How we do it

Keeping you safe
There was a reduction in the number of MRSA bacteraemia cases in 2011/12, 7 cases compared to 8 in the previous year, although the Department of Health’s target of 6 cases was exceeded by 1.

There has been a significant reduction in the number of cases of Clostridium difficile. The Department of Health’s target of 150 hospital acquired cases of Clostridium difficile (2011/12) has been comprehensively met with only 101 cases reported.

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

All MRSA and MSSA bacteraemia and confirmed hospital acquired cases of Clostridium difficile are subject to a Rapid Review or Root Cause Analysis (RCA); a process is now very well established whereby individual cases are reviewed to closely examine the circumstances in which the infection occurred, highlighting both good practice and areas for improvement. A Trust wide Healthcare Associated Infection (HCAI) scorecard is produced on a monthly basis and illustrates performance against the targets. A quarterly HCAI Report is submitted to the Infection Prevention and Control Committee (IPCC) prior to dissemination to all areas of the organisation.
For both MRSA and C. difficile, reported cases have fallen substantially over the past five years.

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

*Influenza* activity in the 2011/12 season has been low; this has been reflected in the numbers of admissions to the Trust during the winter season, with significantly less admissions than the previous year. The IPC Team continues to support clinicians where there were admissions in relation to safe patient management and access to the appropriate Personal Protective Equipment (PPE).

The Trust achieved a high level of staff immunisation with a high profile Influenza Vaccination programme led by Occupational Health. *Transforming Community Services* saw the integration of the IPC service across the health economy. This has provided the opportunity for a greater understanding of the infection risks to patients across acute and community healthcare, the sharing of knowledge and expertise and the provision of standardised IPC principles and practices ultimately leading to a more co-ordinated approach.

Following integration, a review of the IPC nursing team structure has taken place resulting in a number of changes. The team is now managed by one Matron and a new Practice Development Lead IPC post has been established; both posts have trust wide responsibility. The revised IPC nursing team structure enhances the skill mix of the team, improves flexibility and supports future succession planning.

The Healthcare Acquired Infections Prevention and Control Strategy has been revised to reflect these changes within the organisation, identifying clear structures, roles and responsibilities both strategically...
MRSA Bacteraemia Five Year Trend March 2012

Number of cases

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and operationally. In addition, the HCAJ Action Plan has been developed to support the Strategy; this Action Plan provides a framework to facilitate IPC service provision, it outlines key objectives for the coming year and progress is monitored on a quarterly basis by the IPCC.

Since integration the team has worked collaboratively to standardise IPC policies and practice, with specific reference to hand hygiene, environmental decontamination, MRSA and Clostridium difficile management; links have also been established with the Equitable Access Centres at Battlehill and Ponteland Road.

The Department of Health’s Saving Lives programme was re-launched across the Trust in May 2011, this followed work from the previous year where sub-groups of the Saving Lives Steering Group were convened to review polices, documentation and educational material for each High Impact Intervention (HII). This included introduction of the principles of Aseptic Non-Touch Technique (ANTT). This was supported by a series of education sessions, introduction of ANTT Advisors in acute and community settings, Saving Lives eLearning package and development of new promotional material to support the initiative.

The Clinical Assurance Tool (CAT) is the Trust’s main nursing audit tool and comprises a number of quality indicators; however it also continues to provide assurance on cleanliness and IPC practice and knowledge. A monthly report is submitted to the Trust Board and more specific data is feedback to directorates and individual clinical areas in relation to their performance and progress. Hand hygiene audit activity has now been incorporated in to CAT and continues to monitor staff compliance with the 5 Moments for Hand Hygiene, appropriate hand hygiene technique and compliance with Bare Below the Elbow (BBE) on a monthly basis. CAT is now well established in the acute setting and roll out to community services has commenced; in those community areas where CAT has not yet been introduced, quarterly submission of the Essential Steps audit tool continues.

The results from the National Patient Survey of Inpatients 2011, indicate 98% of patients said “the hospital room was very / fairly clean” and 94% said “hand wash gels were visible and available to use”. In the CQC benchmark report the findings demonstrate Newcastle upon Tyne Hospitals perform ‘better than other Trusts’ in relation to cleanliness and hand washing.
We justify our promise of ‘Healthcare at its very best’ because our doctors, nurses and resources really are good enough to give you the ‘very best’. Similarly, promising ‘a personal touch’ reflects our great respect for the ‘person inside each patient’. This is all because we recruit, train and retain the best staff in all fields.

NORTH CANCER DRUG PROVEN TO STALL THE DISEASE

by Nicola Weatherall

A BREAKTHROUGH in how to keep breast cancer at bay for longer has been made thanks to research from North East medical experts.

A new drug tried and tested in the region has proven to stall the disease for longer than current treatments, providing fresh hope for patients. The Freeman Hospital in Newcastle was among a handful of centres involved in the international clinical trial to test a new treatment for advanced breast cancer.

A new film has been launched in the North East to help teach parents and medics more about the experiences of cleft lip and palate patients.

Called ‘Easing the First Few Hours’, the film focuses on the different types of cleft, causes of the condition, the medical care a baby, or child, will receive, and the experiences and advice of parents with a child born with the condition.

Scores of parents and healthcare professionals attended the Centre for Life last night to watch the first screening of the 50-minute film that was put together by a team of specialists at Newcastle’s Royal Victoria Infirmary (RVI).

Mother-of-two Angela Porritt, 37, is a key contributor to the film as her son, Cameron, four, was born with a cleft lip and palate and has undergone two major operations.

The occupational therapist, from Shadforth, Durham, said: “When Cameron was born with his condition it was a shock and I felt numb as we had no idea he would have a cleft lip and palate.

“I had many questions that I wanted answers to and I was keen to get as much information as I could.

“The staff at the hospital were fantastic but not all nurses and midwives have had experience of the condition and misinformation can be given.

“To have a film like this that parents and healthcare professionals can access is great.

“It gives you everything you would want to know and you can watch it at your own pace so that you’re not overloaded with information.

“It’s also really useful to see other parents talking about their experiences of having a child born with a cleft lip and palate.”

The film is the first of its kind to be produced in the UK and it is now hoped the project will be rolled out across the country.

The £28,000 project was funded with donations from medical groups, the Cleft Lip and Palate Association and parents.

Peter Hodgkinson, Consultant Cleft and Plastic Surgeon for Newcastle Hospitals NHS Foundation Trust said: “The film will be an excellent resource in the field of cleft lip and palate.

“It is really important that people get the correct information and see first-hand what other parents experience have been.

“The film is all about giving hope and looking at things positively. The first few hours and days can be a really difficult time for parents and by accessing this film they will get a lot of information to help them.”

Clefts of the lip and palate are the most common facial difference babies can be born with.

“In the North East, one in every 1,000 babies is born with a cleft – a gap in the lip or a gap in the roof of the mouth – which is repaired surgically during the first year of life.

“Discovery of the cleft, often before birth on a scan, can be very distressing for parents and families and they need time and help to adjust to the news.”

Dr Sue Brown, Consultant Clinical Psychologist at the RVI said: “The film is such a powerful way to get across what can be complex issues and it can be made accessible to a large number of people via the internet.”

A slightly different version of the film has been made accessible for healthcare professionals, such as midwives, speech therapists and nurses.

To view the Easing the First Few Hours film log on to www.newcastle-hospitals.org.uk.

Good evening everyone. My name is John Smith and my wife Orla and I are delighted to welcome you to this special occasion tonight. We wanted to take this opportunity to share a few thoughts with you about how the work of Crumlin’s Children Hospital Dublin, and the Freeman Hospital in Newcastle upon Tyne have touched the lives of our family, and in particular the impact of the work of their inspiring staff.

But first, a few thank yous. We want to thank all of you for being here tonight. Your generous support for this occasion is testament to how you feel about these charities and the work that they do.

You have come from near and far and it would be remiss of me not to mention friends of ours who have traveled all the way from Dubai to be here tonight. We are so grateful for all of your support.

We want to thank two special guests, Dr David Coleman from Our Lady’s Hospital Crumlin, and Dr Richard Kirk from Freeman Hospital, Newcastle upon Tyne, who have taken time out of their busy schedules to be with us this evening.

We are here for 2 reasons. We are here to celebrate; to have a great night! And the very act of you being here tonight is meeting the second purpose, of raising money and awareness for these amazing charities. When I was thinking about what to say to you here tonight, I have to admit I was a bit nervous. How do you sum up the work of these people who we handed over our trust... and our little girl to, almost 3 years ago to the day. I was reminded of a conversation I had a few days after we returned from Newcastle with a work colleague. When speaking about what it must take to work with these children, day in and day out, he reflected that he had such admiration as it is such courageous work. And that was it! That word captured the spirit of what we experienced in these hospitals. That was what we saw, day in and day out in Crumlin, and in The Freeman Hospital; Courage in action. And if courage is the principle, then its not really stretching it to say that those people who commit themselves to this every day, are heroes. They are heroes to us anyway. And you know, the same applies to the patients, to Keela, and it also applies the donor families that make organ donation possible. Heroes All!

And so we have one more thing we want to share with you. And it is here that we want to bring us all back to why we are here tonight.

We are here to associate ourselves with these hospitals, their staff and the amazing work they do, to think about their courage and that of donor families; to see what is made possible, and Yes, let’s not forget... to have a good night!

Charity Fundraiser speech

John & Orla Smith, Ireland
Clinical Governance encompasses a variety of principals, commonly referred to as the ‘seven pillars’. These comprise:

- risk management
- clinical audit
- staff management
- patients’ experience and involvement
- use of information
- education and training
- clinical effectiveness.

The Trust has continued to work with a group of other Foundation Trusts, under the aegis of Monitor, the Independent Regulator, in defining and measuring a series of parameters to assess the quality of care we deliver. These centre around three domains: patient safety, clinical effectiveness and the patient’s experience. The Board of Directors receive a report each month in which a variety of parameters which indicate our performance in these areas are measured. Trends are analysed and actions put in place to improve performance.

Risk Management

In respect to patient safety the list of ‘never events’ has been further expanded this year, in accordance with recommendations from the Department of Health. Work has been undertaken to ensure that the Trust has clearly defined processes to minimise the risk of any of these occurring. Any ‘never event’ is investigated in detail using root cause analysis. The underlying causes are established and an action plan is developed and implemented to prevent recurrence.

The National initiative to ensure that all patients admitted for procedures are screened to identify risk factors for venous thrombosis is in place. Audits of all patients suffering hospital acquired thrombosis have been implemented and reviews of practice arise from these.

Work to reduce the risk of all forms of healthcare acquired infection (HCAI) within the Trust continues. The Ward accreditation tool has been replaced by the Clinical Assurance Tool in all clinical areas to drive up further standards in relation to: hand hygiene, environmental cleanliness and aseptic no touch technique. The Trust has participated actively in the ‘Matching Michigan’ project to ensure that the care of central venous catheters is optimised in all clinical areas. All appropriate patients coming into hospital are screened for nasal, throat and skin colonisation with methicillin resistant staphylococcus aureus (MRSA). More than 40,000 MRSA screening swabs per month are now analysed in Microbiology Laboratory.

Every patient who develops an MRSA bacteraemia or any other serious infection has a detailed ‘root cause analysis’ with the aim of identifying the source of infection. The case is reviewed in detail by senior members of the clinical team, together with the Medical Director, Nursing & Patient Services Director and the Director of Infection Prevention & Control. The Trust has also been working proactively with colleagues in community settings to reduce the level of MRSA skin colonisation in patients in high risk environments, such as nursing homes. These measures have resulted in a further reduction in the incidence of MRSA bacteraemias among the Trust’s patients in the last year. Further measures to reduce the incidence of C.Difficile infection have also been implemented and the number of patients suffering this has also significantly reduced in the last year. The Trust regards MRSA bacteraemias and rates of C.Difficile infection as simply being ‘markers’ of its overall ability to minimise the risk of all forms of HCAI. Stringent external targets for both C.Difficile and MRSA bacteraemia rates have been set for the next year with the aim of continuing to drive down rates of all forms of HCAI.

Clinical Audit

There is an active programme of clinical audit, which is the process by which the quality of local care is compared with exemplar standards. Each Clinical Directorate has an audit lead, who is responsible for identifying topics for audit. Priority is given to the comparison of standards of care within the Trust against external benchmarks, such as guidelines from the National Institute for Health and Clinical Excellence (NICE). Increasing emphasis is placed on re-audit after an interval to ensure that lessons have been learned from initial examinations and that corrective actions have been put in place.

Priority is given to comparison of standards of care against external benchmarks.
**Staff Management**

A programme of work to introduce enhanced appraisal for all medical staff has been ongoing throughout the last year. These appraisals will form the basis of the process of revalidation, which all medical staff will have to undergo over a continuous rolling five yearly cycle to retain their license to practice. Revalidation is an extension of good processes of clinical governance through which all doctors will need to demonstrate that they are: safe, up to date and communicating effectively both with colleagues and with patients. The Medical Director has been appointed as the Trust’s ‘Responsible Officer’ and will be responsible to the General Medical Council for recommending that each of the Trust’s employed doctors have fulfilled the requirements to be revalidated. All staff groups are subject to annual appraisal and performance review. These assessments include confirmation of the individual’s completion of statutory and mandatory training as well as evidence of their Continuing Professional Development. The Trust has an active programme to promote equality and diversity and to support minority groups.

**Patient Experience and Involvement**

Active participation by patients in the running of the Trust is sought through the Patient and Public Involvement Forum. The Council of Governors has received a number of presentations in year in the course of which the Trust’s strategic development plans have been outlined and Governors’ approval sought. Governors sit as members on a number of the Trust’s committees, including the Clinical Governance and Quality Committee and the Complaints Review Panel. At this meeting, which is attended by both the Nursing and Patient Services and Medical Directors, every complaint received by the Trust in the previous month is reviewed. Annually, representatives from each Directorate attend the panel and all complaints received about the Directorate within the previous year are reviewed. The aims of this meeting are to ensure appropriate action has been taken when complaints occur and to seek to identify recurring themes contributing to patient dissatisfaction. The Trust is developing further questionnaires for patients after discharge and also those attending outpatients, asking them to rate the quality of their overall experience. Work to collect real time patient feedback continues.
The MAGIC project, funded by the Health Foundation and undertaken in conjunction with the Institute of Health and Society at Newcastle University has continued through the year. This is looking at the best way of implementing the principals of shared decision making into routine clinical practice. The three specific projects include:

- The choice between mastectomy and breast conserving surgery in patients with early breast cancer
- Choice between elective caesarean section and attempted vaginal birth in women who have previously undergone caesarean section
- Choice between self monitoring, drug treatment and surgery in men presenting with lower urinary tract symptoms

**Use of Information**

The Trust benchmarks its performance against similar organisations using data provided by CHKS, Dr Foster, the National Audit Office and other such sources including the Care Quality Commission.

The Trust was assessed by the NHS Litigation Authority within the last year against both its general standards and maternity standards. It was successful in retaining its level 3 standard for maternity and in moving to level 3 (the highest level) against the general standards.

The Trust has also been subject to scrutiny in a number of peer reviews by external organisations. Various cancer services have also been assessed against Improving Outcomes Guidance by the cancer network. The Trust participates in a wide range of external reviews undertaken by organisations such as NCEPOD. These have all been satisfactorily completed and action plans to comply with the recommendations of the peer review teams have been implemented.

An active clinical guidelines database is maintained on the Trust intranet. This includes locally developed and national guidelines summarising best practice in the management of a wide variety of clinical conditions.

Trust policies and procedures are developed, revised where necessary after discussion at the relevant committees and published on the intranet. All staff have access via the Trust network to the intranet and internet.

Each Clinical Directorate is subject to performance management review three times per year. These reviews concentrate on: business issues, review of waiting lists, activity levels and financial performance. Directorates are also subject to an annual review of their clinical standards and practice which examine the components of clinical governance. This combination of meetings provides an integrated governance mechanism for each directorate, following a regular annual programme, in the course of which all aspects of each Directorate’s performance are reviewed.

The Trust has been fully licensed in respect to standards of tissue retention and storage in accordance with the requirements of the Human Tissue Authority, which has conducted various compliance assessments within the last year.

**Education and Training**

The Trust operates active undergraduate training programmes for: doctors, dentists, nurses and various groups of therapists. It acts as a training institution for clinical scientists and other allied health professionals.

Postgraduate studies continue in many disciplines across the Trust for staff in training grades. A challenge for the forthcoming year is to demonstrate compliance with externally defined and assessed standards in postgraduate education and training.

There are ongoing continuous professional development programmes for all groups of permanent staff. Increasingly rigorous standards for statutory and mandatory training for all staff are also met.

**Clinical Effectiveness**

The Trust seeks to ensure that all treatments offered are supported by a clear evidence base derived from research and ongoing clinical evaluation. Before new treatments or procedures are implemented approval needs to be obtained – from the Drug and Therapeutics committee for medicinal treatments and from the Clinical Governance committee for new procedures – such as new operations or interventional radiological techniques. The person seeking to introduce the new treatment has to make an application to one of these two committees indicating: what the treatment involves, what the evidence is for its efficacy and in what way the new treatment is superior to the conventional therapy. Consideration is also given to the information which patients must be given if they are to receive a new treatment. The practitioner needs to demonstrate that they have had the necessary training and have acquired the appropriate skills for it to be safely undertaken. Only after all of these conditions have been met are practitioners allowed to proceed.

A series of ‘dashboards’ has been developed for each Directorate indicating a bespoke selection of effectiveness indicators for the procedures undertaken in that clinical service. These are monitored by the directorate management teams and by the Executive.

The Trust also has a large portfolio of research activity. Much of this is undertaken in a collaborative fashion with the University of Newcastle under the supervisory umbrella of the Joint Research Executive. Research funding is derived from The NHS Research and Development budget and from many external grant giving and funding sources.

It is only possible for the Trust to achieve continuing success in terms of Clinical Governance and, in particular, to strive continuously to improve the quality of patient care with the active support and high professional standards of all colleagues within the Trust and also our external advisors and collaborators. I am extremely grateful for the continuing support of colleagues from all disciplines in moving forward actively with the clinical governance agenda.

**Timothy Walls**

Medical Director
Two key developments - at opposite ends of the year - have been the merging of Community Health Services into the Trust, and the designation of the Royal Victoria Infirmary as a Major Trauma Centre. For CGARD, ‘integration’ i.e. coming together after so many years with Community Health has involved the amalgamation and alignment of a large number of policies, procedures and guidelines – a considerable body of work, still in progress, particularly in respect of the guidelines database. National guidelines with community relevance now have to be included in the Trust’s assessment and implementation process, adding to the workload of the Clinical Effectiveness, Audit and Guidelines Committee. Furthermore, earlier guidance needs to be reviewed for community requirements (as these will now also have to be implemented) although we anticipate relatively few guidelines will be involved.

Being a Major Trauma Centre (one of 22 such centres across England) has many implications for standards of patient care, but significantly, because Trust income is linked to the quantity and quality of care provided, every patient seen in the Trauma Centre/Accident & Emergency Department is now given a ‘severity score’ reflecting their condition – this score influences the tariff or payment the Trust receives in respect of that patient. It is thus very important to capture this information in an accurate and timely manner, and CGARD has put in place a new and dedicated system and staff to acquire the necessary data. Their success was reflected by Newcastle achieving a score of 95% (and ‘four tick’ status, the maximum) in terms of the completeness of data submitted.
The RVI officially became a Major Trauma Centre on 1st April this year, one of 22 such centres across England

Mirroring the move away from medical paternalism, there has been in recent years increasing interest in capturing patients’ opinions of their experience of NHS care, and various initiatives have been, or are being, introduced. Locally, the Trust is a pilot site for a system of ‘doctor-specific’ feedback, which it is hoped will be obtained via standalone kiosks to be placed in out-patient areas across the Trust. The information collected could also be of value to doctors as part of their revalidation (due to be introduced within the next year), in which feedback from both colleagues and patients will be a mandatory requirement. Another new concept has been the introduction of monthly directorate Clinical Effectiveness ‘dashboard’ reports. These include a wide range of indicators (derived both from local incident reporting and information systems, and from CHKS, an external healthcare data processor) to measure and compare directorates’ performance against their peers nationally - where possible - or to their performance in previous months. The aim is to enable clinicians to respond promptly to areas of concern, and to help to assure Trust management that care is safe and clinically effective. Again, some of this information may help doctors during revalidation - indeed, in the future NHS Trusts will be obliged to provide medical staff with personalised data to support the process.

Both of these developments were recently presented by CGARD staff at a major international meeting, the International Forum on Quality and Safety in Healthcare, held in Paris in April 2012. Both were well received, with the concept of ‘real time’ patient feedback generating very considerable interest. For those particularly interested in the measurement of patient experience, a recent editorial in the British Medical Journal (1) is worth reading.

The avalanche of national guidelines, standards and targets continues unabated, and virtually all require some form of baseline assessment (to establish the current situation in the Trust), followed if necessary by an action plan – which may have financial implications – to ensure the Trust is compliant. As I have pointed out previously, the Trust is a pilot site for a system of ‘doctor-specific’ feedback, which it is hoped will be obtained via standalone kiosks to be placed in out-patient areas across the Trust. The information collected could also be of value to doctors as part of their revalidation (due to be introduced within the next year), in which feedback from both colleagues and patients will be a mandatory requirement. Another new concept has been the introduction of monthly directorate Clinical Effectiveness ‘dashboard’ reports. These include a wide range of indicators (derived both from local incident reporting and information systems, and from CHKS, an external healthcare data processor) to measure and compare directorates’ performance against their peers nationally - where possible - or to their performance in previous months. The aim is to enable clinicians to respond promptly to areas of concern, and to help to assure Trust management that care is safe and clinically effective. Again, some of this information may help doctors during revalidation - indeed, in the future NHS Trusts will be obliged to provide medical staff with personalised data to support the process.

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The avalanche of national guidelines, standards and targets continues unabated, and virtually all require some form of baseline assessment (to establish the current situation in the Trust), followed if necessary by an action plan – which may have financial implications – to ensure the Trust is compliant. As I have pointed out previously, the sheer size and diversity of the Trust means that there are very few guidelines or standards which are not applicable to Newcastle. Some idea of their range and number is given by the following list:


- **Quality Standards (QSTs)** – these are broad quality standards, some aspects of which are highly defined, others less so, and cover conditions such as diabetes, glaucoma, and chronic renal failure. To date, 12 have been issued, with another 120 or so in the pipeline.

- **Commissioning for Quality and Innovation (CQUIN) targets** – an increasing proportion of Trust income depends on meeting these quality standards, which are agreed with local commissioners, and are relatively specific (e.g. on HIV testing.

- **National Patient Safety Agency (NPSA) Alerts** – for example, recent guidance on the safe use of nasogastric tubes.

- **Medical Royal College and other standards** – these are not generally mandatory, but no self-respecting Trust would ignore them.

In addition, the Trust regularly contributes data to a range of continuous national audits - for example, those concerned with intensive care (ICNARC), trauma (TARN), and lung cancer (LUCADA). Oversight of the assessment and implementation of guidelines etc is the responsibility of CGARD, and of the Clinical Effectiveness, Audit and Guidelines (CEAG) Committee. This committee meets every month, with a full agenda, but several additional meetings had to be arranged earlier this year to accommodate the increasing workload. As part of the monitoring process, each Directorate has to present an annual report of its audit activities and future plans to the Committee. However, directorate audit programmes are going to have to become much more focussed, principally on key areas for the Trust, with clear action plans to follow – basically, we shall be expecting fewer, better designed, and more effective audits. This is largely a consequence of the introduction of a new NHS Litigation Authority (NHSLA) requirements. Over the last year, the Trust applied both for the NHSLA level 3 risk management standard, and for the Clinical Negligence Scheme for Trusts level 3 for Maternity Services. Both applications were successful (thereby saving the Trust a considerable sum in insurance costs), but both involved the Department in considerable additional work, and impose increasingly demanding standards on the Trust – for example, in monitoring and acting upon clinical audit outcomes.

Finally, and perhaps at a more mundane level, CGARD now publishes a bi-monthly newsletter, describing new initiatives and developments, in an effort to publicise its work among staff. Its intranet site has also been redesigned for greater clarity, and to provide a clearer indication of the Department’s structure and function. How effective these initiatives will be in the longer term remains to be seen, but informal staff feedback so far has been favourable.

As ever, it is my colleagues in the Department who do most of the real work, and once again, I want to thank them for this, and for their continuing expert support, advice and guidance. I also wish to thank my fellow CEAG Committee members for their significant contributions and advice.

Ian R Fletcher
Consultant Anaesthetist
Chairman, Clinical Effectiveness, Audit & Guidelines Committee

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Improving your care
Moving forward in challenging times... building pride in our nursing and midwifery services

The Trust ‘Proud of Nursing and Midwifery in Newcastle – Strategy for Success 2010-13’ has provided the guiding principles and underpinned a plan of action to continue to provide excellence in nursing and midwifery. Ongoing work establishes the drivers, priorities and action to inform the next strategy. Productivity, safety, enhanced patient experience as well as workforce recognition continue to be the primary focus.

Our patients: Our services...

The safety and quality of care provided is paramount and a central focus for all. April 2011 saw the pilot and subsequent launch of the Clinical Assurance Tool (CAT). This initiative is a robust audit process which is owned by Ward Sisters/Charge Nurses and provides an overview of the fundamentals of governance and patient safety at ward (patient level). The project has gone from strength to strength. The tool has been extended to incorporate community based services and is updated to ensure continued relevance. The tool now incorporates patient experience data, collected by the Patient Advice and Liaison Services (PALS) who visit every ward on a rolling programme to ensure that patients’ views are sought and reviewed to inform service development and the quality of patient care. Work is ongoing to develop a staff facing report and refresh patient facing information at ward level, so that everyone can see what’s being achieved and what can be done better.

Further developments include a renewal of the very successful hand hygiene campaign, and integration of the ‘Productive Ward’. Saving Lives continues to be a high priority; the introduction of Aseptic Non Touch Technique (ANTT) is a particular source of pride, this provides a framework for assuring high standards in asepsis (clean safe care). The majority of clinically active staff in Newcastle Hospitals are competency assessed in this technique.

The availability and intake of nutritious food is crucial and has been a significant focus this year. Older patients are particularly vulnerable. It is acknowledged that well nourished patients have a reduced hospital stay, less complications and fewer interventions. A nutrition high impact multidisciplinary group has been established to improve the provision of nutrition to all adult in-patients. Regular audits have been conducted. The high impact group has been monitored and the quality of patient care work is progressing.

A number of developments has been introduced by the Learning Disability Liaison Service to ensure that patients with learning disability are identified early and follow pathways of care that are reasonably adjusted to meet individual need. Patients with a learning disability are offered a hospital passport to ensure information exchange between patients and staff. A high profile awareness campaign was undertaken, underpinned by face to face training and the launch of an e-learning package, and this has increased staff awareness of the needs of patients with a learning disability. Quotes from patients with a learning disability confirm a positive experience.

Meeting the healthcare needs of patients with complex needs is a priority. A team of Nurse Specialists involved in alcohol liaison have successfully introduced ‘symptom triggered’ management of patients in acute alcohol withdrawal. They have developed and introduced an online referral system within the patient e-record to ensure a prompt and speedy referral. This system ensures a seamless approach and optimal management for this complex patient group.

Since 2010, the RVI has been part of a pilot audit project which measures standards of family centred care against the BLISS Baby Charter. The RVI has been identified as a National best practice exemplar.

Other initiatives within neonates include the development of the Buddy Group. Staff encourage groups of parents to offer peer support to other parents on the unit. All Buddy parents have had an experience of having a baby on the unit, although some are grandparents or siblings. Parents are offered a buddy during their stay on the unit. They can choose to text, email or meet each other. The initiative is beneficial and offers increased support to parents.
Our Staff....

With almost 5,000 whole time equivalents, nurses and midwives constitute the largest staff group within the organisation. The diverse and vibrant workforce are supported by a Nurse Bank, which has 1,300 staff registered with them.

To continue to respond to changes in patient care and service requirements a number of roles have been developed. Six highly motivated Advanced Critical Care Practitioner nurses completed a two year masters level competency based training programme. The practitioners offer an important role within the critical care team and provide cover for Junior Doctors. The Trust has agreed to support the development of eight further roles which will be instrumental in moving care forward for critically ill patients.

In partnership with the University of Teesside an Assistant Practitioner Programme has been developed. The Trust is committed to develop a robust programme to support the introduction of Assistants to work at ward and department level. They will study for a Foundation Degree and be guided by Registered Nurse, Mentors and Preceptors during their two year training, this enhances the workforce diversity as nursing moves to an all graduate profession in 2013.

Existing and new staff continue to report feeling valued and energised. The Trust continues to develop a range of education programmes to meet the need of new and evolving roles. The corporate nursing team demonstrate ongoing commitment to further enhance and value the roles of Matron and Ward Sister/Charge Nurse. The roles are pivotal to the provision of highly skilled care and to optimise the positive patient experience. In recognition of the challenging role and to ensure Ward Sister/Charge Nurses are supported to develop the required skills, a bespoke Sister/Charge Nurse Programme was developed and delivered. Forty three Sisters/Charge Nurses from a wide range of specialities have completed the programme so far. Evaluations have been very positive.

A comprehensive review of the Matron role has taken place. The review highlights the crucial and influential role whilst at the same time acknowledges its complexity. The review concludes with a number of recommendations endorsed by the Executive Team and Trust Board. In recognition and valuing the importance to build on existing leadership knowledge and skills, a bespoke Matron strategic leadership programme has been developed and will be delivered during 2012/13.

A review of nurses in specialist role has been undertaken. Recommendations from the review have enhanced the development of nurse led services streamlining and enhancing the patient care pathway. Ongoing work has increased clarity and consistency of roles and a team leadership programme has been developed and will be delivered over the next year. The drive and commitment to increase efficiency and effectiveness of all staff is ongoing.

The corporate nursing team has developed a ‘Quality & Productivity’ review process working in conjunction with Directorate Matrons and management teams to focus upon nursing & midwifery providing a consistent and challenging leadership focus within a structured forum.

In December 2011, a Clinical Engagement ‘World Café’ event was held, nursing and midwifery staff below the level of Ward Sister/Charge Nurse, including Health Care Assistants, Play Specialists, Housekeepers etc. were invited, for coffee and discussion of hot topics including equality and diversity, working better - together, research in practice, complaints and safeguarding. The event was lively and vibrant with over 120 staff attending. Evaluations were extremely positive.

I was treated just like everyone else

Patient with a learning disability – February 2012

I became a Matron, in the Directorate of Medicine, as a result of the Transforming Community Services programme. As a new matron I had to learn a whole range of different working practices and priorities, meet and get to know new teams and also adapt to the new challenges the Matron role gave me. I am delighted to say that I have felt supported and valued by the new team I work in and I would like to think that I have also been able to impart some of my knowledge of community services to influence decisions. I feel together we have worked to challenge existing practice, and streamline processes to improve patient journeys and enable more effective and productive care.

(Tracey Kelly, Matron - Community Medicine)

Staff were very efficient, friendly and explained the procedure in a manner I could understand

Patient with a learning disability – March 2012
The people we met on the Unit are truly amazing and we feel that their collective dedication to the families that pass through their doors, coupled with excellent clinical care, help to support parents with a very traumatic experience.

Parent of baby on the Neonatal Unit 2011
Having worked at the Royal Victoria Infirmary as a Children’s Nurse since 1983, I now feel I am at the pinnacle of my nursing career. I am so proud to be a Senior Sister at the amazing Great North Children’s Hospital. It is such a joy and privilege to be at the core of the region’s children and young people. The future is exciting and my colleagues and I are passionate about the year ahead and the continued delivery of world class care.

Our achievements...

The 14th Annual Nursing and Midwifery Conference was held at Northumbria University’s School of Business Studies and Law. The event has gone from strength to strength and last year, over 350 nurses and midwives attended. It continues to be a highlight of the nursing and midwifery calendar. Keynote speakers included Jane Cummings, Chief Nursing Officer for NHS Commissioning Board Authority in England. She spoke of her hope and aspirations for the future and the development of the safety thermometer. Concurrent sessions were extended this year in response to the large number of applications, and well deserved stories of success, service improvement and innovation across the organisation. Each year and as part of our Annual Nursing & Midwifery conference we hold an annual application process for all qualified Nurses and Midwives to submit an example of best practice for service improvement, innovation or research. The hospital Trustees sponsor the awards and provide a £5000 award for innovation and excellence in practice, as well as a £5000 award for research.

In 2012, twelve applications were received and all were of a very high standard and across a wide range of specialties and population groups. There were two joint winners: Ruth Wyllie, Kathy Seed and Lucy Craig for their work concerning optimal pain relief for children undergoing painful procedures; and Lesley Flynn on behalf of her team for their work regarding the new drop-in sexual health service for young people.

A further achievement is receipt of the British Journal of Nursing 2012 Oncology Nursing Award. In partnership with patients and staff within the teenage cancer unit, a ‘Your Welcome’ DVD was produced. The idea, in response to patients on the unit who highlighted that at diagnosis they often experienced fear and uncertainty, resulting in a reduced ability to concentrate on written leaflets/pamphlets. The diagnosis they often experienced fear and uncertainty, resulting in a reduced ability to concentrate on written leaflets/pamphlets. The production of the DVD was led, directed and edited by young people with guidance from a professional animator and the ward sister to ensure it was fit for purpose.

The work was recognised by the Trust and was awarded The Annual Nursing and Midwifery Achievement Award 2011. This has provided a springboard for other services within the Children’s Directorate to review their methods of information sharing with young people. Since winning the award the Teenage Cancer Unit have been working towards developing the next DVD, which will focus on information concerning the side effects of chemotherapy.

Our achievements are wide ranging across the organisation. Almost every hour of every day a baby is born in the Maternity Unit at the Royal Victoria Infirmary. In 2011 there were over 7000 births. The every hour of every day a baby is born in the Maternity Unit at the Royal Victoria Infirmary. In 2011 there were over 7000 births. The nurses and midwives across the trust have risen to the challenge of use of early warning scores which support clinical staff to provide consistent early intervention thus protecting patients whose condition is deteriorating. The Trust is fully compliant with the mandated commissioner quality improvement targets which relate to this initiative. Clinical staff have worked together to focus on reducing the number of inpatient falls by introducing a number of practice changes and raising awareness of falls risks. Falls have reduced by 9% across the organisation, despite increased clinical activity. A Falls Co-ordinator has led this work through a multi-disciplinary task force who are absolutely committed to achieving a further 10% reduction over the next 12 months.

Neonatal Care

Claire Campbell, Research Nurse on Ward 35 at the RVI, was shortlisted out of 800 entries for the Annual Nursing Times Award, which is a huge achievement. The work focused on improving family centred care in the Neonatal Unit. Her work currently involves a research project funded by Tiny Lives. Additionally within neonates, the Royal Victoria Infirmary Special Care Baby Unit won the National Neonatal Unit of the Year. The unit was nominated by three buddy group mums. All three mums had a baby on the unit and felt very passionate about expressing their gratitude for the excellent care they received. The award is testament to the hard work and dedication of the whole Neonatal Team.

In summary...

In undertaking a review of the year, it is evident in every turn, that clinicians across Newcastle Hospitals remain extremely proud of Nursing and Midwifery in Newcastle. It has been a good and productive year and provided a very firm foundation in moving forward to meet the challenges of 2012/13.
It takes a team of very special people to turn the place where you experienced some of your most distressing life events into a place that you don’t want to leave behind. We are three mums and we each owe our children’s lives to the SCBU at Newcastle RVI. Our experiences are very different but we have all experienced first-hand the utmost dedication and professionalism that characterises the people that work in this Unit.

Arriving on the Unit for the first time, feeling afraid and helpless as we entrusted the lives of our precious babies to strangers, we were all struck by the genuine warmth and humanity that underpinned our babies care. Our babies were treat as people and our role as parents was respected throughout. In Bev’s words “We were shown on the Unit that we were at the centre of Freya’s care, there was no hierarchy, no us and them with the doctors and nurses, there was just one team”.

Between us and our partners, we have many special memories of kangaroo care and cuddles with our babies while on the Unit. As Gillian says, “the nurses really encouraged kangaroo care and, without putting on any pressure, would always endeavour to find the precious screens for us to do this whenever we wanted”.

Not only did our babies receive exemplary care but we did too, far exceeding any expectations we may have had. We were supported in every way possible as we learnt to care for our babies, from meeting the challenges of breastfeeding through to confidently caring for a baby with a tracheostomy. This emotional support helped Bev to remain positive: “even on those low days when we were given yet more bad news, they held us up and showed us the way back and gave us belief”.

The Unit is a busy place but nothing was too much trouble (even at the end of a phone in the middle of the night) and the nurses always found the time to offer support, chatting when you needed to and allowing you peace when you didn’t. They facilitated access to financial support where needed, entertained siblings and ultimately made us feel ‘at home’ in a place that initially felt so intimidating.

At every opportunity, care was enhanced by small, personal touches that now form the basis of treasured memories and keepsakes. Parents are provided with memory boxes, diaries, disposable cameras and gifts for their baby on special occasions. Often, however, it was the words or actions of individual staff members that made all the difference:

- Gillian remembers coming into the Unit one day to find a picture of Lexi with no tubes or breathing support, which she had never seen before. The nurse had written on the back: ‘Good morning mummy and daddy’. On another day, she found a huge star in Lexi’s incubator saying she had joined the ‘Kilo Club’. She felt so thrilled, as if Lexi had made a huge leap.

- Bev recalls the way that staff would ring every ward that Freya was on for updates, even after she had left the Unit. “Freya had had open heart surgery in the Freeman Hospital some 3 weeks after leaving the Unit and while sitting next to her bed willing her recovery on there was a phone call enquiring after her from a nurse who had regularly cared for Freya in the Unit. She lifted me in 5 minutes and again we knew we could do this!”

All three of us have been so moved by our experiences that we have found ways to stay in touch with the Unit. Gillian and Bev are involved in an innovative buddy scheme that enables parents on the Unit to access peer support, and Marina is involved in the Unit’s charity (Tiny Lives Fund). The people we met on the Unit are truly amazing and we feel that their collective dedication to the families that pass through their doors, coupled with excellent clinical care, is worthy of this award.

1Bev’s daughter was born at 28 weeks and spent 13 weeks in the high dependency area before moving onto PICU; she was discharged aged 5 months and requires ongoing care at home. Gillian’s daughter was born at 27 weeks after she had suffered pre-eclampsia and spent 12 weeks on the Unit. Marina’s son was born at 35 weeks after an intrauterine haemorrhage and spent one week in special care.
Newcastle’s Great North Children’s Hospital was delighted to welcome two nurses from Ghana in West Africa – Delaena Ami Ocloo and Rose Charlotte Owane Tweneboah – who were in the North East for the first time from the Komfo Anokye Teaching Hospital in Kumasi. Their visit to the UK follows three previous trips made by clinical staff from the RVI to Ghana as part of the Newcastle – Kumasi link – an NHS Partnership for Global Health initiative established in accordance with the Tropical Health Education Trust (THET) back in 2005.
Delaena and Rose, Principal Nursing Officers (same level as Senior Ward Sister in the UK) heading up nursing care for children at the Komfo Anokye Teaching Hospital in Kumasi, had the opportunity to observe paediatric nursing practice in many areas across the Children’s Hospital, including the Children’s Emergency Department. In particular they were keen to understand the triage system in use there to facilitate rapid assessment and subsequent course of treatment or onward referral, and the protocol in place known as PEWS (Paediatric Early Warning System) to help them detect an acutely ill child in the crowded and busy environment they are used to at home.

Both Delaena and Rose are now confident that they can take many elements of Newcastle’s protocols and pathways back to Kumasi to support their nurses to make rapid, and often life saving decisions. Introducing a robust prioritization and rapid assessment system will make a huge difference to the six or seven nurses at the Komfo Anokye Teaching Hospital who see in excess of 300 sick children every week.

Another area of excellent practice which interested our Ghanaian guests was the role of our Nursery Nurses or Hospital Play Specialists who work closely with our young patient and their families to reassure and ease them into what can seem a daunting experience in hospital. They immediately recognised the positive effects of their holistic and ‘child-friendly’ approach, allowing the child, their parents and other close relatives to feel more relaxed and involved in their care. Delaena and Rose would very much like to introduce similar practice into their care pathways, modified to meet their own cultural needs, and plan to set up presentations for their nursing colleagues upon their return to Kumasi.

An ongoing area of development which has taken a step forward towards fruition is the establishment of a substantive Kumasi-based paediatric nursing course in collaboration with the University of Northumbria and the Kwarne Nkurumah University of Science and Technology (KNUST). This means that for the first time there will be a syllabus dedicated specifically for paediatric nursing to Diploma level in Kumasi. From there, a Degree standard can be developed.

Of course as with any educational activity, the benefits are mutual. Kumasi is the second largest city in Ghana with all children’s healthcare provided at the Komfo Anokye Teaching Hospital – there is no community paediatric service such as we enjoy here in the UK. The main hospital building dates from the 1950s, adjoined to various purpose built annexes. The nurses work under great pressure in an often crowded and chaotic environment with extremely limited access to essential equipment such as basic resuscitation apparatus, monitors, incubators and even thermometers. And yet the hospital has won an international neonatal award for its ‘back to basics’ approach to care for premature babies.

Staff at Komfo Anokye Teaching Hospital have established the principle of ‘Kangaroo mother care’, where pre-term babies are kept in skin-to-skin contact with their mothers and until they are at least at the stage where they would have been born. This way their heartbeat, breathing and temperature become stabilized. This technique also promotes breastfeeding, with babies more likely to exclusively breastfeed for 6 months, and increases weight gain helping them to thrive. But more importantly, this practice reduces the dependence on the few incubators they do have and has brought about a vast reduction in mortality rates. The Western world recognises the extraordinary statistics which demonstrate staggeringly better survival rates following this approach compared to resorting to more interventional methods.

Delaena and Rose both found their experience in Newcastle to be invaluable and were extremely impressed by how quickly and efficiently the nursing staff assessed and treated each child. They were also very pleased to be openly introduced to the carers of the patients who were all more than happy for them to observe the clinical practice. This made them feel welcomed into each family’s personal situation – a rich and positive experience they say they won’t forget.

Members of our staff now plan to re-visit Ghana in September this year with an education programme.

Sue Vernon
Nurse Consultant
Transforming Newcastle Hospitals

After 10 years of extensive redevelopment at the Royal Victoria Infirmary site, best in class clinical facilities are fully operational.
We now enter the final phase of the most ambitious healthcare project ever seen in the North of England, which will include a state of the art Culture Centre and teaching complex, a comprehensive Clinical Office Building and new 900 space Multi Storey Car Park. Whole site reconfiguration set for final completion in 2014.
From 1st April 2012, the Royal Victoria Infirmary has offered the services of a nationally designated Major Trauma Centre.

This brings together the specialties of:

- Emergency Department
- Neurosurgery
- Orthopaedics
- General surgery
- Vascular surgery
- Cardiothoracic surgery
- Trauma theatre (available at all times)
- Anaesthesia
- Critical care
- Plastic surgery (burns and reconstruction)
- Paediatric surgery
- Blood transfusion
- Radiology
  - CT
  - MRI
  - Interventional

Newcastle is responsible for the care of patients with major trauma throughout the regional Trauma Network.

The North East Ambulance Service uses appropriate triage of major trauma directly to the Major Trauma Centre and ensures rapid transfer of major trauma cases from Trauma Units to either Newcastle or Middlesbrough.
Major Trauma Bypass Protocol

This protocol is used if major trauma is likely to have occurred based on a significant mechanism of injury. Examples may include:

- High speed road traffic collisions
- Motorcycle road traffic collisions
- Pedestrian or cyclist versus vehicle
- Death of an occupant in the same vehicle
- Ejection from a vehicle
- Fall from 2 storeys or more
- Crush injuries
- Assault with a weapon
- Prolonged entrapments
- Blast injuries

**STEP 1**
Physiological assessment

- Any one of:
  - Current GCS 13 or less
  - Sustained loss of radial pulse or systolic BP <90mmHg
  - Respiratory rate <10 or >29

**STEP 2**
Anatomical assessment

- Any one of:
  - Penetrating trauma proximal to elbow or knee
  - Spinal injury with new abnormal neurology
  - Traumatic amputation proximal to wrist or ankle
  - Chest injury with hypoxia or suspected flail
  - Significant burns* or inhalational injury
  - Pelvic fracture with obvious deformity /instability

**STEP 3**
Special circumstances

- No trigger in step 1 or 2 but **high degree of clinical concern**
  - PLUS Any one of:
    - Age > 65 years
    - Bleeding tendency
    - Pregnancy >20 weeks

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Is Major Trauma Centre within 45 minutes?

- **Yes**
  - **BYPASS TO MAJOR TRAUMA CENTRE**
  - PRE-ALERT RECEIVING EMERGENCY DEPARTMENT
    - Royal Victoria Infirmary 0191 2820311
    - James Cook University Hospital 01642 282767

- **No**
  - Transport to nearest trauma receiving hospital. Pre-alert ED for all triggering cases

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* 10% burns in a child, 15% burns in an adult, Circumferential burns, Hand or facial burns
One year on and the vision of the Institute of Transplantation has become a reality. Since the last annual report, transplant clinicians and research scientists working within our Trust and Newcastle University have begun to collaborate to generate advances in both clinical service and translational science that meets the current and future needs of our patients. It has been extremely heartening to see how transplant professionals in Newcastle have embraced this project over the last year. We have demonstrated our resolve in meeting the challenge set by the Department of Health to enhance the national programme, and have laid down the gauntlet for other national and international centres to follow suit. 260 organ transplants were completed in 2011-12.
Cissy, the girl saved by second opinion

A child rejected for a heart transplant by Great Ormond Street is alive after another hospital gave her a chance, writes Sarah-Kate Templeton.

Cissy Metcalfe, 17, was diagnosed with a heart defect at six months old. However, the condition was not serious enough for her to be referred to a heart specialist, and she had a normal school life at Berwick Academy until she was 14.

Then Cissy’s troubles began. In January, she developed a cough and was taken to hospital, but her condition worsened. She was transferred to Great Ormond Street Hospital, London, where she was told that she needed a heart transplant.

However, the hospital in London rejected her because of her condition, and Cissy’s family was told that she had a “ respiratory condition” and so was not suitable for a heart transplant. They were also told that she would need a heart and lung transplant.

Cissy’s parents were devastated. They had been doing all they could to help their daughter, and now they were told that she would need two operations. The family were told that Cissy would need a heart and lung transplant, and that the operation would be “very complex.”

Cissy’s family were then told that she could be sent to a different hospital, but they were not given any details about the hospital. The family were left with no choice but to accept the offer from a different hospital, and Cissy was sent to the Freeman Hospital, where she received the heart transplant.

Cissy’s family were overjoyed when they heard the news. They were able to return home and Cissy was able to go back to school. She is now well and her family are grateful to the hospital for saving her life.

The Freeman Hospital saved Cissy’s life, and the family are now determined to raise awareness about the importance of heart transplants. They are also keen to thank the medical staff at the hospital for their hard work and dedication.

The Freeman Hospital has a long history of providing heart transplants to children and young people. The hospital has had a very successful record, and has helped many children and young people to live healthy lives.

The Freeman Hospital is now offering a second opinion for heart transplants, and the family are encouraging others to take advantage of this service. They hope that their story will encourage others to seek a second opinion.

The Freeman Hospital is one of the leading heart transplant centres in the UK, and has helped many children and young people to live healthy lives. The hospital is committed to providing the best possible care for its patients, and is always looking for ways to improve its services.

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Crawford House has 23 private family bedrooms, 14 bathrooms, a fully equipped kitchen, a large communal dining area, a well stocked playroom, a shared living room and full laundry facilities. There are also direct telephone lines in all of the family bedrooms linking them to the hospital wards so families can be contacted immediately in the event of an emergency.

Crawford House is open 365 days a year and can accommodate 23 families each night. Rooms are allocated on a first come, first served basis according to our admission criteria and are offered to families completely free of charge. We rely entirely on voluntary donations to provide our free service to families when they need it most.

Through our ‘Home from Home’ we help to alleviate some of the emotional, financial and practical stresses parents face when their child is very sick in hospital.

During the 2011-12 financial year we have seen an increased demand for rooms at Crawford House. This is partly due to the relocation of children’s services from Newcastle General Hospital (NGH) to the GNCH and RVI, but also a reflection of the increased numbers of children now receiving treatment on this site. We have seen a 33% increase in PICU families, a 54% increase in neonatal families and a 108% increase in neurology families compared to the previous year. We have also seen an increased intake of families with children who have general medical conditions and gastrology problems and we have accommodated more families travelling long distances and needing overnight stays for early morning outpatient appointments.

The average stay at Crawford House increased from to 11 days to 12 days. The longest stay since Crawford House opened in 1996 has been 248 days.

The house staff at Crawford House work very closely with staff from the children’s directorate to prioritise families on our waiting list and provide a calm, comfortable place for families who need it most. We are very grateful for the continued support we receive from staff in the chaplaincy and social work departments. We hope to build on these relationships in the future and strengthen representation from the hospital on our local management committee.

2012 sees the start of a year of celebrations for The Sick Children’s Trust as we mark our 30th Anniversary. We awaited the final decision of the Safe and Sustainable Review into children’s heart units across England and Wales which was announced in July 2012. The number of families referred to Crawford House from the paediatric cardiac unit has doubled in 2011-12 and despite increased demand on our ‘Home from Home’ services from the RVI and GNCH, we have always tried to accommodate these families wherever possible. The decision was in favour of keeping the Freeman Hospital Paediatric Cardiac Unit and as a result The Sick Children’s Trust will be building a new ‘Home from Home’ at the Freeman Hospital site.

Sixteen years from its first admission Crawford House, The Sick Children’s Trust’s ‘Home from Home’ at the Royal Victoria Infirmary (RVI) continues to support the children’s services based there and at the Great North Children’s Hospital (GNCH).
Each year tens of thousands of people are diagnosed with cancer and this figure is rising annually. The good news is that people are living for longer with cancer and Maggie’s helps them to live as well as possible through a tailored programme designed to meet the individual needs of every visitor. Maggie’s welcomes those at all points of their cancer journey: from diagnosis, to treatment, post-treatment, at stages of recurrence, end of life or in bereavement.

The NHS provides excellent cancer treatment but people with cancer, and their families and friends, need more than treatment, diagnosis and prognosis. They need help with the emotional, psychological and practical side effects of the disease and the opportunity to meet others facing cancer and, together, to take control of their own wellbeing. At Maggie’s this support is provided within an open, easily accessible, architecturally inspiring, community centre which acts as an antidote to the isolation and despair of a cancer diagnosis. In a nutshell, Maggie’s helps visitors to have the best life possible with, through and beyond cancer.

Maggie’s are delighted to be working alongside The Newcastle Hospitals NHS Foundation Trust to bring our Centre to the region by April 2013. Maggie’s North East will be located a few steps away from the Northern Centre for Cancer Care (NCCC) at the Freeman Hospital. Maggie’s will come within the North of England Cancer Network, a region that encompasses an area from the east coast across to Cumbria and down to the River Tees.

The foundations for Maggie’s North East have been laid and the structure is taking shape with the external walls now constructed. The area around the Centre is being prepared for landscaping and work inside the building continues. We are currently raising £3million to complete the build and ensure the centre is sustained into the future.

Maggie’s North East has been designed by renowned architect, Ted Cullinan, who is a leading advocate of sustainable architecture. The bold, innovative building incorporates cutting edge environmental technologies such as micro-generation via solar roof cells, ground source heating, and making use of recycled material. The design of Maggie’s North East will see a vibrant landscape surround the sheltered centre, which itself will partly enclose a courtyard. There are two wings to the centre – one housing counselling rooms and a large living room space, the other leads to the all-important kettle and kitchen table.

For more information about Maggie’s North East please contact Katie Drummond on 07826 948 142 or by katie.drummond@maggiescentres.org.

www.maggiescentres.org
Significant progress has been made in the development and delivery of the Trusts Information Systems throughout the year, most notably the integration of support for Community care, ongoing development of the Electronic Patient Record system and significant infrastructure upgrades delivering benefits to performance and resilience.
Electronic Patient Record

The initial implementation of Cerner Millennium, the Patient Administration System (PAS), A&E System, Theatre Scheduling, Electronic Ordering and Medicines Management functionality represents only part of the application’s full potential. A major core upgrade of the Cerner Millennium platform, to allow the build of ‘18 weeks Referral to Treatment’ functionality, was the main focus for 2011/2012. However this has not held back the planning and development of the application’s capability. Development is underway in a number of key areas such as SurgiNet (Theatres Management System) which will focus on one of the Trust’s most high cost and high income areas and will drive significant process improvement, provide audit capability and transparency while reducing cost and maximising theatres utilisation. In addition, the strategic imperative for SurgiNet is to provide precise costing and timing information to the Patient Level Costing System. Following the success of electronic prescribing and electronic ordering to in-patient areas, work is underway to deliver this capability to all outpatient areas. To support this transition, development has commenced on the electronic endorsement of results which will reduce clinical risk, operating costs and greatly improve workflow. The Trust is also working with Cerner to enhance the look and feel of the application to enrich the user experience of the system.

Further to the electronic transmission of Pathology results and discharge summaries to GPs, development is nearing completion on the next phase to deliver Radiology results. These developments have been well received by local GPs and have greatly improved the primary care – secondary care interfaces.

A major transformational programme has been initiated to move the Trust to a ‘paper-light’ state. This will focus upon: developing the capability to enter more patient information directly into the Electronic Patient Record (EPR) to replace paper forms and notes; implementing a digitisation strategy for historic paper and inbound correspondence, streamlining and standardising processes. This will significantly reduce cost, clinical risk, improve workflow and release real estate as long term paper storage is reduced.

Elsewhere the internal development of an electronic Clinical Assurance Toolkit (Ward Accreditation Scheme replacement) led to a nomination for an award by the Nursing Times and the Trust Nursing Achievement Awards.

Community Integration

In support of the integration of Community Services into the Trust from April 2011, a complex programme of activity to integrate IT systems with the Trust systems commenced. IT and telephony support for 15 key community sites across the city, including over 20 additional clinical sites had to be integrated, it was key that disruption to the clinical services during the migration was avoided. IT are working with the clinical directorates to facilitate greater integration of community and acute processes, examples include direct messaging between IT systems, and the introduction of enhanced mobile working to ensure healthcare staff have access to the patient information as they require it.

RIS / PACS

A new RIS system has been developed in conjunction with our managed service provider, Infinitt. Planned to go live in April 2011, this brings closer integration between the EPR and PACS systems, and supports current and future data requirements including the introduction of NICIP coding. A comprehensive hardware refresh was undertaken delivering improved system performance and full dual site resilience, ensuring the system will continue to operate with full functionality should an issue be encountered at either of the Trust datacentres. The full patient image archive is now held immediately available online providing clinicians with instant access to previous studies. Digital breast screening and assessment has been introduced at the RVI and some mobile sites, using the Infinitt PACS platform. Other systems have also been consolidated onto the core PACS systems, including cardio angiography. Dedicated 3D workstations have been introduced in some areas to provide enhanced image interpretation and reporting capabilities. A pilot is in development to expand this to further areas through the use of thin client technology.

Electronic Rostering

Deployment of the Electronic Rostering and Attendance system is continuing across the Trust, and is now in use by over 5000 employees. The system introduces an automated and consistent mechanism for planning staff rotas and recording attendance, including the use of biometric hand scanners to record the start and end of employee shifts. It produces an auditable duty record, and ensures the Trust is adhering to Working Time Directive regulations, reducing both management time spent on this activity and removing previous paper based practices.

Infrastructure

A continued programme of investment has delivered significant improvements to the IT infrastructure, improving resilience and robustness in support of the Trusts business continuity needs and to increase overall reliability and performance. This has included data Storage consolidation protecting the Trusts electronic data; server virtualisation, providing enhanced disaster recovery whilst also reducing overall power consumption as a result of the reduction in physical servers; data centre hosting, an expansion of the datacentre at the Freeman Hospital whilst construction is underway of a new datacentre at the RVI to provide a fully diverse hosting capability between sites, this project also delivered a major upgrade of power delivery and backup systems for core IT switch rooms. An initiative is underway to rationalise desktop printing, work practices will be enhanced whilst environmental impact and operating costs will be reduced through the deployment of shared workgroup devices.

Andy Jardine
Director of Information Technology (IT)
It is pleasing to report that Research activity for 2011/12 showed significant growth on previous years, in line with our ambition to double the level of activity over three years.

There were 322 separate studies running in the course of the year (now 404 in 2012/13) – the largest number for any Trust in England. Recruitment into National Institute of Health Research portfolio studies was up 15% on the previous year, making Newcastle the fourth largest centre in England.

For Research activity funding, Newcastle is now tenth, with a 50% split between the Trust and Newcastle University for research posts. We anticipate that funding should reach £2 million in the next year.

We are of course very proud of the Biomedical Research Centre and Clinical Ageing Research Unit funding – a sign that we continue to do well for infrastructure.

The dashboard shows that our commercial project approval times in Q1 of 2012/13 were 41 days. The approval process is under review and we may need to consider refusing studies with other centres, given that contractual wrangles often delay final sign-off.

Newcastle is now a preferred provider to Quintiles for clinical studies and Pfizer is interested in making Newcastle one of its Top 100 international centres.

Newcastle receives around 50% of the Northern Comprehensive Local Research Network funding (circa £5 million). Commercial income is forecast to increase from £1.8 million to £2.4 million in 2012/13.

In terms of patient recruitment, there are around 800 studies still ‘live’ and hence total patient numbers are greater than indicated in the graph. We have managed a three-fold increase in three years. Studies typically run for one to four years.

A successful year overall and with a favourable outlook for 2012/13 and beyond.

Professor Gary Ford
Clinical Director – Research & Development
**Patent News**

The Trust filed a patent on the Electronic Urine Flow Meter (or PeePod) in August 2011. This patent has recently been filed internationally and the device has attracted a commercial partner, with whom license negotiations are ongoing.

A UK patent has recently been filed on a prototype device which was developed by a locum breast surgeon within the Trust. The device will aim to support surgeons in determining margins for excision in breast surgery.

Two devices, the Penile Cuff (second generation) and the Urine Bag Clip entered the European and US phases of their international patent applications. Negotiations are ongoing with a potential licensee for the former.

The Trust has recently been granted a patent in the UK for neonatal ECG technology for the safe positioning of feeding lines in neonates. The patent on this technology was initially filed in 2007 and a license deal has recently been agreed with a commercial partner, Vygon Ltd, who will incorporate the technology into a device called Safe Place.

A patent applied for by the Trust in 2005 has recently been granted in Europe. The patent covers technology to improve lab processing during IVF treatment.

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**Olympian Legacy**

The Games were not a jamboree doomed to fade in the memory. The spirit of large-scale enterprise should be harnessed to boost sustainable economic recovery

Boris Johnson rightly said yesterday that the Olympic Games had been an extraordinary event that Londoners would remember for the rest of their lives. The entire nation has been transfixed for a fortnight by a sporting occasion that proved glorious, but as they fade into memory, the question remains whether the Games will have any effect greater than spectacle.

They can and they should. The Olympic spirit and the role of government in fostering it have widened significantly from mere temporary relief from a double-dip recession in the UK and a severe debt crisis in the eurozone. The Games were not just a jamboree, but an instance of how the State can advance a large and complex project that could not have arisen spontaneously. The same approach is needed to promote big changes in the economy. The motor of recovery will be Britain’s corporate sector selling in competitive markets. That effort could be helped by reducing regulation, easing the corporate tax burden and investing in skills. But the UK economy has a deep er weakness than those measures will address. It is a geographical and structural imbalance.

The long business expansion of the early years of this century was skewed by the banking sector and the South East of England. A new industrial strategy, harnessing the spirit of enterprise and public-private partnership that made the Olympics a success, should encourage a more balanced form of growth. This would place greater emphasis on exports and on diversifying Britain’s sectoral and geographical strengths.

First, there is the regional question. Clusters of excellence often create economic dynamism. Newcastle upon Tyne is a centre of advanced medical research. The demographic pressures caused by ageing populations in the advanced industrial economies are intensifying, thereby increasing the long-run demand for high-quality medical care.

Tax incentives to create a British equivalent, in the North East, of the Mayo Clinic in the US, might make Newcastle a byword for invisible export earnings in the same way as the City of London. Incentives for investment through regional enterprise zones should be extended to other scientific enterprises. For example, Cambridge is a centre of home research, which is crucial to understanding the role of genes in combating disease. Cultivating this specialism in East Anglia and creating a high-tech corridor between Oxford and Cambridge would boost Britain’s growth potential in advanced technologies.

Second, allied to regional enterprise, industrial policy can intervene in support of high-value sectors in which Britain has a potential competitive advantage, such as broadband, pharmaceuticals and creative industries. This is a case of picking winning companies or national champions. Nor is sponsorship by the State the same as ownership. It is, rather, a case of assessing which sectors can generate the greatest productivity gains and hence drive improvements in real incomes.

Finally, there is an essential role for government in pulling the psychological lever that will create a vibrant business climate. As John Maynard Keynes remarked: “If the animal spirits are dimmed and the spontaneous optimism fades, enterprise will fade and die.” Infrastructure projects such as a new hub airport for the South East and High Speed 2, a rail network connecting London and the Midlands, can help to do this. They will not have a direct impact on growth in the short term, but they can convey the message to international investors that Britain is an exciting place in which to do business. The Olympics have shown Britain can mount large-scale projects and do them well. They can remake the economic geography of this country. The Olympics were an exceptional example of that. They should not be the last.
Newcastle is top of the league for research activity

We are leading the way in providing opportunities for patients to take part in clinical research studies. Highlighted in a league table(1) published by the National Institute for Health Research (NIHR) Clinical Research Network, Newcastle upon Tyne Hospitals currently tops the table for conducting the most studies (404), an increase of 83 studies on last year’s figure.

Dr Jonathan Sheffield, Chief Executive of the NIHR Clinical Research Network which provides specialist research nurses and resources to enable NHS Trusts to deliver clinical research opportunities for patients, praised the achievement of the Newcastle upon Tyne Hospitals and explains:

“This is marvellous news and illustrates that our partners in Newcastle are truly placing research at the core of NHS business. We know from recent polls that patients want to see the NHS do research, and they want the chance to get involved. This Trust’s recruitment of 13,812 patients indicates a strong commitment to research and innovation as well as their drive to improve clinical outcomes for patients.

We are keen to see other Trusts follow their example and truly embed research as a standard option within their care culture, and this year we’re able to report that 99% of NHS Trusts in England were involved in delivering research during 2011/12. With their help we recruited almost 600,000(2) patients, which was a fantastic achievement. The league table helps us recognise the research commitment of NHS staff throughout England and shows that clinical research is not just for the large teaching hospitals - it is absolutely core business for all NHS Trusts.

Developing a research-active culture brings a host of benefits for patients, clinicians and the NHS. It drives innovation, gives rise to better and more cost-effective treatments, and creates opportunities for staff development. Growing evidence also suggests that NHS organisations that are research-active appear to do better in overall performance.

Commenting on the league table results, Professor Dame Sally Davies, Chief Medical Officer and Chief Scientific Adviser for the Department of Health, does say:

“This data from the NIHR Clinical Research Network is encouraging and shows us that high quality research is happening but we need to keep pushing for research to have the profile it deserves with both doctors and their patients.”

The ‘Top 50’ are highlighted with Newcastle the only organisation represented in the North East.

To view the research activity league table in full visit: www.crncc.nihr.ac.uk/nhs-performance

Note;

1. The Newcastle upon Tyne Hospitals NHS Foundation Trust research activity:
   • 404 research studies recruiting patients in 2011/12
   • 13,812 patients recruited into research studies in 2011/12
   Data is from the NIHR Clinical Research Network Portfolio 2011/12; a national database of studies, which is supported by the NIHR Clinical Research Network. Only studies that meet specific eligibility criteria set by the Department of Health are included in the Portfolio. These are high quality studies that have been awarded funds as a result of open national competition, for research that is of clear value to the NHS and which takes account of Department of Health and NHS priorities.

2. Actual figure: 595,540 patients recruited into NIHR Clinical Research Network Portfolio research
   • Patient participation is purely voluntary and requires patient consent. A document explaining how anonymised data supports research called ‘Your health records save lives’ is available at: www.ukrcr.org/publications/informationbooklets/
   • The Clinical Research Network is part of the National Institute for Health Research.
   The Network provides researchers with the practical support they need to make clinical studies happen in the NHS, so that more research takes place across England, and more patients can take part.
   This practical support includes:
   • Reducing the ‘red-tape’ around setting up a study
   • Enhancing NHS resources, by funding the people and facilities needed to carry out research ‘on the ground’
   • Helping researchers to identify suitable NHS sites, and recruit patients to take part in research studies
   • Advising researchers on how to make their study ‘work’ in the NHS environment
NewGene
Next Generation Diagnostics

NewGene. Pioneering the application of new technologies in molecular diagnostics

The demand for testing of genetic variation in patients is growing year on year. This is being driven by advances in medical genetics coupled with the growth in personalised medicine which involves the determination of a patient’s biological characteristics in order to select the most effective therapy regime. Established through a partnership between the Newcastle Hospitals NHS Foundation Trust and Newcastle University, NewGene is a pioneer in developing, validating and delivering molecular diagnostics using the latest high throughput sequencing and genotyping technologies.

Integrated service provision

NewGene’s core team has a background in molecular genetics within the NHS. By combining this clinical and laboratory expertise with the use of high throughput sequencing platforms, NewGene is able to deliver a high quality, fast turnaround service at an attractive price. NewGene works in collaboration with clinicians and scientists to deliver optimal services to regional and national NHS Trusts and overseas healthcare providers.

NewGene is currently expanding its sequencing platforms to further improve its capabilities and services.

Broad portfolio of tests

NewGene offers a portfolio of tests in clinically significant inheritable disorders and for personalised medicine diagnostics for somatic mutations in cancers that are delivered using its high throughput DNA sequencing platforms.

- Personalised medicine
  - KRAS / BRAF combined test for colorectal cancer
  - EGFR test for non-small cell lung cancer
  - IL28 and PNPLA3 genotyping for liver disease
  - TPMT screening for adverse reactions in acute lymphocytic leukemia
  - cKIT / PGDFRx for gastro-intestinal stromal tumors

- Hereditary diseases
  - BRCA1 and BRCA2 full gene sequencing for breast cancer
  - RAS-opathies testing
  - aHUS genotyping to detect hereditary haemolytic uraemia

- Haematology
  - JAK-2 and MPL testing in myeloproliferative disease
  - BCR-ABL monitoring for patients with chronic myeloid leukaemia
Noonan spectrum test: RAS-opathies

NewGene has recently introduced a new service, in collaboration with St George’s Healthcare NHS Trust, that offers, for the first time, a comprehensive diagnostic test for all Noonan spectrum disorders, also known as RAS-opathies. These conditions are inheritable diseases that cause delayed development in children and are associated with a wide range of medical problems, including heart defects, speech and hearing issues and growth and behavioural problems. The range and severity of health complications can vary significantly and the syndromes are not always identified at an early age. Once suspected, it can take up to 18 months for a definitive diagnosis to be made using currently available techniques.

The NewGene test simultaneously screens all coding regions and splice sites of 11 genes and a single exon of one further gene for mutations causative of all the RAS-opathies. This replaces the current standard multi-stage regime hence reducing time to diagnosis and cost and increasing the likelihood of identifying the molecular basis of the disease.

Personalised medicine in liver disease

Within the field of personalised medicine, NewGene is working closely with clinicians from the Regional Liver Unit at the Freeman Hospital to develop molecular tests that can be used to identify appropriate treatment regimes bringing both clinical and cost benefits to the patients and the service.

Chronic hepatitis C is a leading cause of cirrhosis, liver cancer and liver failure. The standard combination therapy is clinically demanding and ineffective in some patients. Novel direct acting anti-viral drugs have given clinicians and patients an alternative treatment pathway, however this approach is expensive. NewGene has established a test for the variation in the IL28B gene that can be used to predict the response of individuals to the standard combination therapy and can be used to determine the appropriate regime that is both clinically and cost effective.

Non-alcoholic fatty liver disease, NAFLD, is associated with obesity, diabetes and high blood pressure and can cause inflammation and fibrosis of the liver leading eventually to cirrhosis. NewGene has developed a molecular diagnostic test for PNPLA3 as an alternative to invasive liver biopsy in some patients. Two variations in the PNPLA3 gene have been demonstrated to indicate the level of risk of disease progression to fibrosis. The ability to differentiate patients that are likely to develop more serious disease could enable clinicians to identify appropriate long term treatment plans.

Research services

In addition to its clinical services, NewGene combines its expertise in the field of genetics with its latest sequencing technologies to offer DNA sequencing and genotyping services to research clients, principally academia and pharmaceutical companies.

To find out more visit our website www.newgene.org.uk Phone: +44 (0) 191 242 1923 Email: info@newgene.org.uk

Photographs kindly supplied by Newcastle University
Cameron speaks out on binge drinking during visit

PM: Time to get tough on boozing

THE Prime Minister has called on Newcastle city leaders to take a tougher approach to violent binge drinkers.

Speaking at Newcastle’s RVI hospital, David Cameron said he wanted a much firmer approach to problem drinkers, and hinted he was prepared to set a minimum unit price for booz.

His visit came as Newcastle council leaders said they would need his support to go ahead with a tax on some of the city’s most popular bars, with the cash used to pay for nighttime policing.

Mr Cameron said the two areas on which focus was needed was on enforcing licensing for irresponsible bars and tackling cheap supermarket alcohol deals.

He said he chose Newcastle to make his announcement because he admired the hospital’s work, which includes having a police officer present in A&E.

“I think the police and local authorities need to work together on this. Yes, of course cities such as Newcastle want to have an active night-time economy, it is one of the attractions of Newcastle.

“But I think where we should show less tolerance is if there are bars or clubs selling to underage people, selling to people who are drunk, and as a result not meeting their responsibilities, then they should have their licences taken away.

“I think that is where the police can work together with council.

“He added that he thought the tough approach could work without damaging the city’s image.

“That does not mean spoiling the image of a city, or saying you can’t have a good night out, but where there is bad practice we need to work on stopping it.

“We don’t want to stop young people and students having a good night out – going to bars and clubs can be part of a good night out – but there is an edge of binge drinking in Britain that goes beyond the pale.

“It ends up with huge amount of people coming to hospitals and going too far. You can have fun without it ending in the gutter.”

Henry Murison, the cabinet member for Newcastle Council tasked with ensuring public safety, said the PM had to offer more than just headline-grabbing comments.

He said: “In Newcastle our policy cabinet last year heard the full picture of the importance of both affordability and availability, as well as some of the key statistics that as well as people drinking in pubs and clubs, 62% are bought in shops and supermarkets, and two out of five people drink before they go out in the evening.

“The police have an active presence, working on key issues like preventing and catching perpetrators of crimes against women.

“But all this is against the back-drop of the coalition slashing police funding and numbers, with the cops who deal with keeping the city centre safe doing that in place of their normal duties to protect local neighbourhoods.

“That’s why we are keen to have a public debate on whether we should charge a levy to those pubs and clubs open past midnight to pay for the necessary policing with funding from the Tory-led government slashed, against the back-drop that the council also supports services like the taxi marshals whilst many in the community contribute through ways like being Street Pastors.”

Northumbria Police have also backed the PM’s plans for a minimum alcohol price.
Outline Planning Permission was received from Newcastle City Council for the development of the Campus for Ageing and Vitality in January 2011. Since then, work has progressed apace to complete the Full Business Case for the Brighton Grove Clinic scheme.

Estimated construction costs are circa £18 million.

The Service Plan is now well advanced and is intended to be flexible to reflect changing priorities for the Trust. There is increasing engagement of clinicians and GPs in shaping the development of the Plan.
The facility makes provision for the Diabetes Centre. Brighton Grove shall also offer diagnostics and a range of other services to support primary care. Planning links have been established with other relevant schemes and initiatives, such as the Translational Research and CRESTA clinics on the Campus, all being part of the regeneration of the former Newcastle General Hospital site.

**Key characteristics of the Service Plan are:**

- **One Stop Care** – assessment, diagnostics and treatment in one visit where appropriate
- **Integrated Care** – across primary and secondary care and across agencies e.g. Social Care (which will be on site)
- **Emphasis on Preventative / Anticipatory Care** – minimising the need for non-elective intervention
- **Emphasis on Managing Older People** – with links to the wider Campus offer
- **Strong Service Synergy** – a good fit between the range of services offered within the facility, which will further support the ‘One Stop’ and ‘Integrated Care’ ethos
- **Flexible, Good Access** – extended hours of working.

The facility makes provision for the Diabetes Centre. Brighton Grove shall also offer diagnostics and a range of other services to support primary care. Planning links have been established with other relevant schemes and initiatives, such as the Translational Research and CRESTA clinics on the Campus, all being part of the regeneration of the former Newcastle General Hospital site.
The Trust owns an 80% stake in Freeman Clinics Limited, a company established in response to the national Equitable Access programme, intended to provide primary care services in areas which did not have a strong presence of GPs/family doctors. The company was successful in two bids under that programme in 2008 and currently provides primary care and walk-in facilities from sites at Battle Hill in North Tyneside and Ponteland Road in Newcastle upon Tyne.
At the time of publication the number of registered patients had reached 2,464 at Battle Hill and 2,090 at Ponteland Road. The average number of patients per day attending the walk-in services is 106 at Battle Hill and 87 at Ponteland Road.

More recently, Freeman Clinics secured a tender award to provide primary care services in North Tyneside and which are currently provided by Earsdon Park Medical Group from two sites: Shiremoor Resource Centre and the Oxford Centre in Longbenton. The transfer of these services into Freeman Clinics is anticipated to take place on 1st September 2012. Earsdon Park staff will transfer to Freeman Clinics employment. The Freeman Clinics service delivery platform is set to expand further as part of the ‘vertical integration’ and ‘value for money’ objectives of a more responsive, patient focussed service in the community.
Pharmacy continues to ensure that the services it provides are cutting edge; making best use of technology and incorporating best practice.

Patient focussed care
The Pharmacy Department is continually looking for ways to improve the quality of services provided, and particularly now with opportunities to work more closely with colleagues in primary care. From the end of April 2011, our Pharmacy became responsible for the provision of medicines management support for community health care.

We are committed to a broader approach to the use of medicines, now referred to as ‘Medicines Optimisation’. For example, in collaboration with Dr Terry Aspray Consultant Physician in Musculoskeletal Services, one of our Pharmacists, Louise Maguire, is working in local GP surgeries to optimise the use of medicines in order to reduce fracture risk in patients with Osteoporosis.

Newcastle Specials continue to expand in provision of special medicines for the Trust
Electronic Prescribing

The implementation of electronic prescribing has enabled the Pharmacy Department to have a major impact on prescribing practice. For example, the creation of ‘caresets,’ which speed up the prescribing process whilst ensuring that the choice of drugs and doses are always according to agreed protocols. In the last year these have focussed on antibiotic treatments, medication in Intensive Care and for patients requiring Palliative Care.

‘Alerts’ within the system are now being used to deliver specific guidance to nursing and medical staff at the point at which it is needed. The first of these greatly improved communication of allergies. Others have focussed on antibiotic prescribing as part of the Trust’s strategy to improve infection control and in helping staff to deal with medication supply problems.

It is planned to increase the range of ‘caresets’ and ‘alerts’ over the next year to guide staff to safer prescribing and to give extra advice where needed. This knowledge will then be used to extend electronic prescribing to Paediatric patients.

Newcastle Specials

Newcastle Specials continue to expand in provision of special medicines for the Trust, other NHS organisations and beyond. Ongoing success supports both savings for the Trust through production of safer, cost-effective ready to use medicines and income from commercial sales. Through reinvestment, the unit has continued to build relationships with customers securing repeat and new business, and support innovation and research through increasing manufacturing for clinical trials.

Neil Watson
Clinical Director of Pharmacy and Medicines Management

Photographs kindly supplied by The Newcastle upon Tyne Hospitals NHS Foundation Trust
The integration of Community Health Services into the Trust began when these services transferred from management by Newcastle Primary Care Trust (PCT) to Newcastle Hospitals on 1st April 2011.

The approach taken within the Trust was to truly integrate the Community Services into the existing Clinical Directorate structure. The exceptions to this are the services which provide City and Trust-wide support. These services were integrated into the Corporate Nursing and Patient Services Directorate.

Progress and benefits are being realised within varying time scales, dependent upon the size and complexity of service and whether early integration was achieved.

Community Nursing Services

The integration of Newcastle Community Health with Newcastle Hospitals in April 2011 afforded acute and community teams the opportunity for developing closer working relationships. The benefits of integration have been felt by staff and patients. Some of the benefits have included:

- improved professional links between acute and community care, enabling best practice developments to be shared across the whole health economy.
- community nurses attend a range of professional nursing forums to share experiences, best practice and contribute to whole systems development.
- the development of the Rapid Discharge pathway to support End of Life Care was developed in collaboration with community nurses, palliative care teams and ward staff. This has enabled patients to be rapidly and safely discharged from hospital to their preferred place of choice at the end stages of their life.
- the community nursing teams are currently working on a range of objectives to improve the pathway of care between acute and community. These objectives include:
  - Developing intravenous therapy support in the community.
  - Identifying real time patient feedback.
  - Developing a nursing forum to look at service improvements between the acute and community settings.

Following integration, there have been specific developments for other community teams. Most notable have been the multi-disciplinary rehabilitation and reablement teams, such as Community Resource Team, Single Point of Access, Primary Care Response and the Supported Discharge Teams.

Working in collaboration with Newcastle City Council Adult Social Care colleagues, a uniform model has been identified to develop an integrated single entry/contact point for Community Health and Adult Social Care.

Continence Service

As a result of the integration of the continence service in April 2011 there is now improved access, using a standardised patient referral point and a transferable continence assessment, with specific care pathways for bladder and bowel dysfunctions and supporting information, with patient education literature.

The focus of the continence service is treatment rather than containment products, which in the first instance is better for the patient.
Tissue Viability

The Tissue Viability team integrated as soon as the merger took place. Care plans for wound assessment, leg ulcer pathways, and skin guidelines have now merged and both settings use the same documentation. A joint interim Wound Management Formulary was launched in June 2011 in order to offer patients a more streamlined experience. A fully integrated Wound Formulary for Newcastle was launched in January 2012.

From an education point of view, the merger has been very beneficial. The link nurses for Tissue Viability now meet together in regular forums and all clinical skilled based courses are accessed by both settings.

In the same way as the Continence Service the patient’s journey has certainly been enhanced through the merger, with increased communication and a ‘working together’ ethos.

Public Health

‘Why Weight’ the weight management service, the Stop Smoking Service (SSS) the Health improvement Service for Ethnic Minorities (HISEM), and the Health Improvement Team (HIT) are now all managed as public health services with a single overall manager.

Having the services together has been an improvement as it has allowed them to share more information and look at possible areas for joint working e.g. SSS and HISEM working together to offer stop smoking clinics at a local food warehouse, and Why Weight having an intermediate stop smoking advisor.

Managers of each of the services have been invited onto several Trust groups to bring a public health perspective on service delivery. The SSS have recently transferred money to both the Outpatients Department and Occupational Health (OH) to enable them to offer intermediate stop smoking advice and HIT are working with the OH manager to submit a proposal for the trust to go forward with the Better Health at Work Award. Why Weight will also be exploring joint work with Orthopaedics and commissioners in regard to developing a pathway for patients to receive help to lose weight before knee/hip surgery.
Infection Prevention and Control Nursing
Integration of the IPC team has provided an excellent opportunity for sharing knowledge and expertise to ensure a more standardised and co-ordinated approach to implementation of IPC strategies and initiatives and undoubtedly this will benefit patients.

Therapy Services
The integration of community services provided the opportunity to review structures within Newcastle Hospitals and create a Therapy Services Department.

- Physiotherapy
- Occupational Therapy
- Dietetics
- Podiatry
- Speech and Language Therapy
- Home loan equipment service
- Psychology

This has enabled a more effective approach to therapy services, with greater alignment and recognition of the contribution of the services across the whole care pathway.

The Diabetes Centre was relocated into improved clinical accommodation on the CAV site. This service is now also working more seamlessly across the patient pathway and into primary care.

The Health Visiting and School Health services integrated into the Children’s Services Directorate. This has resulted in improved communications between the two services and the acute sector, in particular with the Emergency Department and Direct Access services where early identification of 0-19 attendances to the Health Visiting and School Nursing Services has improved, resulting in earlier identification of Children at risk in the community.

The Integrated Sexual Health Services have been working with Gynaecology service within Women’s Services Directorate to meet with the Newcastle CCG’s to build on the existing Community Gynaecology Service and extend to a Continence Service which is linked to the Trust continence service pathway.

It has been possible to build and strengthen care pathways for Sexually Transmitted Infections through more integrated approaches to Women’s Health, including colposcopy and obstetrics.

Chlamydia screening has extended to be undertaken by Community Midwives and is also offered at ante natal clinic appointments.

Sexual Health staff have provided teaching in Long Acting Reversible Contraceptives to Termination Of Pregnancy service staff and this has supported the principle of preventing unplanned pregnancy, particularly in teenagers.

The Community Audio Screening Service is now fully integrated with Audiology, resulting in the following benefits:

- Audio Screening staff are now trained by Audiology staff. Prior to integration with Newcastle Hospitals some staff from the Community Service were untrained.
- Audio Screening staff now have a named Audiologist as a mentor/clinical supervisor to whom they can refer any clinical concerns.
- The Audiology Department has set up refresher training and assessment for Audio screening and from this to include the North Tyneside catchment.
- Any requests for children under 5 years requiring audio screening are now are being reviewed by a trained Audiologist.

The integration of Community Services has brought about improvements across a range of patient pathways. These improvements have enabled a more cost effective, quality service, whilst stripping out waste, duplication, and the inefficiencies generated by organisational boundaries.

The commitment of all staff to improve how services were delivered to ensure a more beneficial patient experience is to be commended.