BRP A6(i)a Cons & Hon Con Appointments - May 2021.pdf

BRP A6(i)b GOSW Annual Report 20-21.docx

BRP A6(i)b GOSW Quarterly Report March 2020-21.docx

BRP A6(iii)b SBLCB_BRP section 7_ May 21.pdf

BRP A6(iii)c Quality Account 2020-21.pdf

BRP A6(iv) HCAI Report & Scorecard April 2021 - HCAI Paper Appendix 1.xlsx

BRP A6(iv) HCAI Report & Scorecard March 2021 - HCAI Paper Appendix 1.xlsx

BRP A9 2021-22 Annual Financial Business Plan CRN North East and North Cumbria - CRN template.pdf

BRP A11 FT4 Self Certification May 2021.xlsm

BRP A11 G6 Self Certification May 2021.xlsm

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	27 May 2021						
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 17 March and interviewed 2 candidates for 2 Consultant Radiologist posts.

By unanimous resolution, the Committee was in favour of appointing Dr Kathryn Siddle and Dr Sebastian Atkinson.

Dr Siddle holds MBBS (Cardiff University) 2012 and FRCR (UK) 2019. Dr Siddle is currently employed as a Specialty Trainee in Radiology based at the Royal Victoria Infirmary.

Dr Atkinson holds MBBS (University of Leeds) 2013 and FRCR (UK) 2019. Dr Atkinson is currently employed as a Specialty Trainee in Radiology based at the Freeman Hospital.

Dr Siddle is expected to take up the post of Consultant Radiologist in October 2021.

Dr Atkinson is expected to take up the post of Consultant Radiologist in June 2021.

1.2 An Appointments Committee was held on 19 March 2021 and interviewed 2 candidates for 1 Consultant Obstetrician post.

By unanimous resolution, the Committee was in favour of appointing Dr Simon Williams.

Dr Williams holds MBBS (University of Newcastle) 2010 and MRCOG (UK) 2018. Dr Williams is currently employed as a Specialty Trainee based at the Royal Victoria Infirmary.

Dr Williams is expected to take up the post of Consultant Obstetrician in August 2021.

1.3 An Appointments Committee was held on 26 March 2021 and interviewed 1 candidate for 1 Consultant Dermatologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Siobhan Muthiah.

Dr Muthiah holds MBBS (University of Newcastle) 2010 and MRCP (UK) 2013. Dr Muthiah is currently employed as a Locum Consultant Dermatologist based at the Royal Victoria Infirmary.

Dr Muthiah is expected to take up the post of Consultant Dermatologist in October 2021.

1.4 An Appointments Committee was held on 26 March 2021 and interviewed 1 candidate for 1 Consultant in Paediatric Intensive Care Medicine and Paediatric Critical Care Transport post.

By unanimous resolution, the Committee was in favour of appointing Dr Raja Said Elsayed Abou Elella.

Dr Abou Elella holds MBBch (Egypt) 1995) and European Diploma of ICM (UK) 2010. Dr Abou Elella is currently employed as a Locum Consultant in PICU & paediatric acute transport based at the Royal Victoria Infirmary, Great North Children's Hospital.

Dr Abou Elella took up the post of Consultant in Paediatric Intensive Care Medicine and Paediatric Critical Care Transport on 26 April 2021.

1.5 An Appointments Committee was held on 31 March 2021 and interviewed 4 candidates for 1 Consultant Cardiologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Ashfaq Mohammed.

Dr Mohammed holds MBBS (University of Newcastle) 2006 and MRCP (UK) 2011. Dr Mohammed is currently employed as a Locum Consultant Cardiologist based at the Freeman Hospital.

Dr Mohammed is expected to take up the post of Consultant Cardiologist in June 2021.

1.6 An Appointments Committee was held on 16 April 2021 and interviewed 1 candidate for 1 Consultant Obstetrician post.

By unanimous resolution, the Committee was in favour of appointing Dr Camilla Dean.

Dr Dean holds MBBS (University of Nottingham) 2009 and MRCOG (UK) 2015. Dr Dean is currently employed as a Specialty Trainee based at the Royal Victoria Infirmary

Dr Dean is expected to take up the post of Consultant Obstetrician in September 2021.

1.7 An Appointments Committee was held on 21 April 2021 and interviewed 1 candidate for 1 Consultant in Oral Maxillifacial Surgery post.

By unanimous resolution, the Committee was in favour of appointing Mr Robert Stuart McCormick.

Mr McCormick holds BDS (University of Newcastle) 2003, MFDS (UK) 2005 and MBBS (University of Newcastle) 2010. Mr McCormick is currently employed as a Locum Consultant Oral and Maxillofacial Surgeon based at the Newcastle Dental Hospital.

Mr McCormick took up the post of Consultant in Oral Maxillifacial Surgery on 5 May 2021.

1.8 An Appointments Committee was held on 07 May 2021 and interviewed 1 candidate for 1 Consultant Paediatric Endocrinologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Amanda Peacock.

Dr Peacock holds MBChB (University of Manchester) 2000 and MRCPCH (UK) 2004. Dr Peacock is currently employed as a Post CCT Clinical Fellow in paediatric metabolic bone by the Sheffield Children's Hospital NHS Foundation Trust.

Dr Peacock is expected to take up the post of Consultant Paediatric Endocrinologist in September 2021.

1.9 An Appointments Committee was held on 12 May 2021 and interviewed 3 candidates for 1 Consultant Paediatric and Adult Congenital Cardiac Surgeon post.

By unanimous resolution, the Committee was in favour of appointing Miss Louise Amelia Kenny.

Miss Kenny holds MBBS (University of Newcastle) 2007 and MRCS (UK) 2011. Miss Kenny is currently employed as a Fellow in Congenital Cardiac Surgery by the Queensland Childrens Hospital.

Miss Kenny is expected to take up the post of Consultant Paediatric and Adult Congenital Cardiac Surgeon in November 2021.

1.10 An Appointments Committee was held on 14 May 2021 and interviewed 3 candidates for 2 Consultant Haematologist posts.

By unanimous resolution, the Committee was in favour of appointing Dr Jennifer Young and Dr Thomas Creasey.

Dr Young holds MBChB (University of Leeds) 2008 and MRCP (UK) 2011. Dr Young is currently employed as a Locum Consultant Haematologist based at the Freeman Hospital.

Dr Creasey holds MBBS (University of Newcastle) 2008 and MRCP (UK) 2011. Dr Creasey is currently employed as a Locum Consultant Haematologist based at the Freeman Hospital.

Dr Young is expected to take up the post of Consultant Haematologist in June 2021.

Dr Creasey is expected to take up the post of Consultant Haematologist in June 2021.

2. RECOMMENDATION

1.1 – 1.10 – For the Board to receive the above report.

Report of Andy Welch
Medical Director
18 May 2021

Agenda item BRP A6(i)a

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 May 2021						
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	Putting patients at the heart of everything we do and 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	Detailed within the report.						
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 Khalil Ur Rahman Memon

Dr Memon, MBBS DOW Medical College 2000, PLAB Examination GMC 2005, MRCPsych 2017 is currently employed by Cumbria and Tyne and Wear NHS Foundation Trust as a Consultant Neuropsychiatrist.

An Honorary Contract has been requested to allow Dr Memon to carry out clinical service provision in the Huntingdon's Disease Clinics. The contract would commence as soon as possible and would be reviewed on an annual basis.

There are no financial implications for the Trust

1.2 Professor David Brooks

Professor Brooks, BA(Hons) Chemistry Oxford 1972, MBBS University College London 1979, MRCP (UK) 1982, MD London 1986, FRCP (UK) 1993, DSc (Medicine) London 1998 is currently employed by Newcastle University as a Professor of Clinical PET Research.

An Honorary Contract has been requested to allow Professor Brooks access within the Neurosciences and Neuroimaging Departments, where he will be based for the duration of his University contract

There are no financial implications for the Trust.

1.3 Dr Niraj Niranjan

Dr Niranjan, MBChB Edinburgh 2006, DTM&H Liverpool 2008, MRCP (UK) 2011, SCE Gastroenterology Specialty Certificate RCP/BSG 2014, CCT 2019, PhD Durham 2019, is currently employed by County Durham and Darlington NHS Foundation Trust as a Consultant Anaesthetist.

An Honorary Contract has been requested to take part in the regional critical care transfer service with NECTAR (adult). The contract would commence as soon as possible and would be reviewed on an annual.

Dr Niranjan may be required to carry out locum sessions on an ad hoc basis. There will be no further financial implications for the Trust

1.4 Dr Richard Holliday

Dr Holliday, MBBS London 1991, MRCPCH (UK) 1994, MD London 2001, is currently employed by Newcastle University as a Clinical Senior Lecturer/ Honorary Consultant in Restorative Dentistry

The contract will commence as soon as possible and will be reviewed on an annual basis.

1.5 Dr Samuel Christopher Stenton

Dr Stenton, BSc Hons (Physiology) QUB 1978, MB BCh BAO 1981, MRCP 1984, FRCP 1999, MFOM 1993, FFOM 2002 is currently employed by North Tees and Hartlepool NHS Foundation Trust as a Consultant Physician and Gastroenterologist.

An Honorary Contract has been requested for Dr Stenton, on his retirement, by Dr Chris Gibbins, Clinical Director Medicine. The Directorate wish to keep his expertise of Occupational Lung Disease accessible to the newer, less experienced colleagues who would then approach him for advice, he would not be in receipt of any payment but would need access to clinical notes when giving advice.

There are no financial implications for the Trust

2. RECOMMENDATIONS

The Board is asked to note:

1.1 Dr Memon be awarded an Honorary Contract as a Consultant Neuropsychiatrist with immediate effect and to be reviewed on an annual basis.
1.2 Professor Brooks be awarded an Honorary Contract as a Consultant Neurologist with immediate effect and to be reviewed on an annual basis.
1.3 Dr Niranjan be awarded an Honorary Contract as a Consultant Anaesthetist with immediate effect and to be reviewed on an annual basis.
1.4 Dr Holliday be awarded an Honorary Contract as a Consultant in Restorative Dentistry with immediate effect and to be reviewed on an annual basis.
1.5 Dr Stenton be awarded an Emeritus Contract with immediate effect.

Report of Andy Welch
Medical Director
19th May 2021

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 May 2021						
Title	Guardian of Safe Working Hours Annual Report						
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 a consolidated annual report on rota gaps, and the plan for improvement to reduce these gaps to be included in the Trust's Quality Account. This report addresses the requirement for the year April 2020 to March 2021.						
Recommendation	The Board of Directors is asked to note the content of this report for inclusion in the Trust's Quality Account.						
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	Annual Report of the Guardian of Safe Working Hours. This report was previously submitted to the People Committee in April.						

GUARDIAN OF SAFE WORKING ANNUAL REPORT

EXECUTIVE SUMMARY

The purpose of this annual report is to highlight the vacancies in junior doctor rotas and steps taken to resolve these during the year from April 2020 to March 2021.

The main areas of persistent or recurrent concern for vacancies are:

- Paediatric Intensive Care - due to difficulty in recruitment of suitable candidates;
- Accident and Emergency - due to large numbers of vacancies and difficulty in recruitment of suitable candidates; and
- Ophthalmology - due to the large number of locally employed doctors required, resulting in recurrent drives for recruitment.

The current issues, obstacles, and actions taken to resolve the issues for these and other areas with high vacancies are outlined below.

Where vacancies exist, the gaps in service coverage are mainly addressed by rewriting work schedules and the use of locums, mainly from the internal locum bank. In some areas we are seeing trainee shifts being covered by consultants when junior doctor locums are unavailable.

GUARDIAN OF SAFE WORKING ANNUAL REPORT

1. INTRODUCTION / BACKGROUND

The 2016 New Junior Doctor Contract came into effect on 3rd August 2016. The terms and conditions of service of the new junior doctor contract (2016) require a consolidated annual report on rota gaps, and the plan for improvement to reduce these gaps to be included in the Trust's Quality Account.

2. HIGH LEVEL DATA

Number of doctors / dentists in training on 2016 TCS:	897 (as at 3rd March 2021)
Number of Locally Employed Doctors on 2002 TCS:	218 (as at 3rd March 2021)
Total number of junior doctors / dentists:	1015 (as at 3rd March 2021)

3. ANNUAL VACANCIES DATA SUMMARY BY SPECIALTY AND GRADE PER QUARTER

During quarter 1 (Q1), there was mass redeployment of junior doctors in response to the commencement of the Covid-19 pandemic. Rota gap information has therefore been omitted for this period due to the focus at that time being on the Trust pandemic response. A full monthly breakdown of gaps in all specialties has been circulated separately.

Site	Specialty/Sub Specialty	Grade	Number required on rota (at full complement)	Q1	Q2	Q3	Q4
	Cancer Services						
FH	Oncology	ST3+	14	n/a	1.06	0.2	0.5
FH	Palliative Medicine	F2/ST1+	13	n/a	2.73	2.8	2.4
FH	Haematology / Oncology	F2/ST1/ST2	10	n/a	0.33	0.33	1.66
FH	Haematology	ST3+	11	n/a	1.2	1.6	1.33
	Cardiothoracic Services						
FH	Cardiology	F2/ST1-2	4	n/a	1.06	1	1
FH	Cardiology	ST3+	15	n/a	1	0	0
FH	Cardiothoracic Anaesthesia	ST3+	9	n/a	2.33	2.33	2
FH	Cardiothoracic Surgery	F2/ST1-2	2	n/a	0.66	0	0
FH	Cardiothoracic Surgery	ST3+	11	n/a	1	0	2
FH	Cardiothoracic Transplant	ST3+	3	n/a	1	1	1

Site	Specialty/Sub Specialty	Grade	Number required on rota (at full complement)	Q1	Q2	Q3	Q4
FH	Paediatric Intensive Care Unit (PICU)	ST3+	3	n/a	0.26	0	1.5
FH	Paediatric Cardiology 1st	F2/ST1/ST2	7	n/a	0.4	0.4	1.06
FH	Paediatric Cardiology 2nd	ST3+	13	n/a	4.8	4.2	2.2
FH	Respiratory Medicine	CMT/ST1-2	4	n/a	0.66	0.4	0
FH	Respiratory Medicine	ST3+	11 (rotate with RVI)	n/a	2.66	1	0
	Children's Services						
RVI	Paediatric Surgery 2nd	ST3+	9 (8 from November 2020)	n/a	0.66	0.33	0.46
RVI	Paediatrics 1st - ST1/ST2 (now includes Paediatric Surgery)	F2/ST1/ST2	26	n/a	2	1.26	0.53
RVI	General Paediatrics	ST3+	20	n/a	2.33	1.66	3.8
RVI	Paediatric Oncology	ST3+	6	n/a	0.33	0	0.33
RVI	PICU	ST3+	9	n/a	2.13	1.26	1.4
	Dental						
RVI	Oral Maxillofacial Surgery	ST3+	2	n/a	0.66	1	0.33
	EPOD						
FH	Ear, Nose & Throat (ENT)	F2 / CST / ST1-2	6	n/a	0.13	0	2
FH	ENT	ST3+	9	n/a	1	1	0.33
RVI	Plastic Surgery	F2/ST1/ST2	10	n/a	0.39	0.39	1.05
RVI	Plastic Surgery	ST3+	12	n/a	0.33	0	2.06
RVI	Ophthalmology	F2/ST1/ST2	5	n/a	0.13	0	0
RVI	Ophthalmology	ST3+	23	n/a	2.64	6.66	3.66
RVI	Dermatology	F2	1	n/a	0.13	0.13	0
RVI	Dermatology	ST3+	9	n/a	2.26	1.4	1.2
RVI	Dermatology	CMT	1	n/a	0	0.06	0.2
	Integrated Lab Medicine						
RVI	Histopathology	ST3+	12	n/a	2.06	2	2.33
RVI	Histopathology	ST1/2	8	n/a	3.4	3	2.33
C4L	Genetics	ST3+	4	n/a	1.43	1.7	1.7
RVI	Medical Microbiology rota integrated with Infectious Diseases, Medical Virology and General Internal Medicine	ST3+	15	n/a	2	1.4	3.2
	Medicine						
FH	General Internal Medicine	F2/GPVTS/CMT/TF	20	n/a	1	0	2.13
RVI	Acute Medicine	Trust Doctors	9	n/a	0	4	5.66
RVI	Core Medical Training Back of House and Front of House Combined (August 2019)	CMT	10	n/a	0.66	0	0.33
RVI	General Internal Medicine	ST3+	23	n/a	3.8	2.6	3.66
FH	Gastroenterology	ST3+	7	n/a	2.8	0	0
FH	Care of the Elderly	ST3+	5	n/a	1.4	0	1.73
RVI	Accident & Emergency 1st	F2	7	n/a	0	0	0
RVI	Accident & Emergency 1st	ACCS/ST1-2/CT1-2	21	n/a	0.4	1.4	2.46

Site	Specialty/Sub Specialty	Grade	Number required on rota (at full complement)	Q1	Q2	Q3	Q4
RVI	Accident & Emergency 2nd	ST3+	15 (14 from Nov 20)	n/a	2.66	2.33	4
	Musculoskeletal						
FH	Rheumatology	ST3+	5	n/a	0.33	0	0.26
FH	Rheumatology	CMT1-2	4	n/a	0	0.06	0.2
FH	Orthopaedics	F2/ST1/ST2	6	n/a	1	1.33	2
RVI	Orthopaedics	F2/ST1/ST2	5	n/a	0.33	0	0
RVI/FRH	Orthopaedics	ST3+	19	n/a	1	3	0
RVI	Spinal Surgery	ST3+	2	n/a	0.33	1	0
	Neurosciences						
RVI	Neurosurgery	F2/ST1/ST2	7	n/a	2	2	1
RVI	Neurosurgery	ST3+	14	n/a	2	2	1
RVI	Neurology	ST3+	13	n/a	1.1	1.2	0.53
RVI	Neurology	IMT/CMT	3	n/a	0	0	0.66
RVI	Neurophysiology	All grades	2	n/a	1.4	1.4	1.4
	Peri-operative FH						
FH	Critical Care	F2 ST1-7	11	n/a	1.8	0.13	1.66
FH	Anaesthetics General	ST1-7 CT1-2	30	n/a	0.46	1.4	1.4
	Peri-operative RVI						
RVI	Critical Care	ST3+	19	n/a	0.2	1	3
RVI	Anaesthetics	ST1-2 / ST3 +	44	n/a	2.06	2.93	1.06
	Radiology						
RVI / FH	Radiology On Call	ST2 / ST3+	33	n/a	1.2	0.66	0.4
RVI / FH	Neuroradiology	All grades	3	n/a	0	0	0.33
	Surgical Services						
FH	Vascular	ST3+	10.5	n/a	3.08	0.59	1
FH	Hpb / Transplant	ST3+	11	n/a	1	2	3
RVI	General Surgery	F2/ST1/ST2	8	n/a	0.66	0.66	0
RVI	General Surgery	ST3+	13	n/a	0.43	0.6	0.86
FH	Institute of Transplantation – Newcastle Surgical Rotation & Teaching Fellows	ST1-2 NSR TFs	4	n/a	0	1	1
	Urology & Renal						
FH	Renal Medicine	F2/ST1/ST2	6	n/a	1.06	0.4	0
FH	Renal Medicine	ST3+	9	n/a	0.33	0.2	0.53
FH	Urology	F2/ST1/ST2	8	n/a	0	0.4	0
FH	Urology	ST3+	11	n/a	0.66	0.33	1.73
	Women's Services						
RVI	Obstetrics & Gynaecology	F2/ST1/ST2	14	n/a	1	0.6	1.53
RVI	Obstetrics & Gynaecology	ST3+	22	n/a	3	2.2	2.53
RVI	Neonates	F2/ST1/ST2	7	n/a	0.93	0	0.33
RVI	Neonates	ST3+	13	n/a	0.4	1	1
	Foundation Year 1						
FH	Cardiology	F1	1 (post removed, replaced with Trust Doctor)	n/a	1	n/a	0

Site	Specialty/Sub Specialty	Grade	Number required on rota (at full complement)	Q1	Q2	Q3	Q4
FH	General Internal Medicine - BOH	F1	8	n/a	0	0	1

4. ISSUES ARISING

The purpose of this report is to highlight any current issues or concerns, including the reasons for the gaps, obstacles in resolving this and actions taken to resolve the issues. Travel restrictions due to the Covid-19 pandemic has resulted in difficulties in recruitment of overseas doctors. This has impacted more on specialties which rely on overseas doctors to fill vacancies.

LED = Locally Employed Doctor
LET = Lead Employer Trust
ACCP = Advanced Critical Care Practitioner

Site	Specialty/Sub Specialty	Reason for Gap	Obstacles to Recruitment	Actions taken to overcome obstacles
	Cancer Services			
FH	Palliative Medicine	Unknown		Accommodating workload within current workforce.
FH	Haematology/ Oncology	LET gap	Funding to be clarified.	Teaching fellow appointed.
	Cardiothoracic Services			
FH	Cardiothoracic Anaesthesia	LEDs leaving	Difficulty in recruitment of suitable candidate. Issues with overseas recruitment due to ongoing pandemic.	Accommodating workload within current workforce.
FH	PICU	LEDs leaving	Difficulty in recruitment of suitable candidates.	Consultants covering absence. ACCPs recruited and currently in training.
FH	Cardiothoracic surgery/ transplant	LEDs leaving		LED appointed, awaiting pre-employment checks. Advert for 2nd.
FH	Paediatric Cardiology	LEDs leaving	Difficulty in recruitment of suitable candidates.	1 LED under pre-employment checks, Consultants covering absence. ACCPs recruited and in training.
	Childrens Services			
RVI	General Paediatrics	Unknown		Accommodating workload within current workforce.

Site	Specialty/Sub Specialty	Reason for Gap	Obstacles to Recruitment	Actions taken to overcome obstacles
RVI	PICU	LET gaps	Problems recruiting suitable candidates.	LED appointed, consultants covering workload, ACCPs appointed – in training.
	Plastic Surgery & Ophthalmology			
RVI	Ophthalmology	LEDs leaving (contract expired) /Natural turnover	High numbers required.	LED posts advertised.
FH	ENT	Unknown		Accommodating workload within current workforce.
RVI	Plastic Surgery	LET gap		Fellow appointed.
	Laboratory Medicine			
RVI	Histopathology	Unknown		Accommodating workload within current workforce.
RVI	Medical Microbiology	Unknown		Accommodating workload within current workforce.
	General Internal Medicine			
RVI /FH	General Internal Medicine/Care of the Elderly	LEDs leaving, LET gaps, GP training gaps. Extra LEDs advertised to accommodate COVID.	Full 'Covid' cohort not recruited.	Teaching fellows, working with available workforce to cover workload.
	Accident & Emergency			
RVI	Accident & Emergency	Longstanding gaps	Difficulty in recruitment.	Further Trust Grade and fellow posts advertised. Specialty fellow roles developed to try to make the posts more attractive.
	Musculoskeletal			
FH	Orthopaedics	GP F2 posts removed	LEDs recruited, but withdrew.	LEDs advertised.
	Neurosciences			
RVI	Neurosurgery	Additional post approved	LEDs recruited, but withdrew.	Fellow posts and Trust Grade posts are currently advertised.
	Perioperative			

Site	Specialty/Sub Specialty	Reason for Gap	Obstacles to Recruitment	Actions taken to overcome obstacles
RVI	Critical Care	LET gaps and LEDs leaving (contracts expired). Extra LEDs advertised to accommodate COVID.	Full 'Covid' cohort not recruited.	LEDs recruited. Accommodating workload within current workforce.
	General Surgery			
FH	Hpb	LEDs leaving NSR rotation early		Recruitment in progress for LED post.

4.1 Actions taken to resolve these issues

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, as well as finance and medical staffing representatives.

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. The teaching fellow programme is popular with junior doctors, with large numbers of applicants.

Other actions to resolve the issues are rewriting work schedules to reflect the number of available doctors, and using locums.

Paediatric Intensive Care has appointed four advanced critical care practitioners to try to overcome the persistent issue of rota gaps within the specialty. These practitioners are currently in training.

4.2 Locum Spend 01.04.20 – 28.02.21

Lead Employer Trust: £844,508
NUTH: 1,422,739
Total: £2,267,247

5. SUMMARY

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.

Overseas recruitment often results in a delay between recruitment and appointment due to visa issues. Currently this is being compounded by travel bans and movement restrictions as a consequence of the Covid-19 pandemic.

The Trust takes a proactive approach to minimising the impact of rota gaps by active recruitment, with a clear focus on staff retention to attract the best candidates, use of advanced nurse practitioners, and by rewriting work schedules to ensure that key areas are covered.

Locum use is high in many areas, and many directorates reported consultants covering junior doctor shifts. The use of internal locums has an impact both on training and workload of junior doctors. The use of consultants to cover these shifts will also impact on the workload of the consultants.

6. RECOMMENDATIONS

The Board of Directors are asked to (i) note the content of this report for inclusion in the Trust's Annual Quality Account and (ii) continue to encourage pro-active recruitment of doctors to mitigate rota gaps.

Report of Henrietta Dawson
Consultant Anaesthetist
Trust Guardian of Safe Working Hours

23 March 2021

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 May 2021						
Title	Guardian of Safe Working Quarterly Report (Q4 2020/21)						
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 December 2020 to 26th March 2021 for consideration by the Trust People Committee, prior to submission to the Trust Board.						
Recommendation	The Trust Board 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, presented to the People Committee in April 2021.						

GUARDIAN OF SAFE WORKING QUARTERLY REPORT

EXECUTIVE SUMMARY

This quarterly report covers the period 27 December 2020 to 26 March 2021.

There are now 897 trainees on the New Junior Doctor Contract and a total of 1,015 junior doctors in the Trust.

There were 61 exception reports in this period. This compares to 85 exception reports in the previous quarter.

The main areas of exception reports are general medicine, haematology/oncology and general surgery.

The main cause of exception reports is when there is excessive workload which was not appropriate to hand over to on call teams. The workforce workload imbalance has been exacerbated by short term absence due to sickness and isolation due to the impact of the Covid-19 pandemic.

GUARDIAN OF SAFE WORKING QUARTERLY REPORT

1. INTRODUCTION / BACKGROUND

The 2016 New Junior Doctor Contract came into effect on 3rd August 2016 and was reviewed in August 2019, with changes implemented in a staggered approach from August 2019 to October 2020.

The TCS of the 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.

2. HIGH LEVEL DATA

		(Previous quarter data for comparison)
Number of Junior Doctors on New Contract	897	(872)
Number of Exception reports	61	(85)
Number of Exception reports for Hours Breaches	55	(83)
Number of Exception reports for Educational Breaches	8	(13)
Fines	2	(0)
Admin Support for Role	Good	
Job Planned time for supervisors	Variable	

3. EXCEPTION REPORTS

3.1 Exception Report by Speciality (Top 3)

General Medicine	28
Haematology Oncology	13
General Surgery	13

3.2 Exception Report by Rota (Top 5)

General Medicine RVI F1	15
Haematology/Oncology F2/ST12	13
General Surgery RVI F1	9
General Medicine FH F1	8
General Surgery FH F1	4

Ophthalmology SpR	4

3.3 Exception Report by Grade

Foundation Year 1	45
F2	17
SHO	5
SpR	5

3.4 Example Themes from Exception Reports

General Medicine RVI/FH

"High volume of workload throughout the day. Unable to take entitled breaks. Unwell patients requiring urgent care. Delayed handover & retrospective documentation. It would not have been safe nor feasible to handover and leave on time."

Haematology/Oncology

Trainees stayed late as minimum staffing due to sickness and short term rota gaps resulted in high workloads that could not be completed in scheduled hours. This is exacerbated by changes in training which require doctors to have scheduled time for personal development away from clinical care. This has been looked into and arrangements made where possible to cover gaps with locum doctors.

General Surgery RVI F1

"Workload greater than time allows so had to stay late."
This is a busy job with large numbers of complex patients. Any increase in workload can require doctors to stay late.

4. EXCEPTION REPORT OUTCOMES

4.1 Work Schedule Reviews

There have been no work schedule reviews carried out due to exception reports.

4.2 Fines

2 fines have been issued:

1. General Surgery F1 Freeman: £101.22. Breach of maximum 13 hour shift length.
2. General Surgery F1 RVI: £92.59. Breach of maximum 13 hour shift length.

5. ISSUES ARISING

5.1 Workforce and workload

The recurring theme as to when exception reports are raised is when there is a reduction of trainee numbers on the ward or high workloads due to multiple unwell patients. Some wards, particularly the medical wards have experienced very high workloads.

The recent surge in Coronavirus cases has resulted in some redeployment of junior doctors (14 in total) to medical wards. This was done with local agreement from the trainees and Health Education North East (HENE). Work schedules were altered to reflect the trainee's working pattern and to ensure no breaches to the TCS.

5.2 Supervisor Engagement

Supervisor engagement is variable, with some supervisors requiring multiple prompts to complete exception reports. There is some improvement as supervisors become more familiar with the process. Weekly prompting by the medical staffing team has also improved this.

5.3 Administrative Support

Administrative support is currently excellent.

6. ROTA GAPS

This is covered in the Annual Guardian of Safe Working Hours report.

6.1 Locum Spend

The total amount of internal locum spend was £853,369.14. This compares to a locum spend of £603,447 in the previous quarter. Early closedown of payroll in December resulted in last quarter's being understated. This, combined with processing of all outstanding claims prior to year-end has resulted in overstatement of this quarter's locum spend.

7. REVISION TO 2016 JUNIOR DOCTOR CONTRACT

It is a recommendation of the contract that no rotas have a frequency of more than 1 in 3 weekends. There remain 5 rotas where the weekend frequency exceeds 1 in 3, but plans are in place to rectify this.

8. RISKS AND MITIGATION

The main risk remains medical workforce coverage across a number of rotas. This was exacerbated due to the Coronavirus pandemic. Proactive recruitment of Locally Employed Doctors to areas of high clinical need has partly mitigated the impact of this in these areas.

Solutions will also need to be enacted for rotas where weekend frequency exceeds 1 in 3.

9. JUNIOR DOCTOR FORUM

The main issues discussed were access for junior doctors to changing facilities, lockers and hot food out of hours.

10. 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
1st April 2021

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The purpose of this survey is to gather information on how much of current standard practice aligns with the interventions that make up the Saving Babies' Lives Care Bundle v2. Each intervention is made up of improvement activities. Improvement activities are the actions that make up the elements of the care bundle.

Collecting this survey allows monitoring of progress towards full implementation of the Care Bundle elements as standard practice and more importantly the identification of areas most in need of additional support with implementation. Please base your responses on your assessment of how much of your current activities match the requirements of the care bundle.

PLEASE CLICK THE ARROW TO USE THE DROP DOWN MENU TO SELECT YOUR ANSWERS.

IF THE CELL IS HIGHLIGHTED IN RED IT MEANS THE CELL IS LOCKED. PLEASE CHANGE YOUR ANSWERS TO THE QUESTIONS ASKING IF ANYTHING HAS CHANGED SINCE LAST SURVEY OR IF YOU HAVE MET ALL REQUIREMENTS OF THE ELEMENT AND THE CELLS SHOULD UNLOCK.

Survey Number	4th
Survey Date	Jan-21
Reducing Stillbirths Care Bundle Elements	
Element 1: Reducing smoking in pregnancy by carrying out a Carbon Monoxide (CO) test at booking to identify smokers (or those exposed to tobacco smoke) and referring to stop smoking service/specialist as appropriate	
Have any of your responses to the below questions 1aii. to 1f. changed since the last survey? *If "yes", answer question 1ai and make your changes below. If "no" answer question 1ai and then go to Element 2.*	No
1ai. Are you meeting all requirements of the modified version Element 1 of the care bundle, which was changed due to the COVID-19 pandemic? *Irrespective of your answer please ensure section 1 is completed on the basis of your Standard Operating Procedure once recovery from COVID has been instigated.*	Yes
1aii Once CO testing is re-introduced, will your trust meet all the requirements of Element 1 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	**Yes**
1b. Are you carrying out any improvement activity designed to reduce smoking in pregnancy? *If "yes", please go to question 1c, If "no", please go to question 1f.*	**Yes**
1c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. CO monitoring at booking and additional CO testing throughout pregnancy including the 36 week antenatal appointment, with the outcome recorded?	**Yes**
ii. Referring expectant mothers, with elevated CO levels (4ppm or above), to a trained stop smoking specialist, based on an opt out system with a pathway that includes feedback and follow up processes?	**Yes**
1d. Do the improvement activities include training all maternity staff on the use of the CO monitor and having a brief and meaningful conversation with women about smoking?	**Yes**
1e. Have all recorded outcomes of CO testing in pregnancy relating to element 1 activities been recorded on your MIS enabling their submission in MSDS v2.0 monthly submissions?	Yes
1f. If you answered "no" to question 1b, are you planning on introducing this type of intervention / improvement activity?	**Not Applicable**
Please use the free text box below to detail any barriers your maternity service is experiencing in implementing element 1 of SBLCBv2 or submitting the required data to MSDSv2; and to provide details of any learning developed as a result of the implementation.	
Element 2: Identification and surveillance of pregnancies with fetal growth restriction	
Have any of your responses to questions 2aii to 2j below changed since the last survey? *If "yes", answer question 2ai and make your changes below. If "no" answer question 2ai and then go to Element 3.*	Yes
2ai. Are you meeting all requirements of the modified version Element 2 of the care bundle, which was changed due to the COVID-19 pandemic? NB The modified version of element 2 should only be implemented in the case of significant COVID-19 related staff shortages. *Irrespective of your answer please ensure section 2 is completed on the basis of your Standard Operating Procedure i.e. once recovery from COVID has been instigated.*	Yes
2aii. In the case of you having no significant COVID related staff shortages, do you meet all requirements of Element 2 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	Yes
2b. Are you carrying out any improvement activity designed to risk assess and manage babies at risk of Fetal Growth Restriction (FGR)? *If "yes", go to question 2c. If "no", please go to question 2j.*	Yes
2c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Assessing women at booking to determine if a prescription of aspirin is appropriate using the algorithm given in Appendix C of the care bundle or an alternative which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network?	Yes
ii. Risk assessment and surveillance of women at increased risk of FGR, with triage of women at increased risk of FGR into an appropriate clinical pathway?	Yes
iii. Risk assessment and management of growth disorders in multiple pregnancy in compliance with NICE guidance or a variant agreed locally following advice from the provider's Clinical Network?	Yes
2d. Regarding women not undergoing serial ultrasound scan surveillance of fetal growth does your standard operating procedure (e.g. guidelines) include assessment performed using antenatal symphysis fundal height (SFH) charts by clinicians trained in their use?	Yes
2e. Does your standard operating procedure (guidelines) include differentiation between the management of the SGA and growth restricted fetus in accordance with the pathways and guidance outlined in version 2 of the Saving Babies Lives Care Bundle?	Yes
2f. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Following recommended guidance on the frequency of ultrasound review of estimated fetal weight (EFW) when SGA is detected, in accordance with appendix D of SBLCBv2 or a variant agreed locally following advice from the provider's Clinical Network?,	Yes
ii. Maternity care providers caring for women with FGR identified prior to 34+0 weeks having an agreed pathway for management which includes network fetal medicine input (for example, through referral or case discussion by phone)?	Yes
2g. Accepting the proviso that all management decisions should be agreed with the mother in the cases of fetuses <3rd centile and with no other concerning features does your standard operating procedure (e.g. guidelines) include the following principles: • Initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation. • Delivery <37+0 weeks can be considered if there are additional concerning features, but these risks must be balanced against the increased risk to the baby of birth at earlier gestations.	Yes
2h. Does your standard operating procedure (e.g. guidelines) include individualised care of fetuses between 3rd – 10th centile using a risk assessment including Doppler investigations, assessment for the presence of any other high risk features such as recurrent reduced fetal movements, and the mother's wishes ; and in the absence of any high risk features the offer of delivery or the initiation of induction of labour at 39+0 weeks?	Yes
2i. Have all findings of small for gestational age fetuses been recorded on your MIS enabling their submission in MSDS v2.0 monthly submissions?	Yes
2j. If you answered "no" to 2b, are you planning on introducing this type of intervention / improvement activity?	Not Applicable
Please use the free text box below to detail any barriers your maternity service is experiencing in implementing element 2 of SBLCBv2 or submitting the required data to MSDSv2; and to provide details of any learning developed as a result of the implementation.	
Element 3: Raising awareness amongst pregnant women of the importance of detecting and reporting reduced fetal movement (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM	
Have any of your responses to the below questions in Element 3 changed since the last survey? *If "yes", make your changes below. If "no", go to Element 4.*	No
3a. Are you meeting all requirements of Element 3 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	**Yes**
3b. Are you carrying out any improvement activity designed to raise awareness among pregnant women of the importance of Reduced Fetal Movement (RFM)? *If "yes", please go to question 3c. If "no", please go to question 3h.*	**Yes**
3c. Do the improvement activities include providing pregnant mothers with information and an advice leaflet on reduced fetal movement based on current evidence, best practice and clinical guidelines,?	**Yes**
3d. Do the improvement activities include giving pregnant mothers this information by 28 weeks of pregnancy at the latest?	**Yes**
3e. Do the improvement activities include discussing RFM with pregnant mothers at every subsequent contact?	**Yes**
3f. Do the improvement activities include making use of an approved checklist to manage the care of pregnant woman who report reduced fetal movement, in line with national evidence-based guidance?	**Yes**
3g. Have all findings of reduced fetal movement been recorded on your MIS enabling their submission as Coded Clinical Entry in MSDS v2.0 monthly submissions?	No
3h. If you answered "no" to 3b, are you planning on introducing this type of intervention / improvement activity?	**Not Applicable**

Please use the free text box below to detail any barriers your maternity service is experiencing in implementing element 3 of SBLCBv2; and to provide details of any learning developed as a result of the implementation.	

Element 4: Effective fetal monitoring during labour	
Have any of your responses to the below questions in Element 4 changed since the last survey? **If "yes", make your changes below. If "no", go to Element 5.**	No
4a. Are you meeting all requirements of Element 4 of the care bundle? ***If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below. Please take extra care to ensure your percentage of trained staff in question 4d is up to date.***	**No**
4b. Are you carrying out any improvement activities designed around effective fetal monitoring during labour? ***If "yes", go to question 4c. If "no", please go to question 4h.***	**Yes**
4c. Do your improvement activities include annual multidisciplinary training and competency assessment on cardiotocograph (CTG) interpretation and use of auscultation for staff who care for women in labour? ***If "yes", go to question 4d. If "no", please go to question 4e.***	**Yes**
4d. What is the percentage of staff who care for women in labour that have undertaken this training in the last 12 months?	Yes 60% to 69%
4e. Do you have a system that, irrespective of place of birth, assesses risk at the onset of labour to determine the most appropriate fetal monitoring method, as described in SBLCBv2?	**Yes**
4f. Do your improvement activities include a review at least every hour of fetal well-being incorporating the following:	
i. CTG or Intermittent Auscultation;	**Yes**
ii. reassessment of fetal risk factors	**Yes**
iii. a fresh eyes/buddy system	**Yes**
iv. clear guideline for escalation if concerns are raised through the use of a structured process?	**Yes**
4g. Do your improvement activities include identifying a Fetal Monitoring Lead for a minimum of 0.4WTE per consultant led unit during which time it is their responsibility to improve the standard of intrapartum risk assessment and fetal monitoring?	**Yes**
4h. If you answered "no" to 4b, are you planning on introducing this type of intervention / improvement activity?	**Not Applicable**

Please use the free text box below to detail any barriers your maternity service is experiencing in implementing element 4 of SBLCBv2; and to provide details of any learning developed as a result of the implementation.

Element 5: Reducing preterm births	
Have any of your responses to questions 5aii to 5g changed since the last survey? ***If "yes", answer question 5ai and make your changes below. If "no" answer question 5ai and then complete the final section.***	Yes
5ai. If you are using the modified version of element 5 of the care bundle, are you meeting all of the requirements? ***Irrespective of your answer please complete the rest of section 5 on the basis of your SOP once recovery from COVID has been instigated.***	Yes
5aii. Are you meeting all requirements of Element 5 of the care bundle? ***If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.***	Yes
5b. Are you carrying out any improvement activity designed around reducing the number of preterm births and optimising care when preterm delivery cannot be prevented? ***If "yes", go to question 5c. If "no", please go to question 5g.***	Yes
5c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Assessing all women at booking for the risk of preterm birth and stratifying to low, intermediate and high-risk pathways as per the criteria in Appendix F of the SBLCB v2 of the care bundle document; or an alternative which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network?	Yes
ii. Assessing women with a history of preterm birth to determine whether this was associated with placental disease and a discussion about prescribing aspirin with the woman based upon her personalised risk assessment?	Yes
iii. All women being offered testing for asymptomatic bacteriuria by sending off a midstream urine (MSU) for culture and sensitivity at booking, and a repeat MSU to confirm clearance following any positive culture?	Yes
iv. Having access to transvaginal cervix scanning (TVCS) and a clinician with an interest in preterm birth prevention with a clinical pathway for women at risk of preterm birth that is agreed with local commissioners (CCGs) following advice from the provider's clinical network (for example, UK Preterm Clinical Network guidance or NICE guidance)?	Yes
5d. Does your standard operating procedure (e.g. guidelines) include risk assessment and management in multiple pregnancy compliant with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network?	Yes
5e. Does your standard operating procedure (e.g. guidelines) include the following:	
i. every provider having referral pathways to tertiary prevention clinics for the management of women with complex obstetric and medical histories including access to clinicians who have the expertise to provide high vaginal (Shirodkar) and transabdominal cerclage?	Yes
ii. women at imminent risk of preterm birth being offered transfer to a unit with appropriate and available neonatal cot facilities when safe to do so and as agreed by the relevant neonatal Operational Delivery Network (ODN)?	Yes
iii. offering Antenatal corticosteroids to women between 24+0 and 33+6 weeks, optimally at 48 hours before a planned birth?	Yes
iv. offering Magnesium Sulphate to women between 24+0 and 29+6 weeks of pregnancy; and considering offering Magnesium Sulphate for women between 30+0 and 33+6 weeks of pregnancy, who are in established labour or are having a planned preterm birth within 24 hours?	Yes
v. ensuring the neonatal team are involved when a preterm birth is anticipated, so that they have time to discuss options with parents prior to birth and to be present at the delivery?	Yes
vi. holding a multidisciplinary discussion before birth between the neonatologist, obstetrician and the parents about the decision to resuscitate the baby for women between 23 and 24 weeks of gestation?	Yes
5f. Have all instances of maternal antenatal administration of corticosteroids for fetal lung maturation been recorded on your MIS enabling its submission as in MSDS v2.0 monthly submissions?	No
5g. If you answered "no" to 5b, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

Please use the free text box below to detail any barriers your maternity service is experiencing in implementing element 5 of SBLCBv2 or submitting the required data to MSDSv2; and to provide details of any learning developed as a result of the implementation.
5f. For all deliveries the question regarding corticosteroids is asked however as we do not have a complete electronic patient record we are also doing an mannual audit to ensure accuracy of the data.

The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

QUALITY ACCOUNT 2020/21

Unconditionally registered with the
CQC since April 2010

CONTENTS

PART 1

CHIEF EXECUTIVE'S STATEMENT

Thank you for reading our Quality Account for 2020/21, which demonstrates how we have continued to deliver high quality, effective care for patients and sets out our key quality and patient safety priorities for 2021/22.

2020/21 has been a challenging year for our Trust and for the NHS. Thanks to the hard work, skill and expertise of our staff, we have been able to continue to provide the highest quality care for patients from Newcastle, across the region and across the UK.

Throughout the pandemic, staff have adapted and fundamentally changed the way we deliver almost all of our services; several examples of this can be seen in this document. Many staff have been retrained or redeployed and our teams have undertaken a comprehensive range of actions that have supported our patients: the introduction of virtual/telephone clinics; centralised surgical hubs; centralised triage and prioritisation based on clinical need; moving towards 7 day chemotherapy services; improvements in referral; and initial diagnostic testing to name but a few. This level and speed of innovation would have been almost impossible before the pandemic, but our teams have risen to the challenge magnificently.

Despite the pandemic, there has also been an enormous amount of work going on over the last year to ensure our services maintain their excellence:

- Our brain tumour centre became a national 'Tessa Jowell Centre of Excellence'. This newly introduced status, awarded by the Tessa Jowell Brain Cancer Mission, follows rigorous expert-led assessments, and recognises the outstanding care and treatment staff at the Trust provide for patients with brain cancer.

- Our cancer services here in Newcastle have a fantastic reputation, which is very much down to our talented teams and state-of-the-art technology we have invested in here in the North East.

- Our theatre teams were recognised for their innovative approach to promoting patient safety and preventing 'never events' through education, training and improved communication by Safer Surgery UK.

- The Trust has achieved Maintaining Excellence in the Better Health at Work Awards - highlighting our determination to keep the delivery of staff health and wellbeing activity going throughout the pandemic.

Also this year, I was delighted to welcome the team at our COVID-19 Lighthouse Lab, based at Baltic Park, Gateshead to the Newcastle Hospitals family. This new facility, part of the national NHS Test and Trace Programme and the Integrated COVID Hub North East, is a valuable resource for our region, supporting the fight against the pandemic.

We have also hosted the North East and North Cumbria COVID-19 Vaccination Programme. We now lead and coordinate the delivery of the vaccine in around 110 sites across the region, in partnership with primary care, NHS trusts and Clinical Commissioning Groups, local authorities, community pharmacies and through directly managed large vaccination centres. The Trust manages the vaccination centres across

the area and has administered over 120 thousand first doses in line with the Joint Committee on Vaccination and Immunisation priority groups, and our programme is expanding to provide additional sites and capacity across our population.

The success of the North East and North Cumbria COVID-19 Vaccine Programme is directly attributed to the hard work of all our staff, partners and, of course, our volunteers who are such an essential part of the team. We are thankful and extend our deepest thanks and appreciation to all of those involved and for the positive impacts they are having for patients and the wider region.

Our excellence has been recognised with the publication of the annual Newsweek ranking of the "The World's Best Hospitals 2021". The RVI ranked at number 56 in the world (3rd in the UK) and the Freeman Hospital was placed in the top 200 in the world (6th in the UK).

During the pandemic our city partnerships have grown stronger. In particular 'Collaborative Newcastle' has really thrived. Our partnership working between the Trust and Newcastle City Council has had a positive impact in supporting the social care sector, and some of our most vulnerable residents in the city. Our relationships with mental health provider Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, primary care networks and our commissioners has accelerated. This partnership will be instrumental in tackling the health inequalities, which have significantly worsened in the North East due to COVID-19.

What is clear is that Newcastle Hospitals will continue to provide excellent services which save and improve lives and which increasingly tackle health inequalities. I would like to commend all of our staff for their diverse skill, loyalty and commitment; I am proud of each and every member of staff and volunteer in the team.

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

Dame Jackie Daniel
Chief Executive
19th April 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 (3Rs)

The COVID-19 pandemic is the biggest healthcare challenge this country has faced since World War 2. Since the first lockdown began in March 2020, the UK has seen further local and national lockdowns.

Over the last year, COVID-19 has had a huge impact upon the Trust:

- During the first wave of COVID the NHS across Newcastle managed patient flow differently. All urgent and cancer referrals continued to be referred to the Trust but, in order to reduce patient flow and free up staff to manage the increase demand on services placed on them by the pandemic, patients assessed as a lower priority, and where it was safe to do so, continued to be managed in primary care by the GPs.
- There have been periods where lower priority elective work was suspended;
- The Trust has supported NHS partners both nationally and locally in the management of demand for services and care, particularly in critical care provision;
- Overall capacity has reduced as the Trust has been mindful of government advice around social distancing, enhanced testing, cleaning and use of PPE as appropriate;
- Levels of activity fell to 20-30% of the pre-COVID-19 activity levels. This has led to growing waiting lists and a significant number of patients waiting long periods for treatment.

It is worth noting that during the active phases of the COVID-19 pandemic, and unlike many other Trusts, Newcastle Hospitals was 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 expanding the capacity of other services such as Diagnostic COVID-19 testing and our COVID-19 vaccination programme.

At the end of April 2020, as wave 1 COVID-19 activity declined, the 3 stage Restart, Reset and Recovery programme (3Rs programme) for clinical and enabling services at Newcastle Hospitals was established.

1.1 The Restart, Reset and Recovery Programme

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.

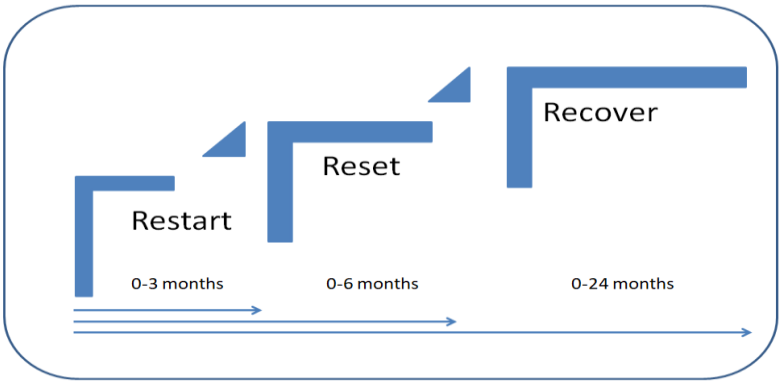


Figure 1. The 3 Rs programme

1.2 Progress with 3Rs to date

A robust process to ensure the restart of all services was undertaken based on a balance of clinical priority, clinical risk and ease of setting up (e.g. no interdependencies). The focus and priority was on safety for both patients and staff.

However, COVID-19 has had a huge impact on the backlog of work the Trust has. Those waiting over 52 weeks for treatment is increasing and in line with government guidance, the focus of Newcastle Hospitals is now firmly on the recovery element of the 3R programme.

In order to maintain the outstanding quality we have always achieved, various innovations and transformation projects have been implemented:

Pathway Improvements

Cataract Theatres
Following investment from the Commissioners and a growing waiting list for cataract surgery, an innovative development to give Ophthalmology the opportunity to improve the patient pathway and provide an off-site theatre suite. The three theatres went live at the Centre for Aging and Vitality on 6th April 2021 with great success. The project took 6 months to operationalise and it is planned that 250 patients will go through the centre per week which is an average increase of 50 patients than in the traditional hospital based theatres. The clinical teams are really excited to work together to reduce the waiting list and improve the patient experience.

FIT testing
Traditionally patients with suspected colorectal cancer were referred directly to the Trust and were offered a colonoscopy. However, the COVID-19 pandemic expedited an improvement initiative to prevent unnecessary colonoscopies. Patients are now offered a faecal immunochemical test (FIT) prior to being referred for a colonoscopy. FIT is a stool test designed to identify possible signs of bowel disease by detecting blood in faeces. Many bowel abnormalities which may develop into cancer over time are more likely to bleed than normal tissue. So, if there is blood in the stool this can indicate the presence of abnormalities in the bowel. Patients with a positive FIT result are referred for further investigation by colonoscopy. This has streamlined the patient pathway and reduced the number of unnecessary colonoscopies performed.

Musculoskeletal Trauma Service
Pre COVID-19, patients were seen in the Emergency Department and brought back the next day to the fracture clinic to be seen. Now there is an Orthopaedic consultant available in the minor injuries department 8am-8pm daily. This prevents patients having to return to the hospital unnecessarily the day after. A patient information leaflet has been developed which outlines what an individual should look out for and when to get back in contact with the team, otherwise they are reviewed in clinic 4/6 weeks after.

Spinal Injections Pathway
Pre COVID-19, patients requiring a spinal injection were admitted to a ward and taken to theatre for their procedures. Limited theatre capacity over the last year resulted in the team needing to redesign the pathway. The team now use downtime in a Radiology room (on a Saturday and Sunday) and are seeing 16-20 patients in a five hour session as opposed to the 6 patients that were being booked onto a theatre list. The psychological benefit has been noted through patient satisfaction methods – they are no longer being admitted to hospital and just attend for the procedure. The benefits of the new pathway have been recognised throughout the Trust with other specialities looking to adopt similar pathways. There is also a wider Trust project underway looking to move other procedures undertaken in theatres to different locations which will free up the theatre capacity to tackle some of the backlog elective work.

Outpatient Delivery Hub
Pharmacy and the transport department are working together to deliver prescriptions and medications to patients who have had remote consultations. The service is also used for some attendances within the main outpatient department in order to prevent the queues and minimise people in one area.

Delivering treatments at home – Dermatology:
The homecare service has been increased which has meant that traditional immunosuppressed patients no longer attend the hospital for treatment but are given full training to self-administer at home.

Chronic Limb Threatening Ischaemia (CLTI):
CLTI is the leading cause of amputation in the UK. Patients present with rest pain and gangrene. The 5 year mortality is more than 50% - which is worse than most cancers. Early revascularisation improves outcomes. Each year in Newcastle more than 500 patients are referred as an emergency and at the start of this project >80% admitted with long lengths of stay. COVID-19 meant the team had to review the pathway and reduce reliance on long hospital admissions. A one stop emergency vascular clinic pathway was established and management of patients on the outpatient pathway increased from 20-50%. Length of stay has reduced from 13 to 5 days and there is increased compliance with Vascular Society Quality Improvement Framework targets (outpatient revascularisation <14 days has increased from 33% to 68% and inpatient revascularisation <5 days has increased from 31% to 52%). Other 80% of patients now receive nurse led follow-up.

Technological improvements

Electronic Prescribing Service

A system has been developed which involves using the GP IT system, SystmOne, to give a direct link to the community pharmacies. This has been used throughout the last year in paediatrics to support the remote outpatient delivery. Pharmacy are now looking at how they can expand the service to incorporate adult services. A longer term development would be to provide a direct link between our hospital IT system, Cerner, and the community pharmacies which would allow extensive expansion of the service.

My Skin Selfie

During the various waves of the pandemic, patients have continued to be seen based on their clinical priority – those of a higher priority being seen first. In Dermatology, Basal Cell Carcinoma (most common form of skin cancer), due to the nature of the condition, has a lower clinical priority than other skin conditions. Traditionally, this would have meant these patients would have waited longer for their appointments. However, an app. has been developed by one of our consultants which has allowed the Trust to continue seeing Basal Cell Cancer patients throughout the pandemic. Pictures of their skin are taken by the patient, submitted via the app. and reviewed by a consultant. If there are concerns, the patient is usually put straight onto a list for a procedure or in some cases, they may require a face to face outpatient appointment, if there are no concerns they are discharged. This has ensured a high quality service has continued and patients are only required to attend the hospital where essential.

Patient Videos

A range of patient videos have been developed including:

- **Sleep Services** – teaching videos for patients to guide them through instruction on how to use Continuous Positive Airway Pressure (CPAP) machines at home. About 60% patients were able to receive instruction for their CPAP machines at home instead of coming in with this in place (based on approx. 25 patients needing to come in vs 45 able to use videos in the past month). The Sleep team are currently in the process of evaluating outcomes and comparing with past outcomes to inform long term approach.
- **Transplant videos** – used to inform transplant patients of what to expect when they go through this process, saving coordinator time and onsite visits – (resources being developed through collaboration between our transplant coordinator team and an external digital company).

Urgent/Emergency Dental Care

COVID-19 saw all dental practices stop work due to aerosol generating procedures. Newcastle Hospitals remained the only dental facility open in the North East – treating a 3.2 million population. Traditionally the Trust operated an open access emergency clinic. When the pandemic hit a new pathway was required. We worked with 111 to triage, signpost and offer appointments where necessary to either the Dental Hospital or the Urgent Dental Treatment Centres which the Trust worked with Commissioners to set up around the North East. A front of house triage desk for those that attended the Dental Hospital on foot did operate still to pick up those who just attended. The pathway will continue post COVID-19 as it's a much better way of managing flow and demand and patient satisfaction.

System Wide Improvements

Care Home Liaison Team:

The Pandemic has facilitated excellent examples of partnership working and working across the system. There is active engagement with care homes with inter-disciplinary working across all organisations. Examples include:

- A COVID-19 specific Emergency Health Care Plan (EHCP) used by the appropriate health care professional in discussion with carers and residents, to review plans for all patients in residential and nursing homes across the city.
- Expansion and diversification of the work of the Specialist Care Home Support Team (SCHST).
- Visiting care homes where cases of COVID-19 had occurred to give support and advice by SCHST nurses, GPs and geriatricians, as appropriate;
- Dissemination of the results of COVID-19 swabs to residents.

Discharge Model:

In March 2020, the government issued new discharge guidance to facilitate early discharge as soon as a patient no longer required acute hospital care, to reduce the risk of infection transmission and to free up beds for patients with COVID-19. To achieve this a collaboration between discharge nurses specialist, Therapy teams, Community Directorate, Local Authority and CCG working together, led to a daily meeting of health and social care professionals to coordinate and facilitate discharge support and collect daily data to support the national COVID-19 response and resilience. The evaluation and fantastic partnership working demonstrated significant success and work continues to develop this model to support the recovery of services post pandemic.

Developments with the University:

Dental – worked with the university to develop guidelines for how to work with aerosol generating procedures which have now been adopted nationwide. As a result, we were the first Dental Hospital in the UK to reopen all its services and in September 2020 all students returned and were treating patients also.

PART 2

QUALITY PRIORITIES FOR IMPROVEMENT 2021/22

Following discussion with the Board of Directors, the Council of Governors, patient representatives, staff and public, the following priorities for 2021/22 have been agreed. A public consultation event was held in January 2021 and presentations have been provided at various staff meetings across the Trust.

PATIENT SAFETY

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

Why have we chosen this?

Preventing healthcare acquired COVID-19 infections during the ongoing pandemic is a priority currently, in line with the principles and framework of patient and staff safety.

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

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

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

What we aim to achieve?

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

How will we achieve this?

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

- Working with partner organisations to reduce infections throughout the Health Care Economy.
- Early recognition and management of suspected infective diarrhoea.

How we will measure success?

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

Where we will report this to?

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

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

Why have we chosen this?

Reducing patient harm from pressure damage continues to be a priority – this year we are focusing on reducing the rate of community pressure damage, specifically, community acquired pressure damage whilst under care of our District Nursing Teams. The increase in patient age, acuity and frailty means that the Trust is seeing more patients with a higher risk of acquiring pressure damage. It is therefore essential that the Trust identified this as a priority to ensure the risks of this are mitigated with accurate assessment and plans of care, together with the implementation of best practice care.

What we aim to achieve?

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

How will we achieve this?

- Dashboards of pressure ulcer incidence to be sent to community teams on a monthly basis, the Tissue viability team can do some targeted work within those teams.
- Team led, rolling monthly audits of care and assessments of a cross section of their caseload.
- Increase frequency of pressure risk score (currently 3 monthly) being undertaken.
- Increase use of the skin integrity assessment template (currently 6 monthly).
- Education will be continued alongside some targeted work in specific areas.

How we will measure success?

- Measurement of incidents by locality.
- Monitoring of amount of RCA's completed.

Where we will report this to?

- Across the city to each locality.
- Trust Board.

Priority 3 - Management of Abnormal Results

Why have we chosen this?

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

What we 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 - Modified Early Obstetric Warning Score (MEOWS)

Why have we chosen this?

There have been several maternal deaths regionally over the past couple of years where the lack of MEOWS systems for outliers from a Women's Services Directorate played a significant part. At present, pregnant/recently pregnant patients outside Women's Services are not monitored using a MEOWS system and there is no way of identifying the presence of these patients. This is likely to be a significant area of risk for the Trust.
The need for early recognition and management of deterioration of the pregnant woman has been highlighted by:

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

What we aim to achieve?

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

How will we achieve this?

- Create an IT solution for identification of a pregnant/recently pregnant woman outside Women's Services.
- IT development of an electronic MEOWs system to replace NEWS for this group of women.

How we will measure success?

The NUTH Maternity and Neonatal patient safety collaborative team will audit whether the MEOWS chart has been used appropriately to enable the early recognition of the deteriorating pregnant/recently pregnant woman outside Women's Services.

Where we will report this to?

- Women's Service Quality and Safety.
- MatNeoSIP.
- Trust Board.

Priority 5 – Enhancing capability in Quality Improvement (QI)

Why have we chosen this?

COVID-19 has demonstrated the need to make rapid changes and our ability to do so. We now face the need to make ongoing changes to recover from the impact of COVID-19. Despite the delays of COVID-19 we have established an infrastructure to build capability and capacity for improvement at scale with Newcastle Improvement. Our partnership with the Institute for Healthcare Improvement (IHI) will accelerate this work. This is critical in maintaining our outstanding performance and the patient focused high quality of care we deliver in a sustainable way.

What we aim to achieve?

- Train 15-20 improvement teams each focused on a piece of improvement work and coach them through the work.
- Train 30 coaches to build capability independent of the Newcastle Improvement team support for future improvement work across the organisation.
- Train 80 senior leaders (Directorate Managers, Clinical Directors, Matrons or comparable senior level staff) in the organisation in Leading for Improvement to provide the senior support for the improvement teams to effectively progress their improvement work.
- Develop a return on investment evaluation framework and assess the programme against this.
- Adapt the IHI training programme following feedback from the training and evaluation, integrating sustainability tools linking the Sustaining Healthcare in Newcastle (SHINE) programme into improvement. Move towards being independent in ongoing delivery of training.

How will we achieve this?

- Use the IHI to deliver the training programmes.
- Co-design future training with the IHI and Newcastle Improvement / SHINE faculty.
- Use the existing resource of the Newcastle Improvement team to support the improvement teams and coaches as they progress their work.
- Newcastle Improvement team members to shadow the IHI delivery to learn how to deliver the program after the IHI support period has finished.

How we will measure success?

- Measure completion of planned training programme 15-20, 4 to 5 member multidisciplinary teams through the Quality Improvement Practicum, 30 Coaching for Improvement and 80 senior team staff through Leading for Improvement.
- Produce a structured return on investment framework to evaluate the whole programme and investment against.

- Evaluation of training programmes from learners perspective and from a progression of improvement work.
- Staff survey results to identify improvement in involvement and ability to contribute to improvement domains.

Where we will report this to?

- Improvement Advisory Group.
- Trust Board.

PATIENT EXPERIENCE

Priority 6 – Mental Health in Young People

Why have we chosen this?

In 2013, the Royal College of Paediatrics and Child Health published their 'Overview of Child Deaths in the Four UK Countries'. This report highlighted that 30-40% of 13-18 year olds who died were affected by mental health, learning difficulties or behavioural conditions. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) is an independent body to which a corporate commitment has been made by the Medical and Surgical Royal Colleges, including the Royal College of Psychiatrists, Associations and Faculties related to its area of activity. The NCEPOD Mental Healthcare in Young People and Young Adults report published recommendations 2019.

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

This, and the negative impact of the pandemic, has strengthened the need to review current service provision for children, young people and young adults in order to assure that we identify gaps, areas of good practise and plan to improve the care provided in the acute Trust for these patients.

What we aim to achieve?

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

How will we achieve this?

- Dedicated group to identify gaps, areas of good practise and develop actions to support adherence to NCEPOD standards.

- Work collaboratively with regional colleagues in services for children and CNTW to access the We Can Talk training programme and ensure staff trained.
- Link in with Mental Health First Aider Course from Child Health Network.
- Rapid review of Datix relating to risk / restraint.
- Listen to patients and families and work with them to improve the service.

How we will measure success?

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

Where we will report this to?

- Clinical Outcomes & Effectiveness Group.
- Trust Board.

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

Why have we chosen this?

People (children, young people and adults) with a Learning Disability are four times more likely to die of something which could have been prevented than the general population. As a Trust, we are committed to ensuring patients with a learning disability 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?

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

How will we achieve this?

The North East and Cumbria Learning Disability Network has been working with Learning Disability Liaison Nurses in acute hospitals in the North East and Cumbria to revise reasonably adjusted care pathways (emergency and elective admission pathways) for people with learning disability. These replace the previous learning disability pathways developed 2011.

To support the implementation of the pathways, an e-learning programme has been developed for the workforce to access. The Learning Disability Diamond Standard Pathways that have been developed fulfil both the Learning Disabilities Mortality Review (LeDeR) Programme and NHS Improvement Learning Disability Standards requirements.

An Implementation Plan is in place which will include:

- Review of pathways and e-learning to determine if any adaptions required.
- Work in conjunction with North East and Cumbria Learning Disability Network and Great North Children Hospital (GNCH) anaesthetics to incorporate theatre attendance within passport for Children & Young People (CYP).
- Pathways to be developed for adult patients requiring MRI / CT under sedation.
- Continue to ensure Learning Disability flags are visible for adults and children with a learning disability.
- Gather feedback from patients and service users and carers to identify gaps.
- Showcase and share the exemplary work some of the Trust's clinical teams do in terms of provision of reasonable adjustments.
- Work to ensure mortality reviews for patients with a Learning Disability who die whilst in Trust care are timely.
- Audit documentation to provide evidence of best practice in relation to use of pathways of care, provision of reasonable adjustments to meet individual needs, appropriate use of hospital passports and application of the Mental Capacity Act including Deprivation of Liberty Safeguards.
- Respond to outcome of 2020 self-assessment when received.

How we will measure success?

- Diamond Standards embedded across the organisation.
- Staff have accessed and completed training.
- Passports for CYP and adults updated and relaunched.
- Continued audit with regard to 'flags'.
- Share learning and showcase examples of good practise.
- Maintain timely Learning Disabilities Mortality Review (LeDeR) Programme reviews.

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

STATEMENT OF ASSURANCE FROM THE BOARD

During 2020/21, 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 2020/21, represents 100 per cent of the total income generated from the provision of relevant health services by Newcastle Hospitals for 2020/21.

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

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

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

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

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

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

outpatient departments, day units and clinics and questions are revised periodically in line with NHSE/I and PHE guidance. The Assurance Audit reflects the key lines of enquiry in the IPC Board Assurance Framework document. The Chief Nurse's team work plan this year includes an update and refresh of CAT.

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

PART 3

REVIEW OF QUALITY PERFORMANCE 2019/20

The information presented in this Quality Account represents information which has been monitored over the last 12 months by the Trust Board, Council of Governors, Quality Committee and the Newcastle & Gateshead CCG. 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?

Reducing HCAI is an international priority recognised by the World Health Organisation, who in 2020 identified it as the most recurring adverse event within health care, estimating that globally it affects hundreds of millions of patients annually. Within Newcastle Hospitals, the focus remains on reducing MSSA, E.coli and other gram-negative bacteraemias that can cause significant harm for patients.

Additionally, Clostridium difficile can result in a range of symptoms from mild diarrhoea to potentially life threatening infection, therefore effective diarrhoea management for early detection of symptoms remains key for early detection of illness and to minimise the risk of cross-infection. This reduction strategy is in line with the national ambition and it is a mandatory requirement to monitor and report the incidence of these infections.

In May 2020 a national definition of hospital onset healthcare associated COVID-19 was provided and divided into three categories:

- Hospital onset indeterminate healthcare associated (day 3-7)
- Hospital onset probable healthcare associated (day 8-14)
- Hospital onset definite healthcare associated (day 15+)

Reports are submitted daily to NHSE to declare the incidence of COVID-19 in all of the above categories. New cases of COVID-19 are investigated by the Infection Prevention and Control Nurses to identify any potential transmission and to support clinical areas as required. IPC guidance is updated in line with national changes to minimise the risk of transmission of COVID-19 to promote the safety of both patient and staff.

What we aimed 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. difficile infections in line with national trajectory.
- Avoidable transmission of COVID-19 in hospital.

What we achieved?

There was a national change to the reporting of all bacteraemia; patients who have been a previous in-patient in Newcastle Hospitals within the previous 4 weeks and readmitted with a positive blood culture within the first 2 days of admission are now also assigned to Newcastle Hospitals as community onset healthcare associated (COHA) cases. This has resulted in an increase of the total number of cases comparably to the previous year. In order to know if a reduction had been achieved, the previous year's data had been reviewed to recalculate the incidence inclusive of a COHA as follows:

MSSA bacteraemias – no more than 88 cases; unfortunately the Trust has seen a 3% increase as there have been 100 cases in total and predominately more cases during the second and third pandemic waves.

E. coli bacteraemias – no more than 194 cases; unfortunately, the Trust did not achieve its 10% reduction aim as 195 cases were assigned to Newcastle Hospitals. However there was a 9.36% reduction.

Klebsiella bacteraemias – no more than 135 cases; Newcastle Hospitals had 129 cases assigned, which is a 14% reduction.

Pseudomonas aeruginosa bacteraemias – no more than 46 cases; Newcastle Hospitals had 45 cases assigned, which is an 11.76% reduction.

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

Due to the COVID-19 pandemic NHSE/I did not publish updated C.difficile guidance therefore, with agreement with CCG, Newcastle Hospitals worked towards not exceeding the previous year's trajectory of 113 cases. This aim was achieved with 111 reported cases which is a small reduction of 2 cases from the previous year.

How we measured success?

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

Priority 2 – Pressure Ulcer Reduction

Why we chose this?

Reducing the incidence of inpatient pressure damage is of high priority to the Trust. While the Trust has achieved an overall reduction in patients sustaining pressure damage, the rates remain higher than what we were 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.

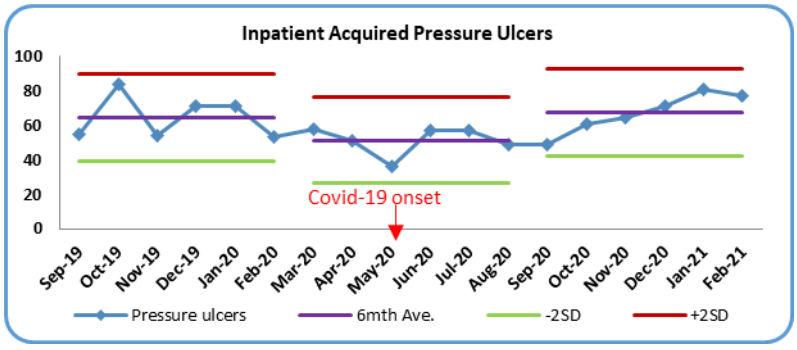
What we aimed to achieve?

- 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?

- There has been a gradual rather than a significant reduction in category II pressure damage. A significant reduction is evident in category III and above damage in some directorates where focused work had been performed.
- Quality Improvement work took place across directorates, targeting areas of high incidence. The impact of which is evident in these areas with a significant reduction in serious harm. This is evident within the Medicine Directorate, where a reduction of 43% in serious harm has been achieved; particularly in Older People's Medicine whereby more focused work has taken place.
- This support included teaching sessions of preventative measures, leadership development and support, auditing resources, and support in the development of the use of the electronic patient record. Following which a reduction in incidents is evident. In June 2020 dashboards were formulated per directorate and ward allowing a visual demonstration of incidents, the aim of which is to allow transparency, promotion of ownership and understanding of data at ward level with the aim of monitoring for improvement.
- Engagement with the RCA process from clinical teams has improved greatly over the last year, with a turnaround time of around 2-3 weeks in comparison to the previous time of 2-3 months. These previous delays led to overdue requests from our commissioning body, and affected the reputation of the Trust. Outputs from the RCA's have identified great improvements in practice in relation to care and documentation particularly in assessment and monitoring.
- From October 2020 there was an increase in the number of pressure ulcers reported. This is consistent with other winter periods in previous years, however with the added impact of the pandemic this year we have seen an increase. This directly correlates with the Trust safe care data, in that the acuity of patients has increased, this is consistent with other Trust's in the Shelford group. These increases are particularly evident in areas such as Critical Care and clinical areas which have changed their primary speciality to allow surge capacity during the second and third wave of the pandemic. Any increases have been monitored and feedback given to individual wards, to promote ownership and understanding at ward level. The Tissue Viability Team, continue working with these areas, to instigate preventative measures to reduce incidence.



How we measured success?

- Incidence and rate of pressure ulcers was monitored at ward, directorate and Trust level. Results were shared monthly with Matrons.
- Production of a monthly individual area dashboard highlighting a reduction or increase in incidents was completed.
- Bench-marking with Shelford group.
- Utilised recognised quality improvement methodology for measuring data.

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 aimed to achieve?

We aimed to be a world leader by improving patient safety through ensuring that appropriate clinical safety investigations resulted in timely clinical care decisions, and a reduction in the risk of significant information being overlooked resulting in delays to treatment.

What we achieved?

We have had a series of meetings with the patient safety team to agree priorities and define the scope of this project. We now have a much better understanding of the problems associated with requesting investigations, receiving and then taking action on their results, but building the system has been delayed by the competing requirements of the pandemic.

How we measured success?

Success was measured by real-time monitoring of the process (the completeness of results being endorsed) and ultimately by a reduction in adverse events attributable to results not being actioned in a timely manner.

CLINICAL EFFECTIVENESS

Priority 4 – Closing the Loop

Why we chose this?

Previously entitled System for Action Management and Monitoring (SAMM), this project was initially identified to support development or procurement of a centralised, robust IT

system to enhance governance processes following internal and/or external reviews. The purpose of capturing recommendations and resultant actions in one central location was to assist the directorate management teams in monitoring, progressing and implementing action plans (Closing the Loop). The project to date has involved review and consideration of possible commercial solutions however, none had the required functionality that were cost effective and this led us to explore the development of the internal incident reporting system as an option.

What we aimed to achieve?

To develop the internal incident reporting system as a potential IT solution to enable a pilot of this in one directorate, facilitating staff to record, prioritise, monitor and complete all required actions identified by the internal and external assessments within the agreed timescales.

What we achieved?

Established a multidisciplinary task and finish group and developed the current internal incident reporting system functionality to encompass the scope of the project.
One directorate received training on how to use the system and commenced a pilot however; this has been temporarily deferred pending an upgrade to the current incident reporting system.

How we measured success?

- Group established to map Trust performance requirements and actions.
- Formal evaluation of IT systems resulting in sourcing the correct IT system.
- Agreed processes and key changes required in Datix to accommodate closing the loop.

Priority 5- Enhancing capability in Quality Improvement (QI)

Why we chose 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 increases 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 aimed 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 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.

What we achieved?

- Integrated service improvement and transformation and financial improvement teams with the Quality Improvement team to form Newcastle Improvement. This forms the single point of access for all staff and the team is now the faculty that will continue to deliver ongoing training and will learn how to deliver the IHI training programmes.
- Signed a contract with IHI to help accelerate our capability and capacity for improvement work across the organisation.
- Delivered and evaluated multidisciplinary team based quality improvement training with four improvement teams. Planned and taught 'bite-sized' improvement sessions on focused topics supplementing practitioner based programmes.
- Consolidated our Intranet training resources and information under Newcastle Improvement.

How we measured success?

- Formation of Newcastle Improvement as a real entity.
- Successful closure of contractual negotiations with the IHI.
- Formal evaluation of the four formal work streams and 'bite-sized' sessions. The evaluation has demonstrated a positive increase in the team members' confidence at undertaking improvement work using the model for improvement as the scientific approach to effective and efficient improvement work.

PATIENT EXPERIENCE

Priority 6 – Treat as One

Why we chose this?

The 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. Due to the extensive scope of the project we were not able to complete all objectives in the first year of this being a priority

but the remaining recommendations that have only been partially addressed remain key aspects for the Trust to develop and complete.

What we aimed to achieve?

We aimed 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 Newcastle Hospitals and CNTW. 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?

The joint forum between Newcastle Hospitals and CNTW is now well established with cooperative working and strong communication links between the Trusts at a senior level. In addition, a smaller steering group within Newcastle Hospitals, and including CNTW staff, continued to define immediate priorities for a task and finish approach for the NCEPOD guidelines. COVID-19 caused a hiatus in progress of these meetings for both groups but with use of internet meeting platforms, meetings were still held and progress made.

Effective information sharing has been a key priority both from the NCEPOD report and from quality assessments of individual case reviews. E-record systems compatibility across Newcastle Hospitals and CNTW has now been greatly improved with staff able to access relevant clinical details across both systems. A standardised method of recording mental health assessments in Newcastle Hospitals patient records has been designed and trialled.

Education is another critical factor for further development. A nationally developed eLearning package is now available. Work has been undertaken to adapt the available on-line training to fit the differing needs of a variety of staff groups. This targeted training has been focused on those who are considered ‘front-line’ in managing patients with mental health diagnoses. Persisting COVID-19 restrictions has made delivery of training sessions deeply challenging as for this particular type of training it is far more effective when delivered in group seminars and small group teaching face to face. There remains work to be done in ensuring delivery and maintenance of skill-sets.

The task and finish group is due to meet for a final time in April 2021 with the aim of signing-off optimal compliance with the NCEPOD guidelines. Following that the continued work related to the key areas of Treat as One will be combined and encapsulated within a broader Newcastle Hospitals Mental Health Strategy.

How we measured success?

Good progress has been made with developing policy, process and training for caring for patients with mental health challenges. The Trust is now largely compliant with all the recommendations of the Treat as One NCEPOD 2017 guidance. The task and finish group meeting in April 2021 will identify any areas where further work is still necessary and feasible to enhance compliance. Those important aspects will be highlighted to ensure they continue to be addressed as the focus moves to the wider Newcastle Hospitals Mental Health Strategy.

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

Why we chose this?

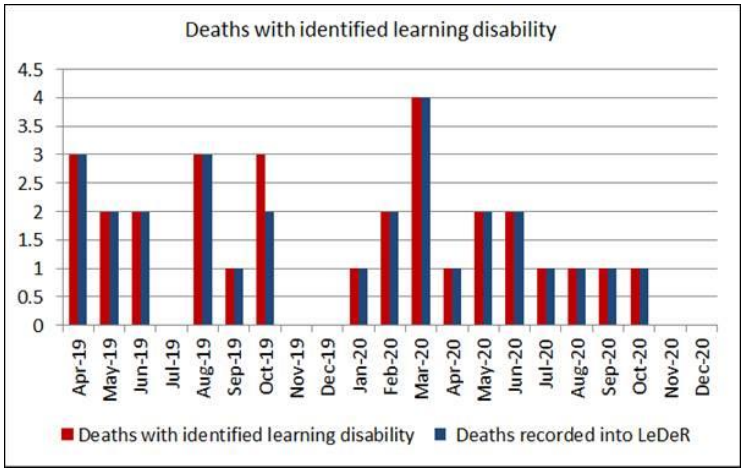
People (children, young people and adults) with a Learning Disability are four times more likely to die of something which could have been prevented than the general population. As a Trust, we are committed to ensuring patients with a learning disability have access to services that will help improve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

What we aimed to achieve?

Assurance that patients and their families have appropriate reasonable adjustments as required. That they are listened to, feel listened to and have a positive experience whilst in our care and appropriate follow up.

What we achieved?

- Bi-monthly Learning Disability Steering Group with clear appropriate and timely actions.
- Identified patient and family participation.
- 2020 Improvement Standard self-assessment submitted.
- LeDeR review and timely reviews due to dedicated medical support. Ongoing work stream regarding transition for children and young people with learning disability.



The graph above shows the data from April 2019 – December 2020 and includes those patients who have been recorded into the national LeDeR database. The Trust has recently appointed a Trust clinician on a temporary basis to help improve compliance with LeDeR submissions. This appointment has dramatically helped to reduce delays and the current position indicates that all patients who have died with a learning disability have been reported into the LeDeR National database.

- Learning Disability Liaison Nursing Team increased visibility and profile.
- Positive examples of patient experience across the Trust.

How we measured success?

- Assurance of outcomes against standards.
- Ongoing audit.
- Staff training.
- Positive feedback from patients and families.
- Self-assessment of Improvement Standards.

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

Update on Duty of Candour (DoC)

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

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

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

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

DoC training is targeted at those staff with responsibility for leading both serious incident (SI) investigations and local directorate level investigations. DoC is included in Trust incident investigator training which is delivered to multi-disciplinary staff once a month. Most recently an electronic DoC template has been in development as part of the electronic patient record. This will not only act as a prompt for clinicians to complete their DoC requirement but will also make it easier for the Trust to monitor compliance.

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

Due to the increasing pressures upon systems in responding to the COVID-19 pandemic, the Board Assurance Framework submissions for 2020/21 were deferred. However, whilst the necessity for the formalised completion of the audit was not required, the Trust has endeavoured to remain increasingly active in its commitment to the delivery of seven day services to the patients of Newcastle Hospitals during these very challenging times. Previously, the Trust had identified areas for improvement in terms of Emergency Vascular Services and a range of service developments have been introduced including the appointment of two new consultants in April 2019 who took up posts in October 2019 and October 2020. In addition, the Trust has taken over the

vascular service for Gateshead and as part of that has implemented a consultant of the week (COTW) system on an 8 week cycle. COTW was initially in place for 6 weeks out of 8, going to full implementation as the new colleagues took up post. The implementation of the COTW is clear evidence of the Trust's continued commitment to enhancing services to our patients in an ever changing world.

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

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

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

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

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

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

Work in confidence – the anonymous dialogue system

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

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

Freedom to Speak up Guardian

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

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

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

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

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

This policy provides employees who raise such concerns, assurance from the Trust that they will be supported to do so, and will not be penalised or victimised 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 trade unions and works collaboratively in partnership with their representatives to improve the working environment for all. Staff are able to engage with these representatives to obtain advice and support if they wish to raise a concern.

Chaplaincy

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

Staff Networks

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

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

Cultural Ambassadors

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

A summary of the Guardian of Safe Working Hours Annual Report

This consolidated Annual Report covers the period April 2020 – March 2021. The aim of the report is to highlight the vacancies in junior doctor rotas and steps taken to resolve these.

Rota gaps are present on a number of different rotas. This is due to both gaps in the regional training rotations and lack of recruitment of suitable locally employed doctors. The main areas of recurrent or residual concern for vacancies are Accident and Emergency, Ophthalmology 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 into locally employed doctor posts, the Trust runs a number of successful trust-based training fellowships and a teaching fellow programme to fill anticipated gaps in the rota. These are 12 month posts aimed

to maintain doctors in post and avoid the problem of staff retention. There are also Foundation Year 3 posts to encourage doctors to work at Newcastle Hospitals. In specialties which are hard to recruit to, there has also been recruitment of advanced critical care practitioners, who are currently in training.

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 2020/21, 1860 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; 352 in the second quarter; 496 in the third quarter; 565 in the fourth quarter.

2. During 2020/21, 1263 case record reviews and 40 investigations have been carried out in relation to 1860 of the deaths included in point 1 above. In 21 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: 341in the first quarter; 242 in the second quarter; 356 in the third quarter; 345 in the fourth quarter.

3. Four, 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: three, representing 0.2% deaths for the first quarter and one, representing 0.08% for the second quarter. (To date, not all incidents have been fully investigated. Once all investigations have been completed, any death found to have been due to problems in care will be summarised in 2021/22 Quality Account. All deaths will continue to be reported via the Integrated Quality Report). These numbers have been estimated using the HOGAN evaluation score as well as root cause analysis and infection prevention control investigation toolkits.

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

Summary	Lessons learned from review	Action	Impact/Outcome
Communication failure. Patient misunderstood that his operation had been cancelled due to COVID-19. As a result he was registered as a Did Not Attend (DNA) by the hospital. In preparation for this surgery the patient had stopped taking his	This case resulted from a collection of unique circumstances during a national pandemic however it his highlighted to the organisation that when a patient's admission is cancelled, they may need advice on changes to their	Formulation of information for patients attending Pre-assessment clinic with a focus on changes to their medication and an appropriate contact number should they have any queries. Explore robust safety-	Appropriate safety netting in place for patients and their relatives/ carers should they have any changes made to their regular medication in preparation for a surgical procedure.

Summary	Lessons learned from review	Action	Impact/Outcome
regular anti-coagulation medication. He did not restart taking this and sadly went on to suffer a stroke	regular medication. It may be beneficial for patients to have appropriate contact information to seek advice on this.	netting processes for patients who do not attend the Trust for operative procedures.	
Misdiagnosed Pulmonary Embolism using a new COVID-19 triage protocol.	When implementing new guidance and/or protocols at speed the Organisation needs to be assured that staff using the guidance understand and can implement it with ease and that systems are in place to support them to do this.	The new COVID-19 protocol was amended to reinforce clinical application to patients with specific COVID-19 symptoms. Education was provided to the staff working in ED to reinforce that Band 6 nurses and above were able to make the decision to send patient's home using the new COVID-19 protocol.	Senior clinicians are responsible for triaging and discharging patients safely within this new protocol.
Rare surgical complication – Insertion of central venous catheter under ultrasound guidance	This was a sad and rare but recognised complication of a necessary procedure that was performed at a time when other therapies had failed. There was appropriate multidisciplinary discussion prior to the decision to initiate treatment that was made at consultant level.	A new training programme has been implemented in relation to the insertion of central venous catheters employing ultrasound guidance.	All staff undertaking this procedure will have received the necessary training required.
Medication Overdose	The importance of having an accurate and up to date weight for patients is essential to ensure correct dosing of medication. When patients with complex medical needs present it is important that a	When patients are weighed electronically this should be inputted into the electronic system immediately. Long-term patients should be weighed at a minimum of two-week intervals. An automatic electronic reminder will be	Patients now have up to date weight measurements with the safety net of an electronic reminder. This ensures safe dosing of medication where required.

Summary	Lessons learned from review	Action	Impact/Outcome
	specialist opinion is sought.	flagged on the system. When Patients are transferred from the emergency department or admissions unit to specialty wards they will have their weight confirmed.	

4. 196 case record reviews and 40 investigations were completed after April 2020 which related to deaths which took place before the start of the reporting period.

5. Four, representing 1.7% 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. Seven, representing 0.6% 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.

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

Part 3 – Other Information - Overview of Board assurance 2020/21

This is a representation of the Quality Report data presented to the Trust Board on a bi-monthly basis in consultation with relevant stakeholders for the year 2020/21. 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 local priorities outlined in section 2, the indicators below demonstrate the quality of the services provided by the Trust over 2020/21 has been positive overall.

Patient Safety	Data source	Standard	Actual 2019/20	Q1	Q2	Q3	Q4	Actual 2020/21
Number of MSSA bacteraemia cases	PHE's Data Capture System	Mandatory reporting by NHSI/NHSE	72	HOHA* = 6 COHA* = 6	HOHA* = 18 COHA* = 4	HOHA* = 21 COHA* = 7	HOHA* = 30 COHA* = 8	HOHA* = 75 COHA* = 25
Number of MRSA bacteraemia cases	PHE's Data Capture System	Mandatory reporting by NHSI/NHSE	1	HOHA* = 1 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 1 COHA* = 0
Number of *C. difficile* infection cases	PHE's Data Capture System	Mandatory reporting by NHSI/NHSE	HOHA*= 95 COHA*= 18	HOHA* = 18 COHA* = 3	HOHA* = 15 COHA* = 9	HOHA* = 25 COHA* = 9	HOHA* = 27 COHA* = 5	HOHA* = 85 COHA* = 26
Number of *E. coli* bacteraemia cases	PHE's Data Capture System	Mandatory reporting by NHSI/NHSE	159	HOHA* = 33 COHA* = 10	HOHA* = 31 COHA* = 15	HOHA* = 43 COHA* = 8	HOHA* = 39 COHA* = 16	HOHA* = 146 COHA* = 49
Number of Klebsiella bacteraemia cases	PHE's Data Capture System	Mandatory reporting by NHSI/NHSE	111	HOHA* = 12 COHA* = 5	HOHA* = 26 COHA* = 14	HOHA* = 33 COHA* = 6	HOHA* = 23 COHA* = 10	HOHA* = 94 COHA* = 35
Number of Pseudomonas aeruginosa bacteraemia cases	PHE's Data Capture System	Mandatory reporting by NHSI/NHSE	36	HOHA* = 6 COHA* = 4	HOHA* = 11 COHA* = 3	HOHA* = 8 COHA* = 2	HOHA* = 7 COHA* = 4	HOHA* = 32 COHA* =13
Total number of patient incidents reported (Datix)	Internal Datix Incident reporting system	Local Incident Policy	18,854	3,697	4,221	4,868	4,734	17,520
Patient Incidents per 1000 bed days (Datix)	Internal Datix Incident reporting system	Local Incident Policy	37.7	46.4	41.6	45.2	43.2	44.0
% Patient incidents that result in severe harm or death	Internal Datix Incident reporting system	Local	0.3%	0.4%	0.2%	0.5%	1.1%*	0.5%
Slip, trip and fall - patient (Datix)	Internal Datix Incident reporting system	N/A	2,611	494	551	698	646	2,389
Slip, trip and fall - patient (Datix) per 1,000 bed days	Internal Datix Incident reporting system	National definition	5.2	6.2	5.4	6.5	5.9	6.0
Inpatients acquiring pressure damage	Internal Datix Incident reporting system	National	688	144	155	196	211	706

Pressure Ulcers per 1000 bed days	Internal Datix Incident reporting system	Local	1.4	1.8	1.5	1.8	1.9	1.8
Total number of Never Events reported	Internal Datix Incident reporting system	National definition	5	1	0	1	1	3
Total number of Serious Incidents reported	Internal Datix Incident reporting system	Local SI Policy	128	37	24	38	52	151
Needlestick injury or other incident connected to sharps	Internal Datix Incident reporting system	Local Policy	353	61	76	92	123	352
Reporting of Injuries, Disease and Dangerous Occurances (RIDDOR)	Internal Datix Incident reporting system	Local Policy	26	10	7	15**	7	42
Slip, Trip, Fall – Staff/Visitors/relatives	Internal Datix Incident reporting system	Local Policy	183	29	38	44	53	164

* There is an increase in SI's and severe harms/ death in Q4. This is due to the National directive to report all hospital acquired COVID-19 deaths as SI's. As an organisation we did this from January 2021 and have had 12 cases in Q4.
**In Q3 four of the RIDDORs reported were COVID-19 related.

Clinical Effectiveness	Data Source	Standard	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21
Summary Hospital Mortality Index (SHMI)	CHKS	100	99.86	94.95	106.20	94.08	Not published	Not published
Learning from Deaths	Internal Mortality Review Database	Reviewing and Monitoring Mortality Policy	436	389	337	239	352	335

Patient Experience	Data source	Standard	Actual 2019/20	Q1	Q2	Q3	Q4	Actual 2020/21
Number of complaints received	Internal Datix Incident reporting system	Local Complaints Policy	637	83	132	140	112	467
National Inpatient Survey	CQC	*National average 67.1)	72.6	The NHS Outcomes Framework Indicator 4.2 (Responsiveness to inpatients personal needs) provide one score for the survey, it is sourced from NHS Digital (https://digital.nhs.uk) but is not published until summer 2021 for the 2020/21 survey, therefore a single score cannot be provided as yet.'				
Friends and Family response rates (inpatients and A&E)	Locally collected reported	Not applicable	The NHS Friends and Family Test was postponed by NHS England from March 2020 due to COVID-19.					

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

NHS Improvement 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.

Inconsistencies in data reported in the 2020/21 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.

There is an increase in SIs and severe harms/ death in Q4. This is due to the national directive to report all hospital acquired COVID-19 deaths as SIs. As an organisation we did this from January 2021 and have had 12 cases in Q4.

OVERVIEW OF QUALITY IMPROVEMENTS

Pages 44-64 give some examples of other service developments and quality improvement initiatives the Trust has implemented, or been involved in, throughout the year.

NEW NORTH EAST LIGHTHOUSE LABORATORY STRENGTHENS THE FIGHT AGAINST COVID-19

A new, high capacity COVID-19 Lighthouse Laboratory has now opened at Baltic Park in Gateshead.

Part of the NHS Test and Trace programme, the purpose-built facility will initially serve the North East, Cumbria, Yorkshire and Humberside as part of a national network of COVID-19 testing laboratories, with potential to receive swabs from further afield.

Its creation has led to hundreds of new public sector jobs.

Managed by The Newcastle Hospitals NHS Foundation Trust, the Laboratory houses state of the art equipment and provides an important addition to the regional infrastructure for testing.

The Trust's chief executive, Dame Jackie Daniel, said:

"The Department of Health and Social Care's investment in this new Lighthouse Laboratory provides a valuable resource for our region, supporting in the fight against this pandemic and strengthening our resilience even further.

"The facility was built by partners pulling together and puts us in a stronger position to manage and control the virus. It is testimony to the collaborative approach we have taken to tackling COVID-19.

"All involved have worked very hard and my deepest thanks go to everyone who has played a part."

Garry Hope, regional managing director, Robertson Construction, said:

"As the main contractor responsible for the delivery of the lab, we are proud to play a small part in enabling the Trust to continue its hard work to combat the virus.

"The speed of delivery has been made possible through the excellent working relationships that we have with Newcastle Hospitals and our local supply chain partners, many of which are based within a mile of the project.

"Our site teams have worked 24/7 and are honoured to have been able to make a contribution."

The Lighthouse laboratory is part of the Integrated COVID-19 Hub for the North East, which places the region at the forefront of managing the virus, through:

- Providing state-of-the-art testing capacity, via the new Lighthouse lab.
- Strengthening coordination between local authorities and the health service, including sharing more data, insight and resources to manage outbreaks.
- Accelerating new methods of COVID-19 testing – led by a new innovation lab connecting NHS, industry and universities.

CENTRE OF EXCELLENCE AWARD FOR NEWCASTLE'S BRAIN TUMOUR CENTRE

Newcastle Hospitals' brain tumour centre has been named a national 'Tessa Jowell Centre of Excellence'.

The newly introduced status, awarded by the Tessa Jowell Brain Cancer Mission, follows rigorous expert-led assessments, and recognises the outstanding care and treatment staff at Newcastle Hospitals NHS Foundation Trust provide for patients with brain cancer.

With around 370 people in the North East and North Cumbria diagnosed with brain cancer every year, there has never been a more important time to recognise the work of the teams that help patients and their families through their brain tumour journey.

The Tessa Jowell Brain Cancer Mission was founded by former Labour cabinet minister Baroness Tessa Jowell who died aged 70 after battling brain cancer in May 2018, alongside her daughter Jess Mills.

"Mum's mission throughout 50 years of her political life was to tackle systemic inequality", said Jess. "So, it was tragic whilst fitting, that her final campaign was a call to arms to create universal equality in access to excellence in cancer care throughout the NHS. It is with immeasurable pride that just 3 years later, the Tessa Jowell Brain Cancer Mission has begun the real-world translation of that vision into reality.

"We are thrilled to have awarded Newcastle Hospitals for its excellent ongoing work for patients and commitment to support other centres in reaching the same level of Excellence.

"The UK still has one of the worst cancer survival rates in Europe, but in time, the Tessa Jowell Centres will make the UK a global leader in the treatment and care of brain tumour patients. We have a long way to go until the cutting edge of science is delivered to every patient, but this is a huge and transformational first step."

The 'Excellence' status provides reassurance about the availability of excellent care within the NHS and positive recognition for its staff who, despite the challenges of the COVID-19 pandemic, continue to go above and beyond for their patients.

Newcastle was measured on a range of criteria, including its excellent clinical practice and training opportunities; emphasis on patient quality of life; providing clinical trials and offering a high standard of research opportunities.

Led by a committee of experts in the field and virtual site visits, the assessments were backed up by patient feedback about the care they received. It is one of ten hospitals across the UK to receive the recognition.

Damian Holliman, Consultant Neurosurgeon and Neuro-oncology MDT Lead for Newcastle Hospitals says:

“This fantastic honour will mean so much to the patients of the North East and Cumbria knowing that they are receiving care in a centre of excellence. The wider Newcastle/North East neuro-oncology team are delighted that there is recognition of their efforts to provide such a high standard of care.

“It is the Geordie “shy bairns get nowt” tenacity of so many members of the team that has resulted in the holistic, integrated multi-disciplinary care pathway for patients and specialist interventions such as bevacizumab for symptomatic radiotherapy effects.

“We look forward to supporting the Tessa Jowell Brain Cancer Mission in its aim to promote excellence in care for brain tumour patients and assisting the Tessa Jowell Academy in disseminating evidence of great practice. No one unit gets everything right all the time so we know there is a lot we can learn and hopefully help other units too.”

Founded to design a new national strategy for brain tumours, the Tessa Jowell Brain Cancer Mission is committed to helping as many hospitals as possible achieve the “Excellence” status in the future. To achieve this, the mission is launching the Tessa Jowell Academy, a national platform allowing hospitals to share best-practice to improve their services, as well as one-year fellowships for doctors to further specialise in brain tumours.

“To be designated by the Tessa Jowell Brain Cancer Mission is a great honour for the team,” adds Dr Joanne Lewis, Consultant Clinical Oncologist at the Freeman Hospital’s Northern Centre for Cancer Care.

“The recognition of our “human centred culture of kindness and compassion” was the highest compliment we could have wished for. I am excited by the opportunities we have to push forward change for brain tumour patients, we are also keen to adopt best

practice and learn from the Tessa Jowell Academy. This award has made us even more determined to give our patients the best possible care."

Newcastle Hospitals' Chief Executive Dame Jackie Daniel is delighted to see the team's efforts rewarded with Tessa Jowell Centre of Excellence status and says:

"Our cancer services here in Newcastle have a fantastic reputation, which is very much down to our talented teams and state of the art technology we have invested in here in the North East.

"To receive national recognition as one the top brain tumour centres in the country is testament to the commitment and compassion of our wonderful neuro-oncological team. The care they display each and every day is second to none. I'm incredibly proud to see them honoured with this award which they so richly deserve."

Professor Katie Bushby, Emerita Professor of Neuromuscular Genetics at Newcastle University has been working with the Tessa Jowell Brain Cancer Mission on the assessment and designation of the centres. She drew on her personal experience of the brain tumour centre where her husband was treated when he was diagnosed with glioblastoma, the same brain tumour as Baroness Tessa Jowell, just over two years ago.

Katie explains: "My husband Jimmy Steele (who was Professor of Dentistry and Head of the Dental School in Newcastle) was diagnosed with a glioblastoma in December 2015. Like Tessa Jowell, he lived less than two years following the diagnosis.

"Brain tumours are a relatively rare form of cancer, and progress in developing curative treatment options has been slow. This makes it especially important that the team caring for you is really aware of your priorities and enables you to live well even under the most challenging of circumstances.

"We got that from day one from the team at the Newcastle Hospitals. There was a fantastic feeling of being absolutely listened to and that every treatment and conversation was totally personalised. Support was there and utterly compassionate every step of the way."

Having taken early retirement after Jimmy's death, Katie became aware of the Tessa Jowell Brain Cancer Mission and realised that this was a fantastic initiative that she would like to volunteer to help.

She adds: "The last year of working with Jess Mills and her team to realise the concept of Tessa Jowell Centres of Excellence for brain tumour care and treatment has been really rewarding and I think something that Jimmy, who was a passionate believer in equality of health opportunities for all, would have been very pleased to see happening.

“We have set up a process which has been led by the brain tumour community, experts and patient groups alike. In total 20 centres applied to become centres of excellence and nine were awarded in the first round, though several more were very close. It’s wonderful that Newcastle is one of these first centres, and people in the North East can really have confidence that their care is amongst the best in the UK.

“Moving forward the task is to build even more on excellence, both within the centres already designated and also developing and spreading excellence more broadly so that in the end no patient with a brain tumour is left behind.

A MOMENTOUS WEEK AND START TO VACCINATION

Early in December 2020 the media was dominated by positive news as the first COVID-19 vaccines were given in the UK. Newcastle Hospitals played an important part in this programme, operating with partners as the COVID-19 vaccination programme for the North East and North Cumbria. It was a very emotional moment to see our first patients Dr Hari Shukla and his wife Ranjan receive their injections from Suzanne Medows at the RVI. They were so grateful and optimistic about the opportunity for the vaccine to return our lives to something more 'normal'.

The Covid Vaccination Programme is led nationally by NHS England and coordinated in each Integrated Care System (ICS) area by a lead NHS Trust. Newcastle Hospitals was asked to take on this responsibility for the North East and North Cumbria ICS and now leads and coordinates the delivery of the vaccine in around 110 sites across the region, in partnership with primary care, NHS trusts and CCGs, local authorities, community pharmacies and through directly managed large vaccination centres.

Newcastle Hospitals operating as a hospital hub has administered a COVID-19 vaccine to in excess of 16 thousand Trust staff plus over 6 thousand to local health and social care workers. The second dose staff campaign commenced at the beginning of March 2021.

The Trust managed vaccination centres across the ICS have administered over 120 thousand first doses in line with Joint Committee on Vaccination and Immunisation cohorts and our programme is expanding to provide additional sites and capacity across our population. Each of these centres is bookable through the National Booking System. The centres are very much part of the organisation and have successfully completed both the CQC assurance and monitoring exercise and external Home Office security audits.

As a wider programme working with primary care and community pharmacy we have administered over one and a half million doses, with more than one-third of the adult population in the region having received a dose. The programme is on target to offer

first dose vaccination to all in cohorts 1-9 by mid-April and to all of the remaining adult population by end of July.

The vaccine programme will not provide a quick fix to this pandemic. We all need to maintain the highest standards of infection control, both at work and at home, to keep us all safe from COVID-19 into next year.

TO BOLDLY GO WHERE NO NEWCASTLE PHYSIO HAS GONE BEFORE…

Hello, my name is Rachel Stout and I wanted to share my reflections on covering Ward 18 during the coronavirus outbreak so far…

Ward 18 was the first critical care unit to accept COVID-19 patients at Newcastle Hospitals.

The changes started with cubicles becoming isolated and multi-coloured tape being used to square off portions of the floor. This quickly escalated into the central double doors being taped up to block off ITU entirely.

Before we knew it, beyond the doors was a mysterious environment nominally identified as ‘dirty’. It felt so wrong to not only have a segregated unit, but one which was split into ‘dirty’ and ‘clean’ zones within a usually impeccably clean environment.

To make light of the situation – and make visits across the border more bearable – we took it upon ourselves to rename ITU as ‘going abroad’. It felt much better to envisage the donning and doffing area as duty free – where specific items were free and in abundance, before stepping through the mysterious doors to go abroad.

I’m not sure any of us will ever forget the feelings we had during our first visit beyond those double doors. That feeling of foreboding and apprehension, which steadily rose

with every additional PPE layer donned, building into a culmination of anxiety as we stepped over the threshold into the unknown.

A lot of people described a feeling of being underwhelmed once over the threshold, as at the end of the day, it was just the same ITU with an added element of guess the nurse behind the visor!

As COVID-19 was an unknown entity, the breadth and intensity of learning became quickly overwhelming. The first two weeks were a whirlwind of pathophysiology, ventilator manuals and setting personal challenges in order to quickly muster confidence. Comfort zones were breached daily; teaching visiting therapists on a regular basis about ventilation and guidelines, in an eager bid to embed our knowledge, as well as trying to set up ventilators in anticipation of what our emerging role may require.

In pre-Covid life, the whole MDT on the unit were accustomed to treating neurologically impaired patients, whose other organs were usually unaffected. Yet, suddenly, acute respiratory distress syndrome (ARDS) was in every other sentence and we were more focused than ever on chest X-rays, rather than brain scans.

The first patient to be successfully extubated was one we will all remember. It was a scary toe to be dipped into the water of progression. From there, we had a lot of successful stories in this otherwise sad time.

Overall, it has been a very strange time. However, morale has never been low: the whole MDT grouped together to welcome new faces, to never judge a colleague for their questions and to provide a constant stream of sugar based snacks with a comforting smile. Our blood sugar levels have never been so high, but the overwhelming generosity of people has certainly helped us all during this incredibly difficult time.

SUPPORTING STAFF WELLBEING DURING THE PANDEMIC

During the pandemic, life in the UK became very different for everyone! The Government imposing a national lockdown due to the COVID-19 pandemic presented lots of own challenges for the physical and mental wellbeing of individuals – in particular healthcare workers.

Newcastle Occupational Health Service (OHS) provides occupational health support for over 15,000 staff working across Newcastle Hospitals, as well as doctors working across the region.

During March and April 2020, the numbers of staff contacting the service with COVID-related concerns almost doubled the normal activity levels for the department. This meant that support services usually offered by the department for physiotherapy, psychology and counselling for staff were temporarily put on hold as efforts were focused on the COVID-19 effort, including introducing urgent telephone support for emotional wellbeing.

Fast forward to May we had developed systems and familiarity with the situation meaning that COVID-related activity in the department had become more manageable. The OHS Physiotherapy and Psychology Teams considered ways to increase support available for the physical and emotional wellbeing of staff working through this uncertain period, who were perhaps yet to notice or consider the toll that this stressful time had taken on all aspects of their own health.

One of the things we did was think about new ways to reach staff who might need support as we were not able to meet face-to-face. We created the OHS Streamed Pilates session which is a live session streamed over lunchtime (12:00-12:20) accessed for free over the StarLeaf platform. The aim of the session is to engage staff in physical activity during their working day. With more staff more desk based and working remotely the session emphasized the importance of taking breaks from prolonged static postures to get blood flowing and reduce stiffness. The session has engaged over 300 staff since it started in June and continues to be delivered every Monday lunchtime.

The Psychology and Counselling team followed this up with our Streamed Mindfulness session which still runs every Thursday lunchtime at 12pm via Starleaf. The session which has been very well received, aims to help us stay in the present and be aware of what is happening in our minds and in the external environment. Becoming aware of our present moment experience can be beneficial for our mental health and wellbeing.

CHIEF NURSING OFFICER AWARDS AT NEWCASTLE HOSPITALS

England's Chief Nursing Officer, Ruth May surprised seven nurses working for the Newcastle Hospitals today, when she awarded them with her coveted Chief Nursing Officer medals.

Six nurses received a Silver Medal which recognises major contributions to patient care and the nursing and midwifery profession.

Ms May also awarded her highest possible accolade – the Gold Medal – recognising a nurse or midwife's lifetime achievement and is only given in exceptional circumstances, for unique individuals.

The Gold Award was bestowed to senior nurse, Suzanne Medows on the very day she retired from the Newcastle Hospitals following a much respected nursing career spanning over 40 years.

Suzanne was nominated for the Gold Medal in recognition of her superb leadership skills with many nurses and student nurses citing her as the reason they have enjoyed outstanding learning and mentoring experiences whilst developing their own nursing careers.

Ms May – who announced her awards during a virtual ceremony due to COVID-19 restrictions – described Suzanne as highly valued and respected because she worked tirelessly to go above and beyond, and showed a passion for education and the development of others.

During her speech she said “There are not many people that I give a Gold Award to and I’d like to give this to you to say a personal and huge thank you for your leadership over a number of years, and investing in the next generation of our profession. Thank you for what you have done.”

Of her Gold Medal Suzanne said “I don’t think anybody could begin to understand how much it’s meant to me to work with such fantastic people over the last 40 odd years in Newcastle. This award means so much. Thank you.”

Suzanne’s nursing career began in October 1976 at Newcastle’s Royal Victoria Infirmary, where she worked in acute medicine and then coronary care. Over the years she became a recognised nursing leader with a passion for education and developing others.

Chief Executive Nurse for Newcastle Hospitals, Maurya Cushlow said “I am delighted to see so many of my colleagues receive a Chief Nursing Officer Award – each and every one of them a worthy winner – and I would like to extend my personal thanks to them for all that they do, and to Ruth for making this event so special for them.

“In particular, Suzanne’s Gold Medal – the highest of our Chief Nursing Officer’s awards – is a most fitting accolade to celebrate the significant contribution she has had made through her career towards high quality, safe patient care, and ensuring educational and practice development opportunities of the highest standard are available for all our nurses and midwives. I’m sure everyone joins me in wishing her a very happy and healthy retirement”.

Silver Medal winners

Ian Joy, Associate director of nursing who was awarded in recognition of his dedicated work as the Trust Lead for ensuring nursing and midwifery safe staffing. His citation describes Ian as someone in whom staff feel complete trust and confidence, who demonstrates expert leadership and knowledge and whose work has been recognised both regionally and nationally.

Dr Clare Abley is a Nurse consultant for vulnerable older adults and is greatly respected for her expertise in the care of older, vulnerable adults specialising in dementia. She is passionate about ensuring patient centred care for patients with dementia when in hospital, and has developed a Dementia Care Leaders’ Toolkit which has been published in national journals.

Peter Towns, Associate director of nursing was awarded his Silver Medal in recognition of his commitment to challenging stereotypes that affected him and have discouraged men from pursuing a nursing career. This has led to a recently launched children’s book ‘My Daddy is a Nurse’ which challenges the assumption that all nurses are women, by showcasing men working in the profession.

Sharon De Vera is a staff nurse working in the Freeman Hospital’s cardiothoracic theatres. Sharon left the Philippines nearly 10 years ago to join the nursing and midwifery family at Newcastle Hospitals and her passion for helping international nurses settle in the UK is key to the ongoing success of the pastoral support programme at Newcastle Hospitals, advising on matters of finance, well-being and social.

Hilary Earl, Matron and service lead for babies, children and young people up to the age of 19 years received her medal recognising her leadership in empowering staff to create a dedicated safeguarding ‘oversight team’ with a single point of contact to ensure families with young children could continue to be supported during the COVID-19 pandemic when face to face contact was no longer possible.

Jackie Rees is a Nurse consultant leading on issues affecting the bladder and bowels, an area many people feel uncomfortable talking about. Jackie’s passion for helping people with these conditions is legendary in Newcastle, and has been recognised nationally. In particular she is known for her dedication to ensuring that patients with bladder or bowel health care needs are assessed, with treatment options offered, rather than a containment product.

HOW A CONSETT POWERLIFTER CHAMPION WON THE BIGGEST FIGHT OF HIS LIFE

Last year, 63 year old gym founder Alan Turner was preparing to join thousands of international competitors at the annual Global World Powerlifting Championships in Canada.

But instead of defending his World Champion title, Alan found himself up against the most formidable opponent of his life, as coronavirus took hold.

The father of two from Consett believes he may have picked up COVID-19 from someone who came to his gym who was feeling unwell.

A few days after the first national lockdown was announced, Alan started to cough which wouldn't go away and became very persistent. His wife Susan said he should get it checked out but he decided not to.

Weighing in at 20st 10lbs Alan was big and very fit. "I'm also very stubborn", said Alan.

"I thought I would get over it but the coughing got worse and I started to feel sick. Susan urged me to speak to someone but I just took myself to bed with a bucket. Then I started to cough up blood."

Eventually Susan put her foot down and they dialled 111. Alan was told he needed to get to hospital as quickly as possible.

"When I arrived at the University Hospitals in Durham the staff were all waiting for me", continued Alan. "They took bloods and x-rayed my lungs. We were told it wasn't good."

Alan, known as 'Big Al' in the powerlifting community and to everyone he knows in his hometown of Consett, was taken to an isolation 'COVID-19 ward' where his battle with the virus began.

The clinical team there found his lungs were so badly affected that he was unable to breathe on his own and he was given specialist respiratory support known as CPAP or continuous positive airway pressure. This involved a large plastic hood with a pump and a tube which help to keep a constant flow of air to help those with breathing difficulties.

However, a week later Alan's lungs needed more support. He was put into an artificial coma so that he could be intubated, with a ventilator taking control of his breathing completely.

Five days later, Alan went into multi organ failure. His liver and kidneys weren't working anymore so he was transferred to the intensive care unit at Newcastle's Freeman Hospital.

"They did everything they could to help my kidneys recover," explained Alan, "and my lungs started to improve."

During his time in hospital, Alan's weight plummeted from 20st 10lbs to just over 11st and he felt incredibly weak. He developed pneumonia, sepsis and was in pain everywhere.

"Everyone who knows me calls me 'Big Al'. I'm an ex-Strongman. I'm ex-military. But I nearly died. I was frightened. Really frightened."

And his family were frightened too. "Every time Susan took a call from hospital staff she was terrified that she was going to be told 'that was it'. It really was touch and go for a while."

Alan was brought out of his artificial coma and he was given a tracheostomy to help him breathe more easily. Four days later he was transferred across to the RVI's intensive care unit where they started to give him lots of physiotherapy and just over a week later he was well enough to be transferred from intensive care to one of the medical wards to begin his recovery.

"The tracheostomy could be taken out so I could start to breathe on my own and I'd been nil by mouth for 5 weeks so I had to learn to how to swallow again. This was all good news but I was terrified of something going wrong and that I would get pneumonia again."

Alan added: "The physios were absolutely amazing. They helped my confidence with breathing and swallowing, and did everything they could to help me start building my strength back".

Megan Ball, an advanced physiotherapist and one of the physiotherapy team who helped Alan to recover recalls him very clearly.

"Alan is extremely motivated," said Megan. "He couldn't even stand, never mind walk, when he came down to the ward from the intensive care unit. But his determination to get back to his usual self was clear for everyone to see."

Alan even made a makeshift gym at his hospital bed using resistance bands that he asked the physio team to bring. This allowed him to start doing what he loves best as soon as he could.

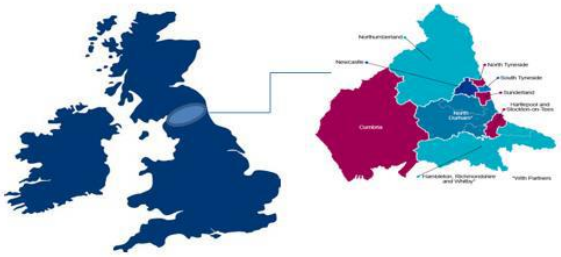
Megan added "He called us up recently to let us know how he was getting on. He told us how he was planning to get back into competitive powerlifting again as soon as possible which was so amazing to hear."

Altogether Alan was in hospital for 7 weeks with over of a month of this time in intensive care. Now, he is back to his original powerlifting weight of 20st 11lbs.

COLLABORATION DURING COVID TO IMPLEMENT CHANGE

Authors: Ruth Wyllie Lead Nurse Paediatric Rheumatology, Karen Hartley, Lead Pharmacist Paediatric Rheumatology, Dr Sunil Sampath, Consultant Paediatric Rheumatology, Great North Children's Hospital.

Context



The Paediatric Rheumatology Team (PRT) based within the Great North Children's Hospital offers care to CYP across the northern region from the Scottish borders to North Yorkshire and east to west coast. In our service, on average 70 new CYP are diagnosed annually with rheumatic conditions such as juvenile idiopathic arthritis. Approximately 1/3 will require long-term treatments and all require long-term rheumatology follow-up. Currently the team supports over 300 patients who receive various treatments for their rheumatic disorders at home, with 75 CYP requiring regular treatments administered in the hospital.

Service Review Background

Medications used for rheumatic conditions are immunosuppressive drugs and require the expertise of a highly specialised multidisciplinary team of specialist nurses, consultants and pharmacists. All CYP and their parents/carers starting treatment require counselling and education. This includes precautions, management of opportunist infections/illnesses, safe storage and delivery of the medications. Most anti-rheumatic drugs are administered via subcutaneous (s/c) injection or by intravenous infusion. Subcutaneous injections are increasingly used to control disease and most patients/families receive education and training to administer s/c injection in a specialist nurse (CNS)-led clinic; some families may require the support of a community nursing team.

What we did

Tocilizumab is a type of specialist medication that targets a protein in the blood stream called IL-6 and is used to treat a number of rheumatic conditions. Tocilizumab was approved for use in children with certain subtypes of Juvenile Idiopathic Arthritis in 2011 and was normally administered via an intravenous infusion on the Paediatric Day Unit at GNCH. The procedure can take approximately 3 hours and involves having a cannula for administration. In 2018, tocilizumab in the subcutaneous form (which can be administered at home) was approved for use in CYP with Juvenile Idiopathic Arthritis and the PRT were considering moving some patients to this preparation for patient convenience, to minimise school absence and for economy of health resources.

As part of Continuity and Emergency Planning for the COVID- 19 pandemic the Medicines & Healthcare Products Regulatory Agency (MHRA) compiled a list of

medications that cannot be exported from the UK or hoarded. Tocilizumab was added to this list in April 2020.1 Tocilizumab was a proposed treatment for the hyper-inflammatory response that can occur in COVID-19 and there was concern that supplies for other indications could be affected. At the same time NHS hospitals were advised to reduce routine activity and footfall through the hospital.

The PRT reviewed the patient attendances and identified the cohort attending GNCH for intravenous infusions. 38/65 (58 %) patients were receiving tocilizumab and travelling across the region for treatments. The pharmacist explored alternative methods and the PRT decided to switch CYP from the intravenous to subcutaneous form of tocilizumab. Patients were required to fulfil all the following criteria:

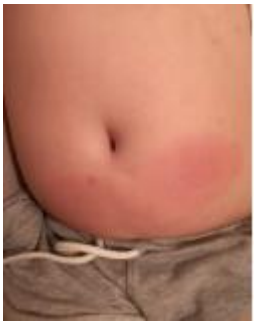
- Stable Disease
- Compliant
- Competent at administering medication

A total of 34 eligible patients were identified (32/38 current patients and 2 new patients)

A multi-disciplinary approach was required. The rheumatology dedicated pharmacist established agreement from the Trust, arranged supply of medication and delivery of supplies to the families. The CNS contacted all families via nurse-led telephone clinic and invited eligible CYP to a face-to-face clinic, where they received counselling and training to administer the subcutaneous tocilizumab. The rheumatology consultants supported the change with prescription management. Over a 6-week period all eligible CYP transferred to the subcutaneous form of tocilizumab administered at home. Following contract agreements, s/c tocilizumab medication is transported to families across the region via a home care delivery company with prescriptions supplied by PRT.

Of the 34 patients who switched to s/c tocilizumab, 9/34(26%) reported localised injection-site reactions; although this varied in severity it could lead to discontinuation of treatment. An inconsistent approach to managing these reactions was recognised by the pharmacist and the CNS. After further collaboration with the paediatric and allergy medical teams, a standardised approach to manage injection-site reactions was adopted. This included some general measures (ensuring medication was at room temperature, use of cold compress and rotation of injection site) and pharmacological interventions using antihistamines that are easily accessible over the counter. Telephone support from the dedicated pharmacist was provided to assist in managing the CYP site reactions effectively.

Sex	Age	Description of reaction
F	11	Slight redness and swelling, went down after 2 hrs
F	11	More "stingy" than MTX, red itchy patch
M	11	Red patch
F	11	Red, itchy patch increasing in size & duration
F	5	Itchy patch
F	12	Small red lump
F	17	Red patch
M	10	Site reaction within 10 mins
F	8	Previous history site reaction



Medicine	Age	Starting Dose	If no response consider increasing dose
Certirazine			
Give 1 hr prior to injection & take for 3 days or until symptoms resolve	Up to 1 yr	0.25mg/kg BD	
	2-5 yrs	2.5 mg	5mg BD
	6- 11 yrs	5mg	10mg BD
	12-17 yrs	10mg	10mg BD
Chlorphenanime	1-23 mths	1mg BD PRN	
Given if site itchy	2-5 yrs	1mg QDS PRN	
	6-11yrs	2mg QDS PRN	
	12-17	4mg QDS PRN	

Key Activities

Establish a Process -

- Identifying the risk to patients.
- Establishing a solution to the problem.
- Coordination and implementation of change.
- Support and guidance to families to make the change in treatment at a time when there is high level of concern/anxiety.
- Identification of complication - site reactions.
- Reduction in attendance to hospital.

Summary

32 patients changed over in 6 weeks (2 patients changed later as treatment changes necessitated)

- 1 failure –non-compliant.
- Site reactions managed effectively.
- Patient satisfaction –very positive.
- Transferable outcomes for other treatments.
- In process of writing this up collaboratively for national audience.

What Happens Next?

The importance of collaborative working has become even more apparent, during the pandemic. By working cohesively together, the team were able to implement a change in treatment safely and swiftly. When a problem arose, a joint approach to find a resolution was effectively devised.

Sharing our experience within the Paediatric rheumatology community and other teams is important. Many treatments are given to children via subcutaneous route and injection-site reactions are a common side effect. A systematic approach to minimise injection-site reactions adopted here can also be used for other drugs.

We would like to formalise the feedback from families to capture their thoughts and feelings relating to this change in treatment delivery during the pandemic.

Impact of the changes

- Reduce pressure on precious hospital resources - Attendance to the hospital during the pandemic was reduced. 27/34 patients who previously attended at least once/month for half day admission are now receiving their treatment at home.
- More convenient for families – minimise long distance travel for treatment and time off school and work.
- True collaboration and recognition of multidisciplinary team working swiftly to find a solution to a problem impacting upon patients, their family and the Trust.

Reflections

Tocilizumab has proved to be useful in treatment of critically unwell patients infected with COVID-19. By moving our paediatric rheumatology cohort onto an s/c preparation this has freed up the intravenous medication for COVID-19 patients.

References

1. List of medicines that cannot be exported from the UK or hoarded. Department of Health and Social Care and Medicines & Healthcare Products Regulatory Agency: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/933527/medicines_that_cannot_be_parallel_exported_from_the_UK.csv/preview

THE Q FACTOR 2021 – CELEBRATING QUALITY IMPROVEMENT AND CLINICAL EFFECTIVENESS DURING THE COVID-19 PANDEMIC

The Q Factor event was launched by the Trust Clinical Audit and Guidelines Group in 2019 to highlight and publicise the excellent work that happens throughout the Trust to deliver Quality Improvement (QI) both in our hospitals and in the community. The first event was held in December 2019 and was a huge success, with over 100 staff members in attendance to hear about a wide range of projects from raising awareness of button battery ingestion, to huge cost savings made in community wound dressings. A wide range of healthcare professionals were represented including Consultants, Junior Doctors, Pharmacists and Nurses and therapists.

Following on from the success of this event, we knew we had to continue to encourage QI work throughout the Trust and that giving staff a platform to showcase and share their work was vital. During 2020 and the COVID-19 pandemic, we had to consider if we would still be able to stage this event, however; we soon realised that rather than COVID-19 suspending QI work, it did in fact create many COVID-19 related projects as staff and Directorates responded to the challenges of improving patient care during the pandemic. This became the theme for the event and staff were asked to submit clinical audit and QI projects which were specifically related to the COVID-19 pandemic.

We weren't sure what to expect as we publicised the event which would be held virtually this year. We knew clinical teams were working harder than ever and usual ways of working had changed. However, an impressive 57 projects were submitted to our shortlisting panel for consideration, which is a testament to our staff for always putting patients first and constantly striving to improve standards of care.

The shortlisting panel had the difficult task of selecting just 6 finalists, who were invited to present their work to the judging panel and audience at the Q Factor which was held virtually on 16th March 2021.

The final 6 projects shortlisted to present at the event were:

- Katy Hester: Conversion of respiratory clinics to telephone clinics: patient satisfaction, future preferences and redesigning services.

- Lizzi Zabrocki: Review of end of life care for adult inpatients that died with a COVID-19 antigen swab positive at Newcastle Hospitals.

- Clodagh Mitchell: Rapid quality improvement in critical limb threatening ischaemia pathways during the COVID-19 pandemic.

- Stephanie van Eeden: Video consultations for speech therapy appointments.

- Rebecca George: Children's out-patients and Child Development Centre reopening.

- Jane Noble: Service development within the Older People's Day Unit during the COVID-19 pandemic: enhancing multidisciplinary care for frail older adults.

Congratulations to Clodagh Mitchell, Foundation Year 2 Doctor and her team who were awarded first prize of £500. Clodagh's project was about improving patient safety by reducing COVID-19 exposure, improving efficiency of our chronic limb threatening ischaemia management pathways and supporting patients on discharge to the community during the pandemic. Runners-up Katy Hester and Stephanie Van Eeden were also awarded £250 for their work in Respiratory Clinics and Speech Therapy consultations.

All prize monies awarded from the Q Factor will used to further develop these QI projects and continue to enhance patient care. Winners will be invited back next year to update us their progress and we are already thinking about next year's event and plans are underway to make it even bigger and better!

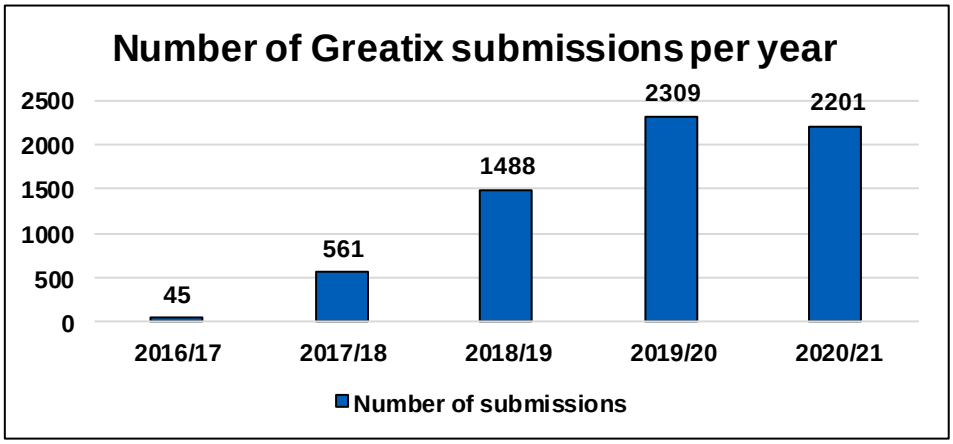
Greatix

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. Colleagues are encouraged to recognise and share these examples, so that everyone can learn from them.



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

By the end of March 2021, four and a half years after launching, the Trust has received over 6600 Greatix submissions. This is an outstanding achievement and one that reflects just how valued Greatix is by the staff working at Newcastle Hospitals.

The number of Greatix submissions has grown year by year. Across October and November 2020 the system was closed due to upgrades, despite this we have managed to surpass the 2000 mark yet again. On current projections the total submissions in 2021/22 will surpass the previous year's totals.

QUALITY STRATEGY UPDATE

When the Care Quality Commission (CQC) inspected Newcastle NHS Foundation Trust in 2019 they awarded an outstanding rating overall. Peer review is Newcastle Hospitals internal inspection process. It uses CQC quality domains to rate the services provided by each directorate and ensure high quality outstanding care is achieved.

In the year 2019/20, peer review action plans were made by each Directorate. Due to COVID-19 these were informally reviewed and outstanding actions taken forward into 2020/21.

The 2020/21 peer review process needed to transform due to COVID-19. This year, 18 Directorates have participated in the process. Each Directorate, supported by the Clinical Governance and Risk Department (CGARD), has evaluated their own performance across all of the CQC domains. Most Directorates have undertaken limited walkabouts onto clinical areas to review the quality of care being provided to patients. This evidence has been presented on peer review self-assessment days where the Directorates have rated themselves. In order to ensure moderation of the ratings a senior peer review team reviewed all of the submitted evidence to finalise the ratings each Directorate was awarded.

The 2020/21 peer review concludes in June 2021. The Chief Operating Officer receives updated ratings for all Directorates and a report is submitted to the Quality Committee annually.

INFORMATION ON PARTICIPATION IN NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

During 2020/21, 63 national clinical audits and two national confidential enquiry reports / review outcome programmes covered NHS services that the Newcastle upon Tyne Foundation Hospitals NHS Foundation Trust provides.

During that period, the Newcastle upon Tyne Hospitals NHS Foundation Trust participated in 59 (94%) of the national clinical audits and 100% of the national confidential enquiries / review outcome programmes which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Newcastle upon Tyne Hospitals NHS Foundation Trust was eligible to participate in during 2020/21 and the national clinical audits / national confidential enquiries that the Newcastle upon Tyne Hospitals NHS Foundation Trust participated in during 2020/21 are as follows:

National Clinical Audits			National Confidential Enquiries
Antenatal and Newborn National Audit Protocol 2019-2022	National Asthma and COPD Audit Programme – Paediatric Asthma Secondary Care	National Gastro-intestinal Cancer Programme (GICAP)	Child Health Outcome Review Programme
British Association Urological Surgeons (BAUS) Audit – Cytoreductive Radical Nephrectomy Audit	National Asthma and COPD Audit Programme – Pulmonary Rehabilitation	National Joint Registry	Medical and Surgical Clinical Outcome Review Programme (NCEPOD)
BAUS Urology Audit - Female Stress Urinary Incontinence	National Audit of Breast Cancer in Older People	National Lung Cancer Audit	
BAUS Urology Audit – Renal Colic	National Audit of Cardiac Rehabilitation	National Maternity and Perinatal Audit (NMPA)	
British Spine Registry	National Audit of Dementia (Care in General Hospitals)	National Neonatal Audit Programme – Neonatal Intensive and Special Care (NNAP)	
Case Mix Programme (CMP)	National Audit of Pulmonary Hypertension	National Ophthalmology Database Audit	
Cleft Registry and Audit Network (CRANE)	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	National Paediatric Diabetes Audit (NPDA)	
Elective Surgery – National PROMs Programme	National Cardiac Arrest Audit (NCAA)	National Prostate Cancer Audit	
Emergency Medicine QIPs – Fractured Neck of Femur (care in emergency departments)	National Cardiac Audit Programme (NCAP) – Adult Cardiac Surgery	National Vascular Registry	
Emergency Medicine QIPs- Homelessness inclusion health (care in emergency departments)	National Cardiac Audit Programme (NCAP) – Cardiac Rhythm Management	Neurosurgical National Audit Programme	

National Clinical Audits			National Confidential Enquiries
Emergency Medicine QIPs – Pain in Children (care in emergency departments)	National Cardiac Audit Programme (NCAP) – Congenital Heart Disease in Children and Adults	Paediatric Intensive Care Audit Network (PICANet)	
Falls and Fragility Fracture Audit Programme – Fracture Liaison Service Database	National Cardiac Audit Programme (NCAP) – Heart Failure	Perioperative Quality Improvement Programme (PQIP)	
Falls and Fragility Fracture Audit Programme – National Audit of Inpatient Falls	National Cardiac Audit Programme (NCAP) – Myocardial Ischaemia / MINAP	Sentinel Stroke National Audit Programme (SSNAP)	
Falls and Fragility Fracture Audit Programme – National hip Fracture Database	National Cardiac Audit Programme (NCAP) – Percutaneous Coronary Interventions	Serious Hazards of Transfusion (SHOT)	
Inflammatory Bowel Disease (IBD) Audit (Biological Therapies Audit)	National Diabetes Audit – Adults: Diabetic Inpatient Harms	Society for Acute Medicine's Benchmarking Audit (SAMBA)	
Inflammatory Bowel Disease (IBD) Audit (Service Standards)	National Diabetes Audit – Adults: National Core Diabetes Audit	Surgical Site Infection Surveillance Service	
Learning Disability Mortality Review Programme (LeDeR)	National Diabetes Audit – Adults: National Diabetes Foot Care Audit	Trauma Audit and Research Network (TARN)	
Mandatory Surveillance of HCAI	National Diabetes Audit – Adults: National Diabetes Inpatient Audit	UK Cystic Fibrosis Registry	
Maternal, Newborn and Infant Clinical Outcome Review Programme	National Diabetes Audit – Adults: National Pregnancy in Diabetes Audit	UK Registry of Endocrine and Thyroid Surgery	
National Asthma and COPD Audit Programme – Adult Asthma Secondary Care	National Early Inflammatory Arthritis Audit (NEIAA)	UK Renal Registry National Acute Kidney Injury Programme	
National Asthma and COPD Audit Programme – COPD Secondary Care	National Emergency Laparotomy Audit (NELA)		

The national clinical audits and national confidential enquiries that the Newcastle upon Tyne Hospitals NHS Foundation Trust participated in during 2020/21 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 2020/21	Percentage Data completion	Outcome
Antenatal and Newborn National Audit Protocol 2019-2022	Public Health England (PHE)	The audit reviews some of the critical points in the screening pathways.	Y	100%	Published report expected 2021
BAUS Urology Audit - Cytoreductive Radical Nephrectomy Audit	British Association of Urological Surgeons	The audit has collected data on the current management of patients undergoing radical nephrectomy in the UK to reduce tumour volume.	Y	Continuous data collection	No publication date yet identified
BAUS Urology Audit - Female Stress Urinary Incontinence Audit	British Association of Urological Surgeons	The audit addresses open surgery for stress incontinence of urine in women.	Y	Continuous data collection	No publication date yet identified
BAUS Urology Audit - Renal Colic Audit	British Association of Urological Surgeons	The audit has collected baseline data on the assessment and management of patients presenting with renal colic.	Y	100%	No publication date yet identified
British Spine Registry	Amplitude Clinical Services Ltd	This audit collects data on patients receiving spinal surgery in the UK.	Y	Continuous data collection	No publication date yet identified
Case Mix Programme (CMP)	Intensive Care National Audit & Research Centre (ICNARC)	This audit looks at patient outcomes from adult, general critical care units in England, Wales and Northern Ireland.	Y	Continuous data collection	No publication date yet identified
Cleft Registry and Audit Network (CRANE)	Royal College of Surgeons (RCS)	The CRANE Database collects information about all children born with cleft lip and/or cleft palate in England, Wales and Northern Ireland.	Y	Continuous data collection	No publication date yet identified
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	Published report expected Spring 2021
Emergency Medicine QIPs - Fractured Neck of Femur (care in emergency departments)	Royal College of Emergency Medicine (RCEM)	This audit aims to improve the care provided to adult patients in the ED who have a diagnosis of fractured neck of femur.	Y	Data collection October 2020 to April 2021	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2020/21	Percentage Data completion	Outcome
Emergency Medicine QIPs – Infection Control (care in emergency departments)	Royal College of Emergency Medicine (RCEM)	The purpose of the QIP is to improve patient safety and quality of care as well as, workspace safety through sufficient measurement to track change but with a rigorous focus on action to improve.	Y	Data collection October 2020 to April 2021	No publication date yet identified
Emergency Medicine QIPs - Pain in Children (care in emergency departments)	Royal College of Emergency Medicine (RCEM)	The purpose of the QIP is to improve patient care by reducing pain and suffering, in a timely and effective manner through sufficient measurement to track change but with a rigorous focus on action to improve.	Y	Data collection October 2020 to October 2021	No publication date yet identified
Falls and Fragility Fracture Audit Programme (FFFAP) - Fracture Liaison Service Database	Royal College of Physicians (RCP)	Fracture Liaison Services are the key secondary prevention service model to identify and prevent primary and secondary hip fractures. The audit has developed the Fracture Liaison Service Database to benchmark services and drive quality improvement.	Y	Continuous data collection	Published report expected April 2021
Falls and Fragility Fracture Audit Programme (FFFAP) - National Audit of Inpatient Falls	Royal College of Physicians (RCP)	The audit provides the first comprehensive data sets on the quality of falls prevention practice in acute hospitals.	Y	Continuous data collection	Published report expected April 2021
Falls and Fragility Fracture Audit Programme (FFFAP) - National Hip Fracture Database	Royal College of Physicians (RCP)	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	Report published January 2021
Inflammatory Bowel Disease (IBD) Audit (Biological Therapies Audit)	IBD Registry	The audit aims to improve the quality and safety of care for IBD patients throughout the UK.	The Trust did not participate in the audit due to resource issues within the department as well as IT software compatibility. These issues are being addressed with a view to participate in the next audit.		
Inflammatory Bowel Disease (IBD) Audit (Service Standards)	IBD Registry	The audit aims to improve the quality and safety of care for IBD patients throughout the UK.	The Trust did not participate in the audit due to resource issues within the department as well as IT software compatibility. These issues are being addressed with a view to participate in the next audit.		

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2020/21	Percentage Data completion	Outcome
Learning Disability Mortality Review Programme (LeDeR)	University of Bristol's Norah Fry Centre for Disability Studies	The audit aims to improve the health of people with a learning disability and reduce health inequalities.	Y	Continuous data collection	No publication date yet identified
Mandatory Surveillance of HCAI	Public Health England (PHE)	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	University of Oxford / MBRRACE-UK collaborative	The aim of the audit is to provide robust national information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services.	Y	Continuous data collection	No publication date yet identified
National Asthma and COPD Audit Programme - Adult Asthma Secondary Care	Royal College of Physicians (RCP)	The audit looks at the care of people admitted to hospital adult services with asthma attacks.	Y	Continuous data collection	No publication date yet identified
National Asthma and COPD Audit Programme - COPD Secondary Care	Royal College of Physicians (RCP)	The aim of the audit is to drive improvements in the quality of care and services provided for COPD patients.	Y	Continuous data collection	No publication date yet identified
National Asthma and COPD Audit Programme - Paediatric Asthma Secondary Care	Royal College of Physicians (RCP)	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	100%	No publication date yet identified
National Asthma and COPD Audit Programme - Pulmonary Rehabilitation	Royal College of Physicians (RCP)	This audit looks at the care people with COPD get in pulmonary rehabilitation services.	Y	Continuous data collection	No publication date yet identified
National Audit of Breast Cancer in Older Patients	Royal College of Surgeons (RCS)	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	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2020/21	Percentage Data completion	Outcome
National Audit of Cardiac Rehabilitation	University of York	The audit aims to support cardiovascular prevention and rehabilitation services to achieve the best possible outcomes for patients with cardiovascular disease, irrespective of where they live.	Y	Continuous data collection	No publication date yet identified
National Audit of Dementia (Care in General Hospitals)	Royal College of Psychiatrists (RCPsych)	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	Data collection was suspended	No publication date yet identified
National Audit of Pulmonary Hypertension	NHS Digital	The audit measures the quality of care provided to people referred to pulmonary hypertension services.	Y	Continuous data collection	No publication date yet identified
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Royal College of Paediatrics and Child Health (RCPCH)	The audit aims to address the care of children and young people with suspected epilepsy who receive a first paediatric assessment within acute, community and tertiary paediatric services.	Y	Data collection April 2020 to March 2021	No publication date yet identified
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit & Research Centre (ICNARC)	The project audits cardiac arrests attended to by in-hospital resuscitation teams.	Y	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme (NCAP) - Adult Cardiac Surgery	Barts Health NHS Trust / National Institute for Cardiovascular Outcomes Research (NICOR)	This audit looks at heart operations. Details of who undertakes the operations, the general health of the patients, the nature and outcome of the operation, particularly mortality rates in relation to preoperative risk and major complications.	Y	Data collection April 2020 to March 2021	No publication date yet identified
National Cardiac Audit Programme (NCAP) - Cardiac Rhythm Management	Barts Health NHS Trust / National Institute for Cardiovascular Outcomes Research (NICOR)	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 2020 to March 2021	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2020/21	Percentage Data completion	Outcome
National Cardiac Audit Programme (NCAP) - Congenital Heart Disease in Children and Adults	Barts Health NHS Trust / National Institute for Cardiovascular Outcomes Research (NICOR)	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 2020 to March 2021	No publication date yet identified
National Cardiac Audit Programme (NCAP) - Heart Failure	Barts Health NHS Trust / National Institute for Cardiovascular Outcomes Research (NICOR)	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 2020 to March 2021	No publication date yet identified
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia/ MINAP	Barts Health NHS Trust / National Institute for Cardiovascular Outcomes Research (NICOR)	The Myocardial Ischaemia National Audit Project was established in 1999 in response to the National Service Framework for Coronary Heart Disease, to examine the quality of management of heart attacks (Myocardial Infarction) in hospitals in England and Wales.	Y	Data collection April 2020 to March 2021	No publication date yet identified
National Cardiac Audit Programme (NCAP) - Percutaneous Coronary Interventions (PCI)	Barts Health NHS Trust / National Institute for Cardiovascular Outcomes Research (NICOR)	The audit collects and analyses data on the nature and outcome of PCI procedures, who performs them and the general health of patients. The audit utilises the Central Cardiac Audit Database, which has developed secure data collection, analysis and monitoring tools and provides a common infrastructure for all the coronary heart disease audits.	Y	Data collection April 2020 to March 2021	No publication date yet identified
National Diabetes Audit - Adults: Harms - diabetic inpatient harms	NHS Digital	The National Diabetes Inpatient Audit - Harms is a continuous collection of four diabetic harms which can occur during an inpatient stay.	Y	Data collection April 2020 to March 2021	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2020/21	Percentage Data completion	Outcome
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 achieved their treatment targets as set out by NICE guidelines.	Y	100%	No publication date yet identified
National Diabetes Audit - Adults: National Diabetes Foot Care Audit	NHS Digital	Patients referred to specialist diabetes footcare services for an expert assessment on a new diabetic foot ulcer.	Y	Data collection April 2020 to March 2021	No publication date yet identified
National Diabetes Audit - Adults: National Diabetes Inpatient Audit	NHS Digital	The National Diabetes Inpatient Audit is an annual snapshot audit of diabetes inpatient care in England and Wales and is open to participation from hospitals with medical and surgical wards. The audit allows hospitals to benchmark hospital diabetes care and to prioritise improvements in service provision that will make a real difference to patients' experiences and outcomes.	Y	100%	No publication date yet identified
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 (NEIAA)	British Society for Rheumatology	The audit aims to improve the quality of care for people living with inflammatory arthritis.	Y	Data collection April 2020 to March 2021	No publication date yet identified
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists (RCOA)	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	No publication date yet identified
National Gastro-intestinal Cancer Programme (GICAP)	NHS Digital	The audit aims to evaluate the quality of care received by patients with oesophago-gastric cancer in England and Wales.	Y	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2020/21	Percentage Data completion	Outcome
National Joint Registry	Healthcare Quality Improvement Partnership (HQIP)	The audit covers clinical audit during the previous calendar year and outcomes including survivorship, mortality and length of stay.	Y	Continuous data collection	No publication date yet identified
National Lung Cancer Audit (NLCA)	Royal College of Physicians (RCP)	The audit was set up to monitor the introduction and effectiveness of cancer services.	Y	100%	No publication date yet identified
National Maternity and Perinatal Audit (NMPA)	Royal College of Obstetricians and Gynaecologists (RCOG)	A large scale audit of NHS maternity services across England, Scotland and Wales, collecting data on all registrable births delivered under NHS care.	Y	100%	No publication date yet identified
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Royal College of Paediatrics and Child Health (RCPCH)	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	No publication date yet identified
National Ophthalmology Database Audit	The 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.	Y	Continuous data collection	No publication date yet identified
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health (RCPCH)	The audit covers registrations, complications, care process and treatment targets.	Y	Data collection April 2020 to March 2021	Published report expected April 2021

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2020/21	Percentage Data completion	Outcome
National Prostate Cancer Audit	Royal College of Surgeons (RCS)	The National Prostate Cancer Audit is the first national clinical audit of the care that men receive following a diagnosis of prostate cancer.	Y	Date collection April 2020 to March 2021	Published report expected 2022
National Vascular Registry	Royal College of Surgeons (RCS)	The National Vascular Registry collects data on all patients undergoing major vascular surgery in NHS hospitals in the UK.	Y	Data collection April 2020 to March 2021	No publication date yet identified
Neurosurgical National Audit Programme	Society of British Neurosurgeons	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	Data collection April 2020 to March 2021	No publication date yet identified
Paediatric Intensive Care Audit Network (PICANet)	University of Leeds / University of Leicester	PICANet aims to continually support the improvement of paediatric intensive care provision throughout the UK by providing detailed information on paediatric intensive care activity and outcomes.	Y	Data collection April 2020 to March 2021	No publication date yet identified
Perioperative Quality Improvement Programme (PQIP)	Royal College of Anaesthetists (RCOA)	This programme aims to improve the care and treatment of patients undergoing major surgery in the UK.	Y	Continuous data collection	No publication date yet identified
Sentinel Stroke National Audit Programme (SSNAP)	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	Data collection April 2020 to March 2021	No publication date yet identified
Serious Hazards of Transfusion (SHOT)	Serious Hazards of Transfusion (SHOT)	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	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2020/21	Percentage Data completion	Outcome
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Society for Acute Medicine	SAMBA is a national benchmark audit of acute medical care. The aim is to describe the severity of illness of acute medical patients presenting to Acute Medicine, the speed of their assessment, their pathway and progress at seven days after admission and to provide a comparison for each participating unit with the national average.	The Trust did not participate in the programme due to local resourcing issues.		
Surgical Site Infection Surveillance Service	Public Health England (PHE)	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	Data collection April 2020 to March 2021	No publication date yet identified
Trauma Audit & Research Network (TARN)	Trauma Audit & Research Network (TARN)	The audit aims to highlight areas where improvements could be made in either the prevention of injury or the process of care for injured patients.	Y	Continuous data collection	Major Trauma Dashboards (quarterly), Clinical Feedback reports (3 per year), PROMs reports (quarterly).
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	This audit looks at the care of people with a diagnosis of cystic fibrosis under the care of the NHS in the UK.	Y	Continuous data collection	No publication date yet identified
UK Registry of Endocrine and Thyroid Surgery	British Association of Endocrine and Thyroid Surgeons (BAETS)	The audit aims to improve the quality of services and outcomes for patients undergoing endocrine surgical operations.	Y	Continuous data collection	No publication date yet identified
UK Renal Registry National Acute Kidney Injury programme	UK Renal Registry	The audit collects and reports data on kidney patients on renal replacement therapy in the UK and the care provided to these patients.	Y	Data collection April 2020 to March 2021	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2020/21	Percentage Data completion	Outcome
Child Health Clinical Outcome Review Programme - Transition	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	The audit aims to assess the quality of healthcare and stimulate improvement in safety and effectiveness.	Y	Data collection period TBC	No publication date yet identified
Medical and Surgical Clinical Outcome Review Programme – Death and disability in Epilepsy	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	The audit aims to assess the quality of healthcare and stimulate improvement in safety and effectiveness.	Y	Data collection period TBC	No publication date yet identified

An additional 9 audits have been added to the list for inclusion in 2021/22 Quality Account, only 7 of these audits are relevant to services provided by the Trust. The audits include:

- Chronic Kidney Disease Registry.
- National Audit of Cardiovascular Disease Prevention.
- National Child Mortality Database.
- National Perinatal Mortality Review Tool.
- Prescribing for substance misuse: alcohol detoxification.
- National Outpatient Management of Pulmonary Embolism.
- Transurethral Resection and Single instillation mitomycin C evaluation in bladder cancer treatment.

The reports of national clinical audits were reviewed by the provider in 2020/21 and the Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

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

The reports of 815 local audits were reviewed by the provider in 2020/21 and the Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following action to improve the quality of health care provided:

- Each Clinical Directorate is required to present an Annual Clinical Audit Report to the Clinical Audit and Guidelines Group detailing all audit activity undertaken both national and local.

INFORMATION ON PARTICIPATION IN CLINICAL RESEARCH

Newcastle Hospitals has been key to the research response to COVID-19 in 2020/21 and made a significant contribution to several of the COVID-19 vaccine studies.

When the COVID-19 pandemic started, Newcastle paused all trials unless they related to COVID-19, or where the treatment involved was essential for serious or life-threatening conditions. Forty-three specific COVID-19 studies were opened at Newcastle and 4,146 patients recruited.

At the height of the pandemic Newcastle, clinicians worked on several trials now used to help patients across the UK. Newcastle was part of the trial that found the steroid dexamethasone might substantially reduce mortality in severely ill COVID-19 patients. The drug is now in use in the NHS as a treatment for severe COVID-19. The drug Remdesivir was also trialled at Newcastle and approved for use following evidence that the drug can shorten recovery time in hospitalised patients.

After rigorous review, Newcastle restarted paused trials and 328 of the open studies went on to recruit 10,525 participants provided or hosted by Newcastle Hospitals of which 10,116 enrolled on to UK National Institute Health Research (NIHR) Clinical Research Network (CRN) portfolio studies, equating to 21% of all patients recruiting to NIHR portfolio studies in the region.

INFORMATION ON THE USE OF THE CQUIN FRAMEWORK

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

In previous years a proportion of Newcastle Hospitals income had been conditional upon achieving quality improvement and innovation, through Commissioning for Quality Innovation (CQUIN) payment framework. For 2020/21 that is not the case and the suspension of healthcare contract implies the suspension of CQUIN as well.

However, the Trust has continued to observe CQUIN requirements where feasible given the operational need to respond to the COVID-19 pandemic. The schemes we have been able to progress include: Staff Flu Vaccinations; Personalised Care; Cystic Fibrosis; and Dental Quality Dashboards.

At present we do not know when healthcare contracting will restart. We assume that CQUIN will be part of those restarted contracts but not whether that means all former schemes will be brought forward for completion or a new set of schemes agreed.

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

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

INFORMATION ON THE QUALITY OF DATA

Newcastle Hospitals submitted records during 2020/21 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data:

which included the patients valid NHS number was:
99.6% for admitted patient care;
99.8% for outpatient care;
99.2% for accident and emergency care.

which included the patients valid General Medical Practice Code was:
100% for admitted patient care;
100% for outpatient care;
99.9% for accident and emergency care.

Clinical Coding Information

Score for 2020/21 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 2020/21 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 an excellent level of attainment and satisfies the requirements of the Data Security and Protection Toolkit Assessment.

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

- Respiratory Medicine (COVID-19 SARS-CoV-2)
- Clinical Oncology
- Neurosurgery

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

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

	Levels of Attainment		
	Standards Met	Standards Exceeded	NUTH Level
Primary diagnosis	>=90%	>=95%	100.0%
Secondary diagnosis	>=80%	>=90%	99.5%
Primary procedure	>=90%	>=95%	98.4%
Secondary procedure	>=80%	>=90%	97.1%

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

- Update coders on the standards and guidance surrounding the errors found in this audit.
- The management should ensure full and accurate validation of COVID-19 (SARS-CoV-2) data.

The clinical coding trainer is advised to review the local policies in-line with coding standards PCSU1: Diagnostic imaging procedures.

KEY NATIONAL PRIORITIES 2020/21

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 2020/21 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**	**Annual Performance 2020/21**
Incidence of Clostridium (*C .difficile:* variance from plan)	No more than 113 cases	113	111*
Incidence of MRSA Bacteraemia	Zero tolerance	1	1
All Cancer Two Week Wait	93%	82.8%	62.5%
Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	93%	24.1%	50.7%
31-Day (Diagnosis To Treatment) Wait For First Treatment	96%	93.8%	93.0%
31-Day Wait For Second Or Subsequent Treatment: Surgery	94%	86.0%	89.1%
31-Day Wait For Second Or Subsequent Treatment: Drug treatment	98%	97.0%	96.4%
31-Day Wait For Second Or Subsequent Treatment: Radiotherapy	94%	98.7%	97.5%
All cancers: 62-day wait for first treatment from: • urgent GP referral for suspected cancer	85%	77.1%	76.3%
All cancers: 62-day wait for first treatment from: • NHS Cancer Screening Service referral	90%	89.4%	63.7%
RTT – Referral to Treatment - Admitted Compliance	90%	76.4%	67.3%
RTT – Referral to Treatment - Non-Admitted Compliance	95%	87.8%	78.9%
RTT – Referral to Treatment - Incomplete Compliance	92%	90.2%	65.5%
Maximum 6-week wait for diagnostic procedures	99%	96.0%	80.7%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	95%	94.32%	91.9%
Delayed Transfers	N/A – Reporting suspended re COVID-19	2.7%	N/A – Reporting suspended re COVID-19
Cancelled operations – those not admitted within 28 days	Offered a date within 28 days of none clinical cancellation	51	93.41% (789 cancelled ops with 52 breaching 28 day target)
Maternity bookings within 12 weeks and 6 days	Not defined	87.02%	88.4%
Data completeness: Community Services comprising: Referral to treatment information	Not defined	99.7%	99.7%
Data completeness: Community Services comprising: Referral information	Not defined	94.9%	93%
Data completeness: Community Services comprising: Treatment activity information	Not defined	98.0%	94%

Details on Hospital-level Mortality Indicator please refer to page 90.
Details on Venous thromboembolism (VTE) risk assessment please refer to page 93.
* 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:

Cancer Performance Targets

The reasons for cancer performance deterioration have included:

- Reduced capacity due to COVID-19 (Staffing)
- Increased DNA rates at the initial impact of COVID-19
- Patients choosing to delay appointments and investigations due to concerns around the pandemic
- Regional frailty in a number of services has impacted NUTH.

Alternative treatments have been given in some tumour groups which have not been counted within the standards due to CWT guidelines.

Pressure continues in diagnostics, specifically Radiology and Endoscopy. Ongoing work is in place to improve pathways, new ways of working have been introduced including centralised triage, Tele-dermatology and the introduction of FIT testing in Colorectal. Short term funding has been allocated via the Cancer Alliance to support the introduction of rapid diagnostic services.

The Trust played a key role during the Jan / Feb surge, chairing the Northern Cancer Alliance North Surgical Hub and performing theatre activity on behalf of other Trusts who no longer had capacity to ensure equity of access remained across the region.

NB: March 2021 data will not be finalised until May 2021. Revisions to the data uploaded to the national database NHS Digital system for the period October 2020 to March 2021 can be made up to June 2021, which can impact on numbers. The new process of re-allocation can also impact especially with the introduction of middle trust involvement making the allocation process more complex and unpredictable.

A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge

COVID-19 measures were successful in managing outbreaks and surges but it impacted patient flow in several key areas that affected the A&E target. There has been a 16% reduction of acute beds due to social distancing measures and the removal of the clinical decisions unit in ED. There were also delays in obtaining rapid COVID-19 test result that allowed us to safely move the patients from ED to base wards. In addition, there was a strategic decision taken to increase the geographical catchment area of emergency patients that would default to Newcastle Hospitals. The initiation of ambulance boarder control gave North East Ambulance Service (NEAS) the power to divert patients to an ED with the shortest handover time that led to a further increase in the regional percentage of ambulance admissions to ED.

There has been a significant reduction in Type 2 and Type 3 activity during the year which has resulted in the Trust receiving a higher proportion of high acuity patients, this directly impacts on the Trust's ability to meet the overall 4 hour standard.

Delayed Transfers

Delayed transfer of care reporting was suspended due to COVID-19. New guidance introduced in March 2020 requires every patient to be matched against the criteria to reside in hospital and those patients who do not meet the criteria to reside should be discharged within 3 hours of the criteria being checked. This data has been reported daily from 16th April 2020 (when data collection commenced) to 31st March 2021. 89% of patients met the criteria to reside. The 11 % of patients who did not meet the criteria to reside where supported to discharge with the discharge to assess hub.

Cancelled operations – those not admitted within 28 days

The 3 surges of COVID-19 led to the Trust having to expand its medical capacity to accommodate the increase of inpatients. This led to many wards converting from surgical specialities to medicine. Newcastle Hospitals was at the forefront of the national effort to take out of area patients whom required level 3 (ITU) support. This expansion of Newcastle Hospitals critical care beds resulted in theatre closures to allow the redeployment of nursing staff with the required skills.
Non-urgent elective operations were subsequently postponed over the COVID-19 surge period; with the Trust maintain P1 and P2 operations.

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	2020/21				2019/20				2018/19		
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 19 – Sept 20 **NUTH Value:** 0.9795 **NUTH Band 2**	Jul 19 - Jun 20 **NUTH Value:** 0.9948 **NUTH Band 2**	Apr 19 - Mar 20 **NUTH Value:** 0.9791 **NUTH Band 2**	Jan19 - Dec 19 **NUTH Value:** 0.9700 **NUTH Band 2**	Oct 18 - Sep 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 - Sep 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**
			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	1.1795	1.2074	1.1997	1.1999	1.1877	1.1916	1.2058	1.2264	1.268	1.257	1.2321
			Lowest National	0.6869	0.6764	0.6851	0.6889	0.6979	0.6967	0.7069	0.6993	0.692	0.698	0.6994
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		35%	33%	32%	31%	32%	33%	33%	32%	29.2%	28.7%	28.4%
			National Average	36%	36%	37%	36%	36%	36%	35%	34%	33.6%	33.1%	32.5%
			Highest National	60%	60%	58%	60%	59%	60%	60%	60%	59.5%	58.7%	59.0%
			Lowest National	9%	9%	9%	10%	12%	15%	12%	15%	14.3%	13.4%	12.6%

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 continues to monitor the quality of its services, by involving the Coding team and End of Life team in routine mortality reviews to ensure accuracy and consistency of palliative care coding. We continue to monitor and discuss patients with a palliative care coding at the quarterly Mortality Surveillance Group.

Measure	Data Source	Value	2020/21	2019/20	2018/19	2017/18	2016/ 17
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				
		National Average					
		Highest National					
		Lowest National					
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				
		National Average					
		Highest National					
		Lowest National					
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	Not available	0.46	0.50	0.47	0.44
		National Average:	Not available	0.46	0.47	0.47	0.44
		Highest National:	Not available	0.54	0.56	0.57	0.54
		Lowest National:	Not available	0.35	0.35	0.38	0.31
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	Not available	0.36	0.31	0.33	0.33
		National Average:	Not available	0.34	0.34	0.34	0.32
		Highest National:	Not available	0.42	0.41	0.42	0.40
		Lowest National:	Not available	0.22	0.27	0.23	0.24

Please note that finalised PROMs data is now available for 2019/20. Finalised 2020/21 data will not be available until September 2021.

Measure 3. The patient reported outcome measures scores (PROMS) for groin hernia surgery.

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

Measure 4. The patient reported outcome measures scores (PROMS) for varicose vein surgery.

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

Measure 5. The patient reported outcome measures scores (PROMS) for hip replacement surgery.

Newcastle Hospitals considers that this data is as described for the following reasons: Newcastle Hospitals PROMS outcomes are good and we are committed to increasing our participation rates going forward. We encourage patients to complete these and discuss completion rates and results in the Arthroplasty Multidisciplinary team (MDT). Data for 2020/21 has not yet been released, but data for 2019/20 has been populated.

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

Newcastle Hospitals considers that this data is as described for the following reasons: Newcastle Hospitals PROMS outcomes are good and we are committed to increasing our participation rates going forward. We encourage patients to complete these and discuss completion rates and results in the Arthroplasty MDT. Data for 2020/21 has not yet been released, but data for 2019/20 has been populated.

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

Year	Total number of admissions/spells	Number of readmissions (all)	Emergency readmission rate (all)
2011/12	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
2018/19	36,387	2,003	5.5
2019/20	42,238	4,609	10.9
2020/21	29,319	2,643	9.0

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)
2011/12	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
2018/19	185,967	10,461	5.6
2019/20	192,365	12,648	6.6
2020/21	142,629	10,730	7.5

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

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

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 data is 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.

In 2020/21 (October 2020) paediatric ambulatory care started being recorded on firstnet as an Emergency Department attendance reducing the numbers of children emergency admissions and therefore readmissions.

Measure	Data Source	Value	2020/21	2019/20	2018/19	2017/18	2016/17	2015/16
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	72.6%	73.1%	74.9%	74.6%	76.1%
		National Average:	Not available	67.1%	67.2%	68.6%	68.1%	69.6%
		Highest National:	Not available	84.2%	85.0%	85.0%	85.2%	86.2%
		Lowest National:	Not available	59.5%	58.9%	60.5%	60.0%	54.4%
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	Not available	90%	90%	96%	95%	91%
		National Average:	Not available	71%	70%	81%	80%	72%
		Highest National:	Not available	95%	95%	100%	100%	95%
		Lowest National:	Not available	36%	33%	43%	44%	48%

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 2020/2021 has not yet been released, but data for 2019/2020 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 2019/2020 has been added as it was not available at time of publication last year.

Measure	Data Source	Target	2020/21				2019/20				2018/19			
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 %	Q1	Q2	Q3	Q4	Q1 97.65 %	Q2 96.80 %	Q3 97.21 %	Q4	Q1 96.49 %	Q2 95.72 %	Q3 97.23 %	Q4 96.64 %
		National Average:	Not available	Not available	Not available	Not available	95.63 %	95.47 %	95.33 %	Not available	95.63 %	95.49 %	95.65 %	95.74 %
		Highest National:	Not available	Not available	Not available	Not available	100%	100%	100%	Not available	100%	100%	100%	100%
		Lowest National:	Not available	Not available	Not available	Not available	69.76 %	71.72 %	71.59 %	Not available	75.84 %	68.67 %	54.86 %	74.03 %

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

Data for Q4 2019/20 will not be published until June 2021. Data for 2020/21 will not be published until Summer 2021. Therefore, the Trust has reviewed its own internal data

and used its own methodology of reporting the following data for the number of patients who have had a VTE Assessment on Admission, Q1 97.6%, Q2 97.6%, Q3 97.0% and Q4 97.2%.

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. The Trust has continued with use of the practice of undertaking Root Cause Analysis (RCA) on patients who develop a hospital acquired VTE.

Measure	Data Source	Target	2020/21	2019/20	2018/19	2017/18
11. The number of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over	PHE Data Capture System	Trust number of cases	111 HOHA* = 85 COHA* = 26 (no appeals process this financial year)	113 HOHA* = 95 COHA* = 18 National figure 89 (minus 24 successful appeals**)	77 National figure 51 (minus successful appeals)	88 National figure 77 (minus successful appeals)
		National Average number of cases	HOHA* = 34 COHA* 15	HOHA* = 42 COHA* = 17	31	34
		Highest National number of cases	HOHA* = 149 COHA* 60	HOHA* = 122 COHA* = 77	130	138
		Lowest National number of cases	HOHA* = 0 COHA* 0	HOHA* = 0 COHA* = 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	2020/21		2019/20		2018/19		2017/18	
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 2020 - March 2021 9570	April-2020 Sept 2020 7927	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
		Trust %	43.8	43.6	41.5	41.8	39.8	38.3	36.53	35.57
		National Average	Not available	Not available	49.1	48.5	44.7	44.52	42.5	42.8
		Highest National	Not available	Not available	110.2	103.8	95.9	107.4	124	111.56
		Lowest National	Not available	Not available	15.7	26.3	16.9	13.1	24.2	23.5

Measure	Data Source	Target	2020/21				2019/20				2018/19			
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 2020-Mar 2021 **Severe Harm** 33	Oct 2020-Mar 2021 **Death** 34	April-2020 Sept 2020 **Severe Harm** 18	April-2020 Sept 2020 **Death** 5	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
		Trust %	0.3%	0.4%	0.1%	0.0%	0.3%	0.0%	0.2%	0.0%	0.3%	0%	0.3%	0%
		National Average	Not available	Not available	Not available	Not available	Not available	Not available	0.15%	0.04%	0.15%	0.01%	0.26%	0.11%
		Highest National	Not available	Not available	Not available	Not available	Not available	Not available	0.23%	0.08%	0.23%	0.09%	0.9%	0.6%
		Lowest National	Not available	Not available	Not available	Not available	Not available	Not available	1.22%	0.66%	1.18%	0.65%	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; Quarterly HCAI Report to share lessons learned and best practice from 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. The 2019/20 data has now been updated where it was not available last year. The national data for 2020/21 is due for release in Sept 2021.2020/21 Trust data has been compared with all other Organisations described as Acute Trusts in NRLS.

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 2019/20 data has now been updated where it was not available last year. The national data for 2020/21 is due for

release in Sept 2021. 2020/21 Trust data has been compared with all other Organisations described as Acute Trusts in NRLS.

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)

	Dec 2019	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20
The Newcastle Upon Tyne Hospitals	5.04%	4.99%	4.70%	5.06%	5.57%	4.70%	4.45%	4.17%	3.95%	4.20%	4.94%	5.43%
South Tyneside and Sunderland	5.62%	5.62%	5.39%	5.07%	5.99%	6.07%	4.77%	4.51%	4.70%	4.85%	5.16%	5.62%
County Durham and Darlington	5.83%	5.58%	5.17%	5.77%	8.86%	7.07%	5.46%	4.75%	4.89%	5.07%	5.46%	6.78%
Gateshead Health	4.87%	4.93%	4.62%	5.25%	6.52%	4.49%	3.73%	3.73%	4.21%	4.78%	5.38%	6.21%
North Tees and Hartlepool	5.45%	5.14%	4.56%	5.40%	6.90%	6.49%	5.56%	4.83%	4.71%	4.85%	5.50%	6.79%
Northumbria Healthcare	5.06%	4.73%	4.38%	4.52%	4.83%	4.35%	3.82%	3.79%	3.94%	4.37%	4.84%	5.67%
South Tees Hospitals	5.14%	5.44%	4.84%	4.74%	5.07%	4.94%	4.28%	4.03%	4.36%	4.74%	5.20%	6.05%
England	4.86%	4.81%	4.51%	5.36%	6.20%	4.72%	4.04%	3.88%	3.90%	4.19%	4.52%	4.92%

The table below 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
2009/10 no. of days	251	414	581	298	1544
2010/11 no. of days	118	254	267	366	1005
2011/12 no. of days	253	299	247	153	952
2012/13 no. of days	154	138	174	209	675
2013/14 no. of days	489	331	785	147	1752
2014/15 no. of days	333	284	178	206	1001
2015/16 no. of days	360	194	365	219	1138
2016/17 no. of days	230	387	136	84	837
2017/18 no. of days	137	90	51	122	400
2018/19 no. of days	214	131	188	326	859
2019/20 no. of days	249	172	67	123	611
2020/21 no. of days	Not available	Not available	Not available	Not available	Not available

2020 NHS STAFF SURVEY RESULTS SUMMARY

As part of the local questions in the 2020 NHS Staff Survey, we asked staff about the options available to them to raise concerns. The results were very encouraging indicating an awareness of the resources available, and indicating an improvement in staff feeling safe at work, secure in raising concerns about unsafe clinical practice, and confident that the Trust acts on concerns.

A standard survey was sent via email to all employees of the Trust (via external post for those on maternity leave), giving all 14,933 members of our staff a voice. 7,072 staff participated in the survey, equalling a response rate of 48%, which is in the sector average and was a 4% improvement on the 2019 response rate of 44%.

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

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

- Advocacy, measured by Q18a, Q18c and Q18d (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 7.3 (out of possible 10).
This score was 0.2 below top position in the sector (Combined Acute & Community Trusts) and has maintained the Trusts score for 2020.

The Trust scored significantly better on 8 of the 10 themes when compared with other Combined Acute & Community Trusts in England.

Equality, Diversity & Inclusion
NuTH Score: 9.32 out of 10
Sector Score: 8.96 out of 10
Health & Wellbeing
NuTH Score: 6.32 out of 10
Sector Score: 6.07 out of 10
Morale
NuTH Score: 6.46 out of 10
Sector Score: 6.23 out of 10
Quality of Care
NuTH Score: 7.62 out of 10
Sector Score: 7.50 out of 10

Safe Environment – Bullying & Harassment
NuTH Score: 8.40 out of 10
Sector Score: 8.02 out of 10
Safe Environment – Violence
NuTH Score: 9.62 out of 10
Sector Score: 9.49 out of 10
Safety Culture
NuTH Score: 7.04 out of 10
Sector Score: 6.76 out of 10
Staff Engagement
NuTH Score: 7.26 out of 10
Sector Score: 7.04 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 – Bullying & harassment: 8.4 out of 10
Safe Environment – Violence: 9.6 out of 10
#1 in Shelford Group for
Equality, Diversity & Inclusion: 9.3 out of 10
Health & Wellbeing: 6.3 out of 10
Morale: 6.5 out of 10
Safe Environment – Violence: 9.6 out of 10

The Trust also compares favourably against the sector in a number of the 90 questions in the survey. Some to note include:

- 91% agree that they would be happy with the standard of care provided by the organisation should a friend of relative need treatment. This is 17% higher than sector average and the best in the sector.
- 89% agree that care of patients/service users is the organisations top priority. This is 10% 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.
- 65% agree that they are given feedback about changes made in response to reported errors, near misses and incidents. This is 3% higher than sector average.
- 66% are confident that the organisation would address their concerns. This is 6% higher than sector average.
- 38% stated they have felt unwell due to work related stress in the last 12 months. This is 6% 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 4% higher than the sector average.
- 76% would recommend the organisation as a place to work. This is 9% 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 scoring theme for the organisation is:
Team Working: 6.5 out of 10

INVOLVEMENT AND ENGAGEMENT 2020/21

Engagement and Involvement is about how we work together with people who use Trust's services to ensure their voice is heard; from ward and team level through to Trust Board and beyond. This includes having a range of supportive and effective mechanisms to feed back about services as well as systems and structures to ensure this experience is listened to, learnt from and acted upon to improve the services we offer.

COVID-19 has challenged nearly everything about health care delivery, including the experiences of patients and families. While the full impact of COVID-19 has yet to be fully understood, there are many ways in which the Trust has rapidly adapted over the past year to ensure we have continued to involve and listen to our patients and local communities.

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

The Trust is very proud of the close partnership work with local communities and voluntary groups in order to ensure that equal and diverse opportunities are promoted to all and that COVID-19 information has been shared in a timely manner.
This year, the Trust has successfully launched the new Family and Friends Test guidance and was successfully shortlisted to participate in a project led by Imperial College Healthcare NHS Trust to establish a means of using semi-automated methods for analysing Friends and Family Test (FFT) free text patient feedback. This will help NHS provider organisations better understand and be reactive to FFT feedback, gaining deeper insights to make service improvements.

In 2021 – 2022 the focus will be:

- Work in partnership with local communities and voluntary groups in order to ensure that equal and diverse opportunities are promoted to all;
- Continue to 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 FFT patient experience data to inform continuous improvement and transformation;
- To develop a clear and accessible social media presence to promote patient and public involvement.

ANNEX 1:

STATEMENT ON BEHALF OF THE NEWCASTLE HEALTH SCRUTINY COMMITTEE

19 May 2021

As Vice-Chair of the Health Scrutiny Committee, I welcome the opportunity to comment on your draft Quality Account for 2020/21, which we discussed at our meeting on 17 May 2021.

We recognise the importance of the Quality Account as a tool in ensuring that services are reviewed objectively and as a means of illustrating to patients, carers and partners the performance of the trust in relation to your quality priorities. We would like to congratulate you on this year's report which we found to contain a good level of technical detail whilst still being easy to follow. It is particularly impressive given the circumstances under which it was produced.

In relation to progress against your 2020/21 priorities:

- Whilst we are pleased to see that there have been some small wins in reducing rates of E. coli, Klebsiella and Pseudomonas aeruginosa infections over the last year, we also note that there have been some significant challenges around prevention and control due to Covid and that there could be practical difficulties in continuing the special measures around infection prevention that have been put in place during the pandemic over the long-term, even though funding for those measures is currently continuing. We are therefore pleased to see that infection control remains a priority for 2021-22 and we look forward to hearing more about progress in next year's report.
- We note that 'never events' are not currently included within quality priorities and are pleased and reassured to learn that this is due to the very low number which now occur within the organisation following the implementation of safety standards and improvement work.
- We are slightly concerned that there seems to have been a small increase in the rate of emergency readmissions to hospital within 28 days of discharge but note that this could be due to a change in the way that data is recorded. The Committee would like to receive further information about this, and we hope to see an improvement in next year's report.

In relation to the 2021/22 priorities, we believe the document is a fair and accurate representation of the services provided by the trust and reflects the areas that are of high importance to Newcastle residents.

In relation to the impact of the Covid-19 pandemic we acknowledge the continuing significant impact that this is having on health care services.

- We note that workforce fatigue continues to be a concern but are pleased to hear that there is recognition of this at a senior level and that support for staff is in place and there are plans for projects and initiatives to increase workforce resilience. We would be interested to see an update on the wellbeing of the workforce and on the outcome of the work to build resilience in next year's report, if not earlier.

- We note that there will be lessons that can be learned from the experience of Covid around good practice in reducing the transmission of winter flu and other respiratory viruses, and we look forward to seeing more about this in future reports.
- We were pleased to learn more about some of the innovative ways of delivering services introduced during Covid, including the Spinal Injections Pathway and the My Skin Selfie app, and we would hope to see these sort of solutions and creative thinking continue in the long term.

Finally, I would like to acknowledge and give thanks for the ongoing and open dialogue that the trust has established with us over the past few years, and which has been particularly valuable over the more recent difficult months. We look forward to seeing this continue.

Yours sincerely
Cllr Lara Ellis
Vice-Chair, Health Scrutiny Committee

STATEMENT ON BEHALF OF NORTHUMBERLAND COUNTY COUNCIL

Awaiting response, not received at end of 30-day consultation.

STATEMENT ON BEHALF OF THE NEWCASTLE & GATESHEAD CLINICAL COMMISSIONING GROUP ALLIANCE

NHS Newcastle Gateshead Clinical Commissioning Group

NHS Northumberland Clinical Commissioning Group

NHS North Tyneside Clinical Commissioning Group

18 May 2021

The Clinical Commissioning Groups (CCGs) welcome the opportunity to review and comment on the Annual Quality Account for Newcastle upon Tyne Hospitals NHS Foundation Trust for 2020/21 and would like to offer the following commentary:

As commissioners, Newcastle Gateshead, Northumberland and North Tyneside Clinical Commissioning Groups (CCGs) are committed to commissioning high quality services from Newcastle Upon Tyne Hospitals NHS Foundation Trust and take seriously their responsibility to ensure that patients' needs are met by the provision of safe, high quality services and that the views and expectations of patients and the public are listened to and acted upon.

Firstly, the CCGs acknowledge that 2020/21 has been an extremely challenging time for the Trust and the entire NHS. The CCGs would like to extend their sincere thanks to the Trust and all their staff for the excellent commitment shown in responding to the pandemic and for rapidly adapting and transforming services and pathways to deliver new ways of working, whilst ensuing that patient care continued to be delivered to a high standard.

The Trust is to be commended for maintaining delivery of all emergency activity and many urgent and life extending services during the active phases of the COVID-19 pandemic; as well as expanding capacity of services such as diagnostic COVID-19 testing and the COVID-19 vaccination programme. It is acknowledged that COVID-19 has unfortunately had a significant impact on the backlog of work and consequently increasing waiting times, which inevitably will have had an impact on patient experience and outcomes. The CCGs will continue to work collaboratively with the Trust to support and ensure delivery of the recovery element of the Restart, Reset and Recovery Programme.

As highlighted in the Chief Executive's statement the Trust's partnership working with 'Collaborative Newcastle', Newcastle City Council, neighbouring Trusts, primary care networks and commissioners has accelerated and strengthened over the past year. Health inequalities have significantly worsened in the North East due to the COVID-19 pandemic and this valuable working partnership will be key in tackling this; ensuring there is exceptional high-quality healthcare delivered with equitable access and excellent patient experience and optimal outcomes for all.

Throughout 2020/21 the CCGs have continued to hold regular quality review group meetings with the Trust which were well attended and provided positive engagement for the monitoring, review and discussion of quality issues. The Trust's Quality Account provides a comprehensive description of the improvement work undertaken and an open account where improvements in priorities have been made. The CCGs welcome that quality remains a top priority for 2021/22.

The CCGs recognise the continuing initiatives to reduce health care acquired infections and are pleased to note that the Trust achieved their aims in the reduction of Klebsiella and Pseudomonas Aeruginosa bacteraemias. The Trust achieved a 9.36% reduction in E. coli bacteraemias, which was slightly below their aim of 10%. Unfortunately, there has been a 3% increase in MSSA cases however it is noted that there had been more cases seen during the second and third wave of the pandemic. The number of C. Difficile cases remained slightly under the previous year's trajectory and the Trust reported one case of MRSA in April 2020. The CCGs commend the Trust for remaining below national and regional averages for the number of healthcare associated COVID-19 cases. The CCGs would like to thank the Trust and their Infection Prevention and Control Team for the invaluable advice and support they have provided to partner organisations throughout the pandemic. The CCGs fully supports that reducing healthcare acquired infections remains a quality priority for 2021/22 with a focus on COVID-19, MSSA, gram-negative blood stream infections and C.difficile infections.

The CCGs recognise the Trust's commitment in reducing inpatient pressure damage and it is positive to see that targeted improvement work resulted in a 43% reduction in serious harm within the Medicine Directorate, particularly Older People's Medicine. The CCGs note that since October 2020 there has been an increase in the number of pressure ulcers reported, which is consistent with previous winters and the added impact of the pandemic due to the increased acuity of patients. The CCGs welcomed the improved root cause analysis investigation process which resulted in a significantly improved turnaround of reports. The implementation of dashboards in June 2020 to allow a visual demonstration of incidents to promote ownership, understanding and monitoring for improvement is an excellent initiative. The CCGs recognise the Trust's commitment in pressure ulcer reduction and support this continuing as a quality priority in 2021/22; with a focus on community acquired pressure damage whilst under the care of the District Nursing Teams.

The CCGs note the progress made in developing a long-term electronic solution for the management of abnormal investigations quality priority, however, acknowledge that the building of the system has been delayed due to the competing requirements of the pandemic. The CCGs acknowledge the importance of this quality priority in improving patient safety and patient experience and fully support this continuing as a quality priority in 2021/22.

The Trust has made progress with the Closing the Loop quality priority to develop a centralised IT system to capture recommendations and resultant actions in one location. This included establishing a multi-disciplinary task and finish group and developing the functionality of Datix, the internal incident reporting system. It is noted that one directorate received training on the system and a pilot commenced, but this was temporarily deferred pending an upgrade to the Datix system. It is noted that once the new Datix system is in place and tested it is planned to roll this out Trust-wide. The CCGs look forward to receiving an update on the progress of this work at a future QRG meeting.

The CCGs congratulate the Trust on the excellent progress made in the Enhancing Capability in Quality Improvement priority, including the formation of Newcastle Improvement, signing a contract with the Institute for Healthcare Improvement and the formal evaluation of four work streams and bite sized sessions. It is pleasing to see that the evaluation demonstrated a positive increase in staff confidence in undertaking

improvement work. The CCGs recognise the importance of building capability and capacity for quality improvement at scale and fully support this continuing as a quality priority in 2021/22.

The CCGs congratulate the Trust for the achievements made with the ‘Treat as One' quality priority and for the excellent collaborative working with Cumbria, Northumberland Tyne and Wear NHS Foundation Trust. It is reassuring to see that the e-records compatibility across both Trusts has greatly improved and staff are able to access relevant clinical details across both systems. It is positive to see that the Trust is largely compliant with all the recommendations of the Treat as One NCEPOD 2017 guidance and that the task and finish group were meeting for a final time in April 2021 to identify any areas where further work is still necessary to enhance compliance.

The CCGs recognise the Trust's achievements in ensuring reasonable adjustments are made for patients with suspected or a known learning disability quality priority. It is pleasing to note the improvements made to the Learning Disabilities Mortality Review (LeDeR) process and that the current position demonstrates that all patients who have died with a learning disability have been reported into the national database. The CCGs fully support the Trust's plans to build further on this important work in 2021/22.

In 2020/21 the Trust reported three never events, which is a decrease on the previous year when five were reported. All never events are managed through the serious incident process and the CCGs continue to work with the Trust to identify learning and appropriate actions; gaining assurance through the CCG SI Panels and Quality Review Group meetings.

The emphasis that the Trust gives to national clinical audits and confidential enquiries demonstrates that the Trust is focussed on delivering evidence-based best practice. The CCGs commend the Trust for their significant contribution to clinical research during the pandemic including COVID-19 vaccine studies and working on several important drug trials, which are now being used to treat patients across the UK.

It is fully acknowledged that the NHS has faced huge pressures due to the COVID-19 pandemic and this has impacted on the Trust's performance across a number of the key national priorities. It is noted that there are continuing pressures in diagnostics, specifically Radiology and Endoscopy and work is ongoing to improve pathways. Throughout the pandemic the Trust has implemented new ways of working and short-term funding has been allocated from the Cancer Alliance to support the introduction of rapid diagnostic services. The Trust is to be commended for performing theatre activity on behalf of other Trusts who did not have capacity to ensure there was equity of access across the region. The CCGs will continue to work in partnership with the Trust and fully support the ongoing work and initiatives in place to improve cancer waiting times as well as other national key priorities.

The CCGs congratulate the Trust for the positive results received in the NHS Staff Survey; with 91% of staff stating they would be happy with the standard of care provided should a friend or relative need treatment and 89% agreeing that care is the top priority. It is acknowledged that where improvement areas have been identified appropriate action is taken to address this. The CCGs also note the Trust's strong performance in the National Patient Surveys and in particular the positive results from the Cancer Survey. The CCGs are also pleased to see the continued involvement and engagement work over the past year with the Trust rapidly adapting, using digital

technology, to ensure patients and local communities have been involved and listened to.

The CCGs would like to congratulate the Trust and staff for their excellent achievements in 2020/21, including wining a number of national awards. The CCGs also thank the Trust for their outstanding contribution to the COVID-19 vaccination programme and for being one of the best Trust's in the country for their COVID-19 outcomes. The CCGs found it particularly heart-warming to read the member of staff's story reflecting on their time working on the COVID-19 ward and the patient who shared his story on his amazing recovery from COVID-19.

The CCGs welcome the specific quality priorities for 2021/22 highlighted in the Quality Account. These are appropriate areas to target for continued improvement and link well with CCGs commissioning priorities. The CCGs can confirm that to the best of their ability the information provided within the Annual Quality Account is an accurate and fair reflection of the Trust's performance for 2020/21. It is clearly presented in the format required and contains information that accurately represents the Trust's quality profile and is reflective of quality activity and aspirations across the organisation for the forthcoming year.

The CCGs look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned in 2021/22.

Julia Young
Executive Director of Nursing,
Patient Safety & Quality

Dr Dominic Slowie
Medical Director

May 2021

For and on behalf of
NHS Newcastle Gateshead Clinical Commissioning Group
NHS Northumberland Clinical Commissioning Group
NHS North Tyneside Clinical Commissioning Group

STATEMENT ON BEHALF OF HEALTHWATCH NEWCASTLE AND HEALTHWATCH GATESHEAD

19th May 2021

We would like to thank the trust for the opportunity to respond to NUTH quality account for 2020/21. We recognise the challenges NUTH has faced during the Covid 19 pandemic and the impact on services due to increased demand and would like to thank all the staff for their hard work during these unprecedented times.

We a recognise the 'outstanding' grade by The Care Quality Commission and that no special reviews or re enforcement has taken place during the 2019/20 reporting period.

We are encouraged by the Restart, Reset and Recovery Programme that has enabled NUTH to maintain delivery of emergency, urgent and life extending services as well as delivering COVID-19 testing and vaccination programme and note the progress made in the pathway improvements which clearly have the patient at the heart of its ethos.

We are aware of issues around access to dental treatment nationally for Dental Care during Covid, and we recognise that the Trusts initiative for improving the process for patient flow which will continue post Covid.

QUALITY PRIORITIES FOR IMPROVEMENT 2021/22

Priority 1 - Reducing Healthcare Associated Infections (HCAI) – focusing on COVID-19, Methicillin-Sensitive Staphylococcus Aureus (MSSA)/ Gram Negative Blood Stream Infections (GNBSI)/ C.difficile infections.
We are pleased that infection control with further focus on Covid 19, continues to be a priority for the Trust and that there is a clear plan for delivery on this priority.

Priority 2: Pressure Ulcer Reduction
We are pleased to see that this priority is being carried forward into 2021-22 and welcome the Trust's plans to focus on the reducing the rate of community pressure damage. Again we are encouraged by the quality improvements that have been implemented against this priority and note the introduction of targeted localities to identify the highest number and rate of pressure damage.

Priority 3: Management of abnormal results
The Trust appears to have made good progress in this area and is reassuring that the Trust recognise the impact caused by the delays in test results for the patient and continue to prioritise this as a quality objective.

Priority 4 - Modified Early Obstetric Warning Score (MEOWS)
The implementation of an electronic system MEOWS to identify recently pregnant woman outside of the usual women's services, demonstrates the Trusts proactive approach to Maternity services. We look forward to hearing about the progress in the next quality account.

Priority 5: Enhancing capability in Quality Improvement (QI)
We acknowledge the Trusts commitment to Quality improvement throughout the Covid 19 pandemic. The Trust has demonstrated the ability to make rapid changes including the ability to build capability and capacity. We welcome the Trust commitment to Quality improvements.

Priority 6 – Mental Health in Young People
Healthwatch are aware of the negative impact of the pandemic on young people and echo the Trust concerns. We are pleased that there is a plan to improve the care provided in the acute Trust for these patients and that there is a collaborative approach with CNTW around service provision. We look forward to following progress on this priority.

Priority 7 – Ensure reasonable adjustments are made for patients with suspected, or known, Learning Disabilities.
We are pleased that the Trust has chosen this as a priority and recognise the health inequalities that exist within the LD community. We are pleased that the Trust is 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. We wish you success in achieving the diamond standard in this area.

We wish the Trust continued success with these priorities in the coming year and look forward to supporting the Quality Account engagement next year.

STATEMENT ON BEHALF OF NORTHUMBERLAND HEALTHWATCH

12 May 2021

Thank you for the draft Quality Account of Newcastle upon Tyne Hospitals NHS Foundation Trust. We commend and thank the Trust for all its work during the COVID-19 pandemic and the vaccine programme and on the many positive achievements that have been made.

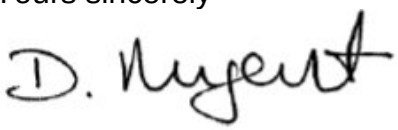
Access to Newcastle Hospital services from Northumberland is a theme in feedback to us about, especially audiology and ophthalmology services. For patients using these services, travel is a potential major barrier and they greatly value Newcastle Hospitals services being delivered in Northumberland locations. A comment in the Quality Account about how this aspect of your services will continue to be developed either digitally or face to face, and particularly in the north of the county, would be helpful.

Last year we mentioned the lack of detail provided about complaints and what the Trust learnt from them. We are disappointed once again at the level of detail given. A Healthwatch England report Shifting the Mindset highlights how important complaints are in ensuring high quality services.

Regarding the Trust's priorities for 2021/22 in our view the plans to improve performance appear positive and achievable with priorities that align with areas highlighted for improvement. We welcome the focus on patient experience.

In summary, we consider the report does give a fair reflection of the service provided by the Trust and we look forward to working with the Trust in the coming year and continuing to build on the positive working relationship we have established.

Yours sincerely



Derry Nugent
Project Coordinator

ANNEX 2:

ABBREVIATIONS

Abbreviations	
3Rs	Restart, Reset and Recovery
7DS	Seven Day Service
A&E	Accident & Emergency
APEX	Advising on Patient Experience
ARDS	Acute Respiratory Distress Syndrome
BAETS	British Association of Endocrine and Thyroid Surgeons
BAF	Board of Assurance Framework
BAME	Black, Asian and Minority Ethnic
BAUS	British Association of Urological Surgeons
C.diff	Clostridium difficile
CAT	Clinical Assurance Tool
CAV	Campus for Ageing and Vitality
CCGs	Clinical Commissioning Group
CGARD	Clinical Governance and Risk Department
CLTI	Chronic Limb Threatening Ischaemia
CMP	Case Mix Programme
CNTW	Cumbria, Northumberland and Tyne and Wear
COHA	Community Onset – Healthcare Associated
COPD	Chronic Obstructive Pulmonary Disease
COTW	Consultant of the Week
CPAP	Continuous Positive Airway Pressure
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRANE	Cleft Registry and Audit Network
CT	Computed Tomography
CYP	Children and Young People
DoC	Duty of Candour
DSP	Data Security & Protection
E.coli	Escherichia coli
ED	Emergency Department
EHCP	Emergency Health Care Plans
FFFAP	Falls and Fragility Fracture Audit Programme
FFT	Friends and Family Test
FIT	Faecal Immunochemical Test
FTSU	Freedom to Speak up
GICAP	Gastro-Intestinal Cancer Programme
GNBSI	Gram Negative Blood Stream Infections
GNCH	Great North Children's Hospital
GP	General Practitioner
HCAI	Healthcare Associated Infection
HOHA	Hospital Onset – Healthcare Associated
HQIP	Healthcare Quality Improvement Partnership
HR	Human Resources
IBD	Inflammatory Bowel Disease

Abbreviations	
ICNARC	Intensive Care National Audit & Research Centre
ICS	Integrated Care System
IHI	Institute for Healthcare Improvement
IPC	Infection Prevention & Control
IPCC	Infection Prevention & Control Committee
IT	Information Technology
ITU	Intensive Treatment Unit
IV	Intravenous
LD	Learning Disability
LeDeR	Learning Disability Mortality Review
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer
M&M	Mortality and Morbidity
MatNeoSIP	Maternity and Neonatal Safety Improvement Programme
MBRRACE	Mothers and Babies, Reducing Risk through Audits and Confidential Enquiries
MDT	Multi-Disciplinary Team
MEOWS	Modified Early Obstetrics Warning Score
MHRA	Medicines & Healthcare Product Regulatory Agency
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant *Staphylococcus aureus*
MSSA	Methicillin Sensitive *Staphylococcus Aureus*
N/A	Not Applicable
NCAA	National Cardiac Arrest Audit
NCAP	National Cardiac Audit Programme
NCEPOD	National Confidential Enquiries into Patient Outcome & Death
NEAS	North East Ambulance Service
NEIAA	National Early Inflammatory Arthritis Audit
NELA	National Emergency Laparotomy Audit
NEWS	National Early Warning System
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement
NICE	National Institute for health and clinical excellence
NICOR	National Institute for Cardiovascular Outcomes Research
NLCA	National Lung Cancer Audit
NMPA	National Maternity and Perinatal Audit
NNAP	National Neonatal Audit Programme
NPDA	National Paediatric Diabetes Audit
NRLS	National Reporting & Learning System
NUTH	Newcastle upon Tyne NHS Foundation Trust
OHS	Occupational Health Service
PCI	Percutaneous Coronary Interventions
PHE	Public Heath England
PICANet	Paediatric Intensive Care Audit Network

Abbreviations	
PPE	Personal Protection Equipment
PQIP	Perioperative Quality Improvement Programme
PROMS	Patient Reported Outcome Measures Scores
PRT	Paediatric Rheumatology Team
QI	Quality Improvement
QIP	Quality Improvement Programme
RCA	Root Cause Analysis
RCEM	Royal College of Emergency Medicine
RCOA	Royal College of Anaesthetists
RCOG	Royal College of Obstetricians and Gynaecologists
RCP	Royal College of Physicians
RCPCH	Royal College of Paediatrics and Child Health
RCPsych	Royal College of Psychiatrists
RCS	Royal College of Surgeons
RIDDOR	Reporting of Injuries, Disease and Dangerous Occurances
RTT	Referral to Treatment
RVI	Royal Victoria Infirmary
SAMBA	Society for Acute Medicine's Benchmarking Audit
SAMM	Systems for Action Management and Monitoring
SCHST	Specialist Care Home Support Team
SHINE	Sustaining Healthcare in Newcastle
SHMI	Summary Hospital-level Mortality Indicator
SHOT	Serious Hazards of Transfusion
SIs	Serious Incidents
SSNAP	Sentinel Stroke National Audit Programme
TARN	Trauma Audit and Research Network
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. Gram-negative Bacteria

Gram-negative bacteria cause infections including pneumonia, bloodstream infections, wound or surgical site infections, and meningitis in healthcare settings. Gram-negative bacteria are resistant to multiple drugs and are increasingly resistant to most available antibiotics. These bacteria have built-in abilities to find new ways to be resistant and can pass along genetic materials that allow other bacteria to become drug-resistant as well.

7. HOGAN evaluation score

Retrospective case record reviews of 1000 adults who died in 2009 in 10 acute hospitals in England were undertaken. Trained physician reviewers estimated life expectancy on admission, to identified problems in care contributing to death and judged if deaths were preventable taking into account patients' overall condition at that

time. The Hogan scale, ranging from 1 (definitely not preventable) to 6 (definitely preventable), was used to determine if deaths were potentially avoidable, taking into account a patient's overall condition at the time.

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

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

9. IHI

The Institute for Healthcare Improvement (IHI) are committed to supporting all who aim to improve health and health care. They bring like-minded colleagues at global conferences, trainings, and career development programs to help grow the safety, improvement, and leadership skills of the health and health care workforce. They advance learning by leading collaborative initiatives that enrich, accelerate, and spread the latest improvement ideas and leadership strategies.

10. MRSA

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

11. MSSA

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

12. Near Miss

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

BRP - Agenda item A6(iv)

The Newcastle upon Tyne Hospitals
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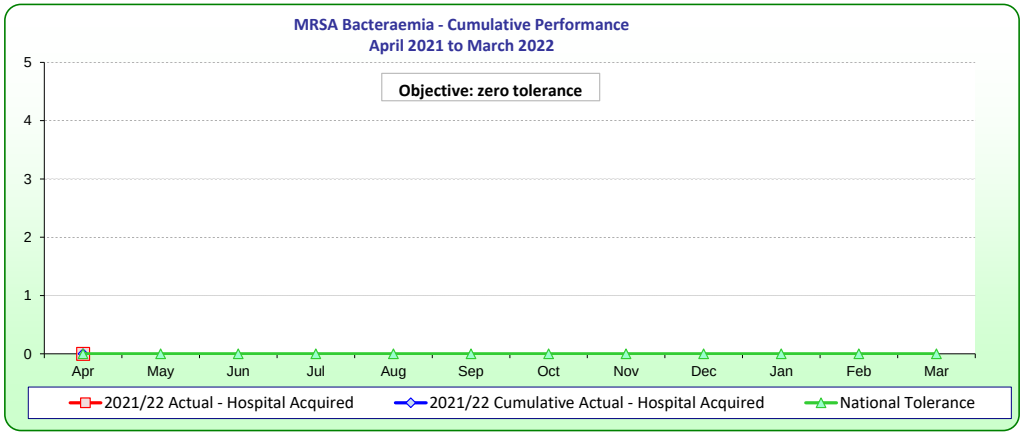
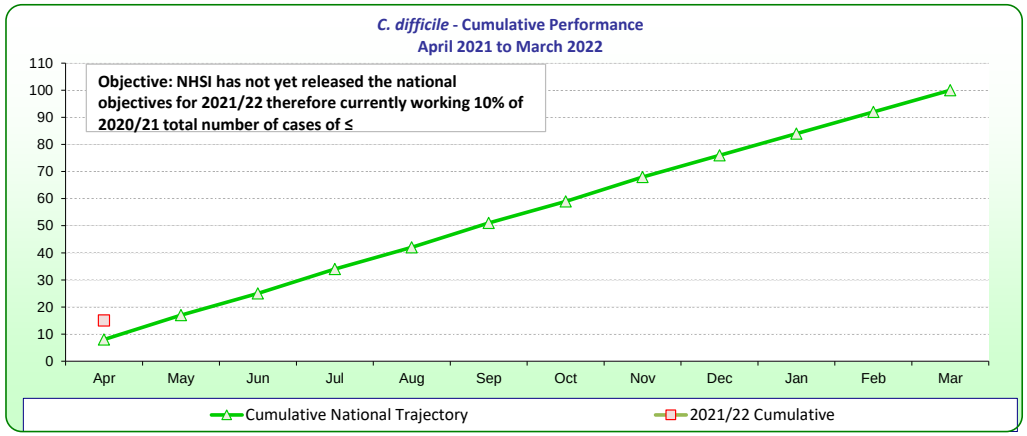
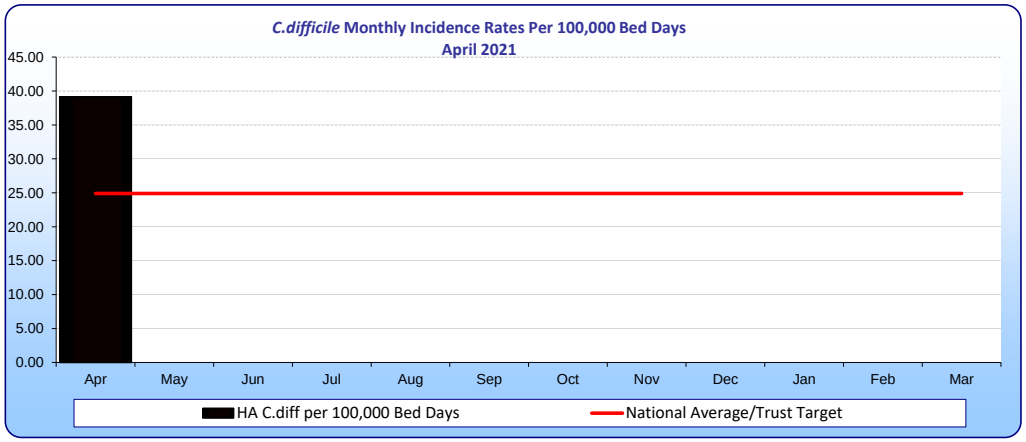
Healthcare-Associated Infections Report
April 2021

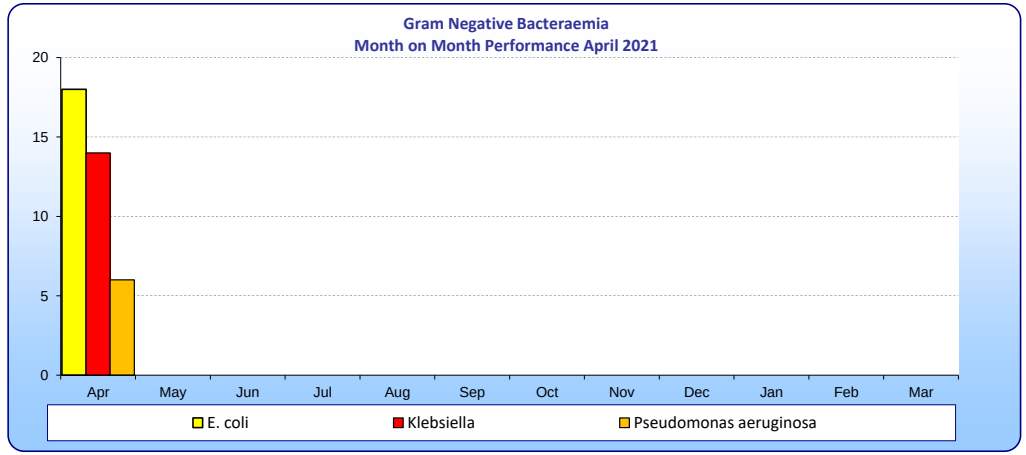
Healthcare-Associated Infection Report April 2021

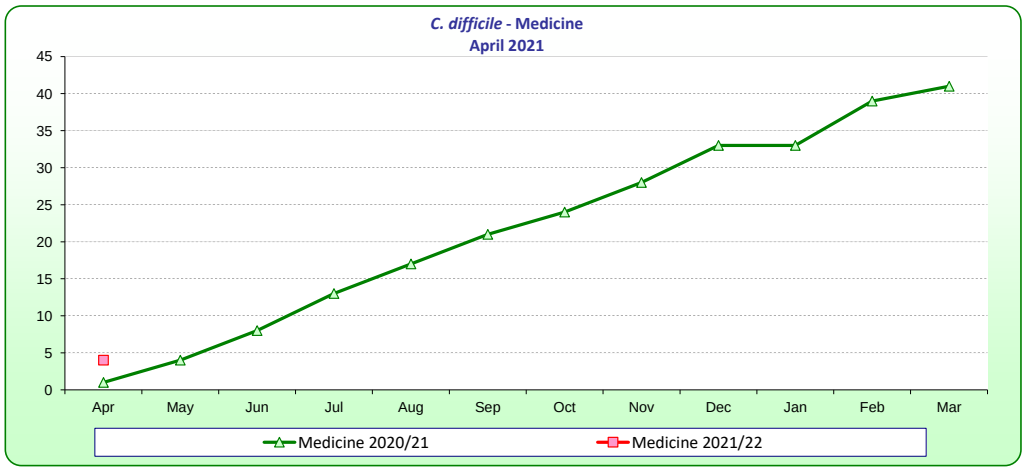
The Newcastle upon Tyne Hospitals NHS Foundation Trust

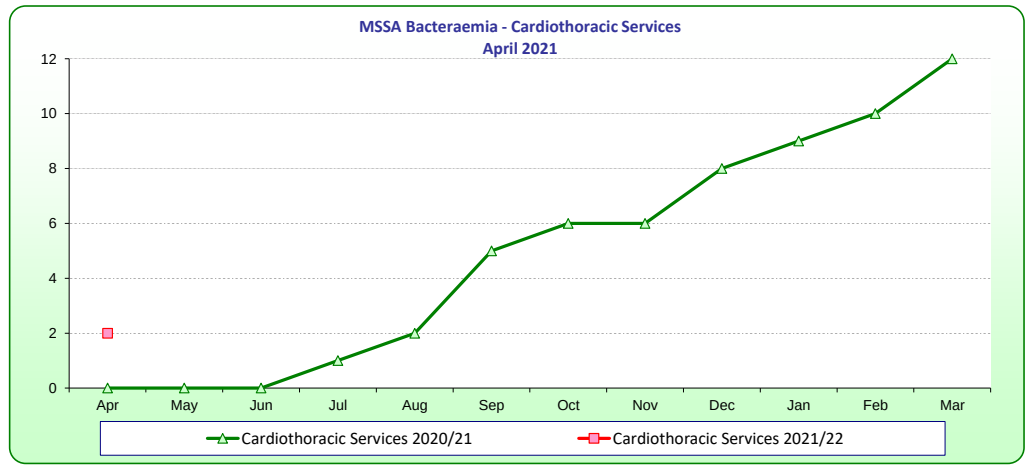






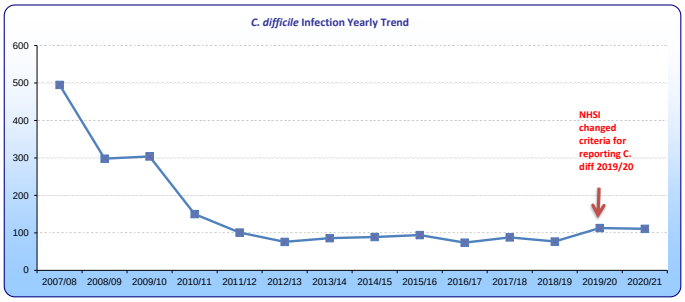


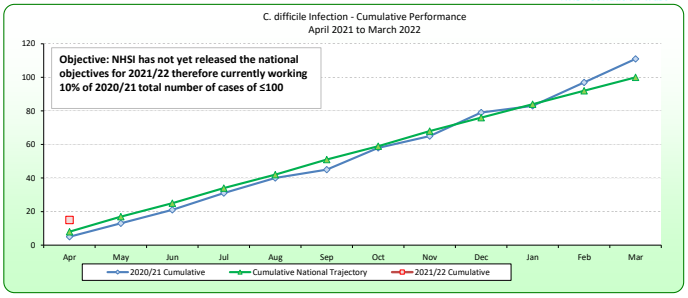


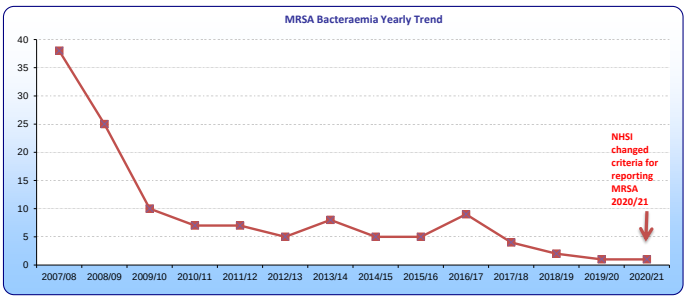


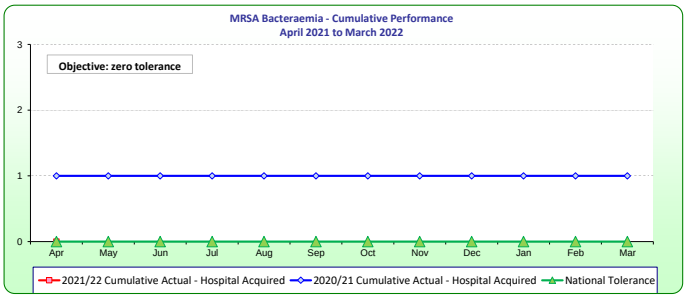
Healthcare-Associated Infection Report April 2021

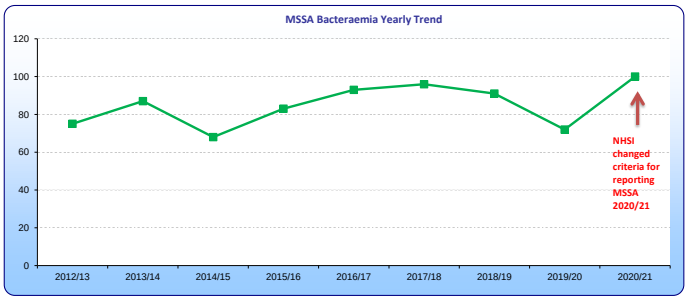
The Newcastle upon Tyne Hospitals NHS Foundation Trust

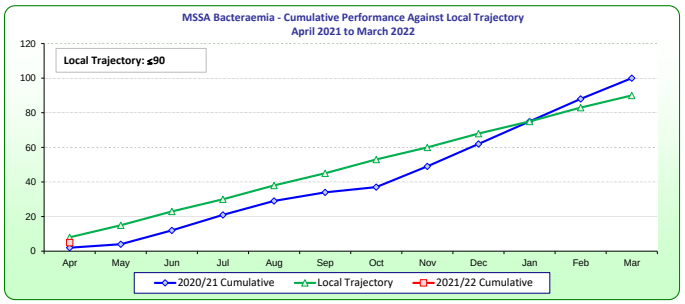


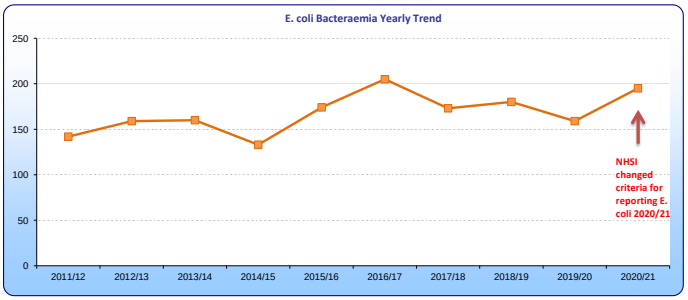


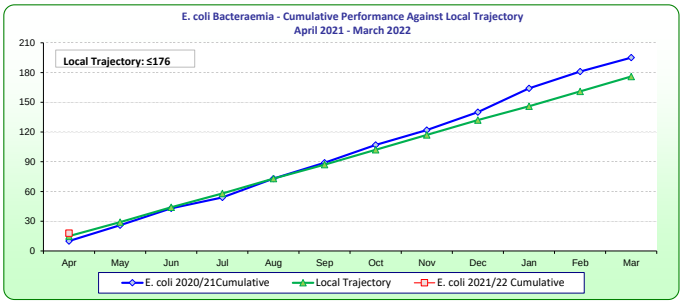


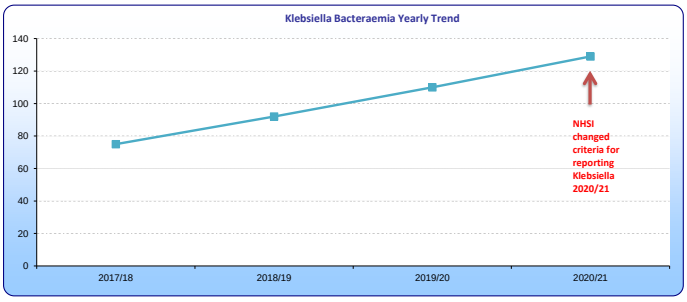


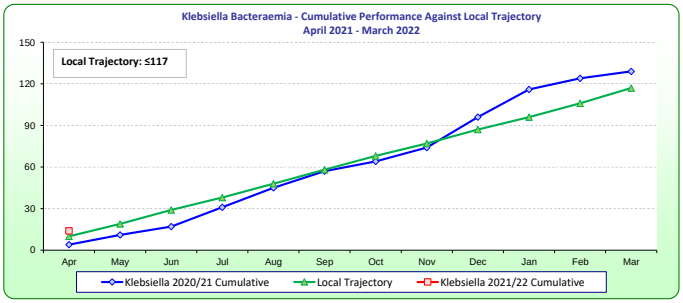


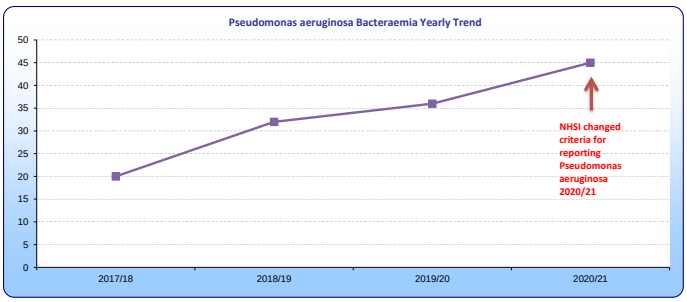


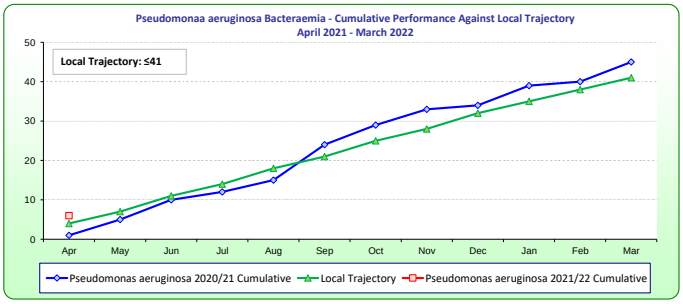












Healthcare-Associated Infection Report April 2021

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)	0												0
MRSA HA acquisitions	2												2
MSSA Bacteraemia - post-48 Hours Admission (local objective ≤90)	5												5
E coli Bacteraemia - post-48 Hours Admission (local objective ≤176)	18												18
Klebsiella Bacteraemia - post-48 Hours Admission (local objective ≤117)	14												14
Pseudomonas aeruginosa Bacteraemia - post-48 Hours Admission (local objective ≤41)	6												6
C.diff - Hospital Acquired (objective ≤100)	15												15
C.diff related death certificates	3												3
Part 1	2												2
Part 2	1												1

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	3												3
Patients affected	6												6

Healthcare Associated COVID-19 cases (reported to DH)	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Hospital onset Probable HC assoicated (8-14 days post admission)	-												0
Hospital onset Definite HC assoicated (≥15 days post admission)	-												0

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	-												0
Patients affected (total)	-												0
Staff affected (total)	-												0
Bed days losts (total)	-												0
COVID Outbreaks	-												0
Patients affected (total)	-												0
Staff affected (total)	-												0
Bed days losts (total)	-												0

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	09:56												09:56
Laboratory Turnaround Time	02:28												02:28
Total to Result Availability	12:24												12:24

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 and awaiting new assurance tool												
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	89%												89%

Aseptic Non Touch Technique Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Nov	Jan	Feb	Mar	Average
ANTT (M&D staff only)	57%												57%

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The Newcastle upon Tyne Hospitals
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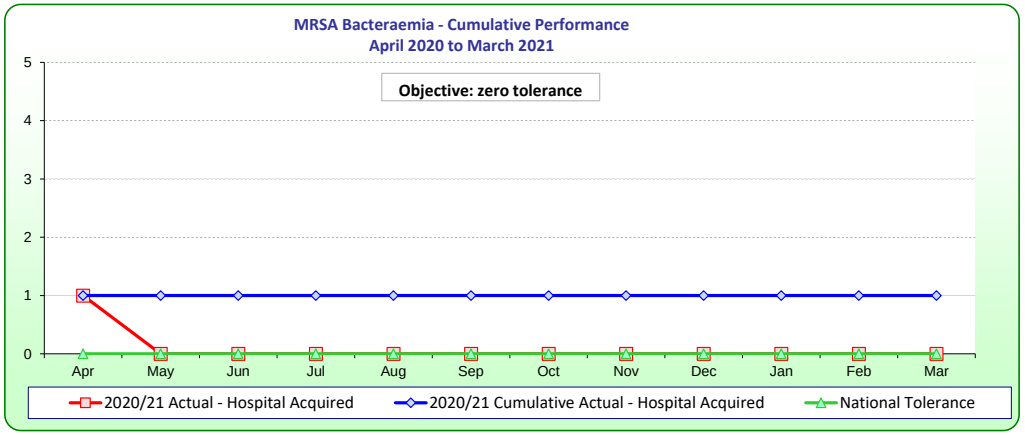
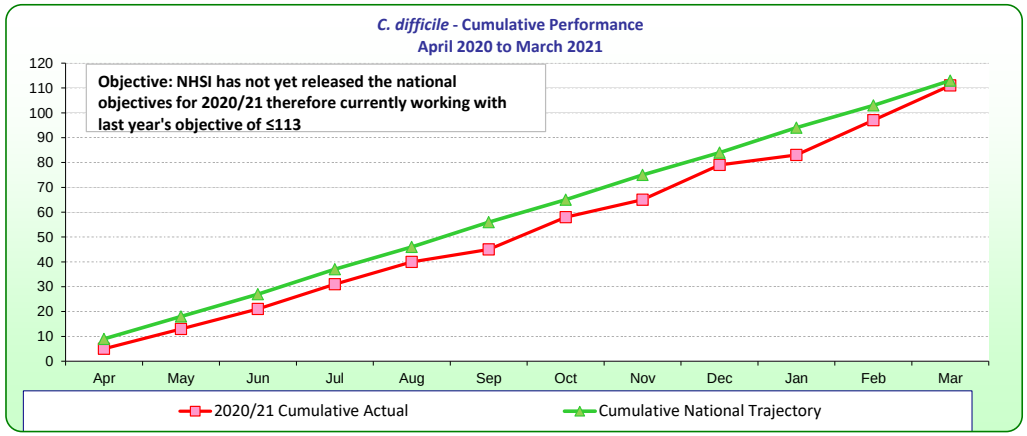
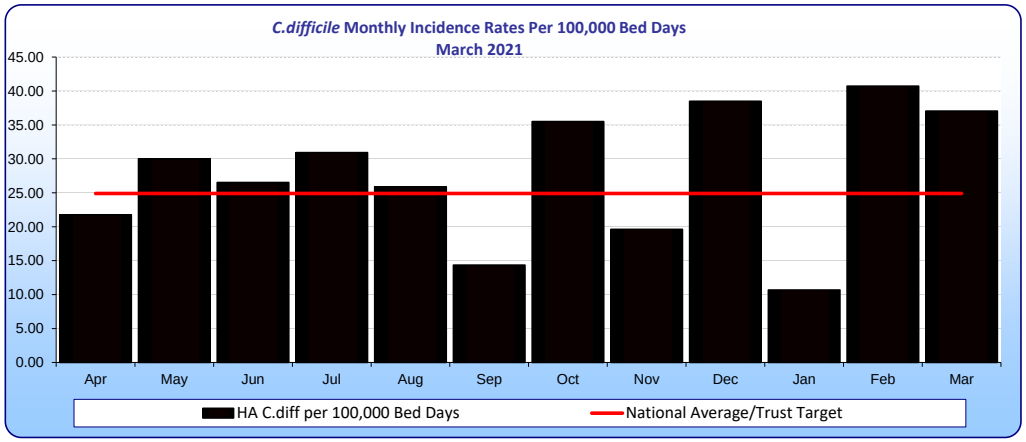
Healthcare-Associated Infections Report
March 2021

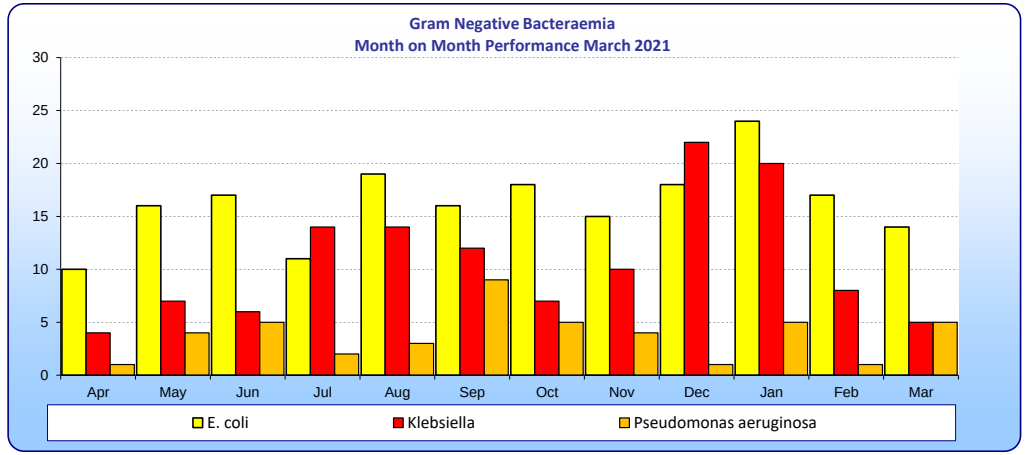
Healthcare-Associated Infection Report March 2021

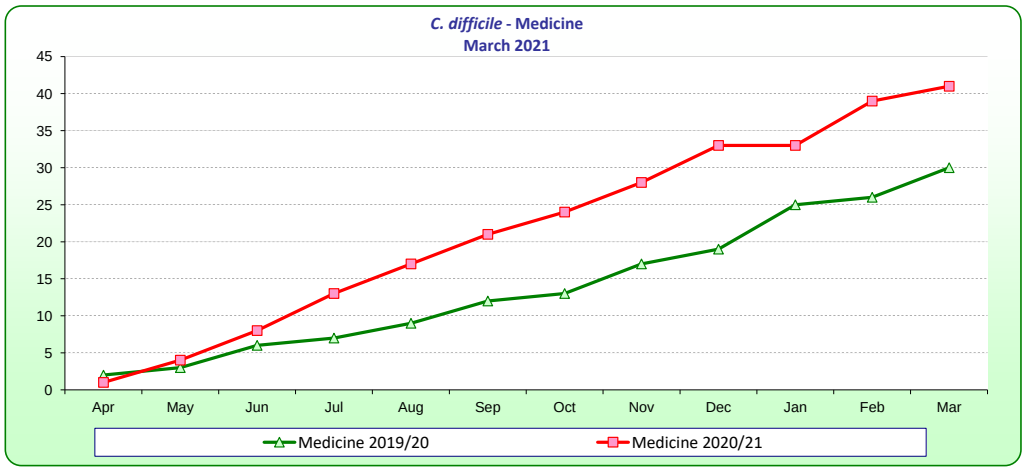
The Newcastle upon Tyne Hospitals NHS Foundation Trust

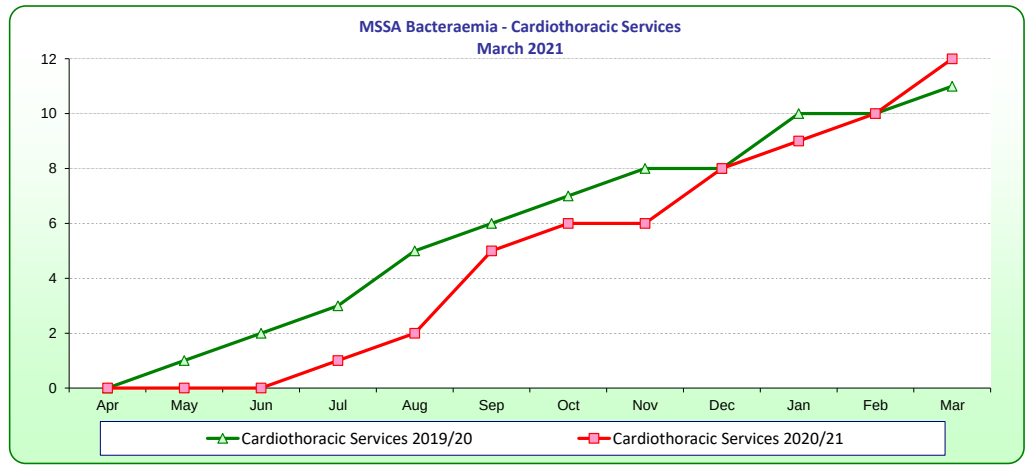












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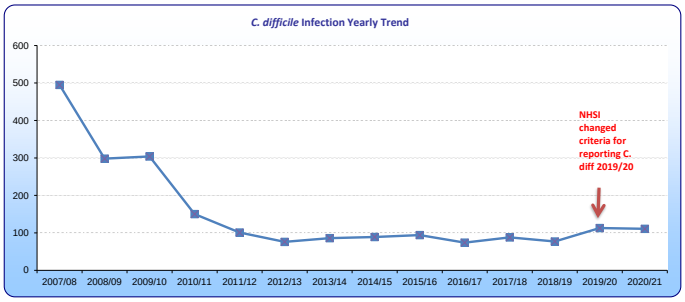

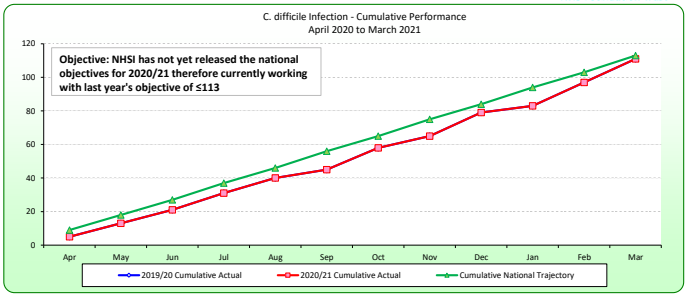

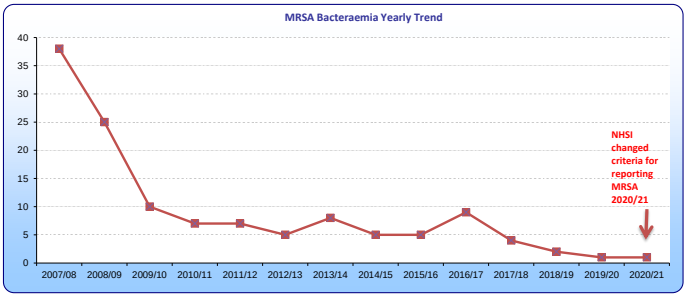

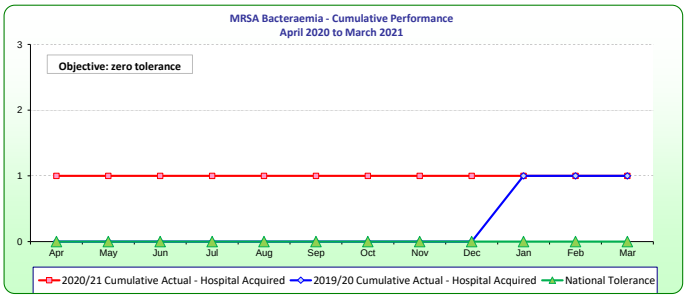

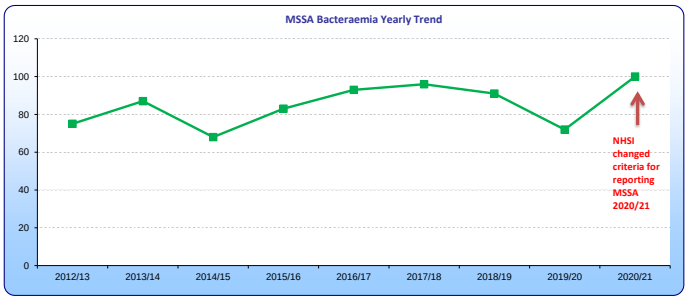

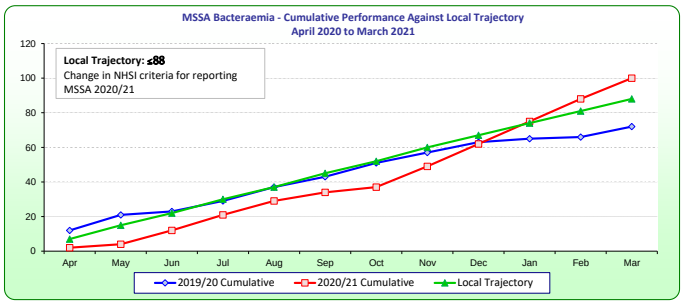

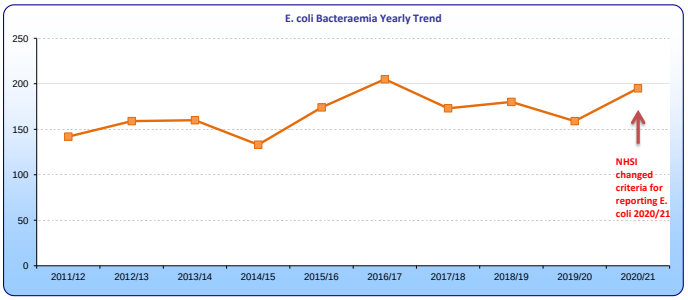

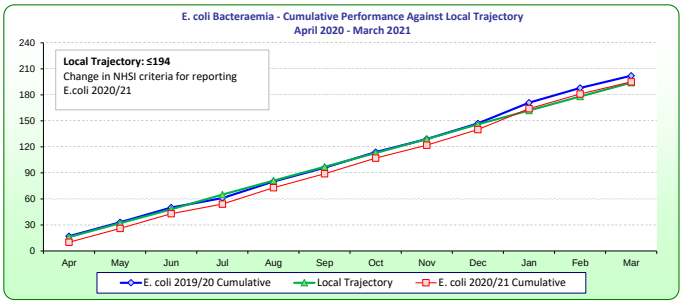

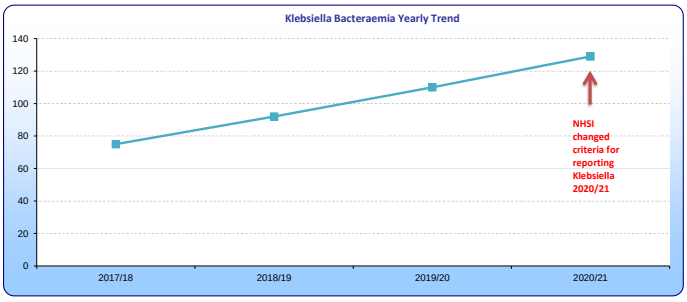

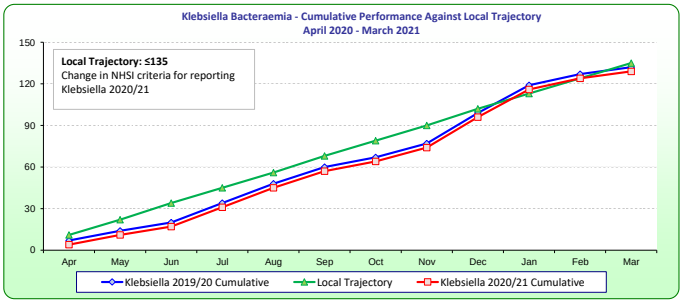

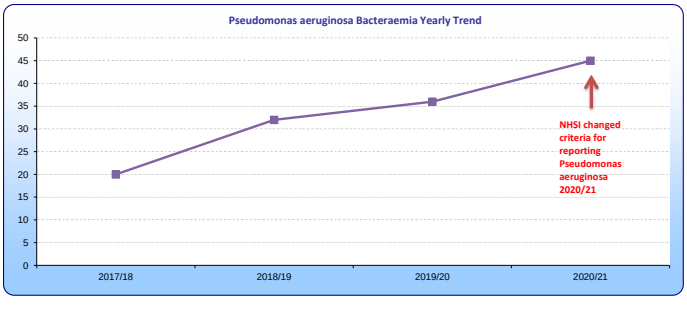

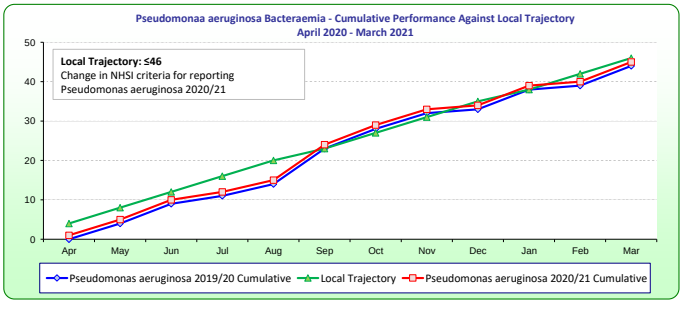

Healthcare-Associated Infection Report March 2021

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	0	0	0	0	0	0	0	1
MRSA HA acquisitions	1	1	4	1	1	5	1	2	2	1	3	4	26
MSSA Bacteraemia - post-48 Hours Admission (local objective ≤88)	2	2	8	9	8	5	3	12	13	13	13	12	100
E coli Bacteraemia - post-48 Hours Admission (local objective ≤194)	10	16	17	11	19	16	18	15	18	24	17	14	195
Klebsiella Bacteraemia - post-48 Hours Admission (local objective ≤135)	4	7	6	14	14	12	7	10	22	20	8	5	129
Pseudomonas aeruginosa Bacteraemia - post-48 Hours Admission (local objective ≤46)	1	4	5	2	3	9	5	4	1	5	1	5	45
C.diff - Hospital Acquired (objective ≤113)	5	8	8	10	9	5	13	7	14	4	14	14	111
C.diff related death certificates	-	-	-	2	1	0	0	0	0	1	0	0	4
Part 1	-	-	-	-	1	0	0	0	0	1	0	0	2
Part 2	-	-	-	2	0	0	0	0	0	0	0	0	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	2	0	2	0	1	1	8
Patients affected	-	-	-	2	0	2	4	0	5	0	2	2	17

Healthcare Associated COVID-19 cases (reported to DH)	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Hospital onset Probable HC assoicated (8-14 days post admission)	5	1	1	0	0	2	12	15	6	11	11	0	64
Hospital onset Definite HC assoicated (≥15 days post admission)	12	2	1	0	0	2	8	23	4	13	6	0	71

Outbreaks	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Norovirus Outbreaks	-	-	-	-	-	-	-	-	-	-	-	1	1
Patients affected (total)	-	-	-	-	-	-	-	-	-	-	-	5	5
Staff affected (total)	-	-	-	-	-	-	-	-	-	-	-	3	3
Bed days losts (total)	-	-	-	-	-	-	-	-	-	-	-	45	45
Other Outbreaks	-	-	-	-	2	2	0	0	1	0	0	1	6
Patients affected (total)	-	-	-	-	7	17	0	0	12	0	0	5	41
Staff affected (total)	-	-	-	-	16	0	0	0	1	0	0	0	17
Bed days losts (total)	-	-	-	-	59	23	0	0	31	0	0	17	130
COVID Outbreaks	-	-	-	-	-	3	8	10	5	8	5	1	40
Patients affected (total)	-	-	-	-	-	2	28	37	6	26	21	0	120
Staff affected (total)	-	-	-	-	-	11	69	76	49	24	20	2	251
Bed days losts (total)	-	-	-	-	-	119	521	376	24	0	0	0	1,040

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	13:34	10:50	11:23	11:59	11:31	10:58	10:21	11:26
Laboratory Turnaround Time	02:27	02:08	03:18	03:25	03:00	03:18	03:00	02:42	03:26	02:27	03:20	02:48	02:56
Total to Result Availability	12:57	13:21	15:19	15:48	13:32	16:52	13:50	14:05	15:25	13:58	14:18	13:09	14:22

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%	87%	87%	88%	88%	88%	89%	89%	87%

Aseptic Non Touch Technique Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Nov	Jan	Feb	Mar	Average
ANTT (M&D staff only)	61%	61%	61%	61%	60%	59%	58%	58%	58%	57%	57%	56%	59%

CRN North East and North Cumbria Financial Management			
n1	In respect of the LCRN 2021/22 local funding model, please confirm if the principles have changed from the 2020/21	Yes or No. If yes, refer to question 2	No
n2	In respect of the LCRN 2021/22 local funding model, please complete the following table* by entering the proportion of LCRN funding (%) within the funding elements detailed. If there are any other elements to the model please describe what this is for and the proportion of funding allocated to this		
*Notes	1. It is assumed that the local funding model is net of any national top-sliced funding as this is pass through cost		
	2. If the funding element category is not applicable to your local funding model, please enter 0%		
	3. The percentages (%) entered in the table should equate to 100%		

Funding Element	Examples	Description of model	% of Total CRN Funding Budget 2021/22 Budget (Please note that these should total 100%)
Host Top-sliced element	Core Leadership team, Host Support costs, LCRN Centralised Research Delivery team	Funding to support IT/HR and Finance in Host Org. Leadership and management team defined as COO, DCOO, CD, RDMs and IOM only. LPMS procured by Host; provider - Infonetica	12.8%
Block Allocations	Primary care, Clinical support services (i.e. pharmacy), R&D contributions	Partner Orgs determine level of funding to support Pharmacy/Radiology/Pathology from their overall allocation. LCRN does not currently prescribe anything in this regard. No 'block' payments for Primary Care - payments are either 'infrastructure funding or SSCs and identified as such. R&D contributions not used.	0.0%
Activity-based	Recruitment HLO 1, number of studies, activity weighting	Funding is allocated to PO's based on historical allocation, remainder is adjusted to reflect network allocation for the year and then adjusted for 2yr complexity adjusted recruitment which is used as a key KPI.	16.4%
Historic Allocations	PO funding previously agreed	To maintain staffing stability funding is allocated to PO based on 80% of historical (2019/20) baseline delivery funding value.	52.6%
Performance-based	HLO performance, value for money metric		0.0%
Population-based	Adjustments for NHS population needs		0.0%
Project-based	Study start up		0.0%
Contingency / Strategic Funds	Funds to meet emerging priorities during the year, including targeting local health needs	Strategic funding available to executive Group to support initiatives in-year based on LCRN priorities. Contingency not used. Local Notes: This includes PG approved 3% strategic funds, additional funding awarded from uplift in CRN funding (proportion of £10 million allocation to support restarting research) and Transforming Research Delivery - Direct Delivery Team allocation (£833,000)	10.0%
Other Funding Allocations		Support for Principal Investigators top-sliced (£1.6m for 2021-22) and allocations agreed by SGLs (supported by RDMs and PO R&D Depts) RDA & Greenshoot awards	8.1%
Total			
Cap and Collar	Please provide your upper and lower limits if applicable	CAP +3%	
		COLLAR -0%	
Comments			

n.3	Please provide the pros and cons of the 2021/22 LCRN local funding model, and include constraints you face whilst determining the model	Pros: Stability of workforce is maintained whilst allowing for some movement of funding on the basis of performance; A non-NHS budget has been created and this can flex dependent on performance as well; strategic funding allows for significant investment in relation to priority areas and population needs - predominantly this funding is shared for research delivery in a more targeted fashion but it does allow for strategic investment to make step change differences to CRN ways of working and delivery in line with our local Strategy Cons: it remains difficult to find a fair and appropriate performance measure beyond research recruitment activity - further long term discussions and planning are underway to try to include novel elements in the model in the future; Predicted research activity can be taken into place for strategic investment but with no contingency it is difficult to base funding accurately on this. We will test this for the first time with the additional funding received. Significant work is underway to accurately forecast research activity - this is a predominantly manual process currently- to more fully underpin the allocation of funding to our Partners.	
n.4	In which financial year did your previous internal audit take place? Have all of the auditor's recommendations been implemented and, if not, when will they be implemented?	Internal audit review was completed during the 2018/19 financial year and all recommendations and management actions where implemented.	
n.5	If the next internal audit is due in 2021/22, please give the estimated date of the audit	The next audit is due in 2021/22 - it is likely to take place in Q3 owing to existing commitments within the Finance Team who will be undertaking the audit, and to clear post-COVID backlog of work. Preliminary discussions are underway and will strengthen when the finalised CSD for Minimum Financial Controls and Performance and Operating Framework have been signed off by DHSC.	

Agenda item A11

Worksheet "FT4 declaration"

Financial Year to which self-certification relates | May-21

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. 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 and schedules of business. 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 for Enterprise and Business Development, Finance Director and an Executive Chief Nurse. - Board approved Quality Account - Patient stories to every Board meeting - Board line of sight as part of Leadership Spotlight on Services - 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.

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

Signature 

Name Dame Jackie Daniel

Signature 

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 May-21

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	27.05.2021	**Date**	27.05.2021

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

Agenda item A11

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates May-21

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.
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 Audit Committee in April 2021 and considered by the Trust Board members in April 2021.

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	27.05.2021	**Date**	27.05.2021

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