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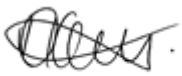
Northumberland
County Council

Your ref:
Our ref:
Enquiries to: Andrea Todd
Email: Andrea.Todd@northumberland.gov.uk
Tel direct: 01670 622606
Date: 21 April 2022

Dear Sir or Madam,

Your attendance is requested at a meeting of the **HEALTH AND WELLBEING OSC** to be held in **COUNCIL CHAMBER - COUNTY HALL** on **TUESDAY, 3 MAY 2022** at **1.00 PM**.

Yours faithfully



Daljit Lally
Chief Executive

To Members of the Health and Wellbeing OSC

Any member of the press or public may view the proceedings of this meeting live on our YouTube channel at https://www.youtube.com/NorthumberlandTV. Members of the press and public may tweet, blog etc during the live broadcast as they would be able to during a regular Committee meeting.

Members are referred to the risk assessment, previously circulated, for meetings held in County Hall. Masks should be worn when moving round but can be removed when seated, social distancing should be maintained, hand sanitiser regularly used and members requested to self-test twice a week at home, in line with government guidelines.

AGENDA

PART I

It is expected that the matters included in this part of the agenda will be dealt with in public.

1. APOLOGIES FOR ABSENCE

2. DISCLOSURE OF MEMBERS' INTERESTS

Unless already entered in the Council's Register of Members' interests, members are required to disclose any personal interest (which includes any disclosable pecuniary interest) they may have in any of the items included on the agenda for the meeting in accordance with the Code of Conduct adopted by the Council on 4 July 2012, and are reminded that if they have any personal interests of a prejudicial nature (as defined under paragraph 17 of the Code Conduct) they must not participate in any discussion or vote on the matter.

NB Any member needing clarification must contact the Monitoring Officer at monitoringofficer@northumberland.gov.uk. Please refer to the guidance on disclosures at the rear of this Agenda letter.

3. FORWARD PLAN (Pages 1 - 4)

To note the latest Forward Plan of key decisions. Any further changes to the Forward Plan will be reported at the meeting.

4. HEALTH AND WELLBEING BOARD (Pages 5 - 22)

The minutes of the Health & Wellbeing Board held on 10 March 2022 and 14 April 2022 are attached for the scrutiny of any issues considered or agreed there.

REPORTS FOR CONSIDERATION BY SCRUTINY

5. NORTH EAST AMBULANCE SERVICE 2022/2023 QUALITY ACCOUNTS (Pages 23 - 58)

Annual report on the quality of service. The Committee is requested to receive and comment on the presentations from each Trust, and also agree to submit a formal response to each Trust.

6. NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST 2022/2023 QUALITY ACCOUNTS (Pages 59 - 178)

Annual report on the quality of service. The Committee is requested to receive and comment on the presentations from each Trust, and also agree to submit a formal response to each Trust.

7. CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST 2022/2023 (Pages 179 - 188)

Annual report on the quality of service. The Committee is requested to receive and comment on the presentations from each Trust, and also agree to submit a formal response to each Trust. (The formal Quality Accounts will follow).

8. HEALTH AND WELLBEING OSC WORK PROGRAMME (Pages 189 - 196)

To consider the work programme/monitoring report for the Health and Wellbeing OSC for 2022/23.

9. URGENT BUSINESS

To consider such other business as, in the opinion of the Chair, should, by reason of special circumstances, be considered as a matter of urgency.

10. DATE OF NEXT MEETING

The date of the next meeting is scheduled for Tuesday, 31 May 2022 at 1.00 p.m.

IF YOU HAVE AN INTEREST AT THIS MEETING, PLEASE:

- Declare it and give details of its nature before the matter is discussion or as soon as it becomes apparent to you.
- Complete this sheet and pass it to the Democratic Services Officer.

Name (please print):
Meeting:
Date:
Item to which your interest relates:
Nature of Registerable Personal Interest i.e either disclosable pecuniary interest (as defined by Annex 2 to Code of Conduct or other interest (as defined by Annex 3 to Code of Conduct) (please give details):
Nature of Non-registerable Personal Interest (please give details):
Are you intending to withdraw from the meeting?

1. Registerable Personal Interests – You may have a Registerable Personal Interest if the issue being discussed in the meeting:

a) relates to any Disclosable Pecuniary Interest (as defined by Annex 1 to the Code of Conduct); or

b) any other interest (as defined by Annex 2 to the Code of Conduct)

The following interests are Disclosable Pecuniary Interests if they are an interest of either you or your spouse or civil partner:

(1) Employment, Office, Companies, Profession or vocation; (2) Sponsorship; (3) Contracts with the Council; (4) Land in the County; (5) Licences in the County; (6) Corporate Tenancies with the Council; or (7) Securities - interests in Companies trading with the Council.

The following are other Registerable Personal Interests:

(1) any body of which you are a member (or in a position of general control or management) to which you are appointed or nominated by the Council; (2) any body which (i) exercises functions of a public nature or (ii) has charitable purposes or (iii) one of whose principal purpose includes the influence of public opinion or policy (including any political party or trade union) of which you are a member (or in a position of general control or management); or (3) any person from whom you have received within the previous three years a gift or hospitality with an estimated value of more than £50 which is attributable to your position as an elected or co-opted member of the Council.

2. Non-registerable personal interests - You may have a non-registerable personal interest when you attend a meeting of the Council or Cabinet, or one of their committees or sub-committees, and you are, or ought reasonably to be, aware that a decision in relation to an item of business which is to be transacted might reasonably be regarded as affecting your well being or financial position, or the well being or financial position of a person described below to a greater extent than most inhabitants of the area affected by the decision.

The persons referred to above are: (a) a member of your family; (b) any person with whom you have a close association; or (c) in relation to persons described in (a) and (b), their employer, any firm in which they are a partner, or company of which they are a director or shareholder.

3. Non-participation in Council Business

When you attend a meeting of the Council or Cabinet, or one of their committees or sub-committees, and you are aware that the criteria set out below are satisfied in relation to any matter to be considered, or being considered at that meeting, you must : (a) Declare that fact to the meeting; (b) Not participate (or further participate) in any discussion of the matter at the meeting; (c) Not participate in any vote (or further vote) taken on the matter at the meeting; and (d) Leave the room whilst the matter is being discussed.

The criteria for the purposes of the above paragraph are that: (a) You have a registerable or non-registerable personal interest in the matter which is such that a member of the public knowing the relevant facts would reasonably think it so significant that it is likely to prejudice your judgement of the public interest; **and either** (b) the matter will affect the financial position of yourself or one of the persons or bodies referred to above or in any of your register entries; **or** (c) the matter concerns a request for any permission, licence, consent or registration sought by yourself or any of the persons referred to above or in any of your register entries.

This guidance is not a complete statement of the rules on declaration of interests which are contained in the Members' Code of Conduct. If in any doubt, please consult the Monitoring Officer or relevant Democratic Services Officer before the meeting.

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Forward Plan

FORTHCOMING CABINET DECISIONS MAY TO AUGUST 2022

DECISION	PROPOSED SCRUTINY DATE	CABINET DATE
Electric Vehicle Charging Strategy 2022-25 To update on Electric Vehicle Charging Infrastructure and proposals for increasing provision across the next three years. (G. Sanderson/ Matt Baker 07957 385638)	TBC	10 May 2022
Proposals for Coquet Partnership This report sets out the findings of the meetings that have taken place with schools in the Coquet Partnership during the Spring Term 2022 to discuss the organisation of schools in the partnership, as requested by the first schools and in light of obtaining best value for capital funding for investment in schools in the partnership as allocated in the Council's Medium Term Plan. Cabinet is also asked to permit the initiation of informal consultation on proposals for individual schools with stakeholders in the area served by Coquet Partnership**.** (G Renner Thompson/S. Aviston - 07770934182)	FACS 5 May 2022	10 May 2022
Bus Service Improvement Plan and Enhanced Partnership	TBC	10 May 2022

The Enhanced Plan and Scheme is a proposed statutory partnership with regard to a statutory transport plan including the Bus Service Improvement Plan. Cabinet is asked to approve prior to these being considered by the Joint Transport Committee. The Enhanced Plan and Scheme(s) need to be approved by deadline imposed by Central Government of 30th June 2022. (W. Ploszaj/N. Easton - 07979 233477)		
Arrangements for Future Disposals of Land at East Sleekburn This report describes the arrangements proposed to secure the land necessary for the construction of a Supply Chain park for the battery manufacturing complex at Cambois. **Confidential Report** (R. Wearmouth/R. O'Farrell – 01670 620441)	CSEG 6 June 2022	7 June 2022
Financial Performance 2021-22 – Provisional Outturn 2021-22 The report will provide Cabinet with the revenue financial position as at Provisional Outturn for the Council against the Budget for 2021-22 (R. Wearmouth/S. Dent 01670 625515)		7 June 2022
Trading Companies' Financial Performance 2021-22 - Position at the end of March 2022 The purpose of the report is to ensure that the Cabinet is informed of the current financial positions of its trading companies for 2021-22 (R. Wearmouth/M. Calvert - 01670 620197)	CSEG 6 June 2022	7 June 2022

(Confidential report)		
Trading Companies' Financial Performance 2022-23 - Position at the end of June 2022 The purpose of the report is to ensure that the Cabinet is informed of the current financial positions of its trading companies for 2022-23 (R. Wearmouth/M. Calvert - 01670 620197) (Confidential report)	CSEG 12 September 2022	13 September 2022

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NORTHUMBERLAND COUNTY COUNCIL

HEALTH AND WELL-BEING BOARD

At a meeting of the **Health and Well-being Board** held in County Hall, Morpeth on Thursday, 10 March 2022 at 10.00 a.m.

PRESENT

Councillor B. Flux
(Chair, in the Chair)

BOARD MEMBERS

Morgan, E.	Syers, G.
Pattison, W.	Thompson, D.
Riley, C. (Substitute)	Travers, P.
Sanderson, H.G.H.	Watson, J.
Simpson, E.	

IN ATTENDANCE

L.M. Bennett	Senior Democratic Service Officer
Dr. R. Hudson	Northumberland CCG
P. Lee	Public Health Consultant
G. Matthewson	Northumbria NHS Foundation Trust
S. McMillan	Assistant Director Policy Team
E. Wheeler	Northumbria NHS Foundation Trust

43. APOLOGIES FOR ABSENCE

Apologies for absence were received from J. Boyack, S. Brown, J. Lothian, C. McEvoy-Carr, P. Mead and R. O'Farrell.

44. MINUTES

RESOLVED that the minutes of the meeting of the Health and Wellbeing Board held on 10 February 2022, as circulated, be confirmed as a true record and signed by the Chair:

45. UPDATE ON THE EPIDEMIOLOGY OF COVID 19, THE NORTHUMBERLAND COVID 19 OUTBREAK PREVENTION AND CONTROL PLAN, AND THE VACCINATION PROGRAMME

Members received an update on the epidemiology of COVID 19 in Northumberland, developments with the Council's COVID 19 Outbreak Prevention and Control Plan, and Vaccination Programme. Presentation filed with the signed minutes.

Liz Morgan, Interim Executive Director for Public Health and Community Services, gave a presentation to the Board and the key points included:-

- It was increasingly difficult to make sense of the case data due to the changes in Government guidance. Testing rates had dropped and testing in schools had ceased. There was an increase in case rates due to the BA2 sub-variant which appeared to have a transmission advantage although there was no evidence of any impact on severity of illness or vaccine effectiveness. Routine asymptomatic and symptomatic testing would end on 31 March 2022.
- As a result of the Government announcement on 21 February 2022, contact tracing had ceased. There was no longer a legal requirement to self isolate (although there was still a need to self isolate) and self-isolation support payments were no longer available.
- Changes in statutory sick pay would revert back to previous arrangements.
- Mobile, local and regional testing sites would cease to function at the end of March 2022 and most would then be demobilised and sites handed back.
- The best source of data was the ONS Survey which provided estimates of the prevalence of infection. In the week up to 26th February it was estimated about 1 in 30 people in England would have tested positive which was a decrease from the previous week. Covid was not naturally a mild disease, it was just less severe in people with reasonable immunity.
- **Living with Covid** – the new plan covered four main areas:-
    - Removing domestic restrictions whilst encouraging safer behaviours through public health advice, in common with longstanding ways of managing other infectious illnesses.
    - Protecting the vulnerable through pharmaceutical interventions and testing, in line with other viruses.
    - Maintaining resilience against future variants.
    - Securing innovations and opportunities from the Covid-19 response, including investment in life sciences.
- **Next Steps and Future Response**
    - It was planned to revert back to previous arrangements with outbreaks being handled by the Regional Health Protection Team.
    - Maintaining and building on the Infection Prevention and Control (IPC) skills and capacity within care homes, high risk settings, education and child care settings and businesses.
    - There was an opportunity to review the sickness benefits system nationally to help families on low incomes and employed in jobs with less favourable sickness benefits so that they could self-isolate without financial consequences.
- **Vaccination Programme**
    - The programme was continuing and had an evergreen offer of 1st, 2nd and booster jabs. It was expected that there would be an autumn booster programme which would have greater alignment with other vaccination programmes.

- Local Authorities had a clear role to support the vaccination programme by working closely with the CCG.
- There was now a vaccination offer to 5-11 year olds, and there would be a spring booster dose for over 75s, residents of older adult care homes, and 12+ who were immunosuppressed. This was in addition to the evergreen offer and continued community engagement to promote uptake and access to the vaccine.
- Contingency plans had to be in place in case of a surge in cases.
- It was important to embed behaviours to prevent the spread of Covid which would also prevent the transmission of most other infectious respiratory illnesses. This included looking at the 'presenteeism' culture. Communication remained crucial and should comprise of simple, consistent messages.

RESOLVED that the presentations be received.

46. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2020

Members received a report presenting the Director of Public Health (DPH) Annual Report for 2020/21 which focused on protecting the health of our communities from the impact of Covid 19. (Report and Presentation from Liz Morgan, Interim Director of Public Health and Community Services).

Liz Morgan highlighted the following key points:-

- Directors of Public Health had a statutory duty to write an Annual Public Health Report on the health of the local population. The report was developed during the 4th wave of COVID-19 in July 2021 and reflected the situation up to that point.
- The report focused on inequalities experienced within different sectors of the community such as mortality in people with BAME backgrounds, with disabilities, and those in the most deprived areas. The effects were not just direct but also indirect including loss of employment amongst young people, some children finding it difficult to study from home and health & social care staff who were at increased risk of adverse mental health outcomes.
- A lot of mitigation measures had been put in place which were highlighted in a series of videos attached to the report and these had had a very positive impact on Northumberland's communities.
- The report also made recommendations on what more could be done to address the widening inequalities attributable to COVID-19.
- The videos focused less on health and more on the social determinants of health
    - Video 1 – Introduction and Overview
    - Video 2 – Impact of COVID-19 on income, job security, social isolation and mental health
    - Video 3 – How the wider determinants of health have shaped the experience

- Video 4 – The groups disproportionately affected by COVID-19, children and young people; digital inclusion.
- Video 5 – The Council's response and recommendations

The following comments were made:-

- There was some disappointment that the report had not acknowledged the valuable, joined-up approach of the LA7 Local Authorities working together during the pandemic for the benefit of the community. Northumberland County Council's Officers and Members had worked very well together to ensure that local Members were aware of what was happening on a weekly basis. It was noted that the aim of the report was to highlight the impact the pandemic had had on the community and about the Council's response over the last two years.
- With regard to the quality of housing, every effort was made to ensure that the quality of the housing managed on the Council's behalf met the required quality standard and had good pathways in place to ensure a rolling programme of routine maintenance and repairs. It was more difficult in the private rental sector as there was less influence over the quality of the housing. It could be time consuming to go through the legal processes available to address issues in this area. A Selective Licensing Scheme could be used in particular areas of Northumberland to improve the quality of housing which also had an impact on other things such as anti-social behaviour, improving social cohesion and health and wellbeing.
- The Inequalities Summit would focus on inequalities and what could be done collectively across Northumberland to address this. The pandemic had highlighted that COVID-19 had exacerbated existing inequalities.
- Following the report at a previous meeting by Dr. Kathryn Bush on excess deaths data, work was just commencing on drilling down into the data to find out where the issues were such as cardiovascular disease or stroke.
- Some of the data used within the report would also be included within the data pack being used at the Inequalities Summit to focus the minds of attendees on the inequalities that existed. There would be wide representation at the Summit and there would then be consideration as to how Northumberland could address them and involving many other agencies and including the voluntary sector.
- The report had been considered at Informal Cabinet and Health and Wellbeing Scrutiny but it was suggested that in future years the draft Annual Report be brought to the Health & Wellbeing Board to enable Members to have some input.

RESOLVED that the recommendations contained within the Director of Public Health's Annual Report be accepted as follows:-

- Undertake a COVID-19 Inequalities Impact Assessment and use that to inform the council's recovery plan to ensure that areas of deepening inequalities are recognised and addressed. This should inform future budget and planning cycles.

- Develop an integrated carbon reduction, equality and health inequality approach as part of our policy development and appraisal process. This would be consistent with the Health in All Policies approach we are developing.
- Build on the strong community networks and increased social cohesion to ensure residents are at the centre of processes to design initiatives and services which meet their needs and aspirations.
- Encourage people to shop local, support local businesses, support the local development of skills to enable employment, especially those living in Northumberland who are furthest away from the employment market and exploit the wider social value of the Northumberland pound.

47. NORTHUMBERLAND SUICIDE PREVENTION STRATEGY 2021-25

Members received a report describing progress to date to reduce suicide in Northumberland and setting out priorities for continuing to help reduce suicide over the period 2021-2025.

Pam Lee, Consultant in Public Health, raised the following key points:-

- Suicide figures for Northumberland were low but the rate was higher than the regional and national average. However, one or two incidents could quickly cause a change in the trend and data.
- The Executive Summary took into account where Northumberland was in terms of its data and COVID-19. The psychological effects of the pandemic could be present for 10-20 years. The data appeared to show a reduction in suicide figures nationally, however, this could be a false picture due to delays within the Coroner's system in confirming suicides.
- Priorities – Some people were at higher risk than others and the risk spread over a whole range of the population from those in our most to least deprived areas.
- There was a multi-agency approach with the CCG, Adults and Children's Safeguarding Teams, Mental Health Trust, and the Voluntary Sector. All the services which were commissioned were listed in the report.
- Defining suicide was very important as it was a very emotive subject. A lot of information was contained in the report to aid this understanding.
- The economic impact of suicide could not be underestimated and there was a clear link between unemployment and suicide. Good quality jobs with support built in were very important.
- The way suicide was reported in the press was important as there could be a contagious effect.
- The following factors were known to increase the risk of suicide: Age and sex, mental illness, substance misuse, social isolation and loneliness, gender and ethnicity, veterans, prisoners and those in contact with the criminal justice system.
- Efforts were being made in conjunction with the British Transport Police and Network Rail to design out the likelihood of suicide and trespass on railway lines.

- A lot of work was carried out around good mental health promotion and prevention and support. Efforts were being made to improve young people's mental health.
- There were a whole range of online sites and trainers who could help someone identified to be at risk.

The following comments were made in response to questions:

- It was important to ensure that professionals were trained and sensitive to risk to be able to make a difference to a person. Also to look for opportunities missed and what services were available. Some individuals may attempt suicide several times before succeeding whereas with others there was no warning.
- The Samaritans was a very highly regarded service, however, they were only able to signpost people to other services who may be able to help an individual. The organisation did promote itself at sites where there was a high risk of suicide.
- The CNTW Mental Health Trust dealt with individuals who were distressed or depressed. It was feared that suicides would increase during the pandemic due to social isolation, however, this appeared not to be the case. Many did still feel anxiety arising out of the pandemic and also with fears about society opening up again. The Trust worked with a number of other organisations in this area. Some people in the public eye such as footballers or social media stars were opening up about what it was like to be considering suicide.
- Discussions had been held with Network Rail regarding the unmanned railway station at Cramlington to see if there were ways to improve the outlook of the station. It was hoped to secure the open line around the station and it was known to be an area popular with young people using alcohol and drugs. It was noted that local County Councillors and Cramlington Town Council were keen to see improvements and refurbishment at the station.

RESOLVED that

(1) Progress to date be noted.

(2) The revised Suicide Strategy 2021-25 be accepted.

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48. NORTHUMBERLAND CANCER STRATEGY AND ACTION PLAN

Members received a presentation from Dr. Robin Hudson, Medical Director at Northumberland CCG and Graham Matthewson Operations Service Manager at the Northumbria Healthcare NHS Foundation Trust.

- It was emphasised that the levels of collaboration had been very high in Northumberland. The Cancer Locality Strategy Group was joined with North Tyneside to align priorities and thinking and there was also a wider ICP Cancer Group which met with the three hospital Trusts, Newcastle,

Northumbria and Gateshead and the four CCGs. These Forums looked at performance relating to cancer in the whole region.

- Overall there was a lot of volatility in performance. Currently, activity levels were back to pre-pandemic levels, however, over the two years of the pandemic there had been a reduction in the number of expected referrals.
- Performance by speciality – key areas of focus were dermatology and breast cancer pathways. The figures regarding children appeared to be poor and had been the subject of a deep dive and it was found that the majority of referrals were found not to be cancer.
- A key area of pressure regarding breast cancer was the volume of cases and there was an issue with diagnostic capacity. In dermatology, a tele-derm app had been introduced which enabled remote referral including a photograph of skill tissue to a consultant. Patients in this pathway were now being seen well within the two week standard following referral.
- Primary Care was encouraged to keep services running during the pandemic particularly for cervical screening and funding was provided to practices for this purpose. It was important to build patients' confidence generally to encourage them to visit their GP. Also ensuing that patients stuck to the pathway and did not fall through the net.
- A lot of effort had been put into the Cancer Recovery Plan and particularly focused on people who had waited a long time.
- There were interesting trends as to how patients were coming through the system. 6,000 colorectal patients seen last year and the diagnosis rate remained roughly the same over the last four years. In haematology pathway, referrals remained similar but diagnosis rate had gone up to 75%.
- The biggest focus nationally was the way cancer pathways were looked at and would move towards '28 days past diagnosis'. The aim was to diagnose patients more quickly and to start their treatment plan.
- Work was concentrating on breast and skin cancer. The new system using photographs for dermatology was working well.
- Colorectal services was a challenging pathway at the moment and work had been done to ensure that the pathway was a smooth as possible. Diagnosis was now quicker and there was increasing use of CTC (computed tomographic colonagraphy). A new CTC scanner was due to be installed at North Tyneside which would double capacity across all services.
- Vague Symptoms Pathway was being trialled for patients with unexplained symptoms such as weight loss and abdominal pain.
- NHS Galleri Research Trial was aimed at 50-77 year olds with no cancer symptoms and would detect 22 cancers early.
- Lung cancer pilot jointly with North Tyneside to encourage early diagnosis. In the last 12 months, 300 patients had been scanned with 10 lung cancers detected, nine of which had curative treatment.
- Personalised care, including rehabilitation, health and wellbeing information and advice and signposting, empowering and improving patient outcomes. A digital monitoring system had been introduced to monitor patients throughout the process.

- Challenges to the service included the impact of Covid on staffing which created slight increases in diagnostic times; social distancing reducing capacity and increases in treatment length for Oncology services.
- Highlights were increasing staffing in Oncology, new Cancer Navigator posts to support new pathways and the installation of a second CT scanner due to be operational by March 2022.
- Cancer awareness should be raised with emphasis on the importance of early diagnosis, symptom awareness, cancer screening campaigns and support of national and regional campaigns.

RESOLVED that the presentation be received.

49. NORTH OF TYNE COMBINED AUTHORITY WELLBEING FRAMEWORK: NORTHUMBERLAND APPROACH

Members were briefed on the work across North of Tyne to develop and agree a Wellbeing Framework, and the Board's views were sought on the proposed actions to implement the framework by Northumberland County Council and how the Board would wish to be involved in its adoption and implementation. Report by Sarah McMillan, Assistant Service Director, Policy.

The following key points were made:-

- The Framework was developed by local Government to help understand what mattered to people in terms of their own wellbeing. This assisted policy makers to think through important issues as connected issues rather than in isolation. This was looked at in terms of recovery from the pandemic and what it looked like for the region's wellbeing. It supported the North of Tyne's inclusive economy vision at the heart of the devolution deal.
- A roundtable approach was used to develop the framework and 12 specialists from various sectors were selected to carry out this work. Views from citizens and experts were gathered over a period of six months to form the evidence base.
- The model used was developed by the Carnegie Trust, comprising social, economic, environmental and democratic wellbeing and was used as a framework on which to base evidence and discussions. Different components of evidence gathering included:-
    - Policy and Literature Review
    - Call for Evidence
    - Community-Led Consultations
    - YouGov Survey
- Ten wellbeing outcomes were identified and mapped across the social, economic, environmental and democratic wellbeing for people living in the North of Tyne. These outcomes had 52 indicators sitting below them.
- The Framework comprised the Vision, the 10 wellbeing outcomes which were underpinned by 52 indicators based on regional, national, local data sets which allowed tracking of progress towards the 10 outcomes.

- Implementing the Framework – the NTCA Cabinet endorsed the report and the method of implementation was being considered. Progress would be regularly monitored and updates provided as necessary.
- In terms of Northumberland County Council, it was being considered how to take forward the Framework alongside its own priorities and strategies. The Framework would be discussed at the Health Inequalities Summit. Also, to develop the 'Health in all Policies Approach' and develop a tool to assist officers in ensuring that wellbeing was embedded in the decision-making process.

RESOLVED that

(1) the Wellbeing Framework and the proposed areas for its implementation in Northumberland be endorsed.

(2) Regular reports be submitted to the Health & Wellbeing Board.

50. IPC PROGRESS REPORT

Members received a presentation updating on IPC Progress from Dr. Graham Syers.

Dr. Syers raised the following key issues:

- The Clinical Commission Group had a statutory duty to sign off decisions and monitor the quality of services in Northumberland. From July 2022 that statutory function would transfer to the Integrated Care Board (ICB). Northumberland partners needed to think about how 'place' worked within that.
- The new arrangement had to build on the strength of what already existed in Northumberland. The Health & Wellbeing Board had to ensure that it played into this rearrangement of governance in the county.
- A Chief Executive Officer, Sam Allan, was now in place and she was listening to what needed to happen in place to ensure the right decisions were made and which were most appropriate to the needs of the people in Northumberland.
- A shadow board would be in place from April 2022 and a transitional process was going on with an operational framework now being suggested.
- Integrated Care Partnership – There was a huge footprint across the North East and Cumbria and this had presented huge challenges. The long established sub-regional partnership working between CCGs, Trusts and Local Authorities was recognised.
- Northumberland had a System Transformation Board (STB) where partners met to discuss issues around certain pathways. There was work to be done as to how the Health & Wellbeing Board interacted with the STB.
- A diagram showed how the ICS would work alongside the ICP. It was important to remember that Northumberland was a very large county with

many diverse communities in it. Listening to local communities to ensure appropriate primary care groupings and there was involvement by voluntary organisations.

- Structures had to be effective and appropriate planning arrangements.
- The decision process for allocation of resources would look slightly different. Whilst decisions were still made by ICB, it was still expected that spending would be delegated to a place level to ensure the right decisions were made for the people of Northumberland. The STB needed a refresh in the light of the revised ICB governance arrangements to ensure the right representation and leadership.

The following comments were made:-

- The Chief Executive of the ICS was currently undertaking an engagement process and it was expected that she would meet with the Health & Wellbeing Board at some point.
- There needed to be a closer liaison between the Health & Wellbeing Board and STB, but it was unclear where the Health & Wellbeing Overview and Scrutiny Committee fitted into the process.
- It would be a huge challenge to simplify the complex range of organisations involved to avoid duplication and to ensure they all complemented each other.
- Social determinants such as housing and education must be part of the conversation about meeting the challenges otherwise it would be a retrograde step.
- The public and communities needed to be involved to aid awareness and contribute to what was being decided. The People and Communities Strategy was being prepared in this respect.

RESOLVED that the presentation be received.

51. HEALTH AND WELLBEING BOARD FORWARD PLAN

Members received the latest version of the Forward Plan.

RESOLVED that the Forward Plan be noted.

52. DATE OF NEXT MEETING

The next meeting will be held on Thursday, 14 April 2022, at 10.00 a.m. in County Hall, Morpeth.

CHAIR _____

DATE _____

NORTHUMBERLAND COUNTY COUNCIL

HEALTH AND WELL-BEING BOARD

At a meeting of the **Health and Well-being Board** held in County Hall, Morpeth on Thursday, 14 April 2022 at 10.00 a.m.

PRESENT

Councillor B. Flux
(Chair, in the Chair)

BOARD MEMBERS

Bailey, M. (Substitute)	Nugent, D. (Substitute)
Brown, S.	Sanderson, H.G.H.
Lothian, J.	Simpson, E.
Mead, P.	Syers, G.
Morgan, E.	Watson, J.

IN ATTENDANCE

L.M. Bennett	Senior Democratic Service Officer
A Johnson	Northumberland CCG
G. O'Neill	Deputy Director of Public Health

53. APOLOGIES FOR ABSENCE

Apologies for absence were received from J. Boyack, R. O'Farrell, W. Pattison, G. Renner-Thompson, D. Thompson and P. Travers.

54. MINUTES

RESOLVED that the minutes of the meeting of the Health and Wellbeing Board held on 10 March 2022, as circulated, be confirmed as a true record and signed by the Chair:

55. LIVING WITH COVID

Members received a presentation from Liz Morgan, Interim Executive Director for Public Health and Community Services.

Liz Morgan highlighted the following key areas:-

- **Changing the way we manage the pandemic –** There was still a high number of cases in the UK. The pandemic would continue to take its course and it was important to expect the unexpected over the next 18 months/two years. The high prevalence of COVID did not appear to be

translating into high hospital admissions, however, hospitals were still under significant pressure.

- **Principles** –
  - Encouraging safer behaviours through public health advice.
  - Protecting people most vulnerable to COVID-19
  - Maintaining resilience
  - Securing innovations
- **Changes to Testing** – Free testing had largely ceased and was replaced by a more targeted approach
  - Testing for care – in hospitals, community and primary care, on emergency/unplanned admission, in advance of elective admission and on discharge into other care settings.
  - Testing to treat – High risk patients in the community – symptomatic testing to access treatment.
  - Testing to protect – symptomatic and asymptomatic testing in high risk settings such as NHS staff, social works, hospices and detention settings.
- **Surveillance** – The ONS survey was the main source of information currently and it was estimated that 1:13 people had COVID-19 in the week ending 2 April 2022. There was some evidence that the rate of increase was slowing.
- The case rates were levelling off in some age groups but still increasing in others. Some sectors not covered by the ONS survey were covered by the Vivaldi and Siren studies.
- **Advice to the public**
  - Living safely with respiratory infections including COVID-19 – get vaccinated, fresh air, good hand and respiratory hygiene, choose to wear a face covering.
  - Guidance for people with symptoms of respiratory infection including COVID-19 – people with respiratory symptoms and high temperature or do not feel well enough to work should stay at home.
  - After positive test, stay at home for at least five days (if you can).
  - Follow guidance to minimise spread of COVID.
  - Advise against presenteeism.
- **Opportunities** –
  - Good practice of COVID-19 vaccination programme to be applied to other vaccination programmes.
  - Build on infection prevention and control processes built up during pandemic.
  - Pivot the role of the Health Protection Board to consider wider health protection issues.
  - Work across the LA7 and wider North East area re. goals, short to medium term priorities and next steps.
- **Communications**
  - There had been a very successful programme based on behavioural insights. Messages appeared to resonate with the public when they came from local NHS partners and the Local Authority.

    - Emphasis on keeping the message simple and consistent and explain why this shift was being made and nuanced for different communities.
- **Key Messages**
    - Further waves were expected over the next few years, and it was important to be able to respond to these quickly with vaccination, mass testing and contact tracing.
    - Vaccination remained the main protection from severe disease and death and boosters would be required.
    - It was important to continue with basic hygiene measures which were effective in reducing transmission of COVID-19 and other respiratory diseases.

The following comments were made:-

- There was no longer a statutory requirement to self-isolate but people were advised to do so if they felt unwell. It was noted that many in less secure jobs or with less generous benefits packages may not be able to afford to do so.
- There may be an opportunity to look at sickness benefit packages to see if they were still fit for purpose and to try to ensure that no-one was disadvantaged. This was a matter for the Government.
- The retention of the Health Protection Board and its widened remit was welcomed. Gaps in the areas of immunisations, health care acquired infections and cancer screening affected some of Northumberland's most deprived populations. Some of the lessons learned through the pandemic could be applied to other programmes.
- There were still higher than average staff absence rates within the Northumbria Trust. COVID-19 was still putting an enormous strain on services and there was still a lot of activity that had not needed to be dealt with prior to the pandemic.
- Anecdotally, it was believed that the infection was lasting for longer, even in fully vaccinated people and causing people to be quite unwell. The impact of the virus did shift with each variant.
- Recovery of services was being monitored very carefully and targets based on COVID-19 case numbers falling. However, case rates remained high along with expectations of services

RESOLVED that

(1) the presentation be received.

(2) the COVID-19 Local Outbreak Control Management Plan be withdrawn.

(3) The Health & Wellbeing Board's role as the COVID-19 Control Board and Engagement Board be stood down.

(4) The Health Protection Board be maintained with broader terms of reference to provide assurance across a wider range of health protection

issues – infectious disease management, health care associated infections, immunisation uptake, cancer screening, surge testing and vaccination and future pandemic planning.

56. HEALTH INEQUALITIES SUMMIT

Members received a presentation from Gill O'Neill, Deputy Director for Public Health.

Gill O'Neill highlighted the following key areas:-

- The summit had taken place on 25 March 2022, chaired/facilitated by Professor Chris Bentley and with the keynote speaker, Cormac Russell and was working towards production of an Inequalities Plan for Northumberland.
- The event was not badged under any one organisation but aimed was to bring together a number of inequalities plans. Discussions included immersive experience, sharing examples of local best practice, social determinants and holding ourselves to account to deliver.
- **Key Messages from Cormac Russell**
    - Asset Based Community Development – working alongside communities and enabling them to do things for themselves.
- **Key Messages from Professor Chris Bentley**
    - Thinking about issues from a civic level responsibility perspective and what were the best levers to use all the tools in the tool box but also how best to enhance services at the right time and right place but also what could come from community. This would enable true 'Place' based working.
- **Interface between civic and community and services and community**
- Workshops identified the current position regarding civic into community seams and services into community seams. Discussions surrounded moving from Emerging/Developing/Maturing and Thriving. Attendees' opinion had been that Northumberland was emerging to developing when considering the whole system how to best work from a community centred perspective and to maximise the opportunities with civic responsibilities, services and empowering communities. However, it was stressed that there were pockets of mature and thriving examples.
- **Key Ambitions**
    - Improve data and insights sharing
    - Upscale community centred approaches as the core delivery model, using the three questions from Cormac Russell
        - What is it that communities can do best?
        - What do communities require help with?
        - What do communities need outside agencies to do for them?
    - Align the organisations and resources from a cultural and workforce perspective.
    - Look at everything through an inequalities lens.

The following comments were made:-

- It was acknowledged that there was disappointment from the voluntary sector representative that they had not been invited to attend the event. Invitations had been very restricted in order to keep the event COVID-19 safe. It was noted that invitations had been spread out over the NHS, Local Authority private sector, VCS. Advice had been taken from Citizens Advice and Northumberland Communities Together as to who was best to attend. The Summit had only been the start of the conversation and there would then be a move towards locality events to enable a richer conversation. Membership of the Task Group referred to was still to be discussed.
- Although there had not been an opportunity for members of the local community to attend, there had been video injects such as from the group 'Forget-Me-Nots', from a young man about his life experience and from a front line teacher.
- It was good to be recognised to be at the 'Emerging' stage and that a culture change was required. It was suggested that 'Emerging Together' may be a more appropriate title.
- The aim was to decide what more could be done across a range of areas. Ideally the Action Plan should be ready by September 2022 in order to feed into the 2023/24 budget process.
- It was stressed that the summit was an 'Inequalities' Summit and not a 'Health Inequalities' Summit. There was a shift in thinking as to what health was and what created a healthy life. To stay healthy included personal responsibility, choices, and how health services were accessed. Focusing on 'Inequalities' moved the focus from purely health to focus on the wider determinants.
- How the citizen's voice was written into the Action Plan would be very important.

RESOLVED that

(1) a Task Group be established under the Health & Wellbeing Board to progress the locality events and the Action Plan.

(2) the Summit's priority areas be agreed and included in the Inequalities Action Plan.

- To agree better share data and insights.
- To agree to work towards and embed a shred understanding and delivery of a community centred approach
- To work together to better share resources
- To consider all policies, strategies and action plans through an inequalities lens.

(3) to work towards a draft plan in the summer of 2022 and to formally sign it off in September 2022.

57. CHILD DEATH OVERVIEW PANEL (CDOP) ANNUAL REPORT (APRIL 2020-MARCH 2021)

Members received the Child Death Overview Panel Annual Report from Alison Johnson, Northumberland CCG.

Alison Johnson raised the following key points:-

- This was the first annual report of the reconstituted Panel which covered Gateshead, Newcastle, Northumberland, North and South Tyneside, and Sunderland. The purpose of the Panel was to scrutinise the circumstances of every child's death and, if appropriate, provide challenge to the agencies involved to enhance learning and make recommendations to improve service delivery and patient experience.
- In each case the cause of death was classified and contributory factors identified along with any modifiable factors. Recommendations were also made to prevent future similar deaths or to improve the safety and welfare of children in the local area and further afield.
- A total of 82 deaths had been reviewed (20 of which were in Northumberland). Nine had modifiable factors including maternal smoking, parental drug misuse, high maternal BMI, a child who did not have the flu vaccine, late pregnancy booking including drug misuse and alcohol misuse.
- The ages of the child deaths were not broken down, however, the highest category of child death 45% (37) was within the first 27 days of life.
- An example of actions taken included:
    - After the death of a young person after ingesting MDMA, the Substance Misuse Team had worked with Public Health to deliver a session in schools on recognising the signs of substance misuse and first aid.
    - Introduction of a question on food allergies was incorporated into existing asthma review templates following the death of a child from anaphylaxis.
- A breakdown of the modifiable factors and ages of children for each area had been requested

The following comments were made:-

- It was confirmed that still births were not included in the figures.
- The request for a further breakdown of modifiable factors was welcomed along with assurance that the appropriate processes were in place to assess the deaths. Alison Johnson confirmed that she attended all of the review and that any learning from issues highlighted would be taken forward.
- The review process itself was assessed to ensure that it remained robust.
- The Panel report had previously gone to the Children's Safeguarding Partnership but was now felt to be more Public Health related. The Partnership had taken on board the modifiable factors to be the areas that

it should focus on. For example, the issue of safe sleeping had resulted in work being carried out with Midwives and Health Visitors and interventions put into place at the recommendation of the Safeguarding Partnership.

- The Annual Report would continue to be submitted to the Safeguarding Partnership as well as the Health & Wellbeing Board.
- It was suggested that there was an opportunity for all of the CDOP Panels across the region to collaborate and share reports.

The Chair thanked Alison Johnson for the report.

RESOLVED that the report be received.

58. HEALTH AND WELLBEING BOARD FORWARD PLAN

Members received the latest version of the Forward Plan.

RESOLVED that the Forward Plan be noted.

59. DATE OF NEXT MEETING

The next meeting will be held on Thursday, 12 May 2022, at 10.00 a.m. in County Hall, Morpeth.

CHAIR _____

DATE _____

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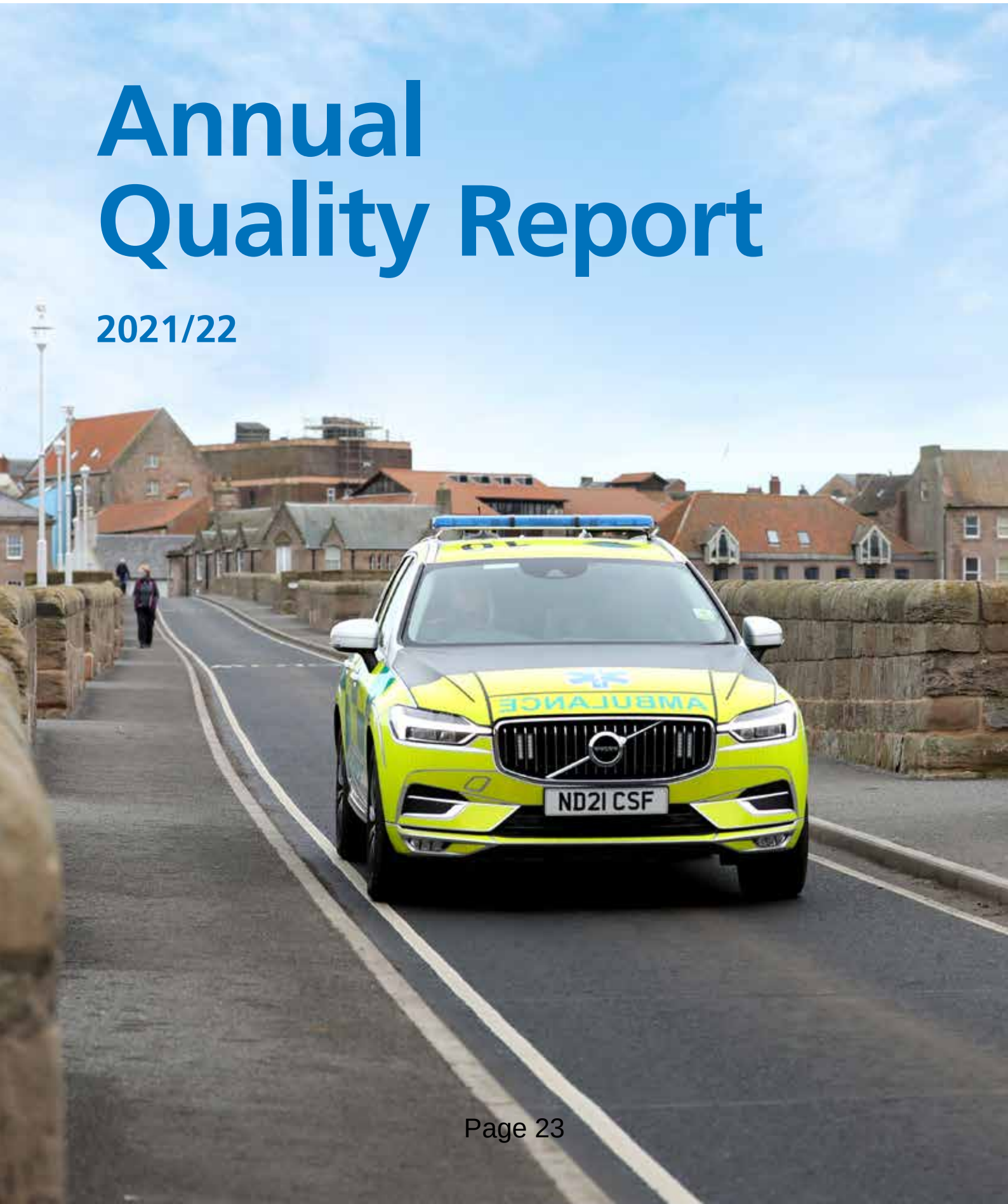
NHS
North East
Ambulance Service
NHS Foundation Trust

Annual Quality Report

2021/22



About us

At NEAS we provide an unscheduled care service to respond to 999 calls and a scheduled care service which offers pre-planned non-emergency patient transport in the region.

We operate NHS111 for our region which is supported by a clinical assessment service, providing clinical support to health advisors and patients ringing 111 and 999. These services are supported by our operations centres based in Newburn, Hebburn and Billingham, managing more than 1.5 million calls per year. We also deliver specialist response services through our Hazardous Area Response Team (HART) who deal with hazardous untoward incidents

Our Mission:
Safe, effective, responsive care for all

Our Vision:
Unmatched quality of care

Our 2022/23 Quality Priorities

Safety		Clinical Effectiveness	Patient Experience
Working with system partners to reduce handover delays	Learn from incidents and prepare for PSIRF	Use our resources as efficiently as possible	Involve our patients and communities to improve care

The formatting and sequencing of this document are in accordance with the National Health Service (Quality Accounts) Regulations 2010 and Department of Health and Social Care (DHSC) Quality Accounts Toolkit 2010/11 and NHS England and NHS Improvement Detailed requirements for Quality Reports 2019/20 guidance

Contents

Statement from the Chief Executive

I am delighted to introduce the North East Ambulance Service (NEAS) 2021/22 Quality Report which demonstrates our commitment to the continued delivery of high quality patient focused care over the past year.

It's hard to believe in my statement last year that I wrote about the challenges being faced by the COVID-19 pandemic and at that time we were starting to see some positive recovery. However, as we all know the Omicron variant of COVID-19 arrived and we saw another difficult and challenging year. Like all our health and social care colleagues across the country, NEAS had to continue to manage the impact of this new variant. In spite of this our staff continued to provide amazing services to our patients and I am so grateful to each and every one of the NEAS family.

Despite the commitment of our staff, the ongoing impact of the pandemic meant we had to make some difficult decisions about pausing some non-critical work and focus on our priority of ensuring we provided safe and effective care for our patients and a safe working environment for our staff.

As we now emerge from the pandemic our focus must move to the recovery of services, supporting our workforce and preparing for the changes in our external environment. 2022/23 will bring major changes which will impact on the way we deliver our services and the lessons we have learnt throughout the pandemic.

As ever our staff continue to go above and beyond our expectations and amongst all the challenges they faced last year, they supported us to develop our new five year trust strategy which we launched in July 2021. The strategy sets out a clear direction for NEAS to deliver our vision of unmatched quality of care, whilst keeping the patient at the centre of all we do. Within the strategy we have identified four ambitions which we fondly call our Ps and Qs: -

- **People** - a great place to work and grow
- **Performance** - deliver outstanding performance, every time
- **Partner** - collaborate and innovate with other partners
- **Quality and safety** - safe, compassionate and inclusive care

These form the cornerstones for our strategy and are supported by nine underpinning plans, which will provide the foundations for the delivery of the priorities we will work on over the next five years.

Our quality report outlines the progress against our 2020/21 quality priorities but, also recognises where we were not able to achieve all the key actions as planned due to prioritising patient care and the unprecedented demands we experienced on our services. However, we will ensure the outstanding actions will be completed during the year ahead.

With the easing of COVID-19 restrictions we were able to undertake a period of consultation with our internal and external stakeholders throughout April and May 2022 which enabled us to ensure our 2022/23 priorities fully addresses the needs of patients, our staff, partner NHS organisations and other business partners across our region.

This Quality Report can only provide a glimpse of what we have achieved in 2021/22 and what we hope to achieve in 2022/23.

Finally, I would like to say I continue to be immeasurably proud of our staff, NEASUS colleagues and our valued volunteers for their hard-work, dedication, compassion and care which has never wavered during an unimaginable time both personally and professionally for everyone. You really do make a difference and we CARE about you. My sincere thanks also go to our partners and the people in the communities who have supported us throughout and who we are extremely proud to serve.

Helen Ray
Chief Executive

Peter Strachan
Chairman

2021/22 At a glance

520,899
999 calls answered

675,912
NHS 111 calls answered

412,068
Patients taken to hospital

115,319
Patients treated and discharged at home

48,054
Patients treated and discharged over telephone

272,186
Patients taken to hospital appointments

387,440
incidents attended

06:56
Average C1 response

Ambulance response times

C1	C2	C3	C4
06:56	36:39	1:52:48	1:32:33
1st	4th	3rd	1st

Ranked out of 10 ambulance trusts

Safety

2493
Patient safety incidents (17 per 1,000 calls)

6
Serious incidents

Clinical Effectiveness

2,565
cardiac arrests attended

Ambulance Care Quality Indicators

25.8%
Patients achieved a return of spontaneous circulation (ROSC)

85%
Sepsis care bundles delivered

99.3%
Stroke care bundles delivered

78.9%
STEMI care bundles delivered

TOP PERFORMERS

50%
Patients achieved return of spontaneous circulation (Utstein)

26.9%
Cardiac arrest patients survived to 30 days (Utstein)

7.3%
Cardiac arrest patients survived to 30 days

Patient Experience

96.8%
999 see and treat rated very good/good

93.2%
Patient transport service rated service very good/good

90.6%
999 see and convey rated very good/good

76%
111 service rated very good/good

70+
Workshops delivered to BAME communities

Looking Forward

All NHS Trusts are required to produce a Quality Report to provide information on the quality of the services they provide to patients, their families and carers. The report allows NEAS to demonstrate how we are performing and identify areas for improvement considering the views our service users, carers, staff and the public.

NEAS strives continuously to improve patient safety, patient experience and clinical effectiveness. As we emerge from the pandemic our focus is shifting to the recovery of services, supporting our workforce and preparing for the changes in our external environment. 2022/23 will bring major changes which will impact on the way we deliver our services.

Our quality priorities have been chosen to align with NHS England and NHS Improvement's 2022/23 operational planning guidance and priorities for the National Health Service, the Care Quality Commission Domains and our Trust five-year strategy 2021-2026. We have outlined four quality priority options for 2022/23.

We are pleased to report COVID-19 restrictions are easing and we are able to undertake a period of consultation with our internal and external stakeholders throughout April and May 2022. This will enable us to ensure our 2022/23 priorities fully address the needs of patients, our staff, partner NHS organisations and other business partners across our region.

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Proposed Priorities for 2022/23

Safety

Why is this important to us?

We want to reduce risks, errors and harm for our patients and improve our services by learning from things that go wrong.

Priority 1: Working with system partners to reduce handover delays

Lead: Stephen Segasby, Chief Operating Officer

Why did we choose this priority?

To reduce the risk of harm to our patients, improve outcomes and patient experience.

We know there is a risk to patients waiting outside in ambulances for admission to the Emergency Department (ED). Delays can result in poor patient outcomes, poor patient experience and impact negatively on ambulance crews.

The national handover target for hospitals is 15 minutes with no ambulances waiting more than 30 minutes.
The average handover time for NEAS during 2021/22 was 22 minutes 16 seconds (7 minutes over the target).

Hospitals are clinically responsible for patients as soon as the ambulance arrives at ED but we all have a role in managing demand pressures and reducing risks to patient safety.

Our aim?
To handover over patients to ED safely within 15 minutes, effectively reducing the risk to our patients, improving patient outcomes and patient and staff experience.

How will we do this?

- Undertake a thematic analysis of handover delays
- Review the procedures in place between NEAS and each acute hospital Emergency Department (ED)
- Understand the impact on the overall patient experience of patients waiting in ambulances
- Understand the impact of handover delays on our staff
- Work with our partners to consider ways to improve effectiveness across all parts of our system
- Review and refine our risk management and escalation arrangements during times of demand

Indicators of success

- Increased understanding of the patient harm caused by delayed handovers and improved learning
- Reduction of harm to patients
- Improved patient experience
- Improved staff experience
- Collaborative working with our partners and a system wide approach to finding a solution
- Achievement of waiting time targets
- Clinically effective escalation processes to keep patients safe in periods of high pressure
- Improved governance arrangements including an increase in incident reporting to promote learning and improvements

Priority 2:
Learn from incidents and prepare for the Patient Safety Incident Response Framework (PSIRF)

Lead: Sarah Rushbrooke, Director of Quality, Patient Safety, Innovation & Improvement

Why did we choose this priority?

To improve our services by learning from things that go wrong.

The PSIRF calls for a new approach to incident management; doing fewer "investigations" but doing them better and by people that have been trained to do them.

The new framework will be introduced during 2022 and we will need to ensure we have support structures in place for staff and patients involved in patient safety incidents.

Our aim?
To develop the cultures, systems and behaviours necessary to respond to patient safety incidents (PSIs) in a way that ensures we learn from mistakes and improve.

How will we do this?
- Development of robust governance and oversight procedures to support an effective organisational response to incidents
- We will review the feedback from PSIRF early adopters and draw on good practice from healthcare and other sectors to promote learning and continuous improvement
- We will complete a thematic analysis of incidents
- We will continue to learn from when things go well as well as when they go wrong, ensuring that learning is shared both internally and externally to improve the quality of care we provide to our patients
- We will work closely with partners to identify and mitigate risks across the system and implement the Patient Safety Incident Response Framework once published
- Establish a PSIRF implementation oversight group

Indicators of success
- Completion of thematic analysis to identify patient safety priorities including development of a dynamic reporting dashboard
- Improved triangulation of incidents and feedback to understand themes
- Improved quality, timeliness of investigations and learning from PSI investigations
- Reduction in the number of patient safety incidents
- Reduce the numbers of Never Events and/ or PSIIs involving death, severe harm and moderate harm
- Establish and provide training for all staff undertaking investigations
- Effective use of investigation process outcomes to inform Trust wide improvements
- Improved working environment for staff in relation to their experiences of patient safety incidents and investigations

Clinical effectiveness:

Priority 3:
Use our resources as efficiently as possible by making better use of our clinical model

Lead: Mathew Beattie, Medical Director

Why did we choose this priority?

To create a culture of continuous improvement and learning so our patients receive the best care.

As we emerge from the COVID-19 pandemic and enter systemwide partnership working we need to establish our role as providers of urgent and emergency care by ensuring our patients are treated in the right place at the right time by a skilled workforce.

Our aim?
To release the pressure that is being placed on hospital Emergency Departments (EDs) by managing some patients in different ways such as providing more treatment and care on scene, in their own home, or referring them to alternative pathways.

Why is this important to us?

We want to do the right thing, at the right time, for the right patient and demonstrate improvements in the quality and performance of our services.

How will we do this?
- We will work with colleagues from the performance team and operational directorates to undertake initial analysis of hear and treat and see and treat rates and scope options for improvement
- We will develop a blended workforce model with the right sills to be responsive to the needs of our patients in our communities reducing the reliance on EDs
- We will improve access to additional clinical advice for our staff
- We will review and increase the non-medical prescribing capability
- We will evaluate a mental health car pilot and explore other pathways to provide mental health support
- We will evaluate end of life service provision and look to explore ways to improve working
- We will look to introduce technology for remote consultation in EOC
- We will work with our partners in the region to develop urgent care 2-hour community pathways

Indicators of success
- Reduction in conveyance to hospital
- Increased hear and treat rates
- Increased see and treat rates
- Improved patient experience and outcomes
- First cohort of rotational paramedics to support primary care networks
- Increased staff training
- Non- medical prescriber workforce capacity increased
- Real time data alerts to identify issues and trends to support redistribution of resources
- Access to additional clinical advice for frontline staff
- Improved workforce skill mix

Patient experience:

Why is this important to us?

What matters to our service users matters to us. We want to ensure our patients, their families and carers have the best possible experience of care when they use our services.

Priority 4: Involve our patients & communities to improve care

Lead: Sarah Rushbrooke, Director of Quality, Patient Safety, Innovation & Improvement

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Why did we choose this priority?

Our patients are at the heart of everything we do and are paramount to helping us shape the care we deliver.

We strive to deliver the highest possible quality of care that is accessible to all. We want to shape our services on what matters to our patients, their carers and our communities.

Our aim?

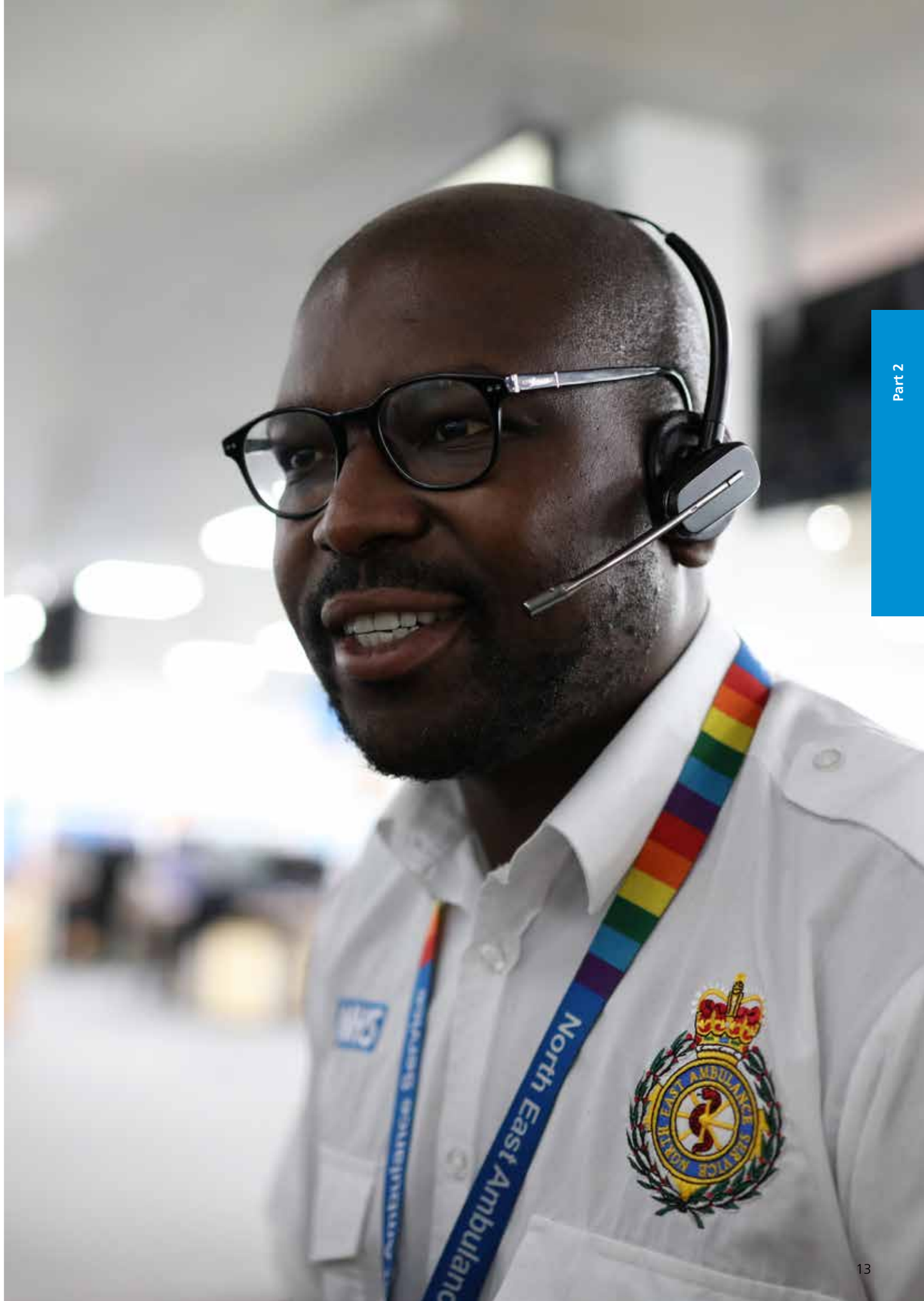
We want to create a positive experience for our patients/service users and their families/carers by delivering excellent services. We recognise that some patients do not participate in our survey and we will look to new ways to improve how we listen to and use feedback from patients' carers and families to improve our services.

How will we do this?

- We increase our engagement events in person and virtual including through joint engagement opportunities with local health providers, Healthwatch organisations, local authorities and commissioners
- We will explore opportunities to develop volunteers (e.g. community responders) as ambassadors in their areas
- We will listen to patients to understand their priorities
- We will seek patient feedback and involvement in service change, service delivery, design and redesign
- We will look for opportunities to include patient representatives on assurance committees
- We need to widen and increase our public involvement in both the development of these new services and monitoring of their success
- We need to listen to our patients, their families and carers, and respond to their feedback

Indicators of success

- Improved patient experience shown by reduced complaints
- Increase in positive feedback from patients via Friends and Family Test, compliments, National Patient Surveys and other social media platforms, indicating that patients feel involved in planning our services
- Increased capacity to engage with local communities
- Improved patient outcomes for selected patient groups
- Improved working relationships with stakeholders and partners
- Projects and developments will benefit from patient engagement and statutory requirements will be met



2021/22 Review

Quality Priority Performance 2021/22

Monitoring of the progress against our quality priorities was reported to our Clinical Quality Committee.

We were not able to achieve all of the key actions as planned due to prioritising patient care in response to the COVID-19 pandemic and unprecedented demands on our services but we will ensure the outstanding actions will be completed during the year ahead. We are pleased to outline the progress we have made so far in delivering the 2021/22 quality priorities.

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Priority 1
Managing the deteriorating patient in the Emergency Operations Centre (EOC)

Our aim was to ensure we have robust processes to manage the identification of deteriorating patients in the care of the EOC efficiently and effectively.

We planned to reduce the number of patients who suffer harm or deterioration in their condition while they wait for an ambulance by identifying 'at risk' patients at the earliest opportunity and escalating them to the most appropriate service for treatment.

How did we do?
Our updated Clinical Safety Plan helped to identify and allocate resources safely and efficiently to the sickest patients during unprecedented periods of demand.

What do we need to do now?
We recognise that there are still further improvements to be made and we continue to review and adapt our processes including the use of digital systems to support our EOC teams to achieve this priority.

What we wanted to achieve	Did we achieve this?
Further review and survey of clinicians regarding upgrading of patients in a peri arrest situation	✗
Review our research findings to determine if the timing and frequency of call backs can be linked to determining if patients are clinically deteriorating and any learning that can be used to improve the systems we use	✓
We will look at the role of clinicians based in the dispatch area to understand the impact of this on the deteriorating patient	✓
We will look at the data linking learning from deaths reviews and patient safety incidents with any delays in responding to the patient to determine learning from this	✓
We will continue to review the impact of the 'No send' policy when we are in times of escalation	✓
We will further review patient safety incidents relating to scheduled care services and how we may learn from these.	✓

What did we do?

Multiple call backs study

The study was led by our consultant paramedics and aimed to identify the link between frequent call backs, conditions of concern and patient deterioration. The team met weekly with operational colleagues to review patient outcome and mortality data, and as a result, significant improvements have been made to recognise and manage the deteriorating patient. The study identified a shift in the clinical profile of patients who were likely to deteriorate whilst waiting for an ambulance resulting in new cohorts of patients that should be prioritised. New actions were introduced to support dispatchers and EOC clinicians to review clinical need and respond to the clinical risk safely by allocating ambulances based on clinical need.

Dispatchers - conditions for review:

- Marked by a clinician as a priority
- Resource on scene requiring back up
- Uncontrolled haemorrhage
- Inter-facility transfers (IFT) level 2
- Stroke
- Declared hypoxia (<85%) or National Early Warning Score (NEWS) >7
- Paediatric patients

Clinicians - patients prioritised for validation:

- Clinical concern identified by the shift coordinator
- Unconscious
- Bleeding
- Stroke
- Breathing problems
- Paediatrics
- Chest pains

If validation confirms the case does not require prioritisation the priority code will be removed, and an ambulance will be dispatched under as per normal procedures. This is to ensure only the sickest patients are being prioritised.

We continue to evaluate our findings to determine if there is a statistically significant correlation between calls and deterioration and will continue to use this work to inform future changes.

Safety in times of demand

Challenges with staffing resource levels and peaks in demand resulted in pressures which affected our performance against the ambulance response and clinical performance standards. Our Clinical Safety Plan (CSP) allowed us to respond quickly in times of pressure whilst maintaining patient safety.

We used the findings from the 'multiple call backs' study data from the multiple call backs study, patient safety incidents and learning from deaths to develop our dispatch clinical risk assessment procedure for EOC and update our clinical safety plan.

We implemented these actions to improve the early recognition of deteriorating patients leading to a reduction in the expected number of incidents associated with failure to recognise and address patient deterioration. Early findings suggest a reduction in the number of Inter Facility Transfer (IFT) call upgrades, improvements in stroke performance and a decrease in the patient pre-alerted following long waits category.

Dispatch Clinicians

We undertook a study to understand clinicians' rationale when considering upgrades to Category 1 ambulance response targets and found clinicians appeared to upgrade to a priority 1 due to individual patient risk and were not aware of the priorities of patients outside their area already waiting for a response. We initiated a pilot allocating clinicians to a designated dispatch desk working with individual dispatch teams to inform decision making and found this reduced deaths and pre-alerts and allowed the early recognition of deteriorating patients. However, this was resource intensive, and we were unable to sustain this approach due to staffing levels and periods of high demand.

We recognise clinically led prioritisation so that the most urgent cases are scheduled first, improves the safety and outcomes for patients and plans to increase EOC clinician capacity are on-going including recruitment to core clinical advisor vacancies, and additional sessional GP activity and Vocare sub-contracted support from external providers.

Review of no send policy

We follow our internal Demand Management Plan in times of pressure this which includes asking patients who can safely make their own way to hospital to do so. This frees up an ambulance resource to respond to those patients in greater clinical need. We evaluate every ambulance re-attendance to a patient within 24 hours to review whether the initial non-conveyance was clinically safe or whether there was potential for patient harm. We formally report our no send activity to the Trust's Executive Management Ggroup and Quality Committee on a quarterly basis. Introduction of the no send policy has not resulted in any serious patient safety incidents or complaints.

We introduced a 'no send' patient survey in 2021 to allow us to review the number of people re-contacting the service, their reason for doing so and also monitor their satisfaction with the service. The latest data shows despite the continued high levels of Ccategory 1 and Ccategory 2 incident volumes the number of patients re-contacting the service within 24 hours was 7.1%, and 61.9% patients rated the service as good or very good compared to 21.4% poor or very poor. We will continue to collect survey data until September 2022.

We explored the possibility of accessing data for patients who may have presented at any Emergency Department (ED) after calling NEAS but however, under the General Data Protection Regulation (GDPR) we are unable to access personal data within from a separate part of the NHS system.

Learning from deaths and patient safety incidents. There have been marginal improvements in the number of patients who died in care (which still correlates to operational performance) but, the profile of the patients that now die in care has changed since the full implementation of the updated Clinical Safety Plan.

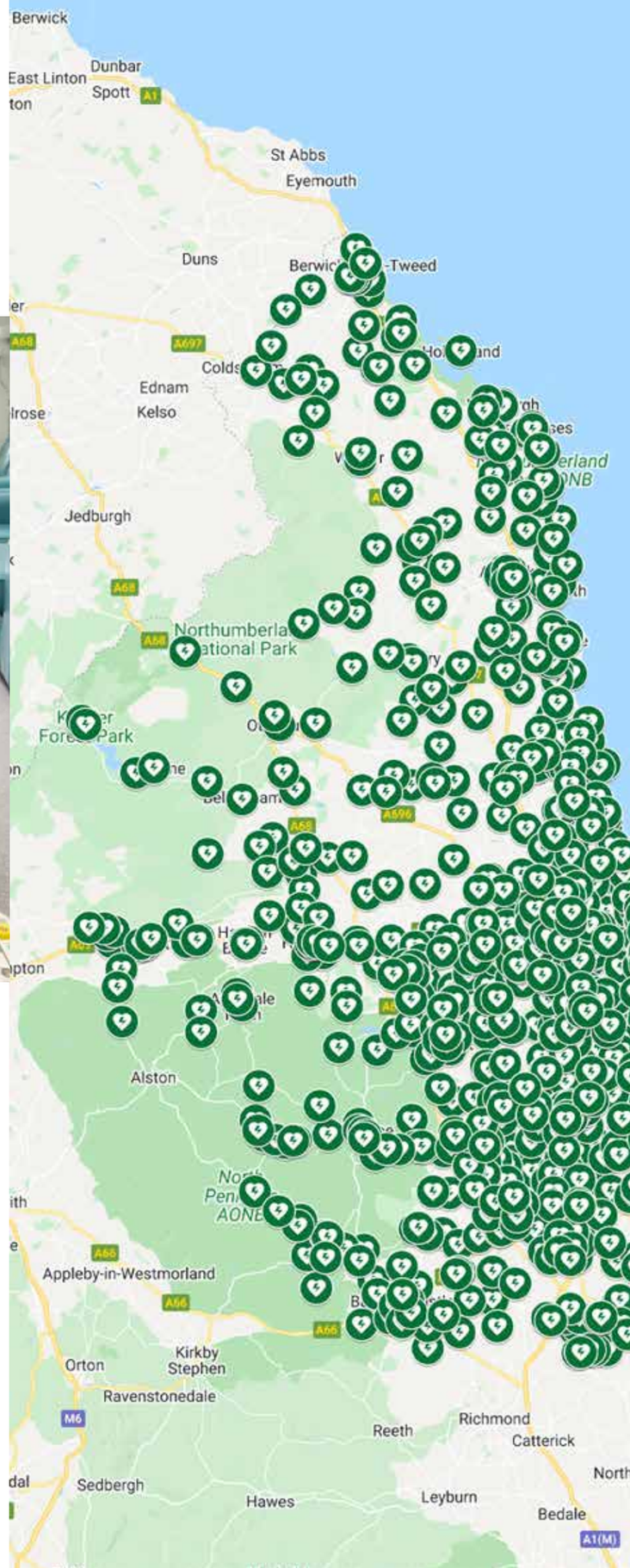
Priority 2
Improving cardiac arrest care

Our aim was to improve cardiac arrest outcomes for our communities. It is well known that survival for patients experiencing a cardiac arrest is dependent on receiving treatment within a very short timeframe. Early recognition and access to treatment, early cardiopulmonary resuscitation (CPR) and early defibrillation are all key to survival.

How did we do?
We have increased the number of Community Public Access Defibrillators (cPADs) throughout the north east and we are working with the British Heart Foundation to map the location of all defibrillators

What do we need to do now?
We will look to reduce inequalities in our region through our research projects.
We will increase life-saving skills training events as COVID-19 restrictions ease.

What we wanted to achieve	Did we achieve this?
Continue to support the purchasing of community public access defibrillators (cPADs), through our NEAS Trust Fund to place in areas we feel would benefit most, based on our local intelligence	✔
Review the impact of the specialist paramedics in emergency care dispatch desk in deploying dedicated resource to patients who have had a cardiac arrest.	✔
Use smart technologies to activate the public and clinical staff to a nearby cardiac arrest to enable early intervention	✔
Contribute to research regarding cardiac arrest in the out of hospital setting	✔



What we did

cPADs

We know that prompt resuscitation and using a defibrillator (where this is required) helps to save lives, and the number of cPADs has continued to increase across the Trust area.

The Trust is working with the British Heart Foundation on a national project to map every defibrillator across the north east area to automatically populate in our Control Room when a 999 call comes in. A 999 call that requires CPR advice now automatically receives that coaching from a health advisor.

Bystander CPR

Despite the North East and Cumbria having a higher number of cardiac arrests in the community compared to other parts of the country, statistics show that if you have a cardiac arrest outside of hospital in our region, you are less likely to receive CPR and therefore less likely to survive.

We launched a targeted communications strategy to improve cardiac awareness via social media Facebook and Twitter and we have continued to work with the local community to provide education and training at face to face events where permitted.

Whilst NEAS remains in the lowest 25% of all Ambulance Trusts for bystander CPR our position has improved from last year and we have seen an improvement in our cardiac outcomes.

Specialist Paramedic Emergency Care (SPEC) deployment

Following changes to our operating model specialist paramedics no longer work within EOC. We have worked with informatics colleagues to develop a specialist paramedic utilisation report. Using the dispatch deployment criteria for our specialists we have determined by hour of the day and geographical area where these incidents most frequently occur. Our intention now is to use this to trial dynamic stand by bases with a view to assessing if this improves the utilisation and appropriateness of tasking for specialist paramedics.

Research

The research team at North East Ambulance Service has secured £50,000 in funding from the National Institute of Health Research Applied Research Collaboration to undertake a 12-month project, to better understand the reasons why people are less likely to perform CPR in the north east, and to begin to address these inequalities. The research includes a regionwide face to face survey with the public on their understanding of CPR.

There is also a multi centred research project ongoing looking at the different routes to give medication to a patient in cardiac arrest.

NEAS contribute to the national out-of-hospital cardiac arrest outcomes study which is facilitated by Warwick University. This national registry is used to inform policy and practice changes.

All findings and action plans are monitored regularly through the Trust's Clinical Quality Governance Group and Quality Committee. In addition to this NEAS has a well embedded learning from deaths process, with a continuous commitment to reviewing and improving care provided to patients.

Patient Frank Kelly reunited with Nissan workers who delivered bystander CPR and the 999 call handler and ambulance crew who attended

3.1.3 Priority 3
Improving End of Life Care

Our aim was to ensure patients receive end of life care and a calm and peaceful death, in their preferred place of care, wherever possible.

We want to allow our patients with a life limiting illness to die with dignity enabling them to achieve what they would consider 'a good death' whilst supporting their families and carers. Our aim for every patient is to provide treatment and support in line with their wishes, to the best of our ability, to ensure the alleviation of pain and suffering.

In order to fulfil this priority, we need to have skilled staff within our EOC and throughout the operations department to support high quality assessment and care when caring for a patient at the end of their life and providing support to their loved ones by having access to information to support clinical decision making.

How did we do?

- We reviewed our service delivery to ensure it is consistent with the Association of Ambulance Chief Executives guidance 'the route to success in end life care – achieving quality in ambulance services'
- We are working closely with our regional palliative care stakeholders to continually improve our services
- We have updated and improved our training content

What do we need to do now?

- We will continue to work with our stakeholders to develop efficient integrated systems to improve information sharing
- We will continue working with our commissioners to secure funding to provide a 7-day end of life transport service
- We will implement our patient and carer feedback survey to determine effectiveness and identify areas for improvement

What we wanted to achieve	Did we achieve this?
Embed the process to triangulate learning from patient safety incidents, feedback from carers, feedback from acute providers and themes identified from the learning from deaths process to better understand what we need to do within NEAS and across the system to support end of life care	✓
Continue to collect data on Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) information shared with NEAS, broken down to Clinical Commissioning Group level and report the findings to identify where information sharing gaps occur	✓
Review the data for non-conveyance of patients where we know there is a DNACPR in place, by CCG area and work with key partners to determine reasons for this	✓
Identify and work within a locality to review conveyance rates to hospital of patients in the care home sector who die within 24 hours to determine learning from this	✗
Develop the business case for commissioners to consider so that we can provide a 7-day end of life transport service	✓

What did we do?

Learning from patient safety incidents, deaths and feedback from our service users

The end of life team received 76 incidents from 2018 to date via complaint form submissions or the patient experience team. The incidents and feedback have identified trends relating to ambulance delays and issues regarding 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms.

NEAS has three dedicated ambulances provided by St John Ambulance Service, one for each operational division. The vehicles are equipped to transport patients at the end of life comfortably and efficiently and are staffed by an emergency care technician-led crew who have undergone palliative care training.

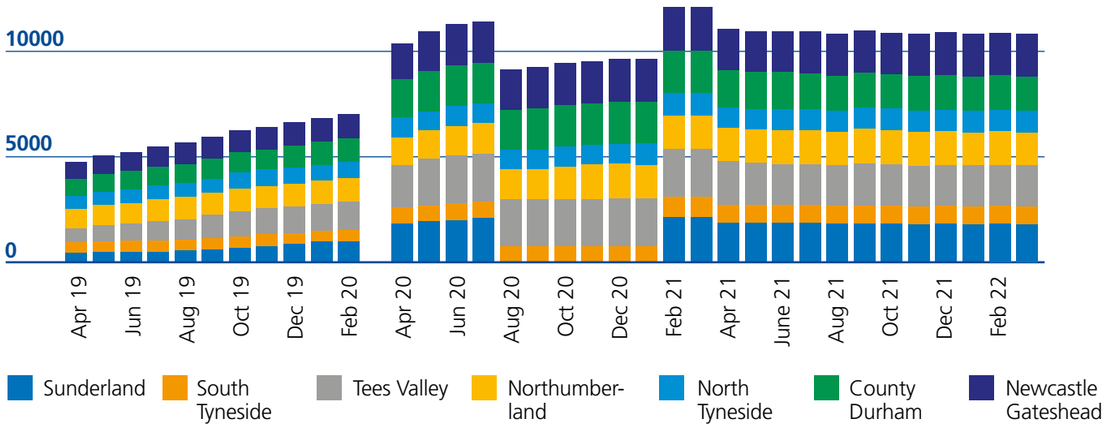
We aim to provide a vehicle within one hour of booking where possible but if this response is not met, a NEAS call handler will contact the person who placed the booking with an explanation and an updated expected time of collection. Our performance against this target in 2021/22 was 1 hour 27 minutes on average and we are working with St John Ambulance and our Operations Centre to protect the service to improve response times.

DNACPR issues included inconsistencies with documentation, concerns regarding the validity of the document and out of date documents. The end of life team has provided training, issued medical alerts and released DNACPR Frequently Asked Questions (FAQ) information to help staff understand the principles and implications of DNACPR.

DNACPR data

Sharing information across services eg plans and stated preferences such as DNACPR is essential to allow our clinicians to make appropriate decisions. We have collected DNACPR data at Clinical Commissioning Group (CCG) level since April 2019. We have not identified any reportable gaps or inconsistencies with the data, although it is highly likely DNACPR data is underreported to NEAS.

DNACPR Data April 2019-January 2022



It is estimated around 1% of the population will be in the last year of their life and on the palliative care register (with a vast proportion having a DNACPR in place), although we have seen an increase in the number of DNACPRs reported to NEAS this only equates to between 0.3%-0.7% across the various CCGs.

We are working with our partners and palliative care network to improve information sharing information across all services.

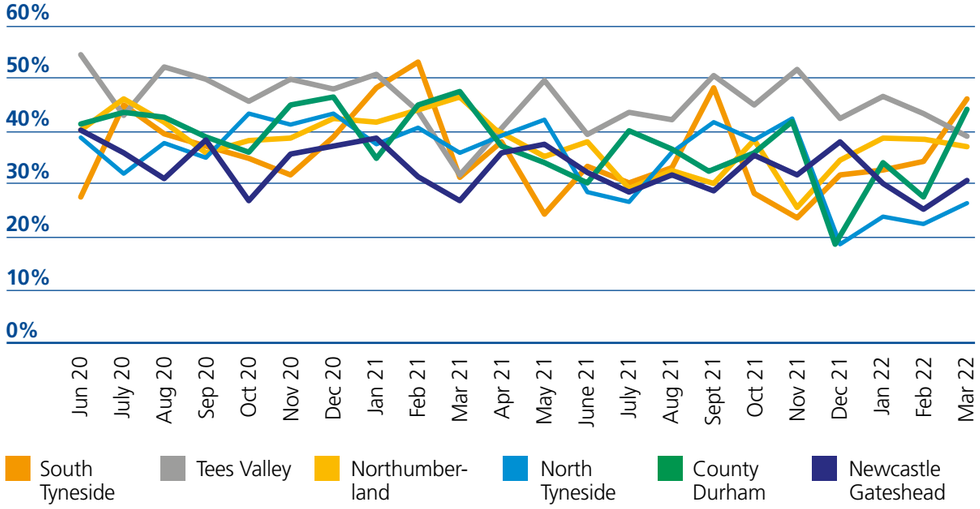
There is a clear link between increased information sharing and a reduction in palliative and end of life care patients being conveyed to hospital after an ambulance has arrived on scene. This is reported monthly to the Palliative and End of Life Care regional clinical network and to CCG representatives.

Review of conveyance rates

It is vital that ambulance services are made aware when care plans and DNACPRs are in place to prevent unnecessary conveyances for people nearing the end of life.

Non -conveyance rates have fluctuated throughout the year but continue to demonstrate the correlation between increased information sharing and fewer palliative patients being conveyed to emergency departments. We are currently working with South of Tyne partners to review non-conveyance rates.

Non-conveyance rates June 2020- January 2022



7- day end of life (EOL) transport

There is sufficient evidence to support a 7-day transport service. 12.6% of all transport requests are received over a weekend and all weekend requests are responded to by core emergency vehicles. Introducing a 7-day service would allow appropriately skilled crews to attend to our EOL patients, reduce waiting time delays, release A&E resources to respond to emergency calls, reduce bed pressures in hospitals and align our service with the national ambition for 7-day palliative and EOL services. We have developed the business case to provide a 7-day EOL transport service and will be working with our commissioners to support our request.

Education and training

We have updated and improved our education and training resources to ensure our staff understand the issues and implications around caring for people nearing the end of life. The training includes communication and listening skills, tackling difficult conversations, understanding other organisations' roles and relevant guidance. We have delivered training to 241 front line staff and health advisors this year and plan to develop bespoke training packages for Associate Practitioners and GPs, bitesize training videos for front line staff, and to release a frequently asked questions factsheet.

Case Study

We were asked to transfer a patient who wanted to visit home prior to their transfer to St Oswald's Hospice. The patient wanted to see his home and his friend one last time as his friend was unable to visit the patient at hospital or hospice due to their own limiting health conditions. Our Dispatch Manager and St John Ambulance team worked together to ensure the patient's wishes were fulfilled.

Thanks to NEAS and St John Ambulance team's responsiveness and compassion the patient was able to spend precious time with his wife and friend one last time prior to arriving safely at the hospice where he died peacefully.

Statement of Assurance from the Board of Directors

During 2021/22 the North East Ambulance Service NHS Foundation Trust (NEAS) provided and/or sub-contracted three relevant health services. For NEAS relevant health services are defined as Emergency Care (Unscheduled care), Patient Transport Services (Scheduled care), NHS111, including our Clinical Assessment Service and GP Out of Hours services.

NEAS has reviewed all the data available to them on the quality of care in all three of these relevant health services.

Financial and reporting arrangements including CQUIN

This section of the report is common to all healthcare providers and ensures that all quality accounts are comparable.

High level indicators of quality and safety are routinely reported to the Board and Council of Governors and our quality report gives information under the headings of patient safety, clinical effectiveness and patient experience, measuring areas of compliance, progress and improvement throughout the financial year. Performance is also compared to local and national standards where these are available.

All members of the Board would usually undertake regular quality walkarounds and report issues and concerns into individual directorates as and when necessary. However due to COVID-19 this has not been possible. The Board has therefore received assurance from Executive colleagues at Board and received reports focussed on responding to COVID-19 and how quality and safety has been maintained.

The income generated by the relevant health services reviewed in 2021/22 represents X% of the total income generated from the provision of relevant health services by NEAS for 2021/22. This represents a minimal change with just over £Xk of reported £X million coming from non-NHS partners, mainly around event cover and local authority funding.

The Commissioning for Quality and Innovation (CQUIN) payment framework is designed to support the cultural shift to put quality at the heart of the NHS. Local CQUIN schemes contain goals for quality and innovation that have been agreed between the Trust and our Commissioners across the region. NHS England continued the block payments approach for arrangements between NHS commissioners and NHS providers in England for the first half of the 2021/22 financial year. Block payments to NHS providers are deemed to include CQUIN, and there will be no 2021/22 CQUIN scheme (either CCG or specialised) published at this stage.

NEAS did not submit (and is not required to submit) records during 2021/22 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

NEAS's Data Security and Protection Toolkit status for 2020/21 is ''Approaching Standards".

NEAS was not subject to the Payment by Results clinical coding audit during 2021/22 by the Audit Commission.

Clinical Audit

During 2021/22, 25 national clinical audit projects and 8 clinical outcome quality indicators covered the relevant health services that NEAS provides. There were no national confidential enquiries that NEAS was eligible to take part in this financial year. NEAS submitted 100% eligible cases for the national ambulance clinical quality indicators and two eligible national clinical audit projects; myocardial ischaemia national audit project and sentinel stroke national audit project.

National Clinical Audits the Trust was eligible to participate in	Did the Trust participate	Number of cases submitted
Data presented represents nationally published performance between April – September 2021. This is subject to change due to the bi-annual re-submission period.		
Cardiac arrest: return of spontaneous circulation	Yes	100% (1017)
Cardiac arrest: return of spontaneous circulation (Utstein)	Yes	100% (168)
Cardiac arrest: survival to 30 days	Yes	100% (992)
Cardiac arrest: survival to 30 days (Utstein)	Yes	100% (158)
Post-ROSC	Yes	100% (135)
STEMI	Yes	100% (147)
Stroke	Yes	100% (852)
Sepsis	Yes	100% (642)
Myocardial Ischaemia National Audit Project (MINAP)*	Yes	*Annual data returns not available
Sentinel Stroke National Audit Project (SSNAP)*	Yes	*Annual data returns not available

*Ambulance Clinical Quality Indicators are reported quarterly to NHS England 4 months in arrears, except for cardiac arrest data which is reported monthly.

NEAS intends to take the following actions to improve the quality of healthcare provided:

- Implement the locally developed clinical performance indicators
- Implement a new clinical audit tool
- Implement system developments to electronic patient care records (ePCR) and replace the current devices
- Explore automated referrals direct from ePCR
- Explore embedding clinical governance at an operational level
- Work with informatics colleagues to expand the use of the application and develop a suite of reports to support individual and service development
- Provide training to clinical team leaders so they have the skills, knowledge and resource to undertake audits and reviews to support their team's development

25 local clinical audit projects were completed by NEAS in 2021/22 and we intend to take the following actions to improve the quality of healthcare provided:

Local clinical audits completed	Number of cases reviewed	Summary and actions to improve practice
Pre-alert	100	Overall good assurance in the appropriateness of patients being pre-alerted. • Reminder to use Age, Time of onset, Medical complaint/injury, Investigation, Signs and Treatment (ATMIST) to structure handovers and ensure all pertinent information is passed concisely.
Post-partum haemorrhage	4	Thankfully a small sample due to rare incidence. • Ensure all treatments are delivered and documented.
COVID	235	Care bundle developed to support the assessment and management of COVIDovid patients.
PGD compliance x6	284	Overall good assurance provided in the use of Patient Group Directions (PGDs) by paramedics. • ePCR developments requested to improve data quality. • Communication regarding appropriate use of PGD indications.
Adult seizures	418	There is scope to improve the care provided to adult seizure patients. • Ensure early oxygenation, assessment of injuries and ECG are recorded.
COPD	221	Further work is required to clarify the NEWS2 scales and education to improve the recognition of COPD exacerbations.
Delayed hospital handover	71	Performance consistent with previous year. • Communication reissued to staff. • Checklist to support managers providing hospital situation reports.
Hyperventilation	177	Good compliance with history taking. • Communication to staff to ensure alternative diagnosis are considered and early assessments to exclude life-threatening presentations.
Paediatric cardiac arrest	45	Sustained improvement for fourth consecutive year. • Ensure Recognition of Life Extinct (ROLE) forms are completed for all paediatric patients not resuscitated. • All deceased paediatric patients should be conveyed to emergency department.
Drug overdose cardiac arrest	56	Re-audit demonstrated improvements in airway and ventilation. • Communication with staff to increase naloxone administration. • Local guideline to be reviewed.
Conveyed with Advanced Life Support (ALS) ongoing	65	Sustained improvement during re-audit. • Communications regarding public place arrests and the early use of specialist resources.
Co-amoxiclav for open fractures	-	Deferred audit at time of the report
Febrile convulsions	250	Ongoing

Re-contact within 24 hours	69	To understand if Non-conveyance was safe and appropriate and to determine if there were earlier opportunities to refer to alternative services and avoid subsequent contact.
Discharge by non-qualified clinicians	374	Ongoing
Discharge by Newly Qualified Paramedics (NQPs)	374	Ongoing
Category1 calls	141	Focused work exploring the C1 case mix. • Targeted work for Healthcare Professional (HCP)/Inter Facility Transfers (IFT) calls. • Recommendations for managing seizures.
HCP calls	462	Disproportionate number of HCP calls requesting high dispositions. • Review and update of external communication tools. • EOC to review requests from primary care.
IFT calls	358	Disproportionate number of IFT calls requesting high dispositions. • Recommendation for updating internal processes. • Dispatch clinical risk assessment procedure to prioritise IFT level 2.
EOLCEnd of Life Care: DNACPR	98	Only 20% of patients with a DNACR were recorded on the NEAS system. • Internal education to support appropriate resuscitation. • External engagement to improve the special patient notes.
NHS Pathways: Health Advisors	10444	81% call pass rate with an average score of 88%. 96% of the 411 performance improvement plans have been completed. To support EOC with service improvement initiatives, the following groups of calls were targeted for audit: Category 2 dispositions, urgent dispositions and Directory of Services (DoS) first choice. Next year an annual cycle of business has been developed to target call and competencies to support continuous improvement within EOC.
NHS Pathways: Clinicians	3719	79% call pass rate with an average score of 94%. 96% of the 76 performance improvement plans have been completed. Work is ongoing to increase establishment of clinical call auditors to achieve license compliance with the NHS Pathways end-user license agreement.
Head injury with tranexamic acid administration	156	58% of our patients received this treatment. We are working with the Northern Trauma Network to improve this.

We replaced the previous data quality and correct use of ePCR audits with automated reports that can be used by service lines to drill down into the data to monitor compliance and improve performance for their area.

NICE guidance

The National Institute of Health and Care Excellence (NICE) produces evidence-based recommendations developed by independent committees, including professional and lay people for health and social care organisations in England. Whilst many of the guidance documents produced are not applicable for the ambulance sector there are some which are relevant.

NEAS reviewed 373 NICE guidelines and identified 104 as relevant to our services. Baseline assessments have been completed and NEAS is compliant with 73 (71%) of the relevant guidance. Action plans are in place to address the non-compliance guidelines and will be reviewed April-June 2022.

Clinical research

The NHS Constitution states that research is a core part of the NHS's role, enabling the NHS to improve the current and future health of the population. The Trust's commitment to research as a driver for improving the quality of care and patient experience remains strong despite the challenges presented by the ongoing pandemic.

Participation in clinical research is important for both our patients and staff as it enables our clinical teams to stay up to date with the latest possible treatments, and network with other research teams across the world. The Research Department strives to increase opportunities for patients and staff to engage in research studies and this is the fourth year in a row the team hasve increased patient recruitment into research studies. During 2021/22, our research team have continued to work on internationally recognised studies, recruiting 1,384 patients to participate in research approved by the Health Research Authority or a research ethics committee.

We are currently conducting 12 clinical research studies, 11 of which were adopted onto the National Institute for Health Research portfolio, and successfully sponsored 4 National Institute for Health Research (NIHR) portfolio studies, aswhere the organisation that takes on overall responsibility for proportionate, effective arrangements being in place to set up, run and report a research project.

The Network analyses trends over the year to understand research performance, in particular;

- How quickly participants are recruited once a study is set up-time between date site selected and date of the first participant recruited?
- How many clinical trial participants are recruited to time and target?

The NIHR publish a comparison table showing the performance of all NHS organisations that submit to the Performance in Delivering exercise, and trends analysing performance across the country.

As a result on the number of patients we were able to recruit (accruals) we were ranked 2nd out of all of the UK Ambulance services.

The Research and Development team published five papers in peer reviewed journals during 2021/22.

Publication Title	Journal	Author/s	Link
'Incidence of emergency calls and out-of-hospital cardiac arrest deaths during the COVID-19 pandemic: findings from a cross-sectional study in a UK ambulance service' (2021)	EMJ	Karl Charlton, Matt Limmer, Hayley Moore	https://emj.bmj.com/content/early/2021/04/07/emermed-2020-210291.full?ijkeyG7rkwvzXOnZOriW& keytype=ref
'Defining major trauma: a Delphi study' (2021)	Scandinavian Journal of Trauma, Resuscitation & Emergency Medicine	Lee Thompson, Gary Shaw, Michael Hill, Fiona Lecky	https://sjtrem.biomedcentral.com/track/pdf/10.1186/s13049-021-00870-w.pdf
'Do methods of hospital pre-alerts influence the on-scene times for acute pre-hospital stroke patients? A retrospective observational study' (2021)	BMJ Journals	Jacob Gunn	
'Ambulance service call handler and clinician identification of stroke in North East Ambulance Service' (2021)	BMJ Journals	Graham McClelland, Emma Burrow	
'Hangings attended by ambulance clinicians in the North East of England' (2021)	BMJ Journals	Graham McClelland, Lee Thompson, Gary Shaw	https://www.ingentaconnect.com/contentone/tcop/bpj/2021/00000006/00000003/art00007

What others say about us as a Provider

Care Quality Commission (CQC)

NEAS is required to register with the Care Quality Committee and its current registration is 'Registered Without Conditions'.

NEAS has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period. The Care Quality Commission has not taken enforcement action against the Trust during 2021/22.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency & urgent care	Good Nov 2016	Requires improvement 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Patient transport services	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Emergency operations centre	Requires improvement ↔ 2019	Good ↔ Jan 2019	Good ↔ Jan 2019	Good ↔ Jan 2019	Good ↑ Jan 2019	Good ↑ Jan 2019
Resilience	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Overall	Good ↔ Jan 2019	Good ↔ Jan 2019	Good ↔ Jan 2019	Good ↔ Jan 2019	Good ↔ Jan 2019	Good ↔ Jan 2019

2018 Unannounced Inspection CQC rating. Core services inspected; Emergency Operations Centre and NHS111 Service
NB. all inspections are currently paused due to the COVID-19 pandemic

Audit One

Governance, risk management and control arrangements should provide a good level of assurance that the risks identified are managed effectively. Audit One provides external auditing of our services on an annual basis.

Three services were reviewed during 2021/22:

- Infection Prevention Control: High level of compliance with the control framework. Good compliance with some minor updates to policies required.
- Coroners and Claims: Audit commenced: results expected April 2022.
- Board Assurance Framework and Risk Management: planning stages.

Review of 2021/22 Performance

NHS Foundation Trusts are required to report performance against a core set of indicators using data available through NHS Digital. Trusts are required to report only on the indicators that are relevant to the services they provide or subcontract. For ambulance services these include the speed of response, performance, and clinical indicators.

We know that the last 18 months have arguably been the hardest ever for NEAS. This financial year has continued to be dominated by efforts to respond to the pandemic. Despite the significant challenges seen during 2020/21, national response standards for C1 and C4 have both been achieved, with improvements across all categories compared to 2019/20. NEAS continues to be one of the best performing Trusts nationally for responding to those patients who are most seriously ill (category 1 response).

Ambulance Response Programme Indicators

Target (minutes)	Mean response time	National response time	Response 90th Percentile	National response 90th percentile	Benchmark Ambulance trusts	Better or worse than previous year
Category 1 - Life threatening (eg rescuscitation needed)						
07 90% within 15	06:56	08:51	12:13	16:08	1st	↑
Category 2 - Emergency (eg stroke, chest pain)						
18 90% within 40	36:39	18:00	01:17:13	40:00	4th	↑
Category 3 - Urgent (eg conditions needing treatment and transfer to hospital)						
90% within 120	01:52:48	02:00:00	04:50:58		3rd	↑
Category 4- Non-Urgent (eg transportation to ward or clinic)						
90% within 180	01:32:33	03:00:00	03:37:55		1st	↑

Previous performance	Mean	National	90th %	National
2018/19	06:10	07:21	10:36	12:48
2019/20	06:39	07:19	11:22	12:51
2020/21	06:26	07:07	11:01	12:33

Previous performance	Mean	National	90th %	National
2018/19	21:33	21:50	45:18	00:44:59
2019/20	29:29	23:53	01:03:32	00:49:16
2020/21	25:38	20:57	00:53:37	00:42:43

Previous performance	90th %	National
2018/19	02:55:50	02:26:00
2019/20	03:47:41	02:50:20
2020/21	02:54:57	02:07:53

Previous performance	90th %	National
2018/19	02:54:23	03:09:04
2019/20	03:09:18	03:19:42
2020/21	02:36:59	02:57:20

Ambulance Quality Indicators (AQIs)

All UK ambulance services participate in the national ambulance clinical quality indicators. These measures benchmark the clinical care provided by ambulance services for patients who have had a cardiac arrest including post-Return of Spontaneous Circulation (ROSC), stroke, ST Elevation Myocardial Infarction (STEMI), which is a heart attack where there are changes seen on an ECG heart tracing, and sepsis patients.

Each indicator is calculated based on clinically relevant times, delivery of relevant clinical care criteria which can include patient outcomes. They are routinely reported four months in arrears so current data is complete until September 2021.

NEAS considers that this data is as described for the following reasons:

- National guidance and definitions for Ambulance Quality Indicators (AQI) submissions to NHS Digital when producing category-performance information.
- This information is published every month on the NHS England statistics web pages as part of the AQIs.
- Ambulance trusts peer review AQI definitions interpretations and calculations as part of the annual workload of the NAIG (National Ambulance Information Group) to make sure that all are measured consistently.
- We are aware through peer review audits that are some variances in the way other Trusts are reporting.
- This information is reported to the Board of Directors monthly in the Integrated Quality and Performance Report

The reports of the national audits and clinical outcomes programmes were reviewed by NEAS in 2020/21. NEAS attended 2,565 cardiac arrests in the six months period published, which is the highest number ever recorded and despite this increase we saw improvements in our cardiac arrest outcomes, with performance above the national average in all measures.

ACQI	2020/21	2021/22	Peer	Comments
Return of spontaneous circulation*	21.38% Mar 21	25.8% Sep 21	34.20%	NEAS performs in the highest 25% of all Ambulance Trusts
Return of spontaneous circulation (Utstein)**	50.0% Mar 21	50.0% Sep 21	77.80%	NEAS performs in the highest 25% of all Ambulance Trusts
Survival to 30 days*	-	7.3%	9.40%	Using survival to 30 days allows us to identify the outcome for 99% of cardiac arrest patients which is significantly higher that the survival to discharge
Survival to 30 days (Utstein)*	-	26.9%	43.50%	Using survival to 30 days allows us to identify the outcome for 99% of cardiac arrest patients which is significantly higher that the survival to discharge
Sepsis care bundle	76.0% April 21	85.05%	83.7%	Assessment and care provided to patients for suspected sepsis and the pre alert call we make to the receiving hospital, so that they are prepared for the patients arriving. Performance against the sepsis care bundle has remained relatively consistent. It should be noted that within the North East there is a regionally agreed sepsis process which differs slightly to the national indicator.
Stroke care bundle**	99.0% Apr 21	98.50%	98.5% Aug 21	Assessment and care provided for suspected stroke patients by our staff on scene, with onward transfer to an appropriate hospital site providing acute stroke care. NEAS perform consistently well against the stroke care bundle metric and is one of the highest performing ambulance trusts.
STEMI care bundle**	94% April 21	83.70%	77.1% Aug 21	Patients with symptoms a heart attack and visible changes on their ECG (heart tracing), indicating a heart attack is occurring, this is known as a ST Elevation Myocardial Infarction (STEMI). NEAS perform consistently well against the station STEMI care bundle.

* (metric introduced 2021/22)
**Data taken from Model Hospital and NHS England and NHS Improvement website: Statistics » Ambulance Quality Indicators (england.nhs.uk)

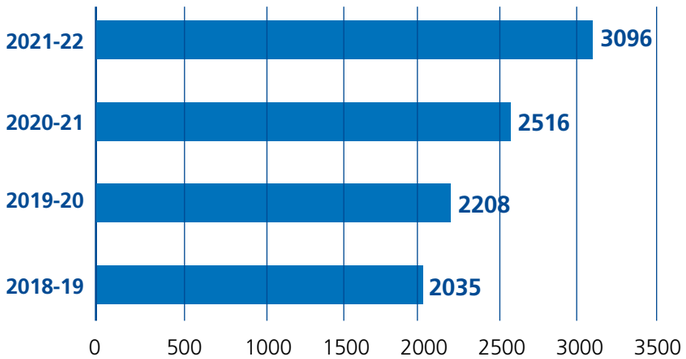
Patient safety data

Patient safety incidents

The Trust aims to provide safe, effective and high-quality care for all patients and service users. One of our priorities is to ensure that lessons are learned wherever possible from patient safety incident investigations, serious incidents (SIs) and Never Events.

We aim to foster a strong patient safety culture and a commitment to improving patient safety. The Patient Safety team promotes a just and restorative culture by providing a psychologically safe space in which staff can openly discuss patient safety incidents and learn from what went well, and what didn't.

The team actively promoted Patient Safety week 2021 emphasising that we want our staff to feel safe so they openly talk about and report incidents, knowing they will be supported throughout investigations with the purpose of reducing the risk of harm and improving patient safety.



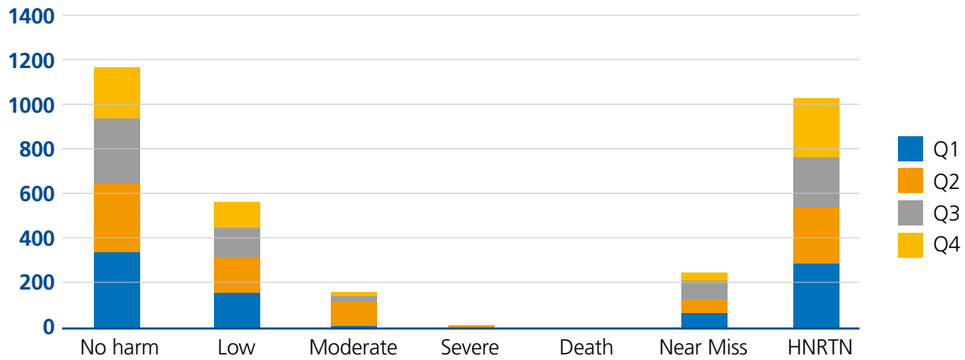
Patient safety incident reporting continues to improve with the available reporting data to date suggesting 2021/22 reporting will surpass 2020/21.

During April 2021 - March 2022 the Trust recorded 3,096 patient safety incidents. This equates to a rate of 1.7% per 1,000 calls answered.

High incident reporting rates with low levels of harm is an indicator of a good safety culture. NEAS continue to be one of the highest reporters of patient safety incidents in the ambulance service in England. NEAS like all Ambulance services faced extraordinary pressure over the past 18 months and demand for 999 and 111 services was unprecedented.

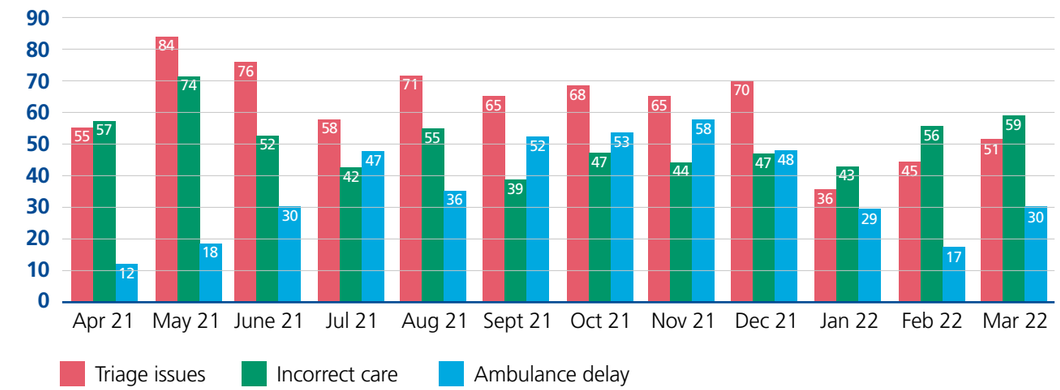
Calls for the most serious conditions, such as cardiac arrests, rose significantly during this period, placing significant pressures on our services and the wider system. Whilst we experienced an increase in incident reporting during 2021/22 to date 96.5% of all incidents have resulted in a low level of harm to our patients.

Patient Safety Incidents Levels of Harm



2020/21 highlighted '111 triage', 'third party provider issues' and 'access, admission, delay, transfer, discharge' as the top three causes for patient safety incidents whilst the top three causes of patient safety incidents for 2021/22 are triage issues, incorrect care and ambulance delays.

PSI Themes: Top 3 Cause Groups



We updated the Ulysses system on 1st April 2021 to include two sub causes of the incident to enable better analysis of incidents being reported. This has enabled the Patient Safety Team to undertake a thematic analysis of the top 3 three patient safety incident cause groups highlighting:

- The majority of incidents in triage are related to a 'delay in assistance' which is mainly due to problems with accessing a translator.
  - We identified this was due to requests for specific languages where UK based interpreters were limited so we negotiated with the current provider to increase capacity by expanding access to their translators in America.
- Ambulance delays in category 2 ambulances accounted for 50% of the overall ambulance delays with 13% resulting in moderate harm or above to patients.
  - We identified our ambulance disposition rate was increasing and was high when compared to other providers. We acknowledged that this would have been influenced by initiating the no-send policy but introduced a work group to gain a better understanding. We have chosen reducing ambulance delays as a quality priority for 2022/23.
- Inadequate assessment/ monitoring and inappropriate treatment were the dominant themes relating to incorrect care.
  - We introduced a number of initiatives to reduce the number of incidents in relation to sub-optimal care and recognising deteriorating patients.
  - We have chosen to look at using our resources as efficiently as possible by making better use of our clinical model to improve patient care as a quality priority for 2022/23.

We have continued to develop our understanding and insights of patient safety incidents and recurrent themes over the past year, and we have communicated our findings via regular discussions and engagement through our committees, Executive Safety Panel group and a weekly Patient Safety and Patient Experience Bulletin.

We have reviewed and will continue the following initiatives introduced in 2020/21:

Daily Rapid Review: daily oversight and timely review of all patient safety incidents received within a 24-hour period and determine the next steps for investigation.

Clinical Review Panel: twice weekly review of moderate harm and over incidents. Membership has been reviewed and streamlined to ensure appropriate attendance. The group determines the harm level and level of investigation required and whether Duty of Candour Coronial Notification is applicable.

Executive Safety Panel: weekly review of moderate harm and over incidents with executive oversight and measurement against the serious incident framework. In addition, a thematic review of all incidents discussed to aid the early identification of themes/trends.

In addition, the following groups have been introduced:

Scheduled Care Task and Finish Group: Scheduled Care (patient transport) staff highlighted there was a lack of appropriate feedback following incident reporting. The group was introduced to address concerns and formulate plans to improve feedback and disseminate learning post incident reporting.

Third Party Provider Task and Finish Group: the meeting was introduced to understand the underlying themes arising from patient safety incidents within this category. The number of reported incidents for Third Party Providers reduced as a result of the findings of this group which identified the requirement to reshare NEAS policies and procedures to ensure each Third-Party Provider had access to the most up to date information.

Serious incidents

When things go wrong, we want the investigation process to be as timely as possible so that we do not cause additional harm to service users or their families. We have focussed on responding to serious incidents throughout 2021/22 with 100% of serious incident investigations completed within the 60-day timeframe.

Six cases were reported as a serious incident in 2021/22. Three of the six serious incidents declared are associated with missed opportunities during the call triage aspect of patient care. This theme has continued from 2020/21 where 50% of serious incidents declared were associated with call triage. No recurrent themes were identified for the remaining 3 three serious incidents.

Work continues to refine the management and analysis of patient safety incidents, particularly in the form of thematic analysis, and senior oversight at Director level is in place where there are patient safety incidents which meet the moderate harm or over threshold.

The Serious Incident Review Group is chaired by the Director of Quality, Patient Safety, Innovation and Improvement (Executive Nurse), and membership includes the Medical Director and Chief Operating Officer, other executives and senior clinical managers. The group reviews all patient safety investigation reports including Serious Incident (SI) reports.

The Clinical Commissioning Groups formally review our SI reports and progress against action plans, and we share investigation reports and action plans for SIs and other patient safety incident investigations for oversight and challenge, with our regulators, the Care Quality Commission. NEAS considers that this data we reported is as described for the following reasons:

- We use the Ulysses Safeguard system for reporting and managing all patient safety incidents;
- We use the system to create reports and add data to the National Risk Learning System (NRLS) and have been a contributor to the DPSIMS beta testing project. We also share information with other external agencies such as NHS Protect and the Health and Safety Executive (HSE);
- We conduct weekly/monthly data quality checks to ensure reporting is as accurate as possible.

Learning from deaths

We review the care given by our service for every admitted patient that we find out dies in the 24-hour period after the 999 or 111 call. This allows us to identify any lessons which need to be learned and to make improvements in patient care.

All NHS Trusts and Foundation Trusts use the Structured Judgement Review (SJR) approach for mortality reviews. The process involves a critical review of the healthcare record by trained assessors who comment on specific phases of clinical care reporting on lessons learned and areas for improvement. Between April 2021 - December 2022 NEAS completed 100 SJR level 1 first stage reviews, with 1 case being passed to SJR second stage review.

NEAS changed the way that delayed ambulance responses were reported and investigated. These are now handled via the patient safety process instead of Learning from Deaths. NEAS also changed the way that patients that die in care are monitored and reported. We have developed a suite of reports to understand mortality which specifically explores the impact of delayed ambulance handover, responses and outcomes following contact with NEAS services.

We have developed real time alerts to contribute to public health work with the aim of reducing avoidable drug overdose related deaths and this initial project is currently being evaluated.

NEAS has not received any Regulation 28 prevention of future deaths notices during 2021/22.

Preparing for Patient Safety Incident Response Framework (PSIRF)

The PSIRF calls for a new approach to incident management, one which facilitates learning and improvement with the emphasis placed on the system and culture. The aim is to support continuous improvement in patient safety through how we respond to patient safety incidents. One of the underpinning principles of PSIRF is to do fewer investigations but to do them better by ensuring systems-based investigations are undertaken by people that have been trained to do them.

PSIRF will be introduced during 2022 and we will need to ensure we have support structures for staff and patients involved in patient safety incidents, part of which is the fostering of a psychologically safe culture shown in our leaders, our trust-wide strategy and our reporting systems. We have identified preparing for PSIRF as a Quality Priority for 2022/23 as we recognise there is a significant amount of work to be completed to achieve this ambition.

Infection Prevention and control (IPC)

The pandemic response for ambulance services across the UK continues to be managed centrally for IPC. The National Ambulance Service IPC Group (NASIPCG) consists of the Heads of IPC from all UK Ambulance Services and represents the Ambulance sector within the National IPC Cell, led by NHS England, which is responsible for the development and review of the National IPC Guidance. The NEAS IPC Manager is an active member of this group and currently meets with specialists from the four UK nations weekly to review the latest IPC evidence and guidance and to assist with the development and implementation of new national ambulance service policy.

The last year has continued to present a number of challenges to the Ambulance Service buthowever we have mitigated the risk to our patients and staff by following nNational IPC guidance for the management of COVID-19 including the Association of Ambulance Chief Executives (AACE) 'Hierarchy of Controls', Working Safely in UK Ambulance Services during Winter 2021-22 and IPC precautions during hospital handover delays guidance.

All areas of the service have been risk assessed against the 'Working Safely' guidance to ensure the environment is COVID-19 secure. All staff are expected to adhere to 1 one metre plus distancing, perform adequate hand hygiene and twice weekly Lateral Flow Tests (LFTs) testing. Patient facing staff have access to appropriate Personal Protective Equipment (PPE) supplies and been fit tested to maintain staff and patient safety. Non-clinical areas are kept COVID-19 secure by perspex screens between desks in the Emergency Operations Centre and aAgile workspaces and the use of surgical masks when walking around buildings.

It is important that staff maintain high standards of infection prevention and control practice when caring for patients. The number of clinical practice audits to monitor compliance was limited during 2021/22 but the results demonstrated high standards were achieved:

Vehicle Cleanliness scores

Emergency Vehicles
97.8% 102 audited

Patient Transport vehicles
99.7% 162 audited

Ambulance care service vehicles
97% 19 audited

Staff IPC compliance scores

Hand hygiene
97.2% 107 audited

Glove use
97.2% 108 audited

Apron use
97.2% 196 audited

Bare below the elbow
97.3% 113 audited

Incidents relating to COVID-19 and IPC were reviewed for incident trends, key learning and also levels of harm. All of the incidents reported were no or low harm. Our IPC Team successfully managed outbreaks at a number of our sites including EOC reducing the pressure on our operational delivery during what was an already challenged period due to increased demand and staff absences.

The safety of our patients, communities and staff is paramount and we have taken a strong and proactive approach to staff vaccination throughout the pandemic and as a result the majority of our staff received both doses of the COVID vaccine.

Patient experience

Patient feedback

The Trust recognises that sometimes things do not happen in the way we would wish and there are occasions where our services either fall short of the required standards or do not meet the expectations of our patients, their families or care providers. NEAS fosters a culture of openness and accountability when dealing with complaints and we will apologise and investigate matters to understand why things went wrong and ensure that appropriate action is taken to reduce the risk of them being repeated.

We have been working in preparation for the new Parliamentary and Health Service Ombudsman (PHSO) Complaints standards. The Complaint Standards should provide a more consistent approach to complaint handling across organisations delivering NHS services promoting a culture that seeks to learn from complaints, treats people fairly, and works to resolve problems in a timely way.

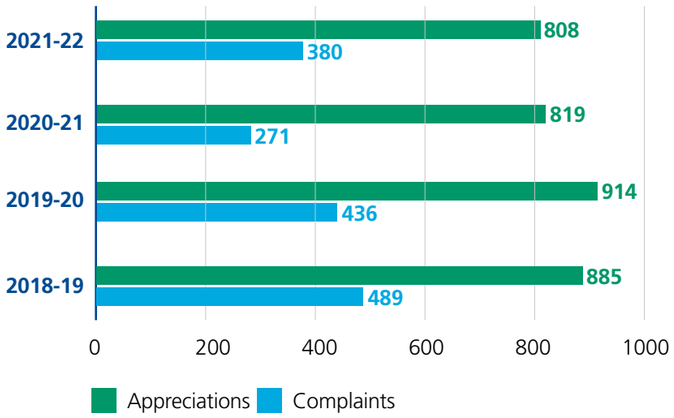
NHS Trusts were invited to pause the management of complaints during the first wave of the COVID-19 pandemic. There was no national pause in the management of complaints during the second wave and, it was accepted that Trusts could extend their timescales for responding in negotiation with complainants.

Throughout 2021/22 the Patient Experience Team streamlined their governance processes and prioritised responding to service user complaints to ensure there is a timely response and action as appropriate.

Research consistently confirms that positive patient experience correlates with better health outcomes.

The Trust continues to receive more appreciations than complaints.

Patient Feedback Complaints vs Appreciations



Our service users, their families and care givers expect quick, seamless interactions with us and want to receive a response through their preferred methods of communication. We offer email, Microsoft Teams conference calling technology and face to face meetings where possible to help us understand your concerns and feedback.

We also provide people with an opportunity to let us know how we have handled a complaint by providing a weblink for feedback in our formal response letter to a complaint.

Understanding patient experience is critical to our recovery from COVID-19 and for our services to be successful going forward. The top 3 three themes for patient complaints are quality of care, staff attitude and timeliness of response. Complaints and lessons learned from them are shared at individual, team and divisional meetings and with the Board, Commissioners and CQC via the Quality and Safety Quarterly Report.

Further details and analysis of the Trust Complaints, Concerns and Comments data can be found in the Trust's Annual Patient Experience Report available at How we are doing - North East Ambulance Service - NHS Foundation Trust (neas.nhs.uk).

The Trust recognises it has more work to do to learn from and improve its complaint handling and has identified 'Involve our patients & and communities to improve care' as a quality priority for 2022/23.

You said. We did.

We do consider all feedback about the management of the process and we have ensured that we have made some changes to how we manage complaints to improve the process for complainants as a result of their feedback:

> You felt that you wanted a quicker complaint response.

- We explained that, due to demand on our service, there were delays in responding to complaints.
- We made every effort to minimise any delay to responses, and during the first 6 months of 2021/22 we still managed to maintain an average response timeframe of 33 days.

Friends and Family survey and engagement

Thinking of the service we provide. Overall how was your experience of the service.

		Very good / good	Poor/ very poor	Responses
PTS	Percentage	93.2%	2.4%	1,200
	Count	1118	29	
111	Percentage	76.0%	13.5%	1,890
	Count	1436	255	
999 See and Convey	Percentage	90.6%	5.0%	4,234
	See and Convey	3836	211	
999 See and Treat	Percentage	96.8%	1.1%	469
	See and Treat	454	5	

The engagement and inclusion team would usually work closely with community groups, attend public events and host a number of community events across the year but the ongoing pandemic response has posed challenges for patient and community engagement and all physical engagement was paused during this period of time.

Despite the restrictions the team has achieved the following:

- Collected, collated and analysed 7,793 responses to our patient surveys between April 2021 to January 2022
- Delivered a Positive Action Project targeting ethnic minority communities. The project has worked with 96 community organisations to deliver 53 sessions and train 768 individuals. 687 people have been trained in service awareness and 658 people in lifesaving skills including CPR and defibrillators
- Recruited and trained 60 community ambassador volunteers to work in ethnic minority communities and improve awareness of our services and how to access them
- Developed new online engagement spaces on our website www.neas.nhs.uk/patient-info.aspx. This includes areas for adults, young people, people with learning disabilities and British Sign Language users with content tailored to the needs of each group and delivered in accessible communication formats
- Developed 108 individual videos to help patients and the public obtain more information about our services including an interactive ambulance 360 tour and service awareness and information videos
- Liaised with the public to identify key questions they wanted answers for from paramedics and developed an 'ask a paramedic' section of our website with short videos answering each question www.neas.nhs.uk/patient-info/ask-a-paramedic.aspx
- Attended two virtual Pride events in Newcastle and Sunderland and sponsored one of the Sunderland sub events
- Attended four community/school events to promote our services
- Liaised with several schools virtually as part of 'restart a heart' day
- Held a virtual disability and ethnic minority recruitment event in partnership with six regional NHS Trusts
- Continued to hold our Health Watch Ambulance forum virtually each quarter and liaise with them on key decisions and service challenges and receive community feedback
- Continued to hold our Stakeholder Equality group every four months and reviewed key decisions relating to diversity and inclusion, undertaking assessments against the NHS Equality Delivery System and receiving community feedback
- Launched an Engagement Diversity and Inclusion Twitter page and attracted over 150 followers @NEAS-EDI

Clinical Effectiveness

	2020/21	2021/22
999 calls answered	439,940	**520,899**
111 calls answered	864,050	**675,912**
Patients taken to hospital	266,013	**412,068**
Patients treated at home	127,352	**115,319**
Patients treated over the phone	34,306	**48,054**
Patients taken to hospital appointments	284,507	**272,186**
incidents attended by our crews	393,365	**387,440**
average C1 Ambulance response times for our emergency patients	06:26	**06:56**

	2018/19	2019/20	2020/21	2021/22
Hear & Treat	**20.996**	**23,958**	**34,306**	**48,054**
	5.1%	5.7%	8.0%	11.03%
See & Treat	**104,697**	**113,465**	**127,352**	**115,319**
	25.20%	26.80%	29.78%	26.48%
See, Treat & Convey	**289,009**	**285,846**	**266,013**	**272,186**
	69.70%	67.50%	62.20%	62.49%
See & Convey to ED	**242,112**	**242,864**	**229,497**	**230,687**
	58.04%	57.40%	53.66%	9.53%

At the start of the first wave and lock down of the COVID-19 pandemic NEAS worked with private ambulance providers to increase the number of frontline ambulances available to respond to emergencies, and to provide resilience in the event the Trust lost high numbers of our own staff due sickness or self-isolation. This allowed us to allocate the most appropriate resource to our category 3 and 4 calls so we could ring fence practitioners to respond to patients. treating them in their own home where appropriate. This is has led to a safer and better experience for our patients and has relieved the pressure on Emergency Departments throughout the region.

Acute Mental Health

NEAS's Executive Director for Quality and Patient Safety is currently co-sponsor of the ICS Mental Health Crisis Leadership Group alongside the Deputy Chief Operating Officer for Cumbria Northumberland Tyne and Wear (CNTW) NHS Foundation Trust. The aim of the group is to work with our partners to seek alternatives to crisis services and how these can improve patient pathways.

2 Hour Urgent Community Response Teams (100-day challenge)

In line with NHS planning guidance, by 31st March 2022 all Integrated Care Systems (ICSs) in England must deliver the national community two-hour crisis response standard. As part of the standard, crisis response care must be provided to people in their homes or usual place of residence within two hours. The trust is currently working with our partners throughout the ICS to review Urgent Community Response and Community Services to fulfil this challenge.

Quality Improvement (QI)

Why do we do QI?

The overall aim of healthcare QI is simple - to provide high-quality care to patients. For everything we do well there is something else that is not working right or that causes frustration, delay or wasted effort. Sometimes processes and systems can get in the way of delivering the best possible service and that is where the QI team can help.

The QI team works together with many departments across our organisation to consider which approach is best suited and how we can work together to resolve problems. There are always problems to solve, and the team has benefitted from support by operational colleagues posted to alternative duties throughout the COVID-19 pandemic. This support has helped the team undertake more projects and the team has benefited from the knowledge of operational colleagues whilst these colleagues will be able to use the quality improvement skills and techniques they have developed whilst working with the team in their everyday work.

We want all our staff to look continually to improve our services, and understanding QI is an important part of the Trust's induction programme.

New employees are also given a guide on the key principles of the QI approach.

The 'Model for Improvement' guide and Plan, Do, Study, Act cycle (PDSA) is used as part of internal project management training to help support departments throughout the QI process.

The QI team delivered sessions to partners across the higher education sector from Teesside University and Sunderland University and supported a cohort of student nurses from Northumbria University through 2021. This is part of our ongoing work to look at embedding the principles of quality improvement into everything we do.

We are active in and have shared learning with multiple groups including the regional Human Factors group, the National Ambulance Association QI forum, the Academic Health Service Network and Ambulance QI.

What have we done this year?

1 Handover work at James Cook University Hospital

Why? Handovers delays can pose a risk to our patients and have a negative effect on patient and staff experience. Reducing handover delays will free up our crews so they are in the community responding to the patients who need them the most.

How? We worked with staff at James Cook University Hospital and North Tees General Hospital to look at how we can improve the pathways into the ED department and use established referral pathways to reduce waits. We also looked at using technology to improve the effectiveness of the booking processes.

How have we helped? We have seen some improvement at North Tees in the turnaround time for our patients at the ED which means our patients are admitted quickly and our crews are released to see other patients quicker. We are working with South Tees and Tees Valley Commissioners to help improve the flow of patients in their ED. We are already seeing improvements including new IT support, better signage and new systems and we expect to see further improvements in 2022/23.

2 Downtime

Why? We wanted to review our ability to be able to respond safely to our patients and understand our reasons for 'downtime' (the times our crews are not available for patients).

How? We looked at the codes used by our crews to understand why they were not available and if a more appropriate code could be used to provide our operational teams with the best information possible so they could make decisions on how to best manage resource against patient demand.

How have we helped? Understanding where our downtime is and why allows us to safely manage resource against patient demand, so we can respond to patients.

3 Electronic Vehicle Daily Inspection (EVDI)

Why? We must, by law, complete a list of vehicle daily checks to ensure our vehicles are safe to use. We used to complete checks on paper which meant finding and auditing vehicle inspection results and identifying repeated faults was time consuming.

How? We worked with North East Ambulance Service Unified Solutions (NEASUS), Operational colleagues and Informatics to develop an electronic Vehicle Daily Inspection report and supporting app.

How have we helped? The electronic app and vehicle report are now live and widely used throughout the Trust.

What our people tell us?

We engage with and gather feedback from our people in several ways, including: the annual NHS Staff Survey, our Quarterly People Pulse Survey, our recently formed Task Group and we have a number of staff networks. We also gather informal feedback when senior leaders visit hospitals in the welfare car and our internal Workplace social media platform. The executive team have also undertaken live Q and As and roadshows throughout 2021.

NHS Staff Survey 2021

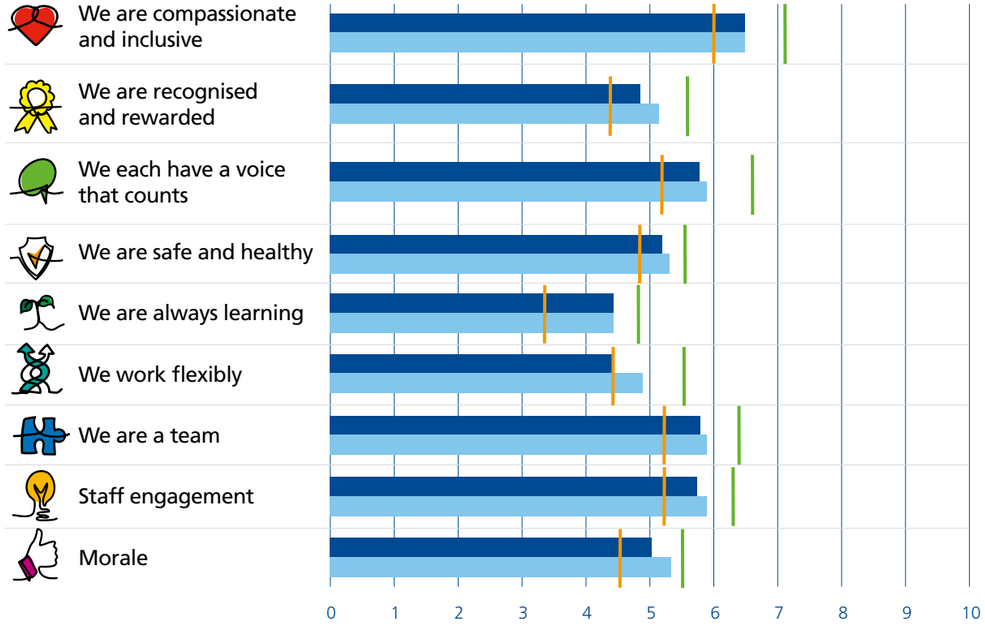
The national annual NHS Staff Survey collates employee views on their experience at work in several key areas and this year the survey has seen significant changes. Many new questions were added, and some removed, to align to the National People Promise and to support the delivery of the NHS People Plan. Due to the significant changes to this year's survey we do not have historical data for all aspects to compare our performance to 2020.

Our response rate however has increased to 50%, recovering the dip we had seen in the last few years. With the size of our workforce, a response rate over 30% indicates that the results are statistically significant.

People Promise Results

The Trust's summary score for each of the seven People Promise elements, and two key themes of morale and staff engagement are shown in Figure 1. It shows the score for NEAS, the average across Ambulance Trusts and the best and worst scores for each Promise and Theme, with 10 being the highest possible positive score. As shown, NEAS scores comparably with the two People Promise elements of 'we are compassionate and inclusive' and 'we are always learning', with all other scores sitting below the average for Ambulance Trusts. We have the lowest score when compared to other Ambulance Trusts for the promise 'we work flexibly'.

Figure 1: NEAS overall scores in relation to the Ambulance Sector average, and the best and worst scores.



Best	7.1	5.6	6.6	5.6	4.9	5.6	6.4	6.3	5.5
NEAS	6.6	4.8	5.7	5.2	4.4	4.4	5.8	5.7	5.0
Average	6.6	5.1	5.9	5.3	4.4	4.9	5.9	5.9	5.3
Worst	6.0	4.4	5.2	4.9	3.3	4.4	5.2	5.2	4.6
Reponses	1456	1453	1446	1451	1367	1448	1454	1455	1456

We have studied the feedback from the Staff Survey in conjunction with the data from our January 2022 People Pulse and Task Group which compromises a cross-section of our people. Data shows us that overall performance has declined this year. Some of this data is expected due to the pandemic. However, we are below average when comparing to other Ambulance Trusts in several key areas, where action is needed to improve the experience for our teams and colleagues.

We are doing well around some areas including teams working well together, colleagues supporting each other and over the last 5 years, there has been a positive upward trend in terms of colleagues feeling able to raise concerns around clinical practice and reporting violence and aggression.

Our health and wellbeing score from the staff survey is below average, however positive feedback from the January People Pulse indicates recent actions taken to support wellbeing, from the introduction of a wellbeing task and finish group in Autumn 2021 may be starting to have a positive impact for our people.

Despite this, there is a clear indication that colleagues are feeling burnt out. Colleagues stated they were demotivated with feelings of being overworked most prevalent. Colleagues have also highlighted that they feel they don't always have adequate materials and equipment to the do their job properly, which has been on a downward trend over the last 5 years.

Our response to the results

We will continue to review all feedback we receive from our people, triangulate the key findings, and use this to ensure the actions we have outlined in our NEAS 9 People Plan will address any concerns raised. Current activities that are in progress that align to our Trust strategy and focus on recovery of our people, include:

Health and Wellbeing:

- Health and Wellbeing Task and Finish group and two Health and Wellbeing Leads in post on a temporary basis
- We have supported COVID vaccine and flu vaccine delivery
- Redesigned 'Help Hub' on our Intranet, for quick access to wellbeing resources.
- We have recently introduced the TRiM (Trauma Risk Management) support programme to support colleagues with difficult and traumatic experiences
- A mental health practitioner will be joining our occupational health team in April 2022

Engagement:

- We continue to gather feedback from our colleagues through a number of routes, including staff networks, live Q&As and roadshows, informal feedback through Workplace and our welfare cars
- Our recently formed Task Group is made up of colleagues across the organisation and they are in the process of considering over 200 ideas from colleagues, such as key operational issues around equipment and resources

Additional Activities:

- We have redesigned our leadership roles in operational teams to improve visibility and provide dedicated clinical team leadership support
- We are reviewing leadership development to better support our leaders and offer a more flexible approach to training opportunities, including CPD and dedicated time
- Our appraisal approach is under review and will launch later this year
- A refresh of our behaviour framework is underway and due to be launched in the next few months

We will continue to look for new ways to engage with our colleagues to ensure we build a healthy culture across our organisation. We have committed as a Trust to ensure over the coming years we have a set of achievable actions within our People Plan to try and realise our ambition for NEAS to be a great place to work and grow.

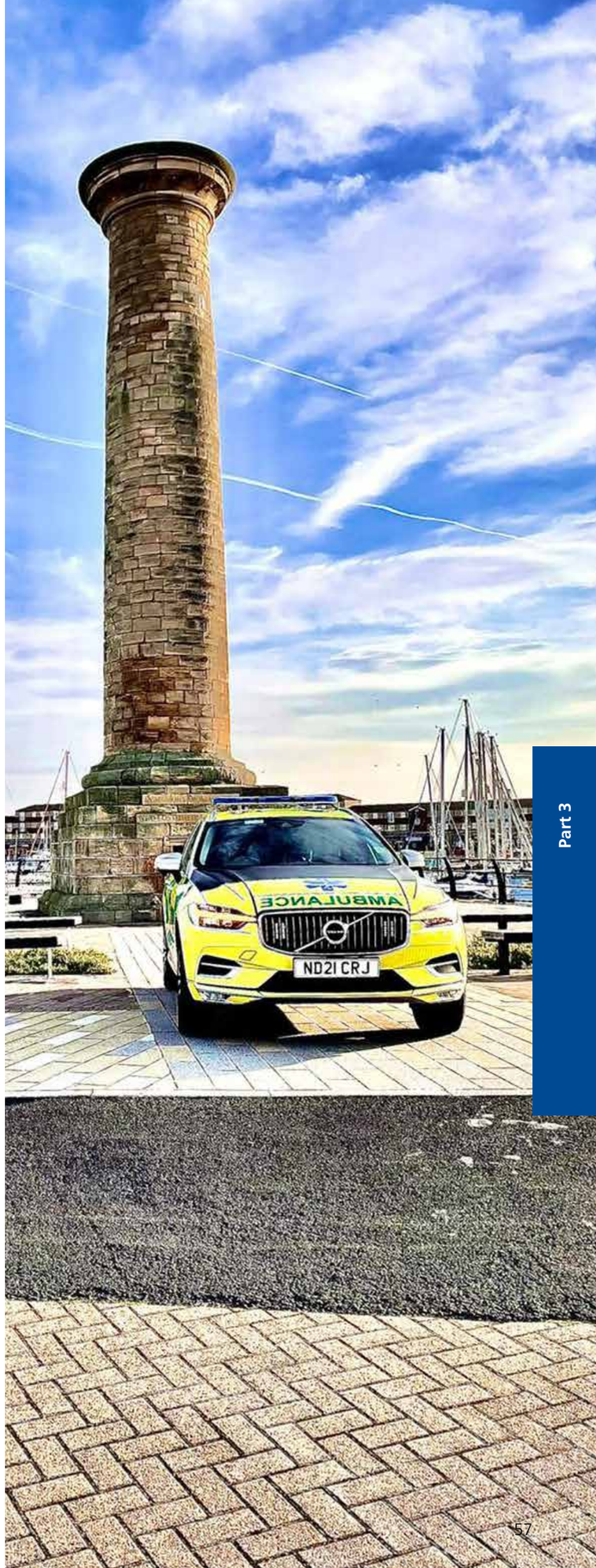
Freedom to Speak Up (FTSU)

FTSU is one component of a wider strategy to develop the Trust as a more open and inclusive place to work. Staff are encouraged to raise concerns about risk, malpractice or wrongdoing with the Trusts Freedom to Speak Up Guardians.

Seven FTSU concerns were raised during 2021/22, none of which related to patient care:

- 2 cases Systems and Process
- 1 case Infrastructure and Environment
- 2 cases Leadership and Management Behaviour
- 2 cases Misuse of NHS Property and Victimisation and Bullying

It is recognised that Freedom to Speak Up is only one mechanism for raising concerns within the Trust. The Trust is also a high reporter of incidents, which again provides assurance that staff feel confident in reporting issues through the formal incident reporting channels; however, further work is required to promote engagement with the staff survey. The People and Development Committee and Board of Directors have been apprised of Freedom to Speak Up activity during the year.



Annexes

Stakeholder Engagement

We have developed our Quality Accounts with, and for, those who have an interest in and influence on our approach to the quality of our services. We recognise the value of listening to patients, public and staff when setting our quality priorities. When producing this report, we have involved everyone who has an interest in our organisation. This has been a continuing process throughout the financial year.

Statement of directors' responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report. Guidance used for this quality report was published for 2021/22 reports.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2021/22 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
- board minutes and papers for the period April 2021 to March 2022;
- papers relating to quality reported to the board over the period April 2021 to March 2022;
- feedback from commissioners dated X;
- feedback from governors X;
- feedback from local Healthwatch organisations X;
- feedback from Overview and Scrutiny Committees; Durham County Council Adults Wellbeing and Health Overview and Scrutiny Committee, . X Newcastle City Council Overview and Scrutiny Committee;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated X;
- the latest national staff survey 2021
- the Head of Internal Audit's annual opinion over the trust's control environment – not applicable for 2021/22 Quality Report;
- CQC inspection report dated 10 January 2019.
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered; 1st April 2021 to 31st March 2022
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Peter Strachan Chair **Helen Ray CEO**

Abbreviations

AED	Automated External Defibrillator
ARP	Ambulance Response Programme
ACQIs	Ambulance Clinical Quality Indicators
AQIs	Ambulance Quality Indicators
BAME	Black, Asian & Minority Ethnic
CARe	Care and Referral
CQC	Care Quality Commission
CCG	Clinical Commissioning Group
CPR	Cardiopulmonary Resuscitation
CQUIN	The Commissioning for Quality and Innovation payments framework
DBS	The Disclosure and Barring Service
DoS	Directory of Services
CCM	Clinical Care Manager
ED	Emergency Department
EMR	Emergency Medical Responder
EOC	Emergency Operations Centre
EoLC	End of life care
ESR	Electronic Staff Record
EPRF	Electronic Patient Report Form
FOT	Forecast Outturn
FTE	Full Time Equivalent
HENE	Health Education North East.
HSE	Health and Safety Executive
ICaT	Integrated Care and Transport
LGBT	Lesbian, Gay, Bisexual and Transgender
NCA	National Clinical Audit
NEAS	North East Ambulance Service NHS Foundation Trust
NHS	National Health Service
NRLS	National Reporting and Learning System
PALS	Patient Advice and Liaison Service
PbR	Payment by Results
PHKiT	Pre-Hospital Knowledge in Trauma
QGG	Quality Governance Group
RCA	Route Cause Analysis
SPN	Special Patient Note
UEC	Urgent & Emergency Care

Glossary of Terms

Term	Definition
Accessible Information Standard	The Accessible Information Standard aims to make sure that disabled people have access to information that they can understand and have any communication support they might need. All organisations must follow this standard in full by 31st July 2016.
Advanced Practitioner (AP)	An Advanced Practitioner provides advanced primary care skills. May be a paramedic or a nurse with advanced skills.
Ambulance Quality Indicators	These are the Ambulance sector's national quality indicators.
Ambulance Response Programme (ARP)	NHS England is conducting a programme of work that is exploring strategies to help ambulance services reduce operational inefficiencies whilst remaining focused on the need to maintain a very rapid response to the most seriously ill patients and improve the quality of care for patients, their relatives and carers.
Care bundle	A care bundle is a group of between three and five specific procedures that staff must follow for every single patient. The procedures will have a better outcome for the patient if done together within a certain time limit, rather than separately.
Care Quality Commission (CQC)	The independent regulator of all health and social-care services in England. The commission makes sure that the care provided by hospitals, dentists, ambulances, care homes and services in people's own homes and elsewhere meets government standards of quality and safety.
Category 1	For those patients that require an immediate response to a life threatening condition and where this requires resuscitation or emergency intervention from the ambulance service. This requires a 7 minute response, and 90th percentile is measured.
Category 2	For those with symptoms linked to a serious condition, for example stroke or chest pain, that may require rapid assessment and / or urgent transport. This requires an 18 minute response, and 90 percentile is measured.
Category 3	Is for those urgent problems that require treatment and transport to an acute care provider. This requires a 2 hour response (90th percentile)
Category 4	Is for those that are not urgent and require transportation to a hospital ward or clinic within a given time window. This requires a 3 hour response (90th percentile)
Clinical Commissioning Groups (CCGs)	Clinical Commissioning Groups are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.
Clinical audit	A clinical audit mainly involves checking whether best practice is being followed and making improvements if there are problems with the way care is being provided. A good clinical audit will find (or confirm) problems and lead to changes that improve patient care.
Clinical effectiveness	Clinical effectiveness means understanding success rates from different treatments for different conditions. Methods of assessing this will include death or survival rates, complication rates and measures of clinical improvement. This will be supported by giving staff the opportunity to put forward ways of providing better and safer services for patients and their families as well as identifying best practice that can be shared and spread across the organisation. Just as important is the patient's view of how effective their care has been and we will measure this through patient reported outcomes measures (PROMs).
Commissioning for Quality and Innovation (CQUIN) payment framework	The Commissioning for Quality and Innovation payment framework means that a part of our income depends on us meeting goals for improving quality.
Contact centre	The first point of contact for 999, 111 and Patient Transport Services patients who need frontline medical care or transport.
Core services	Our core services are accident and emergency, NHS 111, Community First Responders, the patient transport service and emergency planning.
Disclosure and Barring Service	The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA)
Directory of Services (DoS)	Once we have decided on the appropriate type of service for the patient – so that we can direct them to a service which is available to treat them – we use a system linked to a directory of services. This directory contains details of the services available, their opening times and what conditions and symptoms they can manage, within an area local to the patient.
End-of-life patients	Patients approaching the end of their life.
Electronic Staff Record (ESR) system	Electronic staff record system used in the Trust to hold personnel related information.
Enforcement action	Action taken against us by the Care Quality Commission if we do not follow regulations or meet defined standards.
Electronic Patient Report Form (EPRF)	The Electronic Patient Report Form uses laptops to replace paper patient report forms. Ambulance staff attending calls can now download information on the way, access patients' medical histories, enter information in 'real time' and send information electronically to the accident and emergency department they are taking the patient to and to the patient's GP practice.

Foundation Trust Boards	These make sure that trusts are effective, run efficiently, manage resources well and answer to the public.
Governors	Foundation Trust members have elected a council of governors. The council is made up of 21 public governors and four staff governors, plus nine appointed governors.
Governor Task and Finish Group	A group set up to identify which priority areas and risks should be included in a specific document, such as the annual plan or quality account.
Handover and turnaround process	Handover is the point when all the patient's details have been passed, face-to-face, from the ambulance staff to staff at the hospital, the patient is moved from the ambulance trolley or chair into the treatment centre trolley or waiting area and responsibility for the patient has transferred from the ambulance service to the hospital. Turnaround is the period of time from an ambulance arriving at hospital to an ambulance leaving hospital.
Health Act 2009	An Act relating to the NHS Constitution, healthcare, controlling the promotion and sale of tobacco products, and the investigation of complaints about privately arranged or funded adult social care.
Hear and Treat	A triage system designed to assess patients over the phone and to provide other options in terms of care, where appropriate, for members of the public who call 999.
Health Education North East	Health Education North East supports Health Education England to ensure local workforce requirements are met and there is a competent, compassionate and caring workforce to provide excellent quality health and patient care.
SIREN	This has is a bespoke Microsoft SharePoint site which has been developed across the trust as a communication tool, sharing information, learning and news updates.
Major trauma	Major trauma means multiple, serious injuries that could result in death or serious disability. These might include serious head injuries, severe gunshot wounds or road-traffic accidents.
Monitor	The independent regulator of NHS Foundation Trusts.
National Ambulance Quality Indicators (AQIs)	Measures of the quality of ambulance services in England, including targets for response times, rates when calls are abandoned, rates for patients contacting us again after initial care, time taken to answer calls, time to patients being treated, calls for ambulances dealt with by advice over the phone or managed without transport to A&E, and ambulance emergency journeys.
National clinical audit	National clinical audit is designed to improve the outcome for patients across a wide range of medical, surgical and mental health conditions. It involves all healthcare professionals across England and Wales in assessing their clinical practice against standards and supporting and encouraging improvement in the quality of treatment and care.
National confidential enquiries	Investigations into the quality of care received by patients to assist in maintaining and improving standards.
NHS (Quality Accounts) Regulations 2010	Set out the detail of how providers of NHS services should publish annual reports – quality accounts – on the quality of their services. In particular, they set out the information that must be included in the accounts, as well as general content, the form the account should take, when the accounts should be published, and arrangements for review and assurance. The regulations also set out exemptions for small providers and primary care and community services.
NHS Foundation Trust Annual Reporting Manual 2014/15	Sets out the guidance on the legal requirements for NHS Foundation Trusts' annual report and accounts.
Pathways	A system developed by the NHS which is used to identify the best service for a patient and how quickly the patient needs to be treated, based on their symptoms. This may mean the patient answering a few more questions than previously. All questions need to be answered as we use them to make sure patients are directed to the right service for their needs. Types of service may include an ambulance response, advice to contact the patient's own GP or an out-of-hours service, visit the local minor injury unit or walk-in centre or self-care at home.
Patient Advice and Liaison Service (PALS)	The Patient Advice and Liaison Service offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.
Patient experience	This includes the quality of caring. A patient's experience includes how personal care feels, and the compassion, dignity and respect with which they are treated. It can only be improved by analysing and understanding how satisfied patients are, which is assessed by patient reported experience measures (PREMS).
Patient safety	Makes sure the environment the patient is being treated in is safe and clean. This then reduces harm from things that could have been avoided, such as mistakes in giving drugs or rates of infections. Patient safety is supported by the National Patient Safety Agency's 'seven steps to patient safety'.
Quality Committee	This committee gives the Board an independent review of, and assurances about, all aspects of quality, specifically clinical effectiveness, patient experience and patient safety, and monitors whether the Board keeps to the standards of quality and safety set out in the registration requirements of the Care Quality Commission.
Quality dashboard	An easy-to-read, often single-page report showing the current status and historical trends of our quality measures of performance.

Clinical Quality Governance Group	This is a core management group which has the primary purpose of operationalising the Trust's Quality Strategy and managing all aspects of safety, excellence and experience. The CQGG directs the programmes and performance of the quality working groups that report to it.
Quality Strategy	Describes the Trust's responsibilities, approach, governance and systems to enable and promote quality across the Trust whilst carrying out business and planned service improvements.
Relevant Health Services	Services provided by the Trust – Emergency Care, Patient Transport and 111.
Research Ethics Committee	This committee helps to make sure that any risks of taking part in a research project are kept to a minimum and explained in full. Their approval is a major form of reassurance for people who are considering taking part. All research involving NHS patients has to have this approval before it can start.
SharePoint	SharePoint is a software package that can be sued to create websites. This can then be used as a secure place to store, organise, share and access information.
See and Treat	A face-to-face assessment by a paramedic that results in a patient being given care somewhere other than an A&E department.
Special reviews or investigations	Special reports on how particular areas of health and social care are regulated.
Ulysses Safeguarding system	The Incident reporting system used by NEAS

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The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

QUALITY ACCOUNT 2021/2022

Unconditionally registered with the
CQC since April 2010

CONTENTS

PART 1

CHIEF EXECUTIVE'S STATEMENT

Thank you for your interest in our 2021/2022 Quality Account.

This year's Quality Account sets out our key quality and patient safety priorities for 2022/2023 and it demonstrates how we have continued to deliver high quality, effective care for patients during the last year. We have continued to tackle the COVID-19 pandemic as well as continuing to provide a full range of community, general and specialist healthcare services to the North East and beyond.

Over the past year, we have not compromised our high standards or our desire to continually improve. Staff have continued to adapt so that we can provide the best care. Some of our achievements include:

- We opened a state-of-the-art theatre hub dedicated to cataract surgery
- We opened a new cancer centre on the site of the Cumberland Infirmary in Carlisle following an investment of £35million in north Cumbria. The Northern Centre for Cancer Care, North Cumbria – a partnership between Newcastle Hospitals and North Cumbria Integrated Care NHS Foundation Trust (NCIC) – brings all non-surgical cancer services under the same roof for the first time.
- We focussed on tackling the climate emergency and taking the voice of our young patients from the Great North Children's Hospital to COP26 in Glasgow – and mum Kaja Gersinska became the first person in the UK to use climate friendly pain relief during labour after giving birth to baby Rosie at the RVI.
- We became the first hospital in the region to launch a new self-service tool, in partnership with NHS Digital, to help everyone to use emergency care appropriately
- The National Institute for Health Research (NIHR) Newcastle Clinical Research Facility (CRF) has received over £5.47million to continue its research into a range of health conditions. The NIHR Newcastle CRF, a partnership between the trust and Newcastle University, is one of 28 in the country to receive funding which will support research into new treatments and early phase clinical trials which test treatments for the first time.
- Continued to roll out the regional vaccination programme for COVID-19.

I would like to thank all of our staff and volunteers for their incredibly hard work, dedication and compassionate care throughout the year.

Dame Jackie Daniel
Chief Executive
19 April 2022

To the best of my knowledge the information contained in this document is an accurate reflection of outcome and achievement.

WHAT IS A QUALITY ACCOUNT?

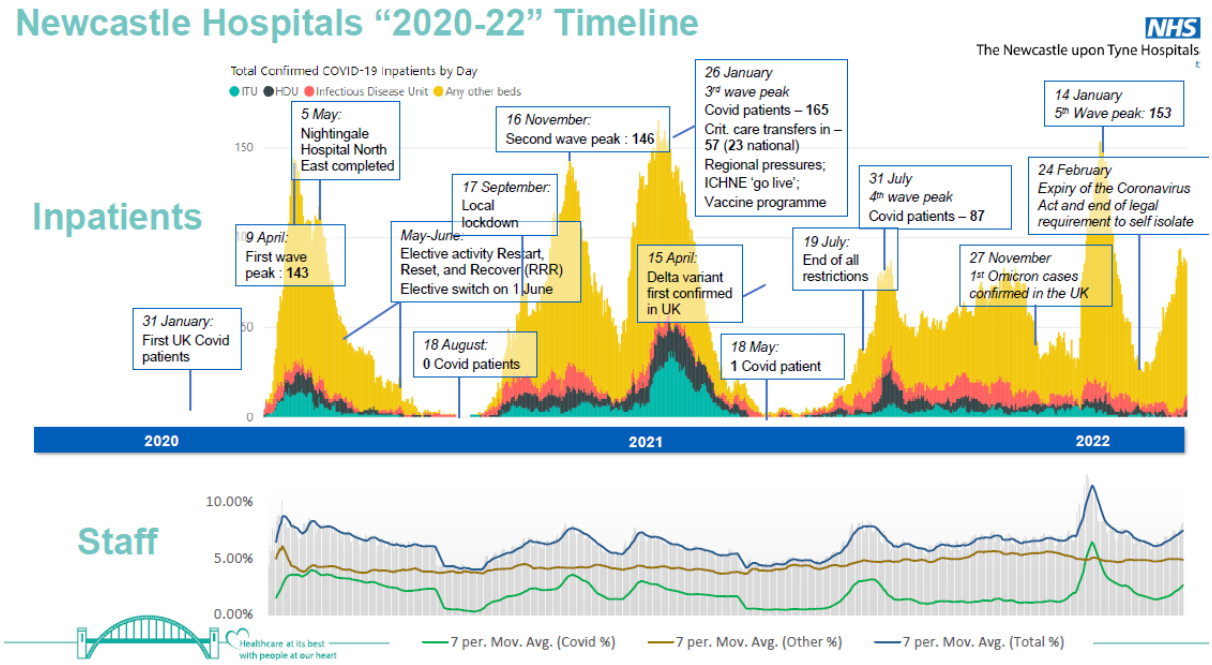
Quality Accounts are annual reports to the public from us about the quality of healthcare services that we provide. They are both retrospective and forward looking as they look back on the previous year's data, explaining our outcomes and, crucially, look forward to define our priorities for the next year to indicate how we plan to achieve these and quantify their outcomes.

RECOVERY and ‘Living with COVID-19’

The COVID-19 pandemic is the biggest healthcare challenge this country has faced since World War 2. Since the first lockdown began in March 2020, the UK have experienced several national and local lockdowns. All restrictions and emergency COVID-19 regulations ended on March 31st 2022 as the nation started its transition into ‘Living with COVID-19’. Publically funded Polymerase Chain Reaction (PCR) testing also ended on 31st March 2022.

Over the last year, COVID-19 has continued to have a significant impact upon the Trust:

- Staff sickness levels have been unprecedented, reaching over 12% in January 2022
- As of March 2022,COVID-19 inpatient numbers stood at 85, which is split between those that are ‘being treated for COVID-19’ and those that happen to ‘have’ COVID-19 but are not receiving treatment for the virus
- Activity levels have not recovered to pre COVID-19 percentages and we are tracking at 75% pre pandemic levels of elective activity
- Patient acuity has worsened due to delays in presentation
- Patient flow through the organisation has been challenged due to increased attendance at Accident & Emergency (A&E), increased length of stay (LOS) and increased occupancy. This has been exacerbated by delay to transfers and higher repatriations, all of which have impacted our elective programme
- Elective waiting lists numbers have increased by 49%
- For the first time in the history of the organisation, we have patients who have waited over two years for their treatment.



At the end of April 2020, and the first wave of COVID-19 infections started to decline, the 3 stage Restart, Reset and Recovery programme (3Rs programme) for clinical and enabling services at Newcastle Hospitals was established.

We are now two years on and Recovery is still our priority, but this is being conducted in parallel with COVID-19 and not in its absence, and therefore there are still significant challenges on our workforce and capacity. Focus also needs to shift to 'closing the gap' and returning the organisation to pre-COVID-19 levels of productivity and efficiency.

1.1 The Restart, Reset and Recovery Programme

The programme consists of three clear, but overlapping phases:

Restart - A short-term switch back on with minor alterations to pre-COVID-19. Completed.

Reset - Recommence but with adoption of new ways of working which are defined by the COVID-19 legacy constraints such as need for Personal Protection Equipment (PPE), testing, shielding, social distancing and workforce fatigue. Completed.

Recovery - A longer term programme, where we embed our new transformative ways of working, recover our performance and clear back logs. In progress and needs to continue as we learn to 'live with COVID-19'.

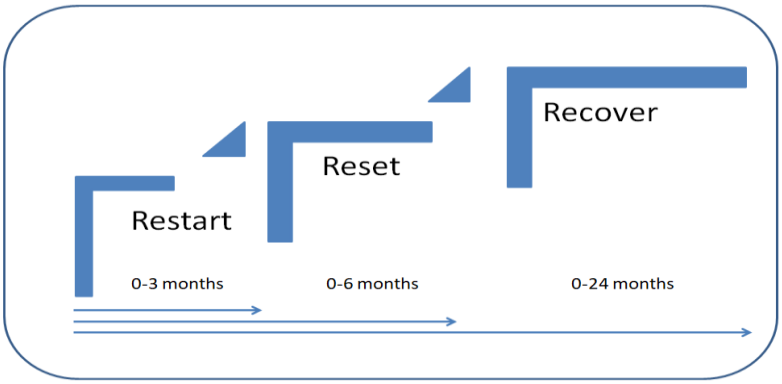


Figure 1. The 3Rs programme

1.2 Recovery progress

In April 2021, an Executive Team Operations Board was convened. This board has met on a weekly basis and its' focus has been to identify, fund and monitor schemes that could deliver increased activity and therefore enable the Trust to access Emergency Recovery Funds – non recurrent money which could be re invested on a temporary basis.

In order to transition into the next phase of recovery, from April 2022 the Operations Board has pivoted its focus to supporting the organisation to 'close the gap', return activity levels to pre-COVID-19 levels and then deliver more. The Board will still have a role in identifying and monitoring schemes that are aligned to correcting the pandemic consequences and delivering the 2022/2023 targets. Success will be measured on:

- Delivery of improved quality
- Delivery of improved productivity
- Delivery of improved efficiency

- Delivery of cost improvement.

Alongside the Operations Board, in order to apply more organisational grip to rectifying the unintended consequences of the pandemic, such as addressing the greater than 52 week, greater than 78 week and over 104 week long waiters, we convened the Newcastle Plan Delivery Board. This meeting is held fortnightly, it is chaired by Dame Jackie Daniel and attended by the full Executive Team.

Pathway Improvements

Cataract Theatres

Following the opening of a purpose built cataract centre (with patient flow improvements) at the Centre of Aging and Vitality on 6th April 2021, the feedback from both staff and patients has been extremely positive. More than 7,000 patients have been treated at the centre since the opening (circa 135 per week) which has exceeded the volume of cases in 2019/2020 (which relied heavily on waiting list initiatives and support from the independent sector). The centre has allowed the team to run high volume lists with a named nurse supporting the patient throughout their stay, thus reducing the time spent on site for patients from five hours to one hour. The waiting list for cataract surgery has reduced from 3000 to just over 1000 patients with the average wait reducing from 36 to 26 weeks.

However, given the ongoing pressures, the team would like to improve productivity in theatres and they are focussing their efforts on increasing the number of cases on lists in the coming months.

Endoscopy

Prior to the COVID-19 pandemic, endoscopy was a paper-based service and gathering an accurate count of waiting list demand was performed manually (based on the paper requests within the department, which was time consuming and open to human error).

The Endoscopy Department implemented Paperlite in June 2021, introducing electronic requesting for endoscopy outpatient procedures. The transition from paper to digital requesting has allowed for accurate waiting list management as well as the ability to measure wait times for patients against Key Performance Indicators such as two week wait cancer target and the six week diagnostic target; something that would have previously taken many hours to compile is now available at the click of a button.

The department can now robustly assess the demands placed upon Endoscopy, enabling the service to allocate capacity effectively, resulting in improved experience for patients as well as minimising delays in the diagnostic phase of the pathway.

Improving the digital maturity of the endoscopy service will continue throughout 2022, including expansion of electronic requesting for inpatients and implementation of a digital pre-assessment solution, which will reduce the need for some patients to come to hospital.

Outpatient Improvement Programme

Patient care delivery within the Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH) outpatient setting accounts for approximately two-thirds of patient contacts per year. Working towards improving services and outpatient pathways for these patients, we launched our Outpatients Transformation Programme just prior to the COVID-19

pandemic. The impact of the pandemic necessitated an immediate shift in the Programme's plans and priorities and played a pivotal role in working alongside clinical services and corporate teams to enable this sector of service delivery to continue throughout the pandemic.

The main enabler for this has been the introduction, formalisation and adoption of Virtual Consultations, via both telephone and the introduction of our video consultation system, Attend Anywhere. At the height of the pandemic, we were delivering over 50% of our consultations virtually. Over the previous year as Face-to-Face appointments have become more available, we have continued to use this new way of working and the programme has continued to support clinical teams to utilise and optimise this consultation type. Through 2021/2022, there have been approximately 2,500 virtual consultations per month, enabling flexible working for our clinical staff and preventing patients travel to hospital; delivering both patient experience improvements as well as environmental benefits.

As we look ahead to 2022/2023 there are several, high-profile, Trust wide initiatives we will be implementing, positively impacting our patients as well as supporting National Planning Guidance.

Patient Initiated Follow Up (PIFU)
The PIFU outcome model allows clinicians to safely manage and ultimately discharge patients that would normally be given a routine follow-up appointment, but do not necessarily require one. It also allows patients greater control and encourages self-management of their condition through a shared decision making process. Additional benefits include a reduction in the total number of follow-ups required, a reduction in 'do not attends' (DNAs) and ensuring that follow up appointments for these patients are of high clinical value. Patients on the PIFU pathway will request an appointment when their symptoms change, rather than being given one in the future that they may not need or attend.

Improving Advice and Guidance (A&G)
Functionality available through the national E-Referral System (ERS) that allows GPs direct access to specialist services. GPs can request advice for the treatment of their patients in Primary Care, as opposed to sending in a referral for patients that may not necessarily need to be seen in secondary care. This reduces demand on our services and ensures that the most appropriate patients are referred and subsequently seen, positively impacting on demand and capacity. Many services across the Trust have participated in this service over previous years and we will be working with clinical teams to expand and optimise the service currently offered and work to include new services.

Electronic Outcome Form
Work continues to convert the current paper based form to an electronic version, enabling the accurate capture of outpatient attendance outcomes and improving on patient safety/'lost to follow up' concerns. This functionality will also significantly reduce the administrative time needed to investigate attendances where no outcome has been reported.

Working alongside clinical teams, scoping is currently underway to identify additional improvement initiatives as well as additional ways to reduce out-patient follow up appointments at a local service level, such as the development of 'One Stop Shops' to

combine multiple appointments into a single visit to hospital, service pathway redesigns and maximizing capacity through efficient clinic builds and booking procedures.

Day Case Improvement Project

Day surgery is a widely established practice with rates increasing around the world and has greatly evolved since the early days of the introduction of this technique, which saw minor procedures carried out on fit patients. Now due to advances in anaesthesia and surgical techniques, day surgery is the standard pathway of care for many complex patients and procedures previously treated through inpatient pathways.

The British Association of Day Surgery (BADS) data shows there is further opportunity to increase and broaden day case surgery across the Trust to improve patient and staff experience and support the recovery of elective care whilst reducing patient days away from home. This will also reduce elective surgical dependence on inpatient bed availability, allowing a greater proportion of elective surgery to continue despite traditional winter surge in admissions.

With this in mind, a Day Surgery Improvement Project launched in 2021 with two global aims:

- Redesign the current day case model (across the Trust) and develop a Universal Day Surgery Pathway (multi-specialty), identifying key components that can be applied to existing inpatient activity to convert to a day case approach (day case expansion);
- Create dedicated self-contained day surgery unit(s) (geographically discrete from inpatient activity) and establish dedicated day surgery teams who deliver (almost) the entire pathway and are fully committed to driving service improvement.

Whilst this is a strategic project, frontline staff are empowered to design the solutions (bottom-up delivery) with Quality Improvement training offered to ensure a legacy of continuous improvement. A number of improvement initiatives are ongoing across the Trust such as development of a universal waiting list addition/pre-assessment request form, 6-4-2 model, Saturday Day Case Pilots, development of enhanced pre-assessment model (incorporating optimisation). The new self-contained Day Treatment Centre (see below) will implement the universal day case pathway before we consider rolling out across the wider organisation.

Day Treatment Centre (DTC)

An exciting new development is taking place at our Freeman Hospital site, where we are investing £20 million in a purpose-built, dedicated facility for day case procedures. A self-contained Day Treatment Centre is currently under construction, with completion scheduled for August 2022 and the facility open to patients from September 2022 onwards.

Part of Newcastle Hospitals' ambitious day case improvement programme, the centre will house four new state-of-the-art theatres, along with a dedicated pre-operative ward and post–operative recovery areas, and will enable us to provide thousands of additional procedures in specialties such as musculoskeletal health, urology, surgery and cardiothoracic services. It will address some of the significant waiting list challenges and backlogs caused by the pandemic, through the transfer of suitable day cases from existing theatre lists to free up space for more complex work.

The DTC aims to:

- Improve patient experience and surgical outcomes
- Improve staff morale and retention
- Lower length of stay (bed day savings)
- Reduce waiting and pathway times
- Support recovery of elective backlog
- Lower emergency readmissions
- Reduce rates of hospital-acquired infection and venous thromboembolism (VTE)
- Reduce on the day surgical cancellations
- Align with other strategic programmes such as Getting It Right First Time (GIRFT) High Volume Low Complexity.

Prehabilitation/Perioperative Disease Management
With the deterioration in mental and physical health during the COVID-19 pandemic, this will place extra burden on overstretched resources and lead to complications, increased bed days and worse patient centric outcomes. Prehabilitation aims to improve the general health and wellbeing of the surgical population, reduce costs and improve success of the surgery. The Trust are currently focusing on a number of areas, with a mix of research and quality improvement projects for major surgery (pancreatic cancer, abdominal aortic aneurysm, upper gasto-intestinal, peripheral arterial disease) and also 'waiting well' programme for the elective surgery cohort targeting issues around smoking, obesity, diabetes and opiate dependency.

The programmes are designed to target those from socially deprived communities whilst embedding interventions that take into consideration health literacy and digital exclusion. To aid in the delivery, a collective approach with therapy services and third sector organisations (Healthworks, Ways to Wellness) has been developed and patient co-design will be a core principle. The evaluation of initiatives will be shared widely in the coming months with a view to piloting in other areas of surgery and oncology services. Sustainability of these initiatives will be considered alongside the results and impact of initiatives on the wider health and care system.

Enhanced Recovery after Surgery – Hepatobiliary and Pancreatic (HPB) Surgery
The Newcastle upon Tyne Hospitals NHS Foundation Trust is one of the UKs largest cancer resection centres for HPB undertaking > 200 liver and pancreas resections/year as well as offering a wide range of novel liver and pancreas directed therapies.

The unit outcomes in terms of mortality and cancer related outcomes are comparable with leading centres in Europe and internationally. However, the length of stay data has historically been an outlier when compared to similar centres in the Shelford Group.[1] In 2019, the team (in conjunction with Newcastle Improvement) started work to develop a new enhanced recovery after surgery (or ERAS) model for HPB surgery at the Freeman Hospital. ERAS launched during the first national lockdown, which made data collection within this period challenging.

However, 87% of patients are now accessing the pre-operative multi-disciplinary (MDT) ERAS clinic (December 2021-March 2022) and the service can demonstrate significant improvements in patient experience for over 300 cancer patients, with one patient commenting, “you must have had hundreds of patients, but I felt like I was your only one”. The liver programme launched in January 2020 and despite the pandemic, it delivered the target length of stay (a reduction of two days) for liver resections within two months. Whilst it has been challenging to deliver the pancreas length of stay reductions, the team have reported improvements. Furthermore, the richness of clinical data now collected is informing new ways of working and over time, this will start to shape the pathway and support the introduction of new technologies e.g. new approaches to regional analgesia.

Liver Transplant Assessment Service
A liver transplant assessment looks at people with chronic liver disease, who are heading towards transplantation. The assessment aims to review whether this is a suitable course of treatment for those patients as timing is critical with transplants, if they are left too late the person would be too unwell for the transplant or if they are too early, they won’t have any real benefit from transplantation.

Traditionally at the Freeman Hospital, the assessment process for liver transplant patients was three days with numerous tests spanning from Wednesday until Friday afternoon. Following extensive feedback from patients, the team wanted to use improvement techniques to reduce this assessment period to just one day, with no overnight stay. The COVID-19 pandemic presented a perfect opportunity to kick-start this development, particularly as there were challenges in getting patients admitted.

The assessment process for liver transplant patients is now one day and all test slots are now at fixed times, which has made it quicker for patients and much easier for staff to manage tests too. The improvement demonstrated a saving of 193 bed days in 2020/2021 and in most cases, patients will know if they are a suitable transplant candidate within a few days (reduced from three-four weeks).

A collaborative approach to reducing hospital admissions and amputations in diabetic patients
The Vascular Team at the Freeman Hospital has transformed care for patients with diabetic foot disease across Northumbria, North Tyneside, Newcastle and Gateshead. It is critical that patients with diabetic foot ulcerations have rapid access to vascular interventions as soon as possible to give them the best opportunity to heal. However, the team at the Freeman Hospital became increasingly concerned as they began to witness an increase in major amputations across their population. To improve care for this group of patients, the vascular team joined forces with stakeholders in the region to form the Newcastle Diabetic Foot Transformation Project.

[1] The Shelford Group is a collaboration between ten of the largest teaching and research NHS hospital trusts in England.

Resulting from this improvement project, all new diabetic foot referrals are now seen by community podiatry within 24 hours (additional podiatry capacity provided), community patients routinely receive a perfusion assessment, clinical reviews are available within 72 hours, specialist (Hot-Clinic) review is available within 72 hours supported by a weekly diabetic foot multi-disciplinary team (MDT). The service expects to see a significant reduction in major amputations in diabetic patients as well as an overall reduction in admissions and length of stay for patients with diabetic foot ulceration.

PART 2

QUALITY PRIORITIES FOR IMPROVEMENT 2022/2023

Following discussion with the Board of Directors, the Council of Governors, patient representatives, staff and public, the following priorities for 2022/2023 have been agreed. A public consultation event was held in January 2022 and presentations have been provided at various staff meetings across the Trust.

PATIENT SAFETY

Priority 1 - Reducing Healthcare Associated Infections (HCAI) – focusing on COVID-19, Methicillin-Sensitive Staphylococcus Aureus (MSSA)/Gram Negative Blood Stream Infections (GNBSI)/*C.difficile* infections.

Why have we chosen this?

Preventing healthcare acquired COVID-19 infections remains a priority whilst we adapt to living with COVID-19.

MSSA bacteraemias can cause significant harm. At The Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH), these are most commonly associated with lines and indwelling devices; achieving excellent standards of care and improving practice is essential to reduce these line infections in line with harm free care.

GNBSI constitute the most common cause of sepsis nationwide. Proportionally, at NUTH, the main source of infection is urinary tract infections, mostly catheter associated, and also line infections. An integrated approach, engaging with the multidisciplinary team across the whole patient journey, focusing on antibiotic stewardship, early identification of risks and timely intervention formulate the basis for our strategy to reduce these infections. The *GNBSI* Steering Group, created in 2021/2022, continue to review reduction strategies.

C. difficile infection is a potentially severe or life-threatening infection, which remains a national and local priority to continue to reduce our rates of infection in line with the national objectives.

What we aim to achieve?

- Prevent transmission and HCAI COVID-19 in patients and staff.
- Internal 10% year-on-year reduction of MSSA bacteraemias.
- National ambition to reduce *GNBSI* with an internal aim of a 10% year-on-year reduction.
- Sustain a reduction in *C.difficile* infections in line with national trajectory.

How will we achieve this?

- Review and update Infection Prevention and Control (IPC) practices in line with renewed national COVID-19 guidance. This is underpinned and supported by the national Board of Assurance Framework (BAF).
- Board level leadership and commitment to reduce the incidence of Health Care Associated Infection (HCAI).
- Quality improvement projects in key directorates running in parallel with Trust-wide awareness campaigns, education projects, and audit of practice, with a specific focus on:
    - Antimicrobial stewardship and safe prescribing.
    - Insertion and ongoing care of invasive and prosthetic devices.
- Ward monitoring of device compliance for peripheral intravenous (IV) and urinary catheters.

- Improve diagnosis and management of infection in all steps of the patient journey.
- Working with partner organisations to reduce infections throughout the Health Care Economy.
- Early recognition and management of suspected infective diarrhoea.
- Reintroduce Root Cause Analysis (RCA) meetings with Directorates (were suspended during the COVID-19 pandemic) to discuss and share learning and good practice.
- Directorate-led Serious Infection Review Meetings (SIRM) to share and support action plans to monitor/reduce HCAI and adherence to best practice.

How we will measure success?

- By ensuring and monitoring compliance with the BAF.
- Continuous monitoring of Hospital Onset COVID-19 prevalence.
- Sharing data with directorates whilst focusing on best practice and learning from clinical investigation of mandatory reporting organisms.
- Continue to report MSSA, *GNBSI* and *C.difficile* infections on a monthly basis, internally and nationally.

Where we will report this to?

- COVID-19 Assurance Group.
- Infection Prevention and Control Committee (IPCC).
- Infection Prevention and Control Operational Group.
- Patient Safety Group.
- Trust Board.
- The public via the Integrated Board Report.
- Public Health England.
- NHS England (NHSE)/NHS Improvement (NHSI).

Priority 2 – Management of Abnormal Results

Why have we chosen this?

The management of clinical tests from their request, through booking, performance, reporting, reviewing and acting on the results, is a major patient safety issue in all healthcare systems. We see evidence of patient harm caused by delays in tests, resulting in delays in treatment and aim to minimise those risks.

We currently lack assurance that investigation results, issued electronically, are appropriately approved in the electronic health record (EHR). Initially, we are going to focus on Radiology where failure to act can cause serious harm, especially in the outpatient setting.

Managing these problems will be a major undertaking, requiring successful completion of the Closed Loop Investigations project.

What we aim to achieve?

This project aims to improve electronic ordering by ensuring that all requests are filed against the ‘correct’ lead consultant. Results will be returned to the same ‘correct’ lead consultant for electronic approval.

How will we achieve this?

A list of ‘lead’ consultants must be defined and agreed.

- Providers must select the ‘lead’ consultant from a list in eRecord when they order a test.
- Results relating to electronic orders must be returned to the same ‘lead’ consultant, to be approved in eRecord.
- Where the ‘lead’ consultant is not available, the result must go back to other members of the ‘lead’ consultant’s team.

How we will measure success?

- A reduction in the incidence of patient harm arising from delayed action on tests results.
- The proportion of results issued to eRecord that have been approved by the ‘correct’ lead consultant.
- A reduction in time between a report becoming available on eRecord and action being taken.

Where we will report this to?

- Clinical Policy Group.
- Trust Board.

CLINICAL EFFECTIVENESS

Priority 3 – Enhancing capability in Quality Improvement (QI)

Why have we chosen this?

COVID-19 continues to demonstrate the need for changes to made quickly to improve healthcare for patients and to recover from the impact of COVID-19. Throughout 2020/2021, we have established an infrastructure to build capability and capacity for improvement at scale with Newcastle Improvement. Our two-year partnership, with the Institute for Healthcare Improvement (IHI), will enable us to accelerate this improvement work. This is critical in maintaining our outstanding performance and the patient-focused high quality of care we deliver.

What we aim to achieve?

- Deliver IHI improvement-training programmes tailored to local teams working on Trust improvement priorities.
- Improvement teams will be led and supported by improvement coaches,in providing an organisational approach to enhance QI capability.
- Develop Newcastle Improvement staff towards being independent to deliver the IHI programmes in the future.

How will we achieve this?

- Train 15-20 improvement teams, each focused on a piece of improvement work and coach them through the work.
- Train 30 improvement coaches to build capability and support teams with their improvement work.
- Adapt the IHI training programme, following feedback from the training and evaluation.
- Newcastle Improvement team members to shadow and co-deliver the IHI delivery of programmes in 2022/2023.

How we will measure success?

- Measure completion of planned training programme comprising 15-20 teams of four-five multidisciplinary members through the 'Improvement for Teams' and 30 'Coaching for Improvement'.
- Evaluate the whole programme using the evaluation framework.
- Evaluate training programmes from learners' perspective and progression of improvement work.
- Staff survey results to identify improvement in involvement and ability to contribute to improvement domains.

Where we will report this to?

- Improvement Advisory Group.
- Trust Board.

Priority 4a - Introduction of a formal triage process on the Maternity Assessment Unit (MAU), in order to improve the recognition of the deteriorating pregnant or recently pregnant woman

Why have we chosen this?

The need for early recognition and management of deterioration of pregnant women has been highlighted by:

- Mothers and Babies, Reducing Risk by Audit and Confidential Enquiry (MBRRACE)
- The Ockenden Report.

To reduce the likelihood of avoidable harm to mothers and babies we need to improve early detection and rapid escalation of women at risk of deterioration on the Maternity Assessment Unit.

What we aim to achieve?

Within five minutes of arrival at the Maternity Assessment Unit (MAU) at the RVI, 95% of pregnant or recently pregnant women (within six weeks of birth), who don't receive immediate treatment, will have formal triage by a designated member of staff trained in triage.

How will we achieve this?

- Project looking at the environment/processes and roles and responsibilities of staff on MAU, one important aspect being the move of day care from MAU to the antenatal ward. This transition has been implemented with further plans to facilitate, 8am-8pm, seven days a week with two members of staff. In addition, an automated telephone system is urgently required, which is in process.
- On-going Plan Do Study Act (PDSA) as part of the IHI project
    - Pilot of triage proforma by triage at quiet times on MAU December 2021/January 2022.
    - Plan is for triage proforma to be used in busier periods from mid-March 2022.
- Staff experience survey – December 2020. Plan to re-do the survey when triage is fully introduced, and a patient experience survey is planned for the future.

How we will measure success?

Regular – monthly initially, audit of percentage of women having formal triage by a designated member of staff trained in triage, within five minutes of arrival at the Maternity Assessment Unit at the Royal Victoria Infirmary (RVI).

Where we will report this to?

- Obstetric Governance Group.
- Women's Services Quality & Safety.
- Trust Board.

Priority 4b - Modified Early Obstetric Warning Score (MEOWS)

Why have we chosen this?

In recent years there have been a number of maternal deaths within England where the lack of MEOWS systems for pregnant women in hospital but outside of a maternity setting played a significant part in their poor outcome.

What we aim to achieve?

Implementation of an electronic MEOWS system in areas of the Trust outwith the Maternity Unit would improve the quality and safety of patient care for those women and provide Obstetric Services with a daily list of pregnant/recently pregnant women regardless of their location throughout the Trust and therefore improve collaborative care.

How will we achieve this?

- Create an Information Technology (IT) solution for identification of a pregnant/recently pregnant women who are not cared for within Womens services by building"Are you/recently been pregnant" question into Electronic Patient Record (EPR) system.
- IT development of an electronic MEOWs system to replace National Early Warning Score/Paediatric Early Warning Score for this group of women.

How we will measure success?

- Identification of pregnancy question built into EPR System.
- Deployment of MEOWS Trust wide.
- Audit of compliance with MEOWS.

Where we will report this to?

- Womens Service Quality and Safety.
- Deteriorating Patients Group.
- Trust Board.

Priority 5 – Trust-wide Day Surgery Initiative

Why have we chosen this?

Day surgery is a widely established practice with rates increasing around the world and has greatly evolved since the early days of the introduction of this technique, which saw minor procedures carried out on fit patients. Now, due to advances in anaesthesia and surgical techniques, day surgery is the standard pathway of care for many complex patients and procedures previously treated through inpatient pathways.

The British Association of Day Surgery (BADS) data, shows there is further opportunity to increase and broaden day case surgery across the Trust to improve patient and staff experience and support the recovery of elective care whilst reducing patient days away from home.

This will also reduce elective surgical dependence on inpatient bed availability, allowing a greater proportion of elective surgery to continue despite traditional winter surge in admissions.

What we aim to achieve?

Initiate a Trust-wide Day Surgery Project.

The Day Surgery project has two global aims:

- Redesign the current day case model (across the Trust) and develop a Universal Day Surgery Pathway (multi-specialty), identifying key components that can be applied to existing inpatient activity to convert to a day case approach (day case expansion);
- Create dedicated self-contained day surgery unit(s) (geographically discrete from inpatient activity) and establish dedicated day surgery teams who deliver (almost) the entire pathway and are fully committed to driving service improvement.

How will we achieve this?

Given the size and complexity of the project, three priorities (key enablers) have been selected for the Quality Account:

- Surgical Assessment: Develop a universal waiting list process to ensure a consistent process across all specialties in order to progress the patient to surgery

- Pre-operative Assessment: Develop a universal request for day case patients to ensure patients get pre-assessed early in the pathway, ensuring any current health conditions are managed and the patients are at their fittest for surgery
- Implement the 6-4-2 method of theatre list planning in the Day Treatment Centre and two specialties on the main sites to ensure we use all of our theatre capacity and reduce the waiting list backlog.

How we will measure success?

- Delivery of three priorities above by March 2023.
- Reduce waiting times.
- Reduce on the day surgical cancellations.

Where we will report this to?

- Operations Board.
- Improvement Advisory Group.
- Trust Board.

PATIENT EXPERIENCE

Priority 6 – Mental Health in Young People

Why have we chosen this?

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Mental Healthcare in Young People and Young Adults report published recommendations in 2019, which are a beneficial tool to benchmark against.

Throughout 2021, there has been significant pressure on specialist mental health Tier 4 inpatient services across the North East and Yorkshire Region (NEY). There has been an increase in children and young people (CYP) presenting and is especially high in those presenting with eating disorders. This has resulted in some patients having delayed access to treatment in the right care environment.

In the NEY a CYP Mental Health Task and Finish Group has been established which has identified a number of work streams looking at the issue from different perspectives. With an overall aim of expediting delivery of a regional approach to manage the current significant challenges faced by children and young people in accessing appropriate mental health services. The Trust has representation within this work stream.

The overarching purpose of these recommendations is to improve the quality of care provided to young people and young adults with mental health conditions.

As an organisation, we will continue to review current service provision for children, young people and young adults in order to assure that we identify gaps, areas of good practice and plan to improve the care provided in the acute Trust for these patients.

What we aim to achieve?

- A dedicated and efficient pathway for assessment and treatment plan working in close conjunction with Cumbria, Northumbria, Tyne & Wear (CNTW) colleagues.
- Timely access to mental health services.
- Trained and skilled workforce.
- Appropriate environment for patients to be cared for.
- Efficient access to identify 'Advocates' for patients detained under the Mental Health Act.
- Clarity and improved pathways and support when patients detained under the Mental Health Act.

How will we achieve this?

- Dedicated group to identify gaps, areas of good practice and develop actions to support adherence to NCEPOD standards.
- Work collaboratively with regional colleagues in services for children and CNTW to access the "We Can Talk" training programme and ensure staff are trained.
- Review the impact of this training.
- Link in with Mental Health First Aider Course from Child Health Network.
- Updated policy outlining prevention of restrictive interventions and safe interventions for adults, children and young people within the organisation.
- Listen to patients and families and work with them to improve the service.

How we will measure success?

- More efficient pathways when patients present acutely.
- More efficient transfer to mental health services for inpatient management.
- Positive impact of training, increased numbers of staff and disciplines trained.
- 'Safe' area configured in Paediatric Emergency Department.
- Policy for patients under 18 years when detained under the Mental Health Act.
- Improved risk assessment and prevention of restrictive interventions.

Where we will report this to?

- Clinical Outcomes & Effectiveness Group.
- Trust Board.

Priority 7 – Ensure reasonable adjustments are made for patients with suspected, or known, Learning Disabilities

Why have we chosen this?

People (children, young people and adults) with a Learning Disability are four times more likely to die of something which could have been prevented than the general population. As a Trust, we are committed to ensuring patients with a learning disability and/autism have access to services that will help improve their health and wellbeing and provide a positive and safe patient experience for them and their families.

What we aim to achieve?

- Assurance that patients and their families have appropriate reasonable adjustments as required. That they are listened to, feel listened to and have a positive experience whilst in our care and appropriate follow-up.
- Assurance that patients are flagged appropriately and that these flags generate the appropriate response to care, treatment and communications.
- Ensure staff have received training in order to understand reasonable adjustments and the needs of patients with a learning disability and/autism.

How will we achieve this?

There are a number of workstreams to support ongoing work and developments to provide improved care for patients with learning disability and autism. The main priorities are;

Workforce

- Review of the existing Learning Disability Liaison Team, consider new roles and responsibilities within the team to better meet the needs.
- Temporary changes within the team to support the team to be more visible on the wards and departments.
- Temporary support to offer dedicated focus on identified priorities.

Training

- Implementation of Diamond Standards across the organisation to not only improve patient experience and pathways, but to educate the workforce.
- Ongoing consideration of joint training with simulation team and Northumbria University.

Skills and Support

- Review of the role of Learning Disability Champions across the organisation.
- Consider the concept of Autism Allies across organisation with appropriate training and support.
- Learning from Learning Disability Forums by showcasing and sharing the exemplary work some of the Trust's clinical teams do in terms of provision of reasonable adjustments.

Better Experience

- Work with patients and families to learn and improve.
- Review of pathways and e-Learning to determine if any adaptions required.
- Work in conjunction with North East and Cumbria Learning Disability Network and Great North Children Hospital (GNCH) anaesthetics to incorporate theatre attendance within passport for Children & Young People (CYP).
- Pathways to be developed for adult patients requiring Magnetic Resonance Imaging (MRI)/Computerized Tomography (CT) under sedation.
- Continue to ensure Learning Disability flags are visible for adults and children with a learning disability.
- Gather feedback from patients and service users and carers to identify gaps.

Learning Disabilties Mortality Review (LeDeR)

- Work to ensure mortality reviews for patients with a Learning Disability who die whilst in Trust care are timely.
- Identify risks in appropriately managing LeDeR reviews for patients with autism.

How we will measure success?

- Improved roles and responsibilities within the Learning Disability Liaison Team, with additional support to lead on autism.
- Diamond Standards embedded across the organisation.
- Staff have accessed and completed training.
- Patient with autism are flagged.
- Maintain timely Learning Disabilities Mortality Review Programme reviews.

Where we will report this to?

- Safeguarding Committee.
- Trust Board.

COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) INDICATORS

The CQUIN payment framework is designed to support the cultural change to place quality at the heart of the NHS. Local CQUIN schemes contain goals for quality and innovation that have been agreed between the Trust and various Commissioning groups. Listed below are the quality and/or innovation schemes which were agreed with the commissioners for 2022/2023.

2022/2023 - Specialised Commissioners, NHS England - CQUIN Schemes, Acute Hospital.	
PSS1	Achievement of revascularisation standards for lower limb ischaemia.
PSS2	Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery.
PSS3	Achieving progress towards Hepatitis C elimination within lead Hepatitis C.
PSS4	Delivery of Cerebral Palsy Integrated Pathway assessments for cerebral palsy patients in specialised children's services.
PSS5	Achieving priority categorisation of patients within selected surgery and treatment pathways according to clinical guidelines.

2022/2023 - Local Commissioning (CCG) - CQUIN Schemes, Acute Hospital.	
CCG1	Flu vaccinations for frontline healthcare workers- acute hospital.
CCG2	Appropriate antibiotic prescribing for UTI in adults aged 16+ years.
CCG3	Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions.
CCG7	Timely communication of changes to medicines to community pharmacists via the discharge medicines services.
CCG9	Cirrhosis and fibrosis tests for alcohol dependent patients

2022/2023 - Local Commissioning (CCG) - CQUIN Schemes, Community	
CCG1	Flu vaccinations for frontline healthcare workers- community staff
CCG14	Assessment, diagnosis and treatment of lower leg wounds.

STATEMENT OF ASSURANCE FROM THE BOARD

During 2021/2022, Newcastle Hospitals provided and/or sub-contracted 22 relevant health services.

Newcastle Hospitals has reviewed all the data available to them on the quality of care in all 22 of these relevant health services.

The income generated by the relevant health services reviewed in 2021/2022, represents 100% of the total income generated from the provision of relevant health services by Newcastle Hospitals for 2021/2022.

Newcastle Hospitals aims to put quality at the heart of everything we do and to constantly strive for improvement by monitoring effectiveness. High level parameters of quality and safety have been reported monthly to the Board and Council of Governors. Activity is monitored in respect to quality priorities and safety indicators by exception in the Integrated Board Report, reported to Trust Board and performance is compared with local and national standards.

Leadership walkabouts across the Trust, coordinated by the Clinical Governance and Risk Department and involving Executive and Non-Executive Directors and members of the Senior Trust management team, were suspended at the start of the pandemic. As an alternative, the Chief Executive has been holding regular virtual check-ins with clinical and non-clinical teams to capture their experiences and feedback of working throughout the pandemic, whether caring for patients with COVID-19 or continuing to maintain other non-COVID-19 services.

In addition, the Trust Chair and Non-Executive Directors have been holding monthly virtual ‘Spotlight on Services’ sessions. These sessions provide an opportunity for the Chair and Non-Executive Directors to engage directly with staff, in the absence of management, to learn more about the services themselves and any particular challenges arising. The virtual sessions provide an open forum for all involved to ask questions in a more informal setting, whether that be for staff to learn more about the role of the Chair and Non-Executive Directors or for the Chair and Non-Executive Directors to gain a better understanding of the quality of care provided to our patients within that particular service.

As the organisation takes steps towards recovery, further engagement work will take place with staff in a much deeper and more structured way so we can really focus on the wider ‘health and wellbeing agenda’, understand what has made our teams stronger and the positive changes we have made to support our patients.

The Trust Complaints Panel is chaired by the Executive Chief Nurse of the Trust and reports directly to the Patient Experience and Engagement Group, picking up any areas of concern with individual Directorates as necessary.

Clinical Assurance Toolkit (CAT) provides overall Trust clinical assurance via a six monthly report. With the advent of the COVID-19 pandemic, this Toolkit has been suspended since March 2020. Trust assurance was required and therefore in May 2020, a condensed Assurance Audit Check survey was commenced to ensure standards were maintained and essential information regarding COVID-19 requirements gathered. This audit survey is now sent out on a fortnightly basis to all Trust wards,

outpatient departments, day units and clinics and questions are revised periodically in line with NHSE/I and Public Health England (PHE) guidance. The Assurance Audit reflects the key lines of enquiry in the IPC Board Assurance Framework document. The Chief Nurse's team work plan, this year, includes an update and refresh of CAT, this is now in a trail phase with some clinical areas.

In September 2020, a multi-disciplinary COVID-19 Assurance Group was established. The purpose of this Group was to take collective ownership to provide oversight and scrutiny of the Infection Prevention and Control (IPC) Board Assurance Framework and associated standards. This included on-going assessment of risk, overseeing the implementation of emerging protocols and guidelines and, highlighting where there were gaps in evidence of compliance and limited assurance, facilitating a process of continual improvement and ensuring effectiveness. During the pandemic response, the Group has worked closely with the senior management team to support operational decision-making and provided assurance to Trust Board via the Director of Infection Prevention and Control.

PART 3

REVIEW OF QUALITY PERFORMANCE 2021/2022

The information presented in this Quality Account represents information which has been monitored over the last 12 months by the Trust Board, Council of Governors, Quality Committee and the Newcastle & Gateshead Clinical Commissioning Group (CCG).The majority of the Account represents information from all 22 Clinical Directorates presented as total figures for the Trust. The indicators, to be presented and monitored, were selected following discussions with the Trust Board. They were agreed by the Executive Team and have been developed over the last 12 months following guidance from senior clinical staff. The quality priorities for improvement have been discussed and agreed by the Trust Board and representatives from the Council of Governors.

The Trust has consulted widely with members of the public and local committees to ensure that the indicators presented in this document are what the public expect to be reported. Comments have been requested from the Newcastle Health Scrutiny Committee, Newcastle Clinical Commissioning Group and the Newcastle and Northumberland Healthwatch teams. Amendments will be made in line with this feedback.

PATIENT SAFETY

Priority 1 - Reducing Healthcare Associated Infections (HCAI) – focusing on COVID-19, Methicillin-Sensitive Staphylococcus Aureus (MSSA)/Gram Negative Blood Stream Infections (GNBSI)/C.Difficile Infections.

Why we chose this?

Preventing healthcare associated COVID-19 infections during the transition to "living with COVID-19" remains a priority, in line with the principles and framework of patient and staff safety.

MSSA bacteraemias can cause significant harm. At Newcastle upon Tyne NHS Foundation Trust (NUTH), these are most commonly associated with lines and indwelling devices; achieving excellent standards of care and improving practice is essential to reduce these line infections in line with harm free care.

GNBSI constitute the most common cause of sepsis nationwide. Proportionally, at NUTH, the main source of infection is urinary tract infections, mostly catheter associated, and also line infections. An integrated approach engaging with the multidisciplinary team across the whole patient journey, focusing on antibiotic stewardship, early identification of risks and timely intervention formulate the basis for our strategy to reduce these infections. A *GNBSI* Steering Group has been created to review reduction strategies.

C. difficile infection is a potentially severe or life threatening infection which remains a national and local priority to continue to reduce our rates of infection in line with the national objectives.

What we aimed to achieve?

- Prevent transmission and HCAI COVID in patients and staff.
- Internal 10% year on year reduction of MSSA bacteraemias.
- National ambition to reduce *GNBSI* with an internal aim of a 10% year on year reduction.
- Reduction in *C. difficile* infections in line with national trajectory.

What we achieved?

C. difficile – national threshold was for no more than 98 cases which was actually less than the Trust's local ambition to reduce cases by 10% of the previous year's total. Unfortunately the Trust has seen an increase of 58% as there have been 169 cases in total. The increase has been multifactorial, including the high acuity of patients and the previous suspension of multidisciplinary post infection review (PIR) meetings due to the additional COVID-19 workload and staffing pressures. Furthermore, antimicrobial Take 5 audits have not been completed due to the cessation of the previous electronic reporting platform whilst waiting for the implementation of the new Synbiotix electronic audit tool. A review of the PIR meetings are underway to establish an effective way to engage with the clinical teams to identify best practice and support any identified learning. Antimicrobial audits are planned to be reinstated from April 2022 with the introduction of an electronic audit system to enable directors to monitor prescribing practices. Other learning includes the need to improve documentation of diarrhoea to

support early sample collection and timely isolation. Some focused diarrhoeal management work is planned by 2022/2023.

MSSA bacteraemias – no more than 90 cases; unfortunately the Trust has seen a 10% increase as there have been 110 cases in total and predominately more cases during the second and third pandemic waves.

E. coli bacteraemias – no more than 176 cases; unfortunately, the Trust did not achieve its 10% reduction aim as 206 cases were assigned to NUTH, however the Trust was within the national threshold of no more than 228 cases.

Klebsiella bacteraemias – no more than 117 cases; NUTH had 146 cases assigned, which is an increase of 25%, however the Trust was within the national threshold of no more than 167 cases.

Pseudomonas aeruginosa bacteraemias – no more than 41 cases; NUTH had 43 cases assigned, which is a 5% increase. The Trust was also within the national threshold of no more than 54 cases.

COVID-19 - Healthcare associated COVID-19 cases (definite and probable) have remained below national and regional average throughout the pandemic.

How we measured success?

- Mandatory reporting of HCAI via Public Health England's Data Capture System.
- Benchmark Newcastle Hospitals' healthcare associated infection rates against other organisations.
- Incidence of declared outbreaks.
- Compliance to IPC practice via audits e.g. hand hygiene.
- Adherence to antimicrobial prescribing guidelines.

Priority 2 – Pressure Ulcer Reduction – Community Acquired Pressure Damage whilst under care of our District Nursing Teams

Why we chose this?

Reducing patient harm from pressure damage continues to be a priority, this year we have focused on reducing the rate of community pressure damage, specifically, community acquired pressure damage in patients under the care of our District Nursing Teams.

The increase in patient age, acuity and frailty means that the Trust is seeing more patients with a higher risk of acquiring pressure damage. It is therefore essential that the Trust identified this as a priority to ensure the risks of this are mitigated with accurate assessment and plans of care, together with the implementation of best practice care.

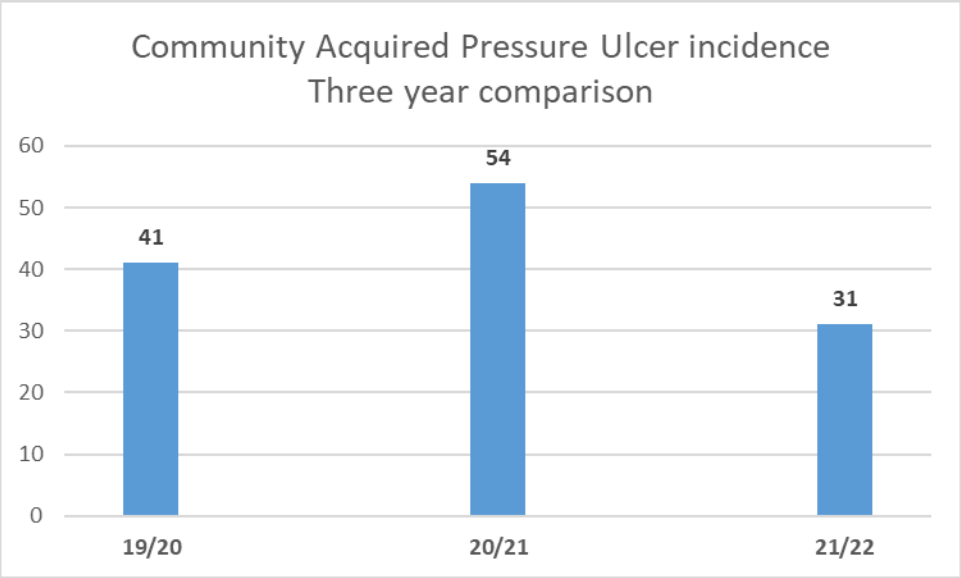
What we aimed to achieve?

- Significantly reduce community acquired pressure ulcers (specifically those graded category II, III and IV).

- Development of dashboards which allow community teams to have a visual aid of where pressure ulcers are occurring, allowing ownership and enabling these teams to make improvements.
- Undertake quality improvement work on targeted localities who report the highest number and rate of pressure damage.
- Increase the visibility and support provided by the Tissue Viability team to frontline clinical staff to assist in the prevention of pressure ulcers.
- Ensure we have a skilled and educated workforce with a sound knowledge base of prevention of pressure ulcers and quality improvement methodology.

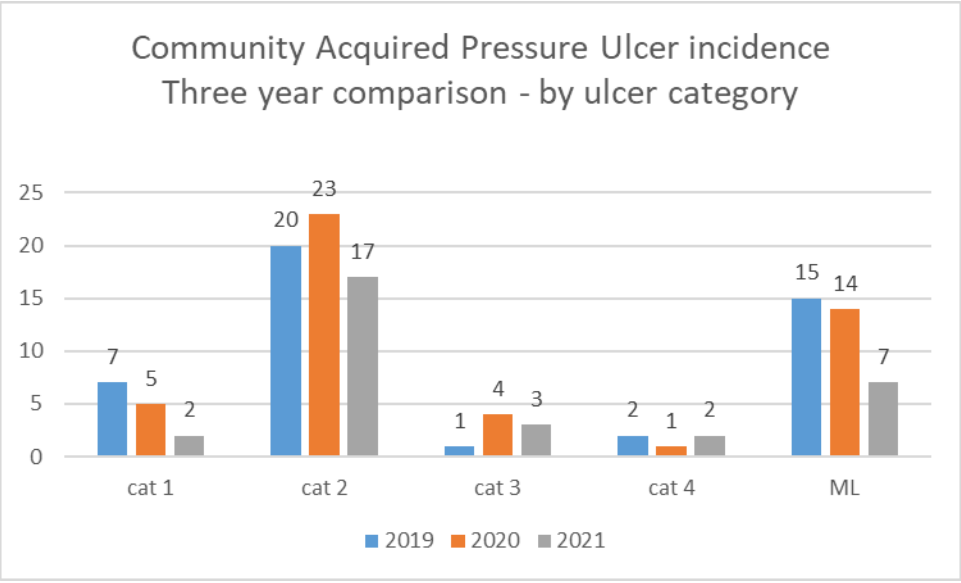
What we achieved?

- A new Pressure Ulcer Prevention Pathway was developed to guide and support staff. The pathway has been shared to all NHS Adult Community Services. Work is ongoing to ensure that this is fully embedded into practice.
- A robust programme of education was developed by the Tissue Viability Team delivering regular 'Pressure Ulcer Prevention' (PUP) updates across the city. Sessions were well attended by staff from community nursing and specialist services. Targeted pressure ulcer update sessions were implemented in teams reporting community acquired category III or IV pressure ulceration following Root Cause Analysis (RCA).
- Promotion of the ethos that PUP is the responsibility of all NHS staff regardless of where it was encountered by patients in their care journey.
- Inspired by Collaborative Newcastle, educational sessions were offered not only to Trust staff, but also to staff working in private organisations such as residential and nursing homes, and to domiciliary carers overseen by private care agencies and Local Authority. This promoted consistent messages across all care providers and ensured that preventative care interventions aligned with current best practice.
- Data collected over the previous three years (January 2019–December 2021) shows that pressure ulcer incidence in community is on a gradual downward trend (49, 47, 45). Data was then analysed by financial year (April 2019–March 2022) in alignment with the period set out for the Trust Quality Account and it is this that has been utilised to demonstrate the reduction in community acquired pressure ulceration. In the last 12 months we have attained a 42.6% overall reduction in community acquired pressure ulcers and a 24.4% reduction when using 2019 data as a pre-pandemic comparator.



There has been a reduction in Category I (60%), Category II (26%), Category III (25%) pressure ulcers and Moisture Lesions (ML) (50%).

The overall number of community acquired pressure ulceration remains small. Category IV pressure damage has increased by 100%, but this accounts for a very small proportion of community acquired pressure ulceration, two ulcers during the last 12 months.



Engagement with the RCA process from district nursing teams reporting community acquired category III and IV pressure ulceration has demonstrated improvements in the frequency of risk assessment and skin inspection, quality of nursing documentation and therefore patient care. Five RCA's have been undertaken in the last 12 months, with no RCA's being called since December 2021. The turnaround time of two weeks has been observed and aligns with the Trust's expectation for investigation. This has ensured that we are able to meet the timeline set by the commissioners with regards Serious Incident reporting.

How we measured success?

- Pressure Ulcer Incidence was measured through monthly analysis of Datix reporting. District Nursing Cluster Co-Ordinators reviewed all reported community acquired pressure ulceration to ensure accuracy in reporting. A final check was then undertaken by the Tissue Viability Team to validate accuracy. Incidence data was presented monthly at the Clinical Governance meeting.
- Dashboards produced weekly by the Quality Team using data submitted by District Nursing Teams via a weekly audit tool. These were circulated to District Nursing Cluster Co-ordinators for dissemination to their District Nursing Teams.
- The Community Tissue Viability Team monitored the amount of RCA's completed and create action plans in response to the findings of each RCA investigation.

Priority 3 – Management of Abnormal Results

Why have we chosen this?

The management of clinical tests from their request, through booking, performance, reporting, reviewing and acting on the results, is a major patient safety issue in all healthcare systems. We see evidence of patient harm caused by delays in tests, resulting in delays in treatment and aim to minimise those risks. This is a highly complex problem and nowhere in the world has an infallible system that can guarantee an important result cannot be missed, with an electronic patient record, paper, or a combination of both.

What we aimed to achieve?

To achieve this will require significant clinical input from the Digital Health Team, clinicians requesting investigations, staff performing the investigations and our technical team to make changes in our digital patient record.

What we achieved?

We have appointed a clinical lead for the management of abnormal results and reviewed our Trust investigations processes, starting with test ordering. We have agreed to progress this work as a top priority for the Digital Leadership Group and met with the Radiology Directorate to agree axial radiology as a pilot for the inclusion of a mandatory field for the lead consultant on their order entry forms. We have entered into a development partnership with 3M to use their "Follow-Up Finder" artificial intelligence technology to highlight the need for follow-up investigations indicated in free-text reports, and develop this functionality to identify gaps in the closed loop from requesting a test to taking appropriate actions for patient care, using the Trust's Clinical Data Warehouse and Document Store.

How we measured success?

Progress to date has comprised the mapping of current processes, agreement on a programme of design and development, and the identification of the resources required to complete the work. However, the success of this change must be measured by a reduction in the incidence of patient harm arising from delayed action on test results which will require long-term data collection. In the shorter term, other important metrics will include the proportion of digitally endorsed results and the time taken between a report becoming available and action being taken on its result.

CLINICAL EFFECTIVENESS

Priority 4 – Modified Early Obstetrics Warning Score (MEOWS)

Why we chose this?

In recent years there have been a number of maternal deaths in England where the lack of MEOWS systems for pregnant women in hospital but outside the maternity setting played a significant part. At present, pregnant/recently pregnant women outside the maternity unit are not monitored using a MEOWS system and observations taken follow the traditional model of NEWS monitoring for non-pregnant patients.

The need for early recognition and management of deterioration of pregnant women has been highlighted by:

- Mothers and Babies, Reducing Risk by Audit and Confidential Enquiry (MBRRACE)
- The Ockenden Report
- The Maternity and Neonatal Safety Improvement Programme (MatNeoSIP).
- Royal College of Physicians (RCP) guidance, which states that all medical pregnant/recently pregnant women should be monitored using a MEOWS system.

What is the aim?

Implementation of an electronic MEOWS system outside the Women's Services Directorate would improve the quality and safety of patient care for those women and provide Obstetric Services with a daily list of pregnant/recently pregnant women regardless of their location throughout the Trust and therefore improve collaborative care.

Our aim is therefore too:

- Create an IT solution for identification of a pregnant/recently pregnant woman outside Women's Services.
- Develop an electronic MEOWs system to replace National Early Warning System for this group of women.

What has been achieved?

- IT solution is ready to go live once tested.
- Newly appointed Clinical Director for Patient Safety to lead on this project.
- Raised change within IT for question to be added in relation to pregnancy status to assist automation of the maternity chart.

How we measured success?

Introduction of the identification of pregnant/recently pregnant woman outside Women's Services (in the rest of the Trust) and they are on the appropriate MEWS chart.

Priority 5 - Enhancing capability in Quality Improvement (QI)

Why we chose this?

Creating a culture of continuous improvement and learning across the Trust is important to deliver sustained improvement in the quality and experience of care. Change can be slow and inefficient if not supported by an improvement culture, a scientific approach and training. Therefore investing time for training on a scientific approach for improvement, to increase staff improvement capability is an important Trust priority. COVID-19 has demonstrated the need to make rapid changes and ongoing changes to recover from the impact of COVID-19, and enhancing QI improvement capability supports staff with this challenging time.

Our partnership with the Institute for Healthcare Improvement (IHI) will accelerate this work. This is critical in maintaining our outstanding performance and the patient-focused high quality of care we deliver in a sustainable way.

What we aimed to achieve?

We aimed to deliver improvement training programmes tailored to local teams working on Trust improvement priorities. The Improvement teams would then be supported by improvement coaches and leadership for improvement, to provide an organisational approach to enhance QI capability.

- Train 15-20 improvement teams, each focused on a piece of improvement work and coach them through the work.
- Train 30 improvement coaches to build capability and support teams with their improvement work.
- Train 30 senior leaders (Directorate Managers, Clinical Directors, Matrons or comparable senior level staff) in Leading for Improvement to provide the senior support for the improvement teams to effectively progress their improvement work.
- Develop a return on investment evaluation framework and assess the programme against this.
- Adapt the IHI training programme, following feedback from the training and evaluation, integrating sustainability tools linking the Sustaining Healthcare in Newcastle (SHINE) programme into improvement. Move towards being independent in ongoing delivery of training.
- Newcastle Improvement Team members to shadow the IHI delivery to learn in year two, to deliver the program after the IHI support period has finished.

What we achieved?

- The Newcastle Improvement Team has successfully recruited staff onto the three programmes.
- The IHI has delivered three training programmes:
    1. 15 improvement teams, involving 83 staff, each focused on a piece of improvement work on the IHI ‘Improvement for Teams’ Programme
    2. 37 improvement coaches to support teams with their improvement work on the IHI ‘Improvement Coach’ programme
    3. 30 senior leaders on the IHI ‘Leading for Improvement’ programme to provide the senior support for the improvement teams to effectively progress their improvement work.

An evaluation framework has been developed utilising 'A Framework to Guide Evaluations of QI Capacity Building' (Mery et al, 2017). The Framework has five core dimensions and within each dimension, key questions have been formulated. A variety of evaluation methods will be utilised to capture and analyse data with the purpose of answering key questions. The evaluation will provide information to assist in the assessment of the success of this novel approach, ahead of making any commitment for Year two of the partnership.

The first IHI training programmes are being adapted based on feedback from the training and evaluation. Sustainability tools have been shared with the improvement teams linking the SHINE programme into improvement. Newcastle Improvement staff have been shadowing the IHI Faculty and are moving towards joint deliver of programmes in year two.

How we measured success?

Each training session has been evaluated and subsequent sessions adapted based on participant feedback. Attendance at the training sessions was high.

The end of programme evaluation of the 37 coaches has shown an increase in confidence to apply improvement tools to their improvement work and to coach others on improvement. The skill level increased on many aspects of improvement for example; skills with organising effective team meetings, how to identify change ideas and using data to measure improvement.

Evaluation continues to capture feedback on the success of all training programmes and to inform the refinement of future programmes.

PATIENT EXPERIENCE

Priority 6 – Mental Health in Young People

Why we chose this?

In 2020, one in six (16.0%) children aged 5-16 years were identified as having a probable mental health disorder, increasing from one in nine (10.8%) in 2017. Greater impact for those with pre-existing mental health needs, young women and those at greater risk of social deprivation.

Nationally and regionally, there has been a surge in demand for specialist Tier 4 mental health inpatient beds for children and young people (CYP). We are currently seeing an increase in demand of up to one third compared to pre-COVID-19 times. The greatest pressure being seen is in the increase in the number of CYP presenting with either an eating disorder or disordered eating (associated with mental health co-morbidities). NHS Long Term Plan builds on the progress and learning from previous programmes and strategies going back to 2004 e.g. the National Service Framework, Every Child Matters, Choice and Partnership Approach, Targeted Mental Health in Schools, Children and Young People's Improving Access to Psychological Therapies Change programme, Future in Mind, Five Year Forward View for Mental Health and

Transforming Children's and Young People's mental health Green Paper, The NCEPOD Mental Healthcare in Young People and Young Adults report published recommendations in 2019.

A National Transformation Programme of work has been established in recent months which is aligned to delivery of the CYP elements of the Long-Term Plan.

What we aimed to achieve?

- A dedicated and efficient pathway for assessment and treatment plan working in close conjunction with Cumbria, Northumbria, Tyne & Wear (CNTW) colleagues.
- Trained and skilled workforce.
- Appropriate environment for patients to be cared for.
- Efficient access to identify 'Advocates' for patients detained under the Mental Health Act.
- Learning from patient and parental experience

What we achieved?

- Multi-disciplinary Team Mental Health Strategy Group established and meet monthly and are joined by CNTW bi-monthly.
- Investment identified by We Can Talk Project.
- Online We Can Talk Training well utilised by staff.
- Ongoing review of environment in Paediatric Emergency to create a 'Safe space'.
- Much improved communications with colleagues at CNTW and collaborative work ongoing.
- Parent information leaflets now in use.
- Evidence of involving patient and parent to learn from experience.
- Policy for Detaining Patients under the Mental Health Act now includes under 18 years.
- Collaborative work with CNTW and Business case to seek investment for more efficient services for CYP nearly complete.
- Training delivered to CNTW staff by GNCH staff and CNTW delivering training to GNCH staff.
- Evidence of a very effective Multi-Disciplinary Team Support Hub including CNTW staff ahead of referral.

How we measured success?

- Review of staff training, staff feedback.
- More efficient communications between GNCH and CNTW.
- More efficient pathways when patients present acutely.
- More efficient transfer to mental health services for inpatient management.
- Review of impact of training.
- 'Patient and parental input in design of Safe' area in Paediatric Emergency Department.
- Policy for patients detained under the Mental Health Act now includes under 18 years.
- Policy for Reducing need for Restrictive Interventions for CYP.
- Improved risk assessment and prevention of restrictive interventions.

Priority 7 – Ensure reasonable adjustments are made for patients with suspected, or known, Learning Disability (LD)

Why we chose this?

People (children, young people and adults) with a Learning Disability are four times more likely to die of something that could have been prevented than the general population. As a Trust, we are committed to ensuring patients with a learning disability have access to services that will help improve their health and wellbeing and provide a positive and safe patient experience.

What we aimed to achieve?

Assurance that patients and their families have appropriate reasonable adjustments as required. That they are listened to, feel listened to and have a positive experience whilst in our care and appropriate follow up. Assurance that patients are flagged appropriately and that these flags generate the appropriate response to care, treatment and communications.

What we achieved?

- Medical support has ensured mortality reviews for patients with a Learning Disability who die whilst in Trust care are timely.
- Pathways continue to be developed for adult patients requiring MRI/CT under sedation.
- Continue to ensure Learning Disability flags are visible for adults and children with a learning disability.
- Audit documentation to provide evidence of best practice in relation to use of pathways of care, provision of reasonable adjustments to meet individual needs, appropriate use of hospital passports and application of the Mental Capacity Act including Deprivation of Liberty Safeguards.
- Learning Disability Liaison team to commence bi-monthly forums Trust wide to share learning and examples of good practise.
- Organisation registered for Improvement Standards 2021/2022.
- Review of pathways and e-learning to determine if any adaptions required.
- Work ongoing in conjunction with North East and Cumbria Learning Disability Network and Great North Children Hospital anaesthetics to incorporate theatre attendance within passport for Children & Young People.
- Review of role of ‘Champion’ commenced with a view to incorporating Autism.
- Collaborative work with University of Northumbria for development of simulation training.
- STOMP and STAMP project work resumed.
- Trust committed to ‘Weigh to Go’ and seek accreditation.
- Diamond Standards launched October 2021.

How we measured success?

- Diamond Standards embedded across the organisation.
- Increased staff training.
- Passports for CYP and adults updated and relaunched.
- Continued audit with regard to ‘flags’.

- Share learning and showcase examples of good practice.
- Maintain timely Learning Disabilities Mortality Review (LeDeR) Programme reviews.
- STOMP and STAMP embedded with organisation.
- Accreditation for ‘Weigh to Go’.
- Increased visibility of Learning Disability Liaison Team.

National guidance requires Trusts to include the following updates in the annual Quality Account:

Update on Duty of Candour (DoC)

Being open and transparent is an essential aspect of patient safety. Promoting a just and honest culture helps us to ensure we communicate in an open and timely way on those occasions when things go wrong. If a patient in our care experiences harm or is involved in an incident as a result of their healthcare treatment, we explain what happened and apologise to patients and/or their carers as soon as possible after the event.

There is a statutory requirement to implement Regulation 20 of the Health and Social Act 2008: Duty of Candour. Within the organisation we have a multifaceted approach to providing assurance and monitoring of our adherence to the regulation in relation to patients who have experienced significant harm.

The Trust's DoC Policy provides structure and guidance to our staff on the standard expected within the organisation. Our DoC compliance is assessed by the CQC; however, we also monitor our own performance on an ongoing basis. This ensures verbal and written apologies have been provided to patients and their families and assures that those affected are provided with an open and honest account of events and fully understand what has happened. An open and fair culture encourages staff to report incidents, to facilitate learning and continuous improvement to help prevent future incidents, improving the safety and quality of the care the Trust provides.

Duty of Candour requirements are regularly communicated across the organisation using a number of corporate communication channels. DoC is a standard agenda item at the Patient Safety Group, where clinical directorates' DoC compliance is monitored for assurance as part of a rolling programme. Staff learning and information sharing, in relation to DoC, also takes place at Trust-wide forums such as Clinical Policy Group, Clinical Risk Group as well as other directorate corporate governance committees.

DoC training is targeted at those staff with responsibility for leading both serious incident (SI) investigations and local directorate level investigations. DoC is included in Trust incident investigator training which is delivered to multidisciplinary staff once a month. In November 2021, an electronic DoC template to enable staff to accurately document DoC completion, went live as part of the electronic patient record. This acts as a prompt for clinicians to complete their DoC requirements correctly and enables the Trust to monitor compliance against this.

Statement on progress in implementing the priority clinical standards for seven day hospital services (7DS)

Due to the increasing pressures upon systems in responding to the COVID-19 pandemic, the Board Assurance Framework submissions since 2020/2021 have been deferred.

Gosport Independent Panel Report and ways in which staff can speak up

"In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS trusts and NHS Foundation Trusts in England to report annually on staff who speak up (including whistleblowers). Ahead of such legislation, NHS trusts and NHS Foundation Trusts are asked to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment. This disclosure should explain the different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the Trust".

As part of its local People Plan, the Trust continues to focus efforts on shaping Newcastle Hospitals as 'the best place to work'; enable people to use their collective voice to develop ideas and make improvements to patient care and services; and create a healthy workplace.

Staff and temporary workers are informed from day one with the Trust, as part of their induction, via the e-handbook 'First Day Kit', and subsequently reminded regularly, that there are a number of routes through which to report concerns about issues in the workplace.

By offering a variety of options to staff, it is hoped that anyone working for Newcastle Hospitals will feel they have a voice and feel safe in raising a concern or making a positive suggestion. This includes the ability to provide information anonymously. Any of the reporting methods set out below can be used to log an issue, query or question; this may relate to patient safety or quality, staff safety including concerns about inappropriate behaviour, leadership, governance matters or ideas for best practice and improvements.

These systems and processes enable the Trust to provide high quality patient care and a safe and productive working environment where staff can securely share comments or concerns.

Work in confidence – the anonymous dialogue system

The Trust continues to use the anonymous dialogue system 'Work in Confidence', a staff engagement platform which empowers people to raise ideas or concerns directly with up to 20 senior leaders, including the Chief Executive and the Freedom to Speak Up Guardian. The conversations are categorized into subject areas, including staff safety.

This secure web-based system is run by a third-party supplier. It enables staff to engage in a dialogue with senior leaders in the Trust, safe in the knowledge that they cannot be identified. This is a promise by the supplier of the system.

Freedom to Speak up Guardian

The Trust Freedom to Speak up (FTSU) Guardian acts as an independent, impartial point of contact to support, signpost and advise staff who may wish to raise serious issues or concerns. This person can be contacted, in confidence, about possible wrongdoing, by telephone, email or in person.

To support this work, capacity has been increased to a network of FTSU Champions, spread across the organisation and sites, to ease access for staff.

Staff engagement to raise awareness about the roles and how to make contact have been undertaken via ‘drop in’ meetings, using poster campaigns and using a range of communications platforms.

In addition, the FTSU Guardian is expected to report bi-annually to the People Committee, a subcommittee of the Board, to provide assurance and ensure learning from cases.

Speak up – We Are Listening Policy (Voicing Concerns about Suspected Wrongdoing in the Workplace)

This policy provides employees who raise such concerns, assurance from the Trust that they will be supported to do so, and will not be penalised or victimised as a result of raising their concerns.

The Trust proactively fosters an open and transparent culture of safety and learning to protect patients and staff. It recognises that the ability to engage in this process and feel safe and confident to raise concerns is key to rectifying or resolving issues and underpins a shared commitment to continuous improvement.

Being open (Duty of Candour) Policy

Promoting a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. This policy involves explaining and apologising for what happened to patients who have been harmed or involved in an incident as a result of their healthcare treatment. It ensures communication is open, honest and occurs as soon as possible following an incident. It encompasses communication between healthcare organisations, healthcare teams and patients and/or their carers.

Additional routes through which staff can voice concerns include Dignity and Respect at Work Policy and the Grievance Procedure.

Trust Contact Officer

The function of the contact officer is to act as a point of contact for all staff if they have work-related or interpersonal problems involving colleagues or managers in the working environment. Officers are contactable throughout the working day, with their details available under the A-Z index on the Trust Intranet.

Union and Staff Representatives

The Trust recognises a number of trade unions and works collaboratively in partnership with their representatives to improve the working environment for all. Staff are able to engage with these representatives to obtain advice and support if they wish to raise a concern.

Chaplaincy

The chaplaincy service is available to all staff for support and they offer one to one peer support for staff who require this. Chaplains are also able to signpost staff to appropriate additional resources.

Staff Networks

The staff networks have been established for a number of years. They provide support for Black and Minority Ethnic (BAME) staff, LGBTQ+ staff, and people with a disability or long standing health issue. Oversight rests with the Head of Equality, Diversity and Inclusion (People).

Each network has a Chair and Vice Chair and is supported in its function by the Human Resources Department. Each network has its own independent email account and staff can make contact this way, and/or attend a staff network meeting. The Staff Networks can either signpost staff to the best route for raising concerns, can raise a general concern on behalf of its members or can offer peer support to its members.

Cultural Ambassadors

Cultural Ambassadors, trained to identify and challenge cultural bias, were introduced into the Trust during 2020. These colleagues are an additional resource to support BAME colleagues who may be subjected to formal employment relations proceedings.

A summary of the Guardian of Safe Working Hours Annual Report

This consolidated Annual Report covers the period April 2021 – March 2022. The aim of the report is to highlight the vacancies in junior doctor rotas and steps taken to resolve these.

Rota gaps are present on a number of different rotas. This is due to both gaps in the regional training rotations and lack of recruitment of suitable locally employed doctors. Existing rota gaps have been exacerbated by both short term and long term sickness absence. The main areas of recurrent or residual concern for vacancies are Cardiothoracic Surgery, Ophthalmology, Acute Medicine and Histopathology. The Trust takes a proactive approach to minimise the impact of these by active recruitment; attempts to make the jobs attractive to the best candidates; utilisation of locums; and by rewriting work schedules to ensure that key areas are covered. In some areas, trainee shifts are being covered by consultants when junior doctor locums are unavailable.

In addition to the specific actions above, the Trust takes a proactive role in management of gaps with a coordinated monthly Junior Doctor Recruitment and Education Group meeting. Members of this group include the Director of Medical Education, Finance, Medical Education and Medical Staffing. In addition to recruitment into locally employed doctor posts, the Trust runs a number of successful trust-based training fellowships and a teaching fellow programme to fill anticipated gaps in the rota. These are 12 month posts aimed to maintain doctors in post and avoid the problem of staff retention. In specialties which are hard to recruit to, there has also been recruitment of advanced critical care practitioners and physician’s assistants.

Learning from deaths

The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. These added new mandatory disclosure requirements relating to 'Learning from Deaths' to Quality Accounts from 2017/2018 onwards. These new regulations are detailed below:

1. During 2021/2022, 1973 of Newcastle upon Tyne Hospitals NHS Foundation Trust's patients died. This comprised the following number of deaths that occurred in each quarter of that reporting period: 436 in the first quarter; 471 in the second quarter; 572 in the third quarter; 494 in the fourth quarter.

2. During 2021/2022, 996 case record reviews and 28 investigations have been carried out in relation to 1973 of the deaths included in point one above. In 19 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 222 in the first quarter; 285 in the second quarter; 325 in the third quarter; 164 in the fourth quarter.

3. Twelve representing 0.61% of the patient deaths during the reporting period 2021/2022, are judged as more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of; three representing 0.15% deaths in the first quarter, four representing 0.20% in the second quarter, four representing 0.20% in the third quarter and one representing 0.05% in the fourth quarter. To date, not all incidents have been fully investigated. Once all investigations have been completed, any death found to have been due to problems in care will be reported in the 2022/23 quality account. All deaths will continue to be reported via the integrated quality report. These numbers have been estimated using the HOGAN evaluation score as well as root cause analysis and infection prevention control investigation toolkits.

Summaries from twelve completed cases judged to be more likely than not to have had problems in care, which have contributed to patient death:

Summary	Lessons learned from review	Action	Impact/Outcome
Patient fall	Investigation of this case found consistent areas of good practice in regards to nurse intentional rounding and falls assessments, with no omissions in care identified.	The good practice found in this investigation was shared with all staff members working in ward areas.	Staff are aware of the importance of fully completing falls assessment documentation and reviewing this regularly.
Patient fall	Local improvement has focused on consistently completing falls assessments in-line with Trust policy and the importance of strong leadership in driving positive changes in clinical practice.	An education programme has been delivered to senior ward staff in relation to the consistent completion of falls assessments.	All staff working in a ward environment are aware of the important link between robust falls assessment and prevention.

Summary	Lessons learned from review	Action	Impact/Outcome
Patient self-harm An in-patient receiving treatment, left the hospital and self-harmed, which sadly resulted in the patient's death	Screening mental health via structured mechanisms such as the patient electronic patient record is important in providing opportunities for staff to assess and communicate patient mental wellbeing.	The feasibility of increasing the visibility of current mental health screening questions is currently being explored.	Patients requiring mental health support may be identified and supported earlier in their care journey.
	Enhanced electronic patient record functionality that allows more than one next of kin and their contact details to be accessible to staff, will enable more timely communication with families.	The functionality of the electronic patient record to store additional next of kin details has been accepted as a priority by the digital team.	Staff will have increased opportunities to communicate critical information to families in a timely manner.
Medication Interaction	Increased pharmacist resource and the development of a medication acuity tool ensures that patients on high-risk medications are identified and prioritised for review as part of medicines reconciliation on discharge.	Business case approved for additional clinical pharmacy resource. Medicines acuity tool developed to help identify and manage patients taking high-risk medications.	Increased medicine reconciliation, especially in patients identified as high-risk will take place across the Trust.
		Dissemination of safety information communicated across multi-disciplinary clinical staff and clinical forums, to ensure learning from this medication interaction case is shared.	Staff have increased awareness of the medication interaction involved in this case.
	Reviewing patients' current medications on hospital admission is important, to support clinical decision making when prescribing new medications for acute treatment.	Medication reconciliation policy reviewed. Additional importance placed on reviewing appropriateness of admission medication in light of patient's current condition.	On admission, patients will have an appropriate review of their medication in relation to their acute presentation.
Medication Incident	Staff who manage patient anti-coagulation require a robust training package that is revisited at regular intervals.	An enhanced training and education package has been developed and is delivered regularly for medical, nursing and pharmacy staff.	Regular training of staff will ensure effective management of anticoagulation.
	The Trust warfarin guidance must be clear and easy to follow for clinical staff when re-introducing anticoagulation in complex post-operative patients.	Warfarin guidance has been reviewed by users in regards to readability and ease of interpretation	Increased awareness of safe warfarin management within the Trust.
	The development of a	Medicines acuity tool developed to help identify	Identification of high-

Summary	Lessons learned from review	Action	Impact/Outcome
	medication acuity tool (as above) would identify patients categorised as high risk in order to prioritise for pharmacist review.	and manage high-risk patients.	risk patients is essential to patient safety.
Medication Incident	Prescribing information within the electronic patient record (EPR) must be clear and concise for prescribers to easily interpret, for multiple clinical indications. An electronic 'flag' in the emergency department (ED) e-prescribing system would provide a digital solution that effectively communicates to nursing staff when medications are due for long stay patients. Enhanced training for all appropriate staff groups would improve understanding of steroid safety in acutely unwell steroid dependent patients.	Steroid prescribing 'alert' within the EPR reviewed & updated to ensure information clear to understand and usable in practice. Identify a digital solution in the ED e-prescribing system, which effectively alerts staff when a recurrent medication is required for a long stay patient. Explore training provided to staff groups to ensure provides appropriate level of education provision.	Staff provided with clear and concise EPR prescribing information to enable safe & appropriate steroid prescribing. An interim digital solution is now in place to alert staff to recurrent medications required. A longer-term plan to implement a permanent solution is in development.
Pressure Ulcer infection A patient developed an infection from a pressure ulcer, leading to sepsis.	Within the community, communication and handover of care between health and social care teams is essential; with named a nurse having oversight of each patient's care. Development and promotion of a pressure ulcer prevention pathway for community staff will drive consistent, high quality care for patients.	Increase staff knowledge of the risk of pressure damage and preventable measures needed, as part of an enhanced community staff training programme. Development of a community pressure ulcer pathway as well as preventative equipment guidance for community staff.	Staff will have increased knowledge and a clear pathway of care, which will improve handover and communication between teams.
Patient fall	It is important to have visual prompts on wheelchairs to remind users to apply brakes on wheelchairs whilst stationary, in order to promote safe use.	Put in place clear signage on all Trust wheelchairs to remind users of applying brakes at all times when stationary.	Patients/visitors choosing to use Trust wheelchairs will be better informed on wheelchair safety advice.
Four possible or probable Healthcare Acquired (Covid-19) Infections	Consistent compliance with Covid-19 screening, use of personal protective equipment (PPE) and hand hygiene is essential in reducing infections and protecting patients from harm.	The infection, prevention & control team to continue to robustly investigate all HCAI Covid-19 cases in order to identify learning to improve practice. All staff to continue to comply with all Covid-19 screening requirements.	The Trust infection prevention measures are shown to be robust in comparison to National peer organisations. National data demonstrates low HCAI rates within the Trust.

4. 174 case record reviews and 20 investigations were completed after April 2021, which related to deaths, which took place before the start of the reporting period.

5. 14 representing 7.22% of the patient deaths before the reporting period are judged more likely than not to have been due to problems in the care provided to the patient.

6. Four representing 0.3% of the investigations completed during 2020/2021 are judged more likely than not to have been due to problems in the care provided to the patient.

The Trust will monitor and discuss mortality findings at the Quarterly Mortality Surveillance Group and Serious Incident Panel, which will be monitored and reported to the Trust Board and Quality Committee.

Part 3 – Other Information - Overview of Board assurance 2021/2022

This is a representation of the Quality Report data presented to the Trust Board on a monthly basis in consultation with relevant stakeholders for the year 2021/2022. The indicators were selected because of the adverse implications for patient safety and quality of care should there be any reduction in compliance with the individual elements. In addition to the 13 local priorities outlined in section two, the indicators below demonstrate the quality of the services provided by the Trust over 2021/2022 has been positive overall.

Patient Safety	Data source	Standard	Actual 2020/21	Q1	Q2	Q3	Q4	Actual 2021/22
Number of MSSA bacteraemia cases	UKHSA Data Capture System	Mandatory reporting by NHSI/NHSE	HOHA* = 75 COHA* = 25	HOHA* = 15 COHA* = 8	HOHA* = 25 COHA* = 7	HOHA* = 19 COHA* = 6	HOHA* = 23 COHA* = 7	HOHA* = 82 COHA* = 28
Number of MRSA bacteraemia cases	UKHSA Data Capture System	Mandatory reporting by NHSI/NHSE	HOHA* = 1 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0
Number of *C. difficile* infection cases	UKHSA Data Capture System	Mandatory reporting by NHSI/NHSE	HOHA* = 85 COHA* = 26	HOHA* = 33 COHA* = 4	HOHA* = 39 COHA* = 16	HOHA* = 29 COHA* = 11	HOHA* = 34 COHA* = 3	HOHA* = 135 COHA* = 34
Number of *E. coli* bacteraemia cases	UKHSA Data Capture System	Mandatory reporting by NHSI/NHSE	HOHA* = 146 COHA* = 49	HOHA* = 42 COHA* = 14	HOHA* = 37 COHA* = 11	HOHA* = 36 COHA* = 16	HOHA* = 38 COHA* = 12	HOHA* = 153 COHA* = 53
Number of Klebsiella bacteraemia cases	UKHSA Data Capture System	Mandatory reporting by NHSI/NHSE	HOHA* = 94 COHA* = 35	HOHA* = 35 COHA* = 6	HOHA* = 39 COHA* = 3	HOHA* = 36 COHA* = 6	HOHA* = 15 COHA* = 6	HOHA* = 125 COHA* = 21
Number of Pseudomonas aeruginosa bacteraemia cases	UKHSA Data Capture System	Mandatory reporting by NHSI/NHSE	HOHA* = 32 COHA* =13	HOHA* = 7 COHA* = 3	HOHA* = 7 COHA* = 4	HOHA* = 12 COHA* = 1	HOHA* = 8 COHA* = 1	HOHA* = 34 COHA* = 9
Total number of patient incidents reported (Datix)	Internal Datix Incident reporting system	Local Incident Policy	17,515	4,543	4,543	4,618	4,736	18,440
Patient Incidents per 1000 bed days (Datix)	Internal Datix Incident reporting system	Local Incident Policy	44.0	37.9	37.1	37.7	37.9	37.5
% Patient incidents that result in severe harm or death	Internal Datix Incident reporting system	Local	0.5%	0.4%	0.7%	0.8%	1.0%	0.7%
Slip, trip and fall - patient (Datix)	Internal Datix Incident reporting system	N/A	2,391	617	580	634	715	2,546
Slip, trip and fall - patient (Datix) per 1,000 bed days	Internal Datix Incident reporting system	National definition	6.0	5.1	4.7	5.1	5.7	5.1
Inpatients acquiring pressure damage	Internal Datix Incident reporting system	National	706	214	234	241	219	908

Pressure Ulcers per 1000 bed days	Internal Datix Incident reporting system	Local	1.8	1.7	1.9	1.9	1.7	1.9
Total number of Never Events reported	Internal Datix Incident reporting system	National definition	3	3	0	1	2	6
Total number of Serious Incidents reported	Internal Datix Incident reporting system	Local SI Policy	151	61	64	76	79	280
Needlestick injury or other incident connected to sharps	Internal Datix Incident reporting system	Local Policy	319	100	84	85	100	369
Reporting of Injuries, Disease and Dangerous Occurances (RIDDOR)	Internal Datix Incident reporting system	Local Policy	39	11	18	11	8	48
Slip, Trip, Fall – Staff/Visitors/relatives	Internal Datix Incident reporting system	Local Policy	158	32	33	34	32	131

Clinical Effectiveness	Data Source	Standard	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22
Summary Hospital Mortality Index (SHMI)	CHKS	100	98	95	94	96	Not Published	Not Published
Learning from Deaths	Internal Mortality Review Database	Reviewing and Monitoring Mortality Policy	363	330	217	274	318	162

Patient Experience	Data source	Standard	Actual 2020/21	Q1	Q2	Q3	Q4	Actual 2021/22
Number of complaints received	Internal Datix Incident reporting system	Local Complaints Policy	467	134	130	156	134	554
National Inpatient Survey	CQC	National average	77.7% *	* This measure uses the results of a selection of five questions from the National Inpatient Survey focussing on the responsiveness to personal needs. Consultation feedback indicated that personalisation and service responsiveness are important issues for inpatients. This indicator aims to capture inpatients' experience of this.2021/2022 Data will not be available until 2023				
Friends and Family response rates (inpatients and A&E)	Locally collected and reported	Not applicable	Not published	98%	97%	96%	FFT results are 2 months in arrears and are not yet available to the Trust	TBC

*HOHA = Hospital Onset – Healthcare Associated
*COHA = Community Onset – Healthcare Associated

NHS Improvement (NHSI) changed the criteria for reporting C. difficile from 2020/2021. The reported figures are therefore not comparable to previous years as the change includes reporting COHA cases. This patient group includes those who have been discharged within the previous four weeks in addition to day-case patients and regular attenders.

Inconsistencies in data reported in the 2020/2021 report

There have been some slight variations in the reported 2020/2021 data – this is due to the fact that the Trust Incident reporting system is a live database which results in fluctuations in actual numbers of incidents reported as investigations are processed through the system.

OVERVIEW OF QUALITY IMPROVEMENTS

Pages 51-62 give some examples of other service developments and quality improvement initiatives the Trust has implemented, or been involved in, throughout the year.

Newcastle Hospitals opens regional ‘cataract centre’ to transform patient care

A state-of-the-art theatre ‘hub’, dedicated to cataract surgery, opened its doors to patients as part of a Newcastle Hospitals’ initiative.

Newcastle Westgate Cataract Centre a three-theatre, purpose-built clinical facility performs up to 1,000 cataract procedures a month, which is almost double the number undertaken before the coronavirus pandemic.

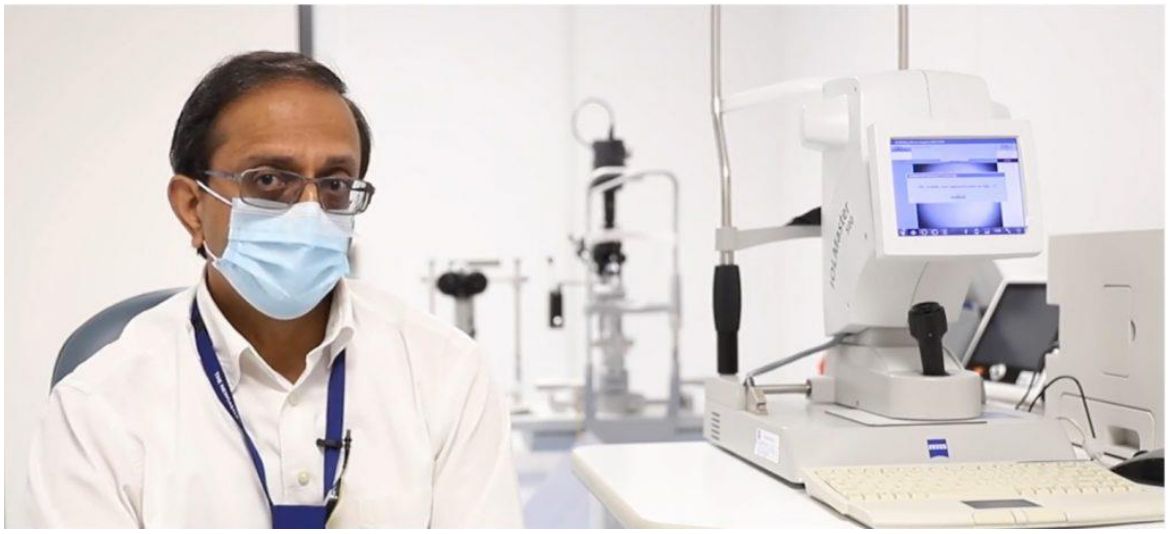
The centre has been designed to ensure that patients have exceptional clinical care from the expert team at the Trust. It has been streamlined to ensure that patients have no waiting meaning that each patient spends between just 40 minutes to an hour in the unit rather than the usual time of about three hours.

Personalised-care is provided throughout by a dedicated nurse who checks on the patient and remains with them throughout their journey. The patient sits in a special chair throughout and is wheeled into theatre for their day case procedure.

After being given information on aftercare, their nurse will escort them to their waiting transport just outside the Centre.

The ophthalmology team in Newcastle provide cataract surgery to patients across the region and every year receive hundreds of referrals. Just over a fifth of patients (21%) live within Newcastle, others come from across the North East.

Demand continues to increase year-on-year and cataract surgery is now the most commonly performed surgery in the NHS. The Royal College of Ophthalmologists estimate that demand will continue to rise by 25% over the next ten years and by 50% over the next 20 years.



Consultant Ophthalmologist and Clinical Lead, Krishnamoorthy Narayanan, said: “Prior to the pandemic, all patients were seen at the RVI and we were already seeing pressures on our waiting lists. Inevitably, waiting times have increased due to the pandemic.

“This is a very distressing situation for patients as cataracts can have a significant impact on quality of life and independence. It has been very difficult for the team to tell patients and their doctors that we couldn’t offer them surgery as quickly as they would wish”.

“Cataract surgery is a very quick, but a very highly technical operation which makes a huge impact on the quality of life as the improved vision means that the patient can go back to their normal activities.”

To find the best solution for patients, the ophthalmology team worked closely with estates colleagues and building contractors Vanguard, drawing up plans to secure a £7 million investment for the state-of-the-art cataract theatre centre on the Campus for Ageing and Vitality site (former Newcastle General Hospital).

To build something using traditional construction methods would have taken around two years to complete, but this build end-to-end, from conception to completion and including commissioning, has taken just seven months.

The team will only be operating on cataracts and will operate all through the working week. Some patients, including those who require a general anaesthetic, will still require their surgery at the Royal Victoria Infirmary.

“When the centre is fully operational we expect to operate between 200-250 cataract cases every week,” added Mr Narayanan.

“Due to the unique design, there is no waiting involved which is great for our patients. Appointment times are staggered so while we are seeing high patient numbers, their safety has been foremost when planning this service.

“A huge amount of preparation goes into getting the patient ready for the operation well before the operation date. We have also managed to cut out unnecessary waiting and delays on the day of surgery”.

“We are very excited and delighted to be able to provide our expertise and improved experience to the people of the North East.”

Chief Executive Dame Jackie Daniel said: “It’s fantastic that we can safely offer so many more patients the chance to have this important surgery and I am incredibly proud of the adaptability and creativity of the teams who have worked so hard to achieve this”.

“This is a great example of transformational thinking to provide a much swifter service with a clear focus on patient care and experience. It’s a model which I’m certain will be rolled out across the wider NHS.”

For Doris McGuire, 86, appearing in Geordie Hospital's final episode was a chance to celebrate for two reasons she was having her second cataract operation and it was also her birthday.

The Chapel House pensioner, and mother of two, said having her operations at the Newcastle Cataract Centre had been almost painless and she said they had made the "world of difference…It's wonderful, I would tell everyone to get it done."

Multi-million pound cancer centre at Cumberland Infirmary opens to patients

A new cancer centre on the site of the Cumberland Infirmary in Carlisle marks the culmination of two years' work with an investment of £35 million in North Cumbria to improve health outcomes for the local population.

The Northern Centre for Cancer Care, North Cumbria – a partnership between Newcastle Hospitals and North Cumbria Integrated Care NHS Foundation Trust (NCIC) brings all non-surgical cancer services under the same roof for the first time.

This means that patients no longer have to travel to different parts of the Infirmary for treatment.

The development of the centre will bring huge benefits to those people who need to access cancer services in North Cumbria as the majority of adult patients will be able to access the state-of-the-art facilities and receive their care closer to home.

Only patients with rare cancers, those requiring very specialist radiotherapy and children and young people with cancer, will continue to be referred to the Freeman Hospital in Newcastle.

Around 2,000 patients are already set to receive treatment or follow-up care at the new centre with approximately 1,200 new referrals each year.

The team also expects to deliver approximately 11,500 radiotherapy treatments and 8,000 chemotherapy treatments, as well as 4,000 supportive therapy treatments, a year.

The building will be managed by NCIC and services at the centre will be run by Newcastle Hospitals as part of the Northern Centre for Cancer Care. Around 80 members of staff, from North Cumbria's non-surgical oncology service, joined the Newcastle team. They will be supported by porters, housekeepers, estates and facilities staff from NCIC who will manage the maintenance of the building.

Together the trusts will be providing one of the biggest combined cancer treatment services in the country.

Dame Jackie Daniel, Chief Executive at Newcastle Hospitals said: "We're delighted to have welcomed our first patients at the Northern Centre for Cancer Care, North Cumbria".

"The centre looks fantastic and all of the teams involved have worked incredibly hard to make sure this is a calm and comfortable environment for our patients".

"The development of the centre demonstrates our commitment to providing high quality and sustainable cancer services to people across North Cumbria and supporting patients to receive care closer to home."

Lyn Simpson, Chief Executive at NCIC, said: "I know many people have closely watched the progress of the centre since construction began and it is excellent to see the building now complete and welcoming patients. The opening of the centre, in partnership with Newcastle Hospitals, is a real milestone in our journey to improve cancer services for patients across North Cumbria."

Newcastle doctor appointed first national speciality advisor for Long COVID

Dr Graham Burns, a consultant physician at Newcastle's Royal Victoria Infirmary, has been appointed as one of five new NHS clinical leads to help spearhead action to address some of the key issues facing the health service.

Dr Graham Burns is the NHS's first ever National Specialty Adviser for Long COVID, a role created to help the NHS meet the new demand for ongoing care from people suffering long-term physical and psychological after-effects from the virus.

He is joined in the role by Dr Melissa Heightman, respiratory physician and clinical lead for the post-COVID-19 clinic at University College London Hospital, and consultant lead for the post-COVID-19 network in North Central London. She has advised NHS England, National Institute of Clinical Excellence (NICE) and the National Institute for Health and care Research (NIHR) funded STIMULATE-ICP research program on care and treatment for patients experiencing Long COVID.

During the pandemic, Dr Burns, who is President of the British Thoracic Society, set up both a respiratory support unit and a post-COVID-19 assessment clinic, both of which became models replicated by other hospitals and in national NHS guidance.

The five new clinical leads, who also cover urgent and emergency care and elective care will provide expert advice to the NHS Medical Director, Professor Stephen Powis, and to the programme teams working to support local NHS teams improve services for patients in these areas.

Professor Julian Redhead has been appointed National Clinical Director for Urgent and Emergency Care, and will be responsible for helping the NHS to continue to improve 999, 111, A&E and other urgent care services, at the same time as the service faces record levels of pressure off the back of the pandemic. Professor Redhead is medical director and chief of service for emergency medicine at Imperial Healthcare and medical director for the North West London Integrated Care Partnership.

Joint National Clinical Directors have also been appointed for Elective Care, bringing a combined 60 years of experience to the NHS efforts to tackle the COVID-19 backlog for non-urgent treatment.

Ian Eardley is a Consultant Urological Surgeon in Leeds, and has held a range of national roles including Vice-Chair of the Royal College of Surgeons (England) and Chair of the Joint Committee for Surgical Training.

He is joined by Stella Vig, consultant in vascular and general surgery and Director of Elective Recovery at Croydon Health Services NHS Trust. Stella has also previously chaired the Joint Committee for Surgical Training, and is a current member of the Royal College of Surgeons of England Council.

NHS Medical Director, Professor Stephen Powis, said: “The fact that the NHS was able to respond so well to the greatest public health emergency in its history is, in large part because of our ability to draw on an unrivalled wealth of clinical experience, expertise and enterprise right the way from ward to board levels.

“So as the NHS works hard to tackle the COVID-19 backlog for non-urgent care, safely treat all those needing urgent and emergency care, particularly as we head into a difficult winter, and address the new challenge of Long COVID, I am delighted to welcome five senior clinicians to help lead this vital work.

“All of my new colleagues bring a wealth of experience and a strong track record of leading improvements in care and treatment for patients at a national level, and I know they are all eager to continue this in their new roles.”

Newcastle Hospitals become first in the UK to use climate-friendly gas and air during labour

Newcastle mum, Kaja Gersinska, has become the first person in the UK to use climate-friendly pain relief during labour after giving birth at Newcastle’s Royal Victoria Infirmary.

Entonox, also known as gas and air, is a mixture of nitrous oxide and oxygen and has been used to provide pain relief for women in labour for over a hundred years. However, nitrous oxide is a powerful greenhouse gas, almost 300 times more potent than carbon dioxide, and escapes into the atmosphere after being exhaled by a patient.

Kaja gave birth to her beautiful daughter, Rosie Martha O'Sullivan, who weighed 6lb 6oz, in the Newcastle Birthing Centre on 9 September 2021 and breathed the gas and air into a Mobile Destruction Unit (MDU), a machine designed to collect and destroy residual nitrous oxide from exhaled gas and air.

"I feel very privileged and proud actually, it's the little things you don't often think about and it's nice that someone thought about making these changes which will be better for the environment and for midwives who are working here all the time".

"I didn't expect this when I came here today I just came to have my baby but I started on the traditional machine and then swapped over. It was quieter and much more comfortable to hold, it's nice to make a little bit of history!"

Little Rosie, who was delivered by midwife Lindsay Craney, is Kaja and dad Craig's second child as they already have a two-year-old daughter Cassie.

The technology, developed by Medclair, is widely used in Sweden and collects the exhaled nitrous oxide and 'cracks' it into nitrogen and oxygen which are harmless.

The MDU purifies 99.6% of the nitrous oxide entering the unit, and as well having a huge benefit to the environment, it also benefits staff by reducing the amount of nitrous oxide they are exposed to while they work.

Chris Allen, Sustainable Anaesthesia Fellow at Newcastle Hospitals said "This is a really exciting day for the whole team involved in developing this project at Newcastle Hospitals. It has been a huge team effort including staff from maternity services and our sustainability and estates teams."

"Rolling this technology out across our maternity unit can help us to continue to support women to use gas and air during labour, whilst making it as environmentally friendly as possible."

"We have an ambitious plan to become a global leader in sustainable healthcare delivery and introducing innovative technology like this can help us to achieve that."

Newcastle Hospitals is well known for its award winning Shine (Sustainable Healthcare in Newcastle) programme and was the first healthcare organisation in the world to declare a climate emergency, in recognition that the climate emergency is a health emergency. The Trust is also committed to the ambitious goal of becoming a net-zero carbon organisation by 2030.

Chief Executive of Medclair Jonas Lundh said: “Working in the green medtech area I’m extremely impressed by the NHS Newcastle team, I’ve never seen such a display of action on the fact that there is a global climate crisis as we saw in Newcastle. We are delighted to be a supplier to the Trust and we look forward to Rosie’s generation being born in a climate friendly way.”

The Trust’s Associate Director Sustainability, James Dixon, added: “We’ve made significant progress in reducing the environmental impact of our anaesthetic care pathways in recent years, with a 23% reduction in anaesthetic gas carbon emissions last year alone”.

“All of this has been led by clinicians who are passionate about planetary, as well as patient health. Our use of Entonox (gas and air) is by far the biggest contributor to our anaesthetic gas carbon footprint and in adopting this innovative technology, we will see thousands of tonnes of carbon saved (or the equivalent annual carbon emissions of 150 UK citizens).”

“This is just one example of how we are embedding sustainability into our healthcare services, working hard to empower staff to make sustainable choices for the benefit of our patients and the planet.”

Geordie Hospital star Kit thrives after heart transplant and 'should inspire organ donation discussion'

Five-year-old Kit Matthews who featured in the first episode of Geordie Hospital.

“The little lad from Retford in the Midlands featured as he and his family prepared for him to be moved from one version of an artificial heart to another more flexible machine as he waits for a transplant”.

The show was filmed last year, and Kit has now had that transplant and is "going from strength to strength" but as his story is told on TV both his family and the consultant who looked after him at the Freeman Hospital are keen to highlight just how important organ donation is.

Kit's dad Joe is a heart-transplant recipient himself. "About April 16 was when it started. He wasn't feeling the best. Kit loves chocolate and we knew he wasn't right as he just wasn't interested," he said.

"Naturally we just thought he had a bad childhood cold like everyone else. Hannah, my wife, took him to the GP and they took some bloods but everything came back alright. He was still off his food."

After Joe and Hannah were told to take Kit to hospital, alarm bells began to ring for medics and they were quickly referred to hospital in Leeds. This was especially difficult as Kit's little brother Monty was just two at the time and the family had to spend lots of time apart, and Joe said he and Hannah were also incredibly proud of their younger son for coping with such upheaval.

Joe continued: "On the Saturday we got referred up to Leeds. Kit was just four and everyone wanted a piece of him to take bloods and do scans. It was awful for Hannah and myself, but clearly really horrible for him." Soon after, when it became clear quite how poorly Kit's heart was he, like his dad more than a decade ago was suffering from cardiomyopathy the family were told he would need specialist care rapidly. Space was available at the Freeman's world-renowned children's heart unit.

Joe added: "We arrived on the Monday evening and they operated to put him on the Ventricular Assist Device (VAD). We had gone from him wrestling with his brother to him in surgery in a critical condition, pretty much just like that. And we knew he might not survive the operation even."

Kit pulled through though, and was fitted with a Berlin Heart which kept him alive while he waited for a transplant. That transplant happened later in the year, the NHS is careful not to say exactly when so as not to identify the donor and by Christmas, Kit was at home with his family, "back to normal" and again playing like any kid should with his little brother.

Joe said: "Now, he's gone from strength to strength. He's shown how strong he really is and how resilient kids are. The majority of adults even would have given up."

"He knows exactly what's happened to him. I was on a VAD and he's seen pictures of me in a similar state to he was before. So he could see that as I'm doing so well now it was going to work and it made sense to him. He doesn't stop running. We have our Kit back. He's almost exactly the same, if anything, he's matured."

Speaking before the show aired, Joe said he was looking forward to seeing Geordie Hospital though he wasn't sure his eldest son felt the same. "For him, now it's something done," he said. "I don't think he really wants to revisit it. But for me, it's important I want everyone to see the benefit transplants can have. To spread that message and raise awareness."

Dr Emma Simpson, a paediatric intensive care consultant who looked after Kit agreed.

Recounting Kit's story and emphasising that it is similar for many children the unit sees, and sadly the outcome is not always a happy one, she added: "Kit, like many of our patients was in a very sick state when he came to us. His heart and circulatory system wasn't providing for his body's needs. He needed intensive care and was really sick and at risk of cardiac arrest and the body's organs failing.

"It was key to get him onto VAD. For someone of Kit's size there was only really one option of a pump and it requires a pretty big operation. The idea is to reduce the risk of cardiac arrest and hopefully put him in a better position for a transplant."

The staff at the Freeman Hospital work very closely with the company who creates Berlin Hearts and were among the first to use the new, smaller device which Kit is seen being fitted with on TV. That allows parents to take their child off the ward for several hours.

"He was very sick after the initial operation, but he got a little better and was able to move back to the ward and we were keen to get him onto the smaller Berlin Heart machine," Dr Simpson added. "It's a real help and we're always really keen to get families as much autonomy as they can”.

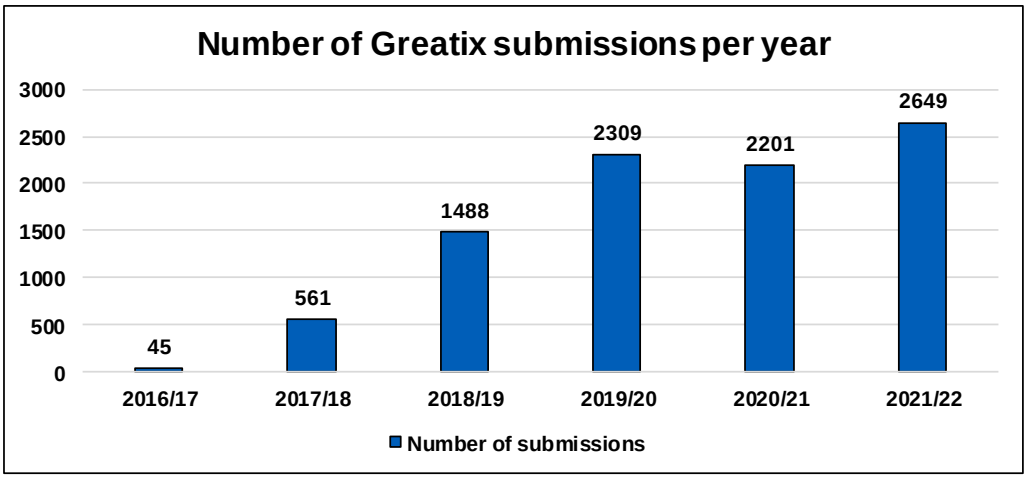
"Kit loved going to the park, or the family would take him around the hospital or to the fruit and veg seller." Echoing Joe, Dr Simpson said she hoped having featured on Geordie Hospital would have a positive impact. "I have no real interest in being on TV myself I did it to showcase the team's achievements and to also highlight that there is this group of patients”.

"Without the generosity of families at the most difficult time imaginable, there's no hope for children like Kit. Organ donation is something that needs to be discussed."

Greatix
Learning From Excellence

So often in healthcare we focus on when things go wrong and how to prevent them happening again. The introduction of Greatix at Newcastle Hospitals encouraged staff to look instead, at where things were going right, what we do well and how we could do more of it.

There are examples of excellence all around us every day. Colleagues are encouraged to recognise and share these examples, so that everyone can learn from them.



Newcastle Hospitals staff complete a simple online form, telling us who achieved excellence and what can be learnt.

By the end of March 2022, over five years after launching, the Trust has received over 9000 Greatix submissions. This is an outstanding achievement and one that reflects just how valued Greatix is by the staff working at Newcastle Hospitals.

The number of Greatix submissions has grown year on year, except 2020/2021 where the system was temporarily closed for a period of time due to upgrades. Since the summer of 2021 Greatix reporting to directorates has been improved with more focused feedback and promoted to all staff via the Trust communication team.

QUALITY STRATEGY UPDATE

When the Care Quality Commission (CQC) inspected The Newcastle upon Tyne NHS Foundation Trust in 2019, they awarded an outstanding rating overall. Peer review is Newcastle Hospital's internal inspection process. The aim of peer review is to strengthen the clinical quality assurance process that ensure patients receive the best experience and best possible care. As part of the usual peer review process, each directorate is reviewed on an annual basis to assess the quality of care delivered using the methodology of the CQC inspection framework.

For 2021/2022, in a change to the previous annual reviews, due to the impact of the pandemic, the directorates were invited to participate in a self-assessment process rather than the usual, comprehensive external peer review. The directorates, with support from the Clinical Governance and Risk Department (CGARD), the Senior Nursing Team and Clinical Directors for Patient Safety and Quality, were asked to self-assess their performance related to the five CQC domains (safe, effective, caring, responsive, well- led), and provide a rating for each domain. They then highlighted areas of achievement and areas for improvement.

The directorate self-assessment ratings were then reviewed and finalised by a ratification panel.

It is clear that the benefits of these reviews, promote learning and sharing of ideas for improvement across departments and individual directorates, whilst providing assurance. To ensure the review process continues to be effective, CGARD continues to align with the CQC inspection process and offers enhanced scrutiny and assurance. The Chief Operating Officer receives updated ratings, for all the Directorates, and a report is submitted to the Quality Committee annually.

Planning is underway for the 2022/2023 review process. In line with the CQC Strategy, the attention will move away from the core level service inspections and focus on the well-led domain.

INFORMATION ON PARTICIPATION IN NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

During 2021/2022, 58 national clinical audits and two national confidential enquiry reports / review outcome programmes covered NHS services that the Newcastle upon Tyne Foundation Hospitals NHS Foundation Trust provides.

During that period, the Newcastle upon Tyne Hospitals NHS Foundation Trust participated in 57 (98%) of the national clinical audits and 100% of the national confidential enquiries / review outcome programmes which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Newcastle upon Tyne Hospitals NHS Foundation Trust was eligible to participate in during 2021/2022 are as follows:

National Clinical Audits			National Confidential Enquiries
Case Mix Programme	National Audit of Breast Cancer in Older People	National Lung Cancer Audit	Child Health Outcome Review Programme
Chronic Kidney Disease Registry	National Audit of Cardiac Rehabilitation	National Maternity and Perinatal Audit	Medical and Surgical Clinical Outcome Review Programme
Cleft Registry and Audit Network	National Audit of Cardiovascular Disease	National Neonatal Audit Programme	
Elective Surgery – National PROMs Programme	National Audit of Care at the End of Life	National Paediatric Diabetes Audit	
Emergency Medicine QIPs – Pain in Children (care in emergency departments)	National Audit of Pulmonary Hypertension	National Perinatal Mortality Review Tool	
Emergency Medicine QIPs- Consultant Sign Off (in emergency departments)	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	National Prostate Cancer Audit	
Falls and Fragility Fracture Audit Programme – Fracture Liaison Service Database	National Cardiac Arrest Audit	National Vascular Registry	
Falls and Fragility Fracture Audit Programme – National Audit of Inpatient Falls	National Cardiac Audit Programme – Cardiac Rhythm Management	Neurosurgical National Audit Programme	
Falls and Fragility Fracture Audit Programme – National hip Fracture Database	National Cardiac Audit Programme – Myocardial Ischaemia	Paediatric Intensive Care Audit	
Inflammatory Bowel Disease Audit	National Cardiac Audit Programme – Adult Cardiac Surgery	Respiratory Audits – National Outpatient Management of Pulmonary Embolism	
Learning Disability Mortality Review	National Cardiac Audit Programme –	Respiratory Audits – National Smoking Cessation	

National Clinical Audits			National Confidential Enquiries
Programme	Percutaneous Coronary Interventions	Audit	
Maternal, Newborn and Infant Clinical Outcome Review Programme	National Cardiac Audit Programme – Heart Failure	Sentinel Stroke National Audit Programme	
National Adult Diabetes Audit – National Diabetes Core Audit	National Cardiac Audit Programme – Congenital Heart Disease in Children and Adults	Serious Hazards of Transfusion	
National Adult Diabetes Audit – National Pregnancy in Diabetes Audit	National Child Mortality Database	Society for Acute Medicine's Benchmarking Audit	
National Adult Diabetes Audit – National Diabetes Footcare Audit	National Comparative Audit of Blood Transfusion – 2021 Audit of Patient Blood Management & NICE Guidelines	Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	
National Adult Diabetes Audit – National Inpatient Diabetes Audit	National Early Inflammatory Arthritis Audit	Trauma Audit and Research Network	
National Asthma and COPD Audit Programme – Paediatric Asthma Secondary Care	National Emergency Laparotomy Audit	UK Cystic Fibrosis Registry	
National Asthma and COPD Audit Programme – Adult Asthma Secondary Care	National Gastro-intestinal Cancer Programme – National Oesophago-gastric Cancer	Urology Audits – Management of the Lower Ureter in Nephrouterectomy Audit	
National Asthma and COPD Audit Programme – COPD Secondary Care	National Gastro-intestinal Cancer Programme – National Bowel Cancer Audit		
National Asthma and COPD Audit Programme – Pulmonary Rehabilitation	National Joint Registry		

The national clinical audits and national confidential enquiries that the Newcastle upon Tyne Hospitals NHS Foundation Trust participated in during 2021/2022 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2021/22	Percentage Data completion	Outcome
Case Mix Programme	Intensive Care National Audit & Research Centre	This audit looks at patient outcomes from adult, general critical care units in England, Wales and Northern Ireland.	✓	Continuous data collection	Published report expected March 2023
Chronic Kidney Disease Registry	The Renal Association / The UK Renal Registry(UKRR)	The UKRR annual reports contain analyses about the care provided to patients with Chronic Kidney Disease (CKD)(including people pre- Kidney Replacement Therapy (KRT) and on KRT) at each of the UK's adult and paediatric kidney centres against the UK Kidney Association's guidelines.	✓	Continuous data collection	No publication date yet identified
Cleft Registry and Audit Network	Royal College of Surgeons - Clinical Effectiveness Unit	The CRANE Database collects information about all children born with cleft lip and/or cleft palate in England, Wales and Northern Ireland.	✓	Continuous data collection	No publication date yet identified
Elective Surgery - National Patient Reported Outcomes Measures (PROMs) Programme	NHS Digital	This audit looks at patient reported outcome measures in NHS funded patients eligible for hip or knee replacement.	✓	Continuous data collection	No publication date yet identified
Emergency Medicine QIPs - Pain in Children (care in emergency departments)	Royal College of Emergency Medicine	The purpose of the Quality Improvement and Patient Safety Competencies (QIP) is to improve patient care by reducing pain and suffering, in a timely and effective manner through sufficient measurement to track change but with a rigorous focus on action to improve.	✓	Data collection October 2021 – October 2022	No publication date yet identified
Emergency Medicine QIPs- Consultant Sign Off (in emergency departments)	Royal College of Emergency Medicine	The purpose of this QIP is to improve patient safety and quality of care as well as workspace safety by collecting sufficient data to track change but with a rigorous focus on actions to improve.	✓	Data collection April 2022 – October 2022	No publication date yet identified
Falls and Fragility Fracture Audit Programme –	Royal College of Physicians	Fracture Liaison Services are the key secondary prevention	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2021/22	Percentage Data completion	Outcome
Fracture Liaison Service Database		service model to identify and prevent primary and secondary hip fractures. The audit has developed the Fracture Liaison Service Database to benchmark services and drive quality improvement.			
Falls and Fragility Fracture Audit Programme – National Audit of Inpatient Falls	Royal College of Physicians	The audit provides the first comprehensive data sets on the quality of falls prevention practice in acute hospitals.	✓	Continuous data collection	No publication date yet identified
Falls and Fragility Fracture Audit Programme – National hip Fracture Database	Royal College of Physicians	The audit measures quality of care for hip fracture patients, and has developed into a clinical governance and quality improvement platform.	✓	Continuous data collection	No publication date yet identified
Inflammatory Bowel Disease (IBD) Audit	IBD Registry	The audit aims to improve the quality and safety of care for IBD patients throughout the UK.	✓	Continuous data collection	Published report expected July 2022
Learning Disability Mortality Review Programme	NHS England	The audit aims to improve the health of people with a learning disability and reduce health inequalities.	✓	Continuous data collection	No publication date yet identified
Maternal, Newborn and Infant Clinical Outcome Review Programme	University of Oxford / MBRRACE-UK collaborative	The aim of the audit is to provide robust national information to support the delivery of safe, equitable, high quality, patient-centred maternal, new-born and infant health services.	✓	Continuous data collection	No publication date yet identified
National Adult Diabetes Audit – National Diabetes Core Audit	NHS Digital	National Diabetes Audit collects information on people with diabetes and whether they have received their annual care checks and achieved their treatment targets as set out by NICE guidelines.	✓	Continuous data collection	No publication date yet identified
National Adult Diabetes Audit – National Pregnancy in Diabetes Audit	NHS Digital	The audit aims to support clinical teams to deliver better care and outcomes for women with diabetes who become pregnant.	✓	Continuous data collection	No publication date yet identified
National Adult Diabetes Audit – National Diabetes	NHS Digital	Patients referred to specialist diabetes foot care services for an	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2021/22	Percentage Data completion	Outcome
Footcare Audit		expert assessment on a new diabetic foot ulcer.			
National Adult Diabetes Audit – National Inpatient Diabetes Audit	NHS Digital	The National Diabetes Inpatient Audit is an annual snapshot audit of diabetes inpatient care in England and Wales and is open to participation from hospitals with medical and surgical wards. The audit allows hospitals to benchmark hospital diabetes care and to prioritise improvements in service provision that will make a real difference to patients' experiences and outcomes.	✓	Continuous data collection	No publication date yet identified
National Asthma and COPD Audit Programme – Paediatric Asthma Secondary Care	Royal College of Physicians	The audit looks at the care children and young people with asthma get when they are admitted to hospital because of an asthma attack.	✓	Continuous data collection	No publication date yet identified
National Asthma and COPD Audit Programme – Adult Asthma Secondary Care	Royal College of Physicians	The audit looks at the care of people admitted to hospital adult services with asthma attacks.	✓	Continuous data collection	No publication date yet identified
National Asthma and COPD Audit Programme – COPD Secondary Care	Royal College of Physicians	The aim of the audit is to drive improvements in the quality of care and services provided for COPD patients.	✓	Continuous data collection	No publication date yet identified
National Asthma and COPD Audit Programme – Pulmonary Rehabilitation	Royal College of Physicians	This audit looks at the care people with COPD get in pulmonary rehabilitation services.	✓	Continuous data collection	No publication date yet identified
National Audit of Breast Cancer in Older People	Royal College of Surgeons	This audit evaluates the quality of care provided to women aged 70 years and older by breast cancer services in England and Wales.	✓	Continuous data collection	No publication date yet identified
National Audit of Cardiac Rehabilitation	University of York	The audit aims to support cardiovascular prevention and rehabilitation services to achieve the best possible outcomes for patients with cardiovascular disease, irrespective of where they live.	✓	Continuous data collection	Published report expected December 2022
National Audit of	NHS	The audit will prioritise		Continuous	No publication

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2021/22	Percentage Data completion	Outcome
Cardiovascular Disease (CVD)	Benchmarking Network	working with system partners to drive CVD quality improvement at individual GP, Primary Care Network (PCN), Clinical Commissioning Group (CCG) and Integrated Care System (ICS) level.	✓	data collection	date yet identified
National Audit of Care at the End of Life	NHS Benchmarking Network	The National Audit of Care at the End of Life is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals, community hospitals and mental health inpatient providers in England, Wales and Northern Ireland.	✓	100%	No publication date yet identified
National Audit of Pulmonary Hypertension	NHS Digital	The audit measures the quality of care provided to people referred to pulmonary hypertension services.	✓	Continuous data collection	Published report expected October 2022
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Royal College of Paediatrics and Child Health	The audit aims to address the care of children and young people with suspected epilepsy who receive a first paediatric assessment within acute, community and tertiary paediatric services.	✓	Continuous data collection	No publication date yet identified
National Cardiac Arrest Audit	Intensive Care National Audit and Research Centre / Resuscitation Council UK	The project audits cardiac arrests attended to by in-hospital resuscitation teams.	✓	Continuous data collection	Published report expected March 2023
National Cardiac Audit Programme – Cardiac Rhythm Management	Barts Health NHS Trust	The audit aims to monitor the use of implantable devices and interventional procedures for management of cardiac rhythm disorders in UK hospitals.	✓	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme – Myocardial Ischaemia	Barts Health NHS Trust	The Myocardial Ischaemia National Audit Project was established in 1999 in	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2021/22	Percentage Data completion	Outcome
		response to the National Service Framework for Coronary Heart Disease, to examine the quality of management of heart attacks (Myocardial Infarction) in hospitals in England and Wales.			
National Cardiac Audit Programme – Adult Cardiac Surgery	Barts Health NHS Trust	This audit looks at heart operations. Details of who undertakes the operations, the general health of the patients, the nature and outcome of the operation, particularly mortality rates in relation to preoperative risk and major complications.	✓	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme – Percutaneous Coronary Interventions(PCI)	Barts Health NHS Trust	The audit collects and analyses data on the nature and outcome of PCI procedures, who performs them and the general health of patients. The audit utilises the Central Cardiac Audit Database, which has developed secure data collection, analysis and monitoring tools and provides a common infrastructure for all the coronary heart disease audits.	✓	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme – Heart Failure	Barts Health NHS Trust	The aim of this project is to improve the quality of care for patients with heart failure through continual audit and to support the implementation of the national service framework for coronary heart disease.	✓	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme – Congenital Heart Disease in Children and Adults	Barts Health NHS Trust	The congenital heart disease website profiles every congenital heart disease centre in the UK, including the number and range of procedures they carry out and survival rates for the most common types of treatment.	✓	Continuous data collection	No publication date yet identified
National Child Mortality Database	University of Bristol	The National Child Mortality Database	✓	Continuous data	No publication date yet

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2021/22	Percentage Data completion	Outcome
		collates information nationally to ensure that deaths are learned from, that learning is widely shared and that actions are taken, locally and nationally, to reduce the number of children who die.		collection	identified
National Comparative Audit of Blood Transfusion – 2021 Audit of Patient Blood Management (PBM) & NICE Guidelines	NHS Blood and Transplant	This audit aims to provide understanding of how to implement PBM and to measure their effectiveness in improving patient care.	✓	100%	Published February 2022. Action plan developed
National Early Inflammatory Arthritis Audit	British Society of Rheumatology	The audit aims to improve the quality of care for people living with inflammatory arthritis.	✓	Continuous data collection	No publication date yet identified
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	NELA aims to look at structure, process and outcome measures for the quality of care received by patients undergoing emergency laparotomy.	✓	Continuous data collection	No publication date yet identified
National Gastro-intestinal Cancer Programme – National Oesophago-gastric Cancer	NHS Digital	The audit aims to evaluate the quality of care received by patients with oesophago-gastric cancer in England and Wales.	✓	Continuous data collection	No publication date yet identified
National Gastro-intestinal Cancer Programme – National Bowel Cancer Audit (NBOCA)	NHS Digital	The NBOCA collects data on items that have been identified and accepted as good measures of clinical care. It compares regional variation in outcomes between English cancer alliances and Wales as a nation. It also compares local variation between English NHS trusts or hospitals, and Welsh MDTs.	✓	Continuous data collection	No publication date yet identified
National Joint Registry	Healthcare Quality Improvement Partnership	The audit covers clinical audit during the previous calendar year and outcomes including survivorship, mortality and length of stay.	✓	Continuous data collection	Published report expected September 2022
National Lung Cancer Audit	Royal College of Physicians	The audit was set up to monitor the introduction	✓	Continuous data	No publication date yet

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2021/22	Percentage Data completion	Outcome
		and effectiveness of cancer services.		collection	identified
National Maternity and Perinatal Audit	Royal College of Obstetricians and Gynaecologists	A large scale audit of NHS maternity services across England, Scotland and Wales, collecting data on all registrable births delivered under NHS care.	✓	100%	No publication date yet identified
National Neonatal Audit Programme	Royal College of Paediatrics and Child Health	To assess whether babies requiring specialist neonatal care receive consistent high quality care and identify areas for improvement in relation to service delivery and the outcomes of care.	✓	Continuous data collection	No publication date yet identified
National Paediatric Diabetes Audit	Royal College of Paediatrics and Child Health	The audit covers registrations, complications, care process and treatment targets.	✓	Continuous data collection	No publication date yet identified
National Perinatal Mortality Review Tool (PMRT)	University of Oxford / MBRRACE-UK collaborative	The aim of the PMRT programme is introduce the PMRT to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales.	✓	Continuous data collection	No publication date yet identified
National Prostate Cancer Audit	Royal College of Surgeons	The National Prostate Cancer Audit is the first national clinical audit of the care that men receive following a diagnosis of prostate cancer.	✓	Continuous data collection	No publication date yet identified
National Vascular Registry	Royal College of Surgeons	The National Vascular Registry collects data on all patients undergoing major vascular surgery in NHS hospitals in the UK.	✓	Continuous data collection	No publication date yet identified
Neurosurgical National Audit Programme	Society of British Neurological Surgeons	This audit looks at all elective and emergency neurosurgical activity in order to provide a consistent and meaningful approach to reporting on national clinical audit and outcomes data.	✓	Continuous data collection	No publication date yet identified
Paediatric Intensive Care Audit (PICANet)	University of Leeds / University of	PICANet aims to continually support the improvement of	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2021/22	Percentage Data completion	Outcome
	Leicester	paediatric intensive care provision throughout the UK by providing detailed information on paediatric intensive care activity and outcomes.			
Respiratory Audits – National Outpatient Management of Pulmonary Embolism	British Thoracic Society (BTS)	The BTS Audit of Outpatient Pulmonary Embolism Management in the UK seeks to identify where improvements can be made in this area to align practice to BTS Quality Standards and other guidance.	✓	100%	No publication date yet identified
Respiratory Audits – National Smoking Cessation Audit	British Thoracic Society	The aim of the BTS audit programme is to drive improvements in the quality of care and services for patients with respiratory conditions across the UK.	✓	100%	No publication date yet identified
Sentinel Stroke National Audit Programme	Kings College London	The audit collects data on all patients with a primary diagnosis of stroke, including any patients not on a stroke ward. Each incidence of new stroke is collected.	✓	Continuous data collection	No publication date yet identified
Serious Hazards of Transfusion	Serious Hazards of Transfusion	The scheme collects and analyses anonymised information on adverse events and reactions in blood transfusion from all healthcare organisations that are involved in the transfusion of blood and blood components in the United Kingdom.	✓	Continuous data collection	No publication date yet identified
Society for Acute Medicine's Benchmarking Audit	Society for Acute Medicine	SAMBA is a national benchmark audit of acute medical care. The aim is to describe the severity of illness of acute medical patients presenting to Acute Medicine, the speed of their assessment, their pathway and progress at seven days after admission and to provide a comparison for each participating unit with the national	The Trust did not participate in the programme due to local resourcing issues.		

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2021/22	Percentage Data completion	Outcome
		average.			
Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	BURST Collaborative / British Urology Researchers in Surgical Training	The aim of BURST Research Collaborative is to produce high impact multi-centre audit and research that can improve patient care.	✓	Data collection 3rd May 2021 – 3rd April 2022	No publication date yet identified
Trauma Audit and Research Network	Trauma Audit & Research Network	The audit aims to highlight areas where improvements could be made in either the prevention of injury or the process of care for injured patients.	✓	Continuous data collection	Major Trauma Dashboards (quarterly), Clinical Feedback reports (3 per year), PROMs reports (quarterly).
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	This audit looks at the care of people with a diagnosis of cystic fibrosis under the care of the NHS in the UK.	✓	Continuous data collection	Published report expected August 2022.
Urology Audits – Management of the Lower Ureter in Nephrouterectomy Audit	British Association of Urological Surgeons	This audit aims to determine which surgical technique offers the best cancer control in terms of survival and recurrence.	✓	100%	No publication date yet identified
Child Health Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	The audit aims to assess the quality of healthcare and stimulate improvement in safety and effectiveness.	✓	Data collection period TBC	No publication date yet identified
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	The audit aims to assess the quality of healthcare and stimulate improvement in safety and effectiveness.	✓	Data collection period TBC	No publication date yet identified

An additional 12 audits have been added to the list for inclusion in 2022/2023 Quality Account, only eight of these audits are relevant to services provided by the Trust. The audits include:

- Breast and Cosmetic Implant Registry
- Assessing for cognitive impairment in older people (Emergency Medicine QIPs)
- Muscle Invasive Bladder Cancer Audit
- National Ophthalmology Audit Database
- Perioperative Quality Improvement Programme
- National Acute Kidney Injury Audit
- Adult Respiratory Support Audit
- UK Parkinson's Audit.

The reports of national clinical audits were reviewed by the provider in 2021/2022 and the Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- The Trust has firmly embedded monitoring arrangements for national clinical audits with the identified lead clinician asked to complete an action plan and present this to the Clinical Audit and Guidelines Group
- On an annual basis the Group receives a report on the projects in which the Trust participates and requires the lead clinician of each audit programme to identify any potential risk, where there are concerns action plans will be monitored on a regular basis
- In addition, each Directorate is required to present an Annual Clinical Audit Report to the Clinical Audit and Guidelines Group detailing all audit activity undertaken both national and local. Clinicians are required to report all audit activity using the Trust's Clinical Effectiveness Register
- Clinical Directorates are asked to include national clinical audit as a substantive agenda item at their Clinical Governance meetings in particular, to review any areas required for improvement
- Compliance with National Confidential Enquiries is reported to the Clinical Outcomes and Effectiveness Group and exceptions subject to detailed scrutiny and monitored accordingly
- Non-compliance with recommendations from National Clinical Audit and National Confidential Enquiries are risk assessed and considered for inclusion on the local risk register.

The reports of 762 local audits were reviewed by the provider in 2021/2022 and the Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following action to improve the quality of health care provided:

- Each Clinical Directorate is required to present an Annual Clinical Audit Report to the Clinical Audit and Guidelines Group detailing all audit activity undertaken both national and local.
- Any areas of non-compliance with standards are risk assessed and escalated as appropriate to the Clinical Outcomes and Effectiveness Group.

INFORMATION ON PARTICIPATION IN CLINICAL RESEARCH

In the last year 11,703 participants were recruited to Clinical Trials provided or hosted by The Newcastle upon Tyne Hospital's NHS Foundation Trust of which 10,846 enrolled on to UK National Institute for Health and Care Research (NIHR) Clinical Research Network (CRN) portfolio studies. These wide-ranging studies included common conditions such as migraines and irritable bowel syndrome, to dosing the first patient in Europe as part of a rare disease clinical trial and using robotics to carry out knee replacements.

Since the pandemic started in March 2020, clinical research at Newcastle has recruited 1,743 participants to 64 COVID-19 studies, contributing towards the approval of COVID-19 vaccines and new treatments that reduce COVID-19 related mortality. Despite the challenges brought on by the pandemic, research continued to see the positive impact clinical trials can have on patients' lives and the role it plays in tackling some of our greatest health challenges. The Newcastle upon Tyne Hospitals NHS Foundation Trust commitment to clinical research is demonstrated in our Clinical Research Strategy 2021-2026,which sets out how research will build on its national and international reputation for research excellence, whilst continuing to make a difference to local people.

INFORMATION ON THE USE OF THE CQUIN FRAMEWORK

In response to the COVID-19 pandemic, NHS England suspended healthcare contracting and introduced an emergency finance regime. That finance regime included provision for the funding of all Trusts via a “block envelope” paid over to Trusts regardless of activity, performance or quality.

In previous years, a proportion of The Newcastle upon Tyne Hospital’s NHS Foundation Trust income had been conditional upon achieving quality improvement and innovation, through Commissioning for Quality Innovation (CQUIN) payment framework. For 2021/2022, that is not the case and the suspension of healthcare contract implies the suspension of CQUIN as well.

INFORMATION RELATING TO REGISTRATION WITH THE CARE QUALITY COMMISSION (CQC)

The Newcastle upon Tyne Hospital's NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'Registered without Conditions'. The Newcastle upon Tyne Hospital's NHS Foundation Trust has no conditions on registration. The Newcastle upon Tyne Hospital's NHS Foundation Trust is registered with the CQC to deliver care from nine separate locations and for 10 regulated activities.

The Care Quality Commission has not taken enforcement action against The Newcastle upon Tyne Hospital's NHS Foundation Trust during 2020/21.

The Newcastle upon Tyne Hospital's NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The Newcastle upon Tyne Hospital's Foundation Trust received a full inspection of all services during January 2019. Following this inspection, Newcastle Hospitals was graded as 'Outstanding'.

Overall Trust Rating - Outstanding

INFORMATION ON THE QUALITY OF DATA

The Newcastle upon Tyne Hospital's NHS Foundation Trust submitted records during 2021/2022 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data:

Which included the patients valid NHS number was:

- 99.6% for admitted patient care;
- 99.8% for outpatient care;
- 99.0% for accident and emergency care.

Which included the patients valid General Medical Practice Code was:

- 100% for admitted patient care;
- 100% for outpatient care;
- 100% for accident and emergency care.

Clinical Coding Information

Score for 2021/2022 for Information Quality and Records Management, assessed using the Data Security & Protection (DSP) Toolkit.

Our annual Data Security and Protection Clinical Coding audit for diagnosis and treatment coding of inpatient activity demonstrated an excellent level of attainment and satisfies the requirements of the Data Security and Protection Toolkit Assessment.

200 episodes of care were audited, covering the following three specialties:

- Vascular Surgery
- Cardiothoracic Surgery
- COVID-19 Infection.

The level attained for Data Security Standard 1 Data Quality – Standards Exceeded.
The level attained for Data Security Standard 3 Training – Standard Exceeded.

Table shows the levels of attainment of coding of inpatient activity

	Levels of Attainment		
	Standards Met	Standards Exceeded	NUTH Level
Primary diagnosis	>=90%	>=95%	98.0%
Secondary diagnosis	>=80%	>=90%	98.5%
Primary procedure	>=90%	>=95%	99.1%
Secondary procedure	>=80%	>=90%	95.8%

It was noted that previous audit recommendations have been taken on board to achieve quality improvements and that the organisation should be highly commended on its clinical coding accuracy.

KEY NATIONAL PRIORITIES 2021/2022

The key national priorities are performance targets for the NHS which are determined by the Department of Health and Social Care and form part of the CQC Intelligent Monitoring Report. A wide range of measures are included and the Trust's performance against the key national priorities for 2021/2022 are detailed in the table below. Please note that changes in performance are in all likelihood due to the impact of COVID-19.

Operating and Compliance Framework Target	Target	Annual Performance 2020/2021	Annual Performance 2021/2022
Incidence of Clostridium (*C .difficile:* variance from plan)	No more than 98 cases	111	169
Incidence of MRSA Bacteraemia	Zero tolerance	1	0
All Cancer Two Week Wait	93%	62.5%	65.7%
Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	93%	50.7%	32.2%
31-Day (Diagnosis To Treatment) Wait For First Treatment	96%	93.0%	90.6%
31-Day Wait For Second Or Subsequent Treatment: Surgery	94%	89.1%	74.6%
31-Day Wait For Second Or Subsequent Treatment: Drug treatment	98%	96.4%	97.1%
31-Day Wait For Second Or Subsequent Treatment: Radiotherapy	94%	97.5%	97.3%
All cancers: 62-day wait for first treatment from: • urgent GP referral for suspected cancer	85%	76.3%	58.9%
All cancers: 62-day wait for first treatment from: • NHS Cancer Screening Service referral	90%	63.7%	77.0%
RTT – Referral to Treatment - Admitted Compliance	90%	67.3%	64.4%
RTT – Referral to Treatment - Non-Admitted Compliance	95%	78.9%	82.1%
RTT – Referral to Treatment - Incomplete Compliance	92%	65.5%	71.4%
Maximum 6-week wait for diagnostic procedures	99%	80.7%	80.6%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	95%	91.9%	86.23%
Cancelled operations – those not admitted within 28 days	Offered a date within 28 days of none clinical cancellation	93.41% (789 cancelled ops with 52 breaching 28 day target)	Cancelled due to COVID reinstated 2022/23
Maternity bookings within 12 weeks and 6 days	Not defined	88.4%	86.9%

Details on Hospital-level Mortality Indicator please refer to page 82.

Rationale for any failed targets in free text please note below:

Cancer Performance Targets**:** Referral numbers have increased following an initial decline impacting performance. Outpatient capacity has been reduced during COVID-19 specifically impacting on Dermatology and Colorectal with a significant backlog of

patients waiting for first appointments/investigations. This has had a major impact on 14 day and 62-day compliance.

Implementation of a teledermatology service has had a significant impact in reducing the backlog of patients and has been extended to cover all suspected skin cancers. Diagnostic pressures (radiology and endoscopy) remain the biggest challenge with demand exceeding capacity.

In Endoscopy nurse led triage was implemented and has steadily improved the position, and more recently additional nurses appointed to support the expansion of the Department along with a new electronic scheduling system.

In radiology a number of actions are being progressed.

- Provision on site of additional MRI staffed mobile units to support recovery – two scanners initially six months.
- Access to private sector imaging centres – outsourcing of appropriate scans CT/MRI.
- Utilisation of Phase 1 CDC Centre – MRI & CT.
- International recruitment of appropriate radiographic and sonographic staff – project initiated.
- Further recruitment of radiologist agreed.
- Outsourcing of reporting – additional provider to be available within next six weeks.
- Working with universities to increase numbers of undergraduate radiographers.

Within the 31 day standard theatre capacity has been a major factor specifically in Urology and Breast. Workforce issues spanning all disciplines (COVID-19 and general sickness) has impacted across all standards. All tumour groups have a cancer improvement plan to support recovery, improved performance and patient experience. These will be regularly reviewed via the Cancer Steering Group.

Referral to Treatment Targets: Throughout the pandemic national guidance has prevailed with infection control measures to maximise safe patient treatments. This continues to be adhered to. Throughout this time, cancer and high clinical priority patients remained the priority to be treated.

The patients on the waiting list continue to be prioritised by clinical need and longest waits. There is intense scrutiny on the longest waiting patients to schedule their treatment as soon as possible. The performance details of long waiters are discussed and reported at Board level. Additional capacity is being utilised in the Independent sector, and measures to redesign patient pathways are proving successful in reducing the long waiters and as a result will improve performance.

Emergency Department (ED) Target: Type 1 attendances have increased by 14.45% compared to 2019/2020 this is an increase of 57 patients per day. Understandably, admissions via ED have increased by 10.57% compared to the same time scale and this is an increase of 13 emergency admissions per day. This increase in the number of emergency admissions coupled with significant gaps in the ED medical and nursing rotas due to vacancies and sickness contributed to achieving 86% performance. NUTH is still one of the best performing ED's in the country.

CORE SET OF QUALITY INDICATORS

Data is compared nationally when available from the NHS Digital Indicator portal. Where national data is not available the Trust has reviewed our own internal data.

Measure	Data Source	Target	Value	2021/22		2020/21				2019/20				
1. The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust	NHS Digital Indicator Portal https://indicators.ic.nhs.uk/webview/	Band 2 "as expected"		Oct 20 – Sept 21 **NUTH Value:** 0.9606	Jul 20 - Jun 21 **NUTH Value:** 0.9369	Apr 20 - Mar 21 **NUTH Value:** 0.9678	Jan20 - Dec 20 **NUTH Value:** 0.9536	Oct 19 – Sept 20 **NUTH Value:** 0.9795	Jul 19 - Jun 20 **NUTH Value:** 0.9948	Apr 19 - Mar 20 **NUTH Value:** 0.9791	Jan19 - Dec 19 **NUTH Value:** 0.9700	Oct 18 - Sep 19 **NUTH Value:** 0.9556	Jul 18 - Jun 19 **NUTH Value:** 0.9555	Apr 18 - Mar 19 **NUTH Value:** 0.9644
				NUTH Band 2	**NUTH Band 2**	**NUTH Band 2**	**NUTH Band 2**	**NUTH Band 2**	**NUTH Band 2**	**NUTH Band 2**	**NUTH Band 2**	**NUTH Band 2**	**NUTH Band 2**	**NUTH Band 2**
			National Average	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
			Highest National	1.1909	1.2017	1.2010	1.1845	1.1795	1.2074	1.1997	1.1999	1.1877	1.1916	1.2058
			Lowest National	0.7132	0.7195	0.6908	0.7030	0.6869	0.6764	0.6851	0.6889	0.6979	0.6967	0.7069
2. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust	NHS Digital Indicator Portal https://indicators.ic.nhs.uk/webview/	N/A	Trust	44%	44%	43%	39%	35%	33%	32%	31%	32%	33%	33%
			National Average	39%	39%	38%	37%	36%	36%	37%	36%	36%	36%	35%
			Highest National	63%	64%	63%	61%	60%	60%	58%	60%	59%	60%	60%
			Lowest National	12%	11%	8%	8%	9%	9%	9%	10%	12%	15%	12%

Measure 1. The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust.

The Newcastle upon Tyne Hospital's NHS Foundation Trust considers that this data is as described for the following reasons:
The Trust continues to perform well on mortality indicators. Mortality reports are regularly presented to the Trust Board. Newcastle Hospitals has taken the following actions to improve this indicator, and so the quality of its services by closely monitoring mortality rates and conducting detailed investigations when rates increase. We continue to monitor and discuss mortality findings at the Quarterly Mortality Surveillance Group; representatives attend this group from multiple specialities and scrutinise Trust mortality data to ensure local learning and quality improvement. This group complements the departmental mortality and morbidity (M&M) meetings within each Directorate.

Measure 2. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust.

The Newcastle upon Tyne Hospital's NHS Foundation Trust considers that this data is as described for the following reasons:
The use of palliative care codes in the Trust has remained static and aligned to the national average percentage over recent years. Newcastle Hospitals continues to monitor the quality of its services, by involving the coding team and End of Life team in routine mortality reviews to ensure accuracy and consistency of palliative care coding. We continue to monitor and discuss patients with a palliative care coding at the quarterly Mortality Surveillance Group.

Measure	Value	2020/21	2019/20	2018/19	2017/18	2016/17	2015/16	2014/15
5. The patient reported outcome measures scores (PROMS) for primary hip replacement surgery (adjusted average health gain – EQ5D)	Trust Score	**0.52**	**0.46**	**0.50**	**0.47**	**0.44**	**0.43**	**0.43**
	National average:	0.47	0.46	0.47	0.47	0.44	0.44	0.44
	Highest national:	0.57	0.54	0.56	0.57	0.54	0.51	0.52
	Lowest national:	0.39	0.35	0.35	0.38	0.31	0.32	0.33
6. The patient reported outcome measures scores (PROMS) for primary knee replacement surgery (adjusted average health gain – EQ5D)	Trust Score	**0.35**	**0.36**	**0.31**	**0.33**	**0.33**	**0.31**	**0.32**
	National average:	0.32	0.34	0.34	0.34	0.32	0.32	0.31
	Highest national:	0.40	0.42	0.41	0.42	0.40	0.40	0.42
	Lowest national:	0.18	0.22	0.27	0.23	0.24	0.20	0.20

Please note that finalised PROMs data is now available for 2020/2021. Finalised 2021/2022 data will not be available until September 2022.

Measure 3. The Patient Reported Outcome Measures scores (PROMS) for groin hernia surgery.

Collection of groin procedure scores ceased on October 1st 2017.

Measure 4. The Patient Reported Outcome Measures scores (PROMS) for varicose vein surgery.

Collection of varicose vein procedure scores ceased on October 1st 2017.

Measure 5. The Patient Reported Outcome Measures scores (PROMS) for hip replacement surgery.

The Newcastle upon Tyne Hospital's NHS Foundation Trust considers that this data is as described for the following reasons:
Newcastle Hospitals PROMS outcomes are good and we are committed to increasing our participation rates going forward. We encourage patients to complete these and discuss completion rates and results in the Arthroplasty Multidisciplinary team (MDT). Data for 2021/2022 has not yet been released, but data for 2020/2021 has been populated.

Measure 6. The Patient Reported Outcome Measures scores (PROMS) for knee replacement surgery.

The Newcastle upon Tyne Hospital's NHS Foundation Trust considers that this data is as described for the following reasons:
Newcastle Hospitals PROMS outcomes are good and we are committed to increasing our participation rates going forward. We encourage patients to complete these and discuss completion rates and results in the Arthroplasty MDT. Data for 2021/2022 has not yet been released, but data for 2020/2021 has been populated.

7a. Emergency readmissions to hospital within 28 days of discharge from hospital: Children of ages 0-14.

Year	Total number of admissions/spells	Number of readmissions (all)	Emergency readmission rate (all)
2012/2013	31,841	2,454	7.7
2013/2014	32,242	2,648	8.2
2014/2015	34,561	3,570	10.3
2015/2016	38,769	2,875	7.4
2016/2017	35,259	1,983	5.6
2017/2018	35,009	2,077	5.9
2018/2019	36,387	2,003	5.5
2019/2020	42,238	4,609	10.9
2020/2021	29,319	2,643	9.0
2021/2022	34,099	3,039	8.9

7b. Emergency readmissions to hospital within 28 days of being discharged aged 15+.

Year	Total number of admissions/spells	Number of readmissions (all)	Emergency readmission rate (all)
2012/2013	173,270	8,788	5.1
2013/2014	177,867	9,052	5.1
2014/2015	180,380	9,446	5.2
2015/2016	182,668	10,076	5.5
2016/2017	186,999	10,219	5.5
2017/2018	182,535	10,157	5.6
2018/2019	185,967	10,461	5.6
2019/2020	192,365	12,648	6.6
2020/2021	142,629	10,730	7.5
2021/2022	184,032	11,923	6.5

Measure 7. The percentage of patients aged— (i) 0 to 15; and (ii) 16 or over readmitted within 28 days of being discharged from hospital.

This indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review. Therefore, the Trust has reviewed its own internal data and used its own methodology of reporting readmissions within 28 days (without Payment by Results exclusions). Newcastle Hospitals considers that this data is as described for the following reasons: The Trust has a robust reporting system in place and adopts a systematic approach to data quality improvement.

The Newcastle upon Tyne Hospital's NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by continuing with the use of an electronic system.

Measure	Data Source	Value	2021/22*	2020/21	2019/20	2018/19	2017/18	2016/17
8. The trust's responsiveness to the personal needs of its patients	NHS Information Centre Portal https://indicators.ic.nhs.uk/	Trust percentage	Not available	77.7%	72.6%	73.1%	74.9%	74.6%
		National Average:	Not available	74.5%	67.1%	67.2%	68.6%	68.1%
		Highest National:	Not available	85.4%	84.2%	85.0%	85.0%	85.2%

		Lowest National:	Not available	67.3%	59.5%	58.9%	60.5%	60.0%
9. NB 2021 question changed to “If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation” .	http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/Results/	Trust percentage	85.4%	91.3%	90%	90%	96%	95%
		National Average:	66.9%	74.3%	71%	70%	81%	80%
		Highest National:	89.5%	91.7%	95%	95%	100%	100%
		Lowest National:	43.6%	49.7%	36%	33%	43%	44%

Measure 8. The Trust’s responsiveness to the personal needs of its patients.

The Newcastle upon Tyne Hospital’s NHS Foundation Trust considers that this data is as described for the following reasons:
This measure uses the results of a selection of five questions from the National Inpatient Survey focussing on the responsiveness to personal needs. Consultation feedback indicated that personalisation and service responsiveness are important issues for inpatients. This indicator aims to capture inpatients’ experience of this.
The historical data shows that the Trust consistently scores above the national average. As of the 2020/2021 survey, changes have been made to the working of the five questions used in this indicator as well as changes to the scoring regime. As a result, 2020/2021 results are not comparable with those of previous years.

The data shows that the Trust scores above the national average. Newcastle Hospitals intends to take the following actions to improve this indicator, and so the quality of its services, by continuing to implement processes to capture patient experience and improve its services. Data for 2021/2022 has not yet been released, but data for 2020/2021 published on March 17th 2022 has been populated.

Measure 9. The percentage of staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends changed to “If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation” for 2021/2022 survey.

The Newcastle upon Tyne Hospital’s NHS Foundation Trust considers that this data is as described for the following reasons:
The Trust score is well above the National average. Newcastle Hospitals has taken the following actions to improve this percentage, and so the quality of its services, by continuing to listen to and act on all sources of staff feedback. Data for 2019/2020 has been added as it was not available at time of publication last year.

Measure 10. The percentage of patients that were admitted to hospital who were risk assessed for Venous thromboembolism (VTE)

Due to COVID-19 National data collection has ceased and is not expected to resume until June 2022.

Measure	Data Source	Target	2021/22	2020/21	2019/20	2018/19
11. The number of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over	PHE Data Capture System	Trust number of cases	169 HOHA* = 135 COHA* = 34 (no appeals process this financial year)	111 HOHA* = 85 COHA* = 26 (no appeals process this financial year)	113 HOHA* = 95 COHA* = 18 National figure 89 (minus 24 successful appeals**)	77 National figure 48 (minus 29 successful appeals)
		National Average number of cases	HOHA* = 28 COHA* = 11	HOHA* = 23 COHA* = 10	HOHA* = 25 COHA* = 12	31
		Highest National number of cases	HOHA* = 185 COHA* = 76	HOHA* = 151 COHA* = 60	HOHA* = 163 COHA* = 77	130
		Lowest National number of cases	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	0

*HOHA = Hospital Onset – Healthcare Associated
*COHA = Community Onset – Healthcare Associated

Measure 11.The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over

The Newcastle upon Tyne Hospital's NHS Foundation Trust considers that this data is as described for the following reasons:
The Trust has a robust reporting system in place and adopts a systematic approach to data quality improvement. Newcastle Hospitals has taken the following actions to improve this rate, and so the quality of its services by having a robust strategy; Quarterly HCAI Report to share lessons learned and best practice from Serious Infection Review Meetings (see page 46).

Measure	Data Source	Target	2021/22	2020/21	2019/20		2018/19	
12. The number and rate per 100 admissions of patient safety incidents reported *NB: Changed to rate per 1000 bed days April 2014*	NHS Information Centre Portal https://www.england.nhs.uk/patient-safety/national-patient-safety-incident-reports/	Trust no.	April 2021 – March 2022 18440	April 2020 - March 2021 17915	Oct 2019-March 2020 9319	Oct 2018-March 2019 9707	Oct 2018-March 2019 9707	April-2018 Sept 2018 8661
		Trust %	37.5	50.3	41.5	39.8	39.8	38.3
		National Average	Not available	58.4	49.1	44.7	44.7	44.52
		Highest National	Not available	118.7	110.2	95.9	95.9	107.4
		Lowest National	Not available	27.2	15.7	16.9	16.9	13.1

Measure	Data Source	Target	2021/22		2020/21		2019/20			
13. The number and percentage of patient safety incidents that resulted in severe harm or death	NHS Information Centre Portal https://www.england.nhs.uk/patient-safety/national-patient-safety-incident-reports/	Trust no.	April-2021 March 2022 **Severe Harm** 85	April-2021 March 2022 **Death** 50	April 2020 - Mar 2021 **Severe Harm** 72	April 2020-Mar 2021 **Death** 49	Oct 2019-Mar 2020 **Severe Harm** 29	Oct 2019-Mar 2020 **Death** 5	April-2019 Sept 2019 **Severe Harm** 14	April-2019 Sept 2019 **Death** 4
		Trust %	0.5%	0.3%	0.3%	0.2%	0.3%	0.1%	0.2%	0.0%
		National Average	Not available	Not available	0.2%	0.2%	0.2%	0.1%	0.15%	0.04%
		Highest National	Not available	Not available	1%	1.3%	0.8%	0.6%	0.23%	0.08%
		Lowest National	Not available	Not available	0.0%	0.0%	0.0%	0.0%	1.22%	0.66%

Measure 12. The number and rate of patient safety incidents reported

The Newcastle upon Tyne Hospital NHS Foundation Trust considers that this data is as described for the following reasons:
The Trust takes the reporting of incidents very seriously and have an electronic reporting system (Datix) to support this. Newcastle Hospitals has taken the following actions to improve this number and rate, and so the quality of its services, by undertaking a campaign to increase awareness of incident/near misses reporting. Incidents are graded, analysed and, where required, undergo an investigation using a systems approach to inform actions, recommendations and learning. Incident data is reported to the Quality Committee to inform our organisational learning themes which are reported to the Board. From 2020/2021 the data is now reported annually, previously this was published bi-annually. The 2020/2021 data has now been updated where it was not available last year. The national data for 2021/22 is due for release in September 2022. 2021/2022 Trust data has been compared with all other organisations described as Acute Trusts in National Reporting and Learning System (NRLS).

Measure 13. The number and percentage of patient safety incidents that resulted in severe harm or death

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:
The Trust takes incidents resulting in severe harm of death very seriously. The rate of incidents resulting in severe harm or death is consistent with the national average. This reflects a culture of reporting incidents which lead to, or have the potential to, cause serious harm or death. Newcastle Hospitals has taken the following actions to reduce this number and rate, and so the quality of its services, by the Board receiving monthly reports of incidents resulting in severe harm of death. From 2020/2021 the data is now reported annually, previously this was published bi-annually. The 2020/2021 data has now been updated where it was not available last year. The national data for 2021/2022 is due for release in September 2022. 2021/2022 Trust data has been compared with all other Organisations described as Acute Trusts in National Reporting and Learning System (NRLS).

WORKFORCE FACTORS

The tables below provide data on the loss of work days. The table directly below reports on the Trust and Regional position rate (data taken from the NHS Information Centre) and the next table provides an update on the Trust number of staff sick days lost to industrial injury or illness caused by work.

This table shows the loss of work days (rate).

	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21
The Newcastle Upon Tyne Hospitals	5.10%	5.51%	4.76%	4.16%	4.32%	4.62%	4.76%	5.70%	5.77%	5.99%	6.51%	6.34%
South Tyneside and Sunderland	5.87%	5.88%	5.50%	4.65%	5.39%	5.78%	6.19%	6.41%	6.59%	7.15%	7.24%	7.25%
County Durham and Darlington	6.78%	7.22%	6.05%	5.06%	5.04%	5.44%	5.81%	6.21%	6.14%	6.95%	7.00%	6.56%
Gateshead Health	5.19%	4.96%	4.42%	4.34%	4.32%	4.60%	5.06%	5.70%	5.61%	6.06%	6.48%	5.89%
North Tees and Hartlepool	7.09%	7.07%	5.80%	5.09%	5.08%	5.52%	5.85%	6.16%	6.25%	6.42%	6.80%	6.50%
Northumbria Healthcare	5.49%	5.89%	5.21%	4.53%	4.77%	4.77%	5.08%	5.46%	5.99%	5.92%	6.01%	5.99%
South Tees Hospitals	5.59%	5.99%	5.25%	4.32%	4.28%	4.62%	5.23%	6.01%	5.99%	6.16%	6.69%	6.61%
England	5.09%	5.75%	4.65%	3.99%	4.06%	4.34%	4.63%	5.07%	5.14%	5.38%	5.66%	5.59%

The table below shows the number of staff sick days lost to industrial injury or illness caused by work.

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year Total
2010/11 no. of days	118	254	267	366	1005
2011/12 no. of days	253	299	247	153	952
2012/13 no. of days	154	138	174	209	675
2013/14 no. of days	489	331	785	147	1752
2014/15 no. of days	333	284	178	206	1001
2015/16 no. of days	360	194	365	219	1138
2016/17 no. of days	230	387	136	84	837
2017/18 no. of days	137	90	51	122	400
2018/19 no. of days	214	131	188	326	859
2019/20 no. of days	249	172	67	123	611
2020/21 no. of days	65	61	335	212	673
2021/22 no. of days	372	539	446	Not available	Not available

2021 NHS STAFF SURVEY RESULTS SUMMARY

The last couple of years have been exceptionally difficult for everyone working in the NHS. Now, more than ever, it is important to hear what colleagues think about working for us to help improve their working lives. A full census survey was sent via email to all employees of the Trust (via external post for those on maternity leave), giving all 16,071 members of our staff a voice. 7,336 staff participated in the survey, equalling a response rate of 46%, which is aligned to the sector average and was the largest number of respondents received when compared to other organisations in the region.

Providing the highest standard of care has always been our priority even more so during the pandemic and we know how important this is to all of our staff here at Newcastle. We were particularly proud to score higher than the national average (by 18.5%) when asked “If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.”

For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the **People Promise,** the biggest re-design in over ten years. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

- **We are compassionate and inclusive**
- **We are recognised and rewarded**
- **We each have a voice that counts**
- **We are safe and healthy**
- **We are always learning**
- **We work flexibly**
- **We are a team.**

Alongside the People Promise are two main themes**:**

- **Staff Engagement**
- **Morale.**

The reporting also includes new sub-scores, which feed into the People Promise elements and themes.

The Staff Engagement score is measured across three sub-themes:

- Advocacy: 7.5 out of 10, measured by Q21a, Q21c and Q21d (Staff recommendation of the trust as a place to work or receive treatment)
- Motivation: 6.8 out of 10, measured by Q2a, Q2b and Q2c (Staff motivation at work)
- Involvement: 6.6 out of 10, measured by Q3c, Q3d and Q3f (Staff ability to contribute towards improvement at work).

At The Newcastle upon Tyne Hospital’s NHS Foundation Trust Newcastle this score was:
Overall: rating of **staff engagement** 6.9 (out of possible 10).
This score was 0.5 below top position and 0.6 above worst position in the sector (Combined Acute & Community Trusts). It sits above sector average by 0.1.

Including Staff engagement, the Trust scored better on five of the nine people promises / themes when compared with 126 other Combined Acute & Community Trusts in England.

We are compassionate and inclusive
NuTH Score: 7.3 out of 10
Sector Score: 7.2 out of 10

We each have a voice that counts
NuTH Score: 6.8 out of 10
Sector Score: 6.7 out of 10

We are safe and healthy
NuTH Score: 6.0 out of 10
Sector Score: 5.9 out of 10

Morale
NuTH Score: 5.9 out of 10
Sector Score: 5.7 out of 10

The Trust scored equal to the sector in two of the people promises, which included:

We are always learning
NuTH Score: 5.2 out of 10
Sector Score: 5.2 out of 10

We are recognised and rewarded
NuTH Score: 5.8 out of 10
Sector Score: 5.8 out of 10

The Trust fell slightly behind sector average on two of the people promises, which included:
We work flexibly
NuTH Score: 5.6 out of 10
Sector Score: 5.9 out of 10

We are a team
NuTH Score: 6.4 out of 10
Sector Score: 6.6 out of 10

Additionally, the Trust scored favourably in a number of the questions in the survey. Some to note include:

- 90% feel trusted to do their job
- 86% feel their role makes a difference to patients
- 76% feel secure raising concerns about unsafe clinical practice. 2.5% increase from 2020
- 65% would recommend Newcastle Hospitals as a place to work. 6.6% higher than the sector average
- 80.9% enjoy working with the colleagues in our teams
- 69.1% believe the people we work with are understanding and kind to one another

- 70.0% think that people we work with are polite and treat each other with respect, 0.5% higher than sector average
- 71.7% of our staff believe our organisation respects individual differences, meaning we are 2.9% above the sector average.

There is unfortunately a national picture of staff experiencing burnout, which is no surprise given the unprecedented demand over the last couple of years. Overall, the latest results show that we are in line with responses from other similar NHS organisations.

Ensuring that the voices of our staff continue to be heard continues to be a priority, and these survey results provide more depth to our understanding of the issues affecting staff and we will incorporate these findings into our ‘What Matters to You’ programme.

The issues highlighted in the staff survey are very much in line with the feedback given through ‘What Matters to You’ including flexible working and compassionate leadership. We are committed to building on improvements in these areas.

INVOLVEMENT AND ENGAGEMENT 2022/2023

Patients, staff and members of the public are at the heart of The Newcastle upon Tyne Hospital's NHS Foundation Trust values and ambitions, which helps to ensure we deliver the best care for everyone. By actively engaging and listening to people who use and care about our services, we can understand what matters most to them and at the same time respond to the diverse health and care needs of our patients

We want to embed engagement and involvement in everything we do and there are already many positive examples of the difference this has already made across the Trust. This includes having a range of supportive and effective mechanisms to feed back about services as well as systems and structures to ensure this experience is listened to, learnt from and acted upon to improve the services we provide to our patients. We want to build upon our progress to date and spread this good practice.

The Newcastle upon Tyne Hospital's NHS Foundation Trust has rapidly adapted to ensure we are able to actively involve and listen to our patients and local communities. The Advising on the Patient Experience (APEX), Young Persons Advisory Group (YPAGne), Maternity Voice Partnership (MVP) and Equality, Diversity and Humans Rights working group have continued to meet virtually, providing a sustainable and strong model of engagement with a diverse range of people.

The Newcastle upon Tyne Hospital's NHS Foundation Trust continues to have a good relationship with, and works in partnership with local communities and voluntary groups in order to ensure that equal and diverse opportunities are promoted to all. This year, we have worked with Deaflink, to develop the health navigator service which we hope to launch in the Spring.

In 2022/2023 the focus will be:

- Continue to work in partnership with local communities and voluntary groups
- Development of a Patient Experience Strategy
- Launch of the Deaf Health Navigator Project
- Improve our use of existing sources of feedback to inform continuous improvement and service transformation.

ANNEX 1:

STATEMENT ON BEHALF OF THE NEWCASTLE HEALTH SCRUTINY COMMITTEE

STATEMENT ON BEHALF OF NORTHUMBERLAND COUNTY COUNCIL

STATEMENT ON BEHALF OF THE NEWCASTLE & GATESHEAD CLINICAL COMMISSIONING GROUP ALLIANCE

NHS Newcastle Gateshead Clinical Commissioning Group

NHS Northumberland Clinical Commissioning Group

NHS North Tyneside Clinical Commissioning Group

STATEMENT ON BEHALF OF HEALTHWATCH NEWCASTLE AND HEALTHWATCH GATESHEAD

STATEMENT ON BEHALF OF NORTHUMBERLAND HEALTHWATCH

STATEMENT ON BEHALF OF NORTH TYNESIDE HEALTHWATCH

ANNEX 2:

ABBREVIATIONS

Abbreviations	
3Rs	Restart, Reset and Recovery
7DS	Seven Day Service
A&E	Accident & Emergency
APEX	Advising on Patient Experience
BADS	British Association of Day Surgery
BAF	Board of Assurance Framework
BAME	Black, Asian and Minority Ethnic
BTS	British Thoracic Society
BURST	British Urology Researchers in Surgical Training
C.diff	Clostridium difficile
CAT	Clinical Assurance Tool
CCGs	Clinical Commissioning Group
CGARD	Clinical Governance and Risk Department
CKD	Chronic Kidney Disease
CNTW	Cumbria, Northumberland and Tyne and Wear
COHA	Community Onset – Healthcare Associated
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRANE	Cleft Registry and Audit Network
CRN	Clinical Research Network
CT	Computed Tomography
CVD	Cardiovascular Disease
CYP	Children and Young People
CYPMH	Children and Young People Mental Health
DoC	Duty of Candour
DSP	Data Security & Protection
DNA	Do Not Attend
DTC	Day Treatment Centre
E.coli	Escherichia coli
ED	Emergency Department
EHR	Electronic Health Record
EPR	Electronic Patient Record
ERAS	Enhanced Recovery After Surgery
ERS	E-Referral System
FTSU	Freedom to Speak up
GIRFT	Getting It Right First Time
GNBSI	Gram Negative Blood Stream Infections
GNCH	Great North Children's Hospital
GP	General Practitioner
HCAI	Healthcare Associated Infection
HES	Hospital Episode Statistics
HOHA	Hospital Onset – Healthcare Associated
HPB	Hepatobiliary and Pancreatic

Abbreviations	
HR	Human Resources
IBD	Inflammatory Bowel Disease
ICS	Integrated Care System
IHI	Institute for Healthcare Improvement
IPC	Infection Prevention & Control
IPCC	Infection Prevention & Control Committee
IT	Information Technology
IV	Intravenous
KRT	Kidney Replacement Therapy
LD	Learning Disability
LeDeR	Learning Disability Mortality Review
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer
LOS	Length of Stay
M&M	Mortality and Morbidity
MAU	Maternity Assessment Unit
MatNeoSIP	Maternity and Neonatal Safety Improvement Programme
MBRRACE	Mothers and Babies, Reducing Risk through Audits and Confidential Enquiries
MDT	Multi-Disciplinary Team
MDU	Mobile Destruction Unit
MEOWS	Modified Early Obstetrics Warning Score
ML	Moisture Lesion
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant *Staphylococcus aureus*
MSSA	Methicillin Sensitive *Staphylococcus Aureus*
MVP	Maternity Voice Partnership
N/A	Not Applicable
NCOBA	National Bowel Cancer Audit
NCEPOD	National Confidential Enquiries into Patient Outcome & Death
NELA	National Emergency Laparotomy Audit
NEY	North East and Yorkshire Region
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement
NICE	National Institute for health and clinical excellence
NIHR	National Institute for Health & Care Research
NRLS	National Reporting & Learning System
NUTH	Newcastle upon Tyne Hospital NHS Foundation Trust
PCI	Percutaneous Coronary Interventions
PCM	Patient Blood Management
PCN	Primary Care Network
PCR	Polymerase Chain Reaction
PDSA	Plan Do Study Act
PHE	Public Heath England

Abbreviations	
PICANet	Paediatric Intensive Care Audit Network
PIFU	Patient Initiated Follow Up
PMRT	Perinatal Mortality Review Tool
PPE	Personal Protection Equipment
PROMS	Patient Reported Outcome Measures Scores
PUP	Pressure Ulcer Prevention
QI	Quality Improvement
QIPS	Quality Improvement and Patient Safety Competencies
RCA	Root Cause Analysis
RCP	Royal College of Physicians
RIDDOR	Reporting of Injuries, Disease and Dangerous Occurrences
RTT	Referral to Treatment
RVI	Royal Victoria Infirmary
SAMBA	Society for Acute Medicine's Benchmarking Audit
SHINE	Sustaining Healthcare in Newcastle
SHMI	Summary Hospital-level Mortality Indicator
SIs	Serious Incidents
UK	United Kingdom
UKRR	United Kingdom Renal Registry
VAD	Ventricular Assist Device
VTE	Venous thromboembolism
YPAGne	Young Persons Advisory Group

ANNEX 3:

GLOSSARY OF TERMS

1. C. *difficile* infection (CDI)

C. *difficile* diarrhoea is a type of infectious diarrhoea caused by the bacteria Clostridium difficile, a species of gram-positive spore-forming bacteria. While it can be a minor part of normal colonic flora, the bacterium causes disease when competing bacteria in the gut have been reduced by antibiotic treatment.

2. CQC

The Care Quality Commission (CQC) is the independent regulator of all health and adult social care in England. The aim being to make sure better care is provided for everyone, whether that's in hospital, in care homes, in people's own homes, or elsewhere.

3. CQUIN – Commissioning for Quality and Innovation

The CQUIN framework was introduced in April 2009 as a national framework for locally agreed quality improvement schemes. It enables commissioners to reward excellence by linking a proportion of English healthcare provider's income to the achievement of local quality improvement goals.

4. DATIX

DATIX is an electronic risk management software system which promotes the reporting of incidents by allowing anyone with access to the Trust Intranet to report directly into the software on easy -to-use-web pages. The system allows incident forms to be completed electronically by all staff.

5. E.coli

Escherichia coli (E.coli) bacteria are frequently found in the intestines of humans and animals. There are many different types of E.coli, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment. E.coli bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. E.coli bacteraemia (blood stream infection) may be caused by primary infections spreading to the blood.

6. Gram-negative Bacteria

Gram-negative bacteria cause infections including pneumonia, bloodstream infections, wound or surgical site infections, and meningitis in healthcare settings. Gram-negative bacteria are resistant to multiple drugs and are increasingly resistant to most available antibiotics. These bacteria have built-in abilities to find new ways to be resistant and can pass along genetic materials that allow other bacteria to become drug-resistant as well.

7. Getting it Right First Time (GIRFT)

GIRFT is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking and presenting data-driven evidence to support change.

8. HOGAN evaluation score

Retrospective case record reviews of 1000 adults who died in 2009 in 10 acute hospitals in England were undertaken. Trained physician reviewers estimated life expectancy on admission, to identified problems in care contributing to death and judged if deaths were preventable taking into account patients' overall condition at that time. The Hogan scale, ranging from 1 (definitely not preventable) to 6 (definitely preventable), was used to determine if deaths were potentially avoidable, taking into account a patient's overall condition at the time.

Source: Dr Helen Hogan, Clinical Lecturer in UK Public Health,

1	Definitely not preventable
2	Slight evidence for preventability
3	Possibly preventable, but not very likely, less than 50-50 but close call
4	Probably preventable more than 50-50 but close call
5	Strong evidence of preventability
6	Definitely preventable

9. IHI

The Institute for Healthcare Improvement (IHI) are committed to supporting all who aim to improve health and health care. They bring like-minded colleagues at global conferences, trainings, and career development programs to help grow the safety, improvement, and leadership skills of the health and health care workforce. They advance learning by leading collaborative initiatives that enrich, accelerate, and spread the latest improvement ideas and leadership strategies.

10. MRSA

Staphylococcus Aureus (S. aureus) is a bacterium that commonly colonises human skin and mucosa (e.g. inside the nose) without causing any problems. Although most healthy people are unaffected by it, it can cause disease, particularly if the bacteria enters the body, for example through broken skin or a medical procedure. MRSA is a form of S. aureus that has developed resistance to more commonly used antibiotics. MRSA bacteraemia is a blood stream infection that can lead to life threatening sepsis which can be fatal if not diagnosed early and treated effectively.

11. MSSA

As stated above for MSSA the only difference between MRSA and MSSA is their degree of antibiotic resistance: other than that there is no real difference between them.

12. Near Miss

An unplanned or uncontrolled event, which did not cause injury to persons or damage to property, but had the potential to do so.

13. Shelford Group

The Shelford Group is a collaboration between ten of the largest teaching and research NHS Trusts in Engla

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

QUALITY ACCOUNT

2021/2022

Overview 2021-22 and our priorities for 2022-23




Healthcare at its best
with people at our heart

Purpose of Session

- Current position in relation to the Pandemic
- Update on progress against Quality Account Priorities 2021/22
- Discuss and provide any feedback on the proposed Quality Account priorities for 2022/23

How we identify Quality Priorities

- National Benchmarking
- Local and national audit
- National priorities
- Analysis of incidents & complaints
- Feedback from national and local patient surveys

Patient Safety

Priority 1 - Reducing Healthcare Associated Infections(HCAIs) – focusing on COVID-19, Methicillin-Sensitive Staphylococcus Aureus (MSSA) / Gram negative Blood Stream Infections (*GNBSI*) / *C. difficile* infections:

- Prevent transmission and HCAI COVID-19 in patients and staff.
- Internal 10% year on year reduction of MSSA bacteraemias.
- National ambition to reduce *GNBSI* with an internal aim of 10% year on year reduction.
- Sustain a reduction in *C. difficile* infections in line with national trajectory.

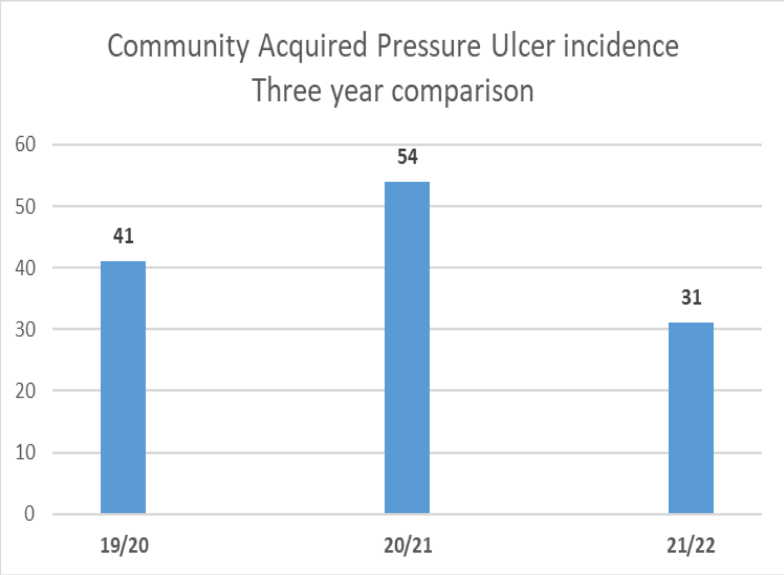
157 cases of hospital acquired *C. difficile* infections	**Staphylococcus Aureus bacteraemias** 0 case MRSA 97 cases MSSA	**Gram negative bacteraemias** 187 cases *E. coli* 138 cases Klebsiella 39 cases Pseudomonas aeruginosa

Figures April 1st 2021 – February 28th 2022

Patient Safety

Priority 2 – Pressure Ulcer Reduction – Community Acquired Pressure Damage whilst under care of our District Nursing Teams

- Significantly reduced Community acquired PU damage (specifically PU graded category II,III,IV)
- Development of dashboards which allowed community teams to have a visual aid of where pressure ulcers are occurring.
- Undertook quality improvement work on targeted localities who report the highest number and rate of pressure damage.
- Increased the visibility and support provided by the Tissue Viability team to frontline clinical staff to assist in the prevention of pressure ulcers.
- Ensure we have a skilled and educated workforce with a sound knowledge base of prevention of pressure ulcers and quality improvement methodology.



Patient Safety

Priority 3 - Management of Abnormal Results

- Appointed a clinical lead for the management of abnormal results & Reviewed Trust Investigation processes.
- Entered into a development partnership with 3M to use their “Follow-Up Finder” artificial intelligence technology to highlight the need for follow-up investigations indicated in free-text reports, and develop this functionality to identify gaps in the closed loop from requesting a test to taking appropriate actions for patient care, using the Trust’s Clinical Data Warehouse and Document Store.
- Until the viewer is fully tested and implemented, paper results will be produced as currently, ensuring at each stage that we are improving patient safety.

Clinical Effectiveness

Priority 4 – Modified Early Obstetrics Warning Score (MEOWS)

- Create IT solution for identification of a pregnant/recently pregnant woman outside Women's services.
- IT development of an electronic MEOWS system to replace NEWS/PEWS for this group of women.
- The IT solution is now ready to proceed to the testing phase prior to go live.

Clinical Effectiveness

Priority 5 - Enhancing capability in Quality Improvement (QI)

- 15-20 improvement teams, involving 83 staff, each focused on a piece of improvement work on the IHI 'Improvement for Teams' Programme.
- 30 coaches to support teams with their improvement work on the IHI 'Improvement Coach' programme.
- 30 senior leaders on the IHI 'Leading for Improvement' programme to provide the senior support for the improvement teams to effectively progress their improvement work.
- An evaluation framework has been developed utilising 'A Framework to Guide Evaluations of QI Capacity Building' (Mery et al, 2017). Evaluation started July 2021 and will run throughout the duration of the IHI capability-building programmes.

Patient Experience

Priority 6 – Mental Health in Young People

The Newcastle upon Tyne Hospitals NHS Foundation Trust

MDT Mental Health Strategy Group established, meet monthly, joined by CNTW bi-monthly.

Investment identified by We Can Talk Project.

Online We Can Talk Training well utilised by staff.

Parent information leaflets .

Improved communications with colleagues at CNTW and collaborative work ongoing.

Policy for Detaining Patients under the Mental Health Act now includes under 18 years

Evidence of involving patients and parents to learn from experience.

Ongoing review of environment in Paediatric Emergency to create a 'Safe space'.

Reciprocal Training arrangement between GNCH and CNTW

Evidence of a very effective MDT Support Hub including CNTW staff ahead of referral.

Patient Experience

Priority 7 - Reasonable adjustments for patients with suspected, or know learning disability

- Mortality reviews for patients with a Learning Disability who die whilst in Trust care are timely.
- Pathways continue to be developed for adult patients requiring MRI/CT under sedation.
- Learning Disability flags are visible for adults and children with a learning disability.
- Learning Disability Liaison team to commence bi-monthly forums Trustwide to share learning and examples of good practise.
- Organisation registered for Improvement Standards 2021/22.
- Review of pathways and e-learning to determine if any adaptions required.
- Work ongoing in conjunction with North East and Cumbria Learning Disability Network and Great North Children Hospital (GNCH) anaesthetics to incorporate theatre attendance within passport for Children & Young People (CYP).
- Review the role of 'Champion' commenced with a view to incorporating Autism.
- Collaborative work with University of Northumbria for development of simulation training.
- STOMP and STAMP project work resumed.
- Trust committed to 'Weigh to Go' and seek accreditation.
- Diamond Standards to be launched in March 2022

2022/23 Proposed Quality Priorities:

Patient Safety

- Reducing Infection – with a focus on Gram negative blood stream Infections
- Management of Abnormal Results

Clinical Effectiveness

- Enhancing capability in QI
- Identify Deterioration in pregnant women (MAU/MEOWS)
- Trust-wide Day Surgery Initiative

Patient Experience

- Ensure reasonable adjustments are made for patients with suspected or known Learning Disability and Learning Difficulty
- Improve services for children and young people with mental health issues.

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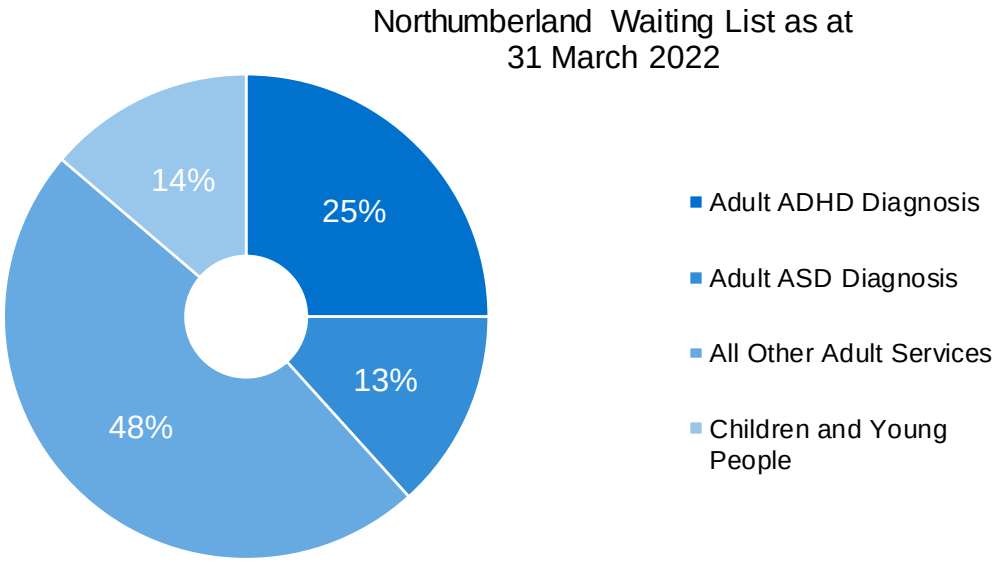
Quality Account 2022 (draft)
Launch of Consultation

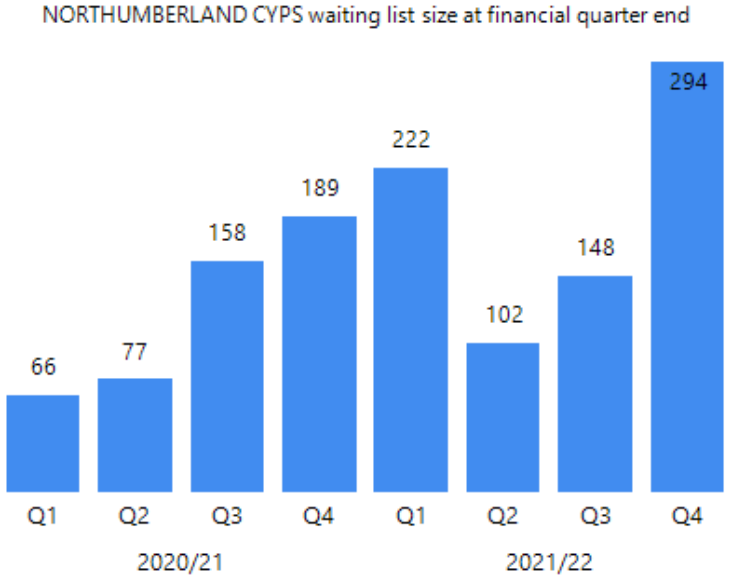
Lisa Quinn – Executive Director of Commissioning & Quality Assurance

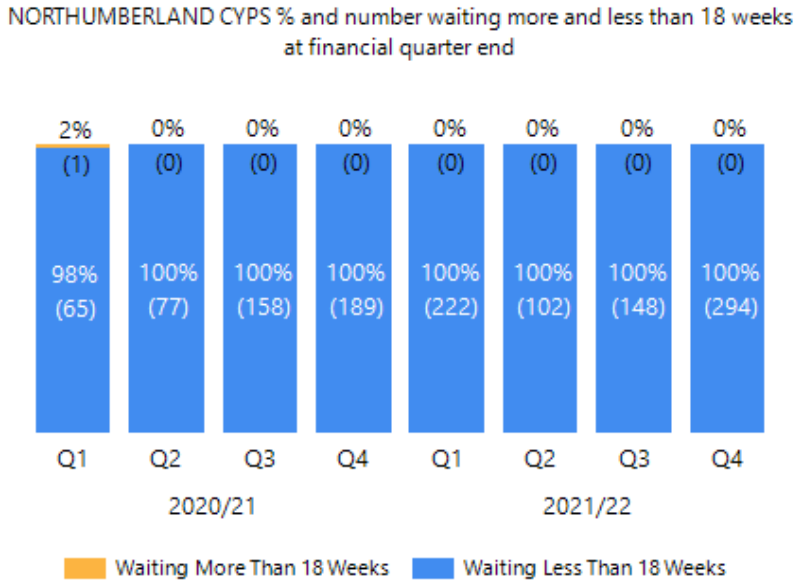
Paul Sams – Feedback & Outcomes Lead, Commissioning & Quality Assurance

Caring | Discovering | Growing | **Together**

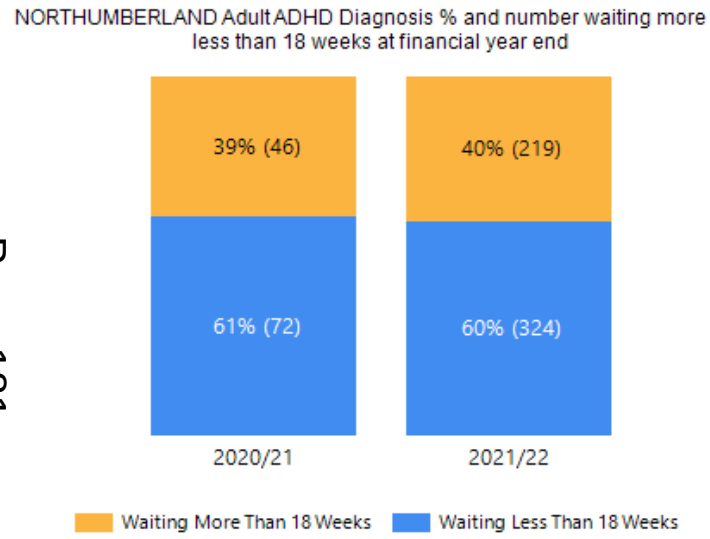
The year in numbers

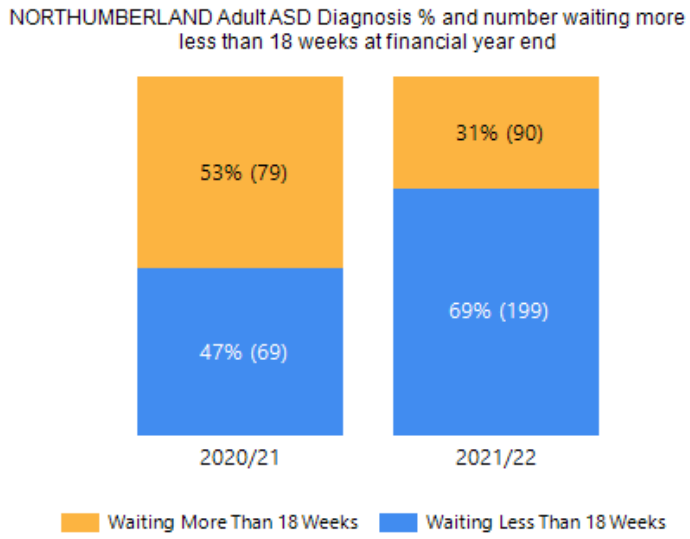


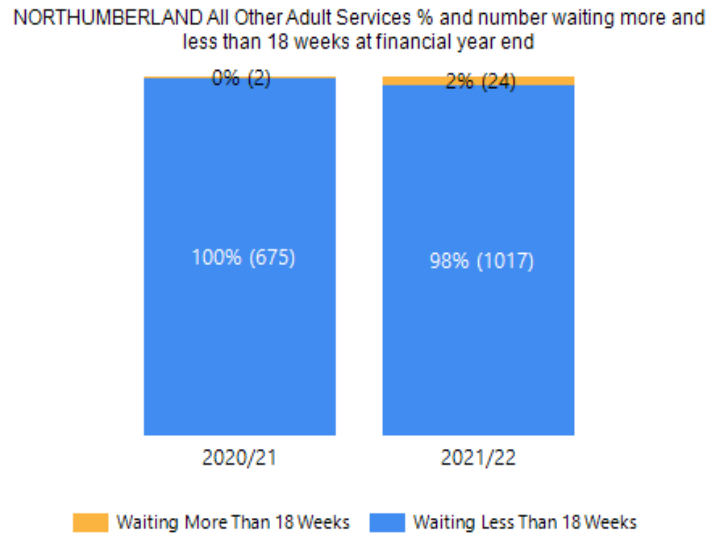




The year in numbers continued







Looking Back: Our Quality Priorities for Improvement during 2021-22

Our 2021-22 Quality Priorities and how we did:

- Coronavirus pressure on staffing and service delivery meant progress was made to support all Quality Priorities, however all have been given the status of 'Partially Completed'
- 3 of our Quality Priorities will continue into the new financial year with robust milestone plans
- Our new priority has been adapted (discussed in look forward section), however lots of baseline work done during the year is transferable to the new priority focus
- The progress across the year is set out in Section 2b of the Quality Account

Looking Ahead: Our Quality Priorities for Improvement in 2022-23

Consultation with service users, carers, staff and stakeholders helped us shape our Quality Priorities for the coming year.

Quality Priorities reflect the greatest pressures that the organisation is currently facing as well as what service users and carers have told us through feedback in the previous year.

We have agreed to continue with three of our Quality Priorities and adapt one to reflect a key theme evident in 3,422 'Points of You' feedback forms (November 1st 2020 to October 31st 2021)

Our 2022-23 Quality Priorities and how they fit with our Quality Goals

What to expect from our Quality Priorities in 2022-23

Quality Priority 1 – Improving the inpatient experience
Improving the inpatient experience by removing barriers to admission and discharge, and improving the therapeutic offer during treatment, through:

- Embedding new ways of working relating to admission and discharge process
- Improved inpatient ward quality standards
- Ensuring the purpose of admission and therapeutic offer add value to patient care

Quality Priority 2 – Improving waiting times
Improving waiting times in areas where demand currently exceeds capacity through:

- Working in partnership with Primary Care to enable better support for patients and carers sooner
- A review of Adult Autism Diagnostic Service (AADS) and Adult Attention Deficit Hyperactivity Disorder Service (AADHDS) pathways
- Gender – Increase capacity through recruitment and retention of staff, developing a community programme with peer support workers and the 3rd sector and develop a clinical model for a Primary Care Trans Health Service with key stakeholders (inc NHSE and GPs)

What to expect from our Quality Priorities in 2022-23 continued

Quality Priority 3 – Support service users and carers to be heard
Support service users and carers to be heard by improving processes and promoting person-centred approaches through:

- Promoting an inclusive approach to positive patient engagement and responsiveness
- Co-production of refreshed digital enablers for patients and carers
- Monitor and respond to feedback themes

Quality Priority 4 – Equality, Diversity, Inclusion and Human Rights (in relation to the core values of Fairness, Respect, Equality, Dignity and Autonomy (FREDA))
Implement a Trustwide approach working across Locality Groups. The Equality & Diversity Lead, CNTW Academy, Chaplaincy, Commissioning & Quality Assurance, Accessible Information Standard Group and Communications and Staff Networks through:

- Improving workforce Race Equality Standard metrics particularly in terms of 'appointment after shortlisting'
- Reducing disciplinary/grievance cases relating to bullying and harassment
- Reduction in restrictive practices through the EMPOWER program


ANY
QUESTIONS?

Northumberland County Council

Health and Wellbeing Overview and Scrutiny Committee

Work Programme and Monitoring Report 2022 - 2023

Chris Angus, Scrutiny Officer
01670 622604 - Chris.Angus@Northumberland.gov.uk

21 April 2022 - CA

TERMS OF REFERENCE

(a) To promote well-being and reduce health inequality, particularly in supporting those people who feel more vulnerable or are at risk.

(b) To discharge the functions conferred by the Local Government Act 2000 of reviewing and scrutinising matters relating to the planning, provision and operation of health services in Northumberland.

(c) To take a holistic view of health in promoting the social, environmental and economic well-being of local people.

(d) To act as a consultee as required by the relevant regulations in respect of those matters on which local NHS bodies must consult the Committee.

(e) To monitor, review and make recommendations about:

- Adult Care and Social Services
- Adults Safeguarding
- Welfare of Vulnerable People
- Independent Living and Supported Housing
- Carers Well Being
- Mental Health and Emotional Well Being
- Financial Inclusion and Fuel Poverty
- Adult Health Services
- Healthy Eating and Physical Activity
- Smoking Cessation
- Alcohol and Drugs Misuse
- Community Engagement and Empowerment
- Social Inclusion
- Equalities, Diversity and Community Cohesion.

ISSUES TO BE SCHEDULED/CONSIDERED

Regular updates: Updates on implications of legislation: As required / Minutes of Health and Wellbeing Board / notes of the Primary Care Applications Working Party
Care Quality Accounts/ Ambulance response times

To be listed: Vaping/E-Cigarettes
Long COIVD
COIVD-19 (Endemic)

Themed scrutiny:
Other scrutiny:

Northumberland County Council
Health and Wellbeing Overview and Scrutiny Committee
Work Programme 2022 - 2023

31 May 2022		
	Progress Report 0- 19 S75 Partnership Agreement with Harrogate and District NHS Foundation Trust Adult Social Care Self-Assessment following the dissolution of the Partnership with NHCT. Restructure of Adult Social Care	Progress Report 0- 19 S75 Partnership Agreement with Harrogate and District NHS Foundation Trust A review of services following the dissolution of the Partnership with NHCT. The Committee had asked that an updated be provided 9-12 months after the dissolution.
July 2022		
	Extra Care and Supported Housing Strategy Complaints Annual Report 2021-22: Adult Social Care and Continuing Health Care Services	An update on the strategy for the development of housing schemes designed to enable people to live independently, approved by Cabinet in 2018. Annual report on complaints and lessons learnt within Adult's social care. Committee to identify any further areas for scrutiny.
6 September 2022		
	HealthWatch Northumberland Annual Report	Annual report from HealthWatch Northumberland.
4 October 2022		

1 November 2022		
6 December 2022		
	Director of Public Health Annual Report 2021 Specialist Dementia Service	Annual report from the Director of Public Health. An update on the implementation of a Specialist Dementia Service. Decision taken by Cabinet in April 22.
3 January 2023		
	Northumberland Safeguarding Adults Annual Reports 2021-22	To provide an overview of the work carried out under the multiagency arrangements for Safeguarding Adults.
7 February 2023		
7 March 2023		
4 April 2023		
	NHCT Quality Accounts NEAS Quality Accounts	Annual report on the quality of service. The Committee is requested to receive and comment on the presentations from each Trust, and also agree to submit a formal response to each Trust. Annual report on the quality of service. The Committee is requested to receive and comment on the presentations from

		each Trust, and also agree to submit a formal response to each Trust.
2 May 2023		
	CNTW Quality Accounts	Annual report on the quality of service. The Committee is requested to receive and comment on the presentations from each Trust, and also agree to submit a formal response to each Trust.
	NUTH Quality Accounts	Annual report on the quality of service. The Committee is requested to receive and comment on the presentations from each Trust, and also agree to submit a formal response to each Trust.

Northumberland County Council
Health and Wellbeing Overview and Scrutiny Committee Monitoring Report 2022-2023

Ref	Date	Report	Decision	Outcome
1				

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