Newcastle Hospitals welcome the decision made by the Department of Health’s ‘Safe and Sustainable’ Review to concentrate children’s cardiac surgery in fewer but larger centres of expertise ensuring better outcomes for young heart patients.

The Freeman Hospital’s Children’s Heart Unit was delighted to learn on 4th July 2012 that it had been selected as one of those specialist centres and will continue to work closely with all other centres across the country. In particular we will be building close relationships with our clinical colleagues across the Leeds Network covering the whole of the Yorkshire and Humberside region. This will ensure we can deliver a seamless transition of care for children and their families who come to Newcastle when the changes take place in 2014.

Sir Leonard Fenwick, Chief Executive spoke of “The underlying strengths of our services have been demonstrated by high quality outcomes and innovation, and all of our healthcare professionals are to be commended. The support of the many parents, carers, and children during the review process has been greatly appreciated.”

Work is now underway to expand our services and in particular the Paediatric Intensive Care Unit and the children’s ward Ward 23. We are also developing brand new accommodation on the Freeman Hospital site for parents and other family members who live out of the area so that they can stay close to their child while they are in hospital. This is being generously funded by The Sick Children’s Trust and will help to make a huge difference to families in their greatest time of need.
Future of Newcastle’s Children’s Heart Unit secured
Our relationships with primary care and social service colleagues have gone from strength to strength over the last 12 months. We have seen many developments come to fruition during this time, many of which ensure that patients experience truly seamless care – from their GP, to hospital and then back home again.

“Working ‘Better Together...’ is not a project. It’s a way of working: one that looks for opportunities for partnership, and to share skills and resources. It puts the needs of the patient above those of the organisations for whom we work. As the many projects underway gather momentum, we are really starting to see patients benefit and thus are proud to be part of the ‘Better Together...’ movement.”

Dr Mike Scott and Dr Steve Turley, Newcastle GPs

Principal aims of working ‘Better Together...’

- Admission Avoidance - reducing unnecessary hospital admissions and readmissions
- Direct Access - improving access to our services and developing new direct access routes
- Telemedicine – creating compatibility between the different IT systems utilised by health and social care and developing new systems to improve access to information and test results
- Service Redesign / Reconfiguration – integrating health and social services to provide more holistic care and streamlining our own hospital and community based services
- Communication – widening our spectrum of communication methods
- Education and Training – sharing clinical knowledge

Developing relationships based on trust

Seeking new ways of working together

Developing the infrastructure to make jointly agreed changes possible
<table>
<thead>
<tr>
<th>Principal aim</th>
<th>How do we do this?</th>
<th>Examples of good practice</th>
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<tbody>
<tr>
<td>Admission Avoidance</td>
<td>Provision of care and support in community settings such as the patient’s own home or local healthcentre.</td>
<td>Establishment of clinics and diagnostic clinics in a number of GP surgeries and healthcentres across the North East. Specialist dieticians now work with community staff to ensure that provision of all supplementary dietary provision is rationalised. Our vascular experts also offer specialist support to staff looking after patients with severe ulcers.</td>
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<td></td>
<td>Greater specialist input to support staff looking after patients with chronic conditions in the community.</td>
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<td></td>
<td>Offering GPs direct access to our hospital specialists for advice and support to help make joint decisions on admissions</td>
<td>GPs can directly call the Assessment Suite and speak to a Consultant for emergency admission opinion. The service receives 4 to 5 calls every day.</td>
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<tr>
<td>Direct Access</td>
<td>Establishment of direct access to an extensive range of diagnostic services including imaging, endoscopy and cardiology related tests, eg. ECHO, ECG.</td>
<td>We now offer direct access to x-ray and ultrasound in the healthcentres based at Battlehill, Ponteland and an open access service at the Westgate Diagnostic Centre in the West of Newcastle. Our regular newsletter Urgent and Open Access Clinics Bulletin for GPs keep colleagues in primary care up to date on developments.</td>
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<tr>
<td>Telemedicine</td>
<td>Working with our partners to optimise electronic communication channels across health and social care.</td>
<td>Integration of IT systems to ensure they communicate effectively with external systems such as SystemOne and EMIS. Development of a specialist reporting service for ECGs recorded in GP practices in collaboration with Newcastle East CCG. Introduction of Firstnet A&amp;E computer system in Eye Casualty which provides GPs with a letter detailing the patient attendance and resultant treatment.</td>
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<td></td>
<td>Developing new systems via ICE (Integrated Clinical Environment) to help streamline workflows between referrers and the Trust.</td>
<td>Since the successful introduction of ICE during 2012, we have worked closely with GPs to identify the need for new batch testing profiles for Cognitive Impairment Screening and a number of other potential profiles are being considered ie. primary care DVT pathway and full liver function screening. Generation of electronic discharge letters on the day of discharge transmitted via ICE.</td>
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<tr>
<td>Service Redesign</td>
<td>Reviewing ways of working to identify opportunities for further health and social care integration and the streamlining of service delivery. Good practice is then shared across all organisations.</td>
<td>Partnership work between the Newcastle Hospitals and Newcastle City Council’s Adult Services seen the development of a new system of integrated single entry point, admission avoidance and reablement/short term support. Key community health services are now progressing the integration of services with Social Care Direct and some other Adult Services teams. A proactive working group involving staff at Newcastle Hospitals and GP colleagues has brought about full integration of acute and community continence services ensuring the delivery of effective and efficient continence care which has seen great benefits for patients. Exploring possibilities of developing the skills of our District Nurse teams to enable them to deliver traditionally hospital care closer to home. Our senior nursing staff liaise with the ‘Better together…’ forum to discuss potential development of pathways of care, in conjunction with GPs and hospital consultants.</td>
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</table>
Our ‘Better Together’ strategy is about developing truly integrated models of joined up care and providing traditionally hospital based services in community settings, closer to home.

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<tr>
<td>Communication</td>
<td>Opening direct lines of communication with colleagues from Clinical Commissioning Groups and various GP Surgeries to cultivate ‘two way’ discussions and consultations.</td>
<td>Monthly meetings continue to take place between local CCG leads, our GP Advisors and Trust clinicians to discuss clinical issues and pathways for patients.</td>
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<td></td>
<td>Providing regular updates for GPs on a wide range of clinical issues.</td>
<td>GP Matters, our regular newsletter for GPs continues to offer invaluable insight into the many strands of developmental work ongoing across the Trust.</td>
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<tr>
<td></td>
<td>Providing regular updates for GPs on the developments underway in Newcastle Hospitals Community Health.</td>
<td>A regular newsletter for GPs and other audiences to keep them up to date on the transformation work underway.</td>
</tr>
<tr>
<td>Education &amp; Training</td>
<td>Holding a range of Open Evenings and GP Events to provide clinical updates and discuss current issues.</td>
<td>Since the merger with Newcastle’s community services, one of our Diabetologists has relaunched her well established ‘GP Club’ in conjunction with colleagues from Cardiology and Falls offering monthly interactive discussion forums for GPs. GP Child Health update events continue to take place at the Great North Children’s Hospital for GPs across the region.</td>
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**Care Closer to Home**

Promoted by our Council of Governors, our ‘Better Together’ strategy is about developing truly integrated models of joined up care and providing traditionally hospital based services in community settings, closer to home. Over recent months we have seen:

- Development of the Benfield Park Healthcare and Diagnostic Centre which opened its doors in March 2012. As well as housing a GP practice - Benfield Park Medical Group – the healthcentre will offer a wide range of outreach Consultant and Specialist Nurse led clinics.
- Establishment of Newcastle Hospitals outpatient clinics at the Village Surgery GP Practice in Cramlington.
- Successful acquisition of the contract to provide Community Dermatology Service in four locations in South Tyneside.
- Development of a new ENT Clinic in Chester-le-Street.
- Progression of the Brighton Grove Centre development on the Campus for Ageing and Vitality at the former Newcastle General Hospital site.

We will be offering more services in new, more convenient locations over the coming months.

Our approach allows all those involved to collectively cultivate new and innovative ideas through synergistic working and understand how we can deliver more for less to the mutual benefit of everyone.

**The Future**

By working closely with our local Clinical Commissioning Groups and GPs, we can all share clinical knowledge, expertise and experience to better understand any areas for improvement, identify opportunities for introducing new and innovative ideas, and agree shared responsibilities in areas such as new patient care pathways and guidelines, and more cost-effective drug prescribing.

Some specific areas for development over the coming months include:

- **Admission Avoidance** - Readmission audit - working collaboratively with Newcastle East and West CCGs - to identify common themes to inform future service development.
- **Pilot** led by the Single Point of Access team reviewing Emergency Department attenders over the age of 80 years to identify those who may benefit from greater support at home.
- **Direct Access** - Expansion of portfolio of direct access diagnostics building on existing platforms and streamlining pathways.

- **Telemedicine** - Further development of clinical communication via ICE focussing on x-ray requests and results, and notification of patient admissions to GPs.

- **Service Redesign / Reconfiguration** - As part of the Integrated Health and Social Care Services project, recent development sessions have begun looking at streamlining complex care coordination approaches while discussions between primary and secondary care medical colleagues are ongoing so that we can provide the appropriate medical input to people who we are supporting to remain at home.

- **Communication** - Working with GP TeamNet - an IT system which allows GP practices who have subscribed to it to share information, practice to practice - to develop a section specific to Newcastle Hospitals’ referral criteria.

- **Education and Training** - New partnership with Hadrian Primary Care Alliance – a federation of primary care medical practices based in and around Tynedale – to develop an education, training and research programme.
The Newcastle ‘Compact’

Newcastle Hospitals and Newcastle City Council have underpinned their joint commitment to improving care across the city by agreeing a joint ‘Compact’, describing how we will work together, alongside a vision of what we aim to achieve.

The “Compact” states that we will “work together for the benefit of adults and older people in the city who require, or may require, health and social care services and support” and offers a “framework for partnership working to encourage integrated decision making, innovative, effective and user focussed service provision, achieve mutual outcomes and make effective use of resources.”

Cathy Bull, Director of Adult Social Care says: “There is a noticeable momentum for change in Newcastle to improve integrated working across health and social care. The Compact represents the Council and Newcastle Hospitals’ joint commitment to change and service redesign. We look forward to being part of new ways of working and are very pleased with the progress being made.”

This means joint health and adult social care services that:
- Are easy to access
- Provide timely and integrated care to help people to remain at home and avoid institutional settings
- Promote independence
- Support them to manage and direct their ongoing health and social care needs.

We will continue to work together at all levels to help develop our joint services and find ways of supporting front line staff to deliver better and more integrated care.
New Outreach Clinic Bulletin for GPs

Bringing Services Closer to Patients

Newcastle Hospitals at the Village Surgery in Cramlington

The Newcastle Hospitals provide a wide range of services for residents in Northumberland and beyond. As part of our continuing drive to improve access and ensure care closer to home, our ongoing collaboration with the Village Surgery in Cramlington offers new patient clinics in Gynaecology and Plastic Surgery with expansion of our service offer over the coming months to include clinics in Respiratory Medicine, Ophthalmology, Dermatology, ENT and Rheumatology.

Gynaecology Clinics

Provided by our Head of Gynaecology - Dr Karen Brown - referrals are welcome for patients presenting with all gynaecological problems including menstrual irregularities, menopausal conditions, pelvic and abdominal pain, recurrent miscarriages and sterilization. Dr Brown would be particularly happy to see women requiring urogynaecological assessment and intervention.

Patients can be referred via the Choose & Book menu - Gynaecology - The Village Surgery Cramlington where you will find a full list of conditions treated and procedures performed. For clinical enquiries call Dr Brown on ☏ 0191 282 5872

For further details please contact the Appointment Department at the RVI on ☏ 0191 282 5900

Plastic Surgery Clinics

These new clinics are provided by Mr Mike Kernohan, Consultant Plastic Surgeon every Wednesday morning for all general plastic surgery conditions excluding children, burns and hand referrals. Mr Kernohan’s special interests are in Head and Neck Surgery, Breast Reconstruction and Skin Cancer.

Please note: children, and burns and hand referrals should be directed to the Plastic Surgery Department at the Royal Victoria Infirmary (RVI).

Patients can be referred via Choose & Book menu - Surgery Plastic - The Village Surgery Cramlington where you will find a full list of conditions treated.

For further details please contact the Plastic Surgery Appointment Centre at the RVI on ☏ 0191 282 6011
Benfield Park Healthcare and Diagnostic Centre

Rt. Hon Nick Brown MP officially opened Newcastle’s newest, state of the art Health Centre

Mr Brown was introduced to the new Health Centre by a welcoming committee which included Mr Kingsley Smith, Chairman and Sir Leonard Fenwick, Chief Executive, as well as the GPs and Practice staff who moved into their new home at the beginning of March. Mr Smith opened the proceedings by welcoming Mr Brown and said how the Newcastle Hospitals had been delighted to work with the GP Practice, Newcastle Commissioners and many other stakeholders who all made this new development possible. Mr Smith spoke of “a fantastic example of partners working together to provide truly integrated services within a superb new facility. I see this way of working as the future for the provision of healthcare for our local community.”

Mr Brown thanked Mr Smith and said “Whilst the way we deliver health care may change over time, providing frontline services does not and is always greatly valued. Sir Leonard is a major advocate for healthcare in the North East - there is no more formidable champion. This is reflected in the high quality services available for the people in Newcastle today, from community healthcare to internationally respected services at the Freeman and RVI.”

Mr Brown closed by saying that is was an honour to be invited to unveil the plaque and officially open the new Health Centre. “This is fantastic building and demonstrates what a difference to service delivery a premises can make.”

Dr Paul Netts, Partner and GP Lead for Benfield Park Medical Group expressed thanks on behalf of the practice explaining “We are thrilled to be in this magnificent building and have a lot of people to thank, not least Sir Leonard for giving us the opportunity to be involved in this exciting development. These fantastic new facilities will really help us to close the gap between medical and social care, helping us to provide a truly holistic service for our patients. This Health Centre will not only benefit the people who live in the Walkergate area but those living further afield as the Centre will offer outreach services provided by the Newcastle Hospitals. People are already delighted to hear we have access to x-ray and ultrasound facilities.”

In closing, Sir Leonard gave formal thanks to Mr Brown and presented a gift as a token of appreciation – a print of the River Tyne. Sir Leonard spoke of “how the Newcastle Hospitals will continue to look after local people working with first class GPs and our many other supporters. This development has enabled us to work more closely with our colleagues at Newcastle City Council than ever before and I would wish to commend the support we have received from Mr Brown over the years.”
Hello, my name is Stuart Snape. I live in North Devon and was diagnosed with a Brain Tumour in December 2000. I had an operation to remove it and then several months later I underwent a seven week course of Radiotherapy. Following a routine scan at Derriford Hospital in 2002 it appeared that the Tumour required further treatment, so a trip to Sheffield Royal Hallamshire Hospital for Stereotactic Radiotherapy was needed. This appeared to succeed and reduce the tumour however in time I realised, as predicted I had lost the hearing in my left ear.

Following an ENT appointment in February 2009 it was recommended by Dr McAlister, Audiologist at North Devon District Hospital that I was a suitable candidate for a BAHA. There was no funding available in North Devon so I was referred to Dr Weiner at RDE Exeter.

In May 2009 I had various hearing tests and took a BAHA headband to try for around 7 weeks with great success. In August 2009 Mr Weiner suggested the BAHA operation and I was told that he would apply for funding and he was very confident that an operation could be performed early in the New Year.

In December 2009 I received a letter stating the decision was pending, awaiting the outcome of a review. In February 2010 I received a further letter stating funding had not been approved due to only mild hearing loss in the left ear. In fact, tests had proved that I had total hearing loss on my left side. In March 2010 I received a second refusal letter from my consultant suggesting I went through my GP if I wished to appeal further. However in May 2010 I received a further letter from the local PCT advising me to go through my consultant. I felt I had been pushed from pillar to post and was not making any headway. During the above dates I had been in contact with my Consultants Secretary Cathy who advised me that Mr Weiner felt he had done as much as he could.

In Jan 2011 I went back to my GP, to ask to be referred to another consultant, this time in Taunton, Somersets at the Musgrove Park. I was aware they were still doing the Operation. I was seen by Dr Andrew Drysdale and was told again that I was a suitable candidate and he would put me forward for an operation, but funding again was an issue. I went to my GP after Taunton contacted me and asked for evidence that funding would be available from Devon PCT.

During this whole process I had been in constant contact with Kate King, Advocacy Manager, Cochlear Europe Ltd. Kate had put me in touch with an advocate in Exeter called Anne Dicker. Anne was able to advise me on all the questions and concerns I had about the Operation, she was also very kind and on several occasions accompanied me to out patient appointments. Anne also put me in touch with another Advocacy called David Marsh from Manchester. We talked in detail of his experiences, worries and concerns which mirrored mine. Listening to both David and Anne and having trialed the Headband, I was more determined to get the opportunity to have an operation. This I hoped would build my confidence and gain family life back after so long.

I had spent several years researching the BAHA and was given a glimmer of hope in 2011 when Kate from Cochlear replied following an email to her asking for help. There appeared to be two possible options. Email addresses for a funding charity and a Mr Ian Johnson, Consultant ENT Surgeon in Newcastle. I emailed Dr Johnson and within 20 mins had a reply telling me to get a referral from my GP. This sounded too good to be true. I researched Mr Johnson only to find that he was the President of the Bone Anchored Hearing Aid Foundation. Several Emails followed and just prior to Christmas, came the news that I would be looking at an operation date in Feb 2012.

Due to the distance in travelling from my home in North Devon to Newcastle, some 900 mile round trip, it became obvious that we would have problems arranging ENT and audiology appointments. However I had my copies of my previous Audiology tests so emailed them directly to Mr Johnson.

We were then able to have an appointment on the Thursday and the operation on the Friday. An appointment would then follow in about five weeks for the fitting. On February the 17th we flew to Newcastle, and met Dr Johnson for the first time. To enable me to participate fully in the conversation he fitted me with a test band which really made all the difference and he talked me through the procedure.

After the operation the following morning, I had a very simple dressing on, which had to stay on and dry for 7 days, this was much smaller than I had imagined. We traveled home later that evening. Seven days later I went to my own GP Surgery back in Devon to see the district nurse, who had already been in touch with Newcastle BAHA nurses to find out what to do. The wound had healed very well and Mr Johnson had asked me to email a couple of photos of the wound to check the healing process.

I contacted both David and Ann to talk over what I had been through. Several weeks later I had an appointment for the fitting in March. So again we flew to Newcastle and went to an afternoon appointment with Audiology for a fitting. Then came the switch on “WOW”. I had been quite anxious before thinking had I built up my expectations too high and that this little device would not work as well as I had hoped, after all it was 3 years ago that I first tried it out. But suddenly I could hear clearly again especially when some one spoke on my left side.

I had been fitted with the BP110 Power BAHA the most powerful BAHA available. The first stop was the coffee shop, this was a good test, as trying to have a conversation in noisy surroundings was impossible before. It worked very well I was able to hold a three way conversation and hear everything for the first time in a long long time.

We flew home that evening and listening to sounds around the airport was really interesting. The next day I phoned both Anne and David to tell them the great news. They both gave me great advice as to what to expect over the coming weeks and months. It was and still is to be able to have contacts like David and Anne from the Volunteer Advocacy team and from Kate at Cochlear, they all have played a big part in my journey for which I am truly grateful.

During the few weeks that have followed I have really noticed such a huge difference in my ability to feel so completely included in all aspects of every day living. My wife, Val and I can not begin to express how truly grateful we are for all the help and support we have been given and especially to Dr Johnson for giving me the opportunity to have the operation. My wife sums everything up by simply saying that she has got her husband back.

Stuart Snape, North Devon
The purpose of the CRESTA is to:

- Provide high quality, streamlined care with fewer out-patient attendances (‘one-stop’ multidisciplinary assessment)
- Improve communication with General Practitioners and other health care professionals
- Identify potential research participants for studies aligned to Biomedical Research Centre and Biomedical Research Unit objectives
- Recruit the relevant patient groups in which new treatments developed through the Clinical Ageing Research Unit (CARU) may be evaluated.

The clinical services provided will be ‘leading edge’ and create a crucible for exciting interaction between clinicians and basic scientists, generating research ideas and educational opportunities. The clinics will mainly (but not exclusively) focus upon the elderly and those patients with complex disorders, who currently represent a challenge to manage efficiently and effectively in an out-patient setting. In doing so, they will also create additional capacity within existing Trust out-patient facilities.

The CRESTA clinics are held on the ground floor of the ‘Newcastle Biomedical Research Building’. This building was funded by several different organisations, including the National Institute for Health Research, Newcastle University, Newcastle upon Tyne Hospitals NHS Foundation Trust and the European Research Development Fund. There is parking available outside the Biomedical Research Building and this is very close to the main entrance.

Upon arrival patients are checked in at reception and shown to a waiting area. Attendees are booked to see a number of people during the morning or afternoon. A nurse guides the patient to see these people in turn. In-between seeing the doctors, nurses, physiotherapists (or whoever is scheduled) the patient can rest in the waiting area. At the end of the different assessments there is a short delay while the people who have seen the patients discuss their findings. They then explain these findings to the patient (and a member of their family if they wish) and suggest a treatment plan. This coordinated treatment plan is sent to the general practitioner.

There is no expectation that the patient’s attendance at a CRESTA clinic automatically implies their involvement in research (even though ‘research’ is in the CRESTA name). If the clinic staff are undertaking research in a particular area that could be relevant to the patient, however, they will approach the person at the time of their visit.

We firmly believe that patient involvement in research offers the chance for better health care, both for the individual and the population in general. The Trust is therefore committed to offering as many people as possible the opportunity to participate in clinical studies or trials.

The first CRESTA clinics began in April 2012 and are steadily increasing in number as the service model develops. Informal feedback received thus far from attendees has been excellent. But because the CRESTA clinics are still new and evolving, we are very interested to hear the views of attendees, both positive and negative. If there are things that can be suggested which may make future visits better, then we would like to know.

David Burn
Professor of Movement Disorder Neurology and Honorary Consultant Neurologist
Developing our staff
There is a strong ethos of partnership working in the Trust, and the last year has delivered a number of benefits for the organisation including:

- Transfer of Community Services. This resulted in over 1400 staff becoming part of the Newcastle upon Tyne Hospitals NHS Foundation Trust. Those staff have made a positive contribution to our understanding and delivery of patient care in the community and the wider staff community has been able to share and learn best practice to benefit the delivery of clinical care.
- A single partnership working agreement with recognised trade unions and staff organisations. Through the appropriate communication and consultation processes, employment policies and procedures continue to be harmonised as part of the normal policy review cycle.
- Excellent cooperation from staff representatives in agreeing a protocol to ensure that with the commitment and support of staff, patient care remained the priority and treatments were delivered safely during the public sector national ‘Day of Action’ despite some disruption.
- A Learning Partnership Agreement to acknowledge the importance of workplace learning, training and education for all staff to effectively contribute to the quality of care and overall patient experience.

The commitment to engaging with staff at all levels to ensure they understand their contribution to achieving the Trust’s business objectives continues to be a key activity. The intention is to encourage broader participation, communication and engagement on key matters and build a culture of mutual trust and responsibility which will generate better outcomes for patients.
The Trust becoming one of the first in the UK to achieve a harmonized on call and continuous processing working agreements

The Trust has also refreshed its Human Resources and Organisational Development strategy focused primarily on managing change and developing staff and their capability. An important part of this has been the introduction of a professional and leadership behaviours framework to articulate the Trust’s expectations of staff in how they are required to deliver the services, and enhance the patient experience. These requirements will be integrated into the leadership development programmes and appraisal processes for all staff to create a common organisational language.

The medical consultant staff recruitment process has been revised with the objective of continuing to attract high calibre staff who are not only proficient in their clinical capabilities but also enhance the existing teams and possess the qualities necessary to compliment the team. In addition to interview panels, the selection process now includes psychometric profiling, the opportunity to deliver presentations and participation in multi-disciplinary team meetings.

A major workforce initiative was the implementation of ‘Every Penny Counts’ a campaign to ensure that in view of the financial challenges the NHS faced, every staff member understood their responsibility to spend tax payers money wisely. It raised awareness amongst staff on how they can make a difference in contributing to reducing costs and delivering savings without compromising patient care. This campaign has been well received by staff, with enthusiastic ideas for saving money continuing to be generated.

Looking ahead, the Trust will continue to promote volunteering opportunities which support staff in providing a caring, compassionate service; staff engagement will remain a priority to continue to enhance the quality of patient care and ensure that ‘healthcare at its very best – with a personal touch’ is a positive experience for all Newcastle Hospital service users – patients, visitors and carers.

Dee Fawcett
Director of Human Resources
The Equality Act 2010 required the Trust to publish information by 31st January 2012 to show compliance with the need to ‘eliminate harassment, advance equal opportunities and foster good relations between protected characteristics’. By 6th April 2012 the Trust was required to set and publish equality objectives in order to comply with the public sector duties of the Act.

The Equality Delivery System (EDS) is an NHS toolkit designed to help NHS organisations improve equality performance, embed equality into mainstream NHS business and support the Trust in meeting the requirements of the 2010 Equality Act and the general and public sector equality duties set out within it.

Equality Diversity and Human Rights is a corporate responsibility. Patient Services and Human Resources lead this agenda, with the Nursing & Patient Services Director as the Executive lead, supported in this work by the Equality and Diversity Lead, Involvement and Equality Officer, Human Resources manager (Projects) and Head of Nursing (Freeman Hospital).

Equality Diversity and Human Rights (EDHR) supports the Trust in complying with equality legislation and to make the organisation a better and fairer place for patients and staff.

Some examples of what we have done over the last year, to progress and embed EDHR in the Trust, are described here:

- Brought together the equality work of the hospital and community through a strengthened and more focused EDHR group. EDHR Sub groups are tackling practical issues such as ‘threading’ equality messages into all of our training.
- Worked in partnership with third sector organisations and staff to develop the Equality Delivery System (EDS). This involved collating equality information about patients and staff, which can now be used as a resource to inform current practice and developments within the Trust. The EDS was recognised as an example of good practice by the National Equality Delivery System Programme Manager.
- Developed objectives to direct the equality work of the Trust over the next four years. These objectives were agreed by third sector organisations and the Trust Board.
- Reviewed and piloted the Equality Impact Assessment process, to make this more robust and effective. We have considered how this would apply to a large development and are undertaking an equality analysis on the potential Brighton Grove development.
- Developed links between hospital, community health and third sector partners, so that we can be better informed and continue to improve services to meet the needs of people with ‘protected characteristics’. An example of this is the work between key hospital services such as Surgery, Emergency Department and the Burns Unit with community health staff, local authority staff and third sector staff who work with homeless people, and homeless people themselves.
- Identified gaps in our understanding of the issues facing people with some protected characteristics. As a result we have, for example, set up an involvement and action group with transgender people and worked in partnership with Public Health on addressing health inequalities that men experience.

- Undertake Access Audits across all our main sites in partnership with service user representatives to identify where provision can be enhanced and to identify and share best practice.
- Provided work experience placements for people with Learning Disabilities.
- In partnership with the other public organisations we have contributed to the wider equality agenda through the Health and Well Being Boards and their subgroups.
- Working together with NHS North East we have focused on sharing progress on the EDS and prioritising an action plan for 2012/13.
- Achieved You’re Welcome accreditation in a number of services. This processes focuses on making services welcoming for young people.
- Involvement in the Gay Pride Event for lesbian, gay, bisexual and transgender people.
- Health outreach to Roma women.
- Dissemination of materials to support people with dementia.
- Mental Health First Aid training to support generic staff to recognise symptoms of mental illness.
- Starting to train peer support workers around antenatal care for minority ethnic women.

There are also many practical examples of what our services have done to meet the needs of people with protected characteristics. These include production of a Ramadan and Diabetes calendar that has been recognised by NHS Employers as an example of good partnership working.
Leadership Development – This year saw the implementation of the NuTH Leadership Development Framework. Informed by the NHS Leadership framework, it outlines the behaviours expected of our clinical and non-clinical leaders across our leadership pathway. The framework is a key part of our strategy to increase our workforce leadership capability and capacity across the organisation in order to be able to deliver our service objectives.

Initiatives have included:
- A new Sister and Charge Nurse Development Programme
- Manager of Managers programme/ Clinical Academic Leadership module
- New Team leader Award (accredited with ILM)

The Education and Training Service is planning on building upon the success of the existing ILM qualification, developing further awards in Leadership and Management up to graduate and post graduate level thus meeting the needs of the entire workforce. The ILM qualification is playing, and will continue to play, a key role in the strategic development of leadership within the organisation. These developments will include new to Consultant role leadership and management development, accreditation of our Manager of Managers programme to ILM 7 Award in Strategic Leadership and an alumni programme for senior managers and clinicians.

Some of the programme feedback from staff who have attended our programmes includes:
- Greater understanding of self and own leadership style
- Better understanding of others perspectives and preferences
- Increased confidence
- Improved communication
- Improved ‘active’ listening skills
- Importance of motivating others
- Greater understanding of what makes an ‘effective’ team
- Understanding strategy and the ‘bigger picture’
- ‘Light bulb’ moments in Coaching
- Understanding NuTH Leadership behaviours
- Seeing leadership as a journey

The Education and Training service can advise of another productive year which included the integration of community learning and development colleagues to the team, enabling us to support the needs of our wider workforce. Key highlights have included new leadership development and clinical programmes to meet organisational objectives and a number of workforce initiatives which we are one of the few organisations nationally to be implementing.
NuTH Leadership Pathway
From specialist and clinical roles to corporate management

First Line Manager
- Managing Others
- Provide direct line management of individual or teams of individuals
- Short term planning responsibility

Manager of Managers
- Service/Clinical Specialist
- Direct reports manage teams/individuals. Service or clinical specialist, perhaps with responsibility for a service
- Mid term planning responsibility

Business/Clinical Leader
- Direct reports are functional specialists or manage teams of individuals
- Long term planning responsibility

Trust core leadership behaviours competency framework

Self Awareness
- Creating & implementing the vision
- Influencing to achieve results
- Adaptable to meet business needs (change facilitator)
- Following through to achieve results
Our aim is to be *the* health service for Newcastle consistent with being a leading national healthcare provider.

The staff that completed the John Lewis Talent Management initiative were instrumental in a new initiative ensuring that all staff are aware of the key aims and values of the Trust, designing a poster which is now used across the Trust:

> These values are embedded into all our leadership and management development and core staff development programmes including patient experience/customer service education.

### Workforce Development Initiatives

This year saw the Advanced Critical Care Practitioners qualify. This exciting new development supported six non-medical professionally qualified members of staff to be trained to undertake a new role in Critical Care, working at the level of a Registrar. We are one of three centres who have introduced this role in the UK, and took a leading role nationally, working with Northumbria University, in establishing the role and the training.

Additional course provision to support clinical skills and high quality, safe patient care has included skills in the assessment of the deteriorating patient and the Early Warning Scoring system (MEWS/PEWS) with 1465 staff being trained. The North East Simulation Centre continues to thrive with new courses being added, and more staff being trained by us in being able to facilitate this specialised clinical training, using Human Factors in the assessment and feedback process. The centre also hosted an international simulation conference through video conference links with Canada.

Nationally the next phase of Modernising Scientific Careers is being implemented which has reviewed the way scientists are trained, and we are part of a local partnership with Newcastle University, Northumbria University and the University of Sunderland in delivering a new master’s programme for Health Care Scientists. This includes being one of only two UK providers for the medical physics pathway of this programme.

### Clinical Academics

A new national pathway has been agreed for Clinical Academics, which Dr Carrick-Sen has contributed to its design. Within the Trust we partnered with Northumbria University to deliver our first clinical academic scholarships and 19 staff across a range of disciplines are completing the programme at masters and doctorate levels. They have undertaken leadership and advanced practice development and will be researching areas linked to key clinical priorities for the Trust including dementia care, falls and women’s health. The 2012/13 pathway now includes the opportunity to study at Newcastle University.

### 2010-11 NVQ Achievements

The Staff Development team have had another successful year of NVQ delivery, our retention and achievement rate currently stands at 98%. This is a significant increase on the previous year’s rate of 84%. The Pathology team had another very successful year, again achieving a 100% timely success rate. Catering also is now operating very successfully, with the last two groups of staff all achieving the qualification. Candidates, assessors and verifiers in both these groups deserve our congratulations. The evaluations included:

- 98% of candidates said their technical skills had improved as a result of doing the NVQ.
- 100% said their knowledge of policies and procedures had improved.
- 87% said their ability to improve the patient experience had increased.
- 79% said the NVQ had taken less time to complete than they had thought.
- 98% were happy with the progress they had made.

Our Adult Learners week events in May 2011 celebrated the success of a number of staff who had undertaken development in leadership or in role specific skills including catering and hotel services, with 20 staff receiving the British Institute of Cleaning Science (BICS) qualification. We continue to work in partnership with Unison for a number of education initiatives as part of ‘Bridges to Learning’ supporting staff to access development.

In January 2012, 19 staff from across the organisation commenced the Foundation Degree in NHS Service Improvement Learning. The Foundation Degree has been designed for all staff groups employed between Bands 1- 4. This is being delivered as a collaborative initiative between the School of Health Community and Education Studies (HCES) at Northumbria University and the Trust. It focuses on role development, service improvement, patient safety, service user involvement public health and the provision of high quality care to contribute to support the Trust in delivering our aim 'To be the health service for Newcastle consistent with being a leading national healthcare provider'.

Other developments include increasing our training provision for dementia care education and patient experience/compassionate care and these will be a major part of our activity for 2012/13.

We eagerly await the opening of our new education facilities at the RVI in the autumn, having been using a range of interim facilities throughout the Transforming Newcastle Hospitals project and looking forward to the opportunity to provide a wide range of internal and external training and development including hosting of conferences.

The national arrangements for workforce commissioning and education provision are changing with the introduction of an employer led approach. This includes both opportunities and challenges for us as it includes significant changes to the funding of professional and vocational education and training.

We are continuing to invest in and develop our workforce skills and knowledge to be able to remain the provider of choice and a leading teaching hospital in the UK.

Karen Giles  
Head of Education and Development
2011-12 has been a further busy year for the trust medical education team both in relation to external developments and in ensuring we continue to deliver high quality training within the trust. This year we did not have the added issue of the BBC cameras following our new FP trainees as they commenced work. For the 2012 intake the Dept of Health mandated a five day period of paid shadowing prior to starting the job proper in order to maximise safety and reduce risk.

In the Northern deanery we have always had a well attended shadowing course with enthusiastic co-operation from clinical teams and making the transition to this requirement was not difficult for the NUTH team. We have always augmented the induction period for new F1 doctors with simulated experiences to facilitate learning in a safe environment gaining experiences in team working and responding as qualified doctors to acutely unwell patients. Making the transition to a qualified doctor will always be a stressful experience for all new graduates but Mike Mckean who is the lead for the FP programme in the trust and Jon Hanson as the lead for simulation hope that with an extended induction programme we can minimise the stress and any ensuing errors to ensure the transition is made as effectively as possible. The trainees continue to provide very positive feedback and the input of the exiting F1 doctors in imparting their experiences and learning is invaluable and we are grateful to all who continue to support this element of trainee transition.

Recruitment to both foundation and specialty training posts in the Deanery and hence to our trust has continued to improve although we have continued to see senior gaps in some programmes which are difficult to fill. Increasingly trainees are using a consumer approach to education and are using all available sources of information about training quality to make decisions about application for specialty training posts — an understandable approach in a climate of run-through training where they are committing up to seven years in one locality. One of their key sources of information is the trainee survey undertaken each year by the GMC. In previous years the analysis and publication of this has been slow and not allowed education providers to respond to concerns before the next cohort of trainees have been recruited. This year the GMC produced results within six weeks of the survey closing making a much more important tool. In 2011 the trust had a varied set of responses with some clinical areas scoring well and identified as above outliers in comparison with other
education providers. As an organisation the workload in our trust will always be high but this should allow for a varied case mix and rich learning experience which can be appreciated by trainees. However some areas scored poorly in the survey and the trust team has worked closely with them to understand the problems and improve training and it has been heartening to see the improvement in feedback in several areas. Overall the feedback in 2011 was good but we can aspire to be better and it would be good to see each specialty being in the top 3 across the deanery in future years. In combination with the output of the Deanery review of quality of training we were successful in achieving a level 3 rating for clinical supervision of medical staff as part of the NHSLA assessment. Sustaining this level of positive feedback across a large organisation will always be challenging and I am grateful to those individuals in each directorate who act as the educational lead as they carry the responsibility for addressing any identified issues with colleagues at a departmental and directorate level to ensure we are delivering consistent high quality training across the whole organisation.

The relative roles of the deanship and trust in relation to measurement and management of quality remain a source of confusion for some. As we work towards recognition of trainers it is vital that the trust team is central to all aspects of PG education to ensure appropriate recognition and spread of workload for all involved. So much of our service to patients is reliant on the care delivered by trainees that it is essential that we continue to attract the highest calibre trainees to work with us in our local training programmes and in our trust. Recruitment to consultant posts is often influenced by the availability of locally trained individuals and getting this investment right is pivotal for our organisation. The correct balance between service and training remains difficult to achieve and further questions raised in the two national reports authored by John Collins on the FP programme and the Temple report reviewing the impact of the new working hours on training. This has resulted in Medical Education England (MEE) commissioning another review of postgraduate training to be undertaken in 2012/13. We can only expect further changes to the structure of PG medical education and must ensure that all opportunities to provide input from the service perspective when such reviews are undertaken. The apprenticeship model of PG medical education remains vital and the end goal of any review must be to ensure that training programmes deliver trainees ready to start work as consultants in the modern NHS.

The white paper on the NHS included several significant changes but we can aspire to be better and it would be good to see each specialty being in the top 3 across the deanery in future years. In terms of national numbers of trainees some specialties have been highlighted for reductions in while others will remain at current levels at least in the short term. The only growth area will be in primary care as more GPs are required to deliver care in the community. The GP school has requested that all rotations through secondary care are of 6 months each and that the GP school to ensure this change was introduced in August 2012. There also plans to extend the duration of GP training and we are likely to see more requests for GP training posts in specialties. Making this transition is challenging and the trust education team is interested to work with clinical teams to see if we can deliver more innovative opportunities for primary care trainees in the secondary care environment. Reductions in trainees will have an impact on our workforce numbers and we are actively considering how best to manage recruitment to posts that may not have Deanery training recognition to ensure that we can continue to deliver high quality care to patients. Some of this may involve considering how work currently done by junior doctors may be undertaken by other members of the team.

Preparing for Revalidation of all doctors has been a major task in 2012 and while the responsible officer for trainees will be the Postgraduate Dean he will need signed assurances from trusts about trainees involvement in critical incidents, complaints and compliments as well as coroner’s investigations in the same way as for consultant staff. Ifs Haq is currently leading a project to clarify how this can be used to enhance learning and to ensure that the workload for supervisors is manageable. The established undergraduate team have had another successful year supporting a group of Tyne based trainees through both the third and final year rotations with good outcomes. Finals remains the key element of ensuring appropriateness for practice and we again hosted our share of the clinical exams without problem. Without the patients who give their time and stories to the examination it would be of limited value and their feedback this year gave some insights to their continued commitment to professional examinations and desire to support training.

‘To give experience of patients with various medical conditions at different stages of their illness, treatment etc, and to prepare them for their careers in all areas of medicine. As a patient it is important to try and explain all aspects of the illness before, during and after it to prepare the new group of future doctors. I learned a great deal by attending and I shall assist in any future training sessions required.’

‘Because I felt that by making myself available I was contributing something to the future of these students and the NHS, and giving a little something back to the people who have given me such excellent treatment, particularly over the last 17 years.’
Staff receiving certificates of achievement for awards in hotel services including porters, catering and domestic staff. Other awards include NVQs in health care, business and administration and ILM award in Leadership and Management.
We have achieved two Learning Disability CQUIN indicators, one in relation to ‘flagging and coding’ and one in relation to use of Care Pathways. This means we are able to identify people with a Learning Disability on the patient management system (e-Record) so staff are alerted and the Learning Disability Liaison Nurse receives an e-mail telling her the patient has had contact with or been admitted to the Trust. The care pathways prompt staff to consider how care may need to be adjusted to meet individual patient needs during that episode of care. Audit has demonstrated good compliance of use of the care pathways and the needs assessment.

The Learning Disability Liaison Service has responded to 280 enquiries/referrals in the period between 1st October 2011 to 31st March 2012 and supported clinical staff with the development of Easy Read Information.

Regular feedback is collected from patients, with Learning Disability, and their families and carers on their experiences with the Trust to further improve services.

A Learning Disability Awareness E-learning Package was launched on 30th January 2012 for all Trust staff to access and by end of March 3360 staff had accessed the programme.

The Trust has also developed a Patient Hospital Passport. This is a patient held record that accompanies the patient and provides key information such as communication needs, how pain or distress may be exhibited, likes, dislikes, and behavioural patterns.

The Trust has contributed to Newcastle’s Learning Disability Self Assessment Framework and feedback noted four areas of good practice in relation to the Trust.

Patients and carers said:

“This was the first time we have been to the RVI for dental work and nice to see the staff are more aware of people with learning disabilities”.

The Trust continues to offer work experience to young people with Learning Disabilities and feedback is very positive from students and mentors.
The Organisation
About Foundation Trusts

The compliance philosophy of Monitor, the Independent Regulator of NHS Foundation Trusts

1. NHS foundation trusts are at the core of the move from a centrally managed NHS to a healthcare system which is responsive both to the needs of the patient and the wishes of the local community. NHS foundation trusts have been given significant freedoms. While they remain public institutions, NHS foundation trusts are not subject to direction by the Secretary of State or the performance management requirements of the Department of Health. They set their own strategies and make their own decisions within the framework of their contracts with their purchasers. They have an independent council of governors which appoints the chairman and other non-executive directors, and which also approves the appointment of the chief executive. They can borrow commercially, retain surpluses and invest to serve local needs.

2. These freedoms create a significant opportunity to continue to reshape and improve the delivery of healthcare in England. NHS foundation trusts can invest in new patient care facilities, enter partnerships with primary care trusts ('PCTs') to manage chronic disease better or develop long term care facilities. They can form partnerships with the private sector, alliances with other hospitals or specialise in selected services. They can also innovate and bring to England models of care that have worked in other countries. They can set local targets in consultation with their members or in contracts with commissioners. In all of these areas, NHS foundation trusts are free to determine how they can most effectively improve patient services through innovation, investment and engagement locally with key stakeholders.
3. These freedoms also carry important responsibilities. The board of directors of each NHS foundation trust ("the board") is accountable for its success or failure. They must ensure that NHS foundation trusts operate effectively, efficiently and economically. While NHS foundation trusts can retain surpluses, they can also fail.

4. Monitor’s Compliance Framework is designed to enable NHS foundation trusts to innovate, respond to local wishes and provide better healthcare. Monitor will maintain an environment conducive to innovation by focusing on providing a regulatory platform that ensures NHS foundation trusts maintain their viability: staying solvent, governing themselves effectively within their constitution, engaging with patients, service users and commissioners, providing all the services that they are required to deliver by law, and complying with the other conditions set out in their Authorisation.

5. Monitor’s view is that a successful NHS foundation trust will be legally constituted in accordance with the National Health Service Act 2006 ("the Act") and be compliant at all times with their Terms of Authorisation, including being financially sustainable. It will also decide on the appropriate balance between investment in current provision and innovation to enable continuing improvement in services for patients and service users.

6. A successful NHS foundation trust can be given considerable latitude to exercise its freedoms. Financially secure NHS foundation trusts will be given an increased ability to borrow. Monitor will not involve itself in determining healthcare strategy or operational policies in NHS foundation trusts.

7. Monitor takes a proportionate regulatory approach. For successful and well governed NHS foundation trusts, the regulatory regime will require very limited generation of additional information and only infrequent contact with Monitor. However, where NHS foundation trusts are experiencing major financial or service problems, oversight will be more intensive and Monitor will intervene rapidly to ensure services to patients are safeguarded. The legislation gives Monitor extensive powers to intervene in the event that an NHS foundation trust is failing to comply with its Authorisation.

8. Effective self-governance is therefore essential. The board takes primary responsibility for compliance with the Authorisation. The chairman of an NHS foundation trust should ensure that the board monitors the performance of the NHS foundation trust in an effective way and satisfies itself that appropriate action is taken to remedy problems as they arise. The Compliance Framework is largely aimed at satisfying Monitor that boards and chairs are receiving independent assurance where appropriate and are discharging their responsibilities effectively.

9. In contrast, councils of governors are expected to focus less on compliance and more on ensuring NHS foundation trusts respond to the needs and preferences of stakeholders, especially local communities. Governors’ statutory roles include:
   - Appointing, removing and deciding the terms of office of the chair and other non-executive directors, and approving the appointment of the chief executive;
   - Appointing and removing the auditor;
   - Reviewing the annual accounts, auditor’s report and annual report at a general meeting; and
   - Expressing a view on the board’s forward plans for the NHS foundation trust.

10. Monitor expects that NHS foundation trusts, and their stakeholders as represented through the council of governors and other mechanisms, will also set their own aspirations for innovation, including determining the balance between investment in current provision and innovation through the development of new services.

The freedoms enjoyed by NHS Foundation Trusts create a significant opportunity to continue to reshape and improve the delivery of healthcare in England

The following principles shape Monitor’s approach to regulation:

- **Self-regulation**: Boards of directors are responsible for ensuring that NHS foundation trusts comply with their Authorisation and statutory obligations at all times;
- **Proportionality**: Monitor takes a risk-based approach to regulation, intervening only when necessary. The intensity of its monitoring of an NHS foundation trust is guided by the risk of a significant breach of their Authorisation;
- **Transparency**: Monitor will use a transparent method for assessing risks to compliance, as set out in the compliance framework;
- **Trust-based approach**: Monitor expects NHS foundation trusts to disclose issues speedily and candidly. Monitor will seek to provide collaborative support in resolving issues before considering intervention;
- **Confidentiality**: Monitor will not, unless it has a statutory obligation to do so, disclose confidential information without prior agreement;
- **Minimal duplication of regulation**: Monitor will not usually act where other bodies have a lead regulatory role unless they have exhausted their powers and an NHS foundation trust still risks a breach of their Authorisation; and
- **Minimal information requirements**: Monitor aims to minimise the information requirements it places on NHS foundation trusts. Its requirements should in any case be a sub-set of the information which a board requires to discharge its functions effectively.
Foundation Trusts - Overview

The first ten NHS Foundation Trusts were authorised in April 2004. Since then, a further 128 have been established, bringing the total (as at August 2011) to some 138, of which 97 are acute services providers, nine of them in the North East. The Trust received its Authorisation on 1st June 2006.

Monitor asks Foundation Trusts to assess their own compliance with the terms of their authorisation, as part of its risk based approach to regulation. NHS Foundation Trusts submit an annual plan, quarterly and ad hoc reports to Monitor. Using this information, Monitor assigns annual and quarterly risk ratings, monitors actual performance against plans, and identifies any steps that need to be taken to address problems.

Monitor publishes quarterly reports covering the performance and risk ratings for NHS Foundation Trusts. These provide a summary of the performance of the foundation trust sector, and also give individual NHS Foundation Trusts the opportunity to understand their own performance in relation to other foundation trusts.

The quarterly reports are a vital part of Monitor’s annual reporting cycle, along with the publication each year of NHS Foundation Trusts Consolidated Accounts.

The foundation trust directory (http://www.monitor-nhsft.gov.uk/home/about-nhs-foundation-trusts/nhs-foundation-trust-directory) shows the current governance and financial risk ratings for each foundation trust. The risk ratings page shows the ratings for all foundation trusts.

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<tr>
<th>At the end of 2010/11 trading year, the Trust was rated by Monitor as follows:</th>
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<tr>
<td><strong>Risk ratings</strong> (using a 1 to 5 scale, where 5 is lowest risk)</td>
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<tr>
<td><strong>Financial</strong></td>
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<tr>
<td><strong>Governance</strong></td>
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<tr>
<td><strong>Mandatory Services</strong></td>
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<tr>
<td><strong>Liquidity Rating of 3, reflecting 23.5 days of operating cash</strong></td>
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The role and purpose of Governor Groups

The Governors of the Trust have the specific role, both as individuals and as the Council of Governors, to hold the Board of Directors to account for its planning and delivery of patient services and for maintaining financial strength and organisational sustainability.

Not only do Governors bring their own skills and experience to this role but, in the process of fulfilling their responsibilities, they are informed by the views and opinions of the Trust members whom they represent. The Governors are, then, able to assist the Executive through contribution to strategic thinking, advice and through monitoring of service delivery.

Carrying out such a role requires an understanding of a complex and sophisticated business, the commitment to its purpose and core values and time and energy. The Governors’ Working Groups exist to enable Governors to carry out this role.

The Governors’ Working Groups
All public Governors are members of a Working Group, of which there are four:
• Business Development Group
• Quality of Patient Experience Group
• Membership and Community Relations Group
• Nominations Committee

The Business Development Group
The aim and objectives of this Group focus on ensuring that the Trust Board takes appropriate action on direction, purpose and financial strength to maintain future sustainability.

The scope of its work covers the scrutiny of operational issues by means of contribution to the strategic three year business plan, monitoring of the achievement of the previous year’s plan through visits to wards and departments and communication of plan priorities to members and gaining views for future plans, along with scrutiny of financial performance reports, examination of the final accounts and receipt of the external auditors’ management letter.

This Group also holds the statutory responsibility of recommending to the Council the appointment or removal of the external auditor which it carries out in full, along with the Trust’s Audit Committee.

The Quality of Patient Experience Group
The aim and objectives of this Group centre around ensuring that the Trust Board maintains the highest level of quality in patient care through achieving targets in areas such as infection prevention and control, safety and service improvement and in striving to improve the quality of patient experience.

The Group works on closely monitoring patient experience on selected wards, analysing information from sources such as complaints, progressing specific quality based projects and regularly scrutinising the Trust’s Quality Account.

The Membership and Community Relations Group
This Group’s aim and objectives are based on representing, understanding and responding to the needs of members, the public and users, all of which are essential to the successful work of all Governors. The Group contributes to ensuring that members are aware of the Trust’s services and to obtaining their views on those services.

Work also covers building external links with existing bodies, forging relationships and encouraging governor/member two way communication, mounting member engagement events, and contributing to the Members’ Newsletter. It is also involved in growing and strengthening the membership base.

The Nominations Committee
Governors have a statutory responsibility not only to appoint (and potentially remove) the external auditor but to recommend the appointment (and potential removal) of the Non Executive Directors of the Trust, including the Chairman.

The Nominations Committee has its aim and objectives related to sourcing and recruiting the most suitable candidates for the roles. Members of the Committee are involved in the full recruitment process and establish the conditions of appointment for each Non Executive Director. In conjunction with the Senior Independent Director in the case of the Chairman and the Chairman and Board in the case of other NEDs, they then play a significant part in the annual assessment of NED performance.

The four Group Chairmen coordinate the work of the Groups, which cooperate together on certain activities, and the full Council is made aware of and is able to debate and comment on matters before any decision or resolution is made. Governors are thus enabled, both individually and as a Council, to hold the Board of Directors to account.
The Trust is committed to involving patient, carers and the public at all levels in order to ensure that services are planned around the needs of patients and that year on year improvements in the patient experience are achieved.

In August 2011, the Trust Board approved a PCPI strategy and plan which covered objectives, actions and outcomes to achieve individual and collective involvement at three levels:

1. Information provision
2. Feedback on trust services
3. Influencing planning and decisions about services

In 2011-12, key achievements in support of the patient, carer and public involvement agenda included:

**Key Achievements during 2011-12**

- Celebrated 10 years of support from our Community Advisory Panel – The Panel is a highly valued group of volunteers who have been patients or carers in the Trust and who all share an interest in improving the healthcare services that this Trust provides. Panel members get involved in various activities to provide the patient or carer perspective on issues. During 2011-12, they have contributed to the review of patient information, food tasting sessions, cleanliness inspections, training programmes and customer care reviews.
- Implemented a programme of Patient Perception surveys with the support of the PALS service to ensure that patients on all inpatient wards are involved in providing feedback on a regular basis.
- Contributed to the Real-time patient feedback project to implement a programme of obtaining real-time feedback for outpatients across the Trust.
- Co-ordinated the work of the Patient, Carer and Public Involvement Group – The Group acts as a conduit of the various involvement forums i.e. Governors, Local Involvement Network (LInk), Patient Advice and Liaison Service (PALS) and the Community Advisory Panel.
- Ensuring patient, carer and public involvement in the provision of patient information. Through the continued work of the Patient Information Review Panel, the department was successful in providing assurance regarding the patient information process to support the Trust in achieving level 3 NHSLA accreditation. The Panel has recently increased their remit and membership to cover community services and continues to benefit from service user representation in order to comment on the readability of internally produced patient information leaflets.
- Achieved a CQUIN patient experience indicator measure of 72.2 (70.5 in 2010). This score was the highest score achieved in the acute teaching trusts cluster.
- Reported 97% compliance with the Patient Reported Outcome Measures (PROMs) data collection.
- Repeated a programme of access audits to collate evidence regarding physical access issues for people getting into and around the hospital sites. Overall, it was felt that access into and around the hospital sites has improved since the last access audits in 2009/10. This is largely a result of the Transforming Newcastle Hospitals programme.
- Co-ordinated the Trust’s continued inclusion in the National Patient Survey Programme – The Programme for 2011-12 included a survey of Outpatients and the annual survey of elective and non-elective inpatients.
Understanding the patient experience through the feedback obtained in the Trust

In order to gain an understanding of the key issues and themes surrounding the patient experience, information from various feedback mechanisms is collected on a Patient Experience Database. This includes feedback from the following mechanisms:

- Details of Patient Advice and Liaison Service (PALS) contacts
- Details of Complaints received
- Comments and Suggestions made on the feedback forms in public areas of the Trust
- Feedback from PALS volunteers
- Comments and feedback received into the trust website
- Comments placed on the NHS Choices website

This patient experience feedback is reviewed by the Patient, Carer and Public Involvement (PCPI) Group and circulated to directorate managers, heads of nursing for information, action and feedback where applicable. Requests are made to share this information with staff in their areas of responsibility in order to raise overall awareness of the issues that matter to patients.

In 2011-12, 2650 separate issues were recorded on the patient experience database and reported in the quarterly patient experience reports. The following chart illustrates the related dimensions of the patient experience within which each issue was recorded.

A number of actions to improve the patient experience have been implemented or continued during 2011/12. These include:

- Patient Environment and Action Team (PEAT) inspections and cleanliness audits on a regular basis with patient representation to ensure the patient perspective regarding the ward environment is included.
- Food tasting sessions on each site with representation from the Council of Governors and Community Advisory Panel who sample the menu and talk to patients about their views on the hospital food. The catering managers actively use this feedback to improve the quality and service of the food on offer.
- New adult and paediatric menu’s introduced in 2011/12 which are the subject of ongoing patient satisfaction reviews.
- A review of car parking concessions and availability to ensure a standard and consistent approach.
- A renewed focus on customer care training within the outpatients and reception areas. This has included bespoke training and a number of observational audits.
- The recruitment of more volunteers to provide meet and greet and mealtime assistance roles.
- The introduction of a telephone reminder system for outpatients which has resulted in an improvement in the Did Not Attend (DHA) rates in the areas used in the pilot.
- Ongoing review of the information provided to patients coming into hospital or those admitted as an emergency.
- Falls stop campaign as part of the work of the Trust Falls Group which is designed to reduce and prevent the incidence of patients falling in hospital. This has included the appointment of a Falls Prevention Co-ordinator.
- Protected mealtime policy now operational to protect the patient mealtime from any unnecessary and avoidable interruptions.
- Review of wheelchair availability carried out by public Governors has resulted in an increase in availability and ongoing work to review storage and accessibility.
- Display boards currently in development for the entrance to all wards with the photograph and name of matron and sister and an explanation of the uniforms.

Comment from the Inpatient Survey 2011

The nurses were lovely, caring and kind. They chatted as they looked after you and cheered you up. I always felt like an individual and not a number, as if I really mattered to all concerned.

The nurses were lovely, caring and kind. They chatted as they looked after you and cheered you up. I always felt like an individual and not a number, as if I really mattered to all concerned.
Undertaking patient surveys as part of the NHS Patient Survey Programme

The national programme (managed by the Care Quality Commission) is intended to be a mechanism for making the NHS more patient focused and provides a quantifiable way of achieving this. The 2010-11 national survey programme for acute trusts consisted of a repeat of the Acute Inpatient survey and a survey of Outpatients. The following section outlines the key findings from the two surveys carried out in 2011-12.

Every person helped me and I felt well looked after and I appreciated very much. The staff & doctors do a great job. I thank you.

Comment from the Inpatient Survey 2011

National Survey of Adult Inpatients 2011

The 2011 national inpatient survey highlighted the many positive aspects of the patient experience. The majority of patients reported that:

- Overall: rating of care was good/excellent 95%
- Overall: doctors and nurses worked well together 94%
- Doctors: always had the confidence and trust 85%
- Hospital: room or ward was very/fairly clean 98%
- Hospital: toilets and bathrooms were very/fairly clean 97%
- Hospital: hand-wash gels visible and available for patients and visitors to use 94%
- Care: always enough privacy when being examined or treated 93%

Compared to the 2010 survey, a total of 87 questions were used in both surveys. Compared to 2010, the Trust is:

- Significantly BETTER on 3 questions
- Significantly WORSE on 1 question
- The scores show no significant difference on 83 questions

Wonderful team and everybody worked together with your interest at heart.

Comment from the Inpatient Survey 2011

The three questions where the Trust has improved significantly are as follows:

- A&E – not given enough privacy when being examined or treated
- Planned admission – not given printed information about condition or treatment
- Overall rating of care as fair or poor

The Trust has worsened significantly on the question related to patients in more than one ward who shared a sleeping area with the opposite sex.
All medical and nursing staff were superb. We are so lucky to have such a good health service. I for one am particularly grateful for the care I received.

Comment from the Inpatient Survey 2011

I was treated with every care and respect. Doctor treated me with kindness, the nurse treated me with kindness also. I would not worry about having to return to hospital. The ward was kept clean at all times. Nurses were always willing to help you.

Comment from the Inpatient Survey 2011
National Patient Survey of Outpatients 2011

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

- 96% of patients reported their overall rating of care as good, very good or excellent.
- 93% of outpatients were treated with respect and dignity all of the time at the Outpatients Department.
- 89% of respondents were definitely given enough privacy when discussing their condition or treatment.
- 85% definitely had confidence and trust in the doctor examining/treating them.
- 78% of patients were definitely involved as much as they wanted to be in decisions about their care and treatment.

I am a long standing rheumatology patient and recently had to undergo dental treatment as outpatient. I have to take a lot of medication and I was impressed out the good level of communication between my rheumatologist & the dental department to organise and manage my medication and the clear way this was communicated to me - verbally & by letter.

Very pleased with the end result. I do have more health problems but hopefully after my next few outpatients appointment they will be sorted.

The outpatient survey was previously carried out in 2009. It is encouraging to note that compared to the 2009 survey, the Trust is:

- Significantly BETTER on 9 questions
- Significantly WORSE on 0 questions
- The scores show no significant difference on 53 questions

I have always found the outpatients appointments very good experience in every way and cannot be better. I would like to thank everyone for such excellent and helpful service.

Comment from the Outpatient Survey
I receive first class treatment every time I visit the hospital.

Comment from the Outpatient Survey

How do we compare?

The Care Quality Commission report of the Outpatient Survey 2011, indicates that the Trust scored in the top 20% of trusts in 31 of the 39 areas including:

Before your appointment, did you know what would happen to you during the appointment?

In your opinion, how clean was the Outpatients Department?

Did a member of staff explain why you needed tests in a way you could understand?

Did a member of staff explain the results of tests in a way you could understand?

Were you told about any risks/benefits in a way you could understand before the treatment?

Did the doctor listen to what you had to say?

If you had important questions to ask the doctor, did you get answers that you could understand?

Did you have confidence and trust in the doctor examining and treating you?

Did the staff treating and examining you introduce themselves?

How much information about your condition or treatment was given to you?

Were you given enough privacy when discussing your condition or treatment?

Were you involved as much as you wanted to be in decisions about your care and treatment?

Did doctors and/or staff ask you what was important to you in managing your condition or illness?

Did your appointment help you to feel that you could better manage your condition or illness?

Did hospital staff explain the purpose of the medicines that you were to take home?

Did you receive copies of letters sent between hospital doctors and your family doctor?

Were you told who to contact if you were worried about your condition or treatment after you left hospital?

Was the main reason you went to the Outpatients Department dealt with to your satisfaction?

Were you treated with respect and dignity at the Outpatients Department?

Overall, how would you rate the care you received at the Outpatients Department?

The following table shows how the Trust performed in each section of the National Patient Survey of Outpatients using the CQC website method of presentation outlined above.

<table>
<thead>
<tr>
<th>Section</th>
<th>Score out of 10</th>
<th>How this score compares with other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before the appointment</td>
<td>8.16</td>
<td>About the same</td>
</tr>
<tr>
<td>Waiting in Hospital</td>
<td>5.04</td>
<td>About the same</td>
</tr>
<tr>
<td>Hospital environment and facilities</td>
<td>9.22</td>
<td>About the same</td>
</tr>
<tr>
<td>Tests and treatments</td>
<td>8.44</td>
<td>About the same</td>
</tr>
<tr>
<td>Seeing a doctor</td>
<td>9.1</td>
<td>About the same</td>
</tr>
<tr>
<td>Seeing another professional</td>
<td>9.01</td>
<td>About the same</td>
</tr>
<tr>
<td>Overall about the appointment</td>
<td>8.6</td>
<td>About the same</td>
</tr>
<tr>
<td>Leaving the outpatients department</td>
<td>7.95</td>
<td>Better</td>
</tr>
<tr>
<td>Overall impression</td>
<td>9.04</td>
<td>About the same</td>
</tr>
</tbody>
</table>

The Year Ahead

We will continue to work in line with the Patient, Carer and Public Involvement Strategy and work plan. This will include:

- Increasing the engagement with our community – To listen and respond to feedback about the Trust and to raise the profile of the services we provide.
- The translation of feedback into action.
- Engagement with staff to understand staff experiences when they (or their relatives/friends) use services.
- To contribute further to the real-time feedback project and the development of reporting systems.
- To continue with and make full use of the patient perception data collected by the PALS service.
- Further work around patient information, including the development of more easy-read information.

In addition, the national patient survey plan for 2012-13 includes:

- Survey of Emergency Department patients
- Annual survey of Adult Inpatients
- National patient survey of highly specialised services
- Survey of paediatric inpatients, outpatients and day case patients (three voluntary surveys)

The department was clean and modern. There were enough seats for everyone attending appointments and there was no overcrowding. Information booklets about various conditions were provided in reception area.

Comment from the Outpatient Survey
Making Good Decisions
In collaboration (MAGIC) with patients

Dedicated to providing better healthcare outcomes

When there are decisions to be made about care and treatment it is very important that patients are part of that process. Increasingly the health service is anticipating that patients will wish to be more involved in decisions about their care and treatment. The phrase ‘Nothing about me without me’, in relation to proposed NHS reforms has been promoted actively in recent years. Patient engagement and choice is high on the NHS agenda, from choosing where to have treatment (choose and book), to discussing and agreeing what treatment to have (shared decision making).

Professor Richard Thomson from the Institute of Health and Society at Newcastle University is leading this internationally recognised project in Newcastle in association with colleagues from Cardiff University and Cardiff and Vale Healthcare. They are working together to find out how shared decision making can become a routine part of all healthcare.

Shared decision making promoted by Newcastle upon Tyne Hospitals NHS Foundation Trust recognises that two experts are involved in the decision making process. The first expert is the healthcare professional who brings expertise in diagnosis, therapy and prognosis. With the patient being the expert on living with a condition or disease and what is important to them. Active engagement of patients in the decision making process should result in the healthcare professional being more aware of what is important to the patient, ensuring that this information is factored in when considering options and choices.

As a way of promoting patient involvement in decision making, Newcastle upon Tyne NHS Foundation Hospital Trust is encouraging patients to ‘ask 3 questions’, whenever they come to the hospital.

What are my options?
Not all options will be available to all patients - this depends on your medical history and other problems you may have. So ask about options specifically for you.

What are the possible risks and benefits?
All treatments have pros and cons and it is important you understand these when making a decision.

How can we make a decision together that is right for me?
You need to consider how the different treatments and their side effects will affect what is important to you and your family.

By getting the answers to these three questions and discussing the options with your healthcare professional you are more likely to make a decision that is right for you. The Newcastle upon Tyne Hospitals website (www.newcastle-hospitals.org.uk/patient-guides) has further information on asking these 3 questions and links to other websites for information and support on shared decision making.

Our initial work in MAGIC has been hugely informed by our work in specific clinical areas, learning about which approaches to shared decision making appear to work most effectively.
Lower urinary tract symptoms such as poor urine flow and having to rush to the toilet are very common amongst older men and are often due to blockage of the outlet of the bladder caused by benign enlargement of the prostate (BPE). These symptoms can be improved by different approaches including altering drinking habits, taking drugs that relax the prostate or undergoing surgery. Teams in the Urology Department of Newcastle upon Tyne Hospitals and Northumbria Healthcare Trust have been using the NHS ‘Benign Prostatic Enlargement’ (BPE) decision support tool to help patients decide which of these three treatment options is right for them.

The decision tool, consists of a booklet and DVD that describes BPE and the treatment options available. It encourages patients to consider what is most important to them personally in choosing between these treatment options. Patients have found the booklet and DVD very useful and said ‘I love that book – have you got any more?!’ and ‘The DVD was great - the wife and I watched it together’.

Professor Robert Pickard, Consultant Urologist reports that the two-way discussion of the pros and cons of treatment choices has been made easier for men offered the booklet and DVD who are eligible for any of the three treatment options described. This patient-clinician partnership in treatment decisions is likely to result in men being more confident that they have made the right decision for their situation, whichever option they choose.

Another area where the Shared Decision Making project has also been active and successful is in the maternity unit. One project looked specifically at those women whose baby was delivered by caesarean section in their previous pregnancy. In this situation women are faced with the choice of whether to attempt a vaginal birth after caesarean (VBAC) or to have a repeat caesarean section. The role of SDM is to support women to balance the risks and benefits of each option and to reach a decision that is right for them and their families. A shared decision making approach offers information and clinician support to understand the pros and cons of these options before and during consultations and has been successfully implemented to help women make the decision that is right for them. This approach results in a more consistent delivery of core information and promotes more effective decision making by women and their healthcare team. Dr Sheila Macphail (Consultant Obstetrician) commented that the introduction of this decision support tool allows the clinical team to focus their specific attention on the areas causing women most uncertainty giving them a chance to air their views and to get answers to their concerns.

The UK National Screening Committee recommends that all pregnant women should be offered a screening test for Down’s syndrome (by either a scan and blood test or a blood test alone if they are more than 14 weeks pregnant). Whether or not to have a screening test is an individual choice, there is no right or wrong decision.

Midwives involved in the Shared Decision Making project have developed and implemented a brief decision aid to help parents make a decision about screening tests based on what is important to them. The brief decision aid aims to help parents visualise the route that the screening test may lead to, so that they can consider the potential consequences before undergoing a test to identify which women may be at increased risk of having a baby with Down’s syndrome. This tool helps parents to understand the process of the test and its outcomes very clearly and helps them to consider what their responses might be. As a consequence women and their families are able to exercise a more informed choice about taking part in the screening programme.

This Trust believes that the active participation of patients in making choices and decisions about their care is one of the key routes to delivering better quality services and we are working to deliver more supported decision making wherever there are treatment choices.
The Newcastle upon Tyne Hospitals NHS Foundation Trust

Healthcare at its very best
with a personal touch
On my visits to the Freeman Hospital I have only encountered understanding and consideration of the highest standard.

Fantastic staff and treatment from start to finish. Thank you NHS.

The RVI & Freeman Hospital could not have done any more than they did. It was excellent. Thank you.

The new cancer centre at the Freeman Hospital was run very professionally, friendly and efficiently.

Evidence of the success of mass screening. Holistic care synchronised via multiple disciplining. Seamless transfers with excellent time management and communication. The patient is part of the process not a commodity. Staff to be proud of.

The treatment was severe but necessary and throughout the whole experience the care was excellent.

I don’t have a bad thing to say. The staff and services I received were fantastic.

I was particularly pleased with the speed in which my cancer was dealt with and the care I received from my consultant and his team.

We were offered Complementary Therapy on the ward which was a lovely way to help us relax. Visiting was very flexible which was good as I live quite a distance from the hospital and so my family were able to come and go as they needed to.

I have complete faith in the Freeman Hospital to receive the best treatment that is available. I have been attending this hospital since when I first had cancer.

National Cancer Patient Experience Programme
2011/12 National Survey
The Newcastle upon Tyne Hospitals NHS Foundation Trust
Patient Comments
August 2012

The National Cancer Patient Experience Survey Programme is being undertaken by Quality Health on behalf of the Department of Health.
The Community Advisory Panel is a group of volunteers who either are, have been patients or carers of patients within the Newcastle upon Tyne NHS Foundation Trust. This year sees it celebrating the 10th year since we came into being.

Those who make up the panel come from a variety of backgrounds and possess a wide range of skills, almost totally from outside the NHS experience. Members have no statutory power within the Trust, and this means that all advice it offers is impartial, truthful and honest and working towards the best interests of both the patient, the public, carers and the Trust. However, the Panel does have an ‘Appointed Member of the Council of Governors’ which allows Panel members a direct line to the governing body. In addition regular visits by a senior Trust Officer, (The Chairman; Chief Executive Officer; Director of Nursing; Trust Secretary) are received at the regular monthly meeting. As a result of these methods the Panel is kept up to date and able to raise pertinent questions as they arise.

As a measure of how effective the Panel has been throughout the 10 years it has existed, it has been described as being, ‘...a critical friend...’ and also, ‘...a thorn in the flesh of the Trust...’. Still, the advice it gives is sought by a wide variety of departmental managers when examining and auditing their departments and is often implemented within the working structures for the benefit of patients and public. In this category recently, the Panel has looked at the ways in which the Trust/Department presents itself to the person approaching Reception Desks, the way the telephone is answered. An update on those issues has been returned to the Panel for information and continued observation.

Throughout the year several audits have been under taken, two which have figured in government messages recently, have once again been the subject of close scrutiny and reports. In February a message regarding the Annual Patient Environment and Action Team (PEAT) was received from the Department of Health via The Nursing Officer in Charge asking for comments and suggestions for its replacement of ‘Patient Led Inspections’. The members of the Panel who had taken part were able to offer solid views on how they thought progress could be made and whom each Inspection Team should consist of. The second matter is that of ‘food for patients’. The Panel has two members who are part of a ‘monthly food tasting team’ who sample the food given to patients at the time the patient is given it. Comments are made together with suggestions about the standard and for the improvement if necessary. At the same time, the ‘menus’ are also considered and any necessary amendments are suggested. This information is then reported to the next meeting of the Panel. The Catering Managers receive invitations from the Panel to give them a presentation from time to time, and in order to raise questions arising from the monthly tasting sessions.

As part of the Annual PEAT Inspection, the team carry out an Access Audit. Since this is time constrained, the Panel has suggested that the Trust Access Audit in which it takes part and which concentrates solely on that aspect of the patient’s journey onto and through the Trust premises should replace the one in the PEAT Inspection. It is felt that this would be fairer to the patient as well as allowing the PEAT more time to concentrate on cleanliness, tidiness, etc.

The advice we offer is impartial, truthful and honest and working towards the best interests of both the patient, the public, carers and the Trust.

Through the course of the year members have continue an active involvement within the training aspects. Once again a member has been invited to give a presentation as a patient and a member of CAP to the NHS Graduate Management Training Scheme.

Members have also been involved in an extensive number of areas including:

- Presentation to Central Manchester University Hospitals NHS Foundation Trust visit
- Staff Training Days
- Volunteer Open Days
- Volunteers in the NHS committee
- Patient Information leaflet reviews
- Membership of Bereavement Group
- Membership of Regional Palliative care group

The high and valuable standard of work undertaken by the Panel has been maintained throughout the last year. Whenever the Panel has been involved, it has been received with courtesy and understanding and where changes have been suggested; they were received and acted upon when possible.

A copy of this report will be forwarded to the Care Quality Commission for information.

Alf Brown
Chairman
April 2012
Care Quality Commission and NHSLA Standards

Two major sets of quality standards by which the Trust is independently measured are the Care Quality Commission’s ‘Outcomes’ and the NHS Litigation Authority (NHSLA) Risk Management Standards. Throughout 2011/12 the Trust also monitored compliance with key national standards and performance indicators to ensure that the excellent ratings achieved in past years were maintained.

The Trust is currently rated at **Level 3** (the highest attainable) for General Acute Services and also holds **Level 3** (the highest attainable) for Maternity Services (Clinical Negligence Scheme for Trusts).

Incident Reporting

The Trust uses a transparent and accessible approach to incident reporting, via the Datix system, which offers a web-based system for reporting, analysis and control. This system facilitates a quick and comprehensive analysis of all reported incidents, in addition to underpinning reporting into the National Patient Safety Agency (NPSA) via the National Reporting & Learning System.

Datix also supports the corporate Risk Register, which again uses a web-based system which is designed for ease of use and which is monitored by the Corporate Governance Committee.

National Patient Safety Agency

As part of our commitment to continual enhancement of patient safety, the Trust worked with the NPSA to develop a ‘community of exemplar patient safety organisations’ across England and Wales. The Trust became one of a select group of hospitals from across the world which formed an international patient safety movement, in support of the World Health Organisation’s World Alliance for Patient Safety. Trust participation was in testing the implementation of a standard operating procedure which was designed to reduce harm from concentrated injectable medicines.

Quality Indicators

As part of the continuing commitment to Risk Management and all this entails, the Trust uses several indicators which have been prioritised for improvement. As ever, the past year has seen a focus on minimisation of the incidence of healthcare associated infection and in particular MRSA bacteraemia and *Clostridium difficile* (C.Diff). Several workstreams ran throughout the year, including continued implementation of specific care bundles as part of the ‘Saving Lives’ campaign; and the Ward Accreditation scheme for clinical practice standards and cleanliness supported the reduction of these infections such that the Trust surpassed all applicable national and locally imposed standards and targets. Continued commitment to further reduction in such infections remains an overriding priority for the year ahead.

A further indicator of patient safety is the hospital standardised mortality ratio, which is a calculation of the expected number of deaths against the actual number. The calculation adjusts for factors which may affect mortality, such as age, sex, diagnosis and admission status and produces a summary estimate of hospital mortality relative to the national pattern. A figure of 100 represents results directly in line with expectations, a higher represents a high mortality rate and a low figure a lower mortality rate than expected. The most recent calculation of 89 was favourable and placed the Trust amongst the most effective providers in England. A new national indicator was launched in Autumn 2011 – the Standardised Hospital Mortality Index - and this enabled more meaningful comparisons to be drawn between Trusts (see pages 40 - 41).

You can find further details of our quality initiatives in the chapter on the Quality Account on pages 242 - 269.
Radical organisational change is already underway across the NHS
Where there are treatment choices, we will continue to progress the work supported by the Health Foundation on ‘Shared Decision Making’ (MAGIC) and to develop the principle of ‘Deciding Right’ to avoid unnecessary or unwanted treatments. We will also continue to be nationally and internationally renowned for our leading edge Research and Development Programmes, which underpin the pioneering services we provide.

Using robust metrics we will continue to ensure that key clinical quality improvements are monitored and included in our Quality Accounts, which are reported to the Trust Board at monthly intervals. The Quality Accounts will highlight key areas of quality performance including incident data for both patients and staff, clinical outcome data and performance in national audits. The content of the Quality Accounts will continue to develop over the next three years to include further benchmarking data and areas of improvement which have been identified.

The achievement of Level 3 for both the NHS Litigation Authority (NHSLA) Acute Standards and the Clinical Negligence Scheme for Trusts (CNST) Maternity Standards was significant for the organisation and validated our view that clinical care being delivered across the organisation is of a consistently high standard and that risks are being managed appropriately.

A key part of the clinical and quality strategy is therefore to ensure that the Trust continues to build on its success by further embedding the NHSLA standards of quality and risk management across the organisation. This will be achieved by monitoring that clinical care is documented to a consistently high standard of quality.
Clinical and Quality Priorities and Milestones

Following discussion with the Board of Directors, the Clinical Policy Group, the Council of Governors and Departmental/Directorate Governance leads as well as having taken account of feedback received from patients, staff and the public, the following priorities for 2012/13 have been agreed in relation to • Safety • Clinical Effectiveness and • Patient Experience.

• Patient Safety

Priority 1 – To reduce all forms of healthcare associated infection (HCAI). We will quantify our success in this by:
  • aiming for the annual number of Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia cases to be no more than 4
  • reducing hospital acquired infections related to Clostridium difficile (C.diff) to be no more than 95 cases in the next year.

Reducing HCAI remains one of our highest priorities. The importance of providing a clean and safe environment for patients, their relatives and our staff cannot be over emphasised. Numbers of MRSA bacteraemias and C.Diff infections are markers of how effective our infection prevention and control measures are and we continue to strive for further improvement year on year. Data will be monitored and measured by the Trust Board in the monthly HCAI scorecard.

Priority 2 – To prevent avoidable harm, disability or death from:
  • Venous thromboembolism (VTE),
  • Pressure Ulcers,
  • Hospital acquired catheter related infection
  • Falls.

This is a CQUIN indicator which will require a monthly survey of all appropriate patients using the NHS Safety Thermometer tool to collect data on four specific outcomes (pressure ulcers, falls, urinary tract infection in patients with catheters and VTE). Data will be collected at the point of care by healthcare professionals using a point prevalence survey method (on one day per month).

Priority 3 – To ensure that all patients receive nutrition screening on admission to hospital and adequate nutritional support.

We will build on the work that we have done to embed assessment and care planning of nutritional need for all our inpatients as part of this we will ensure that needs in relation to hydration (which is often referred to as the hidden nutrient) are also identified. We will continue peer observation and audit of practice to ensure that it truly meets individual needs and preferences and focus on developing our provision for patients with dementia.

We will continue to develop our work to ensure patients receive the appropriate nutritional support, auditing the patients mealtime experience and systematically gathering feedback from patients in relation both to provision of assistance and the quality and acceptability of the food we offer. We are progressing a mealtime volunteers scheme. We will work closely with our catering colleagues to evaluate the significant changes that were made to the adult inpatient menu early in 2012 and further develop this menu.

We will continue to be nationally and internationally renowned for our leading edge Research and Development Programmes, which serve to underpin the pioneering services we provide.
Clinical Effectiveness

Priority 4 – To monitor outcomes for all patients admitted after suffering major trauma by submitting complete information about them to the Trauma Audit and Research Network.

Every year across England and Wales, 10,000 people die after injury. It is the leading cause of death among children and adults under 44. In addition, there are many trauma victims who are left severely disabled for life. Major trauma can have many causes including: road traffic accidents, industrial accidents, falls from a height or violent incidents. Once the injuries have occurred, time is of the essence in trying to achieve the best outcome for patients.

This Trust is organised and equipped to care for major trauma patients and has been designated a Major Trauma centre from the 1st April 2012. The area covered extends from Durham to the Scottish border and west to Cumbria. To ensure that care of the very highest quality is provided here we monitor patient outcomes by submitting data to a national audit group, the Trauma Audit Research Network (TARN.)

Anonymised information about each of our major trauma patients is submitted following discharge. Data includes: the patients pre-accident state (background illnesses) severity of their injuries, investigations undertaken, the timeliness of interventions, seniority of staff involved and outcome data. The TARN team process the information and report back to us on a 3 monthly basis how well our patients did compared with what would usually be expected for patients with that level of injury. This information can then be reviewed by the hospital TARN group and the Trauma peer review group. Even with the excellent level of care provided in the NHS sadly not every patient with severe injuries survives. The feedback from TARN allows us to review all trauma deaths and patients who survive serious injuries where the predicted outcome was poor.

We are monitored by TARN against the completeness of our submission data. The maximum score is 4 ticks. We were the only hospital in the Region to achieve 4 ticks for both the 2010 and 2011 submissions. For the period 2010/11 the RVI had an additional 2.4 survivors over the predicted number per 100 patients and showed good outcomes for those with the more complex patterns of injury. These figures compare well with similar sized units.

We will continue to develop our work to ensure patients receive the appropriate nutritional support.

Priority 5 – Further development of the Early Warning Score (EWS) system, ensuring that changes trigger clinical review to ensure early recognition of the deteriorating patient.

In 2011/2012 we developed and implemented systems to ensure that Early Warning Scores were recorded at appropriate intervals as part of routine clinical care for in-patients. Building on this in 2012/13 we have a CQUIN target to ensure that significant changes in patients EWS trigger clinical review by an appropriately skilled practitioner in a timely fashion.

Priority 6 – To monitor mortality indicators with the aim of reducing avoidable deaths.

The Trust does monitor mortality rates using data from CHKS, the benchmarking organisation. Historically the Trust has the lowest crude and corrected mortality rates of any of the acute hospitals in the Region. The Trust has been working with CHKS and with analysts from the North East Quality Observatory to drill down below the high level data for Trust wide mortality to mortality rates in individual services and clinical teams. It is only by continuously monitoring in this way that assurance can be provided that avoidable deaths are eliminated.

It is our intention to maintain an ‘as expected’ rating in the year ahead. This is monitored quarterly via the Quality Account and the Board of Directors.
• **Patient Experience**

Priority 7 – To monitor and improve the patient experience by:

• Improving the care and health outcomes of people with learning disabilities by using reasonable adjustments through the implementation of Emergency Department (ED) learning disability care pathways in the acute hospital setting, the development of pathways specifically for patients with learning difficulties. This is a CQUIN indicator requiring a quarterly report of progress to Commissioners.

• Developing a patient satisfaction survey for District Nursing services to assess and improve the patient experience in a similar way to Acute providers who must include a nationally defined composite indicator for patient experience that focuses on responsiveness to the personal needs of patients. This is a CQUIN indicator requiring a monthly report of progress, reported to Commissioners on a quarterly basis.

• Development of the Real Time Patient Feedback System.

• Enabling responsiveness to the personal needs of patients. For in-patients by evaluating their experience, based on the Care Quality Commission (CQC) National inpatient survey and for out-patients and those in the community by evaluating their experience by a local survey.

People with learning disabilities experience poorer health and are less likely to access healthcare, resulting in poorer outcomes from treatment than the General population. Through the implementation of this specialist care pathway clinical staff will be assisted to make reasonable adjustments that will impact on quality of care through an agreed ED care pathway. The main challenges identified by acute care clinicians include: limited awareness of the specific clinical needs that may be associated with an individual’s learning disability and therefore limited understanding of how to make the required ‘reasonable adjustments’ to enable their healthcare needs to be met. People with learning disabilities are not asking for something more or better than the general population, but rather a service that is individualised, person-centred and where staff in acute settings have a real understanding of what reasonable adjustments are needed to ensure care is safe, equitable and productive.

The ED pathway, when developed, will provide resources and tools to acute staff in the ED to identify and support patients with learning disabilities, whilst in an emergency hospital setting. This will meet the needs of patients who attend but are not admitted and will promote early identification of Learning Disability. It will also identify those patients who frequently attend ED and identify their individual needs.

Whilst we will monitor responses to all aspects of the National Inpatient Surveys, we will focus specifically on achieving improvements responses received from the Real Time Patient Feedback system – adapting a ‘You Talk We Listen’ culture, in which customers will receive feedback on feedback.

Newcastle Community District Nursing Services is to devise a patient satisfaction survey to support the assessment and improvement of patient experience. This will build on the work undertaken last year with the development of more meaningful surveys for a number of separate services.

**Angela O’Brien**

Director - Quality & Effectiveness

The only hospital in the Region to achieve maximum attainable score of 4 ticks for both the 2010 and 2011 TARN submissions.