The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	24 September 2020						
Title	Guardian of Safe Working Quarterly Report (Q1 2020)						
Report of	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours						
Prepared by	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	The terms and conditions of service of the new junior doctor contract (2016) require the Guardian of Safe Working Hours to provide a quarterly report to the Trust Board to give assurance to the Board that the junior doctors' hours are safe and compliant. The content of this report outlines the number and main causes of exception reports for the period 27th March 2020 to 26th June 2020.						
Recommendation	The Board of Directors is asked to note the contents of this report.						
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☐	☐	☐	☐
Impact detail	In order to maintain quality and safety, we must have a junior doctor workforce who can work within safe hours and receive excellent training.						
Reports previously considered by	Quarterly report of the Guardian of Safe Working Hours.						

GUARDIAN OF SAFE WORKING QUARTERLY REPORT

1. EXECUTIVE SUMMARY

This quarterly report to the Board covers the period 27th March 2020 to 26th June 2020.

There are now 781 trainees on the New Junior Doctor Contract and a total of 952 junior doctors in the Trust.

There were 9 exception reports in this period. This compares to 47 exception reports in the same quarter of 2019. The marked reduction in exception reporting reflects the complete change of working pattern for this period due to the Coronavirus pandemic.

The main area of exception reports is general medicine (FH).

The main cause of exception reports is when there is excessive workload which was not appropriate to hand over to on call teams, therefore doctors stayed late.

2. INTRODUCTION / BACKGROUND

The 2016 New Junior Doctor Contract came into effect on 3rd August 2016. All Lead Employer Trust (LET) employed trainees transitioned to the New Contract Terms and Condition of Service (TCS) in February 2020. The 2016 Contract has recently been reviewed. The changes are to be implemented in a staggered approach from August 2019 to October 2020.

The TCS on the new 2016 contract allows for exception reporting to raise reports on breaches of working hours and educational opportunities. These are ratified or rejected as appropriate by clinical supervisors and the process is overseen by the Guardian of Safe Working Hours.

The TCS require the Guardian of Safe Working Hours to provide a quarterly report to the Trust Board to give assurance to the Board that the junior doctors' hours are safe and compliant.

3. HIGH LEVEL DATA

		(previous quarter data for comparison)
Number of Junior Doctors on New Contract	781	(909)
Number of Exception reports	9	(29)
Number of Exception reports for Hours Breaches	9	(28)
Number of Exception reports for Educational Breaches	0	(2)
Fines	0	(0)

Admin Support for Role	Good
Job Planned time for supervisors	Variable

4. EXCEPTION REPORTS

4.1 Exception Report by Speciality (Top 3)

General Medicine	7
GP	1
Psychiatry	1

4.2 Exception Report by Rota (Top 4)

General Medicine FH F1	5
General Medicine FH SHO	2
GP F2	1
Psychiatry F2	1

4.3 Exception Report by Grade

Foundation Year 1	5
F2	2
SHO	2

4.4 Example Themes from Exception Reports

General Medicine FH COTE (F1/F2)

Exception reports were submitted when doctors stayed late to complete necessary tasks that were not appropriate to hand over to the on call teams. Exception Reports were mainly compensated for with time off in lieu.

5. EXCEPTION REPORT OUTCOMES

5.1 Work Schedule Reviews

There have been no work schedule reviews carried out due to exception reports. All work schedules have been reviewed to ensure compliance with the changes to the Junior Doctor Contract.

5.2 Fines

No fines have been issued during the quarter.

6. ISSUES ARISING

6.1 Coronavirus

In response to the Coronavirus pandemic, a total of 138 trainees working within medicine had their working rotas changed to respond to an anticipated change in demand. In addition, 90 trainees were redeployed to work within medicine from other specialties. Anaesthesia and Intensive Care Medicine also changed their working rotas and redeployed trainees from anaesthesia to Intensive Care to accommodate the increased demand, and the potential for a further surge in demand. As demand decreased, the rotas have been 'de-escalated' to reflect this. The lack of Exception Reporting in this period reflects the good staffing levels and consultant support available to respond to the pandemic. It also reflects the excellent response of trainees and the willingness to help in such a time of uncertainty.

6.2 Supervisor Engagement

Supervisor engagement is currently very good, with fast response to Exception Reports.

6.3 Administrative Support

Replacement personnel are now settled in post and provide excellent administrative support. This has proved extremely timely, as medical staffing has been required to rewrite the majority of working rotas for junior doctors to ensure appropriate remuneration for the work done. This has been vital to ensure that junior doctors feel supported and valued during this time.

7. ROTA GAPS

Work schedules, working patterns and rotas were completely rewritten during this time. It is therefore not appropriate to comment on longer term rota gaps as these did not reflect the actual work carried out by trainees during this quarter. Rotas were rewritten to accommodate the actual number of doctors available. Within these rotas there was a need to plan for worst case scenarios regarding possible mass sickness and potential huge surges in demand. Each directorate found individual solutions to ensure safe staffing levels in the face of unknown demand.

7.1 Locum Spend

The total amount of internal locum spend was £679,915.59. There was no external agency locum spend during the period.

8. REVISION TO 2016 JUNIOR DOCTOR CONTRACT

The 2016 Junior Doctor Contract has been revised. There are a number of changes which are to be implemented in a staggered manner before October 2020. All work schedules are

now compliant, although some will require further changes in the long term to ensure ongoing compliance.

9. RISKS AND MITIGATION

The main risk remains medical workforce coverage across a number of rotas. This will need ongoing review as workload increases to pre-Coronavirus levels.

10. JUNIOR DOCTOR FORUM

Money allocated (£30,000) from central funds to junior doctors to improve working conditions was agreed via the Junior Doctor Forum to be spent on improving rest facilities. The money has been spent on reclining sofas and chairs, sleep pods and refurbishment of the new junior doctors' mess at the Freeman Hospital.

It is a requirement that documentation of the allocation of these funds and justification of its use is provided to the Trust Board.

Work to build the new Junior Doctors' mess and on call rooms at the Freeman Hospital was ongoing during this quarter. This new facility was opened on 19 August 2020. It has been very warmly received by the junior doctors.

I would like to thank the Board on behalf of the junior doctors for enabling this facility to be built.

11. RECOMMENDATIONS

I recommend that we continue to be proactive at assessing the workforce/workload balance, and continue to find local solutions to ensure that patient safety and excellent training are maintained.

Report of Henrietta Dawson
Consultant Anaesthetist
Trust Guardian of Safe Working Hours
21st August 2020

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	24 September 2020						
Title	Consultant Appointments						
Report of	Andy Welch, Medical Director						
Prepared by	Colin Sakhe, HR Advisor (Medical & Dental)						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	The content of this report outlines recent Consultant Appointments.						
Recommendation	The Board of Directors is asked to review the decisions of the Appointments Committee.						
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. People – Supported by Flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☐	☐	☐	☒	☐	☐	☐
Impact detail	Ensuring the Trust is sufficiently staffed to meet the demands of the organisation.						
Reports previously considered by	Consultant Appointments are submitted for information in the month following the Appointments Panel.						

CONSULTANT APPOINTMENTS

1. APPOINTMENTS COMMMITTEE – CONSULTANT APPOINTMENTS

1.1 An Appointments Committee was held on 23 July 2020 and interviewed 1 candidate for 1 Consultant Paediatric Cardiologist post.

By unanimous resolution the Committee was in favour of appointing Dr Kaitav Vibhakar Adhvaryu.

Dr Adhvaryu holds MBBS (University of Mumbai) 1999 and MRCPCH (UK) 2008. Dr Adhvaryu is currently employed as a Specialty Registrar based at the Guy's and St. Thomas' NHS Foundation Trust.

Dr Adhvaryu is expected to take up the post of Consultant Paediatric Cardiologist in October 2020.

1.2 An Appointments Committee was held on 27 July 2020 and interviewed 1 candidate for 1 Consultant Physician in Infectious Diseases & Virology.

By unanimous resolution the Committee was in favour of appointing Dr Brendan Alexander Ingleby Payne.

Dr Payne holds MBBS (University of Nottingham) 2002 and PhD (University of Newcastle) 2014. Dr Payne is currently employed as a Locum Consultant in Infectious Diseases and Virology based at the Freeman Hospital.

Dr Payne took up the post of Consultant Physician in Infectious Diseases & Virology on 31 August 2020.

1.3 An Appointments Committee was held on 26 August 2020 and interviewed 1 candidate for 1 Consultant in Intensive Care Medicine & Anaesthesia post.

By unanimous resolution the Committee was in favour of appointing Dr Donna Kelly.

Dr Kelly holds MBBS (University of Newcastle) 2009 and FFICM (UK) 2019. Dr Kelly is currently employed as a Speciality Trainee based at the Royal Victoria Infirmary.

Dr Kelly is expected to take up the post of Consultant in Intensive Care Medicine & Anaesthesia in March 2022.

1.4 An Appointments Committee was held on 09 September 2020 and interviewed 1 candidate for 1 Consultant Plastic Surgeon with interest in hand and sarcoma surgery post.

By unanimous resolution the Committee was in favour of appointing Mr Timothy Patrick Crowley.

Mr Crowley holds MBChB (University of Glasgow) 2009 and FRCS (UK) 2018. Mr Crowley is currently employed as a Specialty Trainee based at the Royal Victoria Infirmary.

Mr Crowley is expected to take up the post of Consultant Plastic Surgeon with interest in hand and sarcoma in December 2020.

1.5 An Appointments Committee was held on 09 September 2020 and interviewed 1 candidate for 1 Consultant Plastic Surgeon with interest in burns post.

By unanimous resolution the Committee was in favour of appointing Mr Christopher John Lewis.

Mr Lewis holds MBBS (University of London) 2006 and FRCS (UK) 2018. Mr Lewis is currently employed as a Specialty Trainee based at the Royal Victoria Infirmary.

Mr Lewis is expected to take up the post of Consultant Plastic Surgeon with interest in burns in December 2020.

2. RECOMMENDATION

1.1 – 1.5 – For the Board to receive the above report.

Report of Andy Welch
Medical Director
14 September 2020

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	24 September 2020						
Title	Honorary Consultant Appointments						
Report of	Andy Welch, Medical Director/ Deputy Chief Executive Officer						
Prepared by	Andy Welch, Medical Director/ Deputy Chief Executive Officer						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☐	☒	☒				
Summary	The content of this report outlines recent requests for Honorary Consultant Contracts.						
Recommendation	The Board of Directors is asked to note the award of/ extension to the Honorary Consultant Contracts.						
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. Pioneers – Ensuring that we are at the forefront of health innovation and research.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☒	☒	☐	☐	☐
Impact detail	Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality.						
Reports previously considered by	Honorary Consultant Appointment requests are submitted as and when requests are received.						

HONORARY CONSULTANT APPOINTMENTS

1. HONORARY CONSULTANT APPOINTMENT REQUESTS

1.1 Dr John Greenaway

Dr Greenaway, MBBS Newcastle 1990, MRCP (UK) 1994, FRCP 2005 is currently employed as a Consultant Gastroenterologist by South Tees Hospitals NHS Foundation Trust

An Honorary Contract has been requested to access mentorship from Dr Oppong and colleagues to learn additional skills related to the delivery of an endoscopic service.

There are no financial implications for the Trust.

1.2 Dr Azmi Mohammed

Dr Mohammed, MBBS Khartoum 2007, MRCP (UK) 2015, MSc Endocrinology and Diabetes London 2019, SCE in Endocrinology and Diabetes 2018 is currently employed by Newcastle University as a Professor of Primary Care at the Institute of Health and Society.

An Honorary Contract has been requested to allow Dr Mohammed to participate in pituitary and reproductive endocrinology clinics under the supervision of Dr Richard Quinton.

There are no financial implications for the Trust.

2. RECOMMENDATIONS

The Board is asked to note:

1.1 Dr John Greenaway is granted an Honorary Contract as a Consultant Gastroenterologist with immediate effect.

1.2 Dr Azmi Mohammed be awarded an Honorary Contract as a Consultant Endocrinologist and Diabetologist.

Report of Andy Welch
Medical Director
16th September 2020

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Healthcare worker flu vaccination best practice management checklist

For public assurance via trust boards by December 2020

A	**Committed leadership** (number in brackets relates to references listed below the table)	**Trust self-assessment**
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	100% ambition acknowledged
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	Yes in action plan
A3	Board receive an evaluation of the flu programme 2019/20, including data, successes, challenges and lessons learnt	Yes in action plan
A4	Agree on a board champion for flu campaign	Yes, Maurya Cushlow, Executive Chief Nurse and Andy Welch, Medical Director
A5	All board members receive flu vaccination and publicise this	Yes in action plan
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Flu Steering Group well established, staff side representative requested and receipt of minutes. Also discussed at Trust Consultative Group and Employment Partnership Forum.
A7	Flu team to meet regularly from September 2020	In place and included in action plan
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trade unions	In place and included in action plan
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	In place and included in action plan
B3	Board and senior managers having their vaccinations to be publicised	In place and included in action plan
B4	Flu vaccination programme and access to vaccination on induction programmes	In place and included in action plan
B5	Programme to be publicised on screensavers, posters and social media	In place and included in action plan
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	In place and included in action plan
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	Robust training program in place – all directorates supported
C2	Schedule for easy access drop in clinics agreed	In place and included in action plan Clinics are booked clinics not drop in due to COVID-19 and need for social distancing
C3	Schedule for 24 hour mobile vaccinations to be agreed	Twilight shift, weekend and night duty shifts agreed via Staff Bank and Occupational Health Nurse team

D	Incentives	
D1	Board to agree on incentives and how to publicise this	In place and included in action plan – "Get a jab, give a jab" in place and free hot drink with every jab
D2	Success to be celebrated weekly	In place and included in action plan

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Recommended visiting principles for staff

To protect our patients and help prevent the spread of coronavirus (COVID-19), we will continue to limit visitors into our hospitals.

We know visits are an important source of emotional support, care and healing for our patients as well as providing solace for the family members who will often be highly distressed at being separated from their loved ones during a period of severe illness.

However, we are in a pandemic and also have a duty to keep our patients, staff and the public safe by minimising the spread of coronavirus.

It is important we try to get the balance right so we are restricting visiting in a way that is compassionate, patient-centred, fair and consistent across the Trust.

Virtual visits should **still** be the primary method of families staying in contact. However physical visits can now be offered on an individual basis and agreed by the ward sister.

Visiting restrictions

To help ensure safe visiting for all wards and limit the risks to our patients and staff, please note the following:

- Wherever possible only the same named visitor should come into the ward/clinical area during the admission, except for parents where both may be allowed to alternate.
- Visiting should be staggered where possible
- Visitors **must be** over 16 years old, unless there are exceptional circumstances
- Visitors must wear relevant PPE for the area they are visiting. As a minimum face coverings must be worn at all times
- Visits must be pre-booked on a ward rota that facilitates the following:

    - Maximum of one visitor per patient per day for up to one hour (unless in exceptional circumstances, please see below further information for maternity services and children services)

    - Limits may be applied to the duration and frequency of visits based on the needs of the ward balanced with ensuring equity of access. The exception is for regular carers where support may be required every day.

Responsibilities

Ward staff should make contact with family or carers to discuss visiting arrangements and should consider the following:

- Who would like to come in?
- Do they have any signs or symptoms of COVID-19? If this is the case they will be unable to visit
- People who are shielding or living with someone who is shielding or self-isolating should be encouraged to arrange a virtual visit
- Explain the restrictions that are in place in your ward/department including necessary PPE, what to wear and what to do on arrival
- Arrange a suitable time and date for the visit and record this on the visitor track and trace rota. Explain this information will be kept for 15 days (Appendix 1).

On the day of the visit, ward staff should reiterate the responsibility of the visitor and infection control requirements, ensuring the visitor is supported in wearing the relevant PPE.

Additional information for visitors

1. All visitors must wear a face covering covering/mask when coming into hospital buildings (please ask visitors to bring their own). In paediatric areas local guidance should be followed for a parent living with a child
2. One visitor per patient per day for up to one hour (exceptions may apply for eg: maternity and children services, people with Learning Disabilities (LD) - please refer to further guidance below)
3. Where possible the visitors should maintain a 2m social distance.
4. Good hand hygiene must be observed throughout visit
5. Only essential items should be brought by visitor
6. If there is less than 1m between the visitor and patient, and the patient becomes COVID +ve, there will be a requirement for the visitor to isolate for 14 days in line with PHE guidance (visitors will be informed via the ward track and trace process)
7. Visiting in areas undertaking aerosol generating procedures (AGP) should be agreed with the ward/service. For End of Life care, the ward should take advice from IPCN to facilitate visiting wherever possible
8. Continue to promote and utilise virtual visiting whenever possible
9. If a visitor displays symptoms while visiting they will need a referral to tested

Patients who are awaiting screening results should be managed as if +ve until result determined			
Patient Group	**Visiting guidance**	**Specific PPE and IPC for visitors**	**Updated visiting arrangements**
Adult patients -ve	The national restriction of visiting was lifted in June Visiting shall instead be subject to local discretion.	The Trust has provided IPADs to wards with a pre- programmed virtual visiting app – 'attendanywhere'. This app provides a confidential video and voice calling facility. It is not limited to one person at a time so multiple family members can call at once. There is also a bespoke e-mail address to each ward so relatives can send a letter, photo, poem or picture which are being printed off and given to patients on daily basis.	One visitor per day, per patient, for up to one hour. Clear visitor information will be shared through the website and social media Visitors will be asked to wear a face covering at all times while in the hospital. Hand sanitising facilities will be required at the entrances of the hospital. Visiting times will be agreed locally by the ward sisters/charge nurse or senior midwife. End of Life visiting to be supported and encouraged at a local level.

Adult +ve	Visiting shall be subject to local discretion and on an individual basis.	Use of virtual visiting and keeping in touch e-mails should be encouraged. Visitors who do not live with the patient will need to wear surgical mask, eye protection and an apron whilst in the cubicle (FFP3 mask, visor and gown if AGPs are being performed on the patient or if in a cohort bay where AGPS are being undertaken) Good hand hygiene must be emphasised. Staff must assist visitors to don and doff PPE correctly. If any break in PPE visitor will need to isolate for 14 days. If they have had exposure (to the patient) the above PPE is not essential but may be offered. Please consult further with IPC nurses. Visitors should be discouraged visiting a bay where AGPs are being undertaken visitors must wear a fit checked FFP3 mask along with the other recommended PPE	Virtual visiting should be encouraged whenever possible. Visiting will be negotiated locally by the ward sisters/charge nurse or senior midwife.

Adult patients lacking capacity to consent to their admission and those subject to Deprivation of Liberty (DoL)	Ward discretion should be employed to ensure that external assessors and legal representatives are supported to carry out their duties if they request visiting individual patients. Legal representatives can be: Those with a Lasting Power of Attorney for health and welfare matters Independent Mental Capacity Advocates (IMCAs) Relevant Person's Representative (relates to those subject to DoLS)	The Trust has provided IPADs to wards with a pre- programmed virtual visiting app – 'attendanywhere'. This app provides a confidential video and voice calling facility. It is not limited to one person at a time so multiple family members can call at once. There is also a bespoke e-mail address to each ward so relatives can send a letter, photo, poem or picture which are being printed off and given to patient's on daily basis.	The Trust will support remote assessments and visits The Trust will support visits if a patient's legal representative requests it as necessary in order to uphold the patient's rights Clear visitor information will be shared through the website and social media Visitors will be asked to wear a face covering at all times while in the hospital. Hand sanitising will be required at the entrances of the hospital. Visiting times will be agreed locally by the ward sisters/charge nurse or senior midwife.
Paediatrics COVID -ve	One parent is able to remain with their child whilst they are an inpatient. Parents can alternate staying with their child.	No PPE required. Social distancing within the environment and good hand hygiene must be emphasised If the parent becomes symptomatic and another parent / carer is able to stay with the child the symptomatic parent should leave. If there is no-one else to stay with the child a risk assessment should be made considering: • the parent is fit enough to remain with their	Paediatric wards will be required to carry out a local risk assessment to begin utilising bay and communal play areas. One additional visitor for up to one hour per day. Visitors will be asked to wear a face covering at all times while in the hospital.

		child • if the child would be adversely affected if they were left unaccompanied • the ward environment and speciality Based on that assessment the CD or Paediatric ID Consultant on Call and Senior Nurse will make the decision as to whether the symptomatic parent can remain – if they do they are they must remain in a cubicle with their child at all times.	Hand sanitising will be required at the entrances of the hospital. Visiting times will be agreed locally by the ward sisters/charge nurse or senior midwife.
Paediatrics COVID +ve	One parent is able to remain with their child whilst they are an inpatient. Whilst the child is +ve the same parent must stay with them.	If the parent / carer does not live with the child they will need to wear surgical mask, eye protection and an apron whilst in the cubicle (FFP3 mask, visor and gown if AGPs being performed on the patient or if in a cohort bay where AGPS are being undertaken) with their child. Good hand hygiene must be emphasised at all times. Staff must assist parents to don and doff PPE correctly. If any break in PPE, partner will need to isolate for 14 days. If they have had exposure (to the patient) the above PPE is not essential but may be offered. If the parent becomes symptomatic and another parent / carer is able to stay with the child the	Visiting arrangements will remain the same – restricted visiting will remain.

		symptomatic parent should leave. If there is no-one else to stay with the child a risk assessment should be made considering; • the parent is fit enough to remain with their child • if the child would be adversely affected if they were left unaccompanied • the ward environment and speciality Based on that assessment the CD / Paediatric ID Consultant on-call and Matron / Directorate Senior Nurse will make the decision as to whether the symptomatic parent can remain – if they do they must remain in a cubicle with their child at all times.	
Neonates COVID –ve	One parent is able to remain with their child whilst they are an inpatient. Parents can alternate staying with their child.	No PPE is required. Parents are required to wear a face mask. A surgical mask will be provided at Maternity reception for this purpose. For clinical care parents are required to wear PPE as appropriate. Social distancing within the environment and good hand hygiene must be emphasised. If parent becomes symptomatic they will be asked to arrange to be tested for COVID-19. Unfortunately they are unable to remain with their baby. Any alternative visitor in the interim needs to be discussed at the discretion of the Senior Nurse in charge.	One parent can visit at any time for the duration of the day and night. Both parents are able to visit their baby on the NICU however currently not at the same time. Parents will be asked to wear a face mask at all times while in the hospital. Hand sanitising will be required at the entrances of the hospital. Visiting times will be agreed locally by the ward sisters/charge nurse or senior midwife.

Neonates COVID +ve	One parent is able to remain with their child whilst they are an inpatient. Whilst the patient is +ve the same parent must stay with them.	As above. Good hand hygiene must be emphasised. Staff must assist parents to don and doff PPE correctly. If any break in PPE, partner will need to isolate for 14 days. If parent becomes symptomatic they will be asked to arrange to be tested for COVID-19. Unfortunately they are unable to remain with their baby. Any alternative visitor in the interim needs to be discussed at the discretion of the Senior Nurse in charge.	Visiting arrangements will remain the same – restricted visiting will remain.
Maternity patient COVID -ve	One birthing partner only during labour or for elective caesarean section. One Birthing partner for women who attend for induction of labour	All birth partners will be asked to wear a face covering. A surgical mask will be provided to any birth partner entering a theatre environment. Social distancing within the environment and good hand hygiene must be emphasised	No changes being made currently to main delivery suite. Newcastle Birthing Centre – If discharge is planned between 4-6 hours following birth, birth partner can remain present until discharge. If postnatal stay is greater than six hours women may have one designated visitor per day, per patient, for up to one hour (from the following day). Face masks must be worn at all times and adherence to social distancing/

Maternity patient COVID +ve (RVI wards 32,22, 34)	One birthing partner only during labour or for elective caesarean section No visitors - Visiting only at discretion of Senior Midwife in charge for exceptional circumstances	Visitors will be asked to wear a face covering at all times whilst in the hospital. Social distancing within the environment and good hand hygiene must be emphasised	One designated visitor per day, per patient, for up to one hour. It is recommended that this is the birth partner. The designated visitor should remain the same for the duration of the inpatient stay. Hand sanitising will be required at the entrances of the hospital. Visiting times will be agreed locally by the ward sisters/charge nurse or senior midwife.
Maternity patient COVID +ve	One birthing partner only during labour or for elective caesarean section. Patient will be admitted to a single room for the duration of their care.	If the partner does not live with the patient they will need to wear surgical mask, eye protection and an apron whilst in the birthing room. Staff must assist visitors to don and doff PPE correctly. If any break in PPE, partner will need to isolate for 14 days. Hand hygiene to be encouraged. If they have had exposure (to the patient) the above PPE is not essential but may be offered. Face masks must be worn at all times and adherence to social distancing.	No changes being made currently for labour and birth for women who are symptomatic / test positive for COVID-19. Antenatal and postnatal inpatient visiting for women who are symptomatic / test positive of COVID-19, one designated visitor per day, per patient, for up to one hour will be supported. It is recommended that this is the birth partner. The designated visitor should remain the same for the duration of the inpatient stay. Hand sanitising will be required at the entrances of the hospital.

			Visiting times will be agreed locally by the ward sisters/charge nurse or senior midwife.
Learning disability / complex needs patient COVID -ve	Reasonable adjustments must be made for carer(s) to attend if patient requires their support and or to maintain their safety.	No PPE is required. Social distancing within the environment and good hand hygiene must be emphasised.	One visitor for up to one hour per day. Visitors will be asked to wear a face covering at all times whilst in the hospital. Hand sanitising will be required at the entrances of the hospital. Visiting times will be agreed locally by the ward sisters/charge nurse or senior midwife.
Learning disability / complex needs patient COVID +ve	Reasonable adjustments must be made for carer(s) to attend if patient requires their support and or to maintain their safety.	Carers may be paid carers as part of a healthcare package or family member. If the carer does not live with the patient they will need to wear surgical mask, eye protection and an apron whilst in the cubicle (FFP3 mask, visor and gown if AGPs are being performed on the patient or if in a cohort bay where AGPS are being undertaken). Good hand hygiene must be emphasised. Staff must assist parents to don and doff PPE correctly. If any break in PPE, carer /family member will need to isolate for 14 days.	Visiting restrictions will remain.

		If a carer becomes symptomatic they should leave and be replaced by another team member. If the family member becomes symptomatic another family member would be encouraged to attend to support the patient. If this is not possible a discussion must take place with the Learning Disability Nursing Team to identify what adjustments can be made to support the patient without their family and a risk assessment completed as in paediatrics considering; • the family member is fit enough to remain with the patient • if the patient will be adversely affected if they were left unaccompanied • the ward environment and speciality Based on that assessment the nurse in charge and senior clinician caring for the patient swill make the decision as to whether the symptomatic family member can remain – if they do they are they must remain in a cubicle with the patient at all times.	

Visiting End of Life Patients (Last few days of Life)			
Adult Patient COVID –ve	Visitors must be kept to a minimum and only one visitor to be with patient at a time. As a guide visitors should be able to have x2 two hour visiting slots within 24hrs unless death is expected within the hour and the visitor may remain with the patient until death. The above is also dependent upon the ability of the staff to support don and doff	No PPE is required Social distancing within the environment and good hand hygiene must be emphasised	Open visiting at the discretion of the ward sister. Visitors will be asked to wear a face covering at all times whilst in the hospital. Hand sanitising will be required at the entrances of the hospital.
Adult Patient COVID +ve	Visitors must be kept to a minimum and only one visitor to be with patient at a time. As a guide visitors should be able to have a one hour slot per day unless death is expected within the hour and the visitor may remain with the patient until death. The above is also dependent upon the ability of the staff to support don and doff	Visitors who do not live with the patient will need to wear surgical mask, eye protection and an apron whilst in the cubicle (FFP3 mask, visor and gown if AGPs are being performed on the patient or if in a cohort bay where AGPS are being undertaken) Good hand hygiene must be emphasised. Staff must assist visitors to don and doff PPE correctly. If any break in PPE visitor will need to isolate for 14 days. If they have had exposure (to the patient) the above PPE is not essential but may be offered.	Some visiting restrictions will remain.

		Visitors should be discouraged visiting a bay where AGPs are being undertaken visitors must wear a fit checked FFP3 mask along with the other recommended PPE.	
Paediatric / neonates COVID -ve	Two parents may be with their child at end of life. Siblings to be discussed with Sn Sister / CN / Matron	No PPE required Social distancing within the environment and good hand hygiene must be emphasised	No changes made
Paediatrics / neonates COVID +ve	Two parents may be with their child at end of life. Siblings to be discussed with Sn Sister / CN / Matron	If the parent / carer does not live with the child they will need to wear surgical mask, eye protection and an apron whilst in the cubicle (FFP3 mask, visor and gown if AGPs being performed on the patient or if in a cohort bay where AGPS are being undertaken) with their child. Good hand hygiene must be emphasised. Staff must assist parents to don and doff PPE correctly. If any break in PPE, parent / carer will need to isolate for 14 days. If they have had exposure (to the patient) the above PPE is not essential but may be offered.	No changes made

Implementation and Review: It is recommended to start launch the visiting principles week beginning 10 August with the aim to welcome visitors to the Trust from Wednesday 12 August 2020. An evaluation will take place week beginning 24 August to consider the impact on staff, patients and visitors. Further review may have to be undertaken to reflect any changes in national guidance.

Appendix 1 – Visitors' trace and trace ward rota

Visitors Template.xlsx

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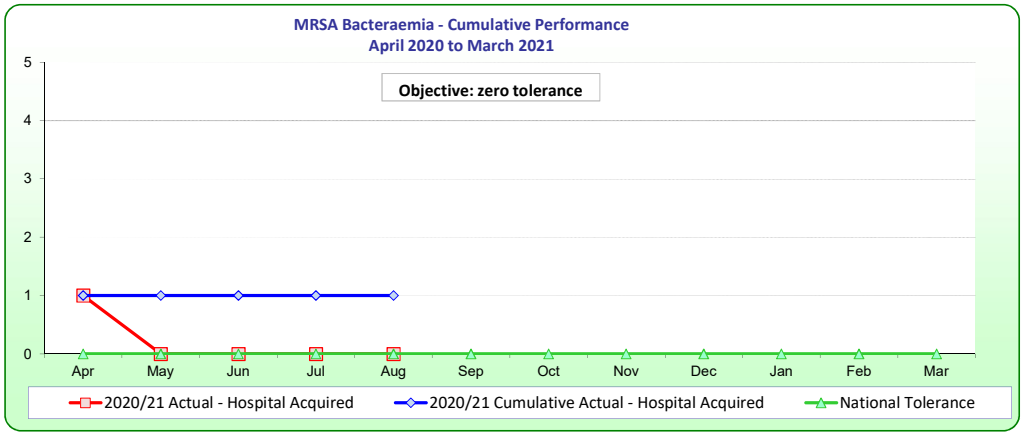
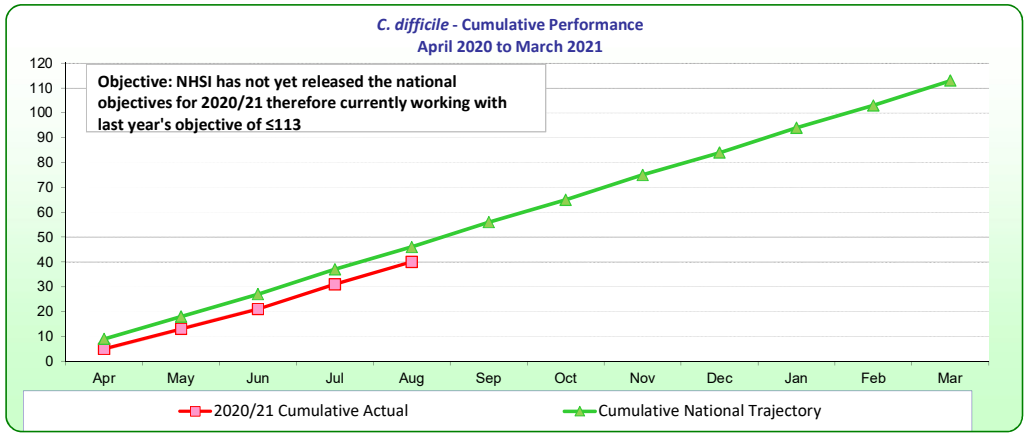
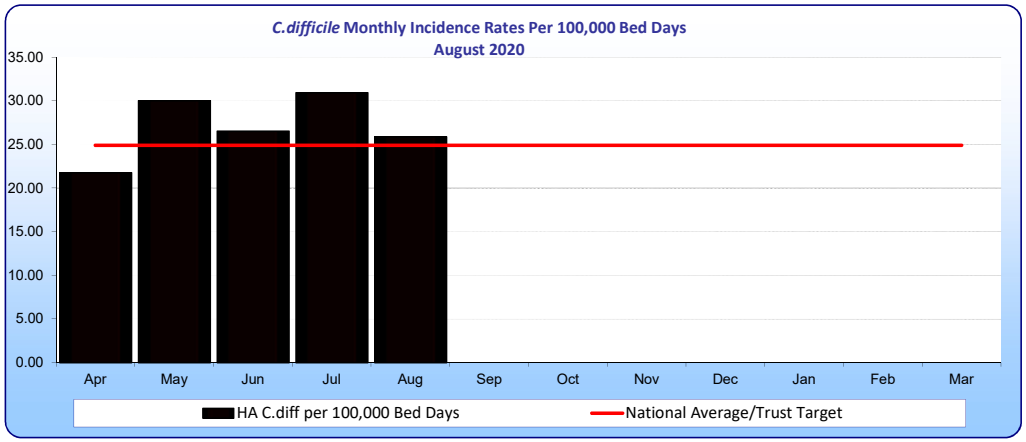
Agenda item A6(iv)

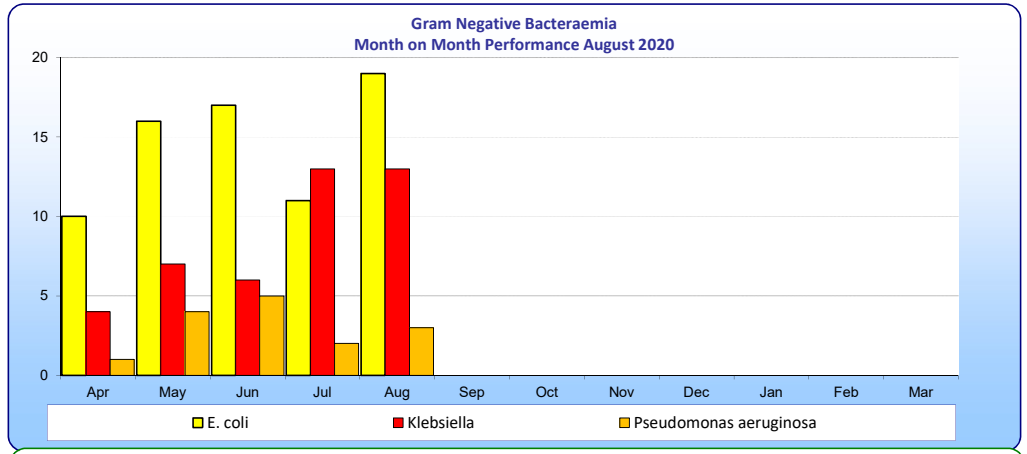
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

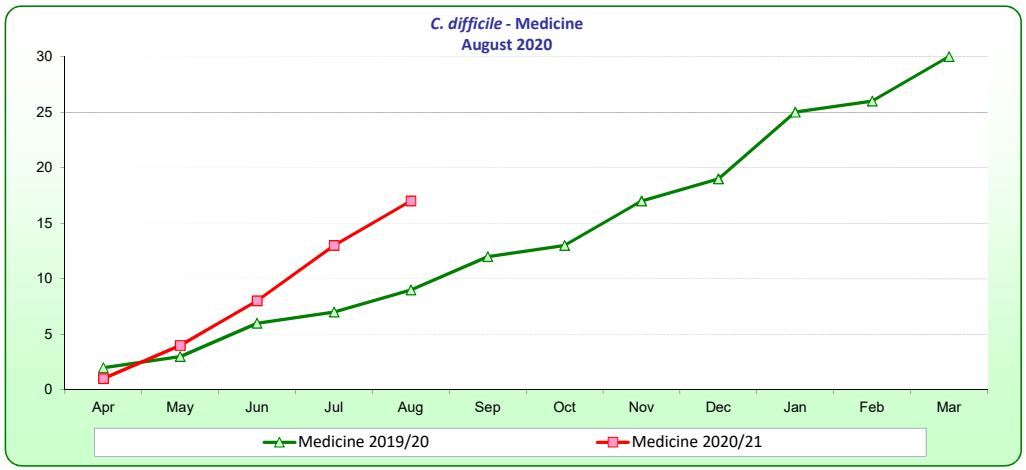
Healthcare-Associated Infections Report
August 2020

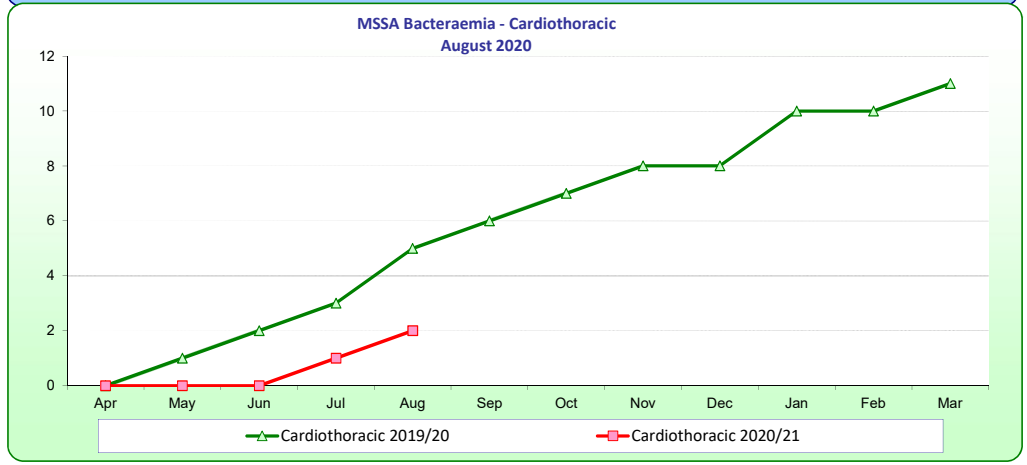

MRSA Bacteraemia - Cumulative Performance
April 2020 to March 2021
Objective: zero tolerance
0
1
2
3
4
5
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2020/21 Actual - Hospital Acquired
2020/21 Cumulative Actual - Hospital Acquired
National Tolerance

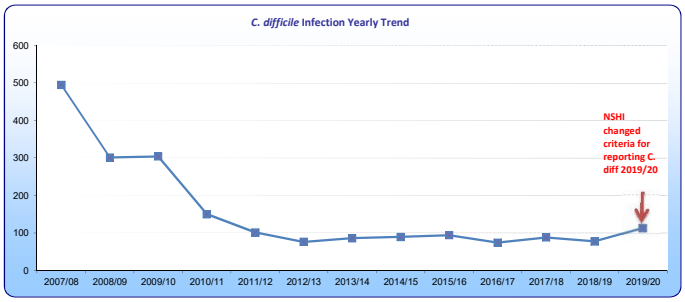

C. difficile - Cumulative Performance
April 2020 to March 2021
Objective: NHSI has not yet released the national objectives for 2020/21 therefore currently working with last year's objective of ≤113
0
10
20
30
40
50
60
70
80
90
100
110
120
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2020/21 Cumulative Actual
Cumulative National Trajectory

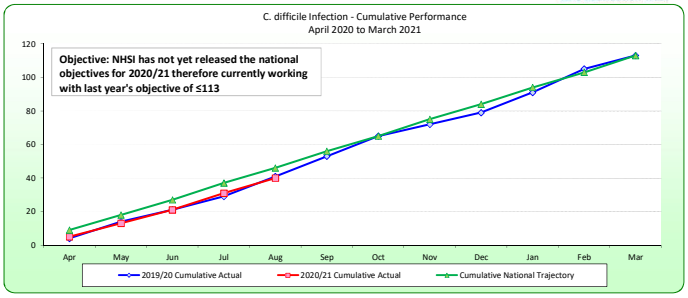

C.difficile Monthly Incidence Rates Per 100,000 Bed Days
August 2020
0.00
5.00
10.00
15.00
20.00
25.00
30.00
35.00
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
HA C.diff per 100,000 Bed Days
National Average/Trust Target

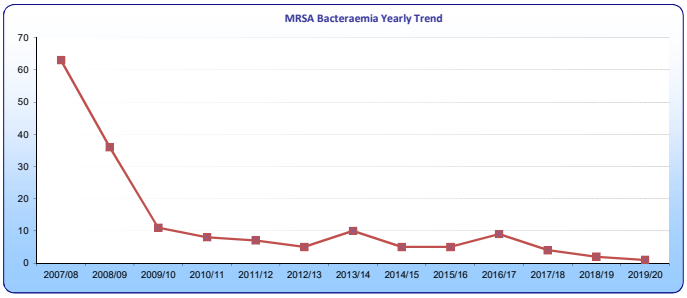

Gram Negative Bacteraemia
Month on Month Performance August 2020
0
5
10
15
20
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
E. coli
Klebsiella
Pseudomonas aeruginosa

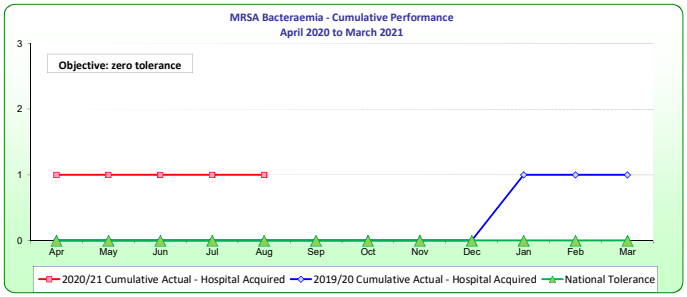

C. difficile - Medicine
August 2020
0
5
10
15
20
25
30
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Medicine 2019/20
Medicine 2020/21

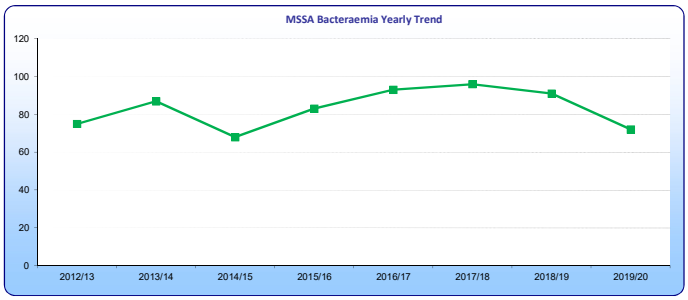

MSSA Bacteraemia - Cardiothoracic
August 2020
0
2
4
6
8
10
12
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Cardiothoracic 2019/20
Cardiothoracic 2020/21

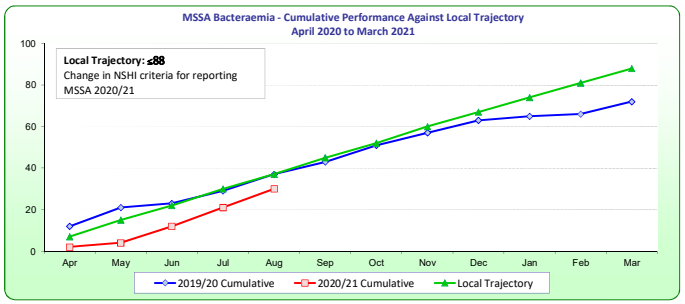

C. difficile Infection Yearly Trend
NSHI changed criteria for reporting C. diff 2019/20
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
2019/20

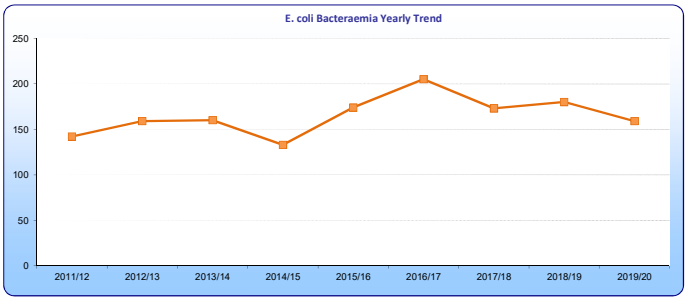

C. difficile Infection - Cumulative Performance
April 2020 to March 2021
Objective: NHSI has not yet released the national objectives for 2020/21 therefore currently working with last year's objective of ≤113
2019/20 Cumulative Actual
2020/21 Cumulative Actual
Cumulative National Trajectory

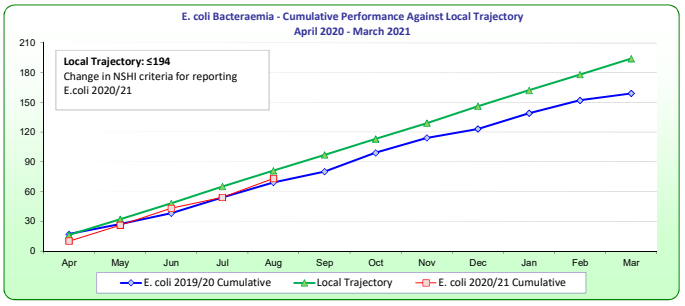

MRSA Bacteraemia Yearly Trend
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
2019/20

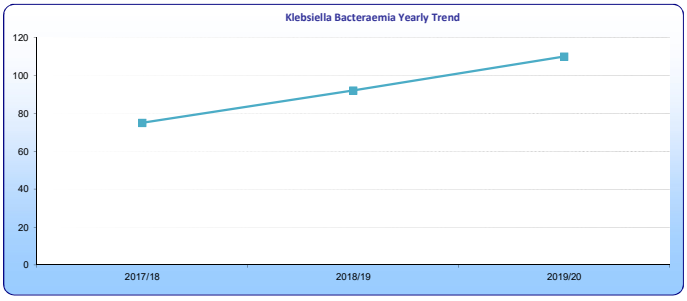

MRSA Bacteraemia - Cumulative Performance
April 2020 to March 2021
Objective: zero tolerance
2020/21 Cumulative Actual - Hospital Acquired
2019/20 Cumulative Actual - Hospital Acquired
National Tolerance

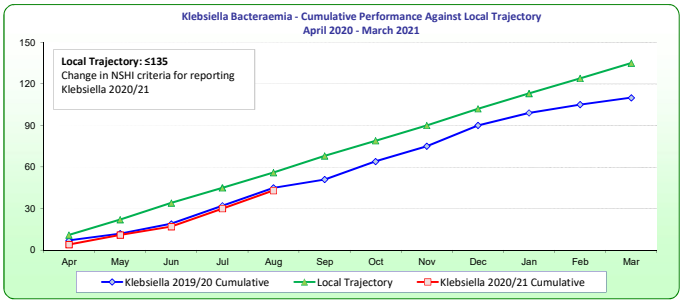

MSSA Bacteraemia Yearly Trend
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
2019/20

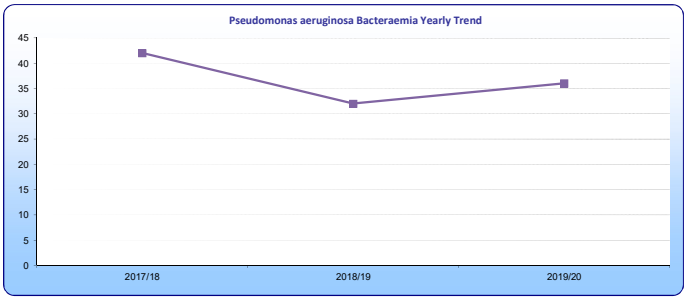

MSSA Bacteraemia - Cumulative Performance Against Local Trajectory
April 2020 to March 2021
Local Trajectory: ≤88
Change in NSHI criteria for reporting MSSA 2020/21
2019/20 Cumulative
2020/21 Cumulative
Local Trajectory

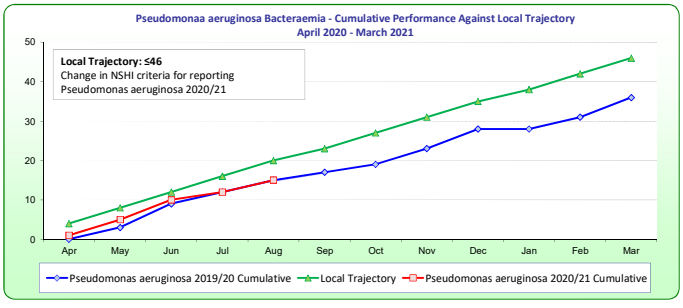

E. coli Bacteraemia Yearly Trend
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
2019/20


E. coli Bacteraemia - Cumulative Performance Against Local Trajectory
April 2020 - March 2021
Local Trajectory: ≤194
Change in NSHI criteria for reporting E.coli 2020/21
E. coli 2019/20 Cumulative
Local Trajectory
E. coli 2020/21 Cumulative


Klebsiella Bacteraemia Yearly Trend
2017/18
2018/19
2019/20


Klebsiella Bacteraemia - Cumulative Performance Against Local Trajectory
April 2020 - March 2021
Local Trajectory: ≤135
Change in NSHI criteria for reporting Klebsiella 2020/21
Klebsiella 2019/20 Cumulative
Local Trajectory
Klebsiella 2020/21 Cumulative


Pseudomonas aeruginosa Bacteraemia Yearly Trend
2017/18
2018/19
2019/20


Pseudomonaa aeruginosa Bacteraemia - Cumulative Performance Against Local Trajectory
April 2020 - March 2021
Local Trajectory: ≤46
Change in NSHI criteria for reporting Pseudomonas aeruginosa 2020/21
Pseudomonas aeruginosa 2019/20 Cumulative
Local Trajectory
Pseudomonas aeruginosa 2020/21 Cumulative

The Newcastle upon Tyne Hospitals NHS Foundation Trust

IPC indicators (reported to DH)	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
MRSA Bacteraemia - non-Trust	-	-	-	-	-								0
MRSA Bacteraemia - Trust-assigned (objective 0)	1	0	0	0	0								1
MRSA HA acquisitions	1	1	4	1	1								8
MSSA Bacteraemia - post-48 Hours Admission (local objective ≤65)	2	2	8	9	9								30
E coli Bacteraemia - post-48 Hours Admission (local objective ≤144)	10	16	17	11	19								73
Klebsiella Bacteraemia - post-48 Hours Admission (local objective ≤99)	4	7	6	13	13								43
Pseudomonas aeruginosa Bacteraemia - post-48 Hours Admission (local objective ≤33)	1	4	5	2	3								15
C.diff - Hospital Acquired (objective ≤113)	5	8	8	10	9								40
C.diff related death certificates	-	-	-	2	1								3
Part 1	-	-	-	-	1								1
Part 2	-	-	-	2									2

Periods of Increased Incidence (PIIs)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
MRSA HA acquisitions	-	-	-	-	-								0
Patients affected	-	-	-	-	-								0
C.diff - Hospital Acquired	-	-	-	1	0								1
Patients affected	-	-	-	2	0								2

Outbreaks	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Norovirus Outbreaks	-	-	-	-	-								0
Patients affected (total)	-	-	-	-	-								0
Staff affected (total)	-	-	-	-	-								0
Bed days losts (total)	-	-	-	-	-								0
Other Outbreaks	-	-	-	-	2								2
Patients affected (total)	-	-	-	-	7								7
Staff affected (total)	-	-	-	-	16								16
Bed days losts (total)	-	-	-	-	59								59

C.diff Transit and Testing Times Target <18hrs	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Trust Specimen Transit Time	10:30	11:13	12:01	12:23	10:32								11:19
Laboratory Turnaround Time	02:27	02:08	03:18	03:25	03:00								02:51
Total to Result Availability	12:57	13:21	15:19	15:48	13:32								14:11

Hygiene Indicators/Audits (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT Trust Total	CAT currently suspended due to COVID-19 pandemic												
Hand Hygiene Opportunity													
Hand Hygiene Technique													
Environmental Cleanliness													

Infection Control Mandatory Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Infection Control	85%	85%	85%	86%	86%								85%

Aseptic Non Touch Technique Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
ANTT (M&D staff only)	61%	61%	61%	61%	60%								61%

BRP - Agenda item A6(iv)

COVID-19 BOARD ASSURACE FRAMEWORK Assurance Overview							
Goal no.	Organisational Goal	Executive Lead	Date Reviewed at Assuring Committee	Rag rate compliance			
				Q1	Q2	Q3	Q4
1	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users	Director of Infection Prevention and Contol					
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	Director of Infection Prevention and Contol					
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	Director of Infection Prevention and Contol					
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion	Director of Infection Prevention and Contol					
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	Director of Infection Prevention and Contol					
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	Director of Infection Prevention and Contol					
7	Provide or secure adequate isolation facilities	Director of Infection Prevention and Contol					
8	Secure adequate access to laboratory support as appropriate	Director of Infection Prevention and Contol					
9	Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections	Director of Infection Prevention and Contol					
10	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	Director of Infection Prevention and Contol					

Goal 1: Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

Trust-Wide Risks:	Last Review Date: 07.06.2020	Risk Score	Q1	Q2	Q3	Q4
2142-Acquistion of HCAI is a risk to patient safety		Initial	20			
		Current	16			
		Target	12			
3789 - Risk of patients and staff acquiring COVID HCAI	Last Review Date: 07.05.2020	Risk Score	Q1	Q2	Q3	Q4
		Initial	20			
		Current	15			
		Target	5			

Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
1.1	Infection risk is assessed at the front door and this is documented in patient notes	IPC risk assessments completed on admissions and pre-assessment documented within electronic patient record (EPR); established practice for all IPC risks. As of 13/05/2020 COVID assessment and shielding patients is included in the admission document for first patient encounter. If any risk identified, info added (shielding, contact, COVID-19 +/-) recorded on banner bar on EPR. If highlighted as a COVID-19 contact, flag added to EPR, automatically removed after 14 days.	No audit of compliance for this assessment.	Development of audit process in progress with PaperLite team (numbers of admissions vs. assessments in EPR).	30/06/2020	10/08/2020				
1.2	Patients with possible or confirmed COVID-19 are not moved unless this is appropriate for their care or reduces the risk of transmission	Medicine clinical pathway for ED/AS. Clinical management of patients with known or suspected COVID-19 admission which is on the Trust Intranet site. Once triage/risk assessment completed and flag added to EPR, no patient transfer until there is an appropriate location to transfer the patient e.g. cubicle/cohort (based on likelihood of positivity). Limited patient transfer and only move based on clinical need and specialist care.	No audit of patient movement	HCAI COVID results are investigated for indeterminate / probable and definate cases which evidence that patients are not moved inapproprately.	30/06/2020	10/08/2020				

Goal 1: Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

Trust-Wide Risks:	Last Review Date: 07.06.2020	Risk Score	Q1	Q2	Q3	Q4
2142-Acquistion of HCAI is a risk to patient safety		Initial	20			
		Current	16			
		Target	12			
3789 - Risk of patients and staff acquiring COVID HCAI	Last Review Date: 07.05.2020	Risk Score	Q1	Q2	Q3	Q4
		Initial	20			
		Current	15			
		Target	5			

	Key line of enquiry/ Systems and processes are in place to ensure:	Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
1.3	Compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patients	National guidance a[C:\Users\sykesa\Desktop\COVID-19 PPE instructions -]nto local guidelines and changed with guidar tes. Evidenced in PPE guidance on Trust intranet page. All non-elective patients tested on admission regardless of symptoms (serology and screening). Screening of elective admissions prior to admission. Patients transferred in-line with National PPE requirements for patients and staff with the exception of the use of gloves. Infection status communicated to receiving area COVID-19 status is part of transfer information. Patients discharged to nursing homes are screened in line with National guidance.	None currently.	The use of gloves during transfer of patients deviates from PHE guidance based upon risk of environmental spread from contamination gloves.	30/06/2020	10/08/2020				

Goal 1: Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

Trust-Wide Risks:	Last Review Date: 07.06.2020	Risk Score	Q1	Q2	Q3	Q4
2142-Acquistion of HCAI is a risk to patient safety		Initial	20			
		Current	16			
		Target	12			
3789 - Risk of patients and staff acquiring COVID HCAI	Last Review Date: 07.05.2020	Risk Score	Q1	Q2	Q3	Q4
		Initial	20			
		Current	15			
		Target	5			

	Key line of enquiry/ Systems and processes are in place to ensure:	Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
1.4	All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	Training delivered by IPC Team and Clinical Educators, PPE buddies in place, multiple guidance posters and videos. Fit-tester training delivered by appropriate trainers (HSE guidance); list of fit testers available on Trust intranet site – on-going process. All staff wear PPE regardless of patients COVID status. The level of PPE is in line with the level of care deliver i.e. AGP or non-AGP. Evidenced on Trust PPE guidance. Contractors supplied with appropriate PPE and if required FFP3 fit testing is undertaken by contractor (i.e. asbestos removal). Robust PPE management with a dedicated team from Procurement overseeing supply and stock levels. All staff in non-clinical areas wear surgical face masks in non-COVID-19-secure areas from Monday 15th June All patients/visitors requested to wear face coverings from Monday 15th June.	None currently.	All staff wear respiratory PPE for patient contacts which will reduce transmission risk to patients. Perspex screens applied in the dialysis unit to reduce contact risk between patients attending for dialysis. Directorates to review how to manage patient flow for shielding patients through reset and recovery.	30/06/2020	10/08/2020				

Goal 1: Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

Trust-Wide Risks:	Last Review Date: 07.06.2020	Risk Score	Q1	Q2	Q3	Q4
2142-Acquistion of HCAI is a risk to patient safety		Initial	20			
		Current	16			
		Target	12			
3789 - Risk of patients and staff acquiring COVID HCAI	Last Review Date: 07.05.2020	Risk Score	Q1	Q2	Q3	Q4
		Initial	20			
		Current	15			
		Target	5			

	Key line of enquiry/ Systems and processes are in place to ensure:	Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
1.5	National IPC PHE guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	Trust guidance updated and communicated via COVID-19 briefs and in-line with national guidance. Trust has dedicated intranet page for COVID-19 with all clinical updates.	There is no correspondence sent from PHE to inform when guidance has been changed.	Government webpage checked on Friday and Monday morning by Senior Nurse (Practice Development IPC) or Matron IPC. IPC Matron holds weekly vertual meeting with Head of IPC at GHFT to share learning & updates. ICS weekly meetings commenced 08/07/2020.	30/06/2020	10/08/2020				
1.6	Changes to PHE guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	Guidance changes communicate to the COVID-19 Hospital Control Team and when relevant, discussed at the executive meetings and escalated to Trust Board.	None currently.		30/06/2020	10/08/2020				

Goal 1: Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

Trust-Wide Risks:	Last Review Date: 07.06.2020	Risk Score	Q1	Q2	Q3	Q4
2142-Acquistion of HCAI is a risk to patient safety		Initial	20			
		Current	16			
		Target	12			
3789 - Risk of patients and staff acquiring COVID HCAI	Last Review Date: 07.05.2020	Risk Score	Q1	Q2	Q3	Q4
		Initial	20			
		Current	15			
		Target	5			

	Key line of enquiry/ Systems and processes are in place to ensure:	Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
1.7	Risks are reflected in risk registers and the Board Assurance Framework where appropriate	COVID-19 risks have been incorporated into the Risk Register at directorate & corporate level. COVID-19 Risk Register entries included in Risk Register Report to Patient Safety Group; this group reports to Quality Committee. Weekly Datix incident report circulated to COVID-19 Hospital Control Team. Comprehensive range of risk assessments undertaken, examples include: shortages of PPE, asymptomatic staff, equipment.	None currently.		30/06/2020	10/08/2020				
1.8	Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	IPC risks assessment included in EPR. Risk assessment re priority for isolation rooms, guidance for staff available via 7-day IPCN cover and out of hours Microbiology support. IPC policies in place and surveillance for mandatory reporting organisms	None currently.	IPCNs perform daily cubicle reviews within medical directorate to support correct isolation and pt. flow - link with PSC and recorded on shared drive.	30/06/2020	10/08/2020				

Goal 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections										
Trust-wide Risks: 3591- Due to ageing infrastructure and lack of suitable investment through lifecycle maintenance ventilation systems are not compliant with HTM03-01 which could result in air bourne disease as well as non compliance with statutory regulation.				Last Review Date: 30.06.2020	Risk Score	Q1	Q2	Q3	Q4	
					Initial	15				
					Current	15				
					Target	5				
					Risk Score	Q1	Q2	Q3	Q4	
					Initial					
					Current					
					Target					

Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
2.1	Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	PPE training delivered by Senior Nurse (Practice Development IPC), IPC nurses and Clinical Educators . Training records held by Clinical Educators.  PE training at ward level by designated cascade staff and local records held. Volunteers had local induction as per Trust guidance.	None currently.		30/06/2020	10/08/2020				
2.2	Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	Hotel services supervisor trained in PPE by IPCT and then delivered training via cascade. Training records held by Hotel Services Manager. Domestic staff assigned to COVID-19 ward.	None currently.		30/06/2020	10/08/2020				

Goal 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections										
Trust-wide Risks: 3591- Due to ageing infrastructure and lack of suitable investment through lifecycle maintenance ventilation systems are not compliant with HTM03-01 which could result in air bourne disease as well as non compliance with statutory regulation.				Last Review Date: 30.06.2020	Risk Score	Q1	Q2	Q3	Q4	
					Initial	15				
					Current	15				
					Target	5				
					Risk Score	Q1	Q2	Q3	Q4	
					Initial					
					Current					
					Target					

Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
2.3	Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE national guidance	Complies with national guidance and evidence in COVID-19 patient management documents on intranet. CapMan requests for AMBER COVID-19 cleans. COVID-19 cleans performed by Rapid Response, in line with all HCAI. Are monitored monthly by the Head of Facilities and reported to IPC Operational group and updated in IPCC for reference. Escalated to board by exception.	None currently.		30/06/2020	10/08/2020				
2.4	Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE national guidance	As above, patient touch points or high touch points included as twice day.	None currently.		30/06/2020	10/08/2020				
2.5	Attention to the cleaning of toilets / bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	As above, touch points included as twice day.	None currently.		30/06/2020	10/08/2020				

Goal 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Trust-wide Risks:	Last Review Date:	Risk Score	Q1	Q2	Q3	Q4
3591- Due to ageing infrastructure and lack of suitable investment through lifecycle maintenance ventilation systems are not compliant with HTM03-01 which could result in air bourne disease as well as non compliance with statutory regulation.	30.06.2020	Initial	15			
		Current	15			
		Target	5			

		Risk Score	Q1	Q2	Q3	Q4
		Initial				
		Current				
		Target				

Key line of enquiry/	Systems and processes are in place to ensure:	Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
2.6	Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local Infection Prevention and Control Team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	Cleaning products used as per Trust policy. There was difficulty in obtaining usual cleaning products as this has now been added to Supplies push orders – other products were delivered which meet same standard. IPCT informed by Procurement prior to product shortage to enable planning and to assess effectiveness of alternative products.	None currently. C:\Users\sykesa\ Desktop\Revised Cleanliness		30/06/2020	10/08/2020				
2.7	Manufacturers' guidance and recommended product "conta[illegible]s must be followed for all cleaning / disinfectant solutions / products	C:\Users\sykesa\ Desktop\IPC advice during C:\Users\sykesa\ Desktop\Staff handbook - version contamination of Patient Environment and Healthcare Equipment Policy.	None currently.		30/06/2020	10/08/2020				

Goal 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Trust-wide Risks:	Last Review Date:	Risk Score	Q1	Q2	Q3	Q4
3591- Due to ageing infrastructure and lack of suitable investment through lifecycle maintenance ventilation systems are not compliant with HTM03-01 which could result in air bourne disease as well as non compliance with statutory regulation.	30.06.2020	Initial	15			
		Current	15			
		Target	5			

		Risk Score	Q1	Q2	Q3	Q4
		Initial				
		Current				
		Target				

Key line of enquiry/	Systems and processes are in place to ensure:	Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
2.8	As per national guidance: 'Frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables & bed rails, should be decontaminated at least twice daily & when known to be contaminated with secretions, excretions or body fluids. Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops & keyboards should be cleaned at least twice daily. Rooms/areas where PPE is removed must be decontaminated, times to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	As previously noted. Twice day cleaning of staff electrical equipment in non-patient areas should be the responsibility of the user, guidance circulated and available on COVID-19 intranet page	 All staff electronic equipment in  areas has not been routinely cleaned twice day.	Trust cleaning schedules are being reviewed to incorporate this requirement by the end of July. - defered to August. Update weekly ward cleanliness assurance tool which included twice daily cleaning of electrical equiment. Linked validation audit for monitoring compliance of the weekyl tool. To commence September 2020 Changes will be available on COVID-19 intranet site and will be communicated via daily COVID-19 bulletin.	30/06/2020	10/08/2020				

Goal 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections										
Trust-wide Risks: 3591- Due to ageing infrastructure and lack of suitable investment through lifecycle maintenance ventilation systems are not compliant with HTM03-01 which could result in air bourne disease as well as non compliance with statutory regulation.				Last Review Date: 30.06.2020	Risk Score	Q1	Q2	Q3	Q4	
					Initial	15				
					Current	15				
					Target	5				
					Risk Score	Q1	Q2	Q3	Q4	
					Initial					
					Current					
					Target					

Key line of enquiry/	Systems and processes are in place to ensure:	Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
2.9	Linen from possible and confirmed COVID-19 patients is managed in line with PHE national guidance and the appropriate precautions are taken	Managed as per Trust Laundry Management Policy. 	Previous annual linen audit was completed pre COVID-19.	National IPC management checklist implemented Trust wide (commenced 24/07/2020) & includes linen management for audit of compliance.	30/06/2020	10/08/2020				
2.10	Single use items are used where possible and according to Single Use Policy	Follow appropriate guidance / policies. Reusing Single Use Equipment Policy during the COVID-19 Pandemic.	Deliver of supplies is not guaranteed where these are being issued centrally through the 'push' chain. Visors are being cleaned and reused to preserve stock. Possible shortages of NIV & CPAP devices.	Cleaning guidance included in PPE document on COVID-19 intranet page. Risk assessment and SOP in place regarding reprocessing of single use items in the event of extreme shortages (NIV and CPAP devices reprocessed via CSD); guidance prepared and in place prior to shortages experienced.	30/06/2020	10/08/2020				

Goal 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections										
Trust-wide Risks: 3591- Due to ageing infrastructure and lack of suitable investment through lifecycle maintenance ventilation systems are not compliant with HTM03-01 which could result in air bourne disease as well as non compliance with statutory regulation.				Last Review Date: 30.06.2020	Risk Score	Q1	Q2	Q3	Q4	
					Initial	15				
					Current	15				
					Target	5				
					Risk Score	Q1	Q2	Q3	Q4	
					Initial					
					Current					
					Target					

Key line of enquiry/	Systems and processes are in place to ensure:	Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
2.11	Reusable equipment is appropriately decontaminated in line with local and PHE national policy	Complies with National guidance and evidence in COVID-19 patient management documents on intranet. Follows cleaning & decontamination of the patient environment & healthcare equipment policy. Electronics and Medical Equipment (EME) keep a record of all 'fault reporting forms' reference numbers which include the decontamination status of the device when it is sent for repair. This process is also audited as part of EME quality system (iso9001). Cleanliness audits include review of cleanliness of reusable equipment	None currently.		30/06/2020	10/08/2020				

Goal 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections										
Trust-wide Risks: 3591- Due to ageing infrastructure and lack of suitable investment through lifecycle maintenance ventilation systems are not compliant with HTM03-01 which could result in air bourne disease as well as non compliance with statutory regulation.				Last Review Date: 30.06.2020	Risk Score	Q1	Q2	Q3	Q4	
					Initial	15				
					Current	15				
					Target	5				
					Risk Score	Q1	Q2	Q3	Q4	
					Initial					
					Current					
					Target					

Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
2.12	Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	Ventilation Safety Group monitors compliance of HTM requirements and planned programmed maintenance (PPM); established escalation process to DIPC where there are concerns.	Some isolation rooms are non-compliant with HTM standards for source isolation.	Refurbishing plan for existing cubicles on RV19; increasing the number of cubicle facilities with an ante room. Additional work for RV49 to create environment to ensure appropriate ventilation in COVID-19 ward (HDU).	30/06/2020	10/08/2020				

Goal 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance										
Trust-wide Risks:				**Last Review Date:**	Risk Score		Q1	Q2	Q3	Q4
					Initial					
					Current					
					Target					
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	**Q1**	**Q2**	**Q3**	**Q4**
							Assurance RAG			
3.1	Arrangements around antimicrobial stewardship(AMS) are maintained	Microbiologists document in patients' eRecord AMS decisions on individual patients.	Some business as usual work has been suspended to support COVID e.g. daily Micro ward rounds, Take 5 Audits, SIRM (including antibiotic reviews).	ABS rules applied at time of authorisation of results. Lab continue to test for antibiotic resistance which informs appropriate prescribing. AMS guidelines reviewed with National & local guidance.	30/06/2020	10/08/2020				
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight	Mandatory HCAI reporting continues. Bimonthly DIPC Reports to Board. Regular reports from DIPC to Quality Committee. Medical Director and Executive Chief Nurse in Gold COVID-19 Command Group.	None currently.		30/06/2020	10/08/2020				

Goal 4: Provide suitable a accurate information on infections to service users, their visitors and any person concerned with providing further support of nursing / medical care in a timely fashion

Trust-wide Risks:	**Last Review Date:**	Risk Score	Q1	Q2	Q3	Q4
3790 - Personal Protective Equipment (PPE)		Initial	20			
		Current	15			
		Target	10			

	Key line of enquiry/ Systems and processes are in place to ensure:	Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
4.1	Implementation of national guidance on visiting patients in a care setting	Visitor information & guidance in line with National guidance; available on intranet. Patient information leaflets reviewed.	None currently.		30/06/2020	10/08/2020				
4.2	Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas marked with appropriate signage and where appropriate with restricted access	PPE signage at entrances. Clearly identified as restricted access and only accessible via swipe card. External company working with Trust Environment Group to enhance COVID-19 and non-COVID-19 signage.	No audit of compliance to correct PPE signage	Correct posters included in the weekly assurance audit tool. COVID-19 PPE updates are circulated in COVID briefing.	30/06/2020	10/08/2020				
4.3	Information and guidance on COVID-19 is available on all Trust websites with easy read versions	Dedicated COVID-19 page which is dated for evidence of last update. Daily email updates for all staff during pandemic, now reduced to three times a week as Trust continues restart work, unless required by exception.	None currently.		30/06/2020	10/08/2020				

Goal 4: Provide suitable a accurate information on infections to service users, their visitors and any person concerned with providing further support of nursing / medical care in a timely fashion										
Trust-wide Risks: 3790 - Personal Protective Equipment (PPE)				**Last Review Date:**	Risk Score		Q1	Q2	Q3	Q4
					Initial		20			
					Current		15			
					Target		10			
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	**Q1**	**Q2**	**Q3**	**Q4**
							Assurance RAG			
4.4	Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	COVID-19 positive status highlighted on EPR (banner bar). Status included in transfer information. Datix report submitted of investigation by receiving area if COVID status has not been communicated. **Weekly report to silver comand and CGARD team of any COVID related datix to help identify potential trends.**	None currently.		30/06/2020	10/08/2020				

Goal 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Strategic Risk: 3789 - Risk of patients and staff acquiring COVID HCAI	**Last Review Date:**	Risk Score	Q1	Q2	Q3	Q4
		Initial	20			
		Current	15			
		Target	5			

	Key line of enquiry/ Systems and processes are in place to ensure:	Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
5.1	Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection, as per national guidelines	ED/AS clinical pathway – clear triage and screening pathway. Dedicated COVID-19 wards have now reverted to non-covid wards due to decreased number in COVID-19 cases. Plan to reconvert wards to COVID if Trust has a surge in cases. Reduce bed capacity in bays to reduce patients exposure risks improve social distancing.	None currently		30/06/2020	10/08/2020				
5.2	Mask usage is emphasised for suspected individuals	Suspected patients are isolated and surgical masks are used during any transfer. All outpatients and visitors are requested to wear face coverings when entering the sites from 15th June 2020.	None currently		30/06/2020	10/08/2020				
5.3	Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	Reception areas have been risk assessed and Perspex screening has been applied. Appropriate PPE is available and worn as per guidance.	None currently		30/06/2020	10/08/2020				

Goal 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Strategic Risk:	**Last Review Date:**	Risk Score	Q1	Q2	Q3	Q4
3789 - Risk of patients and staff acquiring COVID HCAI		Initial	20			
		Current	15			
		Target	5			

	Key line of enquiry/ Systems and processes are in place to ensure:	Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
5.4	For patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	Isolation of symptomatic patients is priority over other organisms. Tracing and flagging of patient contacts via EPR for 14-day monitoring is completed with all COVID-19 cases which is supported by IPCNs, clinical teams flag EPR. Discharged patient contacts from w/c 22/06/2020 are contacted by IPCNs or clinical team to inform of contact & need to self-isolate. All HCAI COVID-19 cases positive from ≥3 days from admission are investigated from 30/05/2020 by IPCNs. (From 24/06/2020 this is now mandatory for all probable HCAI cases ≥ day 8 form admission).	None currently		30/06/2020	10/08/2020				

Goal 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Strategic Risk: 3789 - Risk of patients and staff acquiring COVID HCAI	**Last Review Date:**	Risk Score	Q1	Q2	Q3	Q4
		Initial	20			
		Current	15			
		Target	5			

	Key line of enquiry/ Systems and processes are in place to ensure:	Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
5.5	Patients with suspected COVID-19 are tested promptly	COVID-19 screen on admission or when suspected: • All patients at emergency admission, whether or not they have symptoms • those with symptoms of COVID-19 after admission • for those who test negative upon admission, a further single re-test conducted between 5-7 days after admission (there is a pop-up reminder on EPR to undertake a 7-day test; this can be audited) • test all positive patients on discharge to other care settings, including care homes and hospices • elective patient testing prior to admission	None currently		30/06/2020	10/08/2020				

Goal 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Strategic Risk: 3789 - Risk of patients and staff acquiring COVID HCAI	**Last Review Date:**	Risk Score	Q1	Q2	Q3	Q4
		Initial	20			
		Current	15			
		Target	5			

	Key line of enquiry/ Systems and processes are in place to ensure:	Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
5.6	Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced	Lab monitors transition times of samples received for audit which is reported via lab quality assurance processes and in the quarterly IPC report. Tests are processed in batches and results are reported within 24 hours; CEPHID analyser available to perform tests with a 2-hour turnaround time for transplant patients. HCAI patient COVID-19 cases investigated by IPCNs, including test and trace.	None currently		30/06/2020	10/08/2020				
5.7	Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Screening questions asked prior to appointment and on arrival. General IPC principles and isolation followed as per policy. Patient information describes symptoms and advises what actions to take by patients before coming to hospital if they are symptomatic or have been in contact with someone who is symptomatic (part of triage). Increased use of telephone consultations to replace face-to-face reviews.	None currently		30/06/2020	10/08/2020				

Goal 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection										
Trust-wide Risks:				**Last Review Date:**		Risk Score	Q1	Q2	Q3	Q4
						Initial				
						Current				
						Target				
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	**Q1**	**Q2**	**Q3**	**Q4**
							Assurance RAG			
6.1	All staff (clinical and non-clinical) have appropriate training, in line with latest PHE guidance, to ensure their personal safety and working environment is safe	Refer to Section 2.1. Fit-testing/checking on-going. Fit-testers available in all Directorates, with refresher sessions available for all fit testers. List of fit tester is available centrally on the COVID intranet site. Reusable half and full face masks (FFP3 level) are being allocated to individual staff memebers where appropriate. Powered Air Purifying Respirators (PAPRs) have been purchased and are available in theatres, ICU areas and for other staff where appropriate.	Compliance with fit testing is challenging due to the inconsistent supply of specific types of FFP3 masks. All supplies are push rather than pull. From NHS Supply Chain.	Where staff cannot be fit tested to a disposable or reusable FFP3 mask will have access to a PAPRs, which do not require fit testing. PAPRs to be held in the loan library for use as necessary.	30/06/2020	10/08/2020				
6.2	All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, including correct donning and doffing procedeures	COVID-19 audit to confirm PPE compliance is performed during HCAI COVID-19 investigations. Training information is available on the COVID intranet site, including doffing vidoes and written protocols. Training has been delivered to all clinical areas with PPE cascade trainers encouraged. Clinical Educators, PPE advisors and IPCNs deliver local PPE advise and training.	None currently	PPE snap-shot audits to completed by clincal standards team. Weekly assurance tool amended to include correct PPE in July 2020 PPE included in the National COVID management checklist comemenced Trust wide 24/07/2020 for monitoring of compliance.	30/06/2020	10/08/2020				

Goal 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection										
Trust-wide Risks:				**Last Review Date:**		Risk Score	Q1	Q2	Q3	Q4
						Initial				
						Current				
						Target				
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	**Q1**	**Q2**	**Q3**	**Q4**
							Assurance RAG			
6.3	A record of staff training is maintained	Refer to Section 2.	None currently		30/06/2020	10/08/2020				
6.4	Appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	Existing SOP for cleaning typhoon and 3M FFP3 reusable masks & powered hoods. Disposable items are not reused, risk assessment guides process for reusing items in circumstances for extreme PPE shortages. CAS Alerts co-ordinated via Hospital Control Team.	No audit trial for monitoring compliance of cleaning reusable items.		30/06/2020	10/08/2020				
6.5	Any incidents relating to the re-use of PPE are monitored and appropriate action taken	Users would report any incidences via Datix reporting and monitors.	None currently		30/06/2020	10/08/2020				
6.6	Adherence to PHE national guidance on the use of PPE is regularly audited	Strong peer support and challenge is encouraged to maintain staff safety. No formal audit evidence available. Audit of PPE compliance undertaken since 30/05/20 with any COVID-19 case positive from day ≥day 3 of hospital admission.	No evidence of regular audit program for COVID-19 PPE compliance at the present time.	IPCNs & PPE advisors visible presence across all clinical areas and provide education if identify any incorrect practices. Review of weekly COVID-19 Assurance checklist to include PPE compliance from 13/07/2020	30/06/2020	10/08/2020				

Goal 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection										
Trust-wide Risks:				**Last Review Date:**		Risk Score	Q1	Q2	Q3	Q4
						Initial				
						Current				
						Target				

Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
6.7	Staff regularly undertake hand hygiene and observe standard infection control precautions	Hand hygeine performed in line with Trust Policy. Monthly Matron hand hygiene compliance monitored.	Some business as usual work has been suspended to support COVID-19. This includes program of hand hygiene validation audits undertaken by IPCNs.	Observations for compliance with hand hygiene opportunities has been incorporated into the COVID-19 audit tool which is undertaken as in section 6.6	30/06/2020	10/08/2020				
6.8	Hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	All clinical areas have paper towels for hand hygiene.	Hand dryers are in some Trust non-clinical areas e.g. public toilets.	Reviewed by Estates to and initial plan to electronically isolate hand dryers and replace with hand towels to minimise the environmental risks. Awaiting confirmed date of completion. Plan to review in September.	30/06/2020	10/08/2020				
6.9	Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	Hand washing technique is displayed on the hand soap dispenser.	Display does not include guidance on drying.	Posters to be updated by end of July 2020 by external company.	30/06/2020	10/08/2020				

Goal 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection										
Trust-wide Risks:				**Last Review Date:**		Risk Score	Q1	Q2	Q3	Q4
						Initial				
						Current				
						Target				
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	**Q1**	**Q2**	**Q3**	**Q4**
							Assurance RAG			
6.10	Staff understand the requirements for uniform laundering where this is not provided for on site	Dress and Appearance Policy and COVID-19 information with guidance on Trust intranet page.	Not all clinical staff wear uniforms.	Work in progress to ensure scrubs available for clinical staff where appropriate - implement and completed, communicated via COVID briefings. Medical leadership required for implementation of correct scrub usage.	30/06/2020	10/08/2020				
6.11	All staff understand the symptoms of COVID-19 and take appropriate action in line with PHE national guidance if they or a member of their household display any of the symptoms	Staff and family screening in-house POD – information on intranet on how to contact.	None currently		30/06/2020	10/08/2020				

Goal 7: Provide or secure adequate isolation facilities										
Trust-wide Risk:				Last Review Date:	Risk Score		Q1	Q2	Q3	Q4
					Initial					
					Current					
					Target					
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
7.1	Patients with suspected or confirmed COVID-19 are where possible isolated in appropriate facilities or designated areas where appropriate	Designated COVID wards across both sites. If specialist care is required the patient is prioritised in cubicle for isolation. Agreed pathways for patient flow.	Limited cubicle capacity which could potentially become an issue.	IPCNs undertake daily cubicle review in medicine to support patient flow and prioritisation of cubicles. Daily morning meeting held with PSC to discuss potential cubicle availability. On-going refurbishment on RV19, RV48 and RV49. RVAS as limited isolation capacity due to frabic of the building - review of alterations / estates to improve facilities.	30/06/2020	10/08/2020				
7.2	Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	In COVID-19 patient management guidance.	None currently.	Communication via silver command for changing of wards to COVID-19. IPCNs support clinical area for any advice / support required.	30/06/2020	10/08/2020				
7.3	Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	IPC policies MRSA/MSSA, C .diff, CPE, Isolation Policy.	None currently.	IPC Nurses with Patient Services Co-ordinator support prioritisation of patient placement.	30/06/2020	10/08/2020				

Goal 8: Secure adequate access to laboratory support as appropriate										
Trust-wide Risk:				Last Review Date:	Risk Score		Q1	Q2	Q3	Q4
					Initial					
					Current					
					Target					
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
8.1	Testing is undertaken by competent and trained individuals	Training records held in the lab and in line with UKAS accreditation.	None currently.		30/06/2020	10/08/2020				
8.2	Patient and staff COVID-19 testing is undertaken promptly and in line with PHE national guidance	Staff in-house and household screening available and co-ordinated by OHS. Patient screening performed via relevant pathways.	None currently.		30/06/2020	10/08/2020				
8.3	Screening for other potential infections takes place	Mandatory HCAI reporting ongoing. SSI surveillance for hips / knees /spinal surgery ongoing.	Stopped MRSA screening on 31/03/2020 due to COVID-19 pressures to enable the laboratory to increase COVID screening capacity.	Usual MRSA screening programmes recommenced on 06/05/2020.	30/06/2020	10/08/2020				

Goal 9: Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections										
Trust-wide Risk:				Last Review Date:	Risk Score		Q1	Q2	Q3	Q4
					Initial					
					Current					
					Target					
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
9.1	Staff are supported in adhering to all IPC policies, including those for other alert organisms	Polices on intranet.	Policies are not be monitored for compliance due to suspended auditing to prioritise COVID additional work. **Process for monitoring policies has been temporarily amended.**	High visible presence of IPCNs, senior staff, clinical educators to support adherence to policies. **Audits including RCA, CAT have been suspended but weekly checks have been instigated and are monitored by matrons and reports are produced. Normal process to discuss concerns would be through staffing and outcomes meetings which continued.**	30/06/2020	10/08/2020				
9.2	Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Updated identified on daily COVID-19 briefings and intranet site. Good framework of meetings and management / communicate well.	None currently.		30/06/2020	10/08/2020				
9.3	All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current PHE national guidance	Waste guidance on intranet site for COVID-19.	None currently.	National IPC management checklist implemented Trust wide (commenced 24/07/2020) & includes wates management for audit of compliance. (Allison embed document)	30/06/2020	10/08/2020				
9.4	PPE stock is appropriately stored and accessible to staff who require it	Stored in clinical areas clean utilities. Management of stock PPE oversight processes and systems; centralised ordering system in place.	National Supply channel issues.	Daily PPE stock position update for DIPC (including information on next delivery and PPE expected). Agreed minimal stock levels with trigger points of when to escalate to consider contingency measures.	30/06/2020	10/08/2020				

Goal 10: Have a system in place to manage the occupational health needs and obligations of staff in relation to infection										
Trust-wide Risk:				**Last Review Date:**	Risk Score	Q1	Q2	Q3	Q4	
					Initial					
					Current					
					Target					

Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	Q1	Q2	Q3	Q4
							Assurance RAG			
10.1	Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	All healthcare workers included in communications and support offered by the occupational health service. Risk assessment for at risk/extremely vulnerable groups with bespoke advice sent by email to those with particular concerns: • Pregnant staff • Those with underlying health conditions including respiratory, gastroenterology, neurology, rheumatology, immunosuppression medications, cancer • Other high risk categories including ethnicity (appended information indicating volume and range of concerns and KPI for contact) Support telephone line established. Regular updates for staff and managers via email and COVID-19 intranet page. Enhanced flexible/agile working to support social distancing. Multi-disciplinary Staff Support Cell developed.	None currently.	30 redeployed Trust staff joined OHS to support during the peak of activity as main stream Trust activity declined.	30/06/2020	10/08/2020				
10.2	Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	Fit testing training delivered, records held by IPC admin team.	None currently but acknowledge work on-going.		30/06/2020	10/08/2020				
10.3	Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways as per national guidance	Staffing templates/requirements are reviewed due to reduced bed capacity on wards. Staff Redeployment Cell developed to oversee appropriate staff placement/temporary redeployment. Staff movement limited. Allocate evidence for staff movements / relocations.	None currently.		30/06/2020	10/08/2020				
10.4	All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	Trust signage promoting social distancing and environmental risk assessments available.		Environmental working group devising staff handbooks to reinforce social distancing. Planned completion time is July 2020. - issued via COVID briefing email to staff on 10th July 2020	30/06/2020	10/08/2020				

Goal 10: Have a system in place to manage the occupational health needs and obligations of staff in relation to infection										
Trust-wide Risk:				**Last Review Date:**	Risk Score	Q1	Q2	Q3	Q4	
					Initial					
					Current					
					Target					
Key line of enquiry/ Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Review Date	**Q1**	**Q2**	**Q3**	**Q4**
							Assurance RAG			
10.5	Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	Workplace COVID-19 secure risk assessment tool on the COVID intranet page.	Local risk assessment and changes to directorate working.	Break Trust template created for standardisation and ability to identy staff contacts if required for Test & Trace. - Planned implementation date 03/08/2020	30/06/2020	10/08/2020				
10.6	Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing. Robust process for Test & Tracing for Staff	Staff absence and well-being monitored using ESR and Allocate. HR, OHS and line managers in contact with staff. All staff with symptoms are tested (or the index case if a household member). Contact tracing of staff is undertaken by OHS when social distancing has not been maintained without appropriate PPE. Non-symptomatic staff working in situations where there is a declared COVID-19 outbreak or where a colleague they have been in contact with tests positive will be offered be testing	None currently.		30/06/2020	10/08/2020				
10.7	Staff that test positive have adequate information and support to aid their recovery and return to work.	Sit reps made to COVID-19 team daily and linked with laboratory reported data regarding staff requesting swabs and positive results. OHS control the information to staff re both negative and positive staff screening results. Initial results often resulted in further queries regarding self-isolation and management of household contacts.	None currently.		30/06/2020	10/08/2020				

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

QUALITY ACCOUNT 2019/20

Unconditionally registered with the
CQC since April 2010

Contents

Part 1

Quality Account – CEO Statement

Our Quality Account this year is written as we begin to emerge from the height of the COVID-19 pandemic and what has been one of the most challenging periods in the NHS's history.

On 31 January 2020, our High Consequence Infectious Disease Unit received the first patients in the UK who were confirmed to have the virus, which had been first identified in China during late 2019.

Our teams responded magnificently to support these patients and set the standard for the outstanding clinical response which has continued throughout recent months. The whole Trust, city and the wider NHS has been focussed on the pandemic throughout 2020. The local and national outpouring of support for the NHS through the '#ClapforCarers' has been warmly welcomed by staff across the organisation. Following national guidance, the annual reporting arrangements for Trusts have been streamlined; however we hope this report still provides a flavour of our outstanding achievements over an exciting year.

Most notably we were very proud to be awarded our second 'Outstanding' rating by the Care Quality Commission (CQC) in May 2019, reaffirming our position as one of the UK's top hospitals. The quality of care that we provide for patients has always been, and will continue to be, our driving force each day. Our new Trust strategy which we launched in 2019 highlights how we will continue to ensure that people are at the heart of what we do, and the ambitions we have for the future.

This year, we became the first NHS Trust and the first health organisation in the world to declare a Climate Emergency, committing us to taking clear action to achieve net zero carbon. The significant impact of climate change of the health of the population makes it vitally important for us to take positive action to preserve the planet. We are now working hard to achieve this, and to support and encourage other NHS bodies to follow our lead.

Equality is very important to us in Newcastle, so it was with great pride that we achieved top 100 ranking on the Stonewall index for 2020 and also that we held our first British, Asian and Minority Ethnic (BAME) conference.

As we look ahead to 2020/21, we are restarting and rebuilding the NHS to respond to a world with COVID-19. None of us yet know what this will mean in the medium or long term, so we need to remain alert to the changing outlook. We need to support staff to recover from the personal and professional impact of the pandemic, and to think creatively about new ways of working.

What is clear is that Newcastle Hospitals will continue to provide excellent services which save and improve lives and which increasingly tackle health inequalities.

Thank you to everyone who supports us, our staff, our patients and the local community.

Dame Jackie Daniel
Chief Executive Chair
2nd September 2020

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.

Restart, Reset and Recovery

The Prime Ministers' announcement on March 23rd 2020 signalled clearly that the COVID-19 virus is now the biggest threat this country and the world has faced for decades. It's been inspiring to see the amount of concerted effort and activity that everyone has put into preparing our hospital to respond to the pandemic.
With the advent of the COVID-19 Pandemic, all routine activity within the Trust was suspended and staff redeployed to priority areas. At the end of April 2020, as COVID-19 activity declined, the 3 stage Restart, Reset and Recovery programme (3 Rs programme) for clinical and enabling services at Newcastle Hospitals was established.

It is worth noting that during the active phase of the COVID-19 pandemic, and unlike many other Trusts, Newcastle Hospitals was also able to maintain delivery of all emergency activity along with many urgent and life extending services such as Cancer and Renal as well as considerably expand the capacity of other services such as Diagnostic COVID-19 testing.

<u>The Restart, Reset and Recovery Programme</u>

The programme consists of 3 clear, but overlapping phases:

Restart - A short term switch back on with minor alterations to pre COVID-19
Reset - Recommence but with adoption of new ways of working which are defined by the COVID-19 legacy constraints such as need for PPE, testing, shielding, social distancing and workforce fatigue
Recovery - A longer term programme, where we embed our new transformative ways of working, recover our performance and clear back logs.

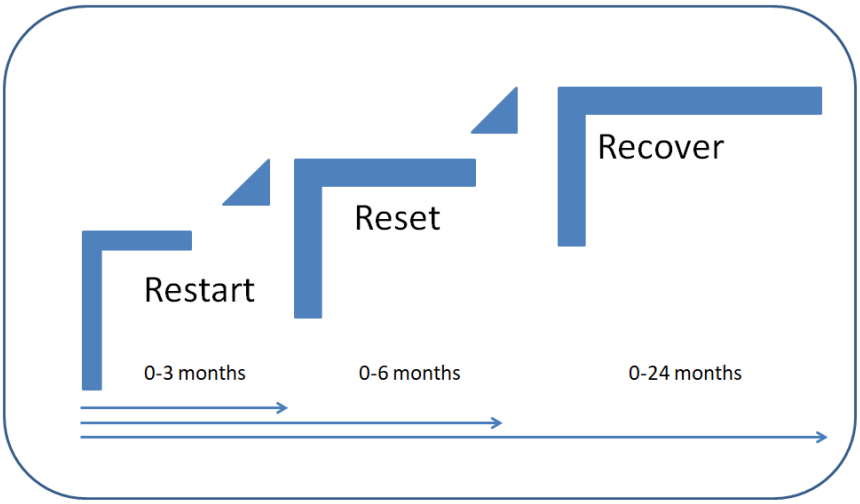


Figure 1. The 3 Rs programme

A multi-disciplinary/professional group was established, led by the Executive Director of Business and Development, with the following terms of reference:

In the short term, we will RESTART & RESET (0-6 months) services that have been paused due to the COVID-19 Pandemic (based on clinical priority versus ease of being able to do so versus clinical risk of doing so) whilst hardwiring in the positive changes that have occurred.

In the longer term, we will RECOVER (3-24 months), continuing to build on our existing Transformational programme, whilst clearing backlogs and recovering performance. We will incorporate positive changes developed during the COVID-19 Pandemic and embrace new technologies/ways of doing things going forward.
We will retain ability to (quickly) flex activity up and down and to be agile to changes.

In order to maintain patient safety at all times, clinical services restarting have had to be mindful of government advice around social distancing, enhanced testing, cleaning and use of PPE as appropriate. This has significantly reduced the Trust's capacity (most notably in Diagnostics, Out-Patients and for inpatients; the reduction from 6 to 4 bedded bays) and it is likely that until a vaccine is developed or COVID-19 disappears, the Trust will continue to operate at a reduced capacity estimated at some 75/80% of previous year's activity levels.

<u>Progress with 3Rs to date:</u>

On March 17th 2020 due to the COVID-19 pandemic we significantly reduced and cancelled much of our non-urgent elective work. Our activity in these services is now up to over 80% of our pre-COVID-19 levels, having increased from around 20-30% in March and April.

Despite continuing with our urgent work and cancer care, we also saw a significant reduction in these areas. For a brief period in late March our non-elective activity was around 50% of what it usually would be, before increasing steadily to between 80-90% currently. Alongside this we also saw referrals for urgent, routine and two-week cancer pathways fall significantly – in one week being 40% the usual level. Thankfully for those patients who need our urgent care, referrals are now back to 90%. We are actively working with our primary care colleagues and other partners to make clear that we are ready to receive and treat these referrals. Local and national communications tell us that due to COVID-19 people are reluctant to come forward for treatment. We will therefore continue to share the safety measures we have in place and to reassure the public. Overall, the increase in activity to levels which are near to those of pre-COVID-19 levels – and over such a short period of time - is an incredible achievement. On 31 July, Sir Simon Stevens and Amanda Pritchard, Chief Executive and Chief Operating Officer of the NHS wrote to trusts setting out the way that the NHS as a whole will be expected to operate for the rest of the year to ensure maximum services can be achieved. We are working proactively and responsively to tackle issues that COVID-19 has brought to ensure our ability to provide excellent care to patients is maintained.

For us in Newcastle, we need to steer a course that not only delivers the quantity of services needed, but ensures they are of the same outstanding quality that we have always achieved.

There are some fantastic examples of how we are responding to these challenges with innovation and imagination:

• In ophthalmology, patients are being booked in for digital imaging and diagnostics at the weekends, so that the whole capacity of the eye department can be used to facilitate social distancing. Surgeons can then review results digitally and discuss a treatment plan with patients by video or phone. This has also made the hospital visit much quicker for patients, who would previously need to wait for some time to see the consultant;

• A huge number of our teams have been holding video consultations for hundreds of patients using the “Attend Anywhere”. This has allowed clinicians to assess their patients visually, ask questions and check on their general wellbeing. In total, 215 ‘waiting room’ clinics are now available online and, to date, 3,250 consultations have taken place with patients which equates to around 1,150 hours and an appetite to continue to roll this out. Feedback from the clinical teams involved suggests the ‘waiting rooms’ are working very well with the same patient outcome and experience as face-to-face appointments;

• Patients whose hearing aids we provide no longer have to attend a booked appointment and then wait for their hearing aids to be repaired. Instead, large numbers are putting their hearing aids in the post and sending them in for repair. The number of face-to-face repairs has reduced by 80%, whilst the number of postal repairs has increased threefold, from around 550 to over 2,400;

• Several services, including MSU, endoscopy and some women’s services, are reviewing their referral pathways to triage as early as possible so that, where appropriate, patients can go straight to diagnostic tests without an additional face-to-face clinic appointment.

There has been some excellent progress made across the organisation on the 3 stage restart, reset and recovery program. All decisions regarding restart have been a balance of clinical priority, clinical risk and ease of stepping up (e.g. no interdependencies). There has been a consistent and priority focus on safety for patients and for staff which will continue.

Part 2

Quality Priorities for Improvement 2020/21

Following discussion with the Board of Directors, the Council of Governors, patient representatives, staff and public, the following priorities for 2020/21 have been agreed. A public consultation event was held in January 2020 and presentations have been provided at various staff meetings across the Trust.

Patient Safety

Priority 1 - Reducing Infection – focus on Methicillin-Sensitive Staphylococcus Aureus (MSSA)/E.coli

Why have we chosen this?

Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemias are important infections which can cause significant harm. They have substantial personal, reputational and resource implications. At Newcastle Hospitals (NUTH), these are most commonly associated with lines and indwelling devices; achieving excellent standards of care and improving practice is essential to reduce these infections in line with our zero tolerance approach.
E.coli and other Gram negative bacteraemias constitute the most common cause of sepsis (also known as blood poisoning, which is the reaction to an infection in which the body attacks its own organs and tissues) nationwide. Proportionally, at NUTH, the main source of infection is urinary tract infections, mostly catheter associated, reflecting the national picture. 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.
C.difficile infection is a potentially severe or life threatening infection which remains a national and local priority to continue to reduce our rates of infection in line with the national objectives.

What we aim to achieve?

- 10% year on year reduction of MSSA bacteraemias.
- 25% reduction of E.coli and other Gram negative bacteraemias by 2021/22.
- Sustain a reduction in C.difficle infections in line with national trajectory.

How will we achieve this?

- Board level leadership and commitment to reduce the incidence of Health Care Associated Infection (HCAI).
- Quality improvement projects in key directorates running in parallel with Trust- wide awareness campaigns, education projects, and audit of practice, with a specific focus on:
  - Antimicrobial stewardship and safe prescribing
  - Insertion and ongoing care of invasive and prosthetic devices

- Ward monitoring of device compliance for peripheral Intravenous (IV) and urinary catheters
- Prevention of surgical site infection
- Improve diagnosis of infection in all steps of the patient journey
- Working with partner organisations to reduce infections throughout the Health Care Economy
- Early recognition and management of suspected infective diarrhoea
- Root cause analysis for all health care associated C.difficile infections.

How we will measure success?

- Sharing data with directorates whilst focusing on best practice and learning from Root Cause Analysis (RCA).
- Continue to report MSSA, C.difficile and E.coli infections on a monthly basis, internally and nationally.

Where we will report this to?

- Quality Committee.
- Trust Board.
- The public via the Integrated Board Report.
- Public Health England.
- NHS England.

Priority 2 - Pressure Ulcer Reduction

Why have we chosen this?

Reducing patient harm from pressure damage will remain a priority. While the Trust has achieved an overall reduction in patients sustaining pressure damage, the rates remain higher than we are striving for. In the last year, we have worked to support and lead quality improvement initiatives to reduce hospital acquired pressure damage which are set to continue. There are opportunities to further enhance the programme of education which is offered to the multidisciplinary team to ensure that the key messages around pressure damage prevention, assessment and care are delivered effectively.

What we aim to achieve?

- Significantly reduce hospital acquired pressure damage (specifically pressure ulcers graded category II, III and IV).
- Lead quality improvement work on adult in-patient wards who are reporting the highest incidence and rate of pressure damage.
- Based on incidence and rate of reported pressure ulcers, provide Tissue Viability support for frontline staff.
- Ensure frontline staff are skilled and educated with a developed knowledge base of pressure damage prevention and quality improvement methodology for their patient group.

How will we achieve this?

- The Clinical Standards and Quality Improvement Lead will continue with focused quality improvement projects using methodology already proven to be successful in reducing falls and pressure damage.
- Quality Improvement training for all Tissue Viability staff to enable the delivery of a preventative, evidence-based strategy.
- Collaborative working for Clinical Leaders to include triangulation of incident and nurse staffing data to highlight areas of risk.
- Deliver a robust programme of education to the multidisciplinary team (MDT) on commencement of Trust employment and continue with shared learning through a programme of Harm Free Care workshops.
- Deliver key pressure damage prevention messages supported with meaningful data based on focus group discussion about the challenges of pressure damage prevention.
- Further enhance the investigation process to provide shared learning opportunities for wards reporting Serious Incidents (SI).

How we will measure success?

- Incidence and rate of pressure ulcers will be monitored at Ward, Directorate and Trust level.
- Bench-Marking with Shelford group.
- Utilise recognised quality improvement methodology for measuring data.

Where we will report this to?

- Falls and Pressure Ulcer Taskforce.
- Harm Free Care Group.
- Quality Committee via Patient Safety Group.
- Integrated Board Report.

Priority 3 - Management of Abnormal Results

Why have we chosen this?

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

What we aim to achieve?

We aim to be a world leader by improving patient safety through ensuring that appropriate clinical investigations result in timely clinical care decisions, and reducing the risk that significant information is overlooked, resulting in delays to treatment.

How will we achieve this?

We are building a “closed loop” investigations system which will track and display all investigations from request, to appointment, to completion, to reporting and then endorsement. This will be visible in each patient’s electronic patient record and in a consolidated viewer for the requester and responsible consultant.

How we will measure success?

The success of this change must be measured by a reduction in the incidence of patient harm arising from delayed action on test results which will require long-term data collection. In the shorter term, other important metrics will include the proportion of digitally endorsed results and the time taken between a report becoming available and action being taken on its result.

Where we will report this to?

- Clinical Policy Group.
- Trust Board.

Clinical Effectiveness

Priority 4 - Closing the Loop

Why have we chosen this?

Previously entitled System for Action Management and Monitoring (SAMM), a system is yet to be identified that meets the need of the organisation to enable the capture of all actions identified in either internal or external reviews. However, there continues to be a drive to establish and embed a centralised, robust IT system to be able to do this and therefore the internal incident reporting system is being explored as a method to be able to deliver this. This project will enhance support for directorates in implementing action plans and provide enhanced governance (‘Closing the Loop’). The project to date has been delayed and scaled down due to the impact of COVID-19 but it is expected that we will at least be able to explore the internal incident reporting system as a system option and test this in one directorate. With this in mind, it is likely that this workstream will need to continue beyond 2020/21.

What we aim to achieve?

To explore the internal incident reporting system as a potential IT solution to enable staff to record, prioritise, monitor and complete all required actions identified by the internal and external assessments within the agreed timescales.

How will we achieve this?

- Explore the current internal incident reporting system functionality for encompassing the scope of the project.
- Incorporate a reporting function within the system that will enable monitoring reports and dashboards to be produced at both directorate and corporate level. This will ensure that key themes and trends are identified in order to allow prioritisation.
- Establish a multidisciplinary task and finish group which will meet to discuss the potential design/functionality of the system and support its roll-out Trust-wide.
- Pilot the system in a selected directorate dependent on COVID-19 impact on activity. This will involve staff training for end users.
- Evaluate the system throughout the pilot time and refine the system if required.
- Once the system is tested in a pilot directorate, we will begin a Trust-wide roll-out programme.

How we will measure success?

- Trust and directorate level key performance action plans entered into the system.
- Pilot the system within a directorate.
- Measure outcomes and results.

Where we will report this to?

- 'Closing the Loop' Task and Finish Group.
- Trust Board.

Priority 5 – Enhancing capability in Quality Improvement (QI)

Why have we chosen this?

As a result of COVID-19, changing the way services are delivered is a current and future requirement. Increasing staff capability, confidence and skills to make changes to lead to improvement is therefore important.
In alignment with the Trust Flourish initiative, this aims to bring joy at work. Joy is associated with increased staff performance and productivity which in turn leads to safer more effective care. This delivers reduced costs and increased productivity and is essential to us remaining an Outstanding NHS trust and financially viable.
This approach will also be a driver for the climate emergency pledge as it offers the ability to highlight the importance of value as a quality pillar and take a sustainable approach to adding value by removing waste.
Patients can be brought into the heart of improvement with their voice and power in co-production and co-design of improvement that 'matters to them'.

What we aim to achieve?

- Establish a single-point of access to all staff for improvement.
- Develop a Quality Improvement Faculty.

- Co-ordinate improvement work across the Trust with existing improvement teams such as the Service Improvement Team and the Transformation Team.
- Recruit The Institute for Healthcare Improvement (IHI) as our global improvement partner.
- Upskill core faculty to support improvement work across the Trust.
- Deliver an effective training strategy to build capability amongst all staff. Starting by training four multi-disciplinary teams on improvement and linking this to local and Trust improvement priorities. This approach will be evaluated and further developed to scale up throughout the Trust.

How will we achieve this?

- Partner with IHI to accelerate the capability and capacity building in the organisation.
- Provide the funding required to establish a team to initiate the delivery of this Trust-wide.
- Utilise existing expertise and resource to initiate the faculty.
- Evaluate the effectiveness of the capability and capacity building by a structured framework.
- Deliver the plans in the agreed business case.

How we will measure success?

- Formal research and evaluation of the approach to;
- Ensure the capability and capacity building increases the staff and patient involvement in improvement work and delivers centralised learning
- Evaluate patient and staff outcomes as well as the return on investment.

Where we will report this to?

- Trust Board.

Patient Experience

Priority 6 – Treat as one

Why have we chosen this?

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report "Treat as One" published in 2017, highlighted inconsistencies in the delivery of physical health care to adult patients with co-existing mental health conditions in NHS hospitals. The study identified a number of areas that could be improved in the delivery of care to this group. Mental Health conditions are complex and challenging to address. Mental health has been gaining much greater public awareness and appreciation in recent years. Despite, and also as a result of, the wide ranging pressures in the NHS relating to COVID-19, mental health and equality of care in relation to it remains a key priority for the NHS.

What we aim to achieve?

We aim to continue to use the key recommendations made in the NCEPOD report as a basis to guide a coordinated approach to current practices and processes within NUTH and Cumbria, Northumberland and Tyne and Wear (CNTW). Where those aspects of care fall short of NCEPOD recommendations, we will work towards optimising and adapting care to meet those standards where possible.

How will we achieve this?

The scope of this project is extensive and the potential need for system change far reaching. The joint forum between NUTH and CNTW is now well established with regular, minuted, meetings promoting cooperative working at a senior level. In addition, a smaller steering group, within NUTH and including CNTW staff, has been established to define immediate priorities for a task and finish approach. COVID-19 has caused a hiatus in progress of these meetings for both groups but with internet meeting platform availability it is hoped to re-establish quarterly meetings of the joint forum and 2 monthly meetings for the task and finish group. Effective information sharing is a key priority and there will be continued efforts to support the on-going development of Paperlite systems and compatibility across NUTH and CNTW. Education is another critical factor for further development. A nationally developed eLearning package is now available. A series of 3 hour seminars had been delivered pre-COVID-19. Work is now needed to develop and provide concise and targeted training compatible with COVID-19 restrictions.

How we will measure success?

We will measure success using the self-assessment template from the NCEPOD report as the main guide. This will include audits of some of the key aspects of current practice against NCEPOD standards that can then be repeated in the future to assess effectiveness of change.

Where we will report this to?

- Joint NUTH and CNTW forum.
- Clinical Outcomes and Effectiveness Group.
- Trust Board via the Integrated Board Report.

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

Why have we chosen this?

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

What we aim to achieve?

Improve and maintain a positive patient experience for patients with a learning disability and families who need to access hospital services.

How will we achieve this?

- Continue to have bi-monthly Learning Disability Steering Group meetings and ensure patient and family participation within the next six months. Starting up again in July 2020.
- Training programme for students implemented and delivered within six months.
- Ensure greater patient participation and learning from their experience.
- Self-assessment against Improvement Standards 2020.
- Act upon the outcome from the Transition Project 2019.
- Consider recommendations to improve the internal LeDeR process.
- Learn and act upon feedback from patients, families and staff.

How we will measure success?

- Number of actions from Steering Group completed.
- Audit effectiveness of training programme.
- Seek feedback from patients and families.
- Self-assessment of Improvement Standards.

Where we will report this to?

- Safeguarding Committee.

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 2020/2021 prior to the COVID-19 pandemic. It is of note, due to the current COVID-19 response nationally; CQUIN has now been suspended for 2020/21. This will be reconsidered later this year for 2021/22.

2020/2021 CQUIN Indicators

CQUIN Indicators - Acute Hospital – (NHS England)	**CQUIN Indicators - Acute Hospital – (CCG)**
• Toward Hepatitis C Virus (HCV) Elimination (Year 2) • Antimicrobial resistance: Targeting use of Antifungals • Optimal approaches to Movement Therapy for Children with Cerebral Palsy • Severe Asthma (Year 2) • Personalised Care: Cystic Fibrosis (up to Sept 2020) • Appropriate Spinal Care: Spinal Surgery (Year 2)	• Appropriate Antibiotic Prescribing for Urinary Tract Infection (UTI) • Staff Flu Vaccinations • Recording NEWS2 Score, Escalation Time and Response Time for Unplanned Critical Care Admissions • Screening and Treatment of Iron Deficient Anaemia • Treatment of Community Acquired Pneumonia (CAP) in line with British Thoracic Society (BTS) Care Bundle • Rapid Rule Out Protocol for Emergency Department (ED) Patients with Suspected Myocardial Infarction • Adherence to Evidence Based Interventions Clinical Criteria
CQUIN Indicators - Acute Hospital – (Public Health/Dental/other)	**CQUIN Indicators - Community**
• Breast screening	• Staff Flu Vaccinations • Assessment, Diagnosis and Treatment of Lower Leg Wounds

Statement of assurance from the Board

During 2019/20, Newcastle Hospitals provided and/or sub-contracted 18 relevant health services.

Newcastle Hospitals has reviewed all the data available to them on the quality of care in all 18 of these relevant health services.

The income generated by the relevant health services reviewed in 2019/20, represents 100 per cent of the total income generated from the provision of relevant health services by Newcastle Hospitals for 2019/20.

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

Leadership walkabouts, coordinated by the Clinical Governance and Risk Department, involving Executive and Non-Executive Directors and members of the Senior Trust management team have been regularly conducted in a variety of departments across the Trust. The Walkabouts have been suspended since March 2020 due to COVID-19. Alternative mechanisms to facilitate socially distanced interaction with clinical teams are being considered. These are reported to the Quality Committee, a standing committee of the Trust Board, and any actions reported, implemented and followed up.

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

The bi-monthly Clinical Assurance Tool (CAT) continues to provide clinical assurance to the Trust Board via a six monthly report, as an overview of performance against a wide range of clinical and environmental measures for each ward and directorate. The aim of the CAT is to measure and demonstrate compliance with the published documents and national drivers such as High Impact Actions, Saving Lives as well as providing useful data to support, verify and offer assurance for external inspectorates.

Part 3

Review of Quality Performance 2018/19

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 Clinical Policy Group. The majority of the Account represents information from all 18 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 (CCGs) and the Newcastle and Northumberland Healthwatch teams. Amendments will be made in line with this feedback.

Patient Safety

Priority 1 - Reducing Infection – focus on MSSA/E. coli

Why we chose this?

Staph aureus bacteraemias are infections that can cause significant harm. E. coli bacteraemias are the most common cause of Gram negative sepsis. At Newcastle Hospitals (NUTH), these are most commonly associated with lines and indwelling devices; achieving excellent standards of care and improving practice is essential to reduce these infections in line with our zero tolerance approach.
E. coli and other Gram negative bacteraemias constitute the biggest cause of sepsis nationwide. Proportionally, at NUTH, the main source of infection is urinary tract infections, mostly catheter associated, reflecting the national picture. 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.

What we aimed to achieve?

We aimed to achieve:

- Internal objective to achieve a 10% year on year reduction of MSSA bacteraemias
- National ambition for a 25% reduction of E. coli and other Gram negative bacteraemias by 2021/22 with a full 50% reduction by 2025
- Internal objective to achieve a 10% year on year reduction of Gram Negative bacteraemias
- Sustain a reduction in C. difficile infections in line with national trajectory.

What we achieved?

The Root cause analysis (RCA) process continues to identify intravenous devices as the main source of infection in relation to MRSA/MSSA. Device management is a standard item which is included in Directorate Serious Incident Review Meetings (SIRM) Action Plans so that they can identify risks and provide assurances that standards of practice are followed.
IV care continues to be promoted throughout the Trust with an increasing awareness of *'right line for the right time'* highlighting device choice for not only the right duration but also to maintain vessel health and reduce the risk of avoidable complications.
The Trust pilot Line Service continues to grow in success and demand with 700+ midlines being placed since its launch in September 2019. The service has not only reduced the number of repeated cannulations needed in certain patient groups but has also enabled some patients to go on to have their treatment at home. There are plans for the service to develop further, with the aim being for the team to begin to insert peripherally inserted central catheters (PICCs). These lines can remain in place for a longer duration and enable the patient to receive certain specific medications, fluid or total parental nutrition.
'No Catheter No CAUTI' (CAUTI – Catheter Acquired Urinary Tract Infection) and the CQUIN UTI are active patient quality improvement projects. Overall, the Trust has reported a decrease in inpatient catheters in situ >28 days, and the number of catheters *in situ* is running at 17%; the national position is 20%. The national position for new CAUTI is 3.6% and the Trust is currently 0.07%.
The Gold Standards of bladder scanning pre and post void and intermittent catheterisation are being advocated rather than urinary catheterisation. There are plans to promote bladder scanning and intermittent catheterisation in Emergency Department and Assessment Suite. In addition to this and as part of ongoing education, collective patient stories are being gathered and shared which focus on the experiences of living life with a urinary catheter and introducing a change to intermittent catheterisation.
All lessons learnt are shared at directorate level and are a part of their Directorates' Serious Infection Review Meetings (SIRMs) action plans.

How we measured success?

OVERVIEW OF QUARTERS 1- 4 AND HEALTHCARE ASSOCIATED INFECTIONS (HCAIs)

Organism	2018/19 Total	2019/20 Total
MRSA	2	1
MSSA	91	72
E. coli	180	159
Klebsiella	92	110
Pseudomonas aeruginosa	32	36

Organism	2018/19 Total		2019/20 Total	
	Reported Cases	Cases Counted Against Contract	Reported Cases	Cases Counted Against Contract
C. difficile	77	48	113	89

National Trajectory for NUTH	≤76	≤113

Sustained reductions of bacteraemias in individual directorates. For 2019/20 we set an internal reduction of 10% of the total number of cases from 2018/19 for MSSA bacteraemias and by the end of March 2020 we achieved a 21% reduction which is a considerable achievement.

An internal reduction of 10% of the total number of cases was also set for E. coli bacteraemia and by the end of March there had been a reduction 12% which again is a considerable achievement.

NHS Improvement (NHSI) changed the criteria for reporting *C. difficile* from 2019/20; therefore figures reported are not comparable to previous years. At the end of March 2020 there were an additional 30 cases assigned to the Trust. Overall, *C. difficile* infections are below the 113 trajectory with 113 cases by the end of March. A total of 24 cases have been successfully appealed for 2019/2020 as by the end of March as the decision was made (fully supported by the CCG) that all C. difficile Infection appeal hearings would be cancelled in order for the Trust to prioritise COVID-19 pandemic work. All appealed cases are reported to Public Health England (PHE) although not counted against trajectory. All lessons learnt are shared at Directorate level and are a part of their Directorates' Serious Infection Review Meetings (SIRMs) action plans.

Priority 2 – Pressure Ulcer Reduction

Why we chose this?

Reducing the incidence of inpatient pressure damage is of high priority both at Trust and national level. Pressure ulcers are a key indicator of the quality and experience of patient care and are largely preventable if the correct assessment and prevention plans are implemented.
Despite national campaigns to reduce them, they remain a significant healthcare problem:

- Over 1,300 new pressure ulcers are reported nationally each month
- Treating pressure ulcers costs the NHS more than £1.4 million every day
- Developing a pressure ulcer leads to an increased length of hospital stay (an increase on average of 5-8 days).

The increase in patient age, acuity and frailty means that the Trust are seeing more patients with a higher risk of acquiring pressure ulcers and therefore the risk of incidence of pressure ulcers increasing is great. It is therefore essential, that the Trust identified this as a priority to ensure the risks of this were mitigated with accurate assessment throughout admission and on discharge, together with the implementation of best practice interventions.

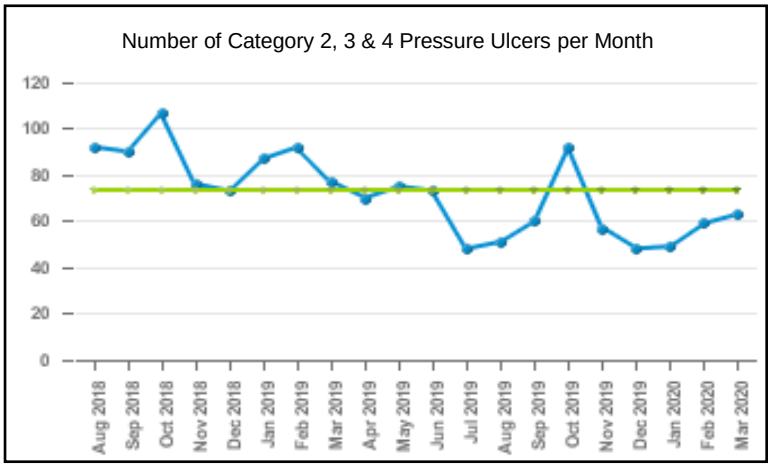
What we aimed to achieve?

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

- Undertake focused quality improvement work on targeted adult inpatient wards who currently report the highest incidence and rate of pressure damage.
- Increase the visibility and support provided by the Tissue Viability team to frontline clinical staff to assist in the prevention of pressure ulcers.
- Ensure we have a skilled and educated workforce with a sound knowledge base of prevention of pressure ulcers and quality improvement methodology.

What we achieved?

Ongoing work throughout the Trust has continued to support and lead quality improvement to continue the reduction in hospital acquired pressure ulcers. With the support of the Executive Chief Nurse and Senior Nurse leads an approach focussed on improvement methodology joined up across pressure ulcer prevention and falls prevention has been continued. This work has been vital in continuing to achieving a statistically significant reduction in pressure damage as reported in the Clinical Standards Dashboard (Graph 1).



Graph 1

Work over the past 12 months which has helped to facilitate this reduction has included:

- Targeted quality improvement work - The Root Cause Analysis (RCA) process has been used to select individual wards that have reported Serious Incidents and a process of educating staff around improvement methods has been implemented as part of action plans.
- The Falls and Pressure Ulcer Taskforce Group is responsible for monitoring incidents and developing work streams across the organisation to reduce harm. This has been a successful approach to ensuring that pressure ulcer prevention is a quality priority and communicating the fundamental messages to reduce pressure ulcers.
- The Critical Care Stop the Pressure working group led by the Nurse Consultant for Critical Care, working alongside the Clinical Improvement Lead (Falls and Pressure Ulcers), has also been instrumental in achieving a statistically significant reduction in pressure ulcers in the four critical care units across the Trust.
- The Clinical Improvement Lead and Associate Director of Nursing (Clinical Standards) have worked closely with Multidisciplinary team members using focus group discussions about the challenges of pressure ulcer prevention and developing quality improvement initiatives to reduce incidence.
- The Tissue Viability Team continue to look at developing new ways of working and one of the most successful implementations has been the introduction of a specialist Tissue Viability Nurse working daily into the Emergency Assessment

Suite at the RVI. This role has been successful in the education of staff to ensure patients are checked for pressure damage on admission, identify those at high risk of developing pressure damage during admission and ensuring care plans are implemented.

Advancing into the next 12 months the Tissue Viability team will continue to be a highly visible team focusing education on what is considered the highest priorities from action plans in RCAs and ongoing audit work. Face to face education in high risk areas will be key during this and under new management the team will continue and evolve work streams as above, develop actions where appropriate and monitor strategies from the monthly Integrated Board Report.

How we measured success?

- We monitor incidence on a Ward, Directorate and Trust Level.

Priority 3 – Management of Abnormal Results

Why have we chosen this?

Incidents continue to occur where abnormal results have not been acted upon by clinical staff. This can lead to delays in treatment with the potential for serious harm to patients.

What we aimed to achieve?

A long term solution for effective and efficient communication of abnormal results across all of the reporting specialties to the responsible clinician in order to minimise incidents. This is a complex problem which will require both a robust technical solution and behaviour change by multiple staff groups including all clinical staff and many administrative staff who interact directly with patients or their results.

What we achieved?

We have built, tested and implemented systems to show in-patient and out-patient blood results, microbiology and radiology reports in eRecord Message Centre with labelling of critical (red flag) results. These were enabled at Paperlite go-live on 27th October 2019, in addition to the current paper reports. We have designed the functionality of a ‘closed loop’ investigations management viewer with advanced analytics and escalations to further enhance patient safety. This requires further design sessions with clinicians and administrative staff to ensure that it meets the needs of all users. Paper reports will not be discontinued until the closed-loop system has been tested end-to-end.

How we measured success?

We have tested the display of results in Message Centre for all appropriate positions in the live eRecord environment and had positive feedback from staff managing high numbers of results.

Clinical Effectiveness

Priority 4 – System for Action Management and Monitoring (SAMM)

Why we chose this?

There was a requirement to establish a robust IT system that would ensure action plans identified by either external and internal reviews were monitored, prioritised, completed and reviewed within given timescales. Previously all actions were captured in a variety of different forms and were not available centrally in order to allow prioritisation, monitoring and discussion.
It was envisaged that this project would enhance support for directorates in implementing action plans and provide enhanced governance.

What we aimed to achieve?

To establish and embed a robust IT system named **S**ystem for **A**ction **M**anagement and **M**onitoring (SAMM) across the Trust which will enable staff to record, prioritise, monitor and complete all required actions identified by internal and external assessment within agreed timescales.

What we achieved?

- A scoping exercise was carried out to identify the requirements of each directorate within the Trust.
- A profile of corporate and individual directorate action plans as well as number of users within each directorate was established.
- Directorates have been selected to pilot the system before it goes live across the Trust.
- Identified an IT system to incorporate the scope SAMM function.
- Extensive work has been undertaken into sourcing the right provider to incorporate the complexity of SAMM. External visits and presentations were received from companies who could provide this service as well as internal meetings with Trust IT development team and viewing internal systems already in use that could potentially incorporate SAMM.
- A final decision was made in January 2020 to use an internal IT system (Datix) currently used across the Trust and incorporate a SAMM function. Work has begun in order to integrate SAMM into Datix using a sample of action plans in order to map the process. This process will be tested with mandatory action plans using pilot directorates identified in the first instance.

How we measured success?

- Trust performance requirements and actions mapped out and prioritised.
- Full engagement with all directorates and the wider Clinical Governance and Risk Department.
- Extensive work in sourcing the correct IT system.
- Agreeing processes and key changes required in Datix to accommodate the scope of SAMM

Priority 5- Enhancing capability in Quality Improvement (QI)

Why we chose this?

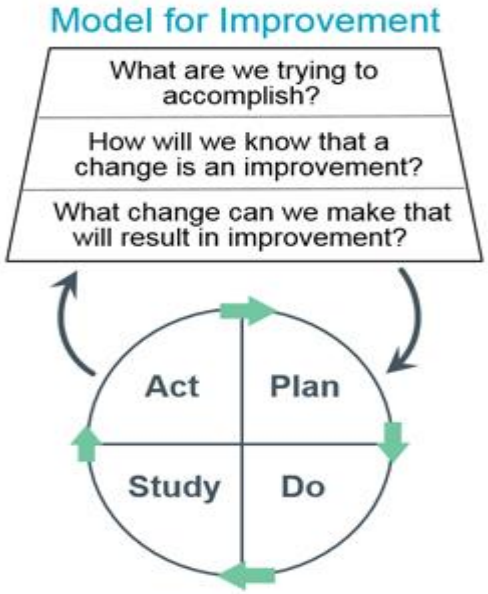
As part of the Trust's commitment to creating a culture of Quality Improvement, we recognised that it was essential to engage patients, carers and families in the early stages of project design.

What we aimed to achieve?

We set out to create a sustainable, accessible model of involvement and engagement which enabled staff to work in collaboration with patients and members of the public from an early project design stage.

What we achieved?

NUTH already undertakes an enormous amount of improvement work and delivers outstanding care; however we didn't have an agreed model for improvement. Recent literature including the Health Foundation's Improvement Journey identified the importance of an organisation having a common language for improvement. We have agreement that the Institute for Healthcare Improvement's Model for Improvement will be the common language that we will base our capability and capacity building around.



Overall the knowledge base for improvement science at NUTH is currently limited to a proportionately small number of interested staff with variable levels of knowledge and expertise ranging from advanced to novice. Currently the service improvement team run an annual ILM level 5 course in service improvement. There is an increasing number of staff that have started to seek Quality Improvement training through a variety of sources. We have trained over 50 staff, by a variety of approaches, as part of this priority workstream. Staff have attended and evaluated the following national courses; the Advancing Quality Alliance (AQuA), Quality Improvement and Service Redesign (QSIR) and Flow Coaching Academy (FCA). On the back of this national course

evaluation, a local one day Quality Improvement Practitioner Training programme has been developed and delivered two cohorts to date. This local programme has been very positively evaluated and further cohorts are planned. The training recognises the critical importance of the team working and human factors as much if not more so than the technical aspects of the model for improvement and tools that are the basis of improvement science. Training is also a driver for cultural change to improve joy at work, leadership skills and integrate sustainable approaches to improvement.
Successful organisational strategies for Quality Improvement rely on the presence of support from Improvement Coaches. Our Service Improvement and Transformation teams have provided this support for improvement work in the organisation. To get to scale, 5% of the workforce need to become improvement coaches and have time to support their teams. This is the challenge growing both the depth and breadth of training in improvement. One or two day courses on improvement will not deliver the results if not supported by a coaching infrastructure.
Our group has had detailed discussions and visits with other large organisations that are more mature in their improvement journeys; Sheffield, East of London, Imperial Hospital London and the Royal Free London. Following visits and a review of the literature, the group has developed detailed plans to progress the capability and capacity building for improvement at NUTH. The plans have three core components; capability and capacity building, evaluation & research into the approach (to ensure effective change and value is delivered on investment), and centralised learning (looking at improving access to all the organisational sources of learning to inform improvement).

How we measured success?

- A multidisciplinary group was assembled to evaluate our quality improvement capability and to develop plans to build capability and capacity for improvement at NUTH. This meant moving towards a goal of improvement becoming simply what 14,500 staff do every day.
- The group has;
- Evaluated internal capacity for improvement and training.
- Gained agreement for the IHI model for improvement as our common language for improvement.
- Evaluated national Improvement courses AQuA, QSIR and FCA.
- Developed and delivered two cohorts of local QI Practitioner training.
- Held detailed discussions with large organisations about their improvement journeys.
- Evaluated options to improve learning for improvement.
- Developed plans to progress capability and capacity building for QI at NUTH.

Patient Experience

Priority 6 – Deciding Right

Why we chose this?

Planning care in advance (Advance Care Planning or ACP) helps patients think about what care they may want to receive in the future should they become seriously ill or unable to make decisions for themselves.

Deciding Right is an initiative that aims to improve and increase the process of ACP for Children, Young People and Adults by encouraging shared decision-making and better informing healthcare professionals of individuals' beliefs and wishes. This is particularly relevant to intensive care where there can be significant physical and mental health issues for survivors and their families to the point of survival being burdensome and not what patients would regard as a high quality of life.
Within England and Wales, approximately 30% of hospital in-patients are in their last year of life, often without any ACP and throughout Europe >80% of intensive care patients undergoing end-of-life care have lost capacity, with fewer than 15% having made any form of advance statement. Additionally in Wales (2006-2013), 1 in 5 intensive care survivors die within a year of discharge home and in Scotland (2005-2013), 24% of intensive care survivors are readmitted to hospital within 90-days of discharge home. In both groups, death and readmission owe more to long-standing life-threatening and life-limiting co-morbidities than the severity of any acute illnesses that precipitated intensive care admission.
ACP thus improves shared decision-making, and for the terminally ill, increasing the likelihood of them dying at-home or in a hospice. In doing so, it also improves the quality of their lives and that of their families. Finally, there is a measureable impact on staff well-being by reducing anxiety, moral distress and burn-out when dealing with acutely ill patients who may be near the end of their natural life.

What we aimed to achieve?

- Improved focus on shared decision-making.
- Improved information for patients and those close to them.
- Develop and perform a *baseline survey* and *needs assessment* to gauge awareness and levels of engagement with *Deciding Right* amongst NUTH clinical staff.
- Develop an awareness programme in line with regional initiatives.
- Develop a video for patients and those close to them; be shown in out-patients and primary care outlining the principles and purpose of *Deciding Right.*

What we achieved?

- Training scheme for ward staff led by Nurse Educators.
- Development of a video and information leaflet and Deciding Right Information Video in out-patient areas.
- Revision of Resuscitation orders on Paperlite.

How we measured success?

- Implementation of work streams.
- Production of the video and other educational resources.
- Numbers of staff trained.
- Improvement in (Emergency Health Care Plan EHCP) or Treatment Escalation Plan (TEP) usage.

Priority 7 – Treat as One

Why we chose this?

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report "Treat as One" was published in 2017 highlighting the inconsistencies in the delivery of physical health care to adult patients with co-existing mental health conditions in NHS hospitals. The study identified a number of areas that could be improved in the delivery of care to this group of patients. We set out to improve the quality of care for these patients.

What we aimed to achieve?

We aimed to use the key recommendations made in the NCEPOD report to guide a coordinated review of practices and processes within NUTH, Northumberland and Tyne and Wear (NTW). Where those aspects of care fell short of NCEPOD recommendations, we worked towards optimising and adapting care to meet those standards where possible.

What we achieved?

- A joint NUTH and NTW Quality Forum established in 2018/19 continued to meet on a quarterly basis to discuss issues and work collaboratively to ensure that patients with mental health needs receive the best holistic care when accessing treatment.
- In addition, a steering in the Trust managed and monitored progress against the 22 recommendations of the 'Treat as One' publication. Having held a number of meetings, progress has been made in a number of areas, including:
- Continued NUTH NTW quarterly meetings to coordinate actions
- Audit of documentation and practice has been undertaken
- A review of recording of Psychiatric Liaison entries in NUTH notes and in particular A+E electronic record has been carried out: location identified and a standardised format and content guide established
- Development of an e-learning package
- NUTH Task and Finish group monthly meetings to advance Treat as One compliance
- Raising the profile of Mental Health Champions

How we measured success?

- Compliance with the recommendations of the Treat as One publication have been monitored and reported to the NUTH/NTW Combined Governance Forum on a quarterly basis.

Priority 8 – Ensure reasonable adjustments are made for patients with suspected or known Learning Disability (LD)

Why we chose this?

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

What we aimed to achieve?

Improve and maintain patient experience for patients with a learning disability and families who need to access hospital services.

What we achieved?

- Clear and efficient pathway for the admission of patients requiring MRI under General Anaesthetic.
- Robust Learning Disability Steering Group with key actions in line with Improvement Standards.
- Patient participation on Steering Group.
- Training programme outlined in conjunction with Simulation Centre and University to upskill students with scenario based training.
- Improvement Standards submitted for 2019.
- Project researching experience of children and young people with learning disability complete outcome of which will be used to support better adjustments and effective transition from paediatric services to adult services.
- Current audit in process to review assurance of appropriate 'flags'.
- Review of LeDeR process complete – recommendations to be considered.

How we measured success?

- Audit of patient records for use of 'flags' and reasonable adjustments.
- Audit of patient mental capacity.
- Review use of hospital passports (adult and paediatric).
- Implementation of STOMP and STAMP across the organisation.
- Patient feedback.
- Self-assessment of Improvement Standards.
- Report to Safeguarding Committee with governance structure.

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

Update on Duty of Candour (DoC)

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

There is a contractual requirement to implement the Being Open guidance and the Trust Duty of Candour (DoC) Policy has helped staff to achieve this. Our compliance with DoC is assessed by the CQC; however, we also monitor our own performance on a monthly basis at the Serious Incident (SI) Panel to ensure verbal and written apologies are provided. This reassures us that those affected by an incident are offered a truthful account and fully understand what happened. This open and fair culture encourages staff to report incidents, to facilitate learning and continuous improvement to help prevent future incidents, improving the quality of care.

Duty of Candour requirements are regularly communicated across the organisation using a number of corporate communication channels including presentations at a range of Trust-wide forums such as Clinical Policy Group, Clinical Risk Group as well as other Corporate Governance and Risk committees. Throughout the year, regular updates on progress with implementation and audit results have been submitted via the Clinical Risk Group and Patient Safety Group.

Training has been targeted at those staff with responsibility for leading both serious incident investigations and also for staff involved in local investigations. DoC is included in Incident Investigator Training which is delivered to a wide range of staff once a month. The requirement to be open with patients and their relatives is emphasised every month at the Patient Safety Briefings.

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

The Trust has been implementing the priority clinical standards for seven day hospital services.

Board Assurance Framework to identify compliance:

This new measurement system replaced the previous self-assessment survey in 2018. It consists of a standard measurement and reporting template, which all providers of acute services complete with self-assessments of their delivery of the 7DS clinical standards. This self-assessment is formally assured by the Trust Board and the completed template submitted to regional 7DS leads to enable measurement against national ambitions. The Trust has completed and submitted the Board Assurance Framework every 6 months. The autumn 2019 compliance was:

Standard 2: The national compliance threshold is 90% for weekdays and weekends. Data shows 68% compliance with documented evidence of consultant reviews. However; we are confident that actual compliance is 90% as we can evidence consultant rotas/job plans which ensure patients have access to consultant reviews on a 24/7 basis. In addition, the intensive care units and Emergency Assessment Suite have twice daily consultant ward rounds. We will continue to make best efforts to demonstrate compliance by improving record keeping in all emergency areas.
Standard 5 and 6: compliant with these standards.
Standard 8: Case note reviews show compliance is above 90% for daily and twice daily reviews. The majority of Directorates have board round systems in place and a clear process for identifying patients who do not require a daily ward round.

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".

Staff and temporary workers across the Trust, are informed at their day one induction with the Trust, and subsequently reminded regularly, that there are a number of routes through which to report concerns and raise issues that may occur in the workplace. By offering a variety of options to staff, should they have an issue to report, including the ability to provide information anonymously, it is hoped that anyone working for Newcastle Hospitals will feel they have a voice should they wish to raise a concern or put forward a positive suggestion.

Any of the reporting methods below can be used to log an issue, query or question; this may relate to patient safety or quality, staff safety including concerns about inappropriate behaviour, leadership, governance matters or ideas for best practice and improvements.

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

Work in confidence – the anonymous dialogue system.

The Trust continues to use the anonymous dialogue system 'Work in Confidence', a staff engagement platform which empowers people to raise ideas or concerns directly with up to 20 senior leaders, including the Chief Executive and the Freedom to Speak Up Guardian. The conversations are categorized into subject areas, including staff safety.
This secure web-based system is run by a third-party supplier. It enables staff to engage in a dialogue with senior leaders in the Trust, safe in the knowledge that they cannot be identified – this is a promise by the supplier of the system.

Freedom to Speak up Guardian

The Trust Freedom to Speak up Guardian (FTSUG) acts as an independent, impartial point of contact to support, signpost and advise staff who wish to raise serious issues or concerns. This person can be contacted, in confidence, about possible wrongdoing, by telephone, email or in person. Posters promoting the role of the FTSUG have been distributed Trustwide, and open drop-in sessions held for staff at all Trust locations. The FTSUG has been attending team engagement meetings, staff forums and staff networks to raise awareness of his role and how to make contact.

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

This policy provides employees who raise such concerns, assurance from the Trust that they will be supported to do so, and will not be penalised or victimised as a result of raising their concerns. The Trust proactively fosters an open and transparent culture of safety and learning to protect patients and staff. It recognises that the ability to engage in this process and feel safe and confident to raise concerns is key to rectifying or resolving issues and underpins a shared commitment to continuous improvement.

Being open (Duty of Candour) Policy

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

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

Trust Contact Officer

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

Union and Staff Representatives

The Trust recognises a number of unions and works in partnership with their representatives to improve the working environment. Staff are able to engage from 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

Three staff networks exist within the Trust; LGBT, BAME and Disability, with oversight by the Head of Equality, Diversity and Inclusion. Each network has a Chair and Vice Chair and is supported in its function by the HR Department. Each network has its own 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, will be introduced into the Trust during 2020. These colleagues are an additional resource to support BAME colleagues who may be subjected to formal disciplinary proceedings.

A summary of the Guardian of Safe Working Hours Annual Report

This consolidated Annual Report covers the period April 2019 – March 2020. The aim of the report is to highlight the vacancies in junior doctor rotas and steps taken to resolve these.

Junior doctor rota vacancies occur due to gaps in the regional training rotations and problems with recruitment of locally employed doctors. Rota gaps are present on a number of different rotas. This is due to both gaps in the regional training rotations and lack of recruitment of suitable locally employed doctors. There are, however, fewer vacancies compared to last year (these include: neurosurgery, obstetrics and gynaecology and general medicine). The main areas of recurrent or residual concern for vacancies are accident and emergency, anaesthesia and intensive care medicine, paediatric Cardiology and paediatric intensive care. The Trust takes a proactive approach to minimise the impact of these by active recruitment, attempts to make the jobs attractive to the best candidates, utilisation of locums and by rewriting work schedules to ensure that key areas are covered. In some areas, trainee shifts are being covered by consultants when junior doctor locums are unavailable.

In addition to the specific actions above, the Trust takes a proactive role in management of gaps with a coordinated weekly junior doctor recruitment group meeting. Members of this group include the Director of Medical Education, Finance Team representative and Medical Staffing personnel. In addition to recruitment to locally employed doctor posts, the Trust runs a number of successful Trust based training fellowships and a teaching fellow programme to fill anticipated gaps in the rota. These are 12 month posts aimed to maintain doctors in post and avoid the problem of staff retention. There are also Foundation Year 3 posts to encourage doctors to work at Newcastle Hospitals.

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 2017/18 onwards. These new regulations are detailed below:

1. During 2019/20, 1917 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: 447 in the first quarter; 445 in the second quarter; 535 in the third quarter; 490 in the fourth quarter.
2. During 2019/20, 1302 case record reviews and 13 investigations have been carried out in relation to 1917 of the deaths included in point 1 above. In 6 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: 336 in the first quarter; 345 in the second quarter; 390 in the third quarter; 231 in the fourth quarter.
3. Six representing 0.3% of the patient deaths during the reporting period are 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: two representing 0.1% deaths for the first quarter, one representing 0.1% for the second quarter and three representing 0.2% for the third quarter. All deaths resulting in a serious incident in quarter four are currently being investigated. (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 2020/21 quality account. All deaths will continue to be reported via the integrated board report). These numbers have been estimated using the HOGAN evaluation score as well as root cause analysis and infection prevention control investigation toolkits.
4. 198 case record reviews and five investigations were completed after April 2019 which related to deaths which took place before the start of the reporting period.
5. 0 representing 0% 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. Six representing 0.3% of the patient deaths during 2019/20 are judged to be more likely than not to have been due to problems in the care provided to the patient.

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

Deterioration due to sepsis

A 64 year old complex patient was admitted into hospital due to an unresponsive episode at home and for ongoing treatment of leg ulcers. Her sudden deterioration due to sepsis was not assessed or escalated in a timely way.

Action taken

• Local Multi-Disciplinary Team (MDT) handover processes have been introduced to improve communication. Handovers now include a greater consultant presence to increase senior support to junior doctors and junior ward leaders.
• Work is underway across the Trust to improve the functionality in the electronic patient record (e-record) in order to more effectively trigger clinical alerts in relation to Early Warning Scores (EWS) both within e-record and on the electronic whiteboards in order to make these more visible to staff in clinical areas. Support and training for EWS champions has been introduced to deeply embed EWS processes.

Post-operative complication

A 49 year old patient was admitted for an elective surgical interventional procedure on his liver ahead of planned surgery. The patient unexpectedly deteriorated overnight, the reason for this was due to a rare complication of the procedure, however this was not recognised in a timely way.

Action taken

• A post procedure pathway has been enhanced to improve assessment and escalation of concerns. The pathway includes any patient with pain or high EWS, after any liver procedure, to have senior specialty or consultant review and consideration of CT angiogram. In addition, education is included in speciality induction and improved working patterns and handovers have increased senior support to junior staff.

• As above, work is underway to improve the functionality clinical alerts in the electronic patient record in order support the escalation of concerns effectively.

Self-harm following hospital assessment

A 42 year old patient with a mental health history was admitted into hospital for treatment of abdominal pain and constipation. The patient was appropriately reviewed and assessed to have capacity, insight and forward planning and the patient subsequently self-discharged against medical advice.

Action taken.

• Staff education delivered to provide a clearer understanding in relation to the application of Deprivation of Liberty Safeguards (DoLS) and Mental Health Act legislation.

• The Psychiatric Liaison team (PLT) and clinical team to review processes for improving communication in relation to MDT assessment outcomes.

Lost to follow-up patient

A 74 year old patient with a complex medical history, having ongoing medical treatment, had a CT scan which reported an incidental finding of an abdominal aortic aneurysm (AAA). A referral for vascular team follow-up and surveillance was not undertaken and he was lost to follow-up.

Action taken

• Medical teams to raise awareness of appropriate AAA management and highlight the risks of managing complex patients with advanced disease and multiple competing morbidities.

• Trust-wide work is being undertaken to find robust solutions for the flagging up of incidental findings, identified following radiological investigation, to clinicians.

Delay in CT result/missed medication

A 64 year old patient was prescribed a 14 day course of medication for a suspected blood clot whilst awaiting a CT scan. Delayed performing and reporting of the CT scan resulted in the patient running out of medication before the results could be acted upon.

Action taken

• Radiology to provide clinical areas with information regarding average waiting time for outpatient radiological investigations.

• Appropriate clinical lead & MDT to introduce robust processes for monitoring patients commenced on anti-coagulants.

• Patient information developed explaining the dangers and risks of stopping the medication without seeking medical advice.

Surgical complication

An 84 year old patient undergoing surgery for a bowel obstruction sustained an unexpected injury to a major blood vessel during the operation.

Action taken

• The rare complication in relation to this patient’s case was shared with clinical teams locally.

Part 3 – Other Information - Overview of Board assurance 2019/20

This is a representation of the Quality Report data presented to the Trust Board on a monthly basis in consultation with relevant stakeholders for the year 2019/20. The indicators were selected because of the adverse implications for patient safety and quality of care should there be any reduction in compliance with the individual elements. In addition to the 13 local priorities outlined in section 2, the indicators below demonstrate the quality of the services provided by the Trust over 2019/20 has been positive overall.

Patient Safety	Data source	Standard	Actual 2018/19	Q1	Q2	Q3	Q4	Actual 2019/20
MSSA per 100,000 bed days	PHE's Data Capture System	Mandatory reporting by NHSI/NHSE	20.05	20.32	17.48	17.48	7.95	15.82
MRSA per 100,000 bed days	PHE's Data Capture System	Mandatory reporting by NHSI/NHSE	0.44	0.00	0.00	0.00	0.88	0.21
C.*difficile* per 100,000 bed days	PHE's Data Capture System	Mandatory reporting by NHSI/NHSE	16.96	HOHA* =15.91 COHA* =2.65	HOHA* =21.85 COHA* =6.12	HOHA* =20.10 COHA* =2.62	HOHA* =25.62 COHA* =4.42	HOHA*= 20.87 COHA*= 3.95
E.coli per 100,000 bed days	PHE's Data Capture System	Mandatory reporting by NHSI/NHSE	39.65	33.58	36.71	37.58	31.81	34.93
Klebsiella per 100,000 bed days	PHE's Data Capture System	Mandatory reporting by NHSI/NHSE	20.27	16.79	27.97	34.09	17.67	24.17
Pseudomonas aeruginosa per 100,000 bed days	PHE's Data Capture System	Mandatory reporting by NHSI/NHSE	7.05	7.95	6.99	9.61	7.07	7.91
Hand Hygiene audits (opportunity)	Internal	Local CAT tool	99.13%	98.38%	97.75%	98.73%	99.42%	98.51%
Hand Hygiene audits (technique)	Internal	Local CAT tool	98.71%	97.92%	96.83%	97.46%	98.25%	97.59%
Total number of patient incidents reported (Datix)	Internal Datix Incident reporting system	Local Incident Policy	18,581	4,742	4,602	4,694	4,495	18,533
Patient Incidents per 1000 bed days (Datix)	Internal Datix Incident reporting system	Local Incident Policy	37.0	37.8	37.8	36.9	37.5	37.5
% Patient incidents that result in severe harm or death	Internal Datix Incident reporting system	Local	0.3%	0.3%	0.2%	0.2%	0.4%	0.3%

Slip, trip and fall - patient (Datix)	Internal Datix Incident reporting system	N/A	2,764	662	642	661	644	2,609
Slip, trip and fall - patient (Datix) per 1,000 bed days	Internal Datix Incident reporting system	National definition	5.5	5.3	5.3	5.3	5.3	5.3
Inpatients acquiring pressure damage	Internal Datix Incident reporting system	National	934	202	144	186	156	688
Pressure Ulcers per 1000 bed days	Internal Datix Incident reporting system	Local	1.9	1.6	1.2	1.5	1.3	1.4
Total number of Never Events reported	Internal Datix Incident reporting system	National definition	7	2	1	2	0	5
Total number of Serious Incidents reported	Internal Datix Incident reporting system	Local SI Policy	106	41	32	33	22	128
Needlestick injury or other incident connected to sharps	Internal Datix Incident reporting system	Local Policy	444	106	95	94	73	368
Reporting of Injuries, Disease and Dangerous Occurances (RIDDOR)	Internal Datix Incident reporting system	Local Policy	30	4	6	7	6	23
Slip, Trip, Fall – Staff/Visitors/relatives	Internal Datix Incident reporting system	Local Policy	187	45	51	51	38	185

*HOHA = Hospital Onset – Healthcare Associated
*COHA = Community Onset – Healthcare Associated
NHS Improvement (NHSI) changed the criteria for reporting C. difficile from 2019/20. The reported figures are therefore not comparable to previous years as the change includes reporting COHA cases. This patient group includes those who have been discharged within the previous 4 weeks in addition to day-case patients and regular attenders.

Clinical Effectiveness	Data Source	Standard	Q3 2018/19	Q4 2019/20	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
Summary Hospital Mortality Index (SHMI)	CHKS	100	92.95	91.10	96.56	101.98	101.22	Not Published
Learning from Deaths	Internal Mortality Review Database	Reviewing and Monitoring Mortality Policy	385	346	336	345	392	308

Patient Experience	Data source	Standard	Actual 2018/19	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2019/20
Number of complaints received	Internal Datix Incident reporting system	Local Complaints Policy	535	171	161	161	144	637
National Inpatient Survey	CQC	National standard	73.1%*	n/a	n/a	n/a	n/a	Not published
Friends and Family response rates (inpatients and A&E)	Locally collected reported	National standard	96.7%	5.9%	5.5%	3.9%	4.6%	5%

Additional patient experience data is included on page 78.

Inconsistencies in data reported in the 2019/20 report

There have been some slight variations in the reported 2018/2019 data – this is due to the fact that the Trust Incident reporting system is a live database which results in fluctuations in actual numbers of incidents reported as investigations are processed through the system.

Overview of Quality Improvements

Pages 38-51 give some examples of other service developments and quality improvement initiatives the Trust has implemented, or been involved in, throughout the year.

The RVI Haven opens its doors for families and carers of end of life patients

The Royal Victoria Infirmary, Newcastle opened its doors on 27 November 2019 to the newly built 'Haven': a dedicated space to support families and carers of patients receiving end of life care. The space has facilities to make a meal, take a shower, and offers a place to relax for those who need some rest away from the ward environment.

The Haven was officially opened by Newcastle Hospitals Chairman Professor Sir John Burn as well as Will Welch and Sam Lockwood, players from Newcastle Falcons Rugby Union team.

A moving speech was given by Sir John along with Author Kathryn Mannix and Palliative Medicine Consultant Dr Rachel Quibell.

Dr Kathryn Mannix; Author of 'With The End in Mind' said; "The way people die lives on in those who love them, it is so important to have a place like this where those people can retreat to, make a last family meal together, play cards or even just talk to one another."

The Haven was funded by an anonymous generous donation for this purpose and this donation was match funded by Newcastle Hospitals charitable funds.
'A Gift of Kindness' fund supports patients receiving end of life care; their family and carers at Newcastle Hospitals and is one of many charitable funds administered by Newcastle Hospitals NHS Charity.

When a patient is receiving end of life care, their comfort is always a priority for all staff. The well-being of their family and carers is also important. During end of life care, there can be stresses felt by the patient's family and carers.
It is not unusual for families and carers to spend many days at the patient's bedside either at home or in hospital. "A Gift of Kindness" fund aims to provide the little things that make a big difference to patients, their families and carers at this time.

Palliative Medicine Consultant Rachel Quibell says; "We are delighted to have opened our new facility for families and carers of patients receiving end of life care at the RVI, the RVI Haven. This is a peaceful space for families and carers during a very stressful time. We are very grateful to an anonymous donor and Newcastle Hospitals charitable funds for making this possible. We continue to fundraise through our charity Gift of Kindness to support families at this difficult time and also create a Haven at the Freeman Hospital".

Sir Bobby Robson Cancer Centre Patient's 'Tour De France'

Like many cancer patients, Keith Farquharson from Heaton in Newcastle was in quarantine for at least 12 weeks to shield himself from the COVID-19 virus.

For the 44-year-old software developer, this meant working from home with his wife, Amber, and seven-year-old son, Caspian.
Keith, who has stage 4 bowel cancer and is currently receiving treatment at the Sir Bobby Robson Cancer Trials Research Centre at Newcastle's Northern Centre for Cancer Care, found one aspect of the lockdown especially challenging - not being unable to go outside to train for the Great North Run.

So, he set himself a new challenge - to cycle the Tour de France 2018, all 2,082 miles of it, without leaving home.

Using a turbo trainer to convert his road bike into a static bike and technology that creates tension on the wheel to replicate the many climbs, Keith began his 'Tour' in the kitchen, has cycled in the living room and, on a fine day, set his bike up in the back yard.

Diagnosed in May 2017, after six months of chemotherapy, Keith was told that half of the people with his prognosis would die within twelve months.
It has been an extremely difficult few years for the Farquharson family. In January 2017, Keith's father was diagnosed with stage four kidney and bladder cancer. Two months later, Amber, Keith's wife, was told she had cervical cancer and just two months after that, Keith was diagnosed with bowel cancer. Sadly, his father died last year.

During this time, exercise has proved to be both a great physical and mental benefit for Keith and he decided to take on his first Great North Run last year to raise funds for the Sir Bobby Robson Foundation and St Oswald's Hospice.

Keith says: "After my diagnosis, and after we'd exhausted the standard treatment available, I was offered a trial of a new drug at the Sir Bobby Centre and I began that in February 2018.
"To begin with, the drug was so new it didn't even have a name. Just a few letters and numbers, which I never actually learned. I think about 70 or 80 people globally were trying it at that point. Now it's called Cetrelimab and thankfully I'm feeling pretty fit and well on it.
"I used to run when I was a kid but only started again after my diagnosis because I was told it helps with the chemo and its side effects. I've cycled for years though, both for fun and to commute. I think I've cycled three or four miles for work most days for the last 12 years and I've done the Coast to Coast ride a couple of times.
"I've never tried anything like this though. It's hard now but I think it's going to get a lot more difficult as I go on. I can import the GPS tracks complete with elevation into the programme running the resistance on the turbo. This means I get a pretty realistic effort required to actually ride the course.
"I've always been a fan of the Tour de France but the 2018 race is special for me. It was the year my wife and I were both off work with cancer and I had time to watch it all. It was an iconic race and my Mum's Welsh, so it really meant a lot to me that Geraint Thomas won."

Keith's used his new challenge to raise money for the North East cancer charity, the Sir Bobby Robson Foundation, and was 'meeting' up to virtually ride with friends, who he would normally cycle with.

He adds: "It's been great to chat online and do some riding with friends. Cycling together is the sort of thing we'd normally do if we were allowed out, so that's brought a little bit of normal life home to us all. When we'd completed our first ride together, we all cracked open a beer to celebrate 'in' the French village of Vix, in the Vendée
"The real Tour de France riders can go twice as fast as me though, and ride all day. I'm having to take it easier than that, I have work to do apart from anything else.
"I'm breaking it up into two-hour sections and doing around 50kms a day. I think it will take me most of the planned 12-week isolation to complete.
"This has given me something else to focus on while we're all stuck at home and I'm raising funds for the Sir Bobby Robson Foundation so that others can benefit from research into cancer, as I have.
"It's a big challenge and there are some sections of the race that I'll find very hard indeed. It has the equivalent ascent of climbing Mount Everest five times and contains nine Haute Categorie climbs in the Alps and Pyrenees. But, like the Great North Run was for me last year, it's pushing myself to do something I don't think I can do, if you see what I mean.
"It's a really fantastic activity for me mentally as well as physically. When I'm cycling, I'm not thinking about anything else. I'm just cycling. That's such an important escape for me just now."

Sir Bobby Robson launched his Foundation in 2008. It does not employ professional fundraisers and, relying completely on the incredible generosity of the general public, has gone on to raise over £14 million to find more effective ways to detect and treat cancer.

Professor Ruth Plummer, is the director of the Sir Bobby Cancer Trials Research Centre, which is continuing to provide essential treatment for patients during the COVID-19 lockdown.

Professor Plummer says: "This is obviously an especially worrying time for people who are more vulnerable to the coronavirus.
"I think what Keith's doing is amazing. It's clearly giving him a positive focus while he's stuck at home and the exercise will be helpful for him physically as well."

The 2018 Tour de France race consisted of 21 stages, starting in Noirmoutier-en-l'Île, in western France, and finishing with the Champs-Élysées stage in Paris.

Surgeons develop pioneering technique to identify bone and soft tissue tumours

Surgeons in Newcastle have become the first in Europe to use a pioneering technique to help identify sarcomas during surgery.

Sarcomas are cancers affecting any part of the body, including the muscle, bone, tendons, blood vessels and fatty tissues. They account for around 1% of all cancers.

Surgery to remove a bone or soft tissue tumour involves removing the tumour and some of the surrounding healthy tissue; this is to allow any cancer cells that are not visible to the naked eye to be removed with the tumour, which can reduce the chance of the tumour coming back.
In an effort to reduce the amount of healthy tissue that needs to be removed a team based at the Freeman Hospital in Newcastle are using a dye which makes cancerous tissue glow green using a specially developed infrared camera.

Mr Kenneth Rankin, consultant orthopaedic surgeon at Newcastle Hospitals led the project. He said: “This dye has been used in other cancer types such as breast and bowel cancer, but our patients are the first in Europe to undergo open sarcoma surgery using this dye.”
“We inject the dye the afternoon before surgery and using the Spy PHI infrared camera we are able to see the tumour glow during surgery. We are still in the early stages of evaluating this technology however in the long term we hope this technique will allow us to safely take less healthy tissue from patients during surgery and preserve function for our sarcoma patients without compromising their cancer outcome.”

Diane Rudd, 55 from Guisborough was one of the first patients to be treated using the new technique. Diane was diagnosed with pleomorphic rhabdomyosarcoma earlier this year she said: “I’ve had a lump in my right arm for around four years, which was initially thought to be a herniated muscle. The lump continued to grow and after returning from a cruise to Alaska with my husband, it had become so painful I had to go back to see my GP.”

Diane’s GP referred her for a scan which showed she had a 7cm tumour in the top of her arm and a biopsy at the Freeman Hospital confirmed that the tumour was cancerous. Diane explains: “I knew as soon as I was referred to the Freeman that it must be serious but I never imagined that I would be told I had cancer.
“Everything since then has happened really quickly, Mr Rankin explained that the tumour was near the artery but that he could use the dye to show exactly where the cancerous tissue was.”

Following the operation to remove her tumour Diane is recovering well, she continues: “I was so relieved when I woke up in recovery to find I had feeling in my arm and could still move all of my fingers. Once my scars are healed I’ll start radiotherapy and then I’m looking forward to living and enjoying my life.
“Everyone has taken such good care of me, I couldn’t have been in better hands, they have saved my life, I don’t know how you can say thank you for that.”

Newcastle Hospitals unveils new simulation training centre

The North East's latest NHS centre for simulation training and education officially opened at Newcastle's Royal Victoria Infirmary on 7th June 2019.

Unveiled by Chairman of The Newcastle upon Tyne Hospitals NHS Foundation Trust, Professor Sir John Burn, the SIM centre is a purpose built, simulation facility at the heart of an 'Outstanding', multi-professional education and training skills centre.

Specially designed to recreate clinical environments, it allows staff to put their theoretical knowledge to the test by being placed in the heart of true to life healthcare situations, in a safe and controlled environment.

Consultant Colorectal Surgeon and clinical lead for simulation, Jon Hanson, explains: "As rapid advances are made every day in healthcare, access to simulation-based training has become integral to our staff training and development.
"This new SIM centre and mobile simulation equipment builds on our expertise as a leading training and development centre for the region, allowing our staff and healthcare professionals from across the Region to gain invaluable skills and experience in a range of interactive situations, both clinical and non-clinical.
"It helps them to focus – to rehearse and refine their skills, and be ready to truly put patients at the heart of everything they do when delivering high quality care in our outstanding clinical environments."
But it's not just 'hands on' clinical treatment that the simulation team can offer.
Emma Shipley, former Head of Education, and Workforce and Development says: "Our courses support development of highly performing teams, greatly enhancing patient safety through a human factors' perspective, encouraging effective communication and decision- making through greater awareness and clear leadership.
"This is particularly important in emergency and other difficult situations as it helps staff to think about how they behave and communicate with each other, and as important with patients and families who may be confused and distressed."

Newcastle Hospitals declare climate emergency

Newcastle Hospitals is joining an international movement to declare a climate emergency, becoming the first NHS trust in the UK to do so.

The declaration, made by the Trust Board on 27th June 2019, demonstrates a positive commitment to take action on climate change by aiming to become carbon neutral by 2040. It follows in the footsteps of city partners Newcastle City Council and Newcastle University.

“Newcastle Hospitals already have an outstanding reputation for leading on efforts to reduce the environmental impact of healthcare delivery,” explained Dame Jackie Daniel, Chief Executive.

“The Trust prides itself upon a forward thinking ethos which helps to embed sustainability into everything it does, and helps to play a key role in fighting climate change through how it operates.

“Our declaration of a climate emergency shows our continued commitment to work with our city council and other partners on this vast challenge, and we very much hope others will join us.”

The declaration builds on the development of award-winning, environmentally sustainable approaches taken by the Trust over several years.
Some notable achievements include:

- Generating the energy to power our hospitals through efficient combined heat and power plant since the turn of the century
- Buying electricity from 100% renewable sources when we need to top up our on-site energy production
- Ensuring zero waste to landfill since 2011
- Recycling over 40% of non-clinical waste offering discounts for reusing cups and food containers in our restaurants and cafes
- Removing single use plastics from our restaurants and cafes, providing compostable alternatives
- Encouraging sustainable staff travel through cycle scheme and public transport discounts investing in an electric vehicle fleet for our Estates and Catering Services and procuring electric buses for staff, patients and visitors
- Achieving sustainable catering awards from the Soil Association & Carbon Trust
- Hosting the UK's first Environmentally Sustainable Anaesthesia Fellow, Dr Cathy Lawson
- Having a network of over 300 Green Champions – staff who are dedicated to reducing our environmental impact
- Including sustainability specification and evaluation criteria in all procurement contracts
- Planting over 200 trees on our city centre hospital sites
- Forming a ‘Green Gym’ for staff to volunteer on local beach cleans and conservation projects.

Remarkable Olly marks the start of his teenage years with a run!

Olly McKenna is a true inspiration….

Following an operation to remove a tumour from his brain, he has raised a staggering £81,000 for Newcastle Hospitals and been the catalyst for hundreds of runners to help other children with cancer.

On 7th September 2019 - which also happened to be his 13th birthday - Olly tackled the Junior Great North Run alongside friends James Campbell, Henry Hughes, Josh Porter and Alex Perry.
Their quest was to raise funds for 'Team Olly' – an idea Olly had at the age of 11, while undergoing chemotherapy and radiotherapy, to help other young patients going through a similar experience.

Since then, his huge fundraising endeavours have benefitted the Great North Children's Hospital Foundation and Charlie Bear for Cancer Care fund – and it doesn't look like he has any plans on stopping!

After finishing his treatment in April 2018, Olly decided to do his first Junior Great North Run while still in recovery, leaving parents Jill and Jason unsure whether he would complete it.
But defying all odds, he did, and even managed to sprint over the Millennium Bridge!

Last year proud mum, Jill, said: "Olly is set on doing the run again even though it falls on the day of his birthday; he's so excited for it! There will also be ten Team Olly supporters running the Great North Run on Sunday and Olly will be cheering them all on."

Because of his outstanding fundraising efforts, Olly has been nominated for a Pride of Britain Award as well as winning Young Fundraiser of the Year in 2018 and Child of Courage in the Chronicle Champions Awards 2018.

Business as usual for Newcastle's midwives

Since The World Health Organization declared coronavirus (COVID-19) a global pandemic, almost 1,100 babies have been born at Newcastle's Royal Victoria Infirmary.

While there have been some changes to the way the services are provided, the maternity team have been working hard to remain very much business as usual and keep things as normal as possible for their patients.

However there are concerns that some pregnant women who are worried about their pregnancy might delay coming in to hospital due to a fear of being exposed to coronavirus.
Reanna Martin a midwife at the RVI said: "We understand that this must be a really worrying time for our patients but it's really important that any women who have concerns about their pregnancy, or if they think they are in labour, get in touch with us as soon as possible.
"Our Maternity Assessment Unit is open 24 hours a day, seven days a week and we are here to support our patients and investigate any concerns they might have."

In response to the pandemic the team have worked quickly to adapt services to support women and their families during pregnancy, labour and postnatally. Waiting areas have been rearranged to enable social distancing, protective screens are in place and the team are exploring digital solutions to help meet patient needs.

Charlotte Kennedy, 25, from Newcastle gave birth to her daughter Eliza on Good Friday and was initially nervous about coming into hospital. She said: "I was a bit apprehensive about the birth and I wasn't sure what to expect, I knew my Mum couldn't be my additional birthing partner and my husband Sam couldn't stay with me overnight after I'd given birth.
"Even though I'd had to change my birth plan I had such a positive experience. The staff were all so friendly which made me feel calm and at ease from the moment I arrived at hospital.
"I was so grateful for the compassion and patience of the midwife who delivered my baby – even though the circumstances were a little different and she was wearing PPE. Sam could stay with me until the early hours of the morning but by the time I was moved to the postnatal ward we were both ready for some sleep anyway."

Charlotte a primary school teacher is now home with Sam and baby Eliza and settling in to life as a family of three. Charlotte continues: "Life with a newborn daughter is a far cry from how I envisaged maternity leave would be. Our parents had not expected they would be meeting their new granddaughter for the first time over video call.

“We have been enjoying going for our daily walk in the sunshine around our local area, which admittedly we had never explored in such depth before. I am grateful that my husband has been able to work from home so we have been able to enjoy much more time together as family that we otherwise would not have had.”

Charlotte hopes her positive experience can help reassure any mums to be who may be anxious about coming in to hospital: “I am so grateful to the team of midwives and all of the other staff who looked after me while I was in hospital. They made the ward such a safe and comfortable place to be. I want to thank them all for their hard work, dedication and positivity during these unprecedented times.
“When Eliza grows older, we will certainly have lots to tell her about her first few months in the world.”

Jane Anderson, associate director of midwifery at Newcastle Hospitals said: “We recognise that it may be an incredibly stressful time for many of our women and their families, which may increase levels of worry and anxiety throughout pregnancy, labour and, of course, following the birth of your baby.
“Our services here at the Newcastle Hospitals continue to be available for you and I cannot stress enough the importance of making contact with either your community midwife or, alternatively, our maternity assessment unit, if you would like any information or advice.
“Although some elements of our service have been modified in line with national guidance and recommendation, we would urge you to make contact if you are in any way unsure or concerned. It is important to know that your maternity care is managed on an individual basis and that the safety and quality of your care is a priority for us all.”

Thousands of lives could be saved thanks to ‘Get a jab, Give a jab’ donation

Staff at Newcastle Hospitals have donated 11,500 life-saving tetanus vaccines to protect children from the disease in developing countries across the world.

As part of the flu campaign, the Trust took part in the UNICEF initiative to ‘get a jab, give a jab’, which saw every flu jab received by staff at Newcastle Hospitals matched with a donation of a tetanus vaccine.

With last year’s flu season, staff at Newcastle Hospitals were encouraged to think of others when deciding whether to have their flu vaccine, and the Trust sought to increase on this donation total.

Maurya Cushlow, Chief Nurse at Newcastle Hospitals said:
“Every year, we ask our staff to think about others when getting the flu vaccine. We are delighted to that so many of our staff had their flu vaccine last winter to protect themselves and those around them, whilst also helping to save the lives of thousands of children in other countries”.
“Vaccination is the best means we have to prevent infection and to protect those around us, both in and outside of work, and we are fortunate in the UK to have access to vaccines to protect against viruses such as the flu.
“Last year we vaccinated our highest number of staff, but this year we need to do even better and hope to donate more towards this valuable cause. While neonatal tetanus was eliminated from the industrialised world in the 1950s, it remains a major killer of infants in the developing world, who have little or no access to basic healthcare services”.

Severe asthma patients to receive life-changing treatment at home in UK first

Patients with severe asthma are to receive a life-changing new treatment at home thanks to clinicians at Newcastle's Freeman Hospital.

The drug, mepolizumab, which usually has to be administered by a healthcare professional to patients every four weeks, is now being offered for patients to administer at home through a pre-filled pen or syringe. Mepolizumab is used to treat asthma in patients with eosinophilic asthma, a rare type of asthma which is commonly seen in people who develop asthma in adulthood, although it can occur in children.

55 year-old Sharon Cowey from Newcastle, a retired Ward Sister, is one of the first patients to receive this treatment at home.
At 26, Sharon was diagnosed with asthma shortly after getting pregnant with her daughter, Sharon explains: "I remember taking my daughter out in her pram and having to stop at every lamppost as I couldn't get my breath. I visited the GP and I was prescribed Prednisolone, a strong steroid, and referred to the hospital. This improved my symptoms, but my asthma was never well controlled."

Over the years that passed, Sharon was prescribed a number of different medications alongside the steroid to try and gain control of her asthma, until she was diagnosed eosinophilic asthma - a form of severe asthma - at aged 53.

"It was only recently I was diagnosed with severe asthma after having a blood test, which indicated that my eosinophils level, a type of white blood cell, was high".
Sharon started treatment on mepolizumab, which greatly improved her asthma and enabled her to carry out activities she was unable to do before, like walking the dog and breathing freely, but this treatment had to be administered by a healthcare professional in a hospital every month. After working in collaboration with healthcare professionals, she is now able to administer the treatment for her asthma at home, without having to go into hospital.
"The months used to come around so quickly, so sometimes I would have to cancel plans so I could go to the hospital to receive my treatment. I am able to inject myself at home, with a pen injection like an insulin pen," she added "I can't thank the nurses enough, without them it wouldn't have happened."

John Davison, Senior Nurse Specialist for complex lung disease at Newcastle Hospitals said: "We are delighted to be the first Trust in the UK to provide patients with this treatment in the comfort of their own home. "Severe asthma patients often struggle to manage everyday activities, and frequent visits to a healthcare professional in hospital can be an added burden for them.

"This innovation will empower healthcare professionals and patients with greater flexibility to choose a treatment setting that best fits patients' needs."

Eosinophilic asthma is caused by a type of white blood cell, and the drug is used to reduce the number of these cells to control the inflammation in the lungs.

Of the 5.4 million people with asthma in UK, roughly 250,000 adults and children have severe asthma.

Newcastle Hospitals proud to be named top employer for Lesbian, Gay, Bisexual and Transgender (LGBT) inclusivity

Newcastle Hospitals has been named as one of the most inclusive employers in the UK after being listed in the Top 100 Employers by lesbian, gay, bisexual and transgender (LGBT) equality charity Stonewall.

The Trust was ranked 40th nationally - the fifth highest in the region and the highest ranking new entry in the health and social care sector.

Chief Executive Dame Jackie Daniel said: “I’m incredibly proud to see that Newcastle Hospitals is now recognised as one of Stonewall’s Top 100 Employers and it’s fantastic to be the highest ranking new entry in our sector.”
“Over 5,000 members of staff now wear their NHS Rainbow Badge with pride and have pledged to take action to support inclusion and visibility, as well as highlighting Trans inclusion across our NHS services.
“Flourish’ is our cornerstone programme aiming to enable every member of staff to liberate their full potential at work. An important part of this is supporting every member of staff to be their authentic self. As an organisation, we recognise and celebrate the value that difference and diversity brings.
“Members of our Board and Executive team are highly visible in their support for LGBT inclusion and in championing change for staff and patients regardless of their sexual orientation or gender identity/expression. Our LGBT staff network also plays an important role in ensuring we value and celebrate diversity with passion and energy.
“Building on this foundation, I’m delighted that Newcastle Hospitals will host the first national NHS LGBT+ staff conference in July 2020, encouraging the whole NHS to champion positive change.”

The organisation has entered Stonewall’s Top 100 Employers list after being ranked 149 last year.
The UK Workplace Equality Index is the definitive benchmarking tool for employers to measure their progress on lesbian, gay, bisexual and transgender inclusion in the workplace.
It asks employers to demonstrate their work in 10 areas of employment policy and practice including policy, staff networks, community engagement and all-staff engagement.

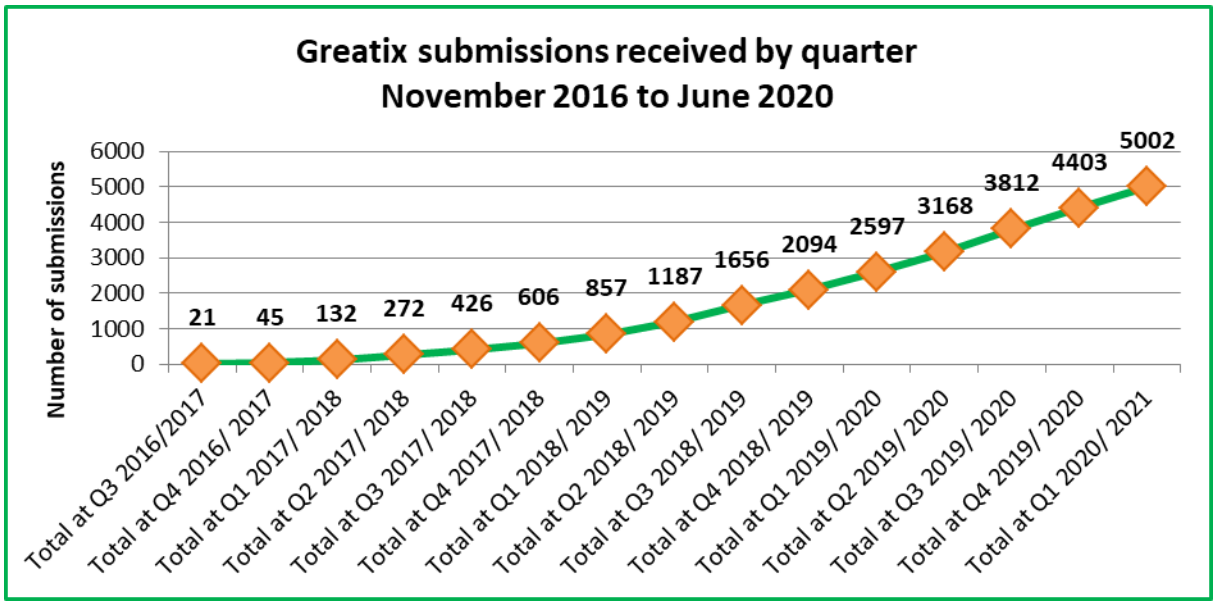
Chair of the Trust LGBT staff network Mark Ellerby-Hedley said: “This is fantastic news, I am so proud to work at Newcastle Hospitals - a Trust that has been working tirelessly over the last few years to make sure our workplace is supportive and inclusive of LGTB+ staff and patients and to show our commitment to LGBT equality.
“To be recognised by Stonewall and being placed so high up in the UK Workplace Equality Index Top 100 is a massive achievement and one we should all celebrate.
As chair of the LGBT staff network I would like to say a heartfelt thank you to Karen Pearce, Martin Wilson, Lucy Hall and the LGBT staff network for all of their hard work, and to Dame Jackie and the Executive Board for their continued support.”

Greatix
Learning From Excellence

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

In November 2016, with the launch of Greatix, Newcastle Hospitals joined a growing movement of organisations who felt it was just as important to recognise and learn from the excellent work and practice which happens on a day to day basis as it is to learn from when things go wrong.
There are examples of excellence all around us every day. Staff are encouraged to recognise and share these examples, so that everyone can learn from them.

Staff complete a simple online form, telling us who achieved excellence and what can be learnt.
By the end of June 2020, just three and a half years after launching, the Trust received its 5000th Greatix submission.
This is an outstanding achievement and one that reflects just how valued Greatix is by the staff working at Newcastle Hospitals.



Greatix
Learning From Excellence

"As a trainee assistant practitioner in cardiothoracic theatres, it can be daunting to scrub in and learn / perform new procedures. Professor Clark continuously made me feel not only at ease, but welcomed in the surgical environment. Professor Clark has shown excellent patience and commitment to teaching over the past two months."

Staff Nurses Erlyn Tubon, Josephine Agustin and Lucy Burn from Recovery Theatres were nominated for the 3000th Greatix in September 2019 for outstanding care of a critically ill baby.

"Siobhan was the lead in setting up the Singing for Wellbeing sessions in the Trust. These sessions are open to staff and patients and are an innovative way to engage people proactively in an activity that is known to benefit psychological wellbeing. I have attended a couple of sessions and it was especially wonderful to see two inpatients participating fully in the sessions and getting so much out of them."

Staff Nurses Gwen Arthurs and Helen Todd were nominated for the 5000th Greatix in June 2020 for excellent teamwork and care when they were redeployed to another ward during the COVID-19 outbreak.

Information on participation in National Clinical Audits and National Confidential Enquiries

During 2019/20, 67 national clinical audits and three national confidential enquiry reports / review outcome programmes covered NHS services that the Newcastle upon Tyne Foundation Hospitals NHS Foundation Trust provides.

During that period, Newcastle Hospitals participated in 61 (95.3%) 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 Newcastle Hospitals was eligible to participate in during 2019/20 and the national clinical audits / national confidential enquiries that Newcastle Hospitals participated in during 2019/20 are as follows:

National Clinical Audits			National Confidential Enquiries
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – COPD in Secondary Care	National Early Inflammatory Arthritis Audit	Child Health Outcome Review Programme - Long-term ventilation in children, young people and adults
British Association Urological Surgeons (BAUS) Audits: Cystectomy	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – Paediatric Asthma Secondary Care	National Emergency Laparotomy Audit	Medical and Surgical Clinical Outcome Review Programme (NCEPOD) – Out of Hospital Cardiac Arrests
BAUS Urology Audits: Female Stress Urinary Incontinence	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – Pulmonary Rehabilitation	National Gastro-intestinal Cancer Programme – National Oesophago-gastric Cancer (NOGCA)	Medical and Surgical Clinical Outcome Review Programme (NCEPOD) – Dysphagia in Parkinson's Disease
BAUS Urology Audits - Nephrectomy	National Audit of Breast Cancer in Older People	National Gastro-intestinal Cancer Programme – National Bowel Cancer Audit (NBOCA)	
BAUS Urology Audits - Percutaneous Nephrolithotomy	National Audit of Cardiac Rehabilitation	National Joint Registry	
BAUS Urology Audits - Radical Prostatectomy	National Audit of Care at the End of Life	National Lung Cancer Audit	
Care of Children in Emergency Departments	National Audit of Dementia (Care in general hospitals)	National Maternity and Perinatal Audit	
Case Mix Programme (CMP)	National Audit of Pulmonary Hypertension	National Neonatal Audit Programme – Neonatal Intensive and Special Care	
Elective Surgery – National PROMs Programme	National Audit of Seizure Management in Hospitals	National Ophthalmology Audit	
Endocrine and Thyroid National Audit	National Audit of Seizures and Epilepsies in Children	National Paediatric Diabetes Audit	

National Clinical Audits			National Confidential Enquiries
	and Young People		
Falls and Fragility Fractures Audit Programme – Fracture Liaison Programme	National Cardiac Arrest Audit	National Prostate Cancer Audit	
Falls and Fragility Fractures Audit Programme – Hip Fracture Database	National Cardiac Audit Programme – Adult Cardiac Surgery	National Smoking Cessation Audit	
Falls and Fragility Fractures Audit Programme – National Audit of Inpatient Falls	National Cardiac Audit Programme – Cardiac Rhythm Management	National Vascular Registry	
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	National Cardiac Audit Programme – Congenital Heart Disease in Children and Adults	Neurosurgical National Audit Programme	
Major Trauma Audit	National Cardiac Audit Programme – Heart Failure	Paediatric Intensive Care Audit (PICANet)	
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	National Cardiac Audit Programme – Myocardial Ischaemia	Perioperative Quality Improvement Programme (PQIP)	
Maternal, Newborn and Infant Clinical Outcome Review Programme – Perinatal Mortality Surveillance	National Cardiac Audit Programme – Percutaneous Coronary Interventions	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	
Maternal, Newborn and Infant Clinical Outcome Review Programme – Perinatal Morbidity and Mortality Confidential Enquiries	National Diabetes Audit – Adults: Foot Care	Sentinel Stroke National Audit Programme	
Maternal, Newborn and Infant Clinical Outcome Review Programme – Maternal Mortality Surveillance and Mortality Confidential Enquiries	National Diabetes Audit – Adults: National Diabetes Inpatient Audit (NaDIA) - Reporting data on services in England and Wales	Serious Hazards of Transfusion: UK National Haemovigilance Scheme	
Maternal, Newborn and Infant Clinical Outcome Review Programme – Maternal Morbidity Confidential Enquiries	National Diabetes Audit – Adults: NaDIA Harms – Reporting on diabetic inpatient harms in England	Society for Acute Medicine's Benchmarking Audit (SAMBA)	
Mental Health – Care in Emergency Departments	National Diabetes Audit – Adults: National Core Diabetes Audit	Surgical Site Infection Surveillance Service	
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – Adult Asthma Secondary Care	National Diabetes Audit – Adults: National Pregnancy in Diabetes Audit	UK Cystic Fibrosis Registry	

The national clinical audits and national confidential enquiries that Newcastle Hospitals participated in during 2019/20, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases requires by the terms of that audit or enquiry.

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2019/20	Percentage Data completion	Outcome
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	Royal College of Emergency Medicine	The audit reviews current performance against best practice clinical standards when assessing over 75s for signs of delirium/ cognitive impairment when presenting to the ED.	Y	100%	Published report expected Spring 2020
British Association of Urological Surgeons (BAUS) Audits: Cystectomy	British Association of Urological Surgeons	The audit addresses open, keyhole or robotic-assisted removal of the bladder for cancer.	Y	100%	Published report expected October 2020
BAUS Urology Audits: Female Stress Urinary Incontinence	British Association of Urological Surgeons	The audit addresses open surgery for stress incontinence of urine in women.	Y	100%	Published report expected May 2020
BAUS Urology Audits - Nephrectomy	British Association of Urological Surgeons	The audit addresses partial or complete kidney removal (± the ureter) using open or "keyhole" techniques.	Y	100%	Published report expected August 2020
BAUS Urology Audits - Percutaneous Nephrolithotomy	British Association of Urological Surgeons	The audit addresses percutaneous "keyhole" removal of stones from the kidney (or upper ureter).	Y	100%	Published report expected May 2020
BAUS Urology Audits - Radical Prostatectomy	British Association of Urological Surgeons	The audit addresses open, keyhole or robotic removal of the prostate gland (± lymph nodes) for cancer.	Y	100%	Published report expected September 2020
Care of Children in Emergency Departments	Royal College of Emergency Medicine	The audit addresses injuries in non-mobile infants aged 12 months and under, patients under 18 who abscond or leave the ED without being seen and appropriate assessment of psychosocial risk in 12 – 17 year olds.	Y	100%	Published report expected Spring 2020

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2019/20	Percentage Data completion	Outcome
Case Mix Programme	Intensive Care National Audit and Research Centre	This audit looks at patient outcomes from adult, general critical care units in England, Wales and Northern Ireland.	Y	Continuous data collection	Published report expected November/ December 2020
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.	Y	Continuous data collection	Provisional published report expected August 2020
Endocrine and Thyroid National Audit	British Association of Endocrine and Thyroid Surgeons	The Registry collects data on all patients undergoing thyroid surgery performed by any surgeon registered with the audit.	Y	Continuous data collection	No publication date yet identified
Falls and Fragility Fractures Audit Programme – Fracture Liaison Programme	Royal College of Physicians	Fracture Liaison Services (FLS) 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 (FLS-DB) to benchmark services and drive quality improvement.	The Trust did not participate in the national clinical audit due to the Directorate's capacity to undertake data collection. A business case is being compiled to identify future resource capacity.		
Falls and Fragility Fractures Audit Programme – 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.	Y	Continuous data collection	Published report expected November 2020
Falls and Fragility Fractures 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.	Y	Continuous data collection	Action plan currently being developed
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	IBD UK/ IBD Registry Ltd	The IBD Registry biological therapies audit collected data on all patients of all ages diagnosed with the ICD-10 codes and receiving biological therapy at any time during the year. The data was requested at three time points:	The Trust did not participate in the audit due to national IT infrastructure issues. Local resolution has been achieved and it is planned to participate in 2020/2021.		

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2019/20	Percentage Data completion	Outcome
		initiation, post-induction review and 12-month review.			
Major Trauma Audit	Trauma Audit Research Network (TARN)	TARN is working towards improving emergency health care systems by collating and analysing trauma care.	Y	Continuous data collection	Major Trauma Dashboards (quarterly), Clinical Feedback reports (3 per year), PROMs reports (quarterly), national reports based on a) injured children and b) older people (every 2 years)
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Public Health England	Mandatory HCAI surveillance outputs are used to monitor progress on controlling key health care associated infections and for providing epidemiological evidence to inform action to reduce them.	Y	Continuous data collection	Reports published as national statistics, on Monthly Quarterly and Annual basis
Maternal, Newborn and Infant Clinical Outcome Review Programme – Perinatal Mortality Surveillance	Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries Across the UK (MBRRACE-UK)	The study addresses late foetal losses – baby delivered between 22+0 and 23+6 weeks of pregnancy showing no signs of life, irrespective of when the death occurred. Terminations of pregnancy - resulting in a pregnancy outcome from 22+0 weeks gestation onwards. Stillbirths – baby delivered from 24+0 weeks gestation showing no signs of life. Early neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an	Y	Continuous data collection	Published report expected December 2020

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2019/20	Percentage Data completion	Outcome
		accurate estimate of gestation is not available) occurring before 7 completed days after birth. Late neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.			
Maternal, Newborn and Infant Clinical Outcome Review Programme – Perinatal morbidity and mortality confidential enquiries	Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries Across the UK (MBRRACE-UK)	This enquiry concerns intrapartum stillbirths and intrapartum related neonatal deaths in multiple births.	Trust will be contacted by MBRRACE-UK if they are requested to provide cases of multiple births for the enquiry	Trust was not asked to participate	
Maternal, Newborn and Infant Clinical Outcome Review Programme – Maternal Mortality Surveillance and mortality confidential enquiries	Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries Across the UK (MBRRACE-UK)	All deaths of women who die during pregnancy or up to one year after the end of the pregnancy regardless of how the pregnancy ended or the cause of death.	Y	Continuous data collection	Action plan currently being developed
Maternal, Newborn and Infant Clinical Outcome Review Programme – Maternal morbidity confidential enquiries	Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries Across the UK (MBRRACE-UK)	The aim is to identify avoidable illness and deaths so the lessons learned can be used to prevent similar cases in the future.	Trust will be contacted by MBRRACE-UK if they are requested to submit a pulmonary embolism case	Trust was not asked to participate	
Mental Health – Care in Emergency Departments	Royal College of Emergency Medicine	The audit looks at the performance in EDs against clinical standards focusing on initial assessment by ED staff, assessment of suicide risk and documentation of a	Y	100%	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2019/20	Percentage Data completion	Outcome
		mental state examination.			
National Asthma and Chronic Obstructive Pulmonary Disease (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.	Y	Continuous data collection	Action plan currently being developed
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme- COPD in Secondary Care	Royal College of Physicians	The aim of the audit is to drive improvements in the quality of care and services provided for COPD patients.	Y	Continuous data collection	Published report expected July 2020
National Asthma and Chronic Obstructive Pulmonary Disease (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.	Y	Continuous data collection	No publication date yet identified
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – Pulmonary Rehabilitation	Royal College of Physicians	This audit looks at the care people with COPD get in pulmonary rehabilitation services.	Y	Continuous data collection	Action plan currently being developed
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.	Y	Continuous data collection	Action plan currently being developed
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	Y	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2019/20	Percentage Data completion	Outcome
		cardiovascular disease, irrespective of where they live.			
National Audit of Care at the End of Life	NHS Benchmarking Network	The aim of the audit is to improve the quality of care of people at the end of their life for people receiving NHS funded care in England, Wales and Northern Ireland.	Y	100%	Action plan currently being developed
National Audit of Dementia (Care in general hospitals)	Royal College of Psychiatrists	The audit measures the performance of general hospitals against criteria relating to care delivery which are known to impact upon people with dementia while in hospital.	Y	Freeman Hospital 92% RVI 102%	Action plan currently being developed
National Audit of Pulmonary Hypertension	NHS Digital	The audit measures the quality of care provided to people referred to pulmonary hypertension services.	Y	Continuous data collection	No publication date yet identified
National Audit of Seizure Management in Hospitals	University of Liverpool	Looks at the facilities and care available to patients experiencing seizures that will help identify how best to change services to reduce the number of patients presenting at hospital with preventable seizures.	Y	April 2019 to June 2019	Published report was expected in Winter 2019/20 – not yet published
National Audit of Seizures and Epilepsies in 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 assessment from April 2018 within acute, community and tertiary paediatric services.	Y	April 2019 to March 2020	Published report expected July 2020
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.	Y	Continuous data collection	Published report expected November 2020
National Cardiac Audit Programme – Adult Cardiac	Barts Health NHS Trust	This audit looks at heart operations. Details of who undertakes the	Y	Data collection April 2019 to March	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2019/20	Percentage Data completion	Outcome
Surgery		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.		2020	
National Cardiac Audit Programme – Cardiac Rhythm Management	Barts Health NHS Trust	The audit aims to monitor the use of implantable devices and interventional procedures for management of cardiac rhythm disorders in UK hospitals.	Y	Data collection April 2019 to March 2020	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.	Y	Data collection April 2019 to March 2020	No publication date yet identified
National Cardiac Audit Programme – Heart Failure	Barts Health NHS Trust	The aim of this project is to improve the quality of care for patients with heart failure through continual audit and to support the implementation of the national service framework for coronary heart disease.	Y	Data collection April 2019 to March 2020	No publication date yet identified
National Cardiac Audit Programme – Myocardial Ischaemia	Barts Health NHS Trust	The Myocardial Ischaemia National Audit Project (MINAP) was established in 1999 in response to the National Service Framework (NSF) for Coronary Heart Disease, to examine the quality of management of heart attacks (Myocardial Infarction) in hospitals in England and Wales.	Y	Data collection April 2019 to March 2020	No publication date yet identified
National Cardiac Audit Programme – Percutaneous Coronary	Barts Health NHS Trust	This project looks at percutaneous coronary intervention (PCI) procedures performed in the UK. The audit	Y	Data collection April 2019 to March 2020	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2019/20	Percentage Data completion	Outcome
Interventions		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 (CCAD) which has developed secure data collection, analysis and monitoring tools and provides a common infrastructure for all the coronary heart disease audits.			
National Diabetes Audit – Adults: Foot Care	NHS Digital	Patients referred to specialist diabetes footcare services for an expert assessment on a new diabetic foot ulcer.	Y	Data collection April 2019 to March 2020	No publication date yet identified
National Diabetes Audit – Adults: National Diabetes Inpatient Audit (NaDIA) - Reporting data on services in England and Wales	NHS Digital	The National Diabetes Inpatient Audit (NaDIA) 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. NaDIA 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.	Y	100%	Published report expected May 2020
National Diabetes Audit – Adults: NaDIA Harms – Reporting on diabetic inpatient harms in England	NHS Digital	The National Diabetes Inpatient Audit - Harms (NaDIA-Harms) is a continuous collection of four diabetic harms which can occur during an inpatient stay.	Y	Data collection April 2019 to March 2020	Published report expected May 2020
National Diabetes Audit – Adults: National Core Diabetes Audit	NHS Digital	National Diabetes Audit collects information on people with diabetes and whether they have received their annual care checks and	Y	Continuous data collection	Published report expected November 2020

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2019/20	Percentage Data completion	Outcome
		achieved their treatment targets as set out by NICE guidelines.			
National Diabetes Audit – Adults: 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.	Y	Continuous data collection	No publication date yet identified
National Early Inflammatory Arthritis Audit	British Society for Rheumatology	The audit aims to improve the quality of care for people living with inflammatory arthritis.	Y	Data collection May 2019 to March 2020	Action plan currently being developed
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.	Y	Continuous data collection	Action plan currently being developed
National Gastro-intestinal Cancer Programme – National Oesophago-gastric Cancer (NOGCA)	Royal College of Surgeons	The oesophago-gastric (stomach) cancer audit aims to examine the quality of care given to patients and thereby help services to improve. The audit evaluates the process of care and the outcomes of treatment for all O-G cancer patients, both curative and palliative.	Y	Continuous data collection	Published report expected December 2020
National Gastro-intestinal Cancer Programme – National Bowel Cancer Audit (NBOCA)	Royal College of Surgeons	Colorectal (large bowel) cancer is the most common cancer in non-smokers and second most common cause of death from cancer in England and Wales. Each year over 30,000 new cases are diagnosed, and bowel cancer is registered as the underlying cause of death in half of this number.	Y	Continuous data collection	Published report expected December 2020
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.	Y	Continuous data collection	Published report expected September 2020
National Lung Cancer Audit	Royal College of Physicians	Lung cancer has the highest mortality rate of	Y	Data collection	Action plan currently

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2019/20	Percentage Data completion	Outcome
		all forms of cancer in the western world and there is evidence that the UK's survival rates compare poorly with those in the rest of Europe. There is also evidence that, in the UK, standards of care differ widely. The audit was set up to monitor the introduction and effectiveness of cancer services.		April 2019 to March 2020	being developed
National Maternity and Perinatal Audit	Royal College of Obstetricians and Gynaecologists	A new large scale audit of NHS maternity services across England, Scotland and Wales, collecting data on all registrable births delivered under NHS care.	Y	Data collection is via the NHS Digital Maternity Services Dataset	Action plan currently being developed
National Neonatal Audit Programme – Neonatal Intensive and Special Care	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.	Y	Continuous data collection	Published report expected November 2020
National Ophthalmology Audit	Royal College of Ophthalmologists	The project aims to prospectively collect, collate and analyse a standardised, nationally agreed cataract surgery dataset from all centres providing NHS cataract surgery in England & Wales to update benchmark standards of care and provide a powerful quality improvement tool. In addition to cataract surgery, electronic ophthalmology feasibility audits will be undertaken for glaucoma, retinal detachment surgery and age-related macular degeneration (AMD).	Y	100%	Action plan currently being developed
National Paediatric	Royal College of Paediatrics and	The audit covers registrations,	Y	Data collection	Action plan currently

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2019/20	Percentage Data completion	Outcome
Diabetes Audit	Child Health	complications, care process and treatment targets.		April 2019 to March 2020	being developed
National Prostate Cancer Audit	Royal College of Surgeons	The National Prostate Cancer Audit is the first national clinical audit of the care that men receive following a diagnosis of prostate cancer.	Y	Data collection April 2019 to March 2020	Action plan currently being developed
National Smoking Cessation Audit	British Thoracic Society	This audit concerns smoking cessation activity and treatment in secondary care trusts and how this is recorded in patient records.	Y	100%	No publication date yet identified
National Vascular Registry	Royal College of Surgeons	The National Vascular Registry collects data on all patients undergoing major vascular surgery in NHS hospitals in the UK.	Y	Data collection April 2019 to March 2020	Action plan currently being developed
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.	Y	100%	No publication date yet identified
Paediatric Intensive Care Audit (PICANet)	University of Leeds and 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.	Y	Data collection April 2019 to March 2020	Action plan currently being developed
Perioperative Quality Improvement Programme	Royal College of Anaesthetists	This programme aims to improve the care and treatment of patients undergoing major surgery in the UK.	The Trust did not participate in the programme due to local resourcing issues. A proposal has been submitted to resolve this and it is planned to participate in 2020/2021		
Reducing the impact of serious infections (Antimicrobial Resistance and	Public Health England	This programme aims to improve the timely assessment and treatment of healthcare acquired infections.	Y	Continuous data collection	Monthly reporting except for Surgical Site Infections which reports

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2019/20	Percentage Data completion	Outcome
Sepsis)					quarterly
Sentinel Stroke National Audit Programme	King's 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.	Y	100%	Action plan currently being developed
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.	Y	Continuous data collection	Published report expected July 2020
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Society for Acute Medicine	The 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 audit due to local resourcing issues. Resolution has been achieved and it is planned to participate in 2020/2021		
Surgical Site Infection Surveillance Service	Public Health England	The aim of the national surveillance program is to enhance the quality of patient care by encouraging hospitals to use data obtained from surveillance to compare their rates of SSI over time and against a national benchmark, and to use this information to review and guide clinical practice.	Y	100%	Published report expected December 2020
UK Cystic Fibrosis	Cystic Fibrosis Registry	This audit looks at the care of people with a	Y	Adults 99.4%	Published report

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2019/20	Percentage Data completion	Outcome
Registry		diagnosis of cystic fibrosis under the care of the NHS in the UK.		Children 100%	expected December 2020
UK Parkinson's Audit	Parkinson's UK	The UK Parkinson's Audit collects data on patients with a diagnosis of Parkinson's disease who are seen for a review by their Neurology or Elderly Care consultant during the data collection period, or who are seen by an occupational therapist, physiotherapist or speech and language therapist having been referred for treatment related to their Parkinson's disease.	Y	100%	Published report expected March 2020
Child Health Outcome Review Programme - Long-term ventilation in children, young people and adults	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	The study reviewed the quality and organisation of care provided to children and young people receiving long-term ventilation (LTV).	Y	100%	Compliant
Medical and Surgical Clinical Outcome Review Programme – Out of Hospital Cardiac Arrests	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	The aim of this study is to investigate variation and remediable factors in the processes of care of patients admitted to hospital following an out of hospital cardiac arrest (OHCA).	Y	100%	Action plan currently being developed
Medical and Surgical Clinical Outcome Review Programme – Dysphagia in Parkinson's Disease	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	This study aims to examine the pathway of care of patients with Parkinson's disease (PD) who are admitted to hospital when acutely unwell. In particular, to identify and explore multidisciplinary care and review organisational factors in the process of identifying, screening, assessing, treating and monitoring the ability to swallow.	Y	Data collection July 2019 to March 2020	Published report expected December 2020

An additional 10 audits have been added to the list for inclusion in 2020/21 Quality Accounts and all 10 of these audits are relevant to services provided by the Trust. The audits include:

- Antenatal and newborn national audit protocol 2019 to 2022
- BAUS Cytoreductive radical
- BAUS Renal colic audit
- British Spine Registry
- Cleft Registry and Audit Network
- Fractured neck of femur – care in emergency departments
- Homelessness inclusion health (care in emergency departments)
- National Comparative Audit of Blood Transfusion Programme – 2020 audit of the management of perioperative paediatric anaemia
- NHS provider intentions with suspected/ confirmed carbapenemase producing Gram negative colonisations/ infections
- UK Renal Registry National Acute Kidney Injury programme.

The reports of national clinical audits were reviewed by the provider in 2019/20 and Newcastle Hospitals 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 six-monthly 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 nationally and locally. Clinicians are required to report all audit activity using the Trust's Clinical Effectiveness Register
- Involvement in National audits is monitored at the Patient Safety and Quality Reviews where a data pack is provided that contains audit compliance
- 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 793 local audits were reviewed by the provider in 2019/20 and Newcastle Hospitals 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 nationally and locally.

Information on Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Newcastle Hospitals in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 8,471 of which 7,911 were UK Clinical Research Network National Portfolio studies which equates to 31% of all patients recruited to National Portfolio studies in the region.

Information on the use of the CQUIN framework

A proportion of Newcastle Hospitals income in 2019/2020 was conditional upon achieving quality improvement and innovation goals agreed between Newcastle Hospitals and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through Commissioning for Quality Innovation (CQUIN) payment framework.
The monetary total for the amount of income in 2019/20, conditional upon achieving quality improvement and innovation goals is £10.3 million. The monetary total for the amount of income on 2018/19 was £16.9 million.
It is of note that all CQUIN schemes were suspended in quarter 4 due to the COVID-19 pandemic and there was no expectation for organisations to submit data or reports during this time.

Information on the use of the CQUIN framework

CQUIN Indicators - Acute Hospital – (NHS England)	**CQUIN Indicators - Acute Hospital – (CCG)**
Toward HCV Elimination Personalised Care: Cystic Fibrosis Medicines Stewardship: Immunoglobulin Medicines Stewardship: Medicines Optimisation Appropriate Spinal Care: Spinal Surgery Severe Asthma	Staff Flu Vaccinations Alcohol and Tobacco brief advice Three High Impact Actions to Prevent Falls Antimicrobial Resistance: Urinary Tract Infections and Antibiotic prophylaxis for Elective Colorectal Surgery Same day Emergency Care – Pulmonary Embolus/Tachycardia with Atrial Fibrillation /Pneumonia
CQUIN Indicators - Acute Hospital – (Public Health/Dental/other)	**CQUIN Indicators - Community**
Dental Quality Dashboards Breast screening Armed Forces Covenant.	Staff Flu Vaccinations Alcohol and Tobacco brief advice

Further details of the agreed goals for 2019/20 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 Hospital NHS Foundation Trust is registered with the CQC to deliver care from five separate locations and for eleven regulated activities.

The Care Quality Commission has not taken enforcement action against Newcastle Hospitals during 2019/20.

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

Information on the Quality of Data

Newcastle Hospitals submitted records during 2019/20 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 patient's valid NHS number was:
99.5% for admitted patient care;
99.8% for outpatient care;
98.4% for accident and emergency care.
which included the patients valid General Medical Practice Code was:
99.9% for admitted patient care;
99.8% for outpatient care;
99.8% for accident and emergency care.

Clinical Coding Information

Score for 2018/19 for Information Quality and Records Management, assessed using the Data Security & Protection (DSP) Toolkit

Newcastle Hospitals was not subject to the Payment by Results clinical coding audit during 2019/20 by the Audit Commission due to significant improvements in previous years.

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

The level was attained for Data Security Standard 1 Data Quality – Standards Met.

The level attained for Data Security Standard 3 Training – Standard Exceeded.
Table shows the - levels of attainment of coding of inpatient activity

	Levels of Attainment		
	Standards Met	Standards Exceeded	NUTH Level
Primary diagnosis	>=90%	>=95%	91.0%
Secondary diagnosis	>=80%	>=90%	88.9%
Primary procedure	>=90%	>=95%	90.1%
Secondary procedure	>=80%	>=90%	89.4%

Newcastle Hospitals will be taking the following actions to improve data quality:

Re-enforce guidance with Clinical Coders around all national clinical coding standards highlighted throughout the audit.
Work immediately to standardise areas where there are differences in coding practice, so all staff are coding consistently.
Review the recruitment strategy in order to satisfy and execute a full clinical coding audit programme, at the earliest opportunity.
Review all local coding policies within 3 months to ensure accurate policies are held within the Policy and Procedure Document.

The Data Security and Protection Clinical Coding Audit undertaken in February 2020 also demonstrated high quality clinically coded data and out of the 200 episodes audited only 8.5% resulted in an HRG change which impacted on payment.

Key National Priorities 2019/20

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 2019/20 are detailed in the table below. Please note that changes in performance are in all likelihood due to the impact of COVID-19.

Operating and Compliance Framework Target	**Target**	**Annual Performance 2019/20**
Incidence of Clostridium (*C .difficile:* variance from plan)	No more than 113 cases	113 cases (24 cases successfully appealed; 89 cases against target)*
Incidence of MRSA Bacteraemia	Zero tolerance	1 case
All Cancer Two Week Wait	93%	82.8%
Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	93%	24.1%
31-Day (Diagnosis To Treatment) Wait For First Treatment	96%	93.8%
31-Day Wait For Second Or Subsequent Treatment: Surgery	94%	86%
31-Day Wait For Second Or Subsequent Treatment: Drug treatment	98%	97%
31-Day Wait For Second Or Subsequent Treatment: Radiotherapy	94%	98.7%
All cancers: 62-day wait for first treatment from: • urgent GP referral for suspected cancer	85%	77.1%
All cancers: 62-day wait for first treatment from: • NHS Cancer Screening Service referral	90%	89.4%
RTT – Referral to Treatment - Admitted Compliance	90%	76.4%
RTT – Referral to Treatment - Non-Admitted Compliance	95%	87.8%
RTT – Referral to Treatment - Incomplete Compliance	90.2%	92%
Maximum 6-week wait for diagnostic procedures	99%	96%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	95%	94.32%
Delayed Transfers	3.5%	2.7%
Cancelled operations – those not admitted within 28 days	0	51
Maternity bookings within 12 weeks and 6 days	Not defined	87.02%
Data completeness: Community Services comprising: Referral to treatment information	Not defined	99.7%
Data completeness: Community Services comprising: Referral information	Not defined	94.9%
Data completeness: Community Services comprising: Treatment activity information	Not defined	98.0%

Details on Hospital-level Mortality Indicator please refer to page 75.
Details on Venous thromboembolism (VTE) risk assessment please refer to page 79.
* *C. difficile* Infection appeal hearings have been cancelled. This decision has been supported by the Newcastle/Gateshead CCG to prioritise COVID-19 pandemic work.

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

The reasons for cancer performance deterioration have included increased volume of referrals and pressure on diagnostics, specifically Radiology and Endoscopy. Staff vacancies and time taken to recruit and train have been a particular concern. Ongoing work is in place to reach targets set, as of January, Radiology have recruited an additional Breast Radiologist – waiting times should be impacted on positively as a result of this.

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. Any and all updated data is presented.

Measure	Data Source	Target	Value	2019/2020				2018/2019				2017/2018		
1. The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust	NHS Digital Indicator Portal https://indicators.ic.nhs.uk/webview/	Band 2 "as expected"		Oct 18 – Sept 19 **NUTH Value:** 0.9556 **NUTH Band 2**	Jul 18 - Jun 19 **NUTH Value:** 0.9555 **NUTH Band 2**	Apr 18 - Mar 19 **NUTH Value:** 0.9644 **NUTH Band 2**	Jan18 - Dec 18 **NUTH Value:** 0.9867 **NUTH Band 2**	Oct 17 - Sept 18 **NUTH Value:** 0.9847 **NUTH Band 2**	Jul 17 - Jun 18 **NUTH Value:** 0.9553 **NUTH Band 2**	Apr 17 - Mar 18 **NUTH Value:** 0.9359 **NUTH Band 2**	Jan 17 - Dec 17 **NUTH Value:** 0.9282 **NUTH Band 2**	Oct 16-Sept 17 **NUTH Value:** 0.93 **NUTH Band 2**	Jul 16-Jun 17 **NUTH Value:** 0.95 **NUTH Band 2**	Apr 16-Mar 17 **NUTH Value:** 0.95 **NUTH Band 2**
			National Average	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
			Highest National	1.1877	1.1916	1.2058	1.2264	1.268	1.257	1.2321	1.2181	1.25	1.23	1.21
			Lowest National	0.6979	0.6967	0.7069	0.6993	0.692	0.698	0.6994	0.7204	0.73	0.73	0.71
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		32%	33%	33%	32%	29.2%	28.7%	28.4%	27.3%	25.1%	24.3%	22.5%
			National Average	36%	36%	35%	34%	33.6%	33.1%	32.5%	32.2%	31.5%	Not available	Not available
			Highest National	59%	60%	60%	60%	59.5%	58.7%	59.0%	60.3%	59.8%	58.6%	56.9%
			Lowest National	12%	15%	12%	15%	14.3%	13.4%	12.6%	11.7%	11.5%	11.2%	11.1%

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

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

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

Newcastle Hospitals considers that this data is as described for the following reasons: The use of palliative care codes in the Trust has remained static and aligned to the national average percentage over recent years. Newcastle Hospitals intends to take the following actions to improve this indicator, and so the quality of its services, by involving the Coding team in routine mortality reviews to ensure accuracy and consistency of palliative care coding.

Measure	Data Source	Value	2019/2020	2018/2019	2017/2018	2016/ 2017	2015/2016	2014/2015
3. The patient reported outcome measures scores (PROMS) for groin hernia surgery (average health gain score)	NHS Digital information portal http://content.digital.nhs.uk/proms	NUTH	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	0.11	0.08	0.09
		National Average:	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	0.09	0.08	0.08
		Highest National:	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	0.14	0.15	0.15
		Lowest National:	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	0.01	0.03	0.03
4. The patient reported outcome measures scores (PROMS) for varicose vein surgery (average health gain)	NHS Digital information portal http://content.digital.nhs.uk/proms	Trust	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	0.12	0.10	0.08
		National Average:	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	0.09	0.09	0.09
		Highest National:	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	0.15	0.15	0.15
		Lowest National:	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	Ceased to be collected 1st October 2017	0.01	002	-0.01
5. The patient reported outcome measures scores (PROMS) for primary hip replacement surgery (average health gain)	NHS Digital information portal http://content.digital.nhs.uk/prom	Trust	Data not yet published	0.50	0.47	0.44	0.42	0.43
		National Average:	Data not yet published	0.47	0.47	0.44	0.43	0.44
		Highest National:	Data not yet published	0.56	0.57	0.54	0.50	0.52
		Lowest National:	Data not yet published	0.35	0.38	0.31	0.39	0.33
6. The patient reported outcome measures scores (PROMS) for primary knee replacement surgery (average health gain)	NHS Digital information portal http://content.digital.nhs.uk/proms	Trust	Data not yet published	0.31	0.33	0.33	0.31	0.32
		National Average:	Data not yet published	0.34	0.34	0.32	0.32	0.31
		Highest National:	Data not yet published	0.41	0.42	0.40	0.38	0.42
		Lowest National:	Data not yet published	0.27	0.23	0.24	0.23	0.20

Please note that finalised PROMs data is now available for 2018-2019. Finalised 2019/20 data will not be available until February 2021.

Provisional 2019/20 data was published in February 2020, however Adjusted Average Health Gain data is not available for most providers, as described below. The reason for this is that the EQ-5D survey is sent to patients 6 months post-surgery, these survey scores can then be modelled. The data published by NHS Digital requires a provider to have at least 30 modelled records before a score can be calculated.

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.
Newcastle Hospitals did not meet the Participation in Assessment requirement against PROMS figures for Hips target. Newcastle does not have more than 30 records for 2019/20 and so no PROMs figure is available. This is not unusual, only 34 providers in the country have more than 30 records modelled so far. The national average is 0.47. Currently the

national high is 0.56 and the national low is 0.41 but all are based on very limited results and so the document has not been populated due to the very limited scores. These provisional scores will be updated next in August/September and finalised in February 2021. Newcastle Hospitals PROMS outcomes are good and we are committed to increasing our participation rates going forward to meet and surpass the target levels. We encourage patients to complete these and discuss completion rates and results in the Arthroplasty Multidisciplinary team (MDT).

Measure 6. The patient reported outcome measures scores (PROMS) for knee replacement surgery.

Newcastle Hospitals did not meet the Participation in Assessment against PROMS figures for Knee replacement target. Newcastle does not have more than 30 records for 2019/20 and so no PROMs figure is available Only 38 providers have more than 30 modelled records recorded so far. The national average is 0.35. Currently the national high is 0.43 and the national low is 0.26 but all are based on very limited results and so the document has not been populated due to the very limited scores. These scores will be updated next in August/September. Newcastle Hospitals PROMS outcomes are good and we are committed to increasing our participation rates going forward to meet and surpass the target levels. We encourage patients to complete these and discuss completion rates and results in the Arthroplasty MDT.

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

This indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review. Therefore, the Trust has reviewed its own internal data and used its own methodology of reporting readmissions within 28 days (without PbR exclusions). Newcastle Hospitals considers that this data is as described for the following reasons: The Trust has a robust reporting system in place and adopts a systematic approach to data quality improvement. Newcastle Hospitals 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. 2019/20 are significantly higher than previous years as we changed the recording of both ambulatory care and paediatric ambulatory care from an outpatient attendance to an emergency admission

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

Year	Total number of admissions/spells	Number of readmissions (all)	Emergency readmission rate (all)
20/11/12	31,548	2,500	7.9
2012/13	31,841	2,454	7.7
2013/14	32,242	2,648	8.2
2014/15	34,561	3,570	10.3
2015/16	38,769	2,875	7.4
2016/17	35,259	1,983	5.6
2017/18	35,009	2,077	5.9
2018/2019	36,387	2,003	5.5
2019/2020	42,238	4,609	10.9

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

Year	Total number of admissions/spells	Number of readmissions (all)	Emergency readmission rate (all)
20/11/12	175,836	9,435	5.4
2012/13	173,270	8,788	5.1
2013/14	177,867	9,052	5.1
2014/15	180,380	9,446	5.2
2015/16	182,668	10,076	5.5
2016/17	186,999	10,219	5.5
2017/18	182,535	10,157	5.6
2018/2019	185,967	10,461	5.6
2019/2020	192,365	12,648	6.6

Measure	Data Source	Value	2019/20	2018/19	2017/18	2016/17	2015/16	2014/15
8. The trust's responsiveness to the personal needs of its patients	NHS Information Centre Portal https://indicators.ic.nhs.uk/	Trust percentage	Not available	73.1%	74.9%	74.6%	76.1%	76.8%
		National Average:	Not available	67.2%	68.6%	68.1%	69.6%	68.9%
		Highest National:	Not available	85.0%	85.0%	85.2%	86.2%	86.1%
		Lowest National:	Not available	58.9%	60.5%	60.0%	54.4%	59.1%
Measure	Data Source	Value	2019/20	2018/19	2017/18	2016/17	2015/16	2014/15
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	90%	90%	96%	95%	91%	89%
		National Average:	71%	70%	81%	80%	72%	69%
		Highest National:	95%	95%	100%	100%	95%	89%
		Lowest National:	36%	33%	43%	44%	48%	46%

Measure 8. The Trust's responsiveness to the personal needs of its patients.
Newcastle Hospitals considers that this data is as described for the following reasons: The data shows that the Trust scores above the national average. Newcastle Hospitals intends to take the following actions to improve this indicator, and so the quality of its services, by continuing to implement processes to capture patient experience and improve its services. Data for 2019/2020 has not yet been released, but data for 2018/2019 has been populated.

Measure 9. The percentage of staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends.
Newcastle Hospitals considers that this data is as described for the following reasons: the Trust score is well above the National average. Newcastle Hospitals has taken the following actions to improve this percentage, and so the quality of its services, by continuing to listen to and act on all sources of staff feedback. Data for 2018/2019 has been added as it was not available at time of publication last year.

Measure	Data Source	Target	2019/20				2018/19				2017/18			
10. The percentage of patients that were admitted to hospital who were risk assessed for Venous thromboembolism (VTE)	https://www.england.nhs.uk/statistics/statistical-work-areas/vte/	Trust (CQUIN Target 95%)	Q1 97.65 %	Q2 96.80 %	Q3	Q4	Q1 96.49 %	Q2 95.72 %	Q3 97.23 %	Q4 96.64 %	Q1 96.25 %	Q2 96.73 %	Q3 96.07 %	Q4 95.61 %
		National Average :	95.63 %	95.47 %	Not available	Not available	95.63 %	95.49 %	95.65 %	95.74 %	95.20 %	95.25 %	95.36 %	95.21 %
		Highest National:	100 %	100 %	Not available	Not available	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
		Lowest National:	69.76 %	71.72 %	Not available	Not available	75.84 %	68.67 %	54.86 %	74.03 %	51.38 %	71.88 %	76.08 %	67.04 %

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

Newcastle Hospitals considers that this data is as described for the following reasons: The Trust has a robust reporting system in place and adopts a systematic approach to data quality improvement. Newcastle Hospitals has taken the following actions to improve this percentage, and so the quality of its services, by completion of assessment being electronic to allowing capture of compliance rates and the implementation of the Safety Thermometer. The Trust has continued with use of the practice of undertaking Root Cause Analysis (RCA) on patients who develop a hospital acquired VTE. Data for Q4 2019/20 will not be published until June 2020.

Measure	Data Source	Target	2019/20	2018/19	2017/18	2016/17
11. The number and rate per 100,000 bed days of cases of C. difficile infection reported within the trust amongst patients aged 2 or over	PHE Data Capture System	Trust number of cases	113 National figure 89 (minus 24 successful appeals**)	77 National figure 48 (minus successful appeals)	88 National figure 77 (minus successful appeals)	74 National figure 57 (minus successful appeals)
		Trust Rate (per 100,000 bed days)	(national) HOHA* = 20.87 COHA* = 3.95	16.96 (national)	18.65 (national)	15.44 (national)
		National Average rate (per 100,000 bed days)	HOHA* = 14.67 COHA* = 7.06	11.70	13.48	13.22
		Highest National rate (per 100,000 bed days)	HOHA* = 60.44 COHA* = 34.54	79.66	92.75	82.59
		Lowest National rate (per 100,000 bed days)	HOHA* = 0 COHA* = 0	**0**	**0**	**0**

*HOHA = Hospital Onset – Healthcare Associated
*COHA = Community Onset – Healthcare Associated
NHS Improvement (NHSI) changed the criteria for reporting C. difficile from 2019/20. The reported figures are therefore not comparable to previous years as the change includes reporting COHA cases. This patient group includes those who have been discharged within the previous 4 weeks in addition to day-case patients and regular attenders.

** 24 successful appeals; additional C. difficile Infection appeal hearings have been cancelled. This decision has been supported by the Newcastle/Gateshead CCG to prioritise COVID-19 pandemic work.

Measure	Data Source	Target	2019/20		2018/19		2017/18		2016/17	
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 http://www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports/	Trust no.	Oct 2019-March 2020 9319	April-2019 Sept 2019 9484	Oct 2018-March 2019 9707	April-2018 Sept 2018 8661	Oct 2017-March 2018 8662	April-2017 Sept 2017 8215	Oct 2016-March 2017 6483	April 2016-Sept 2016 6501
		Trust %	37.6	41.8	39.8	38.3	36.53	35.57	27.02	27.15
		National Average	Not available	48.5	44.7	44.52	42.5	42.8	41.1	40.8
		Highest National	Not available	103.8	95.9	107.4	124	111.56	69	71.8
		Lowest National	Not available	26.3	16.9	13.1	24.2	23.5	23.1	21.15

Measure	Data Source	Target	2019/20				2018/19				2017/18			
13. The number and percentage of patient safety incidents that resulted in severe harm or death	NHS Information Centre Portal http://www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports/	Trust no.	Oct 2019-Mar 2020 **Severe Harm** 28	Oct 2019-Mar 2020 **Death** 6	April-2019 Sept 2019 **Severe Harm** 14	April-2019 Sept 2019 **Death** 4	Oct 2018-Mar 2019 **Severe Harm** 14	Oct 2018-Mar 2019 **Death** 1	April-2018 Sept 2018 **Severe Harm** 23	April-2018 Sept 2018 **Death** 3	Oct 2017-Mar 2018 **Severe Harm** 20	Oct 2017-Mar 2018 **Death** 1	April-2017 Sept 2017 **Severe Harm** 23	April-2017 Sept 2017 **Death** 4
		Trust %	0.3%	0.0%	0.2%	0.0%	0.3%	0%	0.3%	0%	0.2%	0%	0.3%	0%
		National Average	Not available	Not available	0.15 %	0.04 %	0.15 %	0.01 %	0.26 %	0.11 %	0.27 %	0.1%	0.3%	0.1%
		Highest National	Not available	Not available	0.23 %	0.08 %	0.23 %	0.09 %	0.9%	0.6%	1.2%	0.5%	1.5%	0.5%
		Lowest National	Not available	Not available	1.22 %	0.66 %	1.18 %	0.65 %	0%	0%	0%	0%	0%	0%

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

Newcastle Hospitals considers that this data is as described for the following reasons: The Trust has a robust reporting system in place and adopts a systematic approach to data quality improvement. Newcastle Hospitals has taken the following actions to improve this rate, and so the quality of its services, by having a robust strategy that includes the review of all Trust-apportioned cases to ensure no avoidable cases occur: completion of root cause analysis (RCA) forms for all such cases, including a multidisciplinary meeting to discuss the case; Quarterly Health Care Acquired Infection (HCAI) Report to share lessons learned and best practice from the RCAs and Serious Infection Review Meetings.

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

Newcastle Hospitals considers that this data is as described for the following reasons: The Trust take the reporting of incidents very seriously and have an electronic reporting system (Datix) to support this. Newcastle Hospitals has taken the following actions to improve this

number and rate, and so the quality of its services, by undertaking a campaign to increase awareness of incident/near misses reporting. Incidents are graded, analysed and, where required, undergo a root cause analysis investigation to inform actions, recommendations and learning. Incident data is reported to the Clinical Risk Group to inform our organisational learning themes which are reported to the Board.

Measure 13. The number and percentage of patient safety incidents that resulted in severe harm or death

Newcastle Hospitals considers that this data is as described for the following reasons: The Trust takes incidents resulting in severe harm of death very seriously. The rate of incidents resulting in severe harm or death is consistent with the national average. This reflects a culture of reporting incidents which lead to, or have the potential to, cause serious harm or death. Newcastle Hospitals has taken the following actions to reduce this number and rate, and so the quality of its services, by the Board receiving monthly reports of incidents resulting in severe harm of death. (The Trust would classify major and catastrophic as permanent harm or death. This would include a fracture following a fall if the patient did not fully recover their normal level of independence).

Workforce Factors

Wellbeing –the tables below provide data on the loss of work days. The table directly below reports on the Trust and Regional position rate (data taken from the NHS Information Centre) and the next table provides an update on the Trust number of staff sick days lost to industrial injury or illness caused by work.

This table shows the loss of work days (rate)

	Jan 19	*Feb 19*	*Mar 19*	*Apr 19*	*May 19*	*Jun 19*	*Jul 19*	*Aug 19*	*Sep 19*	*Oct 19*	*Nov 19*
The Newcastle Upon Tyne Hospitals	5.07%	4.80%	4.04%	3.73%	3.90%	3.91%	4.11%	4.20%	4.21%	4.54%	5.03%
South Tyneside and Sunderland	5.08%	4.92%	4.21%	4.25%	4.50%	4.58%	4.79%	4.87%	4.79%	5.47%	5.53%
County Durham and Darlington	5.24%	4.82%	4.60%	4.74%	4.68%	4.65%	4.96%	5.13%	5.17%	5.34%	5.81%
Gateshead Health	5.53%	5.25%	4.33%	4.22%	4.27%	4.12%	3.98%	3,78%	4.20%	4.44%	4.98%
North Tees and Hartlepool	5.28%	4.94%	4.55%	4.58%	4.93%	4.74%	4.64%	4.55%	4.15%	5.22%	5.56%
Northumbria Healthcare	5.13%	4.99%	4.19%	4.23%	4.22%	4.37%	4.47%	4.41%	4.45%	4.69%	4.81%
South Tees Hospitals	5.49%	5.12%	4.63%	4.42%	4.09%	4.00%	4.24%	4.24%	4.41%	4.57%	4.92%
England	4.77%	4.51%	4.08%	4.06%	4.01%	4.12%	4.23%	4.14%	4.25%	4.60%	4.73%

The table blow shows the number of shift staff sick days lost to industrial injury or illness caused by work

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year Total
2009/2010 no. of days	251	414	581	298	1544
2010/2011 no. of days	118	254	267	366	1005
2011/2012 no. of days	253	299	247	153	952
2012/2013 no. of days	154	138	174	209	675
2013/2014 no. of days	489	331	785	147	1752
2014/2015 no. of days	333	284	178	206	1001
2015/2016 no. of days	360	194	365	219	1138
2016/2017 no. of days	230	387	136	84	837
2017/2018 no. of days	137	90	51	122	400
2018/2019 no. of days	214	131	188	326	859
2019/2020 no. of days	249	172	67	123	611

2019 NHS Staff Survey Results Summary

A standard survey was sent via email to all employees of the Trust (via external post for those on maternity leave), giving all 14,542 members of our staff a voice. 6,485 staff participated in the survey, equalling a response rate of 45% which is in the sector average and was a 2% deterioration on the 2017 response rate of 47%.

The results are arranged under 11 themes:
THEME 1: Equality, diversity & inclusion
THEME 2: Health & wellbeing
THEME 3: Immediate managers
THEME 4: Morale
THEME 5: Quality of appraisals
THEME 6: Quality of care
THEME 7: Safe Environment - Bullying & Harassment
THEME 8: Safe Environment - Violence
THEME 9: Safety Culture
THEME 10: Staff Engagement
THEME 11: Team Working (new for 2019)

The Staff Engagement score is measured across three sub-themes:
Advocacy, measured by Q21a, Q21c and Q21d (Staff recommendation of the trust as a place to work or receive treatment)
Motivation, measured by Q2a, Q2b and Q2c (Staff motivation at work)
Involvement, measured by Q4a, Q4b and Q4d (Staff ability to contribute towards improvement at work)

At Newcastle Hospitals this score was:
Overall: rating of staff engagement 7.35 (out of possible 10).
This score was 0.25 below top position in the sector (Combined Acute & Community Trusts) and has maintained the Trusts score for 2017.

The Trust scored significantly better on 7 of the 10 themes when compared with other Combined Acute & Community Trusts in England.

Equality, Diversity & Inclusion
NuTH Score: 9.33 out of 10
Sector Score: 9.07 out of 10
Morale
NuTH Score: 6.42 out of 10
Sector Score: 6.27 out of 10
Quality of Care
NuTH Score: 7.71 out of 10
Sector Score: 7.55 out of 10
Safe Environment – Bullying & Harassment
NuTH Score: 8.38 out of 10
Sector Score: 8.14 out of 10
Safe Environment – Violence
NuTH Score: 9.65 out of 10
Sector Score: 9.55 out of 10
Safe Environment – Violence
NuTH Score: 9.65 out of 10
Sector Score: 9.55 out of 10

Safety Culture
NuTH Score: 7.09 out of 10
Sector Score: 6.86 out of 10
Staff Engagement
NuTH Score: 7.35 out of 10
Sector Score: 7.18 out of 10

Of note, the Trust is also in top position for a number of themes against various comparators:
#1 in Region for
Safe Environment – Violence: 9.6 out of 10
#1 in Shelford Group for
Equality, Diversity & Inclusion: 9.3 out of 10
Morale: 6.4 out of 10
Safe Environment – Bullying & Harassment: 8.4 out of 10
Safe Environment – Violence: 9.6 out of 10

The Trust also compares favourably against the sector in a number (56) of the 90 questions in the survey. Some to note include:
90% agree that they would be happy with the standard of care provided by the organisation should a friend of relative need treatment. This is 14% higher than sector average and the best in the sector
90% agree that care of patients/service users is the organisations top priority. This is 9% higher than sector average
79% agree that when errors, near misses or incidents are reported, the organisation takes action to ensure that they do not happen again. This is 5% higher than sector average
67% agree that they are given feedback about changes made in response to reported errors, near misses and incidents. This is 4% higher than sector average
67% are confident that the organisation would address their concerns. This is 5% higher than sector average
35% stated they have felt unwell due to work related stress in the last 12 months. This is 4% under the sector average.
89% agree that the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age. This is 5% higher than the sector average.
74% would recommend the organisation as a place to work. This is 6% higher than the sector average

As previously stated, the Trust did not fall below sector average for any of the 10 themes. However, the lowest 3 scoring themes for the organisation were:
Morale: 6.42 out of 10
Health & Wellbeing: 6.09 out of 10
Quality of Appraisals: 5.48 out of 10.

Involvement and engagement 2019/20

We strongly believe patients, their families and carers, together with the wider community, should be partners in the design, development and delivery of our services. The support and contributions of patient-public stakeholders continues to be important, as we work together to find new ways to provide high quality care and services in different ways. This year we have adopted a flexible model of involvement that allows us to develop different approaches for different people.

We are committed to encouraging engagement with patients, carers, their relatives and members of the public. The Trust's patient and public involvement group, APEX (Advising on the Patient Experience) provides a strong model of engagement alongside clinical specialties which have patient forums that are also working well, for example Maternity Voices Partnerships and the Young Persons Advisory Group (YPAGne). We continue to work in partnership with local community and voluntary groups seeking the views of a diverse range of people, including those people whose voices are less often heard. We are very proud; our work with carers was recognised and shortlisted for the RCNi Carers Award and our partnership work with gender diverse people which was shared at the Regional North East Leadership Academy Event.
This year we have been working in collaboration with patient representatives to prepare for the implementation of the refreshed National Friends and Family Test guidance which included facilitating a workshop led by and with the involvement of patients, members of the public, staff and the NHS England Insight team.

The Trust was also successfully shortlisted to take part in a CQC led pilot looking at a mixed method approach to the mandated national patient surveys of Inpatients and Maternity patients and we look forward to further involvement in the development of the national survey programme.

In 2020 -21 the focus will be:

- Embed patient and public engagement in our approaches to service improvement and transformation, in particular the significant transformation plans;
- Improve our use of existing sources of patient experience data to inform continuous improvement and transformation;
- To implement the new guidance in relation to the NHS Friends and Family Test.

Annex 1:

Statement on behalf of the Health Scrutiny Committee

(To be added post 30 day consultation period)

Statement on behalf of Northumberland County Council

(To be added post 30 day consultation period)

Statement on behalf of the Newcastle & Gateshead Clinical Commissioning Group Alliance

(To be added post 30 day consultation period)

Statement on behalf of Healthwatch Newcastle and Healthwatch Gateshead

(To be added post 30 day consultation period)

Statement on behalf of Northumberland Healthwatch

(To be added post 30 day consultation period)

Annex 2: Abbreviations

Abbreviations	
3D	Three Dimensional
7DS	Seven Day Service
ACP	Advance Care Plan
AHP	Allied Health Professional
AMD	Age-Related Macular Degeneration
APEX	Advising on Patient Experience
AQuA	Advancing Quality Alliance
BAME	Black, Asian and Minority Ethnic
BAUS	British Association of Urological Surgeons
BREATHE	Beating Regional Asthma Through Health Education
BTS	British Thoracic Society
C.diff	Clostridium difficile
CAP	Community Acquired Pneumonia
CAT	Clinical Assurance Tool
CAUTI	Catheter Acquired Urinary Tract Infection
CAV	Campus for Ageing and Vitality
CCAD	Central Cardiac Audit Database
CCGs	Clinical Commissioning Group
CGARD	Clinical Governance and Risk Department
CMP	Case Mix Programme
CNTW	Cumbria, Northumberland and Tyne and Wear
COHA	Community Onset – Healthcare Associated
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DBD	Donors after Brain-Stem Death
DCD	Donated after Circulatory Death
DoC	Duty of Candour
DoLS	Depravation of Liberty Safeguards
DSP	Data Security & Protection (DSP) Toolkit
E.coli	Escherichia coli
ED	Emergency Department
EHCP	Emergency Health Care Plans
EWS	Early Warning Score
FCA	Flow Coaching Academy
FLS	Fracture Liaison Services
FTSUG	Freedom to Speak up Guardian
GNCH	Great North Children's Hospital
GP	General Practitioner
HCAI	Healthcare Associated Infection
HCV	Hepatitis C Virus
HES	Hospital Episode Statistics
HR	Human Resources

Abbreviations	
HOHA	Hospital Onset – Healthcare Associated
IBD	Inflammatory Bowel Disease
ICDs	Implantable Cardioverter-Defibrillators
IHI	Institute for Healthcare Improvement
IT	Information Technology
IV	Intravenous
KLOEs	Key Lines of Enquiry
LD	Learning Disability
LGBT	Lesbian, Gay, Bisexual, Transgender
LTV	Long-Term Ventilation
M&M	Morbidity & Mortality
MBRRACE-UK	Mothers and Babies, Reducing Risk through Audits and Confidential Enquiries across the UK
MDT	Multi-Disciplinary Team
MINAP	Myocardial ischemia National Audit Project
MRSA	Methicillin-resistant *Staphylococcus aureus*
MSSA	Methicillin Sensitive *Staphylococcus Aureus*
N/A	Not Applicable
NaDIA	The National Diabetes Inpatient Audit
NBOCA	National Bowel Cancer Audit
NCEPOD	National Confidential Enquiries into Patient Outcome & Death
NHS	National Health Service
NHSI	NHS Improvement
NICE	National Institute for health and clinical excellence
NOGCA	National Oesophago-Gastric Cancer Audit
NSF	National Service Framework
NTW	Northumberland, Tyne and Wear
NUTH	Newcastle upon Tyne NHS Foundation Trust
OCS	Organ Care System
OHCA	Out of Hospital Cardiac Arrest
PCI	Percutaneous Coronary Intervention
PD	Parkinson's Disease
PHE	Public Heath England
PICCs	Peripherally Inserted Central Catheters
PICU	Paediatric Intensive Care Unit
PQIP	Perioperative Quality Improvement Programme
PROMs	Patient Reported Outcome Measures
PS&QR	Patient Safety and Quality Review
QI	Quality Improvement
QSIR	Quality Improvement and Service Design
RCA	Root Cause Analysis
RIDDOR	Reporting of Injuries, Disease and Dangerous Occurances
RVI	Royal Victoria Infirmary
SAMBA	Society for Acute Medicine's Benchmarking Audit
SAMM	Systems for Action Management and Monitoring

Abbreviations	
SHMI	Summary Hospital-level Mortality Indicator
SIRM	Serious Incident Review Meeting
SIs	Serious Incidents
STAMP	Supporting Treatment and Appropriate Medication in Paediatrics
STOMP	Stop Overmedicating People with a learning disability or autism
SUS	Secondary Uses Service
TARN	Trauma Audit Research Network
TEP	Treatment Escalation Plans
UK	United Kingdom
UTC	Urgent Treatment Centres
UTI	Urinary Tract Infection
VTE	Venous thromboembolism
YPAGne	Young Persons Advisory Group

Annex 3: Glossary of Terms

1. C. *difficile* infection (CDI)

C. *difficile* diarrhoea is a type of infectious diarrhoea caused by the bacteria Clostridium difficile, a species of gram-positive spore-forming bacteria. While it can be a minor part of normal colonic flora, the bacterium causes disease when competing bacteria in the gut have been reduced by antibiotic treatment.

2. CQC

The Care Quality Commission (CQC) is the independent regulator of all health and adult social care in England. The aim being to make sure better care is provided for everyone, whether that's in hospital, in care homes, in people's own homes, or elsewhere.

3. CQUIN – Commissioning for Quality and Innovation

The CQUIN framework was introduced in April 2009 as a national framework for locally agreed quality improvement schemes. It enables commissioners to reward excellence by linking a proportion of English healthcare provider's income to the achievement of local quality improvement goals.

4. DATIX

DATIX is an electronic risk management software system which promotes the reporting of incidents by allowing anyone with access to the Trust Intranet to report directly into the software on easy -to-use-web pages. The system allows incident forms to be completed electronically by all staff.

5. E.coli

Escherichia coli (E.coli) bacteria are frequently found in the intestines of humans and animals. There are many different types of E.coli, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment. E.coli bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. E.coli bacteraemia (blood stream infection) may be caused by primary infections spreading to the blood.

6. Global Digital Exemplar

Global Digital Exemplar is an internationally recognised NHS provider delivering improvements in the quality of care, through the world-class use of digital technologies and information.

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. HOGAN evaluation score

Retrospective case record reviews of 1000 adults who died in 2009 in 10 acute hospitals in England were undertaken. Trained physician reviewers estimated life expectancy on admission, to identified problems in care contributing to death and judged if deaths were preventable taking into account patients' overall condition at that time. The Hogan scale, ranging from 1 (definitely not preventable) to 6 (definitely preventable), was used to determine if deaths were potentially avoidable, taking into account a patient's overall condition at the time.

Source: Dr Helen Hogan, Clinical Lecturer in UK Public Health,

1	Definitely not preventable
2	Slight evidence for preventability
3	Possibly preventable, but not very likely, less than 50-50 but close call
4	Probably preventable more than 50-50 but close call
5	Strong evidence of preventability
6	Definitely preventable

9. HSMR

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than would be expected.

10. MRSA

Staphylococcus Aureus (S. aureus) is a bacterium that commonly colonises human skin and mucosa (e.g. inside the nose) without causing any problems. Although most healthy people are unaffected by it, it can cause disease, particularly if the bacteria enters the body, for example through broken skin or a medical procedure. MRSA is a form of S. aureus that has developed resistance to more commonly used antibiotics. MRSA bacteraemia is a blood stream infection that can lead to life threatening sepsis which can be fatal if not diagnosed early and treated effectively.

11. MSSA

As stated above for MSSA the only difference between MRSA and MSSA is their degree of antibiotic resistance: other than that there is no real difference between them.

12. Near Miss

An unplanned or uncontrolled event, which did not cause injury to persons or damage to property, but had the potential to do so.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD MEETING

Date of meeting	24 September 2020						
Title	Equality, Diversity and Inclusion – Annual Publication Requirements						
Report of	Dee Fawcett, HR Director						
Prepared by	Karen Pearce, Head of Equality, Diversity and Inclusion (People)						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☒		☐		☐		
Summary	The Trust is required each year to publish the following on its website: - Equality Delivery System (EDS2) – assessment of grading against goal 3 (a representative and supported workforce) and goal 4 (inclusive leadership at all levels) by 30 Sept 2020 - Public Sector Equality Duty – workforce data by 30 Sept 2020 - Workforce Race Equality Standard (WRES) – data and action plan by 31 Oct 2020 - Workforce Disability Equality Standard (WDES) – data and action plan by 31 Oct 2020						
Recommendation	The Trust Board is requested to approve publication of the items listed above.						
Links to Strategic Objectives	People – Supported by Flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☒	☒	☒	☒	☒
Impact detail	Differences in staff experience could potentially breach legislation and lead to legal challenge resulting in significant financial and reputational consequences.						
Reports previously considered by	A paper including all items listed in the 'Summary' section above was submitted for People Committee meeting held on 25 August 2020.						

WORKFORCE EQUALITY, DIVERSITY AND INCLUSION

1. BACKGROUND

As an NHS organisation, the Trust has a responsibility each year to publish on its website the following information related to workforce equality, diversity and inclusion:

Publication	Requirement	Date
Equality Delivery System (EDS2)	To publish self-assessment of grading against: • Goal 3 – a representative and supported workforce • Goal 4 – inclusive leadership at all levels	By 30 Sept 2020
Public Sector Equality Duty	To publish workforce data	By 30 Sept 2020
Workforce Disability Equality Standard (WDES)	To publish workforce data and action plan	By 31 Oct 2020
Workforce Race Equality Standard (WRES)	To publish workforce data and action plan	By 31 Oct 2020

The purpose of these publications is fundamentally part of action under legislation and other requirements intended to:

- eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act 2010.
- advance equality of opportunity between people who share a protected characteristic and people who do not.
- foster good relations between people who share a protected characteristic and people who do not.

Looking after our staff, treating them equally and with dignity, and enabling them to liberate their potential is integral to our cornerstone programme #FlourishAtNewcastleHospitals and underpins our People Strategy.

The recently published: 'We are the NHS: People Plan 2020/21 – Action for all of us' focusses attention and action on four key areas, including **'looking after our people'** (delivering 'Our People Promise' to work together to improve the experience of working in the NHS for everyone) and **'belonging to the NHS'** (tackling discrimination and making the culture of the NHS universally understanding, kind and inclusive). Our action plans are aligned to these priorities.

2. PEOPLE OBJECTIVES

People Objective: To be the recognised employer and educator in the North East to enable all staff to liberate their potential

Goal: Employer of Choice
Strategy: Build an inclusive and diverse workforce
Measures: Increase BAME diversity to 15%, deliver Single Equality Action Plan, Sustain and improve Stonewall ranking, deliver Gender and Ethnicity Pay Gap report

Workforce equality objectives 2020-2024:

Objective	Action	Measure	Aim
Disability Confident	Become accredited Disability Leader	Disability Leader status	Dec 2021
Stonewall Work Place Equality Index	To be in Stonewall Workplace Equality Index Top 20 by 2024	Top 20 employer	Mar 2024
Workforce Disability Standard	Use the NHS WDES to understand the differences in staff experience between disabled and non-disabled staff and inform improvement plans	Equal staff experience	Mar 2022
Workforce Race Equality Standard	Use the NHS WRES to understand the differences in staff experience between White and BAME staff and inform improvement plans	Equal staff experience	Mar 2022

3. PEOPLE ACTIONS

Area of activity	Highlights last 12 months	Highlights next 12 months
Equality Delivery System (EDS2)	**Fair NHS recruitment and selection processes lead to a more representative workforce – assessment changed from 'Achieving' to 'Developing' based on:** – Widening of WRES data – White more likely to be appointed than BAME (non-medical) – Surash-Pearce Report on ethnicity pay gap highlights areas of concern in relation to recruitment – Decrease in likelihood of males	Delivery of Single Equality Action Plan

	being appointed over females (non-medical) – Widening gap between likelihood of disabled applicants being appointed over non-disabled (non-medical) **Flexible working options are available to all staff consistent with needs of service and way people lead their lives – assessment changed from 'Achieving' to 'Developing' based on:** – Staff from minority groups are less satisfied with the opportunities for flexible working – Flexible working requests rejected more for disabled than non-disabled – Above Trust all staff average and national average, but percentage of disabled reporting workplace adjustments have been made has decreased	
Workforce Disability Equality Standard (WDES)	**Metric 4b – Percentage staff saying last time they experienced harassment, bullying or abuse at work, they or a colleague reported it:** – Disabled national comparator has improved slightly. Trust is lower than national, but marked improvement in last year **Indicator 6 – Percentage staff saying they felt pressure from manager to attend work, despite not feeling well enough**: – Disabled national comparator has worsened. Trust is worse than national, but marked improvement in last year • Formed Disability Equality Standard Sub-Group reporting to Disability Staff Network • Disability conference held • Disability Staff Network Chair	Delivery of WDES Action Plan including: implementation of equality dashboard; holding a virtual recruitment event; implementation of disability passport; improvement in data quality via use of Robotic Process Automation (RPA)

	asked to speak at NHS England's Disability Staff Engagement Event • Project Choice - 'Highly Commended' in Neurodiversity category by the Employers Network for Equality & Inclusion; winner of Inclusive Recruitment Award	
Workforce Race Equality Standard (WRES)	**Indicator 6 – Percentage BAME experiencing harassment, bullying or abuse from staff in last 12 months**: – BAME national comparator has improved. Trust is worse than national and own position has worsened in last year – number is markedly higher. Percentage of White has improved slightly **Indicator 7 – percentage BAME believing Trust provides equal opportunities for career progression/ promotion:** – BAME national comparator has worsened. Trust is better than national, but own position has worsened markedly in last year. Percentage of White has improved slightly **Indicator 8 – Percentage BAME experiencing discrimination from manager or colleague in last 12 months:** – BAME national comparator has worsened. Trust is worse than national and own position has worsened in last year. Percentage of White has worsened **A Model Employer: increasing BAME representation at senior levels across NHS:** – Deep dive shows in certain areas the likelihood of being appointed is worse compared to Trust-wide figure for non-medical appointments generally and	Delivery of WRES Action Plan including: implementation of equality dashboard; holding a virtual recruitment event; implementation of BAME Career Development Programme;

	specifically nursing appointments (Surash-Pearce report) **A fair experience for all: achieving rates for disciplinary action within range 0.82 and 1.25:** – Trust within target range – BAME less likely to enter formal disciplinary processes • BAME recruitment event held • NHS Stepping-up Programme – 4 staff secured a place • Diverse recruitment panels in place for senior appointments • Cultural Ambassadors in place • Reverse Mentoring launched • BAME risk assessments in place • Trust asked to participate in the first HSJ Workforce Review • Inclusive recruitment award by the Employers Network for Equality and Inclusion	

4. RECOMMENDATION

The Trust Board is requested to:

a) Endorse the proposed action plans for WDES and WRES
b) Approve publication of the following:

i) EDS2 – assessment of grading
ii) PSED – data
iii) WDES – action plan and data
iv) WRES – action plan and data

Report of Dee Fawcett, Director of HR and
Karen Pearce, Head of Equality, Diversity and Inclusion (People)
11 September 2020

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The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

Equality Delivery System2 Grades

2019-20

Equality Delivery System2 Grading by Protected Characteristic

Goal 3 – A representative and supported workforce

Outcome Measure	19/20	18/19	17/18	16/17	15/16	14/15	13/14	12/13	11/12
3.1 Fair NHS recruitment and selection processes lead to a more representative workforce									
3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations									
3.3 Training and Development opportunities are taken up and positively evaluated by staff									
3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source									
3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives									
3.6 Staff report positive experiences of their									

membership of the workforce									

Excelling – **Purple**
Achieving - **Green**
Developing – **Amber**
Undeveloped – **Red**
Overall grade – Developing

Goal 4 – Inclusive Leadership at all Levels

Outcome Measure									
	19/20	18/19	17/18	16/17	15/16	14/15	13/14	12/13	11/12
4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations									
4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed									
4.3 Middle Managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination									

Potential grades

1. Excelling – **Purple**
2. Achieving - **Green**
3. Developing – **Amber**
4. Undeveloped - **Red**

Overall grade – Achieving

Equality Delivery System (2) Grading by Protected Characteristic

Goal 3 - Empowered, Engaged and Well Supported Staff

Outcome	2019/2020	1819	17/18	16/17	15/16	14/15	13/14	12/13	Overall Grade
3.1 Fair NHS recruitment and selection processes lead to a more representative workforce	Race								
	Age								
	Trans								
	Sex								
	Disability								
	Religion								
	Sexual Orientation								
	Marriages/Civil Partnership								
	Pregnancy/ Maternity								

Outcome	19/20	18/19	17/18	16/17	15/16	14/15	13/14	12/13	Overall Grade
3.2 - The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	Race								
	Age								
	Trans								
	Sex								
	Disability								
	Religion								
	Sexual Orientation								
	Marriages/Civil Partnership								
	Pregnancy/ Maternity								

Outcome	19/20	18/19	17/18	16/17	15/16	14/15	13/14	12/13	Overall Grade
3.3 - Training and Development opportunities are taken up and positively evaluated by staff	Race							n/a	
	Age								
	Trans								
	Sex								
	Disability								
	Religion								
	Sexual Orientation								
	Marriages/ Civil Partnership								
	Pregnancy/ Maternity								

Outcome	19/20	18/19	17/18	15/16	15/16	14/15	13/14	12/13	Overall Grade
3.4 - When at work, staff are free from abuse, harassment, bullying and violence from any source	Race								
	Age								
	Transgender								
	Sex								
	Disability								
	Religion								
	Sexual Orientation								
	Marriages/ Civil Partnership								
	Pregnancy/ Maternity								

Outcome	19/20	18/19	17/18	16/17	15/16	14/15	13/14	12/13	Overall Grade
3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Race								
	Age								
	Transgender								
	Sex								
	Disability								
	Religion								
	Sexual Orientation								
	Marriages/ Civil Partnership								
	Pregnancy / Maternity								

Outcome	19/20	18/19	17/18	16/17	15/16	14/15	13/14	12/13	Overall Grade
3.6 Staff report positive experiences of their membership of the workforce	Race							**n/a**	
	Age								
	Transgender								
	Sex								
	Disability								
	Religion								
	Sexual Orientation*								
	Marriages/ Civil Partnership								
	Pregnancy /								

Outcome	19/20	18/19	17/18	16/17	15/16	14/15	13/14	12/13	Overall Grade
	Maternity								

Goal 4 – Inclusive Leadership at all Levels

Outcome	18/19	17/18	16/17	15/16	14/15	13/14	12/13	Overall Grade
4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	Race							
	Age							
	Transgender							
	Sex							
	Disability							
	Religion							
	Sexual Orientation							
	Marriages/Civil Partnership							
	Pregnancy/ Maternity							

Outcome	18/19	17/18	16/17	15/16	14/15	13/14	12/13	Overall Grade
4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	Race							
	Age							
	Transgender							
	Sex							
	Disability							
	Religion							
	Sexual Orientation							
	Marriages/Civil Partnership							
	Pregnancy/ Maternity							

- Equality Analysis requirements remain outstanding in some areas. Patient Services leading

Outcome	18/19	17/18	16/17	15/16	14/15	13/14	12/13	Overall Grade
4.3 Middle Managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	Race							
	Age							
	Transgender							
	Sex							
	Disability							
	Religion							
	Sexual Orientation							
	Marriages/Civil Partnership							
	Pregnancy/ Maternity							

Recruitment (Medical) Figures by Protected Characteristic - April 2019 to March 2020

Protected Characteristic		% Census Data	% Staff in Post	% of all Applicants	% of all Shortlisted	% of all Appointed
Gender	Female	52.00%	78.38%	72.29%	78.20%	83.00%
	Male	48.00%	21.62%	27.37%	21.51%	16.92%
	Not Recorded	0.00%	0.00%	0.34%	0.29%	0.08%
	Grand Total	100.00%	100.00%	100.00%	100.00%	100.00%
Disability	No	not available	73.19%	92.67%	91.35%	93.35%
	Yes	not available	2.85%	5.73%	6.64%	3.85%
	Not Recorded	not available	23.95%	1.60%	2.01%	2.80%
	Grand Total		100.00%	100.00%	100.00%	100.00%
Ethnic Origin	BME	14.70%	8.92%	22.62%	13.93%	11.20%
	White	85.60%	89.18%	75.96%	84.56%	87.38%
	Not Recorded	0.00%	1.90%	1.42%	1.50%	1.42%
	Grand Total	100.00%	100.00%	100.00%	100.00%	100.00%
Religious Belief	Christianity	56.40%	46.10%	49.15%	50.29%	49.94%
	Islam	6.30%	1.39%	4.46%	2.79%	1.87%
	No Religious Belief	28.40%	15.72%	21.24%	22.68%	26.61%
	Other	2.60%	9.26%	15.72%	14.14%	11.93%
	Not Recorded	6.30%	27.53%	9.42%	10.09%	9.66%
	Grand Total	100.00%	100.00%	100.00%	100.00%	100.00%
Age	16-29	29.05%	18.16%	41.25%	38.32%	43.00%
	30-59	36.05%	71.90%	55.81%	59.41%	55.58%
	60+	8.68%	9.94%	2.94%	2.27%	1.42%
	Not Recorded	0.00%	0.00%	0.00%	0.00%	0.00%
	Grand Total	73.78%	100.00%	100.00%	100.00%	100.00%
Sexual Orientation	Heterosexual	not available	73.97%	91.29%	91.48%	92.13%
	LGB	not available	2.34%	5.87%	5.53%	4.79%
	Not Recorded	not available	23.69%	2.83%	3.00%	3.08%
	Grand Total	not available	100.00%	100.00%	100.00%	100.00%

Staff in Post Figures by Protected Characteristic - April 2019 to March 2020

Protected Characteristic		% Census Data	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Students	% Total Workforce
Gender	Female	52.00%	3.59%	15.21%	12.53%	5.14%	5.20%	2.69%	3.93%	29.91%	0.17%	78.38%
	Male	48.00%	1.07%	3.05%	3.44%	0.99%	3.82%	1.76%	5.12%	2.34%	0.03%	21.62%
	Not Recorded	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	100.00%	4.66%	18.26%	15.97%	6.13%	9.02%	4.45%	9.06%	32.26%	0.20%	100.00%
Disability	No	not available	3.55%	13.19%	11.12%	4.88%	5.43%	2.94%	6.81%	25.10%	0.19%	73.19%
	Yes	not available	0.13%	0.60%	0.67%	0.24%	0.24%	0.05%	0.07%	0.83%	0.01%	2.85%
	Not Recorded	not available	0.99%	4.47%	4.17%	1.02%	3.35%	1.46%	2.17%	6.32%	0.01%	23.95%
	Total	not available	4.66%	18.26%	15.97%	6.13%	9.02%	4.45%	9.06%	32.26%	0.20%	100.00%
Ethnic Origin	BME	14.70%	0.31%	1.00%	0.49%	0.27%	0.57%	0.33%	2.20%	3.70%	0.04%	8.92%
	White	85.60%	4.29%	17.01%	15.15%	5.80%	8.27%	3.81%	6.54%	28.15%	0.16%	89.18%
	Not Recorded	0.00%	0.06%	0.25%	0.33%	0.05%	0.17%	0.31%	0.32%	0.41%	0.00%	1.90%
	Total	100.00%	4.66%	18.26%	15.97%	6.13%	9.02%	4.45%	9.06%	32.26%	0.20%	100.00%
Religious Belief	Christianity	56.40%	2.08%	8.27%	7.05%	3.04%	3.51%	1.45%	2.81%	17.80%	0.09%	46.10%
	Islam	6.30%	0.09%	0.21%	0.14%	0.06%	0.01%	0.06%	0.62%	0.19%	0.00%	1.39%
	No Religious Belief	28.40%	0.94%	2.77%	2.48%	1.28%	0.75%	0.94%	1.78%	4.73%	0.05%	15.72%
	Other	2.60%	0.45%	2.06%	1.54%	0.39%	0.98%	0.24%	0.91%	2.66%	0.03%	9.26%
	Not Recorded	6.30%	1.10%	4.96%	4.75%	1.37%	3.77%	1.76%	2.94%	6.87%	0.03%	27.53%
	Total	100.00%	4.66%	18.26%	15.97%	6.13%	9.02%	4.45%	9.06%	32.26%	0.20%	100.00%
Age	16-29	29.05%	0.84%	3.78%	2.08%	1.36%	0.85%	0.75%	1.54%	6.91%	0.05%	18.16%
	30-59	36.05%	3.55%	12.07%	11.76%	4.57%	6.12%	3.44%	6.79%	23.45%	0.15%	71.90%
	60+	8.68%	0.27%	2.42%	2.13%	0.19%	2.04%	0.26%	0.73%	1.90%	0.00%	9.94%
	Not Recorded	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	73.78%	4.66%	18.26%	15.97%	6.13%	9.02%	4.45%	9.06%	32.26%	0.20%	100.00%
Sexual Orientation	Heterosexual	not available	3.67%	13.56%	11.70%	4.95%	5.46%	2.84%	6.22%	25.40%	0.17%	73.97%
	LGB	not available	0.09%	0.47%	0.37%	0.19%	0.07%	0.10%	0.23%	0.81%	0.01%	2.34%
	Not Recorded	not available	0.89%	4.24%	3.89%	0.99%	3.49%	1.50%	2.61%	6.04%	0.02%	23.69%
	Total	not available	4.66%	18.26%	15.97%	6.13%	9.02%	4.45%	9.06%	32.26%	0.20%	100.00%

Appraisal Figures by Protected Characteristic - April 2019 to March 2020

Protected Characteristic		% Census Data	% Staff in Post	% of all Appraisals Completed for Eligible Staff
Gender	Female	52.00%	78.38%	78.13%
	Male	48.00%	21.62%	81.60%
	Not Recorded	0.00%	0.00%	0.00
	Total	100.00%	100.00%	78.85%
Disability	No	not available	73.19%	79.04%
	Yes	not available	2.85%	78.43%
	Not Recorded	not available	23.95%	77.90%
	Total	not available	100.00%	78.85%
Ethnic Origin	BME	14.70%	8.92%	81.90%
	White	85.60%	89.18%	83.48%
	Not Recorded	0.00%	1.90%	78.49%
	Total	100.00%	100.00%	78.85%
Religious Belief	Christianity	56.40%	46.10%	78.05%
	Islam	6.30%	1.39%	82.73%
	No Religious Belief	28.40%	15.72%	80.18%
	Other	2.60%	9.26%	78.87%
	Not Recorded	6.30%	27.53%	80.31%
	Total	100.00%	100.00%	78.85%
Age	16-29	29.05%	18.16%	80.06%
	30-59	36.05%	71.90%	78.65%
	60+	8.68%	9.94%	78.62%
	Not Recorded	0.00%	0.00%	0.00%
	Total	73.78%	100.00%	78.85%
Sexual Orientation	Heterosexual	not available	73.97%	78.83%
	LGB	not available	2.34%	80.21%
	Not Recorded	not available	23.69%	78.79%
	Total	not available	100.00%	78.85%

Harassment & Grievance Figures by Protected Characteristic - April 2019 to March 2020

Protected Characteristic		% Census Data	% Staff in Post	% of staff in post reporting Harassment	% of staff in post registering a Grievance
Gender	Female	52.00%	78.38%	0.02%	0.09%
	Male	48.00%	21.62%	0.03%	0.06%
	Not Recorded	0.00%	0.00%	0.00%	0.00%
	Total	100.00%	100.00%	0.02%	0.08%
Disability	No	not available	73.19%	0.03%	0.07%
	Yes	not available	2.85%	0.00%	0.47%
	Not Recorded	not available	23.95%	0.00%	0.06%
	Total	not available	100.00%	0.02%	0.08%
Ethnic Origin	BME	14.70%	8.92%	0.07%	0.00%
	White	85.60%	89.18%	0.01%	0.09%
	Not Recorded	0.00%	1.90%	0.00%	0.00%
	Total	100.00%	100.00%	0.02%	0.08%
Religious Belief	Christianity	56.40%	46.10%	0.01%	0.09%
	Islam	6.30%	1.39%	0.00%	0.00%
	No Religious Belief	28.40%	15.72%	0.00%	0.13%
	Other	2.60%	9.26%	0.00%	0.00%
	Not Recorded	6.30%	27.53%	0.05%	0.07%
	Total	100.00%	100.00%	0.02%	0.08%
Age	16-29	29.05%	18.16%	0.00%	0.00%
	30-59	36.05%	71.90%	0.03%	0.11%
	60+	8.68%	9.94%	0.00%	0.00%
	Not Recorded	0.00%	0.00%	0.00%	0.00%
	Total	73.78%	100.00%	0.02%	0.08%
Sexual Orientation	Heterosexual	not available	73.97%	0.01%	0.09%
	LGB	not available	2.34%	0.00%	0.00%
	Not Recorded	not available	23.69%	0.06%	0.06%
	Total	not available	100.00%	0.02%	0.08%

Flexible Working Figures by Protected Characteristic - April 2019 to March 2020

Protected Characteristic		% Census Data	% Staff in Post	% of all Requests Accepted by PC	% of all Requests Rejected by PC	Total % of all Applications by PC
Gender	Female	52.00%	78.38%	6.66%	0.03%	6.69%
	Male	48.00%	21.62%	2.13%	0.03%	2.16%
	Not Recorded	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	100.00%	100.00%	5.68%	0.03%	5.71%
Disability	No	not available	73.19%	6.13%	0.02%	6.15%
	Yes	not available	2.85%	4.92%	0.23%	5.15%
	Not Recorded	not available	23.95%	4.40%	0.03%	4.43%
	Total	not available	100.00%	5.68%	0.03%	5.71%
Ethnic Origin	BME	14.70%	8.92%	3.52%	0.00%	3.52%
	White	85.60%	89.18%	5.91%	0.03%	5.94%
	Not Recorded	0.00%	1.90%	5.26%	0.00%	5.26%
	Total	100.00%	100.00%	5.68%	0.03%	5.71%
Religious Belief	Christianity	56.40%	46.10%	5.95%	0.01%	5.97%
	Islam	6.30%	1.39%	6.73%	0.00%	6.73%
	No Religious Belief	28.40%	15.72%	6.24%	0.00%	6.24%
	Other	2.60%	9.26%	7.07%	0.00%	7.07%
	Not Recorded	6.30%	27.53%	4.39%	0.07%	4.46%
	Total	100.00%	100.00%	5.68%	0.03%	5.71%
Age	16-29	29.05%	18.16%	4.82%	0.00%	4.82%
	30-59	36.05%	71.90%	6.00%	0.04%	6.04%
	60+	8.68%	9.94%	4.97%	0.00%	4.97%
	Not Recorded	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	73.78%	100.00%	5.68%	0.03%	5.71%
Sexual Orientation	Heterosexual	not available	73.97%	6.20%	0.03%	6.23%
	LGB	not available	2.34%	3.70%	0.00%	3.70%
	Not Recorded	not available	23.69%	4.26%	0.03%	4.29%
	Total	not available	100.00%	5.68%	0.03%	5.71%

Disciplinary & Capability Figures by Protected Characteristic - April 2019 to March 2020

Protected Characteristic		% Census Data	% Staff in Post	% of all Disciplinary Cases by staff in post	% of all Capability Cases (No Underlying Health Reason)	% of all Capability Cases (Underlying Health Reason)
Gender	Female	52.00%	78.38%	1.58%	2.87%	1.12%
	Male	48.00%	21.62%	1.17%	1.20%	0.74%
	Not Recorded	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	100.00%	100.00%	1.49%	2.51%	1.04%
Disability	No	not available	73.19%	1.41%	2.49%	0.94%
	Yes	not available	2.85%	2.58%	2.81%	2.34%
	Not Recorded	not available	23.95%	1.59%	2.54%	1.20%
	Total	not available	100.00%	1.49%	2.51%	1.04%
Ethnic Origin	BME	14.70%	8.92%	0.52%	0.82%	0.37%
	White	85.60%	89.18%	1.60%	2.70%	1.09%
	Not Recorded	0.00%	1.90%	1.05%	1.75%	1.75%
	Total	100.00%	100.00%	1.49%	2.51%	1.04%
Religious Belief	Christianity	56.40%	46.10%	1.29%	2.25%	1.09%
	Islam	6.30%	1.39%	0.03%	0.03%	0.00%
	No Religious Belief	28.40%	15.72%	0.58%	1.01%	0.25%
	Other	2.60%	9.26%	0.30%	0.59%	0.19%
	Not Recorded	6.30%	27.53%	1.03%	1.56%	0.74%
	Total	100.00%	100.00%	1.49%	2.51%	1.04%
Age	16-29	29.05%	18.16%	1.69%	3.38%	0.51%
	30-59	36.05%	71.90%	1.45%	2.39%	1.11%
	60+	8.68%	9.94%	1.41%	1.81%	1.48%
	Not Recorded	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	73.78%	100.00%	1.49%	2.51%	1.04%
Sexual Orientation	Heterosexual	not available	73.97%	1.41%	2.46%	0.98%
	LGB	not available	2.34%	2.28%	3.42%	1.14%
	Not Recorded	not available	23.69%	1.66%	2.59%	1.21%
	Total	not available	100.00%	1.49%	2.51%	1.04%

Leaver Figures by Protected Characteristic - April 2019 to March 2020

Protected Characteristic		% Census Data	% Staff in Post	% of all Resignations	% of all Fixed Term Contracts	% of all Retirements	% of all Flexi Retirements	% of all Other	% Total Leavers
Gender	Female	52.00%	78.38%	5.63%	1.10%	1.48%	0.83%	0.41%	9.45%
	Male	48.00%	21.62%	5.81%	0.96%	1.64%	3.00%	0.40%	11.80%
	Not Recorded	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	100.00%	100.00%	5.67%	1.07%	1.52%	1.30%	0.41%	9.96%
Disability	No	not available	73.19%	6.61%	0.42%	0.83%	1.59%	0.33%	9.78%
	Yes	not available	2.85%	7.73%	0.23%	0.47%	1.64%	0.94%	11.01%
	Not Recorded	not available	23.95%	2.54%	3.15%	3.74%	0.36%	0.59%	10.37%
	Total	not available	100.00%	5.67%	1.07%	1.52%	1.30%	0.41%	9.96%
Ethnic Origin	BME	14.70%	8.92%	5.54%	0.37%	0.22%	4.27%	0.45%	10.86%
	White	85.60%	89.18%	5.68%	1.10%	1.64%	0.94%	0.40%	9.76%
	Not Recorded	0.00%	1.90%	5.61%	2.81%	1.75%	4.21%	0.70%	15.09%
	Total	100.00%	100.00%	5.67%	1.07%	1.52%	1.30%	0.41%	9.96%
Religious Belief	Christianity	56.40%	46.10%	5.88%	0.81%	1.42%	1.10%	0.41%	9.62%
	Islam	6.30%	1.39%	9.62%	0.00%	0.00%	11.54%	0.00%	21.15%
	No Religious Belief	28.40%	15.72%	7.48%	0.17%	0.42%	1.53%	0.13%	9.73%
	Other	2.60%	9.26%	6.71%	0.29%	0.43%	2.16%	0.43%	10.03%
	Not Recorded	6.30%	27.53%	3.74%	2.33%	2.74%	0.68%	0.58%	10.07%
	Total	100.00%	100.00%	5.67%	1.07%	1.52%	1.30%	0.41%	9.96%
Age	16-29	29.05%	18.16%	10.04%	0.00%	0.04%	3.24%	0.29%	13.61%
	30-59	36.05%	71.90%	4.89%	0.73%	0.71%	0.92%	0.43%	7.68%
	60+	8.68%	9.94%	3.29%	5.44%	10.08%	0.47%	0.47%	19.76%
	Not Recorded	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	73.78%	100.00%	5.67%	1.07%	1.52%	1.30%	0.41%	9.96%
Sexual Orientation	Heterosexual	not available	73.97%	6.42%	0.56%	1.02%	1.52%	0.34%	9.86%
	LGB	not available	2.34%	7.98%	0.28%	0.00%	1.42%	0.28%	9.97%
	Not Recorded	not available	23.69%	3.10%	2.73%	3.21%	0.59%	0.62%	10.26%
	Total	not available	100.00%	5.67%	1.07%	1.52%	1.30%	0.41%	9.96%

Full & Part Time Figures by Protected Characteristic - April 2019 to March 2020

Protected Characteristic		% Census Data	% Staff in Post	% of part time staff
Gender	Female	52.00%	78.38%	42.59%
	Male	48.00%	21.62%	14.45%
	Not Recorded	0.00%	0.00%	0.00%
	Total	100.00%	100.00%	36.50%
Disability	No	not available	73.19%	32.50%
	Yes	not available	2.85%	33.72%
	Not Recorded	not available	23.95%	49.07%
	Total	not available	100.00%	36.50%
Ethnic Origin	BME	14.70%	8.92%	18.95%
	White	85.60%	89.18%	38.19%
	Not Recorded	0.00%	1.90%	39.65%
	Total	100.00%	100.00%	36.50%
Religious Belief	Christianity	56.40%	46.10%	36.13%
	Islam	6.30%	1.39%	19.23%
	No Religious Belief	28.40%	15.72%	24.89%
	Other	2.60%	9.26%	36.44%
	Not Recorded	6.30%	27.53%	44.65%
	Total	100.00%	100.00%	36.50%
Age	16-29	29.05%	18.16%	14.20%
	30-59	36.05%	71.90%	38.54%
	60+	8.68%	9.94%	62.50%
	Not Recorded	0.00%	0.00%	0.00%
	Total	73.78%	100.00%	36.50%
Sexual Orientation	Heterosexual	not available	73.97%	33.73%
	LGB	not available	2.34%	16.52%
	Not Recorded	not available	23.69%	47.14%
	Total	not available	100.00%	36.50%

Maternity, Paternity & Adoption Figures by Protected Characteristic - April 2019 to March 2020

Protected Characteristic		% Census Data	% Staff in Post	% taking Adoption Leave	% taking Maternity Leave	% taking Paternity Leave (Adoption)	% taking Paternity Leave (Birth)	% taking Shared Parental Leave
Gender	Female	52.00%	78.38%	87.50%	100.00%	50.00%	0.00%	0.00%
	Male	48.00%	21.62%	12.50%	0.00%	50.00%	100.00%	100.00%
	Not Recorded	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Grand Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Disability	No	not available	73.19%	87.50%	92.11%	100.00%	85.71%	50.00%
	Yes	not available	2.85%	0.00%	2.95%	0.00%	0.00%	0.00%
	Not Recorded	not available	23.95%	12.50%	4.95%	0.00%	14.29%	50.00%
	Grand Total	not available	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Ethnic Origin	BME	14.70%	8.92%	0.00%	5.37%	0.00%	5.71%	0.00%
	White	85.60%	89.18%	100.00%	93.47%	100.00%	85.71%	100.00%
	Not Recorded	0.00%	1.90%	0.00%	1.16%	0.00%	8.57%	0.00%
	Grand Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Religious Belief	Christianity	56.40%	46.10%	25.00%	55.37%	50.00%	42.86%	50.00%
	Islam	6.30%	1.39%	0.00%	1.68%	0.00%	5.71%	0.00%
	No Religious Belief	28.40%	15.72%	37.50%	20.74%	50.00%	20.00%	0.00%
	Other	2.60%	9.26%	0.00%	11.26%	0.00%	8.57%	0.00%
	Not Recorded	6.30%	27.53%	37.50%	10.95%	0.00%	22.86%	50.00%
	Grand Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Age	16-29	29.05%	18.16%	0.00%	20.32%	0.00%	8.57%	0.00%
	30-59	36.05%	71.90%	100.00%	79.68%	100.00%	91.43%	100.00%
	60+	8.68%	9.94%	0.00%	0.00%	0.00%	0.00%	0.00%
	Not Recorded	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Grand Total	73.78%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Sexual Orientation	Heterosexual	not available	73.97%	75.00%	94.00%	50.00%	85.71%	50.00%
	LGB	not available	2.34%	12.50%	1.58%	50.00%	0.00%	0.00%
	Not Recorded	not available	23.69%	12.50%	4.42%	0.00%	14.29%	50.00%
	Grand Total	not available	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Personal Development Training Figures by Protected Characteristic - April 2019 to March 2020

Protected Characteristic		% Census Data	% Staff in Post	% Received Training
Gender	Female	52.00%	78.38%	80.77%
	Male	48.00%	21.62%	19.23%
	Not Recorded	0.00%	0.00%	0.00%
	Grand Total	100.00%	100.00%	100.00%
Disability	No	not available	73.19%	78.13%
	Yes	not available	2.85%	3.31%
	Not Recorded	not available	23.95%	18.56%
	Grand Total	not available	100.00%	100.00%
Ethnic Origin	BME	14.70%	8.92%	8.09%
	White	85.60%	89.18%	90.45%
	Not Recorded	0.00%	1.90%	1.47%
	Grand Total	100.00%	100.00%	100.00%
Religious Belief	Christianity	56.40%	46.10%	50.15%
	Islam	6.30%	1.39%	0.88%
	No Religious Belief	28.40%	15.72%	17.51%
	Other	2.60%	9.26%	8.71%
	Not Recorded	6.30%	27.53%	22.75%
	Grand Total	100.00%	100.00%	100.00%
Age	16-29	29.05%	18.16%	19.02%
	30-59	36.05%	71.90%	75.62%
	60+	8.68%	9.94%	5.36%
	Not Recorded	0.00%	0.00%	0.00%
	Grand Total	73.78%	100.00%	100.00%
Sexual Orientation	Heterosexual	not available	73.97%	78.13%
	LGB	not available	2.34%	2.93%
	Not Recorded	not available	23.69%	18.94%
	Grand Total	not available	100.00%	100.00%

Recruitment & Selection Training Figures by Protected Characteristic - April 2019 to March 2020

Protected Characteristic		% Census Data	% Staff in Post	% Received Training
Gender	Female	52.00%	78.38%	84.11%
	Male	48.00%	21.62%	15.89%
	Not Recorded	0.00%	0.00%	0.00%
	Grand Total	100.00%	100.00%	100.00%
Disability	No	not available	73.19%	78.81%
	Yes	not available	2.85%	2.23%
	Not Recorded	not available	23.95%	18.95%
	Grand Total	not available	100.00%	100.00%
Ethnic Origin	BME	14.70%	8.92%	3.38%
	White	85.60%	89.18%	95.08%
	Not Recorded	0.00%	1.90%	1.55%
	Grand Total	100.00%	100.00%	100.00%
Religious Belief	Christianity	56.40%	46.10%	53.68%
	Islam	6.30%	1.39%	0.26%
	No Religious Belief	28.40%	15.72%	16.15%
	Other	2.60%	9.26%	7.67%
	Not Recorded	6.30%	27.53%	22.24%
	Grand Total	100.00%	100.00%	100.00%
Age	16-29	29.05%	18.16%	5.93%
	30-59	36.05%	71.90%	89.55%
	60+	8.68%	9.94%	4.52%
	Not Recorded	0.00%	0.00%	0.00%
	Grand Total	73.78%	100.00%	100.00%
Sexual Orientation	Heterosexual	not available	73.97%	79.44%
	LGB	not available	2.34%	1.86%
	Not Recorded	not available	23.69%	18.69%
	Grand Total	not available	100.00%	100.00%

Probation Dismissal Figures by Protected Characteristic - April 2019 to March 2020

Protected Characteristic		% Census Data	% Staff in Post	% dismissed within 9 months
Gender	Female	52.00%	78.38%	0.00%
	Male	48.00%	21.62%	0.00%
	Not Recorded	0.00%	0.00%	0.00%
	Total	100.00%	100.00%	0.00%
Disability	No	not available	73.19%	0.00%
	Yes	not available	2.85%	0.00%
	Not Recorded	not available	23.95%	0.00%
	Total	not available	100.00%	0.00%
Ethnic Origin	BME	14.70%	8.92%	0.00%
	White	85.60%	89.18%	0.00%
	Not Recorded	0.00%	1.90%	0.00%
	Total	100.00%	100.00%	0.00%
Religious Belief	Christianity	56.40%	46.10%	0.00%
	Islam	6.30%	1.39%	0.00%
	No Religious Belief	28.40%	15.72%	0.00%
	Other	2.60%	9.26%	0.00%
	Not Recorded	6.30%	27.53%	0.00%
	Total	100.00%	100.00%	0.00%
Age	16-29	29.05%	18.16%	0.00%
	30-59	36.05%	71.90%	0.00%
	60+	8.68%	9.94%	0.00%
	Not Recorded	0.00%	0.00%	0.00%
	Total	73.78%	100.00%	0.00%
Sexual Orientation	Heterosexual	not available	73.97%	0.00%
	LGB	not available	2.34%	0.00%
	Not Recorded	not available	23.69%	0.00%
	Total	not available	100.00%	0.00%

Pay Grade Figures by Protected Characteristic - April 2019 to March 2020

Protected Characteristic		% Census Data	% Staff in Post	1	2	3	4	5	6	7	8a	8b	8c	8d	9	Ad Hoc	VSM	Consultant	Foundation	Non Consultant	Trust Grade
Gender	Female	52.00%	78.38%	15.78%	8.21%	6.30%	21.03%	12.36%	7.86%	0.02%	1.80%	0.57%	0.27%	0.07%	0.04%	0.12%	0.08%	2.16%	0.58%	0.51%	0.61%
	Male	48.00%	21.62%	4.50%	2.00%	1.13%	3.17%	2.48%	1.80%	0.00%	0.61%	0.35%	0.21%	0.05%	0.03%	0.11%	0.09%	3.35%	0.57%	0.40%	0.77%
	Not Recorded	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	100.00%	100.00%	20.28%	10.21%	7.43%	24.20%	14.84%	9.66%	0.02%	2.41%	0.92%	0.48%	0.11%	0.07%	0.23%	0.17%	5.51%	1.16%	0.91%	1.38%
Disability	No	not available	73.19%	14.45%	6.64%	4.60%	18.88%	11.62%	6.97%	0.01%	1.86%	0.71%	0.38%	0.08%	0.01%	0.15%	0.12%	3.69%	1.07%	0.63%	1.34%
	Yes	not available	2.85%	0.79%	0.33%	0.21%	0.77%	0.40%	0.15%	0.00%	0.03%	0.02%	0.00%	0.00%	0.03%	0.03%	0.00%	0.02%	0.04%	0.00%	0.01%
	Not Recorded	not available	23.95%	5.04%	3.25%	2.62%	4.55%	2.82%	2.54%	0.01%	0.51%	0.19%	0.10%	0.03%	0.03%	0.05%	0.05%	1.80%	0.05%	0.28%	0.03%
	Total	not available	100.00%	20.28%	10.21%	7.43%	24.20%	14.84%	9.66%	0.02%	2.41%	0.92%	0.48%	0.11%	0.07%	0.23%	0.17%	5.51%	1.16%	0.91%	1.38%
Ethnic Origin	BME	14.70%	8.92%	1.22%	0.44%	0.21%	3.71%	0.75%	0.31%	0.00%	0.08%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	1.16%	0.22%	0.21%	0.61%
	White	85.60%	89.18%	18.75%	9.57%	7.06%	20.20%	13.78%	9.18%	0.01%	2.27%	0.88%	0.47%	0.11%	0.07%	0.21%	0.17%	4.23%	0.82%	0.69%	0.71%
	Not Recorded	0.00%	1.90%	0.31%	0.20%	0.16%	0.29%	0.31%	0.17%	0.01%	0.06%	0.03%	0.01%	0.01%	0.00%	0.03%	0.01%	0.12%	0.11%	0.01%	0.07%
	Total	100.00%	100.00%	20.28%	10.21%	7.43%	24.20%	14.84%	9.66%	0.02%	2.41%	0.92%	0.48%	0.11%	0.07%	0.23%	0.17%	5.51%	1.16%	0.91%	1.38%
Religious Belief	Christianity	56.40%	46.10%	9.13%	4.30%	3.12%	12.17%	7.59%	5.00%	0.01%	1.16%	0.40%	0.23%	0.04%	0.03%	0.05%	0.09%	1.72%	0.30%	0.35%	0.41%
	Islam	6.30%	1.39%	0.19%	0.09%	0.05%	0.25%	0.13%	0.05%	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.23%	0.03%	0.07%	0.29%
	No Religious Belief	28.40%	15.72%	2.55%	1.24%	0.98%	4.29%	2.70%	1.45%	0.00%	0.42%	0.14%	0.08%	0.03%	0.00%	0.06%	0.03%	0.83%	0.51%	0.12%	0.29%
	Other	2.60%	9.26%	2.36%	1.02%	0.76%	2.16%	1.14%	0.56%	0.00%	0.22%	0.09%	0.01%	0.00%	0.01%	0.00%	0.01%	0.52%	0.08%	0.07%	0.24%
	Not Recorded	6.30%	27.53%	6.05%	3.57%	2.51%	5.33%	3.29%	2.60%	0.01%	0.61%	0.29%	0.16%	0.04%	0.03%	0.12%	0.04%	2.20%	0.23%	0.31%	0.15%
	Total	100.00%	100.00%	20.28%	10.21%	7.43%	24.20%	14.84%	9.66%	0.02%	2.41%	0.92%	0.48%	0.11%	0.07%	0.23%	0.17%	5.51%	1.16%	0.91%	1.38%
Age	16-29	29.05%	18.16%	3.87%	1.22%	1.06%	7.72%	2.16%	0.42%	0.00%	0.02%	0.01%	0.00%	0.00%	0.03%	0.12%	0.00%	0.00%	1.04%	0.03%	0.47%
	30-59	36.05%	71.90%	12.78%	7.36%	5.66%	15.07%	11.80%	8.52%	0.02%	2.30%	0.87%	0.45%	0.11%	0.02%	0.08%	0.13%	4.89%	0.12%	0.80%	0.91%
	60+	8.68%	9.94%	3.63%	1.63%	0.71%	1.41%	0.87%	0.71%	0.00%	0.09%	0.03%	0.03%	0.00%	0.02%	0.03%	0.05%	0.62%	0.00%	0.09%	0.00%
	Not Recorded	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	73.78%	100.00%	20.28%	10.21%	7.43%	24.20%	14.84%	9.66%	0.02%	2.41%	0.92%	0.48%	0.11%	0.07%	0.23%	0.17%	5.51%	1.16%	0.91%	1.38%
Sexual Orientation	Heterosexual	not available	73.97%	14.73%	6.96%	4.98%	18.89%	11.88%	7.11%	0.01%	1.87%	0.69%	0.33%	0.07%	0.03%	0.13%	0.11%	3.38%	0.95%	0.59%	1.24%
	LGB	not available	2.34%	0.35%	0.25%	0.08%	0.79%	0.35%	0.17%	0.00%	0.08%	0.01%	0.01%	0.00%	0.01%	0.00%	0.02%	0.08%	0.05%	0.03%	0.07%
	Not Recorded	not available	23.69%	5.20%	3.01%	2.36%	4.52%	2.60%	2.38%	0.01%	0.46%	0.21%	0.14%	0.04%	0.03%	0.10%	0.04%	2.05%	0.15%	0.29%	0.08%
	Total	not available	100.00%	20.28%	10.21%	7.43%	24.20%	14.84%	9.66%	0.02%	2.41%	0.92%	0.48%	0.11%	0.07%	0.23%	0.17%	5.51%	1.16%	0.91%	1.38%

Ad hoc = Student placements & other non VSM Ad Hoc Payscales e.g. Apprentice

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Workforce Disability Equality Standard (WDES) 2020

1. Name of organisation

The Newcastle upon Tyne Hospitals NHS Foundation Trust.

2. Date of report

Month: September.
Year: 2020.

3. Name and title of Board lead for the Workforce Disability Equality Standard

Dee Fawcett HR Director.

4. Name and contact details of lead manager compiling this report

Karen Pearce – Head of Equality, Diversity and Inclusion (People).

5. Names of commissioners this report has been sent to

Co-ordinating commissioner - NHS England Newcastle Gateshead CCG.

6. Name and contact details of coordinating commissioner this report has been sent to North Tyneside CCG, Northumberland CCG, South Tees CCG, South Tyneside CCG, North Durham CCG, Durham, Dales, Easington & Sedgefield CCG, Hartlepool & Stockton CCG, Darlington CCG, Sunderland CCG, Cumbria CCG.

7. Unique URL link on which this Report and associated Action Plan will be found

https://www.newcastle-hospitals.org.uk/about-us/equality-and-diversity_workforce-disability-equality-standard.html

8. This report has been signed off by on behalf of the board on

Date: August 2020.
Name: Dee Fawcett, HR Director.

Background narrative

9. Any issues of completeness of data

Unknown/null data relating to disability of current staff still exists.

10. Any matters relating to reliability of comparisons with previous years

None.

11. Total number of staff employed within this organisation at the date of the report (March 2020)

14967.

12. Proportion of Disabled staff employed within this organisation at the date of the report?

2.90%.

13. The proportion of total staff who have self–reported their disability?

77.45%.

14. Have any steps been taken in the last reporting period to improve the level of self-reporting by disability?

Fully implemented Employee Self Service.

Full roll out of the ESR employee portal complete.

Trust has the highest usage of the employee portal nationally – this has increased accessibility for staff to be able to input their personal information including ethnicity status.

Bespoke rolling adverts added within the portal to further encourage staff to update their personal information.

15. Are any steps planned during the current reporting period to improve the level of self-reporting by disability?

An action is included within the WDES Action Plan to encourage staff to update their personal information in ESR via Employee Self Service and any other appropriate means to reduce the number of 'Nulls.'

Workforce data

16. What period does the organisation's workforce data refer to?

April 2019 - March 2020.

Workforce Disability Equality Indicators

17. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of disabled/non-disabled staff.

Data for reporting year: March 2020 Data (Headcount)

	Non Clinical Band/Grade		Clinical Band/Grade	
Payband	% disabled of the non-clinical workforce	% non-disabled of the non-clinical workforce	% disabled of the clinical workforce	% non-disabled of the clinical workforce
Under band 1	0.06	0.09	0.01	0.21
Band 1	0.04	0.01	0.00	0.00
Band 2	0.40	7.40	0.62	11.39
Band 3	0.23	4.90	0.20	3.84
Band 4	0.18	3.04	0.09	3.02

Band 5	0.08	2.19	0.94	22.65
Band 6	0.05	1.01	0.47	14.27
Band 7	0.03	1.09	0.18	8.07
Band 8a	0.00	0.48	0.04	1.97
Band 8b	0.03	0.33	0.00	0.62
Band 8c	0.00	0.26	0.00	0.25
Band 1	0.00	0.04	0.00	0.07
Band 8d	0.00	0.01	0.00	0.00
Band 9	0.00	0.12	0.00	0.02
VSM	0.00	0.00	0.00	0.00
Cluster 1	0.91	15.44	0.91	15.44
Cluster 2	0.16	4.29	0.16	4.29
Cluster 3	0.03	0.81	0.03	0.81
Cluster 4	0.00	0.43	0.00	0.43
Medical and Dental Consultants			0.03	4.84
non consultant career grade			0.02	2.55
Medical and Dental Trainee Grades			0.05	1.53
Other			0.00	0.00
Cluster 1	0.92	18.46		
Cluster 2	1.59	44.99		
Cluster 3	0.04	2.58		
Cluster 4	0.00	0.33		
Cluster 5	0.03	4.84		
Cluster 6	0.02	2.55		

Cluster7	0.05	1.53		

- 77.45% of staff have recorded their disability.

18. Indicator 4a Percentage of staff experiencing harassment, bullying or abuse from service users their family of the public

Data for reporting year:

Non-Disabled: 20.5%.

Disabled: 26.6 %.

Data for previous year:

Non-Disabled: 22.7%.

Disabled: 29.7 %.

19. Indicator 4a Percentage of staff experiencing harassment, bullying or abuse from managers

Data for reporting year:

Non-Disabled: 7.5%

Disabled: 15.9 %

Data for previous year:

Non-Disabled: 15.5%

Disabled: 7.7 %

20. Metric 4a Percentage of staff experiencing harassment, bullying or abuse from colleagues

Data for reporting year:

Non-Disabled: 15.2%.

Disabled: 26.1 %.

Data for previous year:

Non-Disabled: 14.5%.

Disabled: 25.8%.

21. Metric 4b Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

Data for reporting year:

Non-Disabled: 43.5%.

Disabled: 45.8%.

Data for previous year:

Non-Disabled: 42.6%.

Disabled: 41.2%.

22. Indicator 5 Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion

Data for reporting year:

Non-Disabled: 90.7%.

Disabled: 83.7%.

Data for previous year:

Non-Disabled: 90.7%.

Disabled: 84.4%.

23. Indicator 6 Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

Data for reporting year:

Non-Disabled: 21.4%.

Disabled: 34.5%.

Data for previous year:

Non-Disabled: 25.0%.

Disabled: 37.0%.

24. Indicator 7 Percentage of staff saying that they are satisfied with the extent to which their organisation values their work

Data for reporting year:

Non-Disabled: 53.8%.

Disabled: 42.9%.

Data for previous year:

Non-Disabled: 53.2%.

Disabled: 38.5%.

25. Indicator 8 Percentage of staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work

Data for reporting year:

Disabled: 77.0%.

Data for previous year:

Disabled: 77.1%.

26. Indicator 9a The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

Data for reporting year:

Non-Disabled: 7.4%.

Disabled: 6.9%.

Data for previous year:

Non-Disabled: 7.4%.

Disabled: 6.9%.

27. Indicator 9b Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)

Yes.

<u>Workforce Disability Equality Indicators</u>

28. Indicator 2 Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.

Data for reporting year: 1.06.

Data for previous year: 1.6.

29. Indicator 3 Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Data for reporting year: 1.06.

Data for previous year: 1.89.

Board Representation Indicators

30. Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

Data for reporting year: -3 by voting membership and Executive membership.
Data for previous year: -3 by voting membership and Executive membership.

31. Are there any other factors or data which should be taken into consideration in assessing progress?

None.

32. Organisations should produce a detailed WDES action plan, agreed by its board. It is good practice for this action plan to be published on the organisation's website, alongside their WDES data. Such a plan would elaborate on the actions summarised in this report, setting out the next steps with milestones for expected progress against the WDES indicators. It may also identify the links with other work streams agreed at board level, such as EDS2. You are asked to provide a link to your WDES action plan in the space below.

https://www.newcastle-hospitals.org.uk/about-us/equality-and-diversity_workforce-disability-equality-standard.html

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WDES ACTION PLAN 2020-22

Objectives	Goals	Strategies	Measures
A workforce representative of the local population	▪ All our staff are enabled to support EDI ▪ EDI is a strategic priority for all our leaders/managers ▪ Increase inclusion to ensure our workforce reflects the level of people in the general population that are disabled and working ▪ Eliminate nulls in our ESR data for disability status	Develop an EDI strategy for an open and inclusive workforce Engage local communities Implement widening access campaign, including overhaul of recruitment and promotion practices Use RPA to improve quality of data in ESR To be recognised as a Disability Confident Leader organisation	Deliver recruitment event for people with disabilities 2021/22 20% of workforce have disclosed a disability by March 2022 Zero nulls in ESR for disability status by December 2021 Indicator 6 improved in 2020 and sustained in 2021

WDES ACTION PLAN 2020-22

Objectives	Goals	Strategies	Measures
A workplace where all staff can flourish and liberate their potential	▪ Eliminate disabled staff feeling pressure to attend work when not feeling well enough ▪ Increase number of disabled staff feeling valued ▪ Eliminate disabled staff complaints of bullying and harassment by other staff ▪ Disabled staff feel safe and enabled to report harassment, bullying or abuse at work	Ensure disabled staff feel safe to raise concerns at work and they are enabled to seek support Ensure all staff feel welcome and valued, have support when they need it and have opportunities to develop Include disability in EDI performance management framework to monitor progress Refresh training and awareness on unconscious basis and micro aggressions	WDES Indicator 4b improved (2020) and sustained (2021) WDES Indicator 6 improved (2020) and sustained (2021) Implement disability metrics and dashboard by April 2021 Provide resources for staff and share disabled staff experiences (e.g. personal stories) 2020/21

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

WORKFORCE RACE EQUALITY STANDARD (WRES) 2020

1. Name of organisation

The Newcastle upon Tyne Hospitals NHS Foundation Trust.

2. Date of report

Month: August.
Year: 2020.

3. Name and title of Board lead for the Workforce Race Equality Standard

Dee Fawcett HR Director.

4. Name and contact details of lead manager compiling this report

Karen Pearce – Head of Equality, Diversity and Inclusion (People).

5. Names of commissioners this report has been sent to

Co-ordinating commissioner - NHS England , Newcastle Gateshead CCG.

6. Name and contact details of coordinating commissioner this report has been sent to North Tyneside CCG, Northumberland CCG, South Tees CCG, South Tyneside CCG, North Durham CCG, Durham, Dales, Easington & Sedgefield CCG, Hartlepool & Stockton CCG, Darlington CCG, Sunderland CCG, Cumbria CCG.

7. Unique URL link on which this Report and associated Action Plan will be found

http://www.newcastle-hospitals.org.uk/about-us/equality-and-diversity_workforce-race-equality-standard.aspx

8. This report has been signed off by on behalf of the board on

Date: August 2020.
Name: Dee Fawcett, HR Director.

Background narrative

9. Any issues of completeness of data

A comparatively small number of unknown/null data relating to ethnicity of current staff still exist.

10. Any matters relating to reliability of comparisons with previous years

None.

11. Total number of staff employed within this organisation at the date of the report (March 2020)

14967.

12. Proportion of BME staff employed within this organisation at the date of the report?

9.56% (FTE).

13. The proportion of total staff who have self–reported their ethnicity?

98.11%.

14. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity?

Fully implemented Employee Self Service.
Full roll out of the ESR employee portal complete.
Trust has the highest usage of the employee portal nationally – this has increased accessibility for staff to be able to input their personal information including ethnicity status.
Bespoke rolling adverts added within the portal to further encourage staff to update their personal information.

15. Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity?

Plans to use robotic automation to increase staff reporting of ethnicity.

Workforce data

16. What period does the organisation's workforce data refer to?

April 2019 - March 2020.

Workforce Race Equality Indicators

17. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.

Data for reporting year: March 2020 Data (Headcount)

	Non Clinical staff in each band/grade		Clinical staff in each band/grade	
Pay band	% White (of total non-clinical Workforce)	% BME (of total non-clinical Workforce)	% White (of total clinical Workforce)	% BME (of total clinical Workforce)
Under Band 1	0.42	0.03	0.19	0.02
Band 1	0.94	0.24	0.00	0.00

Band 2	7.24	2.44	14.21	0.65
Band 3	5.26	0.54	6.36	0.28
Band 4	4.42	0.24	3.69	0.15
Band 5	7.36	0.36	25.48	4.57
Band 6	4.25	0.12	16.72	0.74
Band 7	3.83	0.18	10.69	0.25
Band 8A	1.36	0.06	2.32	0.06
Band 8B	1.30	0.00	0.86	0.02
Band 8C	0.84	0.00	0.27	0.00
Band 8D	0.15	0.00	0.13	0.00
Band 9	0.03	0.00	0.01	0.00
VSM	0.45	0.00	0.01	0.00
Medical Consultants			5.58	1.43
of which managers			0.24	0.04
Non-consultant Career Grades			1.93	1.18
Trainee grades			1.36	0.36
Other			0.00	0.00

Data for reporting year: March 2019 Data (Headcount)

	Non Clinical staff in each band/grade		Clinical staff in each band/grade	
Pay band	% White (of total Workforce)	% BME (of total Workforce)	% White (of total Workforce)	% BME (of total Workforce)

Under Band 1	0.77	0.03	0.23	0.04
Band 1	3.69	0.17	0.00	0.00
Band 2	30.65	2.38	14.27	0.81
Band 3	21.84	0.72	6.35	0.31
Band 4	18.12	0.37	3.70	0.16
Band 5	8.07	0.40	24.65	4.56
Band 6	4.29	0.11	17.20	0.84
Band 7	4.01	0.11	10.75	0.32
Band 8A	1.46	0.06	2.39	0.07
Band 8B	1.29	0.00	0.84	0.02
Band 8C	0.80	0.00	0.25	0.00
Band 8D	0.11	0.00	0.11	0.00
Band 9	0.11	0.00	0.01	0.00
VSM	0.43	0.00	0.01	0.00
Medical Consultants			5.71	1.46
of which managers			0.26	0.05
Non-consultant Career Grades			1.96	1.10
Trainee grades			1.20	0.38
Other			0.00	0.00

- 98.11% of staff have recorded their ethnicity.
- The figures referenced in the above tables do not include the small percentage of staff who have not shared their ethnicity, they have been excluded for the purposes of the data capture.

18. Relative likelihood of staff being appointed from shortlisting across all posts.

Data for reporting year: 1.29.

Data for previous year: 1

Trust data identifies BME applicants are less likely to be appointed from shortlisting than white candidates. In all previous years BME applicants have been more likely to be appointed. This position has worsened in the last 12 months.

Recruitment data is analysed annually under Trust Public Sector Equality Duty requirements and the Equality Delivery System.

19. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year

Data for reporting year: 0.83.

Data for previous year: 0.82.

Trust data identifies BME members of staff are less likely to entre formal disciplinary processes.

Employee Relations data is analysed annually under Trust Public Sector Equality Duty requirements and the Equality Delivery System.

20. Relative likelihood of staff accessing non-mandatory training and CPD

Data for reporting year: 1.01.

Data for previous year: 0.89.

Trust data identifies BME members of staff are more likely to access non-mandatory training and CPD.

Access to training is analysed annually under Trust Public Sector Equality Duty requirements and the Equality Delivery System.

Workforce Race Equality Indicators

21. KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

Data for reporting year:

White 21.6%.

BME 22.2%.

Data for previous year:

White 24%.

BME 21.6%.

- BME Staff Network continues to grow and engage in raising awareness.
- WRES sub group continues to meet monthly.
- Corporate objective in place.

22. KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

Data for reporting year:

White 20.6%.

BME 29.1%.

Data for previous year:

White 20.8%.

BME 21.9%.

- The percentage of white staff reporting harassment in the last 12 months has increased whilst the percentage of BAME staff has decreased slightly. The percentage difference has increased.

23. KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion

Data for reporting year:

White 90.6%.

BME 71.8%.

Data for previous year:

White 90.4%.

BME 78.2%.

24. Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

Data for reporting year:

White 5%.

BME 16.5%.

Data for previous year:

White 4.4%.

BME 14.4%.

Board representation indicator

25. Percentage difference between the organisations' Board voting membership and its overall workforce

Data for reporting year:

White -1.9.

BME -8.1.

Data for previous year:

White 10.5.

BME -8.5.

26. Are there any other factors or data which should be taken into consideration in assessing progress?

None.

27. Organisations should produce a detailed WRES action plan, agreed by its board. It is good practice for this action plan to be published on the organisation's website, alongside their WRES data. Such a plan would elaborate on the actions summarised in this report, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at board level, such as EDS2. You are asked to provide a link to your WRES action plan in the space below.

http://www.newcastle-hospitals.org.uk/about-us/equality-and-diversity_workforce-race-equality-standard.aspx

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WRES ACTION PLAN 2020-22

Objectives	Goals	Strategies	Measures
A workforce representative of the local population	▪ Deliver WRES aspirational targets for band 8 and above, including Board ▪ All our staff are enabled to support EDI ▪ EDI is a strategic priority for all our leaders/managers ▪ Increase inclusion to ensure our BAME workforce reflects the diversity of the local population ▪ Roll-out use of diverse interview panels	Develop an EDI strategy for an open and inclusive workforce Engage local communities Include BAME in EDI performance management framework to monitor progress Implement widening access campaign, including overhaul of recruitment and promotion practices Implement interventions to enable BAME staff to develop skills and competencies for career progression	Deliver BAME recruitment event 2021/22 Implement BAME metrics and dashboard by April 2021 A workforce that is 15% BAME by end-March 2022 WRES Indicator 7 Improved in 2020 and sustained in 2021 BAME representative on all appointment panels for band 7 and above

WRES ACTION PLAN 2020-22

Objectives	Goals	Strategies	Measures
A workplace where all staff can flourish and liberate their potential	▪ Eliminate BAME staff complaints of bullying and harassment by other staff ▪ Eliminate BAME staff complaints of discrimination by managers and other staff ▪ Improve opportunities for career progression for BAME staff ▪ A well workforce	Refresh training and awareness on unconscious basis and micro aggressions Ensure all staff feel welcome and valued, have support when they need it and have opportunities to develop Implement development programme for BAME staff (band 5 and above) Implement BAME mentorship programme to identify and address issues Implement HAWB risk assessment for BAME staff	WRES Indicator 6 improved in 2020 and sustained in 2021 Directorate action plans in place/staff survey results/ engagement score by 2021/22 WRES Indicator 8 improved in 2020 and sustained in 2021 Increased number of BAME staff in senior and leadership positions All BAME staff offered HAWB risk assessment 2020/21

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates Sep-20

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Confirmed

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust has taken all necessary precautions as were necessary to comply with the conditions.
The Trust has continually achieved its Control Total.
Transformation,performance and finance management arrangements are in place to support the delivery of the Trust Cost Improvement plans, overseeen by the Trust Finance Committee.
The Transformation, Performance and Finance Teams continue to work on the Trust's long-term sustainability and improvement programme.
The annual going concern assessment was presented to the Trust Board in April 2019 and an update presented in March 2020 as part of the Finance Director report.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Dame Jackie Daniel	**Name**	Professor Sir John Burn
Capacity	Chief Executive Officer	**Capacity**	Chairman
Date	September 2020	**Date**	September 2020

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | **Sep-20**

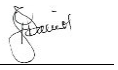
Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.		Confirmed. No material risks identified. Assurances include Annual Report (declaration of compliance with Code of Governance and Annual Governance Statement, both are subject to independent review and scrutiny by External Audit as part of the year end external audit). CQC Inspection of 'Well Led' Domain assessed as 'Outstanding'.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time		Confirmed. No material risks identified. Key documents are highlighted/circulated to the Board through the Chief Executive Update report, items to note and agenda items.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.		No material risks identified. The CQC reviewed the effectiveness of the Board and confirmed Committee structure as part of the 'Well Led' review, assessed as 'Outstanding'. There are a wide range of controls in place, including: an approved Scheme of Delegation, Standing Financial Instructions, Board approved committee structure and terms of reference in place, a Board member appraisal process is in place, agreed Executive portfolios and clear organisational structure/reporting lines.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.		Confirmed. No material risks identified. There are a range of systems and/or processes in place which evidence the Trust's on-going compliance with this requirement, including: Trust Board meetings (except in August when the Board does not meet). Routine Integrated Board Reports (covering Quality, Performance, People & Finance). Regular meetings of the Trust Executive Team, Executive Risk Group, Finance, Quality, Audit and People Committees. Board approved terms of references. Board approved Annual Plan. Regular detailed Board finance report. Board Assurance Framework and Risk Registers. External and Internal audit annual opinion and Internal Audit annual plan approved by the Audit Committee.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		Confirmed. No material risks identified. There are a range of systems and/or processes in place which evidence the Trust's on-going compliance with this requirement, including: - Trust Board composition includes Chief Executive Officer, Chief Operating Officer, Medical Director, Director of Enterprise, Business and Development, Finance Director, Executive Chief Nurse and a medical Non-Executive Director - Board approved Quality Account - Patient stories to every Board meeting - Board line of sight as part of Leadership Walkabouts - Positive external stakeholder feedback (re Quality Account) - Routine Integrated Qualityand Performance Report to Trust Board (including SIRI reporting) - Quality Committee meetings to seek assurance over quality of care including scrutiny of SIRIs and Never Events - Clinical Audit Plan - Mortality Surveillance Group
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.		There are a range of controls in place to mitigate staffing risks, including: Directorate Ward staffing reviews and a single centralised bank for nursing and midwife posts.

Please Respond

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature  **Signature** 

Name Dame Jackie Daniel **Name** Sir John Burn

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Worksheet "Training of governors"

Financial Year to which self-certification relates Q3 19/20

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Dame Jackie Daniel	**Name**	Professor Sir John Burn
Capacity	Chief Executive Officer	**Capacity**	Chairman
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A