning process. Further information on risk within the Group and Trust's annual plans is included within the Accounting Policy on Going Concern in Note 1.3.1.

25. Events after the reporting year

There were no significant events after the end of the reporting year.

26. Related party information

26.1 Related party transactions

South Tees Hospitals NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health. The note has been prepared in accordance with the requirements of IAS 24 "Related Party Disclosures".

26.2 Whole of Government Accounts bodies

All government bodies which fall within the Whole of Government accounts boundary are regarded as related parties because they are all under the common control of HM Government and Parliament. This includes for example, all NHS bodies, all local authorities and central government bodies.

Significant transactions and balances with all Whole of Government account bodies are detailed below. The following tables incorporates information extracted from the accounts of the Group and Trust and is included in the income, expenditure and on the face of the Statement of Financial Position of the Group and Trust for the financial year ending 31 March 2019.

	Income	Expenditure	Receivables	Payables
	£000	£000	£000	£000
NHS North Cumbria CCG	591	0	0	0
NHS Darlington CCG	6,740	0	0	0
NHS Durham Dales, Easington and Sedgefield CCG	12,292	0	0	0
NHS Hambleton, Richmondshire and Whitby CCG	80,096	12	725	0
NHS Harrogate and Rural District CCG	2,524	0	33	0
NHS Hartlepool and Stockton-on-Tees CCG	38,495	0	0	0
NHS North Durham CCG	1,376	0	0	0
NHS Scarborough and Ryedale CCG	969	0	3	0
NHS South Tees CCG	220,303	0	161	0
NHS Sunderland CCG	902	0	114	0
NHS Vale of York CCG	1,418	0	0	0
NHS England	23,371	0	14,359	0
Cumbria and North East Local Office	7,225	0	1,248	0
North East Specialised Commissioning	167,500	0	4,674	0
Yorkshire and the Humber Local Office	1,300	0	17	0
South West (North)	1,896	0	0	0
Department of Health	6,675	0	0	0
Care Quality Commission	0	408	0	0
Health Education England	15,712	0	1,777	0
NHS Property Services	470	7,819	1,070	0
NHS Resolution	0	17,890	0	0
Other NHS bodies	3,053	805	932	102
County Durham & Darlington NHS Foundation Trust	600	5,396	995	3,521
Newcastle Upon Tyne Hospitals NHS Foundation Trust	2,448	699	299	124
North Tees and Hartlepool NHS Foundation Trust	1,382	2,094	2,709	3,212
Tees, Esk and Wear Valleys NHS Foundation Trust	1,540	98	1,288	9
Harrogate and District NHS Foundation Trust	150	0	325	0
Northumbria Healthcare NHS Foundation Trust	31	2,576	11	156
Salford Royal NHS Foundation Trust	6	758	1	64
Other Trusts	604	1,224	169	35
Middlesbrough Borough Council	820	674	146	37
North Yorkshire County Council	358	191	0	0
Redcar and Cleveland Borough Council	654	9	44	0
Other local authorities	15	0	0	0

26. Related party information (continued)

	Income £000	Expenditure £000	Receivables £000	Payables £000
NHS Blood and Transplant	62	2,669	13	883
HM Revenue and Customs	0	28,415	2,029	6,953
NHS Pensions Agency	0	32,058	0	0
Ministry of Defence	196	1,445	22	0
NHS Professionals	0	5,785	0	0
Department of Work and Pensions	30	1,506	0	0
Other WGA bodies	0	0	51	0

Significant transactions and balances with all Whole of Government account bodies in 2017/18 are detailed below:

	Income £000	Expenditure £000	Receivables £000	Payables £000
NHS Cumbria CCG	680	0	0	0
NHS Darlington CCG	5,691	0	60	0
NHS Durham Dales, Easington and Sedgefield CCG	11,138	5	51	0
NHS Hambleton, Richmondshire and Whitby CCG	81,800	13	3,328	299
NHS Harrogate and Rural District CCG	2,791	0	224	0
NHS Hartlepool and Stockton-on-Tees CCG	36,070	13	1,003	0
NHS Newcastle Gateshead CCG	320	0	0	0
NHS North Durham CCG	1,335	0	19	0
NHS Scarborough and Ryedale CCG	717	0	341	0
NHS South Tees CCG	225,176	129	7,763	1,017
NHS Sunderland CCG	646	0	241	199
NHS Vale of York CCG	1,393	0	91	0
Cumbria and North East Local Office	6,476	0	783	0
NHS England	14,333	74	3,787	0
North East Specialised Commissioning	163,116	0	4,293	0
Yorkshire and the Humber Local Office	1,376	0	0	0
South Central Local Office	2,457	0	1	0
Department of Health	1,605	0	169	159
Care Quality Commission	0	332	0	0
Health Education England	15,965	5	115	287
NHS Property Services	581	6,900	590	909
NHS Resolution	0	15,151	0	12
Other NHS bodies	0	0	0	0
County Durham & Darlington NHS Foundation Trust	455	1,930	1,588	2,685
Newcastle Upon Tyne Hospitals NHS Foundation Trust	2,498	801	425	539
North Tees and Hartlepool NHS Foundation Trust	1,000	3,224	2,288	3,321
Tees, Esk and Wear Valleys NHS Foundation Trust	1,441	203	97	37
Northumbria Healthcare NHS Foundation Trust	139	96	11	1,321
Salford Royal NHS Foundation Trust	0	741	0	253
Other Trusts	729	715	445	1,300
Middlesbrough Borough Council	992	416	171	9
North Yorkshire County Council	403	183	7	0
Redcar and Cleveland Borough Council	846	21	136	10
Other local authorities	198	358	138	0
NHS Blood and Transplant	24	1,582	0	143
HM Revenue and Customs	0	28,395	3,750	6,832
NHS Pensions Agency	0	34,588	0	0
Ministry of Defence	72	376	72	0
NHS Professionals	0	5,346	0	0
Department of Work and Pensions	10	779	0	0
Other WGA bodies	11	73	96	0

26. Related party information (continued)

26.3 Charitable funds

The Trust receives revenue and capital payments from a number of charitable funds, including South Tees Hospitals Charity and Associated Funds. The Trust Board members are also corporate trustees of the charity. The accounts of South Tees Hospitals Charity and Associated Funds are consolidated into the Trust's Annual Accounts as detailed in Accounting Policies 1.2 and Note 13 to the Accounts.

26.4 Board members and directors

During the year no Group Board Members or members of the key management staff, or parties related to any of them, have undertaken any material transactions with South Tees Hospitals NHS Foundation Trust.

Declarations of interests, completed on an annual basis by Executive and Non-Executive Directors, have been reviewed to identify any related party relationships requiring disclosure within this note.

IAS 24 specifically requires the separate disclosure of compensation payments made to management. In line with the standard, the HM Treasury has given dispensation that this requirement will be satisfied through disclosure in the Remuneration Report included in the Group and Trust's Annual Report.

27. Third party assets

The Group and Trust held £4,007 cash and cash equivalents at 31 March 2019 (£1,952 at 31 March 2018) relating to monies held by the Group and Trust on behalf of patients.

The Group and Trust held £833,380 cash and cash equivalents at 31 March 2019 (£804,954 at 31 March 2018) which related to monies held by the Group and Trust on behalf of staff, participating in the staff savings scheme. This has been excluded from the cash and cash equivalents figure reported in the accounts.

The Group and Trust held £28,181 cash and cash equivalents at 31 March 2019 (£18,301 at 31 March 2018) which related to monies held by the Group and Trust on behalf of the staff lottery scheme. This has been excluded from the cash and cash equivalents figure reported in the accounts.

28. Losses and special payments

The total number and value of losses and special payments in year amounted to the following:

Group and Trust	2018/19		2017/18	
	Number of cases	**Total value of cases**	Number of cases	Total value of cases
		£000		£000
Losses				
Losses of cash	**11**	**7**	16	1
Bad debts and claims abandoned	**341**	**41**	0	0
Damage to buildings, property as a result of theft, criminal damage etc.	**102**	**15**	81	8
Special payments				
Ex gratia payments	**127**	**195**	159	293
Total	**581**	**258**	256	302

The amounts included above are reported on an accruals basis and exclude provisions for future losses.

There were no special severance payments (2017/18, there were no cases over £100,000 and there were no severance payments requiring HMT approval) arising from divisional restructuring or other cases of clinical negligence, fraud, personal injury, compensation under legal obligation or fruitless payment cases where the net payment exceeded £300,000.

29 Initial application of IFRS9

IFRS 9 Financial instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. the standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS9, borrowings from the DHSC, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £0.160 million and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0.044 million decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these recevables at 1 April 2018 was £6.074 million.

30 Initial application of IFRS15

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application. In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard the Trust does not disclose information regarding performance obligations as part of a contract that has an original expected duration of one year or less,
- Similarly, the Trust has not disclosed information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application. In line with this requirement, the Trust has analysed its contract terms and has not identified any contractual income that require specific disclosure. No adjustments have been made to the income figures reported on the adoption of IFRS15 in either the current or previous year.

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Excellence in Patient Outcome and Experience