Putting patients at the heart of everything we do

Review of the Year
Incorporating the Annual Report and Accounts
2014/15
Freeman Hospital
High Heaton, Newcastle upon Tyne. NE7 7DN
Telephone (0191) 233 6161 Fax (0191) 213 1968

Newcastle Hospitals Community Health
Molineux NHS Centre, Molineux Street,
Newcastle upon Tyne. NE6 1SG
Telephone (0191) 282 6605

The Dental Hospital
Richardson Road, Newcastle upon Tyne. NE2 4AZ
Telephone (0191) 233 6161 Fax (0191) 282 4671

Northern Genetics Service
Institute of Human Genetics, International Centre for Life,
Central Parkway, Newcastle upon Tyne. NE1 4EP
Telephone (0191) 241 8600 Fax (0191) 241 8799

Campus for Ageing & Vitality
Westgate Road, Newcastle upon Tyne. NE4 6BE
Telephone (0191) 233 6161

Royal Victoria Infirmary
Queen Victoria Road, Newcastle upon Tyne. NE1 4LP
Telephone (0191) 233 6161 Fax (0191) 201 0155

Northern Centre for Cancer Care
Freeman Hospital, High Heaton, Newcastle upon Tyne. NE7 7DN
Telephone (0191) 233 6161 Fax (0191) 213 1968

Newcastle Fertility Centre
Biosciences Centre, International Centre for Life, Times Square,
Newcastle upon Tyne. NE1 4EP
Telephone (0191) 219 4740 Fax (0191) 219 4747
The Newcastle upon Tyne Hospitals NHS Foundation Trust

Review of the Year
Incorporating the Annual Report & Accounts
2014/15

Presented to Parliament pursuant to Schedule 7, paragraph 25(4) (a) of the National Health Service Act 2006
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year in Brief</td>
<td>4 5</td>
</tr>
<tr>
<td>Chairman’s Statement</td>
<td>6 7</td>
</tr>
<tr>
<td><strong>What we do</strong></td>
<td></td>
</tr>
<tr>
<td>Service Portfolio</td>
<td>10 11</td>
</tr>
<tr>
<td><strong>How we did</strong></td>
<td></td>
</tr>
<tr>
<td>Summary of Service Statistics</td>
<td>15</td>
</tr>
<tr>
<td>Performance</td>
<td>16 25</td>
</tr>
<tr>
<td>Our Annual Plan</td>
<td>26 31</td>
</tr>
<tr>
<td>Speak up - We are listening</td>
<td>36 37</td>
</tr>
<tr>
<td>Complaints</td>
<td>38 41</td>
</tr>
<tr>
<td>National Survey of Inpatients</td>
<td>42 47</td>
</tr>
<tr>
<td>Take 2 minutes... See how we did</td>
<td>48 49</td>
</tr>
<tr>
<td><strong>How we do it</strong></td>
<td></td>
</tr>
<tr>
<td>Infection, Prevention &amp; Control</td>
<td>52 65</td>
</tr>
<tr>
<td>Healthcare at its very best - The fundamental challenge we face</td>
<td>66 73</td>
</tr>
<tr>
<td>NHS Five Year Forward View</td>
<td>74 75</td>
</tr>
<tr>
<td>Patient Safety &amp; Quality</td>
<td>76</td>
</tr>
<tr>
<td>Quality Strategy and Quality Account</td>
<td>77</td>
</tr>
<tr>
<td>Clinical Effectiveness &amp; Audit</td>
<td>78 79</td>
</tr>
<tr>
<td><strong>Improving your care</strong></td>
<td></td>
</tr>
<tr>
<td>Patient-led Assessments of the care environment (PLACE)</td>
<td>82 85</td>
</tr>
<tr>
<td>Safe, Effective, Quality Occupational Health Service</td>
<td>86 87</td>
</tr>
<tr>
<td>Proud of Nursing and Midwifery in Newcastle</td>
<td>88 99</td>
</tr>
<tr>
<td>Safeguarding and Learning Disability</td>
<td>100 101</td>
</tr>
<tr>
<td>Relocation to Regent Point</td>
<td>102 103</td>
</tr>
<tr>
<td>Engaging with young people in schools &amp; colleges</td>
<td>104 105</td>
</tr>
<tr>
<td>Chaplaincy</td>
<td>106 107</td>
</tr>
<tr>
<td>Great North Trauma &amp; Emergency Centre</td>
<td>108 109</td>
</tr>
<tr>
<td>Great North Children’s Hospital Turns Five</td>
<td>110 111</td>
</tr>
<tr>
<td>Maggie’s Newcastle</td>
<td>114 115</td>
</tr>
<tr>
<td>Health Informatics &amp; IT</td>
<td>116 117</td>
</tr>
<tr>
<td>Research &amp; Development</td>
<td>118 121</td>
</tr>
<tr>
<td>North East &amp; North Cumbria Genomic Medicine Centre</td>
<td>124 125</td>
</tr>
<tr>
<td>NewGene</td>
<td>129</td>
</tr>
<tr>
<td>Medical Director’s Statement</td>
<td>130</td>
</tr>
<tr>
<td>Freeman Clinics Ltd</td>
<td>136 137</td>
</tr>
<tr>
<td>Pharmacy and Medicines Optimisation</td>
<td>138 139</td>
</tr>
<tr>
<td><strong>Developing our staff</strong></td>
<td></td>
</tr>
<tr>
<td>Our Workforce</td>
<td>142 145</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>148 151</td>
</tr>
<tr>
<td>Support for the Armed Forces</td>
<td>152 153</td>
</tr>
<tr>
<td>Project Choice</td>
<td>154 155</td>
</tr>
<tr>
<td>Education and Workforce Development</td>
<td>156 159</td>
</tr>
<tr>
<td>Celebrating Healthy Schools</td>
<td>160 161</td>
</tr>
<tr>
<td><strong>The organisation</strong></td>
<td></td>
</tr>
<tr>
<td>About NHS Foundation Trusts</td>
<td>164 165</td>
</tr>
<tr>
<td>Governors’ Working Groups</td>
<td>166</td>
</tr>
<tr>
<td>Patient, Carer and Public Involvement</td>
<td>168 169</td>
</tr>
<tr>
<td>Community Advisory Panel</td>
<td>172 173</td>
</tr>
<tr>
<td>Corporate Governance and Risk Management</td>
<td>174 177</td>
</tr>
<tr>
<td><strong>Our partners</strong></td>
<td></td>
</tr>
<tr>
<td>Faculty of Medical Sciences, Newcastle University</td>
<td>180 181</td>
</tr>
<tr>
<td>Newcastle Dental Hospital &amp; School</td>
<td>182 183</td>
</tr>
<tr>
<td>Northumbria University</td>
<td>184 185</td>
</tr>
<tr>
<td>Working in Partnership with Newcastle City Council</td>
<td>186 187</td>
</tr>
<tr>
<td>Supporters &amp; Volunteers</td>
<td>188 189</td>
</tr>
<tr>
<td>Daft as a Brush</td>
<td>193 197</td>
</tr>
<tr>
<td>Charity Matters</td>
<td>198 247</td>
</tr>
<tr>
<td>The Sir Bobby Robson Foundation</td>
<td>230 237</td>
</tr>
<tr>
<td>The Newcastle Healthcare Charity</td>
<td>238 239</td>
</tr>
<tr>
<td>Board of Directors and Senior Professional Staff</td>
<td>248 252</td>
</tr>
<tr>
<td><strong>Annual Report &amp; Accounts 2014/15</strong></td>
<td></td>
</tr>
<tr>
<td>Chief Executive’s Statement</td>
<td>256 257</td>
</tr>
<tr>
<td>Strategic Report</td>
<td>258 259</td>
</tr>
<tr>
<td>Directors’ Report</td>
<td>260 271</td>
</tr>
<tr>
<td>Board of Directors</td>
<td>272 275</td>
</tr>
<tr>
<td>Our Governors</td>
<td>276 281</td>
</tr>
<tr>
<td>Operating and Financial Performance Review</td>
<td>282 283</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Interest Disclosure</td>
<td>284</td>
</tr>
<tr>
<td>Statement of Chief Executive’s Responsibilities as Accounting Officer</td>
<td>286 287</td>
</tr>
<tr>
<td>Annual Governance Statement</td>
<td>288 295</td>
</tr>
<tr>
<td>Quality Report</td>
<td>296 355</td>
</tr>
<tr>
<td>Statement of Director’s Responsibilities</td>
<td>356</td>
</tr>
<tr>
<td>Independent Auditors’ Limited Assurance Report</td>
<td>357 361</td>
</tr>
</tbody>
</table>
A TAXI has crashed into the historic lodge building at Newcastle’s Royal Victoria Infirmary, causing its roof to collapse.

Huge bricks landed on the roof of the white Five Star cab after it reversed into a support pillar at the building, situated just at the entrance of the hospital.

No one was injured in the bizarre smash, which happened at around 3pm yesterday, however it did cause chaos for motorists.

Some onlookers told the Chronicle they thought the car had rolled into the lodge after the handbrake was left off.

However, police say the cause of the incident is under investigation.

Stunned onlookers watched on as police cordoned off the damaged cab and surrounding area, in front of perplexed hospital workers.

Kayleigh Trainer, 27, was walking past at the time. She said: “It’s just really lucky there were no passengers inside.

“That must be a listed building, it’s probably been there for hundreds of years - you can see how old it is.

“But maybe it’s a good thing it’s happened now, it can’t have been that safe if it could just fall down like that.”

There were large traffic jams outside the hospital as police diverted motorists away from the car park.

A Northumbria Police spokesman said: “No one was injured and inquiries are ongoing.”

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THE CHRONICLE WEDNESDAY, MAY 28, 2014

Taxi causes road chaos with crash outside hospital

By Sophie Doughty
Crime Reporter
sophie.doughty@ncjmedia.co.uk

The scene after a taxi crashed into a building at the RVI in Newcastle

Stunned onlookers watched on as police cordoned off the damaged cab and surrounding area, in front of perplexed hospital workers.

Kayleigh Trainer, 27, was walking past at the time.

She said: “It’s just really lucky there were no passengers inside.

“That must be a listed building, it’s probably been there for hundreds of years - you can see how old it is.

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EDITORIAL FROM THE CHRONICLE
Monitor applied a rating system from 1 to 4, where higher numbers are better, from 1st October 2013, which produced the following ratios in 2014/15:

**Continuity of Services Ratios 2014/15**

1. A risk was declared against the following three targets when the annual plan was submitted in April 2014:
   - RTT, admitted patients
   - RTT, non-admitted patients
   - Cancer 62 week waits (from GP referral).

2. Both of the RTT targets were breached in Q2 and Q3 but this was as part of the national programme to manage down the backlog of “long waiters”.

**Income & Expenditure 2014/15**

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<tr>
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<th>Before exceptional items and charitable funds (i.e. Trust)</th>
<th>Exceptional Items</th>
<th>Charitable Funds</th>
<th>Total for Group</th>
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<tbody>
<tr>
<td>Income</td>
<td>971,339</td>
<td>34,982</td>
<td>2,445</td>
<td>1,008,766</td>
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<tr>
<td>Expenditure</td>
<td>(934,998)</td>
<td>(919)</td>
<td>(935,917)</td>
<td></td>
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<tr>
<td>Operating Surplus</td>
<td>36,341</td>
<td>34,982</td>
<td>1,526</td>
<td>72,849</td>
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<tr>
<td>Net Finance Costs</td>
<td>(29,843)</td>
<td>0</td>
<td>306</td>
<td>(29,537)</td>
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<tr>
<td>Surplus for the year before exceptional items:</td>
<td><strong>6,498</strong></td>
<td><strong>34,982</strong></td>
<td><strong>1,832</strong></td>
<td><strong>43,312</strong></td>
</tr>
</tbody>
</table>

**Governance Ratings 2014/15**

<table>
<thead>
<tr>
<th></th>
<th>Annual Plan</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debt Service Cover Ratio</td>
<td>2</td>
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<tr>
<td>Liquidity Ratio</td>
<td>4</td>
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<tr>
<td>Overall</td>
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<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Annual Plan</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT – Referral to Treatment - Admitted Compliance</td>
<td>90%</td>
<td>Q1 90.5%</td>
<td>Q2 88.3%</td>
<td>Q3 88.6%</td>
<td>Q4 90.5%</td>
</tr>
<tr>
<td>RTT – Referral to Treatment - Non-Admitted Compliance</td>
<td>95%</td>
<td>Q1 95.6%</td>
<td>Q2 94.8%</td>
<td>Q3 93.0%</td>
<td>Q4 92.7%</td>
</tr>
<tr>
<td>RTT – Referral to Treatment - Incomplete Compliance</td>
<td>92%</td>
<td>Q1 93.3%</td>
<td>Q2 92.6%</td>
<td>Q3 92.1%</td>
<td>Q4 92.8%</td>
</tr>
</tbody>
</table>
Year in Brief

Key Patient Activity 2014/15

- Non-elective Inpatient FCEs: 37.7%
- Elective Inpatient FCEs: 13.3%
- Day Case FCEs: 49.0%

Expenditure Split by Specialty

- Cardiothoracic Services, 12.06%
- Dental Hospital and Oral Surgery, 1.97%
- Trauma And Orthopaedics, 5.48%
- ENT, 2.38%
- Clinical Genetics, 0.80%
- Haematology, 3.24%

Expenditure Split by Specialty

- R&D, 3.0%
- Education & Training, 6.3%
- Community Services, 4.02%
- SITF, 2.36%
- R&D, 4.02%
- Neuroscience, 6.34%
- Rheumatology, 1.38%
- Internal Medicine, 12.79%
- Childrens Services, 8.28%
- Other NHS bodies, 2.3%
- Local Government, 1.0%
- Non NHS bodies, 3.5%

Income by Source 2014/15

- NHS England, 35.7%
- Newcastle North and East CCG, 9.8%
- Newcastle West CCG, 10.6%
- North Tyneside, CCG 6.5%
- Other CCGs, 1.8%
- Foundation Trusts, 1.4%
- R&D, 3.0%
- Other NHS bodies, 2.3%
- Newcastle North and East CCG, 9.8%
- Newcastle West CCG, 10.6%
- North Tyneside, CCG 6.5%
- NHS England, 35.7%
- Cumbria CCG, 1.2%
- Sunderland CCG, 0.9%
- South Tyneside CCG, 1.2%
- Gateshead CCG, 3.4%
- Northumberland CCG, 6.1%

Periop and Critical Care, 1.07%
Plastic Surgery, 2.67%
Dermatology, 1.51%
Ophthalmology, 3.19%
Renal Services, 4.56%
Womens Services, 5.39%
Surgical Services, 7.72%
Cardiothoracic Services, 12.06%
Childrens Services, 8.28%
Foundations Trusts, 1.4%
Education & Training, 6.3%
Chairman’s Statement
The year ended 31st March 2015 was our ninth year as a Foundation Trust. We treated more patients than ever before, had first class quality outcomes and maintained a strong financial position.

This reflects our acknowledged national and international reputation for putting our patients at the centre of everything that we do and providing the highest quality of care to them in the key areas of clinical outcomes, safety and patient experience. It is the demonstrable quality of care that influences patients in exercising their choice and why they come to us for their care and treatment.

This was achieved despite many challenges including the Government’s demands for continuing expenditure reductions year on year - in our case £35m a year; more and more patients coming to our hospitals; severe pressure on our Accident and Emergency services; and ever-increasing demands from NHS England and Monitor for information and data.

The response from our clinicians, nurses and indeed the whole workforce to meet these challenges has been and continues to be magnificent.

It is also worth noting that in the 2015/16 trading year it is forecast that nearly 80 Foundation Trusts will be in financial deficit, which makes our strong financial position all the more remarkable.

This year we treated 1.66 million patients, there were 184,917 attendances at A&E and our Walk-in Centres, 80,078 children were seen at our Great North Children’s Hospital, 7,335 babies were born under our care, and 8,201 cataract operations, 1,811 joint replacements and 404 organ transplants were carried out.

Our Foundation Trust, working with its key partner, Newcastle University, continues to be one of the very best in the country for patient involvement in successful clinical research and development, with nearly 16,000 patients enrolled in clinical studies.

We shall continue to remain one of the highest performing in the country. We will ensure continuing strong clinical engagement, understanding and support. We will not be complacent and will continue not just to maintain our high level of care but through research and development and seeking out world best practice, further enhance clinical treatments and quality of care for our patients. The overriding principle in our delivery of care is to treat our patients to the best standards that they would expect not just for themselves but for their family and loved ones.

May I express appreciation for the Board of Directors, who are committed and single-minded in their drive to deliver the Trust’s vision and strategic goals. I would also like to thank our Governors, who have been diligent, dedicated and committed to holding the Board to account for its performance and have engaged constructively with the Board to maintain our position as one of the best Foundation Trusts in the country.

In conclusion, I would like to thank most sincerely our workforce for the massive contribution that they have made to our success. It is their commitment, dedication, caring qualities and the high standards that they deliver and maintain that are the bedrock of our success and I am most pleased to acknowledge and record how much they are valued and appreciated.

Kingsley W Smith OBE DL
Chairman

The Newcastle upon Tyne Hospitals NHS Foundation Trust can once again reflect with pride upon a most successful and busy year.

The year ended 31st March 2015 was our ninth year as a Foundation Trust. We treated more patients than ever before, had first class quality outcomes and maintained a strong financial position.

This reflects our acknowledged national and international reputation for putting our patients at the centre of everything that we do and providing the highest quality of care to them in the key areas of clinical outcomes, safety and patient experience. It is the demonstrable quality of care that influences patients in exercising their choice and why they come to us for their care and treatment.

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Review of the Year

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

Yet another world first has been carried out at Newcastle’s Freeman Hospital.

On this occasion, surgeons implanted a circulatory pump into Harry Chivers, which will stop his heart failing.

The breakthrough offers real hope to thousands of patients awaiting transplants.

And the beauty of it is, if it fails, it can simply be replaced.

As for Harry? Well, as he said “I feel fantastic. This has saved my life... and has the potential to save more.”
How we did
# Summary of Service Statistics

## Inpatient and Daycase activity

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Non-elective inpatient FCEs</td>
<td>70,988</td>
<td>76,051</td>
<td>83,231</td>
<td>84,341</td>
<td>82,499</td>
<td>85,716</td>
<td>88,503</td>
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<tr>
<td>Elective inpatient FCEs</td>
<td>38,814</td>
<td>37,148</td>
<td>30,904</td>
<td>32,413</td>
<td>32,171</td>
<td>31,315</td>
<td>31,235</td>
</tr>
<tr>
<td>Day case FCEs</td>
<td>82,248</td>
<td>83,771</td>
<td>97,584</td>
<td>107,889</td>
<td>106,942</td>
<td>111,514</td>
<td>115,051</td>
</tr>
<tr>
<td><strong>Total FCEs</strong></td>
<td>192,050</td>
<td>196,970</td>
<td>211,719</td>
<td>224,643</td>
<td>221,612</td>
<td>228,545</td>
<td>234,789</td>
</tr>
<tr>
<td>% Elective FCEs undertaken as daycases</td>
<td>68%</td>
<td>69.3%</td>
<td>75.9%</td>
<td>76.9%</td>
<td>76.9%</td>
<td>78.1%</td>
<td>78.6%</td>
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<tr>
<td>Average length of FCE (days)</td>
<td>4.08</td>
<td>4.35</td>
<td>4.08</td>
<td>4.17</td>
<td>4.25</td>
<td>4.19</td>
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<tr>
<td>Average % bed occupancy</td>
<td>78%</td>
<td>78%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>81%</td>
<td>82%</td>
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</table>

## Outpatient Activity

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New outpatient attendances</td>
<td>230,955</td>
<td>254,588</td>
<td>297,304</td>
<td>306,730</td>
<td>310,414</td>
<td>336,405</td>
<td>339,537</td>
</tr>
<tr>
<td>Review outpatient attendances</td>
<td>653,815</td>
<td>662,303</td>
<td>681,854</td>
<td>727,486</td>
<td>748,430</td>
<td>882,083</td>
<td>901,809</td>
</tr>
<tr>
<td><strong>Total Outpatient Attendances</strong></td>
<td>884,770</td>
<td>916,891</td>
<td>979,158</td>
<td>1,034,216</td>
<td>1,058,844</td>
<td>1,218,488</td>
<td>1,241,346</td>
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## Diagnostic services

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<tr>
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<tr>
<td>Laboratory requests</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>
<td>3,138,125</td>
<td>3,082,496</td>
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<tr>
<td>Radiological examinations</td>
<td>434,264</td>
<td>441,361</td>
<td>463,614</td>
<td>498,605</td>
<td>504,751</td>
<td>564,241</td>
<td>587,294</td>
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## Accident & Emergency

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<tbody>
<tr>
<td>A&amp;E attendances</td>
<td>92,872</td>
<td>91,382</td>
<td>103,489</td>
<td>125,213</td>
<td>128,634</td>
<td>130,756</td>
<td>134,289</td>
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<tr>
<td>Walk in centre attendances</td>
<td>38,316</td>
<td>36,115</td>
<td>28,252</td>
<td>43,949</td>
<td>49,288</td>
<td>49,948</td>
<td>50,628</td>
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<tr>
<td><strong>Total A&amp;E attendances</strong></td>
<td>131,188</td>
<td>127,497</td>
<td>131,741</td>
<td>169,162</td>
<td>177,922</td>
<td>180,704</td>
<td>184,917</td>
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## Surgical Procedures

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</thead>
<tbody>
<tr>
<td>Cardiopulmonary transplants</td>
<td>78</td>
<td>78</td>
<td>82</td>
<td>77</td>
<td>96</td>
<td>99</td>
<td>79</td>
</tr>
<tr>
<td>Liver transplants</td>
<td>43</td>
<td>34</td>
<td>35</td>
<td>39</td>
<td>41</td>
<td>47</td>
<td>35</td>
</tr>
<tr>
<td>Renal transplants</td>
<td>98</td>
<td>123</td>
<td>139</td>
<td>130</td>
<td>138</td>
<td>147</td>
<td>117</td>
</tr>
<tr>
<td>Bone marrow transplants</td>
<td>99</td>
<td>131</td>
<td>176</td>
<td>206</td>
<td>185</td>
<td>190</td>
<td>173</td>
</tr>
<tr>
<td>Heart Operations (CABGs &amp; PCIs)</td>
<td>3,249</td>
<td>3,248</td>
<td>3,206</td>
<td>3,326</td>
<td>3,068</td>
<td>3,146</td>
<td>2,970</td>
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<tr>
<td>Joint Replacements (Hips &amp; Knees)</td>
<td>1,024</td>
<td>1,110</td>
<td>1,385</td>
<td>1,424</td>
<td>1,638</td>
<td>1,648</td>
<td>1,811</td>
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<tr>
<td>Cataracts</td>
<td>7,787</td>
<td>8,174</td>
<td>8,023</td>
<td>8,074</td>
<td>8,330</td>
<td>8,349</td>
<td>8,201</td>
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## Reproductive medicine - Centre for Life

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<tbody>
<tr>
<td>No. of IVF treatments started</td>
<td>779</td>
<td>982</td>
<td>843</td>
<td>769</td>
<td>646</td>
<td>566</td>
<td>617</td>
</tr>
<tr>
<td>Clinical Pregnancy Rate per Treatment (Pre 11/12 figures shown are for ‘Live birth rate per cycle started’)</td>
<td>27.8%</td>
<td>24.9%</td>
<td>26.6%</td>
<td>28.6%</td>
<td>27.9%</td>
<td>28.0%</td>
<td>26.4%</td>
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## Other key statistics

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<tbody>
<tr>
<td>Total no. of renal dialysis sessions</td>
<td>41,702</td>
<td>43,774</td>
<td>44,227</td>
<td>39,099</td>
<td>39,723</td>
<td>39,695</td>
<td>41,100</td>
</tr>
<tr>
<td>Total no. of births</td>
<td>6,301</td>
<td>6,683</td>
<td>7,062</td>
<td>6,992</td>
<td>7,441</td>
<td>7,446</td>
<td>7,335</td>
</tr>
<tr>
<td>Day hospital attendances</td>
<td>3,710</td>
<td>3,124</td>
<td>3,617</td>
<td>4,834</td>
<td>5,785</td>
<td>4,944</td>
<td>4,477</td>
</tr>
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</table>
Delivering Commissioners’ Requirements 2014/15

2014/15 saw the second year of the new commissioning structure in the NHS, with Clinical Commissioning Groups (CCGs) and NHS England responsible for commissioning the vast majority of the Trust’s services. The Trust operated Legally Binding Contracts with thirteen CCGs during 2014/15, as well as a substantial contract with NHS England for services which they commission. Service Level Agreements (SLAs) were also operated with two Scottish Health Boards (Borders and Dumfries and Galloway), and three Local Authorities, as well as other commissioning bodies such as NHS Blood and Transplant.

There was an overall increase in activity during 2014/15. Chart 1 shows the year on year increase in the number of patients seen for admitted care (finished consultant episodes), A&E attendances and new outpatients for the last 11 years. There was a further rise in the number of patients seen during 2014/15, just over 13,500 more patients were seen overall compared to the previous year, which equates to a 1.8% increase in activity. The most significant growth was inpatient and daycase activity which saw a 2.7% increase.

Chart 1: Patient Activity

Chart 2 summarises performance against the Plan in relation to elective & non-elective spells, new & review outpatients and outpatient procedures by main Commissioners.

Chart 2: Variance from Plan – Admitted and Non-Admitted Care by Main Commissioners
**Planned Activity**

The 2014/15 year end position was marginally below internal plan for overall elective activity (-1%), though the day case proportion is slightly above (+0.4%). This is in part due to an increase in the proportion of same day surgery and work does continue to identify areas where this can be further improved.

In contrast total non-elective activity, particularly emergency is above plan by 6.7% (3,857 spells). This over performance was not across all Directorates but was caused primarily by unusually high emergency admissions in a relatively small number of Directorates. Outpatient activity was overall extremely close to plan (+0.5%). New outpatient attendances were 3.1% below while review were 2.3% above.

**Achieving Waiting Times and National Targets**

**Cancelled Operations**

The Trust reports cancelled operations as defined by the Department of Health as follows:

“Planned operations that are cancelled for non-medical reasons on the day the patient was due to be admitted to hospital or after they have arrived in hospital.”

There were 573 cancelled operations reported during the year which is a slight decrease in comparison to the previous year (591).

The most prevalent reasons for last minute cancellations during the year included:

- Theatre list overruns including complexity of case-mix and the precedence given to emergency surgery (53%)
- Critical care bed availability (26%), general bed availability (4%)
- Equipment failure/availability (8%)

Three Service Directorates reported 75% of the last minute cancellations i.e. Cardiothoracic Services; Neurosurgical Services; and General / Vascular Services.

In relation to cancellations as a proportion of elective activity, the year end performance was 0.4% which is within the standard performance threshold of less than 0.8%.

There were 4 patients where the standard of re-admission within 28 days following a last-minute cancelled operation was not met. 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 endeavour to work with the patients to offer a suitable date for them. As a proportion of cancellations, the year-end breach performance was 0.7% which is within the standard performance threshold of less than 5%.

**Referral to Treatment Target (RTT)**

Prior to the financial year 2014/15, Newcastle Hospitals had consistently achieved the aggregate referral to treatment targets of 90% for admitted pathways (being completed within 18 weeks); 95% of non-admitted pathways; and 92% of incomplete pathways in line with NHS Constitution pledges and Monitor requirements.

Following an increased focus nationally on the 18 weeks targets, additional activity was commissioned across provider Trusts, between July and November 2014, to treat long waiting patients. It was recognised by local CCGs and NHS England commissioners that this would adversely affect the achievement of RTT targets hence, the deterioration of admitted and non-admitted compliance in the corresponding months shown in Chart 3 below.

**Chart 3: Trust RTT Performance**

![Chart showing Trust RTT Performance over time](chart3.png)

Local commissioners and NHS England had declared an amnesty over this period and did not apply financial penalties.

From December onwards, the Trust was expected to be compliant against all RTT targets for all Specialities. As shown in Chart 3, the December to March position shows maintenance of the incompletes target, recovery of the admitted target but non-admitted remained non-compliant at an aggregate level until April 2015. This was mostly due to the performance of the Dental Hospital and School which continued to treat long waiters throughout December to March. Trust performance has returned to compliance since April 2015.

Nationally it has been recognised that monitoring of the combination of the 3 targets provides some level of disincentive for Trusts to treat long waiters. This has been recognised in Sir Bruce Keogh’s review of NHS Constitution standards and Trust targets “Improving access and simplifying measurement” which has recommended that the focus should be on the incompletes target of RTT as the one true measure of all patients on the waiting list. The NHS Constitution Standard for treating patients within 18 weeks remains.
6 Week Diagnostic Target

During 2014/15, The Trust consistently met the 6 week diagnostic target for the 15 key diagnostic tests, achieving 99.5% compliance against a target of 99% and this is despite significant growth in diagnostic demand.

The volume of tests in 2014/15 increased by 6,363 compared to 2013/14 with the main drivers being CT (additional 1,097) and non-obstetrics ultrasound (additional 1,124). Chart 4 shows the number of patients waiting and the numbers seen during the month of March 2015 with MRI, CT and Non-obstetrics ultrasound making up the bulk of activity.

Chart 4: Diagnostic Waiters and Activity – March 2015

Chart 5 shows the changes in diagnostic waiting lists, with the most notable increase in Radiology; an additional 648 patients were waiting for an MRI in March 2015 compared to March 2014 and this is the main risk to future non-compliance.

Chart 5: Changes in Diagnostic Waiting lists (March 2015 Compared to March 2014)

Cancer Waiting Times

Performance in all of the cancer standards was sustained during 2014/15 with all targets achieved.

There was an overall increase in activity compared to previous years. In the two week suspected cancer standard, there were 19,739 referrals across all tumour groups, an increase of 15%. Chart 6 shows that this upward trend has continued for several years.

The numbers referred in the two week Breast Symptomatic standard also increased by 23%. The impact of the increase was felt across all diagnostic services, particularly Radiology and Endoscopy where waiting times increased for both tests and reporting of images. Almost 6,000 patients received their first treatment for cancer, an increase of 6% and all within the required standard.
Although the standards were achieved, the 62 day standard remains the biggest challenge within the Trust and nationally. Late referrals from other local providers were a significant contributor to the numbers of breaches. The reasons for late referrals are multi-factorial and collaboration with the referring providers and the North of England Strategic Clinical Network to try to improve pathways between Trusts is ongoing.

In order to support earlier diagnosis of cancer and improve survival rates, the "Be Clear on Cancer" awareness campaigns continued in 2014/15. A number of national campaigns were rolled out including Lung, Urology and Oesophago-gastric. The Trust was prepared for the campaigns with the referring providers and the North of England Strategic Clinical Network to try to improve pathways between Trusts is ongoing.

Editorial from The Journal

Through the support and generosity of people from across the North East, who have made donations to these local charities, the NCCC was provided with funding of £1.2m to contribute towards the purchase of this new technology, only previously available in London.

Sean Duffy, national clinical director for Cancer at NHS England, said: “This is a great day for hundreds of cancer patients who will now be able to access this cutting-edge innovative treatment. “This programme will allow us to assess this promising type of radiotherapy while enabling people who may benefit to access it as close to home as possible.”
A&E Waiting Times

The Care Quality Commission national Emergency Department waiting time standard is 95%. Despite an increase of 3% in the number of patients attending the RVI Emergency Department in comparison to the previous year, the Trust achieved 96% for the 12 month period ending March 2015. The number of patients attending the Trust’s urgent care facilities is shown below; the variance in attendances at the RVI Emergency department in comparison to 2013-14 equates to an average daily increase of 10.

There was a decline in the Trusts’ ability to meet the 4 hour waiting time standard from September 2014 which corresponded with a rise in Emergency Department attendances and emergency caseload presentations, resulting in capacity pressures.

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Trust rated top by patients

by Barry Nelson, Reporter Health & Education Editor

THE Newcastle Hospitals NHS Trust emerges as the clear regional winner after a survey of hospital inpatients published by the Care Quality Commission. The Tyneside trust, which runs the Newcastle Royal Victoria Infirmary and the Freeman Hospital, also in Newcastle, was rated better than the national average in eight out of 11 categories of performance.

The highest score at the Newcastle trust was a satisfaction rating of 9.3 out of 10 for the emergency and accident and emergency departments. Elsewhere in the region the Gateshead Healthcare NHS Trust, which runs the Queen Elizabeth Hospital, was rated better than average in two out of 11 categories.

The Northumbria Healthcare NHS Trust was rated as having one ‘better than average’ rating along with South Tyneside Hospitals NHS Trust and South Tyneside Healthcare NHS Trust. Trusts which were rated as the same as the national average in all 11 categories included County Durham and Darlington NHS Trust and the North Tees and Hartlepool NHS Trust.

Nationally 84 per cent of respondents rated their overall experience as an NHS outpatient as seven or higher out of 10, with about one in four rating it as 10 out of 10.

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The predominant reasons for breaches included those due to patients waiting placement in an appropriate clinical setting and patients receiving and waiting to be treated in the emergency department. No patients waited over 12 hours to be admitted.

During the year there was particular emphasis in relation to the timely clinical handover of patients arriving by ambulance to the Emergency Department. During the year there were minimal over 30 minute delays in handover; 54 in total representing 0.2% of all ambulance arrivals to the Emergency Department.

Detailed Resilience planning was undertaken and despite challenging periods when there were significant surges in the number of emergency patients presenting, successful implementation of additional capacity and resources was achieved. All staff working across the organisation responded in a positive and timely way to support a safe patient experience.
Ambulance Handovers

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

If ambulances are delayed at a hospital it means they cannot get out on the road to answer 999 calls. Ambulances are allowed 15 minutes to handover the patient and a further 15 minutes to prepare the vehicle for the next call. Therefore the Trust is monitored on delays over 30 minutes, which are tough targets to achieve. In most cases the staff within the department are so busy caring for the patient, that the handover button is not pressed in a timely fashion. It is worth noting that whilst ambulance delays are increasing nationally, the Trust has continued to report very low numbers. For all breaches, a full review is carried out and whilst any non-performance is undesirable, NuTH has not demonstrated that in all cases, the patients were physically handed over within the timescales but the IT systems were not updated in time.

During the year, there were minimal delays in ambulance handover; 52 in total. In comparison to other local Trusts, NuTH is currently one of the top performers.

Chart 8: A&E Ambulance Handovers

Ambulance Arrival at Hospital and Handover
Breaches per 1000 > 30 mins at North East Regional A&E, April 2014-March 2015

NHS Number Coverage

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

Within hospital administration, the NHS Number is important because it helps create a complete record for each patient, enabling information to be safely transferred across organisational boundaries and even babies are given their own NHS Number to link their healthcare records for life.

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

Nationally the NHS Number is monitored within the Secondary Uses Services (SUS) and Chart 9 shows that NuTH is achieving the nationally mandated targets for patients, only a small proportion of patients do not have an NHS Number (which includes the Scottish patients who are not issued with NHS Numbers).

The Trust continued to remain compliant with the 99% Admitted and Outpatient target and the 95% A&E target.

Chart 9: NHS Number Coverage
IMRT

There is currently a national requirement for Trusts providing Radiotherapy to deliver 24% of treatment as Intensity Modulated Radiation Therapy (IMRT). The target is considered a minimum requirement as IMRT delivers more accurate treatment with less side effects and better patient outcomes. The target is calculated as the percentage of new Inverse Planned IMRT Patients as a proportion of all New Radical Episodes. The numbers rely heavily on the overall case mix, as the denominator includes cases which are not eligible for IMRT.

**Chart 10: New Inverse Planned IMRT Patients as a percentage of all new Radical Episodes Apr 2012 - March 2015 (Target 24%)**
Best Practice Tariffs

Best Practice Tariffs (BPTs) are one of the enablers for NHS Trusts to improve quality by reducing variation and incentivising best practice care. With best practice defined as care that is both clinical and cost-effective, these tariffs will also help the NHS deliver the productivity gains required to meet the tough financial challenges ahead.

A significant review of BPTs was undertaken in the Trust in 2013/14 to assess current compliance, identify how implementation could be improved and from that, draw out actions to continually improve the quality of care for our patients.

There have been some notable areas of improvement as identified below:

**Day Cases**

BPTs were introduced for one procedure in 2010/11, and in 2013/14 they covered 15. Performing procedures as day cases offers substantial benefits to patients, including minimum disruption to daily life and reduced waiting times and Chart 11 shows how the Trust compares to peer organisations in 2014/15. The Trust performance is expected to improve in 2015/16 as pathway redesign is currently underway in a number of Directorates.

![Chart 11: Day Case Rate](image)

**Fragility Hip Fracture**

The fragility hip fracture BPT was introduced alongside a national clinical audit and together they aim to improve the level of compliance with defined elements of evidence-based best practice care. There is a clear and steady increase in care meeting the fragility hip fracture BPT criteria and in 2014/15, the Trust delivered the complete package of best practice care to 71.8% of eligible patients or compared to the 64% national compliance in Q4 2013/14 (NHFD National Report 2014).

**Outpatient Procedures**

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

There are three procedures covered in the BPT and the table below shows that the Trust performance for diagnostic cystoscopies and hysteroscopy is above target and aspirational target.

<table>
<thead>
<tr>
<th>Best Practice Tariff Indicator</th>
<th>Target</th>
<th>Aspirational Target (set by Trust or national aspiration)</th>
<th>Performance</th>
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</thead>
<tbody>
<tr>
<td><strong>BPT Target</strong></td>
<td></td>
<td></td>
<td>FY14/15</td>
</tr>
<tr>
<td><strong>Aspirational Target</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic cystoscopy</td>
<td>50%</td>
<td>50%</td>
<td>82.2%</td>
</tr>
<tr>
<td>Hysteroscopic sterilisation</td>
<td>No target set</td>
<td>65%</td>
<td>38.7%</td>
</tr>
<tr>
<td>Diagnostic hysteroscopy</td>
<td>60%</td>
<td>80%</td>
<td>80.2%</td>
</tr>
</tbody>
</table>

There is significant variation in performance for BPTs nationally and the Trust will continue to remain one of the higher performing organisations by ensuring:

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

WHILE visiting relations and having two fantastic weeks break in Newcastle and surrounding area, I escorted my sister to an appointment at the RVI. She attended the chest clinic main outpatients department, New Victoria Wing. May I through your local paper give my sincere thanks to all staff concerned, very professional and courteous. Also may I add the cleanliness of the outpatients department was absolutely immaculate. I feel it gives you confidence in the risk of infections as they are cleaned to such a high standard.

The Newcastle Hospital Trust should be proud of its cutting-edge innovation and research facilities, it is a role model to all hospitals nationwide.

BETH CURTIS, matron (retired), Bristol

Length of Stay, day case rates, readmissions

The Trust has shorter average length of stay compared to the leading cluster of specialist providers. Pre-operative length of stay is still one of the shortest in the peer group, meaning we do not bring patients in too early before surgery is performed (Chart 13).

Emergency Readmissions are generally indicative of ineffective patient management and call the quality of care provided across the continuum into question. However, while many readmissions are preventable, some are clinically necessary or unavoidable. Whilst NuTH show relatively low readmission rates when compared to Shelford, there is a recognition that more can be done to further reduce the readmission rate and minimise any ‘avoidable’ admissions.

NuTH risk adjusted length of stay is higher than expected; this compares the Trust to other patients with similar diagnoses. The Trust recognises that there is scope for further reduction in length of stay and specific actions are being taken within those specialties with potential for reduction.

Chart 12: Average Length of Stay Newcastle Hospitals (Site) compared to leading specialist provider peers

Chart 13: Pre-OP length of stay Newcastle Hospitals (Site) compared to leading specialist provider peers

Chart 14: Emergency Readmission within 30 days Newcastle Hospitals (Site) compared to leading specialist provider peers

Chart 15: Adjusted LOS Index (Adjusted for casemix) against leading specialist provider (lower than 100 = better than expected)
The increase in day surgery rates for appropriate procedures has the potential to improve the service for patients by achieving shorter waiting times, promoting a speedier recovery for patients and making best use of NHS capacity. Although our day case rates are continuing to improve, there are still improvements that can be made to ensure maximum efficiency and better outcomes for patients.

Chart 16: Day Case Rates Newcastle Hospitals (Site) compared to leading specialist provider peers

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 organisation. 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 liaise with clinicians and managers to understand information about quality and productivity within health services.

Once again this year, the exhibit following shows that out of their Programmed Activities (PAs), Newcastle Consultants spend 81.7% of their time devoted to Direct Clinical Care (DCC), the highest amongst similar teaching hospitals.

Source: Civil Eyes 2013/14
This document forms the Operational Plan for the period 2015/16 and describes how the Trust Board plans to deliver appropriate, high quality and cost effective services for patients on a sustainable basis in light of the particular challenges facing the sector.

The Plan is drawn together within the context of the Trust’s Five Year Strategy as submitted to Monitor, the Independent Regulator, in June 2014.

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

Executive Summary

The Trust acknowledges that the NHS is facing the most fundamental challenge ever as a consequence of the economic climate and rising demand on service scope and provision. As one of the largest and most successful teaching hospitals in England, providing world class services, employing world class clinicians to benefit all of our patients, we remain confident of our strategy to continue to grow and develop to provide healthcare of the highest standard in terms of quality and safety whilst maintaining operational, clinical and financial sustainability.

The Trust completed its 9th year as an NHS Foundation Trust, with 2014/15 being another busy and successful year. We continued to strive for excellence and remain one of the leading providers of quality healthcare spanning community, secondary and tertiary services for adults and children. Our excellence in healthcare is recognised nationally and internationally.

We saw more patients in 2014/15 than ever before with over 1.72 million patient contacts.

In line with the Trust’s longstanding commitment as the healthcare provider for Greater Newcastle, we continue to deliver cutting edge healthcare with new procedures and best in class facilities. This is underpinned by the principal of delivering safe, high quality services by the right people in the right place at the right time and within financial balance.

We put patients at the heart of everything we do by continuing to invest in the future to enhance the quality and safety of services.

We continue to perform well against various national standards including the Annual Inpatient Survey, CQC Benchmark Report and NHS Friends and Family. Quality and safety are the cornerstone of our Clinical Strategy to ensure the safe and effective delivery of patient care.
The Trust achieved one of the top scores in the 2014 National Staff Survey with employees recommending the Trust as a place to work or receive treatment. The Survey's overall indicator for staff engagement placed the Trust in the best 20% of acute hospitals in the country.

2014/15 was a most successful year for the Trust with staff winning a number of regional, national and international awards in recognition of the outstanding work they do every day. The Trust Board appreciates and highly commends the performance and excellence of its loyal and dedicated staff, recognising the achievements of individuals and teams across the organisation to continue to deliver ‘Healthcare at its very best, with a personal touch’.

Acknowledging the various influences nationally and locally that are driving the current NHS ‘business agenda’, the Trust Board considered the various risks to financial, operational and clinical sustainability.

The Board recommitted to Trust Business Strategy of targeted growth in key clinical areas to meet rising demand as a result of demographic and disease prevalence, ensuring patient choice and to protect the Trust in what it acknowledges to be an increasingly competitive market in many areas. This growth in activity is supported by a strong financial balance sheet that continues to provide opportunities for capital investment in key clinical areas alongside investment for essential clinical staff.

Building capacity and improving efficiency remain intrinsic to the delivery of the Trust strategy over the next five years. This is underpinned by strong leadership at all levels across the organisation to drive performance and deliver change to meet the needs of the local health economy.

The Trust’s longstanding objective to deliver comprehensive community outreach with care closer to home and service integration via transformation and in several cases collaboration, is aligned to the national and local initiatives including The NHS Five Year Forward View and Better Care Fund.

The strong culture of research and innovation supported by formal management relationships with Newcastle University allows the Trust to further develop and promote research and innovation to secure health science, innovation and commercial opportunities to the North East.

The Trust has an underlying strength and track record as a first class teaching hospital, consistently delivering high quality services to patients both in and out of hospital including the ability to adapt and change to the environment. Our plans are responsive to the changing needs of the population which allow us to declare that a sustainable future for the Trust and the wider NHS community will be one that embraces collaboration and innovation and identifies means of driving the highest quality clinical care through continuous improvements.

While we remain in a strong position, the Trust is not complacent and acknowledges there is always room for improvement. The Board remains confident however that we have a solid base from which the Trust is able to continue to deliver world class clinical services and maintain our position as one of the largest and most successful teaching hospital Groups in England.
A Sexual Health doctor wins Award

Dr Laura Percy, a Senior Trainee Doctor in Community Sexual Health and Reproductive Care, is the first winner of a national prize set up by The Journal of Family Planning and Reproductive Health Care – the Anne Szarewski Journal Memorial Award.

The Award is given to a healthcare practitioner who has submitted a single-author article on new initiatives or improvements in clinical practice, which merits publication in the Journal.

Dr Percy won the inaugural award for her article entitled: ‘Would an exclusively contraceptive clinic help meet the needs of patients attending an integrated sexual health service?’

Dr Diana Mansour, Consultant in Community Gynaecology and Reproductive Healthcare, and Head of Newcastle’s Sexual Health Service says: “We are delighted for Laura who has worked extremely hard to achieve this first-time award. Her article focuses on the success of an ‘express’ style contraceptive clinic for those requesting repeat contraceptive pills, patches, vaginal rings and injectables.

This daily drop-in service has been highly evaluated by patients and staff. It is meeting the needs of those who only require a short consultation by a nurse freeing up consultation time for other staff to see those with more complex problems.”

This award was established to commemorate the life of Anne Szarewski who was Editor-in-Chief of The Journal of Family Planning and Reproductive Health Care for 10 years until her untimely death in August 2013, a well-respected sexual and reproductive healthcare doctor and pioneering researcher in the prevention of cervical cancer.

Engineer wins award

Whilst studying for a MEng in Building Services Engineering at Northumbria University, Stephen has won an award from Rolton Engineering for his Conceptual Design Project.

Stephen, who has been with the Trust for eleven years, completed a Bachelor’s Degree before moving onto a two years Master’s Degree to develop his technical and theoretical knowledge in line with his professional development.

The award was won for the best and most innovative example of low carbon and renewable technology integration within a community, taking not only individual buildings into account but rather creating a joined-up design that takes a bold, holistic approach.

Any location from around the world could be selected and Stephen created his project in Newcastle on the banks of the Tyne. He created a low carbon sustainable design, whilst challenging the social and economic reasoning for making Newcastle a banking headquarters.

The report covered solutions not only to the clients brief for mechanical and electrical design, but the overall structure of the project. concept design.

Stephen says: “Receiving the award is an honour especially coming from both the University and an industry specialist.

The award represents years of hard work progressing through academia under the universities’ dedicated specialist lecturers, which I could not have achieved without the support and commitment of the Trust from the start of the Degree program, as well as my family back home.”

Bright Ideas Winners

The CRESTA Clinic Team won the Service Improvement category in this year’s Bright Ideas in Health Awards.

The Bright Idea was to develop The Newcastle CRESTA Clinic for Fatigue associated with chronic illness, modelled on a pain clinic. It combines expertise from psychology, physiotherapy, OT and sleep therapy in each consultation, plus support from a health champion.

Fatigue is the main symptom in 5-10% of GP consultations, and in 50% of these cases, fatigue is related to chronic disease. Pain, under-nutrition, infection, dehydration, stress, depression, anxiety or hormone imbalances may all contribute to fatigue.

The winning Innovators are:

- Professor Julia Newton, Honorary Consultant Physician
- Lynne Hogg, Sister
- Vincent Deary, Health Psychologist
- Katie Hackett, Occupational Therapist
- Victoria Strashein, Physiotherapist
- Zoe Gotts, Sleep Therapist
- Rebecca Lambson, Medical Student

Trust saluted by Ministry of Defence

The Newcastle Hospitals have been awarded a Bronze Award by the Defence Employer Recognition Scheme.

The scheme, run by the Armed Forces Corporate Covenant which is an arm of the Ministry of Defence, recognises those employers who support and demonstrate their commitment to the Armed Forces, and take a positive stance towards existing or prospective employees who are members of the Armed Forces community.

The Award recognises the Trust as Armed Forces ‘friendly’ and open to employing Reservists and Armed Forces Veterans.

We are delighted with this recognition and would wish to salute all of our staff who are Reservists and who provide ongoing support to our Armed Forces.

Find out more about how to become a reservist at the SaBRE website.
The medal was awarded in recognition of outstanding contributions to the advancement of clinical care in the specialist field of blood related cancers.

Professor Graham Jackson – who has worked for the Trust for over 25 years – specialises in myeloma in particular, and this award acknowledges his internationally acclaimed clinical and research work which has had a great impact on progressing treatment options for these life-threatening conditions over the years.

Professor Jackson said: “I am delighted to have received this wonderful accolade from the British Society of Haematology, of which I have been a member since 1996. Whilst I realise the Medal has been awarded to myself, I really believe I wouldn’t have

Newcastle Geneticist wins Award

Professor Kate Bushby - Professor of Neuromuscular Genetics and committed researcher in the field of rare diseases - has won a prestigious European award in recognition of her outstanding research into rare inherited neuromuscular genetics.

Nominations for this award were received from the public, giving an opportunity for everybody in the rare disease community and beyond to have their say on who should get the top accolade.

Professor Bushby is an expert in neuromuscular genetics working as an Honorary Consultant Geneticist at Newcastle’s International Centre for Life, and is Director of the John Walton Muscular Dystrophy Research Centre where she conducts pioneering research for Newcastle University.

The Research Centre is at the forefront of developments in neuromuscular diseases as its team works with experts and patient organisations from around the globe to help improve diagnosis, care and treatment for patients.

Professor Bushby said: “I am delighted to have received this award: a real sign of recognition that the John Walton Muscular Dystrophy Research Centre is a world leader in the field of rare diseases.”

Dr Marita Pohlschmidt, from Muscular Dystrophy UK, said: “Professor Bushby is an outstanding scientist, and clinician, who has made the John Walton Muscular Dystrophy Research Centre an internationally renowned centre of excellence for neuromuscular research and standards of care.”

Florence Nightingale Award

Newcastle Health Visitor, Louise Marsland, was recently presented with a very special certificate from the Patron of the Florence Nightingale Foundation – Sir Robert Francis QC.

Louise was granted the Florence Nightingale Travel Award a couple of years ago to study the effects of Domestic Violence on infant mental health in Australia. The aim of the Travel Scholarships is to provide nursing practitioners with a real opportunity to study different approaches to care, and research being carried out elsewhere in the UK or overseas, then use what is learnt to enhance patient care in local practice.

Louise explains: “Around 75% of children who are subject to child protection plans in my caseload have been subject to domestic violence. The effects on infant brain development in the early years are extremely important, especially in the first two years of life. Not only that, 30% of domestic violence begins during pregnancy and is known to be a prime cause of miscarriage or still-birth. The importance of good ante-natal care for vulnerable families cannot be overemphasised and as a Health Visitor, I feel uniquely placed to influence the mental health of parents of the future by carrying out early intervention work. I was delighted to be awarded this scholarship and found the trip to Australia most inspirational.”

As a Solihull trainer and supervisor, Louise trains other Health Visitors and School Health Practitioners. She is now able to offer expert advice on caseload management of difficult cases, often involving trauma or poor attachment. “Since returning from Australia I have been able to give presentations of my findings to the local children’s centres and the Domestic Violence citywide strategy group. I also presented my findings at the World Infant Mental health conference in June 14, the CPHVA conference and European Paediatric Society Conference last year. It’s certainly been a very busy few months!”

Mrs Helen Lamont, Nursing and Patient Services Director says: “We are thrilled that Louise has learnt so much from her scholarship and been able to embed her new knowledge into her own clinical practice. Infant mental health is certainly an incredibly important area for our Health Visitors and I know that Louise has had a most positive influence on her colleagues and others since her return from Australia. Keep up the good work!”
Mountford explains: a BAPEN Trainee Group of which he was the Founder Chair. Dr Mountford's award was in recognition of the establishment of nutrition among residents.  Dr Okonkwo, now a Foundation Training Doctor with Newcastle Hospitals, was part of a research group with Dr Christopher Mountford and Dr Nick Thompson, also a Consultant Gastroenterologist, that delivered a nutritional screening project to over 200 elderly residents of care homes in Newcastle, to discover how effective a 12 week treatment programme was at improving nutrition among residents.

In a separate initiative, Dr Okonkwo co-ordinated an audit with Barbara Davidson to showed how a new type of diet which excludes certain food types called ‘low FODMAPs’, helped to improve symptoms of irritable bowel syndrome. This project was successful and contributed to new Regional Guidelines, and the diet is being adopted as therapy for patients in the area.

After leaving his placement with Gastroenterology Services, Dr Okonkwo continued with the research group and presented the results from the care home project to the British Society of Gastroenterology, and the Nutrition Society. He also helped draft a report for publication and won the Royal Society of Medicine Student Research Prize.

This has now been adopted as policy by BAPEN and I am now, as part of BAPEN’s Education and Training Committee, tasked with bringing these nation-wide Networks into being! I very much look forward to taking this forward and am delighted to have won this very special acknowledgement. “

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Dr Christopher Mountford, Consultant Gastroenterologist and Barbara Davidson, Lead Specialist Dietician both won ‘roll of honour’ awards, and Dr Arthur Okonkwo picked up the national Student Award.

Dr Mountford’s award was in recognition of the establishment of a BAPEN Trainee Group of which he was the Founder Chair. Dr Mountford explains: “This was back in late 2012 and I was still a trainee at the time. Under my leadership, successes of the Group included conducting the largest ever survey of UK trainees on nutrition training, developing training resources hosted through BAPEN including conference web-based e-learning and hosting an inaugural trainee symposium at the BAPEN Annual Conference.”

Dr Mountford will continue to provide mentorship for the group’s new Chair.

Barbara Davidson won a special achievement award for her work over the last year, in her role as Chair of the BAPEN Regional Representatives. Barbara says “This work focused very much on promoting the awarding winning Northern Nutrition Network as a role model to be rolled out across the UK.

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Clinical Pharmacist wins Award

Dr Julia Blagburn, Senior Lead Clinical Pharmacist for Older People's Medicine and Community Health at the Newcastle Hospitals, won the Clinical Pharmacist of the Year Award at this year’s Royal Pharmaceutical Society Awards.

Dr Blagburn received the coveted award in recognition of the positive outcomes of a 12 month project called ‘REACH’, with the aim of preventing medication-related, emergency readmissions to hospital.

The project was developed with colleagues Karen Glasper – a Pharmacy Technician focusing on home follow up, and Ben Fatemi, a Pharmacist who helped develop the REACH model.

Dr Blagburn explains the background to the project: “An audit of emergency readmissions to the Newcastle Hospitals showed us that a range of problems relating to patients’ medications were a potential cause of around 20% of avoidable readmissions to hospital. We worked with one of our local Clinical Commissioning Groups to explore ways of identifying the problem points, and came up with the concept of the REACH model.”

By working with two Elderly Care Wards at the Newcastle Hospitals, the project introduced the REACH model on one ward, and left the other as a ‘control’ environment, ie. no changes were made here.

In November 2013, the Newcastle Hospitals launched the REACH model on one ward, and it aimed to improve medication-related outcomes.

Dr Blagburn explained the background to the project: “An audit of emergency readmissions to the Newcastle Hospitals showed us that a range of problems relating to patients’ medications were a potential cause of around 20% of avoidable readmissions to hospital. We worked with one of our local Clinical Commissioning Groups to explore ways of identifying the problem points, and came up with the concept of the REACH model.”

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Angel of Newcastle’s Royal Victoria Infirmary recognised for her devotion to children

Caring Claire Campbell wins top award after devoting her career to helping some of the most poorly youngsters in North

By Craig Thompson
Health Reporter
Craig.thompson01@ncjmedia.co.uk

Claire Campbell wins top award after devoting her career to helping some of the most poorly youngsters in North

This award aims to recognise a person or team who has made a significant difference to the lives of patients.

Claire is currently a sister on the Neonatal Unit at Newcastle’s Royal Victoria Infirmary.

She was nominated for the award because of the innovative work she has developed in recent years in family centred care, which is a key aspect of neonatology.

Examples of her work include setting up a “Buddy Group” for the parents, carers and families of the sick and premature babies looked after on the unit.

This unique approach differs from traditional “support groups” by linking - or buddying - parents with others who have volunteered to provide support and advice to others with babies in similar circumstances to their own.

Claire added: “I've been a neonatal nurse for over 23 years and I love my job, in particular working in partnership with parents.

“I feel very passionately about empowering parents and helping them to find a voice during their journey through the neonatal unit.

“Many parents suffer from stress, anxiety and grief, and can often suffer post traumatic stress. “I set up the parent support "Buddy Group" in 2011 which involves facilitating parents to support each other.

“The group has helped many parents who feel that they cannot talk to family or partners in the same way. Parents who have “walked in their shoes” truly understand how it feels during this rollercoaster time.

“I feel it’s really important that nurses at all levels take on the role of leaders and become involved in innovations and initiatives.”

The Buddy Group model has now been utilised both locally and nationally.

Clare added: “I feel very proud to have won this award. And this would not have been possible without the dedication of the parents involved.

A parent recently said that “the Buddy Group was a lifeline for her during her darkest days”.

Claire has also developed other new approaches to family centred care that have been recognised and adopted nationally by charities such as BLISS and Best Beginnings.

This includes acting as a project lead and overseeing a regional Parent Survey that was conducted across the Northern Network and had provided valuable feedback to staff to enable them to further improve and develop their services.
We put patients at the heart of everything we do

The Newcastle upon Tyne Hospitals NHS Foundation Trust is one of the largest and most successful teaching hospitals in England providing academically led acute, specialist and community services locally to a large and diverse population across the North East and Cumbria, as well as nationally and internationally.

Healthcare at its very best - with a personal touch
The robot doctor that is making a huge difference to patients’ lives

Paul Renforth, a surgical coordinator at the Freeman Hospital with Da Vinci surgical robot, with its multiple arms

A ROBOT medic is saving lives after a Newcastle hospital became the first in the UK to “hire” a digital doctor.

The city’s Freeman Hospital is one of only a handful in the world to use the Da Vinci Surgical Robot to perform surgery on patients who have lung cancers.

The robot, with its multiple, spider-like arms, allows the hospital’s surgeons to carry out highly accurate keyhole surgery. That means less pain and a shorter recovery time.

Sylvia Barnes, 77, from Gosforth, Newcastle, became one of the first patients in the UK to benefit when she had robotic lobectomy surgery.

She said: “I felt lucky to have the robotic surgery as I think I recovered much better than the other ladies on the ward who had conventional operations.

“My recovery was so good that I was even walking my grandson to school just three weeks after the surgery.”

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It means patients experience less pain, develop fewer complications and spend a shorter amount of time recovering from their operation.

The ‘minimally invasive’ surgery provided by the robot means some people are able to go home only two days after their surgery. While, those who need chemotherapy after their operation may also be able to start their therapy sooner.

Sylvia Barnes from Gosforth, has become one of the first patients in the UK to benefit from the robot’s skills.

The 77-year-old had robotic lobectomy surgery - removing a lobe or section of the lung.

She said: “I think, like anybody, I didn’t want to have an operation at first. I walk my grandson to school every day and didn’t want to miss out on that. In the end, I felt lucky to have the robotic surgery as I think I recovered much better than the other ladies on the ward who had conventional operations.

In fact, only six days after the operation I left hospital.

“When I got home, I had some difficulties lying down in bed, but it only took around two months to get back to normal. My recovery was so good that I was even walking my grandson to school just three weeks after the surgery.”

A team of specialists from the Freeman went to Paris in October 2013 where they received training on the robot, which is made up of three spider-like arms and a special camera arm.

Mr Sasha Stamenkovic, consultant thoracic surgeon at the Freeman Hospital, said: “We have been evaluating the Da Vinci system over the past 16 months and have now completed 15 surgical procedures for lung cancer patients using the robot.

“We believe that this is a safe way of operating and that patients benefit hugely from this type of surgery as they have far less, and sometimes no pain post operatively, in comparison to conventional surgical treatment.

“Keyhole surgery is becoming the norm for patients with small lung cancers and Newcastle Hospitals already carries out a large amount of minimally-invasive lung surgery.”

Starting off with small, simple robotic operations, the surgical team is now moving on to perform complex major lung surgery, with support from a world-renowned expert from the University Hospital of Pisa in Italy.

Mr Stamenkovic added: “The robot offers 3D, HD vision - it is impeccable allowing us to see with greater depth than ever before.”
UNICEF Baby Friendly award

The RVI’s Maternity experts - who deliver over 7,000 babies every year - have been awarded the UNICEF Baby Friendly Initiative Accreditation acknowledging the high standards of feeding and bonding support its midwives provide to women with newborn babies.

Joyne McDonald, Infant Feeding Co-ordinator at the Maternity Unit who has been helping parents to feed their newborns for 15 years explains: “We’re thrilled to receive this accreditation. Breastfeeding helps to reduce the risk of babies becoming ill with gastroenteritis and respiratory infections, and lowers the risk of conditions such as asthma, cardiovascular disease and diabetes developing later in childhood. It also helps protect the mother’s health, lowering the risk of certain types of cancer, and helping to develop strong bones in later life. So there are lots of physical and emotional benefits for both mother and baby.”

Health Visitor gains national appointment

Kate McBride, a Senior Health Visitor, is one of a select few in England, and the first in the North East, to be appointed as a Fellow of the National Institute of Health Visiting (NIHV).

Kate is one of only 29 Senior Health Visitors across the country to be recognised for outstanding contributions in their clinical field as part of a new scheme which not only recognises professional achievement, but also identifies a group of expert and inspirational Health Visiting leaders nationwide.

The new fellows will work with the Institute, as well as their own employers, to help strengthen Health Visiting as a profession.

Annual Personal Touch Award names Employees of the Year

Governors, Charitable Trustees and staff came together at the annual Personal Touch Awards earlier this year, to celebrate and give thanks and recognition to the outstanding contribution made by hospital staff to providing healthcare at its very best - with a personal touch.

The evening was also an opportunity to announce the launch of the Personal Touch Award for Volunteers. This award recognises volunteers who demonstrate an outstanding commitment to their role in supporting staff and patients.

If you would like to nominate a member of staff or volunteer, visit www.newcastle-hospitals.nhs.uk/personaltouchawards.

Innovation in School Nursing Award

Newcastle Hospitals’ Outer West School Nursing Team recently received a very special award from Her Royal Highness The Princess Royal, when they recently attended the fifth annual Cavell Nurses’ Trust Awards in London.

The award recognised the team’s pioneering approach to engaging young people by developing a ‘pop up’ health stall which they use to deliver health messages at local schools.
Another Bumper Crop of Awards

Community Nurse crowned a ‘Queen’s Nurse’

Fiona Cook, a Community Nurse specialising in the care of patients with Tuberculosis (TB), has been given the prestigious title of Queen’s Nurse by the Queen’s Nursing Institute (QNI). The QNI is dedicated to improving the care of people in their homes.

Fiona, who has been a qualified nurse for 22 years and worked as a Community Nurse in Newcastle for ten years, is one of only 79 Community Nurses out of some 4,000 nominated, who received this year’s honour.

Fiona says: “I love my job and can honestly say I look forward to coming in every day. I find my work challenging and extremely rewarding, and to hear the lovely comments that patients have made about how I help them is really gratifying. The whole experience has given me a huge boost and I feel even more proactive and energised than ever before!”

RVI’s Special Care Baby Nurse wins ‘Patient Champion’ Award

Sister Claire Campbell, who works on the Special Care Baby Unit at the RVI, was named ‘Patient Champion of the Year’ recently, in recognition of her work on family-centred care - an important part of Neonatology.

Claire’s work has included setting up a “Buddy Group” for parents, carers and families of sick and premature babies on the unit.

Claire said: “I’ve been a Neonatal Nurse for over 23 years and I love my job. I feel very passionately about empowering parents and helping them to find a voice during their journey through the Neonatal Unit.

“Many parents suffer from stress, anxiety and grief, and can often suffer post-traumatic stress. I set up the parent support “Buddy Group” in 2011 to help parents support each other.”

The ‘Buddy’ model has since been adopted by other Neonatal Units across the Northern Neonatal Network and beyond.

Jo’s Cervical Cancer Trust Award

A partnership between the North East’s Cervical Screening Training team, Sexual Health and community arts organisation ‘Them Wifies’, has won a national Jo’s Cervical Cancer Trust Award.

The award was for ‘Josephine Visits the New Croft Centre’ – a campaign designed to improve uptake of cervical screening amongst women with learning disabilities.

Research has shown that only 19% of women with learning disabilities go for screening compared to 77% in the general population.

Jill Fozzard, Cervical Screening Training Facilitator said: “We were approached by ‘Them Wifies’ to work collaboratively to raise awareness around cervical screening and sexual health, using Josephine.”

Josephine is a life-sized cloth woman, used as an interactive learning resource. Women with learning disabilities follow Josephine’s experience of attending cervical screening, from initial invitation, to a live screening consultation and receiving her results.

Jill continues: “What became apparent was the emotional attachment which developed between the women and Josephine – one of care and concern for her wellbeing.

“We’re delighted to have been recognised for our work in targeting this often overlooked group of women. We hope to continue to run this education programme and continue to work alongside ‘Them Wifies’.”
Speak Up – We Are Listening

When the Francis Report into the failings in Mid Staffordshire was published in February 2013, the Trust reflected on the learning identified in the report and sought to assure itself that its own systems and processes were sufficiently robust to appropriately address any concerns which staff might wish to raise.

We are very proud of the many indicators which are so positive about patient safety and quality of care for example great patient feedback, excellent national patient survey results, excellent mortality rates, a robust, patient centred complaints process, and well established appraisal and development processes. However, we also recognised that we could not be complacent about something which is so fundamental to the patient care we provide.

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Freedom To Speak Up Guardian

Any member of staff with concerns relating to safety, quality or perceived wrongdoing, including unacceptable behaviours, can contact the Trust’s Freedom To Speak Up Guardian. Investigation of concerns will remain the responsibility of Trust clinicians and managers.

As an independent, impartial adviser, the Trust’s Freedom To Speak Up Guardian, Mrs Sokhjinder Morgan, acts as the point of contact for staff who wish to report serious issues or concerns, and provides support, advice and guidance to ensure that appropriate investigation into concerns is undertaken properly.

The FTSU Guardian is available to all staff, across all professional and workforce groups, including student and trainee healthcare professionals, locums, bank and agency staff.

The FTSU Guardian has the authority to engage directly with the Chief Executive, the Trust Board, clinical and line management and if required, the external Independent National Officer (INO).

Newcastle.SpeakUpGuardian@nhs.net

Independent, impartial, in confidence.
Therefore, with the support of the Trust Board, we embarked upon a series of ‘listening and sharing’ engagement events with staff to actively explore whether or not staff felt confident and able to raise concerns. The feedback received indicated that staff did not always find this process easy, and did not feel that they were provided with sufficient feedback regarding whether or not any action was taken as a result.

These events led the Trust to undertake further work to explore and examine the concerns raised in more detail. We were very clear about our objective – to develop a ‘just’ culture in which all staff felt able to speak up, and to know that they will be supported in doing so. This process has involved wide consultation with staff, of all bands and disciplines, and using a range of anonymous surveys to gather information. The findings have been used to shape our activity and is summarised below under the single theme of ‘You Said, We did’:

**We Said We Would...**

- Develop a supportive environment and foster a ‘just’ culture
- Improve communications at all levels & provide feedback
- Ensure one consistent message for all staff
- Remove barriers to raising concerns – if necessary, providing a vehicle to raise concerns anonymously
- Increase awareness of patient safety & best practice
- Widen staff participation and engagement
- Encourage reflective practice and learning
- Acknowledge ‘discretionary effort’ given by many many staff
- Dispel myths!

**We have**

- Undertaken a Trust wide Anonymous Staff Survey to seek staff views
- Instigated a number of Directorate Level Surveys
- Offered several Listening & Sharing events
- Introduced Trust wide Safety Culture Surveys
- Established new engagement forums for
  - Junior Doctors
  - Nurses, Midwives and Allied Health Professionals
- Published a Trust e-bulletin focussing on ‘Post Francis’ work
- Implemented regular monthly Safety Briefings for all staff in the Trust
- Introduced ‘Speak in Confidence’ an anonymous dialogue system enabling staff to raise issues with Senior Managers
- Piloted the introduction of Schwartz Rounds
- Revised our Incident Investigation approach – focussing on ‘how’ an incident has occurred
- Begun the process of appointing a Freedom to Speak up Guardian and advocates
- Established a ‘Speak up we’re Listening web page for staff so they can easily find the support available to them.

All of the above are in addition to regularly briefing Trust Board, The Governors and Staff and complying with national and statutory requirements including:

- NHS Family and Friends Test
- Fit and Proper Persons Requirement
- Regularly briefing Trust Board, The Governors and Staff.

**We are**

- Developing an internal communications strategy – to achieve a ‘shared’ brand and consistent message
- Extending duration of ‘Speaking in Confidence’
- Expanding the underlying Thematic Analysis of Directorate Survey content
- Reviewing our Whistleblowing Policy – ‘Speak up- We’re Listening’
- Restructuring ‘Patient Experience’ functions
- Embedding a ‘just culture’
- Correlating data from the range of staff surveys.

**We will**

- Publish and further share learning
- Continue to promote the need for change and value feedback from staff
- Encourage and support collaboration
- Reduce ‘silo’ initiatives & thinking
- Encourage innovation
- Eliminate undermining behaviours.

In all of this work what was constantly reinforced was the importance of our committed and hard working staff, and the difference they make to the patient experience. We are keen to ensure they feel supported, which will in turn be of benefit of our patients.
Complaints
Good complaint handling has to start from the top of the organisation and the Board of Directors do very much recognise the valuable opportunities complaints provide to improve services, especially in terms of delivery; outcomes; and overall patient experience. Therefore, when people complain about our Hospital or Community Services, it is very much appreciated that the main intent is to help us learn from what has happened, and to take all necessary action to prevent the same thing happening to anyone else in future.

There were 728 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 4% over the previous year and a 64% increase from ten years ago with an average of 28 more complaints being received year on year over the period.

In addition, some 533 patient related enquiries (PREs) were received by the Patient Relations Department staff during the year which identified issues that had the potential to develop into a formal complaint or grievance if left unresolved. Of the 533 PREs raised, only 5% 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 appropriate Matron or Consultant on the same day.

Some 54% of the complaints received referred to aspects of clinical treatment, and which was a decrease of 10% on the previous year. Complaints, in respect of appointment delays, and cancellations, decreased by 3%. Regrettably, there was an increase of 5% in complaints relating to poor communication and information, and a 2% increase in complaints relating to attitude. The other categories of complaint remained generally similar to the previous year.

The overall categories or subject matter of the complaints received has remained comparably the same as previous years; however the trend in the increasing volume of complaints has continued to rise, and when compared with activity this demonstrates that the Trust received 1 complaint for every 2545 patient contacts in 2014/15 (1:2633 in 2013/14).
In terms of accessibility to make a complaint the use of the Trust’s website mailbox for comments, compliments, concerns and complaints continues to grow year on year with many of the issues raised being dealt with the same day (90%).

Traffic figures from the formal complaints page on the Trust website demonstrate just over 3600 ‘hits’ for the year of which 2800+ hits were unique, reinforcing the trend that this has become a valuable resource for direct contact with the Trust’s Patient Relations Team. This is highlighted by an increase in the complaints received via email from 190 in 2013/14 to 217 in 2014/15 and which represents 30% of the complaints received by the Trust in the last financial year (see below).

These figures suggest improved access to information on how to make a complaint for patients via the Trusts website and corresponding Patient Relations pages, helping improve access for patients, relatives and carers and facilitating the complaints procedure.

The percentage of complaints resolved within timescales negotiated with complainants during the year was 98% (2013/14 also 98%) against a target of 95% continuing to demonstrate consistent performance year on year. Our overall performance in respect of complaint handling; learning from complaints; and the outcome of reviews performed by the Parliamentary and Health Services Ombudsman (PHSO), continues to be closely scrutinised on a monthly basis by the Trust Complaints Panel and reported to the Board of Directors each month. The panel is chaired by a non-Executive member of the Board and with other membership including Medical Director and Nursing & Patient Services Director, and two directly elected Public Governors of the Trust.

A few examples of some of the improvements made to services and which arose from or which were associated with a complaint include:

<table>
<thead>
<tr>
<th>Complaint Access Route 2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letter 53%</td>
</tr>
<tr>
<td>Email 30%</td>
</tr>
<tr>
<td>Telephone 6%</td>
</tr>
<tr>
<td>PALS 4%</td>
</tr>
<tr>
<td>Complaint Form 2%</td>
</tr>
<tr>
<td>Other 3%</td>
</tr>
</tbody>
</table>

| ENT | Patient complained following a prolonged waiting time in the Audiology Repair Clinic. The Directorate have reviewed and adjusted the process for managing the clinic and also appointed 2 Assistant Audiologists to undertake simple hearing aid repair. As a consequence, the waiting time, for hearing aid repair, has now been reported by patients as being very satisfactory. |
| NCC | A complaint regarding delay in a day patient receiving chemotherapy due to poor scheduling has resulted in the department introducing patient scheduling to the E-prescribing chemotherapy care system, and with a plan to address the slippage despite external delays. |
| IMCOE | The family of a patient complained regarding their father’s discharge, in particular his ability to manage at home. The Ward reviewed their MDT communication and planning to ensure patient and carer perspective is included in rehabilitation & discharge plans. A daily “Ward Safety Huddle” has also been implemented, in which a number of issues are discussed including patient discharges planned for that day, specifically discharge destination and any relevant information. |
The main intent is to help us learn from what has happened, and to take all necessary action to prevent the same thing happening to anyone else in future.

<table>
<thead>
<tr>
<th>Department</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetics</td>
<td>A complaint from a patient with a family history of breast cancer who had previously been seen by the Northern Genetics Service detailed how the patient was not called for routine breast screening at the appropriate age (40 years) in 2009. The department has reviewed their system and implemented a revised procedure for calling women for breast screening at the appropriate age to ensure this situation does not reoccur.</td>
</tr>
<tr>
<td>Neuro/Peri Op</td>
<td>A patient complained that following spinal surgery he developed compartment syndrome. This was attributed to the length of time the patient had to remain in a prone position on the operating table, as well as the patient’s weight. A comprehensive review has been undertaken, and which has resulted in the introduction and use of an airflow mattress as a pressure relieving aid to be used in similar cases. Additionally training was also arranged for theatre staff, including a “Master class in Best Practice for Proning Patients”.</td>
</tr>
<tr>
<td>POD (Plastics, Ophthalmology and Dermatology)</td>
<td>The complaint followed a delay in the patient having a lesion excised. Following an investigation the Department has recognised the need to have a mechanism whereby the patient can raise concerns regarding a significant change to their presenting lesion. A Standing Operating Procedure has also been developed &amp; implemented; and a patient leaflet produced.</td>
</tr>
<tr>
<td>Children’s Services</td>
<td>A child’s mother complained that her son, who was receiving Botox treatment, required review by a Consultant Paediatrician and an Orthopedic Consultant. At the time these specialist clinics were held separately and therefore the child’s review was delayed. Adjustments have been made and a monthly combined Clinic with both specialists attending was introduced in December 2014.</td>
</tr>
<tr>
<td>Surgery</td>
<td>Patient complaint in regard to a delayed diagnosis following a breast core biopsy reported as being benign (B1). Eight months later a cancer was diagnosed. Following this incident clinical practice has changed and all patients with core biopsies reported as a B1 will have a repeat biopsy performed. This will ensure the sample is adequate and will avoid potential cancers being missed.</td>
</tr>
</tbody>
</table>

Review of the Year 2014/15  41
The following section outlines the key findings from the surveys carried out in 2014-15.

**National Survey of Adult Inpatients 2014**

The 2014 National Inpatient Survey highlighted the 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

**How do we compare?**

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

The benchmark report shows how the Trust scored for each question in the survey, compared with the range of results from all other trusts that took part. It uses an analysis technique called the ‘expected range’ to determine if the Trust is performing ‘about the same’, ‘better’ or ‘worse’ compared with other trusts.

The Trust performs ‘about the same’ as other trusts in 41 of the 60 questions.

The Trust performs ‘better than other trusts’ in 19 questions. These questions were:

- Information in A&E about condition or treatment
- Planned admission – hospital specialist given all the necessary information about your condition/illness
- Wait for a bed following arrival at hospital
- Noise at night from hospital staff
- Availability of hand-wash gels
- Help from staff to eat meals
- Answers from doctors to important questions
- Confidence and trust in doctors
- Confidence and trust in nurses
- Nurses talking in front of patients
- Involvement in decisions about condition or treatment
- Confidence in decisions made about condition or treatment
- Notice given about discharge
- Explanation of the purpose of medications to take at home
- How to take medication
- Being told who to contact if worried about condition or treatment after leaving hospital
- Discussion by staff about any further need for health of social care services
- Treated with respect and dignity
- Feeling well looked after by hospital staff.

The national programme (managed by the Care Quality Commission) is intended to be a mechanism for making the NHS more patient focused and provides a quantifiable way of achieving this.

<table>
<thead>
<tr>
<th>The 2014-15 the national survey programme for acute trusts consisted of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Annual Acute Adult Inpatient Survey</td>
</tr>
</tbody>
</table>

**PHOTO: FROM SOURCE**
The scores had shown a significant improvement since 2013 for two questions:

- Wait for a bed following arrival
- Being told who to contact if worried about condition or treatment after leaving hospital

2.5 The Trust did not score ‘worse than other Trusts’ in any questions but the scores are significantly lower than last year on two questions:

- Rating of hospital food
- Information given about condition or treatment

The following chart shows how the Trust performed in each section of the National Patient Survey of Inpatients using the CQC website method of presentation compared to how the Trust performed in the 2013 survey. The first bar within each section is the 2014 performance and the second is the 2013 performance.
The following tables show the performance across the sections for the surveys for local trusts and trusts in the Shelford Group. These tables demonstrate that the Trust is the leading performing trust with regard to patient experience with more sections in the Green – ‘Better than other Trusts’ than any other Trust.

### Local Trusts - Comparison of Section Results - National Inpatient Survey 2014

<table>
<thead>
<tr>
<th>Category</th>
<th>Trust</th>
<th>NUTH</th>
<th>Northumbria Healthcare NHS FT</th>
<th>City Hospitals Sunderland</th>
<th>Gateshead Health</th>
<th>North Tees and Hartlepool</th>
<th>South Tees Hospital</th>
<th>County Durham and Darlington</th>
<th>South Tyneside</th>
<th>North Cumbria</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E Department</td>
<td>9.3</td>
<td>8.7</td>
<td>8.6</td>
<td>8.6</td>
<td>8.4</td>
<td>8.6</td>
<td>8.6</td>
<td>8.9</td>
<td>8.4</td>
<td>8.4</td>
</tr>
<tr>
<td>Waiting list / planned admissions</td>
<td>9.2</td>
<td>9.3</td>
<td>8.7</td>
<td>9.2</td>
<td>8.9</td>
<td>8.9</td>
<td>8.6</td>
<td>9.1</td>
<td>8.8</td>
<td>8.8</td>
</tr>
<tr>
<td>Waiting to get to a bed on the ward</td>
<td>8.8</td>
<td>7.8</td>
<td>7.8</td>
<td>7.8</td>
<td>7.8</td>
<td>8.5</td>
<td>7.6</td>
<td>7.7</td>
<td>7.6</td>
<td>7.6</td>
</tr>
<tr>
<td>The Hospital and Ward</td>
<td>8.6</td>
<td>8.2</td>
<td>8.1</td>
<td>8.6</td>
<td>8.0</td>
<td>8.4</td>
<td>8.1</td>
<td>8.3</td>
<td>8.1</td>
<td>8.1</td>
</tr>
<tr>
<td>Doctors</td>
<td>9.1</td>
<td>9.0</td>
<td>8.5</td>
<td>8.9</td>
<td>8.4</td>
<td>8.7</td>
<td>8.4</td>
<td>8.8</td>
<td>8.4</td>
<td>8.4</td>
</tr>
<tr>
<td>Nurses</td>
<td>8.9</td>
<td>8.7</td>
<td>8.3</td>
<td>8.6</td>
<td>8.2</td>
<td>8.6</td>
<td>8.1</td>
<td>8.6</td>
<td>8.3</td>
<td>8.3</td>
</tr>
<tr>
<td>Care and treatment</td>
<td>8.2</td>
<td>8.0</td>
<td>7.7</td>
<td>8.1</td>
<td>7.6</td>
<td>8.0</td>
<td>7.4</td>
<td>8.1</td>
<td>7.6</td>
<td>7.6</td>
</tr>
<tr>
<td>Operations and procedures</td>
<td>8.6</td>
<td>8.6</td>
<td>8.4</td>
<td>8.9</td>
<td>8.6</td>
<td>8.9</td>
<td>8.2</td>
<td>8.6</td>
<td>8.4</td>
<td>8.4</td>
</tr>
<tr>
<td>Leaving hospital</td>
<td>7.9</td>
<td>7.7</td>
<td>7.2</td>
<td>7.8</td>
<td>7.2</td>
<td>7.5</td>
<td>7.2</td>
<td>7.7</td>
<td>7.2</td>
<td>7.2</td>
</tr>
<tr>
<td>Overall views</td>
<td>6.2</td>
<td>5.9</td>
<td>5.5</td>
<td>5.9</td>
<td>5.5</td>
<td>5.8</td>
<td>5.5</td>
<td>5.7</td>
<td>5.8</td>
<td>5.8</td>
</tr>
<tr>
<td>Overall experience</td>
<td>8.5</td>
<td>8.1</td>
<td>8.1</td>
<td>8.4</td>
<td>7.9</td>
<td>8.3</td>
<td>7.9</td>
<td>8.4</td>
<td>8.0</td>
<td>8.0</td>
</tr>
</tbody>
</table>

The doctors, nurses, consultants, auxiliaries, cleaners, and porters were all great! The care I received was great! I cannot thank everyone enough!
As with the inpatient survey summarised above, the results of this patient survey highlight many positive aspects of the patient experience. **Key results show:**

- 73% of patients scored 7 or better from a scale of 0-10. The average score was 7.8 which compares with an average of 8 for all trusts using the Picker Institute to undertake the survey.
- the Accident and Emergency Department was fairly clean/very clean, 99%.
- that they received test results before leaving the trust, 75%.
- they did not feel threatened by other patients, 88%.
- that overall patients felt treated with respect and dignity, 74%.

A response rate of 26.3% was achieved (211 responses). This should be seen in the context of overall activity within the Trust as, during the year 2013-14, 130,756 people attended the Emergency Department. Therefore responses were received from just 0.16% of patients.

The Emergency Department survey was last undertaken in 2012. A total of 32 questions were used in both the 2012 and 2014 surveys. Compared to the 2012 survey, the Trust results have significantly improved in zero areas but have significantly worsened in seven areas. In response to the findings, the management team are examining the full report alongside the respondent comments and other patient experience data in order to action improvements.

The NHS Friends and Family Test has enabled the Trust to capture feedback from over 13,500 patients who attended the Emergency Department – 93% of whom said they were ‘Extremely Likely’ or ‘Likely’ to recommend the Department to their family or friends if they needed similar care or treatment.

### National Survey of Emergency Department Patients 2014

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### National Trusts - Comparison of Section Results - National Inpatient Survey 2014

<table>
<thead>
<tr>
<th>Category</th>
<th>Score out of 10 and overall performance against other trusts (orange – average, green – better than other trusts, red – worse than other trusts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E Department</td>
<td>9.3</td>
</tr>
<tr>
<td>Waiting list / planned admissions</td>
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<tr>
<td>Doctors</td>
<td>9.1</td>
</tr>
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<td>Nurses</td>
<td>8.9</td>
</tr>
<tr>
<td>Care and treatment</td>
<td>8.2</td>
</tr>
<tr>
<td>Operations and procedures</td>
<td>8.6</td>
</tr>
<tr>
<td>Leaving hospital</td>
<td>7.9</td>
</tr>
<tr>
<td>Overall views</td>
<td>6.2</td>
</tr>
<tr>
<td>Overall experiences</td>
<td>8.5</td>
</tr>
</tbody>
</table>
Individual results for all NHS Trusts which took part in the Survey are also published on the Care Quality Commission website (www.cqc.org.uk). The following chart shows how the Trust performed in each section of the National Patient Survey of Emergency Department patients using the CQC website method of presentation compared to how the Trust performed in the 2012 Survey. The first bar within each section is the 2014 performance and the second is the 2012 performance. This shows that the performance within ‘Waiting’ and ‘Care and Treatment’ has deteriorated since 2012 with both sections now in the ‘Worse than other Trusts’ category.

![CQC Benchmark Summary 2014 vs 2012](image)

**Some verbatim comments from the Emergency Department Survey**

<table>
<thead>
<tr>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>The staff were as ever kind, considerate and helpful, even at 2.00am in the morning.</td>
</tr>
<tr>
<td>I am most appreciative of the help given to me from the journey to A&amp;E in the ambulance to discharge from A&amp;E. Although I had to wait for so long I could see that the members of staff were very busy, cheerful, helpful all the time. Thank you.</td>
</tr>
<tr>
<td>Staff were very gentle whilst cleaning &amp; dressing my wound and pleased with my condition 2 days later.</td>
</tr>
<tr>
<td>During my short stay at A&amp;E all members of staff both polite &amp; helpful, which made me feel at ease.</td>
</tr>
</tbody>
</table>

**National Survey of Children and Young People 2014**

A total of 850 patients from the Trust were sent a questionnaire of which 257 returned a completed questionnaire, giving a response rate of 30%. The average response rate across all Trusts using the same company to undertake the Survey was 27%.

**Key results:**

- Overall: 91% of parents rated care 7 or more out of 10
- Overall: 89% of children and young people rated care 7 or more out of 10
- Hospital ward: 95% of parents felt their child (aged 0-7 years) was always safe on the ward, and 90% of children and young people (aged 8-15 years) always felt safe
- Hospital ward: 69% of parents of children aged 0-7 years stated there were definitely appropriate things for their child to play with on the ward, whereas 23% of young people aged 12-15 years felt there was a lot for their age group to do
- Hospital staff: 77% of children and young people (aged 8-15 years) stated that someone at the hospital spoke with them about their worries, and 78% felt that the people looking after them always listened to them
- Hospital staff: 82% of parents always had confidence and trust in the members of staff treating their child (0-15 years)
- Overall: 89% of parents stated they were always treated with dignity and respect by the people looking after their child (0-7 years).

**During my short stay at A&E all members of staff both polite & helpful, which made me feel at ease**
The Survey of Children’s Inpatient and Day cases was last undertaken in 2012. 17 questions were used in both Surveys. The Trust results showed no significant difference in 12 of these questions.

The Trust has improved significantly on the following:

<table>
<thead>
<tr>
<th>(Note - Lower scores are better)</th>
<th>2012</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent did not feel that child was always safe on the hospital ward</td>
<td>12 %</td>
<td>5 %</td>
</tr>
<tr>
<td>Child not always given enough privacy when receiving care and treatment</td>
<td>21 %</td>
<td>9 %</td>
</tr>
<tr>
<td>Child not always given enough privacy when receiving care and treatment</td>
<td>22 %</td>
<td>11 %</td>
</tr>
<tr>
<td>Child not fully told what would be done during operation</td>
<td>16 %</td>
<td>5 %</td>
</tr>
</tbody>
</table>

The Trust has worsened significantly on the following question:

<table>
<thead>
<tr>
<th>(Note - Lower scores are better)</th>
<th>2012</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned admissions: hospital changed admission date at least once</td>
<td>9 %</td>
<td>19 %</td>
</tr>
</tbody>
</table>

(Please note that problem scores in red text show data from the children (8-11 years) and young people (12-15 Years), those in blue text are from parents).

Some verbatim comments from the national survey of children and young people

The nurses on my daughters ward were amazing they chatted to me and made sure I had everything they looked after my daughter like they would their own very friendly and helpful. Thank you.

The care my child received at the RVI was fantastic. All of the staff, including the surgeon, were excellent, they put our minds at rest and took excellent care of him. Having a small child go through an operation is extremely stressful, but they made the experience as stress-free as possible. We were very pleased with all aspects of his care.

Each time we visit hospital for appointments/tests/treatment the nursing staff are always kind and helpful. Our son rarely complains about coming to hospital (except for blood/prick tests) which is great as he is able to come to hospital in a calm state. The staff at the RVI are always helpful and are happy to spend the time explaining things to us which is much appreciated.

Fantastic staff lovely clean wards overall great hospital.

Newcastle RVI has always provided outstanding care and support to our family. We have spent 3 months in special care baby unit, coupled with numerous outpatients visits to the children’s hospital - we cannot commend these services highly enough. The staff, care and facilities are exceptional and we feel very lucky to have such an outstanding facility available to us in Newcastle. The RVI should be very proud of its staff and services. Many thanks.

The CQC Benchmark report - children and young people’s survey 2015.

The national patient survey plan for 2015-16 includes:

- Survey of Maternity patients
- Annual survey of Adult Inpatients
In summary – we received 730 (up 221/30%) of the Take 2 minutes comments cards in 2014-15. The cards ask two basic questions – was there anything particularly good about your experience with the Trust? And is there anything that you think could be improved?

The elements of patient experience recorded under each are as follows:

- Emotional Support
- Co-ordination and Integration of Care
- Physical Comfort
- General Miscellaneous
- Access to Care
- Information, Communication and Education
- Transition and Continuity

In 2014-15 there were a total of 542 cards with positive comments - The main elements of a patient’s stay that gave a positive experience were Emotional Support and Co-ordination and Integration of Care (these two elements have swapped order of % share on past year). Both these areas are heavily dependent on staff members the patients come in to contact with, with an emphasis on the way in which patients are treated and assisted throughout their care pathway.

Within these categories there is a strong use of emotional language describing staff members as being helpful, friendly and caring and acting in an efficient and professional manner.

Everyone was lovely, polite and patient with my mother. Thank You for all your help :) x x

Arrived 10 minutes early and was seen before my appointment time. Very clear way of explaining what would happen. Very impressed.

All the staff were friendly & accommodating when my partner came in with a sore tooth. They acknowledged what we were saying & explained clearly what would happen - that there was a bit of a wait. Felt cared for & confident in the care we were given. Facilities were clean & tidy too.

Excellent waiting area and excellent staff. Very positive experience (especially appreciated the tea and coffee!)

Doctor was very thorough & kind

I spent 13 days in Ward 43, Bay 1 at the RVI. Everyone on that ward was very helpful. Nothing was a trouble to them. They were kind and patient at all times.

Everything was of an excellent standard. Staff extremely helpful from Directorate Staff to Consultants. My husband wouldn’t be alive today but for the care & treatment at this hospital.

The nursing staff and the team of doctors are FIRST CLASS. The food is very good too. Keep it up!
In 2014-15 there were a total of 438 cards with negative comments - Patients have felt that the Elements of Care most in need of improvement are Physical Comfort and Access to Care respectively (same order of % share on last year). These elements focus mainly on the infrastructure of the hospital and wards, the processes that are involved and additional services required while visiting/staying at the hospital.

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

Areas for Improvement 2014/15

- Physical Comfort: 46%
- Access to Care: 16%
- Co-ordination and Integration of Care: 14%
- Information, Communication and Education: 11%
- Emotional Support: 10%
- General Miscellaneous: 5%
- Welcoming the involvement of family and friends: 3%
- Specific: 2%
- Transition and continuity: 2%
- Respect for patient-centred values, preferences and expressed needs: 1%
How we do it
Keeping you safe
The Newcastle upon Tyne Hospitals NHS Foundation Trust (NuTH) recognises that the effective prevention and control of healthcare-associated infection (HCAI) is essential to patient and staff safety. The over-riding principle in our delivery of care is to treat patients to the standard they would expect for their own family or loved ones.

During 2014/2015 the Trust continued to review Infection Prevention and Control (IPC) services in response to the continuing challenges of reducing rates of Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia, Clostridium difficile (C. difficile) associated diarrhoea and meeting targets, the requirements of the Hygiene Code 2006 (revised Jan. 2008), the Healthcare Commission’s report on an investigation at Maidstone and Tunbridge Wells (2007) and Mid Staffordshire (2009). These drivers have been largely superseded by The Health and Social Care Act (2008) published in December 2009 providing focus for the refinement of the IPC strategy. Further guidance has been published by NICE (CG 139 Infection Prevention and Control of healthcare-associated infections in primary and community care), NICE public health guidance 36 (2011) and HPA (epic 3: National Evidence Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England), these have been reviewed and where possible/practical are followed.

Ten criteria which the Board of Directors recognise and endorse as the Framework for delivery of appropriate safe care were incorporated in the current HCAI Strategy with associated policies and selected audit to facilitate the monitoring of compliance.

The criteria set are:

- To have in place systems to manage and monitor the prevention and control of infection.
- To provide and maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections.
- To provide suitable accurate information on infections to service users and visitors.
- To provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.
- To ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to treat the patient and consequently reduce the risk of passing on the infection to other people.
- To ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.
- To provide or secure adequate isolation facilities.
- Secure adequate access to laboratory support as appropriate.
- To have and adhere to policies, designed for the individual’s care and provider organisations, that will help to prevent and control infections.
- To ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.
HCAI Prevention and Control Strategy

The principal objective of the Strategy is to set out the Board level agreement in terms of IPC. It also seeks to provide the Board of Directors with a categorical assurance that appropriate structures and processes are in place to minimise the risks of HCAI to patients, staff and visitors. The Nursing & Patient Services Director and also the Director of Infection Prevention and Control (DIPC) are responsible for the monthly update provided to the Board of Directors.

The aims of the strategy are to ensure that:

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

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

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

IPC Assurance Framework

The IPC Committee continues to meet on a monthly basis, chaired by the DIPC. The IPCC ensures that IPC policy and strategy is developed, implemented and monitored; and that an integrated IPC service is maintained with consistent high standards, protocols and policies. Issues surrounding audit, education and training, communication and any other emerging matters are also dealt with in a timely manner. The IPCC is represented at the monthly Trust Board by the Nursing & Patient Services Director and is supported by the IPC Operational Group, which meets on a monthly basis.

MRSA

Methicillin Resistant Staphylococcus aureus (MRSA) is a gram positive organism that can colonise patients. MRSA is resistant to first line antibiotics for Staphylococcus aureus and therefore can be difficult to treat and is life threatening when bacteraemia leads to sepsis. The Trust’s MRSA Policy reflects national and local policy and includes the Post Infection Review (PIR) process. A review of the MRSA screening policy for patients prior to/on admission has been undertaken and changes made in line with changes to the national guidance. This has led to a reduction of screening in areas of low risk.

There has been a significant reduction in the number of MRSA bacteraemia over a number of years. There has been a zero tolerance for MRSA bacteraemia in 2014/2015, however in this year there were 5 cases of HCA MRSA bacteraemia in the Trust.

Chart 1: Cumulative MRSA Bacteraemia 2014-15
There has been year on year reduction in bacteraemia from over 70 cases 2006/7 to 5 in 2014/2015 (Chart 2), the numbers of the last three years have been low and stable. Reducing the number of MRSA bacteraemia to zero is a significant challenge. All cases have been reviewed in Serious Infection Review Meetings (SIRM) and key lessons disseminated to departments and to the trust as a whole. All cases were in patients with previous history of colonisation and the majority had significant comorbidities and serious long term illnesses requiring complex treatment. No serious breakdown of infection control procedures was found in any of the cases, however, documentation was occasionally lacking. In two cases there was poor communication between the referring trust and ours which has been bought up in the regional HCAI meeting.

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

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

All of these initiatives are under active review and audited accordingly.

Chart 2: Trend over 5 years of MRSA bacteraemia
**Clostridium Difficile (C. difficile)**

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

Risk factors include:

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

The national incidence of *C. difficile* has previously increased in the past decade.

All cases of *C. difficile* in patients over the age of 2 and occurring 48 hours after admission are attributable to the Trust (hospital acquired, HAI) and are mandatorily reported to the Public Health England via the national Data Capture System. There has been a year on year requirement to reduce the incidence thus reflecting improved levels of hygiene and adoption of prudent antibiotic stewardship. The nationally set target for the year 2014/15 was 80. Unfortunately this target was exceeded and the end of year total for the trust was 89 cases. In recognition of the fact that some cases of *C. difficile* are difficult to avoid (i.e. a significant proportion of the population carry *C. difficile* and patients in hospitals sometimes require life-saving antibiotic treatment which leads to *C. difficile* associated diarrhoea) an appeals process has been established. We successfully appealed 16 cases so far (a further eight cases have been put forward for appeal), therefore our end of year number of HCA *C. difficile* is 73 cases at present (Chart 3). Overall the rate of infection was similar to national average rates at around 66 cases/1000 bed days. The five-year trend is of improving numbers, however, the quantum of cases over the last three years has remained relatively static probably reflecting the initial gains made by overall improvements in IPC practice and antibiotic prescribing and the consequent smaller gains due to difficulty in eradicating *C. difficile* from the population and engraining good practice in the organisation.

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**Chart 3: Monthly Cumulative *C. difficile* 2014/15**

**Chart 4: 5 year cumulative Directorate *C. difficile* totals to 2014/15**
C. difficile has been the focus of a number of learning events over the past year and has been the focus in some patient safety briefings. It has been highlighted in a number of forums including CPG, clinical governance meetings and a range of Nursing Forums.

The majority of cases of C. difficile in this period have been reviewed in SIRM after root cause analysis (RCA) have been completed within one week of the case occurring. Learning points from these are disseminated by the directorates to staff members and shared with Clinical Directors (CD) and Matrons with a quarterly HCAI report providing further information. The major issues identified are:

1) Appropriate antibiotic prescribing: This is generally good, 81% of antibiotics were prescribed entirely appropriately. There were a number of instances where the course was prescribed for too long or were inappropriate prescribing for the indication.

2) Early isolation: The majority of patients were isolated at onset of diarrhoea (65%), where isolation has not been achieved this is reviewed. On ITU the lack of isolation is due to the fact that over 50% of patients have diarrhoea and therefore an active multi-disciplinary review is required to assess the need for isolation. On other wards there have been occasions when there has been difficulty in isolating a patient due to lack of isolation rooms. Isolation is essential and this has been fed back to directorates, a review of capacity for isolation beds in areas that have high numbers of C. difficile is underway.

3) Not sending stools early in onset of diarrhoea: In 59% of cases stool was sent on the second episode of diarrhoea in line with policy. The majority of instances where this has not happened have been due to difficulty in obtaining a sample due to incontinence. In some cases diarrhoea was considered secondary to laxatives therefore samples were only referred to microbiology after these have been stopped. A strong message has been fed back to medical and nursing staff about when to send stool samples and the importance of medically reviewing all patients with diarrhoea.

Overall the number of stools sent to the laboratory for testing has increased by 11% from 2013/14. Delays in stool specimens getting to the laboratory have been reviewed and has revealed problems on the weekend after porters have done rounds to collect specimens to the laboratory has been reviewed and has revealed problems on the weekend after porters have done rounds to collect specimens. This is being addressed.

Period of increased incidence (PII - defined as more than one case within 28 days) are reported and investigated urgently with meetings between ward sister, microbiology, IPCN and senior clinicians. There have been seven PII across the Trust this year, these are summarised, presented to the IPCC and a quarterly report is reviewed quarterly by IPCN, Healthcare scientist, Infection Prevention and Control Doctors, Antimicrobial Pharmacist, Head of Nursing, DIPC and the rest of the IPCC. This is a robust and active document with significant outcomes as indicated below:

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

RCA are completed by the relevant Matron, Ward Sister/Charge Nurse, IPCN and Medical representative for each incidence of C. difficile infection that is attributed to the Trust. On a quarterly basis RCAs are summarised, presented to the IPCC and a quarterly report is produced that highlights the main learning outcomes this is disseminated via Matrons Forum and CPG.

C. difficile Saving Lives audits are performed weekly following all hospital acquired C. difficile cases. These audits continue for a maximum of four weeks.

The affected clinical areas undergo “deep cleaning” along with repair and replacement of any damaged furniture and / or potentially contaminated equipment. On one occasion a ward has been decanted to enable this and to use Hydrogen Peroxide Vapour (HPV) throughout the ward. The learning from all PIs are disseminated to all appropriate personnel.

There are Integrated Care Pathways (ICP) for Diarrhoea and C. difficile (completed in 93% of cases). This documentation is used in conjunction with the C. difficile Infection Management Policy and clinical algorithm complying with the DoH document “Clostridium Difficile infection: How to deal with the problem” and the update guidance on the diagnosis and reporting of Clostridium difficile (2012).

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

There were also two C. difficile awareness campaigns during the year; “Give C. difficile it’s Marching Orders” and “Wave Goodbye to C. diff in July”. Both campaigns incorporated the key learning from the RCA process and promoted best practice in the prevention of, and management of patients, with infective diarrhoea including C. difficile and also good antibiotic stewardship. The IPCC team visited clinical areas in both acute and community settings and the Laboratory staff provided clinical staff with a ‘behind the scenes’ view of what happens to specimens once they leave the ward.

An annual C. difficile action plan is developed and progress is reviewed quarterly by IPCN, Healthcare scientist, Infection Prevention and Control Doctors, Antimicrobial Pharmacist, Head of Nursing, DIPC and the rest of the IPCC. This is a robust and active document with significant outcomes as indicated below:

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

This trust wide team approach has been demonstrably effective in reducing the incidence of hospital acquired C. difficile infection however commitment must remain to ensure further necessary improvement.

The number of cases over the last three years has remained relatively static probably reflecting the initial gains made by overall improvements in IPC practice and antibiotic prescribing...
Aseptic Non-Touch Technique (ANTT)

The principles of Saving Lives strategy continue to be built upon and consolidated with clinical leads in all areas. Aseptic Non-Touch Technique (ANTT) as a principle to underpin asepsis is incorporated into the Breeze e-learning packages, with links to ANTT and highlight of the more relevant points to each group. All medical junior doctors who undertake ANTT procedures must demonstrate competence in ANTT at induction and are assessed individually. Insertion of Peripheral IV Cannula must be documented including compliance with ANTT ANTT observation work has been embedded in CAT and this helps to ensure that knowledge of ANTT is raised.

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

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

Clinical Assurance Toolkit (CAT)

The Clinical Assurance Toolkit (CAT) is now well established within the organisation as a Trust-wide tool to provide continuing clinical assurance to the Trust Board as an overview of performance for each ward / department and Directorate. The aim of the CAT is to measure and demonstrate compliance with the published documents and national drivers such as High Impact Interventions (HII), Saving Lives as well as providing useful data to support, verify and offer assurance for external inspectorates. This is well established and is highlighting good practice in hand hygiene and cleanliness in >98% of reviews.
Hand Hygiene

All members of staff in the Trust are required to adhere to and practice good hand hygiene technique. All members of staff are also expected to comply with the “5 Moments for Hand Hygiene”. This is vital to ensure a safe environment for patients, visitors and staff by reducing the transmission of potentially harmful infections.

An extensive hand hygiene audit programme, which monitors adherence to Bare Below the Elbow (BBE), opportunity and technique has continued to demonstrate sustained improvement and compliance (>98% compliance in the most recent review). Hand hygiene audits are now incorporated into CAT and a monthly ‘by exception’ report is submitted to IPCC by the Matron IPC.

Hand hygiene with soap and water is essential for patients symptomatic of diarrhoea; it is also important to wash hands regularly during the day in addition to using alcohol hand gel (which is not effective against C. difficile spores). These messages continue to be propagated through Matrons, CPG and clinical governance meetings.

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

Don’t forget your fingertips, webs, thumbs and wrists because...

Ebola: Patient still under assessment

A PATIENT who came into contact with a diagnosed Ebola patient remains under assessment at Newcastle’s Royal Victoria Infirmary. The military health worker was one of two flown into the city from Sierra Leone for monitoring on Friday.

After 48 hours in the hospital’s infectious diseases’ unit, the worker remained under observation yesterday. A colleague was discharged before the weekend but will need to be monitored for the next 21 days to ensure they show no signs of the disease.

Public Health England said the situation remained as prior to the weekend and both cases were being treated in line with UK health policy on Ebola. A statement said: “On Thursday, the UK military healthcare worker with Ebola was safely transported to the Royal Free Hospital in London and admitted to its special high-level isolation unit.

“Two further UK military healthcare workers, identified as contacts, were transported to the Royal Victoria Infirmary in Newcastle for assessment. “One has now been discharged. None of the four individuals identified as contacts have been diagnosed with Ebola.”
Antibiotic Prescribing

The Antimicrobial Stewardship Steering Group (AMSG) meets quarterly and continues to monitor antibiotic usage. Total antibiotic usage has remained stable (Chart 5) despite increased patient numbers. Cefuroxime usage continues to decline (Chart 6). The use of the CERNER electronic prescribing (EP) system plays a large part in the implementation of the restrictions in antibiotic usage, with the utilisation of pop up messages and mandatory fields for indication and duration.

Guidelines and policies continue to be proactively reviewed and most recently the surgical prophylaxis and surgical treatment guidance was updated to further restrict higher risk antibiotics, with a view to lower C. difficile incidence.

There is concern that this has been replaced by piperacillin-tazobactam and education continues on appropriate use of antibiotics in a number of settings. The resistance pattern for gram-negative bacteria for Newcastle Hospitals continues to be reviewed. We have made sepsis a priority and work is underway to improve the management of sepsis which should in turn increase the appropriateness of IV antibiotic prescribing.

Antimicrobial stewardship from committee and policy level through to the prescription at the bedside is proactively promoted. The need for indications for antibiotics, their course duration, review at 48-72hrs and the importance of culture prior to initiation has been emphasized in a number of forums. The ‘Start Smart and Focus’ agenda is followed to ensure antibiotics are given where appropriate, they are prescribed appropriately and reviewed with results and clinical condition of the patient. These messages are incorporated into the Breeze education package and included in the CAT tool. Antibiotic guidelines and antibiotic cards are given to all antibiotic prescribers.

Antibiotic education continues with direct teaching sessions to all F1 at induction, antibiotic usage and guidance is incorporated into induction for all staff.

On eRecord, duration of antibiotics is mandatory to record and there are a number of order sets for common infection which ensure standard courses of antibiotics are given. IV antibiotics have a review pop up after 48hrs to ensure early IV oral switch where appropriate. Proton pump inhibitors may increase risk of C. difficile infection, if proton pump inhibitors are prescribed in someone on antibiotics a pop-up is triggered to warn of this potential risk and reminds doctors to review.

Antibiotic Champions have been appointed in all clinical areas and are key to dissemination of messages to staff members and audit of antimicrobial usage in their areas; their role is being reviewed. A large point-prevalence audit was undertaken over one day by Pharmacy and an Infection Expert (Infectious Disease Microbiology Teams).

All antibiotic audit results are fed back through Directorate antibiotic champions and to the Clinical Policy Group.

Chart 5

Total Antibiotic Use - Excluding Outpatients

![Graph showing total antibiotic use excluding outpatients from June 2009 to August 2014](chart5.png)

- **Grand Total**
- **Grand Total IV**
- **Grand Total PO**

Chart 6

High Risk Antibiotics

![Graph showing high risk antibiotics usage from July 2009 to January 2015](chart6.png)

- **Cefuroxime**
- **Ciprofloxacin**

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

The IPC Team works in collaboration with Estates to review new building works, water and environmental issues to ensure a safe environment is established and then maintained. Regular meetings occur between ICD, IPCN and Estates representatives. More recently a separate water group and meetings has been set up (see below).

A forward plan of ward refurbishment and improvement of the environment is being further developed to ensure that wards are refurbished in a proactive way and not reactively. This requires decant wards. A decant Ward is available at the Freeman Hospital, and has been used twice to decant wards to ensure thorough cleaning after PII. A decant ward still needs to be identified at the RVI to enable this to happen; this is being actively explored. However, at present refurbishment is occurring on wards at the RVI by moving wards across to the Freeman Hospital.

Water Group

A Trust Water Group has the remit to ensure safety of water supply on all Trust sites. Regular reports on water issues provide assurance that water is safe and testing occurs appropriately. This delivery ensures compliance with national guidance such as the Health and Safety Commission’s approved Code of Practice and current relevant Health Technical Memoranda such as HTM 04-01; The Control of Legionella, Hygiene “Safe” Hot Water, Cold Water and Drinking Water Systems, Parts A & B and Health Technical Memorandum 04-01 Addendum: Pseudomonas aeruginosa – advice for augmented care units. These are reflected in the water safety plan which is now complete and being implemented.

We have an Authorising Engineer and a designated Responsible Officer appointed with regards to water policies and the water plan. The responsible officer has deputies appointed. An external company (Hydrop) is in place and is auditing and reviewing water safety across the Trust. The degree of control in regards to water policies is now moderate to high, with significant improvements in many areas. There are still a large number of issues that require addressing, these include: dead legs, temperature regulation in some areas, improving documentation of review and process.

Legionella Risk Assessments BS 8580:2010

BS 8580:2010 came into effect on 31st December 2010. Risk assessments are being performed at the RVI. These have shown problems in the water systems and significant risk has occurred in Claremont and previously in Leazes with significant improvement in control of the water. An on-going programme of remedial action is in progress and a number of dead legs have been identified and are being removed.

A similar risk assessment process is occurring at the FH site with ongoing work to identify problems. The new Institute of Transplantation has also been amalgamated into the Legionella risk assessment process.

Pseudomonas testing has started in augmented care areas after assessment of the water systems in individual areas and remedial work. Where issues are found there is active communication between Estates and ICD with an action plan to correct any issues found. The water systems within Dental chairs have been reviewed and a more robust policy developed to ensure that they are decontaminated effectively.

Taps

It has been recognized over recent years that thermostatic mixer taps can increase the risk of colonization with Legionella; a Trust standard has been agreed and in areas where there are mixer taps, a gradual programme of tap replacement is planned and will occur as refurbishment of the wards progresses.

Review is underway of water chillers to identify those which are not in use to remove and to ensure those that remain are maintained.

Community Premises

There is ongoing work with Estates via the Community Environmental Action Team (CEAT) to monitor standards in community premises not owned by the Trust and to clarify appropriate escalation process ensuring any shortfalls are addressed in a timely manner. There have been continued difficulties in escalation of identified issues and this is being addressed at a local and national level.

Surveillance

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

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

Declaration of MSSA (Methicillin-Sensitive Staphylococcus Aureus) bacteraemia has been mandatory from January 1st 2011 with mandatory E.coli bacteraemia reporting from June 1st 2011. Currently there are no targets associated with MSSA or E.coli bacteraemia. The Department of Health is using this information to establish baseline trends for both infections.

This has shown that we have below average rates of hospital acquired E.coli bacteraemia. We continue to highlight ANTT in the use of urinary catheters with training on ANTT and e-learning packages highlighting this. We have ensured the policy on antibiotic prophylaxis for catheter changes is robust. There continues to be a drive to improve management of urinary catheters in the community nursing homes. Building on the “Prevent CAUTI/UTI” initiative, this multi-disciplinary team has now been incorporated in to the Specialist Care Home Support Team and continues to support improvement in catheter management in the care homes involved, with a consequent reduction in catheter usage, reduction in admissions and a decrease in catheter associated infections.

In collaboration with clinical staff and the Continence Team, an evaluation of the HOUDINI Framework is in progress in Musculoskeletal and Neurosciences Directorates. This framework prompts staff to continually review the need for a urinary catheter to ensure safe and early removal.

MSSA bacteraemia appear to be higher than other Trusts, although when the rate is looked at Newcastle Hospitals is just above average. The 2 areas that have the largest number of MSSA bacteraemia are Renal and Cardiothoracic reflecting the large number of lines used in these areas and the vulnerability of their patient groups. A large amount of work has been undertaken to screen for MSSA in vulnerable groups, use of chlorhexidine washes in high risk patients is occurring in Renal and Cardiothoracic and a policy of using chlorhexidine washes in higher risk patients has been introduced. Numbers of MSSA bacteraemia have reduced by 44% in Cardiothoracic following focused work through microbiology, IPCN and Cardiothoracic. MSSA bacteraemia has remained stable in renal after previous reductions. SIRM are used to investigate bacteraemic episodes where IPC issues are identified. Any lessons learnt during the SIRM or in RCA are promptly fed back to directorates.

“Matching Michigan” is a quality assurance tool for the audit and monitoring of insertion and on-going management of central venous catheters, to prevent catheter related blood stream infections (CR-BSI). This tool has been introduced in areas of high use across the Trust and as a consequence there continues to be a reduction of line associated bacteraemia rates in Haematology, Oncology and Paediatrics. In all adult ICCUs across the trust where Matching Michigan has been in place for some time the rates of infection have remained below the Matching Michigan rates in adult ITU across the trust (0.72/1000 catheter days in March 2015).

Mandatory reporting of Orthopaedic knee and hip surgical site infections (SSI) and voluntary reporting of Spinal SSI via the Public
Health England Surgical Site Infection Surveillance Service continues on a quarterly basis. The Trust is continuing to perform well nationally for elective total knee replacements (0.7% vs 0.9% national average) and elective total hip replacements (1.2% trust rate vs 0.9% national average). A number of initiatives such as chlorhexidine pre-operative washes given to patients having operations continue. There have been higher rates of SSI in patients undergoing spinal surgery may be related to case mix. RCA have occurred and these have shown a need to standardise some practice such as post-surgical dressings and skin preparation. Patients undergoing surgery are being given chlorhexidine washes to apply prior to surgery and nursing staff are encouraged to discuss good hygiene practices with the patient prior to theatre where practical and apply further washes where needed, this practice is being reviewed to improve compliance. There has been an expansion of the spinal ward to increase side rooms and allow for complex patients to be managed in a 4 bedded bay to improve the overall management of these patients. The last quarter revealed a reduction in rates of infection.

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

Examples of “alert” organisms under continual surveillance are:

- Invasive Group A Streptococci (IGAS)
- Mycobacteria
- Multi-drug resistant gram negative bacteria.

Two IGAS PII have occurred in the trust this year leading to enhanced environmental screening and in one case a ward decant to clean the ward.

### Multi-Resistant Organisms

#### Glycopeptide Resistant Enterococci (GRE)

GRE (also known as Vancomycin Resistant Enterococci or VRE) is mainly acquired in the community from the food chain and many people have GRE in their gut naturally. Patients who are hospitalised and treated with glycopeptides very occasionally experience a GRE infection as a result, and outbreaks of cross-infection could potentially occur. However the Trust continues to have a low incidence of GRE infection with only one bacteraemia identified during the past year.

#### Carbapenemase-producing Enterobacteriaceae (CPE)

Carbapenemase-producing Enterobacteriaceae are highly resistant bacteria and are recognised as a growing problem in Europe and in some areas of the UK, patients may be colonised with this organism and in hospitals transmission can occur. Newcastle Hospitals has established a screening programme, in line with PHE guidance on screening, for patients who have been admitted to hospital outside the North East of England to ensure that where identified patient carrying CPE can be managed appropriately to ensure transmission does not occur.

The IPCN team have undertaken education and training on all in-patient wards to support implementation of the new CPE Policy to aid compliance with this important preventative measure.

#### Norovirus

As expected, frequent cases of Norovirus have been identified throughout the year. A proactive approach is being taken with biannual meetings, one after the Norovirus season in spring to review the practices and issues that have arisen and the second in autumn to look at practices for the winter. This involves representatives from acute admissions and Emergency Department (ED), bed managers and IPC team.
In accordance with national guidance, wards are partially or fully closed, depending on the circumstances, with active cleaning. Excess visitors are discouraged. Posters are visible during the seasons when outbreaks occur to highlight to staff, patients and visitors to come in visit if symptomatic of diarrhoea and vomiting in the last 48hrs. Key messages on the prevention and management of outbreaks are highlighted to staff each year with hand washing being mandated when seeing patients with diarrhoea and vomiting. There has also been collaborative working with Patient Services Coordinators, ID and IPC to proactively locate cubicles at the height of outbreaks.

**Influenza/Measles/Novel Coronavirus**

Influenza remains a sporadic problem, this season has seen a rise in cases due to lack of efficacy of the vaccine. Fit testing of FFP3 masks occurs in appropriate clinical areas delivered by a trained fit tester. New guidance on use of PPE has been reviewed and where appropriate incorporated into a Newcastle Hospitals policy which has been ratified. This year’s staff vaccination campaign resulted 65.2% of staff being vaccinated. This has involved a lot of work to train peer vaccinators and establish clinics. Occupational Health has led on this and it has been recognised that uptake may be challenging after the poor efficacy of this year’s vaccination. In response an even more robust campaign is already being planned for next season.

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

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

**Ebola**

Newcastle Hospitals has been integral in the national response to the large and tragic outbreak of Ebola in Sierra Leone, Guinea and Liberia. To ensure safe management of patients with Ebola / Viral Haemorrhagic Fever (VHF), or any patient with a confirmed hazard group 4 pathogen, many training materials and policy documents have been developed, through liaison with many internal and external departments.

This included undertaking significant building work to create 4 high level isolation suites and a Trellex Isolation Unit housing two Trellex Isolators. The safety of staff members has been the utmost priority and to this extent over 230 multidisciplinary multinational staff have undergone training appropriate to their role. Some staff members have also visited the Royal Free Hospital in London to gain real life experience in the care of patients with Ebola.

A number of patients with a high risk of infection with Ebola have been admitted and safely managed and assessed for the possibility of Ebola infection.

The Trust is now able to care for patients with Ebola/VHF/hazard group 4 pathogens and a substantial legacy has been left from this work. The Trust is also now the main centre in the UK able to care for these types of paediatric cases, due to our on-site specialities.

**CJD**

A robust mechanism is in place to ensure that patients at risk of having been infected with CJD are identified and are treated and counselled accordingly. The Trust vCJD/CJD Group continues to meet, reviewing and responding to changes in national policy and guidance. There is on-going work in Neurosciences and Ophthalmology to monitor compliance with vCJD/CJD screening questions prior patients undergoing procedures. Some endoscopes have been released following new guidance that they do not pose a risk following previous quarantine. There have been no significant problems with this process during 2014/15.

**Cleaning Routines, Specifications and Audits**

All patients admitted to Newcastle Hospitals must be cared for in a clean environment with clean equipment and as such, all staff have a responsibility to ensure compliance. There is an established policy, ‘Decontamination of the Patient Environment (which includes Terminal Cleaning)’ to provide detailed guidance for staff and identify specific areas of responsibility.

Routine environmental cleaning continues to be provided by an in-house team of staff, this includes a Rapid Response Team to undertake terminal cleans following isolation.

A number of initiatives have improved the efficiency of cleaning. Increasing the workforce and consolidating teams to enable improved turnaround time and the ability to be more proactive into the evening and during busy times to reduce delays in bed turnaround. Hydrogen peroxide vapour (HPV) decontamination has been introduced in certain circumstances as part of a deep cleaning programme or as part of the terminal cleaning process following known or suspected infectious diarrhoea.

Monitoring of cleanliness standards is performed by a range of Trust audits and the annual Patient-led Assessments of the Care Environment (PLACE); these assessments and audits adopt a multidisciplinary approach comprising Nursing, Hotel Services, Estates and patient representatives. The Matrons Monthly Checklist has been incorporated into CAT to provide further evidence of environmental and decontamination compliance.

Hotel Services continue to use ‘Credits for Cleaning’ to monitor cleanliness standards in all clinical areas on a monthly basis. A plan has been developed and is being put forward to introduce ATP monitoring to test for presence of residual organic matter following cleaning. There is potential to incorporate this technology into local assessment strategies to monitor the effectiveness of cleaning.

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

**Education and Training**

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

Training of Estates staff on IPC issues and water has been delivered. Increasing the workforce and consolidating teams to enable improved turnaround time and the ability to be more proactive into the evening and during busy times to reduce delays in bed turnaround. Hydrogen peroxide vapour (HPV) decontamination has been introduced in certain circumstances as part of a deep cleaning programme or as part of the terminal cleaning process following known or suspected infectious diarrhoea.

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**E-learning**

IPC mandatory training has been delivered to the all of staff through on-line training programmes. There have been six bespoke programmes for several years to meet the educational needs of different staff groups. These programmes have now been renewed and increased to seven, with collaboration between the IPCNs and the Training Department, to give a fresh new look to the programmes, ensure the information is current and evidence based and to facilitate greater user engagement.

The programmes are now:

- Infection Prevention and Control AHP 2015-2016 – for allied health professionals
Face-to-face training is delivered to members of the Council of Governors and Board of Directors.

Monthly data monitoring compliance also are the subject of regular review under ways and means of improving compliance.

**Induction**

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

The IPC Nurses also deliver training to Year 1 Foundation Doctors; Medical Students, Nurses during Preceptorship, Student Nurses; as well as Project Choice and work experience students during their induction process. The IPC team are working with Human Resources to improve the process of giving information to medical staff entering the trust. We are looking towards introducing mandatory ANTT training to all Medical Staff entering the Trust.
Healthcare Assistant (HCA) Development Programme

It is recognised that the Healthcare Assistants have a vital role to play in the delivery of clean safe care to our patients, and as such the continued education and training of this group of staff is essential. The IPC Nursing Team continue to support the Healthcare Assistant Academy via delivery of IPC training sessions.

IPC Education Forum

This Forum meets bi-monthly for one hour and targets an audience of multidisciplinary staff where participation and discussion is most proactively encouraged. The programme aims to deliver IPC information on a variety of topics delivered through different ways such as presentations; quizzes; and videos, which will be of interest to all staff groups. CPD points are offered to medical personnel who attend and a broad range of subjects are covered.

The Forum is currently being reviewed to enhance and sustain interest and engagement.

IPC Link Group (IPCLG)

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

The Community based IPCLG meets bi-monthly and includes staff from Community Services and also staff from Nursing and Residential Homes in the Newcastle area.

Annual study days are held for Acute and Community staff to provide the foundations for new link staff and enhance the knowledge of our current staff.

Medical Staff

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

- Hand hygiene education and training sessions to medical students in their 2nd, 4th and final year.
- A specific IPC education session in venepuncture, cannulation and other IPC practices, is given to EJR students in their 3rd year by IPC Nursing Team, Clinical Educators and Medical Education team.
- Individual IPC education and training to each new F1 doctor during their initial "shadowing week".
- Microbiology trainees shadowing of the IPCNs for a period of time during their training to gain knowledge and expertise in infection prevention and control practice.

Additional Education and Training

Whenever there have been concerns about rising HCAI levels in specific areas or Trust-wide, the IPC Team have promptly responded to address any perceived or actual gaps in knowledge and training. This has resulted in many extra education sessions on a variety of subjects, including hand hygiene, at Ward and Departmental level.

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

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

Patient/visitor/carer

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

Conclusion

Although there have been a lot of challenges this year the IPC team has been integral to the continuing successful reduction of HCAI. Staff members have been well engaged in this and understand the aim of ensuring a working environment in which the risks of developing a HCAI is minimized. This has led to maintenance of the previous dramatic reductions of the total number of MRSA bacteraemia.

C. difficile still remains a great concern from the point of view of HCAI within the Trust, focus remains on ensuring all staff are vigilant, the environment is clean and antibiotic stewardship is made a high priority. The prescription and continuation of antibiotics remain the responsibility of the medical staff, their future response is vital to successfully reducing C. difficile and reducing the emergence of resistant strains of micro-organisms.

The IPC Team has made further steps in integrating the hospital and community services where possible. The team has also been integral to the response to the threat of Ebola.

The overriding principle that IPC is everyone’s responsibility has become ingrained into the working ethos. We need to avoid complacency and continue to consolidate on this success such that it continues.

Overall there are a number of ongoing issues and future challenges that need to be tackled in the forthcoming year. The IPC Team and the Trust are well placed to meet these challenges.

Dr Ashley Price

Director of Infection Prevention & Control

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Healthcare at its very best
The fundamental challenge we face

Hunt casts doubt on the future of a publicly-funded NHS
Health Secretary wants priority to be empowering patients not meeting targets

It will take a “huge effort” to maintain the NHS as a fully taxpayer funded service, Jeremy Hunt has said, days after a fellow health minister said the NHS funding system should be “questioned” if economic growth does not keep up with patient demand.

Mr Hunt’s comments to The Independent came as he set out a “25-year vision” for the NHS, which called for a “fundamental shift” away from a target-driven system towards “patient power”.

The Health Secretary said that a target focus had “dehumanised” the NHS, and called for more power to be put in patients’ hands, with greater access to health records and self-monitoring via health apps.

However, asked whether he was confident the NHS could continue for 25 years as a solely taxpayer funded service, Mr Hunt said: “I am confident but I don’t have a crystal ball. If I look at the challenges we face in delivering the Forward View [NHS England’s plan to reform services up to 2020] I think that our model will work but it’s going to need a huge effort from NHS organisations and NHS leaders to deliver that.”

Earlier this week, health minister David Prior said in the House of Lords that an independent inquiry into future NHS funding may be needed.

Mr Prior, the former chair of the Care Quality Commission who was made a life peer and appointed to the Department of Health after May’s election, said that while he was “personally convinced” a taxpayer funded system was “the right one”, but added: “if demand for healthcare outstrips growth in the economy for a prolonged period, of course that premise has to be questioned.”

Speaking at the King’s Fund think-tank yesterday, Mr Hunt announced a range of measures to improve patient safety and patient control over their own healthcare.

In a wide-ranging speech, he announced that five NHS trusts would receive support from the US hospital corporation Virginia Mason, whose Seattle hospital has been held up by Mr Hunt as an exemplar of patient safety.

Meanwhile, internet entrepreneur Martha Lane-Fox will be asked to report on ways to increase uptake of new digital health devices among patients who could benefit. Mr Hunt said that patients should be able to monitor their own heart rates and blood pressure, and share information with their doctor in what he called “power-sharing” arrangements.
Report criticises rivalry between heart units

By Helen Rae
Health Reporter
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COMPETITION between heart surgeons in Newcastle and Leeds has been condemned in an independent report.

Proposals to cut the number of children’s heart units nationally led to strained professional relationships between staff in Leeds and Newcastle, damaging trust between the two centres, the report says.

Children’s heart surgery at Leeds General Infirmary was temporarily suspended for more than a week last year after fears were raised about mortality rates at the facility.

Surgeons at Newcastle’s Freeman Hospital were critical of the care patients received in Leeds and gave NHS England a dossier of 14 cases where the child was either not offered surgery, faced delays in referrals or was placed on palliative care pathways.

That came at a time when the future of both Leeds’ and Newcastle’s units were under threat as part of a national review which planned to slash the number of children’s heart units in order to centralise service into fewer, more specialised centres.

A review of the Leeds unit concluded that improvements have been made and the service can go from strength to strength.

But the Verita report brings to light tensions between staff in Leeds and those in Newcastle from as far back as 2011.

The family of a child included in Newcastle’s dossier of cases of concern were worried that clinicians in Leeds wanted a complex case off their books.

But the parents were also worried that staff in Newcastle could take on the tricky case to “score points” against Leeds at a time when both units were being scrutinised.

Sir Leonard Fenwick, chief executive of Newcastle Hospitals NHS Foundation Trust, said: “The 14 cases all came to Newcastle Hospitals to receive care and treatment with expectations and outcomes met. Patients were being referred to us for second opinions by specialists and GPs, as well as family and friends in great distress. “I believe the report is badly drafted, lacks good cross reference material and some of the findings are contradictory. I acted professionally and evidence-based.”

Paediatric heart surgery is a small speciality, with about 30 consultant paediatric cardiac surgeons in the NHS, who should share expertise, the report expressed.

The report said: “Any disagreements and personality clashes should be in a context of mutual respect, but this is not the case at Leeds and Newcastle, where we found evidence of a strained relationship between clinicians.”

REPORT ‘MISLEADING’ SAYS HEART PATIENT’S MUM

A MUM whose son was transferred from Leeds to Newcastle for life-saving heart treatment claims the Verita report is misleading.

Little George Hall was born with complex heart problems and began to receive care at Leeds General Hospital.

The family, from Skipton, North Yorkshire, claim doctors in Leeds told them that they could only offer palliative care for George, who celebrates his third birthday in January, but after being treated in Newcastle he was now “fixed.” Mum Hollie Pearson, 21, who also has son Harvey, five, said: “I’m appalled at the report because it suggests that parents have been too over-reactive. I feel the report is not factual and is misleading. When George was at Leeds I was told that his care would be palliative, but he now needs no more heart surgery and is doing well thanks to the Freeman Hospital. “Staff at the Freeman are amazing and if George was not treated at the hospital then he would not be alive today.”

NHS England’s deputy medical director, Dr Mike Bewick, said: “This thorough process would not have been possible without the full co-operation and participation of patients, families and clinicians. Releasing painful events or opening oneself up to public scrutiny is not easy. “Verita has made some positive recommendations which local oversight bodies will now consider with care and will also be considered as part of the national review.”

EDITORIAL FROM THE CHRONICLE

Readers of the Year 2014
Cancer patients doing better in city

PATIENTS being treated for cancer in Newcastle hospitals have a better chance of survival than in many other parts of the country, new figures show.

The latest National Lung Cancer Audit Report showed that Newcastle hospitals scored better than the national average for the percentage of patients who survive one year, the percentage of patients surviving for three months and for average survival rates.

Dr Ann Ward, consultant in respiratory medicine and lead for lung cancer at Newcastle Hospitals, said: “We are delighted with these results. They reflect the positive attitude and dedication of the entire team who work incredibly hard to ensure the care and treatment we offer our patients is the best it possibly can be.

“We will continue to strive to improve our standards of care and outcomes.

“Finding lung cancer early gives the best chance of successful treatment, and it is always best to have new symptoms checked. Stopping smoking is the best way to reduce the risk of lung cancer developing.”

The annual audit was for patients who were diagnosed and treated for lung cancer during 2012.

MP praises work of hospital unit

NEWCASTLE North Catherine McKinnell has praised the work of a specialist unit at the city’s RVI Hospital which holds children with little or no immune system.

The Children’s Bone Marrow Transplant Unit - also known as the Bubble Unit - is one of only two in the country and treats patients from around the UK and Ireland, with children also coming from other countries to benefit from its work.

Mrs McKinnell was invited to meet with staff, patients and parents by Gill Johnston, fundraising manager at The Bubble Foundation UK, a charity set up over 20 years ago to support the unit’s work.

“The Bubble Foundation clearly plays a hugely important role in supporting the incredible work that is taking place under the leadership of Prof Andrew Cant - making life just that little bit easier for young children and families who are going through a very challenging time.”

Prof said: “We were delighted that Catherine McKinnell visited the unit and took such a keen interest in meeting patients, families and staff.”

A Thank You card made by a patient for Ward 29
“Nursing shortage is very real” RCN tells Migration Advisory Committee

The Royal College of Nursing (RCN) today responded to news that the Migration Advisory Committee has opted not to put nursing roles on the shortage list for recruitment overseas.

Responding to the news, Dr Peter Carter, Chief Executive & General Secretary of the RCN, said: “We are deeply disappointed that the Migration Advisory Committee has significantly misrepresented the position of the RCN in order to claim that there is no shortage of staff in the nursing profession - they should tell that to the people waiting many hours for treatment on trolleys on a Friday night. We will be contacting the Committee about this as a matter of urgency and would urge them to reconsider their position in the light of this misinterpreted evidence. “Let us be very clear: we provided detailed, extensive and unambiguous evidence of the shortage of nurses in the UK and the effect this was having on patients. We have consistently called for both a long term solution to the lack of staff, and for nursing roles to be on the shortage list. Nurses who are stretched to breaking point will be utterly bemused as to how this conclusion has been reached, which reflects none of the realities of delivering daily care to patients.”

RCN evidence to the committee

In its evidence to the Migration Advisory Committee, the RCN pointed to:
• the fall in commissions experienced in 2012/13, which is expected to impact on numbers of newly qualified nurses in 2015/16
• general staff shortages reported across NHS employers and the independent sector, where gaps are increasingly being plugged with expensive and unsustainable use of agency nursing
• the ageing UK nursing workforce
• changes to the immigration system and eligibility for indefinite leave to remain may lead to many non-EU nurses leaving the UK from 2016
• a lack of systematic workforce planning for nursing across the UK that has (in part) contributed to the current problems
• an ageing population with more complex health needs.

Dr Carter continued: “In the long run, it’s absolutely right that we should be training enough people within the UK to meet the nation’s demand for nursing. People want to be nurses, they apply to be nurses, but over a period of years the number of training places was slashed as a short term, cost-saving measure. However, if every nurse from overseas left the UK tomorrow, there would barely be a hospital or clinic that could function safely.

“You can argue that the NHS has always been reliant on nurses from overseas, but recent years have seen the figures become completely skewed as hospitals in particular have plugged huge gaps in their workforce with overseas nurses. The NHS has finally woken up to the fact that it has not had enough nurses to deliver safe care, so large-scale recruitment has been taking place overseas.”

Long term solution needed

Dr Carter concluded: “Recruiting from overseas is not a sensible long-term solution to a profound nursing shortage, but in the NHS as it operates today it is absolutely necessary. This means recruiting and retaining nurses from outside the EU as well, given the projected shortage of half a million nurses across Europe over the next five years.

“There is a huge difference between aspiring to be self-sufficient in nurses and saying that we don’t need to recruit them from overseas, and we would hope that the Migration Advisory Committee would take on board the desperate need for more nurses in the immediate term.”

“Nursing shortage is very real” RCN tells Migration Advisory Committee

The Royal College of Nursing (RCN) today responded to news that the Migration Advisory Committee has opted not to put nursing roles on the shortage list for recruitment overseas.
Some 30 years ago...
A&E units will be forced to declare nurse shortages

Warnings that A&E units are desperately short-staffed as new guidance says there should be one nurse for every four patients

By Laura Donnelly, Health Editor

ACCIDENT & Emergency departments will be forced to tell the public if they have unsafe nursing levels following guidance which says there should be a maximum of four patients per nurse.

The National Institute for Health and Care Excellence (Nice) suggests many units are desperately short-staffed, and failing to provide enough staff to meet the needs of acutely-ill patients.

Its recommendations come amid a spiralling crisis in A&E, with record numbers of patients forced to endure long trolley waits.

Inspections have warned of “widespread evidence” of staff shortages and overcrowding in A&E, with many hospitals recruiting high numbers of nurses from abroad, in a bid to plug gaps.

Labour said struggling hospitals would not be able to meet the new demands.

Andy Burnham, shadow health secretary, said: “This clear guidance is welcome but many hospitals are nowhere near this level. The Government needs to set out how it will meet this. You can only deliver it with a plan to invest in the NHS and recruit more staff.”

Figures published today are expected to show a deepening crisis, after a period over Christmas and New Year which saw the longest waiting times for more than a decade.

The new draft guidance from Nice says A&E units should have a maximum of four patients per nurse, with one nurse to two patients, for cases of trauma and cardiac arrests and one to one care for resuscitation.

It warns that too often, NHS staffing levels are currently being agreed without proper account of just how sick the patients are, or responses to surges in demand.

In future, NHS trusts will have to publish monthly data on a central NHS website, showing how their staffing ratios compare with the recommendations, and will be encouraged to publicise daily staff levels at the units.

Casualty units have also been told to put up notices in waiting rooms, urging patients to raise the alarm if they are forced to endure overcrowding, staff shortages or left in pain and hungry.

The guidance says staff, patients and relatives should be told that such incidents should be treated as “red flag” events which mean immediate action should be taken - such as drafting in immediate extra staff, or moving patients out of A&E.

Dr. Katherine Rake, chief executive of Healthwatch England, said: “The new draft guidance will not only help to ensure A&E wards have the right number of nursing staff at all times, but if properly displayed this information can also be used to reassure patients that the hospital has enough staff to cope with demand.

Prof Sir Mike Richards, Chief Inspector of Hospitals at the Care Quality Commission, welcomed the recommendations.

He said: “The inspections we have carried out during the last year found widespread evidence of the impact of staffing issues on patients.”

A Department of Health spokesman said: “We welcome NICE’s work, which is a major step forward.”

He said extra recruitment by hospitals since the Mid-Staffs scandal meant there were now more than 6,000 extra nurses working in NHS hospitals, including 1,366 more in A&E, compared with May 2010.

On Thursday Chancellor George Osborne said the case of a patient who spent three days in an NHS hospital stock room because wards were full was “a matter of regret” for every member of the Government.

Michael Steel, 63, was reportedly put in a storage room filled with medical supplies and lit by a fluorescent strip light at the Princess Alexandra Hospital in Harlow, Essex. He was unable to sleep due to constant interruptions as staff retrieved equipment.

We are confident that here in Newcastle upon Tyne we shall sustain essential standards in this setting

Helen Lamont, Nursing & Patient Services Director
An outbreak of common sense

Quick, call the men in the white coats - an outbreak of what appears to be common sense seems to have broken out among the powers that be.

Who knows, if it proves to be contagious, then correct decisions could be taken all over the country for a change...

On this occasion it means that a decade of uncertainty and speculation, and all the subsequent fears, concerns and anguish, about the future of the children’s heart unit at Newcastle’s Freeman Hospital may soon be over.

A consultation paper on the long-term future of such centres in England has just been issued by the NHS.

And in a departure from the past it suggests that under-threat centres may survive - if they meet strict criteria.

Such units across the country had been put in competition against each other.

Some were to close and centres of excellence were set to replace them, under the plans which were seen by many as simply cost-cutting measures.

This sparked intense outrage as families fought to save their threatened local units which, so often, had performed near-miracles to save young children.

Inevitably the decision went to appeal and the courts as determined campaigners fought to save these incredibly valuable local assets.

This new move has been welcomed by Sir Leonard Fenwick, chief executive of Newcastle Hospitals NHS Foundation Trust, which runs the Freeman.

Likewise it will be welcomed by the thousands of tiny lives, all over the UK and beyond, which have been saved by the incredible staff at the hospital’s unit.
The NHS Five Year Forward View was published by NHS England on 23rd October 2014, setting out how the health service needed to adapt and change to take advantage of the opportunities that science and technology offered; working alongside social care to promote integrated models of care.

These changes were needed at a time when the challenges associated with an ageing population, a rise in the number of people with long-term conditions, lifestyle risk factors in the young, combined with rising costs and constrained financial resources, threatened the long-term sustainability of the health service.

The Five Year Forward View into Action, published on 19th December 2014, described ‘the approach for national and local organisations to make a start in 2015/16 towards fulfilling the vision set out in the NHS Five Year Forward View, whilst at the same time delivering the high quality, timely care that the people of England expect today’. This was also reflected in the requirements for the Operational Plan, which sought to identify progress against strategic vision / sustainability alongside operational resilience.

The Forward View into Action stressed that ‘planning for tomorrow and delivering for today go hand in hand’. It stated that ‘next year will not see a relaxation in NHS Constitution standards for providing timely care for patients, or in the requirement set by taxpayers and Parliament that the NHS lives within its means.’

NHS England and its national partners announced a new programme to focus on the acceleration of the design and implementation of new models of care in the NHS in January 2015. Through the New Models of Care Programme, individual organisations and partnerships, including those with the voluntary sector, were invited to apply to be ‘vanguard’ sites. This was described as an ‘opportunity to work with national partners to co-design and establish new care models, tackling national challenges in the process’.

**Key themes throughout the Forward View included:**
- Prevention and supported self-care
- Integration
- Breaking down barriers and co-ordinated care
- Innovation
- Focus on a new deal for primary care.

**New Care Delivery Options included:**
- Networks of care
- Out of hospital care
- Integrated care to meet the needs of patients
- Improving the experience for patients and carers
- Value for money.

In March 2015 the first 29 ‘Vanguard Geographies’ were chosen from 269 applications. Each vanguard site will take a lead on the development of new care models which will act as the blueprints for the NHS moving forward and the inspiration to the rest of the health and care system.

**Integrated Primary and Acute Care Systems – joining up GP, hospital, community and mental health services**
1. Wirral University Teaching Hospital NHS Foundation Trust
2. Mansfield and Ashfield and Newark and Sherwood CCGs
3. Yeovil Hospital
4. Northumbria Healthcare NHS Trust
5. Salford Royal NHS Foundation Trust
6. Lancashire North
7. Hampshire and Farnham CCG
8. Harrogate and Rural District CCG
9. Isle of Wight

**Multispecialty Community Providers – moving specialist care out of hospitals into the community**
10. Calderdale Health and Social Care Economy
11. Derbyshire Community Health Services NHS Foundation Trust
12. Fylde Coast Local Health Economy
13. Vitality
14. West Wakefield Health &Wellbeing Ltd
15. NHS Sunderland CCG and Sunderland City Council
16. NHS Dudley CCG
17. Whistable Medical Practice
18. Stockport Together
19. Tower Hamlets Integrated Provider Partnership
20. Southern Hampshire
21. Primary Care Cheshire
22. Lakeside Surgeries
23. Principia Partners in Health
24. NHS Wakefield CCG
25. Newcastle Gateshead Alliance
26. East and North Hertfordshire CCG
27. Nottingham City CCG
28. Sutton CCG
29. Airedale NHS Foundation Trust

With regard to the Five Year Forward View and Vanguard Sites, many of the proposals put forward in the Forward View are aligned to initiatives and areas of work the Trust has been involved in for some time. The Trust needs to build and develop this work in the future to maintain its position as a national leader in the delivery of the new NHS; to be the provider of choice; and to work with the Universities and Academic Health Science Networks to be one of ‘the new test bed sites for worldwide innovators and new green field sites where completely new NHS services will be designed from scratch’.
Thousands of hospital operations are needless

One in seven treatments not necessary and waste billions of pounds, warns NHS chief

By Robert Mendick and Laura Donnelly

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We have every confidence this is not the case here in the Newcastle Hospitals

Andrew Welch, Medical Director
Quality Strategy and Quality Account

Unconditionally registered with the CQC since April 2010

Quality Account 2014/15

Unconditionally registered with the CQC since April 2010

Healthcare at its very best - with a personal touch
The activity and duties of the Clinical Effectiveness, Audit and Guidelines Committee (CEAGC) has continued much as in previous years. As its name suggests, the role of the CEAGC is to oversee audit activity and its governance within Directorates but more importantly, to monitor compliance with, and implementation of, national guidance within the Trust.

Guidance may come from several different sources, including the medical Royal Colleges, the General Medical Council, and the Care Quality Commission, but the principal (and most prolific) producer is NICE, the National Institute for Health and Clinical Excellence. NICE guidelines are issued in a number of different categories – Clinical, Intervventional Procedures, Medical Technology, Public Health, Technology Appraisal, and most recently, Quality Standards. Over the last year, the CEAGC considered some 90 different items of guidance. The large majority of these were already followed in the Trust, albeit with some minor variations. Occasionally, however, local clinicians cannot endorse a particular guideline, either because they are already using a preferred alternative (produced by a specialist professional group, for example), or because they feel that the evidence base for the guideline in question is inadequate. In all such cases, significant deviations have to be presented to and approved by the CEAGC. Rarely, the matter may require referral to the Trust Clinical Governance and Quality Committee (parent committee for the CEAGC) for further consideration, and a final ruling.