REVIEW OF THE YEAR
INCORPORATING THE ANNUAL
REPORT AND ACCOUNTS
2012/13

www.newcastle-hospitals.org.uk
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The year was the busiest and most diverse ever for one of the leading specialist healthcare providers from both a national and local perspective.

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<th>Income &amp; Expenditure 2012/13</th>
<th>£,000</th>
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<tbody>
<tr>
<td>Income</td>
<td>892,944</td>
</tr>
<tr>
<td>Expenditure</td>
<td>-837,548</td>
</tr>
<tr>
<td>Operating Surplus</td>
<td>55,396</td>
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<tr>
<td>Net Finance Costs</td>
<td>-28,572</td>
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<tr>
<td>Surplus for the year (before exceptional items):</td>
<td>26,824</td>
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</table>

Financial Risk Ratios 2012/13
Monitor (the Independent Regulator of NHS Foundation Trusts) applies a rating system from 1 to 5, where higher numbers are better.

<table>
<thead>
<tr>
<th>Ratio</th>
<th>Rating</th>
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<tr>
<td>EBITDA Margin</td>
<td>4</td>
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<tr>
<td>EBITDA % Plan Achieved</td>
<td>5</td>
</tr>
<tr>
<td>Return on Assets</td>
<td>5</td>
</tr>
<tr>
<td>I &amp; E Surplus Margin</td>
<td>5</td>
</tr>
<tr>
<td>Liquidity Ratio</td>
<td>4</td>
</tr>
<tr>
<td>Overall:</td>
<td>5</td>
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</table>
Key Patient Activity 2012/13

- Day Case FCEs: 48.3%
- Elective Inpatient FCEs: 14.5%
- Non-elective Inpatient FCEs: 37.2%

Income by Source 2012/13

- Non-patient Care
- Other
- R&D
- Training and Education
- National Commissioning Group
- Community Contract
- North East Specialist Commissioning Group
- Tees Consortium
- Cumbria PCT
- Newcastle PCT
- North Tyneside PCT
- Northumberland Care Trust
- Gateshead PCT
- South Tyneside PCT
- Sunderland PCT
- Durham and Darlington PCTs

Expenditure by Specialty 2012/13

- Cancer Services
- Women’s Services
- Surgical Services
- Renal Services
- Dermatology
- Ophthalmology
- Plastic Surgery
- Teaching
- R&D
- Community
- Other
- Neurosciences
- Haematology
- Cardiothoracic Services
- Children’s Services
- Dental Hospital and Oral Surgery
- ENT
- Genetics
- Internal Medicine
- Trauma and Orthopaedics
- Rheumatology
CHAIRMAN’S STATEMENT

We have been a Foundation Trust for seven years and can reflect upon a year of remarkable success. Once again excellent performance with high quality outcomes was sustained, all serving to reinforce our position as being amongst the very best in the NHS. We treated more patients than ever before, met all our key clinical targets, remain financially strong, were cited in the CHKS “40 Top Hospitals” list for the 13th successive year and maintained our excellent and extensive service portfolio as well as our asset base, all of which contribute to such underlying strengths.
This continued success, year on year, reflects the professionalism, the caring qualities and the high standards set and delivered by our loyal and dedicated workforce.

We cannot be complacent however as there are so many significant challenges to meet over the coming years. We are operating in a new radical NHS structure which became operational from 1st April 2013. The government continue to demand significant year on year savings which in our case amount to a further £35million for the year ending 31st March 2014 and at the same time we are subjected to ever increasing competition from some of the other service providers here in the North East. Major teaching hospitals are also being stripped of significant funds and which in our case amounts to £12million, albeit this quantum of money is the subject of redistribution elsewhere in the North East and North Cumbria.

The Trust is confident however that we can meet these challenges and will continue to grow. We provide world class services, employ world class clinicians and the high reputation which we enjoy will ensure that patients, when able to exercise informed choice, will opt to be cared for here in Newcastle upon Tyne. In order to meet this increased demand we are investing significantly in our services to increase capacity to meet this demand and maintain high clinical standards. We intend to continue to drive and enhance integrated care with our partners, treating more patients in their homes and in the community. We shall continue to invest in the best and most modern clinical technologies, ensuring our clinicians have access to the best facilities available. In partnership with Newcastle University Faculty of Medical Sciences and others we are nationally and internationally respected for our successful clinical research and development programme which leads to significant benefits in healthcare for our patients and we are determined this will continue unabated.

The Board of Directors is very clear about our direction of travel in sustaining a clear vision, aims and objectives for the Trust. Our Vision “to be the health service for Newcastle and a leading national healthcare provider" is as relevant now as it was a number of years ago when first set.

The Board of Directors is very clear about our direction of travel in sustaining a clear vision, aims and objectives for the Trust. Our Vision “to be the health service for Newcastle and a leading national healthcare provider” is as relevant now as it was a number of years ago when first set. May I pay tribute to the Board which has had the will and determination to drive this agenda forward and has been totally committed and single minded in ensuring that our Trust remains one of the very best in the country for our patients “providing healthcare at its very best with a personal touch”.

Our Governors too have acquired new powers as a consequence of legislation which serves to strengthen their hand in holding the Board to account for performance. Without any shadow of doubt the Governors are distinctly dedicated and focused in all that they do to ensuring that the Newcastle Hospitals continue to excel and build upon their first class reputation. Involvement in matters both operational and strategic is very much acknowledged. I would like to thank them most sincerely for all the work, time and commitment that they give to the NHS.

Kingsley W Smith OBE DL
Chairman
Scan this QR Code with your smartphone.
REVIEW OF THE YEAR

What we do
SERVICE PORTFOLIO
A most comprehensive local, regional and national offer

- Designated Supra-regional Services
- Designated National Receiving Services

CANCER SERVICES
Comprehensive Non Surgical Oncology services including Radiotherapy and Chemotherapy
Palliative care
Macmillan Cancer Information Centre
Clinical Trials Centre
Sir Bobby Robson Foundation

CARDIOTHORACIC SERVICES
Adult and Paediatric Cardiology
Adult and Paediatric Respiratory Medicine
Adult and Paediatric Cardiothoracic Surgery

Electrophysiology
Pacing and defibrillator implantation
Angioplasty
Thoracic Surgery
Pulmonary hypertension
Sleep investigation

- Neonatal and Paediatric extra corporeal membrane oxygenation

Cardiothoracic Anaesthesia
- Primary Pulmonary Hypertension
Cardiothoracic Intensive Care

CHILDREN’S SERVICES
Paediatric Medicine
Paediatric and Neonatal Surgery
Paediatric Oncology including Neuro-onycology
Paediatric Nephrology
Paediatric Respiratory Medicine
Paediatric Rheumatology
Paediatric Gastroenterology
Paediatric Continence and Stomacare
Forensic Paediatrics
Paediatric Endocrinology
Paediatric metabolic disease
Paediatric Intensive Care

- Paediatric Immunology and Infectious Diseases including Severe Combined Immunodeficiency Syndrome

Paediatric Neurology and Neurosurgery
Paediatric Bone Marrow Transplantation

CLINICAL SUPPORT SERVICES
Physiotherapy
Occupational Therapy
Dietetics
Speech Therapy
Chirology
Pharmacy
Psychology

COMMUNITY SERVICES
Outreach and independent living
Primary Care interface
Assessments and diagnostics
Walk-in Centres

DENTAL SERVICES
(Dedicated Dental Hospital and School)
Restorative Dentistry
Oral Surgery
Oral Medicine
Oral and Maxillo Facial Surgery
Paediatric Dentistry
Orthodontics
Specialist Radiology
Prosthodontics
Periodontology
Dental Sedation
Dental Emergency Clinic
Undergraduate training
Postgraduate training
Training of dental care professionals

DERMATOLOGY SERVICES
Dermatology outpatients clinics
Dermatology outpatient treatments including Phototherapy and vascular laser treatment
Dedicated in-patient services
Dermatological Surgery including MohS
Paediatric Dermatology
Phototesting

ELDERLY CARE SERVICES
Acute Elderly Care
Cardiovascular investigation unit
Elderly rehabilitation including Stroke
Continuing care
Day hospital
Respite care
Intermediate care
Integrated falls services

GENETICS SERVICES
Clinical Genetics
Cytogenetics
Molecular Diagnostic Genetics
- Diagnostic Service for Rare Neuromuscular Diseases

Genetics Knowledge Park
- Mitochondrial DNA Laboratory

INTERNAL MEDICINE
Emergency Admissions
General Medicine
Endocrinology
Diabetes

Cystic fibrosis
Respiratory Medicine
Acute Stroke Medicine
- Auto-immune gut disorder
Gastroenterology
Cardiology
Clinical Immunology and Allergy
- Infectious Diseases and Tropical Medicine (including high security isolation unit)
Hepatology
Clinical Pharmacology and Poisons Information Service
Accident and Emergency Services
Urgent Care Services
Walk in Centres

LABORATORY MEDICINE
Clinical Biochemistry
Maternal serum screening
Clinical Haematology and blood transfusion
Microbiology and Infection Control
Cellular Pathology (including Neuropathology)
Muscle and Nerve Biopsy Service
Immunology
Open access service
Cytology
Virology

MUSCULOSKELETAL SERVICES
Trauma
Adult Orthopaedics
Paediatric Orthopaedics
Rheumatology
Metabolic Bone Disease Services
- Bone tumour services
Specialist spinal surgery

NEUROSCIENCE SERVICES

Neurosurgery
Neurology
Epilepsy Services
Neurovascular Service
Neurophysiology
Neuroradiology

• Deep Brain Stimulation Centre

OPHTHALMOLOGY

Cataract service
Glaucoma service
Adult and Paediatric Strabismus (squint) services
Oculoplastic service including socket service
Multidisciplinary Thyroid orbital service
Vitreoretinal surgery
Corneal service including transplantation
Eye casualty
Optometry and Orthoptic clinics
Nurse-led pre-admission assessment clinics
Dedicated separate adult and paediatric daycase facilities
Medical photography
Tertiary centre for Photodynamic therapy for age-related maculopathy
Rehabilitation for newly registered blind and partially sighted patients

OTOLARYNGOLOGY, HEAD AND NECK

Ear, Nose and Throat
Head and Neck Surgery
Audiology and Hearing Aid Services
Otology implant services

PERI-OPERATIVE AND CRITICAL CARE

Anaesthetics
Theatres
Resuscitation
Intensive Care
Chronic and Acute pain management
High dependency care
Recovery
Multi-specialty day unit
Home ventilation service
Critical Care Outreach service

PLASTIC AND RECONSTRUCTIVE SURGERY

General Plastic and Reconstructive Surgery
Vascular laser treatments
Cleft lip and palate surgery
Burns
Hand surgery
Head and Neck Surgery (with ENT)
Breast reconstructive surgery
Paediatric plastic surgery

RADIOLOGY

General X-ray
Contrast Studies
Interventional Radiology
Magnetic Resonance Imaging
Computed Tomography
Ultrasound
Ward Imaging

REGIONAL MEDICAL PHYSICS

Nuclear Medicine
Radiotherapy Physics and Technology
Physiological measurement
Critical Care physics

Bone mineral measurement
Audiological science
Vascular Ultrasound
Photomedicine
Clinical instrumentation
Radiation protection
Ultrasound quality assurance
Audiometer calibration and repair
Technical Aid service
Rehabilitation engineering and mobility
Clinical and scientific computing equipment development and calibration
Bioengineering

RENAL SERVICES

Acute Nephrology
Haemodialysis
Specialist Hypertension Services

HAEMATOLOGY

Transplantation
Continuing care and support
Specialist Haematology Services
Haemato-oncology
Haemophilia
Bone marrow transplantation
Thrombophilia
DVT service

SURGICAL SERVICES

General Surgery
Upper gastro-intestinal services
Vascular Surgery
Colorectal Surgery
Endocrine Surgery

• Liver Transplantation
Renal Transplantation

• Pancreas and islet Transplantation

Hepatobiliary and Pancreatic Surgery
Breast care services
Disability services
Endoscopy

UROLOGY

General and Specialised Urological Surgery
General Urology
Uro-oncology
Laparoscopy
Incontinence
Reconstruction
Urodynamics
Surgical Andrology
Endourology and Lithotripsy
Laser Prostatectomy

WOMENS SERVICES

Gynaecology including Urogynaecology 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 pregnant women with substance misuse problems
Specialist services (multidisciplinary) for twins and multiples
Termination of Pregnancy service
Bereavement counselling
Birthing Centre (Midwife led)
HOW WE DID

Review of the Year 2012/13

Newcastle Eye Centre, Royal Victoria Infirmary
The Care Quality Commission (CQC) has been the independent regulator of health and social care in England since 2009 and as part of their regulatory framework the Trust is required to be registered with the CQC in order to be legally able provide healthcare. The standards of care which the CQC expect the Trust to deliver are detailed in the Essential Standards of Quality and Safety (CQC 2010) which includes the 16 key outcomes which the Trust must deliver and which may form part of any inspection.
Registration
The Trust has been registered with the CQC since 1st April 2010 and is **Registered without Conditions**. Details of our locations and regulated activities form part of our Statement of Purpose which is an additional legal requirement of CQC registration. Following developments and changes to primary care registration, the Trust is now registered to deliver healthcare across six locations and to provide ten regulated activities.

Assurance
To provide assurance that the Trust is compliant with the essential standards, evidence identification and review process is in place for each of the key outcomes. Each of the outcomes has both designated Outcome and Executive Lead who are responsible for the identification of compliance evidence and then compiling this onto an assurance statement. The statements also ask for any actions to improve assurance to be identified and this process is repeated every six months with updated evidence being collected and quality checked.

Compliance and Inspection
The CQC continues to collect information from a wide variety of sources on Trust performance which is assimilated into a Quality and Risk Profile (QRP) in which the data from each of the information sources is risk assessed and graded as better, worse than or as expected. To date the Trust has not had any overall outcomes identified as being at high risk of non compliance since the creation of the QRP’s.

The Trust had a four day unannounced inspection in 2012-13 involving both RVI and Freeman Hospital sites. The inspection report was overwhelmingly favourable and the improvements suggested by the CQC were introduced with immediate effect.

The Trust also had an announced inspection in relation to care of patients detained under the Mental Health Act. The report although satisfactory overall, suggested some improvements which have been implemented.

The Trust is registered to deliver healthcare across six locations and to provide ten regulated activities
### SUMMARY OF SERVICE STATISTICS

#### Inpatient and Daycase activity

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<tbody>
<tr>
<td>Non-elective Inpatient FCEs</td>
<td>68,253</td>
<td>70,988</td>
<td>76,051</td>
<td>83,231</td>
<td>84,341</td>
<td>82,499</td>
</tr>
<tr>
<td>Elective Inpatient FCEs</td>
<td>38,851</td>
<td>38,814</td>
<td>37,148</td>
<td>30,904</td>
<td>32,413</td>
<td>32,171</td>
</tr>
<tr>
<td>Day Case FCEs</td>
<td>78,289</td>
<td>82,248</td>
<td>83,771</td>
<td>97,584</td>
<td>107,889</td>
<td>106,942</td>
</tr>
<tr>
<td>Total FCEs</td>
<td>185,393</td>
<td>192,050</td>
<td>196,970</td>
<td>211,719</td>
<td>224,643</td>
<td>221,612</td>
</tr>
<tr>
<td>% Elective FCEs undertaken as daycases</td>
<td>67%</td>
<td>68%</td>
<td>69.3%</td>
<td>75.9%</td>
<td>76.9%</td>
<td>76.9%</td>
</tr>
<tr>
<td>Average Length of stay</td>
<td>4.16</td>
<td>4.08</td>
<td>4.35</td>
<td>4.08</td>
<td>4.17</td>
<td>4.25</td>
</tr>
<tr>
<td>Average % Occupancy</td>
<td>79%</td>
<td>78%</td>
<td>78%</td>
<td>80%</td>
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#### OP Activity

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<tbody>
<tr>
<td>New Outpatient attendances</td>
<td>217,750</td>
<td>230,955</td>
<td>254,588</td>
<td>280,083</td>
<td>306,730</td>
<td>310,414</td>
</tr>
<tr>
<td>Review Outpatient attendances</td>
<td>606,990</td>
<td>638,410</td>
<td>653,418</td>
<td>665,403</td>
<td>727,486</td>
<td>748,430</td>
</tr>
<tr>
<td>Total outpatient attendances</td>
<td>824,740</td>
<td>869,365</td>
<td>908,006</td>
<td>945,486</td>
<td>1,034,216</td>
<td>1,058,844</td>
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#### Diagnostic services

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<tbody>
<tr>
<td>Laboratory requests</td>
<td>2,289,628</td>
<td>2,490,628</td>
<td>2,772,824</td>
<td>2,759,575</td>
<td>2,882,675</td>
<td>3,002,236</td>
</tr>
<tr>
<td>Radiological examinations</td>
<td>410,238</td>
<td>434,264</td>
<td>441,361</td>
<td>463,614</td>
<td>498,605</td>
<td>504,751</td>
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#### Accident & Emergency

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<tbody>
<tr>
<td>A&amp;E attendances</td>
<td>93,709</td>
<td>92,872</td>
<td>91,382</td>
<td>103,489</td>
<td>125,213</td>
<td>128,634</td>
</tr>
<tr>
<td>Walk in Centre attendances</td>
<td>37,885</td>
<td>38,316</td>
<td>36,115</td>
<td>28,252</td>
<td>43,949</td>
<td>49,288</td>
</tr>
<tr>
<td>Total attendances</td>
<td>131,594</td>
<td>131,188</td>
<td>127,497</td>
<td>131,741</td>
<td>169,162</td>
<td>177,922</td>
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#### Surgery

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<tbody>
<tr>
<td>Cardiopulmonary transplants</td>
<td>74</td>
<td>78</td>
<td>78</td>
<td>82</td>
<td>77</td>
<td>104</td>
</tr>
<tr>
<td>Liver transplants</td>
<td>21</td>
<td>43</td>
<td>34</td>
<td>35</td>
<td>39</td>
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<tr>
<td>Renal transplants</td>
<td>108</td>
<td>98</td>
<td>123</td>
<td>139</td>
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<tr>
<td>Bone marrow transplants</td>
<td>68</td>
<td>99</td>
<td>131</td>
<td>176</td>
<td>206</td>
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<tr>
<td>Heart Operations (CABGs &amp; PCIs)</td>
<td>2,519</td>
<td>3,249</td>
<td>3,248</td>
<td>3,206</td>
<td>3,326</td>
<td>3,068</td>
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<tr>
<td>Joint Replacements (Hips &amp; Knees)</td>
<td>998</td>
<td>1,024</td>
<td>1,110</td>
<td>1,385</td>
<td>1,424</td>
<td>1,638</td>
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<tr>
<td>Cataracts</td>
<td>7,365</td>
<td>7,787</td>
<td>8,174</td>
<td>8,023</td>
<td>8,074</td>
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#### Reproductive Medicine - Centre for Life

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<tr>
<td>No of IVF treatments started</td>
<td>729</td>
<td>779</td>
<td>982</td>
<td>843</td>
<td>817</td>
<td>656</td>
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<tr>
<td>Live birth rate per cycle started</td>
<td>23.6%</td>
<td>27.8%</td>
<td>24.9%</td>
<td>26.6%</td>
<td>23.3%</td>
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#### Other key statistics

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<tr>
<td>Total no of Renal Dialysis sessions</td>
<td>37,995</td>
<td>41,702</td>
<td>43,774</td>
<td>44,227</td>
<td>39,099</td>
<td>39,723</td>
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<tr>
<td>Number of births</td>
<td>6,228</td>
<td>6,301</td>
<td>6,683</td>
<td>7,062</td>
<td>6,992</td>
<td>7,441</td>
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<tr>
<td>Day hospital attendances</td>
<td>3,366</td>
<td>3,710</td>
<td>3,124</td>
<td>3,617</td>
<td>4,834</td>
<td>5,785</td>
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<tr>
<td>Disablement service attendances</td>
<td>7,288</td>
<td>7,502</td>
<td>7,268</td>
<td>6,529</td>
<td>7,134</td>
<td>5,890</td>
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FCEs: Finished Consultant Episodes
This document forms the Strategic Plan for the year up to 31st March 2014 and describes how the Board of Directors intend to continue to deliver high quality and cost-effective services for our patients on a sustainable basis. Within this context, the document includes an assessment of the key challenges we face, and our strategy to address those challenges over the coming years.
The 7th year as an NHS Foundation Trust was our strongest yet

Executive Summary

We have seen more patients than ever before whilst still managing to deliver a wide range of frontline service improvements. Our focus over the past 12 months has been on delivering “Healthcare at its very best, with a personal touch” for the residents of Newcastle and Greater Tyneside as well as those who are referred to our specialist services from across the region and beyond.

In terms of performance, we have continued to comply with all of Monitor’s requirements and to perform well against challenging contract performance targets and benchmarked indicators. Financially, the Trust achieved over and above Plan for 2012/13 and ended the year with a Financial Risk rating of 5 whilst both Income & Expenditure and cash positions remained strong.

The Business Strategy articulated within our 2012/13 Plan was primarily concerned with:

- Delivering growth in targeted specialties with these plans having been informed by our detailed capacity planning work during the Business Planning round
- Driving greater efficiencies to sustain the operational base through service redesign, greater use of technology and reprofiling the workforce
- Forging ahead with our plans to deliver integrated care in the most appropriate setting for patients, whether that be at home, some other community setting or in hospital. This work will see a continuation of delivering the “Better Together...” Strategy (published in 2009) and which articulated our plans to work with colleagues particularly in Newcastle City Council, Primary Care and Community Services to jointly drive this agenda.

In implementing the above, Service Directorates were charged with delivery of a total of 272 specific actions and successfully delivered 96.6% of these, the majority of which translated into tangible improvements in services for patients.

Alongside the above, measures of patient satisfaction (Annual Patient Survey) were achieved as follows:

- 86% rated care as 7+ out of 10
- 86% said they were treated with respect and dignity
- 99% said they were treated with respect and dignity
- 99% said the room or ward was very/fairly clean
- 98% said the toilets and bathrooms were very/fairly clean

Whilst in the Annual Staff Survey, the Trust performed particularly well against the following key measures:

- Staff saying that hand washing materials are always available – 77% (national average 60%)
- Staff feeling satisfied with the quality of patient care they are able to deliver 86% (national average 78%)

Clearly there is room for further improvement but all in all, our overall performance in 2012/13 provides a solid base from which we are able to move into 2013/14 with a measure of comfort and optimism about our ongoing ability to deliver.

As part of the Business Planning Cycle, the Board of Directors reviewed the organisational vision, values, strategic goals and underpinning objectives for the coming year, to determine with limited refinements only, that we should remain on our existing, course to deliver the vision to be “The Health Service for Newcastle and a leading national healthcare provider”.

We recognise aspects of turbulence within the external environment and wish to highlight two particular areas of concern. Firstly, the development of a Specialist Emergency Care Hospital (now understood to be circa 270 beds) just 9 miles north of Newcastle at East Cramlington and which is set to become operational in 2015. In essence, our primary concern is the undoubted impact this major healthcare delivery investment will have upon the whole local health economy, given that there is already a level of overcrowding in the secondary care sector. Whilst planned as a centre for non elective activity, it is now clear that the overall service offer will be significantly more diverse. Secondly, a neighbouring NHS Foundation Trust is beginning to deliver new services outwith their previous DGH function, as well as developing links with a tertiary provider some 40 miles south of Newcastle upon Tyne.

In terms of competitive response, the Trust is taking a strategic approach within the framework of our Competition and Collaboration Strategy, which articulates a multi layered programme of work, setting out plans from both a specialty and locality perspective including how we promote and enable Patient Choice and Engagement.

To conclude, our overall intention is to accelerate the pace across the following lines of activity:

- Continuing to deliver safe, clinically effective services and a first class patient experience across our whole portfolio
- Building upon our Research and Development reputation as the biggest clinical trials centre in the country and in this regard continuing to work with Newcastle University as well as other valued partners, for example, we have established a Memorandum of Understanding with Guys and St Thomas’. Further strengthening our Academic and Teaching profile which, will be partly achieved through the recent confirmation of Academic Health Sciences Network status for the North East within which Newcastle is to be recognised as the “central hub” of activities.

We are confident about the strategic approach and, believe that local people as well as our service users from further afield deserve the very best. We shall be striving harder than ever to improve on our leading position within the top 10 healthcare providers in England.
The Trust operated Legally Binding Contracts (LBCs) with six clusters of Primary Care Organisations (PCOs) during 2012/13 (NHS North of Tyne, Durham, Tees, North Cumbria, South of Tyne and North Yorkshire and York) as well as Service Level Agreements (SLAs) with two Scottish Health Boards (Borders and Dumfries & Galloway). LBCs were also in place with the North East Specialised Commissioning Group with regard to a range of Specialist Services, including Neurosciences, Renal Dialysis, Cystic Fibrosis, Burns and a number of other services, as well as the National Commissioning Group (NCG) for nationally designated services such as organ transplantation.
There was an overall increase in activity during 2012/13. The following exhibits show the year on year increase in the number of patients seen and summarises performance against the Annual Plan in relation to: elective & non-elective spells, new & review outpatients and outpatient procedures.

There was a further rise in the number of patients seen during the year. In total 9,413 more patients were seen compared to the previous year, which equates to a 1.3% increase in activity across the board. The following exhibit shows patient activity for admitted care (finished consultant episodes), A&E attendances and new outpatients for the last 10 years.

Planned Activity

The year-end position was slightly below plan for both admitted care -1.0% and -0.9% for non-admitted care.

This has been a challenging year for a number of directorates as there were a number of changes to Payments by Result (PbR) rules. For instance some day case admissions were reclassified as outpatients and there were significant changes made to specialist services.

A number of Directorates experienced difficulties and delays with consultant recruitment and this resulted in lower elective and outpatient activity levels than were anticipated. In addition the capacity of the independent sector capacity for Neurosurgery proved lower than expected.

Trust wide factors which have impacted include the closure of a number of Wards through the Winter as a consequence of Norovirus. This impeded elective activity throughput, as did the very high level of medical boarders.

Orthopaedics reported an increase in case mix/complexity. This has been attributed to the designation of Level 1 Trauma Centre status and also more complex spinal caseloads. In addition Thoracic Services reported a significant increase in the volume of cancer referrals. During 2012/13, the Trust treated all of the patients waiting more than 52 weeks.
Achieving Waiting Times and National Targets

Cancelled Operations

The Trust reports cancelled operations which are defined by the Department of Health as follows: *Cancelled 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 475 operations cancelled during the year which is an increase in comparison to the previous year. Inpatient and daycase elective activity decreased during the 12 month period ending March 2013 and this, by around 1400 spells, is a 1% reduction in comparison to 2011/12. In relation to cancellations as a proportion of elective activity the year end performance was 0.3% which is within the standard performance threshold of less than 0.8%.

There were 2 patients who were not re-admitted within 28 days following a last minute cancellation. This is comparable to 2011/12 when there were also 2 breaches to the standard. Directorate management and clinical teams are aware of the importance placed upon ensuring patients are readmitted within 28 days of cancellation for non-clinical reasons and will endeavour to work with the patients to offer a suitable alternative date. As a proportion of cancellations, the year end breach performance was 0.4%, and this is within the standard performance threshold of less than 5%.

Activity at the Great North Children’s Hospital rose by 18% over the past 12 months following the region’s strategy to establish children’s assessment centres in district general hospitals, whilst centralising specialist care here in Newcastle upon Tyne.
This has been a challenging year for a number of Clinical Directorates as there were a number of changes to Payments by Result (PbR) rules.

**Referral to Treatment Target**

Over the year, the Trust has consistently achieved the aggregate Referral to Treatment Targets of 90% of admitted pathways; 95% of non-admitted pathways; and 92% of incomplete pathways. In line with the commissioning contracts there were no financial penalties applied for failure to achieve. Moreover, action plans have been developed to improve the compliance in some challenged specialties in line with the increased demand; treating the backlog; improving the timeliness of treatment and therefore the patient experience of their completed journey to treatment.

**6 Week Diagnostic Target**

During the year the Trust had 3 reported breaches of the 6 week diagnostic wait for the fifteen key diagnostic tests. The 3 breaches were in Audiology and new procedures have been put in place to ensure that this doesn’t happen in the future.

The number of patients waiting for diagnostic tests at the end of March had risen by 296 (4%) compared to the previous year, approximately 15,000 patients per month are seen within the Trust.

The exhibit below shows the number of patients waiting for diagnostic tests at March 2013 and volume seen during that month.

![Diagnosis graphic]

The following exhibit shows the changes in diagnostic waiting times. Although more patients are waiting there has been a notable decrease in Audiology Assessments.

![Diagnosis graphic]
In order to support earlier diagnosis of cancer and improve survival rates, the “Be Clear on Cancer” awareness campaigns continued in 2012/13 with a national lung cancer awareness campaign, a local bladder cancer awareness campaign and a re-fresh of the previous campaign for bowel cancer awareness. These campaigns may have contributed to the increase in referrals to the Trust.

Further campaigns are being launched in 2013/14.

Cancer Waiting Times

Performance in all of the cancer standards was sustained during 2012/13 with all targets achieved.

The Trust saw a 5.5% annual increase in the numbers of patients referred through the two week rule across all tumour groups, as well as a 3% increase in the numbers of patients receiving first treatments for a cancer diagnosis.

The 62 day target remained challenging throughout the year with late referrals from other local providers contributing significantly to the numbers of breaches. 50% of patients referred late in the pathway by those providers breach the 62 day target.

The reasons for late referrals are multi-factorial and there is continuous collaboration with the referring providers across the North of England Cancer Network to improve patient pathways.
Dear Doctor Evaan,

When we first met you with Kate on 25th September, perhaps typically for newly diagnosed cancer we were both in a state of shock and terror.

Since starting to attend the NCCC on 27th September, we have been inspired and strengthened by all the people we have met during our thirty visits for Roy’s radiotherapy sessions.

All the staff have provided Roy with professional, caring service. They have reassured us by the way they walk around their departments with a sense of purpose.

As we complete the first phase of our journey with you, we extend our sincere thanks to all personnel at NCCC - the service providers we meet and all of those ‘back shop’ staff who we do not meet.

You have provided a really special environment and a truly excellent service.

Yours very sincerely,
Roy & Anne

A&E Waiting Times

The Care Quality Commission national A&E waiting time standard that 95% of patients should wait no longer than 4 hours to be treated. The Trust reported a standard of 98.2% for the 12 month period ending March 2013.

During 2012/13 there was a 6% increase in all types of A&E activity in comparison to the previous year. All types of A&E include:

- Royal Victoria Infirmary Emergency Department (RVI ED)
- Royal Victoria Infirmary Eye Casualty
- Westgate Walk in Centre
- Molineux Street Walk in Centre

When compared to 2011/12 the most distinctive increases in activity were in the Westgate and Molineux Street Walk in Centres where attendances increased by 21% and 8% respectively.

There were a limited number of occasions during the year where the number of patients waiting for more than 4 hours peaked. The predominant reasons for this emerged as a consequence of patients awaiting placement to an appropriate clinical setting as well as a surge of activity in the Emergency Department.
PROVIDING TOP QUALITY CARE

The Newcastle upon Tyne Hospitals NHS Foundation Trust named as one of the CHKS 40Top Hospitals 2013

The Newcastle Hospitals won the CHKS 40Top Hospitals award for 2013, as healthcare intelligence and improvement services specialist, CHKS, announced the winners of its Top Hospitals programme awards at a special ceremony held in London on 30 April 2013.

The 40Top award is one of several awards that are part of the CHKS Top Hospitals programme. As well as national awards for patient safety, quality of care and data quality, CHKS celebrates excellence amongst its clients across the UK. The 40Top award is based on the evaluation of 22 key performance indicators covering safety, clinical effectiveness, health outcomes, efficiency, patient experience and quality of care.

Kingsley Smith, Chairman explains: “It is a great honour to receive this prestigious award for the 13th consecutive year. We are one of only three Trusts in the country to have accomplished this, which is a great demonstration of the high standards of care patients can expect to receive, in our hospitals and out in the community. As ever, it is our staff I must thank who are so dedicated, committed and hard working, and I would like to pay tribute to all those who have contributed so much to the continuing success of the organisation.”

Jason Harries, Managing Director for CHKS said: “We are delighted that the Newcastle Hospitals is one of our 40Top Hospitals for 2013”.

Collecting the award on behalf of the Trust are: Pam Yanez (Directorate Manager Urology & Renal Services, Jason Harries (CHKS), Mr Kingsley Smith (Chairman) and Maureen Tann (Assistant Director – Performance).
List of indicators from Top Hospitals 2013

40 Top Awards

Revised annually to take into account of newly-available performance information, this year’s indicators include:

- Reported C-difficile rate for patients aged 65 and over
- Day case rate (relative weighted performance across BADS directory)
- Day case conversion to inpatient rate (vs national rates, case mix adj per BADS)
- Depth of coding (not case mix adjusted)
- Percentage of coded episodes with signs and symptoms as a primary diagnosis
- Percentage of uncoded episodes
- Inpatient survey (overall care question)
- Percentage of outpatient first appointments not attended (specialty adjusted)
- Rate of emergency readmission to hospital (>16; 28 days)
- Emergency readmission within 28 days of discharge following hip fracture (65+)
- Percentage of elective admissions where planned procedure not carried out (not patient decision)
- Reference Cost Index (RCI)
- Summary Hospital-level Mortality Index (SHMI)
- Staff survey (overall job satisfaction question)
- Risk adjusted length of stay
- Risk adjusted mortality index
- Rate of emergency readmission to hospital following AMI within 28 days
- Rate of emergency readmission to hospital within 14 days - COPD
- Percentage of elective inpatients admitted on day of procedure
- Patient misadventure rate (ICD-based)
- Percentage of patients >65 with fractured neck of femur with pre-op LoS <=2
- Unnecessary admissions via A&E (zero LoS as % emergency)

We are one of only three Trusts in the country to have received this prestigious award for the 13th consecutive year, which is a great demonstration of the high standards of care patients can expect to receive, in our hospitals and out in the community.

General Explanation of Methods

Since the natural variability in some indicators will be quite large compared to others, CHKS have calculated a z-statistic for each indicator, in order to remove this bias. In any particular indicator, each hospital’s z-statistic is calculated. Each indicator is oriented to ensure the more desirable performance produces a positive z-score, and expressed in more convenient units by multiplying the indicator value by -10 (where low is good) or +10 (where high is good). All the indicators are therefore oriented in the same direction.

The 3 areas where the Trust did particularly well are:-

**Rate of emergency readmission to hospital following AMI within 28 days**

The rate of emergency readmissions to hospital within 28 days of discharge from the hospital, following admission with a primary diagnosis of acute myocardial infarction. Period covered is January to December 2012.

**Staff survey (overall job satisfaction question)**

External indicator from the Department of Health 2012 Staff Survey. Courtesy of Picker Institute, this indicator uses the response to question 13 (overall job satisfaction), measuring the percentage of respondents who were satisfied or very satisfied (averaged across 8 aspects of job satisfaction).

**Inpatient survey (overall care question)**

External indicator from the Care Quality Commission Inpatient Survey 2011. Courtesy of Picker Institute, this indicator reflects the mean rating for question 75 ‘overall care received’ from inpatients surveyed in each Trust.
The "Executive Summary" of the second Francis Report into the Mid Staffordshire Hospitals NHS Foundation Trust runs to more than 120 pages and contains some 290 recommendations. Some of the more striking themes identified in the Report are described here.
What emerges most clearly from the Francis Report is a concern that the leadership of Mid Staffs lost sight of the patient and focused on financial matters, hence allowing a spiral of decline to develop. This shaped the culture of the organisation to an extent that no-one felt that they had ownership of the care of patients and hence did not assume responsibility for highlighting deficiencies in the quality of care.

Other elements identified were as follows.

**A single regulator for financial and care quality**
There should be a single regulator dealing with corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts. Francis proposed that the Care Quality Commission and Monitor should be merged to achieve this.

**More powers to suspend or prosecute boards and individuals**
A service incapable of meeting fundamental standards should not be permitted to continue. Breach should result in regulatory consequences, attributable to an organisation in the case of a system failure, and to individual accountability where individual professionals are responsible. Where serious harm or death has resulted to a patient as a result of a breach of the fundamental standards criminal liability should follow.

**Duty of candour**
Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful. The Department of Health has already issued directions in this regard. The NHS Constitution should be revised to reflect the changes recommended with regard to a duty of openness, transparency and candour, and all organisations should review their contracts of employment, policies and guidance to ensure that, where relevant, they expressly include and are consistent with the above principles and these recommendations.

**Gagging clauses should be banned**
Gagging clauses or non-disparagement clauses should be prohibited in the policies and contracts of all 22 healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.

**Only registered people should care for patients**
A registration system should be created under which no unregistered person should be permitted to provide direct physical care to patients currently under the care and treatment of a registered nurse or a registered doctor (or who are dependent on such care by reason of disability and/or infirmity) in a hospital or care home setting. The system should apply to healthcare support workers. This approach is applicable to all patients but requires special attention for the elderly.

**It should be clear who is in charge**
This goes to the heart of the Mid Staffs problems. Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient’s case, so that patients and their supporters are clear who is in overall charge of a patient’s care.

**A new role for the CQC**
The secretary of state should consider transferring the functions of regulating governance of healthcare providers and the fitness of persons to be directors, governors or equivalent persons from Monitor to the Care Quality Commission (CQC).

**Specialist inspectors**
The CQC should develop a specialist cadre of inspectors by thorough training in the principles of hospital care.

**Media reports**
Those charged with oversight and regulatory roles in healthcare should monitor media reports about the organisations for which they have responsibility.

**Directors should be ‘fit and proper’**
There should be a requirement that all directors of all bodies registered by the Care Quality Commission as well as Monitor for foundation trusts are, and remain, fit and proper persons for the role. Such a test should include a requirement to comply with a prescribed code of conduct for directors.

**Complaints should be published on hospital websites**
Subject to anonymisation, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust’s response should be published on its website.

**Role of GPs**
GPs need to undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services.

**Role of local Healthwatch**
Local authorities should be required to pass over the centrally provided funds allocated to its local Healthwatch (the new “consumer champion” body for healthcare), while requiring the latter to account to it for its stewardship of the money.

The Francis Inquiry reported on 6th February 2013, producing a substantial document with 290 recommendations. These recommendations were considered by the Medical Director, Nursing and Patient Services Director, and the Director of Quality and Effectiveness, then “RAG” rated, and were presented to the Board. A number of “Listening Events” for staff have taken place, led by the Nursing and Patient Services Director, Director of Human Resources, and the Director of Quality and Effectiveness, and these have been extremely well attended by staff of all grades.

The sessions outlined the content of the report, the Trust’s current assurance processes, and asked the staff whether they would recommend the Trust’s services to their family and friends, and whether or not they felt confident, and able, to raise concerns should they feel the need to do so.

At one of the main sessions, an anonymous voting opportunity was provided and it was noted that 36% of those present in an audience of over 100 felt that they would not be confident to raise concerns. This highlighted the need to ensure a more open culture and to ensure staff were aware of the need to, and how to, report concerns so they could be addressed at the earliest opportunity. This was consistent with the recent staff safety culture survey, which also highlighted opportunities for improvement. A follow-up survey three months later identified that the number of staff feeling confident about raising concerns and knowing how to do so had increased considerably, to more than 80%.

A Steering Group of senior staff from across the organisation, led by the Nursing and Patient Services Director, has addressed the various work streams arising from the report and a significant amount of work continues to be undertaken to address the findings and to confirm that there are good assurance processes in place within the Newcastle Hospitals with demonstrable evidence to support this. The Trust will also continue to ensure that staff are confident and competent to raise concerns and know they will be appropriately supported and their concerns resolved.
The Shelford Group comprises ten leading NHS multi-specialty academic healthcare organisations. It is dedicated to excellence in clinical research, education and patient care. It aspires to demonstrate system-wide leadership for the benefit of patients and the prosperity of our country.

The ten members collectively employ over 83,000 people with a turnover in excess of £7 billion. The institutions that make up the Shelford Group are of strategic significance to NHS care, the life sciences industries and the wider UK economy. They provide the very best care to patients with some of the most complex conditions and diseases.

As leading tertiary centres, Shelford Group members deliver state-of-the-art training and education opportunities for clinicians, as well as the fundamental infrastructure for the UK’s medical research sector. The Group was formed in 2011 to benchmark and share best practice in key service areas across the membership through working groups, and constructively engage with Government, Parliament and industry to represent the interests of large tertiary centres and the wider National Health Service.

The Shelford Group is led by its member Chief Executives and has active Sub-Groups for Chief Nurses, Finance Directors and Medical Directors.
For example in May 2013, the Shelford Group forwarded to the Parliamentary Health Select Committee’s Inquiry into Emergency Services and Emergency Care, a formal submission intended to give the Committee a clear picture of the current pressures being felt in Accident & Emergency (A&E) Departments, their consequent effects, causes and possible solutions. The submission addressed the following areas on which the Committee was seeking comment:

- The role of Community and Primary Care Services in the delivery of emergency healthcare, and the appropriate structure for service delivery to meet the demands of different geographic areas
- Progress towards moving some minor injury and urgent care services outwith A&E and into more accessible community settings
- The range, severity and incidence of conditions that can be treated within an A&E Unit but not managed at an Urgent Care Centre
- Experience to date of the transition from NHS Direct to the NHS 111 Service
- Clinical evidence about outcomes achieved by specialist regional centres, taking account of associated travel times, compared with more generalist hospital based services
- Aspects of care which are likely to improve by being located in regional specialist units and the risks associated with removing services from existing A&E provision

The Shelford Group analysed some of the root causes of the increased pressures in A&E and these were listed in a submission under the following headings:

- A reduction in bed numbers and the Marginal Tariff for A&E
- Ageing population and acuity issues
- Universal increase in demand
- Large acute Trusts absorbing needs arising from closures or reduced capacity of local A&E’s
- Adverse weather conditions and related infection outbreaks
- Inadequate A&E staffing
- Inadequate Community and/or Social Care Provision
- Loss of confidence in the NHS 111 Service and reduced Out-of-Hours GP Services

The Shelford Group believes that the long term solution to the increased pressure in A&E Departments is the integration of Primary Care, Social Care and Community Care Services with Acute Services. From the data included in the submission, it was evident that those Trusts with a degree of integrated services have more flexibility to manage the increase in demand than those that do not. This is not to say that being integrated per sé has in all cases prevented an escalation in A&E admissions and attendances.

There was a need for a model of integration, and a definition of the term, which should encompass alignment between Primary and Secondary Care, and Care in the Community.
Leading the way in medical productivity

Over twenty teaching hospitals across the UK have been working to benchmark and understand medical productivity with Civil Eyes Research, a leading benchmarking organization. The programme of work is agreed by a steering group of the participating hospitals. This project was started in 2006 with the active collaboration of the Association of UK University Hospitals. Civil Eyes liaises with clinicians and managers to understand information about quality and productivity within health services.

Once again this year, the exhibit below serves to demonstrate that out of their Programmed Activities (PAs), Newcastle Consultants spend 81% of their time devoted to Direct Clinical Care (DCC), the highest amongst the peer group.

Proportion of time spent in Direct Clinical Care

Make good headlines for our NHS

My experience stands in stark contrast to that of Jenni Russell (Look beyond the politics – healthcare really is in crisis, 18 July). Three years ago I was extremely ill and admitted to the Freeman hospital in Newcastle. I had to wait a couple of hours on the renal ward while the isolation ward just recently vacated was prepared for me. That same day I had a kidney biopsy. The following day I was given the diagnosis (myeloma and progressive renal failure) and treatment for both started the following day. The speed of the hospital’s response to my condition left me breathless. I was facing chemotherapy and possibly dialysis.

In the following days I was visited by a pharmacist, a dietician, phlebotomists, two consultant nephrologists, two consultant haematologists and their respective teams. At one point I felt like Fletch in Porridge – I couldn’t get a minute’s peace to read my book! Then a bone biopsy, x-ray of my skeleton... In a matter of weeks, due the efforts of the renal team, the threat of dialysis retreated and I was well enough to be discharged.

I was treated with respect and concern by the consultants. The nursing staff and junior doctors were caring and sympathetic. Meals cooked on the premises were ordered by patients from menus with certain items highlighted as not available to patients with kidney problems. Now there’s a simple effective system. I can offer similar reports from friends in Teesside. But good hospitals don’t hit the headlines. Instead of concentrating on poor performance in areas of the NHS, might it not be useful to make a study of hospitals such as the Freeman? Ask why they perform so well and use them as a national model for the NHS.

Mary Moore
Newcastle upon Tyne
Choose and Book

In terms of the number of bookings received through the Choose and Book system, the Trust consistently has the highest number of bookings in the country as shown in the table below.

Top ten in the country – March 2013

<table>
<thead>
<tr>
<th>Provider</th>
<th>C&amp;B Bookings</th>
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<td>9429</td>
</tr>
<tr>
<td>PENNINE ACUTE HOSPITALS NHS TRUST</td>
<td>8824</td>
</tr>
<tr>
<td>BARTS HEALTH NHS TRUST</td>
<td>8798</td>
</tr>
<tr>
<td>CORNWALL AND ISLES OF SCILLY PCT</td>
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<tr>
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<td>UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST</td>
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</tr>
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<td>7531</td>
</tr>
<tr>
<td>SALFORD ROYAL NHS FOUNDATION TRUST</td>
<td>7364</td>
</tr>
<tr>
<td>GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST</td>
<td>7135</td>
</tr>
<tr>
<td>NORTH BRISTOL NHS TRUST</td>
<td>6511</td>
</tr>
</tbody>
</table>

and here in the North East – March 2013

<table>
<thead>
<tr>
<th>Provider</th>
<th>C&amp;B Bookings</th>
</tr>
</thead>
<tbody>
<tr>
<td>THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST</td>
<td>9429</td>
</tr>
<tr>
<td>COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST</td>
<td>7531</td>
</tr>
<tr>
<td>SOUTH TEES HOSPITALS NHS FOUNDATION TRUST</td>
<td>5947</td>
</tr>
<tr>
<td>CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST</td>
<td>5746</td>
</tr>
<tr>
<td>NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST</td>
<td>3174</td>
</tr>
<tr>
<td>NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST</td>
<td>2898</td>
</tr>
<tr>
<td>GATESHEAD HEALTH NHS FOUNDATION TRUST</td>
<td>2733</td>
</tr>
<tr>
<td>SOUTH TYNESIDE NHS FOUNDATION TRUST</td>
<td>1562</td>
</tr>
</tbody>
</table>

Source: Choose and Book National Reports

New development for Choose and Book include:

- Almost all of the two week wait services are available to book direct
- About to introduce a means for GPs to access urgent services
- Starting the roll out of Choose and Book for community services
- Advice and guidance services will be rolled out throughout the coming year
Access to the system to book appointments is also very good. The exhibit below shows the total number of Choose & Book bookings at the Trust and where clinics are full to capacity and where there is no available slot these are called “slot issues”. The person booking the appointment can automatically contact the hospital and an appointment can be found by the respective appointment staff.

![Graph showing monthly proportion of slot issues]

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**So miracles DO happen!**

As flesh-eating bug left toddler at death’s door, his mother turned to prayer... and just look at him now

**By Chris Brooke**

A TODDLER facing death after being ravaged by a flesh-eating bug was told by his heart-broken mother that he could ‘go’ if he wanted to.

Lucy Dove gently whispered the words into 18-month-old Frankie Mould’s ear because she couldn’t bear to see him suffer any more.

Her son had been through a nine-and-a-half hour operation to remove skin and tissue from his back and thigh, but doctors did not think he would survive the night and had told his parents to hope for a miracle.

Although the odds were stacked against him, Frankie showed extraordinary resilience to battle back from the brink – and is now home from hospital after six weeks of treatment.

‘He is doing well at the moment and we are so happy that he is alive,’ said Miss Dove from Sunderland.

‘We weren’t religious, but we are now. When doctors haven’t got any hope what are you left with? We started praying to save him and our prayers were answered.’

Frankie is thought to have got the necrotising fasciitis bug from a graze to his forehead a few weeks earlier. Bacteria got into his body, lay dormant and then ran wild.

At one point a nurse told Miss Dove, 25, and the boy’s father Wayne Mould, also 25, that he was ‘the sickest boy in the country’.

Frankie was put in a drug-induced coma for 12 days to help his body fight for life.

He had a second operation lasting five hours to remove more infected tissue and then had skin graft surgery to repair the terrible damage caused by the bug.

Skin was taken from his legs and trunk and stretched across his back and damaged thigh.

The terrifying bug was stopped just in time and the prompt treatment at Newcastle’s Royal Victoria Infirmary has been a success.

The family’s ordeal began on April 8 when Frankie developed flu-like symptoms and behaved ‘strangely’ as if he was in agony.

‘Being a mum you have to put your children first, and I thought, “is it selfish of me to want him to get through this, because of the damage to his body?” We were told bad things all the time so I whispered in his ear, “Frankie, if you want to go, you go.” But he didn’t want to go and stayed stable throughout. He is so tough.’

Peter Hodgkinson, consultant plastic surgeon in charge of his treatment, said the skin grafts ‘were healing beautifully’. The skin is swathed in bandages but Frankie is full of energy, although he will need treatment until he is grown.

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Peter Hodgkinson, consultant plastic surgeon in charge of his treatment, said the skin grafts ‘were healing beautifully’. The skin is swathed in bandages but Frankie is full of energy, although he will need treatment until he is grown.

‘The infection was spreading at a frightening rate,’ said Miss Dove. ‘I’m convinced their speedy action saved his life.’

There are 500 cases of necrotising fasciitis a year in the UK.
The Trust subscribes to the North East Quality Observatory System (NEQOS). The exhibits set out here are drawn from the fourth report produced by NEQOS, using the Healthcare Evaluation Data (HED) system.
Summary Hospital-level Mortality Indicator (SHMI) is the main measure of mortality. Trusts in the North East perform ‘as expected’, with no outliers. Over the period of data released by the Health & Social Care Information Centre (HSCIC), the method has not detected any outliers in the North East.

Trusts need a longer period of time to visualise trends. NEQOS have used the HED system provided by University Hospitals Birmingham NHS Foundation Trust (UHB). UHB used the methods set out by the national group that established the SHMI to show four years of data from October 2008 to December 2012, showing both SHMI and crude (unadjusted) mortality rate for each Trust. SHMI and crude mortality rates show considerable variability through time, but the underlying trends appear to be stable for all Trusts. Hospital Standardised Mortality Ratio (HSMR) is also provided, along with the proportion of discharges that have palliative care codes.

The report includes the following conclusions:

- SHMI is the main measure used to monitor hospital mortality rate. However, HSMR remains important and the report included both, along with the unadjusted mortality rate (all deaths divided by all spells included in SHMI).
- Trusts in the North East continue to perform well on mortality indicators, with none showing as statistically high outliers on SHMI. The two mortality indices are fairly consistent across the eight trusts.

The HSCIC will provide acute Trusts with a breakdown of SHMI in diagnostic groups using Variable Life Adjusted Display) VLAD charts from May 2013. NEQOS will support acute Trusts to understand and utilise these and will include more detailed information in its next report.

Patients First and Foremost, The Initial Response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry was published by the Department of Health in March 2013. It said “Mortality data must be interpreted with care, but it must also be accurate so that the public and patients can trust that they are hearing the truth”.

The NEQOS mortality reports and other support around monitoring of mortality across the region by trust. NEQOS also provides a service to teams and organisations across the region on quality measurement driving quality improvements.

SHMI is the hospital-level indicator which reports all deaths in hospital and all deaths that occur within 30 days of discharge from hospital across the NHS in England. It was first released by the Health and Social Care Information Centre (HSCIC) for use in the NHS in October 2011. It compares the observed number of deaths for each hospital with the number expected from a statistical model that takes account of patients’ age, sex, method of admission to hospital, diagnosis and comorbidities.

The primary diagnosis and comorbidities are taken from the first consultant episode within the provider spell only; the exception to this is where the primary diagnosis is an R-code (i.e. from within the ICD10 Signs and Symptoms chapter) and provided this is not also the case for the second episode: in this situation the primary diagnosis and comorbidities are taken from the second episode. This methodology applies to the derivation of the Dr Foster HSMR as well as to the HSCIC’s SHMI.

Funnel plots give the cross sectional analysis of Trusts in the period October 2011 to September 2012. The funnel plots display the SHMI (a ratio of observed over expected deaths, where 1 indicates that both the observed and expected deaths are the same, and is the average across England) on the vertical axis against the number of expected deaths (the denominator for the SHMI) along the horizontal axis. Trusts are identified as outliers if the SHMI places them outside the control limits on the funnel plots. The 95% Control Limits with adjustment for over-dispersion are used for banding Trusts as ‘low’, ‘as expected’, or ‘high’.

Trends through time are presented for each Trust using 16 quarters of data from October 2008 to September 2012 for both SHMI and unadjusted mortality. Charts display the SHMI and the unadjusted (or crude) mortality rate for each Trust. The trends have not been subjected to statistical testing for significance (a method for doing so has yet to be agreed nationally) and so caution must be exercised in interpreting variation of SHMI through time.

Figure 1 shows the SHMI for all Trusts in England, using the funnel plot adjusted for over-dispersion for October 2011 to September 2012.
SHMI by CCS Super-group for NE Acute Trusts, October 2011 to September 2012

SHMI: Summary Hospital Mortality Indicator
Source: NEQOS Hospital Mortality Monitoring: Report 16
Data extracted from HED, April 2013
Mortality data must be interpreted with care, but it must also be accurate so that the public and patients can trust that they are hearing the truth.

Patients First and Foremost, The Initial Response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

Source: NEQOS Hospital Mortality Monitoring: Report 16
Data extracted from HED, April 2013
There is no doubt that the vast majority of our patients experience very positive and greatly valued care and treatment, but we do recognise that, sometimes things can go wrong and lead to a complaint. When this is the case, how we deal with the issues raised is an integral part of how our services will be judged by service users; their families; commissioners; regulators; the media and the public.

Therefore the importance of not only responding to complaints in an open and appropriate way, but capturing and measuring the patient’s experience and using this to develop and promote (and embed) good practice is fundamental to the long term success of the Trust from “Ward level to Board level”.

There were 650 complaints received from service users during the year, and which included queries relating to clinical treatment, waiting times and delays, attitude of staff and communication issues. This represents an increase of 5% over the previous year.

In addition, some 617 patient related enquiries (PREs) were received by the Patient Relations Department staff which identified issues that had the potential to develop into a formal complaint or grievance if left unresolved. Of the 617 PREs raised, only 4% of the issues highlighted progressed to a formal complaint or grievance. The majority of these potential complaints were resolved by the Patient Relations Department or by staff at Ward or Department level, often with the involvement of the respective Matron or Consultant on the same day.

Some 66% of complaints referred to aspects of clinical treatment and which was an increase of 2% on the previous year. Complaints relating to appointment delays and cancellations increased by 2%. Regrettably, there was an increase of 4% in complaints relating to the perceived attitude of staff, and a 2% increase in complaints relating to appointment delays and cancellations. Complaints involving communication shortcomings also increased by 4%. Other categories of complaint remained generally similar to the previous year.

<table>
<thead>
<tr>
<th>Category</th>
<th>% of Total</th>
<th>Change on previous year</th>
</tr>
</thead>
<tbody>
<tr>
<td>All aspects of clinical treatment</td>
<td>66%</td>
<td>+2%</td>
</tr>
<tr>
<td>Appointment delays/cancellation both inpatient &amp; outpatient</td>
<td>9%</td>
<td>+2%</td>
</tr>
<tr>
<td>Communication/information both written &amp; oral</td>
<td>7%</td>
<td>+3%</td>
</tr>
<tr>
<td>Perceived attitude of staff</td>
<td>9%</td>
<td>+4%</td>
</tr>
<tr>
<td>Admission, discharge and transfer arrangements</td>
<td>6%</td>
<td>+3%</td>
</tr>
<tr>
<td>Personal records</td>
<td>&lt;1%</td>
<td>-</td>
</tr>
<tr>
<td>Hotel Services (including food)</td>
<td>&lt;1%</td>
<td>-</td>
</tr>
<tr>
<td>Failure to follow procedures</td>
<td>&lt;1%</td>
<td>-</td>
</tr>
<tr>
<td>Aids, appliances, equipment/premises</td>
<td>1%</td>
<td>-</td>
</tr>
<tr>
<td>Patient privacy &amp; dignity</td>
<td>&lt;1%</td>
<td>-</td>
</tr>
<tr>
<td>Transport</td>
<td>&lt;1%</td>
<td>-</td>
</tr>
<tr>
<td>Policy &amp; Commercial decision</td>
<td>&lt;1%</td>
<td>-1%</td>
</tr>
<tr>
<td>Consent to treatment</td>
<td>&lt;1%</td>
<td>-</td>
</tr>
<tr>
<td>Mortuary &amp; Post Mortem procedures</td>
<td>&lt;1%</td>
<td>-</td>
</tr>
<tr>
<td>Patient’s status, discrimination</td>
<td>1%</td>
<td>+1%</td>
</tr>
<tr>
<td>Other categories</td>
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<tr>
<td>Other categories</td>
<td>-</td>
<td>-1%</td>
</tr>
</tbody>
</table>

NHS received 3,000 complaints a week last year

The Independent
Examples of some of the improvements made to services and which arose from or which were associated with a complaint include:

**NCCC**
Complaint regarding waiting times and arrangements for day case chemotherapy.

Treatment pathways within the chemotherapy unit were addressed and revised to improve the patient flow.

**Surgery**
Part of complaint pertained to information regarding clarification of the need to be accompanied when attending for a gastroscopy. The Patient Information leaflet has been changed to advise that patients attending for a gastroscopy with the use of a throat spray do not need to be accompanied.

**Medicine**
Following a patient with hearing impairment experiencing difficulties in making and receiving communications with the diabetes education programme administrators, the Directorate now uses SMS text or Email to communicate with programme attendees.

**Children and Adult Services**
Following a complaint from the mother of a patient whose care was in transition from Child to Adult Services the Directorate have reviewed and validated a new Transition (children to adult) Policy and have identified suitable patient pathways, in consultation with Adult Services.

**Northern Centre for Cancer Care**
A patient’s relative contacted NCCC for advice regarding a patient, who was at home and unwell, however subsequently there was no documentary evidence of this communication or the advice given. The national chemotherapy advice tool based on the United Kingdom Oncology Nursing Society Guidelines has as a consequence been implemented. This facilitates assessment of the patient as well as ensuring the giving and documenting of appropriate advice.

**MSU**
Fracture Clinic waiting time has been reduced following restructuring to encompass a team and patient sharing approach with new patients now being seen in the morning and follow up patients in the afternoon.

**Dental**
Patients attending the Newcastle Dental Hospital now receive improved information regarding treatment provided by Dental Students and the availability of urgent care in between appointments.

Of the 19 requests made to the PHSO during the period (11 in 2011/12), being 3% of all complaints made in regard of Trust Services, one was partially upheld and two cases were referred back to the Trust for further information to be supplied to the complainant.

The Trust continues to endeavour to ensure good feedback of learning points from complaints to Directorates and Departments via Action Plans, so that changes in policy and protocols and other practical improvements can be followed up to ensure these are achieved and the “loop closed”.

**Radiology**
A patient did not receive an appointment for an annual mammogram at the correct time and subsequently waited a month for the mammogram results. The Radiology Department and the Surgical Team reviewed the processes involved, and as a consequence the Breast Unit now has control of the five year follow up appointments rather than awaiting requests from the surgeons. The process for filing & reporting of mammograms has also been amended to expedite the patient receiving results.

**Neurosciences**
A patient was admitted for spinal surgery, which unfortunately, due to an emergency case had to be cancelled. The patient complained that they were given no information as to how or when their surgery would be re-scheduled. The Directorate have designed and produced a leaflet to be given to provide patients with the necessary information in the event of a cancellation.

**Womens Services**
Following the stillbirth of her child a patient complained in regard to the lack of information provided to pregnant mothers about fetal movements and stillbirths. The Directorate produced an “Information for Pregnancy” booklet encompassing all aspects of pregnancy. This document is given to all pregnant women, and contains a section about the importance of fetal movements.

**Children’s Services**
After discharge, parents expressed concerns regarding the care of a child’s wound following surgery for incision & drainage of a perianal abscess. Discharge advice leaflets for parents in respect of several different conditions were refreshed accordingly.

**Perioperative Services**
A complaint was made in regard to staff having failed to inform the patient to discontinue Clopidogrel medication prior to admission for surgery. The department shared this issue at the staff governance meeting to highlight and indicate lessons learnt. As a consequence the Medication Advice leaflet was reviewed and updated.
The NHS Patient Survey Programme, managed by the Care Quality Commission (CQC) is intended to be a mechanism for making the NHS more patient focused and provides a quantifiable way of achieving this.

Survey Of Adult Inpatients 2012

Purpose and Methodology
The purpose of the Survey was to understand what patients think of healthcare services provided by the Trust. A standard postal Survey was sent to a random sample of 850 patients discharged from the Trust in July 2012. A response rate of 58.5% was achieved (465 responses). This should be seen in the context of overall activity within the Trust as, during the year 2011-2012, a total of 224,643 patients (day case, elective and non-elective) were cared for in the Trust.

Results
The results highlight many positive aspects of the patient experience, including:

- 86% rated care as 7+ out of 10
- 86% said they were treated with respect and dignity
- 89% always had confidence and trust in the doctors
- 99% said the room or ward was very/fairly clean
- 98% said the toilets and bathrooms were very/fairly clean
- 90% said there was always enough privacy when being examined or treated

The results above indicate that most patients are highly appreciative of the care that they receive. However, it is evident that there is room for improving the patient experience. The Picker Institute use a score – the 'problem score', to indicate where there may be a problem or there is room for improvement (the less desirable results). The problem score shows the percentage of patients for each question who, by their response, indicated that a particular aspect of their care could have been improved; therefore lower scores reflect better performance.

Questions where more than 50% of respondents reported room for improvement are listed below. Focusing on these areas could potentially improve the patient experience for a large proportion of our patients.
The Trust improved significantly in respect of the following questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital: shared sleeping area with opposite sex</td>
<td>9 %</td>
<td>4 %</td>
</tr>
<tr>
<td>Hospital: toilets not very or not at all clean</td>
<td>3 %</td>
<td>1 %</td>
</tr>
<tr>
<td>Hospital: did not always get enough help from staff to eat meals</td>
<td>33 %</td>
<td>20 %</td>
</tr>
<tr>
<td>Doctors: some/none knew enough about condition/treatment</td>
<td>9 %</td>
<td>5 %</td>
</tr>
<tr>
<td>Care: staff contradict each other</td>
<td>30 %</td>
<td>23 %</td>
</tr>
<tr>
<td>Discharge: not fully told purpose of medications</td>
<td>21 %</td>
<td>15 %</td>
</tr>
<tr>
<td>Discharge: not fully told side-effects of medications</td>
<td>57 %</td>
<td>48 %</td>
</tr>
</tbody>
</table>

The position worsened in relation to the following questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital: patients did not get the food they ordered</td>
<td>21 %</td>
<td>27 %</td>
</tr>
<tr>
<td>Discharge: family not given enough information to help</td>
<td>37 %</td>
<td>46 %</td>
</tr>
</tbody>
</table>

I recently had an MRI scan which involved an injection into my hip so I was very nervous. The way I was treated from entering the hospital to the end was fantastic. All the staff had a smile on their face which helped so much. I was advised every step of the way about what was going to happen, and I was even allowed to ask questions without being scorned at. I would definitely recommend this hospital, even if it means travelling from Leeds (as I did!!)

Quote from a patient who rated the Diagnostic Physiological Measurement Service at the Freeman Hospital 5 stars
This Trust:
- Sees around 1.4 million patients every year
- Has 1800 beds in our hospitals across Newcastle
- Employs over 13,300 staff

Yet:
Every patient matters and their experience is very important to us. We collect and listen to feedback from patients, carers, staff and visitors and where we can, make changes to improve the patient experience.

In Quarter 1 2013-14:
We saw and treated:
- 292,455 Outpatients
- 43,755 A&E attendances (including Eye casualty and Walk in Centre attendances)

and we received:
- 158 formal complaints
- 513 PALS contacts

- 59,113 Inpatients
- patients in the community – through a range of community services managed by the Trust including four walk-in centres, nursing, health visiting and health improvement teams.

- 30 comments and suggestions cards
- 32 postings on NHS Choices and/or Patient Opinion websites

Spotlight on... Easy read Patient Information
In order to make our services more accessible, we have been developing some of our patient information leaflets into Easy-read versions. These leaflets can help people with learning disabilities to understand the information and can also help people whose first language is not English as the leaflets contain pictures and photo’s to explain the text.

The Trust now has a license with ‘Photosymbols’ for use in easy-read literature. If you would like access to this facility to create your own easy-read information or would like advice on the development of patient information, have a look at the patient information intranet site (within Patient Services) or contact:
Alison Forsyth, Learning Disabilities Liaison Nurse ext 20959 or Caroline McGarry, Patient Experience and Involvement Officer on ext 31214.

Healthcare at its very best - with a personal touch
What patients have been telling us...

The NHS Friends and Family Test

From 1 April 2013, patients across the country are being asked whether they would recommend inpatient hospital Wards and A&E Departments to their friends and family if they needed similar care or treatment. Maternity Departments will be included in this Survey from October 2013.

In this Trust, we are using postcards given to patients at discharge or following their attendance in the Emergency Department, to ask the friends and family question. Patients can either return completed cards in the postboxes provided on your ward or Emergency Department, or by freepost to a company who are running the test for us – Quality Health.

It is really important for us to get this feedback from patients – their answers will help us to identify where improvements are needed and where good practice can be shared. It will also provide regular and timely feedback to wards about their performance via the ‘How We Are Doing Boards’.

Results of the Friends and Family Test will be published nationally on the NHS Choices website (www.nhs.uk). This gives the public a chance to see how hospitals compare. A score – called the ‘Net Promoter Score’ is used to present the result. It is calculated by taking the proportion of patients who would be ‘extremely likely’ to recommend us minus the proportion who said they would be neither likely nor unlikely, unlikely or extremely unlikely to recommend the ward. The highest possible score is 100 and the lowest is -100.

In the first month of the Test – April 2013, the Trust score was 73.17. We access individual Ward scores via the Clinical Assurance Tool (CAT) as well as the associated comments made by patients and carers, all to enable inform improvement where called for.
Continually improving the patient experience is an essential priority for the Trust as outlined by the following key drivers:

- Care Quality Commission standards of quality and safety
- CQUIN indicator – Patient Experience
- NICE Quality Standard and Guideline for adult inpatients
- NHS White Paper: Equity and excellence: Liberating the NHS

In order to improve, it is vital that we listen to and learn from service user feedback. The following gives some examples of recent actions taken as a result of what patients and the public have told us.

**You told us...**

That patients who use textphones for minicom cannot always get through to the Trust.

This can be a big concern especially if people need to speak to someone urgently e.g. if they are contacting the Emergency Department or the Maternity Unit or advice in labour. It can also be an issue if staff need to contact a deaf or hard-of-hearing patient by telephone e.g. to arrange an appointment at short notice.

That there can be a wait in pharmacy for prescriptions to be dispensed. There is not a great deal of room within the department for people to sit and wait.

**Top Tip:**

If your clinic or area experiences any delays – tell patients on arrival that there is a delay, the reason why and how long they can expect to wait. Don’t forget to apologise for any inconvenience caused.

**We did...**

To enable us to communicate with deaf, hard of hearing and speech impaired people, staff can now contact people using ‘Text Relay’ on any trust telephone.

The UK’s text-to-voice relay service is available 24 hours a day, seven days a week. Guidance has been provided for staff on how to access and use the system. The system can also be used by patients to contact the Trust – staff will receive a message for the Text Relay assistant to alert them to the call.

People can now ask staff to contact their mobile phone number to let them know when their prescription is ready for collection. This enables patients to go for a coffee, to the shop or wait outside the department.

**Please tell us if you have made changes as a result of patient feedback so we can include directorate or service specific information within future reports.**

Caroline.mcgarry@nuth.nhs.uk ext 31214
Care Connect is a new online service enabling patients and the public to act as the “eyes and ears” of the NHS in an open and transparent way. Launched on 31 July 2013 the Trust has agreed to become part of a Newcastle pilot.

Members of the public can use the site to:
1. Share their experience
2. Ask a question
3. Report a problem

It is hoped that this service will make the NHS more accessible and transparent to the public and will help the NHS quickly understand areas of concern and respond accordingly.
HOW WE DO IT
Keeping you safe
The Newcastle Hospitals are committed to achieving excellent standards in Infection Prevention and Control (IPC) and delivering safe, high quality care to patients. Environmental cleanliness is everyone’s responsibility; across the whole health economy we take a positive approach to providing our patients, visitors and staff with clean, well maintained facilities which are fit for purpose.

The Trust promotes a culture of continuous improvement and an integrated approach which is reflected throughout the organisation via the Board of Directors to all members of staff to ensure a sustained reduction in healthcare associated infection (HCAI).

The Trust can report a reduction in the number of MRSA bacteraemiae cases in 2012/13, with 4 cases compared to 7 in the previous year and matching the Department of Health target of no more than 4 cases.

There was a significant reduction in the number of cases of Clostridium difficile. The Department of Health target of 95 hospital acquired cases of Clostridium difficile (2012/13) was comprehensively met, with 76 cases reported.

In January 2011, national mandatory surveillance was extended to include all MSSA bacteraemiae and again in June 2011 to include E. coli bacteraemiae. Whilst there are no national targets at present, by contributing to this surveillance it will enable a greater understanding of the national and local position in respect of these infections.

All MRSA and MSSA bacteraemiae and confirmed hospital acquired cases of Clostridium difficile are subject to a Rapid Review or Root Cause Analysis (RCA); being a process now very well established whereby individual cases are reviewed to closely examine the circumstances in which the infection occurred, highlighting both good practice and areas for improvement. A Trust wide HCAI scorecard is produced on a monthly basis and illustrates performance rates against the targets and a quarterly HCAI Report is submitted to Infection Prevention and Control Committee (IPCC) prior to dissemination to all Departments and Directorates.

As reflected in the wider community, frequent cases of Norovirus have been identified throughout the year. The Trust has responded in a very proactive way ensuring patients are cared for safely and effectively, achieving a balance between preventing spread of infection and maintaining organisational activity. All Trust outbreak documentation has been reviewed to promote accurate communication between clinicians and the IPC Team. Education sessions on outbreak management were delivered to nursing staff throughout the organisation prior to the winter months. This has facilitated prompt identification of symptomatic patients and improved organisation wide communication regarding bed closures.

Influenza activity in the 2012/13 season was low being reflected in the numbers of admissions during the winter season, with significantly less admissions than the previous year. The IPC Team continue to support clinicians where there were admissions in relation to safe patient management and access to the appropriate Personal Protective Equipment (PPE).

The Trust achieved a high level of staff immunisation with a high profile Influenza Vaccination programme led by Occupational Health. The Healthcare Acquired Infections Prevention and Control Strategy was refreshed, to reflect changes within the organisation, identifying clear structures, roles and responsibilities both strategically and operationally. In addition, the HCAI Action Plan has been updated to support the Strategy. The Action Plan provides a framework to facilitate IPC service provision, outlining key objectives for the coming year. Progress is monitored on a quarterly basis by the IPCC.

The principles of Aseptic Non-Touch Technique (ANTT) were further reinforced and promulgated across the Trust in the course of the year. This was supported by a series of education sessions and reinforcement of the role of ANTT Advisors in both our acute and community settings.

The Clinical Assurance Tool (CAT) is the Trust’s main nursing audit tool and comprises a number of quality indicators and it also continues to provide assurance on cleanliness and IPC practice and knowledge. A monthly report is submitted to the Board of Directors and more specific, meaningful data is fed back to directorates and individual clinical areas in relation to their performance and progress. Hand hygiene audit activity has now been incorporated in to CAT and continues to monitor staff compliance with the 5 Moments for Hand Hygiene, appropriate hand hygiene technique and compliance with Bare Below the Elbow (BBE) on a monthly basis. This information is included in the “How We Are Doing” boards in every Ward and Department. CAT is now well established in the acute setting and the roll out to community services in 2011/12 has now embedded it there too.

The results from the National Patient Survey of Inpatients 2012, which is managed by the Care Quality Commission (CQC), indicated that 99% of patients said “the hospital room was very / fairly clean” and 94% said “hand wash gels were visible and available to use”. In a CQC benchmark report, the findings demonstrated that the Trust performed ‘better than other Trusts’ in relation to cleanliness and hand washing.
Please clean your hands when entering & leaving wards, departments and clinics
don’t spread germs
HEALTHCARE AT ITS VERY BEST
THE FUNDAMENTAL CHALLENGE WE FACE

Ensuring we meet expectations at all times in a caring and compassionate manner
Failing NHS hospitals are ‘trapped in mediocrity’

- NHS chief Sir Bruce Keogh gives damning diagnosis of trusts with highest death rates
- Health Secretary puts 11 of the country’s 14 worst care centres into special measures
- Overstretched staff and substandard management led to hundreds of deaths
Clinical Governance is a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

Clinical Governance encompasses a variety of principles which comprise:

- Education and Training
- Clinical Audit
- Clinical Effectiveness
- Research and Development
- Openness
- Risk Management
- Information Management

**Education and Training**

The Trust engages in active undergraduate training programmes for doctors, dentists, nurses and various therapy groups. It also acts as a training institution for clinical scientists and other allied health professionals.

All practitioners undergo annual appraisal which includes the monitoring of continuing professional development (CPD), evidence of clinical effectiveness, audit and patient and colleague surveys. Recently the General Medical Council (GMC) has introduced rigorous revalidation processes for medical staff on a 5 year recycle.

**Clinical Audit**

There is an active programme of clinical audit by which the quality of local care can be compared with expected standards. Priority is given to the comparison of standards of care within the Trust against external benchmarks such as guidelines from the National Institute for Health and Clinical Excellence (NICE). Emphasis is placed on re-audit after an interval to ensure that progress has been made from initial findings and that any necessary action plan has been put in place.

Each clinical directorate has an audit lead that is responsible for supervising this process in individual directorates.

**Clinical Effectiveness**

The Trust ensures that there is a clear evidence base derived from research and ongoing clinical evaluation for all treatments that are offered. Rigorous evaluation is employed at corporate level for any new procedures including operations or other interventional techniques. It is further ensured that the relevant practitioner has undergone the necessary training prior to such procedures being carried out.

The Executive and the directorate management teams closely monitor a bespoke selection of effectiveness indicators which are displayed on a series of “dashboards”.

**Research and Development**

Good professional practice has always been in a state of flux in the light of evidence from research. The Trust has an impressive portfolio of research activity much of which is undertaken in collaboration with Newcastle University. We are fortunate that Newcastle University is one of the foremost institutions in the field of medical research. Research funding is derived from the NHS research and development budget and a range of national and international sources.
Hydrotherapy pool, Royal Victoria Infirmary
Openness

Patient involvement is essential to a policy of openness. Any organisation providing high quality care has to show that it is meeting the needs of the population it serves. Health needs assessment and patient surveys are crucial to this aim.

The Trust encourages active participation by patients through the Patient and Public Involvement Forum. Our Board of Governors are also pivotal in influencing the high standard of patient experience. Given that it is members of a number of Trust committees including the Clinical Governance and Quality Committee and the Complaints Review Panel. Complaints are treated individually and proper investigation ensures that any appropriate lessons are learnt and potentially avoided in the future. Patterns and trends of complaints are also analysed to ensure a prompt response if appropriate.

In order to ensure our primary value of “placing patients at the heart of everything we do”, patient experience and involvement is actively encouraged.

Risk Management

The risk management process is inclusive of patients, practitioners and the organisation itself. The Trust complies with statutory regulations which help to minimise risks to patients. Incident reporting is encouraged with subsequent investigations in order to complete a learning process. The Trust attempts to provide an enabling culture which encourages reporting of untoward incidents. The underlying causes can then be established and an action plan developed and implemented to prevent recurrence. Such learning processes are then disseminated throughout the directorate system for educational purposes.

Work is continually progressing to reduce the risk of all forms of healthcare acquired infection (HCAI) within the Trust. Standards relating to aseptic techniques, environmental cleanliness and hand hygiene are continually monitored and audited. Cases of severe infection undergo a detailed root cause analysis with review by senior members of the clinical team together with the Medical Director, Nursing & Patient Services Director and the Director of Infection Prevention & Control. These measures have resulted in reduction in the incidents of MRSA bacteraemias and in the incident of C.difficile infections. Vigilance continues in this important field.

Two Clinical Directors of Quality & Patient Safety have recently been appointed. They will work in close collaboration with the Director of Clinical Governance & Risk to ensure that any potential clinical risk issues are proactively managed.
Information management

Each clinical directorate is subject to performance management three times per year. These reviews concentrate on all aspects of the directorate including activity levels, review of waiting lists and financial and business performance. Directorates are also subject to an annual review of their clinical standards and practice which examine the components of clinical governance. Each directorate therefore has some governance mechanism within the framework of the Trust corporate governance procedures.

The Trust benchmark sits performance against similar organisations using data provided by CHKS; the National Audit Office; the Care Quality Commission; and Dr Foster. The Trust has also been subject to scrutiny in a number of peer reviews and by external organisations including National Cancer Peer Review from which it has received a commendation.

An active clinical guideline database is maintained on the Trust intranet which includes locally developed and national guidelines summarising best practice in the management of a wide variety of clinical conditions. Trust policies and procedures are developed and revised where necessary after discussion at the relevant committees and published on the intranet. All staff has access to either Trust network to the intranet and the internet.

I am confident that the Trust is achieving continuing success in terms of clinical governance which is reflected in the high quality of patient care and outcomes within the organisation. This success can only be achieved with the active support and high professional standards of all of our colleagues within the Trust. The Trust and our patients are grateful for the continuing support of all concerned.

Andrew Welch
Medical Director
As with many aspects of Trust management, the role and function of the Clinical Effectiveness, Audit and Guidelines (CEAG) Committee have not changed significantly over the past year - any change has been incremental rather than dramatic. It may be helpful to begin this report by reviewing the principal duties of the Committee. These are firstly, the monitoring and promotion of audit (and allied activities) within the Trust, and secondly, assessing current compliance with and implementation of national guidance and recommendations.

All Directorates produce an annual report of their audit activities and guideline implementation, which is presented to the CEAG Committee at its monthly meetings. The requirement for reports to follow a standard structure is now well-established, and this both facilitates analysis of the report and enables the Committee to gain a clearer picture of exactly what is going on – or not going on – within the Directorate. Inevitably, the organisation, range and standard of audit activity vary, but most departments appear to be making satisfactory progress. All medical staff are expected to participate in audit activities, but it would be pleasing to see a higher proportion of nursing and other health professional staff also involved.

Monitoring the implementation of national guidance, while linked to audit activity, is a much more significant role. I have commented in previous reports that the sheer size and diversity of the Trust means that nearly every standard or guideline emerging from the National Institute for Health & Care Excellence (NICE), a Royal College, or some other source will be applicable somewhere in the Trust. Each standard needs to be considered by the relevant clinical group(s), a baseline assessment made of the level of compliance, and any gaps identified. Not infrequently, Trust staff have themselves contributed to development of the guidance, which helps in this process. Significant variations from the national recommendations – because of inadequate staffing or facilities, or because local clinical opinion differs materially from the guidance – are referred to the Clinical Governance and Quality Committee (the ‘parent’ committee for the CEAG). Trust management is thereby kept aware of important gaps in compliance with national guidelines, which could potentially present a risk to the Trust (for legal, reputational or other reasons).

A relatively new range of guidelines from NICE are Quality Standards (QSTs), which provide broad standards or expected norms in respect of a range of conditions or areas of care, rather than the more detailed and specific guidance provided by the other NICE guidelines. They are designed to promote quality improvement, are evidence-based, and incorporate both professional and lay opinion. Early examples cover conditions such as dementia, stroke, diabetes and heart failure. Although they are not mandatory, and (to quote from the NICE website) should be seen as “aspirational but achievable”, they may well come to be seen as minimum standards, particularly by commissioners, thereby becoming effectively obligatory. Their implementation can represent a major challenge to the Trust, mainly because the standards are so broad, often crossing directorate boundaries. These standards are also reviewed by the CEAG Committee.

Another key set of quality indicators are CQUIN (Commissioning for Quality and Innovation) targets, which are agreed with local commissioners, and influence income received by the Trust. They are designed to enable the commissioners to reward local quality improvements, and are mainly concerned with Trust-wide practice considerations such as dementia screening and referral, or assessment of venous thromboembolism risk, although may also cover more specific aspects of care, such as screening of neonates for retinopathy. Again as part of their annual reports, Directorates are expected to report to the CEAG Committee on their achievement of CQUIN targets.

In addition to all the above, the Trust participated in 45 of the 46 National Clinical Audits running in 2012–13 – examples include management of heart failure, asthma deaths and cardiac arrest. While participation is not strictly obligatory, it would be inconceivable that a major hospital such as Newcastle would not contribute data to these audits, whose purpose is to improve practice. To facilitate reporting on Trust status in these audits, the Clinical Governance & Risk Department has developed a standardised template for clinicians to use to identify areas of good practice, and those aspects where improvement is required. This information is publically available in the Trust’s Annual Quality Account, and again, details are expected to be presented to the CEAG Committee.

At a more ‘local’ level, innovations during the past year have included development of an on-line register of clinical audit and effectiveness activity. Service evaluations and patient experience reports, while not strictly audit, can also be logged. Surveys of reporting levels pre- and post-introduction of the on-line system suggested that it has nearly doubled levels of reporting – a significant improvement, given that the capture of audit activity in the Trust is a persistent concern. Another proposal, currently at an early stage, is the re-introduction of the Sharing Good Practice Awards scheme. This started life as the Clinical Audit Prize in 1992, and was specifically commended by the Commission for Health Improvement (CHI) when it visited the Trust in 2002. However, the Awards were discontinued in 2008/09, with time and financial pressures cited as the reason. The Clinical Governance and Risk Department (CGARD) hopes to obtain alternative funding, with a view to their re-introduction next year – we shall see. As for the CEAG Committee itself, it is essentially unchanged, although securing the regular participation of senior medical staff is a perennial problem (largely because of the demands of clinical duties) to which there is no easy answer.

As always, I end my report by thanking all those members of staff who have contributed to the work of the CEAG Committee and of CGARD. Their helpful advice, willing counsel and attention to detail have all helped to ensure that business has run smoothly and effectively, and that the chairman has not got it too wrong, too often.

Ian R Fletcher
Chairman, Clinical Effectiveness, Audit and Guidelines Committee
IMPROVING YOUR CARE
More women are shunning the hospital bed in favour of an active birth. KERRY WOOD visits the RVI Birthing Centre

Walking, squatting or on all fours: it’s a million miles away from lying in a hospital bed. Gone are the visions of sweating, screaming women on their backs in the grip of labour as thousands embrace the calming and pain-relieving effects of active birth.

More and more women in the region, with the support of a wave of classes, are hoping to have ‘normal’ and ‘drug-free’ births by staying active as their contractions quicken.

The move away from pain-relieving drugs and intervention is buoyed by the opening of the Royal Victoria Infirmary’s (RVI) Birthing Centre. In the 20 months since it opened its doors, more than 2,600 babies have been born at the unit which offers 12 spacious en-suite rooms equipped with a plethora of birthing aids.

From its decor, bouncing balls and birthing seat to the absence of traditional hospital beds and option for epidural pain relief, everything at the centre is geared towards reaping the benefits of an active birth.

Elaine Blair is head of midwifery at the RVI. She said: “Currently there is a huge NHS drive to get as many women as possible to have ‘normal’ births and to increase these rates because of the health benefits to both mother and baby. “If a woman’s first birth is normal with no complications then this increases the chances of her having subsequent normal births and active birth is something we encourage. It is up to each woman to decide what anti-natal preparation they want to do, some are very active in seeking out as much information as possible while others are not so.

“Others are not so. “There are three key factors in having a normal birth. Ante-natal preparation, good support from those attending the birth and one-to-one care.

“Some women unfortunately due to reasons beyond their
control are unable to have normal births but preparation is so important. Active birth is about movement and being mentally prepared for labour.

Nationally among maternity wards a ‘normal’ birth is deemed to be one that commences, continues and then completes without any intervention such as the use of forceps or administration of an epidural.

Research used by the NHS shows the benefits achieving a normal birth can have on both mother and baby. Straightforward births can result in shorter or no hospital stays and fewer admissions to neonatal units, and is also associated with higher rates of successful breast-feeding.

During the past six years there has been concern nationally about the rising rate of interventions during labour with the belief that maternity units applying ‘best practice’ during labour and delivery – free from the need for epidurals – can greatly lower this rate.

Amy Ritchie, 27, swears by the pain-relieving power of water after giving birth to her first baby Amelia Rose, weighing 6lb 13ounces, on her birthday February 28 at the Newcastle’s birthing centre.

“I came into the centre at 6.30am and gave birth at 8.30am with no pain relief.”

Getting into the birthing pool really helped and I just let my body do what it wanted to do. The atmosphere in the centre is very relaxed and helps keep you calm during labour.”

Something as subjective as the feel of a room and lighting can affect a woman’s progress through labour, experts say, and Newcastle’s birthing centre is designed to create just the right environment.

Elaine added: “Overwhelmingly the women that have used the birthing centre have loved it. The rooms are very spacious and the birthing environment has a big factor in a woman’s labour and how they cope, so things such as not having a very bright room, having quiet and privacy can all affect a delivery.

“The birthing environment downstairs is something we want to replicate in the delivery unit. A refurbishment is already planned and is getting under way shortly.”

Helping pregnant women plan for their labour is Lynn Campbell who holds active birth sessions at the birthing centre’s training room as well as Dance City in Newcastle and the Sage, Gateshead.

Having started the classes 12 years ago she moved to the RVI in 2004. Lynn said: “When I started, active birth was a very new concept to the North East and there were not many classes. At first women came to me as they wanted to focus on movement and we do yoga as part of the class. At the moment active birth and interest in it is strong and certainly my classes are always full and there’s a waiting list.

“I think women are more aware now of the importance of doing something for their own well-being during pregnancy and preparing mentally for the birth. As well as yoga, we use lots of visual aids to give women and their partners a greater understanding of how their body will change during labour and what will happen.

“Active birth is good practice in lots of hospitals, yet all you ever see on TV are women laying on their backs, not moving. It is a false image of how labour is for a lot of women.

“It is key to stay active during labour, using movement and your breath to help manage pain.”

Preparation for labour and birth classes are offered to would-be parents on the NHS.

FACTFILE:

Newcastle Birthing Centre at the RVI:

- Opened in June 2011, midwifery-led and free to use
- Available to pregnant women deemed ‘low risk’ between 37 and 42 weeks pregnant
- Includes facilities
- Provides women with gas and air or Diamorphine and Pethidine for pain
- No epidurals are administered at the centre
- Women wanting one will be transferred upstairs to the RVI’s delivery unit

The centre is also available free to women living outside of the Newcastle area

Unlike stand-alone centres Newcastle’s is co-located which means there are additional health professionals upstairs

For more information about the centre, visit www.newcastlебirthcentre.co.uk

BIRTH RATE Elaine Blair

Birthing Centre.

Speaking to The Journal hours after giving birth, she said: “I knew as soon as I found out I was pregnant I knew that I wanted a water birth and I read up as much as I could about staying active.

“I came into the centre at 6.30am and gave birth at 8.30am with no pain relief.”

Going into labour at 8pm the previous evening, Amy, from Wallsend, managed to handle the pain of her contractions by staying mobile while at home.

She added: “Before labour I never said there were drugs I would or wouldn’t have I just said I’d see how I go with the pain but was able to managed it by staying active and when I came to the centre I was already fully dilated.

Some women unfortunately due to reasons beyond their control are unable to have normal births
LOCAL HEROES HONOURED FOR HEALTH WORK

A team providing care for children suffering from cancer was among the first to receive an ‘NHS Heroes’ certificate.

The Paediatric Oncology Unit, based at the Great North Children’s Hospital at the RVI, was nominated by a member of the public for the work it does as “a fantastic team, dealing with stressed parents facing their worst nightmare, and treating sick children with awful life-threatening illnesses.”

This national NHS Heroes scheme sees special certificates presented to teams and individuals in the NHS to celebrate the extraordinary work that staff do every day.

The scheme is designed to formally recognise all those who make a difference to their patients, communities and colleagues. People across the country nominated staff and volunteers in the NHS, with the regional Strategic Health Authorities making the final decision on who received the honour.

The Paediatric Oncology Unit’s nomination continued: “The ward is always so busy (sadly) and they work together as a team, always smiling.”

NHS Heroes certificates were also awarded to Consultant Orthopaedic & Spinal Surgeon, David Fender and Specialist Nurse, Gillian Smith, both based at the RVI as well as district nurse Pat Milligan.

The nomination for Pat read: “Pat is a caring, dedicated district nurse who has looked after many of our patients and goes the extra mile. When she finally retires she will have worked for the NHS for 50 years.”

Gillian’s nomination read: “I always find Gill really practical and a good active listener, who suggests practical solutions. I really appreciate how she discusses things with me as a person rather than a patient/problem to be solved.”

Mr Fender was nominated by one of his patients who said in his nomination: “He never gave up hope that he could help to improve my quality of life. He fought for my dignity whilst I was in hospital and is so approachable and never shies away from my questions.”

Sir Leonard Fenwick, Chief Executive at the Newcastle Hospitals, said: “We know that we employ wonderful and dedicated staff who make sure that our patients receive the best possible care, but this scheme gives us the opportunity to show just how much we appreciate the work they do.

“I’d like to congratulate each of the winners and thank them for all the good work they do on a daily basis.”
We know that we employ wonderful and dedicated staff who make sure that our patients receive the best possible care, but this scheme gives us the opportunity to show just how much we appreciate the work they do. I’d like to congratulate each of the winners and thank them for all the good work they do on a daily basis.
Nurses, Midwives, and the staff who support them in the delivery of care have, in line with the Trust’s Nursing Strategy, continued to strive to deliver care that enables us to be “Proud of Nursing and Midwifery in Newcastle”. Delivering Care which is recognised to be compassionate and of high quality is fundamental to patients having a positive experience whether that be within one of our Critical Care units, Out-Patient settings or whilst receiving care in their own home. A key priority in this year has been to build on previous achievements to ensure patients receive excellent care that is personalised to their needs.

Fully understanding the needs of our patients is of overriding importance and with this in mind the Trust introduced a scheme to support patients with Dementia. The ‘Forget me not’ scheme, to improve communication with patients who have dementia and delirium, was introduced across the Trust in October 2012. Nursing staff ask a family member or carer to complete a ‘Forget me not card’, which provides details of the patient’s likes and dislikes, what they enjoy doing and what may cause anxiety. The card is kept beside the patient where all clinical and support staff can look at it. Use of the card prompts staff to have conversations with patients on familiar topics which is reassuring and person centred. The ‘Forget me not card’ can also be used for patients who have other communication difficulties, e.g. those who have had a stroke or those with learning disabilities.

Other changes which have been introduced to support people with dementia include alterations to the environment on wards which care for high numbers of people with dementia. A multi-disciplinary team, led by nursing has supported the introduction of new crockery and equipment to promote better nutrition, pictorial signage to support and promote orientation and independence. This work will continue during the coming year to further enhance the patient experience.

Excellent multi-disciplinary working has been at the heart of work around good nutritional care, and nursing expertise plays a pivotal role in this. Some key successes this year include embedding of Trust-wide personalised nutritional care plans and mealtime audits demonstrating excellent nutrition practice. The Trust is also developing bespoke nutritional care for patients with cognitive impairment. The Shire Awards for Gastrointestinal Excellence (SAGE) award was received by the Freeman nutrition team as part of the ‘Northern Nutrition Network’ which is a collaboration of multi disciplinary teams including physicians, surgeons, dieticians, nurses, pharmacists and biochemists, all based in the North East and dedicated to improving outcomes for patients in need of nutritional support.

Compassion

Compassion is a fundamental part of nursing care and there are many examples of how nurses in their everyday practice provide compassionate care and how nursing developments underpin compassionate care.

Nurses are at the front line of delivering high quality, compassionate cancer care, playing an important role in the successful implementation of initiatives to improve cancer services. Nurses are often the main point of contact for patients and as a result help to; shape services for each patient according to need and patient choice; improve patients’, and their families’, ability to self manage symptoms and side effects of treatment. Nurses are also involved in designing and delivering new services to deliver care closer for home:

- A Trust wide Acute Oncology Service has been established, resulting in patients being assessed promptly when admitted to hospital as a result of complication of their illness and/or treatment.
- A Nurse led homecare chemotherapy service has been developed for some renal and haematology conditions, resulting in a high level of patient satisfaction.

In early 2013, Newcastle Hospitals working collaboratively with Macmillan Cancer Support launched an innovative pilot in the community to address unmet needs of patients living with and beyond cancer.

Despite an increasing incidence of the disease many patients’ experiences of care have been enhanced. The National Cancer Patient Experience Survey results were published in August 2012, and 90% of respondents rated the cancer care they had received in the Trust as ‘excellent’. Patients felt that their privacy and dignity needs had been met and with a confidence in the Ward Nurses and Nurse Specialists.

My Macmillan nurse has been invaluable with help and support. She speaks to my doctor to discuss medication and treatments. My illness would have been much more difficult to cope with had we not had our Macmillan nurse