QUALITY ACCOUNT

Unconditionally registered with the CQC since April 2010

2018/19

The Newcastle upon Tyne Hospitals
NHS Foundation Trust
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PART 1

Quality Account – Chief Executive’s Statement
Providing high quality, patient focused care remains our highest priority. Our staff work tirelessly to ensure that patients receive the safest, most clinically effective care and a positive patient experience each and every time they use one of our services. Feedback from our patients shows that 97% of our inpatients would recommend our care to family and friends.

We are continually learning and improving and I am committed to encouraging a culture of openness and honesty.

I am very conscious of how busy staff and our leadership teams are right now and want to take this opportunity to thank them. It’s a challenging time but one with many opportunities as we begin working to deliver a new long-term plan for the NHS and at the same time lay out our own strategic plan for the next five years here at Newcastle Hospitals. Delivering great care today, whilst co-designing our approach for our future, is essential if we are to support a sustainable health and care system. That doesn’t mean it’s easy, but we have a strong track record of leading the NHS from the North East.

Last year, Newcastle’s Dialysis Unit celebrated its 40th birthday. Based at the Freeman Hospital, the service has offered pioneering, revolutionary procedures to improve the efficacy of patient care. A particular highlight was the first description of aluminium bone disease in dialysis patients (so called ‘Newcastle Bone Disease’) which led to improved dialysis water standards benefitting patients across the world.

The Northern Centre for Cancer Care (NCCC) continues to be at the forefront of lifesaving treatment and has become the first radiotherapy centre in the UK to offer cutting-edge radiosurgery technology to treat patients with brain cancer. It has also treated the first UK prostate cancer patients using pioneering MRI-only planning technology and radiotherapy.

We have also been able to bring care closer to patients by introducing the new ‘single point of access’ musculoskeletal service for people across Gateshead and Newcastle offering self-care and fast access to information, resources and expert opinion about a variety of back, neck, joint or general muscle conditions.

Much of this pioneering work is a result of our commitment to research and a culture focussed on continuous improvement. The Trust currently tops the NHS Research Activity league; conducting more research programmes than any other NHS provider - an incredible 550 studies last year and an increase on the previous year.

It is with pride that I note we have received a "Gold Award" for our outstanding support to the armed forces. We were one of 50 organisations in the UK, to receive the highest badge of honour in the Defence Employer Recognition Scheme for our long-term commitment to the armed forces community.

Our second Quality Strategy was launched in 2018. This new strategy outlines our aim to create a culture of continuous improvement to increase and sustain the quality of our services for the people of Newcastle and beyond. Quality Improvement has become an integral part of everyone’s daily work.

I would like to end by thanking and commending all of our staff. Without their skill, loyalty and commitment we would not be able to achieve such high quality services. Their dedication and focus is firmly on ensuring the very best outcomes for our patients.

Dame Jackie Daniel
Chief Executive
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

To the best of my knowledge the information contained in this document is an accurate reflection of outcome and achievement.
Quality Accounts are annual reports to the public from us about the quality of healthcare services that we provide. They are both retrospective and forward looking as they look back on the previous year’s data, explaining our outcomes and, crucially, look forward to define our priorities for the next year to indicate how we plan to achieve these and quantify their outcomes.
Following discussion with the Board of Directors, the Council of Governors, patient representatives, staff and public the following priorities for 2019/20 have been agreed. A public consultation event was held in January 2019 and presentations have been provided at various staff meetings across the Trust.
Priority 1 - Reducing Infection – focus on Methicillin-Sensitive Staphylococcus Aureus (MSSA) / E.coli

Why have we chosen this?
Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemias are important infections which can cause significant harm. They have substantial personal, reputational and resource implications. At The Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH), these are most commonly associated with lines and indwelling devices; achieving excellent standards of care and improving practice is essential to reduce these infections in line with our zero tolerance approach.

E.coli and other Gram negative bacteraemias constitute the most common cause of sepsis (also known as blood poisoning, which is the reaction to an infection in which the body attacks its own organs and tissues) nationwide. Proportionally, at NUTH, the main source of infection is urinary tract infections, mostly catheter-associated, reflecting the national picture. An integrated approach engaging with the multidisciplinary team across the whole patient journey, focusing on antibiotic stewardship, early identification of risks and timely intervention formulate the basis for our strategy to reduce these infections.

C.difficile infection is a potentially severe or life threatening infection which remains a national and local priority to continue to reduce our rates of infection in line with the national objectives.

What we aim to achieve?
- 10% year on year reduction of MSSA bacteraemias.
- 50% reduction of E.coli and other Gram negative bacteraemias by 2021/22.
- Sustain a reduction in C.difficile infections in line with national trajectory.

How will we achieve this?
- Board level leadership and commitment to reduce the incidence of Health Care Associated Infection (HCAI).
- Quality improvement projects in key directorates running in parallel with Trust-wide awareness campaigns, education projects, and audit of practice, with a specific focus on:
  - Antimicrobial stewardship and safe prescribing
  - Insertion and ongoing care of invasive and prosthetic devices
  - Ward monitoring of device compliance for peripheral Intravenous (IV) and urinary catheters
  - Prevention of surgical site infection
  - Improve diagnosis of infection in all steps of the patient journey.
- Working with partner organisations to reduce infections throughout the Health Care Economy.
- Early recognition and management of suspected infective diarrhoea.
- Root cause analysis for all health care associated C.difficile infections.

How we will measure success?
- Sharing data with Directorates whilst focusing on best practice and learning from Root Cause Analysis (RCA).
- Continue to report MSSA, C.difficile and E.coli infections on a monthly basis, internally and nationally.

Where we will report this to?
- Quality Governance Group.
- Trust Board.
- The public via the Integrated Quality Report.
PATIENT SAFETY

Priority 2 - Pressure Ulcer Reduction

Why have we chosen this?
Reducing harm from pressure damage will remain a priority as the Trust has not yet achieved the significant, sustained reduction it set out to achieve last year. Whilst reductions have been made specifically in relation to heel damage, the overall incidence and rate of all pressure damage has remained higher than we are satisfied with.

We believe there is further work to be done to reduce the incidence of harm, improve the patient experience and support staff to embed evidence-based best practice. We want to drive the key messages that pressure ulcers are largely preventable and together with the correct assessment and prevention plans, pressure ulcers can be significantly reduced.

What we aim to achieve?
- Significantly reduce hospital acquired pressure ulcers (specifically those graded category II, III and IV).
- Undertake focused quality improvement work on targeted adult inpatient wards who currently report the highest incidence and rate of pressure damage.
- Increase the visibility and support provided by the Tissue Viability team to frontline clinical staff to assist in the prevention of pressure ulcers.
- Ensure we have a skilled and educated workforce with a sound knowledge base of prevention of pressure ulcers and quality improvement methodology.

How will we achieve this?
- The Clinical Improvement Lead (Falls and Pressure Ulcers) will lead targeted quality improvement work to reduce pressure ulcers using methodology that has already been successful in reducing inpatient falls. This will include supporting clinical staff to embed best practice, analyse data and take ownership of improvement projects at ward level.
- The skill mix and resources in the Tissue Viability team are being reviewed to deliver a change in practice to a more preventative, evidence-based quality improvement approach.
- Collaboration between clinical leads, will be enhanced with work to ensure data is triangulated with nurse staffing data to provide senior support to wards where problems or risks have been identified.
- The Root Cause Analysis process will continue to provide learning and actions from serious incidents and the communication strategies used to promote the learning from these will be strengthened.

How we will measure success?
- Recognised quality improvement methodology strategies of measuring data embedded over time.
- The incidence and rate of pressure damage will be monitored at ward, Directorate and Trust level.

Where we will report this to?
- Falls and Pressure Ulcer Taskforce Group.
- Quality Governance Group.
- Trust Board via the Integrated Quality Report.
Priority 3 - Management of Abnormal Results

Why have we chosen this?
Incidents continue to occur nationally where abnormal or unexpected diagnostic results have not been seen or acted upon by medical staff. This can directly lead to delays in treatment which can have serious consequences for patients.

What we aim to achieve?
We are developing a long-term solution for effective communication of abnormal results across all of the reporting specialties to the responsible clinician. This will highlight abnormal results automatically with a failsafe system in place to ensure that results are acted upon within a short, pre-defined time period.

How will we achieve this?
The concept has been finalised after the analysis of themes arising from over 60 previous incidents. Abnormal results will be sent as a red flag message to the requesting consultant, viewable in the Erecord message centre. Red flag messages will move with the patient through their admission journey.

If a red flag message remains in a consultant’s inbox for more than a defined period (e.g. 5 days), it will automatically be forwarded to another Directorate defined team member. This ensures that patient management is unaffected by absence at work or inaction.

Alert thresholds require careful development, as it is important to avoid a situation where inboxes are filled with inappropriate red flag messages. In radiology, these can be well defined through existing guidelines and medical judgment. In other disciplines, such as haematology and biochemistry, defining thresholds is more challenging as “normal abnormal” and “abnormal normal” results may occur.

Strong links with the Information Technology (IT)/Global Digital Exemplar (GDE) teams have ensured that the concept is now deliverable using our electronic clinical records system.

How we will measure success?
- Define reporting specialty thresholds for escalation.
- Implementation of clinician alerting system within the GDE project.
- The implementation timeframe is of great importance to avoid further incidents or the need for interim solutions. To be notified of abnormal results a change in culture/workflow for consultants to focus on their message centre inbox is needed. Radiology missed abnormal results account for the majority of incidents so this will be our focus at the start of implementation.
- Measurable reduction in incidents resulting from delayed action over abnormal results.

Where we will report this to?
- Clinical Policy Group.
- Quality Governance Group.
- Trust Board.
Priority 4 System for Action Management AND Monitoring (SAMM)

Why have we chosen this?
Previously entitled ‘Closing the Loop’, the project and IT system that will be used, has been named SAMM (System for Action Management & Monitoring).

There continues to be a drive to establish and embed a centralised, robust IT system to enable the capture of all actions identified by either internal or external reviews. This project will enhance support for Directorates in implementing action plans and provide enhanced governance.

What we aim to achieve?
To establish and embed a robust IT system (SAMM) across the Trust which will enable staff to record, prioritise, monitor and complete all required actions identified by internal and external assessments within the agreed timescales.

How will we achieve this?
In Year 2 (2019-2020), we will look to:

Create
- Establish an IT system (SAMM) that encompasses the scope of the project and has the required functionality.
- Incorporate a reporting function in SAMM that will enable monitoring reports and dashboards to be produced at both a Directorate and corporate level. This will ensure that key themes and trends are identified in order to allow prioritisation.

Communication plan/consultation
- Establish a multi-disciplinary SAMM Task and Finish Group, which will meet to discuss the design/functionality of SAMM and support its roll-out Trust-wide.

Test and Refine
- Pilot SAMM in selected Directorates. This will involve staff training for end users.
- Evaluate SAMM over time, and refine the system if required.

Plan Roll-out Trust-wide
- Once SAMM is established and embedded in pilot Directorates, we will begin a Trust-wide roll-out programme.

How we will measure success?
- Trust and Directorate level key performance action plans entered into SAMM.
- Pilot SAMM with Directorates.
- Full engagement with Directorates.
- Measure outcomes and results.

Where we will report this to?
- SAMM Task and Finish Group.
- Quality Governance Group.
- Trust Board via Integrated Quality Report.

Priority 5 – Enhancing capability in Quality Improvement (QI)

Why have we chosen this?
We are in the era of increasing complexity of healthcare; continuous change is therefore required to deliver high quality care. Our patients and front-line staff operate in this complex position and hold the knowledge of what works, what doesn’t and what is needed. Effective change must use the collective intelligence, of our patients and staff, to inform where change is needed and to generate creative ideas to make continuous improvement. A structured organisational approach to Quality Improvement (QI) will increase the capability to support, learn and deliver effective and efficient change.
What we aim to achieve?
Grow the capacity for continuous change, improvement and learning.

How will we achieve this?
• Adopt across the whole system, the Institute of Health Care Improvement’s Model for Quality Improvement as our organisational approach.
• Establish a Quality Faculty to co-ordinate the system-wide approach to quality and learning at NUTH. The Faculty will facilitate learning from change, training programmes on QI for all staff, online resources and workbooks and co-ordinated support structure for staff embarking on QI. The Quality Faculty will build on, and integrate, the work and expertise from the Service Improvement, Transformation and Financial Improvement and Quality Improvement teams.
• Central co-ordination for learning and facilitated data management to support quality improvement work.
• Deliver Board level training in the principles and practice of QI.
• Use data in a meaningful way to identify change early with increased use of Run charts or Statistical Process charts throughout the organisation in clinical and non-clinical areas.
• Integrate the growing understanding and application of Human Factors Principles in healthcare.
• Integrate with a patient-centred collaborative design approach for QI.
• Support with leadership that embraces change and acknowledges failures as learning opportunities.

How we will measure success?
• Number of completed Plan Do Study Act (PDSA) cycles with central learning that all can access.
• Numbers trained in Institute for Healthcare Improvement (IHI) model of improvement, numbers of trained IHI support network.
• Numbers of successful projects.

Where we will report this to?
• Quality Governance Group.
• Trust Board.
Priority 6 – Deciding Right

Why have we chosen this?
Within England and Wales, over 30% of in-patients are in their last year of life and across Europe, greater than 80% of intensive care patients having treatments withheld or withdrawn lack capacity at the time such decisions are made. Furthermore, less than 15% of such patients have ever indicated (verbal or written) what their wishes would be i.e. the majority lack an Advance Care Plan (ACP).

Deciding Right is an initiative that aims to improve and increase the process of ACP for Children, Young People and Adults and, in doing so, inform health care professionals about values and beliefs enabling the delivery of care that is more focused on an individual’s Best Interests.

What we aim to achieve?
• Improved focus on shared decision-making.
• Improved information relating to patients’ beliefs and values.
• Greater transparency about the advantages and disadvantages of serious medical treatments.
• Increased usage of Treatment Escalation Plans and Emergency Health Care Plans. Potentially this could involve 30-35% of in-patients (DoH: in 2015-16, 35% of adult in-patients were in the last year of their life).

How will we achieve this?
• Establish a multi-disciplinary group (including lay representation) to oversee the implementation.
• Awareness programmes for staff about the purpose and processes of Deciding Right.
• Awareness programme within Primary Care.
• Inclusion of Deciding Right in Healthy Conversations Project for Allied Health professionals (AHPs) within NUTH.
• Patient/relative presentation to Trust Board.
• Video and hard-copy information available within Out-Patient Departments and Primary Care (Autumn 2019).

How we will measure success?
• Number of staff trained.
• Monitoring of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) discussions and documentation. In time, this may change to the ReSPECT Forms (Recommended Summary Plan for Emergency Care and Treatment).
• Increased presence of Treatment Escalation Plans (TEP)/Emergency Health Care Plans (EHCP) in patient notes and ongoing improvements in the implementation of such documentation.
• Patient/Relative feedback.

Where we will report this to?
• Quality Governance Group.
• Trust Board.

Priority 7 – Treat as one

Why have we chosen this?
The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report “Treat as One” was published in 2017, highlighting the inconsistencies in the delivery of physical health care to adult patients with co-existing mental health conditions in NHS hospitals. The study identified a number of areas that could be improved in the delivery of care to this group of patients. Although many aspects of Mental Health conditions are complex and challenging to address, it is a subject which is gaining much greater public awareness and appreciation. There is a clear need to make progress toward achieving equality of care for this patient group.

What we aim to achieve?
We aim to use the key recommendations made in the NCEPOD report to guide a coordinated review of current practices and processes within NUTH, Northumberland and Tyne and Wear (NTW). Where those aspects of care fall short of NCEPOD recommendations, we will work towards optimising and adapting care to meet those standards where possible.

How will we achieve this?
The scope of this project is extensive and the potential need for system change far reaching. The first step has been to formalise a joint committee between NUTH and NTW with regular, minuted, meetings to establish cooperative working at a senior level. This group has met on a number of occasions to date and will continue to meet quarterly. In addition, a smaller steering committee, within NUTH, has been established to define immediate priorities for a task and finish approach. Effective information sharing is a key priority and must be designed to work in a paper-lite format across NUTH and NTW. We will review current admission paperwork to assess inclusion of Mental Health review on admission to hospital. Education is another immediate priority as well as raising awareness. A day of seminars is planned for late 2019 and we will look to national organisations to assist with educational materials.

How we will measure success?
We will measure success using the self-assessment template from the NCEPOD report as the main guide. We aim to begin initial audits of some aspects of current practice against NCEPOD standards that can then be repeated in the future to assess effectiveness of change.
Where we will report this to?
• Joint NUTH and NTW Quality Committee.
• Quality Governance Group.
• Trust Board via the Integrated Quality Report.

Priority 8 – Ensure reasonable adjustments are made for patients with suspected, or known, Learning Disabilities

Why have we chosen this?
People with a Learning Disability are four times more likely to die of something which could have been prevented than the general population (Disability Rights Commission, 2006).

The Trust is fully committed to ensuring that patients with a Learning Disability have access to services that will help to improve people's health so this doesn’t happen in the future.

What we aim to achieve?
We aim to improve the experience for patients and their families who need to access hospital services and to improve health outcomes.

How will we achieve this?
We aim to achieve this by:
• Improving access to healthcare by ensuring reasonable adjustments are available
• Supporting STOMP (STop Over Medicating People with a learning disability or autism)
• Supporting STAMP (Supporting Treatment and Appropriate Medication in Paediatrics)
• Learning from LeDeR Mortality Reviews
• Embedding the use of the Hospital Passport across adult and children's services
• Ensuring that records for patients with a Learning Disability are clearly identified to support staff in tailoring care and reasonable adjustments for the individual
• Contributing to multi-agency safeguarding processes within Newcastle that support improving the quality of care for individuals from residential care settings
• Asking patients and their families about their personal experience of their journey through Trust services and enabling communication and engagement with the Trust to express their views and experiences of services.

How we will measure success?
• Audits of patient records to ensure that reasonable adjustments have been made and application of the Mental Capacity Act has been documented.
• Reviewing the use and application of Hospital Passports.
• Implementation of learning from LeDeR reviews.
• Review the implementation of STOMP and STAMP.
• Conduct surveys of patient and family carers’ experience of hospital services.
• Inviting Quality Checkers to review Trust services.

Where we will report this to?
• Trust Safeguarding Committee.
• Learning Disability Steering Group.
• The Trust Board will receive updates from the Safeguarding Committee within the Trust Governance Structure.
COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) INDICATORS

The Commissioning for Quality and Innovation (CQUIN) payment framework is designed to support the cultural shift to put quality at the heart of the NHS. Local CQUIN schemes contain goals for quality and innovation that have been agreed between the Trust and various Commissioning groups. Listed below are the quality and/or innovation projects which have been agreed with the Commissioners for 2019/2020.

**2019/2020 CQUIN Indicators**

<table>
<thead>
<tr>
<th>CQUIN Indicators - Acute Hospital – (NHS England)</th>
<th>CQUIN Indicators - Acute Hospital – (CCG)</th>
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<tbody>
<tr>
<td>• Medicines Stewardship: Medicines Optimisation</td>
<td>• Staff Flu Vaccinations</td>
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<tr>
<td>• Toward HCV Elimination</td>
<td>• Alcohol and Tobacco brief advice</td>
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<tr>
<td>• Personalised Care: Cystic Fibrosis</td>
<td>• Three High Impact Actions to Prevent Falls</td>
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<tr>
<td>• Medicines Stewardship: Immunoglobulin</td>
<td>• Antimicrobial Resistance: Urinary Tract Infections and Antibiotic prophylaxis for Elective Colorectal Surgery</td>
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<tr>
<td>• Appropriate Spinal Care: Spinal Surgery</td>
<td>• Same day Emergency Care – Pulmonary Embolus/Tachycardia with ATRIAL Fibrillation/ Pneumonia</td>
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<tr>
<td>• High Cost Drug Stewardship</td>
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<tr>
<td>• Severe Asthma</td>
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<tr>
<th>CQUIN Indicators - Acute Hospital – (Public Health/Dental/other)</th>
<th>CQUIN Indicators - Community</th>
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</thead>
<tbody>
<tr>
<td>• Dental</td>
<td>• Staff Flu Vaccinations</td>
</tr>
<tr>
<td>• Breast screening</td>
<td>• Alcohol and Tobacco brief advice</td>
</tr>
<tr>
<td>• Stereotactic Radiosurgery</td>
<td></td>
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<tr>
<td>• Armed Forces Covenant</td>
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During 2018/19, The Newcastle upon Tyne Hospitals NHS Foundation Trust provided and/or sub-contracted 18 relevant health services.

The Newcastle upon Tyne Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 18 of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19, represents 100 per cent of the total income generated from the provision of relevant health services by The Newcastle upon Tyne Hospitals NHS Foundation Trust for 2018/19.

The Newcastle upon Tyne Hospitals NHS Foundation Trust aims to put quality at the heart of everything we do and to constantly strive for improvement by monitoring effectiveness. High level parameters of quality and safety have been reported monthly to the Board and Council of Governors. Activity is monitored in respect to quality priorities and safety indicators by exception in the Integrated Quality Report, reported monthly to Trust Board and performance is compared with local and national standards.

Leadership walkabouts, coordinated by the Clinical Governance and Risk Department, involving Executive and Non-Executive Directors and members of the Senior Trust management team have been regularly conducted in a variety of departments across the Trust. These are reported to the Clinical Governance and Quality Committee, a standing committee of the Trust Board, and any actions reported, implemented and followed up.

The Trust Complaints Panel is chaired by a Non-Executive Director of the Trust and reports directly to the Trust Board, picking up any areas of concern with individual Directorates as necessary.

The bi-monthly Clinical Assurance Tool (CAT) continues to provide clinical assurance to the Trust Board as an overview of performance against a wide range of clinical and environmental measures for each ward and Directorate. The aim of the CAT is to measure and demonstrate compliance with the published documents and national drivers such as High Impact Actions, Saving Lives as well as providing useful data to support, verify and offer assurance for external inspectorates.

Feedback and, where necessary, reports on improvement actions are provided to the Trust Board via the monthly Integrated Quality Report.
The information presented, in this Quality Account, represents information which has been monitored over the last 12 months by the Trust Board, Council of Governors, Clinical Governance and Quality Committee and the Clinical Policy Group. The majority of the Account represents information from all 18 Clinical Directorates presented as total figures for the Trust. The indicators, to be presented and monitored, were selected following discussions with the Trust Board. They were agreed by the Executive Team and have been developed over the last 12 months following guidance from senior clinical staff. The quality priorities for improvement have been discussed and agreed by the Trust Board and representatives from the Council of Governors.
PATIENT SAFETY

The Trust has consulted widely with members of the public and local committees to ensure that the indicators presented in this document are what the public expect to be reported. Comments have been requested from the Newcastle Health Scrutiny Committee, Northumberland County Council, Newcastle Clinical Commissioning Group (CCG) and the Newcastle, Northumberland and North Tyneside Healthwatch teams. Amendments will be made in line with this feedback.

Patient Safety

Priority 1 - Reducing Infection – focus on MSSA/E.coli

Why we chose this?
Staph. aureus bacteraemias are infections that can cause significant harm. E.coli bacteraemias are the most common cause of Gram negative sepsis. At The Newcastle Upon Tyne Hospitals NHS Foundation Trust (NUTH), these are most commonly associated with lines and indwelling devices; achieving excellent standards of care and improving practice is essential to reduce these infections in line with our zero tolerance approach.

E.coli and other Gram negative bacteraemias constitute the biggest cause of sepsis nationwide. Proportionally, at NUTH, the main source of infection is urinary tract infections, mostly catheter-associated, reflecting the national picture. An integrated approach engaging with the multidisciplinary team across the whole patient journey, focusing on antibiotic stewardship, early identification of risks and timely intervention formulate the basis for our strategy to reduce these infections.

What we aimed to achieve?

We aimed to achieve

- 10% reduction year on year of MSSA bacteraemias.
- 50% reduction of E.coli bacteraemias by 2021.

What we achieved?

- Worked in partnership with the CCG on a quality improvement programme to reduce healthcare associated urinary tract infections (UTIs), and catheter-associated urinary tract infections (CAUTIs).
- Increased understanding and awareness of the causative factors, avoidance, earlier recognition and diagnosis of UTI/CAUTI, as well as timely removal of indwelling devices.
- Introduction of a urethral catheter care plan incorporating the HOUDINI tool, based on best evidence practice.
- Held focus groups to recruit champions and discuss improvement strategies.
- Introduced Aseptic non-touch technique (ANTT) assessment mandatory for medical staff (as an addition to the current competency for all other staff groups).
- Introduced care bundles to prevent line-related infections and surgical site infections.
- Introduced care plans for surgical wounds.
- National guidance for surgical skin preparation with 2% chlorhexidine AND 70% alcohol incorporated into the Infection Control Practice in the Operating Department Policy.
- Introduced peripheral IV cannula packs.
- Undertaken quality improvement projects that have led to MSSA reductions in areas of high prevalence, for example, a quality improvement project to prevent line-related sepsis in patients undergoing long-term renal replacement therapy.
PATIENT SAFETY

- Created working groups to look at specific areas, such as central venous lines in paediatrics.
- IV Nurse Specialist-led audits of practice in areas of high incidence which have assisted in identifying areas for improvement and focused education.
- Developed education resources such as posters, screensavers, bedside prompts, catheter safety cross, use of mobile education boards.
- Undertook a quality improvement project with surgical services to focus on hepatobiliary sepsis.

How we measured success?
- Sustained reductions of bacteramias in individual directorates.
- Audited compliance with best practice which demonstrated:
  - 25% decrease of the use of urinary catheters
  - 21% reduction in the use of catheters used for over 28 days
  - 34.75% reduction in the number of older people living in care homes being admitted to hospital with a UTI
  - Improved management of IV devices.

Priority 2 – Pressure Ulcer Reduction

Why we chose this?
Reducing hospital-acquired pressure ulcers was chosen as a priority as it was recognised that the incidence within the Trust and nationally remained high and therefore targeted work around reducing harm from pressure damage was required.

Pressure ulcers are a key indicator of the quality and experience of patient care. Despite national campaigns to reduce them, they remain a significant healthcare problem:
- over 1,300 new pressure ulcers are reported nationally each month
- treating pressure ulcers costs the NHS more than £1.4 million every day
- developing a pressure ulcer leads to an increased length of hospital stay (an increase on average of 5-8 days).

The increase in patient age, acuity and frailty means that the Trust are seeing more patients with a higher risk of acquiring pressure ulcers and therefore the risk of the incidence of pressure ulcers increasing is great. It is therefore essential that the Trust identified this as a priority to ensure the risks of this were mitigated with accurate assessment throughout admission and on discharge, together with the implementation of best practice interventions.

Furthermore, pressure ulcers are largely preventable if the correct assessment and prevention plans are implemented and therefore the organisation is committed to reviewing and embedding processes which would improve patient care and outcomes.

What we aimed to achieve?
- To minimise the episodes of preventable harm which occur in the Trust related to pressure damage.
- Undertake focused work to achieve a reduction in the development of heel damage by 10%.
- Ensure we have a skilled and educated workforce with sound knowledge base related to pressure damage.
- Sustain Critical Care Task Force sharing best practice across all areas to support sustained pressure ulcer reduction.

What we achieved?
Despite various work streams, and the efforts of the Tissue Viability team working with staff on the wards and in the community, a significant reduction in Trust acquired pressure damage has not been achieved.

In spite of this, some success has been achieved including:
- A 6% reduction in pressure damage incidence to heels
- 20 wards or departments did successfully achieve a 20% reduction or more in pressure ulcer incidence (35% of the wards and departments across the organisation)
- On-going face to face training has been delivered via the Preceptorship Course, the Healthcare Academy, link nurse study days, compression bandage study days, wound debridement course and mattress champion training
- The Trust e-learning package for pressure ulcer prevention remains best practice and compliance with this has increased.

The critical care task force group has been revised and now has a new Chair (Nurse Consultant for Critical Care) who is working closely with the Tissue Viability Team to refocus the work streams ongoing in the four critical care units.

How we measured success?
Despite not reporting a significant reduction in Trust acquired pressure ulcers overall across the organisation, the ongoing monitoring and analysis of incidents has been maintained by the Tissue Viability team. Every pressure ulcer or moisture lesion incident is reviewed by the team to ensure validity of reporting and consistency in grading of incidents. This ensures that the organisation is consistent in reporting and gives an accurate baseline to measure improvement.
In the latter half of the year, an innovative approach to pressure ulcer prevention was therefore implemented. The Trust took the opportunity to re-focus and strengthen the approach to reduction in pressure ulcers and falls under single leadership. The Clinical Improvement Lead (Falls and Pressure Ulcers) is now working with the team to embed Quality Improvement (QI) methodology in targeted areas where there is a high rate and incidence of pressure ulcers and falls. It is too early to measure improvement with this strategy but it will be continually monitored via the Integrated Quality Report.

**Priority 3 – Management of Abnormal Results**

**Why we chose this?**

There have been over 60 reported incidents, over the two years, where abnormal or unexpected diagnostic results had not been seen or acted upon by medical staff. Causes were varied but included failure to receive, view or act on the relevant report, errors in communication and administration and the lack of a failsafe mechanism for dealing with abnormal results when physicians were away from the hospital. In some instances, this has resulted in serious incidents by causing delays in the patients’ treatment pathway.

**What we aimed to achieve?**

A long-term solution for the effective and efficient communication of abnormal results across all of the reporting specialties to the responsible clinician in order to minimise incidents. The solution will be, user-friendly and accessible offering consistency 365 days of the year. It will be unaffected by busy periods of work, staff sickness or annual leave. Abnormal results will be automatically highlighted for action to the clinician and auditable. This will be distinct from the reporting of normal test or investigation results.

A failsafe system will also be in place to ensure that abnormal results are acted upon within a short, pre-defined period by another designated responsible clinician if the primary physician is away from the Trust or has not taken action.

**What we achieved?**

The way in which the reporting system will operate has now been finalised by the working group after exploring the lessons learned from incidents within the Trust, reviewing national guidelines and observing systems used in other Trusts. Abnormal results will be sent as a red flag message from the reporting specialty to the requesting consultant, viewable in the Erecord message centre. Red flag messages can only be deleted by the consultant. Action may have been taken by another member of the team and this will be viewable. Red flag messages will move with the patient through their admission journey e.g. from Accident and Emergency to a general medical ward, so a change of location or specialty does not lead to results being missed.

A recent Serious Incident (SI) concerning missed radiology results further highlighted the need for our robust system. The incident was reviewed by the Healthcare Safety Investigation Branch and gave us an opportunity to share our vision and concept and gain feedback. The plan was well received.

If a red flag message remains in a consultant’s inbox for more than a defined period (e.g. five days) it will automatically be forwarded for action to another team member. By default, this will be the Clinical Director but Directorates may define an alternate failsafe. This will ensure that patient management is unaffected by absence or periods of inaction.

There have been ongoing discussions regarding alert thresholds and their definition. It is important to avoid a situation where inboxes are filled with red flag messages as the impact will diminish. In radiology these can be well defined through existing guidelines and medical judgment at the time of reporting. In other disciplines, such as haematology and biochemistry, defining thresholds is more challenging particularly where “normal abnormal” and “abnormal normal” results may occur. To assist with this we have visited neighbouring Trusts to review their mechanisms, protocols and thresholds for reporting abnormal results electronically to inform our own processes.

**How we measured success?**

There is now a shared vision of how the abnormal diagnostic results system will operate and how it will look to users in parallel with the full implementation of the GDE project.

Through strong links with the IT and GDE teams, we have determined that the concept is now fully deliverable using our current and proposed electronic clinical records system. The implementation timeframe is now of great importance to avoid further incidents or the need for an interim solution. Implementation will require a change in culture and workflow for consultants to focus on the message centre inbox to be notified of abnormal results.

As radiology missed abnormal results account for the vast majority of incidents we will focus on this reporting specialty at the start of implementation in the Trust.

The working group continues to analyse incidents to highlight common causative themes and map the incident to the new alerting system to determine whether it could have been prevented.
Priority 4 – Local Safety Standards for Invasive Procedures (LocSSIPs)

Why we chose this?
National Safety Standards for Invasive Procedures (NatSSIPs) are essentially a set of key standards that should govern the delivery of care that involves an invasive procedure(s). Their aim is to reduce the risk of the three surgical never events that can occur during invasive procedures:
• Wrong Site / Procedure
• Retained foreign body
• Wrong implant inserted.

It is recognised that they should govern practice throughout the hospital, not just in the operating theatres.

The aim of NatSSIPs is that they should standardise key elements of procedural care. The process involves the use of checklists, but not limited to them. The standards should be implemented against a background of education in human factors and working as teams and a key element is that they should reinforce the importance of education to patient safety. As part of the process, organisations should review their invasive procedures and adapt the NatSSIPs to develop local standards for invasive procedures (LocSSIPs) that reflect local circumstances. The standards for a major surgical procedure performed under general anaesthesia in an operating theatre cannot and should not be identical to those supporting a procedure under local anaesthesia in a ward.

Each LocSSIP should address each of the 13 standards set out in the NatSSIPs:

Organisational
1. Governance and audit
2. Documentation of invasive procedures
3. Workforce
4. Scheduling and list management
5. Handovers and information transfer

Sequential
6. Procedural verification and site marking
7. Safety briefing
8. Sign in
9. Time out
10. Prosthesis verification
11. Prevention of retained foreign objects
12. Sign out

What we aimed to achieve?
• All Directorates would look at the range and number of invasive procedures carried out (not including those performed in operating theatres).
• Teams involved in performing these invasive procedures would then review their current processes and start to incorporate the NatSSIPs process to develop their own LocSSIPs.
• Directorates produce and share their own LocSSIPs.
• Areas deemed to be of particular priority (based upon national reporting of complications rates) included:
  • Endoscopy
  • Cardiac catheter labs
  • Interventional radiology
  • Dermatology
  • Chair dentistry.
• By the end of 2018/19 a minimum of ten LocSSIPs will have been implemented.

What we achieved?
LocSSIPs have managed to make their way up the safety agenda of all Directorates within the Trust and the process has become embedded in practice in most, if not all, of our clinical areas where invasive procedures are performed. The process was never about throwing out old and trusted methods of approaching safety, but building on the success of many years’ experience in delivering safe care by incorporating these newer ideas to create a standardised and up-to-date approach to team working. As such, the introduction of the LocSSIP process has allowed multidisciplinary teams to review their working practices and create updated processes that ensure a more team-based approach, standardisation of care and better education for all staff around human factors and risk reduction.

The introduction of LocSSIPs was initially part of the surgical stream of the Sign Up to Safety campaign: a multi-disciplinary group initially developed two complete LocSSIPs; one highly complex (governing all invasive procedures undertaken in the Trust’s operating theatres) and one relatively simple (covering the insertion of chest drains in the ward setting). Using these two exemplar LocSSIPs, Directorates had a template to develop their own set of local standards. Following presentations at the Trust Clinical Risk Group, individual Directorate risk management teams identified the range and breadth of invasive procedures within each clinical area, reviewed current safety practice and then developed LocSSIPs for individual invasive procedures.

All of the above planned aims for introducing the LocSSIP process into The Newcastle upon Tyne Hospitals NHS Foundation Trust have been achieved,
and in particular, LocSSIPs have been developed and introduced into the five priority areas. Directorates have taken ownership of their own areas and are responsible for ensuring that the LocSSIP process is ongoing in terms of staff education and audit of outcomes updating of safety processes when is necessary.

**How we measured success?**
Our measure of success is the introduction of a standardised safety process for invasive procedures within the Trust that minimises risk to our patients. We have identified all invasive procedures and where they are performed, in each Directorate, each invasive procedure has a LocSSIP process underway. The progress of this forms part of each Directorate's Clinical Governance review process, and this feeds back to the Clinical Risk Group which has overall responsibility to ensure that compliance is monitored.

**Priority 5 – Human Factors Training**

**Why we chose this?**
From learning nationally, we know that patients can come to harm from avoidable errors in hospitals. Such errors are not intentional but can occur if the processes and equipment used are not designed well enough to fit alongside human capabilities and limitations. Giving staff an understanding of this enables them to design ways of working that makes it easier for staff to get work done in the right way and reduces the likelihood of errors occurring.

Having a human factors approach to patient safety differs from traditional safety training in that the focus is less on the technical knowledge and skills required to perform tasks and administer care, and rather on the cognitive and interpersonal skills needed to effectively manage patient care safely.

**What we aimed to achieve?**
Through Human Factors education, we aimed for all grades of staff to have an understanding of human factors in order to apply this understanding to enable them to improve the systems and processes that they work with day after day.

By using a human factors approach, we aimed to improve the Trust’s safety culture due to the potential for reducing risk and avoidable harm, improving our investigation processes when things do go wrong, and by developing a culture where staff are confident to speak up when they have concerns.

**What we achieved?**
- Multiple human factors staff education sessions (including Simulation training) and ad hoc human factors awareness sessions delivered to staff across the Trust to a range of staff groups.
- All Foundation Doctors receive Human Factors Training.
- Leadership from the Trust Board with a commitment to quality improvement, which is linked to higher quality care. Human Factors education was delivered to the Trust Board in April 2018.
- A human factors approach has been incorporated into Trust processes for investigating patient safety incidents including; Serious Incident (SI) investigation; the development of a Trust Incident Investigation Tool and revision of the Trust incident investigator training course.
- A human factors approach is incorporated into the Trust’s Quality Improvement Strategy.

**How we measured success?**
A change in culture within an organisation, which is the main focus of this Quality Account Priority, is difficult to measure however it is hoped that adopting a human factors approach across multiple staff disciplines and specialities (both clinical and non-clinical) will ultimately support a reduction in patient harm and improved patient experience.

It is difficult to evidence that these are a result of Human Factors training.

However, measurable outputs which indicate that these aims are being delivered include:
- The completion of Human Factors education sessions to raise awareness.
- The evaluation of feedback from staff undertaking training and awareness was uniformly good. This was from a diverse cross-section of the hospital team including nursing, portering, medical, and allied professional staff.
- New Incident investigation training course development (incorporating human factors & NHSI ‘A Just Culture’).
- New generic Trust Incident Investigation Tool (incorporating human factors) available for staff to uses.
- All Serious Incident (SI) investigations incorporate human factors approach.
- Ongoing development of short & long-term objectives to help facilitate Trust-wide roll-out of Human Factors training.
Priority 6 – Digital enhancements to care

Why we chose this?
IT offers the ability to overcome several limitations of the human mind (Human Factors) but is also recognised for potentially introducing new or unintended risks into the system. One of NHS Improvements top priorities is Deteriorating Patients and this focus is being driven through the Patient Safety Collaborative. Moving from the paper-based observation charts to electronic enables a significant lift in patient safety. Targeting the known weaknesses in the paper-based system of missing observations, incorrect scores and delayed observations.

What we aimed to achieve?
Establish a data warehouse, analyse data to identify factors involved in determining the effectiveness of the IT healthcare interface. Build, test and deploy an electronic observations system for adults across the organisation. Refine the interface, educational model and make data available to all frontline staff. Share identified areas of good practice.

What we achieved?
The new data warehouse was installed in December 2018 and is now in a trial phase, moving towards the ability to give front-line staff access to clinical data very close to real time. Data from the whiteboards has been analysed locally and externally. We have identified critical factors associated with improved outcomes related to the clinical alerts. Two critical factors are good clinical leadership and ward processes that have an integrated multidisciplinary team morning board round. The combination of these two factors was associated with significantly reduced variation and improved glycaemic control.

The electronic observation system has been developed and tested on wards 16 and 30 at the RVI. After several iterative rounds of improvement to the design, the system was rolled out. A novel educational strategy was used where the electronic tablets were deployed to the wards two weeks before the system went live. This enabled the staff to upskill as the education was built into the tablets as we had designed a training mode. This approach significantly reduced the time staff required away from the clinical area to be trained and enabled a large scale go live of 25 wards in a single day, which we repeated two weeks later moving from the RVI to the FH, without incident. This was a transformative step in educational approach in terms of effectiveness and efficiency.

Following the go live in November, we are already approaching one million observation sets. This has placed us in a position to collaborate with the academic teams in the local Universities to look at this big data set to make further improvements in the detection of deterioration.
Our approach to the implementation of NEWS 2 and risk rating has been shared on the Future NHS Collaboration platform. The National Lead for Deteriorating Patients, Dr Matt Inada-Kim, has expressed a real interest in our integrated approach, which we are continuing to share with colleagues around the UK.

**How we measured success?**
Run charts of diabetic control showed reduced variation and improvement in well-led wards with integrated multidisciplinary team morning board rounds.

Staff feedback received following the electronic observation deployment, showed that more than 80% were happy with the new electronic observations.

Time in motion studies demonstrated over 1 minute, on average, saving per full set of observations on the electronic system compared to the paper system. We take on average around 6000 observation sets per day across the adult wards at the RVI and the FH. This equates to over 100 hours of released time per day.

Observation completeness has improved from 90% on paper audits to 98%.

Observation scores correctly calculated has improved from 90% on paper to 100%.

Oxygen alerts built into the tablets have improved compliance with patients in their target oxygen zones to 92%.

This has all been achieved without any negative impact on critical care admissions. There has been stable numbers of unplanned admissions to the adult critical care units and average predicted mortality. Nor has there been an increase in clinical incidents related to the electronic observations system. This is important as new IT has the potential to introduce unwanted unintended consequences.

**Priority 7 – Closing the Loop**

**Why we chose this?**
We wanted to establish a robust IT system that would ensure action plans identified by either internal or external reviews were monitored, prioritised, completed and reviewed within given timescales. All actions were captured but in a variety of different forms and were not available collectively in order to allow prioritisation, monitoring and discussion.

It was envisaged that this project would enhance support for Directorates in implementing action plans and provide enhanced governance.

**What we aimed to achieve?**
In Year one, we aimed to achieve the following:
- Map Trust key performance targets
- Map individual Directorate profiles – looking at requirements in each area
- Propose a process to manage (record/monitor/complete/review/alert)
- Prioritise actions/performance targets
- Complete a scoping exercise in relation to available IT systems to support the recording/monitoring of performance targets.

**What we achieved?**
- We renamed the project SAMM (System for Action Management & Monitoring).
- Key meetings were undertaken with each Directorate management team to discuss SAMM and its benefits.
- Individual Directorate profiles have been mapped out (looking at key requirements within each area).
- Meetings have also taken place with the Trust’s Senior Management team in order to map out Trust key performance targets/actions.
- We have process mapped and proposed a process that will enable action plans to be collated/identified/monitored/prioritised/alerted/reviewed and completed.
- A scoping exercise was undertaken to see if there is a suitable IT system that can provide what is required.
- Key meetings with the Trust’s IT development team, in order to discuss the project and consider whether there is another IT system that is Trust supported and suitable for the project.
- Establishment of the Trust multi-disciplinary SAMM Task and Finish group. This group is made up of key individuals that have a particular interest, knowledge or influence. The group has key involvement in the design/functionality processes of SAMM as well as reviewing and support during the pilot and final roll-out phases.
- Pilot Directorates in place ready to test SAMM.

**How we measured success?**
Trust key performance requirements and actions have been mapped out and prioritised.

The project has full engagement with all Directorates and we have recruited key individuals to membership of the SAMM Task and Finish Group.
Priority 8 – Deciding Right

Why we chose this?
Intensive Care Medicine has contributed to significant improvements in survival since the publication of Comprehensive Critical Care (DoH, 2000); however, one in five intensive care survivors die within 12 months of their admission. Furthermore, 24% of Scottish intensive care survivors (2005-2013) are re-admitted to hospital within 90 days of discharge home. Causes of readmission are often related to long-standing health problems rather than the acute illness that precipitated intensive care admission.

In many of these circumstances, survival of intensive care is also associated with significant burdens (physical and psychological) and, when death occurs, over 80% of patients lack capacity when decisions are made in relation to withholding or withdrawing treatments and have no advance statement referencing their wishes and beliefs (Ethicus 2 Study). As a result, many patients could therefore be subjected to inappropriate and burdensome treatments without having any documented input into the process.

Additionally, within general ward settings in England and Wales (2015-2016), approximately 36% of hospital in-patients were in their last year of life. The use of Advance Care Plans (ACPs) has demonstrated an increase in shared decision-making and reduced death within hospital, enabling more structured, individualised care.

What we aimed to achieve?
- Develop and perform a baseline survey and needs assessment to gauge awareness and levels of engagement with Deciding Right amongst NUTH clinical staff.
- Audit acute admissions in patient groups with potential to need Emergency Health Care Plans.
- Reviewing North of England Critical Care Network audit of Consultant Review and Treatment Escalation Plans in acute care areas.
- Develop an awareness programme in line with regional initiatives.
- Document the number of clinical staff trained.
- Work with patient representatives and colleagues involved in Consent, Mental Capacity Act (MCA) 2005 and Shared Decision Making.
- Develop a video for patients and those close to them; be shown in out-patients and primary care outlining the principles and purpose of Deciding Right.
- Review the role of the group after two years (January 2020).

What we achieved?
- Survey performed demonstrating that approximately 60% of front-line staff felt they required more training and awareness in relation to having Difficult Conversations.
- Audit completed showing 36 of 39 patients admitted to intensive care had missed opportunity for ACP and the median stay in hospital prior to intensive care admission was 16 days.
- 1.57% of NUTH adult inpatients had Emergency Health Care Plans (EHCP) or Treatment Escalation Plans (TEP); whilst 36% of in-patients are in their last year of life which highlights an area for improvement.
- Ongoing work with patients and relatives to describe experiences to staff, including the Trust Board.
- An educational video has been produced and is ready for launch in Autumn 2019.

How we measured success?
- Implementation of workstreams.
- Production of the video and other educational resources.
- Numbers of staff trained.
- Improvement in EHCP or TEP usage (January 2019 audit results awaited from North of England Critical Care Network).

Priority 9 – Enhancing Patient and Public Involvement in Quality Improvement (QI)

Why we chose this?
As part of the Trust’s commitment to creating a culture of QI, we recognised that it was essential to engage patients, carers and families in the early stages of project design.

What we aimed to achieve?
We set out to create a sustainable, accessible model of involvement and engagement which enabled staff to work in collaboration with patients and members of the public from an early project design stage.

It was important to ensure patients and members of the public were empowered and aware of QI initiatives and were able to attend forums through which they could make a meaningful contribution to the scope and ambition of projects.

The importance of capturing the overall impact of patient and carer involvement was also recognised, to help ensure that the views and feedback of patients were being embedded in the QI plan.
What we achieved?
Over the past 12 months, we have made a number of changes to meet our ambitions in this area. We have created a range of role profiles for individuals interested in engaging in QI projects, recruited a large group of diverse individuals interested in engaging in this work and created a group, APEX (Advising on Patient Experience) through which this work can be undertaken. APEX has been established since October 2018 and several QI projects have been presented, discussed and subsequently informed by the group with more planned over the coming months.

How we measured success?
We have developed a framework which supports staff to consider how best to involve patients and members of the public in their QI projects. We routinely capture feedback from staff presenting their QI project and from the APEX attendees. This feedback is evaluated following each meeting and is shared with staff and APEX members to provide reassurance that discussions have been embedded in the QI project plan. The success of the initiative will be monitored by the number of QI projects being presented to APEX and the evaluation of the impact it has had on both staff and patients.

Priority 10 – Improving the experience of vulnerable patients

Why we chose this?
The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report “Treat as One” was published in 2017 highlighting the inconsistencies in the delivery of physical health care to adult patients with co-existing mental health conditions in NHS hospitals. The study identified a number of areas that could be improved in the delivery of care to this group of patients. Deprivation of Liberty Safeguarding (DoLS) has been another key area of focused attention for healthcare institutions in the last few years and remains an important area to ensure appropriate delivery.

The consent process for vulnerable adults who lack capacity to consent for treatment has also featured as a prominent area for scrutiny.

The Learning from Deaths NHS Guidance (July 2018) called for enhanced awareness of learning from mortality review, in particular for those patients with known mental health conditions.

Although many aspects of Mental Health conditions are complex and challenging to address, it is a subject which is gaining much greater public awareness and appreciation. There is a clear need to make progress towards achieving equality of care for this patient group.
What we aimed to achieve?
We aimed to use the key recommendations made in the NCEPOD report to guide a co-ordinated review of current practices and processes within NUTH and Northumberland, Tyne and Wear (NTW). Where those aspects of care fall short of NCEPOD recommendations, we will continue to work towards optimising and adapting care to meet those standards where possible.

A focus on raising awareness and understanding of the DoLS process for all staff groups in all clinical areas.

A review of the consent process for all patient groups in the last year and an update of Trust policy. A focus area was the use of Form 4 Consent and the application of Mental Capacity Assessments (1 and 2).

Mortality review has also been given attention to improve the process as a whole and to include highlighting the added importance of enhanced review of deaths of patients with mental health conditions to scrutinise aspects of care and identify learning issues.

What we achieved?
A joint NUTH and NTW Quality Forum has been established and meets on a quarterly basis to discuss issues and work collaboratively to ensure that patients with mental health needs receive the best holistic care when accessing treatment.

In addition, a steering group has been established in the Trust which will manage and monitor progress against the 22 recommendations of the ‘Treat as One’ publication. Having held a number of meetings, progress has been made in a number of areas, including:

• Completion of a full baseline assessment of services against the recommendations.
• Identification that the Trust are compliant, or partially compliant, with the majority of recommendations.
• Identification of key areas where there is room for improvement (and the development of associated action plans) such as communication, information sharing between Trusts and workforce training and education.
• Documentation and practice has been adapted to normalise the discussions about mental health.
• Plans are being developed to hold a cross-site educational forum later in 2019 which will raise staff awareness of ‘Treat as One’ and their role in improving care for patients with mental health needs.

• A patient representative has been identified to join the steering group to offer opinion and insight on service developments.
• The NUTH DoLS policy has been revised and updated and compliance of its’ use assessed by the Safeguarding Team. Review of DoLS awareness for staff, in all areas of the Trust, has become a key part of recent internal peer reviews.
• The Consent process review included a specific video training module for completion of consent for patients who lack capacity.
• The Consent Form 4 was modified to standardise the recording of a mental capacity assessment (MCA 1 and 2) as an integral part of the Trust Consent Form 4.
• The Trust mortality review process has been standardised and the use of an intranet-based mortality database established. That database requires the teams completing the mortality review to notify if any patient reviewed had mental health problems to enable a specific in-depth review of the patient’s care to identify any learning points that could improve care for future patients.

How we measured success?
Compliance with the recommendations of the Treat as One publication, will be monitored and reported to the joint Quality Forum on a quarterly basis.

The Trust has assessed and amended the NUTH DoLS policy and has used compliance with this policy and an assessment of staff awareness of the policy and practice in recent directorate peer reviews. It was a key aspect of recent CQC assessments.

Consent processes and particularly Consent Form 4 use, receive scrutiny in the form of departmental audits and peer review processes.

Mortality review is a formal part of the Trust Clinical Governance framework and review of patients with mental health conditions forms part of that review.

National guidance requires Trusts to include the following updates in the annual Quality Account:

Update on Duty of Candour (DoC)
Being open and transparent is an essential aspect of patient safety. Promoting a just and honest culture helps us to ensure we communicate in an open and timely way on those occasions when things go wrong. If a patient in our care experiences harm or is involved in an incident as a result of their healthcare treatment, we explain what happened and apologise to patients and/or their carers as soon as possible after the event.
There is a contractual requirement to implement the Being Open guidance and the Trust Duty of Candour (DoC) Policy has helped staff to achieve this. Our compliance with DoC is assessed by the CQC; however, we also monitor our own performance on a monthly basis at the Serious Incident (SI) Panel to ensure verbal and written apologies are provided. This reassures us that those affected by an incident are offered a truthful account and fully understand what happened. This open and fair culture encourages staff to report incidents, to facilitate learning and continuous improvement to help prevent future incidents, improving the quality of care.

Duty of Candour requirements are regularly communicated across the organisation using a number of corporate communication channels including presentations at a range of Trust-wide forums such as Clinical Policy Group, Clinical Risk Group as well as other Corporate Governance and Risk committees. Throughout the year, regular updates on progress with implementation and audit results have been submitted via the Clinical Risk Group.

Training has been targeted at those staff with responsibility for leading both serious incident investigations and also for staff involved in local investigations. DoC is included in Incident Investigator Training which is delivered to a wide range of staff once a month. An educational video is available to all staff, via the Trust intranet, and the requirement to be open with patients and their relatives is emphasised every month at the Patient Safety Briefings.

Statement on progress in implementing the priority clinical standards for seven day hospital services

The Trust has been implementing the priority clinical standards for seven day hospital services in a number of ways.

An early implementer site:
The Trust became one of the national early implementer sites for 7 Day Service (7DS) at the beginning of the financial year 2016/2017.

Implementation of new Board Assurance Framework to identify compliance:
This new measurement system replaced the previous self-assessment survey in 2018. It consists of a standard measurement and reporting template, which all providers of acute services complete with self-assessments of their delivery of the 7DS clinical standards. This self-assessment is formally assured by the Trust Board and the completed template submitted to regional 7DS leads to enable measurement against national ambitions. The Trust has taken part in the new Board Assurance Framework and the compliance was:

- **Standard 2**: The national compliance threshold is 90% for weekdays and weekends. Data shows 80% compliance with documented evidence of consultant reviews. However; we are confident that actual compliance is 90% as we can evidence consultant rotas/job plans which ensure patients have access to consultant reviews on a 24/7 basis. In addition, the intensive care units and Emergency Assessment Suite have twice daily consultant ward rounds. We will continue to make best efforts to demonstrate compliance by improving record keeping in all emergency areas.

- **Standards 5 and 6**: Audits have demonstrated that we were compliant with these standards.

- **Standard 8**: We are confident that compliance is above 90% indicated by previous audit data for daily and twice daily reviews. The majority of Directorates have board round systems in place and a clear process for identifying patients who do not require a daily ward round.

Staff engagement/awareness
A 7DS Delivery group reports to a 7DS Steering Group. This group has worked towards compliance with the four priority standards. The group has identified interventions and changes to improve compliance plus supports and coordinates the changes. Staff awareness sessions have been delivered and a Trust intranet page is available for staff.

Implementation of a new Electronic Review Board
The Trust developed a new system to focus on consultant activity in the Assessment Suite. This electronic review system helps to identify which emergency patients need to be reviewed by length of time in hospital and flags patients needing ongoing clinical review based on clinical need, which is identified by consultants. The new system was designed collaboratively by consultants and IT staff, and the benefits are evidenced by improved compliance with standard 2. Consultant feedback, on the new system, highlights the ability to identify where to start ward rounds, provides a good way of handing over patients and that also provides mechanisms to ensure a second review is completed when required.

Gosport Independent Panel Report and ways in which staff can speak up
“In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS trusts and NHS foundation trusts in England to report annually on staff who speak up
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(including whistleblowers). Ahead of such legislation, NHS trusts and NHS foundation trusts are asked to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment. This disclosure should explain the different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the trust”.

Staff and temporary workers, across the Trust, are informed at their induction on day one with the Trust, and subsequently reminded regularly, that there are a number of routes through which to report concerns and raise issues that may occur in the workplace. By offering a variety of options to staff, should they have an issue to report, including the ability to provide information anonymously, it is hoped that anyone working for The Newcastle upon Tyne Hospitals NHS Foundation Trust will feel they have a voice should they wish to raise a concern or put forward a positive suggestion.

Any of the reporting methods below can be used to log an issue, query or question; this may relate to patient safety or quality, staff safety including concerns about inappropriate behaviour, leadership, governance matters or ideas for best practice and improvements. These systems and policies enable the Trust to provide high quality patient care and a safe and productive working environment where staff can securely share comments or concerns.

Speak in confidence – the anonymous dialogue system
The Newcastle upon Tyne Hospitals NHS Foundation Trust continues to use the anonymous dialogue system ‘Speak in Confidence’. This secure web-based system is run by a third-party supplier. It enables staff to engage in a dialogue with senior leaders in the Trust, safe in the knowledge that they cannot be identified – this is a promise by the supplier of the system. Conversations are categorised into subject areas and there are 20 very senior leaders, including the Chief Executive, who can be accessed directly to ‘start’ a dialogue.

Freedom to Speak up Guardian
The Trust Freedom to Speak Up Guardian acts as an independent, impartial point of contact to support, signpost and advise staff who wish to raise serious issues or concerns. This person can be contacted, in confidence, about possible wrongdoing, by email or in person. Posters promoting the role of the Guardian have been distributed Trustwide and open drop-in sessions held for staff at all Trust locations.

Speak up – We Are Listening Policy (Voicing Concerns about Suspected Wrongdoing in the Workplace)
This policy gives employees, who raise such concerns, the assurance from the Trust that they will be supported to do so, and will not be penalised or victimised as a result of raising their concerns. The Trust proactively fosters an open and transparent culture of safety and learning to protect patients and staff. It recognises that the ability to engage in this process and feel safe and confident to raise concerns is key to rectifying or resolving issues and underpins a shared commitment to continuous improvement.

Being open (Duty of Candour) Policy
Promoting a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. It involves explaining and apologising for what happened to patients who have been harmed or involved in an incident as a result of their healthcare treatment. It ensures communication is open, honest and occurs as soon as possible following an incident. It encompasses communication between healthcare organisations, healthcare teams and patients and/or their carers.

Trust Contact Office
The function of the contact officer is to act as a point of contact for all staff if they have work related or interpersonal problems involving colleagues or managers in the working environment. Officers are contactable throughout the working day, with their details available under A-Z index on the Trust Intranet.

Union and Staff Representatives
The Trust recognises a number of unions and works in partnership with their representatives to improve the working environment. Staff are able to engage from these representatives to obtain advice and support if they wish to raise a concern.

A summary of the Guardian of Safe Working Hours Annual Report
This consolidated Annual Report covers the period April 2018 – March 2019. The aim of the report is to highlight the vacancies in junior doctor rotas and steps taken to resolve these.

Junior doctor rota vacancies occur due to gaps in the regional training rotations and problems with recruitment of locally employed doctors. The main areas of recurrent or residual concern for vacancies are neurosurgery, accident and emergency, obstetrics and gynaecology, anaesthesia and intensive care medicine, paediatrics and general medicine. The Trust takes a proactive approach to minimise the impact of these by active recruitment, attempts to make the jobs attractive to the best candidates, and by rewriting work schedules to ensure that key areas are covered.
Additional actions taken to resolve the issues are outlined below:

Where vacancies exist, the gaps in service coverage are mainly addressed by rewriting work schedules and the use of locums, mainly from the internal locum bank. In some areas, trainee shifts are being covered by consultants when junior doctor locums are unavailable.

In addition to the specific actions above, the Trust takes a proactive role in management of gaps with a coordinated weekly junior doctor recruitment group meeting. Members of this group include the Director of Medical Education, Finance Team representative and Medical Staffing personnel. In addition to recruitment to locally employed doctor posts, the Trust runs a number of successful Trust based training fellowships and a teaching fellow programme to fill anticipated gaps in the rota. These are 12 month posts aimed to maintain doctors in post and avoid the problem of staff retention. There are also Foundation Year 3 posts to encourage doctors to work at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Learning from deaths

The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. These added new mandatory disclosure requirements relating to ‘Learning from Deaths’ to Quality Accounts from 2017/18 onwards. These new regulations are detailed below:

1. During 2018/19, 1795 of The Newcastle upon Tyne Hospitals NHS Foundation Trust’s patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 467 in the first quarter; 429 in the second quarter; 451 in the third quarter; 448 in the fourth quarter.

2. During 2018/19, 1451 case record reviews and 24 investigations have been carried out in relation to 1795 of the deaths included in point 1 above. In 20 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; 307 in the first quarter; 350 in the second quarter; 382 in the third quarter and 436 in the fourth quarter.

3. Seven, cases 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: Two cases representing 0.1% deaths for the first quarter, two cases representing 0.1% for the second quarter and three cases representing 0.2% for the third quarter. All deaths resulting in a serious incident in quarter four are currently being investigated. (To date, not all incidents have been fully investigated. Once all investigations have been completed, any death found to have been due to problems in care will be summarised in the 2019/20 Quality Account. All deaths will continue to be reported via the Integrated Quality Report). These numbers have been estimated using the HOGAN evaluation score as well as root cause analysis and infection prevention control investigation toolkits.
## PATIENT EXPERIENCE

Summaries from the seven cases judged to be more likely than not to have had problems in care which have contributed to patient death are detailed in the table below:

<table>
<thead>
<tr>
<th>Summary</th>
<th>Lessons learned from review</th>
<th>Action</th>
<th>Impact/Outcome</th>
</tr>
</thead>
</table>
| Unexpected death of a patient following admission due to severe trauma.| Alternative rigid collars to be available in Emergency Department.  
Neuro Nurse Specialists to provide training on the application of alternate options. 
Review spinal injury pathway. | Spinal injury pathway to include timing of removal of neck collars. 
Trainee Induction information to include specific reference to guideline for a neck collar removal. | Heightened awareness of staff regarding management of unusual presentations in high risk patients. |
| Death related to a post-operative complication.                        | Verbal handover supported by comprehensive transfer documentation when transferring patients from cath. lab. to recovery. | Standardisation of procedures for handover and transfer. 
Communication during handover to include transfer checklist for all patients. 
Cardiac monitoring on transfer for all patients. | Robust transfer checklist now routinely carried out by staff. |
| Delay in recognition of abnormal radiological findings may have been a contributory factor in a patient's death. | Improved timely communication of abnormal results recognised as a local & Trust-wide quality priority. | Local arrangements to improve communication of abnormal radiology results between departments. 
Trust-wide quality project to improve process for communication of abnormal results is underway aligned to Global Digital Exemplar (GDE) work-stream. | Learning shared Trust-wide via Patient Safety Briefing and internal governance mechanisms. |
Review of patient radiology referral pathway to ensure a more robust process for prioritisation of high risk patients. | Heightened awareness of staff regarding complications in high risk patients. Learning shared Trust-wide via Patient Safety Briefing and internal governance mechanisms. |
| Unexpected death of a vulnerable patient in the post-operative period. | Improve local guidance and staff awareness to ensure this reflects Trust's standards for assessing and meeting vulnerable patients' care needs. | Review of local Learning Disability (LD) guidelines in-line with Trust pathways and acute care needs assessment. 
Raise awareness of LD Team's staff support role locally and Trust-wide. | Heightened staff awareness of importance of assessing how post-operative complications may present in vulnerable patients. Learning shared Trust-wide via Patient Safety Briefing and internal governance mechanisms. |
<table>
<thead>
<tr>
<th>Summary</th>
<th>Lessons learned from review</th>
<th>Action</th>
<th>Impact/Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sepsis related death.</td>
<td>Sepsis identification and medical handover between departments required further review.</td>
<td>Review of Emergency Department (ED) sepsis identification processes, handover and audit of practice undertaken. Appointment of Sepsis Nurse Specialist to work closely with Trust Clinical Leads to improve timely detection and management of sepsis and deteriorating patients.</td>
<td>New easy to use handover proforma routinely used by all ED staff, to be integrated into paperless solutions, including e-observations in the future. Learning shared Trust-wide via Patient Safety Briefing and internal governance mechanisms.</td>
</tr>
<tr>
<td>Sepsis related death.</td>
<td>Processes for the recognition of the deteriorating patient and triage to be reviewed.</td>
<td>Development of revised sepsis pathway in Paediatrics which includes; Improved triage process, standardised Paediatric Early Warning Score (PEWS) documentation and to improve completion of “parental concern” score.</td>
<td>Recruitment of additional nurses and introduction of a formal triage process within Paediatric Emergency Department. Heightened awareness of staff of importance of compliance with PEWS. Improvements to the sepsis trigger tool after collaborative working with staff. PEWS scores now on the patient white boards and planned for forthcoming introduction of e-observations.</td>
</tr>
</tbody>
</table>

4. 186 case record reviews and one investigation were completed after April 2018 which related to deaths which took place before the start of the reporting period.

5. 0 representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

6. Seven representing 0.4% of the patient deaths during 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

The Trust will monitor and discuss mortality findings at the quarterly Mortality Surveillance Group and Serious Incident Panel which will be monitored and reported to the Trust Board and Quality Governance Group.
Part 3 – Other Information - Overview of monthly Board assurance 2018/19

This is a representation of the Quality Report data presented to the Trust Board on a monthly basis in consultation with relevant stakeholders for the year 2018/19. The indicators were selected because of the adverse implications for patient safety and quality of care should there be any reduction in compliance with the individual elements. In addition to the 13 local priorities outlined in section 2, the indicators below demonstrate the quality of the services provided by the Trust over 2018/19 has been positive overall.

<table>
<thead>
<tr>
<th>Patient Safety</th>
<th>Data source</th>
<th>Standard</th>
<th>Actual 2017/18</th>
<th>Target 2018/19</th>
<th>Monthly Target</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
<th>Actual 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSSA per 100,000 bed days</td>
<td>PHE's Data Capture System</td>
<td>Mandatory reporting by NHSI/NHSE</td>
<td>20.35</td>
<td>Not defined</td>
<td>Not defined</td>
<td>25.51</td>
<td>22.71</td>
<td>15.98</td>
<td>12.89</td>
<td>19.29</td>
</tr>
<tr>
<td>MRSA per 100,000 bed days</td>
<td>PHE's Data Capture System</td>
<td>Mandatory reporting by NHSI/NHSE</td>
<td>0.84</td>
<td>Zero Tolerance</td>
<td>Not defined</td>
<td>0.85</td>
<td>0.84</td>
<td>0.00</td>
<td>0.00</td>
<td>0.42</td>
</tr>
<tr>
<td>C.difficile per 100,000 bed days</td>
<td>PHE's Data Capture System</td>
<td>Mandatory reporting by NHSI/NHSE</td>
<td>18.65</td>
<td>No more than 16.1</td>
<td>Not defined</td>
<td>12.75</td>
<td>21.02</td>
<td>16.82</td>
<td>14.61</td>
<td>16.32</td>
</tr>
<tr>
<td>E.coli per 100,000 bed days</td>
<td>PHE's Data Capture System</td>
<td>Mandatory reporting by NHSI/NHSE</td>
<td>36.88</td>
<td>Not defined</td>
<td>Not defined</td>
<td>49.31</td>
<td>32.80</td>
<td>35.32</td>
<td>35.25</td>
<td>38.15</td>
</tr>
<tr>
<td>Klebsiella per 100,000 bed days</td>
<td>PHE's Data Capture System</td>
<td>Mandatory reporting by NHSI/NHSE</td>
<td>15.90</td>
<td>Not defined</td>
<td>Not defined</td>
<td>22.11</td>
<td>15.98</td>
<td>21.02</td>
<td>18.91</td>
<td>19.50</td>
</tr>
<tr>
<td>Pseudomonas per 100,000 bed days</td>
<td>PHE's Data Capture System</td>
<td>Mandatory reporting by NHSI/NHSE</td>
<td>4.24</td>
<td>Not defined</td>
<td>Not defined</td>
<td>8.50</td>
<td>7.57</td>
<td>5.05</td>
<td>6.02</td>
<td>6.78</td>
</tr>
<tr>
<td>Hand Hygiene audits (opportunity)</td>
<td>Internal</td>
<td>Local CAT tool</td>
<td>99.5%</td>
<td>98%</td>
<td>98%</td>
<td>98.82%</td>
<td>99.40%</td>
<td>99.40%</td>
<td>98.87%</td>
<td>99.13%</td>
</tr>
<tr>
<td>Hand Hygiene audits (technique)</td>
<td>Internal</td>
<td>Local CAT tool</td>
<td>98.8%</td>
<td>98%</td>
<td>98%</td>
<td>98.58%</td>
<td>98.86%</td>
<td>98.20%</td>
<td>98.97%</td>
<td>98.71%</td>
</tr>
<tr>
<td>Total number of patient incidents</td>
<td>Internal Datix Incident reporting system</td>
<td>Local Incident Policy</td>
<td>17,802</td>
<td>Not defined</td>
<td>Not defined</td>
<td>4,426</td>
<td>4,520</td>
<td>4,581</td>
<td>4,832</td>
<td>18,359</td>
</tr>
<tr>
<td>per 1000 bed days (Datix)</td>
<td>Internal Datix Incident reporting system</td>
<td>Local Incident Policy</td>
<td>34.9</td>
<td>Not defined</td>
<td>Not defined</td>
<td>35.3</td>
<td>37.2</td>
<td>37.2</td>
<td>37.0</td>
<td>36.7</td>
</tr>
<tr>
<td>% Patient incidents that result in severe harm or death</td>
<td>Internal Datix Incident reporting system</td>
<td>Local</td>
<td>0.35%</td>
<td>Not defined</td>
<td>Not defined</td>
<td>0.25%</td>
<td>0.36%</td>
<td>0.38%</td>
<td>0.31%</td>
<td>0.33%</td>
</tr>
<tr>
<td>Slip, trip and fall - patient (Datix)</td>
<td>Internal Datix Incident reporting system</td>
<td>N/A</td>
<td>3,100</td>
<td>Not defined</td>
<td>Not defined</td>
<td>743</td>
<td>626</td>
<td>653</td>
<td>744</td>
<td>2,766</td>
</tr>
<tr>
<td>Inpatients acquiring pressure damage</td>
<td>Internal Datix Incident reporting system</td>
<td>National definition</td>
<td>6.1</td>
<td>Not defined</td>
<td>Not defined</td>
<td>5.9</td>
<td>5.2</td>
<td>5.3</td>
<td>5.7</td>
<td>5.5</td>
</tr>
<tr>
<td>Pressure Ulcers per 1000 bed days</td>
<td>Internal Datix Incident reporting system</td>
<td>Local</td>
<td>1.6</td>
<td>Not defined</td>
<td>Not defined</td>
<td>1.6</td>
<td>2.0</td>
<td>2.0</td>
<td>1.8</td>
<td>1.9</td>
</tr>
<tr>
<td>Total number of Never Events reported</td>
<td>Internal Datix Incident reporting system</td>
<td>National definition</td>
<td>7</td>
<td>Not defined</td>
<td>Not defined</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Total number of Serious Incidents</td>
<td>Internal Datix Incident reporting system</td>
<td>Local SI Policy</td>
<td>85*</td>
<td>Not defined</td>
<td>Not defined</td>
<td>21</td>
<td>26</td>
<td>26</td>
<td>29</td>
<td>102**</td>
</tr>
<tr>
<td>Medication incidents</td>
<td>Internal Datix Incident reporting system</td>
<td>Local</td>
<td>1,839</td>
<td>Not defined</td>
<td>Not defined</td>
<td>438</td>
<td>481</td>
<td>450</td>
<td>448</td>
<td>1,817</td>
</tr>
</tbody>
</table>
### Clinical Effectiveness

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Standard</th>
<th>Q3 2017/18</th>
<th>Q4 2017/18</th>
<th>Q1 2018/19</th>
<th>Q2 2018/19</th>
<th>Q3 2018/19</th>
<th>Q4 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary Hospital Mortality Index (SHMI)</td>
<td>CHKS</td>
<td>100</td>
<td>98.82</td>
<td>106.23</td>
<td>96.68</td>
<td>91.50</td>
<td>Not available</td>
</tr>
</tbody>
</table>

### Patient Experience

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Standard</th>
<th>Q3 2017/18</th>
<th>Q4 2017/18</th>
<th>Q1 2018/19</th>
<th>Q2 2018/19</th>
<th>Q3 2018/19</th>
<th>Q4 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of complaints received</td>
<td>Internal Datix Incident reporting system</td>
<td>Local Complaints Policy</td>
<td>610</td>
<td>Not defined</td>
<td>Not defined</td>
<td>130</td>
<td>119</td>
</tr>
<tr>
<td>National Inpatient Survey</td>
<td>CQC</td>
<td>National standard</td>
<td>74.9%</td>
<td>Not defined</td>
<td>Not defined</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Friends and Family response rates (inpatients and A&amp;E)</td>
<td>Locally collected reported</td>
<td>National standard</td>
<td>9.3%</td>
<td>Not defined</td>
<td>Not defined</td>
<td>7.83%</td>
<td>7.04%</td>
</tr>
</tbody>
</table>

### Inconsistencies in data reported in the 2018/19 report

There have been some slight variations in the reported 2017/2018 data – this is due to the fact that the Trust Incident reporting system is a live database which results in fluctuations in actual numbers of incidents reported as investigations are processed through the system.

**This figure includes five Serious Incidents that have been subsequently de-registered from 2017/18 since initial reporting.

**This figure includes six Serious Incidents that have been subsequently de-registered in 2018/19 since initial reporting.

Please note that the HCAI figures for per 100,000 bed days is taken from Public Health England’s Data Capture System (DCS) which means that they differ from the in-house figures we have previously produced due to the number of bed days fluctuating within Business Objects system.
The Trust has launched a new Quality Strategy 2018-21 to inform staff and service users how the Trust intends to deliver Safe, Effective, and High Quality Patient Care.

As a Trust we are committed to providing services which:

- Maintain patient safety at all times and in all respects;
- Are clinically effective and lead to the best possible health outcomes for patients;
- Provide a positive patient experience;
- Are timely, equitable and efficient; responding to the needs of our population;
- Are well-led, open and collaborative and are committed to learning and improvement.

This strategy sets out how NUTH aims to continue to deliver the high quality care for which it is renowned and continue to put patients at the heart of all we do.

**Seven Steps to Improve Quality**

This strategy follows the ‘Seven Steps’ to improving quality as outlined by the National Quality Board but have been modified to align with the Trust’s own goals and expectations. The steps define what we need to do, to continually improve the quality of care we provide to our patients and ensure we have a skilled and motivated workforce for the future.

We are confident that by implementing this strategy and continuing to put patients at the heart of everything we do, we will continue to ensure that our services are safe, effective, caring, responsive and well-led. By working hard to foster a culture of continuous improvement, by empowering staff and patients to make the changes they want to see, we will continue to deliver the best possible care to the people of Newcastle and beyond. We will monitor the implementation of this strategy closely and look forward to working together to make The Newcastle upon Tyne Hospitals NHS Foundation Trust even better.
The Trust has developed and embedded a robust quality surveillance programme designed to provide assurance to the Board that high quality care is being delivered across all services and that areas requiring improvement can be quickly identified. The Patient Safety and Quality Review (PS&QR) process is aligned to the CQC inspection approach.

The PS&QR process involves an in-depth annual inspection including:

- Staff interviews – a range of professional groups and staff of varying seniority
- Patient and family/carer opinion
- Direct observations of clinical practice
- Documentation of care
- An inspection of the physical environment.

This process is supported by a data pack. The data pack is based on the five CQC inspection domains and contains a variety of indicators pertinent to each Directorate. In preparation for the review visit, Key Lines of Enquiry (KLOE) are developed, based on analysis of the data pack. The outcomes of the peer review and data pack are discussed at an annual PS&QR panel chaired by the Medical Director and supported by senior clinical leadership from across the Trust.

The objectives of the PS&QR process are as follows:

- To ensure each Directorate attends a PS&QR panel every 12 months as a minimum. This will be supported by a six month follow-up meeting
- For each Directorate to participate in a peer review inspection prior to each PS&QR panel
- To provide a framework for monitoring Quality Indicators at a Directorate level
- To provide a structure to help identify areas of care requiring improvement and the support and expertise to address the more difficult issues that may be impacting on quality and patient safety.
For the period 2018-2019, the Clinical Governance and Risk Department have facilitated 18 internal peer reviews. This robust quality surveillance programme provides assurance to the Board that high quality care is being delivered across all services and quickly identifies both areas of excellence and opportunities for improvement.

A common theme throughout the review process is that staff are always very welcoming and receptive when the inspection team arrive unannounced. The review process provides a valuable opportunity for services to be observed by ‘a fresh pair of eyes’ and also offers an opportunity for learning and sharing for both the clinical teams being reviewed and the inspection team, who often report having observed innovations or ideas which they will replicate in their service.

Examples of innovations and improvements resulting from peer reviews are as follows:

- **Patient Safety** - introduction of electronic Venous thromboembolism (VTE) risk assessment which links to prescribing of thrombo-prophylaxis reducing the risk of avoidable thromboembolism, increased length of stay and costly drug treatments.
- **Patient Safety** - Enhanced Patient ID with wristbands introduced in Rheumatology Day Unit, reducing the likelihood of harm caused by errors resulting in inadvertent administration of drugs to the incorrect patient.
- **Patient Safety** - Promotion of best practice in Infection Prevention and Control. Introduction of initiatives to minimise the likelihood of cross-infection and provision of specific training to clinical teams in ANTT.
- **Patient Experience** - NCCC/Haematology are exploring the introduction of electronic communication to patients waiting for appointments.
- **Patient Experience** - Improved signage in a number of areas to reduce late arrivals for clinics, DNAs and to minimise anxiety for patients.
- **Patient Experience** - Improved staff experience and increased efficiency by clearly defining roles and responsibilities and providing protected time for disseminating key safety messages during and after ward rounds.
- **Patient Experience** - Raised awareness of reasonable adjustments made to accommodate carers and where appropriate include them in the provision of care.

These internal reviews could not take place without the support of multi-disciplinary staff from all services across the Trust who volunteer as inspectors. In 2018/19, 149 staff have acted as inspectors, some of them multiple times. An additional 34 staff have registered to participate in the next annual cycle of reviews. The Trust is extremely grateful to all staff involved for their commitment to the process.
OVERVIEW OF QUALITY IMPROVEMENTS
A BETTER LIFE FOR OTHERS
A DONOR FAMILY’S STORY

When Michael Weedy sadly died aged 69 earlier this year, his family had no hesitation in carrying out his wishes to help others after he was gone. Michael was at home in Northumberland when he suffered a massive, unexpected aneurysm.

His wife, Gillian, said: “He was a healthy, active man, so it came as such a shock. The paramedics and everyone at the RVI did everything they could to save him, but I felt deep down, as they took him out of the house, that he was gone”.

“I got a phone call from my niece and she asked if Michael was a donor. I wasn’t sure, because we’d never talked about it, but then something clicked in my mind and I remembered a donor card that he had in his wallet. He’d carried that tatty card around for years, and it turned out he had been on the donor register for 18 years. I knew there and then, if that was what he wanted then that’s how it had to be.”

Gillian had everything explained to her, without any pressure, including which organs could be used.

She said: “The hardest part was signing the forms, but everyone was absolutely brilliant and there was nothing to worry about. They were very thoughtful and went through everything slowly. I didn’t realise how many things you can donate. If you don’t want to give up some of the main organs, there are so many other things like skin and bones that they can use.”

Gillian said she definitely has no qualms about authorising her husband’s donation.

“I haven’t regretted it at all,” she said. “In fact, I’ve got some solace and comfort from the fact that other people are living full and better lives because of Michael.”

“I know it’s a hard decision to make for a lot of people, but I feel better for doing it, and our daughters both said it’s what dad wanted. So, in a way, he lives on.”

At Michael’s funeral, his family held a collection towards memory boxes for donors’ families.

Gillian added: “I’ve got one and our grandchildren have them. They are a lovely way to remember a loved one and what they gave for others. I think they are a great idea.”

There are currently 986,945 people from the North East on the NHS Organ Donor Register.

Tell your family you want to save lives through organ donation and join the NHS Organ Donor Register at www.organdonation.nhs.uk

"The hardest part was signing the forms, but everyone was absolutely brilliant and there was nothing to worry about. They were very thoughtful and went through everything slowly."
NEWCASTLE TRUST TOPS NATIONAL INSTITUTE FOR HEALTH RESEARCH (NIHR) CLINICAL RESEARCH ACTIVITY LEAGUE TABLE FOR SEVENTH YEAR

The Newcastle upon Tyne Hospitals NHS Foundation Trust is the country’s best performing trust for volume of clinical research for the seventh year running.

It topped the national league tables for the number of health research studies with a total of 550 studies supported by the Trust, exceeding last year’s record of 528.

The table also shows that 16,884 patients, at the Trust, helped to shape the NHS of tomorrow by taking part in clinical research, a rise of 34% since the year before.

The Trust also reported the country’s biggest increase in research activity involving commercial studies, up by 22% from 117 to 143, reflecting the city’s reputation as a global hub for the fast-growing life sciences sector.

Dame Jackie Daniel, Chief Executive, said: “We’re thrilled to be leading the way nationally in clinical research once again. As a Trust, we are committed to delivering the best possible care to patients by investing in research which can help improve the lives of people not just regionally, but also nationally and internationally.

“If it wasn’t for the continued hard work and dedication from our team of medical professionals we wouldn’t be able to achieve all that we do in the clinical research field. Special recognition also has to go to all of the patients, across the region, who give their time to enable us to carry out this important research. Without them, none of this would be possible.”

Dr Jonathan Sheffield OBE, Chief Executive Officer of the NIHR Clinical Research Network (CRN) said: “By taking part in life sciences industry studies, patients are participating in new and innovative forms of treatment which will provide evidence for future improved care for all patients. The knowledge gained could provide the evidence to license new treatments in the NHS securing healthy lives for future generations”.

The NIHR League Table can be accessed from the NIHR website: www.nihr.ac.uk/nihrleaguetable.

“By taking part in life sciences industry studies, patients are participating in new and innovative forms of treatment which will provide evidence for future improved care for all patients.”
NEWCASTLE’S DIALYSIS UNIT CELEBRATES 40 YEARS AT FREEMAN HOSPITAL

Staff on the haemodialysis unit (Ward 31) threw a party to celebrate the 40th anniversary of providing dialysis at Newcastle’s Freeman Hospital.

When the unit first opened in 1978, forty patients received their treatment in a single, 10 station facility. Since then, the service has grown to provide life-saving treatment to hundreds of patients with kidney failure in a state of the art, purpose built dialysis unit at the Freeman Hospital’s Renal Services Centre, as well as our satellite dialysis units at North Shields and Alnwick.

Dr Kanagasundaram, Consultant Nephrologist and Haemodialysis Lead said: “Renal Services in Newcastle has a long and proud history of treating patients from across the region and further afield, allowing thousands of patients with many different types of kidney disease to regain their health and wellbeing”.

Particular highlights have included:

• The first description of aluminium bone disease in dialysis patients (so called ‘Newcastle Bone Disease’) That led to improved dialysis water standards and benefitting patients across the world.
• The first use of single-needle dialysis (‘click-clack’ dialysis) that allowed people with poor vascular access to be dialysed, successfully.

• Newcastle’s recognition as a centre of excellence for patients with genetic and immune-mediated kidney diseases – this has culminated in the service’s successful nomination as the UK’s National Centre for Complement Therapeutics, managing the treatment of patients across the country with the potentially devastating kidney condition, ‘atypical HUS’.

He added: “The technology and treatments we now use for our dialysis patients have changed beyond recognition since dialysis first started in Newcastle but one thing that the renal team shares in common with the first dialysis pioneers in Newcastle, is the desire to place our patients at the centre of all that we do.

“I would also like to express my gratitude to Matron Julia Ibbotson and Mrs. Joanne Ridden for all their hard work in getting the celebratory events off the ground and making these such a great success.”

Here’s to many more decades of providing outstanding renal services to our dialysis patients.
NEWCASTLE HOSPITALS WINS ‘GOLD AWARD’ FOR ITS SUPPORT TO THE ARMED SERVICES

Newcastle Hospitals has received a ‘gold award’ for its outstanding support to the Armed Forces. The Trust was one of 50 organisations in the UK to receive the highest badge of honour in the Defence Employer Recognition Scheme for their long-term commitment to the armed forces community.

The scheme encompasses bronze, silver and gold awards for employer organisations that pledge, demonstrate or advocate support to defence and the armed forces community, and align their values with the Armed Forces Covenant, which each has signed. Currently, Newcastle Hospitals has 34 reservists, 48 known veterans and a Cadet Force Adult Volunteer in its employment and some of the steps taken to support them include:

- Developing a dedicated Reserve Forces training and mobilisation policy which includes additional paid leave to enable them to attend their annual camp
- Offering flexibility for spouses to take time off before, during and after a partner’s deployment, injury or during bereavement, in line with the Trust’s special leave policy
- Offering a guaranteed interview scheme to those who identify themselves as a reservist or veteran, where they meet the minimum criteria
- Working closely with the Career Transition Partnership (CTP) to offer bespoke work attachments to service leavers, taking into consideration the service leavers experience and where their interests lie to develop an attachment which will help to guide them towards a career they will enjoy and be successful in.

Chief Executive Dame Jackie Daniel said: “This is fantastic news for us all but particularly the team who have dedicated their time to supporting our Armed Forces of which we are truly fortunate to have working in our Trust. We have taken a number of steps to ensure this community are not disadvantaged by the sacrifice they make in helping to keep this country safe and are honoured to be recognised by the Ministry of Defence for the work we do. It is important for us to celebrate the contribution made, particularly by our staff, who also serve as Reservists or our ex-forces and we very much value the extra skills and experience that they bring to our organisation.”

“This is fantastic news for us all but particularly the team who have dedicated their time to supporting our Armed Forces of which we are truly fortunate to have working in our Trust.”

VETERAN AWARE
UK FIRST AS NEWCASTLE HOSPITALS OFFERS CUTTING-EDGE RADIOSURGERY TECHNOLOGY FOR BRAIN CANCER PATIENTS

The Northern Centre for Cancer Care (NCCC) has become the first radiotherapy centre in the UK to offer cutting-edge radiosurgery technology to treat patients with brain cancer.

The centre at the Freeman Hospital is now using a new treatment planning software system – known as ‘Brainlab Elements’ – which rapidly generates radiosurgery plans for the efficient treatment of multiple brain metastases (cancer cells that have spread to the brain from primary tumours in other organs in the body).

This advanced technique allows for the treatment of multiple tumours at a time with a delivery of large doses of precisely focused radiation whereas before each individual metastasis had to be planned and treated separately.

The NCCC is one of only 17 centres in the UK with the expertise and capability to deliver Stereotactic Radiosurgery - a highly specialised and precise radiotherapy – to patients with certain types of malignant and benign brain tumours across the Northern Region.

Head of Radiotherapy Physics, Chris Walker said: “We’re really pleased to be the first in the country to bring the very latest in stereotactic radiosurgery technology from Germany - it’s another example of how we’re embracing technology and working hard to achieve better services and outcomes for our patients.

“This is a step-change in our ability to treat multiple metastases in the brain in a way that is non-invasive and delivers high precision treatments in a significantly shorter time. The biggest benefit will be seen by patients who will spend less time on the treatment bed.”

Using specially configured linear accelerators, Stereotactic radiosurgery is a very precise, intense form of radiotherapy (radiation therapy).

Despite the use of the word ‘surgery’ in its name, it does not involve removing the tumour with a surgical blade. Instead, a focused high-intensity beam of radiation is used to target the tumour, which can help to preserve healthy tissue; more effectively treat the target tumour and reduce side-effects.

It offers an excellent treatment option for some patients whose primary cancer is under control, but have developed a small number of secondary brain lesions and whose previous options were extremely limited.

Chris added: “At the NCCC, our aim is to improve the diagnosis and management of cancers in the region by using the best available techniques and equipment. This complements our specialist cancer centre portfolio by ensuring we are keeping up with developing technologies so we can deliver the very best care for our patients.”
NEW ‘SINGLE POINT OF ACCESS’ MUSCULOSKELETAL SERVICE TO BENEFIT PATIENTS ACROSS GATESHEAD AND NEWCASTLE

A new ‘single point of access’ service for thousands of patients with muscle and joint (musculoskeletal - MSK) problems is to be launched across Newcastle and Gateshead. TIMS – Tyneside Integrated Musculoskeletal Services – offers self-care and fast access to information, resources and expert opinion about a variety of back, neck, joint or general muscle conditions.

A key aspect of the service is about giving patients greater control of their own care and making it easier for them to self-manage muscular conditions through a dedicated website – www.tims.nhs.uk. If additional advice or support is needed, patients can also use the website to refer themselves to access local NHS physiotherapy and other musculoskeletal and pain services without having to visit their own GP first. This, in turn, will mean those with more complex conditions can be seen more quickly by specialist teams who will, where appropriate, refer them onto a hospital consultant for further assessment. The community-based initiative follows a period of engagement in 2014 when patients and local service providers were asked for their views on the current services available across Newcastle and Gateshead and how these might be improved in the future.

Their views helped to establish key elements of the service, including:

- A dedicated website providing a range of advice, on-line exercises and guidance to support people to self-manage their own MSK problems
- A help and advice telephone line for patients and GPs
- Providing services closer to home, reducing the need for hospital care and empowering and supporting people to play a role in improving their own health and wellbeing
- Locations and opening times: the service will have clinics operating from eight different locations across the area. Service times are 8am and 8pm, Monday to Friday and 9am to midday on Saturdays
- A more joined-up community-based service between the two Trusts developed to help patients with musculoskeletal problems manage their condition in the most effective way.

Newcastle’s Head of Therapy Services Stella Wilson said: “A key focus of our service is supporting self-management and we’ve created a dedicated website to make it easier for patients to manage their own health conditions and access support from other agencies, allowing them to lead as fulfilling and independent lives as possible with less reliance on the healthcare system. For those who need further support, TIMS is about ensuring patients’ with musculoskeletal conditions and chronic pain, have equal access to therapy, assessment and treatment, no matter where they live across Newcastle and Gateshead – essentially they’re seeing the right person, in the right place at the right time. We’re also working closely with third sector, voluntary organisations and leisure services to guide patients to other appropriate services which can benefit them.”
Health Play Specialists from across Newcastle’s Great North Children’s Hospital, including cardio, ophthalmology and dermatology, showcased their services at a day of fun and information in October 2018.

The ‘Everyday Heroes’ event, held outside the Medicinema in the New Victoria Wing at the RVI, featured Gerry the Storyteller, Clown Doctors, Mrs Merlin and Harvey’s Gang, amongst examples of innovative projects to support the wellbeing of children and young people within our care.

We have more than 30 Health Play Specialists and Nursery Nurses across wards, departments and in the community - all providing a wide range of services and activities specially designed to prevent the anxiety that many children and young people feel when they find themselves in hospital.

Helga Charters, Matron for Children’s Services, explained: “Many of the children and young people who come into our care are often overwhelmed by the combination of a physical illness or injury, together with the emotional stress of being in an unfamiliar environment, surrounded by people they have never met before. We want to bring a sense of normality to their time in hospital, and to help them cope we use the medium of play as a form of distraction, interaction, development and, perhaps most importantly, fun.”
A consultant neonatologist at Newcastle’s Royal Victoria Infirmary has won the Healthcare Professional category at the 2018 Butterfly Awards. The annual awards are organised by Finley’s Footprints, a national organisation for parents and professionals to find information and support following the death of a baby.

Professor Nick Embleton has worked with premature and sick newborn babies on the neonatal intensive care unit at the RVI for more than 25 years. He won the accolade for his work to develop the coincidentally-named Butterfly Project, which supports bereaved parents of multiple births who still have a baby on the neonatal unit.

One aspect of the project is to place a card in the shape of a butterfly - with the name of the child who has died - in the cot to remind staff that the surviving baby had a sibling.

Since the initiative began at the RVI in 2015, the butterfly cot cards have been used in around 300 hospitals all over the world, together with a range of resources for healthcare professionals including guidelines, leaflets and a video of parents sharing their stories.

Professor Embleton was nominated for the Butterfly Award by Jeanette Proud, whose daughter Sophie made news headlines 22 years ago when she was born weighing less than a bag of sugar. Sophie survived thanks to the work of Professor Embleton and his team and is now a staff nurse on the same special care baby unit herself.

Jeanette said: “Every now and again, a very special person comes into your life - that person is Nick Embleton. Sophie was 23 weeks gestation and weighed just 750 grams. Sadly, her twin sister Beth died. During her 16 weeks in hospital, Nick spent far too many hours to count saving Sophie’s life, through many bouts of pneumonia, a blocked artery and a duct ligation. Nick remains a part of our lives to this day. He never gave up on Sophie and indeed never will.”

Professor Embleton said: “I am humbled to have been given this award. I will admit that no-one is more surprised than I am to have arrived where I find myself now - trying to help other doctors and nurses better understand the feelings of parents whose babies died. I am immensely proud of our neonatal Butterfly Project and indebted to all the researchers and staff who helped me. However, most of all, I see this award as not for me but for the parents of those babies, and especially those who felt able to give their time and emotional energy to help others better understand what it feels like. The Butterfly Awards are for them.”
NEWCASTLE NEONATAL NURSE SCOOPS NATIONAL AWARD

A member of the Northern Neonatal Transport Service (NNeTS) has been named national Neonatal Nurse of the Year. Matt Cray, who is based in the special baby care unit at Newcastle’s Royal Victoria Infirmary, won the award for his work in setting up a team to support fathers of babies born prematurely, the first of its kind in the UK.

Matt explained: “Mums are incredibly well supported in neonatal care, but dads have very much been the forgotten parent. My matron, Yve Collingwood, tasked me with finding out what support was out there for dads and after much research I was astounded to find that of the 196 neonatal units in the UK, none had any specific support for dads. In fact, the nearest was in Melbourne, Australia.”

After receiving permission from the hospital in Melbourne to replicate its support service, Matt contacted dads who had previously had babies on the ward through the charity Tiny Lives.

The Special Care Baby Unit (SCBU) Dads’ team was created, with a number of dads participating who had previously had babies on the unit. The team was launched in December 2018, they have helped 50 dads whose babies were born prematurely or with other difficulties. Matt said: “These men are truly amazing dads and I am incredibly proud to win this award on their behalf. Men have very different needs that are being unmet. They have to deal with immense stress – working, keeping the home going and possibly looking after other children. It has been shown that meeting other dads who have been through the same experience improves their mental health, which in turn improves the mums’ mental health and therefore improves the care for their babies”.

“I hope that winning this award makes other neonatal units aware of the importance of this vital innovation to dads. The plan into 2019 is to work, towards implementation of the SCBU Dads team model, throughout the northern region of neonatal units.”

“Men have very different needs that are being unmet. They have to deal with immense stress – working, keeping the home going and possibly looking after other children.”
OLIVIA IS THE FIRST HARVEY GANG VISITOR AT THE RVI’S BLOOD SCIENCES LABORATORY IN 2019

Blood Sciences at Newcastle's Royal Victoria Infirmary welcomed its first visitor of 2019 when six-year-old Olivia and her mum, Terry, came to visit the laboratory.

Olivia requires red cell transfusion every four weeks so she was really excited to find out what happens to her blood samples and to look at where the bags of blood come from. She brought her samples down to the laboratory and booked them onto the laboratory computer system with some help from Marc. She then loaded them onto the different analysers, or train tracks as we like to call them! We made a blood film of Olivia’s sample and she was able to look at this down the microscope! She really enjoyed looking at her blood cells, and finding all the different white blood cells. In transfusion, we showed Olivia and her mum all the different blood products and found some blood that was the same group as her. Finally in Biochemistry, George showed Olivia how the analyser works by demonstrating some colour change reactions – Olivia was especially excited when one turned her favourite colour, pink!

About Harvey’s Gang
Harvey Buster Baldwin was a young patient who was also taken around his local hospital’s laboratories before he sadly lost a 20-month battle with leukaemia in October 2014. Harvey’s mum Claire Baldwin commented how much the tour had meant to Harvey, which prompted the launch of Harvey’s Gang – a project dedicated to his memory.

To find out more about Harvey’s Gang visit http://harveysgang.com/harveys-story/

“We made a blood film of Olivia’s sample and she was able to look at this down the microscope! She really enjoyed looking at her blood cells, and finding all the different white blood cells.”
NEWCASTLE HOSPITALS IS REVOLUTIONISING PROSTATE CANCER TREATMENT

The Northern Centre for Cancer Care (NCCC), based at the Freeman Hospital, has treated the first UK prostate cancer patients using pioneering MRI-only planning technology and radiotherapy.

Prostate cancer is the commonest cancer among men in the UK. Radiotherapy is an often used treatment given to prostate cancer patients and involves delivering a very high dose of radiation to the prostate gland and as low a dose as possible to surrounding healthy organs, such as the bowel and bladder.

The treatment normally requires patients to attend for a Computerised Tomography (CT) scan in the radiotherapy department as well as an Magnetic Resonance Imaging (MRI) scan to gain a better image of the target and organs at risk - in this case the prostate, bowel and bladder respectively. NCCC was one of the first UK radiotherapy centres to use MRI in this way specifically for radiotherapy treatment planning.

Conventional workflow has been to combine the MRI scan with the CT data needed for accurate radiotherapy dose calculations.

Dual imaging requires patients to attend for two separate sessions. However, new MRI-only planning technology is now available which means the CT scan can be omitted. Careful validation of this approach now means that the patients need only attend for a single scanning session.

Head of Radiotherapy Physics, Chris Walker, said: “It is particularly gratifying that the implementation of the most up-to-date technology allows our patients to benefit from spending less time in hospital.”

Consultant Clinical Oncologist, Rachel Pearson, added: “This new MRI-only system is already being used in several European radiotherapy departments and now, here in Newcastle, we have treated the first patients in the UK using this treatment pathway. Using one image rather than two, allows us to better target the tumour and avoid healthy organs. It also reduces the amount of time patients are in hospital and the severity of side-effects, both in the short and longer term.

“We are very excited that, with support from the charity Charlie Bear for Cancer Care, we are able to bring this state-of-the-art treatment to our patients in the North East.”

Keith Kirby, aged 69, from Gosforth, is one of the first patients to benefit from the new technology at NCCC. He said: “Anything that can improve the technique and make the delivery of the radiotherapy more accurate has to be a good thing. I’m only too pleased to help by being a part of this new pre-treatment.”

From left, Hazel McCallum, Consultant Clinical Scientist; Rachel Pearson, Consultant Clinical Oncologist; Karen Pilling, Clinical Lead Superintendent Radiographer; Keith Kirby, MR-only planning radiotherapy patient, Jonathan Wyatt, Clinical Scientist; Serena West, Imaging Superintendent Radiographer; Michele Wilkinson, Principal Dosimetrist.
Maternity services across Newcastle Hospitals have been rated among the best in the country for their care provided to mums and babies. In January 2019, the Care Quality Commission (CQC) published results of its national maternity survey – with the Trust identified as one of nine nationally who performed ‘better than expected’ in many key areas.

The survey asks women about their experiences of care at three different stages of their maternity journey - antenatal care, labour and birth and postnatal care – and 181 women who gave birth at the Royal Victoria Infirmary responded.

Their feedback placed staff highly for:

- introducing themselves before examination or treatment
- attention during labour
- clear communication
- respect and dignity during labour and birth
- patients having confidence and trust in the staff caring for them
- care in hospital after birth.

Our maternity teams – who oversee the safe delivery of over 6,500 babies every year - were also recognised for reducing delays with discharge, attending to patients when needed, being treated with kindness and understanding, and providing information and explanations after birth.
In healthcare, we have traditionally focused on errors in an effort to learn from our mistakes and avoid further harm. Whilst this is important, it fails to recognise that the vast majority of what we do on a daily basis is good; indeed some of it is excellent.

If we only focus on when things go wrong, the opportunity to learn from excellent practice is missed. We would like to join a growing movement aiming to redress the balance by studying excellence and in doing so improve care, morale and resilience.

We ask our staff to report excellence – by completing an online (GREATIX) form and telling us who achieved excellence and how they did it.

In March 2019 we received 149 submissions compared to 10 received in March 2017 and 81 in March 2018.

We also received our 2000th submission on the 14th March 2019. This is fantastic and we didn’t think we would get here this quickly.
INFORMATION ON PARTICIPATION IN NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES
During 2018/19, 66 national clinical audits and six national confidential enquiry reports / review outcome programmes covered NHS services that The Newcastle upon Tyne Foundation Hospitals NHS Foundation Trust provides.

During that period, The Newcastle upon Tyne Hospitals NHS Foundation Trust participated in 63 (95%) national clinical audits and 100% of the national confidential enquiries / review outcome programmes which it was eligible to participate in. The national clinical audits and national confidential enquiries that The Newcastle upon Tyne Hospitals NHS Foundation Trust was eligible to participate in during 2018/19 and the national clinical audits / national confidential enquiries that The Newcastle upon Tyne Hospitals NHS Foundation Trust participated in during 2018/19 are as follows:

<table>
<thead>
<tr>
<th>National Clinical Audits</th>
<th>National Confidential Enquiries</th>
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<tbody>
<tr>
<td>Adult Cardiac Surgery</td>
<td>Myocardial Ischaemia National Audit Programme (MiNAP)</td>
</tr>
<tr>
<td>Diabetes - The National Diabetes Inpatient Audit (NaDIA) - Harms - reporting on diabetic inpatient harms</td>
<td>Child Health Outcome Review Programme - Long-term ventilation in children, young people and adults</td>
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<tr>
<td>Adult Community Acquired pneumonia</td>
<td>Neonatal Audit Programme</td>
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<tr>
<td>Diabetes - Pregnancy in Diabetes</td>
<td>Medical and Surgical Clinical Outcome Review Programme (NCEPOD) - Acute Heart Failure</td>
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<tr>
<td>Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Adult Asthma</td>
<td>Diabetes (Paediatric)</td>
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<tr>
<td>Neurosurgical National Audit Programme</td>
<td>NCEPOD - Cancer in Children, Teens and Young Adults</td>
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<tr>
<td>Asthma and COPD Audit Programme – COPD in Secondary care</td>
<td>Early Inflammatory Arthritis</td>
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<tr>
<td>Non-invasive Ventilation (Adults)</td>
<td>NCEPOD - Perioperative Diabetes</td>
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<tr>
<td>Asthma and COPD Audit Programme – Pulmonary Rehabilitation</td>
<td>Elective Surgery Patient Reported Outcome Measure (PROMS) Programme - Hip</td>
</tr>
<tr>
<td>Oesophago-gastric Cancer</td>
<td>NCEPOD - Pulmonary Embolism</td>
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<tr>
<td>British Association Urological Surgeons (BAUS) Audits: Cystectomy</td>
<td>Elective Surgery (PROMS) Programme - Knee</td>
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<tr>
<td>Ophthalmology Audit</td>
<td>NCEPOD Acute Bowel Obstruction</td>
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<tr>
<td>BAUS Urology Audits: Female Stress Urinary Incontinence</td>
<td>Emergency Laparotomy Audit</td>
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<tr>
<td>Percutaneous Coronary Interventions</td>
<td>Prostate Cancer</td>
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<tr>
<td>BAUS Urology Audits - Nephrectomy</td>
<td>Falls and Fragility Fractures Audit Programme – Fracture Liaison Service database</td>
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<tr>
<td>PAEDiatric Intensive Care</td>
<td>Pulmonary Hypertension</td>
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<tr>
<td>BAUS Urology Audits - Percutaneous Nephrolithotomy</td>
<td>Falls and Fragility Fractures Audit Programme – National Hip Fracture Database</td>
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<td>National Clinical Audits</td>
<td>National Confidential Enquiries</td>
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<tr>
<td>Bowel Cancer</td>
<td>Feverish Children (Care in Emergency Department)</td>
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<td></td>
<td>Reducing the Impact of Serious Infections - Antibiotic consumption</td>
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<tr>
<td>Breast Cancer in Older People</td>
<td>Heart Failure</td>
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<td></td>
<td>Reducing the Impact of Serious Infections - Antimicrobial stewardship</td>
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<tr>
<td>Cardiac Arrest</td>
<td>Inflammatory Bowel Disease Programme</td>
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<td></td>
<td>Seizures and Epilepsies in Children and Young People (Epilepsy 12)</td>
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<tr>
<td>Cardiac Rehabilitation</td>
<td>Intermediate Care</td>
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<td>Sentinel Stroke National Audit Programme</td>
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<tr>
<td>Cardiac Rhythm Management</td>
<td>Joint Registry</td>
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<td></td>
<td>Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme</td>
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<tr>
<td>Care at End of Life</td>
<td>Learning Disability Mortality Review Programme</td>
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<td>Seven Day Hospital Services</td>
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<td>Case mix Programme</td>
<td>Lung Cancer</td>
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<td>Surgical Site Infection Surveillance Service</td>
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<tr>
<td>Comparative audit of Blood Transfusion Programme - Use of</td>
<td>Major Trauma Audit</td>
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<tr>
<td>fresh frozen plasma and Cryoprecipitate in neonates and</td>
<td>UK Cystic Fibrosis Registry</td>
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<td>children</td>
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<tr>
<td>Comparative audit of Blood Transfusion Programme -</td>
<td>Mandatory Surveillance of Bloodstream Infections and Clostridium</td>
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<td>Management</td>
<td>Difficile Infection</td>
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<td>Vascular Registry</td>
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<tr>
<td>Congenital Heart Disease</td>
<td>Maternal, Newborn and infant Clinical Outcome review programme -</td>
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<tr>
<td></td>
<td>Perinatal Mortality Surveillance</td>
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<td>Dementia</td>
<td>Maternal, Newborn and infant Clinical Outcome review programme -</td>
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<tr>
<td></td>
<td>Maternal Mortality Surveillance</td>
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<tr>
<td>Diabetes (Adults) - Footcare Audit</td>
<td>Maternal, Newborn and infant Clinical Outcome review programme -</td>
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<tr>
<td></td>
<td>Maternal Morbidity and Mortality Confidential Enquiry</td>
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<tr>
<td>Diabetes - Inpatient audit</td>
<td>Maternity and Perinatal</td>
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</table>
The national clinical audits and national confidential enquiries that The Newcastle upon Tyne Hospitals NHS Foundation Trust participated in 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.

<table>
<thead>
<tr>
<th>National Audit issue</th>
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<tr>
<td>BAUS Urology Audits: Cystectomy</td>
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<tr>
<td>BAUS Urology Audits: Female Stress Urinary Incontinence</td>
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<tr>
<th>Sponsor / Audit</th>
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<tbody>
<tr>
<td>British Thoracic Society</td>
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<td>Royal College of Physicians</td>
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<td>British Association of Urological Surgeons</td>
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<table>
<thead>
<tr>
<th>What is the Audit about?</th>
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<tbody>
<tr>
<td>This audit looks at heart operations. Details of who undertakes the operations, the general health of the patients, the nature and outcome of the operation, particularly mortality rates in relation to preoperative risk and major complications.</td>
</tr>
<tr>
<td>The audit includes all adult cases admitted through an acute admission area with a diagnosis of pneumonia.</td>
</tr>
<tr>
<td>This audit programme brings together primary care, secondary care, and pulmonary rehabilitation, along with patient experience and pilot linkage. Its partnership approach with multidisciplinary, collaborative working aims to drive improvements in COPD patient care. The audit programme supports the Department of Health (DH) aim to improve the quality of services for people with COPD by measuring and reporting the delivery of care as defined by standards embedded in guidance.</td>
</tr>
<tr>
<td>The audit addresses open, keyhole or robotic-assisted removal of the bladder for cancer.</td>
</tr>
<tr>
<td>The audit addresses open surgery for stress incontinence of urine in women.</td>
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<tr>
<th>Trust participation in 2018/19</th>
<th>Percentage Data completion</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>✓</td>
<td>100%</td>
<td>No publication date yet identified</td>
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<tr>
<td>✓</td>
<td>Data collection December 2018 – May 2019</td>
<td>Published report expected December 2019</td>
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<tr>
<td>✓</td>
<td>Data Collection November 2018 – March 2019</td>
<td>Published report expected September 2019</td>
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<tr>
<td>✓</td>
<td>Continuous data collection April 2018 – March 2019</td>
<td>Published report expected April 2019</td>
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<tr>
<td>✓</td>
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<td>Published report expected May 2019</td>
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<td>Sponsor / Audit</td>
<td>What is the Audit about?</td>
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<tr>
<td>BAUS Urology Audits - Nephrectomy</td>
<td>British Association of Urological Surgeons</td>
<td>The audit addresses partial or complete kidney removal (± the ureter) using open or “keyhole” techniques.</td>
</tr>
<tr>
<td>BAUS Urology Audits - Percutaneous Nephrolithotomy</td>
<td>British Association of Urological Surgeons</td>
<td>The audit addresses percutaneous “keyhole” removal of stones from the kidney (or upper ureter).</td>
</tr>
<tr>
<td>BAUS Urology Audits - Radical Prostatectomy</td>
<td>British Association of Urological Surgeons</td>
<td>The audit addresses open, keyhole or robotic removal of the prostate gland (± lymph nodes) for cancer.</td>
</tr>
<tr>
<td>Bowel Cancer</td>
<td>Royal College of Surgeons of England</td>
<td>Colorectal (large bowel) cancer is the most common cancer in non-smokers and second most common cause of death from cancer in England and Wales. Each year over 30,000 new cases are diagnosed, and bowel cancer is registered as the underlying cause of death in half of this number.</td>
</tr>
<tr>
<td>National Audit issue</td>
<td>Sponsor / Audit</td>
<td>What is the Audit about?</td>
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<tr>
<td>Breast Cancer in Older People</td>
<td>Clinical Effectiveness Unit, The Royal College of Surgeons of England</td>
<td>The audit will assess the processes of care and outcomes for women aged over 70 years. The National Audit of Breast Cancer in Older Patients (NABCOP) results will help NHS breast cancer services in England and Wales to benchmark and improve the care delivered to these women. NABCOP is a new project that began in April 2016. It is run by the Association of Breast Surgery and the Clinical Effectiveness Unit at the Royal College of Surgeons of England. The clinical audit will focus on the patient pathway from diagnosis to the end of primary therapy, for women diagnosed with breast cancer from 2014 onwards.</td>
</tr>
<tr>
<td>Cardiac Arrest</td>
<td>Intensive Care National Audit &amp; Research Centre</td>
<td>The purpose of the audit is to monitor the incidence of, and outcome from, in-hospital cardiac arrest in the UK and Ireland.</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>University of York</td>
<td>The audit aims to support cardiovascular prevention and rehabilitation services to achieve the best possible outcomes for patients with cardiovascular disease, irrespective of where they live.</td>
</tr>
<tr>
<td>Cardiac Rhythm Management</td>
<td>National Institute for Cardiovascular Outcomes Research (NICOR)</td>
<td>The audit aims to monitor the use of implantable devices and interventional procedures for management of cardiac rhythm disorders in UK hospitals.</td>
</tr>
<tr>
<td>Care at End of Life</td>
<td>Royal College of Physicians</td>
<td>The audit has been designed to ensure that the priorities for care of the dying person outlined in the document One Chance to Get it Right are monitored at a national level.</td>
</tr>
<tr>
<td>National Audit issue</td>
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<tr>
<td>Case mix Programme</td>
<td>Intensive Care National Audit Research Centre</td>
<td>The aim of the audit is to improve resuscitation care and patient outcomes for the UK and Ireland.</td>
</tr>
<tr>
<td>Comparative audit of Blood Transfusion Programme - Use of fresh frozen plasma and Cryoprecipitate in neonates and children</td>
<td>NHS Blood and Transplant</td>
<td>The audit aims to determine the dosage used, whether standard coagulation testing is performed pre and post administration, assess changes in standard coagulation testing after administration and evaluate clinical use in infants and paediatrics.</td>
</tr>
<tr>
<td>Comparative audit of Blood Transfusion Programme - Management of massive haemorrhage</td>
<td>NHS Blood and Transplant</td>
<td>The audit addresses all patients who have been transfused due to experiencing large volume blood loss.</td>
</tr>
<tr>
<td>Congenital Heart Disease</td>
<td>National Institute for Cardiovascular Outcomes Research (NICOR)</td>
<td>The congenital heart disease website profiles every congenital heart disease centre in the UK, including the number and range of procedures they carry out and survival rates for the most common types of treatment.</td>
</tr>
<tr>
<td>Dementia</td>
<td>Royal College of Psychiatrists</td>
<td>The audit measures the performance of general hospitals against criteria relating to care delivery which are known to impact upon people with dementia while in hospital.</td>
</tr>
<tr>
<td>Diabetes (Adults) - Footcare Audit</td>
<td>NHS Digital</td>
<td>National Diabetes Foot Care Audit enables all diabetes foot care services to measure their performance against NICE clinical guidelines and peer units, and to monitor adverse outcomes for people with diabetes who develop diabetic foot disease.</td>
</tr>
<tr>
<td>Diabetes - Inpatient audit</td>
<td>NHS Digital</td>
<td>The National Diabetes Inpatient Audit (NaDIA) is an annual snapshot audit of diabetes inpatient care.</td>
</tr>
<tr>
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<tr>
<td>Diabetes - NaDIA-Harms - reporting on diabetic inpatient harms</td>
<td>NHS Digital</td>
<td>The National Diabetes Inpatient Audit - Harms (NaDIA-Harms) is a continuous collection of four diabetic harms which can occur during an inpatient stay.</td>
</tr>
<tr>
<td>Diabetes - Pregnancy in Diabetes</td>
<td>NHS Digital</td>
<td>The audit aims to support clinical teams to deliver better care and outcomes for women with diabetes who become pregnant.</td>
</tr>
<tr>
<td>Diabetes (Paediatric)</td>
<td>Royal College of Paediatrics and Child Health</td>
<td>The audit covers registrations, complications, care process and treatment targets.</td>
</tr>
<tr>
<td>Early Inflammatory Arthritis</td>
<td>British Society of Rheumatology</td>
<td>The audit aims to improve the quality of care for people living with inflammatory arthritis.</td>
</tr>
<tr>
<td>Elective Surgery (PROMS) Programme - Hip</td>
<td>NHS Digital</td>
<td>This audit looks at the change in patients' self-reported health status.</td>
</tr>
<tr>
<td>Elective Surgery (PROMS) Programme - Knee</td>
<td>NHS Digital</td>
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<tr>
<td>Emergency Laparotomy Audit</td>
<td>Royal College of Anaesthetists</td>
<td>The National Emergency Laparotomy Audit aims to look at structure, process and outcome measures for the quality of care received by patients undergoing emergency laparotomy.</td>
</tr>
<tr>
<td>Falls and Frailty Fractures Audit Programme – Fracture Liaison Service database</td>
<td>Royal College of Physicians</td>
<td>Fracture Liaison Services (FLS) are the key secondary prevention service model to identify and prevent primary and secondary hip fractures. The audit has developed the Fracture Liaison Service Database to benchmark services and drive quality improvement.</td>
</tr>
<tr>
<td>Falls and Frailty Fractures Audit Programme – National Hip Fracture Database</td>
<td>Royal College of Physicians</td>
<td>The audit measures quality of care for hip fracture patients, and has developed into a clinical governance and quality improvement platform.</td>
</tr>
<tr>
<td>National Audit issue</td>
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<tr>
<td>Falls and Fragility Fractures Audit Programme –Falls Audit</td>
<td>Royal College of Physicians</td>
<td>The audit provides the first comprehensive data sets on the quality of falls prevention practice in acute hospitals.</td>
</tr>
<tr>
<td>Feverish Children (Care in Emergency Department(ED))</td>
<td>Royal College of Emergency Medicine</td>
<td>The audit addresses the care of children, under the age of 5 years, who present to the Emergency Department with fever or febrile illness as part of their prescribing practice.</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>National Institute for Cardiovascular Outcomes Research</td>
<td>The aim of this project is to improve the quality of care for patients with heart failure through continual audit and to support the implementation of the national service framework for coronary heart disease.</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD) Programme</td>
<td>Inflammatory Bowel Registry</td>
<td>The IBD Registry biological therapies audit collected data on all patients of all ages diagnosed with the ICD-10 codes and receiving biological therapy at any time during the year. The data was requested at three time points: initiation, post-induction review and 12-month review.</td>
</tr>
<tr>
<td>Intermediate Care</td>
<td>NHS Benchmarking Network</td>
<td>The audit focuses on services which support, usually frail, elderly people, at times of transition when stepping down from hospital or preventing them being admitted to secondary or long term care.</td>
</tr>
<tr>
<td>Joint Registry</td>
<td>Healthcare Quality Improvement Partnership</td>
<td>The audit covers clinical audit during the previous calendar year and outcomes including survivorship, mortality and length of stay.</td>
</tr>
<tr>
<td>Learning Disability Mortality Review Programme</td>
<td>University of Bristol</td>
<td>The programme was established to drive improvement in the quality of health and social care service delivery for people with learning disabilities by looking at why people with learning disabilities typically die much earlier than average.</td>
</tr>
<tr>
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<tr>
<td>Lung Cancer</td>
<td>Royal College of Physicians</td>
<td>Lung cancer has the highest mortality rate of all forms of cancer in the western world and there is evidence that the UK’s survival rates compare poorly with those in the rest of Europe. There is also evidence that, in the UK, standards of care differ widely. The audit was set up in response to The NHS Cancer Plan, to monitor the introduction and effectiveness of cancer services.</td>
</tr>
<tr>
<td>Major Trauma Audit</td>
<td>The Trauma Audit &amp; Research Network (TARN)</td>
<td>TARN is working towards improving emergency health care systems by collating and analysing trauma care.</td>
</tr>
<tr>
<td>Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection</td>
<td>Public Health England</td>
<td>Mandatory Health Care Acquired Infection surveillance outputs are used to monitor progress on controlling key health care associated infections and for providing epidemiological evidence to inform action to reduce them.</td>
</tr>
<tr>
<td>Maternal, Newborn and infant Clinical Outcome review programme - Perinatal Mortality Surveillance</td>
<td>MBRRAECE (Mothers and Babies, Reducing Risk through Audits and Confidential Enquiries across the UK) -UK, National Perinatal Epidemiology Unit, University of Oxford</td>
<td>The study addresses late fetal losses – baby delivered between 22+0 and 23+6 weeks of pregnancy showing no signs of life, irrespective of when the death occurred. Terminations of pregnancy - resulting in a pregnancy outcome from 22+0 weeks gestation onwards. Stillbirths – baby delivered from 24+0 weeks gestation showing no signs of life. Early neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth. Late neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.</td>
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<tr>
<td>Maternal, Newborn and infant Clinical Outcome review programme - Maternal Mortality Surveillance</td>
<td>MBRACE-UK, National Perinatal Epidemiology Unit, University of Oxford</td>
<td>All deaths of women who die during pregnancy or up to one year after the end of the pregnancy regardless of how the pregnancy ended or the cause of death.</td>
</tr>
<tr>
<td>Maternal, Newborn and infant Clinical Outcome review programme - Maternal Morbidity and Mortality Confidential Enquiry</td>
<td>MBRACE-UK, National Perinatal Epidemiology Unit, University of Oxford</td>
<td>The aim is to identify avoidable illness and deaths so the lessons learned can be used to prevent similar cases in the future.</td>
</tr>
<tr>
<td>Maternity and Perinatal Royal College of Obstetricians and Gynaecologists</td>
<td>Royal College of Obstetricians and Gynaecologists</td>
<td>The Audit (NMPA) is a new large scale audit of the NHS maternity services across England, Scotland and Wales.</td>
</tr>
<tr>
<td>Myocardial Ischaemia National Audit Project (MINAP)</td>
<td>National Institute for Cardiovascular Outcomes Research (NICOR)</td>
<td>The Myocardial Ischaemia National Audit Project (MINAP) was established in 1999 in response to the National Service Framework (NSF) for Coronary Heart Disease, to examine the quality of management of heart attacks (Myocardial Infarction) in hospitals in England and Wales.</td>
</tr>
<tr>
<td>Neonatal Audit Programme</td>
<td>Royal College of Paediatrics and Child Health</td>
<td>To assess whether babies requiring specialist neonatal care receive consistent high quality care and identify areas for improvement in relation to service delivery and the outcomes of care.</td>
</tr>
<tr>
<td>Neurosurgical National Audit Programme</td>
<td>Society of British Neurological Surgeons</td>
<td>The aim of this programme is to engage units in a comprehensive audit programme that reflects the full spectrum of elective and emergency neurosurgical activity, and to provide a consistent and meaningful approach to reporting on national clinical audit and outcomes data.</td>
</tr>
<tr>
<td>National Audit issue</td>
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<tr>
<td>Non-invasive Ventilation (NIV) Adults</td>
<td>British Thoracic Society</td>
<td>The audit addresses patients with acute hyperapnic respiratory failure treated with acute NIV.</td>
</tr>
<tr>
<td>Oesophago-gastric Cancer</td>
<td>NHS Digital</td>
<td>The oesophago-gastric (stomach) cancer audit aims to examine the quality of care given to patients and thereby help services to improve. The audit evaluates the process of care and the outcomes of treatment for all O-G cancer patients, both curative and palliative.</td>
</tr>
<tr>
<td>Ophthalmology Audit</td>
<td>The Royal College of Ophthalmologists</td>
<td>The project aims to prospectively collect, collate and analyse a standardised, nationally agreed cataract surgery dataset from all centres providing NHS cataract surgery in England &amp; Wales to update benchmark standards of care and provide a powerful quality improvement tool. In addition to cataract surgery, electronic ophthalmology feasibility audits will be undertaken for glaucoma, retinal detachment surgery and age-related macular degeneration.</td>
</tr>
<tr>
<td>Percutaneous Coronary Interventions (PCI)</td>
<td>National Institute for Cardiovascular Outcomes Research (NICOR)</td>
<td>This project looks at percutaneous coronary intervention (PCI) procedures performed in the UK. The audit collects and analyses data on the nature and outcome of PCI procedures, who performs them and the general health of patients. The audit utilises the Central Cardiac Audit Database which has developed secure data collection, analysis and monitoring tools and provides a common infrastructure for all the coronary heart disease audits.</td>
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<tr>
<td>National Audit issue</td>
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<tr>
<td>Prostate Cancer</td>
<td>Royal College of Surgeons of England</td>
<td>This first audit covers organisational elements of the service and whether key diagnostic, staging and therapeutic facilities are available on site for each provider of prostate cancer services.</td>
</tr>
<tr>
<td>Paediatric Intensive Care</td>
<td>University of Leeds</td>
<td>PICANet was established in 2002 and aims to continually support the improvement of paediatric intensive care provision throughout the UK by providing detailed information on paediatric intensive care activity and outcomes.</td>
</tr>
<tr>
<td>Pulmonary Hypertension</td>
<td>NHS Digital</td>
<td>The audit measures the quality of care provided to people referred to pulmonary hypertension services.</td>
</tr>
<tr>
<td>Reducing the Impact of Serious Infections - Antibiotic consumption</td>
<td>Public Health England</td>
<td>This is currently part of the national Commissioning for Quality and Innovation (CQUIN) payment framework for NHS Acute Trusts in England.</td>
</tr>
<tr>
<td>Reducing the Impact of Serious Infections - Antimicrobial stewardship</td>
<td>Public Health England</td>
<td>This is currently part of the national Commissioning for Quality and Innovation (CQUIN) payment framework for NHS Acute Trusts in England.</td>
</tr>
<tr>
<td>Seizures and Epilepsies in Children and Young People (Epilepsy 12)</td>
<td>Royal College of Paediatrics and Child Health</td>
<td>The audit aims to address the care of children and young people with suspected epilepsy who receive a first paediatric assessment from April 2018 within acute, community and tertiary paediatric services.</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme</td>
<td>Royal College of Physicians</td>
<td>The audit collects information about care provided to stroke patients in first three days of hospital. Data is continuous.</td>
</tr>
<tr>
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<tr>
<td>Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme</td>
<td>Serious Hazards of Transfusion</td>
<td>The scheme collects and analyses anonymised information on adverse events and reactions in blood transfusion from all healthcare organisations that are involved in the transfusion of blood and blood components in the United Kingdom.</td>
</tr>
<tr>
<td>Seven Day Hospital Services</td>
<td>NHS England</td>
<td>The audit addresses the care of patients admitted as an emergency.</td>
</tr>
<tr>
<td>Specialist Rehabilitation for Patients with Complex Needs following major Injury</td>
<td>London North West Healthcare NHS Trust</td>
<td>The audit aims to provide a comparative assessment of services provided in relation to specialist injuries caused by events such as road accidents and falls.</td>
</tr>
<tr>
<td>Monitoring of Surgical Site Infection (SSI) through Surveillance Service</td>
<td>Public Health England</td>
<td>The aim of the national surveillance program is to enhance the quality of patient care by encouraging hospitals to use data obtained from surveillance to compare their rates of SSI over time and against a national benchmark, and to use this information to review and guide clinical practice.</td>
</tr>
<tr>
<td>UK Cystic Fibrosis Registry</td>
<td>Cystic Fibrosis Trust</td>
<td>The audit addresses the care of all patients with a diagnosis of UK.</td>
</tr>
<tr>
<td>Vascular Registry</td>
<td>Royal College of Surgeons of England</td>
<td>The audit addresses the outcome of surgery for patients who underwent two types of vascular procedure. The first is an elective repair of an infra-renal abdominal aortic aneurysm. The second is a carotid endarterectomy.</td>
</tr>
<tr>
<td>Vital Signs (Care in Emergency Department)</td>
<td>Royal College of Emergency Medicine</td>
<td>The audit addresses adults over the age of 18 years of age which presented to the Emergency Department and were triaged to the major areas of the Emergency Department.</td>
</tr>
<tr>
<td>National Audit issue</td>
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<tr>
<td>VTE Risk in Lower Limb Immobilisation (Care in Emergency Departments)</td>
<td>Royal College of Emergency Medicine</td>
<td>The audit includes adults and adolescents 17 years and over presenting to the Emergency Department or a Minor Injuries unit with a lower limb injury and is discharged with temporary immobilisation of the limb using a plaster cast or airboot.</td>
</tr>
<tr>
<td>Child Health Outcome Review Programme – Long-term ventilation in children, young people and adults</td>
<td>The National Confidential Enquiry into Patient Outcome and Death</td>
<td>The audit includes patients up to 25th birthday who are receiving, or have received long-term ventilation where the intention of to discharge patient home on same level of continuing respiratory support.</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme (NCEPOD) - Acute Heart Failure</td>
<td>NCEPOD</td>
<td>To identify and explore avoidable and remediable factors in the process of care for patients treated with acute non-invasive ventilation (NIV).</td>
</tr>
<tr>
<td>NCEPOD - Cancer in Children, Teens and Young Adults</td>
<td>NCEPOD</td>
<td>The aims of this study are to study the process of care of children, Teens and Young Adults under the age of 25 years who died/or had an unplanned admission to critical care within 30 days of receiving systemic anti-cancer therapy.</td>
</tr>
<tr>
<td>NCEPOD - Perioperative Diabetes</td>
<td>NCEPOD</td>
<td>A review of the quality of care provided to patient over the age of 16 who had diabetes and underwent a surgical procedure.</td>
</tr>
<tr>
<td>NCEPOD - Pulmonary Embolism</td>
<td>NCEPOD</td>
<td>To identify and explore avoidable and remediable factors in the process of care for patients diagnosed with pulmonary embolism.</td>
</tr>
<tr>
<td>NCEPOD Acute Bowel Obstruction</td>
<td>NCEPOD</td>
<td>To identify remedial factors in process of care of patients with both large and small intestinal obstruction.</td>
</tr>
</tbody>
</table>
An additional four audits have been added to the list for inclusion in 2019/20 Quality Accounts and all four audits are relevant to services provided by the Trust. The four audits include:

- Assessing cognitive impairment in older people (Care in Emergency Departments)
- Endocrine and thyroid
- Mental Health – Care in Emergency Department
- Seizure management in hospitals.

The reports of national clinical audits were reviewed by the provider in 2018/19 and The Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- The Trust has firmly embedded monitoring arrangements for national clinical audits with the identified lead clinician asked to complete an action plan and present this to the Clinical Effectiveness, Audit and Guidelines Committee.
- On an annual basis the Committee receives a report on the projects in which the Trust participates and requires the lead clinician of each audit programme to identify any potential risk, where there are concerns action plans will be monitored on a six monthly basis.
- In addition, each Directorate is required to present an Annual Clinical Audit Report to the Clinical Effectiveness, Audit and Guidelines Committee detailing all audit activity undertaken both national and local. Clinicians are required to report all audit activity using the Trust’s Clinical Effectiveness Register.
- Involvement in National audits is monitored at the Patient Safety and Quality Reviews where a data pack is provided that contains audit compliance.
- Compliance with National Confidential Enquiries is reported to the Clinical Governance and Quality Committee and exceptions subject to detailed scrutiny and monitored accordingly.
- Non-compliance with recommendations from National Clinical Audit and National Confidential Enquiries are considered in the Annual Business Planning process.

The reports of 792 local audits were reviewed by the provider in 2018/19 and the Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following action to improve the quality of health care provided:

- Each Clinical Directorate is required to present an Annual Clinical Audit Report to the Clinical Effectiveness, Audit and Guidelines Committee detailing all audit activity undertaken both national and local.
The number of patients receiving relevant health services provided or sub-contracted by The Newcastle upon Tyne Hospitals NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 14,814 of which 13,859 were UK Clinical Research Network (UKCRN) National Portfolio studies which equates to 33% of all patients recruited to National Portfolio studies in the region.

Newcastle in 2018/19 is ranked 2nd in the top league of 14 trusts for completing commercial trials to Time and Target.
INFORMATION ON THE USE OF THE CQUIN FRAMEWORK

A proportion of The Newcastle upon Tyne Hospitals NHS Foundation Trust income in 2018/2019 was conditional upon achieving quality improvement and innovation goals agreed between The Newcastle upon Tyne 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 Commissioning for Quality Innovation (CQUIN) payment framework. The monetary total for the amount of income in 2018/19, conditional upon achieving quality improvement and innovation goals is £16.9 million. The monetary total for the amount of income on 2017/18 was £17.7 million.

<table>
<thead>
<tr>
<th>CQUIN Indicators - Acute Hospital – (NHS England)</th>
<th>CQUIN Indicators - Acute Hospital – (CCG)</th>
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<tbody>
<tr>
<td>• Shared Decision Making – Year 2</td>
<td>• Improving staff health and wellbeing Year 2</td>
</tr>
<tr>
<td>• SACT (Dose banding for intravenous anticancer therapy) Year 2</td>
<td>• Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Year 2</td>
</tr>
<tr>
<td>• Optimising palliative chemo decision making Year 2</td>
<td>• Improving services for people with mental health needs who present to A&amp;E Year 2</td>
</tr>
<tr>
<td>• Enhanced supportive care Year 3</td>
<td>• Offering advice and guidance Year 2</td>
</tr>
<tr>
<td>• Cystic fibrosis patient adherence Year 2</td>
<td>• Preventing ill-health by risky behaviours - Alcohol and Tobacco – 1 year scheme.</td>
</tr>
<tr>
<td>• Auto-immune management Year 2</td>
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<td>• Paediatric networked care Year 2</td>
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<tr>
<td>• Neonatal community outreach Year 2</td>
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<tr>
<td>• Improving HCV treatment pathways Year 3</td>
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<td>• TECS Project Year 3</td>
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</table>

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<thead>
<tr>
<th>CQUIN Indicators - Acute Hospital – (Public Health/Dental/other)</th>
<th>CQUIN Indicators - Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Dental Quality Dashboards</td>
<td>• Improving staff health and wellbeing Year 2</td>
</tr>
<tr>
<td>• Breast screening</td>
<td>• Improving the assessment of wounds Year 2</td>
</tr>
<tr>
<td>• Stereotactic Radiosurgery</td>
<td>• Personalised care and support Year 2</td>
</tr>
<tr>
<td>• Armed Forces Covenant.</td>
<td>• Preventing ill-health by risky behaviours - Alcohol and Tobacco 1year scheme.</td>
</tr>
</tbody>
</table>

Further details of the agreed goals for 2018/19 and for the following 12 month period are available electronically at: [https://www.england.nhs.uk/nhs-standard-contract/cquin](https://www.england.nhs.uk/nhs-standard-contract/cquin)
The Newcastle upon Tyne Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is ‘Registered Without Conditions’. The Newcastle upon Tyne Hospitals NHS Foundation Trust has no conditions on registration. The Newcastle upon Tyne Hospital NHS Foundation Trust is registered with the CQC to deliver care from five separate locations and for eleven regulated activities.

The Care Quality Commission has not taken enforcement action against The Newcastle upon Tyne Hospitals NHS Foundation Trust during 2018/19. An Improvement Notice was issued in August 2018 following a CQC IR(ME)R inspection. This was lifted following a re-inspection in November 2018.

The Newcastle upon Tyne Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The Newcastle upon Tyne Hospitals NHS Foundation Trust received a full inspection of all services during January 2016. Following this inspection Newcastle Hospitals was graded as ‘Outstanding’. There has been a well-led visit in January 2019, with management interviews held in February 2019. The Trust was awarded a rating of ‘Outstanding’ for the second time.

**Overall Trust Rating - Outstanding**

<table>
<thead>
<tr>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>★☆ Outstanding</td>
<td>★☆ Outstanding</td>
<td>★☆ Outstanding</td>
<td>★☆ Outstanding</td>
<td>★☆ Outstanding</td>
</tr>
</tbody>
</table>

![Image of the Newcastle upon Tyne Hospitals NHS Foundation Trust](image-url)
The Newcastle upon Tyne Hospitals NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service (SUS+) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data (April 2018 to January 2019). The percentage of records in the published data which included the patients valid NHS number was:

- 99.3% for admitted patient care
- 99.7% for outpatient care
- 98.1% for accident and emergency care.

The number which included the patients valid General Medical Practice Code was:

- 100% for admitted patient care
- 100% for outpatient care
- 100% for accident and emergency care.

Clinical Coding Information

Score for 2018/19 for Information Quality and Records Management, assessed using the Data Security & Protection (DSP) Toolkit

The threat to digital services through cyber-attack is recognised by the Trust and we are committed to ensuring the organisation complies with the UK Data Protection Act 2018, NHS Data Security Standards and achieving the Cyber Essentials Plus certification.

The Trust has effective arrangements in place for Information Governance and monitoring of performance against the Data Protection and Security Toolkit with reporting through the Information Governance Committee and reporting to Board of Directors.

In May 2018, the UK Data Protection Act 2018 came into force. This act aligns with the NHS Data Security Standards and includes requirements for new or changed IT systems to be developed with data privacy by design as a pre-requisite with the starting point being the protection and security of the personal data held and processed by the Trust. The Trust has implemented processes and procedures to monitor the privacy throughout the lifecycle of developments.

The Data Protection and Security Toolkit is the mandated method for monitoring the Trust performance in the key areas of Data Protection and technical/cyber security. This will be based on the NHS Data Security Standards and is focussed on ensuring the Trust remains compliant with laws concerning personal information handling and sharing, along with remaining resilient to current and future cyber threats.

In 2018/2019, the Trust reported two Information Governance incidents to the Information Commissioners Office (ICO) which was classified at level 2 in accordance with ICO guidance.

The first Data Security and Protection Toolkit submission was completed on 31 March 2019, the evidence to show our progress with the toolkit was externally assessed and the Trust are currently graded as ‘standards not fully met (plan agreed)’.

The Newcastle upon Tyne Hospitals NHS Foundation Trust was not subject to a Payment by Results clinical coding audit at any time during the reporting period.

The Newcastle upon Tyne Hospitals NHS Foundation Trust Clinical Coding Audit achieved DSP advisory level (Good) in all four coding indicators. This is the highest level of attainment and was achieved for all areas reviewed. Please see table below for results.

Table shows the levels of attainment of coding of inpatient activity

<table>
<thead>
<tr>
<th>Area</th>
<th>Levels of Attainment</th>
<th>NUTH Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary diagnosis</td>
<td>≥90%</td>
<td>≥95%</td>
</tr>
<tr>
<td>Secondary diagnosis</td>
<td>≥80%</td>
<td>≥90%</td>
</tr>
<tr>
<td>Primary procedure</td>
<td>≥90%</td>
<td>≥95%</td>
</tr>
<tr>
<td>Secondary procedure</td>
<td>≥80%</td>
<td>≥90%</td>
</tr>
</tbody>
</table>

The services reviewed within the sample included Major Trauma (50), General Surgery (75) and Ophthalmology (75). The audit results were good, exceeding the percentages required to achieve the highest level of attainment in all areas. Only four spells in the audit of 200 case notes impacted on payment. The results should not be extrapolated further than the actual sample audited.

The Newcastle upon Tyne Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

- Feedback all areas of error found during the audit to the coders including the importance of recording all relevant conditions and the importance of data extraction skills within the coding process.
- Ensure all coders understand the national coding guidance relating to intravenous infusions, external cause code, site codes and laterality codes.
- Ensure that coders access histology and update the coded data.
- Review and update the local clinical coding policy on cataracts.
The key national priorities are performance targets for the NHS which are determined by the Department of Health and Social Care and form part of the CQC Intelligent Monitoring Report. A wide range of measures are included and the Trust’s performance against the key national priorities for 2018/19 are detailed in the table below:

<table>
<thead>
<tr>
<th>Operating and Compliance Framework Target</th>
<th>Target</th>
<th>Annual Performance 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence of Clostridium difficile (C. difficile: variance from plan)</td>
<td>No more than 76</td>
<td>77 (26 appealed, 51 against target, with potentially further appeals to be heard)*</td>
</tr>
<tr>
<td>Incidence of MRSA Bacteraemia</td>
<td>Zero tolerance</td>
<td>2</td>
</tr>
<tr>
<td>All Cancer Two Week Wait</td>
<td>93%</td>
<td>91.9%**</td>
</tr>
<tr>
<td>Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)</td>
<td>93%</td>
<td>86.7%**</td>
</tr>
<tr>
<td>31-Day (Diagnosis To Treatment) Wait For First Treatment</td>
<td>96%</td>
<td>95.5%**</td>
</tr>
<tr>
<td>31-Day Wait For Second Or Subsequent Treatment: Surgery</td>
<td>94%</td>
<td>92.3%**</td>
</tr>
<tr>
<td>31-Day Wait For Second Or Subsequent Treatment: Drug treatment</td>
<td>98%</td>
<td>98.2%</td>
</tr>
<tr>
<td>31-Day Wait For Second Or Subsequent Treatment: Radiotherapy</td>
<td>94%</td>
<td>99.4%</td>
</tr>
<tr>
<td>All cancers: 62-day wait for first treatment from: urgent GP referral for suspected cancer</td>
<td>85%</td>
<td>79%**</td>
</tr>
<tr>
<td>All cancers: 62-day wait for first treatment from: NHS Cancer Screening Service referral</td>
<td>90%</td>
<td>90.8%</td>
</tr>
<tr>
<td>RTT – Referral to Treatment - Admitted Compliance</td>
<td>90%</td>
<td>85.1%***</td>
</tr>
<tr>
<td>RTT – Referral to Treatment - Non-Admitted Compliance</td>
<td>95%</td>
<td>92%***</td>
</tr>
<tr>
<td>RTT – Referral to Treatment - Incomplete Compliance</td>
<td>92%</td>
<td>93.5%</td>
</tr>
<tr>
<td>Maximum 6-week wait for diagnostic procedures</td>
<td>99%</td>
<td>98.3%</td>
</tr>
<tr>
<td>A&amp;E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge</td>
<td>95%</td>
<td>95.4%</td>
</tr>
<tr>
<td>Delayed Transfers</td>
<td>3.5%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Cancelled operations – those not admitted within 28 days</td>
<td>0</td>
<td>54****</td>
</tr>
<tr>
<td>Maternity bookings within 12 weeks and 6 days</td>
<td>Not defined</td>
<td>86.6%</td>
</tr>
<tr>
<td>Data completeness: Community Services comprising: Referral to treatment information</td>
<td>Not defined</td>
<td>99.8%</td>
</tr>
<tr>
<td>Data completeness: Community Services comprising: Referral information</td>
<td>Not defined</td>
<td>95.2%</td>
</tr>
<tr>
<td>Data completeness: Community Services comprising: Treatment activity information</td>
<td>Not defined</td>
<td>98.5%</td>
</tr>
</tbody>
</table>

The Learning Disability Liaison Nurses work to promote access to Trust services for patients with a known Learning Disability. This provides assurance to the Trust Board by implementing:

- The NHS Improvement Standards (2018) to measure the quality of care the Trust provides to people with learning disabilities
- Implementing the learning from LeDeR Mortality Reviews
- Training and development to ensure Trust staff have the skills and competencies to support patients with Learning Disabilities to access Trust services.
- Monitor the provision of reasonable adjustments and any restrictions or deprivations of liberty associated with the delivery of care and treatment to people with learning disabilities.

Details on Hospital-level Mortality Indicator please refer to pages 33 & 74.

Details on Venous thromboembolism (VTE) risk assessment please refer to page 77.
Rationale for any failed targets in free text please note below:

* Appeals likely to increase to 29, a decision on this will be made on 23rd April which may impact on final breach figure.

** The reasons for cancer performance deterioration have included increased volume of referrals particularly into the Urology service, pressure on diagnostics (radiology) and capacity with respect to theatres and surgeons. Ongoing work is in place to reach targets set. Please also note that the cancer figures included at this time are not fully validated until circa 30th April and may change.

*** As per recommendations from Sir Bruce Keogh that the incomplete pathway operational standard should be the sole measure of patients’ constitutional right to start treatment within 18 weeks. The admitted and non-admitted completed pathway data is used solely for monitoring against operational standards.

**** With regards to the cancelled operations all Directorates involved have been made aware of breaches and there is a planned workshop in May 2019 to agree actions to reduce the 28 day breach.
Measure 1. The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust
The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The Trust continues to perform well on mortality indicators. Mortality reports are regularly presented to the Trust Board. The Newcastle upon Tyne Hospitals NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services by closely monitoring mortality rates and conducting detailed investigations when rates increase. We continue to monitor and discuss mortality findings at the quarterly Mortality Surveillance Group; representatives attend this group from multiple specialties and scrutinise Trust mortality data to ensure local learning and quality improvement. This group complements the departmental mortality and morbidity (M&M) meetings within each Directorate.

Measure 2. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust
The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The use of palliative care codes in the Trust has remained static and aligned to the national average percentage over recent years. The Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by involving the Coding team in routine mortality reviews to ensure accuracy and consistency of palliative care coding.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Target</th>
<th>Value</th>
<th>2018/2019</th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>National average</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Highest national</td>
<td>1.268</td>
<td>1.257</td>
<td>1.2321</td>
<td>1.2181</td>
<td>1.25</td>
<td>1.23</td>
</tr>
<tr>
<td>Lowest national</td>
<td>0.692</td>
<td>0.698</td>
<td>0.6994</td>
<td>0.7204</td>
<td>0.73</td>
<td>0.73</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Target</th>
<th>Value</th>
<th>2018/2019</th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust</td>
<td>NHS Digital Indicator Portal: <a href="https://indicators.ic.nhs.uk/webview/">https://indicators.ic.nhs.uk/webview/</a></td>
<td>N/A</td>
<td>29.2%</td>
<td>28.7%</td>
<td>28.4%</td>
<td>27.3%</td>
</tr>
<tr>
<td>National average</td>
<td>33.6%</td>
<td>33.1%</td>
<td>32.5%</td>
<td>32.2%</td>
<td>31.5%</td>
<td>Not available</td>
</tr>
<tr>
<td>Highest national</td>
<td>59.5%</td>
<td>58.7%</td>
<td>59.0%</td>
<td>60.3%</td>
<td>59.8%</td>
<td>58.6%</td>
</tr>
<tr>
<td>Lowest national</td>
<td>14.3%</td>
<td>13.4%</td>
<td>12.6%</td>
<td>11.7%</td>
<td>11.5%</td>
<td>11.2%</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>-------</td>
<td>-----------</td>
<td>----------------------</td>
<td>----------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>3. The patient reported outcome measures scores (PROMS) for groin hernia surgery (average health gain score)</td>
<td>NHS Digital information portal <a href="http://content.digital.nhs.uk/proms">http://content.digital.nhs.uk/proms</a></td>
<td>NUTH</td>
<td>Ceased to be collected 1st October 2017</td>
<td>Ceased to be collected 1st October 2017</td>
<td>0.11</td>
<td>0.08</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National average:</td>
<td>Ceased to be collected 1st October 2017</td>
<td>Ceased to be collected 1st October 2017</td>
<td>0.09</td>
<td>0.08</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Highest national:</td>
<td>Ceased to be collected 1st October 2017</td>
<td>Ceased to be collected 1st October 2017</td>
<td>0.14</td>
<td>0.15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lowest national:</td>
<td>Ceased to be collected 1st October 2017</td>
<td>Ceased to be collected 1st October 2017</td>
<td>0.01</td>
<td>0.03</td>
</tr>
<tr>
<td>4. The patient reported outcome measures scores (PROMS) for varicose vein surgery (average health gain)</td>
<td>NHS Digital information portal <a href="http://content.digital.nhs.uk/proms">http://content.digital.nhs.uk/proms</a></td>
<td>Trust score:</td>
<td>Ceased to be collected 1st October 2017</td>
<td>Ceased to be collected 1st October 2017</td>
<td>0.12</td>
<td>0.10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National average:</td>
<td>Ceased to be collected 1st October 2017</td>
<td>Ceased to be collected 1st October 2017</td>
<td>0.09</td>
<td>0.09</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Highest national:</td>
<td>Ceased to be collected 1st October 2017</td>
<td>Ceased to be collected 1st October 2017</td>
<td>0.15</td>
<td>0.15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lowest national:</td>
<td>Ceased to be collected 1st October 2017</td>
<td>Ceased to be collected 1st October 2017</td>
<td>0.01</td>
<td>0.02</td>
</tr>
<tr>
<td>5. The patient reported outcome measures scores (PROMS) for primary hip replacement surgery (average health gain)</td>
<td>NHS Digital information portal <a href="http://content.digital.nhs.uk/proms">http://content.digital.nhs.uk/proms</a></td>
<td>Trust Score</td>
<td>Not Yet Published</td>
<td>0.47</td>
<td>0.44</td>
<td>0.42</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National average:</td>
<td>Not Yet Published</td>
<td>0.47</td>
<td>0.44</td>
<td>0.43</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Highest national:</td>
<td>Not Yet Published</td>
<td>0.38</td>
<td>0.54</td>
<td>0.50</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lowest national:</td>
<td>Not Yet Published</td>
<td>0.57</td>
<td>0.31</td>
<td>0.39</td>
</tr>
<tr>
<td>6. The patient reported outcome measures scores (PROMS) for primary knee replacement surgery (average health gain)</td>
<td>NHS Digital information portal <a href="http://content.digital.nhs.uk/proms">http://content.digital.nhs.uk/proms</a></td>
<td>Trust Score</td>
<td>Not Yet Published</td>
<td>0.33</td>
<td>0.33</td>
<td>0.31</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National average:</td>
<td>Not Yet Published</td>
<td>0.34</td>
<td>0.32</td>
<td>0.32</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Highest national:</td>
<td>Not Yet Published</td>
<td>0.42</td>
<td>0.40</td>
<td>0.38</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lowest national:</td>
<td>Not Yet Published</td>
<td>0.23</td>
<td>0.24</td>
<td>0.23</td>
</tr>
</tbody>
</table>

Please note that in relation to PROMs - 2018/19 data is not available for most providers, the reason for this is that the EQ-5D survey is sent to patients six months post-surgery, these survey scores can then be modelled. The data published by NHS Digital requires a provider to have at least 30 modelled records before a score can be calculated.

Measure 3. The patient reported outcome measures scores (PROMS) for groin hernia surgery
Collection of groin procedure scores ceased on 1 October 2017.

Measure 4. The patient reported outcome measures scores (PROMS) for varicose vein surgery
Collection of varicose vein procedure scores ceased on 1 October 2017.

Measure 5. The patient reported outcome measures scores (PROMS) for hip replacement surgery
The Newcastle upon Tyne Hospitals NHS Foundation Trust did not meet the Participation in Assessment requirement against PROMS figures for Hips target for reasons explained above.

The Newcastle upon Tyne Hospitals NHS Foundation Trust PROMS outcomes are good and we are committed to increasing our participation rates going forward to meet and surpass the target levels. We encourage patients to complete these and discuss completion rates and results in the Arthroplasty Multidisciplinary team (MDT).
Measure 6. The patient reported outcome measures scores (PROMS) for knee replacement surgery. The Newcastle upon Tyne Hospitals NHS Foundation Trust did not meet the Participation in Assessment against PROMS figures for Knee replacement target for reasons explained above.

The Newcastle upon Tyne Hospitals NHS Foundation Trust PROMS outcomes are good and we are committed to increasing our participation rates going forward to meet and surpass the target levels. We encourage patients to complete these and discuss completion rates and results in the Arthroplasty MDT.

Measure 7. The percentage of patients aged — (i) 0 to 15; and (ii) 16 or over readmitted within 28 days of being discharged from hospital

This indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review.

Therefore, the Trust has reviewed its own internal data and used its own methodology of reporting readmissions within 28 days (without PbR exclusions). The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The Trust has a robust reporting system in place and adopts a systematic approach to data quality improvement. The Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by continuing with the use of an electronic system.

7a. Emergency readmissions to hospital within 28 days of discharge from hospital: Children of ages 0-15

<table>
<thead>
<tr>
<th>Year</th>
<th>Total number of admissions/ spells</th>
<th>Number of readmissions (all)</th>
<th>Emergency readmission rate (all)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>31,548</td>
<td>2,500</td>
<td>7.9</td>
</tr>
<tr>
<td>2012/13</td>
<td>31,841</td>
<td>2,454</td>
<td>7.7</td>
</tr>
<tr>
<td>2013/14</td>
<td>32,242</td>
<td>2,648</td>
<td>8.2</td>
</tr>
<tr>
<td>2014/15</td>
<td>34,561</td>
<td>3,570</td>
<td>10.3</td>
</tr>
<tr>
<td>2015/16</td>
<td>38,769</td>
<td>2,875</td>
<td>7.4</td>
</tr>
<tr>
<td>2016/17</td>
<td>35,259</td>
<td>1,983</td>
<td>5.6</td>
</tr>
<tr>
<td>2017/18</td>
<td>35,009</td>
<td>2,077</td>
<td>5.9</td>
</tr>
<tr>
<td>2018/19</td>
<td>36,388</td>
<td>1,991</td>
<td>5.5</td>
</tr>
</tbody>
</table>

7b. Emergency readmissions to hospital within 28 days of being discharged aged 16+

<table>
<thead>
<tr>
<th>Year</th>
<th>Total number of admissions/ spells</th>
<th>Number of readmissions (all)</th>
<th>Emergency readmission rate (all)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>175,836</td>
<td>9,435</td>
<td>5.4</td>
</tr>
<tr>
<td>2012/13</td>
<td>173,270</td>
<td>8,788</td>
<td>5.1</td>
</tr>
<tr>
<td>2013/14</td>
<td>177,867</td>
<td>9,052</td>
<td>5.1</td>
</tr>
<tr>
<td>2014/15</td>
<td>180,380</td>
<td>9,446</td>
<td>5.2</td>
</tr>
<tr>
<td>2015/16</td>
<td>182,668</td>
<td>10,076</td>
<td>5.5</td>
</tr>
<tr>
<td>2016/17</td>
<td>186,999</td>
<td>10,219</td>
<td>5.5</td>
</tr>
<tr>
<td>2017/18</td>
<td>182,535</td>
<td>10,157</td>
<td>5.6</td>
</tr>
<tr>
<td>2018/19</td>
<td>185,672</td>
<td>10,452</td>
<td>5.6</td>
</tr>
</tbody>
</table>

Measure 8. The Trust’s responsiveness to the personal needs of its patients

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust percentage</td>
<td>NHS Information Centre Portal <a href="https://indicators.ic.nhs.uk/">https://indicators.ic.nhs.uk/</a></td>
<td>Not available until Summer 2019</td>
<td>74.9%</td>
<td>74.6%</td>
<td>76.1%</td>
<td>76.8%</td>
<td>77.3%</td>
<td></td>
</tr>
<tr>
<td>National average:</td>
<td>Not available until Summer 2019</td>
<td>68.6%</td>
<td>68.1%</td>
<td>69.6%</td>
<td>68.9%</td>
<td>68.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest national:</td>
<td>Not available until Summer 2019</td>
<td>85.0%</td>
<td>85.2%</td>
<td>86.2%</td>
<td>86.1%</td>
<td>84.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lowest national:</td>
<td>Not available until Summer 2019</td>
<td>60.5%</td>
<td>60.0%</td>
<td>54.4%</td>
<td>59.1%</td>
<td>54.4%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Measure 8. The Trust’s responsiveness to the personal needs of its patients

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The data shows that the Trust scores above the national average. The Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by continuing to implement processes to capture patient experience and improve its services. Data for 2018/2019 has not yet been released, but data for 2017/2018 has been populated.

Measure 9. The percentage of staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: the Trust has improved on last year’s score and is well above the National average. The Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by continuing to listen to and act on all sources of staff feedback. Data for 2017/2018 has been added as it was not available at time of publication last year.

Measure 10. The percentage of patients that were admitted to hospital who were risk assessed for Venous thromboembolism (VTE)

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The Trust has a robust reporting system in place and adopts a systematic approach to data quality improvement. The Newcastle upon Tyne Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by continuing to listen to and act on all sources of staff feedback. Data for 2017/2018 has been added as it was not available at time of publication last year.
Measure 11. The rate per 100,000 bed days of C. difficile infection reported within the Trust amongst patients aged 2 or over

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The Trust has a robust reporting system in place and adopts a systematic approach to data quality improvement. The Newcastle upon Tyne Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by having a robust strategy that includes the review of all Trust-apportioned cases to ensure no avoidable cases occur: completion of root cause analysis (RCA) forms for all such cases, including a multidisciplinary meeting to discuss the case; Quarterly Health Care Acquired Infection (HCAI) Report to share lessons learned and best practice from the RCAs and Serious Infection Review Meetings.

Measure 12. The number and rate of patient safety incidents reported

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The Trust take the reporting of incidents very seriously and have an electronic reporting system (Datix) to support this. The Newcastle upon Tyne Hospitals NHS Foundation Trust has taken the following actions to improve this number and rate, and so the quality of its services, by undertaking a campaign to increase awareness of incident/near miss reporting. Incidents are graded, analysed and, where required, undergo a root cause analysis investigation to inform actions, recommendations and learning. Incident data are reported on a monthly basis to the Trust Board. Analysis of this data is reported to the Clinical Risk Group to inform our organisational learning themes which are reported to the Board. No further information after September 2018 is currently available.

Measure 13. The number and percentage of patient safety incidents that resulted in severe harm or death

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The Trust takes incidents resulting in severe harm of death very seriously. The rate of incidents resulting in severe harm or death is consistent with the national average. This reflects a culture of reporting incidents which lead to, or have the potential to, cause serious harm or death. The Newcastle upon Tyne Hospitals NHS Foundation Trust has taken the following actions to reduce this number and rate, and so the quality of its services, by the Board receiving monthly reports of incidents resulting in severe harm of death. (The Trust would classify major and catastrophic as permanent harm or death. This would include a fracture following a fall if the patient did not fully recover their normal level of independence). No further information after September 2018 is currently available.
Wellbeing – the tables below provide data on the loss of work days. The table directly below reports on the Trust and Regional position rate (data taken from the NHS Information Centre) and the next table provides an update on the Trust number of staff sick days lost to industrial injury or illness caused by work.

This table shows the loss of work days (rate)

<table>
<thead>
<tr>
<th></th>
<th>Jan 18</th>
<th>Feb 18</th>
<th>Mar 18</th>
<th>Apr 18</th>
<th>May 18</th>
<th>Jun 18</th>
<th>Jul 18</th>
<th>Aug 18</th>
<th>Sep 18</th>
<th>Oct 18</th>
<th>Nov 18</th>
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</thead>
<tbody>
<tr>
<td>The Newcastle Upon Tyne Hospitals</td>
<td>5.42%</td>
<td>4.81%</td>
<td>4.13%</td>
<td>3.90%</td>
<td>3.85%</td>
<td>3.97%</td>
<td>4.06%</td>
<td>3.77%</td>
<td>3.87%</td>
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<tr>
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<td>4.13%</td>
<td>4.08%</td>
<td>3.81%</td>
<td>3.95%</td>
<td>3.82%</td>
<td>3.97%</td>
<td>4.28%</td>
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</tr>
<tr>
<td>County Durham and Darlington</td>
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<td>4.18%</td>
<td>4.32%</td>
<td>4.41%</td>
<td>4.60%</td>
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<td>4.00%</td>
<td>3.89%</td>
<td>4.43%</td>
<td>4.01%</td>
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<td>3.99%</td>
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<tr>
<td>Northumbria Healthcare</td>
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<td>4.01%</td>
<td>3.80%</td>
<td>3.87%</td>
<td>4.01%</td>
<td>4.04%</td>
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<td>South Tees Hospitals</td>
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<tr>
<td>England</td>
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<td>3.96%</td>
<td>4.15%</td>
<td>4.12%</td>
<td>4.19%</td>
<td>4.41%</td>
<td>4.53%</td>
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</tbody>
</table>

The table below shows the number of shift staff sick days lost to industrial injury or illness caused by work

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<tr>
<th>Year</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
<th>Year Total</th>
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<tr>
<td>2009/2010 no. of days</td>
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<td>414</td>
<td>581</td>
<td>298</td>
<td>1544</td>
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<td>2010/2011 no. of days</td>
<td>118</td>
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<td>267</td>
<td>366</td>
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<td>2011/2012 no. of days</td>
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<td>247</td>
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<td>2013/2014 no. of days</td>
<td>489</td>
<td>331</td>
<td>785</td>
<td>147</td>
<td>1752</td>
</tr>
<tr>
<td>2014/2015 no. of days</td>
<td>333</td>
<td>284</td>
<td>178</td>
<td>206</td>
<td>1001</td>
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<tr>
<td>2015/2016 no. of days</td>
<td>360</td>
<td>194</td>
<td>365</td>
<td>219</td>
<td>1138</td>
</tr>
<tr>
<td>2016/2017 no. of days</td>
<td>230</td>
<td>387</td>
<td>136</td>
<td>84</td>
<td>837</td>
</tr>
<tr>
<td>2017/2018 no. of days</td>
<td>137</td>
<td>90</td>
<td>51</td>
<td>122</td>
<td>400</td>
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<tr>
<td>2018/2019 no. of days</td>
<td>214</td>
<td>131</td>
<td>188</td>
<td>172</td>
<td>705</td>
</tr>
</tbody>
</table>
2018 NHS Staff Survey Results Summary

A standard survey was sent via email to all employees of the Trust (via external post for those on maternity leave), giving all 14,109 members of our staff a voice. 6,655 staff participated in the survey, equaling a response rate of 47% which is above the sector average of 41%, and was a significant improvement on the 2017 response rate of 33%.

The results are arranged under 10 themes:

- THEME 1: Equality, diversity & inclusion
- THEME 2: Health & wellbeing
- THEME 3: Immediate managers
- THEME 4: Morale
- THEME 5: Quality of appraisals
- THEME 6: Quality of care
- THEME 7: Safe Environment - Bullying & Harassment
- THEME 8: Safe Environment - Violence
- THEME 9: Safety Culture
- THEME 10: Staff Engagement.

The Staff Engagement score is measured across three sub-themes:

- Advocacy, measured by Q21a, Q21c and Q21d (Staff recommendation of the Trust as a place to work or receive treatment).
- Motivation, measured by Q2a, Q2b and Q2c (Staff motivation at work).
- Involvement, measured by Q4a, Q4b and Q4d (Staff ability to contribute towards improvement at work).

In NUTH this score was:
- Overall: rating of staff engagement 7.3 (out of possible 10).

This score was only 0.1 below top position in the sector (Combined Acute & Community Trusts) and is 0.1 above the Trusts score in 2017.

The Trust scored significantly better on seven of the 10 themes when compared with other Combined Acute & Community Trusts in England. It is also worth noting that the Trust did not score below sector average in any themes.

Safety Culture
- NUTH Score: 7.1 out of 10
- Sector Score: 6.7 out of 10

Staff Engagement
- NUTH Score: 7.3 out of 10
- Sector Score: 7.0 out of 10

Equality, Diversity & Inclusion
- NuTH Score: 9.4 out of 10
- Sector Score: 9.2 out of 10

Morale
- NUTH Score: 6.4 out of 10
- Sector Score: 6.2 out of 10

Quality of Care
- NUTH Score: 7.7 out of 10
- Sector Score: 7.4 out of 10

Safe Environment – Bullying & Harassment
- NUTH Score: 8.4 out of 10
- Sector Score: 8.1 out of 10
Safe Environment – Violence
• NUTH Score: 9.6 out of 10
• Sector Score: 9.5 out of 10.

Of note, the Trust is also in top position for a number of themes against various comparators:
• #1 in Sector for
  o Safety Culture: 7.1 out of 10
• #1 in Region for
  o Safe Environment – Bullying & Harassment: 8.4 out of 10
  o Safe Environment – Violence: 9.6 out of 10
  o Safety Culture: 7.1 out of 10
• #1 in Shelford Group for
  o Equality, Diversity & Inclusion: 9.4 out of 10
  o Immediate Managers: 6.9 out of 10
  o Morale: 6.4 out of 10
  o Safe Environment – Bullying & Harassment: 8.4 out of 10
  o Safe Environment – Violence: 9.6 out of 10
  o Safety Culture: 7.1 out of 10.

The Trust compares favourably against the sector in 67% of the 90 questions in the survey. Some to note include:
• 90% agree that they would be happy with the standard of care provided by the organisation should a friend or relative need treatment. This is 20% higher than sector average.
• 89% agree that care of patients/service users is the organisation top priority. This is 12% higher than sector average.
• 81% agree that when errors, near misses or incidents are reported, the organisation takes action to ensure that they do not happen again. This is 11% higher than sector average.
• 70% agree that they are given feedback about changes made in response to reported errors, near misses and incidents. This is 11% higher than sector average.
• 67% are confident that the organisation would address their concerns. This is 9% higher than sector average.
• 32% stated they have felt unwell due to work related stress in the last 12 months. This is 7% under the sector average.

As previously stated, the Trust did not fall below sector average for any of the 10 themes. However, the lowest 3 scoring themes for the organisation were:
• Morale: 6.4 out of 10
• Health & Wellbeing: 6.1 out of 10
• Quality of Appraisals: 5.6 out of 10.

There are several other areas which are worth noting:
• Q21a – Care of patients/service users is my organisation top priority has seen an increase this year from 87.6% to 88.7% of staff agreeing.
• Q7b – I feel that my role makes a different to patients/service users has declined from 91.5% to 90.8% however still remains above sector average. It is also worth noting that the sector average has also declined.
• Q7c – I am able to deliver the care I aspire to has increased from 72.6% to 73.9% where the sector average has declined.
• Q17a – My organisation treats staff who are involved in an error, near miss or incident fairly has significantly improved from 57.8% to 64.0%.
• Q18c – I am confident that my organisation would address my concern has increased from 64.7% to 67.4% where the sector average has declined.
• Q21b – My organisation acts on concerns raised by patients/services users has improved from 82.8% to 83.8%.
• Q14 – Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age has declined form 90.8% to 89.7%.
Patient, carer and public involvement and engagement is at the heart of everything we do within The Newcastle Upon Tyne Hospitals NHS Foundation Trust. The Trust offers a variety of opportunities for patients and members of the public to get actively involved including a diverse range of volunteering roles, public governors, patient steering and support groups. Patients and members of the public are also able to participate in an active patient research ambassador and engagement campaign.

We have been extremely busy this year, having successfully refreshed and relaunched the patient engagement and involvement group, APEX (Advising on the Patient Experience) which has provided a strong model of involvement for quality improvement. We have also developed the Newcastle Maternity Voices Partnership, which has a large and active social media membership. We have recruited a dedicated role to support YPAGne, (Young Person’s Advisory Group, North England) ensuring the voices of children and young people are also being clearly heard.

The Trust works very closely and maintains strong links with local community and voluntary groups to ensure that we are listening to the diverse views of all our patients and that their views and feedback are informing the shape of services we are delivering.

Patients and members of the public are also actively encouraged to give feedback through NHS Friends and Family Test, social media, NHS Choices and Care Opinion websites, Take Two Minutes postcards and a variety of local and national surveys.

In 2019/20, the focus will be to invest in a structured approach to capture real time patient experience feedback to help provide further assurance that we are delivering safe and excellent quality care to all of our patients and members of the public.
ANNEX 1:
Dear Anne Marie,

Newcastle upon Tyne Hospitals NHS Foundation Trust Quality Account 2018/19
Response of Health Scrutiny Committee

As Vice-Chair of the Health Scrutiny Committee, I welcome the opportunity to comment on your draft Quality Account for 2018/19, which we discussed at our meeting on 9 May 2019.

We recognise the importance of the Quality Account as a tool in ensuring that services are reviewed objectively and as a means of illustrating to patients, carers and partners the performance of the trust in relation to your quality priorities.

In relation to progress against your 2018/19 priorities:

- We acknowledge the ongoing reduction in E.coli infections and MSSA over the past three years, but we note that although MRSA infections have reduced to two, they remain above the trust’s zero tolerance target. We welcome the trust’s approach to reviewing these cases to understand how the infection has been acquired and sharing lessons learned and best practice.

- We welcome the trust’s approach to ‘red flag’ abnormal or unexpected diagnostic results with the requesting consultant but note that the system needs to be accessed for the red flag to be visible. Although, we understand that results that require immediate attention would be highlighted by telephone.

- We welcome actions the trust has taken on human factors training, particularly training for security staff on dealing with patients presenting at the hospital with an acute episode of a mental health related condition, Who may need support until a crisis team referral is made.

If you need this information in another format or language, please contact the writer.
We welcome the trust’s approach to creating a culture of quality improvement and involvement of patients in providing feedback on quality improvement initiatives. In particular, we note the involvement of the RNIB and other local voluntary organisations in looking at how the environment and signage could be improved.

In respect of improving the experience of vulnerable patients, we acknowledge the progress the trust has made with NTW to share patient information and the joint commitment that has been made to the Great North Care Record. We would like an update on this work, during the coming year.

We noted in our meeting that there are approximately eight serious incidents per month that would be eligible for the professional duty of candour and understand this is similar to that of the Shelford Group of NHS hospital trusts. For transparency, it may be helpful to report this in the quality account. We also note that there have been seven cases during the year judged to have been more likely than not to have had problems in care which contributed to patient death. We acknowledge the trust’s commitment to improving patient safety and learning from the deaths of patients in its care and we will review this against next year.

In relation to board assurance (part 3), we queried the requirement to report on Department of Health prescribed indicators, that do not have defined targets. This clearly needs to be reviewed by the Department of Health.

In relation to days lost through industrial injury or illness we suggested that it may be helpful to also report annual figures.

We welcome the trust’s approach to providing help for employees dealing with work related stress, access to psychologists and physiotherapists that could support people back into work and trying to create a culture where staff feel free to talk about their problems and receive support.

We commend the trust on the high response rate to the staff survey and acknowledge that across a range of themes the trust has performed very well in comparison to other combined acute and community trusts.

Overall, we found that the quality account clearly presented the targets for the year, but information on outcomes was often presented in a different format and was as a result, less clear. The trust may wish to consider this when preparing the 2019/20 quality account.

In relation to the 2019/20 priorities, we believe the document is a fair and accurate representation of the services provided by the trust and reflects the areas that are of high importance to Newcastle residents. We note the level of detail that the trust is required to provide in the quality account: with commentary provided across a wide range of services to a broad range of audiences, whilst also attempting to respond to quality improvement goals and public accountability. Inevitably, this can result in a detailed document that can be a challenge to consider and comment on within the short timescales imposed nationally. In this respect, it may be helpful for the trust to develop an executive summary.

Finally, I would like to welcome the ongoing open dialogue that the trust has established with us during the year and hope that this will continue.

Yours sincerely

Cllr Felicity Mendelson
Vice-Chair, Health Scrutiny Committee

If you need this information in another format or language, please contact the writer.
Dear Ms Troy-Smith

NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST ANNUAL PLAN AND QUALITY ACCOUNT 2018/19

Statement from Northumberland County Council's Health and Wellbeing Overview and Scrutiny Committee

The Health and Wellbeing Overview and Scrutiny Committee welcomes the opportunity to submit a commentary for inclusion in your Annual Plan and Quality Account for 2018/19 as presented to the committee in draft.

At our 5 March 2019 meeting we received a presentation on your draft Quality Account for 2018/19 and your priorities for 2019/20. At that meeting we also received a presentation from the Northumbria NHS Foundation Trust on their own quality account. We then received presentations from the North East Ambulance Service and Northumberland Tyne and Wear NHS Foundation Trusts about their accounts at the committee's next meeting on 26 March 2019. We believe that considering all four Trusts' quality accounts in the same month provides a good joined up picture of the many NHS services in Northumberland. Members responded favourably to the information you presented, with reference to the highly valued staff and clinical support provided.

Following your presentation of the draft Annual Quality Account 2018/19 and future priorities for 2019/20, a copy of the full extract from the minutes of the OSC’s meeting are appended to this letter for your information to form part of our response to your presentation. From the detail presented in these minutes, I would like to highlight some key comments from the committee and additionally what further information has been requested or actions recommended:

- members were reassured that your identified priorities all reflected the importance of emergency department work and the reasoning for why accident and emergency targets are treated as business as usual work

Daljit Ially, Chief Executive
County Hall, Morpeth, Northumberland, NE61 2EF
T: 0345 600 6400
www.northumberland.gov.uk
• members welcomed your offer to provide details of healthcare acquired infections. We thank you for this information that you supplied following the meeting on 5 March, which has been circulated to all members of our committee
• members praised your strong no blame culture and commitment to learn from any mistakes, plus your approach to identify areas for improvement and if any such examples could be shared with other Trusts. Your approach to working with other local Trusts and key partner organisations was also praised
• members also welcomed your proactive work to support people with learning disabilities and mental health needs.

From the information you have provided to the committee over the past year, including the presentation about your draft 2018/19 Quality Account, we believe the information provided is a fair and accurate representation of the services provided by the Trust and reflects the priorities of the community. Members also support your priorities for improvement planned for 2018/19, but also request that you note and consider the various points that they have raised in relation to, your work going forward.

We also would be very grateful if I could get in contact with you again soon to discuss possible agenda items for the Health and Wellbeing Overview and Scrutiny Committee to consider about the Trust’s services during the next council year from 1 May 2019 onwards.

We would also appreciate if we could diarise when you will attend to give next year’s equivalent Quality Account and future priorities presentation. I would be very grateful if you could confirm whether the OSC’s meeting on Tuesday 3 March 2020 (beginning at 1.00pm) would be suitable please?

If I can be of any further assistance about the committee’s response, please do not hesitate to contact me.

Yours sincerely,

Mike Bird
Senior Democratic Services Officer
Democratic Services

On behalf of Councillor Jeff Watson
Chair, Northumberland County Council Health and Wellbeing Overview and Scrutiny Committee
(a) Newcastle upon Tyne NHS Foundation Trust Annual Plan and Quality Account 2017/18

A presentation was provided by Angela O’Brien, Director of Quality & Effectiveness, Andy Pike, Head of Quality Assurance & Clinical Effectiveness, and Liz Harris, Deputy Director of Nursing & Patient Services, all from Newcastle upon Tyne NHS Foundation Trust. (Copy of presentation enclosed with the official minutes of the meeting.) Key headlines and details of the presentation included details of progress made on priorities:

**Patient Safety:**
- Priority 1 - to reduce all forms of healthcare associated infection (HCAI)
- Priority 2 - to reduce inpatient acquired Pressure Ulcers (PU)
- Priority 3 - management of abnormal results
- Priority 4 - local safety standards for invasive procedures (LocSSIPs)
- Priority 5 - Human factors training

**Clinical Effectiveness:**
- Priority 6 - digital enhancements to care
- Priority 7 - closing the loop

**Patient Experience:**
- Priority 8 - deciding right
- Priority 9 - enhancing patient and public involvement in quality improvement
- Priority 10 - improving the experience of vulnerable patients.

2019/20 proposed quality priorities:
- patient safety: reducing infection; pressure ulcer reduction; management of abnormal results
- clinical effectiveness: alignment of quality and clinical effectiveness - SAMM (systems for action management and monitoring); enhancing capability in quality improvement
- patient experience: deciding right; implementation of ‘treat as one’; ensure reasonable adjustments are made for patients with suspected or known learning disabilities.

Detailed discussion followed of which the key details of questions from members and answers from Ms Harris, Ms O’Brien and Mr Pike were:

Regarding differences between the two Trusts’ presentations as for example accident and emergency services had not featured in Newcastle’s, members were advised that this was because it was spread across many of their priority areas. Emergency department work included identifying people with pressure ulcers and sepsis. The priorities all reflected the importance of emergency department work.

The four hour accident and emergency targets were not being currently met in light of winter pressures faced, but the priorities did not include areas considered business as usual.
Regarding the management, frequency and outcomes of abnormal results, members were advised that they were occasionally experienced. Two incidents were referred to of which one case concerned a lesion not being picked up earlier which did not affect the patient’s life expectancy but could have enabled more palliative care support to have been organised.

Mr Young of the CCG acknowledged that it was important that the Trust was identifying areas for improvement and if it was successful in local initiatives that addressed national problems it was important to share them with other local Trusts. It was noted that the Healthcare Safety and Investigation Branch picked up examples of good practice; the Trust worked closely with them.

It was explained that infections could kill or contribute to death if undetected, although it could depend on the health of the individual patient. Members welcomed an offer to provide statistics about healthcare acquired infections after the meeting.

In response to why the referral of any abnormal results to another consultant could not be quicker than three to five days, members were reassured that there needed to be a cut off point and if it bounced quicker, it could lose the link to the original consultant for them to act. The timescale had been agreed on the basis of risk, and this was not expected to occur very often, as it had been introduced to anticipate any results not being picked up in the event of any consultants’ absence from work.

In connection with any risk of any initial data entries of people’s being incorrect, members were advised that it was machines rather than people who recorded blood pressure and temperature, and blood results were then analysed in the lab.

Replying to a question about reducing infections from catheters by 5% and what caused the infections, work took place to educate staff, patients and families about safer catheter use and support. The nurse consultant oversaw both equipment and education provision; staff observed patients and ensured that catheters were safely put in and taken out as soon as reasonably possible.

Regarding the sharing of other best practice, networks existed including regional collaborative programmes and regular meetings between groups of equivalent directors; members welcomed this.

Reference was made to the challenge of mental health conditions as they could be less visible; how was work undertaken and was there any lower age limit for services to be provided? Members were advised about arrangements for identifying people with a learning disability, including work of the Learning Disability Liaison Team. The learning disability passport service, which was not age specific, helped to recognise the behaviour of people in particular scenarios, for example they might respond differently to certain symptoms than other patients. The service provided access to screening and advice. Learning disability death reviews were also carried out as people with learning disabilities were more likely to die younger, and assessed what communication the carers and/or family received.

Regarding what services were provided for people with learning disabilities or mental health problems before they needed to enter the hospital setting, members were
advised that proactive work took place with community groups, including Deaf Link, to ask them for details of their experiences.

In reply to a question about other work not included within the priorities detailed, this presentation had provided a brief summary; full details of all services provided by the Trust would be included in their complete Quality Account report.

In connection with concerns about MRSA infections, members were advised that there was more than one type of MRSA and infections in the blood were more serious. The procedure for discharging patients with MRSA/C-difficile would depend on the condition of the individual patient.

A member welcomed the digital observation system but warned of the impact of any other factors such as power supply, plus also enabling the removal of human error from some situations; members were very pleased to hear that the Trust had a strong no-blame culture as it was the best way to learn from experiences including mistakes.

Regarding consultation undertaken with people and groups outside of Newcastle who used the Trust’s services, members were advised of consultation work with representatives of Northumbria Trusts, Northumberland County Council and work to seek patients’ views using a range of engagement exercises. Their chief executive embraced a culture of working together, for example the development of an Integrated Care System. Patient and public involvement continued to be priority piece of work, but the foundations had been laid for taking it forward when it had previously been one of the Trust’s priorities. The Trust were held to account on delivering their Quality Account aims and continued their patient and public involvement.

Ms Harris, Ms O’Brien and Mr Pike were thanked for their attendance and very good presentation and level of information provided. Following this it was:

RESOLVED that written responses be sent to Northumbria NHS Foundation Trust and Newcastle upon Tyne Hospitals NHS Foundation Trust about the committee’s views on their quality accounts and future priorities.
Corroborative statement from Newcastle Gateshead, Northumberland and North Tyneside Clinical Commissioning Groups (CCGs) for Newcastle Upon Tyne Hospitals NHS Foundation Trust Quality Accounts 2018/19

As commissioners, Newcastle Gateshead, Northumberland and North Tyneside Clinical Commissioning Groups (CCGs) are committed to commissioning high quality services from Newcastle Upon Tyne Hospitals NHS Foundation Trust and take seriously their responsibility to ensure that patients’ needs are met by the provision of safe, high quality services and that the views and expectations of patients and the public are listened to and acted upon. The CCGs welcome the opportunity to submit a statement on the Annual Quality Account for Newcastle Upon Tyne Hospitals NHS Foundation Trust.

The CCGs can confirm to the best of their ability, the information provided within the Annual Quality Account is an accurate and fair reflection of the Trust’s performance for 2018/19. The CCGs would like to provide the following statement:

The CCGs continue to hold regular quality review group meetings with the Trust which are well attended and provide positive engagement for the monitoring, review and discussion of quality issues. Newcastle Gateshead CCG has also continued throughout 2018/19 to conduct a programme of assurance visits to a number of Trust sites to gain assurances and an insight into the quality of care being delivered to patients. This has resulted in valuable partnership working with the Trust and has provided the CCG with an opportunity to make recommendations on suggested areas of improvement. A programme of CCG visits has been planned for 2019/20.

The report provides a comprehensive description of the quality improvement work undertaken within the Trust and an open account of where improvements in priorities have been made. It is acknowledged that a lot of work has been undertaken to deliver the Trust’s ambitions in a number of key areas and the Trust is to be commended on their achievements during 2018/19. We are happy to see that quality remains the Trust’s number one priority for 2019/20 and it is reassuring to see that this is reflective of the CCGs and national priorities.

The Trust aimed to achieve a 10% reduction year on year of MSSA bacteraemia and a 50% reduction of E.coli bacteraemia by 2021. The figures per 100,000 bed days demonstrate a decrease for MSSA and an increase of E.coli compared to 2017/18. Working in partnership with the CCG the Trust has implemented a number of initiatives, for example increased understanding and awareness of UTI/CAUTI, introduction of an evidenced based urethral catheter care plan, quality improvement projects that have led to MSSA reductions in areas of high prevalence. This continues to be a priority for 2019/20.

It is noted that a significant reduction in Trust acquired pressure damage has not been achieved despite the various improvement work streams. This is reflected in the number of pressure ulcers per 1000 beds days which shows an increase on 2017/18. However, the CCGs note that the Trust achieved a 6% reduction in pressure damage to heels and 35% of wards and departments achieved a minimum 20% reduction in pressure ulcer incidence. The CCGs fully support the continued work around reducing pressure ulcers as a priority in 2019/20.

The CCGs note the progress the Trust has made in developing a long-term solution for the management of abnormal results. During 2018/19 the Trust finalised how the reporting system will operate and identified that this will be fully deliverable using current and proposed electronic clinical records system. This continues to be a priority for 2019/20.
Never Events are serious incidents which are preventable when appropriate procedures are in place and can have significant effects on the people affected. It is noted that the Trust reported six never events in 2018/19. The CCGs acknowledge that the Trust has continued to improve surgical safety and has achieved the Local Safety Standards for Invasive Procedures (LocSSIPS) priority; which included identifying all invasive procedures and introducing LocSSIPS into five priority areas. Excellent progress has been made in the human factors training priority. This approach has been incorporated into their investigation processes and also included in their Quality Improvement Strategy.

The CCGs would like to congratulate the Trust on the excellent progress made in implementing the digital enhancements to care priority. This included establishing a data warehouse and developing an electronic observation system: which has been rolled out to 25 wards at the Royal Victoria Infirmary and 28 wards at Freeman Hospital. The Trust is now in a position to collaborate with local universities to look at the data set to make further improvements in the detection of the deteriorating patient. It is pleasing to note that the National Lead for Deteriorating Patients has expressed interest in the Trust's integrated approach.

The CCGs recognise the progress the Trust has made with the Closing the Loop priority by establishing a robust IT system to ensure action plans are monitored, prioritised, completed and reviewed within timescales. The Trust has undertaken mapping and scoping exercises to identify a suitable IT system, as well as establishing a multidisciplinary task and finish group ‘System for Action Management and Monitoring’ (SAMM). This continues to be a priority for 2019/20.

The CCGs acknowledge the progress undertaken on Deciding Right including a baseline survey, audit of acute admissions, ongoing work with patients and relatives and production of an educational video. The CCG notes that the Trust has identified further areas of improvement and this continues to be a priority for 2019/20.

The Trust has made good progress in the enhancing patient and public involvement in quality improvement (QI)’ priority. This has included developing a framework to support staff to consider how best to involve patients and the public in QI projects and the creation and launch of the Advising on Patient Experience (APEX) group. The CCGs note that the success of this initiative will be monitored by the number of QI projects presented to the APEX group and the evaluation of the impact it has had on patients and staff.

The CCGs are pleased to note the excellent progress the Trust has made in improving the experience of vulnerable patients. The Trust is working collaboratively with Northumberland Tyne & wear NHS Foundation Trust and a steering group has been established to monitor progress of the 22 recommendations or the ‘Treat as One’ publication. The mortality review process has been standardised and the use of an intranet-based database established. The Deprivation of Liberties Safeguards (DoLS) policy and consent form have been updated. An increase has been noted in the number of DoLS applications received in 2018/19. The CCGs fully support this as a continuing priority In 2019/20.

The emphasis that the Trust gives to national clinical audits demonstrates that the Trust is focussed on delivering evidence-based best practice. The CCGs commend the Trust for being top of the national league for clinical research studies for the seventh year.

The CCGs would like to congratulate the Trust and staff for their excellent achievements in 2018/19, including winning a number of national awards and the service innovations identified within the report. The CCGs also noted that the Trust has received their 2000th GREATIX submission which is used to capture excellence in practice and is a huge achievement.

The CCGs note the positive results from the NHS staff survey. The CCGs would also like to congratulate the Trust for the excellent results from the national maternity survey and being rated as among the best in the country. Although not included in the Quality Accounts report, the CCGs would also like
to congratulate the Trust on receiving its best ever results in the national cancer patient survey. Where patients rated their overall care 9 out of 10 and reported a positive experience in many areas.

The CCGs welcome the specific priorities for 2019/20 which are highlighted within the report and consider that these are appropriate areas to target for continued improvement. The CCGs look forward to continuing to work in partnership with the Trust in delivering high quality effective care for patients.

Chris Piercy
Executive Director of Nursing, Patient Safety & Quality

Dr Dominic Slowie
Interim Medical Director

For and on behalf of
NHS Newcastle Gateshead Clinical Commissioning Group
NHS Northumberland Clinical Commissioning Group
NHS North Tyneside Clinical Commissioning Group
Healthwatch Newcastle and Healthwatch Gateshead combined statement for the Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH) Quality Account 2018/19

Firstly we would like to congratulate the Trust on receiving the ‘Gold Award’ for its outstanding support to the armed forces. We also welcome the description of the various quality improvement initiatives implemented and would like to congratulate the Trust on the achievements detailed in this section.

The GREATIX initiative is interesting and we are pleased it is being used more and more each year. In future Quality Accounts we would like to learn more about what you have heard via GREATIX and what you did with the information.

The NHS Staff Survey results compare favourably with other Trusts, and NUTH should be proud of this. We are keen to learn more about what the Trust plans to do in the lowest performing areas (Morale, Health and Wellbeing and Quality of Appraisals).

We are pleased that the Trust continues to run a public engagement event for the Quality Account and we would like to learn more about how the public are involved further.

Results from 2018-19 priorities

Priority 1: Reducing infection - focus on MSSA/E.coli

It is good to read that there have been sustained reductions in most bacteraemias in individual directorates last year. In particular, we welcome the Trust’s approach of delivering quality improvement initiatives in areas where the prevalence of MSSA is high. We also congratulate the Trust on the reductions made in catheter usage and prolonged catheter usage via the Houdini tool. We hope that further reductions continue in the future.

As there have been only slight reductions in MSSA and C.difficile and slight increases in E.coli, Klebsiella and Pseudomonas, we are pleased to see that this priority is carrying forward into 2019/20.

Priority 2: Pressure Ulcer Reduction

It is pleasing to see that there have been reductions in pressure damage to heels and that certain wards and departments have also achieved reductions in pressure ulcer instances. However, it is unfortunate that there was an increase in pressure damage last year.

We welcome the Trust’s implementation of an innovative approach to pressure ulcer prevention as a result of focussing on this area last year and that there is a focus to embed this approach into areas where pressure ulcer instances are high.

As there has been an increase in pressure damage last year, we welcome the inclusion of this as a priority for 2019/20.

Priority 3: Management of abnormal results

The Trust has made good progress in implementing a solution to this problem and we look forward to seeing the results as the system gets rolled out across departments. We are pleased that this will be a priority for 2019/20.
Priority 5: Human Factors Training
It is good to see the progress the Trust has made in this area. However, as this priority’s main focus is on changing organisational culture, we feel it would have been good to continue this as a priority for several years, to ensure that it is fully embedded.

We recognise that it will still continue in years to come even though it is not remaining as a Quality Account priority. We would welcome more information on how the Trust plans to monitor the progress of ‘Human Factors’ over the years.

Priority 6: Digital enhancements to care
The Trust made good progress and we were pleased to learn the following:
• 80% of staff have fed back positively about the system
• The system has released about 100 hours of staff time per day
• Observation completeness has improved from 90% to 98%

It is also good to learn that it has been implemented so effectively across all adult inpatient wards and that the large data sets gathered has opened doors for the Trust to work with the local universities.

Priority 7: Closing the loop
The Trust has made good progress with this priority and we are pleased it is being carried forward into 2019/20 as ‘System for Action Management and Monitoring (SAMM)’. We look forward to learning more about the piloting of SAMM in the next Quality Account and hope the Trust achieves its plan to roll out SAMM across the Trust.

Priority 8: Deciding right
The information gathered through this work shows that the Trust really needs to focus on training staff in Deciding Right so that they feel able to have discussions with patients and help them put in place Advanced Care Plans, Emergency Health Care Plans and Treatment Escalation Plans.

Considering this, we are pleased to see that this priority will be continuing into 2019/20 and that one of the ways that the Trust will measure success is via patient and relative feedback. We would be happy to offer advice and support to the Trust in gathering feedback if needed.

Priority 9: Enhancing Patient and Public involvement in Quality Improvement (QI)
The process the Trust has put in place to ensure that this becomes part of its day to day business looks robust. We are pleased that a framework has been designed to support staff to involve patients and the public in their Quality Improvement projects. We would welcome a visit to see this system in action.

Priority 10: Improving the experience of vulnerable patients
We are pleased to see that the Trust and Northumberland, Tyne and Wear NHS Foundation Trust are working together to ensure that the physical health care provided to adult patients with co-existing mental health conditions is delivered consistently and is meeting their needs. It is also good to see that a patient representative is part of the steering group taking this work forward.

As this work is in its early stages and will likely take some time to be implemented and fully embedded, we are pleased to see that this priority will continue into 2019/20.
2019/20 priorities
We notice that most of the priorities for 2019/20 have been carried on from last year and we support this decision.

We are pleased to see the inclusion of a new priority, ‘Ensure reasonable adjustments are made for patients with suspected or known Learning Disabilities’. We welcome that the Trust is committed to ensuring that patients with learning disabilities have access to services that will help improve their health. We particularly welcome the commitment to gathering more patient and carer views and inviting Quality Checkers to review Trust services.

We wish the Trust continued success with these priorities in the coming year and look forward to supporting the Quality Account engagement event next year.
Dear Anne Marie

Draft Quality Account for year ending 31 March 2019

Thank you for the draft quality account of Newcastle upon Tyne Hospitals NHS Foundation Trust and would like to congratulate the Trust on some excellent results. The report gives a lot of performance information which will be useful as reference material for Healthwatch Northumberland (HWN) in the coming year.

We felt that although the document is technical, it is in general, easy to read and understand. We found the report, on the whole, to be clear and concise although it would benefit from a ‘dashboard’ system to highlight progress on individual priorities and overall which could then be explained within the narrative. This point was raised in our response for the last two years.

We commend the Trust on the many positive achievements that have been made and all of the work that has been done to learn lessons from outcomes, the rigour with which monitoring and auditing has taken place and the overall commitment to quality and improving patient outcomes.

We welcome the increased use of digital technology giving easier recognition of the deteriorating patient and producing early “red flag” warnings. We look forward to the results of the pilot project in Children’s Services.
We welcome the priority given to reducing the number of healthcare acquired infections.

As a Healthwatch, our focus is that “the health care system works for the people of Northumberland and that “the views, knowledge and experiences of health service users of Northumberland are listened to and influence health service developments in health in Northumberland and beyond”. We welcome the progress made in 2018/19 with the APEX system of feedback under Priority 9 Enhancing Patient and Public Involvement in Quality Improvement.

We note this it to be part of ‘normal business’ from now would ask that an explicit focus to include patients from Northumberland who are using Newcastle hospitals.

Access to services, particularly for rural areas remains a key priority identified in feedback to Healthwatch Northumberland and we would encourage the Trust to look at how to recognise and address this issue in delivery and reporting. Northumberland residents particularly raise;

**Appointment times** - for appointments to be set taking account of home postcodes so that people travelling from a distance, both by their own car and especially on public transport, have suitable appointment times. People report instances of having to travel the night before and therefore incurring additional expense or missing transport connections to get home. The latter adding to the stress, cost and discomfort of treatment.

Alternatively, where it is appropriate, to ensure that appointments, particularly routine checks and pre-operative assessments are routinely offered as close to the patient’s home as possible and not only when requested request.

**Patient Transport Services** - that all the Trust’s departments are aware of their responsibility in booking Patient Transport for patients undergoing a course of treatment or with an enduring condition.

Regarding the Trust’s priorities for 2019/20 in our view the plans to improve performance appear positive and achievable with priorities that align with areas highlighted for improvement.

In summary, we consider the report does give a fair reflection of the service provided by the Trust and we look forward to working with the Trust in the coming year and continuing to build on the positive working relationship we have established.

Yours sincerely

Derry Nugent
Project Coordinator
STATEMENT ON BEHALF OF NORTH TYNESIDE HEALTHWATCH

Healthwatch North Tyneside statement for The Newcastle upon Tyne Hospitals NHS Foundation Trust’s Quality Account 2018/19

Thank you for the opportunity to comment on the draft 2018/19 Quality Account. We would like to congratulate the Trust on some outstanding achievements this year.

Your quality accounts were very informative and it was good to see the details of your planned actions. Whilst it was relatively easy to read, it could be made more accessible by adopting a more dashboard style of reporting - perhaps something to consider next year.

A further suggestion for future improvements in the way to present your information and report your impact would be to better indicate what services you provide in the different geographical areas you serve. We understand over 40% of your staff live in North Tyneside and North Tyneside ranks third in terms of where your patients come from, but the area isn’t mentioned in your quality accounts. We felt your quality accounts missed an opportunity to show how the Trust relates to the local communities it serves.

We would like to note the following:

We were pleased to see the progress with, and continued commitment to achieving your priorities of reducing health care acquired infections, pressure ulcers, and abnormal results.

We welcome your priority, ‘treat as one’, and to further embedding your relationship with Northumberland Tyne and Wear NHS Foundation Trust on this issue. We would encourage you to be ambitious in your aims whilst looking at tangible benefits that will improve your services.

Your continued work on your ‘deciding right’ priority responds to an issue we are increasingly hearing about. Some people tell us that they wish they could have had these difficult conversations earlier.

We welcome the focus on supporting patients with suspected or known Learning Disabilities and are pleased that your aim includes support for families too.

It was good to see the progress made with Patient and Public involvement in Quality Improvement. We encourage you to continue to focus on service user involvement and would want to see that you are talking to people from North Tyneside as this becomes embedded in your day to day activity.

We look forward building our working relationship over the coming year and working together to ensure the people of North Tyneside’s voice is heard in the services the Trust provide.
<table>
<thead>
<tr>
<th>Abbreviations</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACP</td>
<td>Advance Care Plan</td>
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<tr>
<td>AHP</td>
<td>Allied Health Professional</td>
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<td>ANTT</td>
<td>Aseptic Non Touch Technique</td>
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<td>APEX</td>
<td>Advising on Patient Experience</td>
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<td>BAUS</td>
<td>British Association of Urological Surgeons</td>
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<td>CAT</td>
<td>Clinical Assurance Tool</td>
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<td>CAUTI</td>
<td>Catheter Associated Urinary Tract Infection</td>
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<td>CCGs</td>
<td>Clinical Commissioning Group</td>
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<tr>
<td>C.diff (CDI)</td>
<td>Clostridium difficile</td>
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<tr>
<td>CGARD</td>
<td>Clinical Governance and Risk Department</td>
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<td>CRN</td>
<td>Clinical Research Network</td>
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<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<td>CQC</td>
<td>Care Quality Commission</td>
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<td>CQUIN</td>
<td>Commissioning for Quality and Innovation (CQUIN) payment framework</td>
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<tr>
<td>CT</td>
<td>Computerised Tomography</td>
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<td>CTP</td>
<td>Career Transition Partnership</td>
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<td>DNACPR</td>
<td>Do Not Attempt Cardiopulmonary Resuscitation</td>
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<td>DoC</td>
<td>Duty of Candour</td>
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<td>DOH/DH</td>
<td>Department of Health</td>
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<td>E.coli</td>
<td>Escherichia coli</td>
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<td>ED</td>
<td>Emergency Department</td>
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<td>EHCP</td>
<td>Emergency Health Care Plans</td>
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<td>EPOD</td>
<td>Ear, Nose &amp; Throat, Plastics, Ophthalmology and Dermatology</td>
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<td>FH</td>
<td>Freeman Hospital</td>
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<td>FLS</td>
<td>Fracture Liaison Services</td>
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<td>GDE</td>
<td>Global Digital Exemplar</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HCAI</td>
<td>Healthcare Associated Infection</td>
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<td>HES</td>
<td>Hospital Episode Statistics</td>
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<td>Human Resources</td>
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<td>HSMR</td>
<td>Hospital Standardised Mortality Ratio</td>
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<td>IBD</td>
<td>Inflammatory Bowel Disease</td>
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<td>IHI</td>
<td>Institute for Healthcare Improvement</td>
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<td>IoT</td>
<td>Institute of Transplantation</td>
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<td>IT</td>
<td>Information Technology</td>
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<td>IV</td>
<td>Intravenous</td>
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<td>KF</td>
<td>Key Finding</td>
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<td>Locally Employed Doctor</td>
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<td>Lead Employer Trust</td>
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<td>Loc SSIPs</td>
<td>Local Safety Standards for Invasive Procedures</td>
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<td>MBRACE</td>
<td>Mothers and Babies, Reducing Risk through Audits and Confidential Enquiries across the UK</td>
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<td>MCA</td>
<td>Mental Capacity Act</td>
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<td>MINAP</td>
<td>Myocardial Ischaemia National Audit Programme</td>
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<td>Multi-Disciplinary Team</td>
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<td>M&amp;M</td>
<td>Morbidity &amp; Mortality</td>
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<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
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<td>MRSA</td>
<td>Methicillin-resistant Staphylococcus aureus</td>
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<td>MSSA</td>
<td>Methicillin Sensitive Staphylococcus Aureus</td>
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<td>Musculoskeletal Services</td>
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<td>Nat SSIPs</td>
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<td>N/A</td>
<td>Not Applicable</td>
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<td>NABCOP</td>
<td>National Audit of Breast Cancer in Older Patients</td>
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<td>NaDia</td>
<td>The National Diabetes Inpatient Audit</td>
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<td>NCCC</td>
<td>Northern Centre for Cancer Care</td>
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<td>NCEPOD</td>
<td>National Confidential Enquiries into Patient Outcome &amp; Death</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NICE</td>
<td>National Institute for health and clinical excellence</td>
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<td>NICOR</td>
<td>National institute for clinical outcome research</td>
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<td>NIHR</td>
<td>National Institute of Health Research</td>
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<td>NIV</td>
<td>Non-Invasive Ventilation</td>
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<td>NSF</td>
<td>National Service Framework</td>
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<td>NTW</td>
<td>Northumberland, Tyne and Wear</td>
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<td>NUTH</td>
<td>The Newcastle upon Tyne Hospitals NHS Foundation Trust</td>
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<td>PCI</td>
<td>Percutaneous Coronary Intervention</td>
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<td>PDSA</td>
<td>Plan do Study Act</td>
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<td>PICU</td>
<td>Paediatric Intensive Care Unit</td>
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<td>PROMs</td>
<td>Patient Reported Outcome Measures</td>
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<td>QI</td>
<td>Quality Improvement</td>
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<td>RCA</td>
<td>Root Cause Analysis</td>
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<td>ReSPECT</td>
<td>Recommended Summary Plan for Emergency Care and Treatment</td>
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<tr>
<td>RVI</td>
<td>Royal Victoria Infirmary</td>
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<td>SAMMM</td>
<td>Systems for Action Management and Monitoring</td>
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<td>SCBU</td>
<td>Special Care Baby Unit</td>
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<td>SHOT</td>
<td>Serious Hazards of Transfusion</td>
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<td>SHMI</td>
<td>Summary Hospital-level Mortality Indicator</td>
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<td>SIs</td>
<td>Serious Incidents</td>
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<td>SSI</td>
<td>Surgical Site Infection</td>
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<td>SUS</td>
<td>Secondary Users Service</td>
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<td>STAMP</td>
<td>Supporting Treatment and Appropriate Medication in Paediatrics</td>
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<td>STOMP</td>
<td>Stop OverMedicating People with a learning disability or autism</td>
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<td>TARN</td>
<td>Trauma Audit Research Network</td>
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<td>TEP</td>
<td>Treatment Escalation Plans</td>
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<td>TIMS</td>
<td>Tyneside Integrated Musculoskeletal Services</td>
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<td>UK</td>
<td>United Kingdom</td>
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<td>UKCRN</td>
<td>United Kingdom Clinical Research Network</td>
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<td>UTI</td>
<td>Urinary Tract Infection</td>
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<td>VTE</td>
<td>Venous thromboembolism</td>
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<tr>
<td>24/7</td>
<td>24 hours per day, 7 days per week</td>
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</table>
1. **C. difficile infection (CDI)**

C. difficile diarrhoea is a type of infectious diarrhoea caused by the bacteria Clostridium difficile, a species of gram-positive spore-forming bacteria. While it can be a minor part of normal colonic flora, the bacterium causes disease when competing bacteria in the gut have been reduced by antibiotic treatment.

2. **CQC**

The Care Quality Commission (CQC) is the independent regulator of all health and adult social care in England. The aim being to make sure better care is provided for everyone, whether that's in hospital, in care homes, in people's own homes, or elsewhere.

3. **CQUIN – Commissioning for Quality and Innovation**

The CQUIN framework was introduced in April 2009 as a national framework for locally agreed quality improvement schemes. It enables commissioners to reward excellence by linking a proportion of English healthcare provider’s income to the achievement of local quality improvement goals.

4. **DATIX**

DATIX is an electronic risk management software system which promotes the reporting of incidents by allowing anyone with access to the Trust Intranet to report directly into the software on easy-to-use web pages. The system allows incident forms to be completed electronically by all staff.

5. **E.coli**

Escherichia coli (E.coli) bacteria are frequently found in the intestines of humans and animals. There are many different types of E.coli, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment. E.coli bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. E.coli bacteraemia (blood stream infection) may be caused by primary infections spreading to the blood.

6. **Global Digital Exemplar**

Global Digital Exemplar is an internationally recognised NHS provider delivering improvements in the quality of care, through the world-class use of digital technologies and information.

7. **Gram-negative Bacteria**

Gram-negative bacteria cause infections including pneumonia, bloodstream infections, wound or surgical site infections, and meningitis in healthcare settings. Gram-negative bacteria are resistant to multiple drugs and are increasingly resistant to most available antibiotics. These bacteria have built-in abilities to find new ways to be resistant and can pass along genetic materials that allow other bacteria to become drug-resistant as well.

8. **HOGAN evaluation score**

Retrospective case record reviews of 1000 adults who died in 2009 in 10 acute hospitals in England were undertaken. Trained physician reviewers estimated life expectancy on admission, identified problems in care contributing to death and judged if deaths were preventable taking into account patients’ overall condition at that time. The Hogan scale, ranging from 1 (definitely not preventable) to 6 (definitely preventable), was used to determine if deaths were potentially avoidable, taking into account a patient’s overall condition at the time.

Source: Dr Helen Hogan, Clinical Lecturer in UK Public Health

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Definitely not preventable</td>
</tr>
<tr>
<td>2</td>
<td>Slight evidence for preventability</td>
</tr>
<tr>
<td>3</td>
<td>Possibly preventable, but not very likely, less than 50-50 but close call</td>
</tr>
<tr>
<td>4</td>
<td>Probably preventable more than 50-50 but close call</td>
</tr>
<tr>
<td>5</td>
<td>Strong evidence of preventability</td>
</tr>
<tr>
<td>6</td>
<td>Definitely preventable</td>
</tr>
</tbody>
</table>

9. **HSMR**

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than would be expected.

10. **MRSA**

Staphylococcus Aureus (S. aureus) is a bacterium that commonly colonises human skin and mucosa (e.g. inside the nose) without causing any problems. Although most healthy people are unaffected by it, it can cause disease, particularly if the bacteria enters the body, for example through broken skin or a medical procedure. MRSA is a form of S. aureus that has developed resistance to more commonly used antibiotics. MRSA bacteraemia is a blood stream infection that can lead to life threatening sepsis which can be fatal if not diagnosed early and treated effectively.

10. **MSSA**

As stated above for MSSA the only difference between MRSA and MSSA is their degree of antibiotic resistance: other than that there is no real difference between them.

11. **Near Miss**

An unplanned or uncontrolled event, which did not cause injury to persons or damage to property, but had the potential to do so.