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## Part 1

### Chief Executive Statement

The Newcastle upon Tyne NHS Foundation Trust is committed to providing patients with the highest quality of healthcare and to be the most prolific and innovative Trust in moving the frontiers of excellence in all that we do for the benefit of people everywhere.

We aim to:

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

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

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

We embrace opportunities to be innovative and enhance quality and safety for patients and our staff. All of this activity is supported by an established governance system with an emphasis on honest and open communication.

To the best of my knowledge the information contained within this document is accurate.



**Sir Leonard R Fenwick**

Chief Executive

The Newcastle upon Tyne Hospitals NHS Foundation Trust

April 2010

## What is a Quality Account?

Quality Accounts are annual reports to the public from us about the quality of healthcare service we provide. They are both retrospective and forward looking as they look back on the previous years data, explaining our outcomes and crucially look forward to explain what we have identified as our priorities for the next year, how we plan to achieve and to measure these.



## Part 2

### Quality Priorities for 2010/11

Following discussion with the Board of Directors, Clinical Policy Group, Council of Governors and Departmental/Directorate Governance leads the following priorities for 2010/11 have been agreed

**Priority 1** - To reduce healthcare associated infection by:

- aiming for the annual number of Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia cases to be less than 13
- reducing the rate of MRSA acquisition by 10%
- reducing hospital acquired infection related to Clostridium difficile (*C.diff.*) to less than 296 cases.

MRSA bacteraemia and *C.diff.* cases that are presumed to have been acquired while the patient was admitted during their hospital stay are considered to be hospital-apportioned cases and are derived from the data as follows:

**MRSA bacteraemia infections are apportioned to a hospital** if ALL the following rules are met:

- the location where the specimen was taken is given as 'acute Trust' or 'PCT hospital';
- patient is an inpatient, daypatient, or emergency assessment patient;
- patient's specimen date is on, or after, the third day of the admission (or admission date is null), where the day of admission is day 1

Prevention and control of infection remains a priority for the Trust. Significant improvement has been achieved in reducing the number of MRSA bacteraemia cases to the extent that the national target has been achieved for the last two years. The Trust is keen to maintain and improve on this position.

Several initiatives are already in place to reduce infections, and the following will be monitored by the Infection Prevention and Control Committee:

- compliance with the national recommendations in 'Saving Lives' will be re-audited and interventions applied as necessary
- the Antimicrobial Prescribing policy for the Trust has been amended in view of national guidance, with the replacement of cephalosporins wherever possible given to patients over 65 years by alternative antibiotics for pneumonia and severe infection
- antimicrobial stewardship from committee and policy level to the prescription at the bed side will be promoted across the Trust in the coming months
- use of antibiotics and adherence to the Antimicrobial Prescribing policy.

**C. difficile infections are apportioned to a hospital** if ALL the following rules are met:

- the location where the specimen was taken is given as 'acute Trust' or 'PCT hospital';
- patient is an inpatient, daypatient, or emergency assessment patient;
- patient's specimen date is on, or after, the fourth day of the admission (or admission date is null), where the day of admission is day 1.

The Trust recognises that our approach to reduction of *C.diff.* requires significant effort from all our staff in 2010/11. Specific factors identified to address the current rate of infection are:

- changing antibiotic policy to reduce use of cephalosporins particularly in older patients, except where there is an overriding clinical indication
- enhanced infection control practice to minimise transmission
- aiming to increase compliance with antibiotic stop and review policy, to ensure that patients with clear indications receive antibiotics and that where prescribed they are given for a defined course of treatment which is as short as possible to achieve desired clinical effect
- to increase the audit frequency of antibiotic policy compliance to weekly, reporting weekly to Executives and monthly to the Board
- rapid review analysis of all *C.diff.* cases.

### **Board Sponsor**

Mrs Helen Lamont, Nursing and Patient Services Director

### **Implementation Lead**

Dr Alistair Gascoigne, Director of Infection Prevention and Control

**Priority 2** - To monitor and improve the patient experience by:

- maintaining and improving on our current position in national patient surveys
- expanding the range of departmental surveys
- implementing a system for Real-Time patient feedback in out-patient areas (2010/2011)
- implementing a system for Real-Time patient feedback in in-patient areas (2011/2012).

We aim to provide excellent quality of services and to ensure that all interactions with our staff or departments are consistently safe, effective and to be recommended. To monitor this we will:

- implement a whole organisation Real-Time survey system to assess the patient experience
- implement Directorate specific patient experience reports
- ensure 80% compliance with national Patient Reported Outcome Measures (PROMs)
- involve representatives from the Council of Governors and patient representatives in the development of patient experience reports
- improve timeliness and content of discharge information for in-patients.

### **Board Sponsor**

Dr Tim Walls, Medical Director

Mrs Helen Lamont, Director of Nursing

### **Implementation Lead**

Mrs Diane Palmer, Director of Quality and Effectiveness

Mrs Caroline McGarry, Involvement and Equalities Officer

**Priority 3** - To maintain the position of Hospital Standardised Mortality Ratio (HSMR) at less than 80 for 2010/2011.

One recognised indicator of patients' safety is the HSMR, which is a comparison of expected number of deaths with actual number of deaths taking into account the nature of the conditions being treated. The HSMR calculation adjusts for factors which may affect mortality such as: age, sex, diagnosis and admission status. It produces a summary estimate of in-hospital mortality relative to the national pattern. A figure of 100 represents results directly in line with expectations; a higher figure represents a high mortality rate and a low figure a lower mortality rate. The Trust has a very favourable HSMR however we aim to maintain and where possible enhance this position by:

- developing safety procedures to eliminate 'never events'
- reducing hospital acquired thrombo-embolism by introduction of venous thromboembolism (VTE) assessment for all in-patients and monitoring compliance with policy
- reducing medication errors
- introducing more robust monitoring of outcome measures for specific conditions
- monitoring and reporting of unplanned Intensive Therapy Unit (ITU) admission and re-admissions
- monitoring of mortality in patients admitted for elective procedures
- monitoring compliance with the World Health Organisation (WHO) safe-surgery checklist.

**Board Sponsor**

Dr Tim Walls, Medical Director

**Implementation Lead**

Mrs. Diane Palmer, Director of Quality and Effectiveness

**Priority 4** - To reduce the number of patient safety incidents associated with slips, trips and falls by 10%.

The most frequently reported patient safety incidents are due to falls. A proportion of these falls result in major or catastrophic consequences for the patient. During 2009/10 the Falls Steering Group has recommended several actions to reduce the incidence and/or severity of falls. Continuing with the reduction of falls as a priority for the Trust will ensure that the recommendations are implemented in a timely and consistent manner. Actions recommended are:

- implementation of the new Falls Assessment and Intervention Tool
- for all nursing staff to undertake the Falls Reduction training package, compliance will be monitored monthly by the Trust Board
- evaluation of a study relating to the use of slip resistant footwear in the Internal Medicine and Elderly Care Directorate
- review of the use of pressure sensor monitoring systems
- promotion of the use of low level beds for high risk patients
- enhancement of a monthly report on falls incidents to all Directorate Management Teams
- monitoring the incidence of patient falls monthly by the Trust Board.

**Board Sponsor**

Dr Tim Walls, Medical Director

**Implementation Lead**

Mrs Diane Palmer, Director of Quality and Effectiveness

**Priority 5** - To reduce the number of sharps and needle-stick injuries by 10%.

Sharps and needle-stick injuries pose a significant risk to the health of staff, visitors and patients. The following initiatives to reduce and monitor such injuries will be coordinated by the Sharps and Needlestick Injuries Reduction Group:

- production of an inventory of a range of safe user-friendly products for use in the clinical setting
- provision of education and training in safe practice and handling of sharps devices
- monitoring of sharps incidents, to ensure that corrective training is provided
- poster campaigns on prevention of needlesticks/sharp injuries, and circulation of good practice literature to re-enforce the Trust position on the prevention and reduction of such injuries.

**Board Sponsor**

Dr Tim Walls, Medical Director

**Implementation Lead**

Mrs Diane Palmer, Director of Quality and Effectiveness

## **Commissioning for Quality and Innovation (CQUIN) Indicators**

The Commissioning for Quality and Innovation (CQUIN) payment framework is one of the commitments in *High Quality Care for All* 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 locally between the provider and the commissioner.

Listed below are the quality and/or innovation projects which have been agreed with the Commissioners for 2010/2011

### **CQUIN Indicators (NHS North of Tyne Commissioners)**

1. To reduce avoidable death, disability and chronic ill health from VTE.
2. To facilitate responsiveness to the personal needs of patients.
3. To report the following activity relating to the Liverpool Care Pathway (LCP)
  - Adoption level: proportion of wards using LCP
  - Compliance with completion of the LCP or equivalent pathway
  - Proportion of dying patients on the LCP or on an alternative integrated terminal care pathway.
4. Decrease in the “drop off” rate of breastfeeding between initiation & discharge from delivery spell.
5. Identify pregnant women who smoke and ensure they are referred to smoking cessation services and receive a brief intervention.
6. Monitor patients with pressure sores (new or present) that deteriorate during the patient’s admission.
7. Report the number of inpatient falls – to identify the number of acute patients that experience a fall whilst in hospital.
8. Report on the proportion of stroke patients who receive 8 of the care bundle components as defined in the Sentinel Stroke Audit.
9. To enhance the system for communication between hospital medical teams and GPs at patient’s discharge.
10. To monitor the total number of women discharged from post natal wards & abortion services who are offered a contraceptive method (excluding condoms).
11. Improve access for young people through achievement of “You’re Welcome” accreditation.
12. The development of a more integrated approach to stop smoking interventions.

## CQUIN Indicators (North East Specialised Commissioning Group)

1. The following is to be achieved for patients with HIV:
  - to reduce the length of time from diagnosis of HIV to offered date of first CD4 count to less than or equal to 28 days
  - patients to have a CD4 count of greater than or equal to 200 after one year or more of treatment at the centre
  - to increase the proportion of HIV patients with a viral load less than or equal to 50 and still on therapy 1 year after therapy started.
2. Neurosurgery Services, to reduce the:
  - number of emergency neurosurgery admissions where transfer from another hospital is delayed
  - number of readmissions following neurosurgery procedures within 30 days of discharge.
3. For patients with chronic renal failure to have increased access to therapies including Continuous Ambulatory Peritoneal Dialysis (CAPD), Assisted Automated Peritoneal Dialysis (AAPD) or home dialysis.
4. To increase the number of renal transplants from a living donor.
5. All patients with chronic renal failure to have a decision made when starting dialysis as to whether they are suitable to have a transplant with a minimum of 80% of dialysis patients who are deemed suitable being placed on the national kidney transplant list within 3 months of starting dialysis.



## **Statement of assurance from the Board of Directors and Review of the Trust's position and status on Quality**

During 2009/10 the Newcastle upon Tyne Hospitals NHS Foundation Trust provided and/or sub-contracted 21 specialty NHS services.

The Newcastle upon Tyne NHS Foundation Trust has reviewed data available to them on the quality of care in all 21 of these NHS services.

The income generated by the NHS services reviewed in 2009/10 represents 100 per cent of the total income generated from the provision of NHS services by the Newcastle upon Tyne NHS Foundation Trust for 2009/10.

In 2009 the Trust Board participated in an exercise coordinated by Monitor to review its processes for assessing quality. A review of the Board's agenda was undertaken with the objective of increasing the amount of time that the Board spends considering quality issues. High level parameters of quality have been reported monthly to the Board and Clinical Policy Group, bi-monthly to the Clinical Governance and Quality Committee and to the Council of Governors at each meeting by the Quality & Performance Account. The Quality & Performance Account reports information under the headings of Patient Safety, Clinical Outcomes and Clinical Effectiveness, all of which feature factors relating to the patient experience. Activity is monitored in respect to quality priorities and safety indicators by exception and performance is compared with local and national standards. Leadership walkabouts, coordinated by the Director of Quality and Effectiveness, involving Executive and Non-Executive Directors and members of the Medical Director's team have been regularly conducted in a variety of departments, feedback from these is provided at the Corporate Governance Committee.



## Part 3

# Review of Quality Performance 2009/2010 incorporating Patient Safety, Clinical Effectiveness and Patient Experience

## Quality Priorities 2009/2010

**Priority 1** - Reduce rate of hospital acquired infection by 25%

	2008/2009	2009/2010
MRSA bacteraemia	38	12
MRSA colonisation in hospital	524	402
<i>C.difficile</i>	298	304

There has been a significant reduction in the number of MRSA bacteraemias acquired in the Trust. The Department of Health's target of 30 bacteraemias (2009/10) and the Trust's internal target of 28 have been comprehensively met with only 12 bacteraemias being confirmed. The Trust is currently compliant with the MRSA mandatory screening targets.

The acquisition of MRSA by patients following admission to hospital remains a problem. The reasons behind this are thought to be multi-factorial. The reduction in bacteraemias supports the concept that healthcare professionals are now much more vigilant and that relatives and patients may also be implicated in transmission. This has led to the focus of advertising the need for hand hygiene at the patient's bedside for all to see and be reminded of.

The Trust acknowledges that the rate of *C. diff* increased in 2009/10 rather than decreased. Reducing the rate of this infection has resulted in the development of significant improvement plans which have been identified in 2010/11 priorities.

*C. diff.* is the leading identified cause of nosocomial diarrhoea associated with antibiotic therapy, leading to symptoms which range from mild/severe diarrhoea, pseudo membranous colitis to toxic mega colon and fatal colonic perforation. Whilst we have met the nationally set target we have not met our own internal target. The current rate of *C. diff* now appears to have plateaued. The Directorates with the highest incidence reflect the population of patients most at risk. Several clinical areas across the Trust have had outbreaks of *C.diff*. The Trust has taken robust action on each occasion, closing the wards to admissions, and when the actions put into place appeared insufficient, completely closing the ward and transferring patients to decant facilities. The wards have undergone deep cleaning along with repair and replacement of any damaged fabric or potentially contaminated equipment. Review of antibiotic prescribing in these areas has been undertaken along with feedback to the respective clinical teams. *C.diff* was the focus of attention at the Clinical Governance meeting for Internal Medicine and Care of the Elderly highlighting the Trust concerns and in addition a dedicated teaching session at the Trust Infection Prevention and Control Educational Forum was held. An Integrated Care Pathway for *C. diff.* was introduced Trust-wide in August 2009. The documentation is used in conjunction with the *C.diff* Management Policy and clinical algorithm which was introduced in November 2009 to comply with national guidance. In line with the recommendations from the Chief Medical Officer, arrangements have been put in place in relation to Death Certification and *C.diff*. For any patient where the cause of death is attributable to *C.diff* a Consultant will complete the Death Certificate and undertake a root cause analysis which is then subject to review by the Director of Infection Prevention and Control, the Medical Director and the Nursing and Patient Services Director. This applies to both parts 1 and 2 of the death certificate and all have been

reported to the Strategic Health Authority, or more recently the Primary Care Trust, as serious untoward incidents

**Priority 2** - Reduce incidence of patient falls by 10% and the number of incidents resulting in major or catastrophic occurrences by 10%.

	2008/2009	2009/2010
Patient Falls	2582	2649

Whilst it is disappointing that we have been unable to demonstrate a reduction in falls related incidents the Trust has implemented several initiatives which, when fully implemented throughout the organisation should reduce the incidence of patient falls. As recommended by the National Patient Safety Agency (2007) and the Patient Safety First Campaign (2009), a strategic Falls Prevention Group has been developed. Initiatives proposed by the Falls Prevention Group include:

- development of a new falls assessment and intervention tool which has been modified following a trial period and which will be fully implemented by the summer of 2010
- production of a comprehensive training presentation, available since January 2010 and to date 1,693 staff members have accessed the training
- development and approval of the Management and Prevention of Slips, Trips and Falls policy and development of the Falls Reduction Strategy
- successful application for funding to undertake a study relating to the use of slip resistant footwear in the Internal Medicine and Elderly Care Directorate, to commence Summer of 2010
- review of the use of pressure sensor monitoring systems
- promotion of the use of low level beds for high risk patients
- modification of incident investigation forms to include data on medications
- development of a monthly report on falls incidents to all Directorate Management Teams
- monitoring of the incidence of patient falls accidents monthly by the Trust Board.

**Priority 3** - Reduce the Trust Hospital Standardised Mortality Ratio (HSMR) to less than or equal to 75.

The Trust HSMR has been monitored monthly by the Board of Directors. The ratio has ranged during the year between 76.56 and 79.11. Whilst the Trust is in a very favourable position and has one of the lowest ratios when compared with other hospitals both locally and nationally, the Trust has noted a slight increase in figures during the year. This is thought to be attributable to a change in the recalculation of expected values and risk estimates undertaken by Dr Foster Intelligence and the Dr Foster Unit at Imperial College during September/October 2009, in addition to some adjustments they made to diagnosis codes and groups.

We recognise that we set a challenging target for 2009/10. The month on month variation, inconsistencies between Dr Foster and NHS Choices web-site data and external factors including adjustments to the calculation methodology have compounded interpretation of the HSMR data but overall the Trust position remains very favourable in comparison with the regional and national figures.

**Priority 4** - To ensure that all patients have their concerns addressed and are treated with dignity and respect. To increase the proportion of patients who rate their overall experience as very good or excellent.

Results of the Picker Institute in-patient and out-patient surveys have indicated that the Trust is a strong performer and is in the top 20% of all acute trusts against 13 key indicators which

include: overall impression of department being satisfactory, always being treated with dignity & respect, cleanliness, seeing a doctor (explanation of treatment, being listened to, having opportunity to ask questions, confidence in the doctor and doctors awareness of medical history), medication on discharge with advice to family members and receiving copies of letters sent to their GP. A downside, however, was being cited as 'worse than average' in relation to patients not being offered a choice of an admission date or of hospital– an aspect not under the direct control of the Trust.

Several local departments have undertaken patient satisfaction surveys with favourable results. The Trust is keen to establish a system for real-time patient feedback in all departments and is currently identifying a suitable mechanism for this system.

The national annual survey of the views of adult inpatients asks about the experiences of people who have been admitted to hospital and had at least one overnight stay. The questions in the survey cover the issues that patients consider important in their care. The survey offers an insight into their experiences and this information is used in the assessment of NHS trusts by the CQC.

The national annual survey of the views of adult outpatients asks people about their most recent visit to an Outpatient department. The survey includes questions on waiting for the appointment, hospital facilities, seeing a doctor, any tests and treatment undertaken during the appointment, as well as any medications prescribed.

A summary of the National Inpatient and Outpatient survey results is provided on page 15.



## National Inpatient and Outpatient survey results 2009/2010

Outpatient department survey questions taken from National Out-patient survey 2009	Based on patients' responses to the survey, the Trust scored:	How this score compares with other trusts
For questions about getting an appointment	7.8/10	About the same
For questions about waiting in the Outpatient Department	4.7/10	About the same
For questions about the Outpatient environment and facilities	8.9/10	About the same
For questions about seeing a doctor during the appointment	9.1/10	About the same
For questions about professionals other than a doctor, for those who saw someone else during their appointment	8.9/10	About the same
For questions about what happened during patients' appointments at the outpatient department	8.8/10	About the same
For questions about tests and treatment, for patients who received tests or treatment during their appointment	8.4/10	About the same
For questions about medications prescribed during the appointment	8.5/10	Better
For questions about information given by staff	6.8/10	Better
For questions about overall views and experiences	8.8/10	About the same
In patient survey questions taken from National In-patient survey 2009	Based on patients' responses to the survey, the Trust scored:	How this score compares with other trusts
For questions about the emergency / A&E department, answered by emergency patients only	8.1/10	About the same
For questions about waiting lists and planned admissions, answered by those referred to hospital	5.8/10	About the same
For questions about waiting to get to a bed on a ward	8.6/10	About the same
For questions about the hospital and ward	8/10	Better
For questions about doctors	8.9/10	Better
For questions about nurses	8.5/10	About the same
For questions about care and treatment	7.9/10	Better
For questions about operations and procedures, answered by patients who had an operation or procedure	8.5/10	About the same
For questions about leaving hospital	7.3/10	Better
For questions about overall views and experiences	6.7/10	Better

**Priority 5** - Reduce the number of sharps and needle-stick injuries by 20%.

	2008/2009	2009/2010
Needlestick Injuries	307	334

A Sharps and Needlestick Injury Prevention Group established in 2009 to co-ordinate actions to reduce sharps and needlestick injuries has focused attention on the requirement to adhere to Trust policy following injury so that appropriate support can be provided. The number of incident reports related to sharps and needlesticks has increased in 2009/10 and whilst this number of incidents remains a serious cause for concern the increase may be attributable to increased reporting rather than a significant increase in injury.

The following initiatives have been co-ordinated by the Sharps and Needlestick Injury Prevention Group:

- trial of medical devices including safety cannula, retractable needles and mobile sharps containers
- development of an inventory of Sharpsafe products
- consideration of Sharpsafe education programme, including poster campaigns, to be finalised in 2010.

All of these priority indicators have been monitored monthly. In addition, the Board of Directors, Council of Governors, Clinical Policy Group and Clinical Governance and Quality Committee all monitor other patient safety, outcome and effectiveness parameters: an overview of these is provided on pages 16 - 21.



## Overview of monthly Board assurance 2009/2010

This is a representation of the Quality Account data presented to the Trust Board on a monthly basis for the year 2009/2010.

Safety	Actual 2008/09	Target 2009/10	Monthly Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Actual 2009/10	
Screening MRSA: electives	Not stated	100%	100%	90.6%	●	95%	●	100%	●	100%	●	81.4%	●
Screening MRSA: emergency	Not stated	75%	75%	N/A		N/A		81.7%	●	81.4%	●	81.6%	●
Hand Hygiene audits (opportunity)	96.2%	95%	95%	97.7%	●	96.3%	●	98.8%	●	98.5%	●	97.9%	●
Total number of incidents reported (DATIX)	10,189	N/A	N/A	2,384		2381		2430		2738		9933	
Mismatched Transfusion (severe event)	0	0	0	0	●	0	●	0	●	0	●	0	●
Mismatched Transfusion (near miss)	0	0	0	1	●	1	●	1	●	1	●	4	●
Total number of CNST claims	123	N/A	N/A	36		33		26		28		123	
Number of radiation incidents reported to HSE and CQC	8	N/A	N/A	6		1		0		1		8	
Patients admitted electively and subsequently died	N/A	N/A	N/A	51		33		42		32		158	
Serious Untoward Incident (SUI)	2008/2009 Figures	% reported within 24hrs	% response within 60 days	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Actual 2009/10	
General	14	100% ●	Ongoing ●	4		3		2		6		15	●
HCAI *	11	100% ●	Ongoing ●	3		24*		32*		8		67	●
Information Governance	3	100% ●	Ongoing ●	2		0		1		0		3	●

\*Due to a change in reporting requirements and timeframes an increased number of incidents required reporting, these figures are not representative of infection activity at those time periods.

Clinical Outcomes (ITU)	Actual 2008/09	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2009/10
ITU Readmission (readmitted to ITU within same hospital episode)	347	58	25	54	60	197
ITU SMR (APII SMR - quarterly figure)	65%	62%	66%	69%	Not available	Not Available
ITU discharges out of hours (between 22.00 and 07.00)	318	66	42	35	60	203
ITU delayed discharge ( no. of patients who's discharge is delayed greater than 6 hr from time of request)	1296	207	252	277	288	1024
Matching Michigan Data- CVC Infections **	N/A	Not available	May – Sept: 6	1.9	2.5	Not available

\*\* Calculated on the number of patients each day with 1 or more central lines. Then divide the number of ITU acquired central line associated or related infections by this number x 1000.

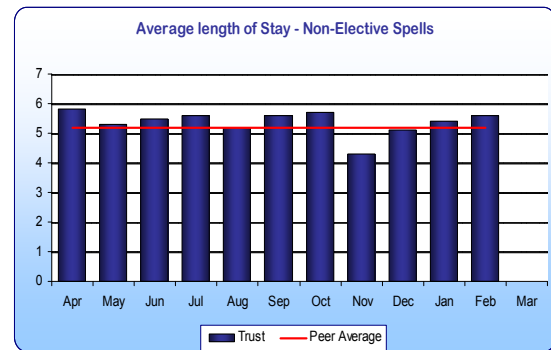
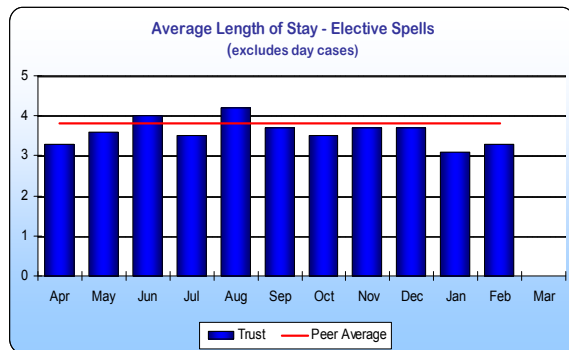
Clinical Outcomes	Actual 2008/09	Target 2009/10	Monthly Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Actual 2009/10	
Breast feeding initiation (Cumulative)	62.2%	Greater than or equal to 62.2%	Greater than or equal to 62.2%	63.3%	●	62.5%	●	62.4%	●	62.3%	●	63.0%	●
Smoking during pregnancy (Cumulative)	18.6%	Less than or equal to 18.6%	Less than or equal to 18.6%	18.0%	●	17.9%	●	17.8%	●	17.7%	●	17.7%	●
Caesarean section rates (Quarterly)	N/A	24%	24%	24.2%	●	24.8%	●	28.4%	●	23.4%	●	25.4%	●
Number of complaints received	568	N/A	N/A	156		142		143		175		616	
% of patients who spend 4 hours or less in A&E	98.9%	Greater than or equal to 98%	Greater than or equal to 98%	98.6%	●	99.2%	●	98.5%	●	98.0%	●	98.7%	●
Inpatients waiting longer than the 26 week standard	0	Less than or equal to 0.3%	0	0	●	0	●	0	●	0	●	0	●
Outpatients waiting longer than the 13 week standard	0	Less than or equal to 0.3%	0	0	●	0	●	0	●	0	●	0	●
Patients seen within 2 weeks of GP referral to a rapid access chest pain clinic	100%	100%	100%	100%	●	100%	●	100%	●	100%	●	100%	●
Cancelled operations rescheduled within 28 days	0.5%	Less than or equal to 0.8%	Less than or equal to 0.8%	0.5%	●	0.3%	●	0.2%	●	0.2%	●	0.3%	●
Those patients not admitted within 28 days (Quarterly)	3.0%	Less than or equal to 5%	Less than or equal to 5%	3.2%	●	3.3%	●	3.6%	●	0.0%	●	2.0%	●
Percentage high risk TIA cases treated within 24 hours (Quarterly)***	N/A	N/A	N/A	38.0%		30.0%		87.5%		88.9%		89%	
Choose and Book: Referrals	Not available	Greater than 95%	Greater than 95%	100.0%	●	100.0%	●	97.0%	●	100.0%	●	99%	●
Choose and Book: Appointments	Not available	100%	100%	99.4%	●	99.7%	●	99.0%	●	99.0%	●	99%	●
Choose and Book: Slot issues	3.8%	Less than or equal to 4%	Less than or equal to 4%	11.7%	●	8.1%	●	5.1%	●	6.4%	●	7.7%	●

\*\*\* The percentage high risk TIA cases treated within 24 hours improved greatly between quarters 1 and 3 - this is based on a number of factors. New guidance was issued. An additional Consultant is now running a TIA clinic resulting in an additional 6 new patients per week being seen. Also the rapid access neurology clinic has unlimited slots available for high score TIA patients to be referred during Monday – Friday with the Acute Stroke Unit having the capability to see all high score TIA patients referred during a on the weekend. Resulting from development of the TIA clinic, Rapid Access Neurology clinic and the Acute Stroke Service and Emergency Assessment Unit all of our new referrals are being seen quicker and more efficiently.

Clinical Effectiveness	Actual 2008/09	Target 2009/10	Monthly Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Actual 2009/10	
All cancer patients: 2 week Wait	98.3%	93.0%	93.0%	93.1%	●	93.3%	●	95.6%	●	95.4%	●	94.6%	●
All cancer patients: 1 month diagnosis to first treatment	97.0%	96.0%	96.0%	98.2%	●	98.6%	●	98.7%	●	99.5%	●	98.8%	●
All cancer patients: 1 month diagnosis to subsequent treatment	97.4%	94.0%	94.0%	97.6%	●	95.5%	●	97.3%	●	98.3%	●	97.0%	●
All cancer patients: 2 month urgent referral to treatment	82.9%	85.0%	85.0%	83.1%	●	81.2%	●	85.4%	●	90.0%	●	85.1%	●
Percentage cancer patients treated within 62 days of consultant decision to upgrade priority status	92.9%	N/A	N/A	100%		90.4%		98.5%		94.4%		95.2%	
Percentage patients referred from cancer screening service treated within 62 days	95.5%	90.0%	90.0%	100%	●	100%	●	95.1%	●	100.0%	●	98.8%	●
18 week RTT times: admitted patients	Greater than or equal to 90%	Greater than or equal to 90%	Greater than or equal to 90%	93.2%	●	93.3%	●	95.0%	●	92.7%	●	Greater than 90%	●
18 week RTT times: non-admitted patients	Greater than or equal to 95%	Greater than or equal to 95%	Greater than or equal to 95%	96.2%	●	96.3%	●	97.2%	●	97.0%	●	Greater than 95%	●
18 week RTT times: direct access Audiology patients	Greater than or equal to 95%	Greater than or equal to 95%	Greater than or equal to 95%	99.9%	●	99.8%	●	99.9%	●	99.1%	●	Greater than 95%	●
18 week RTT times: data completeness Admitted patients	90-110%	90-110%	90-110%	101.6%	●	100.4%	●	97.3%	●	102.7%	●	90 – 110%	●
18 week RTT times: data completeness Non-Admitted patients	90-110%	90-110%	90-110%	98.9%	●	100.0%	●	100.5%	●	102.8%	●	90 – 110%	●
Patients waiting more than 6 weeks for non-audiology diagnostic tests	0	0	0	0	●	0	●	0	●	0	●	0	●
Patients waiting more than 6 weeks for audiology tests	0	0	0	0	●	0	●	0	●	0	●	0	●
New outpatients	216,685	225,957	18,830	54,824	●	57,054	●	55,052	●	55,315	●	222,245	●
Review outpatients	606,336	588,430	49,036	148,294	●	141,567	●	146,809	●	155,309	●	591,979	●

## Average length of stay

The Trust Board receives information on the average length of stay and a comparison with activity from peer hospitals for both elective and non-elective patients and this is presented in the graphs below:



## Information on the use of the CQUIN framework

A proportion of The Newcastle upon Tyne Hospital NHS Foundation Trusts income in 2009/10 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the CQUIN framework. Further details of the agreed goals for 2009/10 and for the following 12 month period are available on request from the Director of Quality & Effectiveness.

The Table below indicates CQUIN indicators agreed with North of Tyne Commissioners for 2009/2010 and the status of activity at 04/06/2010.

CQUIN Indicators 2009/2010	Threshold	Status
<b>1. Care transfers, Handovers &amp; Discharges Intended outcomes:</b> >Improved patient safety >Improved communication >Improved data and records accuracy.	1.1 - 95% of initial letters to be delivered within 2 working days in 2009/2010 as per standard NHS contract.  1.2 - 95% of further formal clinician documentation, where this is required, to be received in general practice within: - 4 weeks in 2009/2010 - 1 week on 2010/2011.	●
<b>2. Surgical Site Infection</b> Zero tolerance for surgical infections.	2.1 - Enhance the standards applied by HPA to review and audit orthopaedic "joint" results quarterly.	●
<b>3. Smoking</b> Intended outcomes: >Reduced prevalence of smoking >Development of a more integrated approach to stop smoking actions.	3.1 - Provider to record all smoking status and interventions for in-patients and out-patients. Record in out-patients including those patients referred for surgery, and in-patients > Smoking or not > Advice given > Referral accepted/declined To be actioned with patients at least once during patients pathway.	●
<b>4. Equitable Access</b> Intended outcomes: >To improve access to services for those patients with physical, sensory or cognitive disabilities and those from minority groups >To improve understanding of numbers of patients with a disability accessing hospital services.	4.1- Undertake joint work through 2009/2010 to develop a shared understanding of disability, opportunities to monitor and potential impacts for patients.	●
<b>5. Waiting in Out-Patients</b> Intended outcomes: >To improve the patient experience by reducing the waiting times in out-patient departments.	5.1 - Aim to deliver over 80% of patients who experience a satisfaction of good or better.  5.2 - To deliver a jointly agreed reduction in the length of time patients wait to be seen, treated and discharged.	●
<b>6. Continuous Quality Improvement</b> Intended outcomes: >To improve the quality and efficiency of service delivery within orthopaedics and demonstrate improvement in year review.	6.1 - Commissioners and providers to jointly agree continuous quality and improvements in year for fast-track/improved orthopaedics service delivery.	●
<b>7. Continuous Quality Improvement</b> Intended outcomes: >To improve the quality and efficiency of service delivery within stroke care.	7.1 - Commissioners and providers to jointly agree a programme for continuous quality and improvement in year for stroke care.	●
<b>8. Continuous Quality Improvement</b> Intended outcomes: >To mortality rates.	8.1 - Commissioners and providers to jointly agree a programme for continuous quality and improvement in year for review of mortality.	●
<b>9. Improving Services for Young People</b> > Implementation of "You're welcome" – quality standard for young people friendly services.	9.1 - Agree with commissioners the service areas/specialties that the "You're Welcome" framework will be introduced within: Providers should complete the first 3 stages of the process. These are: (1) Identify all appropriate settings. (2) Self assessment (3) Action Planning (4) Assessment (5) Verification Providers will undertake to complete implementation in 2010/11.	●
<b>10. Sexual Health</b> Intended outcomes: >To improve sexual health.	10.1 - To continue to work with GUM and CASH services to agree developments to improve sexual health.	●

■ Not Achieved   
 ■ Requires more information   
 ■ Achieved

## Quality Developments achieved in local departments 2009/2010

### Patient Experience

- Achievement of "You're Welcome" status for teenage pregnancy scan clinic.
- Training programmes developed for patients receiving home tube feeding and oxygen at home.
- Development of greater integrated children & family services with Sure Start & Children's services (baby cafes, breast feeding support groups, ante & post natal drop in sessions).
- Improved information booklets and education sessions for patients.
- Hours to facilitate weekend discharge for orthopaedic patients requiring hip and knee replacement.
- Development of rehabilitation gym & extension of physiotherapy
- Shorter & more tolerable appointment time for patients in radiology by giving water prep instead of oral contrast for CT.
- Evening radiology, U/S & MRI appointments available.
- Establishment of specialist hair services in Oncology
- Development of discharge lounges and day of surgery arrival suites.
- Chlamydia Screening programme established.
- Introduction of foam sclerotherapy for treatment of patients with varicose veins.
- Renal Anaemia Clinics are now delivered at health centres at Battle Hill and Ponteland Road.

### Clinical Outcomes

- Audit of carotid stenting outcomes from regional and supraregional services.
- Largely replaced barium enemas with CT colonography.
- Radiology have introduced an on-call system to improve access to emergency interventional services.
- Implementation of Digital Radiotherapy system.
- Improved access to MRI & U/S services.
- Length of stay reduced by use of vessel closure device in radiology.
- Contrast planning scanning for radiotherapy improving quality of CT data.
- DVT assessment criteria developed – with development of nurse led pathway.
- Reduced waiting time for carotid endarterectomy.
- Reduced length of stay following major large bowel surgery.

### Patient Safety

- Obstetric Early Warning Chart successfully modified for use in all areas.
- Specialist Anaesthetic Clinic developed for obese & high risk maternal cases.
- To ensure safety of feeding babies both intravenously & enterally all products changed to meet National guidance.
- Introduction of a specialist Midwifery role for newborn bloodspot screening (haemoglobinopathies).
- Ongoing assessment of Ionisation Radiation equipment to ensure patient dose is checked against Medical Physics reference levels.
- Introduction of safe surgery checklist for all operative procedures.
- Introduction of sentinel node biopsy for breast cancer patients- reduces length of stay and shoulder complications.
- Gastric mobilisation procedure available for patients undergoing laparotomy.

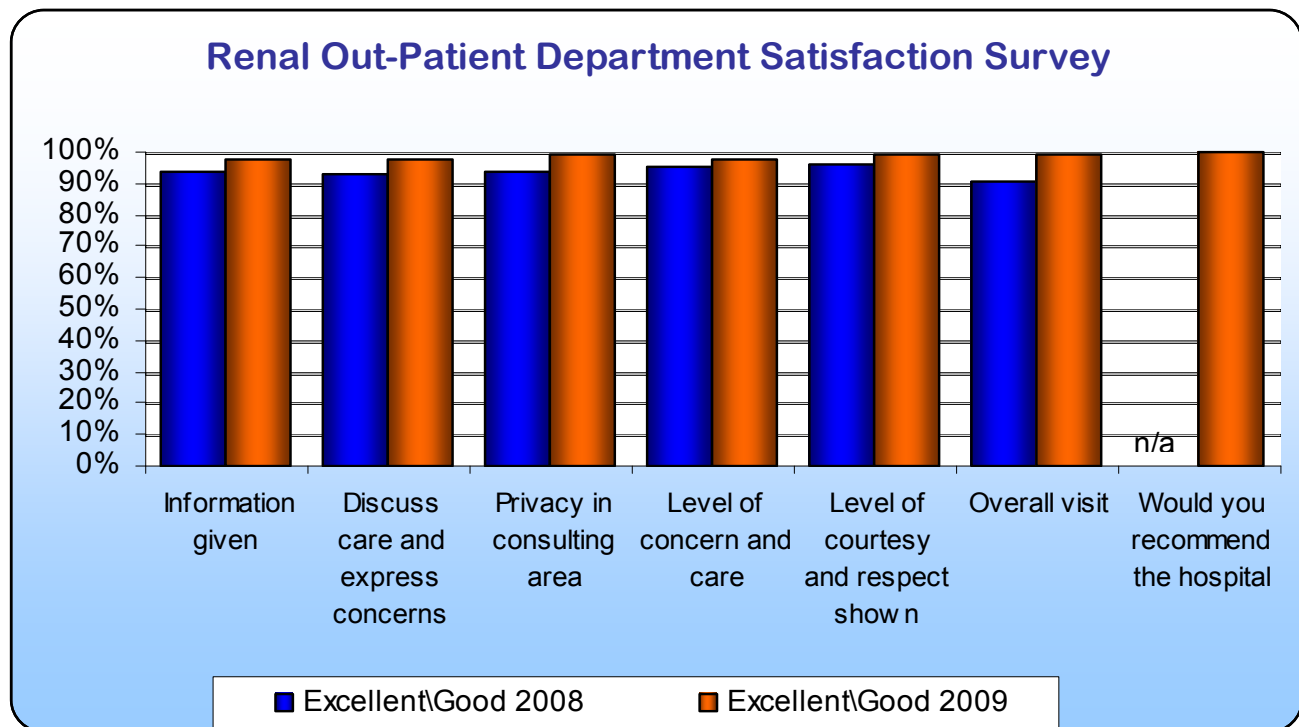
## Renal Out-Patient Department (OPD) Satisfaction Survey

Patients attending the Renal Services Centre OPD during a two-week period in October 2009 were invited to complete a Patient Satisfaction Questionnaire: 398 patients participated in the survey. The results of the 2009 survey are compared with the answers provided by a cohort of 296 patients attending the Renal OPD clinics in October 2008. Results listed indicate the percentage of patients who rated their experience as excellent or good.

The 2009 Renal OPD Survey demonstrates improvement in all areas of patient satisfaction, compared with the 2008 survey. 99% of the 398 patients rated their overall experience in the OPD as excellent or good. The patient questionnaire highlighted only four areas of concern that will require future focus (although in each area significant improvement has been made since the 2008 survey):

1. information relating to delays was considered to not be excellent/good by 12% of patients.
2. the seating in the waiting area was considered to not be excellent/good by 15% of patients.
3. the reading material in the waiting area was considered to not be excellent/good by 30% of patients.
4. waiting time was longer than 30 minutes for 23% of the patients.

All areas of perceived deficiency will be addressed by the Renal Services staff and the Patient Satisfaction Survey repeated in 2010.



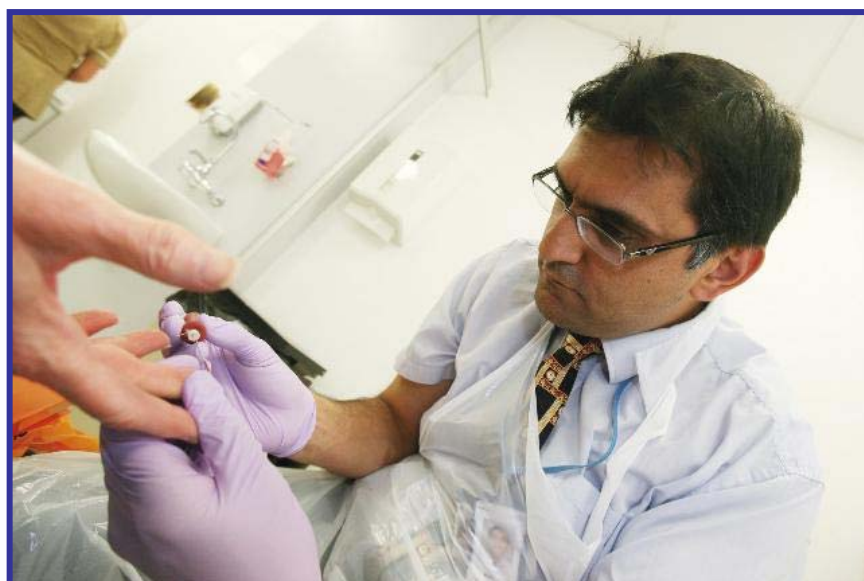
## National Sentinel Stroke Audit Organisational Audit 2009

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

Results from the audit are graded into 3 Quartiles. Nationally, the best organised 25% of hospitals are in the Upper Quartile, the least well organised hospitals for stroke care are in the Lower Quartile with the Middle Quartile between the two.

This table compares results from the 2008 organisational audit with 2009 (North East Region):

Submission	Position in 2008 (Quartile)	Position in 2009 (Quartile)	Domain Score for 2009	Quartile Movement (2008 to 2009)
Newcastle Upon Tyne Hospitals NHS FT	Middle ●	Upper ●	88	↑
North Tyneside General Hospital	Upper ●	Upper ●	88	=
University Hospital of Hartlepool	Upper ●	Upper ●	87	=
Wansbeck General Hospital	Middle ●	Upper ●	87	↑
James Cook collaboration	Upper ●	Upper ●	83	=
University Hospital of North Tees	Upper ●	Upper ●	83	=
South Tyneside NHS FT	Upper ●	Upper ●	82	=
Hexham	Upper ●	Middle ●	77	↓
Bishop Auckland General Hospital	Middle ●	Middle ●	76	=
Gateshead Health NHS FT	Middle ●	Lower ●	64	↓
University Hospital North Durham	Middle ●	Lower ●	64	↓
City Hospitals Sunderland	Middle ●	Lower ●	59	↓
Friarage collaboration	Lower ●	Lower ●	58	=



## Participation in National Clinical Audits and National Confidential Enquiries

The Trust participates in a wide range of audits including those which form the National Clinical Audit Patient Outcome programme.

During 2009/10, 20 National Clinical Audits and five National Confidential Enquiries covered NHS services that Newcastle upon Tyne NHS Foundation Trust provides. These were represented as:

National Clinical Audit Patient Outcome Programme (NCAPOP)	20 audits
National Confidential Enquiries (NCE)	5 studies.

During 2009/10 Newcastle upon Tyne NHS Foundation Trust participated in 100% of the NCAPOP Audits and 100% of the NCEs which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Newcastle upon Tyne NHS Foundation Trust participated in, and for which data collection was completed during 2009/2010, 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:

### NCAPOP and NCE participation

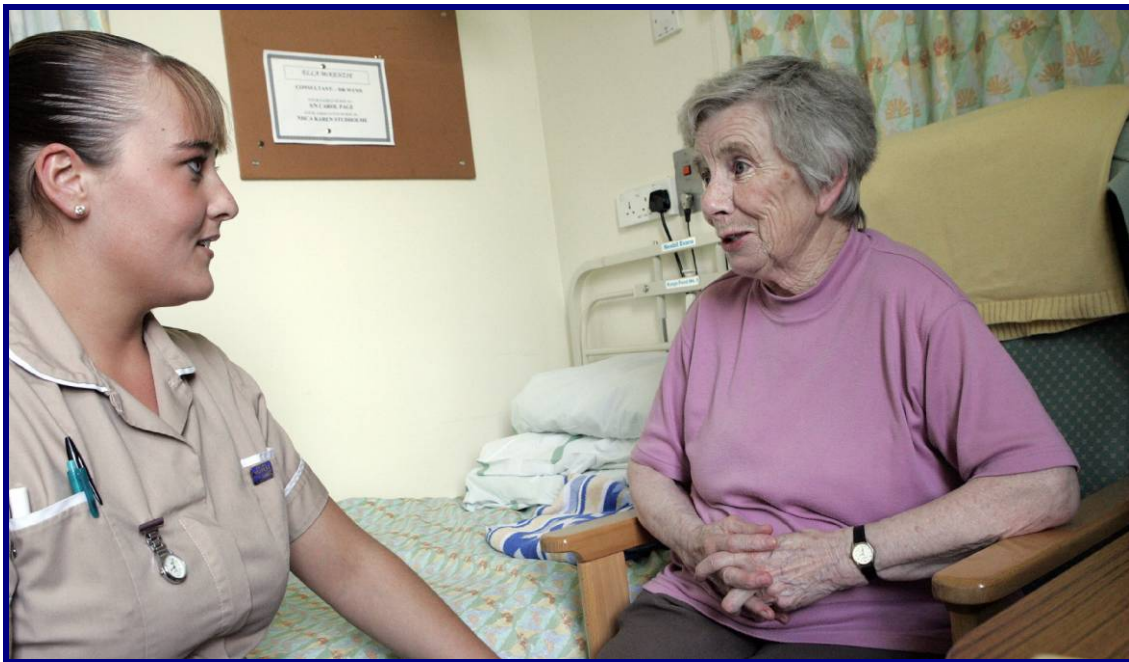
<b>Cancer</b>		
Bowel Cancer		data collection cycle still open
Head & Neck Cancer		data collection cycle still open
National Lung Cancer		data collection cycle still open
Oesophago-gastric Cancer		100%
Mastectomy and Breast Reconstruction	data entry still required (Jan - March 2010)	
<b>Women &amp; Children</b>		
National Neonatal Audit		100%
Paediatric Intensive Care Audit Network (PICANet)		100%
<b>Heart</b>		
Adult cardiac surgery		100%
Congenital heart disease (including paediatric surgery)		data collection open
Coronary Interventions (e.g. angioplasty, opening up heart artery)		100%
Myocardial Ischaemia (MINAP)		data collection cycle still open
Heart Rhythm Management (pacing / implantable defibrillators)		100%
Heart Failure		100%
<b>Long-term Conditions</b>		
Renal Services (vascular access, patient transport)		100%
National Joint Registry		100%
<b>Mental Health</b>		
Dementia		data collection cycle open
<b>Older People</b>		
Stroke: Hospital Services		100%
Carotid Interventions (UKCIA) preventing stroke		75%
Services for People who have fallen		100%
Continence		100%
<b>National Confidential Enquiries</b>		
Deaths in Acute Hospitals	Surgeons	98.6%
	Anaesthetists	100%
Parenteral Nutrition		80.6%
Elective and Emergency Surgery in the Elderly	Surgeons	87.5%
	Anaesthetists	85.7%
Cosmetic Surgery		100%
Surgery in Children		100%
Perioperative Care		data collection ongoing

Following participation in 20 National Clinical Audits, reports were reviewed in 2009/10 and the Trust intends to take the following action, to improve the quality of healthcare provided:

- the Clinical Effectiveness, Audit and Clinical Guidelines Committee to receive a quarterly report on the status of the Trust's performance in relation to participation in the NCAPOP and NCE Programme. The report will cover all 20 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 three monthly basis.

The reports of 327 local audits were reviewed by the Clinical Effectiveness, Audit and Clinical Guidelines Committee and the Trust intends to take the following action to improve the quality of health care provided:

- each Clinical Directorate will produce a report which contains audit activity broken down by national and local priority, results will be reported with details of changes in practice and improvement. All local audit activity will be monitored by the Committee on an annual basis.



## Information on participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by The Newcastle upon Tyne Hospitals NHS Foundation Trust in 2009/2010 that were recruited during that period to participate in our research portfolio was 7,069. The table below illustrates the number and range of research activity within the Northumberland, Tyne and Wear Comprehensive research network.



Recruitment into NIHR Portfolio Studies in NTW CLRN  
April 2009 - March 2010

Primary Topic/SpG	City Hospitals Sunderland	Gateshead Health	North East Ambulance	Northumbria Healthcare	North of Tyne	Northland Tyne & Wear	Newcastle Hospitals	South of Tyne & Wear	South Tyneside	NULL	Total
Cancer	64	122		82	30		615	27	86		1026
DeNDRoN	1	4		36	553	295	388			5	1282
Diabetes	10	27		44	5431		80	30	23		5645
Medicines for Children	13						95				108
Mental Health		4			11	893		16	4		928
PCRN	36	7			249			404		11	707
Stroke	209	5		80			98		27		419
<b>Age &amp; Ageing</b>					14		164				178
Anaesthetics											
Cardiovascular	17	7		77	296		509		1		907
Clinical Genetics	3						47				50
Critical Care	10	19		2			106		2		139
Dermatology					10		188				198
ENT							9				9
Gastrointestinal	1			13			409		60		483
Health Services Research	11		67	81	46	129					334
Hepatology	2			14			69		7		92
Immunology and Inflammation	1	2		3			38				44
Infectious Diseases & Microbiology	1						11				12
Injuries & Accidents	6										6
Metabolic & Endocrine							37				37
Musculoskeletal	7	34		482			457	9			989
Nervous System Disorders					3		18	1			22
Non Malignant Haematology	2										2
Ophthalmology	49						33				82
Oral & Dental							60				60
Paediatrics	8	3		95	6	22	109	1			244
Public Health Research							33				33
Renal							530				530
Reproductive Health & Childbirth	40	14		107	44		1707	17	20		1949
Respiratory		11		297			130		2		440
Surgery											
Urogenital	43			432			1129				1604
<b>Total</b>	<b>534</b>	<b>259</b>	<b>67</b>	<b>1845</b>	<b>6693</b>	<b>1339</b>	<b>7069</b>	<b>505</b>	<b>232</b>	<b>16</b>	<b>18559</b>

- Activity present in 2008/09 (note figures displayed on report represent 2009/10 recruitment)
- New activity in 2009/10 not present in 2008/09
- No activity 2008/09 or 2009/10

## Care Quality Commission (CQC) status and periodic/special reviews

The CQC published ratings in October 2009 based upon the 2008/09 Annual Health Check declaration and performance targets, for which the Trust achieved scores of Excellent for Quality of Services and Excellent for Financial Management for the second year running.

During 2009/10 the Annual Health Check process was still in place, with a requirement to submit an interim declaration on compliance with the core standards to the CQC in December 2009. The Trust Board therefore needed to declare compliance with each of the forty four core standards by determining if there was reasonable assurance that each of the standards had been met without significant lapse between 1<sup>st</sup> April 2009 and 31<sup>st</sup> October 2009. The assurance evidence was reviewed by Operational Leads, Executive Directors and Committee Chairs, following which the Trust Board had confidence that the evidence provided the necessary assurance of compliance. The completed declaration was reviewed and endorsed by the Board of Directors who agreed that the Trust should declare compliance with all of the core standards and the declaration was submitted to the CQC by the deadline.

The CQC have a statutory responsibility to implement a new registration process for NHS providers to replace the Annual Health Check. Initially there was a requirement for healthcare organisations to register based on compliance with the Hygiene Code. The Trust confirmed full compliance with the Hygiene Code on April 1<sup>st</sup> 2009 and HCAI registration was endorsed by the CQC. The CQC made a routine unannounced inspection of the Trust compliance with the new HCAI registration regulations on the 26th November 2009 as part of their ongoing assessment process. The CQC assessed the Trust against 15 measures from the Code of Practice and published a report stating that there was no evidence that the Trust had breached the regulation to protect patients, workers and others from the risk of acquiring a healthcare associated infection.

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 Care Quality Commission has not taken enforcement action against the Trust during 2009/10, the Trust is not subject to periodic review by the Care Quality Commission and has not participated in any special reviews or investigations by the CQC during the reporting period.



## The Quality of Data

The Newcastle upon Tyne Hospitals NHS Foundation Trust submitted records during 2009/2010 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are reported in the latest published data. The percentage of accurate records in the published data is indicated in the table below:

The Newcastle upon Tyne Hospitals NHS Foundation Trust Information Services							
<u>Admitted Patient Care (APC), Outpatient (OP) and Accident &amp; Emergency (A+E) - Number of Valid NHS &amp; GP's submitted to SUS</u>							
1st April 2009 - 31st March 2010							
	Number of records submitted to SUS	NHS Number			General practitioner - No from total records submitted		
		Blank	Non Blank	% Valid NHS Number	Valid GP	Unknown/Not registered	% Valid GP from total records submitted
<b>APC</b>							
<b>Total</b>	210446	7914	202532	96.2%	207590	2856	98.6%
	Number of records submitted to SUS	NHS Number			General practitioner - No from total records submitted		
		Blank	Non Blank	% Valid NHS Number	Valid GP	Unknown/Not registered	% Valid GP from total records submitted
<b>OP</b>							
<b>Total</b>	1326129	49724	1276405	96.3%	1313578	12551	99.1%
	Number of records submitted to SUS	NHS Number			General practitioner - No from total records submitted		
		Blank	Non Blank	% Valid NHS Number	Valid GP	Unknown/Not registered	% Valid GP from total records submitted
<b>A&amp;E</b>							
<b>Total</b>	69124	33308	35816	51.8%	65575	3549	94.9%

## Score for 2009/10 for Information Quality and Records Management, assessed using the Information Governance Toolkit

The Newcastle upon Tyne Hospitals NHS Foundation Trust score for 2009/10 for Information Quality and Records Management, assessed using the Information Governance Toolkit was 87%.

## Clinical Coding Information

The Newcastle upon Tyne Hospitals NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for diagnoses and treatment coding (clinical coding) is awaited. The Healthcare Resource Group (HRG) code error rate is 3.7%.

## Key National Priorities 2009/2010

The key national priorities are performance targets for the NHS which are determined by the Department of Health and form part of the CQC Quality and Risk Profile of the Trust. A wide range of measures are included and the Trust's performance against the key national priorities for 2009/10 are detailed in the following table:

**This table illustrates performance against key national priorities 2009/2010**

Operating & Compliance Framework targets	Target	Performance	Notes
Incidence of Clostridium difficile	Less than 420	Achieved	Below trajectory (Actual 304)
Incidence of MRSA Bacteraemia	Less than 30	Achieved	Below trajectory (Actual 12)
31-Day Wait For Second Or Subsequent Treatment: Surgery	94%	Achieved (97.9%)	Provisional
62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: Classic	85%	84.8% (Still validating)	Provisional
62-Day Wait For First Treatment From Consultant Upgrade	Not released	92.5%	No threshold released not sure if achieved
62-Day Wait For First Treatment From Consultant Screening Service Referral	90%	Achieved (98.8%)	Provisional
18 week referral to treatment times 90% of admitted care less than 18 weeks	90%	Achieved (greater than 90%) & by Spec	
18 week referral to treatment times 95% of non-admitted care less than 18 weeks	95%	Achieved (greater than 95%) & by Spec	
Total time in A&E	98%	Achieved (98.7%)	
All Cancer Two Week Wait: Classic	93%	Achieved (94.6%)	Provisional
31-Day (Diagnosis To Treatment) Wait For First Treatment: Classic	96%	Achieved (98.7%)	Provisional
MRSA Screening - electives	100%	Qtr 1 below 100%, Qtr 2-4 all 100%	
Delayed Discharges	7.5% MONITOR	Achieved (0.7%)	
Inpatients waiting longer than the 26 week standard	Less than or equal to 0.03%	Achieved (0)	
Outpatients waiting longer than the 13 week standard	Less than or equal to 0.03%	Achieved (0)	
Patients waiting longer than three months (13 weeks) for revascularisation	Less than or equal to 0.1%	Achieved (0)	
Waiting times for Rapid Access Chest Pain Clinic	Greater than or equal to 98%	Achieved (100%)	
Cancelled operations - those not admitted within 28 days	Less than or equal to 5%	Achieved (2%)	
6 week diagnostics	0	Achieved (0)	
Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected) - Jan-March 2010	93%	Achieved (96.7%)	Provisional
Maternity Bookings 12 weeks	Between 80-90%	85.3%	By the end of 2008/09 expecting all PCTs to be achieving 80% with a year on year increase aiming to achieve at least 90% by 2010/11.
Staff Job Satisfaction (Key Finding 34 of National NHS Staff Survey 2009)		3.44	Below average when compared to trusts of similar type, but not significantly changed from last year
Patient Survey		Significantly BETTER on 2 questions, Significantly WORSE on 2 questions, The scores show no significant difference on 75 questions	

## Workforce factors

Wellbeing –the table below indicates the loss of work days due to industrial injury or sickness

2009/2010	Quarter 1	Quarter 2	Quarter 3	Quarter 4
No. of days	251	414	581	298

Leadership training has been on going throughout the Trust for the period 2009/2010 with 204 staff trained to date.

Leadership Programme	Delegates
Senior Management Development Programme	25
Institute of Leadership & Management Foundation Award Level 3	55
Institute of Leadership & Management Certificate Level 3	11
Coaching Skills	35
Managing Poor Performing Doctors	35
Core Skills in Mentoring	20
Educational Supervisors Update	23
Total	204

## National NHS Staff Survey 2009

- In the National NHS Staff Survey 2009 (Key Finding 1), 76% of staff in the Trust agreed with at least two of the following three statements: that they are satisfied with the quality of care they give to patients; that they are able to deliver the patient care they aspire to; and that they are able to do their job to a standard they are personally pleased with.
- The Trust's score of 76% in relation to percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver was above (better than) average when compared with trusts of a similar type.
- These results have not changed since the 2008 survey when the Trust also scored 76%.

## Top four ranking scores in National Staff Survey:

TOP 4 RANKING SCORES	TRUST	NATIONAL AVERAGE
KF2 Percentage of staff agreeing that their role makes a difference to patients (Higher Score is Better)	93%	90%
KF20 Percentage of staff saying hand washing materials are always available (Higher Score is Better)	80%	69%
KF24 Percentage of staff experiencing physical violence from patients/relatives in last 12 months (Lower Score is Better)	7%	11%
KF26 Percentage of staff experiencing harassment, bullying or abuse from patients/relatives in past 12 month (Lower Score is Better)	16%	21%

KF – Key Findings

## Bottom four ranking scores in National Staff Survey:

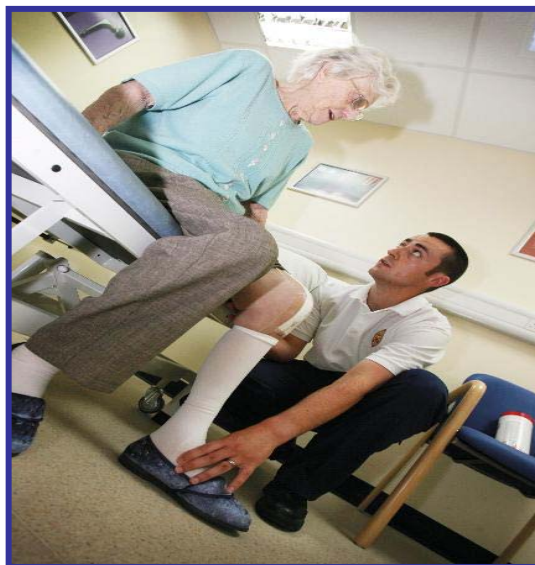
BOTTOM 4 RANKING SCORES	TRUST	NATIONAL AVERAGE
KF10 Percentage of staff using flexible working options (Lower Score is Better)	64%	70%
KF12 Percentage of staff receiving job-relevant training, learning and development in last 12 months (Higher Score is Better)	74%	78%
KF16 Support from immediate managers (Higher Score is Better)	3.46	3.60
KF18 Percentage of staff suffering work-related injury in last 12 months (Lower Score is Better)	21%	17%

KF – Key Findings

## Involvement and engagement

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 21 Clinical Directorates presented as total figures for the Trust. The indicators to be presented and monitored were selected following a series of discussions with Non-Executive members of the Trust Board of Directors, they were agreed by the Executive team and have been developed over the last 12 months following guidance from senior clinical staff. The priorities for improvement have been discussed and agreed by the Trust Board, Clinical Governance and Quality Committee and the Clinical Policy Group.

The Trust intends to consult more widely with members of the public in 2010/11 following publication of this Quality Account to ensure that the indicators presented in this document are what the public expects to be reported. We also welcomed comments from Newcastle City Council Overview and Scrutiny Committee, NHS North of Tyne Commissioners, Professional Executive Committee NHS North of Tyne and our Local Involvement Network and the comments are presented on the following pages:



## **QUALITY ACCOUNT**

The Health and Wellbeing Overview and Scrutiny Panel of Newcastle City Council has asked me to write to thank the Foundation Trust for its invitation to comment on the Trust's Quality Account.

The Panel does not wish to offer any comments at this early stage in the development of Quality Accounts, but is grateful for the opportunity to do so.

Yours sincerely

**Steven Flanagan**  
**Scrutiny officer**

## **Statement on behalf of NHS North of Tyne Commissioners**

NHS North of Tyne welcomes the opportunity to comment on The Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTHFT) draft Quality account 2009/10. It is a clear, comprehensive and well structured document and we were pleased to be involved in an earlier draft during its developmental phase earlier this year.

As commissioners we commend NUTHFT's patient-centred philosophy and commitment to build upon their excellent work to date in driving up quality and improving patient experience. Commissioners feel the report presents a balanced summary of Trust performance against key quality indicators, identifying both areas of high achievement and areas for further development.

In particular the Trust should be commended on their patient survey and improvement programme which has considered patient experience by specialty, and their commitment to the implementation of real time patient experience feedback in outpatient areas in 2010/11.

We acknowledge that NUTHFT have performed well in the National 'in patient' and 'out patient' surveys, and would be interested in any action plan associated with improving performance in future years.

Commissioners would like to be involved further in the significant learning event process and outcomes and would suggest it may be beneficial to see evidence of learning within the Trust from this process.

With regard to the National NHS Staff Survey the Commissioners are pleased to note the areas where the Trust achieved highest ranking scores, and feel that the Quality Account would benefit from the addition of some commentary on plans for improving the lowest ranking scores further.

Commissioners welcome the opportunity to work with NUTHFT on continuous improvement in stroke care and mortality rates in 2010/11 as part of CQUIN.

In summary NHS North of Tyne is satisfied that the document contains accurate data and information. We look forward to continuing the well established clinical partnership working to drive up quality and innovation for our population in 2010/11.

**Lyn Dixon**  
**Executive Nurse**  
**NHS North of Tyne**

**Mike Guy**  
**Medical Director**  
**NHS North of Tyne**

## **Statement on behalf of the Professional Executive Committee, NHS North of Tyne**

The Professional Executive Committee (PEC) confirms that an early draft has been considered by them recently and that the final version will be presented in full in June 2010.

PEC members have been regular participants throughout the year in reviewing the quality of clinical care provided. This has enabled PEC members to monitor and shape progress in a number of significant clinical areas set out in the CQUIN schedule. PEC members have also provided clinical opinion and validation of evidence submitted. PEC members would like to see more information on learning from complaints and serious untoward incidents in future quality reports.

**S. Blair**  
**Chair**  
**Professional Executive Committee**



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Mrs Diane Palmer  
Director of Quality and Effectiveness  
Level 1,  
Peacock Hall,  
Royal Victoria Infirmary  
NE1 4LP

18 May 2010

Dear Mrs Palmer,

### **Re: Newcastle-upon-Tyne NHS Foundation Trust Quality Account Report 2009/2010**

I would like to thank you for allowing Newcastle LINK the opportunity to view and respond to the Newcastle-upon-Tyne NHS Foundation Trust's (NUTH) Quality Account Report for 2009/2010. This document was discussed at the Newcastle LINK Executive Board meeting on Tuesday 18 May 2010 and I have been instructed to prepare the following response.

It is unfortunate that the timing of the consultation hasn't allowed sufficient time for the LINK Executive Board to respond fully to the Quality Account. The timetable of the LINK Executive Board meetings are set in advance and it has proved difficult to have the Quality Account as an agenda item due to this. The Executive Board did find the information contained in the Quality Account both comprehensive and informative. Furthermore, Newcastle LINK would like to offer the opportunity for representatives of NUTH to attend a LINK Executive Board meeting at an early point next year to discuss the 2010 – 2011 Quality Account and to clarify anything that Executive Board members do not understand and to answer any questions. This will be a specially convened half-an-hour slot before the Executive Board's main agenda.

The Executive Board would, however, like to raise a number of general points and specific points in relation to 2009/2010 Quality Account at this stage. First of all the document is written using text size and font which makes it difficult to read.

Those members of the Executive Board who have visual impairments found it impossible to read and those who do not have visual impairments struggled with the majority of the document and in particular the diagrams and tables.

The Executive Board would suggest that the text size in general needs to be increased and it needs to be standard procedure of NUTH to produce any consultation documents in large print and in a timely manor to allow proper consultation.

It would also be of benefit if the report could be written using more plain English. Clearly some medical terminology needs to be used; however, more simple language should be used wherever possible. There is also use of jargon and acronyms without explanation of what they mean. This should be rectified with full names and terms being used initially with the acronyms in brackets afterwards and then the acronyms can be used in the rest of the document. An appendix of acronyms may also be useful to provide at the end of the document.

The LINK Executive Board would also suggest that examples of real cases could be used to support some of the figures and tables provided. This would aid understanding and also bring the document and figures more closer to those who read the document.

Specifically, the LINK suggests that there may be a need to explain some of the data and what it means. For example on page 14 of the Quality Account there is a table representing performance against targets in a number of areas and the *Percentage high risk TIA cases treated within 24 hours (Quarterly)* rises significantly in quarters 3 and 4. This is striking and giving a reason why this has occurred would make it clearer to understand.

The Newcastle LINK Executive Board members trust that their comments and suggestions are helpful and look forward to working closer with NTW on next year's Quality Account.

Yours sincerely,

Craig Duerden,  
Project Manager,  
Newcastle LINK,

## Changes resulting from external stakeholder comments

Following a review by external stakeholders, changes have been made to the Quality Account in the following ways:

- Font size increased to Arial 12
- Abbreviations in the body of the text were written in full and an Abbreviation list developed and included as part of the Quality Account
- Removal of technical terms and symbols
- Glossary of terms was developed and added
- Explanations for some data variations included
- Actual 2009/10 total columns added and populated to overview of Board assurance tables
- Formatting of quality developments in local areas page changed to improve readability
- Outstanding data included in document
- Graphs and tables enlarged to make content clearer
- Added number of staff who attended Leadership training
- Addition of introductory explanations to each section including definition of Quality Account
- Included stakeholder comments
- Additional photographs were added
- A large print version was available during the consultation process and the final version will also be made available in large print
- Medical Directors statement removed
- Included definitions of “hospital-apportioned” cases in relation to MRSA and *C.diff*
- Further details on *C.diff* improvement plans for 2010/11 included
- Quality Account evaluation form added.



Abbreviations	
AAPD	Assisted Automated Peritoneal Dialysis
A&E	Accident & Emergency
APC	Admitted Patient Care
APII SMR	Apache II Standardised Mortality Ratio
CAPD	Continuous Ambulatory Peritoneal Dialysis
CASH	Contraception and Sexual Health
<i>C.diff</i>	<i>Clostridium difficile</i>
CD4	Cluster of Differentiation - molecule on surface of T Cells and Monocytes – CD4 refers to the structure on the surface of the cell.
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation (CQUIN) payment framework
CT	Computerised Tomography
CVC	Central Venous Catheter
DVT	Deep Venous Thrombosis
ENT	Ear, Nose & Throat
FCE	Finished Consultant Episode
FT	Foundation Trust
GP	General Practitioner
GUM	Genito Urinary Medicine
HCAI	Healthcare Associated Infection
HES	Hospital Episode Statistics
HIV	Human immunodeficiency virus
HPA	Health Protection Agency
HRG	Healthcare Resource Group
HSE	Health and Safety Executive
HSMR	Hospital Standardised Mortality Ratio
ITU	Intensive Therapy Unit
LCP	Liverpool Care Pathway
MINAP	Myocardial Ischaemia National Audit Project
MRI	Magnetic resonance imaging
MRSA	Methicillin-resistant Staphylococcus aureus
N/A	Not Applicable
NCAPOP	National Clinical Audit Patient Outcome Programme
NCE	National Confidential Enquiries
NIHR	National Institute for Health Research
NTW CLRN	Northumberland Tyne and Wear Comprehensive Local Research Network
OP	Out-Patient
OPD	Out-Patients Department
PCRN	Primary Care Research Network
SUI	Serious Untoward Incident
SUS	Secondary Uses Services
TIA	Transient Ischaemic Attack
UKCIA	UK Carotid Interventions Audit
U/S	Ultrasound Scan
VTE	Venous thromboembolism
WHO	World Health Organisation

## **Glossary of Terms**

### **1. Colonography**

A colonography is a visual recording of the colon or large intestine obtained using computed tomography (CT) technology. Like a colonoscopy, the purpose of a colonography is to screen the colon for polyps or other abnormalities that could indicate a risk factor for colon cancer or other colon disease. A colonography is less invasive than a colonoscopy, but presents different risks and benefits in comparison.

### **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. Choose and Book**

Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic. If a referral has been made to a specialist by a GP the appointment reference number and a password given at the time of the booking can be used to, change or cancel the appointment online or by telephone.

### **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. Elective Spell**

Elective spell is an admission which is planned in the sense of it is known to happen.

An Elective Admission is one that has been arranged in advance. It is not an emergency admission, a maternity admission or a transfer from a Hospital Bed in another Health Care Provider. The period that the patient has to wait for admission depends on the demand on hospital resources and the facilities available to meet this demand.

Therefore Elective Admissions are planned in advance and all others are classed as Non-elective (emergency, Maternity, Other).

Spells are the complete hospital stay for a patient from admission to discharge and are made up of Finished Consultant Episodes (FCEs), you can have either one FCE or more than one FCE in a spell.

### **6. Dr Foster**

Dr Foster was first launched to the public in January 2001 with publication of the Hospital Guide. This appeared in the Sunday Times as two special supplements and subsequently over the internet and in local newspapers.

Since then, Dr Foster has published a series of guides detailing the availability and standards of local health services in a number of areas - from the Good Birth Guide to the Consultant Guide - the only comprehensive listing of senior hospital specialists available.

Dr Foster has also published a number of regional guides with local newspapers and a series of books with Random House.

Dr Foster also collaborates with a number of organisations in the private and public sector to produce reports and guides in more specialist areas - and individual areas such as diabetes and breast cancer for more information.

## **7. 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.

## **8. Hygiene Code**

Act of Parliament which outlines standards of practice across the NHS specifically relating to management systems for infection prevention and control, maintenance of a clean and appropriate environment for healthcare, provision of adequate isolation facilities and policy in relation to antimicrobial prescribing.

## **9. LCP**

The Liverpool Care Pathway for the Dying Patient (LCP) provides an evidence based framework for the delivery of appropriate care for dying patients and their relatives in a variety of care settings. It encourages a multi-professional approach to the delivery of care that focuses on the physical, psychological and spiritual comfort of patients and their relatives that has also been shown to empower generic staff in the delivery of care.

*(Marie Curie Palliative Care Institute, Liverpool Care Pathway, 2007)*

## **10. Monitor**

Monitor is the independent regulator of NHS foundation trusts. Established in January 2004 to authorise and regulate NHS foundation trusts it is independent of central government and directly accountable to Parliament.

## **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.

## **11. Non-Elective Spell**

Non-elective admissions are admissions at short notice (same day). Elective Admissions are planned in advance and all others are classed as Non-elective (emergency, Maternity, Other).

Spells are the complete hospital stay for a patient from admission to discharge and are made up of Finished Consultant Episodes (FCEs), you can have either one FCE or more than one FCE in a spell.

## **12. NPSA**

The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector.

## **13. Patient Safety First Campaign**

The innovative Patient Safety First Campaign for England was created to change the culture within the NHS; to one that puts the safety of patients as the highest priority. Through both web-based and face-to-face support, the Campaign provides initial resources for both individuals and teams working within the NHS.

## **14. Picker Institute**

Picker Institute is a world leader focusing on the measurement of the patient experience and recognized as an important source of information, advice and support.

## **15. Sure Start**

Sure Start is an English UK Government initiative, originating with HM Treasury, with the aim of "giving children the best possible start in life" through improvement of childcare, early education, health and family support, with an emphasis on outreach and community development. The programme was originally intended to support families from pregnancy until children were four years old but the brand was extended to cover an undefined responsibility up to age fourteen, or sixteen for those with disabilities.

## **16. "You're Welcome"**

You're Welcome quality criteria sets out principles that will help health services (including non-NHS provision) become young people friendly. It covers areas to be considered by commissioners and providers of health services. Content is based on examples of effective local practice. This second edition includes a new section covering Child and Adolescent Mental Health Services.



### Feedback Form

We would like to hear your views on our Quality Account.

The Department of Health will direct some of our content i.e. quality measures that every organisation must publish.

However, the Newcastle upon Tyne Hospitals NHS Foundation Trust have an opportunity to publish information about local quality initiatives. Your feedback will give us an opportunity to include the initiatives you want to hear more about. The results of this feedback will contribute to the development of the Quality Account 2010/2011

Please fill in the feedback form below, tear it off, and return to us, in the post, at the following address:

The Quality and Effectiveness Team,  
Clinical Governance and Risk Department,  
The Newcastle upon Tyne Hospitals NHS Foundation Trust,  
Royal Victoria Infirmary,  
Queen Victoria Road,  
NEWCASTLE UPON TYNE.  
NE1 4LP

Or alternatively e-mail your comments to: [Quality.Standards@nuth.nhs.uk](mailto:Quality.Standards@nuth.nhs.uk)

Thank you for your time.



### Feedback Form (please circle all answers that are applicable to you)

What best describes you: Patient/carer/member of public/staff/other

Did you find the Quality Account easy to read?	Yes	No	
Did you find the content easy to understand?	Yes all of it	Most of it	None of it
Did the content make sense to you?	Yes all of it	Most of it	None of it
Did you feel the content was relevant to you?	Yes all of it	Most of it	None of it
Would the content encourage you to use our hospital	Yes all of it	Most of it	None of it
Did the content increase your confidence in the services we provide	Yes all of it	Most of it	None of it

Are there any subjects/topics that you would like to see included in next year's Quality Account

.....  
.....

In your opinion, how could we improve our Quality Account?

.....  
.....