Review of the Year
incorporating the Annual Report & Accounts
2015/16
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x165800_NuTH_RoY_1-264_p13_sw.indd 3
03/09/2016 12:35
The Newcastle upon Tyne Hospitals NHS Foundation Trust is rated Outstanding by the Chief Inspector of Hospitals

England’s Chief Inspector of Hospitals has found The Newcastle upon Tyne Hospitals NHS Foundation Trust to be Outstanding after an inspection by the Care Quality Commission. It is the fifth Trust to be rated Outstanding under CQC’s programme of comprehensive inspections but only the first Teaching Trust to achieve this rating.

Overall, the Trust has been rated as Outstanding in respect of being caring, effective, responsive and well-led.

There were many factors that contributed to the outstanding rating including:

- Feedback from patients, those close to them and stakeholders was consistently positive about the way staff treated people. There were many examples of exceptional care where staff at all levels went the extra mile to meet patient needs.
- The Trust used innovative and pioneering approaches to deliver care and treatment. This included new evidence-based techniques and technologies. Staff were actively encouraged to participate in benchmarking, peer review, accreditation and research.
- The Trust worked hard to ensure it met the needs of local people and considered their opinions when trying to make improvements or develop services. It was clear that the opinion of patients and relatives was a top priority and highly valued.

Across the Trust there were some excellent examples of innovative practice. For example, at the Royal Victoria Infirmary, the Liaison Team from the Bone Marrow Transplant Unit had developed an open access pathway so post-transplant patients could access urgent care quickly and safely. Children and young people presented their unique passport upon arrival in A&E, which included all information about their condition and any ongoing treatment.

The full report, including ratings, is available at: 
http://www.cqc.org.uk/provider/RTF

The Chief Inspector of Hospitals, Professor Sir Mike Richards explained: “We found the care at The Newcastle upon Tyne Hospitals NHS Foundation Trust to be of exceptional quality. There was a very clear
Review of the Year 2015/16

Vision and strategy for delivering the highest standards of patient care with quality and safety as a key focus. There was open engagement and involvement of patients, staff and external partners in the successful delivery of the Trust’s strategic goals.

The ratings for many of the individual locations were extremely good. We rated the Royal Victoria Infirmary, Freeman Hospital and the Dental Hospital as outstanding and Community Services as good.

I was encouraged to hear about some of the innovative engagement the Trust was involved with. They regularly sought the opinions of patients and received feedback from a number of surveys. Outpatients had implemented a work placement programme for young adults with learning difficulties. Following successful work placements the Trust had employed three young people. Project Choice had won the Workforce Award at the 2015 HSJ Awards.

This is a Trust that clearly has patient-centred care as a priority, evidenced by consistent positive feedback. They are prepared to innovate and work collaboratively with other Trusts. The Trust’s Respiratory Consultants had written the national curriculum for consultant training – a great example of the Trust leading in its field. All of this demonstrates that this is one of the best Trusts in England and I commend them on their outstanding rating.

There is one area where we have told the Trust they must make improvements. They must ensure that care documentation in the Emergency Care Department and on some Wards are fully completed to reflect accurately the treatment, care and support given to patients, and is subject to clinical audit."

Inspectors found many areas of outstanding practice including:

- At the Royal Victoria Infirmary (RVI), the Newcastle Breast Centre was at the forefront of treating breast cancer. The Trust was the first unit in the UK to offer ‘iodine seed localisation’ in breast conservation surgery. Many breast cancer patients were given the chance to take part in national and international breast cancer treatment trials, as well as reconstruction studies.
- Also at the RVI, the home ventilation service delivered care to around 500 patients in their own home. The service led the way for patients who needed total management of their respiratory failure at home with carers. The team offered diagnostics, extensive training and patient support. The team had written the national curriculum for specialist consultant training.
- The domiciliary visits covered the whole of the North of England, up to the Scottish border, West Coast and Teeside.
- At the Freeman Hospital the Trust Falls and Syncope Service was the largest of its kind in Europe and undertook research and treatment for patients presenting with a range of problems such as balance disorders, dizziness, low blood pressure or unspecified lack of co-ordination and falls.
a) Financial Performance

The financial performance of the Trust is described in further detail in the “Operating and Financial Performance” section below but suffice to say that the in-year financial sustainability rating was most satisfactory (closing the year at 3 out of 4, where 4 is lowest risk), all key financial targets were met and an Income & Expenditure surplus of £2.5 million delivered before impairment items.

Summary of Trust financial performance for 2015/16:

<table>
<thead>
<tr>
<th>Plan £m</th>
<th>Actual £m</th>
<th>Variance £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Income</td>
<td>983.3</td>
<td>988.5</td>
</tr>
<tr>
<td>Operating Expenditure (excluding impairments)</td>
<td>947.3</td>
<td>955.9</td>
</tr>
<tr>
<td>Operating Surplus (excluding impairments)</td>
<td>36.0</td>
<td>32.6</td>
</tr>
<tr>
<td>Net Finance Costs</td>
<td>33.5</td>
<td>30.1</td>
</tr>
<tr>
<td>I&amp;E Surplus (excluding impairments)</td>
<td>2.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Net Impairment</td>
<td>5.5</td>
<td>14.4</td>
</tr>
<tr>
<td>I&amp;E Deficit (including impairments)</td>
<td>-3.0</td>
<td>-11.9</td>
</tr>
</tbody>
</table>

NOTE: CCG = Clinical Commissioning Group
## Summary of Service Statistics

<table>
<thead>
<tr>
<th>Inpatient and day case activity</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>Growth in year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-elective inpatient FCEs</td>
<td>84,341</td>
<td>82,499</td>
<td>85,716</td>
<td>88,503</td>
<td>89,108</td>
<td>1%</td>
</tr>
<tr>
<td>Elective inpatient FCEs</td>
<td>32,413</td>
<td>32,171</td>
<td>31,315</td>
<td>31,235</td>
<td>31,906</td>
<td>2%</td>
</tr>
<tr>
<td>Day case FCEs</td>
<td>107,889</td>
<td>106,942</td>
<td>111,514</td>
<td>115,051</td>
<td>115,852</td>
<td>1%</td>
</tr>
<tr>
<td>Total FCEs</td>
<td>224,643</td>
<td>221,612</td>
<td>228,545</td>
<td>234,789</td>
<td>236,866</td>
<td>1%</td>
</tr>
<tr>
<td>% Elective FCEs undertaken as daycases</td>
<td>76.9%</td>
<td>76.9%</td>
<td>78.1%</td>
<td>78.6%</td>
<td>78.4%</td>
<td></td>
</tr>
<tr>
<td>Average length of FCE (days)</td>
<td>4.17</td>
<td>4.25</td>
<td>4.19</td>
<td>4.19</td>
<td>4.03</td>
<td></td>
</tr>
<tr>
<td>Average % bed occupancy</td>
<td>80%</td>
<td>80%</td>
<td>81%</td>
<td>82%</td>
<td>83%</td>
<td></td>
</tr>
</tbody>
</table>

## Outpatient activity

| New outpatient attendances     | 306,730 | 310,414 | 336,405 | 339,537 | 345,326 | 2%             |
| Review outpatient attendances  | 727,486 | 748,430 | 882,083 | 901,809 | 917,208 | 2%             |
| Total Outpatient Attendances   | 1,034,216 | 1,058,844 | 1,218,488 | 1,241,346 | 1,262,534 | 2%             |

## Diagnostic services

| Laboratory requests            | 2,882,675 | 3,002,236 | 3,138,125 | 3,082,496 | 3,124,271 | 1%             |
| Radiological examinations      | 498,605   | 504,751   | 564,241   | 587,294   | 600,099   | 2%             |

## Accident & Emergency

| A&E attendances                | 125,213   | 128,634   | 130,756   | 134,289   | 142,511   | 6%             |
| Walk-in centre attendances     | 43,949    | 49,288    | 49,948    | 50,628    | 48,897    | -3%            |
| Total A&E attendances          | 169,162   | 177,922   | 180,704   | 184,917   | 191,408   | 4%             |

## Surgical procedures

| Cardiopulmonary transplants    | 77        | 96        | 99        | 79        | 86        | 9%             |
| Liver transplants              | 39        | 41        | 47        | 35        | 45        | 29%            |
| Renal transplants              | 130       | 138       | 147       | 117       | 131       | 12%            |
| Bone marrow transplants        | 206       | 185       | 190       | 173       | 185       | 7%             |
| Heart operations (CABGs & PCIs) | 3,326     | 3,068     | 3,146     | 2,970     | 2,957     | 0%             |
| Joint replacements (hips & knees) | 1,424   | 1,638     | 1,648     | 1,811     | 1,835     | 1%             |
| Cataracts                      | 8,074     | 8,330     | 8,349     | 8,201     | 8,274     | 1%             |

## Reproductive medicine - Centre for Life

| No. of IVF treatments started  | 769       | 646       | 566       | 617       | 680       | 10%            |
| Clinical Pregnancy Rate per Treatment (Pre 11/12 figures shown are for ‘Live birth rate per cycle started’) | 28.6%   | 27.9%     | 28.0%     | 26.4%     | 30.3%     | 15%            |

## Other key statistics

| Total number of renal dialysis sessions | 39,099 | 39,723 | 39,695 | 41,100 | 45,794 | 11% |
| Total number of births                 | 6,992  | 7,441  | 7,446  | 7,335  | 6,990  | -5% |
| Day hospital attendances               | 4,834  | 5,785  | 4,944  | 4,477  | 4,175  | -7% |

Review of the Year 2015/16
b) Business Review

All in all, another satisfactory trading year can be advised of with the platform established to enter into our tenth year as a Foundation Trust with some measure of strength from both an operational and strategic perspective.

In addressing the key domains by which success or otherwise can be measured, the following was of note:

a) National Patient Service Targets

The performance measures documented in (i)-(ii) below are reported to the Trust Board at every meeting as part of the Business Delivery & Performance Report. Performance against these measures is reviewed by Board of Directors.

(i) A&E Waiting Times (4 hours)

The Trust declared non-compliance against the A&E waiting time target in Quarter 4, achieving 91.47% (the target being 95%). The Trust has developed an A&E action plan which is committed to delivering a more streamlined patient flow throughout the organisation. This plan is being reported monthly to NHS Improvement and a risk per sé has been declared in the 2016/17 Operational Plan.

<table>
<thead>
<tr>
<th>Maximum waiting time of 4 hours in A&amp;E</th>
<th>Target</th>
<th>Annual Performance 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>95%</td>
<td>93.85%</td>
</tr>
</tbody>
</table>

(ii) Referral to Treatment Target (18 weeks)

<table>
<thead>
<tr>
<th>Referral to Treatment (RTT)</th>
<th>Target</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
<th>Annual Performance 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT Incompletes</td>
<td>92%</td>
<td>94.3%</td>
<td>94.7%</td>
<td>93.9%</td>
<td>93.7%</td>
<td>94.2%</td>
</tr>
</tbody>
</table>

We provide innovative, high standard healthcare, including community services and primary care. Yet despite our size, complexity and national position we remain committed to the healthcare needs of local people.
Whilst the Trust has consistently met the Referral to Treatment (‘RTT’)) Incomplete standard at a Trust level, there are a number of high risk specialties who are the subject of robust RTT Action Plans. This target remains a significant challenge due to increased demand being further compounded by emergency pressures, the ongoing Junior Doctors industrial action and workforce challenges, including the national shortage of suitably trained staff in shortage specialties. As a consequence, the Trust felt it prudent to declare this as a compliance risk in 2016/17.

The Trust has declared non-compliance with the Diagnostics Target for a number of months since December 2015. There are number of pressure areas however Magnetic Resonance Imaging (MRI) and Paediatric Sleep Studies are the most challenging. The Trust is managing an action plan and with additional MRI capacity coming online in June 2016, and a plan for a catch-up in Sleep Studies over the summer months (when emergency pressures are lower), the Trust is confident the target can be achieved.

(b) Care Quality Commission (CQC)

The Trust has been registered with the CQC without conditions since the introduction of the mandatory registration requirement from 1st April 2010.

c) Monitor Ratings

Our Annual Plan for 2015/16 predicted an overall Risk Rating for the year of 3 (where 1 is poor and 4 is excellent), with an “Amber/Green” rating for Governance (risk of breaching the MRSA bacteraemia target of zero cases in the year).

Quarterly performance is set out in the table below. Green demonstrates a service performance score of <1.0, i.e. little or no shortfall in achievement of national measures, i.e. no more than one target not reached. Amber-Green arises when the score is ≥1.0 and <2.0. Amber-red applies when the score is ≥2.0 and <4.0. Red results from a score of ≥4.0.

(ii) Cancer Waiting Times

Against a target of 93% for 2 week waits (all cancers) and breast symptomatic cases, we achieved 95.8% and 94.8% respectively. For the 1 month diagnosis to treatment target of 96%, we delivered 97.7%. We continue to achieve the 31 day subsequent treatment targets for all treatment modalities; for the 94% surgery and radiotherapy target, we achieved 96.4% and 98.9% respectively, in addition to achieving the 98% drug target at 98.5%. For the 2 month urgent referral to treatment target (85%), we achieved 86.6%. The cancer screening target of 90% of patients referred and treated within 62 days was exceeded, with a performance of 96.5%.

The Trust failed to meet the 62-Day Wait for First Treatment from Consultant Upgrade Late referrals Excluded in Local Target due to complex pathways, capacity and patient choice.

Whilst the national targets are challenging, the Trust has been consistently a strong performer in this target. The recent (q4) failure of the drug treatment (31 day) target was due to patients choosing to postpone the start of their treatment over Christmas and into January 2016.

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**Table: Monitor Risk Ratings**

<table>
<thead>
<tr>
<th>Monitor Risk Rating</th>
<th>Weighting</th>
<th>Plan</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue available for Debt Service</td>
<td>25</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Liquidity ratio</td>
<td>25</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>I&amp;E surplus margin</td>
<td>25</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>I&amp;E surplus margin achieved</td>
<td>25</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Overall Risk Rating</strong></td>
<td><strong>100</strong></td>
<td><strong>3</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>

---

**Table: Performance against Monitor Risk Ratings and Governance Rating**

<table>
<thead>
<tr>
<th></th>
<th>Annual Plan</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>CoS</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Governance</td>
<td>Amber/Green</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>Amber/Green</td>
</tr>
</tbody>
</table>

Performance against the Monitor risk ratings and governance rating is reported to the Board on a monthly basis.
We continue to work in partnership with key organisations in the City of Newcastle upon Tyne

d) Social, Community and Human Rights

The Trust has a Community Advisory Panel who represent a group of patients/service users to assist the Trust in developing guidance, share views on proposed initiatives and provide feedback on Trust services/operations.

The Trust is a very proactive employment partner in the Ouseburn Learning Trust (OLT), an educational partnership involving eight schools in the North Central and Eastern areas of Newcastle, and six partner organisations. The Trust was established in October 2014 and their vision is ‘to empower young people to excel as individuals and contribute to society’. The aim is to work in collaboration to raise aspirations and attainment in young people aged 3 to 19 by ‘delivering consistently high quality teaching and inspirational life experiences’.

Over the last year, this collaboration has resulted in some really exciting activities. The OLT has a common fund raising focus benefitting the Great North Children's Hospital; One of our Medical Consultant staff is working with students from the high school to develop some young patient engagement activity, we are also working with the OLT to enable them to secure funding from the Big Lottery to offer a ‘Cooking For All’ programme which will impact on the health and wellbeing of pupils and families, and we are currently supporting the OLT to initiate a primary school ‘What’s My Job’ NHS careers conference.

In addition, we hosted a further two NHS Careers Conferences on our hospitals sites which have been very well received. Our objective is to continue to promote the Trust as ‘the’ NHS Employer of Choice as well as provide the opportunity for people in our local community to talk to health professionals about the wide range of career opportunities and how to secure employment.

The Newcastle Hospitals Apprentice Scheme launched in 2016, the only scheme to guarantee a job on completion of the programme, and we will continue to work with schools and colleges across the city to encourage young people to consider making their careers within the NHS.

The Trust remains an active member of the Newcastle Armed Forces Forum, and positively encourages armed forces personnel and reservists to consider employment with our organisation. In the past 12 months we received the MOD Defence Employer Recognition Scheme Silver Award which recognises our support for armed forces service personnel, established HR policies and support for annual training commitments.

We have also actively participated in the launch of The Royal British Legion’s Drop in Centre in Newcastle delivering sessions through their programme ‘Lifeworks’ to support employability of veterans. Following this, we have been asked to participate in other regional veteran employability programmes including Strive to Thrive.

In addition, we have recently worked alongside local charity Forward Assist to launch practical voluntary placements through our Volunteering Service to enable veterans to experience different roles in the NHS. Forward Assist identifies suitable veterans and then works alongside our Volunteer Services Coordinator, to ensure the veterans are supported and have a positive experience with Newcastle Hospitals. We hope that this is a programme which develops successfully, and continues to expand.

The Trust is committed to creating a fairer and more diverse workplace through the development of staff networks that actively engage and contribute towards promoting awareness of equality and inclusion within the Trust. We have three established networks – the disability staff network, the LGBT staff network and the BAME staff network. From a staff perspective the ongoing review and introduction of HR policies ensures that the Trust discharges responsibilities both in line with current legislation and best practice with regards to Human Rights. The Trust takes part in the Deciding Right initiative which is a North East initiative for making care decisions in advance giving patients access to the right choice for them. In addition many of the Trust policies and procedures consider Human Right legislation such as the Trust Safeguarding policies and procedures.

Some 30 employees were redeployed due to health issues in period 1 April 2015 to 31 March 2016. Depending on each case, the Trust policies that can be deployed in the process include: Redeployment; Wellbeing; Flexible Working; and Stress Management.
Chairman’s Statement

This is the 10th year that I have prepared the Chairman’s Statement for our Review of the Year. Every year I have been delighted to report first class quality outcomes and a strong financial position for our Foundation Trust.

The year ended 31st March 2016 is no exception but in addition I can report that the Care Quality Commission has rated our Foundation Trust as “Outstanding”. This is a remarkable achievement when you consider the size and complexity of our Trust, with 1.7 million patient contacts, a £1 billion turnover and circa 50% of what we do is in Specialist Services. We are one of only five Trusts and the only major teaching hospital and tertiary centre so far to have achieved this status. This is a great tribute to our 13,000 employees who are so committed and dedicated and who work day in and day out to provide the highest quality of care to our patients.

All of this reflects our acknowledged national and international reputation for putting patients at the centre of everything that we do. The “Outstanding” rating is a great platform for us to improve even further. We will not be complacent and will continue to further improve our high level of care and our research and development activities, seeking out world best practice and further enhancing clinical treatments and quality of care for our patients.

May I express my sincere appreciation to the Board of Directors who continue to drive forward our Vision and Strategic Goals, our...
Governors who are so diligent in holding the Board to account for its performance and our fantastic caring workforce. Together they have made Newcastle upon Tyne one of the very best healthcare providers in the country.

Notwithstanding this remarkable achievement we must meet with determination the many challenges that we are now facing and will continue to face over the coming years. These are significant and include the implementation of the NHS 5 Year Forward View and the many initiatives that go with it e.g. the continuous drive to reduce expenditure, Sustainable and Transformational Plans, Accountable Care Organisations and Capitation Grants. Our exit from the European Union will also have implications for the NHS which will need to be addressed.

I am confident however that our Foundation Trust is very well placed to meet these challenges. We are always committed to working together and co-operating with all sections of the NHS and our other Trust colleagues to improve the delivery of care to our patients, to achieve best value for money and continually improve efficiency and effectiveness. There are some fundamental principles however which we and the NHS should not compromise on and these include Patient Choice, which is a cornerstone of the NHS Constitution and Payment By Results when contracting with commissioners which is inextricably linked to patient choice.

This will be my last statement to the Annual General Meeting as I am retiring this year. I am very proud of this Trust and for what it achieves and shall miss greatly working with our Board, Governors and such a fantastic workforce.

In conclusion every good wish and success to our Foundation Trust for the coming years.

Kingsley W Smith OBE DL
Chairman
Review of the Year

What we do
Our top priority is always our patients, putting them at the centre of all that we do and providing the highest quality of care in all areas, clinical, safety and the patient experience.

- Designated Supra-regional Services
- Designated National Receiving Services

<table>
<thead>
<tr>
<th>CANCER SERVICES</th>
<th>Paediatric Respiratory Medicine</th>
<th>Specialist Oral &amp; Maxillofacial Radiology</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Non-Surgical Oncology Services</td>
<td>Paediatric Rheumatology</td>
<td>Prosthodontics</td>
<td>Cystic Fibrosis</td>
</tr>
<tr>
<td>Radiotherapy and Chemotherapy for solid tumours and haematological cancers</td>
<td>Paediatric Gastroenterology</td>
<td>Periodontology</td>
<td>Respiratory Medicine</td>
</tr>
<tr>
<td>Palliative Care (a Trust-wide Service)</td>
<td>Paediatric Intensive Care</td>
<td>Dental Sedation</td>
<td>Acute Stroke Medicine</td>
</tr>
<tr>
<td>Macmillan Cancer Information Centre</td>
<td>Paediatric Metabolic Disease</td>
<td>Dental Emergency Clinic</td>
<td>Auto-immune gut disorder</td>
</tr>
<tr>
<td>Clinical Trials Centre</td>
<td>Paediatric Endocrinology</td>
<td>Undergraduate Training</td>
<td>Gastroenterology</td>
</tr>
<tr>
<td>Sir Bobby Robson Foundation</td>
<td>Paediatric Intensive Care</td>
<td>Postgraduate Training</td>
<td>Cardiology</td>
</tr>
<tr>
<td>Designated Supra-regional Services</td>
<td>Paediatric Immunology and Infectious Diseases including Severe Combined Immunodeficiency Syndrome</td>
<td>Training of Dental Care Professionals</td>
<td>Clinical Immunology and Allergy</td>
</tr>
<tr>
<td>Designated National Receiving Services</td>
<td>Paediatric Bone Marrow Transplantation</td>
<td>Dermatology outpatient treatments including Phototherapy and vascular laser treatment</td>
<td>Hepatology</td>
</tr>
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<table>
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<tr>
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<th>Physiotherapy</th>
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<tbody>
<tr>
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<td>Occupational Therapy</td>
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<td>Urgent Care Services</td>
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<tr>
<td>Adult Respiratory Medicine</td>
<td>Speech and Language Therapy</td>
<td>Paediatric Dermatology</td>
<td>Walk-in Centres</td>
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<tr>
<td>Adult and Paediatric Cardiothoracic Surgery</td>
<td>Podiatry</td>
<td>Phototesting</td>
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</tr>
<tr>
<td>Adult and Paediatric Ventricular Assist Devices (VADs) as a bridge to Cardiopulmonary Transplantation</td>
<td>Pharmacy</td>
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<tr>
<td>Adult and Paediatric Cardiopulmonary Transplantation</td>
<td>Psychology in Healthcare</td>
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<tbody>
<tr>
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<td>Acute Elderly Care</td>
<td>Blood Sciences (including Clinical Biochemistry, Maternal serum screening, Clinical Haematology and Blood Transfusion)</td>
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<tr>
<td>Occupational Therapy</td>
<td></td>
<td>Cardiovascular Investigation Unit</td>
<td>Microbiology and Infection Control</td>
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<tr>
<td>Nutrition and Dietetics</td>
<td></td>
<td>Elderly rehabilitation including Stroke</td>
<td>Cellular Pathology (including Neuropathology)</td>
</tr>
<tr>
<td>Speech and Language Therapy</td>
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<td>Continuing Care</td>
<td>Muscle and Nerve Biopsy Service</td>
</tr>
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<td>Podiatry</td>
<td></td>
<td>Day Hospital</td>
<td>Immunology</td>
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<td></td>
<td>Respite Care</td>
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<td></td>
<td>Intermediate Care</td>
<td>Cytology</td>
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<td>Walk-in Centres</td>
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<td>Diagnostic Service for Rare Neuro muscular Diseases</td>
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<td>Health Visiting and School Nurses</td>
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<td>Mitochondrial DNA</td>
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<td>Integrated Sexual Health Service</td>
<td></td>
<td>Laboratory</td>
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<td>General Medicine</td>
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<td>Endocrinology</td>
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<tr>
<td>LABORATORY MEDICINE</td>
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<td></td>
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</tr>
<tr>
<td>Blood Sciences (including Clinical Biochemistry, Maternal serum screening, Clinical Haematology and Blood Transfusion)</td>
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<tr>
<td>Microbiology and Infection Control</td>
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<tr>
<td>Cellular Pathology (including Neuropathology)</td>
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<tr>
<td>Muscle and Nerve Biopsy Service</td>
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<td>Immunology</td>
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<td></td>
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<tr>
<td>Open access service</td>
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</table>

| MUSCULOSKELETAL SERVICES | | | |
| Trauma | | | |
| Adult Orthopaedics | | | |
| Paediatric Orthopaedics | | | |
| Rheumatology | | | |
| Metabolic Bone Disease Services | | | |

| CHILDREN’S SERVICES | | | |
| Paediatric Medicine including Paediatric Emergency Department | | | |
| Paediatric and Neonatal Surgery | | | |
| Paediatric Oncology including Neuro-oncology | | | |
| Paediatric Nephrology | | | |
| Orthodontics | | | |
| | | | |
| | | | |

16 Review of the Year 2015/16
We are committed to working together and co-operating with all sections of the NHS and our other Trust colleagues to improve the delivery of care to our patients, to achieve best value for money and continually improve efficiency and effectiveness.

**NEUROSCIENCE SERVICES**
- Neurology Service
  - Head and Neck Surgery
- Neuroradiology Service
  - Audiology and Hearing Aid Services
- Neurophysiology Service
  - Otology implant services
- Neurosurgery Service
  - Nuclear Medicine – Durham, Darlington and Hartlepool
- Mitochondrial Disease Service
  - Physiological measurement
- Multiple Sclerosis Service
  - Critical Care Physics
- Movement Disorder Service
  - Bone Mineral Measurement – Durham, Darlington and Hartlepool
- Epilepsy Service
  - Audiological science
- Motor Neurone Disease Service
  - Vascular Ultrasound
- Neurological Sleep Disorders
  - Laser Safety Advice
- Neurogenetic Service
  - Photomedicine
- Specialist Headache Service
  - Clinical instrumentation
- Head Injury Service
  - Radiation protection
- Deep Brain Stimulation Service
  - MRI Physics Services
- Neurovascular Service
  - Ultrasound quality assurance
- Neuro-oncology Service
  - Audiometer calibration and repair

**OPHTHALMOLOGY**
- Cataract Service
  - Technical Aid Service
- Glaucoma Service
  - Rehabilitation engineering and mobility
- Adult and Paediatric Strabismus (squint) Services
  - Clinical and scientific computing equipment development and calibration
- Oculoplastics Service including Socket Service
  - Bone Mineral Assessment
- Multidisciplinary Thyroid Orbital Service
  - Breast Screening/Mammography
- Vitreoretinal Surgery
  - Bone marrow transplantation
- Corneal service including Transplantation
  - Specialist Haematology Services
- Eye Casualty
  - General Surgery
- Optometry and Orthoptic Clinics
  - Haemato-oncology
- Nurse-led pre-admission Assessment Clinics
  - Bone marrow transplantation
- Dedicated separate Adult and Paediatric daycase facilities
  - Continuing care and support
- Medical Photography
  - Specialist Services (multidisciplinary) for pregnant women with substance misuse problems
- Tertiary centre for Photodynamic therapy for age-related maculopathy
  - Specialist Services (multidisciplinary) for twins and multiples
- Rehabilitation for newly registered blind and partially sighted patients
  - Specialist Services (multidisciplinary) for pregnant women with substance misuse problems

**OTOLARYNGOLOGY, HEAD AND NECK**
- Ear, Nose and Throat
  - General Surgery
- Head and Neck Surgery
  - Bone marrow transplantation
- Vascular Ultrasound
- Ward /Theatre Imaging
- Nuclear Medicine
  - Haemoglobinopathy Services
- Bone Mineral Assessment
  - General Surgery
- Breast Screening/Mammography
  - Upper Gastro-intestinal Services
- Vascular Surgery
  - Termination of Pregnancy Service

**REGIONAL MEDICAL PHYSICS**
- REGOateral Services
  - General Nephrology
  - Endocrine Surgery
  - Haemodialysis
  - Liver Transplantation
  - Specialist Hypertension Services
  - Renal Transplantation
  - Breast reconstructive Surgery
  - Pancreas and Islet Transplantation
  - Paediatric Plastic Surgery
  - Hepatobiliary and Pancreatic Surgery
  - Haemophilia
  - Breast care Services
  - Thrombophilia
  - Disability Services
  - Haemoglobinopathy Services
  - Endoscopy
  - Speciality Services (multidisciplinary)
  - General Urology
  - Uro-oncology
  - Surgery
  - Laparoscopy
  - Incontinence
  - Reconstruction
  - Urodynamics
  - Surgical Andrology
  - Endourology and Lithotripsy
  - Laser Prostatectomy
  - WOMENS SERVICES
  - Gynaecology including Uro-gynaecology and Colposcopy
  - Obstetrics
  - Fetal Medicine
  - Reproductive Medicine
  - Neonatal Medicine Intensive Care and Special Care
  - Family Planning Services
  - Community Midwifery
  - Maternity
  - Midwifery/obstetric ultrasound and screening
  - Specialist Services (multidisciplinary) for twins and multiples

Review of the Year 2015/16  17
How we did
Performance

Delivering Commissioners’ Requirements 2015/16

2015/16 saw the third year of the new commissioning structure in the NHS, with Clinical Commissioning Groups (CCGs) and NHS England responsible for commissioning the vast majority of the Trust’s services. It was also the first year of commissioning with the newly-formed Newcastle Gateshead CCG, resulting from the merger of three original CCGs. This changed the number of Legally Binding CCG Contracts to eleven, as well as a substantial contract with NHS England for services which they commission. Service Level Agreements (SLAs) were also operated with two Scottish Health Boards (Borders and Dumfries and Galloway), national commissioners on behalf of Wales and Scotland, and three Local Authorities, as well as other commissioning bodies such as NHS Blood and Transplant.

There was an overall increase in activity during 2015/16. Exhibit 1 shows the year on year increase in the number of patients seen for admitted care (finished consultant episodes), A&E attendances and new outpatients for the last 8 years. There was a further rise in the number of patients seen during 2015/16, with 14,357 more patients seen compared to the previous year, which equates to a 1.9% increase in activity. The most significant growth was A&E attendances which saw a 3.5% increase equating to 6,491 additional attendances. This is attributed to increasing emergency demand and the opening of a new Specialist Emergency Care Hospital in Cramlington, Northumberland.

Exhibit 1: Patient Activity

Exhibit 2 summarises activity against the Plan in relation to elective & non-elective spells, new & review outpatients and outpatient procedures by Main Commissioners.

Exhibit 2: Variance from Plan – Admitted and Non-Admitted Activity by Main Commissioners
Planned Activity

Elective activity is above plan by 1.1% and day cases above plan by 14.1%. Day cases are most notably above plan in specialised commissioning which are above by 64.1%. Non-elective activity is below plan by 1.4% though North Tyneside CCG activity is above plan by 10.6%. Total outpatient activity is above plan by 3.1% and there has been a significant over performance in outpatient procedures which are above plan by 22.6%.

Achieving Waiting Times and National Targets

Cancelled Operations

The Trust reports cancelled operations as defined by the Department of Health as follows i.e. “Planned operations that are cancelled for non-medical reasons on the day the patient was due to be admitted to hospital or after they have arrived in hospital.”

There were 540 cancelled operations reported during the year which is a 5% decrease in comparison to the previous year (573). The most prevalent reasons for last minute cancellations during the year included:

- Theatre list overruns including complexity of case-mix and the precedence given to emergency surgery (50%);
- Critical care bed availability (26%), general bed availability (11%); and
- Shortages of appropriate staff including Surgeons, Anaesthetists, theatre staff and Nurses (6.5%).

A&E Waiting Times

The Care Quality Commission national emergency department waiting time standard is 95%. The Trust has experienced an increase of 7% in the number of patients attending the RVI Emergency department in comparison to the previous year. This, along with other pressures on the service, meant that the Trust did not achieve the national standard with a return of 93.9% performance for the 12 month period ending March 2015.

The number of patients attending the Trust’s urgent care facilities is shown below; the variance in attendances at the RVI during the year included:

<table>
<thead>
<tr>
<th>Month</th>
<th>2014-15</th>
<th>2015-16</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Victoria Infirmary Emergency Department</td>
<td>114,488</td>
<td>122,582</td>
<td>8,094</td>
</tr>
<tr>
<td>Molineux St. Walk in Centre</td>
<td>28,061</td>
<td>26,423</td>
<td>-1,638</td>
</tr>
<tr>
<td>Westgate Road Walk in Centre</td>
<td>22,563</td>
<td>22,316</td>
<td>-247</td>
</tr>
<tr>
<td>Eye Casualty</td>
<td>19,800</td>
<td>19,951</td>
<td>151</td>
</tr>
<tr>
<td>All Types of Emergency Departments combined</td>
<td>184,912</td>
<td>191,272</td>
<td>6,360</td>
</tr>
</tbody>
</table>

Year end performance

96% 93.9%  

Exhibit 3 summarises A&E attendances and performance in 2015/16, when compared to 2014/15.

The predominant reasons for breaches included those due to patients waiting placement in an appropriate clinical setting (30%) and patients receiving and waiting to be treated in the Emergency Department (38%). No patients waited over 12 hours to be admitted.

During the year there was particular emphasis in relation to the timely clinical handover of patients arriving by ambulance to the Emergency Department, Royal Victoria Infirmary. There were minimal over 30 minute delays in handover; 82 in total representing 0.2% of all ambulance arrivals to the Emergency Department.
Referral to Treatment Target
During 2015/2016 Newcastle Hospitals consistently met the Referral to Treatment (RTT) 18 week targets. Nationally, the main focus for RTT is the measurement of the Incompletes target, as the one true measure of all patients on the waiting list. 92% of all Incomplete patient pathways must be treated within 18 weeks, in order to be compliant with National targets; in line with NHS Constitution pledges and Monitor requirements. Additional Referral to treatment targets of 90% for admitted pathways (being completed within 18 weeks); 95% of non-admitted pathways (being completed within 18 weeks); were also achieved. These are no longer a contractual standard. Overall performance for all 3 targets in 2015/16 is shown in Exhibit 4 below.

Exhibit 4: Trust RTT Performance

The Trust has consistently achieved an average of 94% over 2015/16, for aggregate incomplete performance, for the 92% target. As can be seen in Exhibit 5, in April 2016, NuTH achieved a performance of 94.1%, compared to National position of 92.2%, and Peer group (similar Trusts) at 93.9%.

Exhibit 5: Incomplete RTT targets comparison

News

Bed-blocking patients

Chris Smyth Health Editor

Almost £1 billion is wasted every year because thousands of patients every day are stuck “bed-blocking” in NHS hospitals, according to a government report on inefficiency.

The study also found that some hospitals use most of their floor space for administration and other functions unconnected to patient care. Freeing just five extra minutes to spend with patients on every staff shift could save £280 million a year.

The report by Lord Carter of Coles, the Labour peer, confirmed that his earlier target of saving £5 billion a year through back office reforms designed to make NHS hospitals more efficient was achievable. Everything from heating bills to hip operations needed to be streamlined to save cash, he said.

Hospitals spent wildly different amounts on the same supplies. Sickness and infection rates were twice as high in some places as in others.

While the report praised a “call centre model” for booking appointments to cut costs, Katherine Murphy, chief executive of the Patients Association, warned: “The more we outsource, the more distant and remote services become.” However, she agreed that “there is a huge, huge amount of waste in the NHS.” On bed-blocking, Lord Carter wrote: “Nearly all [hospitals] wrestle with the problem of moving those who are medically fit into settings that are more appropriate for the delivery of their care or rehabilitation, and for the families and carers.

“Official statistics on delayed trans-
6 Week Diagnostic Target

In 2015/16 the overall Trust compliance for the 15 key diagnostic tests was 99.1% against a target of 99%, with the volume of tests in 2015/16 increasing by 11,707 compared to 2014/15. The main drivers were Audiology Assessments and non-obstetrics ultrasound. Exhibit 6 shows the number of patients waiting and the numbers seen during the month of March 2016 with MRI, CT and Non-obstetrics ultrasound making up the bulk of activity.

Exhibit 6: Diagnostic Waiters and Activity – March 2016

Exhibit 7 compares the diagnostic waiting list in March 2016 to March 2015. The most notable reduction is the number of patients waiting for a Non-obstetric ultrasound reducing to 2,317 from the 2,858 reported in March last year. This is in part due to increased activity in 2015/16.

Exhibit 7: Changes in Diagnostic Waiting lists (March 2016 compared to March 2015)

The cost of these delays to NHS providers could be around £600 million per year. These delays also have a knock-on effect resulting in cancellations of elective operations because of a lack of bed capacity, and work going out to the independent sector.”

Jeremy Hunt, the health secretary, said: “This groundbreaking review will help hospitals care for patients, making sure every penny possible is spent on frontline patient care and bureaucracy is slashed so doctors and nurses can concentrate on caring.”

Heidi Alexander, the shadow health secretary, said: “Ministers cannot shy away from the fact that this is a crisis in care that has happened on their watch; 300,000 fewer older people are now getting the crucial help they need than when David Cameron came to power. This is having a knock-on effect on the NHS with more and more older people getting stuck in hospital.”

The report also tells hospital to cap management costs at 7 per cent of their income, although Jennifer Dixon, chief executive of the Health Foundation, said: “A crude cap on admin costs may save money in the short term, but will be a false economy if it damages the NHS’s ability, to reform and improve.

She said the proposals “won’t be enough to deliver on the £22 billion efficiency savings needed by 2020-21”.

EDITORIAL FROM THE TIMES

cost NHS £1bn a year
Cancer Waiting Times

Performance across a number of the cancer standards fell below the required threshold during 2015/16. This decrease in performance led to a failure of the 62 day standard and the 14 day Breast standard in Quarter 2 and the 31 day subsequent treatment (drugs) standard in Quarter 4.

There was an overall increase in activity compared to previous years. In the two week suspected cancer standard, there were 21,405 referrals across all tumour groups, an increase of 8%. The numbers of patients receiving first treatment for cancer also increased by 4%.

Late referrals from other local providers continued to be a significant contributor to the numbers of breaches. Analysis showed that 675 referrals were received during 2015/16 and of these 335 (49.6%) were referred outside of the agreed timeline. The reasons for late referrals are multi-factorial and collaboration with the referring providers and the North of England Strategic Clinical Network to improve pathways between respective Trusts is ongoing.

Exhibit 8: 62 Day Performance

The impact of the increase was felt across all diagnostic services, particularly Radiology and Endoscopy where waiting times increased for both tests and reporting of images.

The 62 day standard continued to be a challenge within the Trust and nationally. Despite this Newcastle Hospitals performed significantly better than the national average. See Exhibit 8.

There was increased national focus on cancer with the publication of the Independent Cancer Taskforces new cancer strategy for England “Achieving World Class Cancer Outcomes” setting out 96 recommendations for improving cancer outcomes by 2020.

Providers were also mandated by the Tripartite group to achieve 8 key priorities for cancer including the production of cancer improvement plans for Breast, Lung, Colorectal and Prostate. This work is currently being rolled out to encompass all tumour groups.
The National Cancer Patient Experience Survey (CPES) 2015

This is the first year that The National Cancer Patient Experience Survey (CPES) results have been published as a national statistic. These will form part of Phase 1 of the National Cancer Dashboard which shall be expanded upon to include other Trust performance data such as survival data and cancer waiting times, to inform the nation’s cancer evidence base. The survey has been carried out with amended methodology to improve comparability with other surveys (e.g. Care Quality Commission national patient surveys), and ensure capture of experiences across the whole patient journey.

Summary of overall performance

Asked to rate their care on a scale of zero (very poor) to 10 (very good, respondents gave an average rating of 8.9.

The following questions are included in phase 1 of the Cancer Dashboard developed by Public Health England and NHS England:

- 81% of respondents said that they were definitely involved as much as they wanted to be in decisions about their care and treatment;
- 90% of respondents said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment;
- when asked how easy or difficult it had been to contact their Clinical Nurse Specialist 90% of respondents said that it had been ‘quite easy’ or ‘very easy’;
- 89% of respondents said that, overall, they were always treated with dignity and respect they were in hospital;
- 95% of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital; and
- 62% of respondents said that they thought the GPs and nurses at their general practice definitely did everything they could to support them while they were having cancer treatment.

The Trust rate of care performance was scored as 8.9 out of 10 which is higher than the national average of 8.7, and was one of the highest scoring regionally within NHS England Strategic Clinical Network; however the size of the Newcastle based patient sample was significantly larger than those other Trusts. Comparably the organisation has scored the highest within the Shelford Group of Hospitals.

There were 20 questions which NuTH scored positively outside expected range of care or experience for patients which is an excellent performance. However NuTH scored below the expected range for 2 questions relating to support for people with cancer and it is to be noted that both questions are related to financial support.

Support for people with cancer

<table>
<thead>
<tr>
<th>Q22</th>
<th>Hospital staff gave information on getting financial help</th>
<th>672</th>
<th>48%</th>
<th>49%</th>
<th>60%</th>
<th>55%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q23</td>
<td>Hospital staff told patient they could get free prescriptions</td>
<td>529</td>
<td>72%</td>
<td>75%</td>
<td>85%</td>
<td>80%</td>
</tr>
</tbody>
</table>

Action plans are being developed within site specific Multi-disciplinary Teams (MDTs) and cancer services aiming to demonstrate improvement and ensure a holistic approach to cancer support services provision. This will be measured in the 2016 Survey set to be published in 2017.
Three quarters of hospitals fail to meet basic standards

Three quarters of hospitals fail to meet basic standards

Amblance Handovers

Timely handovers between ambulance and A&E staff are essential. Not only do they benefit the patient but they are important for the smooth running of the NHS system.

If ambulances are delayed at a hospital it means they cannot get out on the road to answer 999 calls. Ambulances are allowed 15 minutes to handover the patient with a further 15 minutes to prepare the vehicle for the next call. However in reality the staff within the department are so busy caring for the patient, that the handover button is not always pressed in a timely fashion. It is worth noting that whilst ambulance delays are increasing nationally, the Trust has continued to report very low numbers. For all breaches, a root cause analysis is undertaken and whilst any non-compliance is undesirable, NuTH has demonstrated that in almost all cases, the patients were physically handed over within the timescales but the IT systems were not updated in time.

Whilst the Trust reported a total of 82 ambulance handover delays in 2015/16, they continue to report the lowest number of handovers as shown in Exhibit 9 below.

NHS Number Coverage

Using the NHS Number helps to share patient information safely, efficiently and accurately aiding in the reduction of clinical risk to patients. Safe clinical treatment of any given patient relies on the information held being accurate and pertinent to that patient.

Within hospital administration, the NHS Number is important because it serves to help create a complete record for each patient thereby enables information to be safely transferred across organisational boundaries; Babies too are given their own NHS Number to link their healthcare records for life.

As the delivery of patient care is now often shared across a number of NHS clinical or business areas and suppliers, the effective linking up and flow of information related to a patient has become even more important.

Nationally the NHS Number is monitored within the Secondary Uses Services (SUS) and Exhibit10 shows that for 2015/16 NuTH achieved the nationally mandated targets for patients for each point of delivery. Only a small proportion of patients do not have an NHS Number, (including overseas and non-English patients who are not issued with an NHS Numbers).
Intensity Modulated Radiation Therapy

There is a national requirement for Trusts providing Radiotherapy to deliver 24% of treatment as Intensity Modulated Radiation Therapy (IMRT). The procurement and installation of a second tomotherapy unit has further supported the efficient delivery of IMRT, with the Trust finishing the fiscal year with a rate of 50.8% which is the highest recorded to date. The target is considered a minimum requirement as IMRT delivers more accurate treatment with less side effects and better patient outcomes. The measure is calculated as the percentage of new Inverse Planned IMRT Patients (excluding breast patients) as a proportion of all New Radical Episodes. The numbers rely heavily on the overall case mix, as the denominator includes cases which are not eligible for IMRT.

Exhibit 11: New Inverse Planned IMRT Patients as a percentage of all new Radical Episodes Apr 2012 - March 2016 (Target 24%)

Best Practice Tariffs

In 2015/16 there were 17 assorted Best Practice Tariffs (BPTs) available to healthcare providers and which are one of the enablers for NHS Trusts to improve quality by reducing variation and incentivising best practice care. With best practice defined as care that is both clinical and cost-effective, these Tariffs will also help the NHS deliver the productivity gains required to meet the tough financial challenges ahead. A Best Practice Working Group is currently undertaking a significant review of BPTs with a particular focus on improving compliance across the Trust to ensure patients receive an evidence based standard of care.

Transient Ischaemic Attack

The BPT provides an additional TIA payment for the investigation and treatment of high risk patients within 24 hours and is designed to incentivise providers to meet the ambition set out in quality markers 5 and 6 of the National Stroke Strategy. Compliance against this standard improved in 2015/16 from 97.6% in 2014/15 to 99%.

Parkinson’s Disease

The aim of this BPT is to enable access to consistent and high quality management of Parkinson’s disease, in line with NICE clinical guidelines. In 2015/16 the Trust set up a process to assess the current level of performance and agree appropriate improvement goals to claim the year of care BPT, with further work ongoing to increase the number of patients that meet best practice. One of these areas relate to having a Parkinson’s Disease Nurse Specialist which Medicine are looking to address, as currently only Neurology have one of these nurses.

Outpatient Procedures

There are significant benefits to performing procedures in an outpatient setting. In particular, patients have a faster recovery time, the ability to recuperate at home and they can get back to work and daily life sooner. However, it is recognised that patient choice and need must be accounted for and not all cases will be clinically suitable for an outpatient setting.

There are three procedures covered by the BPT and the table below shows that the Trust performance for diagnostic cystoscopies and hysteroscopy continues to be above both the BPT target and aspirational targets. All three procedures have seen an increase in the number of procedures performed as outpatients rather than day cases or elective inpatients. Hysteroscopic sterilisation shows the most significant increase going from 38.7% in 2014/15 to 48% in 2015/16.

<table>
<thead>
<tr>
<th>HRG</th>
<th>Name</th>
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</thead>
<tbody>
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<td></td>
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</tr>
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<td>MA10Z</td>
<td>Hysteroscopic sterilisation</td>
<td>No target</td>
<td>No target</td>
</tr>
<tr>
<td>MA21Z</td>
<td>Diagnostic Hysteroscopy</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>LB14E</td>
<td>Diagnostic Cystoscopy</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

There is significant variation in performance of BPTs nationally and the Trust aims to be one of the higher performing organisations by ensuring:

- strong clinical engagement, understanding and support;
- senior management and board involvement;
- frequent accurate reporting of activity data; and
- follow up of individual cases where best practice had not been delivered.
Productivity and Performance

As shown below in Exhibit 12 the Trust has a comparable length of stay when compared to the Shelford Group with whom Newcastle upon Tyne is able to compare and contrast meaningful evidence based performance benchmarking. The Shelford Group comprises ten leading NHS multi-specialty, internationally acknowledged healthcare providers and the group was formed in 2011 to benchmark and share best practice in key service areas. However pre-operative length of stay is performing better than the peer average, meaning we do not bring patients in unnecessarily the night before surgery (Exhibit 13).

Shelford Group of Hospitals:
• Cambridge University Hospitals NHS Foundation Trust
• Central Manchester University Hospitals NHS Foundation Trust
• Guy’s and St Thomas’ NHS Foundation Trust
• Imperial College Healthcare NHS Trust
• King’s College Hospital NHS Foundation Trust
• Oxford University Hospitals NHS Trust
• Sheffield Teaching Hospitals NHS Foundation Trust
• The Newcastle upon Tyne NHS Foundation Trust
• University College London Hospitals NHS Foundation Trust
• University Hospitals Birmingham NHS Foundation Trust

Exhibit 12: Average Length of Stay Newcastle Hospitals (site) compared to Shelford group peers

Exhibit 13: Pre-OP length of stay Newcastle Hospitals (site) compared to Shelford group peers

The risk adjusted length of stay index (RALS) calculates the observed length of stay to the expected length of stay in the patient group being studied (based on patients with comparable diagnoses and co-morbidities). A score lower than 106 means performance is better than expected. Although the Trust performance is slightly higher than the expected rate, performance against the Shelford Group has improved since last year highlighting the challenges that large Acute Trusts are facing.

There are specific transformation workstreams looking specifically at lengths of stay in addition to national projects, such as Getting it Right First Time and the Monitor Elective Care projects.

Emergency Readmissions

The costs associated with hospital readmissions for recently discharged patients manifest themselves in many ways. Furthermore, given our ageing society and the many demands for limited healthcare services, finding ways to reduce readmissions is more critical than ever. However, whilst many readmissions are preventable, some are clinically necessary or unavoidable.

When compared to the Shelford Group, the 30 day readmission rates for NuTH put them at the mid-point of the table. There is an acknowledgement that further improvements can be achieved with a view to minimising ‘avoidable’ readmissions. The Readmissions Steering Group continue to meet with operational and clinical leads to monitor Trust-wide emergency readmissions and the group will be agreeing a Readmissions Reduction Programme.

Exhibit 14: Adjusted LOS Index (Adjusted for case mix) against Shelford Group (lower than 100 = better than expected)

Exhibit 15: Emergency Readmission within 30 days Newcastle Hospitals (site) compared to Shelford Group peers
Health chiefs ditch NHS reforms amid pressure to cut £2bn costs

Chris Smyth Health Editor

Patient care has taken a back seat to cost-cutting in watershed NHS guidance that dumping the government’s main health reforms, experts have warned. Health chiefs are telling hospitals to focus on cost control as they panic about overspending, prompting warnings of a repeat of the Mid Staffordshire scandal as bosses cut staff to meet financial targets.

In a retreat from controversial reforms introduced by Andrew Lansley, the former health secretary; competition, choice and NHS autonomy have all been sidelined as officials revert to top-down central planning to deal with a cash crisis.

Jim Mackey, the chief NHS regulator, said competition was “absolutely not centre-stage” as he admitted to a “change in tone” on finances, telling hospitals: “Don’t just think the only job is how many nurses you can employ.”

In a blizzard of guidance issued over the past month, hospitals have been told failure to balance the books is “not an option”, after years in which the government has been relaxed about overspending to keep staff numbers high.

Hospitals are on course for a £2.2 billion overspend this financial year and Whitehall is terrified that the Department of Health will be forced into a humiliating bailout by the Treasury.

Daycase Rates

Day surgery represents a unique opportunity to achieve both high quality and cost efficient care for patients. There have been significant improvements in day case rates for specific surgical pathways, such as hernia repair and laparoscopic cholecystectomy and a targeted project is to commence in Orthopaedics.

Medical productivity

Over twenty teaching hospitals across the UK have been collaborating to benchmark and understand medical productivity with Civil Eyes Research, a leading benchmarking organisation. The programme of work is agreed by a steering group of the participating hospitals, with professional staff attending national and local workshops reviewing the outputs and generating actions to address areas of improvement. This project was launched in 2006 with the active collaboration of the Association of UK University Hospitals. Civil Eyes effectively engage with clinicians and managers to understand information apropos quality and productivity within health services.

Once again this year, Exhibit 17 shows that out of their Programmed Activities (PAs), Newcastle Consultants spend 83.4% of their time devoted to Direct Clinical Care (DCC), the very highest amongst similar teaching hospitals.
Review of the Year 2015/16

Mortality

Over the past 12 months the Trust has continued to monitor the number of patients that die within our hospitals and also those who pass away shortly after being discharged. A comparison is drawn with the number of patients one would expect to die (given the severity of condition, age etc.) by using nationally recognised models against the number of patients who actually die.

To help us do this we use both the Summarised Hospital-level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR). Over the last 12 months both the SHMI and HSMR indicators have shown the Trust to have “as expected” mortality rates that are consistently the lowest in the region.

However and whilst consistently achieving “as expected” mortality ratings, the Trust is committed to minimising the risk of an avoidable death and learning from outcomes. This is achieved by undertaking patient level reviews for all patients who were not expected to die. To do this we monitor the 140 different diagnostic groups that make up SHMI. If we observe any patterns or increased numbers of deaths in any areas we ensure that these are fully investigated by senior clinicians with expertise in that field.

Over the year 16 such reviews were undertaken with no areas of concern identified. The results of all reviews are presented to the Clinical Risk Group in order to ensure that any lessons are learnt being shared widely and most effectively acted upon.

The Myocardial Ischaemia National Audit Project

The Myocardial Ischaemia National Audit Project (MINAP) is a national clinical audit of the management of heart attack. It supplies participating hospitals and ambulance services in England, Wales and Northern Ireland with a record of their management and compares this with nationally and internationally agreed standards.

Since 2003, MINAP has published an annual public report. Public Reports cover the relevant financial year period and provide comparative data by the hospital, ambulance service, Local Area Teams (England) and Cardiac Networks (Wales) against national averages.

National and international guidance recommend that in the emergency treatment of patients with STEMI (ST segment elevation MI), primary PCI (percutaneous coronary intervention) should be performed within 90 minutes of arrival at the primary PCI centre (door-to-balloon time) and within 150 minutes of a patient’s call for help (call-to-balloon time).

Results are presented against these best practice standards in Exhibit 18. The sooner a patient receives this treatment, the better the outcome.

Exhibit 18: Primary PCI Performance

Exhibit 19: SHMI vs HSMR for North East Trusts

The sooner a patient receives this treatment, the better the outcome.

Exhibit 19: SHMI vs HSMR for North East Trusts Oct 2012 to Sep 2015

Source: NEQOS Hospital Mortality Monitoring: Report 28
Data extracted from HED March 2016
Hip, hip hooray in spite of fall

Even a broken hip didn’t stop centenarian Betty Weightman celebrating her milestone birthday.

Betty celebrated her 100th birthday with cake and a card from the Queen - despite being admitted into hospital just days before.

She fell in her home which meant she had to spend the day in hospital while recovering from a broken hip.

In spite of her painful injury, Betty was pleased to receive her traditional telegram from the Queen.

Nurses on the Royal Victoria Infirmary ward also got into the party spirit as Betty blew out the candles on her huge birthday cake.

Daughter Barbara Weightman said: “She’s never broken a bone in her life before.

“She still lives by herself, but she’s not good on her feet any more.”

Born Elizabeth Graham in Seahouses, Betty was one of eight children and had five sisters and two brothers.

As a schoolgirl she went to the Duchess School in Alnwick in the 1920s, before studying in Edinburgh to become a child’s nurse, or modern day nanny.

She then returned to the North East and was hired by families in Newcastle to look after their young children.

When World War Two broke out, Betty helped her sister run the Bamburgh Castle Hotel when the men were called up to war.

She also married during the war - she wed Stanley Weightman, who worked in the construction industry, in 1942.

After getting married, Betty gave up work and the newlyweds moved to Jesmond, Newcastle, to the house Betty still lives in today.

A daughter, Barbara, was born in 1947, before son Peter followed in 1951.

Sadly, Stanley died of a heart attack just before the couple’s golden wedding anniversary in 1992.

She’s a strong character and stubborn.

“She’s still trying to put the bins out and she can hardly walk. She likes life and socialising.’

She added that she was “so proud” of her mum who is now resting after an operation on her broken hip on Monday.

Even though the big day was spent in hospital, Barbara has been planning a family get together to celebrate the special occasion.

Betty doesn’t have any grandchildren, but she has plenty of extended family who will be gathering in Seahouses to wish her a happy birthday during the bank holiday weekend.

Barbara admitted she wasn’t sure she should plan a party at first, with fears her mum might not make it to 100, but is now glad she did.

“Three months ago I didn’t want to plan anything, but when I started to think about it, I thought she would live to 100, I really did.”

She added that her mum had enjoyed the party put on by the hospital and had received a stack of cards from well-wishers.

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Our Annual Plan

Each year we submit a 12 month Annual Plan to Monitor, the Independent Regulator of NHS Foundation Trusts. The Plan details the Trust’s performance and how we intend to deliver safe, high quality services for patients on a sustainable basis.

It is to be noted that NHS Improvement is now responsible for overseeing Foundation Trusts and NHS Trusts, as well as independent providers that provide NHS-funded care. From 1 April 2016, NHS Improvement became the operational name for an ‘umbrella’ organisation that brings together a number of organisations including Monitor and the NHS Trust Development Authority.

In terms of performance, the Plan details strong financial performance, exceptional performance in terms of quality and safety, and recognises the increase in demand for services and the considerable effort and commitment of staff to deliver high quality clinical care to patients in challenging times.

Introduction

This document forms the Operational Plan for the Newcastle upon Tyne Hospitals NHS Foundation Trust 2016/17.

2015/16 was another busy year for the Trust: our 10th successful year as an NHS Foundation Trust. Our focus continues to be the delivery of “Healthcare at its very best, with a personal touch” for local people in Newcastle, Greater Tyneside and the wider North East and Cumbria, as well as those from further afield who are referred to our specialist services. This is supported by our Business Strategy, the priorities of which are:

- STRAND 1: Targeted growth – improving patient access to services in key specialities;
- STRAND 2: Building capacity and improving efficiency – through investment and transformation;
- STRAND 3: Comprehensive Community Outreach – Care Closer to Home and Service Integration Agenda; and
- STRAND 4: Promoting Research and Innovation – improving clinical outcomes, maintaining high levels of clinical trial recruitment, building academic partnerships and attracting opportunities to the North East.

Having considered the various risks to financial, operational and clinical resilience and sustainability, the Trust Board recommitted to the Trust Vision and Strategy.

Vision Statement

“To be the health service for Greater Newcastle and a leading national healthcare provider”

This longstanding vision is underpinned by four key strategies namely:

**Business Strategy**
- Growing the business
- Building capacity and improving efficiency
- Integrated care
- Extending community outreach

**Clinical Strategy**
- Safe, high quality care
- Seamless care pathways
- Right place, right time
- Convenient and flexible
- Listening and learning

**Quality Strategy**
- Patient safety
- Clinical effectiveness
- Patient experience

**Research and Innovation**
- Improving clinical outcomes
- Clinical trials recruitment
- Academic partnerships
Many of these objectives are in line with the themes identified within the Five Year Forward View around prevention, integration, co-ordinated care and innovation.

Acknowledging the challenges facing the health and social care sector, the Trust Board considers the Trust to be well placed strategically and operationally to respond to the requirements detailed in the NHS Planning guidance published in December 2015 around Sustainability and Transformation.

We are committed to a strategy of providing healthcare of the highest standard in terms of quality and safety whilst maintaining operational, clinical and financial sustainability.

Our Services

We remain one of the largest and most successful teaching hospitals in England, providing world class services and employing world class clinicians to benefit all of our patients.

We are committed to a strategy of providing healthcare of the highest standard in terms of quality and safety whilst maintaining operational, clinical and financial sustainability.

The Trust sees integration as a key component of its strategy and an opportunity to accelerate system transformation and further develop integrated pathways of care for patients in line with the NHS Five Year Forward View.

The Trust acknowledges the role it plays in the delivery of services across the wider local health economy and the opportunities it has to support integrated models of care. This is likely to include closer working with primary care to ensure patients are seen by the right person, in the right place, at the right time.

Demand for services continues to grow and is driven by a number of factors including demographics and disease prevalence / incidence alongside patient expectations.

The Trust had in excess of 1.96 million patient contacts in 2015/16. This is an increase from 2014/15.

Newcastle’s Emergency Department as the best in the country with an overall score of 9.4/10 compared to an average of 8.6.

We scored in the highest 20% of acute Trusts in the 2015 NHS Staff Survey, and over 95% of our employees consistently recommend the Trust as a place to receive treatment – a clear testament that our staff take great pride in the fact that they are part of what makes Newcastle Hospitals so successful.

2015/16 was no exception with our staff winning a number of regional, national and international awards in recognition of the outstanding work they do every day.

The Council of Governors are extremely proud of the professionalism and dedication of its highly committed staff, and recognises the efforts of both individuals and teams across the organisation in their endeavours to deliver ‘Healthcare at its very best - with a personal touch’.
Helen Hanson, a Senior Research Nurse at the Freeman Hospital’s Rheumatology Department, has won two awards and was finalist for another, in recognition of her concerted efforts to increase staff and patient awareness, involvement and recruitment into research studies.

The 13th Bright Ideas in Health Awards, held at the Hilton Newcastle Gateshead, acknowledges the recent ideas and innovations developed by our region’s frontline NHS staff to help make the NHS better. Helen was a finalist in the ‘Quality Improvement Impact’ category.

Helen went on to win the both the Trust Nursing and Midwifery Research and Audit Prize and the NIHR Clinical Research Network North East North Cumbria - Research Practitioner of the Year. The NIHR prize recognises those involved in research delivery, who have been innovative in the way they work to deliver NIHR Portfolio studies. Both prizes acknowledge the high quality, qualitative research she has produced, exploring the experiences of both patients and staff when patients decide whether or not to participate in research.

Helen Hanson receives the NIHR Clinical Research Network North East North Cumbria - Research Practitioner of the Year Award.
**Teenage Cancer Team Finalists**

Staff at the Great North Children’s Hospital’s Teenage Cancer Unit have been shortlisted for a national Award.

They have been shortlisted for the Cancer Care category of this year’s Health Service Journal Patient Safety Awards for a film they produced with young people with cancer, to help other patients understand the effects of cancer treatments.

Sister Sara Donoghue explains: “Keeping patients safe following chemotherapy and radiotherapy is paramount. Teenage patients have often said that they found it difficult to focus on reading through lots of written information around the time of their diagnosis. So we decided to find a way of improving how information is presented to our teenage patients, prior to discharge from hospital following their first episode of treatment.”

**Staff Benefits Team wins Award!**

The Newcastle Hospitals won the ‘Best Staff Travel Benefits’ Award with its Benefits Everyone” Salary Sacrifice and Lease Car Schemes.

This award recognises an employer that has put in place a successful strategy that has made company cars effective as a benefit in the organisation.

Fiona Lee, salary sacrifice manager at the Newcastle Hospitals says: “Absolutely astounded, lost for words that Newcastle Hospitals has won this award. My team consists of myself and two other members of staff to manage 14,000 members of staff and employee benefits and we’re thrilled to bits with this.”

Newcastle upon Tyne Hospitals wanted its staff travel benefit strategy to support employee attraction and retention and contribute to its CO2 - emission reduction targets. Its salary sacrifice car scheme encourages staff to opt for low-emission cars, includes a carbon off-setting initiative for each vehicle over the life of the contract, and provides access to eco-friendly driver training.

The salary sacrifice scheme, which runs alongside the organisation’s company car plan for essential-use drivers, also offers a ‘StopGap’ car, so that employees taking up the benefit can make use of a new car in the time between selling their old car and taking delivery of their new vehicle.

**Newcastle Bone Cancer Expert wins National Award**

Mr Kenny Rankin, an Honorary Consultant in Orthopaedics at Newcastle’s Freeman Hospital has won a National Research Award.

The “Sophie’s Award ideas research grant” was given by the Bone Cancer Research Trust for Mr Rankin’s project on the ‘Evaluation of a novel MT1-MMP activated ferrous nanoparticle as a theranostic and surgery planning tool in Ewing Sarcoma and Osteosarcoma.’
**National Award for Newcastle’s Rheumatologists**

Newcastle’s Rheumatologists have been selected as this year’s winner of the ‘Emerging Best Practice Award’ by the British Society of Rheumatology (BSR).

The BSR judging panel commended the winners for their submission, entitled, “An Integrated Clinical Rheumatology Database Linking Service, Audit and Research”.

Rheumatology covers the diagnosis, care and treatment of a wide range of conditions which affect the joints and surrounding tissues. This includes Rheumatoid Arthritis (RA) which can develop into a serious and debilitating condition for many people if left undiagnosed. Yet if caught early, the symptoms can be treated and for some people, successfully reversed.

An Early Arthritis Clinic was set up in the Freeman Hospital’s Musculoskeletal Outpatient Department several years ago to help patients referred with suspected symptoms of early arthritis. A key member of this clinic is Honorary Consultant Rheumatologist, Dr Arthur Pratt who is the Clinical Lead for Early Arthritis.

Dr Pratt says: “I am a strong believer that integrating clinical services with high quality research activity creates a “virtuous cycle” with real benefits for our patients and their carers.

“Absolutely key to this has been the development of a database which helps our team to collect relevant information from patients in clinic on a ‘real-time’ basis. As well as providing us with a powerful resource for our research programme, this helps us to monitor how well our service performs against national standards. Finally, for example through the database’s ability to “auto-generate” letters from nurse-led clinical appointments we can ensure timely communication with our GP colleagues.”

**Shoulder Surgery Team shortlisted for National Award**

‘Awake’ day case shoulder surgery started at the Royal Victoria Infirmary (RVI) Newcastle back in 2012. The drive was to improve the experience for this group of patients in line with the Trust’s ‘Enhanced Recovery Programme’ and to improve throughput.

Patients undergoing day-case awake shoulder surgery are given highly effective regional anaesthesia (a nerve block) which means they can stay awake during the procedure. They are then discharged home later the same day with oral pain killers to help with pain relief when the effects of the nerve block wears off.

The team find out whether it has won at a ceremony at the Westminster Park Plaza Hotel, London, on May 6 when the RCN Nurse of the Year 2016, selected from the category winners, will be announced on the night.

The Miniboob comforter introduced by Sister Claire Ellerby has helped reduce parental stress, encourage bonding and attachment and has helped mothers establish breastfeeding.

It is made of 100% bamboo to allow a soft texture suitable for both parent and baby that readily absorbs parents’ scent. It is antibacterial, eco-friendly and biodegradable.

**Newcastle’s Special Baby Care Nurses up for National Award**

Newcastle’s neonatology team has been shortlisted for a prestigious national award for helping premature babies and parents bond by using a comforter designed to take on their scent.

The staff from the Special Care Baby Unit based at Newcastle’s Royal Victoria Infirmary (RVI) are finalists in the Child Health category of the RCNi Nurse Awards 2016, the profession’s top accolade for nursing excellence.

The award, sponsored by specialist journal Nursing Children and Young People, recognises innovation that improves the care of children and young people.

The team will find out whether it has won at a ceremony at the Westminster Park Plaza Hotel, London, on May 6 when the RCN Nurse of the Year 2016, selected from the category winners, will be announced on the night.

The Miniboob comforter introduced by Sister Claire Ellerby has helped reduce parental stress, encourage bonding and attachment and has helped mothers establish breastfeeding.

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IVF egg collecting technique set to raise success rates

THOUSANDS of couples could have their chances of having a baby through IVF treatment boosted, thanks to a breakthrough by Newcastle scientists.

A pioneering invention by the team of city scientists could play a pivotal role in improving the chances of women hoping to conceive through IVF.

Developed by experts at Newcastle’s NHS trust, the pioneering project aims to help couples have a family by improving the procedure for collecting eggs.

By keeping the eggs at body temperature, the device will improve egg quality and potentially increase the chance of pregnancy. The unique design has now taken first place in the Innovative Medical Technology category at the Bright Ideas in Health Awards.

The concept is the brainchild of Professor Alison Murdoch, consultant gynaecologist and Professor of Reproductive Medicine at the Newcastle Upon Tyne Hospitals NHS Foundation Trust.

“The current system is that eggs are collected via test tubes, but in test tubes they’re exposed to air and can be damaged by changes in temperature or other factors,” said Professor Murdoch.

“This device keeps them in an airtight chamber which ensures they’re warm all the time and minimises the risks of contamination. Like most good ideas, it’s a very simple concept.”

A team at the trust has spent five years developing the concept, including Rez Prathalingham and Rob Hodgson, Tom Smith and Robert Talintyre of Labman.

The device will help to ensure that the environment in which eggs are stored and transported from the ovary to the laboratory is enclosed, minimising the risks of contamination, and keeping them at body temperature.

Professor Murdoch said: “We don’t know yet what effect it will have on the quality of the eggs.

“For those people whose eggs might be sensitive to small changes in temperature, we hope it might increase the chance of pregnancy, but it’s too early to say for certain.”

On winning the award, she added: “We knew it was a good project so it’s lovely to be recognised.”

> Dr Nicola Wesley, Director of Innovation and Wealth Creation for the Academic Health Science Networks North East and North Cumbria, presenting the award to Professor Alison Murdoch

Gateshead project aimed at empowering GP practice patients to become ‘Practice Champions’.

Sheinaz Stansfield, Practice Manager at Oxford Terrace and Rawling Road Medical Group in Gateshead, was part of the team from NHS Newcastle Gateshead Clinical Commissioning Group that led the scheme, which won the Patient and Public Involvement – Making Research Better award.

The team have developed 39 patients as Practice Champions, who have been trained to support the GP practice, other patients and the broader community.

Sheinaz said: “The Practice Champions initiative has brought such a positive, vibrant and enthusiastic contribution to the practice.”

> Dr Nicola Wesley, Director of Innovation and Wealth Creation for the Academic Health Science Networks North East and North Cumbria, presenting the award to Professor Alison Murdoch

Katie Dickinson
Reportet
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Photograph: Newcastle Hospitals

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National Rising Star Award

A Trainee Clinical Scientist at the Freeman Hospital has been nationally recognised for his work by winning the national ‘Rising Star in Bioinformatics’ award.

Dr Samuel Urwin works in the area of Clinical Bioinformatics (Physical Sciences) and won the prestigious ‘Rising Star in Bioinformatics’ award at the 2016 Healthcare Science Awards in Westminster, London.

Dr Urwin, who was nominated by training co-ordinator Dr Emma Bowers and training supervisor Dr Andrew Sims, was one of two shortlisted for the award before receiving the honour on the 29th of February 2016.

Dr Urwin began working with the Trust in 2013 as a Research Scientist in the Clinical Measurement and Engineering Unit of the Northern Medical Physics and Clinical Engineering Directorate.
Catering Services Manager Shortlisted for Caterer of the Year

Mr Geoffrey Moyle, Catering Services Manager at the Freeman Hospital, has been shortlisted as a finalist for the prestigious Hospital Caterers Association, Caterer of the Year Award.

Serving more than 38 years with the NHS, Geoffrey commenced as a Cook in 1978, progressing his career to his current position as Catering Services Manager, a role he has now been in since 2007.

Geoffrey has flourished in this position and the responsibility of the role has allowed him to lead his team to greater heights in terms of providing excellence around the patient experience.

Newcastle Hospitals wins Bronze Award from the North East Better Health at Work Awards

The Newcastle Hospitals has recently been awarded the Bronze Award from the North East Better Health at Work Awards. The Bronze award is the entry level of these innovative awards, which are unique to the North East and have been established to take health and wellbeing into the workplace. The awards have been taken forward by all of the region’s twelve Local Authorities, the NHS and the Northern TUC, with the support and endorsement from Public Health England.

Improving the health of the adult population through initiatives undertaken in the workplace has enormous potential, and the award encourages local workplaces to make a contribution to improving the health of the people of the North East.

Newcastle’s health visitors achieve Stage 2 of UNICEF Baby Friendly Award

A big part of Newcastle’s Community Services is the Health Visiting team who care for women before they give birth and when they are at home with their newborns.

Our Health Visitors do a fantastic job and have recently been recognised for their excellent knowledge as part of their recent assessment. The staff’s hard work has earned them Stage 2 of UNICEF Baby Friendly Award for Health Visiting.

Macmillan nurse wins award

Kay was nominated by one of her patients, Jill Carlton (to Kay’s right on the photo), and received the award from FACT Cancer Support – a local charity which helps to support people going through the cancer journey whilst building partnerships with health professionals, support groups and many others.

FACT chose Kay McAlindon for the award after reading her nomination saying, “It was heart-warming to read about a professional person going above and beyond their duty, (their job), not only to help, but to care for someone. “For Kay to have given Jill the professional help she needed, and the ongoing support, in a caring and trustworthy way, is invaluable to a cancer patient.”
Ministry of Defence salutes the Newcastle Hospitals... again!

Army reservist NHS workers at the Newcastle Hospitals have once again been recognised for their fantastic efforts by the Ministry of Defence.

The Trust was awarded the Defence Employer Recognition Scheme’s Silver Award at a recent ceremony, the accolade coming less than twelve months after the Trust received the Scheme’s Bronze Award.

Run by the Armed Forces Corporate Covenant, the Awards recognises organisations that are Armed Forces ‘friendly’ and open to employing all members of the Armed Forces Community, Reservists and Veterans.

Freeman Hospital celebrates National Food Award

The Newcastle upon Tyne Hospitals NHS Foundation Trust has today been awarded the Soil Association Food for Life Catering Mark Silver Award, recognising its use of fresh ingredients and use of an increasing amount of locally sourced food for patients, staff and visitors at the Freeman Hospital.

Providing daily meals to over 700 patients and over 1000 to hospital visitors and staff as well as the general public in its Restaurant, the award recognises a move towards cooking from scratch, adhering to nutritional guidelines and ethical, sustainable food.

Critical Care Innovation Award awarded to the Freeman Hospital

A superb, innovative project run on the Intensive Care Unit at the Freeman Hospital has won a prestigious award by the North of England Critical Care Network for its pioneering thinking.

The project looked at the correlation between a hospital’s environmental factors and its impact on patients’ experiences and overall treatment. The study, which was carried out on the Intensive Care Unit (also known as ICU or Ward 37) ICU at the Freeman Hospital, assessed whether the lighting, noise and room temperature played a part in a patient’s ability to rest well.

A leading Consultant Gastroenterologist at the Newcastle upon Tyne Hospitals NHS Foundation Trust has won the prestigious British Society of Gastroenterology (BSG) Hopkins Endoscopy Prize.

Dr Kofi Oppong, who has been a Consultant at the Regional Gastroenterology and Liver Unit at Newcastle’s Freeman Hospital since 1998, specialises in the diagnosis and treatment of disorders affecting the pancreas and bile ducts (pancreatobiliary disease).

The Hopkins Endoscopy Prize (named after Harold Hopkins, a famous physicist who developed fibre optic bundles and therefore facilitated the development of the first endoscopes in the 1950s) is awarded annually for innovations in endoscopy, new methods using existing endoscopic equipment, and contributions to endoscopy research.

Dr Oppong receives the award for his work around the use of endoscopic ultrasound (EUS) in the diagnosis and treatment of pancreatobiliary disease.
North East NHS Leadership Recognition Award Winner!

The NHS Development Champion of the Year Award hones in on those who have utilised their leadership to improve the health needs of staff, patients and the communities they serve, whilst playing an instrumental role in inspiring and motivating others to develop their own leadership skills.

Claire is a leader and teacher who puts patients at the heart of everything and nurtures leaders to have a significant impact on services. Through supporting students to engage in quality improvement and change management, many have moved into new roles of influence and spread authentic leadership throughout the system.

Claire Maxwell from the Newcastle Hospitals’ Education and Training Department receiving her Award

Spotlight on our Nursing Times Award Finalists: Clinical Research Nursing

The team at the Newcastle Hospital’s NIHR Clinical Research Facility is made up of adult and paediatric nurses, Health Care Assistants, Trial Co-ordinators and Data Managers. The team works together to deliver both commercial and non-commercial clinical trials for both adult and paediatric patients at the RVI.

The team is delighted to have been shortlisted with their entry, Child’s Play. Delivering early phase clinical trials for children.

Newcastle’s Clinical Research Facility has developed a dedicated paediatric area which aims to provide a safe a comfortable area for children taking part in early phase clinical trials.

This initiative has allowed the team to increase the numbers of studies offered to children and has ultimately allowed them to deliver clinical trials across all age groups.

Newcastle currently has studies covering numerous specialities, predominantly genetics. Duchenne Muscular Dystrophy is the main focus of the work and is vital as treatment options are limited for this patient group.

Newcastle’s Clinical Research Facility has developed a dedicated paediatric area which aims to provide a safe and comfortable area for children taking part in early phase clinical trials.

Estates Apprentice of the Year

Estates and Facilities apprentice Philip McGuire was awarded the 4th Year Apprentice of the Year cup at this month’s Northern & Yorkshire Regional NHS Estates Apprentice Presentation Evening.

Philip completed his electrical apprenticeship earlier this year and has taken up a full time post in the Electronics & Medical Engineering Department at the city centre’s Royal Victoria Infirmary. He is also beginning a degree in Electrical & Electronic Engineering and we are sure he will have a bright future in engineering and Estates & Facilities.
**Spotlight on our Nursing Times Award Finalists - Nurse of the Year**

Sister Claire Campbell, who works at the RVI’s Neonatal Intensive Care Unit (also known as the Special Care Baby Unit or Ward 35), is a finalist for this year’s Nursing Times Awards in the Nurse of the Year category. She has been shortlisted in recognition of her fantastic and innovative work on promoting family-centred care on her unit - an important and pivotal part of Neonatology.

Sister Claire Campbell on the Special Care Baby Unit

**Spotlight on our Nursing Times Award Finalists - Learning Disabilities Nursing**

This collaborative entry between the North East's Cervical Screening Training team, the Newcastle Hospitals' Sexual Health Service and community arts organisation ‘Them Wifies’ has been shortlisted for their project "Josephine visits New Croft Centre" - a campaign designed to improve uptake of cervical screening amongst women with learning disabilities.

The campaign is designed to improve uptake of cervical screening amongst women with learning disabilities. Research has shown that only 19% of women with learning disabilities go for screening compared to 77% in the general population.

The partnership has already won a national award this year - Jo's Cervical Cancer Trust Award - and so the team are delighted to be in the running for yet another national award.

The Finalists with Josephine who have already won a national award

**Spotlight on our Nursing Times Award Finalists - Cancer Nursing**

**One chance to get it right: A model for paediatric palliative care**

GNCH has a Paediatric Oncology Outreach Nursing Service (POONS) who have been shortlisted for the Cancer Nursing award. POONS are senior paediatric oncology nurse specialists with significant palliative care expertise, many of whom are practicing non-medical prescribers. They pioneered outreach care for children and youngsters with cancer and leukaemia in the UK taking a lead role in the planning, delivery and evaluation of care for patients with complex needs in close liaison with local community teams and GPs.

The POONS team allow children, young people and their families to choose their preferred choice of place for care and death. In a recent carer experience questionnaire of bereaved families we asked “Do you feel the POONS team supported you to be able to care for your child in your preferred place of choice?” 100% of respondents answered ‘yes’.

We should strive to make this choice a reality throughout the country, and for all children with palliative care needs.

Nursing Times Award Finalists - The Great North Children’s Hospital: POONS Team

**Neuro Radiographer wins National Award**

A Radiographer specialising in neurovascular problems at Newcastle’s Royal Victoria Infirmary has won a top national award.

Peter Coles has been named as Radiographer of the Year for the Northern Region by the Society and College of Radiographers, and will receive his award at a glittering ceremony at the House of Commons in November.

Peter Coles will receive his award at a glittering ceremony at the House of Commons in November.

Colleagues including Nicola Hind, a Consultant Radiographer, nominated Peter saying that he greets everyone - his patients, colleagues and visitors - with a smile and helpful attitude, and does not shirk from the less favourite parts of the job, giving the same degree of dedication to the whole of his role.

Nicola says: “Peter works hard and is helpful and supportive to colleagues, always with a smile. He is well respected across Neurosciences and is a great role model for all staff. The award is really well deserved.”

His colleagues added: “He is a radiographer who is well known and extremely well thought of across the hospital, and despite not being in an official leadership role, he reliably trains and supports many radiographers across the department, using his wit and enthusiasm to encourage and motivate.”
Newcastle Eye Liaison Officers have ‘Stars in their Eyes’

Two north east health workers have been seen in a new light after they were identified as being the apple of Healthwatch Newcastle’s eyes. The pair, Dawn Rafferty from Durham and Jennifer Bedale from Seghill, Northumberland, are both Eye Clinic Liaison Officers based at the Newcastle Eye Centre at the city’s Royal Victoria Infirmary, and were nominated by a patient.

Newcastle’s Fracture Liaison Service ‘Goes for Gold!’

Newcastle’s Fracture Liaison Service is delighted to announce that it was recently awarded Gold Status by the International Osteoporosis Foundation (IOF).

Newcastle is the only service recognised by the IOF in the North East of England, and one of only four centres in the British Isles and seven centres across Europe to have been credited with a GOLD standard.

The service scored 4.0 out of a maximum potential of 5.0 points in its evaluation, comparable with Oxford (scoring 3.75) and Kaiser Permanente centres in the USA (average 4.25).

Dr Terry Aspray, a Consultant Physician with a special interest in Osteoporosis explains: “This is a great testament to the hard work of our team looking after patients who fracture, whether as an inpatient Ortho-Rehabilitation Services or an outpatient in our Fracture Liaison Service at the RVI. “Our service has a number of unique features, including its location in Fracture Clinic with a one-stop-shop, all under the review of our Orthopaedic Surgeons.”

Internationally award winning Foot and Ankle Team

Our Foot and Ankle Research Team at Freeman Hospital are proud to be the first recipients from the UK to receive an Award for Excellence from the International Federation of Foot & Ankle Societies (IFFAS). The prestigious Award was presented for their manuscript entitled “Radiographic Severity of Arthritis Affects Functional Outcome in Total Ankle Replacement”.

Photographs: Newcastle Hospitals
Top left to right- Russell Bowman, Sherron Furtado, Phil Powell, Barbara Tait, Andrew Cutts; Bottom left to right- Simon Chambers, Malik Siddique, Jayasree Ramaskandhan

Deborah Hall, Healthwatch Newcastle’s Information Support Officer, was delighted that the pair received the recognition that they deserved.
A specialist nurse is helping some of the most seriously ill children across the North East spend more time off the hospital wards and with their families.

Young patients with Congenital Heart Disease (CHD) will be supported by Jacqui Laydon who aims to make life a little bit easier.

The appointment of the new post will see Jacqui based at the region’s world-leading Cardiothoracic Centre at the Freeman Hospital in Newcastle.

As a ‘WellChild Children’s Cardiac Nutrition Nurse’, she will aim to reduce the time children with CHD have to spend in hospital by arranging and coordinating the care they need at home and providing specialist advice on nutrition as well as emotional support for the whole family.

One little boy benefitting from the new role is seven-month-old Joshua Wilson who was born with a series of health problems, including dilated kidneys, a congenital heart defect and Tracheo-Oesophageal Fistula, where his oesophagus is joined to his windpipe.

Grandmother Jane Wilson said: “Jacqui has been a great support to us when we didn’t know who to turn to. She is always at the end of the phone and there to sort out any problems as they arise. She also helps us coordinate appointments with all the different specialists Joshua needs to see.”

Prior to her new role, Jacqui worked as a Children’s Cardiac Liaison Nurse working between hospital and home supporting families of children with newly diagnosed congenital heart disease.

She also spent 11 years as a staff nurse on the Children’s Cardiac Intensive Care Unit.

She said: "Our cardiac children often have to return to hospital on multiple occasions, due to difficulties with feeding and gaining adequate amounts of weight, for a variety of reasons. I’m looking forward to developing the support around nutrition for these children and their families, as well as working with and providing support and advice for my colleagues in the community and local areas.”

Angie Johnson, matron, at the Freeman’s Children’s Heart Unit, said: "Children with serious heart defects often struggle with feeding and growing which can impact how they respond to surgery and other treatment. This unique new nurse role is crucial in liaising and providing support for families of children with serious heart defects and disease outside the hospital environment. In this way we can help minimise disruption to their home lives and best prepare them for challenges ahead.”

WellChild’s pilot Children’s Nurse programme began in 2006, and its success has already resulted in the creation of posts in Ayrshire, Birmingham, Bristol, Cambridge, Cardiff and Cumbria among other places.

Linda Partridge, WellChild’s director of programmes, said: “We’re particularly excited that this role is the first of its kind to focus on providing expert feeding advice to help children with more serious heart defects thrive in advance of life-saving surgery and other treatment.”

Craig Thompson
Health Reporter
craig.thompson01@trinitymirror.com

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Nurse Jacqui Laydon with Joshua Wilson and his mum Lisa

> Specialist nurse Jacqui Laydon who aims to make life a little bit easier for patients with Congenital Heart Disease (CHD)
Burdett Trust Award

The Neonatal Unit (Ward 35) was recently awarded a grant from the Burdett trust for Nursing – an independent charitable trust which supports nurse-led projects designed to improve patient the care environment.

The Burdett Trust awarded UNICEF a significant grant to support Neonatal Units across the UK to gain Baby Friendly accreditation.

The RVI neonatal unit applied alongside 39 other units across the UK and was delighted to learn that they were one of 6 successful to receive the prestigious award.

Specialist Infant feeding Lead Nurses Maria Douglass and Helen Smith will be overseeing this work. They say “We are delighted that UNICEF have recognized the excellent work that is already going on in our unit, which this grant will help us to enhance even further. As well as supporting breast feeding for sick and preterm babies, our aim is to facilitate a more family integrated model of care in order to improve longer term outcomes”

The project will take place over a 3-year period.

Helen and Maria - Infant Feed Coordinators on SCBU
The Trust Innovation Strategy was launched on 23rd April 2015 with the key outcome to provide a mechanism of capturing ideas, evaluating and supporting them.

Often in a busy hospital there are lots of ideas that never get heard and often there is not time to take a step back, instead develop workarounds to provide improved standards of care. An on-line form was developed to provide a quick and easy way of submitting an idea / solution to a problem. In the first year 95 ideas were submitted:

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<td>Grand Total</td>
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On 6 May 2016 Innovation@NuTH held its first celebration event to promote the ideas, review and reward the success across three categories:

- Education, Training & Research
- Clinical Innovation
- Innovative Service Delivery

*The winners and the judging panel:*
Unsung Hero Award

A special award was designed to recognise innovators who don’t put themselves forward. As part of the COC submission, a 50 page document was presented outlining the innovation, service improvement and transformation on-going within the Trust. Directorates were encouraged to pick a team or individual who is an ‘unsung hero of innovation.’

The winner Michael Whitaker, Clinical Scientist, was nominated for his involvement with the development of the Newcastle Infant Haemodialysis and Ultrafiltration System (NIDUS), a novel device for treating small babies (< 6 kg) born without normal kidney function. For some babies, in whom peritoneal dialysis is impossible, NIDUS is the only treatment available.

The licensed device has been developed in Medical Physics based on its humanitarian use at the RVI (10 patients). Evidence suggests that it will revolutionise the care of critically ill babies who need dialysis, including saving babies who would otherwise die.

Innovation Scouts

The North East and North Cumbria Academic Health Science Network have developed a scheme for front line staff to assist in developing and evaluating ideas and getting a greater understanding of intellectual property.


Transformation Programme

Sustainability and Resilience through Transformation 2015-2020

The Trust commenced a formal Transformation Programme in the Summer of 2015. This programme contains 4 work streams, each of which cuts across all clinical specialties and aims to contribute to sustainable improvement in patient experience and clinical quality.

Admission, Discharge and Patient Flow

- Improve patient care by improving patient flow to ensure patients are seen at the right time in the right place;
- Step change in Performance, Safety and Patient experience by re-setting the system (spanning multiple organisations);
- Implement SAFER patient flow;
- Consistent Discharge Framework; and
- Reduce overall bed occupancy and eradicate boarders.

Outpatients

- Consistent approach to all outpatient clinics across the Trust, reducing waste through duplication and improving patient flow;
- Reduce RTT times;
- Easy access to book appointments and (change/cancel) clinics;
- Performance of outpatient clinics is visible and transparent; and
- Reduce wait times for patients when in clinics.

Telehealth & e-Health

- Delivery of tele health strategy/framework to improve patient experience;
- Empowerment of patients;
- Reduce unnecessary hospital activity (including admissions and A&E);
- Linkage with other providers to make clinical decisions more timely; and
- Remote monitoring of patients to prevent complications.

Demand and Capacity

- Define demand and capacity;
- Ensure all relevant staff understand concepts of demand and capacity;
- Use demand and capacity data to understand potential improvement opportunities;
- Ability to use Historic demand to help forecast future demands; and
- Gather capacity data to formulate a baseline of demand capacity across the Trust.
Florence

The text message-based remote monitoring and support service named ‘Florence’ has been embraced throughout the Trust and is improving patient care in over 10 services. Within the day case Breast Surgery pathway, patients opting to use this free service receive supportive text messages post day-case surgery discharge to monitor their health and wellbeing. Consultants have found ‘Florence’ integral to delivering >40% simple mastectomies as day cases. It provides them with the reassurance that their patients are being supported post-discharge by nurses who wouldn’t otherwise have had the capacity to follow up every patient via telephone.

Patient feedback included:

“I felt I was one text away from everyone I needed.”

“Nice to know there was info re backup if recovery did not go well.”

“Great service felt help was there when needed. Thankey x.”

“Useful and saves medical staff time. Don’t have to follow every patient up.”

“Liked very much, made me feel in contact with the hospital and support if necessary. Not alone, thank you.”

Florence has also been very successful in improving care of women with Gestational Diabetes. By self-monitoring and texting in their blood sugar levels twice daily, women have felt more confident self-managing and midwife time has been released by reducing the need for unnecessary telephone contact. Clinical outcomes have also improved and the number of women who struggle with control to the point that they need insulin has reduced.

Outpatients

Work is ongoing within the Childrens Outpatient Department to develop an electronic system to view and book rooms. The Outpatient area too has seen an annual increase in activity of 4% by maximising deployment of the clinical footprint.
I am delighted to be working with a progressive Trust that really does put patients and their safety at the centre of all care that it provides, supporting staff to facilitate this outcome. Newcastle Hospitals was the first Trust to appoint a truly independent Freedom To Speak Up Guardian. I am external to the Trust - not an employee - thus providing confidence to staff that the Chief Executive and members of the senior team want to hear concerns about patient safety and any wrongdoing that is in the public interest.
The independence gives the role gravitas. When concerns have been raised the independence has helped me ask at times challenging questions and to find out what actions have been taken. By taking up concerns on behalf of any staff member I hold a mirror up to the Trust.

Some six months into post I have had a very busy time working with staff on this vitally important aspect of patient care. My role is one of a number of ways in which staff are able to raise concerns. At the time of my appointment there were no hints and tips from the National Freedom To Speak Up Guardian office to assist. The role has therefore taken shape by speaking to staff in various settings and listening to how they would wish to see the role develop. The key messages I received were about my own ‘visibility’ and the need to improve the ‘feedback’, which the Trust provides following concerns raised.

Taking on the challenge of ‘visibility’ to some 14,000 staff, I have increased the number of walkabouts on wards and in clinics. I have also attended meetings, study days and the nursing preceptorship programme.

Where possible I provide relevant and appropriate feedback. Providing feedback in certain circumstances is very difficult due to the associated sensitivity and confidentiality. Further work will be carried out over the coming year on both visibility and how to provide timely and meaningful feedback.

The nature of the concerns raised has been varied in both subject and level. Some have had a speedy resolution whilst others have been complex and taken longer. There is some anxiety among some staff about raising concerns. This will require the Trust and me to carry on developing a culture that reassures staff that raising concerns is routine.

I have worked closely with the National Guardian Office in developing a role profile and guidance for Trusts. I have sought to develop links with NHS Employers, our local universities and with Health Education England North East. This work will continue over the coming months.

The challenges for the coming year are to create more opportunities for me to speak to staff and to provide some feedback on trends and themes in a manner that retains the confidentiality of those staff raising concerns. More work will also be done to build the confidence of junior doctors, student nurses, support staff and other staff groups to raise concerns. Working with Trust colleagues I will explore the possibility of developing sub-guardians/advocates to assist

I am looking forward to the demanding year ahead requiring a great deal of energy and enthusiasm to work in the interests of good quality and safe care for all patients. A year in which together we can build upon the success of the first six months in post.

Sokhjinder Morgan, Newcastle upon Tyne
Hospitals Freedom to Speak Up Guardian

Sokhjinder has empowered me to follow through with raising issues, has given me the support to ensure that I felt happy and confident in the workplace despite raising these concerns
Complaints

Within the Trust there is recognition at all levels, from the Board to front line staff, that complaints provide valuable opportunities to improve services and positively impact patient experience.

Every endeavour has been in the last year to make the complaints process as straightforward and accessible as possible for patients, carers and their families, including a new ‘Raising concerns and providing feedback’ poster which has been produced and displayed in all public and clinical areas to inform patients of the options available to them should they wish to formally complain or provide feedback informally.

In spite of these initiatives, during 2015-16 the Trust received a total of 629 formal complaints which is an encouraging 14% fewer than during 2014-15. The most common theme of these complaints was ‘All aspects of clinical treatment’ followed by ‘Delayed Appointments’ and ‘Discharge and Transfer Arrangements’. In 2015-16 the rate of complaints per 1000 patient contacts was 0.34 which is a 16% decrease compared to the 0.40 per 1000 patient contacts for 2014-15.
Efforts have been made in the last year to make the complaints process as straight-forward and accessible as possible for patients, carers and their families

All complaint responses from Service Directorates are accompanied by an action plan which ensures learning and underpins the on-going improvement of services. These action plans have been expanded this year to capture not just ‘Actions‘ but also the ‘Learning‘ and ‘Procedural Changes‘ resulting from the complaint along with a detail of how implementation of the plan will be evidenced and a specific timescale.

The learning and actions resulting from complaints are shared with patients and the public through several mediums including the ‘You said... we did’ boards which are displayed in all Trust reception areas. The Trust Complaint Panel continues to scrutinize all complaints received and responses provided on a monthly basis and a monthly mailer is sent out to all staff highlighting themes identified and advice for future avoidance. The Quality Assurance process for complaints has also been expanded to involve a greater number of reviewed complaints and Directorate level reports being produced monthly to highlight good practice and opportunities for improvement. The Patient Relations team also continues to monitor complainant satisfaction via questionnaire and this has been expanded and is now sent out to every complaint with their final response.

Since February 2016 the Patient Relations team have been piloting ‘Early Intervention Meetings‘ with great success. This initiative involves identifying the more complex complaints and arranging meetings with those complainants within 2 weeks of receipt of the complaint. The complainant has the opportunity to discuss their concerns with the clinical teams involved in their care and Directorate Management representatives. A recording and summary of issue sand agreed actions are then provided within 2 weeks of the meeting. This initiative offers a more timely and personal response to complex complaints which previously may have taken several months to resolve. To date, feedback from both Trust staff and complainants has been wholly positive.

This year also saw the launch of ‘Patient Experience Dashboards‘ which are produced for each Directorate on a quarterly basis. This information allows Directorate teams to review all types of patient experience feedback on one report including complaints, concerns, PALS, comments via internet forums such as NHS Choices or Healthwatch and Friends and Family comments. These comments, both positive and negative, provide an overview of their patients’ satisfaction, making identification of themes and trends possible.
The national programme (managed by the Care Quality Commission) is intended to be a mechanism for making the NHS more patient focused and provides a quantifiable way of achieving this.

The 2015-16 the national survey programme for Acute Trusts consisted of:
• The annual acute adult inpatient survey; and
• A survey of Maternity Patients.

The following section outlines the key findings from the surveys carried out in 2015-16.

National Survey of Adult Inpatients 2015

The 2015 national inpatient survey highlighted the many positive aspects of the patient experience including:
• 93% rated care as 7 or more out of 10;
• 92% felt they were treated with respect and dignity ‘always’;
• 91% always had confidence and trust in their doctors;
• 99% said hospital rooms/wards were very or fairly clean; and
• 94% said they always had enough privacy when being examined or treated.

How do we compare?

The publication of the Care Quality Commission benchmark report and data enables the Trust to compare the standardised results of the Inpatient Survey with the results for other Trusts. The data is available on the CQC website (www.cqc.org.uk). The CQC website states that the data from the benchmark reports will be used to inform their activities around registering and inspecting health care services.

The benchmark report shows how the Trust scored for each question in the survey, compared with the range of results from all other Trusts that took part. An analysis technique known as the ‘expected range’ is deployed to determine if the Trust is performing ‘about the same’, ‘better’ or ‘worse’ compared with other Trusts.
The Newcastle upon Tyne Hospitals NHS Foundation Trust is delighted to announce that the independent health and social care regulator, the Care Quality Commission, has rated its services, and the staff who provide them, as ‘Outstanding’. This is a truly remarkable achievement which has not before now been possible - a rating of ‘Outstanding’.

The excellent outcome achieved is a testament to each and every member of staff and it is a celebration of the work they put in every day to deliver healthcare at its very best with a personal touch.

The formal announcement made by the Chief Inspector of Hospitals, Sir Leonard Fenwick, Chief Executive, stated: “The CQC inspection process is impressive and rightly testing. The Newcastle upon Tyne Hospitals has shown that it is constantly looking to improve. The CQC has not only recognised the outstanding services that the Trust provides, but also the outstanding workforce that delivers them.”

The Inspectors spoke to patients, relatives, and staff, and sought views on whether they were safe, effective, caring, responsive and well-led. They examined each of the Trust’s providers in the UK.

The Newcastle upon Tyne Hospitals is one of the best teaching or specialist (tertiary) healthcare providers in the country, and the very first for a Foundation Trust to receive an ‘Outstanding’ Care Quality Commission rating. The CQC report states: “To our knowledge, this is the first time a UK healthcare provider, to receive an ‘Outstanding’ rating in each of the key areas of care we deliver to our patients: clinical governance, leadership and the quality of care. The process is impressive and rightly testing.”

The Newcastle upon Tyne Hospitals NHS Foundation Trust is one of only five Trusts in the UK to be rated as ‘Outstanding’.

The Newcastle upon Tyne Hospitals as one of the best teaching or tertiary providers.

In January this year, a team of more than 80 Inspectors, made up of doctors, nurses, other healthcare professionals, managers and patients, visited our hospitals and community teams.

This is a truly remarkable achievement which rightly recognises Newcastle upon Tyne Hospitals as one of the best teaching or tertiary providers.

The Chief Inspector of Hospitals, Sir Leonard Fenwick, Chief Executive, paid tribute to the Trust’s 14,000 plus dedicated staff: “The CQC inspection is the result of the outstanding work of every member of staff and it is a celebration of the dedication and commitment by each and every member of staff, whether they were safe, effective, caring, responsive and well-led.

The CQC has not only recognised the outstanding services that the Trust provides, but also the outstanding workforce that delivers them. The Newcastle upon Tyne Hospitals NHS Foundation Trust is to be congratulated on becoming one of the first teaching or tertiary providers to receive an ‘Outstanding’ Care Quality Commission rating.”

Visit www.newcastle-hospitals.nhs.uk and look under “Maternity Services” to find out more about what’s on offer and to watch a virtual tour of the Newcastle Birthing Centre.

Congratulations to all our staff...
Some verbatim comments from the Inpatient Survey 2015

‘The staff always introduced themselves and explained what was happening. I cannot suggest anything that could be improved. When I asked about something that the nurses were not sure about, they asked someone who knew the answer. I was impressed by the cleanliness and care.’

‘All staff were very friendly, Surgeon, staff nurse and anaesthetist especially. The operation went even better than expected and I was up and about immediately on recovery and waking. I felt great and was discharged the following day. Thanks everyone.’

‘From my initial appointment right through my treatment and procedure all the staff were very professional and caring, can’t fault anything. Excellent treatment and care.’

‘As I both live alone and being away 4+ weeks I requested that I was able to stop off on the way home for some fresh bread! The staff were so kind and put together a food hamper for me (carrier bag) – so kind.’

‘The hospital staff were very nice if you wanted anything they were there at all times.’

‘Special care and attention on my birthday. Staff alleviated the anxiety I felt after finding out the injury was more serious/complex than anticipated. They attended to my pain with great care, supporting me when it was particularly severe.’

How we do:

• The Trust performs ‘about the same’ as other Trusts in 31 of the 62 questions.

These questions were:
• Information given in A&E about condition or treatment;
• Privacy when being examined or treated in A&E;
• Noise at night from other patients;
• Noise at night from hospital staff;
• Feeling threatened by other patients or visitors;
• Answers to questions from doctors;
• Confidence and trust in doctors;
• Doctors talking in front of you as if you weren’t there;
• Answers to questions from nurses;
• Confidence and trust in nurses;
• Nurses talking in front of you as if you weren’t there;
• Enough nurses on duty to care for you in hospital;
• Members of staff work well together;
• Staff saying contradictory things;
• Involvement in decisions about care and treatment;
• Confidence in decisions made about condition and treatment;

• The Trust performs ‘better than other Trusts’ in 31 questions.

These questions were:
• Information about care and treatment;
• Someone on staff to talk to about worries and fears;
• Emotional support from staff;
• Control of pain;
• Time taken to answer call button;
• Explanations of risks and benefits of operation or procedure;
• Answering any questions about operation or procedure;
• Explanation of how operation or procedure had gone;
• Involvement in decisions about discharge;
• Enough notice about when discharge would take place;
• Explanation of how to take medication;
• Danger signals to watch for after going home;
• Overall treated with respect and dignity;
• Feeling well looked after by hospital staff; and
• Overall Experience.

The following scores had shown a significant improvement since the 2014 report:
• Noise at night from other patients;
• Enough nurses on duty to care for you;
• Information about condition or treatment; and
• Involvement in decisions about discharge.
The Trust did not score ‘worse than other Trusts’ in any questions however when reflecting upon the previous Survey results from 2014, the following scores were significantly lower:

- Given printed/written information about what you should/should not do after leaving hospital
- Being asked to give views on quality of care
- Seeing or being given information about how to complain
- Being told who to contact if worried about condition or treatment after leaving hospital

The following exhibit shows how the Trust performed in each section of the National Patient Survey of Inpatients using the CQC website method of presentation compared to how the Trust performed in the 2014 Survey. The first bar within each section is the 2015 performance and the second is the 2014 performance.
The following tables show the performance across the sections for the surveys for local Acute Service Trusts and also the Teaching Trusts comprising the Shelford Group of Hospitals. These tables demonstrate that the Trust is a top performing healthcare provider with regard to patient experience.

**Local Trusts - Comparison of Section Results - National Inpatient Survey 2015**

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**National Peer Group - Comparison of Section Results - National Inpatient Survey 2015**

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<tr>
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National Survey of Maternity Patients 2015

As with the inpatient survey summarised above, the results of this patient survey highlight many positive aspects of the patient experience. Key results show:

- 96% of respondents were given a choice of where to have their baby;
- 96% of respondents felt that their partner was involved in their care during labour and birth;
- 91% of respondents said that they were treated with respect and dignity;
- 76% of respondents said that the hospital room or ward they were in was very clean; and
- 98% of respondents were visited at home by a midwife.

The Care Quality Commission benchmark reports and data was published in December 2015. The report and data compare the standardised results of the maternity survey in this Trust with the results for other Trusts. Three reports are available to the Trust – Antenatal, Labour and Birth and Postnatal, only data from the Labour and Birth report is published by the CQC as not all Trusts could attribute care in the antenatal and postnatal period to the care provided at their specific Trusts.

The key highlights of the three Trust CQC benchmark reports show that:

Antenatal:
- 11/12 questions scored in the ‘Expected range’ i.e. About the same as other Trusts; and
- One question was ‘Better than most other Trusts’ – During your antenatal check-ups did the midwives listen to you.

Labour and birth:
- 17/19 questions scored in the ‘Expected range’
- 2 questions scored ‘Better’ –
  - Thinking about your care during labour and birth, were you treated with respect and dignity?
  - Did you have confidence and trust in the staff caring for you during your labour and birth?

Postnatal:
- 18/19 questions scored in the ‘Expected range’.
- One question was ‘Better’ – Were you given enough information about any emotional changes you might experience after the birth?

The Trust did not score ‘Worse than expected’ in any questions within the three reports of maternity care.

The CQC Benchmark report on Labour and Birth shows that within the three broad domains – (i) labour and birth, (ii) staff and (iii) care in hospital after the birth, the Trust scores were ‘About the Same’ for (i) and (ii) and ‘Better than other Trusts’ for (ii). This is an improvement in performance from the 2013 which showed that the Trust performed ‘About the Same’ as other Trusts in all three categories.

A Benchmark report regarding Labour and Birth is available for all Trusts providing maternity services in the UK therefore the following tables show our performance in this section compared to local trusts and our national peer group.

Some verbatim comments from the Maternity Survey

‘I can’t highly commend enough the care and excellent level of service I received at the Newcastle Birthing Centre at RVI. The midwives who were involved with the delivery of my daughter were exceptional and the whole experience of being in a midwife led birthing centre was outstanding.’

‘I cannot fault the care I received during pregnancy and birth at the RVI. The staff were caring, considerate and extremely professional. My midwife during labour was simply amazing!’

‘Superb care all round. Particularly impressed with midwife who carried out the delivery - instilled full confidence.’

‘I had an excellent experience whilst pregnant and during labour. I felt I could ask any questions I needed to a not embarrassed or stupid. I felt fully supported throughout.’

‘My partner and I were both very impressed with the care provided by the staff at the RVI. The midwife and consultants were fantastic, making us feel safe and informed during the labour. The postnatal care provided by the midwives in hospital was also brilliant - they were all so approachable, kind and caring.’

‘All the midwives I saw during my stay in hospital were brilliant, their all doing a great job they encourage you to be very hands on independent with your baby which I thought was great for the new younger mothers. One lady sticks in my head who worked on the ward she brought your lunch and made up your bed, gave you advice on feeding and sterilizing bottles she was so jolly and made me smile my whole stay. Thank you to the staff at RVI. Brilliant.’
### Local Trusts

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<thead>
<tr>
<th>Trust</th>
<th>NuTH</th>
<th>Northumbria Healthcare NHS FT</th>
<th>Gateshead NHS Foundation Trust</th>
<th>South Tyneside and Hartlepool</th>
<th>County Durham and Darlington</th>
<th>South Tees and Hartlepool</th>
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### National Peer Group

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The National Patient Survey Programme for 2016-17 includes:

- Annual survey of Adult Elective and Non-Elective Inpatients;
- Survey of Emergency Department Patients; and
- Survey of Children and Young People, Inpatients and Day Cases.
When going in for day surgery perhaps a more accurate operation slot or time could be given we waited 6 hours and obviously patient hasn’t eaten for at least 12 hours minimum
In 2015-16 there were a total of 549 cards with negative comments (30%) from a total of 1819 T2M cards - Patients have felt that the Elements of Care most in need of improvement are Physical Comfort and Access to Care respectively (same order of % share on last year, Access to care almost doubled). These elements focus mainly on the infrastructure of the hospital and wards, the processes that are involved and additional services required while visiting/staying at the hospital.

More specifically within these elements of patient experience, suggestions for improvement are received primarily on waiting times, appointments, parking and food.

Areas for Improvement - 2015-16

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How we do it
keeping you safe
The Newcastle upon Tyne Hospitals NHS Foundation Trust (NuTH) recognises that the effective prevention and control of healthcare-associated infection (HCAI) is essential to patient and staff safety. The over-riding principle in our delivery of care is to reduce infection rates with a zero tolerance approach to avoidable infections, while delivering the best possible care.

The recent CQC rating for the Trust as a whole was outstanding with reference to infection prevention and control (IPC) stating: “The Trust had infection prevention and control policies, which were accessible, and used by staff. Across both acute and community services patients received care in a clean, hygienic and suitably maintained environment” reflecting the hard work done by the IPC team and all staff in ensuring high standards are maintained.

During 2015/2016 the Trust has continued to review IPC services in response to the continuing challenges of reducing rates of Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia and Clostridium difficile (C. difficile) associated diarrhoea to ensure nationally mandated targets are not exceeded. The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (revised 2015) provided focus for the refinement of the IPC strategy. Further guidance has been published by NICE (CG 139 Infection Prevention and Control of healthcare-associated infections in primary and community care), NICE public health guidance 36 (2011) and HPA (epic 3: National Evidence Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England), these have been reviewed and where possible/practical implemented.

The Health and Social Care Act set ten criteria which the Trust Board recognise and accept as the Framework for delivery of appropriate safe care and to prevent infections in both staff and patients. These are incorporated in the current HCAI Strategy with associated policies and audit to monitor compliance, and are as follows:

- Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them;
- Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections;
- Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance;
- Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion;
- Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people;
- Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection;
- Provide or secure adequate isolation facilities;
- Secure adequate access to laboratory support as appropriate;
- Have and adhere to policies, designed for the individual’s care and provider organisations that will help to prevent and control infections; and
- Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.
HCAI Prevention and Control Strategy

The strategy sets out the principles of infection prevention and control in the Trust. It also seeks to provide the Board of Directors with assurance that appropriate structures and processes are in place to minimise the risks of HCAI to patients, staff and visitors. The Nursing & Patient Services Director and Director of Infection Prevention and Control (DIPC) are responsible for the monthly update provided to the Trust Board.

The aims of the strategy are to ensure that:

- Robust HCAI prevention and control has a positive effect on the quality of care, safety and well-being of patients, staff, carers, volunteers and visitors, and on the business, performance and reputation of the Trust;
- The organisation recognises HCAI prevention and control, and wider infection prevention and control issues, as a key element of clinical and non-clinical governance;
- HCAI prevention and control systems and processes are embedded across clinical directorates and in corporate services including business planning, service development, financial planning, facilities planning, project and programme management and education and training;
- The organisation has standardised IPC principles and practices across acute and community settings resulting in improvements in patient care pathways;
- The organisation has a co-ordinated and multi-disciplinary approach in managing HCAI prevention and control through a systematic process of identification, analysis, learning and management of risk. This approach extends to partnership working with other providers and Commissioners;
- The organisation complies with Public Health England (PHE) mandatory surveillance for MRSA, MSSA and E. coli bacteraemia, and C. difficile toxin positive results and other key targets or challenges as identified;
- The organisation complies with PHE voluntary surveillance for reporting of Norovirus outbreaks.

It is recognised that effective IPC requires commitment and active involvement of all employees. It is therefore vital that IPC process is communicated and embedded throughout the organisation. In addition to the corporate responsibilities outlined, Clinical Directors, Matrons, Directorate Managers, and Department Heads are responsible for ensuring effective IPC within their own specialist areas. These include primary responsibility for identification, investigation and follow up of all IPC issues. Where initial assessment indicates a high level of risk or need for expert advice and/or where the level of risk warrants reporting to an external body, the Matron, Directorate Manager, Clinical Director or Department Head is responsible for bringing the issue to the attention of the DIPC, the Clinical Governance and Risk Department and, where appropriate, a Board Director, to agree decisions about subsequent management of the issue.

A Trust HCAI Action Plan has been developed as an active document. This document covers all aspects of HCAI prevention and control and operationally supports the HCAI Strategy; this is reviewed by IPC on a six-monthly basis. In addition Directorate-based Action Plans are submitted to the IPC Operational Group annually, providing evidence of engagement and Directorate actions to prevent HCAI occurrence.

IPC Assurance Framework

The IPC Committee (IPCC) continues to meet on a monthly basis, chaired by the DIPC. The IPCC ensures that IPC policy and strategy is developed, implemented and monitored, and that an integrated IPC service is maintained with consistent high standards, protocols and policies. The IPC Risk Register is reviewed by this committee on a quarterly basis and issues surrounding audit, education and training, communication and any other emerging matters are also dealt with in a timely manner; this also includes submission of a monthly Outbreak and Incident Report. The IPC is represented at the monthly Trust Board by the Nursing & Patient Services Director and is supported by the IPC Operational Group, which meets on a monthly basis; in addition to these regular meetings the IPC Operational Group also meet on an ad hoc basis to ensure key IPC issues are dealt with in a timely manner.

MRSA

Methicillin Resistant Staphylococcus Aureus (MRSA) is a gram positive organism that can colonise patients. MRSA is resistant to first line antibiotics for Staphylococcus Aureus and therefore can be difficult to treat and is life threatening when bacteraemia leads to sepsis. The Trust’s MRSA Policy reflects national and local policy and includes the Post Infection Review (PIR) process.

There has been a zero tolerance for MRSA bacteraemia in 2015/2016, however in this year there were 5 cases of HCA MRSA bacteraemia in the Trust (Exhibit 1).

Exhibit 1: NuTH Cumulative MRSA Bacteraemia 2015-16

![MRSA Bacteraemia - Cumulative Performance April 2015 to March 2016](image)
All cases were reviewed in Serious Infection Review Meetings (SIRM) and key lessons disseminated to departments and to the Trust as a whole. All cases were in-patients with previous history of colonisation and the majority had significant comorbidities and serious long term illnesses requiring complex treatment. On review, documentation was sometimes lacking for cannulation insertion and on-going care; there were two cases where initial antibiotics did not cover MRSA in patients with known previous carriage. There were also lessons to learn in two of the cases regarding appropriate and timely prescription of topical eradication therapy.

Exhibit 2: Trend over 9 years of MRSA bacteraemia

The overall reduction in MRSA bacteraemia is due to a large number of interventions including:

- Comprehensive use of eradication therapy;
- Continued monitoring of hand hygiene;
- Use of Aseptic non touch technique (ANTT);
- Application of the Matching Michigan strategy in clinical areas involved with insertion / management of central lines;
- Education and training in insertion and management of peripheral IV cannula;
- Reviewing and ensuring use of chlorhexidine skin decontamination in theatres;
- Enhanced environmental cleaning; and
- Ensuring correct pre-operative antibiotics are given for high risk procedures.

All of these initiatives are under active review and where possible are audited.

In 2014 national guidance related to MRSA admission screening recommended a more targeted approach. Following a risk assessment at IPCC, the Trust moved away from universal screening and adopted a focused approach in clinical areas deemed to be moderate-high risk. Compliance monitoring of MRSA admission screening continues and monthly compliance reports are circulated to all Directorates.

**Clostridium Difficile (C. difficile)**

C. difficile (gram-positive, spore-forming anaerobic bacilli) can be part of the normal flora in human bowel (3% in healthy adults, 16-35% in hospitalised patients). It is the leading identified cause of nosocomial (hospital-acquired) diarrhoea and is associated with antibiotic therapy. Clinical problems range from mild severe diarrhoea, pseudo membranous colitis to toxic mega colon and fatal colonic perforation. The pathogenesis of C. difficile is multi factorial, involving altered bowel flora due to antibiotics use and production of toxins (A and B) by overgrown C. difficile in a susceptible host.

Risk factors include:

- Older patients;
- Increased severity of underlying disease;
- Non-surgical gastrointestinal procedures;
- Presence of naso-gastric tube;
- Anti-ulcer medications;
- Intensive Care Unit patients;
- Duration of hospital stay;
- Duration of antibiotic course; and
- Administration of multiple antibiotics or multiple courses.

The national incidence of C. difficile prior to 2007 rapidly increased, since then rates of C. difficile have declined dramatically but there has been a small increase observed in recent years. All cases of C. difficile in patients over the age of 2 and occurring 48 hours after admission are attributable to the Trust and are mandatorily reported to the Public Health England via the national Data Capture System. There has been a year on year requirement to reduce the incidence thus reflecting improved levels of hygiene and adoption of prudent antibiotic stewardship.

The Trust’s nationally set target for the year 2015/16 was 77. Unfortunately this target was exceeded and the end of year total for the Trust was 95 cases. However, 27 of these cases were successfully appealed on the basis that there had been no lapses in care and were therefore deemed as unavoidable, bringing our year-end number of HCA C. difficile to 67 cases (Exhibit 3). The appeals process was set up in recognition of the fact that some cases of C. difficile are difficult to avoid as a significant proportion of the population carry C. difficile and patients in hospitals sometimes require life-saving antibiotic treatment which leads to C. difficile associated diarrhoea. Overall our rate of infection was a little above the national average rates, but similar to rates at other large teaching hospitals nationally, at around 19.3 cases/100,000 bed days.

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To aid organisational learning, the cases were also presented at Patient Safety Briefings, to Matrons, Clinical Directors, IPC Link Staff, via other Trust forums and newsletters.

There has been a significant reduction in the number of MRSA bacteraemia over a number of years. Exhibit 2 shows the year on year reduction in bacteraemia from over 70 cases 2006/7 to 5 in 2015/2016, with the numbers of the last three years being low and stable. Reducing the number of MRSA bacteraemia to zero is a significant challenge.
“The Trust had infection prevention and control policies, which were accessible, and used by staff. Across both acute and community services patients received care in a clean, hygienic and suitably maintained environment.”

(Care Quality Commission, June 2016)

Exhibit 3: Monthly Cumulative *C. difficile* 2015/16

![Monthly Cumulative C. difficile 2015/16](chart1.png)

The trend is of improving numbers; however, the number of cases over the last three years has increased slightly (Exhibit 4). This probably reflects the initial gains made by overall improvements in IPC practice and antibiotic prescribing and the consequent smaller gains due to difficulty in eradicating *C. difficile* from the population and engraining good practice in the organisation.

Exhibit 4: 9 year cumulative *C. difficile* totals to 2015/16

![9 year cumulative C. difficile totals to 2015/16](chart2.png)

*C. difficile* has been the focus of a number of learning events over the past year and has been a regular topic at the Patient Safety Briefings. It has been highlighted in a number of forums including Clinical Policy Group (CPG), clinical governance meetings and a range of Nursing Forums.

The majority of cases of *C. difficile* in this period have been reviewed in SIRM following completion of a root cause analysis (RCA) tool; RCA were completed on all 94 cases. On a quarterly basis RCAs are summarised, presented to the IPCC and a quarterly HCAI Report is produced that highlights the main learning outcomes, this is disseminated to all Directorates and key findings communicated via the IPC Matrons Forum and CPG. The major issues identified are:

1) **Appropriate antibiotic prescribing:** This is generally good, 79% of antibiotics were prescribed entirely appropriately. There were a number of instances where the course was prescribed for too long or there was some inappropriate prescribing for the indication.

2) **Early isolation:** The majority of patients were isolated at onset of diarrhoea (66%), where isolation has not been achieved this is reviewed. On ITU the lack of isolation is due to the fact that a large number of patients have diarrhoea and therefore an active multi-disciplinary review is required to assess the need for isolation. On other wards there have been occasions when there has been difficulty in isolating a patient due to lack of isolation rooms. Isolation is essential and this has been fed back to directorates.

3) **Specimen Delay:** In 75% there was no delay in the stool specimen being taken or getting to the laboratory. The Microbiology laboratory closely scrutinise stool sample transit times to ensure timely *C. difficile* diagnosis and subsequent management; this identified delays in the system, particularly at the weekend. In collaboration with the Service Improvement Team, laboratory staff, porters and clinical staff, the process was mapped and this has led to an improvement through ensuring porters come to the wards routinely and introducing...
a specimen box on each ward. Transit times have improved significantly with far fewer samples taking >48hrs to reach the lab (3.2% down to 1.9%) and the majority arriving within 12hrs (92.1%) Other problems in specimen collection have occurred due to difficulty in obtaining a sample due to incontinence. In some cases diarrhoea was considered secondary to laxatives therefore samples were only referred to microbiology after these have been stopped.

Overall the number of stools sent to the laboratory for testing has increased with 4581 samples tested in 2015/16 compared to 4432 in 2014/15.

An audit, based on the *C. difficile* Saving Lives audits, is performed weekly following all hospital acquired *C. difficile* cases. These audits are undertaken for two weeks and focus on practice, knowledge and cleanliness. Generally, audits of cleanliness following cases reveal high standards of environmental cleanliness.

Period of increased incidence (PII – defined as more than one case of *C. difficile* within 28 days) are reported and investigated urgently with meetings between ward sister, microbiology, IPCN and senior clinicians. There have been seven PII across the Trust this year; these have been investigated through RCA and PII meetings leading to actions such as increased environmental cleaning along with environmental screening and audit of antibiotic usage on the wards involved. Ribotyping of isolates has indicated that there is no relation between cases on the same ward in some of the cases where a PII was initially identified. The affected clinical areas undergo “deep cleaning” along with repair and replacement of any damaged furniture and/or potentially contaminated equipment. The learning from all PIs is disseminated to all appropriate personnel.

There are Integrated Care Pathways (ICP) for patients with diarrhoea and *C. difficile* to enhance delivery of high quality patient care and ensure consistency across all disciplines. This documentation is used in conjunction with the *C. difficile* Infection Management Policy and clinical algorithm complying with the DoH document “Clostridium Difficile infection: How to deal with the problem” and the update guidance on the diagnosis and reporting of Clostridium difficile (2013). The annual audit to monitor completion compliance demonstrated 86% completion of all sections of the *C. difficile* ICP. All audit findings are disseminated Trust-wide.

In line with the recommendations from the Chief Medical Officer, arrangements continue in relation to death certification and *C. difficile*. Consultants of any patient where the cause of death is attributable to *C. difficile* are required to complete the death certificate and an RCA. This is subject to review by the DIPC and the Nursing and Patient Services Director. This applies to both parts 1 and 2 of the death certificate and all are reported to the Commissioners as serious untoward incidents (SUI). SIRMs have been carried out for all cases of *C. difficile* related deaths and in cases where problems have been identified in the RCA. Lessons learnt from these are distributed through the quarterly HCAI report to CPG and Matron Forum.

Whilst on ward visits, the IPCNs continually promote best practice and disseminate key messages from the RCA process. There was also a *C. difficile* awareness campaign across acute and community settings during September and October; this included a series of ward-based roadshows with interactive activities to encourage staff engagement. There was a specific focus on antimicrobial stewardship, *C. difficile* prevention and management for junior doctors and within Care of the Elderly. IPC link staff were involved in raising awareness in relation to diarrhoea management to support staff in identifying risk factors to prevent occurrence of *C. difficile*.

An annual *C. difficile* action plan is developed and progress is reviewed 6-monthly by IPCN, Healthcare Scientist, Infection Prevention and Control Doctors, Antimicrobial Pharmacist, Deputy Director of Nursing, DIPC and the rest of the IPCC. This is a robust and active document with objectives as indicated below:

- To monitor prompt isolation of symptomatic patients and appropriate use of personal protective equipment;
- To gain assurance around appropriate antibiotic usage within Newcastle Hospitals;
- To ensure that Newcastle Hospitals policies are current and reflect national guidance and to raise awareness in all groups of staff to promote compliance with;
- To ensure all equipment and the environment are decontaminated effectively;
- To ensure only clinically appropriate specimens are investigated;
- To review testing against national guidance; and
- To monitor and analyse practice regarding management of patients prior to and following confirmed *C. difficile*.

This Trust-wide team approach has been demonstrably effective in reducing the incidence of hospital acquired *C. difficile* infection however commitment must remain to ensure further necessary improvement.
Aseptic Non-Touch Technique (ANTT)

The principles of the Saving Lives strategy continues to be built upon and consolidated with clinical leads in all areas.

Aseptic Non-Touch Technique (ANTT) as a principle to underpin asepsis is incorporated into the Breeze e-Learning packages, with links to ANTT guidelines. All nursing and allied health professionals who undertake procedures requiring asepsis undertake competency in ANTT. To also ensure that the Trust is assured that medical staff understand and are competent in this important process, ANTT assessment of all F1 doctors during their induction period was introduced in 2013. This process is being extended this year to ensure that all junior doctors are assessed.

ANTT observational audits have been undertaken in both acute and community settings, both of which indicate that the process has been embedded into practice in the majority of areas. However additional work is required to ensure full compliance in elements such as documentation. All audit results are fed back to IPCC, CPG, Matrons and SR/CN/ Clinical Leaders Forum.

Step-by-step guidelines for commonly performed aseptic procedures are available from the intranet and in all clinical areas to enable application of ANTT.

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Clinical Assurance Toolkit (CAT)

The CAT is now well established within the organisation as a Trust-wide tool to provide continuing clinical assurance to the Trust Board as an overview of performance for each ward/department and Directorate. The aim of the CAT is to measure and demonstrate compliance with the published documents and national drivers as well as providing useful data to support, verify and offer assurance for external inspectorates.

Where appropriate, community services have moved over from Essential Steps to CAT. Where this is not appropriate, staff continue to complete Essential Steps on a quarterly basis and results are reported to IPCC. The reports demonstrate good compliance with IPC policies.
Hand Hygiene

All members of staff in the Trust are required to consistently and without exception adhere to and practice good hand hygiene practices, including compliance with the "5 Moments for Hand Hygiene". This is vital to ensure a safe environment for patients, visitors and staff by reducing the transmission of potentially harmful microorganisms.

Hand hygiene audits are now incorporated into CAT with staff undertaking monthly self-assessment audits which monitor adherence to Bare Below the Elbow (BBE), opportunity and technique. These audits have continued to demonstrate sustained improvement and compliance (the majority of areas achieve >98% compliance). Where compliance is not >98% an action plan is requested and a monthly 'by exception' report is submitted to IPCC by the Matron IPC.

There are additional Hand Hygiene Validation Audits which are undertaken by the IPCNs across all Directorates and the findings of which are reported to IPCC on a quarterly basis.

Antibiotic Prescribing

The Antimicrobial Stewardship Steering Group (AMSG) meets quarterly and continues to monitor antibiotic usage. Total antibiotic usage has remained stable (Exhibit 5) despite increased patient numbers. The use of the CERNER electronic prescribing (EP) system plays a large part in the implementation of the restrictions in antibiotic usage, with the utilisation of pop up messages and mandatory fields for indication and duration. The Rx Guidelines App was introduced in August 2016 to improve accessibility to Trust antimicrobial guidelines. A monthly clinician-led audit programme (‘Take Five’) was introduced in December 2015.

Exhibit 5: Total Inpatient Antibiotic Use

A CQUIN introduced in April 2016 aims to reduce total antimicrobial usage by 1%, piperacillin/tazobactam usage by 1% and carbapenem usage by 1%. This is from levels in 2015/16, all expressed as Defined Daily Dosage/1000 Admissions. Another target is to achieve documented review of antibiotics within 72hrs to over 80% by the end of the year.

A working group has been set up and this has led to a number of actions:
• Review of antibiotic usage and confirmation of usage data across the Trust;
• Review of guidelines to reduce emphasis on target antibiotics;
• Review of key patient groups who are prescribed target antibiotics by microbiology and acute medicine, partly facilitated by PowerChart; and
• Messages to all prescribers to ensure that they are aware of the need to take cultures and prescribe appropriately and then review within 72hrs.

These actions have led to a significant reduction of target antibiotics and compliance with first quarter review of antibiotics within 72hrs target. Reduction of total Trust usage continues to be reviewed albeit is most challenging to improve upon further.

Exhibit 5: Total Inpatient Antibiotic Use

Total Inpatient Antibiotic Use

<table>
<thead>
<tr>
<th>Month</th>
<th>Grand Total</th>
<th>Grand Total IV</th>
<th>Grand Total PO</th>
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<tr>
<td>Apr 13</td>
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</tr>
<tr>
<td>Sep 13</td>
<td>1000</td>
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</table>

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Guidelines and policies continue to be reviewed through this group to further restrict higher risk antibiotics, with a view to lower the risk of *C. difficile* infection.

Antimicrobial stewardship from committee and policy level to the prescription at the bed side is promoted across the Trust. The need for indications for antibiotics, their course duration, review at 48-72hrs and the importance of culture prior to initiation has been emphasized in a number of forums. The ‘Start Smart and Focus’ agenda is followed. These messages are incorporated into the Breeze education package and included in CAT. Antibiotic guidelines are now widely available to all antibiotic prescribers through the Rx Guidelines package. Trust Antimicrobial Stewardship webpages are also in development.

The Trust continues to support European Antibiotic Awareness Day and World Antibiotic Awareness Week in November and further activities are planned this year.

Antimicrobial prescribing education continues with direct teaching sessions throughout the Foundation Programme, and to other key medical groups such as ‘Preparation for Practice’ in MBBS, Core Medical Trainees and the Newcastle Surgical Rotation. Key messages about antimicrobial stewardship are incorporated into induction for all staff.

It is mandatory to specify intended duration of an antibiotic prescription on PowerChart and there are a number of order sets for common infections which ensure standard courses of antibiotics are given. IV antibiotics have a review pop-up after 48hrs to ensure early IV to oral switch where appropriate. Proton pump inhibitors may increase risk of *C. difficile* infection; if proton pump inhibitors are prescribed for someone receiving antibiotics, a pop-up is triggered to warn of this potential risk and reminds doctors to review.

Antimicrobial Leads have been appointed in many clinical areas and are key to dissemination of messages to staff members and audit of antimicrobial usage in their areas. Completion of appointments to all clinical areas is anticipated.

A ‘Take Five audit’ has been introduced across the trust in all clinical areas. The audit aims to review the appropriateness of antibiotic prescribing and review in five patients receiving antibiotics every month on every ward. Audits have shown >95% compliance with appropriateness and stop and review and around 80% with appropriate sampling for culture.

The Trust has made sepsis a priority and work is underway to improve the management of sepsis which should in turn increase the appropriateness of IV antibiotic prescribing. A CQUIN that aims to improve treatment of sepsis nationally has led to a working group that has improved dose of first dose of antibiotics within 1hr in severe sepsis to >70%.

The Antibiotic Stop/Review and Indication Policy was first introduced in August 2007. Compliance with “Stop” dates is now greater than 95% on wards using e-prescribing.

Review of the Year 2015/16
Estates

The IPC Team work in collaboration with the Estates Department to review new building works, water and environmental issues to ensure a safe patient environment is established and then maintained. Regular meetings occur between ICD, IPCN and Estates representatives. The Trust Water Safety Group and Decontamination Group are well established and more recently a Trust Ventilation Group has been convened.

The delivery of the Trust’s ward refurbishment programme remains a challenge both in terms of feasibility and the increase of in-patient numbers. At present there is a decant ward available on the Freeman Hospital site, however the same facility is not available to the RVI although across site decant is an option that has been utilised.

In 2015/16 there were four ward refurbishments completed within the Trust, Wards 49 and 52 (RVI) and Wards 2 and 3 (Freeman) with the following decant programme i.e.

**Phase 1**
- Ward 49 (RVI) refurbished with decant to Ward 17 (Freeman)
- Ward 3 (Freeman) refurbished with decant to Ward 7 (Freeman)

**Phase 2**
- Ward 52 (RVI) refurbished with decant to Ward 49 (RVI)
- Ward 2 (Freeman) refurbished with decant to Ward 7 (Freeman)

The works to Ward 49 (RVI) included reconfiguration to the ward to provide a suitable nursing station area, larger beverage bay, a new treatment room and walk-in wet room toilet and showers. The works to Ward 52 (RVI) and Wards 2 & 3 (Freeman) included reconfiguration to the ward to provide a suitable nurse station area, increased storage and walk-in wet room toilet and showers. The refurbishment works include upgrade to all mechanical & engineering services and building finishes including compliance with the latest dementia guidance where appropriate.

The challenge moving forward to facilitate the Ward refurbishment programme is for a decant strategy to provide access for Estates to carry out the works and a review of the programme clinically to determine suitability of the proposed refurbishments.

**Water Safety Group**

A multidisciplinary Trust Water Safety Group is now well established with a remit to ensure safety of water supply on all Trust sites. Regular reports on water issues have been set up to provide assurance that water is safe and testing occurs appropriately across the Trust. This group ensures compliance with national guidance such as the Health and Safety Executive’s approved Code of Practice and current and relevant Health Technical Memoranda such as HTM 04-01; Safe Water in Healthcare Premises (Parts A, B and C). These are reflected in the Water Safety Plan which is now complete and being implemented.

An independent Authorising Engineer (Water) is formally appointed in writing, along with Responsible Persons within Estates and nominated Water Safety Group attendees. Each appointment comes with designated responsibilities. A dedicated Water Quality Team has been established within Estates to improve management and control of waterborne pathogens throughout the Trust reporting to the Head of Environmental Management, and appointed Responsible Person (Estates). The Water Quality Team include Deputy Responsible Persons (Estates) covering our major hospital sites and community premises. An external company (currently industry leaders Hydrop and our AE(W)) have indicated a significant improvement in levels of assurance and control.

**Legionella and Pseudomonas Risk Assessments**

Documented Legionella risk assessments for each of the Trust’s buildings are held, as well as Pseudomonas risk assessments for the Freeman Hospital and RVI sites (for augmented care areas), however these are due for re-risk assessment this year. Whilst a considerable amount of work has been undertaken to complete remedial actions identified in the risk assessments there still remains a number of actions outstanding. Progress towards these are updated monthly to the Water Safety Group.
Microbiological testing of water samples for both Legionella & Pseudomonas continues. There is a robust process by which abnormal results are received from the PHE labs into Estates and immediately notified onto the relevant site ICD for agreement of any remedial works that are to be carried out, where necessary.

Pseudomonas testing takes place six monthly in all augmented care areas and the same process of ICD notification and agreement of remedial work takes place.

In addition to this, a procedure has been established to notify both the Medical Director and Nursing & Patient Services Director of any significantly high microbiological counts from water test results, and a summary of the ICD/Estates agreed remedial work to rectify the problem.

The water systems within dental surgery chairs have been reviewed and a more robust policy developed to ensure that these are decontaminated effectively.

**Ventilation Safety Group**

The requirement for a more robust response to ventilation has been identified and a Ventilation Safety Group established to provide assurance and advice to Trust Board on all matters relating to ventilation, ensuring the organisation undertakes efficient, compliant and cost effective Trust-wide ventilation management activities, consistent with legislation, national guidance and best practice. The Terms of Reference have been ratified by IPCC and facilitate closer working between Estates and Microbiology to highlight areas of concern and ensure remedial work is carried out in a timely way.

An active database of ventilated areas is being developed to ensure that all areas of specialist ventilation have adequate air exchanges and when problems are identified a comprehensive plan of action developed.

**Taps**

It has been recognised over recent years that Thermostatic Mixing Valve (TMV) taps can increase the risk of colonisation with Legionella & Pseudomonas; a Trust standard non-TMV tap has been agreed and a gradual programme of tap replacement, in the retained Estate, is planned and will occur as refurbishment of the Wards funding progresses. However, TMV taps in the PFI Estate are widespread and the quote for complete replacement with Trust-standard non-TMV taps is proving to be cost-prohibitive (over £700,000). This has been entered on the Risk Register by the Water Safety Group, with a current agreement to replace colonised taps for Trust-standard non-TMVs via individual risk assessments by site ICDs.

Chilled drinking water outlets are known to be at risk of colonisation by waterborne pathogens, particularly when they are underused or at the end of long pipe-runs (susceptible to stagnation and heat gain). The Trust chilled water outlets are under review, with plans to remove/re-site those at higher risk of colonisation whilst still maintaining access to safe drinking water for staff and patients.

**Community Premises**

There is on-going work with the Estates Department via the Community Environmental Action Team (CEAT) to monitor standards in Community Premises not coming within the freehold of the Trust and to clarify appropriate escalation process ensuring any shortfalls are addressed in a timely manner. There have been continued difficulties in escalation of identified issues and this challenge is being addressed at a local and national level.

**Surveillance**

Mandatory surveillance and reporting by the Trust is now required for the following HCAI:

- C. difficile;
- MRSA bacteraemia;
- MSSA bacteraemia; and
- E.coli bacteraemia.

Declaration of MSSA (Methicillin-Sensitive Staphylococcus Aureus) bacteraemia has been mandatory from January 1 2011 with mandatory E.coli bacteraemia reporting from June 1 2011. Currently there are no targets associated with MSSA or E.coli bacteraemia.

The Department of Health is using this information to establish baseline trends for both infections. This has shown that we have below average rates of hospital acquired E.coli bacteraemia with a rate of 86.6 bacteraemia per 100,000 bed days (compared with national average of 110.1 per 100,000 bed days). We continue to highlight ANTT in the use of urinary catheters with training on ANTT/e-Learning packages.
highlighting this. We have ensured the policy on antibiotic prophylaxis for catheter changes is robust. There continues to be a drive to improve management of urinary catheters in a selection of Care Homes across the city via the Specialist Care Home Support Team.

In collaboration with clinical staff and the Continence Team, there has been an evaluation of the HOUDINI Framework; this framework prompts staff to review daily the need for a urinary catheter to ensure safe and early removal. Draft documentation was successfully piloted in Musculoskeletal and Neurosciences Directorates and the final draft was approved by the Clinical Records Advisory Group. Implementation of this document was suspended as it was anticipated there would be a national tool available in autumn 2016, however this is not yet available and the group has recently reconvened in order to progress within the Trust.

MSSA bacteraemia appear to be higher than other Trusts, when the rate is reviewed, Newcastle Hospitals are above average (36.2 per 100,000 bed days compared with a national average of 30.6 per 100,000 bed days). The two areas that have the largest number of MSSA bacteraemia are the Renal and Cardiothoracic Directorates reflecting the large number of intravenous lines used in these areas, the vulnerability and multiple comorbidities of these patient groups. These two areas are being targeted with more intense review of processes to ensure compliance and share good practice.

A large amount of work has been undertaken to screen for MSSA in vulnerable groups and use of chlorhexidine washes in high risk patients is occurring in Renal and Cardiothoracic.

SIRM are used to investigate bacteraemic episodes where IPC issues are identified. Around 36% of bacteraemia are associated with invasive devices, it has been highlighted peripheral cannula documentation is not always completed. Any lessons learnt during the SIRM or in RCA are promptly fed back to directorates.

As highlighted above, there is a specific focus on ANTT to try and improve compliance and reduce rates of MSSA bacteraemia.

Matching Michigan is a quality assurance tool for the audit and improvement of urinary catheters, to prevent catheter related blood stream infections (CR-BSI). This tool has been introduced in areas of high use across the Trust and as a consequence there stable numbers of line associated bacteraemia rates in Haematology, Oncology and Paediatrics. In all adult ICCUs across the Trust where ‘Matching Michigan’ has been in place for some time, the rates of infection have remained below the ‘Matching Michigan’ rates in adults across the trust (0.77/1000 catheter days in February 2016).

Mandatory reporting of orthopaedic knee and hip surgical site infections (SSI) and voluntary reporting of Spinal SSI via the Public Health England Surgical Site Infection Surveillance Service continues on a quarterly basis. The Trust is continuing to perform well nationally for elective total knee replacements (average 0.3% over the year vs 0.9% national average) and elective total hip replacements (average 0.4% over the year vs 0.9% national average).

There have been higher rates of SSI in patients undergoing spinal surgery in two quarters of last year. The last quarter saw rates of infection of 2.6% vs national average of 1.5%. Some of this increase may be related to case mix; however, it is clear from the data that reduction of infection is possible. A further multi-disciplinary review is planned with audit of pre-op preparation, theatre practice and post-op processes. Information leaflets have been developed for patients regarding infection. There has been an expansion of the spinal ward to increase side rooms and allow for complex patients to be a managed in a 4 bedded bay to improve the overall management of these patients. Meetings are planned over this year to ensure there is sustained action to reduce the spinal SSI rate.

There are plans to expand SSI surveillance to include the Cardiothoracic Directorate over the next year.

In addition, the IPC Healthcare Scientist has established a comprehensive surveillance programme for all “alert” organisms. Microbiology culture results are used to populate monthly spreadsheets which are used as indicators of clinical quality assurance. The IPC team responds proactively to any demonstrable change. Microbiology data collation is an expanding service that reacts promptly to any new Trust-wide requests.

Examples of “alert” organisms under continual surveillance are:

- Invasive Group A Streptococci (IGAS);
- Mycobacteria, and
- Multi-drug resistant gram negative bacteria.
Multi-Resistant Organisms
Carbapenemase-producing Enterobacteriaceae (CPE)

Carbapenemase-producing Enterobacteriaceae (CPE) are highly resistant bacteria and are recognised as a growing problem both nationally and internationally; patients may be colonised with this organism and in hospitals transmission can occur. Newcastle Hospitals has implemented the Public Health England (PHE) CPE Toolkit in the acute setting. There is an established screening protocol for patients who have been admitted to hospital outside the North East of England in the previous 12 months to ensure that where identified, a patient carrying CPE can be managed appropriately to ensure transmission does not occur. To assist clinical staff in identifying high-risk patients, a prompt has been included in part of the Trust admission documentation.

The IPCN team have undertaken education and training on all in-patient wards to support implementation of the CPE Policy to aid compliance with this important preventative measure. An audit was undertaken in January 2015 on all in-patient areas to assess compliance with completing the CPE risk assessment. The findings demonstrated only 65.6% had the risk assessment completed, however management of at risk patients was good. Work continues to raise awareness of this relatively new guidance.

Norovirus

As expected, frequent cases of Norovirus have been identified throughout the year. In total 29 outbreaks were reported from all three main hospital sites over the course of 2015/16. A proactive approach is being taken with biannual meetings, one after the Norovirus season in spring to review the practices and issues that have arisen and the second in autumn to look at practices for the forthcoming winter. This involves representatives from acute admissions and Emergency Department (ED), bed managers and IPC team.

Influenza/Measles/Novel Coronavirus

Influenza remains a sporadic problem, with increased admissions to the Trust over winter 2015/16 in comparison with 2014/15.

Routine point of care testing for influenza was introduced on RVI Medical Assessment Unit. This has had a significant impact. Earlier availability of results has improved time to isolation and treatment. Issues remain regarding a lack of isolation capacity in the Assessment Unit.

Fit testing of FFP3 masks occurs in appropriate clinical areas delivered by a trained fit tester, although review of compliance shows continuing shortfalls in trained staff, this is being escalated through directorates. New guidance on use of PPE has been reviewed and where appropriate incorporated into a Newcastle Hospitals policy.

A CQUIN for 2016 has been introduced to increase front line staff vaccination against influenza. This is recognised to be a challenge and a working group has been set up led by Occupational Health. There will be a drive to enhance vaccination through information, clinics, peer vaccinators and incentives to have vaccination. A review of reasons why vaccination was not taken up last year has taken place and learning from this will be incorporated into the plan.

Occupational Health continue to screen all new staff members for evidence that they have been vaccinated or are immune to measles, no significant outbreaks have occurred this year.

Novel Coronavirus (MERS) is identified as a potential threat and advice about identification of patients has been circulated to admissions areas. There is a robust mechanism of dissemination of information including testing and treatment algorithms for novel infections and plans for the management of cases are being developed to ensure readiness; relevant staff are trained in PPE.

Viral Haemorrhagic Fever (VHF) (including Ebola)

Although the Ebola outbreak in West Africa is no longer prevalent, Newcastle Hospitals continues to be one of the High Level Isolation Units able to take patients with VHF infections. Newcastle are now the main receiving centre in the UK for paediatric VHF cases as they are the only centre with paediatric specialty on site. At present there are 4 high level isolation suites and a purpose built Trexler Isolation Unit housing two Trexler Isolators. The Trust is in a position to care for patients with any hazard Group 4 pathogen and a substantial legacy has been left from this work. There are also plans under development for a new Category 4 Emergency Infection Unit with construction set to begin in late 2016.

The safety of staff members has been the utmost priority and staff continue to undergo training appropriate to their role. A Nurse Educator has been appointed with a remit to ensure that training is ongoing and kept up to date.

Throughout the summer months of 2016 we are the main centre for admission of patients with these pathogens while the Royal Free unit is closed for maintenance/refurbishment.

In preparation for this an exercise with NHS England, Public Health England (PHE), the Health and Safety Executive (HSE), RAF, The Royal Free London, NEAS and other agencies was undertaken to test internal and external processes for the management of these cases with very positive outcomes.

There continues to be a large number of challenges which we are well placed to meet
The temporary availability of a decant Ward at Freeman Hospital has enabled a rolling, deep cleaning programme during early 2016; this has now been suspended to facilitate ward refurbishments but it is anticipated this will re-commence next year following winter pressures activity.

Monitoring of cleanliness standards is performed by a range of Trust audits and the annual Patient-led Assessments of the Care Environment (PLACE); these assessments and audits adopt a multidisciplinary approach comprising Nursing, Hotel Services, Estates and patient representatives. In addition, the Matrons ‘Monthly Checklist’ has been incorporated into CAT to provide further evidence of environmental and decontamination compliance. There is also an established Theatre Cleanliness Inspection programme led by the IPCNs to ensure a regular review of all theatre departments on both RVI and FH sites.

Hotel Services continue to use ‘Credits for Cleaning’ to monitor cleanliness standards in all clinical areas on a monthly basis. ATP monitoring to test for presence of residual organic matter following cleaning has been introduced as an additional objective measure to complement regular visual inspections of cleanliness standards and to monitor the effectiveness of cleaning.

All mattresses in clinical areas are subject to an annual audit conducted by Tissue Viability. In addition mattresses are inspected by ward staff on a quarterly basis. Further assurance is also provided by CAT on a monthly basis.

Education and Training

Education and training continues to be one of the key elements of the IPC strategy to reduce HCAIs. Ensuring that staff have knowledge and understanding of correct infection prevention and control practice is fundamental to its implementation.

Education and training has been provided throughout the year in the following ways:

- **e-Learning**
  - IPC mandatory training has been delivered to the all staff through on-line training programmes which are reviewed on an annual basis. There have been six bespoke programmes for several years to meet the educational needs of different staff groups. These programmes have now been renewed and increased to seven, with collaboration between the IPCNs and the Training and Workforce Development Department, to give a fresh new look to the programmes, ensure the information is current and evidence based and to facilitate greater user engagement.
  - The programmes are now:
    - Infection Prevention and Control AHP 2015-2016 – for allied health professionals;
    - Infection Prevention and Control Community 2015-2016 – for community staff who deliver physical patient care;
    - Infection Prevention and Control Dental 2015-2016 – for staff who work have patient contact and in the dental hospital or community dental practices;
    - Infection Prevention and Control HCA-Support 2015-2016 – for HCAs & support workers;
    - Infection Prevention and Control Medical 2015-2016 – for medical staff;
    - Infection Prevention and Control Nursing and Midwifery 2015-2016 – for registered nursing and midwifery staff; and
    - Infection Prevention and Control Non Clinical 2015-2016 – for staff who work in a non-clinical capacity / do not deliver physical patient care.
  - Face-to-face training is delivered to the Governors and Trust board members.
  - Monthly data monitors compliance and ways of improving compliance are being reviewed at present.

- **Infection Prevention and Control**
  - Community 2015-2016 – for community staff who deliver physical patient care;
  - Dental 2015-2016 – for staff who work have patient contact and in the dental hospital or community dental practices;
  - HCA-Support 2015-2016 – for HCAs & support workers;
  - Medical 2015-2016 – for medical staff;
  - Nursing and Midwifery 2015-2016 – for registered nursing and midwifery staff; and
  - Non Clinical 2015-2016 – for staff who work in a non-clinical capacity / do not deliver physical patient care.

- **Non Clinical**
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- **Medical**
  - 2015-2016 – for medical staff;

- **Nursing and Midwifery**
  - 2015-2016 – for registered nursing and midwifery staff;

- **Infection Prevention and Control**
  - Community 2015-2016 – for community staff who deliver physical patient care;
  - Dental 2015-2016 – for staff who work have patient contact and in the dental hospital or community dental practices;
  - HCA-Support 2015-2016 – for HCAs & support workers;
  - Medical 2015-2016 – for medical staff;
  - Nursing and Midwifery 2015-2016 – for registered nursing and midwifery staff; and
  - Non Clinical 2015-2016 – for staff who work in a non-clinical capacity / do not deliver physical patient care.

- **Face-to-face training**
  - is delivered to the Governors and Trust board members.

- **Monthly data monitors compliance and ways of improving compliance are being reviewed at present.**
Induction

The IPCNs deliver mandatory training to non-clinical staff during induction, while the other groups of staff undertake their on-line mandatory training.

The IPC Nurses also deliver training to Year 1 Foundation Doctors, new nurses Preceptorship nurses, student nurses, Project Choice and work experience students during their induction process and medical students during their 1st, 2nd, 3rd and 5th years on a variety of subjects. The IPC team are working with HR to improve the process of giving information to medical staff entering the trust. There is input into the Trust induction programme for all staff entering the trust. We are currently introducing mandatory ANTT assessment for all medical staff entering the Trust.

Healthcare Assistant (HCA) Academy

It is recognised that the healthcare assistants have a vital role in the delivery of clean safe care to our patients, and as such the continued education and training of this group of staff is essential. The IPC Nursing team continue to support the HCA Academy through their delivery of IPC workshops.

IPC Education Forum

Following a review of the format of the forum it was re-launched in September 2015 and has had four meetings this year to deliver multi-disciplinary education sessions by internal and external speakers on key IPC issues, including, Sepsis 6, Influenza epidemiology and management and reduction of urinary catheter associated infections.

IPC Link Group (IPCLG)

The IPCLG members (approx. 250) are multidisciplinary staff who support the IPC team within their wards/depts. The IPCLG (acute) were meeting on a monthly basis where the IPCNs communicated and discussed new initiatives, changes in practice /policy and concerns over areas of poor IPC practice. As attendance at the group was becoming difficult for staff, particularly from in-patient wards, the group now meets twice a year and communications are delivered via a bulletin which can also be easily shared with other staff. The IPCNs also meet with their link staff in their place of work on a regular basis.

The IPCLG (community) meets bi-monthly and includes staff from Trust community services and also staff from Nursing and Residential Homes in the Newcastle area.

Annual study days are held for acute and community staff to provide the foundations for new link staff and enhance the knowledge of our current staff. Both days were very well evaluated and had unprecedented attendance this year. There was particular engagement of the staff from residential and care homes which will assist in the reduction of HCAI related admissions such as CAUTIs, through increased knowledge and understanding of how these infections can be prevented.

Medical Staff

The IPC team have participated in the education and training of medical staff through the following:

- Hand hygiene education and training sessions to medical students in their 1st, 2nd, 4th and final year;
- A specific IPC workshop in venepuncture, cannulation and other IPC practices, is given to EJR students during their 3rd year by IPC Nursing team, Clinical Educators and Medical Education team;
- IPC session to 3rd year medical students during the ID placement;
- Individual IPC education and training to each new F1 doctor during their shadowing week, including an ANTT assessment programme for all junior doctors; and
- Microbiology trainees shadowing of the IPCNs for a period of time during their training to gain knowledge and expertise in infection prevention and control practice.

Additional Education and Training

Whenever there have been concerns about rising HCAI levels in specific areas or Trust-wide the IPC team have responded appropriately to address any gaps in knowledge and training. This has resulted in many extra education sessions on a variety of subjects, including hand hygiene, at ward / department level. Training has also been delivered to Estates staff on IPC issues and water safety.

There have been a large number of ad-hoc meetings with departments by various members of the IPC team and Trust management to ensure that key messages are disseminated. All members of staff are encouraged to challenge where they see poor practice.

The IPC team continue to work proactively and collaboratively throughout the organisation to improve communication, education and training in IPC practice in order to create a work force that is fit for practice.

Some of the IPC team have presented at regional conferences and three posters were presented at the International Infection Prevention Society (IPS) Conference (2015) covering a range of subjects including C. difficile, CJD/vCJD and Ebola Readiness; one of which (Ebola Readiness) was presented and shortlisted for best poster.

Patients/visitors/carers

Patients, visitors and carers are given education to prevent HCAI through a multitude of IPC information leaflets, the patient C. difficile card, the bedside information sheet; introduced in 2014, posters and via the How we are doing boards.

Conclusion

There continues to be significant challenges within IPC, the IPC team has been integral in responding to these challenges and ensuring good practices seen across the trust are maintained. Staff members continue to be engaged in this process. This is reflected in the CQC report which recognises this integrated approach and the good engagement across the Trust with IPC.

The previous dramatic reductions of the total number of MRSA bacteraemia have been maintained. There is a drive to reduce the numbers of MSSA bacteraemia with a number of planned interventions.

_C. difficile_ remains a great concern from the point of view of HCAI within the Trust, and focus remains on ensuring all staff are vigilant, the environment is clean and antibiotic stewardship is made a high priority. Antimicrobial prescribing is continually reviewed with reduction in prescriptions of target broad spectrum antibiotics achieved and ongoing work to highlight key issues around antibiotic prescribing.

All in all whilst there continues to be a large number of challenges we are well placed to meet with continued engagement at all levels in the organisation to maintain excellent practices.

Dr Ashley Price
Director of Infection Prevention & Control
August 2016

Review of the Year 2015/16 77
Doctor defends strike action

Newcastle junior doctor JOHN MOORE explains why he and his colleagues feel that they had no option but to take part in the doctors’ strike currently affecting the NHS

WHEN you become a doctor it is because you want to help people. No doctor wants to strike, but we’ve been backed into a corner and we have no other choice.

The Health Secretary Jeremy Hunt plans to impose a contract on us that we feel is unfair and, more importantly, unsafe. Patient safety is our main concern and under the proposed contract this will be put in danger.

Let me make it clear - no junior doctor has a problem with working weekends and evenings, we already do.

I work every other weekend in my current job and junior doctors regularly work 12 consecutive day shifts - or seven consecutive night shifts. We all want to feel like we are doing the best possible job for our patients and we know we are not at our best when we’re exhausted.

The proposed contract will have a significant impact on the safe delivery of care to our most vulnerable patients - by putting junior doctors under pressure to work longer hours for less pay.

Mr Hunt says he wants a seven day NHS and that these proposals will help that. We disagree - junior doctors are not a barrier to a seven day NHS.

The new contract forces junior doctors to work increased hours.

In order to make it a true seven day NHS, all professions within it, including support staff and consultants, would need to work these hours.

Our concerns have not been addressed. We feel we have no other option but to take industrial action.

The strike still allows for all emergency care to continue as normal - there’s still about half of the junior doctors providing this care along with GPs and consultants.

To patients who have had their appointments or operations postponed we can only apologise - it’s not a decision we have taken lightly. We believe that the disruption in the short-term is nothing compared to the long-term problems that this contract could cause.

By scrapping the financial penalties to hospital trusts for doctors working over the maximum working hours, junior doctors will end up working longer. Tired doctors make mistakes - this puts patient safety at risk.

Moral is at an all-time low and doctors in training are left feeling undervalued and overworked - many will opt to practice abroad.

If the current contract is imposed then we will lose countless junior doctors - who will either go abroad where pay and conditions are better than in the UK, take time out from the profession, or even leave medicine altogether.

Both Scotland and Wales will not be enforcing the contract, meaning junior doctors in the North East may inevitably be drawn to move north of the border.

This will put more strain and pressure on the NHS in the North East, particularly in under-recruited areas such as GP, A&E, paediatrics and psychiatry.

All these areas are currently desperately short of junior doctors.

The training to become a doctor is long and costly - five years in medical school and then at least five years as a junior doctor to become a GP and eight as a junior doctor to become a specialist.

Many people don’t realise how much junior doctors earn. It’s a starting salary of £22,500, which might seem reasonable, but it doesn’t reflect the level of responsibility or the £70,000 tuition fees. Junior doctors also have to fund any further training - it costs thousands to take exams to become a specialist.

If we had really been offered the 11% pay rise that the government says we will get, we would have no problems accepting this, but this is simply not the case. We have never asked for a pay rise and never expected to get one.

In real terms, the proposals could see a pay cut of 30% for many junior doctors.

If the government wants to make changes to our contract, we want to be treated fairly and be consulted on it - not just threatened with having it imposed on us without our acceptance.

More than 50,000 junior doctors are insisting that this contract is dangerous.

We think the public know better than to trust the spin of this government, and listen when we say it’s not safe, and it’s not fair.

• Dr Moore, 29, lives in Newcastle and works at the RVI. He is married to Kim and has a seven-month old baby boy Alex. He specialises in psychiatry.

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New world opens to Joey as he hears clearly for the first time after surgery

He was also learning to cope with the effects of tinnitus – often described as ‘ringing in the ears’. Joey’s glue ear condition meant that hearing aids were not an effective option. Karin said: “His condition seemed to be getting worse, not better. By the time he was 12 we realised something had to be done if he was to progress.”

Joey was being treated at the Freeman Hospital’s ENT Clinic, where BAHA experts were able to give him a life-line. Karin was keen for her son to undergo the operation, but Joey kept insisting he could manage and didn’t want, or need, yet another surgery.

“As a mother, it was my job to be strong and do what was best for Joey, even though he didn’t appreciate it at time,” said Karin. “Looking back, it’s the best thing we’ve ever done for him.”

The procedure was nowhere near as bad as Joey had feared. He was booked into have an implant inserted, returning home the same day.

Two weeks later, he was back to have his sound processor fitted – and suddenly the world became a different place.

Karin said: “First of all, Mr Johnson, the surgeon, stood behind him and said a few words which, of course, Joey couldn’t hear. Then he put the BAHA on, and went back again. Suddenly Joey could hear what he was saying. I’ll always remember that moment. Joey’s eyes lit up. It was like someone had thrown a light switch.

“I started crying with tears of joy and relief.”

21 years of changing lives:

Newcastle Freeman Hospital’s Bone Anchored Hearing Aid Service reaches its 21st Birthday this year.

Mr Ian Johnson, a consultant ENT surgeon and director of the BAHA Programme, said: “I’m delighted we’ve been able to help so many people over the years, bringing them back into the world of sound. “BAHAs give a much better sound quality than a conventional hearing aid and it’s an absolute joy to hear so many patients tell us how their lives have been completely transformed after having one fitted.”

BAHAs are conduction hearing systems which can help people with hearing loss due to problems affecting the middle ear. Before BAHAs the closest device of its kind was hearing aids. The ENT department at the Freeman Hospital adopted the BAHA pioneering approach 21 years ago and since then, has constantly improved it. Back in the 90s, the surgery used to take around two hours. Now it takes only 20 minutes and in fact there is now a recognised ‘Newcastle technique’ to carrying out the surgery efficiently.

The whole process including surgery leading up to attachment of the device after the wound has healed usually takes up to six days. Newcastle recently made history by being the first in the world to carry out the entire process in just one day for medical reasons.

The reputation the Freeman Hospital’s service has gained is recognised worldwide with several patients struggling with hearing loss flying in from all over Europe.

And it’s not only the patients who travel from far and wide to benefit from Newcastle’s expertise. Mr Johnson also runs an annual course to teach other ENT specialists how to emulate the technique with many attended from abroad to learn and start using the much approved ‘Newcastle technique’.

EDITORIAL FROM THE CHRONICLE

Review of the Year 2015/16

By Craig Thompson
Chief Reporter
craig.thompson@ncjmedia.co.uk

LIFE-CHANGING surgery has helped a teenage boy hear fully for the first time.

Joey Mains eyes “lit up” when Newcastle doctors uttered the first words he had ever heard clearly.

For years the schoolboy had suffered hearing and ear problems, struggling at school he was forced to learn to lip read as his confidence hit rock bottom.

Now, after an operation to fit a Bone Anchored Hearing Aid (BAHA) at Newcastle’s Freeman Hospital, Joey’s life has been transformed forever.

Joey, 15, said: “I now realise that all along, I’d never known what it was like to be able to hear properly, to really know what the world sounded like. “Now the doors’ been opened. I can hear what’s happening around me.

“I can hear everyday things I didn’t know existed. Like the sounds of traffic and car horns. And I never realised our pet cat made those purring and meowing noises.

“All sorts of sounds, the TV and music are much fuller and richer. I was only able to pick up low-pitched noises before.

“I feel much more confident in myself. I can keep up with conversations. I don’t have to keep asking people to repeat themselves.”

Now confident and outgoing, Joey, who lives with mum, Karin, dad Steven, and little sister Morgan, is free to pursue his passion for acting, the theatre and performing arts. A member of a local youth drama group, Joey wants to go on to study drama at university, and even harbours dreams of one day becoming a professional actor.

Between the ages of four and 12 years old, the schoolboy underwent nine operations and hospitals in general.

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Joey soon found himself learning to lip-read.

“I just sort of picked it up,” he said. “But if someone I couldn’t see said something, or there was a lot of noise going on, it didn’t help.”

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school, I realised that his social skills weren’t developing very well. He wasn’t making friends and was sort of withdrawing into himself.

“Although his speech had always been good, he lacked self-confidence and I could see his self-esteem was suffering.

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“I started crying with tears of joy and relief.”
Boy helping to protect others after heart scare

A SCHOOLBOY struck down with the same heart condition as footballer Fabrice Muamba is now working to save the lives of other children.

Cole Taylor was brought back from the dead after he collapsed while playing with his brother in a holiday park caravan park paddling pool.

The seven-year-old’s heart had stopped beating and he was later diagnosed with Long QT syndrome - the rare heart condition which also struck former Premier League star Muamba.

Like the footballer, Cole, of Blyth, has been fitted with an implantable cardioverter defibrillator (ICD), which will increase the chances of him being brought back to life again should his heart stop a second time.

Now, the Bede Academy pupil and his family have joined forces with charity North East Hearts with Goals to try and get more life saving defibrillator machines placed in schools across the area.

The youngster’s proud mum Roisin, 30, said: “We all wanted something positive to come out of a horrific experience.

“I don’t know of a school in Blyth which has one of these machines so if our work can help save a life then this will be worth it.

“Cole is doing well at the minute and really want to do something that’s going to make a difference.” Cole and elder brother Mason, eight, both pupils at Bede Academy, were playing at the caravan park in Amble when he collapsed without warning this summer.

Dad Wayne, 44, used the lifesaving skills he had learnt as a children’s football coach to perform CPR on his son, bringing him back from the dead after around two minutes.

The family was later told only 5% of people who stop breathing survive when CPR alone is used.

The youngster was put on a life support machine and in intensive care.

Cole was diagnosed with Long QT which effects the rhythm of the heart and can cause it to stop suddenly.

Roisin was told she too has the condition, which caused the Bolton star to collapse and die for 78 minutes during a televised football game in 2012. As was the case with Muamba, Cole was fitted with an ICD, at Newcastle’s Freeman Hospital last year.

The device, placed just below his collar bone under his skin, is said to do the jobs of both a pacemaker and a defibrillator in that it attempts to keep the heart’s rhythm normal but also administers an electric shock in an attempt to get it beating again should it stop.

The family were told Cole is one of the youngest recipients of an ICD in the North East.

North East Hearts with Goals aims to get as many defibrillator machines into schools and community venues across the region as possible.

The charity’s work has already saved lives.
Wigs a cut above the rest at cancer unit

By Craig Thompson
Chief Reporter

CANCER care specialists have teamed up with celebrity hairdresser Trevor Sorbie to offer a unique service to patients fighting the killer disease.

The Northern Centre for Cancer Care at Newcastle’s Freeman Hospital is working with a charity set up by the international snipper, for patients affected by hair loss.

The charity, My New Hair, has been described as vital “psychological medicine” for people losing their hair through illness.

The new partnership will allow patients suffering medical hair loss, and patients with alopecia, to access specially trained hairdressers who offer a wig customisation service.

For cancer patients in and around Newcastle, they can now see a trained hairdresser either at the Royal Victoria Infirmary in the city centre, or at salon near their home.

Trevor, patron and founder of the charity, said: “We are going to be helping so many more people in the North East with our partnership working with the Northern Centre for Cancer Care.

“It’s really important that we take every opportunity to help people at a time when they most need it. It is psychological medicine for everyone suffering from hair loss through illness, it is the missing link in their treatment.”

Peter Towns, matron for the Northern Centre for Cancer Care, said: “Our patients have access to the very latest cancer treatment techniques and we know that many of the powerful therapies needed can affect other aspects of their health and wellbeing.”

Some cancer treatments can make patients’ hair fall out.

While there are wigs, cold caps and other products available, this is the first time the hospital has teamed up with a charity to offer a tailored service.

Hair loss from cancer treatment can affect people in different ways. Some treatments cause only partial hair loss or thinning, while others cause patients to lose hair from all over their body.

Different types of chemotherapy drugs have varying effects, while radiotherapy causes hair loss only in the area where treatment is focused.

HELEN’S STORY

Helen McIntyre was diagnosed with cancer of the left breast in July 2013, at the age of 47.

The Consett mum had treatment at the Northern Centre for Cancer Care.

Helen, mum to a 14-year-old daughter, spoke of her difficult journey in regaining her health and self-esteem.

She said: “The first part of my treatment required a biopsy to be taken then removal of the cancerous lump.

“An additional operation followed to remove cancerous nodes from under my left arm, and I opted to have the remaining 17 lymph nodes removed as a precautionary measure.

“My consultant oncologist advised a treatment regime of six months of chemotherapy, three weeks of radiotherapy and 18 doses of Herceptin.

“My treatment was to last 18 months. Whilst having the lump and lymph glands removed I tried to prepare myself both mentally and physically for losing my hair.”

Before my treatment started I went to see a hairdresser trained by My New Hair at the Tribeca Salon in East Boldon. Darren was fantastic and suggested several wigs to match my hair, as I really wanted the wig to be identical to the hair I currently had.

“He reassured me the hair would be a good match and gave me confidence to try the wig before the hair loss started.

“After the second batch of chemotherapy my hair fell out in clumps. It was most obvious in the morning when I woke up - handfuls of hair would be lying on the pillow. During the day hair stuck to my mouth, got up my nose and this all made me feel very agitated.

“So I made the decision to have a friend shave all my hair off. We did this at home as I felt this would give me some time in private to get used to the feeling. I think my friend was more nervous than I was... we dreaded the act of cutting the remaining hair off.

“I made jokes about losing my hair as my friend’s eyes filled up with tears. It is a stark change to your own body image going from medium length hair to millimetres, and then, within a matter of days, being completely bald.

“No one could quite prepare me for that feeling of losing all my self-esteem.

“It was a huge milestone wearing the wig for the first time, trying to feel self-confident and not just putting on a brave face for the people around me. I just wanted to feel normal.

“After some tears and lots of encouragement from my husband and teenage daughter I started meeting up with my friends again and this was a huge boost to my emotional wellbeing. The wig was so like my own hair only those I chose to tell knew it wasn’t and this really did make a difference.”

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Editorial from the Chronicle

Heads have turned to the Freeman Hospital as My New Hair takes wig service to new heights.

The Northern Centre for Cancer Care at Newcastle’s Freeman Hospital has been working with celebrity hairdresser Trevor Sorbie and his charity, My New Hair, to offer a wig customisation service to patients suffering from hair loss through illness.

The new partnership means that patients in and around Newcastle can now see a trained hairdresser either at the Royal Victoria Infirmary in the city centre, or at salon near their home.

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Different types of chemotherapy drugs have varying effects, while radiotherapy causes hair loss only in the area where treatment is focused.
North experts to help save lives 5,000 miles away

THOUSANDS of lives are set to be saved and a country’s healthcare system changed forever thanks to the work of internationally-acclaimed team from a North East hospital.

Medics from Newcastle’s Freeman Hospital are set to play a vital role in revolutionising healthcare in Sri Lanka after helping establish a transplantation programme. North East Hearts with Goals aims to get as many defibrillator machines into schools and community venues across the region as possible. The charity’s work has already saved lives.

No heart transplants have ever been carried out in the South Asian country but they are now set to become a reality thanks, in part, to the pioneering work of Professor Stephen Clark, who is director of Cardiopulmonary Transplantation at Newcastle’s Freeman Hospital.

A series of meetings have been taking place between Sri Lankan government officials and medical experts to rectify any legal issues and help facilitate a comprehensive national Heart and Lung Transplantation Programme for the country.

The historic formation of the programme, at the College of Surgeons office in Colombo, took place under the guidance of Professor Clark.

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The Newcastle medic held meetings with Sri Lanka’s Director-General of Health Services, Dr. Palitha Mahipala, and Attorney General Yuvanjana Wijayatilake who promised official support in medical services and amendments to the Tissue Act to allow the programme to proceed.

Professor Clark, who is also a clinical lecturer with the Institute of Cellular Medicine at University of Newcastle, said: “Sri Lanka has been keen to develop a Heart and Lung Transplantation Programme and make it a centre for neighbouring countries.

“The country has the medical expertise and the will to do so.”

The medic called for transparency and said it was vital to build-up public confidence in the programme from the initial stages.

Under the transplantation programme, organs would be obtained from donors who have been declared brain-dead following injuries such as car accidents. They will then be transplanted into patients with suffering heart failure or end-stage lung failure.

A simple ceremony at the College of Surgeons in Colombo marked the setting up of the Sri Lanka Society for Heart and Lung Transplantation.

Sri Lankan doctors have said the goal is to provide quality transplantations like those done at the Freeman Hospital, which will act as a mentor to the programme.

Consultant thoracic surgeon Dr. Waruna Karunarathne had visited the Newcastle hospital to help set up training for the Sri Lankan team.

“We need to do it right and set up Sri Lanka’s Heart and Lung Transplantation Programme to international standards,” said Dr. Abeywickrama.

Craig Thompson
Chief Reporter
Craig.Thompson01@trinitymirror.com

Professor Stephen Clark, director of cardiopulmonary transplantation at Newcastle’s Freeman Hospital, has played a key role in the link-up with Sri Lankan health authorities.
Facing a race against time, the number of people waiting for a heart transplant at Freeman Hospital has hit its highest level in a decade.

A total of 60 adults were waiting for a heart transplant at the specialist Newcastle centre in March this year. One of these patients was classed as needing them urgently.

This was the highest figure in 10 years of data published by NHS Blood and Transplant.

In the first year of the figures, dating back to 2005/06, there were just 17 patients on the waiting list at Freeman Hospital.

The team at the centre performed 15 heart transplants in 2014/15. Newcastle is one of just two centres, along with Great Ormond Street in London, that conducts children's transplants in the UK.

There were five children on the heart transplant waiting list at Newcastle in March.

Freeman Hospital isn’t the only centre having to deal with additional pressure on the heart transplant list. Three out of the other five specialist adult units also have waiting lists that are the longest or joint-longest in a decade - Birmingham, Manchester and Harefield, west London.

Between 2009 and 2012 it took the average adult patient on the heart waiting list 225 days to get the transplant at Freeman Hospital, compared to an national average of 195 days.

Sally Johnson, NHS Blood and Transplant director of organ donation and transplantation, said: “Statistically, more than one in ten people on the waiting list will die before they get the transplant they need.

“For some organs, the picture is significantly bleaker. More than one in four people waiting for lungs will die.

“I’ll ask you to imagine how you’d feel if someone close to you was waiting for a transplant; their whole life on hold, hoping someone will donate to save them.

“I’m sure we’d all hope an organ would be available to help someone we love - so shouldn’t we all pledge to be organ donors so more lives can be saved?

She added: “If you haven’t told those closest to you that you want to be an organ donor, then please do it today. Tell them you want to be an organ donor and record your decision on the NHS Organ Donor Register.”

To join the register, visit organdonation.nhs.uk

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Delivering the NHS Five Year Forward View

The planning and financial framework for 2016/17 – 2020/21 was published on 22nd December 2015. It stated that “The Spending Review provided the NHS in England with a credible basis on which to accomplish three interdependent and essential tasks: first, to implement the Five Year Forward View; second, to restore and maintain financial balance; and third, to deliver core access and quality standards for patients”.

The NHS Planning Guidance published by NHS England, in partnership with the five arm’s length bodies (NHS Improvement (Monitor and TDA), Health Education England, the National Institute for Clinical Excellence, Public Health England and the Care Quality Commission), set out a clear list of national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules.

Organisations within the NHS were required to produce two plans:

1) All local health and care systems will be required to develop a five year Sustainability and Transformation Plan (STP), covering the period October 2016 to March 2021 subject to a formal assessment in July 2016 following submission in June 2016.

2) All NHS Foundation Trusts and Trusts are required to develop and submit one year operational plans for 2016/17. These plans will need to be ‘consistent with the emerging STP’ and in time to enable contract sign off by end of March 2016.

Sustainability and Transformation Plans (STPs) are place based plans. Set within a local footprint, STPs are intended to be holistic and ambitious plans for accelerating the implementation of the Five Year Forward View and closing the gaps in health inequalities, quality and finance. Five key tasks are identified for system leaders in writing their STPs namely, (i) local leaders coming together as a team; (ii) developing a shared vision with the local community, which also involves local government as appropriate; (iii) programming a coherent set of activities to make it happen; (iv) execution against plan; and (v) learning and adapting.

Key questions within the STP guidance include:

i) How will you close the health and wellbeing gap? – with reference to prevention, patient activation, choice and control, and community engagement;

ii) How will you drive transformation to close the care and quality gap? – with reference to new care model development, improving against clinical priorities, and roll out of digital healthcare; and

iii) How will you close the finance and efficiency gap? – with reference to achievement of financial balance across local health systems and efficiency of NHS services.

The guidance stated that success “depends on having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards”.

To ensure a “truly place-based plan, the STPs must cover all areas of CCG and NHS England commissioned activity including: (i) specialised services, where the planning will be led from the 10 collaborative commissioning hubs; and (ii) primary medical care, and do so from a local CCG perspective, irrespective of delegation arrangements. The STP must also cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies”.

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Review of the Year 2015/16

Whilst the Trust is actively engaged in discussions and work within the Northumberland, Tyne and Wear (NTW) STP footprint, given the specialist, sub-regional and general acute services delivered across a range of clinical areas there are a number of considerations in other geographic areas.

The Trust has a longstanding ambition and vision to be the health service for Greater Newcastle, and a leading national healthcare provider, as first articulated in the Council of Governors inspired manifesto, Better Together (2010). The work of the STP provides an opportunity to build and develop this work in the future to ensure the Trust maintains its position as a national leader in the delivery of high quality healthcare; whilst at the same time addressing some of the challenges facing the wider health and social care system.

The North East is regarded as having a strong history of joint working across health, social care and academia; this includes being shortlisted for national funding opportunities for the development and delivery of services. Newcastle Hospitals as a leading NHS Foundation Trust is a key player in the work around the STP and is committed to working with partners in the health and social care economy to ensure the sustainability of the health and care system to ensure the best interests of residents are placed first and foremost.

There are 44 STP footprints nationally:

| 1 | Northumberland, Tyne and Wear | 1.4 | 5 |
| 2 | West, North and East Cumbria | 0.3 | 1 |
| 3 | Durham, Darlington, Ties, Hambleton, Richmondshire and Whitby | 1.3 | 6 |
| 4 | Lancashire and South Cumbria | 1.6 | 9 |
| 5 | West Yorkshire | 2.5 | 11 |
| 6 | Coast, Humber and Vale | 1.4 | 6 |
| 7 | Greater Manchester | 2.8 | 12 |
| 8 | Cheshire and Merseyside | 2.4 | 12 |
| 9 | South Yorkshire and Bassetlaw | 1.5 | 5 |
| 10 | Staffordshire | 1.1 | 6 |
| 11 | Shropshire and Telford and Wrekin | 0.5 | 2 |
| 12 | Derbyshire | 1.0 | 4 |
| 13 | Lincolnshire | 0.7 | 4 |
| 14 | Nottinghamshire | 1.0 | 6 |
| 15 | Leicester, Leicestershire and Rutland | 1.0 | 3 |
| 16 | The Black Country | 1.3 | 4 |
| 17 | Birmingham and Solihull | 1.1 | 3 |
| 18 | Coventry and Warwickshire | 0.9 | 3 |
| 19 | Herefordshire and Worcestershire | 0.8 | 4 |
| 20 | Northamptonshire | 0.7 | 2 |
| 21 | Cambridgeshire and Peterborough | 0.9 | 1 |
| 22 | Norfolk and Waveney | 1.0 | 5 |
| 23 | Suffolk and North East Essex | 0.9 | 3 |
| 24 | Milton Keynes, Bedfordshire and Luton | 0.9 | 3 |
| 25 | Hertfordshire and West Essex | 1.4 | 3 |
| 26 | Mid and South Essex | 1.2 | 5 |
| 27 | North West London | 2.0 | 8 |
| 28 | North Central London | 1.4 | 5 |
| 29 | North East London | 1.9 | 7 |
| 30 | South East London | 1.7 | 6 |
| 31 | South West London | 1.5 | 6 |
| 32 | Kent and Medway | 1.8 | 8 |
| 33 | Sussex and East Surrey | 1.8 | 8 |
| 34 | Frimley Health | 0.7 | 5 |
| 35 | Surrey Heartlands | 0.8 | 3 |
| 36 | Cornwall and the Isles of Scilly | 0.5 | 1 |
| 37 | Devon | 1.2 | 2 |
| 38 | Somerset | 0.5 | 1 |
| 39 | Bristol, North Somerset and South Gloucestershire | 0.9 | 3 |
| 40 | Bath, Swindon and Wiltshire | 0.9 | 3 |
| 41 | Dorset | 0.8 | 1 |
| 42 | Hampshire and the Isle of Wight | 1.8 | 7 |
| 43 | Gloucestershire | 0.6 | 1 |
| 44 | Buckinghamshire, Oxfordshire and Berkshire West | 1.7 | 7 |
Newcastle hospitals are rated among best in UK

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Hospitals in Newcastle have been labelled "outstanding" by health leaders following a gruelling inspection.

England’s Chief Inspector of Hospitals praised Newcastle upon Tyne Hospitals NHS Foundation Trust - which runs the Royal Victoria Infirmary, the Freeman Hospital and the Great North Children's Hospital - after an inspection by the Care Quality Commission (CQC).

Overall, the trust has been rated as outstanding in respect of being caring, effective, responsiveness and well-led.

There were many factors that contributed to the outstanding rating including:

- Feedback from patients, and those close to them was consistently positive about the way staff treated people. There were many examples of exceptional care where staff at all levels went the extra mile to meet patient needs.
- The trust used innovative and pioneering approaches to deliver care and treatment.
- The trust worked hard to ensure it met the needs of local people and considered their opinions when trying to make improvements or develop services.

The trust is the fifth in the UK to be rated “outstanding” under CQC’s inspections but is the first Teaching trust to achieve this rating.

Prof Richards said that it was a trust that has “patient-centred care as a priority”, but added: “There is one area where we have told the trust they must make improvements. They must ensure that care documentation in the Emergency Care Department is completed to reflect accurately the treatment, care and support given to patients, and is subject to clinical audit.”

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The most comprehensive NHS assessment ever, the CQC’s 120-page report covers 150 hospitals. A shocking 74 per cent were graded either ‘inadequate’ or requiring ‘improvement’ in terms of patient safety.

‘A key concern has been the safety of care – a failure to learn when things go wrong, or not having the right number of staff in place with the right skills,’ he added. ‘Where people are not receiving the quality of care they deserve, we will demand action.’ The report is further evidence that the NHS is struggling to care for an ageing population on a restricted budget. Last week it emerged that hospitals went £1billion into the red in the first three months of this year and waiting times are rising sharply.

Health Secretary Mr Hunt said: ‘We want to make our NHS the safest healthcare system in the world. There are some excellent examples of high quality care across the country but the level of variation is unacceptable.’
Quality Strategy and Quality Account...

So much more to be advised of

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Quality Account
2015/16

Unconditionally registered with the CQC since April 2010, graded as Outstanding by CQC 2016
Region's NHS facing £960m funds shortfall

HEALTH services in the North East are facing a financial "black hole" of £960m over the next five years.

An investigation commissioned by campaign group 38 Degrees has uncovered the scale of the NHS funding crisis in the Northumberland, Tyne and Wear Trust.

Every area of the country has been ordered to identify unsustainable departments in a bid to tackle the cash crisis engulfing the NHS.

The 44 plans, called Sustainability and Transformation Plans (STPs), are being drawn up for each area of England as local NHS leaders are being asked to find savings that will help to plug financial deficits.

And the public plan for Northumberland, Tyne and Wear reveals that by 2021, the health and social care system is projected to be £960m short of the funds it needs to balance its books while maintaining the same level of care for patients if it "does nothing".

The plan discusses a "reconfiguration of services between acute providers" - but doesn't describe what this would mean for patients, leading to fears that some services will be lost.

38 Degrees said the analysis, carried out by health policy experts Incisive Health, "reveals far-reaching plans to close services, which appear to have had little input from patients and the public".

And a petition has been launched calling for North East MPs to ensure that the area's STP plan protects all frontline services.

One member of 38 Degrees in Bedlington said: "Both my wife and I rely on the NHS. If it wasn't for their quick service, my wife would be dead now. Add beds, and ambulances - don't take them away."

The Northumbria Specialist Emergency Care Hospital in Cramlington, which opened last year. A warning has been sounded on a national level that some hospitals may have to close in the years to come.

Director at 38 Degrees Laura Townshend said the findings show the NHS is "dangerously under-funded". She said: "These proposed cuts aren't the fault of local NHS leaders. The health service is struggling to cope with growing black holes in NHS funding. These new revelations will be a test of Theresa May's commitment to a fully funded National Health Service."

"The NHS belongs to all of us - so local people should get a say in any changes to their local services.'

The findings come as Chris Hopson, chief executive of NHS Providers, which represents frontline NHS leaders, warned that a "glut" of hospital services could shut down.

Mr Hopson called on Health Secretary Jeremy Hunt and NHS England boss Simon Stevens to admit there is a disparity between what the NHS is being asked to achieve and the money that is available to do it.

A spokesman for NHS Improvement said: "It is an essential part of the planning process for local areas to identify which services could be unsafe, underused or unsustainable."

"It is absolutely right that decisions on the future of health services are taken locally in consultation with the people who use those services."

"That planning process is still going on and no decisions have been taken.'

And commenting on the Incisive Health investigation, the Department of Health said it had protected the NHS "by giving it an extra £10bn to fund its own plan to transform services."

A spokesman added: "Changes to local services will only go forward where they are designed by doctors and in the clear interests of local patients.'

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