The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

QUALITY ACCOUNT 2022/2023

(Draft for Consultation April 2023)

Unconditionally registered with the
CQC since April 2010

CONTENTS

PART 1

CHIEF EXECUTIVE'S STATEMENT

Thank you for taking the time to read our 2022/2023 Quality Account.

The Quality Account sets out our key quality and patient safety priorities for 2023/2024 and demonstrates how we have continued to deliver high quality, effective care for patients during the last year.

It has been another challenging year for the NHS as we continue to recover from the pandemic, as well as facing the impact of unprecedented industrial action.

Despite this, I know that everyone across the organisation has worked hard to focus on providing the very best care for our patients.

Thanks to this effort and dedication, we have seen a 75% reduction in the number of patients who were left waiting over 78 weeks for treatment as a result of the pandemic. We have also significantly reduced the number of people who have waited for over 104 weeks to 21 people who are awaiting the most complex types of surgery. Crucially, we have also seen a 33% reduction in patients waiting more than 62 days for cancer treatment.

Altogether we have supported 1.1 million outpatient appointments, and 245,000 people have been treated through our emergency care pathways.

We opened our new Day Treatment Centre, recruiting around 200 staff and the team has already delivered more than 2,600 additional procedures, making us one of the biggest providers of day surgery in the NHS. We've invested in new equipment, like our new endoscopy room at the RVI and developed new ways of working, such as our new surgical assessment unit – both of which have made a positive impact on patient flow and treatment pathways.

We've also focussed on our staff because we know that staff who feel cared for are able, in turn, to offer better care. We've kept people safe by providing the highest number of both flu and COVID-19 vaccination of any of the larger NHS organisations; opened our new 24-hour staff restaurant at the RVI; and by working with our dedicated chaplaincy team, catering team and Newcastle Hospitals Charity, we've provided 'too good to throw fridges' and meal cards through the 'Helping Hands' scheme and delivered practical support through direct and confidential access to Citizens Advice to help them navigate the cost of living crisis.

Importantly, we have also continued to learn, innovate and create new knowledge through development and research. This year alone we have introduced new gene treatments for Duchenne Muscular Dystrophy, trialled new stroke treatments using stem cell therapy and pioneered new methods of assessing organ quality using AI. The future of healthcare is being developed here in Newcastle by our dedicated experts and that has a positive impact on the health of those living in the North East.

Later this year, the NHS will celebrate its 75th birthday which is particularly poignant given the difficulties we have lived through in recent years, and as we move forward, it's important to remember that we have a lot to be proud of.

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 2023

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’

Over the last year COVID-19 has continued to impact on operations, however not to the levels experienced during the first two years of the pandemic.

COVID-19 continues to impact in waves of surge every two to three months, with peak numbers reaching around 70 inpatients at any one time, some poorly because of the COVID-19 infection and some who are in for other reasons and happen to have the infection at the time of their admission.

Operationally, the teams continue to manage the spread of infection as they do with other infectious diseases such as Influenza and Norovirus and aim to keep spread and resulting bed closures to a minimum.

Whilst COVID-19 is now just a compounding pressure on day-to-day operations, the impact and scale of the recovery in response to the pandemic is much more profound and our backlogs and recovery have remained the focus throughout 2022/2023.

Endoscopy

Over the past 12 months Endoscopy has continued to build on the transformation projects started in 2021/2022 and is developing digital maturity. The unit has developed a real time digital dashboard that encompasses all aspects of endoscopy delivery, including referral trends, waiting times for procedures and performance against key performance indicators. The dashboard has been key in the expansion of the unit and the Trust has supported the opening of a seventh Endoscopy room. The increase in capacity and ability to flex capacity to meet demands has been a key factor in the unit recovering post COVID-19. Currently improvements in waiting times have resulted in patients waiting less than two weeks for a cancer test and over 80% of routine referrals are receiving a scope within six weeks.

The unit has fully implemented the Medilogik Endoscopy Management System for reporting. This system is compliant with the National Endoscopy Database system and brings the trust up to date with current national reporting requirements.

Continuing the digital journey, the team have introduced a digital pre-assessment platform. This app is used to screen all patients waiting to have an endoscopy and allows the team to identify those patients who need greater pre-assessment support prior to having an endoscopy performed which helps drive up quality and safety for endoscopy procedures.

In the past 12 months, the unit has also been awarded status as a ‘North East Endoscopy Training Academy Immersion Site’ which delivers accelerated training for medics and non-medics across the region ensuring that as a region we are able to meet future work force challenges. This also secures our status as one of the leading endoscopy training units regionally and nationally.

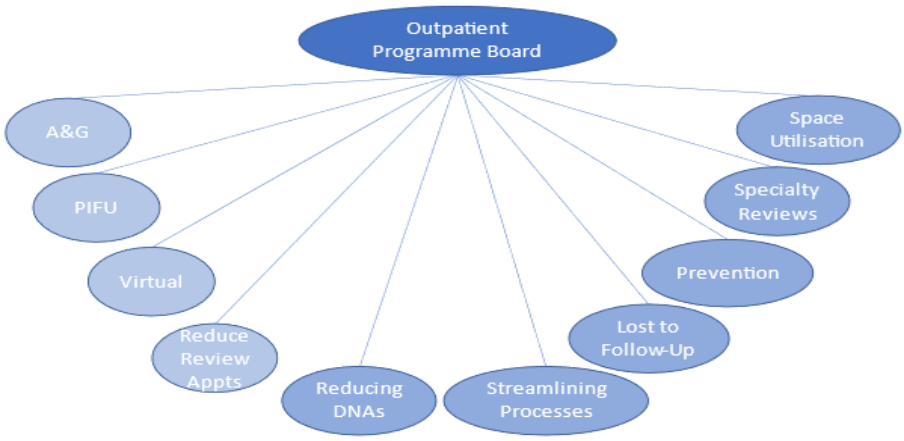
More broadly within the department, there continues to be a focus on quality and innovation with projects in the past 12 months that have delivered within the area of Green Endoscopy: piloting and introducing a new sharps bin which are preferred, greener and cheaper - the results have been shared and shortlisted as a finalist at this year’s Q Factor awards. The department also has at least four National Institute for

Health and Care Research (NIHR) portfolio studies actively recruiting and has published 16 papers in peer reviewed journals over the past 12 months, relating to endoscopy research within the department.

Outpatient Improvement Programme

Patient care delivery within the Newcastle Hospitals 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. Having emerged from the pandemic several inter-connected workstreams have been established as depicted below:



Several high-priority initiatives will continue into 2023/2024, supporting the NHS Operational Plan requirement to reduce Outpatient Follow-Up attendances by 25%.

Patient Initiated Follow-Up (PIFU)

The Patient Initiated Follow-Up (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' 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, and this model has now been implemented in a wide range of specialties across the Trust. At the end of March 2023 there were nearly 10,000 patients on an active PIFU pathway with Dermatology, Ear Nose and Throat and Physiotherapy services leading the way.

There is an ongoing programme of engagement events with clinical teams to further highlight the potential benefits of PIFU to both patients and services in releasing capacity to deliver a greater proportion of new attendances.

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.

Robust testing of the solution has taken place within Ear, Nose and Throat Services with the expectation that a fully working solution is available to roll-out across clinical services in 2023/2024.

Day Treatment Centre (DTC)

An exciting new development, part of Newcastle Hospitals' ambitious day case improvement programme, the Day Treatment Centre (DTC), is a fast-track project which was successfully completed in ten months and opened to patients on 30 September 2022.

The centre was purpose-built to ensure day case operations and procedures could be delivered efficiently, to improve the experience of patients and maximise the number of people that can be treated.

With four state-of-the-art theatres, an admission and recovery area, it provides additional capacity for thousands of less complex procedures in: musculoskeletal health, urology, general surgery, plastic surgery, neurology, and cardiology.

The centre has allowed us to tackle waiting list backlogs caused by the pandemic and many patients are being transferred across from the main hospital theatres which, in turn, frees them up to carry out 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.

At the end of the financial year, over 2300 patients had received treatment in the centre with patients providing excellent feedback on their experience.

PART 2

QUALITY PRIORITIES FOR IMPROVEMENT 2023/2024

Following discussion with the Board of Directors, the Council of Governors, patient representatives, staff and public, the following priorities for 2023/2024 have been agreed. A public consultation event was held in January 2023 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)/Clostridium difficile infections.

Why have we chosen this?

GNBSI constitute the most common cause of sepsis nationwide with associated high mortality. Proportionally, at this trust, the main source of infection is urinary tract infections (UTI), mostly catheter associated, line infections and hepatobiliary. An integrated approach with multi-disciplinary team (MDT) engagement across the whole patient journey, focus on antibiotic stewardship, early identification of risks, surveillance and timely intervention form the pillars of our reduction strategies. Additional emphasis on Antimicrobial Resistance (AMR) reduction, with high rates of resistance in workhorse antibiotics for gram negative infections. The GNBSI Steering Group and Antimicrobial Steering Group (AMSG) continue to review reduction strategies.

MSSA bacteraemia can cause significant harm. These are most associated with lines, indwelling devices and soft tissue infections. Achieving excellent standards of care and improving practice is essential to reduce these infections and complications in line with harm free care.

In addition to COVID-19, there is a surge in Influenza and Respiratory Syncytial Virus (RSV) with significant respiratory infections requiring hospitalisation/intensive therapy unit (ITU) admission and the potential to cause outbreaks.

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 and local objectives.

What we aim to achieve?

- National ambition to reduce GNBSI with an internal aim of a 10% year-on-year reduction.
- Targeted reduction in broad spectrum antibiotic use namely Tazocin
- Internal 10% year-on-year reduction in MSSA bacteraemia
- Prevent transmission of HCAI COVID-19 and other preventable respiratory infections in patients and staff.
- Sustained 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 national framework. Board level leadership and commitment to reduce the incidence of HCAI.
- Improve diagnosis and management of sepsis, collaborative working with Clinical Director (CD) for sepsis and specialist nurses.
- Quality improvement (QI) 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
    - Early recognition and management of suspected infective diarrhoea
    - Ward monitoring of device compliance for peripheral intravenous (IV) and urinary catheters
    - Early recognition and management of suspected infective diarrhoea
    - Insertion and ongoing care of invasive and prosthetic devices
    - Octenisan compliance.
- Directorate-level Serious Infection Review Meetings (SIRM) to share and support action plans to monitor/reduce HCAI and adherence to best practice. Post infection reviews for HCAI with preventable causes and timely review of HCAI deaths to help identify areas of concern and address key issues.
- Working with partner organisations/Integrated Care Board (ICB) to reduce HCAI/AMR for North East North Cumbria (NENC) and wider Health Care Economy.

How will we measure success?

- By monitoring compliance with the Trust's assurance frameworks.
- Continuous monitoring of HCAI infections and deaths.
- Sharing data with directorates whilst focusing on best practice and learning from clinical investigation of mandatory reportable organisms.
- Continue to report MSSA, GNBSI and C. difficile infections monthly, internally, and nationally.

Where will we report this to?

- Infection Prevention and Control Committee (IPCC)
- Infection Prevention and Control Operational Group
- Patient Safety Group
- Trust Board
- The public via the Integrated Board Report
- UK Health Security Agency / ICB NENC
- Health Protection Assurance Board
- NHS England (NHSE)/NHS Improvement (NHSI).

Priority 2 – Management of Abnormal Results

Why have we chosen this?

The management of clinical investigations is a major patient safety issue in all healthcare systems. Nationwide, there is evidence of serious harm caused by unintentional delays in clinical investigations being undertaken, acknowledged, and endorsed, resulting in delays in clinical care, treatment, and follow-up.

What we aim to achieve?

We aim to be a world leader by improving patient safety through ensuring that appropriately ordered clinical investigations are undertaken, acknowledged, and endorsed, resulting in timely clinical care, treatment, and follow-up. Improving the management of abnormal results will require successful completion of the Closed Loop Investigations and Future Orders projects, which aim to ensure that all clinically

appropriate investigation requests are fulfilled; results are returned to the correct consultant; and appropriate action is taken in response to critical results.

How will we achieve this?

- In the process of ordering radiology and laboratory investigations, users of the Trust's Electronic Health Record (EHR), Cerner Millennium, must select the correct lead clinician from a well-maintained list of recognised consultants with patient responsibility.
- Critical results must be returned to the specified consultant's EHR message centre.
- Where the lead clinician is not available for whatever reason, critical results must be acknowledged and endorsed by appropriate members of the consultant's team.

How will we measure success?

- A reduction in the incidence of serious harm arising from unintentional delays in:
    - clinically appropriate investigations being undertaken in response to electronic orders; and/or
    - acknowledgement and/or endorsement of electronically issued critical results; and/or
    - clinical care, treatment and/or follow-up in response to electronically issued critical results.
- The proportion of critical results issued to the EHR that have been acknowledged and endorsed by the lead clinician specified at the time of order entry and/or appropriate members of the consultant's team.
- A reduction in time between critical results becoming available in the EHR message centre and clinical care and treatment being undertaken and/or follow-up arranged.

Where will we report this to?

- Clinical Policy Group.
- Trust Board.

Priority 3 – Implementation of the National Patient Safety Strategy & Patient Safety Incident Response Framework

Why have we chosen this?

The provision of healthcare globally leads to avoidable harm and despite decades of dedicated work, inadvertent harm continues across all providers, with the same types of patient safety incidents occurring time and time again. The NHS Patient Safety Strategy outlines the national ambition for transformational change to continuously improve the safety of patients, by building on and improving patient safety culture and patient safety systems. Aligning to this national ambition is essential for the Trust to provide meaningful patient safety improvement.

What we aim to achieve?

- To transition to Phase 1 of the Trust Patient Safety Incident Response Framework (PSIRF) implementation by Autumn 2023, moving away from the Serious Incident Framework, and defining how we will respond to safety events differently.
- Staff will be skilled and equipped to respond to safety events, to provide opportunities for learning and improvement.
- Meaningful patient and staff involvement, to provide challenge and a positive impact across the wide patient safety agenda.

How will we achieve this?

- A PSIRF Programme Lead and Patient Safety Strategy CD will be recruited to steer implementation and work with new Clinical Boards to define governance mechanisms for effective patient safety incident response.
- Work with stakeholders to complete the Trust's Incident Response Plan (PSIRP) and policy, and outline priorities for improvement, incident types requiring responses and improvement programmes.
- Collaborate with the ICB and agree oversight of the Trust's PSIRP and how new systems of learning and improvement will be measured in Phase 1 to demonstrate robustness.
- Clearly defining and agreeing key roles of 'response leads' and 'engagement leads' at Clinical Board level.
- Increase staff capacity and capability in PSIRF incident response methodology, including in-depth system investigation, rapid review, in-depth incident investigation, thematic review, audit.
- Introducing four patient safety partners to work alongside staff and attend key patient safety related governance committees, supported by patient experience and patient safety leads.

How will we measure success?

- Completion of Trust PSIRP, following stakeholder and ICB agreement.
- Commencement of Phase 1 of PSIRF implementation by autumn 2023.
- Agreement of key response and engagement roles and governance mechanisms at Clinical Board level.
- Able to demonstrate increasing staff capability in incident response methodology, against a training needs analysis.
- Patient safety partners in post, supported, and attending patient safety committees.

Where will we report this to?

- Progress will be reported to Board via the Quality Committee.

CLINICAL EFFECTIVENESS

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

Why have we chosen this?

- The need for early recognition of the deteriorating pregnant woman has been highlighted by Mothers and Babies, Reducing Risk by Audit and Confidential Enquiry (MBRRACE) and the Ockenden Report.
- A formal triage process on the Maternity Assessment Unit (MAU) will enable and facilitate rapid review and prioritisation of care based on individual clinical need.

What we aim to achieve?

- To improve early detection and escalation of women at risk of deterioration on MAU to reduce the likelihood of avoidable harm to mothers and babies.
- The Institute for Healthcare Improvement (IHI) project on 'Identification and management of the deteriorating pregnant woman within the MAU' is a comprehensive QI project and significant changes have already been made. The next step is to introduce formal, objective triage using a bespoke platform within BadgerNet (electronic maternity system) by April 2023.

How will we achieve this?

- Further development of day care.
- Increase in midwifery staffing to support implementation of triage on MAU.
- Clarification of suitability of women for assessment in MAU/day care/antenatal clinic/home blood pressure monitoring.
- This will enable implementation of Birmingham Symptom Specific Obstetric Triage (BSSOTS), a formal objective triage system already embedded in BadgerNet. Preparatory work is on-going including confirmation of licence arrangements, visits to other units currently using this triage system and minor estates changes.
- A Band 7 Midwife (new post) will lead on the training/education needed for the Directorate.

How will we measure success?

- Audit of the percentage of women having formal triage by a designated member of staff trained in triage, on arrival at the MAU.
    - March 2023 - pre-implementation of BSSOTS snapshot audit
    - April 2023 - Following BSSOTS implementation.

Where will we report this to?

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

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

Why have we chosen this?

In recent years there have been several maternal deaths in England where the lack of Modified Early Obstetric Warning Score (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 monitored using the traditional model of National Early Warning System (NEWS) monitoring for non-

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

- 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 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?

IT development of an electronic MEOWs system to replace NEWS for this group of women.

How will we measure success?

- Deployment of MEOWS trust-wide.
- Audit of compliance with MEOWS.

Where will we report this to?

- Women's Service Quality and Safety Forum.
- Deteriorating Patients Group.
- Trust Board.

Priority 5 – Best Interests Decisions/Mental Capacity Assessment (MCA) and Deprivation of Liberty Safeguards (DoLS)

Why have we chosen this?

Completion of mental capacity assessments and best interest decisions when appropriate will provide assurance that staff are providing high quality care that meets individual patient needs and assurance to the organisation. The completion of appropriate documentation and staff understanding of where documents are stored on the electronic system will support this priority.

Staff must also be aware of the process of Deprivation of Liberty Safeguards (DoLS), what this means for the patient and where to retrieve and store the appropriate information.

What we aim to achieve?

- Ensure staff understand the need for mental capacity assessments and where and how to record these assessments.

- Ensure staff recognise when best interest discussions are needed and where and how to document these discussions.
- Ensure staff understand the process for requesting and completing Urgent DoLS authorisations.

How will we achieve this?

- Trust-wide ‘Care for me, with me’ programme.
- E-learning mandatory training available to all clinical staff.
- Additional educational sessions implemented.
- Updated electronic mental capacity assessment (MCA) and best interests decision form.

How will we measure success?

- Compliance with training
- Audit of notes.

Where will we report this to?

- MCA Trust Steering Group
- Safeguarding Committee.

PATIENT EXPERIENCE

Priority 6 – Ensure reasonable adjustments are in place for patients with suspected, or known, Learning Disability &/or Autism.

Why have we chosen this?

We are committed to ensuring patients with a learning disability and or 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.

Under the Equality Act 2010, the Trust must ensure services are accessible to children, young people, and adults with learning disabilities as well as everybody else. Reasonable adjustments can mean alterations to buildings by providing, wide doors and ramps, but may also mean changes to appointment times, duration and location. Policies, procedures, and staff training should identify the requirement for reasonable adjustments to ensure that services work equally well for people with learning disabilities.

What we aim to achieve?

- Ensure all staff are aware of where to document reasonable adjustments.
- Ensure staff are aware of the need to contact the Learning Disability Liaison Team if they have a patient with a confirmed learning disability who does not have an electronic alert flag and or a health and care passport.
- Ensure all clinical staff are compliant with the Diamond Standard training.

How will we achieve this?

- Trust wide improvement programme ‘Care for me, with me’.
- Training sessions for staff on the documentation of reasonable adjustments
- Continue to review the skill mix within the team and greater visibility in clinical areas.
- Re-introduce the role of the Learning Disability Champion.
- Promote the e-learning Diamond Standard training package.
- Participate in the NENC Learning Disability Network pilots for;
    - ‘Passport’ app
    - Reasonable adjustment posters with QR code
    - Implementation of care bags.

How will we measure success?

- Regular audits of patient records.
- Review of training compliance.
- Measure the success of the app, posters, and care bags as part of the NENC Learning Disability Network pilot.

Where will we report this to?

- Safeguarding Committee.

Priority 7 – Improve services in Emergency Department (ED) for children, young people, and adults with mental health issues.

Why have we chosen this?

According to ‘Mental Health of children and young people in England 2022 – wave 3 follow up to the 2017 survey’;

- In 2022 18% of children aged 7-16 years old and 22% of young people aged 17-24 years old had a probable mental disorder.
- In children aged 7-16 years old, rates rose from 1 in 9 (12.1%) in 2017 to 1 in 6 in 2020.
- 1 in 8 (12.6%) 11-16 years old social media users reported that they had been bullied online. This was more than 1 in 4 (29.4%) among those with a probable mental disorder.
- 11-16 years old social media users with a probable mental disorder were less likely to report feeling safe online (48.4%) than those unlikely to have a disorder (66.5%).

Throughout 2021/2022 there has been significant pressure on specialist mental health Tier 4 inpatient services across the North East and Yorkshire Region. 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.

The overarching purpose of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Mental Healthcare in Young People and Young Adults report 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 to assure that we identify gaps, areas of good practice and plan to improve the care we provide for these patients.

What we aim to achieve?

- Improve the pathway and timeliness of access to appropriate services for all CYP presenting acutely.
- Continue to promote the We Can Talk training across paediatric and adult areas.
- Improve the environment within the emergency department to ensure safety and well-being.

How will we achieve this?

- Clinical Manager appointed by Cumbria, Northumberland, Tyne and Wear (CNTW) to lead on the CYP Service liaison proposal. This work will commence April 2023.
- The We Can Talk programme leads visiting the Trust in April for a day to further promote the training.
- Ensure the 'We Can Talk in Private' QI project is fully implemented in adult ED; the project aims to allow patients to indicate they wish to speak in private by holding a card up.
- Ensure the welcoming pack for CYP QI project is fully implemented.
- Progress to improve the environment to better support CYP presenting to the ED.

How will we measure success?

- More efficient pathways and reduced waiting times to access appropriate services.
- Positive impact of training, increased numbers of staff and disciplines trained.
- 'Safe' area configured in the Paediatric ED.

Where will we report this to?

- Clinical Outcomes & Effectiveness Group.
- Trust Board.

Priority 8 – Embed a consistent approach to transition young people from child to adult services.

Why have we chosen this?

Each year over 6,000 13-17 year olds are admitted to our trust with over 11,000 attending outpatient services. The young people within the Great North Children's Hospital (GNCH) are often cared for by multiple teams as rare conditions overlap into a variety of specialties. Co-ordination and preparation for transfer into adult care, including the pathways to adult care can often be inconsistent. Their care may also be transferred to a different area and can be stepped down to their local adult hospital or General Practitioner (GP) depending on their diagnosis.

There is increasing evidence that young people with chronic health conditions are at risk of being lost in the system. They can fail to engage when they move from child to adult services resulting in poor health outcomes for their conditions. Transitional care is a process rather than an event and can facilitate the move between these services.

What we aim to achieve?

- To facilitate and embed a coordinated approach for transition amongst specialist conditions and bespoke groups including mental health, safeguarding, learning disability/difficulty.
- To improve decision making to provide age and developmentally appropriate health care particularly outside paediatric services, for example in the adult ED.
- Provide a dedicated outreach support for young people managed outside paediatric areas (youth worker role).
- To allow patient /family experience feedback.
- To promote a culture that the voice of the child/young person is recognised, valued, and acted upon across the organisation.
- In line with national guidelines the project will support, facilitate standards and principles for the management of young people in our care.

How will we achieve this?

- Funding has been agreed for a project team for 23 months to:
    - Embed the principles of transition across the organisation.
    - Develop bespoke pathways for more complex groups of patients.
    - Ensure youth worker oversight of any patient under 18 years old outside paediatric areas.
    - Recruit a data manager.

How will we measure success?

- Evaluation at the end of the project – patient feedback on their experience, staff feedback surrounding improved knowledge.
- Measuring clinic attendance.
- Benchmark against the National Collaborative Framework.

Where will we report this to?

- Clinical Outcomes & Effectiveness Group.
- Trust Board.

COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) INDICATORS

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 various Commissioning groups. Listed below are the quality and/or innovation projects which were agreed with the Commissioners for 2023/2024.

2023/2024 CQUIN Indicators

2023/2024 - Specialised Commissioners, NHS England - CQUIN Schemes, Acute Hospital.	
CQUIN 1	Flu vaccinations for frontline healthcare workers.
CQUIN 8	Achievement of revascularisation standards for lower limb Ischaemia.
CQUIN 9	Achieving progress towards Hepatitis C elimination within lead Hepatitis centres.
CQUIN 10	Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway.
CQUIN 11	Achieving high quality Shared Decision-Making conversations in specific specialised pathways to support recovery.

2023/2024 - Local Commissioning Integrated Care Board (ICB) - CQUIN Schemes, Acute Hospital.	
CQUIN 1	Flu vaccinations for frontline healthcare workers.
CQUIN 3	Compliance with timed diagnostic pathways for cancer services.
CQUIN 5	Identification and response to frailty in emergency departments.
CQUIN 6	Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service.
CQUIN 7	Recording of and response to NEWS2 score for unplanned critical care admissions.

2023/2024 - Local Commissioning Integrated Care Board (ICB) - CQUIN Schemes, Community	
CQUIN 1	Flu vaccinations for frontline healthcare workers.
CQUIN 13	Assessment, diagnosis, and treatment of lower leg wounds.

STATEMENT OF ASSURANCE FROM THE BOARD

The Quality Account is an annual account that providers of NHS services must publish to inform the public of the quality of the services they provide, in addition to sharing useful information for current and future patients. It also supports us to focus on and to be completely open about service quality and assists us to develop and continuously improve. This report details the approach that we take to improving quality and safety at Newcastle Hospitals and an assessment on the quality of care our patients received in 2022/2023. There are some elements within the report that are mandatory. The following section provides explanation of our quality governance arrangements that provide assurance to the Board.

Quality governance arrangements

The quality governance arrangements at Newcastle Hospitals ensure that key quality indicators and reports are regularly reviewed by clinical teams and by committees up to and including the Board of Directors. The Board of Directors receive a regular Integrated Board Report that includes quality, people, and finance sections.

The Quality Committee is a sub-committee of the Board of Directors which provides them with assurance regarding patient safety, clinical outcomes and effectiveness, compliance and assurance, patient experience and engagement and clinical research.

The Quality Committee is a subcommittee of the Board
The committee is chaired by a non-executive director and has met six times this year.
Membership
• Non-Executive Directors (chair and vice chair) • Medical Director • Executive Chief Nurse • Chief Operating Officer • Director of Quality and Effectiveness • Associate Medical Director, Patient Safety and Quality • Deputy Chief Nurse.

The Quality Committee is responsible for providing assurance to the Board of Directors for the following;

Some examples of how the Quality Committee undertakes its role include;

- Following the May 2019 inspection, the CQC made a small number of recommendations which were categorised as either “must do” or “should do”. The Quality Committee has overseen and supported the internal action plan to complete and close these recommendations.
- In January 2023 the final action in diagnostic imaging, to address waiting times and reporting times was closed. The Quality Committee has supported a business case for expansion of staffing in the Directorate of Radiology to increase the use of both the CT and MRI scanners to operate 12 hours a day, 7 days a week. This has allowed the department to over recruit to ensure that capacity is maintained.
- The Quality Committee supports leadership walkabouts that are undertaken by Executive, Non-Executive and members of the senior trust management team throughout the organisation. These leadership walkabouts enhance links between senior leaders and front-line staff and raise awareness of front-line issues and support the visibility and accessibility of senior leaders within the organisation. Following removal of pandemic restrictions leadership walkabouts were reinstated and a total of 34 leadership walkabouts have been undertaken. This has ensured that feedback has been shared directly from front line staff to the Quality Committee. This direct feedback has provided assurance that frontline staff felt positive about the safe care they are providing to patients.
- The Quality Committee has instigated a deep dives process in order to provide a deeper evaluation in some specific areas of the Trust. These deep dives aim to provide assurance and opportunities for the Non-Executive Directors (NEDS) to discuss key issues in the Trust. In October 2022 following the Ockenden report a deep dive was conducted in the Maternity department. This deep dive discussion focused on their implementation of a digital maternity solution called ‘BadgerNet’.
- The delivery of continuous quality improvement was the focus of a Quality Committee meeting in November 2022 when Newcastle Improvement presented an update. This update highlighted how the Quality Committee continues to support the development of improvement capability, improvement initiatives and sharing improvement stories.
- To improve assurance to the Board an additional agenda item was added to the Quality Committee in January 2023 to highlight issues for escalation strengthening the governance process.
- The Trust Complaints Panel is chaired by the Executive Chief Nurse and reports directly to the Patient Experience and Engagement Group. The Patient Experience and Engagement Group meets monthly, evaluating Trust wide themes for complaints in addition to focusing on complaints received by individual directorates. The important themes are then highlighted to the Quality Committee.
- The Clinical Assurance Tool (CAT) provides an overview of performance for each ward and directorate. It is one way the Trust ensures the highest standards of patient care are being met. A monthly audit is conducted including cleanliness and clinical standards and this is presented to the Quality Committee as part of the Chief Nurse update.

PART 3

REVIEW OF QUALITY PERFORMANCE 2022/2023

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). Most 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)/Clostridium difficile Infections.

Why we chose this?

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

MSSA bacteraemia (Bloodstream Infections – BSI) can cause significant harm. These are most 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.

Gram-negative Bloodstream Infections (GNBSI) constitute the most common cause of sepsis nationwide. Proportionally, at the Trust, the main sources of infection is UTI, mostly catheter associated, and 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 aimed 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.
- Reduction in C. difficile infections in line with national trajectory.

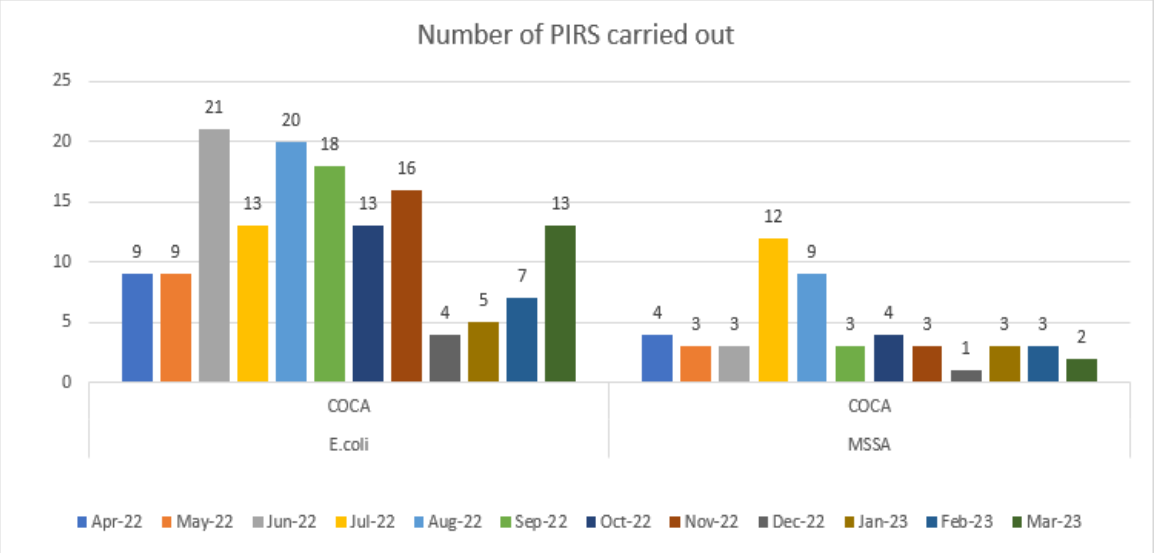
What we achieved?

- Integrated COVID-19 guidance into management of respiratory infections and effectively controlled high rates of infections including respiratory (flu/Invasive group A streptococcal disease/RSV) and diarrhoeal illnesses (Norovirus) to maintain patient safety and optimise patient flow.
- To the end of March 2023, the Trust has reported:
    - Two MRSA bacteraemias.
    - We achieved the internal 10% reduction trajectory for MSSA bacteraemia. There is no national threshold for MSSA.
    - All GNBSI rates were above internal and national trajectories except for Klebsiella which was 17 cases under the national threshold of no more than 159 cases.
    - C. difficile rates were above both national threshold and local 10% reduction trajectory.

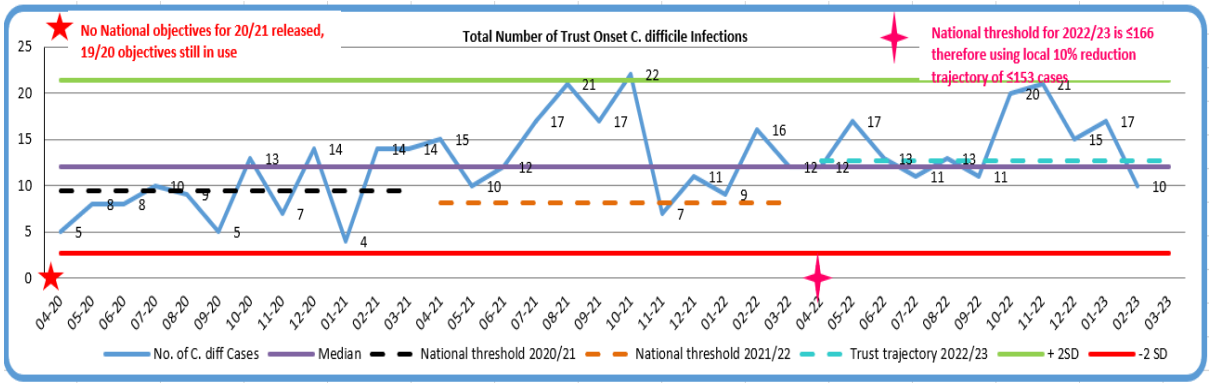
The Trust has not met local and national trajectories for most HCAI due to numerous contributory factors including operational and staffing pressures. This is also reflected in the national HCAI rates. IPC have implemented several strategies to improve these rates.

How we measured success?

- "Gloves off" campaign is a focussed work on correct Personal Protective Equipment (PPE) usage and effective hand hygiene. We achieved 30% glove reduction at the start of the campaign and over the summer months. Glove use increased sharply in several areas across the organisation during the winter months. This correlated with the high number of outbreaks at Freeman Hospital resulting in the increase of 33% of glove use by February 2023. In contrast, Royal Victoria Infirmary (RVI) and community sites glove use reduced to 35% by February 2023. Overall current glove reduction is at 2%. A refresh of the campaign is in progress.
- BSI reduction initiatives to improve compliance with:
    - Skin decolonisation (Octenisan) compliance: The Cardiothoracic Services initiative has demonstrated the effectiveness of focussed initiatives leading to MSSA reduction.
    - IV device management: Improved device management in Cardiothoracic Services.
    - Urinary catheter: Improved practice in Urology/Renal Services and Surgical Services and ED/assessment suite initiatives ongoing. "Trolley dashes" and enhanced education delivered across the Trust. UTI/catheter associated urinary tract infection initiatives ongoing and successful.
    - Northern Cancer Care Centre line care initiative: Implemented and well embedded into clinical practice.
    - GNBSI reduction in Liver Medicine: Antibiotic management for percutaneous transhepatic cholangiography insertion revised and implemented.
    - Implemented Post Infection Reviews for community acquired BSI (E. coli and MSSA)
    - Freeman paediatrics demonstrated a sustained reduction in *Pseudomonas aeruginosa* following focussed IPC initiatives.



- C. difficile reduction initiatives:
    - Hydrogen Peroxide Vapour cleaning: four new machines delivered and in operation at FH and RVI sites.
    - Early recognition of diarrhoea for effective management: Improved digital solutions to support education around diarrhoea management.
    - Antimicrobial stewardship (AMS): Two additional Antimicrobial Pharmacists in post since January 2023, and strategies and policies including use of broad-spectrum antibiotics are under review.
    - Audit process with Synbiotix – Lack of compliance with Take 5 audits across different directorates, plans in place to improve compliance through SIRM and AMS strategies.
    - Clinical MDT review is undertaken for all hospital onset *C. difficile* and appropriately escalated to clinical teams which has improved patient management.



Priority 2 – Management of Abnormal Results

Why have we chosen this?

The management of clinical investigations is a major patient safety issue in all healthcare systems. Nationwide there is mounting evidence of serious harm caused by unintentional delays in clinical investigations being undertaken, acknowledged, and endorsed, resulting in delays clinical care, treatment, and follow-up.

What we aimed to achieve?

We aim to be a world leader by improving patient safety through ensuring that appropriately ordered clinical investigations are undertaken, acknowledged, and endorsed, resulting in timely clinical care, treatment, and follow-up. Improving the management of abnormal results will require successful completion of the Closed Loop Investigations and Future Orders projects, which aim to ensure that all clinically appropriate investigation requests are fulfilled; results are returned to the correct consultant; and appropriate action is taken in response to critical results.

By default, electronically issued investigation results are returned to the clinician associated with the digital “encounter” against which an investigation is ordered. However, this information is frequently incorrect, leading to the result being issued to the wrong clinician’s message centre. In some cases, the lead clinician associated with the digital “encounter” is no longer employed by the Trust.

What we achieved?

A new mandatory field was added to the order entry form (OEF) used to request clinical investigations. Initially, this mandatory field was only added to the OEFs used to request Magnetic Resonance Imaging (MRI) and Computerised Tomography (CT) examinations. This field asks for the user to specify the “lead clinician to receive report”. In the background, the computer system over-writes the incorrect clinician (associated with the “encounter”) with the correct clinician (chosen from a pre-defined list of “lead clinicians”, i.e., consultants with patient responsibility).

As simple as this change may sound, it involved:

- agreeing on a list of >700 consultants with patient responsibility, presently employed by the Trust.
- agreeing on a robust process for new joiners to be added- and leavers to be removed from a well-maintained list of recognised lead clinicians.
- ensuring that the list of lead clinicians is identical in Cerner Millennium, the radiology information management system (RIS), and the laboratory information management system (LIMS).
- ensuring that the message sent from Cerner Millennium includes the information needed by the RIS/LIMS to specify the correct lead clinician, at the point of order entry.
- ensuring that the message sent from the RIS/LIMS in includes the information needed by Cerner Millennium to specify the correct lead clinician, at the point of a result being received.

How we measured success?

The Cerner Millennium data warehouse was interrogated for information on the lead clinician associated with a digital “encounter”.

MRI Results:
Our data showed that, 929 out of 936 MRI reports were electronically sent to the message centre of a recognised lead consultant. We estimate that, over the course of one year, 22,022 more MRI reports will be sent to the message centre of the correct lead clinician.

CT Results:
Our data showed that, 1881 out of 1901 CT reports were electronically sent to the message centre of a recognised lead consultant. We estimate that, over the course of one year, 48,597 more CT reports will be sent to the message centre of the correct lead clinician.

Learning:

- Redesign of OEFs, which are used to submit electronic investigation requests, can massively affect the down-stream performance of systems used to transmit critical investigation results.
- The design of these forms may affect end user perceptions around system accessibility, flexibility, and usability.

- Making seemingly small changes to these forms may require a collaborative, team effort, involving IT, radiology, laboratory medicine, human resources, and medical personnel.

CLINICAL EFFECTIVENESS

Priority 3 – Enhancing Capability in Quality Improvement

Why we chose this?

Recovery of activity post-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.

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 priority.

Throughout 2022, 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), has enabled us to accelerate this improvement work. This is critical in maintaining our performance and the patient-focused high quality of care we deliver.

What was the aim?

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.
- 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 in year two, to deliver the program after the IHI support period has finished.
- Development of bitesize, enhanced induction and e-learning packages.

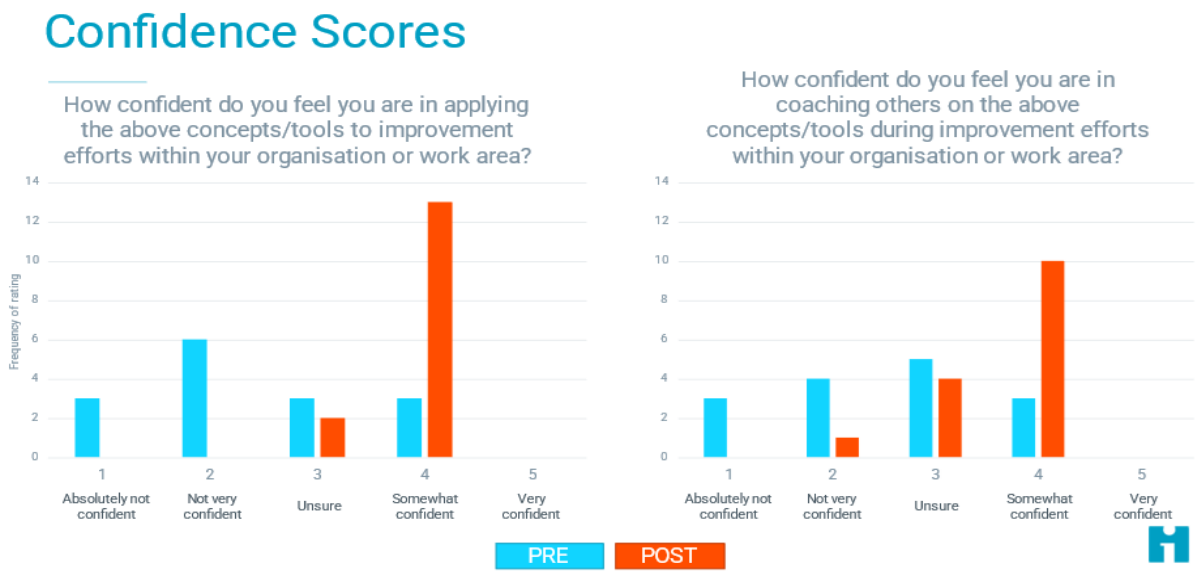
What has been achieved?

Newcastle Improvement recruited 10 improvement teams, each focused on a piece of improvement work and linked coaches to coach them through the work, supported by Newcastle Improvement and IHI faculty. Nine of the 10 teams completed all three workshops and are continuing with their improvement initiatives.

- Recruited 25 improvement coaches to build capability and support teams with their improvement work.
- Developed a return-on-investment evaluation framework and assess the programme against this.
- Adapted the IHI training programme and developed training materials with alignment to “What Matters to You?” and “The Newcastle Way”.
- Moved towards being independent in ongoing delivery of training.
- Newcastle Improvement team members shadowed the IHI delivery in year two of Improvement Coach Programme and co-delivered Improvement Programme for Teams.
- Development of bitesize, enhanced induction and e-learning packages.

How we measured success?

- Number of coaches trained through the IHI Improvement Coach Programme – 18 coaches.
- Number of teams participating in the co-delivered (Newcastle Improvement and IHI) Improvement Programme for Teams – 10 teams / 57 individuals.
- Number of people having completed “An introduction to Quality Improvement” e-learning package – 177.
- Number of people having attended “Introduction to Quality Improvement” session as part of enhanced induction – 201.
- Attendees at bitesize training – 505.
- Number of people registered for learning and sharing events – 459.
- Qualitative survey of IHI programmes (see below).



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 we chose this?

- The need for early recognition and management of deterioration of pregnant women has been highlighted by MBRRACE and the Ockenden Report.
- The Directorate has also identified that not having triage at the point of presentation to MAU was a contributory factor to SI's/Significant Learning Events (SLEs) within Maternity.
- It was therefore recognised that there was a need for formal triage on the MAU at the point of presentation to reduce the likelihood of avoidable harm to mothers and babies.

What was the aim?

Within five minutes of arrival at the 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.

What has been achieved?

As part of the 'IHI Triage in Maternity project', there has been important on-going work to implement formal objective triage on MAU. Achievements over the last year include:

- Introduction of a 'Telephone call queue' to reduce unnecessary calls/queries about scan appointments/induction and caesarean section arrangements. This is working well, with no complaints received from service users.
- Development of Maternity Day-care. A new day-care facility on Ward 41 opened in March 2022. It is a fantastic new facility with a greater footprint.
    - It has freed up a room on the unit that is now an additional assessment room by moving the scan machine to day-care.

    - Day-care is currently staffed 8am to 4pm by one midwife with an appointment system and is working very well. Improvements to current capacity is under review and needs further development.
- Consultant obstetrician presence on MAU Monday-Friday (afternoons only). This has proved beneficial in supporting the MAU in afternoons, when the unit is at its busiest, and management of the ill woman once identified.
- On-going work on environment/culture/teamwork and roles/responsibilities of staff on MAU.
- Appointment of Band 7 Midwife (commenced January 2023). This is a new post and is crucial for leadership/triage education and training.
- In December 2021, the decision was made to move to BadgerNet, a bespoke electronic Maternity end-to-end maternity record, with an in-built triage system Birmingham Symptom Specific Obstetric Triage (BSSOTs). It was therefore decided that this triage system would be used for triage on MAU rather than the bespoke RVI one that was developed by the IHI project in 2021/2022. BadgerNet implementation was delayed by almost a year, which has to a degree hindered moving forward with formal triage. However, BadgerNet was successfully implemented on 10 January 2023 with a plan to implement BSSOTs triage on MAU in April 2023.

How we measured success?

- Snapshot audits of percentage of women having formal triage by a designated member of staff trained in triage, within five minutes of arrival at the MAU at the RVI showed this was achievable in a quiet period in the morning, almost 100%, but as the unit occupancy increases this was unachievable. It was recognised that until day-care was developed further improvement would be challenging.
- Patient experience survey has highlighted the need to make further improvements to the timeliness of review and assessment. Work to make these changes is underway.

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

Why we chose this?

The monitoring of pregnant or recently pregnant patients in non-maternity settings has been identified as an area of risk. Over recent years in England, several situations have arisen where adverse outcomes have occurred in patients where monitoring systems have been deficient in non-maternity settings.

What we aimed to achieve?

We aimed to achieve two things:

1. Creation of a means of identifying a pregnant or recently pregnant patient through our electronic patient record (EPR).
2. Introduce a maternal early warning (MEOWS) observation chart linking to our electronic observations system (EOBS).

What we achieved?

We have developed and brought into current practice a question in our admission documentation within our EPR to identify those patients who are pregnant or have

been pregnant in the previous 42 days. This allows us to identify all patients meeting this criterion within our Trust, particularly for those in a non-maternity setting.

We have created an electronic MEOWS chart for use with the EOBS. This chart has been created and tested. However, the chart has required recoding into a newer and better supported software code (.NET). The newly coded chart is currently undergoing thorough checking through IT services and is expected to be delivered by May 2023. A delivery task group has been created to deliver this chart.

How we measured success?

Success for the identification of pregnant or recently pregnant patients electronically in our EPR is measured by the ability to record this information. This has been completed.

Success for the delivery of MEOWS into non-maternity settings will be measured by audit of the use of this facility once available in the EPR from May 2023.

PATIENT EXPERIENCE

Priority 5 - Trust-wide Day Surgery Initiative

Why we chose this?

Day surgery is a widely established practice and due to advances in anaesthesia and surgical techniques, 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.

What we aimed to achieve?

Initiate a Trust-wide Day Surgery Improvement Programme.

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

a) Surgical assessment – develop a universal waiting list process to ensure a consistent approach across all specialties.
b) Pre-operative assessment – develop a universal request for day-case patients to ensure patients get pre-assessed early in the pathway, making sure any current health conditions are managed and the patients are at their fittest for surgery.
c) 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 optimise our theatre capacity and reduce the waiting list backlog.

What we achieved?

a)

- Agreed best practice model and key components of universal waiting list process utilising the GIRFT and Centre for Peri-Operative Care Day Case Delivery Pack. This process has been documented within a universal Standard Operating Procedure which we are currently testing in Urology and Peri-Ops.
- New streamlined booking and scheduling process agreed and implemented for the DTC.
- Implemented combined universal waiting list addition and pre-admission clinic (PAC) request form in Urology alongside deployment of Care Co-ordination System.

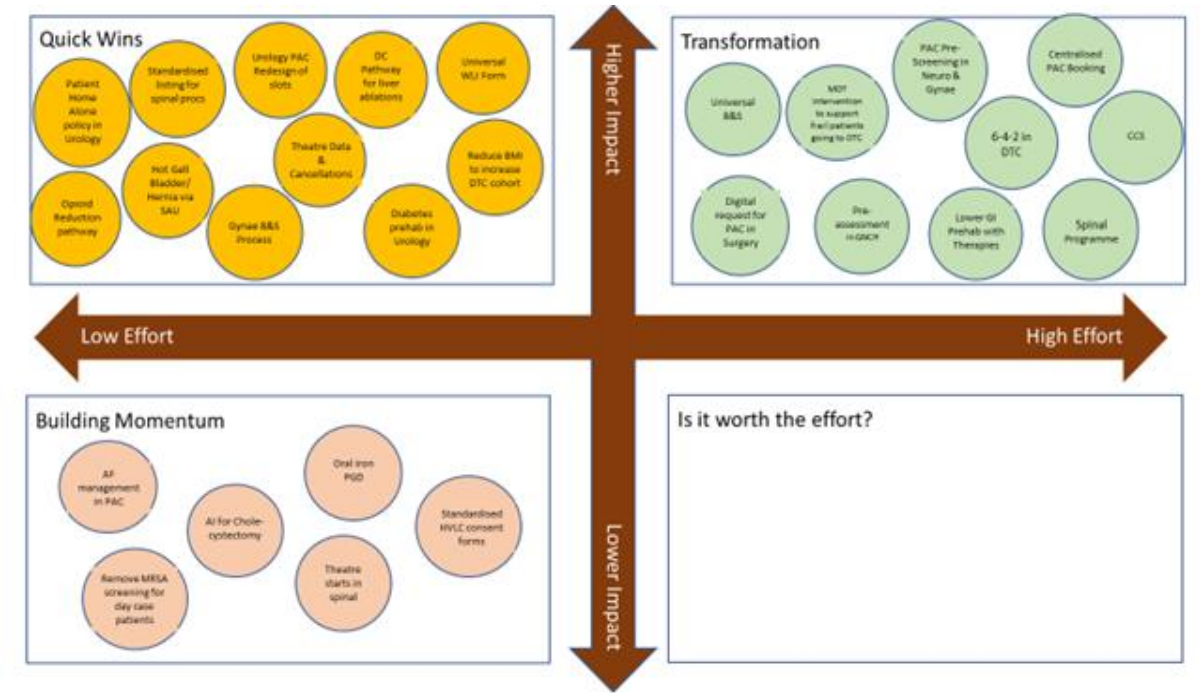
b)

- Implemented new PAC delivery model to create additional capacity; low risk pathway for Health Care Assistants (80 new slots per month), telephone PAC clinic (50% increase in capacity), direct access surgical clinic for patients who require booking following attendance at Surgical Assessment Unit.
- Developed and implemented new day case clinical criteria (May 2022) to assess suitability for day case in main sites or DTC – all patients are assigned a red, amber or green rating denoting surgical, medical, and social suitability.
- In collaboration with pre-assessment, successfully tested a new process for Urology patients who have had minor surgery and are happy to be “home alone” with very positive patient feedback. The plan is to scale this across the organisation.

c)

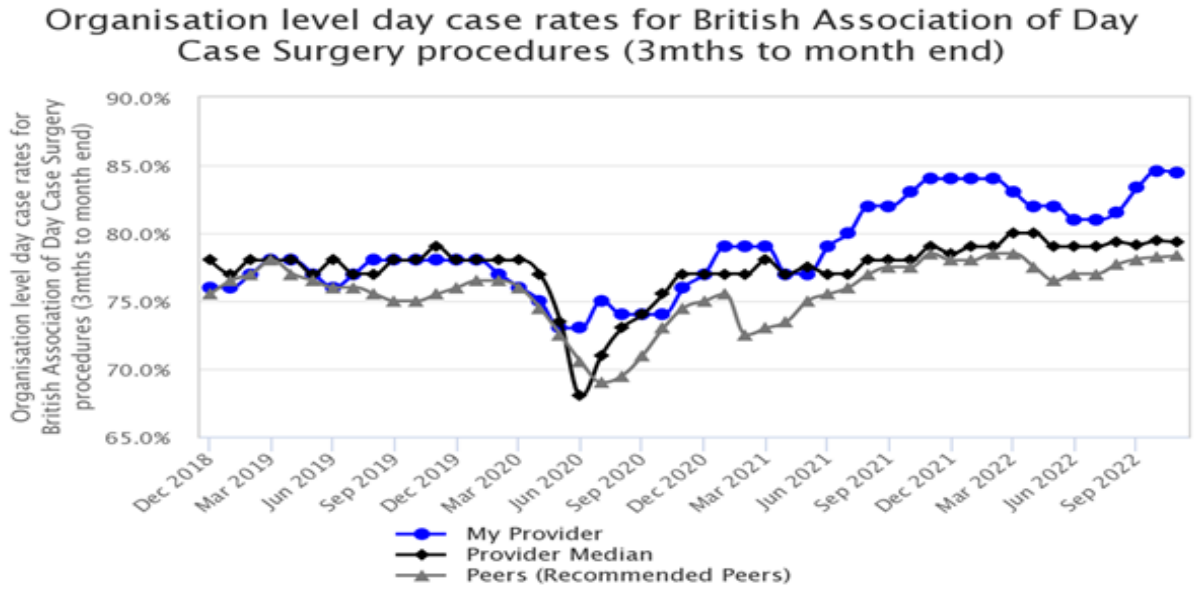
- To support the implementation of 6-4-2 in the DTC and Urology, we successfully deployed Care Coordination System (CCS) in Urology in March 2023. For the first time, CCS is now providing a single consistent waiting list view that is visible to our clinicians, schedulers, theatre teams, operational managers, and administration staff. No longer do they have to review multiple systems, paper diaries or excel spreadsheets, they have all the information at their fingertips to ensure patients are treated at the right time, in the right clinical priority order and within required timeframes.
- In addition, our Freeman theatre management team have deployed CCS to support their 6-4-2 theatre scheduling meetings to achieve optimal utilisation of operating sessions and promote safe and efficient throughput of our patients whilst preventing unavoidable patient cancellations on the day and making the best use of staffing resource including Surgeon, Anaesthetist, Theatre Team, etc.

Whilst this is a strategic project, frontline staff are empowered to design the solutions (bottom-up delivery) with QI training offered to ensure a legacy of continuous improvement. The improvement matrix below shows the sheer volume of initiatives ongoing across the Trust, including some of the achievements identified above.



How we measured success?

In addition to the measures identified above, the chart below shows our day case volumes and the percentage continues to increase (higher than our peers). However, we still have a significant opportunity to create additional elective capacity by converting more patients to day case and we are working with our clinical leads to agree an improvement trajectory for 2023/2024.



Priority 6 – Mental Health in Young People

Why we chose this?

The NCEPOD Mental Healthcare in Young People and Young Adults report published recommendations in 2019, which are a beneficial tool to benchmark against.

There has been significant pressure on specialist mental health Tier 4 inpatient services across the North East and Yorkshire region. There has been an increase in 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 North East and Yorkshire region, a CYP Mental Health Task and Finish Group has been established which has identified several 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 on 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 to assure that we identify gaps, areas of good practice and plan to improve the care we provide for these patients.

What we aimed to achieve?

- A dedicated and efficient pathway for assessment and treatment plan working in close conjunction with 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.

What we achieved?

- Working in collaboration with CNTW – we now have project lead to review and recommend appropriate pathways for CYP – commenced April 2023.
- Continue to promote the We Can Talk training; the organisation currently has 563 staff members signed up to complete the training and 172 staff have completed.
- We Can Talk programme team spending a day in April 2023 in the organisation to showcase and promote the training.
- Training between CNTW and GNCH continues to be of mutual benefit.
- Improved clarity of pathways when CYP are detained under the Mental Health Act.
- Ongoing work to improve environment on the Paediatric Emergency Assessment Unit.

How we measured success?

- Dedicated support to review pathways for CYP who present with mental health issues.
- Training figures and implementation of QI projects.

- Ongoing review of environment with dedicated plans.

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 (LD) are four times more likely to die of something which could have been prevented than the general population. We are committed to ensuring patients with a LD 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 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.
- Ensure staff have received training to understand reasonable adjustments and the needs of patients with a learning disability and/autism, this training will continue for 2023/2024.

What we achieved?

- Investment into the Learning Disability Liaison team to allow greater visibility of the team in the clinical departments.
- Change in skill mix within the Learning Disability team to provide greater flexibility and support for patients and staff.
- Implementation of the e-learning Diamond Standard Learning Disability/Autism mandatory training.
- Working collaboratively with Access to Acute network as pilot site for mandatory training review.

How we measured success?

- Training compliance.
- Staff and patient feedback.

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 because 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 Being Open Duty of Candour (DoC) policy provides structure and guidance to our staff on the standard expected within the organisation. Our DoC compliance is assessed by the Care Quality Commission (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.

Developments within the Trust's EPR, enable clear documentation and communication regarding DoC response and compliance. Most recently a dashboard has been created to strengthen 'realtime' monitoring of compliance across clinical directorates.

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.

DoC requirements are regularly communicated across the organisation using several corporate communication channels, and it is a standard agenda item at the Patient Safety Group, where clinical Directorates' 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 SI investigations and local directorate level investigations. It is included in the Trust incident investigator training which is delivered to multidisciplinary staff once a month.

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

The Board Assurance Framework for seven-day hospital services submissions has been deferred due to the COVID-19 pandemic since 2020/2021.The Board Assurance Framework submissions have not yet been resumed, during 2021/2022 or 2022/23.

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’; enabling 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 several 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 categorised 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 through ‘drop in’ meetings, using posters campaigns and using a range of communications platforms.

In addition, the FTSU Gardian 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 because 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 because 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.

Routes into these formal areas can also be achieved through signposting from:

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 several 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 2022 – March 2023. The aim of the report is to highlight the vacancies in junior doctor rotas and steps taken to resolve these.

Gaps are present on several different rotas; this is due to both gaps in the regional training rotations and lack of recruitment of suitable locally employed doctors. The main areas of recurrent or residual concern for vacancies are haematological oncology, cardiothoracic anaesthesia, paediatric surgery, neonatal medicine, and paediatric oncology. The Trust takes a proactive approach to minimise the impact of these by active recruitment; 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 through the work of the Junior Doctor Recruitment and Education Group (JDREG). Members of this group include the Director of Medical Education, Finance Team representative and Medical Staffing personnel. In addition to recruitment into locally employed doctor posts, the Trust runs several 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.

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 2022/2023, 2118 of the Newcastle upon Tyne Hospitals NHS Foundation Trust’s patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 477 in the first quarter; 487 in the second quarter; 609 in the third quarter; 545 in the fourth quarter.

2. During 2022/2023, 975 case record reviews and 65 investigations have been carried out in relation to 2118 of the deaths included in point 1 above. In 29 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: 280 in the first quarter; 313 in the second quarter; 300 in the third quarter; 147 in the fourth quarter.

3. 10, representing 0.33% of the patient deaths during the reporting period where the investigation is complete and has been judged to be 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 five, representing 0.23% deaths for the first quarter, four, representing 0.19% for the second quarter and one representing 0.04% for the third 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 summarised in 2024/2025 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 nine 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
Three Healthcare Acquired Infections (HCAI) - COVID-19	Compliance with COVID-19 screening, personal protective equipment (PPE) and hand hygiene is essential to reducing infections.	Infection, prevention & control team to continue to investigate all HCAI. All staff to continue to comply with all COVID-19 screening.	The Trust infection prevention measures are shown to be robust in comparison to National peer organisations. National data demonstrates low HCAI rate within organisation.
Healthcare Acquired Infection (HCAI) – Methicillin-sensitive *Staphylococcus aureus* (MSSA) related death	Inconsistent documentation in relation to cannula management.	Ongoing improvement work in relation to cannula care and checks, with robust staff education and nominated Harm Free Care Leads to ensure consistent best practice.	Competence levels have improved with regards to prescribing and using Octenisan.
Unexpected Death associated with a delay in acting upon deteriorating condition.	Training and education to improve response to electronic indicators of deterioration.	Enhanced training and resources, including development of a super-user role to strengthen monitoring and support provided to staff.	Experienced users identified and a workbook has been developed. Audit of training competency compliance was undertaken in

Summary	Lessons learned from review	Action	Impact/Outcome
			December 2022.
Suboptimal management of fluid balance.	Robust training required for clinical members of staff when electronically recording fluid input and output.	Quality improvement working group established as a Trust safety priority for 2023, focused on digital functionality and staff education to support improved fluid monitoring within the electronic patient record.	Changes to nurse rounding process in electronic patient record input and output automatically populates fluid balance chart.
Patient fall.	Review process for individual assessment of risk and subsequent patient supervision and monitoring	Enhanced recruitment of new roles in ED and 'staff pool' completed as per investment plan to support the care of complex patients due to increasing pressures on the emergency pathway. Clinical guidelines and improvements to the environment being reviewed and explored to better support vulnerable patients.	Strengthened internal escalation plans at times of high operational pressures in place, providing key interventions to optimise patient flow through ED. New Clinical Decision Unit opened in early December to improve flow out of ED (currently working towards full utilisation). This provides an area for ED patients awaiting test results and those likely to be discharged.
Patient fall.	Improved use of patient safety tools including falls assessment and care bundle.	Focused local staff education and audit to improve compliance with falls risk assessment and best practice, with the establishment of three Harm Free Care leaders within the area.	Harm Free Care leaders nominated, and continuous audits of safety assessment tools show improved compliance month on month.
Unexpected Death due to electrolyte disturbance.	Training to be given to staff members in relation to the importance of using the optional urine concern measure in relation to NEWS2	Trust quality improvement work programme underway focused on strengthening fluid balance recording and management.	Trust Deteriorating Patient Leads have now implemented mandatory training on responding to the deteriorating patient.

Summary	Lessons learned from review	Action	Impact/Outcome
	risk scoring. Training and education to support staff in caring for patients with mental health conditions.	Uplift in healthcare assistant resource to meet increased patient acuity and dependency locally.	
Patient fall.	Training around appropriate frequency for completion of falls assessment.	Focused work undertaken locally to ensure falls assessments are undertaken consistently as per best practice.	Good practice and requirements of falls assessment and falls care bundle completion cascaded to ward staff.

4. 178 case record reviews and 23 investigations were completed after April 2022 which related to deaths which took place before the start of the reporting period.

5. 15, representing 7.5% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

6. 21, representing 1.6% of the patient deaths during 2021/2022 are judged to be 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.

OVERVIEW OF QUALITY IMPROVEMENTS

Pages 46- 52 give some examples of other service developments and quality improvement initiatives the Trust has implemented, or been involved in, throughout the year.

Day treatment centre

Our new Day Treatment Centre opened its doors on the Freeman Hospital site with capacity to provide thousands of additional operations and procedures and help tackle waiting list backlogs caused by the pandemic.

The £24million purpose-built facility contains four state-of-the-art theatres, plus an admissions and recovery area, and has been specifically designed to ensure operations and procedures can be delivered efficiently.

Advances in technology and care allow a wider range of less complex procedures to be done as day cases, which means patients can return home on the same day as they have their operation.

The new centre provides procedures for orthopaedics, urology, general surgery, plastic surgery, neurology, pain management and some cardiology services and includes operations such as cartilage and joint repairs for knees and hips, injections to manage pain, treatment for bladder and kidney problems, hernias and minor plastic surgery.

Patients offered an appointment at the centre are carefully assessed to ensure they can be safely treated without the need for an overnight stay, while additional capacity at the centre also frees up thousands of slots in the hospitals' main theatres, to make way for more complicated operations.

Expanding our endoscopy services

Endoscopy services were expanded and developed, allowing us to increase our capacity to provide around 100 gastroscopies each week to support patients as well as enhance training provision.

The team have a clear vision for their service – to provide high quality care, clear the waiting backlog improving access to treatment and offer a comprehensive training package for our staff and wider region – and to their credit (and with support of contractors, the estates team and other staff) work took place without any loss of clinical service capacity for patients.

Endoscopy is an increasingly busy and important specialty with 16,000 to 20,000 patients a year being seen in the department, around a third of whom are on a two-week wait pathway, and a lot of effort has gone into improving patient pathways as well as embracing new technology.

For example, the team has used new web-based software that links with both e-record and the national endoscopy database, allowing them to benchmark against national peers and interrogate data much more easily to drive up quality and learning.

They also introduced electronic pre-assessment to identify high risk patients and to streamline pathways and a new room has been fitted with ‘state of the art’ HD equipment, including ‘Scopeguide’ technology which allows trainees to visualise the scope as they learn.

This is also a resource is for the region and our new facility has helped Newcastle to be recognised as a regional training academy, providing six-week training placements for medical trainees and nurse endoscopists, significantly increasing the

capacity for high quality training in the region. It also creates the opportunity for staff to extend their skills and become trainers for the future.

Midwives at Newcastle Hospitals praised in national maternity survey

Maternity services across Newcastle Hospitals were rated amongst the best in the country for their care provided to mums and babies in the national maternity survey published by the CQC.

The trust was rated as much better, better or somewhat better than most trusts in a number of categories and women were asked about their experiences of care at three different stages of their maternity journey – antenatal care, labour and birth and postnatal care.

The maternity team at Newcastle Hospitals oversee the delivery of more than 6,000 babies every year and those who responded to the survey said they were confident in the midwife or midwifery team they saw and that they were treated with respect and dignity. The trust was rated as:

- ‘Much better’ than others at listening to women and taking any concerns raised seriously.
- ‘Much better’ than others at providing help or advice to women about feeding their baby in the first six weeks after giving birth.
- ‘Better’ than others at providing information about recovery and any changes in mental health that might be experienced after giving birth.
- ‘Better’ than others at providing help when needed.
- ‘Somewhat better’ than others in asking about mental health, providing advice about a baby’s health and progress, and making sure women were involved in decisions about their care during labour and birth.

Newcastle Hospitals Maternity services launch Badger Notes app

Expecting parents can now access their maternity healthcare records remotely, thanks to the introduction of the Badger Notes app.

Paper records are being replaced with a new electronic BadgerNet Maternity system across the trust and its community settings which includes an app which allows parents-to-be to log into their notes securely from their mobile device or computer.

By using a single electronic record, it means expectant parents don’t need to remember to take their paper-based notes to every appointment but they can easily view upcoming appointments and access up-to-date pregnancy information and reading.

Patient information can also be shared securely and more easily between different hospitals in the region, should someone pregnant need to receive care from another other hospital.

The BadgerNet Maternity project had input from a number of departments within the Trust, as well as support from the Newcastle Maternity Voices Partnership group.

Newcastle dentists begin new trial to check for heart condition that can cause stroke

Newcastle Dental Clinical Research Facility teamed up with researchers at Edinburgh Napier University to conduct a trial that could identify people at increased risk of strokes.

Dentists and dental students at Newcastle Dental Hospital are monitoring patients to see if they have an often-undiagnosed heart condition – as well as tending to their teeth.

It is suspected there is a link between gum disease and a heart condition called atrial fibrillation (AF) that puts people at increased risk of stroke, so as part of their research a study of 1,000 patients over 65 years who attend Newcastle Dental Hospital is now being conducted.

Queens Nurses

Deputy matron for community nursing, Kerry Puga and health visitor Hazel Galloway were both named a Queen's Nurse during the year – an accolade which is only granted to highly dedicated community nurses who can demonstrate their commitment to providing the highest standards of practice and care.

Queen's nurses also act as an inspiring role model to peers and professional colleagues and are committed to the development of community nursing by providing learning and leadership opportunities.

Hazel also celebrated another special milestone - 50 years of working in the NHS many of which have been dedicated to improving the health and wellbeing of children and families in the inner-city area of Newcastle.

Nurse consultant awarded national position with the British Thoracic Society

Alison Armstrong – a Nurse Consultant for Home Ventilation at Newcastle's Royal Victoria Infirmary (RVI) – was appointed as the first nurse delegate into the role of chair of the BTS Education and Training Committee. This was the first time a non-medic had been appointed into a chair role.

'Trailblazing' care

Healthcare assistant and family-centred care lead at the Freeman Hospital's Cardiothoracic Centre, Lisa Morgan, received one of the very first Chief Nursing Officer's Healthcare Support Worker awards in recognition of her 'Commitment to quality of care.'

Lisa has led on developing and implementing many services changes around family engagement in patient care - to improve patient experience and outcomes – as well as dedicating her time and support to national Healthcare Support Work recruitment events.

Newcastle doses first patient in the UK as part of gene therapy trial for Duchenne muscular dystrophy (DMD)

A four-year old boy was the first person in the UK to be dosed in a gene therapy clinical trial for Duchenne muscular dystrophy (DMD) at the John Walton Muscular Dystrophy Research Centre.

He was able to take part in the study in Newcastle thanks to the work of Newcastle Hospitals, Newcastle University and DMD charity, Duchenne UK.

DMD is a severe genetic disease, mostly diagnosed in boys, which causes muscle wasting disease, leading to gradual loss of mobility and sadly limits life expectancy to around early 20s.

The trial, called EMBARK, is studying the safety and efficacy of Sarepta's gene therapy. Gene therapy is a technique that works by adding healthy new copies of the gene that is broken and causes DMD.


Cancer research at Newcastle receives investment boost

Newcastle's Experimental Cancer Medicine Centre (ECMC) – a partnership between the trust and Newcastle University - received almost £3million in funding to help doctors and scientists find the cancer treatments of the future for both adults and children.

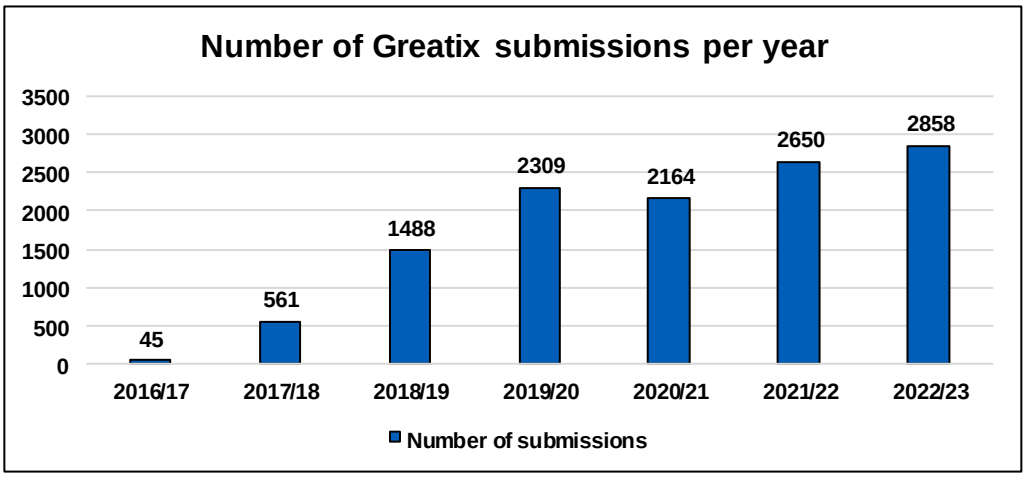
ECMCs work to provide access to cutting-edge cancer treatments with the funding coming from Cancer Research UK, the National Institute for Health and Care Research and the Little Princess Trust specifically for children's cancers.

Thousands of patients have already been provided with access to new drugs and therapies through the Newcastle ECMC and this funding will allow us to further advance how we can treat cancer effectively to benefit people in the North East and beyond.

Greatix
Learning From Excellence

So often in healthcare we realise when something goes wrong and focus on how to prevent it happening again, to learn from our mistakes. Whilst this is important, it does not recognise the many things that go right on a day-to-day basis or that there are examples of excellent practice all around us.

Greatix was launched at Newcastle Hospitals in November 2016 to offer staff the opportunity to recognise and share examples of excellent practice, so that everyone in the Trust can learn from them.



To submit a Greatix staff complete a simple online form telling us who achieved excellence, what they did that was excellent, and what we can learn from this.

Since its launch in 2016 to the end of March 2023, staff have used Greatix to share over 12,000 examples of excellence across the Trust. The number of Greatix submissions has grown year-on-year, with the only exception being during 2020/2021 when the online form was temporarily closed to allow for upgrades. This increasing yearly uptake demonstrates just how valued Greatix is by staff.

During 2022/2023 we have continued to ensure that Greatix submissions are shared monthly with each of the Trust's Directorates, as well as trust-wide communications.

Looking forward into 2023/2024, we aim to further expand our use of staff feedback to continually develop Greatix's potential as a "learning from excellence" tool.

INFORMATION ON PARTICIPATION IN NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

During 2022/2023, 61 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 Trust participated in 59 (97%) 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 Trust was eligible to participate in during 2022/2023 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 2022/2023	Percentage Data completion	Outcome
Breast and Cosmetic Implant Registry	NHS Digital	The Breast and Cosmetic Implant Registry captures the details of all breast implant procedures completed by both the NHS and private providers.	✓	Continuous data collection	Published report expected April 2023
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 2024
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 to be confirmed	No publication date yet identified
Cleft Registry and Audit Network	Royal College of Surgeons - Clinical Effectiveness	The CRANE Database collects information about all	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2022/2023	Percentage Data completion	Outcome
	Unit	children born with cleft lip and/or cleft palate in England, Wales and Northern Ireland.			
Elective Surgery - National 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 - Assessing for cognitive impairment in older people	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 October 2022 – October 2023	No publication date yet identified
Emergency Medicine QIPs – Mental health self-harm	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 October 2022 – October 2023	No publication date yet identified
Epilepsy 12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People	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	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2022/2023	Percentage Data completion	Outcome
		assessment within acute, community and tertiary paediatric services.			
Falls and Fragility Fracture Audit Programme – Fracture Liaison Service Database	Royal College of Physicians	Fracture Liaison Services are the key secondary prevention 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.	The Trust did not participate in the programme due to local resourcing issues.		
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
Gastro-intestinal Cancer Audit Programme – National Bowel Cancer Audit	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	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2022/2023	Percentage Data completion	Outcome
		outcomes between English cancer alliances and Wales as a nation. It also compares local variation between English NHS trusts or hospitals, and Welsh MDTs.			
Gastro-intestinal Cancer Audit 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
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 September 2023
LeDeR – learning from lives and deaths of people with a learning disability and autistic people	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
Medical and Surgical Clinical Outcome Review	National Confidential Enquiry into Patient Outcome	The audit aims to assess the quality of healthcare and stimulate	✓	Data collection period TBC	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2022/2023	Percentage Data completion	Outcome
Programme	and Death (NCEPOD)	improvement in safety and effectiveness.			
Muscle Invasive Bladder Cancer Audit	The British Association of Urological Surgeons	The audit collected data on the management and outcomes of patients diagnosed with muscle invasive bladder at transurethral resection of the bladder and variations in pathways and treatments received in the UK including receipt of neoadjuvant chemotherapy and timings to treatment	✓	100%	Trust fully compliant with report
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	NHS Digital	Patients referred to specialist diabetes foot	✓	Continuous data collection	No publication date yet

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2022/2023	Percentage Data completion	Outcome
Diabetes Footcare Audit		care services for an expert assessment on a new diabetic foot ulcer.			identified
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	Royal College of Physicians	The aim of the audit is to drive improvements in	✓	Continuous data collection	No publication date yet

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2022/2023	Percentage Data completion	Outcome
Programme – COPD Secondary Care		the quality of care and services provided for COPD patients.			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 2023
National Audit of Cardiovascular Disease Prevention	NHS Benchmarking Network	The audit will prioritise working with system partners to drive CVD quality improvement at individual GP, PCN, CCG and ICS level.	✓	Continuous data collection	No publication 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	✓	100%	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2022/2023	Percentage Data completion	Outcome
		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.			
National Audit of Dementia	Royal College of Psychiatrists	The National Audit of Dementia looks at quality of care received by people with dementia in general hospitals.	✓	Data collection September 2023 – March 2024	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 2023
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 2024
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	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2022/2023	Percentage Data completion	Outcome
		hospitals.			
National Cardiac Audit Programme – Myocardial Ischaemia	Barts Health NHS Trust	The Myocardial Ischaemia National Audit Project was established in 1999 in 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.	✓	Continuous data collection	No publication date yet identified
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	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	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2022/2023	Percentage Data completion	Outcome
		secure data collection, analysis and monitoring tools and provides a common infrastructure for all the coronary heart disease audits.			
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 collates information nationally to ensure that deaths are learned from, that learning is widely shared and that actions	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2022/2023	Percentage Data completion	Outcome
		are taken, locally and nationally, to reduce the number of children who die.			
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	Published report expected October 2023
National Emergency Laparotomy Audit	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 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 2023
National Lung Cancer Audit	Royal College of Physicians	The audit was set up to monitor the introduction and effectiveness of cancer services.	✓	Continuous data collection	No publication date yet 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.	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2022/2023	Percentage Data completion	Outcome
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	Published report expected November 2023
National Ophthalmology Audit Database	The Royal College of Ophthalmologists	The Royal College of Ophthalmologists runs the National Ophthalmology Database (NOD) Cataract audit which measures the outcomes of Cataract surgery.	✓	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	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2022/2023	Percentage Data completion	Outcome
		audit of the care that men receive following a diagnosis of prostate cancer.			
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	University of Leeds / University of Leicester	PICANet aims to continually support the improvement of paediatric intensive care provision throughout the UK by providing detailed information on paediatric intensive care activity and outcomes.	✓	Continuous data collection	No publication date yet identified
Perioperative Quality Improvement Programme	Royal College of Anaesthetists	The Perioperative Quality Improvement Programme (PQIP) measures complications, mortality and patient reported	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2022/2023	Percentage Data completion	Outcome
		outcome from major non-cardiac surgery.			
Renal Audits – National Acute Kidney Injury Audit	UK Kidney Association	The UKRR annual reports contain analyses about the care provided to patients with CKD (including people pre-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
Renal Audits – UK Renal Registry Chronic Kidney Disease Audit	UK Kidney Association	The UKRR annual reports contain analyses about the care provided to patients with CKD (including people pre-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	Published report expected June 2024
Respiratory Audits – Adult Respiratory Support Audit	British Thoracic Society	The aim for this audit is to capture data on patients outside critical care that have required respiratory monitoring or intervention, with a view to better understanding variations in clinical practice	✓	Data collection February 2023 – May 2023	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2022/2023	Percentage Data completion	Outcome
		and outcome.			
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 UK National Haemovigilance Scheme	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	Published report expected July 2023
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 average.	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 2022/2023	Percentage Data completion	Outcome
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 2023
UK Parkinson's Audit	Parkinson's UK	This UK-wide audit measures the quality of care provided to people living with Parkinson's against a range of evidence-based guidance.	✓	100%	Trust fully compliant with report

An additional four audits have been added to the list for inclusion in 2023/2024 Quality Account. The audits include:

- British Hernia Society Registry.
- National Comparative Audit of Blood Transfusion: 2023 Bedside Transfusion Audit.
- National Obesity Audit.
- The UK Transcatheter Aortic Valve Implantation (TAVI) Registry.

The reports of national clinical audits were reviewed by the provider in 2022/2023 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, 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 considered in the Annual Business Planning process.

The reports of 782 local audits were reviewed by the provider in 2022/2023 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 over 13,000 participants were recruited to clinical trials provided or hosted by The Newcastle upon Tyne Hospitals NHS Foundation Trust, of which 12,200 enrolled onto the National Institute for Health and Care Research Clinical Research Network (NIHR CRN) portfolio studies.

A wide range of clinical trials are happening across the trust at any one time, ranging from complex and rare disease to common conditions that affect many of our patients. One such trial is using artificial intelligence to ‘score’ the quality of donor organs, which hopes to increase the number of patients receiving life-saving transplants. Another important breakthrough found that by digitally conducting a virtual trial, increased the speed of recruitment resulting in a new treatment for irritable bowel syndrome, that reduced symptoms associated with the condition.

The Trust continues to be one of the top research trusts in the country for the number of individuals participating in research and for the number of studies open, furthering our reputation for world-leading research excellence.

INFORMATION ON THE USE OF THE CQUIN FRAMEWORK

A proportion of Newcastle Hospitals income in 2022/2023 was conditional upon achieving QI and innovation goals agreed between Newcastle Hospitals and any person or body they entered a contract, agreement, or arrangement with for the provision of relevant health services, through CQUIN payment framework. The monetary value for each of the five acute CCG/ICB CQUIN schemes was £1.26 million and £21,000 for the two community CCG/ICB schemes. The five specialised commissioning schemes were each worth £900,000.

Information on the use of the CQUIN framework

CQUIN Indicators - Acute Hospital – (CCG/ICB)	**CQUIN Indicators - Community – (CCG/ICB)**
CCG1: Flu vaccinations for frontline healthcare workers. CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+. 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 service. CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients.	CCG1: Flu vaccinations for frontline healthcare workers. CCG14: Assessment, diagnosis, and treatment of lower leg wounds.

CQUIN Indicators - Specialised Commissioning
PSS1: Achievement of revascularisation standards for lower limb Ischaemia. PSS2: Achieving high quality Shared Decision-Making conversations in specific specialised pathways to support recovery. PSS3: Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres. 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.

Further details of the agreed goals for 2023/2024 and for the following 12-month period are available electronically at: https://www.england.nhs.uk/nhs-standard-contract/cquin

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

Newcastle Hospitals is required to register with the Care Quality Commission and its current registration status is ‘Registered without Conditions’. Newcastle Hospitals has no conditions on registration. The Newcastle upon Tyne Hospitals NHS Foundation Trust is registered with the CQC to deliver care from seven separate locations and for ten regulated activities.

During 2022/2023 the Care Quality Commission undertook an unannounced, focused two-day inspection on 30 November and 1 December 2022. Following this inspection, the trust was served with a Warning Notice under Section 29A of the Health and Social Care Act 2008. Since that time the Trust has undertaken rapid in improvements in the quality and safety of healthcare provided in relation to patients with a mental health need, a learning disability and/or autism.

The CQC also carried out an unannounced inspection of our maternity services and a report into their findings is expected to be published in the next financial year.

Newcastle Hospitals has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Newcastle Hospitals received a full inspection of all services during January 2019. Following this inspection, Newcastle Hospitals was graded as ‘Outstanding’.

Overall Trust Rating - Outstanding

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding

INFORMATION ON THE QUALITY OF DATA

The Newcastle upon Tyne Hospitals NHS Foundation Trust submitted records during 2022/2023 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:

- 99.5% 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 2022/2023 for Information Quality and Records Management, assessed using the Data Security and 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:

- Trauma and Orthopaedics
- Cardiology
- Hepatobiliary Surgery.

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	Trust Level
Primary diagnosis	>=90%	>=95%	95.0%
Secondary diagnosis	>=80%	>=90%	97.3%
Primary procedure	>=90%	>=95%	97.4%
Secondary procedure	>=80%	>=90%	95.8%

The audit results provide assurance that the clinical coding at The Newcastle upon Tyne Hospitals NHS Foundation Trust is of a high standard, achieving the recommended accuracy percentage in all four coding domains. The organisation should be highly commended on its clinical coding performance.

There is a strong sense of cohesion demonstrated throughout the teams that strive to be the best. A shared culture where every effort is made to ‘get it right first time;’ which positively reflects on the Trust’s data quality.

KEY NATIONAL PRIORITIES 2022/2023

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 2022/2023 are detailed in the table below. Please note that changes in performance are likely due to the impact of COVID-19.

Operating and Compliance Framework Target	Target	Annual Performance 2021/2022	Annual Performance 2022/2023
Incidence of Clostridium (C. difficile: variance from plan)	National threshold ≤166 Local trajectory ≤153	169 cases	172 cases
Incidence of MRSA Bacteraemia	Zero tolerance	0	2 cases
All Cancer Two Week Wait	93%	65.8%	76.1%
Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	93%	32.7%	62.5%
31-Day (Diagnosis To Treatment) Wait For First Treatment	96%	90.8%	82.8%
31-Day Wait For Second Or Subsequent Treatment: Surgery	94%	74.5%	60.9%
31-Day Wait For Second Or Subsequent Treatment: Drug treatment	98%	97.3%	96.5%
31-Day Wait For Second Or Subsequent Treatment: Radiotherapy	94%	67.6%	97.6%
All cancers: 62-day wait for first treatment from: • urgent GP referral for suspected cancer	85%	59.7%	53.1%
All cancers: 62-day wait for first treatment from: • NHS Cancer Screening Service referral	90%	77.1%	61.4%
RTT – Referral to Treatment - Admitted Compliance	90%	64.4%	61.5%
RTT – Referral to Treatment - Non-Admitted Compliance	95%	82.1%	77.8%
RTT – Referral to Treatment - Incomplete Compliance	92%	71.4%	69.3%
Maximum 6-week wait for diagnostic procedures	95%	80.6%	80.7%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	95%	86.23%	77.72%
Cancelled operations – those not admitted within 28 days	Offered a date within 28 days of nonclinical cancellation	Cancelled due to COVID-19 reinstated 2022/23	136
Maternity bookings within 12 weeks and 6 days	Not defined	86.9%	86.5%

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

Cancer Performance Targets**:** Referral numbers steadily increased back to pre COVID-19 levels. Significant pressures at the front of the pathway impacted negatively on 14, 28 and 62 day compliance. The closure of the Rutherford Centre impacted negatively on the Breast pathway, increased referrals and the retirement of one of the consultants

in Dermatology resulted in several slot issues and protracted waiting times for first appointments. Colorectal patients were delayed to Colonoscopy and CT Colonography due to capacity issues.

Diagnostic pressures (radiology and endoscopy) remain the biggest challenge with demand exceeding capacity.

31-day treatment numbers increased by 14% when compared to 2021/2022.

An increase in breast screening cases, as a result of working through the backlog created during COVID-19, resulted in more demand. Theatre and robotic capacity has also been a major factor in Urology, Breast, Skin and Lung as well as workforce issues.

In the 62-day standard over 52% of patients referred from local providers for treatment were referred after the agreed transfer point making it challenging to complete treatment within the required timescale.

All tumour groups have cancer improvement plans to support recovery, improved performance and patient experience. These will be regularly reviewed via the Cancer Steering Group. Several actions are detailed below.

- Endoscopy dashboard developed to allow for greater visibility of capacity and demand.
- The Cancer Alliance has supported the appointment of additional nurses and a service improvement facilitator to enable implementation of a combined abdominal pathway which will help to streamline the Upper/Lower GI pathway.
- Increased utilisation of Day Treatment Centre.
- Appointment of an additional Colorectal surgeon.
- Dermatology business case agreed which will support the appointment of additional clinical staff.
- Be-spoke work within Hepatobiliary to identify pathway challenges and implement changes supported by a Project Manager.
- Appointment of an additional Thoracic surgeon.
- Renewed focus on long waiters with targeted reporting and the implementation of weekly pathway review meetings.
- Additional capacity in radiology with mobile CT scanner.

A bi-weekly cancer performance recovery meeting has recently been established attended by the Directorate Leads and led by the Deputy Chief Operating Officer which focuses on addressing real time pressures.

Referral to Treatment Targets: Patients on the waiting list continue to be prioritised by clinical need and longest waits. There has been an increased focus on eliminating longest waits both locally and nationally and this has been successful in reducing waiting times for patients whilst aiming to also treat the backlog of patients from the pandemic. Additional capacity is being utilised in the independent sector, and local organisations. Focussed outpatient and day case “sprints” have provided intensive months of increased activity to treat patients. Targeted validation has given assurance of the validity of the waiting list.

There remains a focus on achieving a sustainable solution to treat patients in a timely manner with pathway redesign and aligning demand and capacity as a result will improve performance. The performance details of long waiters are discussed and reported at Board level.

Additional pressures continue to affect the scheduling of patient care such as industrial action. Throughout this time, cancer and high clinical priority patients remained the priority to be treated.

Emergency Department (ED) Target: We continue to see a year-on-year increase in type 1 attendances. This is exacerbated by the changing of regional catchment areas, region wide emergency care pressure leading to increased number of patients being diverted to RVI from their own area and increased length of patient hospital stays due to ongoing social care challenges. This was further impacted by COVID-19 outbreaks, industrial action and trust wide staff shortages and vacancies.

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	2022/2023		2021/2022				2020/2021			
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"		Oct21 – Sept 22 **NUTH Value:** 0.9105 **NUTH Band 2**	Jul21 - Jun 22 **NUTH Value:** 0.9148 **NUTH Band 2**	Apr21 - Mar 22 **NUTH Value:** 0.9180 **NUTH Band 2**	Jan21 - Dec 21 **NUTH Value:** 0.9804 **NUTH Band 2**	Oct20 – Sept 21 **NUTH Value:** 0.9606 **NUTH Band 2**	Jul20 - Jun 21 **NUTH Value:** 0.9369 **NUTH Band 2**	Apr20 - Mar 21 **NUTH Value:** 0.9678 **NUTH Band 2**	Jan20 - Dec 20 **NUTH Value:** 0.9536 **NUTH Band 2**	Oct19 – Sept 20 **NUTH Value:** 0.9795 **NUTH Band 2**	Jul19 - Jun 20 **NUTH Value:** 0.9948 **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
			Highest National	1.2340	1.2112	1.1942	1.1897	1.1909	1.2017	1.2010	1.1845	1.1795	1.2074
			Lowest National	0.6454	0.7047	0.6964	0.7127	0.7132	0.7195	0.6908	0.7030	0.6869	0.6764
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	41%	41%	42%	42%	44%	44%	43%	39%	35%	33%
			National Average	40%	40%	40%	39%	39%	39%	38%	37%	36%	36%
			Highest National	65%	65%	66%	64%	63%	64%	63%	61%	60%	60%
			Lowest National	12%	12%	11%	11%	12%	11%	8%	8%	9%	9%

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

The Newcastle upon Tyne Hospitals 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. The Newcastle upon Tyne Hospitals NHS Foundation Trust 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 Hospitals 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. The Newcastle upon Tyne Hospitals NHS Foundation Trust 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
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**	**0.48**	**0.44**	**0.43**
	National average:	0.47	0.46	0.47	0.47	0.45	0.44
	Highest national:	0.57	0.54	0.56	0.54	0.54	0.51
	Lowest national:	0.39	0.35	0.35	0.39	0.31	0.32
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**
	National average:	0.32	0.34	0.34	0.34	0.33	0.32
	Highest national:	0.40	0.42	0.41	0.42	0.40	0.38
	Lowest national:	0.18	0.22	0.28	0.25	0.25	0.20

Please note that finalised PROMs data is only available for 2020/2021. The North East Quality Observatory Service are in contact with NHS Digital to try to get an update on when the next PROMs publication will be.

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

Collection of groin procedure scores ceased on 1 October 2017.

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

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

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

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:
The Newcastle upon Tyne Hospitals NHS Foundation Trust 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.

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

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:
The Newcastle upon Tyne Hospitals NHS Foundation Trust 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 0-15.

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	34,112	3,080	9.0
2022/2023	33,950	2,776	8.2

7b. Emergency readmissions to hospital within 28 days of being discharged aged 16+.

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	185,434	12,104	6.5
2022/2023	192,854	13,012	6.7

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 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). The Newcastle upon Tyne Hospitals 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.

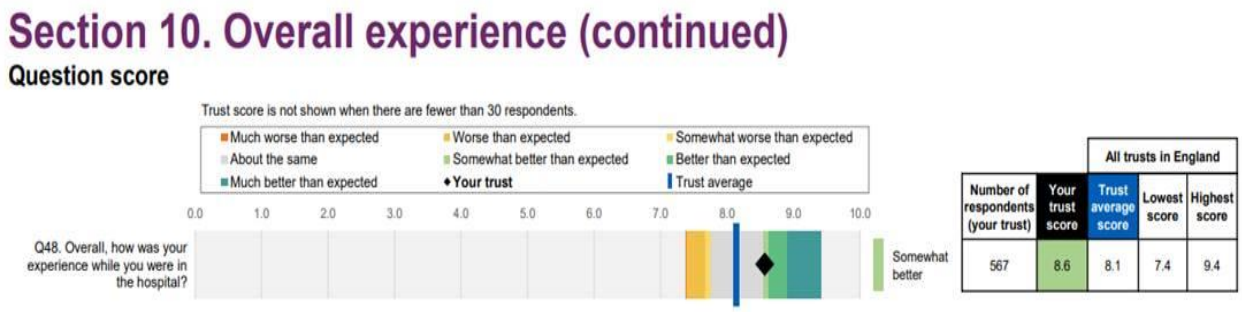
The Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by continuing with the use of an electronic system.

Measure	Data Source	Value	2022/23	2021/22	2020/21	2019/20	2018/19	2017/18
8. The Trust's responsiveness	NHS Information Centre	Trust percentage			77.7%	72.6%	73.1%	74.9%

to the personal needs of its patients	Portal https://indicators.ic.nhs.uk/	National Average:	Ceased Publication August 2020	Ceased Publication August 2020	74.5%	67.1%	67.2%	68.6%
		Highest National:			85.4%	84.2%	85.0%	85.0%
		Lowest National:			67.3%	59.5%	58.9%	60.5%
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	http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/Results/	Trust percentage	82.6%	85.4%	91.3%	90%	90%	96%
		National Average	61.9%	66.9%	74.3%	71%	70%	81%
		Highest National	86.4%	89.5%	91.7%	95%	95%	100%
		Lowest National	39.2%	43.6%	49.7%	36%	33%	43%

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

This data ceased to be published in August 2020.Below is CQC benchmark data which shows that our score on overall patient experience is 8.6/10 and the average for all Trusts in England is 8.1/10.



The data shows that the Trust scores above the national average. The Newcastle upon Tyne Hospitals NHS Foundation Trust 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.

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 the 2021/2022 survey.

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:
The Trust continues to score well above the National average in relation to staff survey Q23d. By ensuring all colleagues have a voice and continuing to listen and act on all sources of staff feedback, The Newcastle upon Tyne Hospitals NHS Foundation Trust is committed to maintaining the highest quality of services for both patients/service users and its staff.

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

National data collection is yet to resume post COVID-19.

Measure	Data Source	Target	2022/2023	2021/2022	2020/2021	2019/2020
11. The number of cases of C. difficile infection reported within the Trust amongst patients aged two or over	PHE Data Capture System	Trust number of cases	172 HOHA* = 138 COHA* = 34 (no appeals process this financial year)	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**)
		National Average number of cases	HOHA* = 52 COHA* = 18	HOHA* = 44 COHA* = 18	HOHA* = 35 COHA* = 16	HOHA* = 39 COHA* = 18
		Highest National number of cases	HOHA* = 210 COHA* = 76	HOHA* = 189 COHA* = 76	HOHA* = 151 COHA* = 60	HOHA* = 163 COHA* = 77
		Lowest National number of cases	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0

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

Measure 11. The number of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over

The Newcastle upon Tyne Hospitals 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. The Newcastle upon Tyne Hospitals NHS Foundation Trust 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.

Measure	Data Source	Target	2022/23	2021/22	2020/21	2019/20	
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 2022 – March 2023 20464	April 2021 – March 2022 18440	April 2020 - March 2021 17915	Oct 2019-March 2020 9319	Oct 2018-March 2019 9707
		Trust %	38.7	37.5	50.3	41.5	39.8
		National Average	Not available	Not available	58.4	49.1	44.7
		Highest National	Not available	Not available	118.7	110.2	95.9
		Lowest National	Not available	Not available	27.2	15.7	16.9

Measure	Data Source	Target	2022/2023		2021/2022		2020/2021	
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 2022 – March 2023 **Severe Harm** 88	April 2022 – March 2023 **Death** 53	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
		Trust %	0.4%	0.2%	0.5%	0.3%	0.3%	0.2%
		National Average	Not available	Not available	Not available	Not available	0.2%	0.2%
		Highest National	Not available	Not available	Not available	Not available	1%	1.3%
		Lowest National	Not available	Not available	Not available	Not available	0.0%	0.0%

Measure 12. The number and rate of patient safety incidents reported

The Newcastle upon Tyne Hospitals 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. The Newcastle upon Tyne Hospitals NHS Foundation Trust 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 2021/2022 data has now been updated where it was not available last year. The national data for 2022/23 is due for release in September 2023. 2022/2023 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. The Newcastle upon Tyne Hospitals NHS Foundation Trust 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 2021/2022 data has now been updated where it was not available last year. The national data for 2022/2023 is due for release in September 2023. 2022/2023 Trust data has been compared with all other Organisations described as Acute Trusts in NRLS.

WORKFORCE FACTORS

The tables below provide data on the loss of workdays. 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 workdays (rate).

	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22
The Newcastle Upon Tyne Hospitals	6.67%	8.81%	6.59%	7.37%	7.00%	5.76%	6.11%	6.61%	5.40%	5.22%	5.91%	5.86%
South Tyneside and Sunderland	7.05%	6.60%	6.37%	6.03%	5.84%	5.60%	5.65%	5.88%	5.86%	5.73%	6.65%	6.68%
County Durham and Darlington	7.33%	9.56%	6.97%	6.91%	7.01%	5.92%	6.11%	6.86%	5.76%	5.58%	6.08%	6.30%
Gateshead Health	6.18%	8.00%	5.40%	5.66%	6.13%	5.35%	5.69%	6.22%	5.19%	5.30%	6.01%	5.89%
North Tees and Hartlepool	6.81%	9.32%	6.32%	5.96%	6.51%	5.49%	6.04%	6.92%	5.17%	5.36%	6.18%	6.12%
Northumbria Healthcare	6.67%	9.46%	6.72%	6.97%	7.07%	5.57%	6.17%	6.87%	5.29%	5.63%	6.39%	6.33%
South Tees Hospitals	6.69%	8.58%	6.17%	6.42%	6.98%	5.99%	6.24%	6.84%	6.06%	5.79%	6.66%	6.35%
England	2.43%	2.46%	2.11%	2.39%	2.26%	2.04%	2.10%	2.46%	2.15%	2.20%	2.60%	2.65%

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	318	475	618	409	1820
2022/23 no. of days	319	119	139	321	898

2022 NHS STAFF SURVEY RESULTS SUMMARY

The last few years have been exceptionally difficult for everyone working in the NHS, and now, more than ever, it is important to hear what colleagues think about working in our Trust – to help improve working lives.

A full census survey was sent via email to all eligible employees of the Trust (via external post for those on maternity leave), giving all 16,752 members of our staff a voice. 6,644 staff participated in the survey, equalling a response rate of 44%, which is 1% lower than the sector average and was a 2% decrease on the 2021 response rate of 46%.

Providing the highest standard of care has always been our priority and we know how important this is to all our staff here at Newcastle Hospitals. The organisation is particularly proud to score higher than the national average (by 20.7%) when asked “If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.”

2021 NHS Staff Survey saw the biggest re-design in over 10 years with the survey questions being aligned to the NHS People Promise. 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 NHS People Promise are two main themes:

- Staff Engagement.
- Morale.

The reporting also includes new sub-scores, which feed into the NHS People Promise elements and themes.

The Staff Engagement score is measured across three sub-themes:

- Advocacy: 7.3 out of 10, measured by Q23a, Q23c and Q23d (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: 6.7 out of 10, measured by Q3c, Q3h and Q3i (Staff ability to contribute towards improvement at work).

At Newcastle Hospitals this score was:
Overall: rating of staff engagement 6.9 (out of possible 10).
This score was 0.4 below top position and 0.8 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 and Acute & Community Trusts in England. These are:

We are compassionate and inclusive
Newcastle Hospitals Score: 7.3 out of 10
Sector Score: 7.2 out of 10

We each have a voice that counts
Newcastle Hospitals Score: 6.7 out of 10
Sector Score: 6.6 out of 10

We are safe and healthy
Newcastle Hospitals Score: 6.0 out of 10
Sector Score: 5.9 out of 10

Morale
Newcastle Hospitals Score: 5.8 out of 10
Sector Score: 5.7 out of 10

The Trust scored equal to the sector in 2 of the people promises, which included:

We are always learning
Newcastle Hospitals Score: 5.4 out of 10
Sector Score: 5.4 out of 10

We are recognised and rewarded
Newcastle Hospitals Score: 5.7 out of 10
Sector Score: 5.7 out of 10

The Trust fell slightly behind sector average on 2 of the people promises but both scores have reassuringly increased when compared to 2021, they include:

We work flexibly
Newcastle Hospitals Score: 5.7 out of 10
Sector Score: 6.0 out of 10

We are a team
Newcastle Hospitals Score: 6.5 out of 10
Sector Score: 6.6 out of 10

Additionally, the Trust scored favourably in several of the questions in the survey. Some to note include:

- 91% feel trusted to do their job.
- 87% feel their role makes a difference to patients.
- 83% feel care of patients is Newcastle Hospitals top priority.
- 65% would recommend Newcastle Hospitals as a place to work. 6.6% higher than the sector average.
- 82% enjoy working with the colleagues in our teams.
- 70% believe the people we work with are understanding and kind to one another.
- 71% think that people we work with are polite and treat each other with respect.

- 71% of our staff believe our organisation respects individual differences, meaning we are 2% above the sector average.

There is unfortunately a national decline across the whole NHS in staff looking forward to going to work, recommending their organisation as a place to work or to receive care from. The Trust's results have also dipped, which is not surprising given the significant pressures and challenges facing staff at Newcastle Hospitals are like those faced in other similar NHS organisations.

Ensuring that the voices of our staff continue to be heard continues to be a priority, and our survey results provide more depth to understanding of the issues affecting staff and these findings will be incorporated into the 'What Matters to You' programme. Some initial organisational improvements appear to relate to work undertaken from previous year's survey results, meaning an increase in involvement, decision-making, opportunities for flexible working and overall satisfaction. These hope to be built on over the coming years.

There is work ongoing to further understand and break down the 2022 results, including how they differ between staff groups and directorates, to help inform the Trust's next steps in supporting staff. This understanding will not only give Newcastle Hospitals refreshed priorities for action but will also form a key part of developing the new People Strategy.

INVOLVEMENT AND ENGAGEMENT 2022/2023

Involvement and Engagement is about how we work together with people who use Trust's services to ensure their voice is heard, from ward and team level through to Trust Board and beyond. 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 offer.

The Patient Experience team have embarked on co-production with patients and carers, with pilots running in Mental Health and the DTC with support from the Newcastle Hospitals Charity. Learnings from these ongoing pilots are supporting the development of a trust-wide patient engagement toolkit to empower and support other services across the Trust to effectively engage and work with patients.

The Trust has successfully embraced digital engagement and moved many of our patient and public involvement meetings virtually. Advising on the Patient Experience (APEX) Young Persons Advisory Group (YPAGne) have continued to meet virtually, providing a sustainable and strong model of engagement with a diverse range of people.

The Trust is very proud of the close partnership work with local communities and voluntary groups to ensure that equal and diverse opportunities are promoted to all. Multiple engagement events have taken place throughout the year with local voluntary organisations, such as Deaflink, Newcastle Vision Support, Newcastle Carers, Be: Trans Support, Disability North, HAREF and many others. This has provided minority groups to have a voice where services can be improved and help drive this work forward.

This year, the Trust continued to participate in the NHS Family and Friends Test (FFT) guidance and is participating in a project led by Nottinghamshire Healthcare NHS Trust to establish a means of using semi-automated methods for analysing FFT free text patient feedback. This will help NHS provider organisations better understand and be reactive to FFT feedback, gaining deeper insights to make service improvements. In addition, the Trust continues to take part in and perform highly in the National Patient Survey programme, often being in the top 20% of Trusts in several sections for each survey.

In 2023/2024 the focus will be to:

- Work in partnership with local communities and voluntary groups to ensure that equal opportunities are promoted to, and all groups have a voice in how services are improved and delivered.
- Continue to embed patient and public engagement in our approaches to service improvement and transformation, in particular the significant transformation plans.
- Develop the Trust-wide patient engagement toolkit to empower and support services in engaging and working with patients.
- Improve our use of existing sources of FFT patient experience data to inform continuous improvement and transformation.
- Develop a Patient Experience Strategy for the Trust with support from WeAreStand, who are providing temporary support, expertise and capacity.

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

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	
A&E	Accident and Emergency
AF	Atrial Fibrillation
AMR	Antimicrobial Resistance
AMSG	Antimicrobial Steering Group
APEX	Advancing the Patient Experience
BADS	British Association of Day Surgery
BAME	Black, Asian and Minority Ethnic
BSOTS	Birmingham Symptom Specific Obstetric Triage System
BTS	British Thoracic Society
C. difficile	*Clostridium difficile*
CAT	Clinical Assurance Tool
CCG	Clinical Commissioning Group
CCS	Care Co-ordination System
CD	Clinical Director
CDI	*Clostridium difficile* Infection
CHUF	Children's Heart Unit Fund
CKD	Chronic Kidney Disease
CNO	Chief Nursing Officer
CNTW	Cumbria, Northumberland, 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	Computerised Tomography
CVD	Cardiovascular Disease
CYP	Children and Young People
DMD	Duchenne Muscular Dystrophy
DoC	Duty of Candour
DoLS	Deprivation of Liberty Safeguards
DSP	Data Security and Protection
DTC	Day Treatment Centre
ECMC	Experimental Cancer Medicine Centre
E. coli	*Escherichia coli*
ED	Emergency Department
EHR	Electronic Health Record
EOBS	Electronic Observation System
EPR	Electronic Patient Record
FFT	Friends and Family Test
FTSU	Freedom To Speak Up
GIRFT	Getting It Right First Time
GMC	General Medical Council
GNBSI	Gram Negative Bloodstream Infection
GNCH	Great North Children's Hospital

Abbreviations	
GP	General Practitioner
HCAI	Healthcare Associated Infection
HCSW	Healthcare Support Worker
HES	Hospital Episode Statistics
HOHA	Hospital-Onset Healthcare Associated
HR	Human Resources
IBD	Inflammatory Bowel Disease
ICB	Integrated Care Board
ICS	Integrated Care System
IHI	Institute for Healthcare Improvement
IPC	Infection Prevention and Control
IPCC	Infection Prevention and Control Committee
IT	Information Technology
ITU	Intensive Therapy Unit
IV	Intravenous
KRT	Kidney Replacement Therapy
LD	Learning Disability
LeDeR	Learning Disabilities Mortality Review
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer +
LIMS	Laboratory Information Management System
LoS	Length of Stay
M&M	Mortality and Morbidity
MatNeoSIP	Maternity and Neonatal Safety Improvement Programme
MAU	Maternity Assessment Unit
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
MCA	Mental Capacity Assessment
MDT	Multidisciplinary Team
MEOWS	Modified Early Obstetric Warning Score
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant *Staphylococcus aureus*
MSSA	Methicillin-sensitive *Staphylococcus aureus*
N/A	Not Applicable
NBOCA	National Bowel Cancer Audit
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NELA	National Emergency Laparotomy Audit
NENC	North East and North Cumbria
NEWS	National Early Warning Score
NEWS2	National Early Warning Score 2
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health and Care Research
NIV	Non-invasive Ventilation
NRLS	National Reporting and Learning System

Abbreviations	
NUTH	Newcastle upon Tyne Hospitals
OEF	Order Entry Form
PAC	Pre-admission Clinic
PHE	Public Health England
PICU	Paediatric Intensive Care Unit
PIFU	Patient Initiated Follow-up
PMRT	Perinatal Mortality Review Tool
PPE	Personal Protective Equipment
PQIP	Perioperative Quality Improvement Programme
PROMs	Patient Reported Outcome Measures
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
QI	Quality Improvement
QIP	Quality Improvement Project
QIPS	Quality Improvement and Patient Safety
QNI	Queen's Nursing Institute
RCP	Royal College of Physicians
RIS	Radiology Information System
RSV	Respiratory Syncytial Virus
RTT	Referral to Treatment
RVI	Royal Victoria Infirmary
SAMBA	Society for Acute Medicine Benchmarking Audit
SDM	Shared Decision Making
SHINE	Sustainable Healthcare in Newcastle
SHMI	Summary Hospital-level Mortality Indicator
SI	Serious Incident
SIRM	Serious Infection Review Meetings
SLE	Significant Learning Event
SUS	Secondary Uses Service
TAVI	Transcatheter Aortic Valve Implantation
UK	United Kingdom
UKRR	United Kingdom Renal Registry
UTI	Urinary Tract Infection
YPAGne	Young Person's Advisory Group North England

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. Gastroscopy

A test that looks at the inside of the food pipe (oesophagus), stomach and the first part of the small intestine (small bowel).

7. 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.

8. 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.

9. 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

10. 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.

11. 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.

12. MSSA

Methicillin-Sensitive *Staphylococcus aureus*. 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.

13. 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.

14. Shelford Group

The Shelford Group is a collaboration between ten of the largest teaching and research NHS Trusts in England.