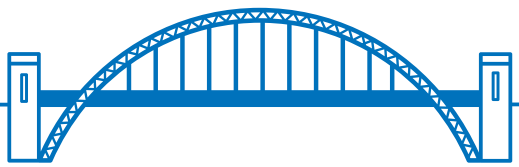
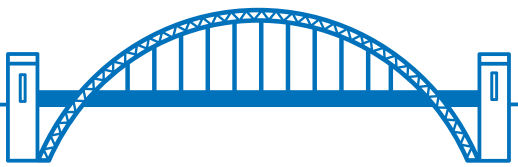
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Quality Account

2023/2024



Healthcare at its best
with people at our heart



Healthcare at its best
with people at our heart

Contents

Part 1

Chief Executive's Statement

Thank you for taking the time to read our 2023/2024 Quality Account which gives us an opportunity to reflect on the last year and to openly share our performance and outcomes with you.

2023/2024 has been a very difficult year for the Newcastle upon Tyne Hospitals NHS Foundation Trust due to serious concerns that we received from the Care Quality Commission following their inspections of our services.

The final report from the Care Quality Commission was received by the Trust in December 2023 which reflected their activity since June in a number of different services. The Trust also received restrictions on our licence to provide services which were imposed through a 'Notice of Decision' on December 18th 2023.

Since becoming Chief Executive on 1st January 2024, I have focussed on the two things that matter the most – how we can provide the best care for our patients, and how we can significantly improve the experience that our staff have at work. There is no denying how difficult and disappointing this has been for everyone working here, but I have seen a genuine strength of spirit and commitment to making swift and significant improvements.

The Trust is on a journey of improvement, and we have responded swiftly to rectify areas of concern raised by the Care Quality Commission, and will continue to do so, ensuring that patients remain truly at the centre of everything we do.

We are committed to encouraging a culture of openness and honesty, to listen, to learn and to innovate so that we can deliver the highest quality and safest care to patients, from skilled staff.

Providing high quality, patient focused care remains our highest priority. Our staff work tirelessly to ensure that patients receive the safest, most clinically effective care and a positive patient experience each and every time they use one of our services.

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

Sir James Mackey
Chief Executive

23rd April 2024

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.

Part 2

Quality Priorities For Improvement 2024/2025

Following discussion with the Board of Directors, the Council of Governors, patient representatives, staff and public, the following priorities for 2024/2025 have been agreed. A public consultation event was held in January 2024.

Patient Safety

Priority 1 – To improve patient safety by ensuring staff feel free to report safety concerns; incidents and near-misses, resulting in an overall increase in incident reporting rates.

Why have we chosen this?

Staff need to have clarity and confidence in the Trust incident reporting and learning mechanisms, knowing reported events will be escalated and acted on in an effective manner and supported by compassionate leadership as part of a 'Just Culture' that supports fairness, openness and learning, whilst encouraging staff to speak up without fear of blame. This priority aligns to the National Patient Safety Strategy and enhances the early implementation work of the Patient Safety Incident Response Framework. Using intelligence gathered from staff and the Trust's recent Care Quality Commission report, there is acknowledgement that we need to simplify the incident reporting system, to make it easier for staff to report when things went wrong and to increase incident reporting rates. In addition, by ensuring that learning and feedback is captured and disseminated, the Trust will strengthen the reporting culture of the organisation and improve safety performance.

What we aim to achieve?

The Trust aims to improve staff understanding and confidence in incident reporting mechanisms, thus improving the incident reporting rates and flow of learning throughout the organisation supporting the reduction of harm. We want staff to feel empowered and psychologically safe to report and escalate concerns in a timely way, demonstrating a positive and supportive culture of learning.

How will we achieve this?

- Review and simplify the Datix system, improving access options and rationalising coding.
- Further development of incident metrics available on the power BI platform and dashboards.
- Provide support to the Quality Oversight Groups to develop sharing mechanisms to devolve learning to front line staff.
- Provide supporting education and training packages that will encourage reporting, effective investigation, supportive leadership and psychological safety.
- Regular communications including weekly safety messages and monthly patient safety briefings.
- Establish twice yearly Patient Safety Incident Response Framework thematic reviews for Clinical Boards.
- Share learning from After Action Reviews and Patient Safety Incident Investigations.
- Review and refresh investigation training and Trust Induction information, including incident reporting & psychological safety themes.
- Key leaders trained in systems-based incident investigation and sharing learning.
- Engagement with staff via weekly Patient Safety Incident Response Framework drop-in sessions.

How will we measure success?

- Increased reporting rates.
- Outcomes from staff questionnaires/ surveys.
- Evaluation & uptake of training packages.
- Attendance at patient safety briefings.
- Determination of incident learning mechanisms within Clinical Boards.
- Future Staff Survey information.
- General Medical Council trainee survey report.

Where will we report this to?

- Quality Oversight Groups.
- Quality and Performance Reviews.
- Patient Safety Group.
- Quality Committee.

Priority 2 – Achieve a reduction in the incidence of surgical 'never events' with a specific focus on Ophthalmology, sharing the learning to inform and improve practice across other surgical specialities.

Why have we chosen this?

A Never Event is "*A serious largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers.*"

Within Ophthalmology the investigation of Never Events is taken very seriously including the investigation of three Never Events in 2023/2024 under the following categories:

- Wrong site surgery x 1
- Wrong lens implant x 2.

The three Never Events above underwent a full investigation by the Trust Clinical Governance and Risk Department with input from the speciality. Any immediate actions were implemented urgently whilst the incidents were fully investigated. Learning has been disseminated and discussed through the appropriate routes internally and with the Integrated Care Board.

The Trust found important learning that has been shared with staff across the organisation, with our commissioners and the patient and/their family.

What we aim to achieve?

Reduction of Never Events in Ophthalmology to zero within 2024/2025.

Recognise the fallibility of practice, understand the tension between the concept of Never Events vs human factors and work to manage risks proactively.

Learning from this work will be shared organisation wide to accelerate learning potential.

How will we achieve this?

- Implement a Quality Improvement programme of work that seeks to implement the Local Safety Standards for Invasive Procedures.
  - Review and implement the Local Safety Standards for Invasive Procedures, with regular compliance audits carried out to monitor performance.
- Strengthen the team brief and debrief process, ensuring all team members are actively involved, and that normal practice is discussed with locum/agency staff and Peri-Operative staff.
- Ensuring there are methodical, systematic checks and confirmations prior to start of any procedure.

Macular injection pathway:

- Review efficiency of the macular injection pathway, from booking to point of administration of treatment, improving the process flow and removing unnecessary tasks.
- Whilst giving injections, implement interventions to stop distractions i.e. place "Do not disturb" signs on treatment doors.
- Agree/develop consistent treatment plans for use on Medisoft.
- Review and update Local Safety Standards for Invasive Procedure checklists.

Cataract Surgery:

- Local review of the "marking" procedure.
- Review and update the local policy on the lens check procedure and specialty specific World Health Organisation checklist, specifically:
  - Timeout so that theatre is quiet and no other tasks are taking place.
  - Lens checking by the surgeon against the cataract summary sheet/biometry summary sheet before floor staff handling the lens to the scrub nurse and signed by floor staff to confirm check.
  - If lens prescription is changed due to the required use of a sulcus lens then the lens check should still be undertaken against the original prescription and confirmation of the change should be noted on the summary sheet.
  - Any change of lens power due to use of a sulcus lens should be the same power or within 1.5 less than the originally chosen lens power.
  - Education for theatre teams into the World Health Organisation checklist including importance of entre team "time out" and importance of a team "knife check" pre-incision pause.

How will we measure success?

- Number of Never Events reported on the Datix Incident Reporting System.
- Number of Never Events presented at the weekly Rapid Review meeting.
- Number of staff trained across Ophthalmology & Peri-operative Theatres.
- Quarterly audit of 10 sets of relevant notes re compliance with Local Safety Standards for Invasive Procedures.
- Quarterly audit of current treatment plans recorded on Medisoft.
- Quarterly observational audit – to ensure standardisation and quality assurance of surgical safety checklist process in Newcastle Westgate Road Cataract Centre, Cataract theatres.
- Patient feedback on the service before and after changes which directly affect patients.

Where will we report this to?

- Ophthalmology surgical audit (Clinical Governance) meeting.
- Surgery & Specialist Services Quality Oversight meeting.
- Quality Committee.

Clinical Effectiveness

Priority 3 – To ensure reasonable adjustments are made for patients with suspected or known Learning Disability &/or Autism. Appropriate and consistent use of Mental Capacity Assessment & Deprivation of Liberty Safeguards for patients with vulnerabilities.

Why have we chosen this?

The Trust must ensure we are compliant with The Mental Capacity Act 2005, April 2007. The Act provides a statutory framework to empower and protect any person over the age of 16 in England and Wales who may not be able to make their own decisions. It sets out roles and responsibilities of carers, both professional and informal. The Mental Capacity Act and Safeguarding legislation have a significant overlap in order to ensure that the rights, as set out in the Human Rights Act 1998, and the safety of adults and young people at risk of harm are protected. The Mental Capacity Act aims to empower and also protect individuals. The Mental Capacity Act empowers by ensuring the fundamental right to make decisions is not inappropriately taken away from the individual. The Mental Capacity Act protects by ensuring where an individual lacks capacity in relation to a specific decision, actions taken by others are made in their best interests.

The Deprivation of Liberty Safeguards legislation was introduced in 2009, as an addendum to the Mental Capacity, 2005, providing a legal framework around depriving people of their liberty (England and Wales). The Deprivation of Liberty Safeguards provides legal protection for those in the main aged 18 and older, who are, or may become, deprived of their liberty.

The involvement of patients with a learning disability in reviewing services and planning improvements supports the Trust in ensuring their needs are heard. This contributes towards tackling the health inequalities faced by this patient group and empowers them to be partners in the care they receive.

What we aim to achieve?

Compliance with Mental Capacity Act, Best Interest Decision making, Deprivation of Liberty Safeguards and the Equality Act 2010.

Therefore, there needs to be assurance that clinical staff understand when and how to complete mental capacity assessments and best interest decisions. Staff also need to document assessments and decision making appropriately in patients' electronic records.

Clinical Staff must understand Deprivation of Liberty Safeguards process and documentation, what this means for the patient and where to store and retrieve the appropriate information.

The collaborative work aims is to reduce health inequalities for patients with a learning disability by working in partnership with people with lived experience.

How will we achieve this?

- Training via E-learning packages in Mental Capacity Act and Diamond Standards for Learning Disability.
- Autism Awareness virtual sessions.
- Trust Forums – sessions delivered by Mental Capacity Act Lead, Learning Disability Liaison and Safeguarding teams.

- Visual information for patients i.e., Reasonable Adjustment Posters, 'How to use a Health and Care Hospital Passport'.
- Scope current position against the National Reasonable Adjustment Digital Flag Information and develop an action plan to achieve compliance and implementation.
- Sign posting of useful information through "Care for Me With Me" resource pages and Learning Lab.
- Collaborative Working with "Skills for People" to develop easy read information, using quality checks in three departments.

How will we measure success?

- Training compliance in line with Trust standard (95%).
- Audit of the patient record in regard to the quality of Deprivation of Liberty Safeguards referrals.
- Patient Feedback via focus groups led by Skills for People.
- Production of ten easy read leaflets.

Where will we report this to?

- Mental Capacity Act Trust Steering Group.
- Safeguarding Committee.
- Patient Experience and Engagement Group.
- Quality Committee.

Patient Experience

Priority 4 – To ensure the Trust has a systematic way of improving from patient and staff feedback in all its forms.

Why have we chosen this?

Our people are central to improving the quality and delivery of safe and compassionate care. How they experience the culture of the organisation and how they feel about their workplace directly impacts on their ability to care for patients, their team, themselves, and their families.

In most NHS organisations, patient experience remains the weakest of the three arms of quality. It does not get the same attention as safety and clinical effectiveness and still tends to be seen as an add-on. This needs to change.

Although patient experience is currently captured through the Friends and Family test and national surveys, there has been remarkably little improvement in NHS patient experience data since surveys were introduced in 2002 – we are not always measuring the right things, feedback is not representative or timely enough, and we don't get information to staff in ways that motivate them to act on results.

We have employed an approach to understanding and improving patient and staff experience across multiple hospital sites, which has been used successfully in other trusts. We set out to really understand quality in real time and with enough granularity to inform improvement.

What we aim to achieve?

Our ambition is to develop a patient and staff experience programme at Newcastle Hospitals that is the most comprehensive in

the NHS. We will capture performance at a site, clinical board, speciality, and ward level. The introduction of individual consultant-level data to inform annual appraisals is relatively unique in the NHS, this will elevate our programme and help to ensure senior medical ownership.

This work also builds on the previous funding provided by the charity to develop the patient experience of care. Patients told us they wanted to be asked about their experience, they wanted their feedback to visible and they wanted to know how their feedback made a difference. This programme will therefore let us deliver the aims set out in the experience of care strategy.

How will we achieve this?

A new seconded role of Chief Experience Officer has been created within the Executive Team, designed to strengthen Trust Board accountability, and provide visibility and momentum for a Trust-wide patient and staff experience programme.

The Chief Experience Officer offers 15 years of experience in designing, developing, and sustaining a pioneering patient and staff experience programme – the first of its kind in the NHS. The programme has won multiple national awards and gained international recognition since first introduced in 2009.

Aims:

- Ensure the organisation has a systematic way of analysing patient and staff feedback in all its forms and dedicated analytics and intelligence support for its patient and staff experience data.
- Support the early implementation of an innovative and evidenced based staff engagement programme.
- Develop transparent and publicly accessible information about the feedback patients and staff have provided, with the organisation's response to this feedback.
- **Our 'real time' programme:** We will train a team of five patient coordinators to carry out hundreds of face-to-face interviews every month to enable a better understanding of the needs of inpatients whilst they are still with us; the results will be shared with staff within three to four hours of speaking to patients enabling a nimble response to any concerns. Charitable funds will support the inclusion of 25% of all wards in the first six months of implementing the programme.
- **Our 'right time' programme** will capture reflective feedback from patients once they are home. We deliberately survey two weeks after leaving hospital, because we know that this is the time, statistically, when people are likely to be at their most dissatisfied – our greatest improvement opportunity. Funds will enable us to appoint a Care Quality Commission approved contractor to provide externally validated patient experience data for inpatients, outpatients, maternity and emergency care users.

How will we measure success?

Patients have a positive experience where there is a culture of safety that puts the patient first and gives patient experience the highest priority with the implementation of real-time patient feedback. Information about real-time patient experience displayed on all wards and clinic areas gives added evidence of priority.

An open and transparent organisational culture has a positive impact on staff and patients. Where there are highly encouraged and evident innovation and quality improvement programmes, there was also a notable improvement in the patient experience. Where there is a culture of all staff groups showing pride in their work and feeling part of the organisation, this leads to a commitment to learn from mistakes.

Based on current activity levels we aim to get feedback from more than 250,000 people every year. The impact will be felt by many more.

- **Inpatients:** We would survey 5,000 individuals every month, to achieve at least 2,000 responses.
- **Emergency Care:** A sample of 20% of patients, 3,000 a month, providing reliable trackable results monthly at each Emergency Department.
- **Outpatients:** 20% or 18,000 responses a month to enable site, speciality, and Clinical Board results.
- **Maternity:** a census rather than sampling approach for every month apart from February which is for the National Survey.
- **Quarterly staff surveys and evidenced based improvement programme.**

Success will be evidenced by excellent engagement with patients, families, and communities – we will be able to demonstrate statistically significant gains in patient and staff experience within 12 months.

Where will we report this to?

- People Committee.
- Trust Management Group.
- Executives.
- Quality Committee.

Priority 4a - With new midwifery leadership, agree a staffing model for the birthing unit and associated staff development plan, to honour our commitment to consistent opening of the birthing centre.

Why have we chosen this?

Although maternity service user experience is currently captured through the Friends and Family test, the Care Quality Commission National Maternity Survey, and feedback gathered by the Maternity and Neonatal Voice Partnership there has been remarkably little improvement in NHS patient experience data since surveys were introduced in 2002 – we are not always measuring the right things, feedback is not representative or timely enough, and we do not share the feedback with staff to 'close the loop' in ways that motivate them to act on results for service improvement.

It has been nationally acknowledged that it is a difficult time to work within Maternity Services and is a time of great change, therefore it is vital that we take steps to understand the experience of the individuals working within Maternity Services in each clinical area in order to support individual development and enhance their working lives.

Our maternity team are central to improving the quality and delivery of safe and compassionate maternity care. How they experience the culture of the organisation and how they feel about their workplace directly impacts on their ability to care for patients, their team, themselves, and their families.

The current reduction in intrapartum maternity service provision due to the long-term suspension of the midwifery-led Newcastle Birthing Centre has had a detrimental impact on the choice of environment afforded to maternity service users planning their birth and when attending in labour at Newcastle Hospitals; and has been a challenging new way of working for Midwives previously based in the Newcastle Birthing Centre.

The limitations of the Delivery Suite estate pose a significant challenge to the birthing environment for service users and is followed by postnatal care in a shared ward environment, restricting the opportunity for families to remain together in the precious first few hours and days following a baby's birth.

The remodelling of the Neonatal Transitional Care service from within postnatal to a stand-alone ward in April 2024 brings a new way of collaborative

working for the maternity and neonatal team. It has provided the opportunity to pause the usual regular rotations of Midwives for a period of six months to bring stability to the implementation period which consequently offers the opportunity to understand individual staff experience within each clinical area of Maternity Services.

What we aim to achieve?

We aim to understand what matters to women and birthing people in Delivery Suite and the experience of postnatal inpatient area as well as the Maternity Team providing their care, to enable the collaborative design of a Maternity Service for the future; that meets the needs and expectations of service users and staff and supports the consistent delivery of safe maternity care in all environments.

How will we achieve this?

Early inclusion in the 'real time' service user and staff experience programme will enable the capture of service user feedback to be captured while service users are inpatients in Delivery Suite or the postnatal ward with information shared with the Maternity Team within three to four hours to provide the opportunity to immediately respond to the feedback and get things right for the families currently in our care.

Initial feedback will be further enhanced by reflective feedback that is captured via the 'right time' programme from service users when they are home. We will deliberately survey two weeks after leaving hospital, because we know that this is the time, statistically, when people are likely to be at their most dissatisfied – our greatest improvement opportunity.

Alongside this there will be a two-weekly staff experience capture of the Maternity Team providing intrapartum and postnatal care. With the combined information correlated to understand the challenges within each clinical area to responsively coproduce and develop quality improvement initiatives to improve service user and staff experience.

A new Director of Midwifery joined the Trust in June 2024. Her leadership within this improvement programme will ensure agreement of a new staffing model for the birthing unit and associated staff development plan, to honour our commitment to consistent opening of the birthing centre.

How will we measure success?

Service Users have a positive maternity experience where there is a culture of safety that puts the Service User first and uses Service User experience feedback to coproduce services.

Information about real-time patient experience displayed in each area gives assurance that Service Users are at the heart of Maternity Services and shows the commitment to improve on the provision of Maternity Services and the environment in which care is provided.

An open and transparent organisational culture has a positive impact on staff and Service Users. Where there are highly encouraged and evident innovation and quality improvement programmes, there was also a notable improvement in the patient experience. Where there is a culture of all staff groups showing pride in their work and feeling part of the organisation, this leads to a commitment to learn from mistakes.

Success will be evidenced by excellent engagement with Service Users, families, and communities. We will demonstrate statistically significant gains in Maternity Service User and staff experience within 6-12 months and coproduce a consistent Maternity Service provision that meets the needs of all.

Where will we report this to?

- People Committee.
- Trust Management Group.
- Executives.
- Quality Committee.

Commissioning for Quality and Innovation Indicators

The Commissioning for Quality and Innovation payment framework is designed to support the cultural shift to put quality at the heart of the NHS. Local Commissioning for Quality and Innovation schemes contain goals for quality and innovation that have been agreed between the Trust and various Commissioning groups.

NHS England have paused the nationally mandated Commissioning for Quality and Innovation scheme in 2024/2025, however have continued to publish Commissioning for Quality and Innovation indicators as a non-mandatory list, comprising the 2023/2024 Commissioning for Quality and Innovation schemes. During 2024/2025 the Organisation is committed to focusing its attention on the Patient Safety Incident Response Framework and digital patient safety improvements across the Trust.

Statement of Assurance from the Board

The Quality Account is an annual account that providers of NHS services must publish to inform the public of the quality of the services they provide, in addition to sharing useful information for current and future patients. It also supports us to focus on and to be completely open about service quality and assists us to develop and continuously improve. This report details the approach that we take to improving quality and safety at Newcastle Hospitals and an assessment on the quality of care our patients received in 2023/2024. There are some elements within the report that are mandatory. The following section provides explanation of our quality governance arrangements that provide assurance to the Board.

Quality governance arrangements

In December 2023 the Trust received restrictions on our license to provide services which were imposed through a 'Notice of Decision'. As a result, it is required to implement an effective governance system which assesses, monitors and drives improvement in the quality, safety and experience of the care it delivers to patients. In particular this included ensuring that:

a. Risks in services are appropriately recorded, assessed, escalated to the Trust's board where required, and regularly reviewed.

b. Progress against action plans is monitored to improve the quality and safety of services and appropriate action is taken without delay where progress is not achieved as expected.

c. An effective system to identify and report incidents including the severity of harm is in place. The system must ensure incidents are appropriately reported to internal and external systems within appropriate timescales. The system must ensure incidents are effectively reviewed, lessons and actions are identified and shared with staff.

d. There are effective quality assurance systems in place to support the delivery of safe and quality care.

e. Feedback from staff is used to drive improvements to the quality and safety of services, and once improvements are identified they are made without delay.

f. Staff are able to report service user safety concerns without fear of reprisal, retribution or detriment using internal routes and in line with policies and procedures.

g. Feedback from external bodies such as royal colleges and other bodies who provide best practice guidance is sought and acted upon.

In order to deliver the requirements above, a dedicated Care Quality Commission delivery group has been established, led by an interim Quality Support Director, with oversight from Trust Board.

In 2023/2024 Newcastle Hospitals underwent a significant organisational restructure, transitioning from 20 Directorates to eight Clinical Boards. In November 2023 this included the introduction of a new clinical board quality and safety governance framework, providing a structure for Clinical Board oversight of the key elements of

quality (patient safety, clinical effectiveness and patient experience) and a mechanism for providing assurance to the Quality Committee and Trust Board that the relevant structure and processes are working effectively.

Each Clinical Board has developed and established a monthly Quality Oversight Group, led by a Quality and Safety Lead, who is a senior medical leader within the Clinical Board. The Quality Oversight Group is attended by key stakeholders within the Clinical Board and supporting corporate services such as the Clinical Governance and Risk Department and Newcastle Improvement. The Clinical Boards have a standard agenda which facilitates a review of each element of quality, including highlighting any risks within the Clinical Board.

Each Clinical Board reports into a monthly Quality and Performance review, led by the Trust Managing Director and attended by Executives to monitor compliance, provide assurance and discuss any risks. These can be further escalated to the Trust Board as required.

Whilst the Clinical Board quality and safety framework becomes embedded, the Trust has continued with its established quality governance arrangements throughout 2023/2024 to ensure that key quality indicators and reports are regularly reviewed by clinical teams and by committees up to and including the Board of Directors.

The Board of Directors also continues to receive a regular Integrated Board Report that includes an overview of the Trust's position across the domains of quality, people, and finance sections.

The Quality Committee

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

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

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

Assurance that quality governance structures, systems, processes and controls meet legal and regulatory requirements.	Delivery of continuous quality improvement.	Identifying any required actions where quality or safety standards are not being met.	Appropriate arrangements for research governance are in place.
Reviewing the quality impact of changing professional and organisational practices including systems based and partnership working.	Providing leadership for service quality, standards and practice. Both as an organisation and regional partner.	Reviewing the current and future quality and patient safety standards and actions needed to address them e.g. Care Quality Committee fundamental standards.	Effectiveness of mechanisms that involve patients, the public, staff, partners and other stakeholders in quality assurance and patient safety.
Assurance that mitigations and action plans set out in the Board Assurance Framework are effective.			

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

- Following implementation of the National Patient Safety Strategy, the Quality Committee has monitored and received assurance on the development and delivery of the Patient Safety Incident Response Plan and Patient Safety Incident Response Framework.
- Following the Trust's Care Quality Commission inspections during June to September 2023, the Quality Committee has received regular updates from the Executive Chief Nurse in relation to the Trust's updated position and any action plan responses, including any 'must do' and 'should do' actions and key themes, seeking assurance on plans for improvement.
- To improve assurance to the Quality Committee and Board, a sub-group of the committee, the Maternity Strategic Oversight Group, was established in relation to maternity services.
- The Quality Committee has a process to undertake 'deep dives' in order to provide a detailed evaluation in some specific areas of the Trust. The deep dives aim to provide assurance and opportunities for the Non-Executive Directors to discuss key issues. In May 2023 a deep dive was undertaken to review pressure ulcer and falls quality data in relation to variations with reporting and comparative data. The deep dive looked at the link between the acuity of patients and associated hospital acquired infections.
- The Quality Committee supports leadership walkabouts that are undertaken by Executive, Non-Executive and members of the senior Trust management team throughout the organisation. The walkabouts enhance links between senior leaders and front-line staff and raise awareness of front-line issues and support the visibility and accessibility of senior leaders within the organisation.
- The delivery of continuous quality improvement was the focus of a Quality Committee meeting in July 2023 when Newcastle Improvement presented an update. This update highlighted how the Quality Committee continues to support the development of improvement capability, improvement initiatives and sharing improvement stories.

Part 3

Review of Quality Performance 2023/2024

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 North East and North Cumbria Integrated Care Board.

Most of the account represents information from all eight Clinical Boards 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 Overview and Scrutiny Committee, North East and North Cumbria Integrated Care Board and Newcastle, North Tyneside and Northumberland Healthwatch organisations. Amendments will be made in line with this feedback.

Patient Safety

Priority 1 - Reducing Healthcare Associated Infections – focusing on COVID-19, Methicillin-Sensitive *Staphylococcus aureus*/Gram Negative Blood Stream Infections /Clostridium difficile Infections.

Why we chose this?

Gram Negative Blood Stream Infections constitute the most common cause of sepsis nationwide with associated high mortality. Proportionally, at the Newcastle Hospitals, the main source of infection is urinary tract infections, mostly catheter associated, line infections and hepatobiliary (liver, bile ducts and / gallbladder). There is an integrated approach to tackling these infections with multidisciplinary team engagement across the whole patient journey, focus on antibiotic stewardship, early identification of risks, surveillance and timely intervention from our reduction strategies. There is additional emphasis on Antimicrobial Resistance reduction, with high rates of resistance in most commonly used antibiotics i.e. Piperacillin-Tazobactam (Tazocin) for gram negative infections. The Gram Negative Blood Stream Infection Steering Group and Antimicrobial Steering Group continue to review reduction strategies on a quarterly basis.

Methicillin-Sensitive *Staphylococcus aureus* bacteraemia can cause significant harm. Within the Trust these are most commonly associated with lines, indwelling devices and soft tissue infections. Achieving excellent standards of care and improving practice is essential to reduce these infections and complications in line with harm free care.

In addition to COVID-19, there is a surge in respiratory infections, in particular Influenza and Respiratory Syncytical Virus. Each has the potential to require hospitalisation / intensive care admission and cause outbreaks across the Trust.

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

What we aimed to achieve?

- There is a national ambition to reduce Gram Negative Blood Stream Infections. We realigned ourselves with national reduction targets as these required greater than10% reductions for some pathogens.
- Targeted reduction in Broad spectrum antibiotic use (namely Tazocin).
- Internal 10% year-on-year reduction in Methicillin-Sensitive *Staphylococcus aureus* bacteraemia.
- Prevent transmission of health care acquired infections, COVID-19 and other preventable respiratory infections in patients and staff.
- Sustained reduction in *C. difficile* infections in line with national trajectory.

What we achieved?

- We adopted the National Infection Prevention and Control Board Assurance Framework (2023) to monitor and report on progress on all related standards in the Trust.
- Improved diagnosis and management of sepsis, collaborative working with Sepsis Clinical Director and specialist nurses. The National Contract data for sepsis identification, screening and treatment only includes a proportion of inpatients who undergo sepsis screening and who, if found to have suspected sepsis received intravenous antibiotic

treatment within one hour of diagnosis. Current sepsis compliance for inpatients increased from 66% to 81% in 2023/2024.

- Quality improvement projects undertaken in key Clinical Boards, running in parallel with trust-wide awareness campaigns, education projects, and audit of practice, with a specific focus on:
  - Antimicrobial stewardship and safe prescribing (Emergency Department). New Sepsis guidelines are in place to move selected patients away from broad spectrum antibiotic use.
  - Early recognition and management of suspected infective diarrhoea. Education and monitoring ongoing in surgical specialties resulting in improved recognition and management of C. difficile infection. This has been reflected in us achieving 144 cases in 2023/2024 which has met the national threshold aim of ≤165 cases.
  - The Trust has also met the national threshold aim for Klebsiella bacteraemia. National threshold aim was less than 130 cases and we achieved a total of 114 cases.
  - Ward monitoring of device compliance for peripheral intravenous and urinary catheters. Improvement work continues with audit and targeted education. Electronic dashboard line surveillance to be implemented in May/June 2024.
  - Optimisation of the management of bladder health and catheter associated infection through quality improvement interventions and recommendations.
  - Insertion and ongoing care of invasive and prosthetic devices. Surveillance monitoring is in place for Joint and Spinal Surgery. Quarter 4 (October – December 2023) saw five (1.3%) Surgical Spine Infections recorded at the RVI which is a slight increase compared to the previous quarter where three infections (0.9%) were recorded. For hips Quarter 3 (July – September 2023), no infections were recorded.
  - Octenisan compliance. Project completed and actions to be implemented April 2024.
  - Evidence of improvement in line care management in Royal Victoria Infirmary Admission Suite.
- Clinical Board Quality Oversight Groups are provided with quarterly infection control updates and attended by senior team representatives.
- Ongoing work with partner organisations such as the Integrated Care Board to improve infection control practice for the wider health care economy.

How we measured success?

- Monitoring compliance with assurance frameworks.
- Continuous monitoring of healthcare associated infections and deaths within the Trust.
- Data sharing with Clinical Boards whilst focusing on best practice and learning from investigation of mandatory reportable organisms.
- Continue to report Methicillin-Sensitive Staphylococcus aureus/Gram Negative Blood Stream Infections /Clostridium difficile Infections monthly, internally and nationally.

Priority 2 – Management of Abnormal Results

Why we chose this?

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

Problems related to the management of abnormal results are amongst the most common contributory factors leading to serious incidents and litigation related to delays in diagnosis/treatment and failures to act on results.

What we aimed to achieve?

- To be a world leader by improving patient safety through ensuring that appropriately ordered clinical investigations are undertaken, acknowledged and endorsed, resulting in timely clinical care, treatment and follow-up.
- Improving the management of abnormal results will require successful completion of Closed Loop Investigations.
- To ensure that all clinically appropriate investigation requests are fulfilled; results are returned to the correct consultant; and appropriate action is taken in response to critical results.
- More specifically, the aim is: When a test/ investigation is ordered and undertaken, the result must be returned to the message centre inbox of the consultant with responsibility for patient care for endorsement and action by the team.

What we achieved?

The Trust has now:

- Agreed a list of over 1000 lead clinicians with patient responsibility (predominantly consultants, but also some senior allied health professionals).
- Implemented a robust process for new joiners to be added and leavers to be removed from the list of lead clinicians.
- Made improvements to our electronic systems so that they share information more effectively across laboratories, radiology and our patient record.
- Added a mandatory field to all electronic order entry forms used to digitally request investigations through eRecord (including radiology, laboratory medicine and echocardiography). This field asks for details of the "lead clinician to receive report", and all results are channelled to the message centre of the specified clinician.
- Put in place measures to avoid blood samples being routinely discarded by the laboratory (blood sciences) where "collected" has not been ticked in "nurse task list" in eRecord.
- Ensured that radiology tests are no longer automatically cancelled when an inpatient is discharged from hospital.
- Made it easier to see the Results Review in eRecord to avoid test results being missed.
- Started to improve the configuration of the 'message centre' make it easier for staff to use. Results will be received in the message centres of recognised clinicians with consultant-level responsibility for patient care. As a result, message centre is now a more reliable method for communication of results, thereby ensuring more timely clinical care, treatment and follow-up.

How we measured success?

We evaluated how often the lead clinician that asked for the investigation, received the results within the electronic patient record. The data was analysed within the following categories:

Magnetic Resonance Imaging Results: Our data shows that the correct clinician received the results as planned in 61.3

percent of cases. The Trust therefore estimates that 22,000 additional MRI reports will be sent to the correct clinician within the eRecord system.

Computerised Tomography Results: Our data shows that the correct clinician received the results as planned in 51 percent of cases.

The Trust therefore estimates that, per year, over 48,500 additional Computerised Tomography reports will be sent to the correct clinician within the eRecord system.

Future work within the Trust aims to build on the results above the further improve and optimise the current systems.

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

Why we chose this?

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

What we aimed to achieve?

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

What we achieved?

- A Patient Safety Incident Response Framework Implementation Lead and a Patient Safety Strategy Clinical Director were successfully appointed. They have led the Patient Safety Incident Response Framework implementation, working with the new Clinical Boards to establish governance mechanisms for effective patient safety incident responses.
- The Trust's Patient Safety Incident Response Plan which outlines priorities for improvement, responses for different types of incidents, guides the identification of proportionate learning responses and outlines training requirements was developed with key stakeholders.
- The Trusts Patient Safety Incident Response Framework Policy which defines the scope and requirements, the types of response, timeframes for response and training requirement were developed and ratified.
- The Trust collaborated with the Integrated Care Board to agree oversight of the new systems for learning and improvement. Additionally, the Integrated Care Board now participate in Trust meetings where proportionate learning responses are identified and meetings where learning responses are agreed.
- We have agreed roles, responsibilities and support available with the Clinical Boards Quality and Safety Leads, Heads of Nursing and Directors of Operations.
- Staff capacity and capability for systems-based investigation has been increased to support the proportionate learning responses identified by After Action Reviews and Patient Safety Incident Investigations.

- A charity funding application has been made to support patient safety partners who would support each of the Clinical Boards and the Patient Safety Team.

How we measured success?

- The Trust's Patient Safety Incident Response Plan was approved by the Integrated Care Board in December 2023.
- The Trust's Patient Safety Incident Review Framework Policy was ratified in January 2024.
- The Trust has now moved away from the Serious Incident Framework and went live with the Patient Safety Incident Review Framework in January 2024.
- All three of the Trust Patient Safety Incident Review Framework priorities have an identified medical lead in addition to support from Newcastle Improvement, the Clinical Governance and Risk Department and a Non-Executive Director.
- A range of proportionate learning responses have been identified by the Patient Safety Incident Response Framework. A proportionate response is one which investigates the incident in the most appropriate level of detail to generate learning and recommendations. These responses fall into four main categories. Rapid Response Assessment, After Action Review, Patient Safety Incident Investigation and Thematic Review.

Clinical Effectiveness

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

Why we chose this?

The need for early recognition and management of deterioration of pregnant women was highlighted by Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries and the Ockenden Report. Internally it was also identified that not having triage at the point of presentation to the Maternity Assessment Unit was a contributory factor to Serious Incidents and Significant Learning Events within Maternity. It was therefore recognised that there was a need for formal triage on the assessment unit at the point of presentation to reduce the likelihood of avoidable harm to mothers and babies. A formal triage process would enable and facilitate rapid review and prioritisation of care, based on individual clinical need.

What we aimed to achieve?

Our aim was to improve early detection and escalation of women at risk of deterioration and to reduce the likelihood of avoidable harm to mothers and babies. A comprehensive Quality Improvement project was undertaken which facilitated significant changes and led to introducing a formal, objective triage using a bespoke platform within BadgerNet (electronic maternity system which was implemented in January 2023).

What we achieved?

Work was ongoing to implement the Birmingham Symptom Specific Obstetric Triage System on the Maternity Assessment Unit. This is the bespoke maternity triage system within BadgerNet. We undertook the following:

- Implemented Badgernet in January 2023. This is an electronic end to end maternity package, which includes community and BadgerNotes, a woman's electronic hand-held record.
- Appointed a new Band 7 post to lead this implementation and training.

- Successfully applied for a Birmingham Symptom Specific Obstetric Triage System licence, enabling access to advice on implementation and training materials.
- Successfully moved elective workload away from the assessment unit. This has been achieved by the development of a new maternity day-care unit, within the antenatal ward. This has included a complete refurbishment of the clinical area and guidance has been developed for place of care/referral pathways. The women attending the assessment unit are now emergencies only, reducing the number of attendances which will support the implementation of electronic triage.
- Visited the maternity unit at a local Trust to see new processes working in practice.
- Implemented a training package for the core team of midwives and medical staff.
- Continued to use the paper version of the previous triage system in the interim and collected baseline audit data to monitor effectiveness. This showed 80% women were seen within 15 minutes in quieter periods, but this fell to 0-20% at busier times, particularly in the afternoons and evenings. This happened because there wasn't a formal electronic process to ensure formal triage took place.
- The Birmingham Symptom Specific Obstetric Triage System went live on December 18th 2023.

How we measured success?

- The Digital midwives have undertaken a weekly audit of women attending the assessment unit looking at:
    - The percentage of women formally triaged by a designated member of staff trained in triage, within fifteen minutes of arrival (target 95%). We have seen an increase in this to almost 90% since implementation.
    - The percentage of women receiving appropriate on-going care according to risk. This has increased to 80% for ongoing midwifery care but remains at approximately 50% for medical review within expected timeframe.

A monthly dashboard is produced based on this data.

- The Triage Oversight and Implementation Group meets monthly to oversee compliance, assurance and effectiveness. The dashboard and process are reviewed, staff feedback is sought and areas for improvement identified. Experience from other users of this triage system in over 60 units are that it can take 6-12 months to achieve desired targets.
- The regional sharing and learning group meets monthly which is helpful for troubleshooting. The national team is also available on request to discuss issues/queries and we are currently meeting quarterly with them.

Priority 4b - Modified Early Obstetric Warning Score

Why we chose this?

In recent years there have sadly been several maternal deaths in England where the lack of Modified Early Obstetric Warning Score systems for pregnant women in hospital, but outside the maternity setting played a significant part. At present, pregnant and recently pregnant women outside the maternity unit are monitored using the traditional model of National Early Warning System monitoring for non-pregnant patients. The need for early recognition and management of deterioration of pregnant women has been highlighted by:

- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
- The Ockenden Report
- The Maternity and Neonatal Safety Improvement Programme.
- Royal College of Physicians guidance,

which states that all medical pregnant and recently pregnant women should be monitored using a MEOWS system.

What we aimed to achieve?

We aimed to achieve two things:

1. Creation of a means of identifying a pregnant and recently pregnant patients through our electronic patient record.
2. Introduce a maternal early warning observation chart linking to our electronic observations system.

What we achieved?

We have developed and brought into current practice a question in our admission documentation within our electronic patient record Electronic Patient Record to identify those patients who are pregnant or have been pregnant in the previous 42 days. This allows us to identify all patients meeting this criteria, particularly for those in a non-maternity setting. We have created an electronic Modified Early Obstetric Warning Score chart. Electronic observations went live in May 2023 within maternity areas, apart from Maternity Assessment unit which remains a high-risk area. All the appropriate equipment is in place to enable staff to undertake the new assessment and we have also made changes to out electronic systems to make recording simpler.

How we measured success?

Success for the identification of pregnant or recently pregnant patients in the Electronic Patient Record is dependent on ability to record this information electronically. Deteriorating patients in adults are identified by reviewing the deterioration patient list, and more generally by observing compliance on the e-Observation compliance dashboard which gives Trust wide data results.

Priority 5 - Best Interests Decisions/Mental Capacity Assessment and Deprivation of Liberty Safeguards.

Why we chose this?

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

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

What we aimed to achieve?

- Ensure staff understand the need for mental capacity assessments and where and how to record these assessments.
- Ensure staff recognise when best interest discussions are needed and where and how to document these discussions.
- Ensure staff understand the process for requesting and completing Urgent Deprivation of Liberty Safeguards authorisations.

What we achieved?

- Trust-wide Care for me With Me programme.
- As part of the Trust's 'Care for Me, With Me' programme a significant amount of training has taken place across the Trust in relation to Mental Capacity Assessment and Deprivation of Liberty Safeguards Current compliance with MCA training is 92%.
- Compliance audits have demonstrated improvement across the Trust in the documentation of Mental Capacity Act assessment prior to Deprivation of Liberty Safeguards being put in place.

- Audit of referrals and electronic documentation for Quarter 3 audit showed 83% completed assessments of capacity for patients subject to Urgent Deprivation of Liberty Safeguards. 72% of assessments are seen as good or meeting minimal requirements. An appraisal of best interests (new audit measure introduced in Quarter 3) found that 32% were regarded as good assessments. There continues to be some exemplary practice of thorough documentation of assessments and best interests' analysis, especially with regards to complex decisions.
- Increase in Deprivation of Liberty Safeguards referrals demonstrates greater awareness.
- Information shared to support staff in the process of completing mental capacity assessments and Best Interest decisions.
- Updated electronic mental capacity assessment and best interests' decision form.

How we measured success?

- Compliance with training.
- Audit of notes.

Patient Experience

Priority 6 – Ensure reasonable adjustments are made for patients with suspected, or known, Learning Disability.

Why we chose this?

We are committed to ensuring patients with a learning disability and or autism have access to services that will help improve their health and wellbeing and provide a positive and safe patient experience for them and their families.

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

What we aimed to achieve?

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

What we achieved?

- Change in digital documentation to ensure staff are prompted to identify if a patient has a confirmed learning disability, if they have a passport and alert flag on the system. There has been greater awareness of how to document reasonable adjustments and work undertaken in collaboration with patients in discussing their needs, as identified in their passports.
- Greater awareness of the role of the Learning Disability Liaison team.
- Implementation of learning disability training (Diamond Standards e-learning)
- Reintroduction of the role of the Learning Disability Champions.
- The Newcastle upon Tyne Hospitals NHS Foundation Trust has been part of the regional pilot with regard to the Oliver McGowan training.
- Reasonable adjustments posters placed across organisation.

How we measured success?

- Regular audits of patient records showing an increase of documenting diagnosis of a learning disability from 25% to 53%. Consideration of reasonable adjustments has increased from 43% to 46%.
- Review of training compliance which is now at 90%.

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

Why we chose this?

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

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

Throughout 2021/2022 there has been significant pressure on specialist mental health Tier 4 inpatient services across the Northeast and Yorkshire Region. There has been an increase in children and young people presenting and is especially high in those with eating disorders. This has resulted in some patients having delayed access to treatment in the right care environment.

The overarching purpose of the National Confidential Enquiry into Patient Outcome and Death Mental Healthcare in Young People and Young Adults report is to improve the quality of care provided to young people and young adults with mental health conditions.

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

What we aimed to achieve?

- Improve the pathway and timeliness of access to appropriate services for all Children and Young People presenting acutely.
- Continue to promote the "We Can Talk" training across paediatric and adult areas.
- Improve the environment within the Emergency Department to ensure safety and well-being.

What we achieved?

- Clinical Manager appointed by Cumbria, Northumberland, Tyne and Wear to lead on the Children and Young People Service liaison proposal. This work commenced April 2023; business proposal submitted.
- The "We Can Talk" programme leads visited the Trust in April for a day to further promote the training.
- The 'We Can Talk in Private' Quality Improvement project is fully implemented in adult Emergency Department; the project aims to allow patients to indicate they wish to speak in private by holding a card up.
- Welcoming pack for the Children and Young People Quality Improvement project is fully implemented.

How we measured success?

- Development of more efficient pathways to access appropriate services such as Children and young people's services for mental health difficulties.
- Positive impact of training, increased numbers of staff and disciplines trained totalling 253.

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

Why we chose this?

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

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

What we aimed to achieve?

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

What we achieved?

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

How we measured success?

As funding has now been agreed this work will progress throughout 2024/2025, led by a project team with the aim of facilitating and embedding a coordinated approach for transition amongst specialist conditions and bespoke groups including mental health, safeguarding, learning disability/difficulty and evaluating by collecting data on:

- Patient feedback on their experience, staff feedback surrounding improved knowledge.
- Measuring clinic attendance.
- Benchmark against the National Collaborative Framework.

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

Update on Duty of Candour

Being open and transparent is an essential aspect of patient safety. Promoting a restorative, just and learning culture helps us to ensure we communicate in an open and timely way on when things go wrong.

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.

If a patient in our care experiences harm or is involved in an incident because of their healthcare treatment, we explain what happened and apologise to patients and/or their family 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 policy provides structure and guidance to our staff on the standard expected within the organisation. Our Duty of Candour compliance is assessed by the Care Quality Commission; 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.

Compliance with recording of Duty of Candour remains challenging. In 2023/2024 further work has been carried out to widen the Electronic Patient Record systems data that can be captured. A dashboard is also being launched to allow Clinical Boards to maintain oversight of their own compliance.

A key element of the Patient Safety Incident Response Framework is patient and family engagement in the investigation process. Over the next year work is planned to develop Duty of Candour to include patient/ families in the investigation process.

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

Training is included in the Trust incident investigator training which is delivered to multidisciplinary staff once a month.

Statement on progress in implementing the priority clinical standards for seven-day hospital services

The Board Assurance Framework or seven-day hospital services submission was deferred due to the COVID-19 pandemic. The framework was then updated in 2022 to reduce internal data collection for Trust Boards, moving from data that was required to be uploaded twice yearly to a national portal, to Trust's producing a report signed off by the Executive Medical Director, at least once a year. The Trust is committed throughout 2024/2025 to undertaking an assessment of its performance as required by this guidance and producing the required reporting.

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".

All staff permanent, temporary and bank workers are informed as part of their induction process, via the e-handbook 'First Day Kit' that there are several routes through which to report concerns about issues in the workplace. There is a recorded presentation at induction by The Freedom to Speak Up Guardian to introduce themselves to staff and to emphasise their role in this process.

We want staff who work for Newcastle Hospitals to be confident they have a voice and that they can raise concerns safely. 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 enables people to raise ideas or concerns directly with up to 20 senior leaders, including the Chief Executive, members of the Executive Team and the Freedom to Speak Up Guardian. The conversations are categorised into subject areas, including staff safety.

This secure web-based system is run by a third-party supplier. It enables staff to engage in a dialogue with senior leaders in the Trust, safe in the knowledge that they cannot be identified. Reports on themes raised are reported to the People Committee.

Freedom to Speak up Guardian

The Trust Freedom to Speak up 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, by telephone, email or in person.

To support this work, a network of Freedom to Speak up Champions, spread across the organisation and sites, has been developed. A new Guardian has recently been appointed and the time dedicated to the role has increased.

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

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

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

This policy provides employees who raise such concerns, assurance from the Trust that they will be supported to do so and will not face any detriment because of raising their concerns.

The Trust is working hard to improve our culture of safety and learning to protect patients and staff. We 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.

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.

Staff Networks

The staff networks have been established for several years. They provide support for Black and Minority Ethnic staff, LGBTQ+ staff, and people with a disability or long-standing health issue.

Each network has a Chair and Vice Chair and 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 Black and Minority Ethnic 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 2023 – March 2024. The aim of the report is to highlight the vacancies in junior doctor rotas and steps taken to resolve these.

Gaps are present on several different rotas; this is due to both gaps in the regional training rotations, challenges recruiting suitable locally employed doctors and less than full time doctors in full time posts. The main areas of recurrent or residual concern for vacancies are Accident and Emergency and Anaesthetics and Critical Care. The Trust takes a proactive approach to minimise the impact of these by active recruitment; utilisation of locums; and by rewriting work schedules to ensure that key areas are covered. In some areas trainee shifts are being covered by consultants when junior doctor locums are unavailable.

In addition to the specific actions above, the Trust takes a proactive role in management of gaps through the work of the Junior Doctor Recruitment and Education Group. Members of this group include the Director of Medical Education, Finance Team representative and Medical Staffing personnel. In addition to recruitment into locally employed doctor posts, the Trust runs several successful trust-based training fellowships, a teaching fellow programme, and has supported temporary and permanent expansion of the Foundation Training Programme.

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. The information included below is provided as a result of those regulations.

1. During 2023/24, 1982 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: 457 in the first quarter; 453 in the second quarter; 548 in the third quarter; 524 in the fourth quarter.
2. During 2023/24, 887 case record reviews and 54 investigations have been carried out in relation to 1982 of the deaths included in point 1 above. In 15 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: 260 in the first quarter; 265 in the second quarter; 260 in the third quarter; 156 in the fourth quarter.
3. 33, representing 1.72% of the patient deaths during the reporting period where the investigation is complete and has been judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 17, representing 0.86% deaths for the first quarter, 10, representing 0.50% for the second quarter and five representing 0.25% for the third quarter. (To date, not all incidents have been fully investigated). Once all investigations have been completed, any death found to have been due to problems in care will be summarised in 2024/25 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 completed cases judged to be more likely than not to have had problems in care which have contributed to patient death:

Summary	Key Lessons learned from review	Action	Impact/Outcome
14 Healthcare Acquired Infections - Covid-19.	Compliance with Covid screening, Personal Protective Equipment and hand hygiene is essential to reducing infections.	Infection, prevention & control team to continue to investigate all Healthcare Associated Infection. All staff to continue to comply with all Covid screening.	Infection prevention measures are shown to be robust in comparison to national peer organisations. National data demonstrates low Healthcare Associated Infection rate within organisation.
Trust guidance not followed in relation to febrile convulsion.	Ongoing continued education of all new medical and nursing staff at the time of induction.	Training for staff during the first two weeks of rotation into the clinical area.	Improved awareness of protocols within relevant areas.

Summary	Key Lessons learned from review	Action	Impact/Outcome
Patient died post operatively due to aspiration pneumonia.	Requirement for improved planning prior to commencement of Transapical Transcatheter Aortic Valve Implantation procedure.	Introduction of a technical Multi-Disciplinary Team prior to procedure and updated patient consent form.	Strengthened processes throughout the completion of the Transapical Transcatheter Aortic Valve Implantation programme.
Unexpected death post-transplant.	Lack of awareness of retroperitoneal bleeding post renal transplant.	Renal Transplant Protocol and Renal Transplant Enhanced. Recovery After Surgery Protocol re-written to include a specific section on Post-operative bleeding.	Written guidance and support for staff updated and additional guidance material produced.
Unexpected death due to medical device fault.	All patients with implanted Ventricular Assist Devices should not disconnect both power sources at the same time.	Updates and changes to HAVD equipment now undertaken with patients during an inpatient stay.	No further HVAD devices have been implanted in patients since April 2021.
Unexpected death due to surgical complication.	Requirement to introduce alternative equipment to prevent risk of air-embolism.	Anti-air embolism lines have been trialled and are in place on all adult units for use.	There is a reduced risk to patients of air embolisms through the introduction of new equipment.
Sepsis related death.	Patients and families require additional support with temperature monitoring. Triage Tool reference document needs to be accessible to all staff dealing with out of hour's helpline calls.	Ambulatory Care Unit Safety Checklist amended to ensure patient/ carers are observed and able to monitor temperatures with a tympanic thermometer. Improved availability across the department of the triage tool.	Improved compliance to completion of triage tool through the introduction of regular audits.
Hospital Acquired Infection.	Policies for the management of complex Meticillin-Sensitive Staphylococcus Aureus bacteraemia to be reviewed.	Updated guidance for antimicrobial prescriptions.	The Trust infection prevention measures are shown to be robust in comparison to National peer organisations. National data demonstrates low Health Care Acquired Infection rate within organisation.
Patient died due to inpatient fall.	Trends and themes in patient falls are monitored and learning is targeted to areas of high risk.	Ongoing work Trust wide to reduce the rate of falls with harm.	The Harm Free Care Team have a strategic action plan to support falls reduction across the Trust.

Summary	Key Lessons learned from review	Action	Impact/Outcome
Patient died due to aspiration of food.	Review of the induction and training for volunteer mealtime assistants.	Updated induction and training delivered to volunteers.	Reduced patient risk from volunteers due to increased compliance with training and induction of volunteers.
Patient died due to post-operative wound infection.	Processes to be implemented to enable patients a point of contact for concerns over their wound on discharge.	Process of escalation and in / out of hour's contacts put in place for patients on discharge.	Improved lines of communications for patients with concerns about their wounds on discharge.
Surgical complication causing hypoxic brain injury.	Extremely rare complication that may have been attributable to equipment used.	Equipment of concern reviewed, and the decision made to discontinue its use.	Equipment of concern withdrawn from use within the Trust.

4. 174 case record reviews and 40 investigations were completed after April 2023 which related to deaths which took place before the start of the reporting period.
5. 14, representing 0.71% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.
6. 21, representing 1.6% of the patient deaths during 2022/23 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 the Patient Safety Incident Forum (formerly the Serious Incident Panel) which will be monitored and reported to the Trust Board and Quality Committee.

Information on Participation in National Clinical Audits and National Confidential Enquiries

During 2023/2024, 65 national clinical audits and two national confidential enquiry reports / review outcome programmes covered NHS services that the Newcastle hospitals provides.

During that period, we participated in 58 (89%) 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 we were eligible to participate in during 2023/2024 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/24	Percentage Data completion	Outcome
Adult Respiratory Support	British Thoracic Society	To capture data on patients outside critical care that have required respiratory monitoring or intervention.	✓	Data Collection February 2023 – May 2023	No publication date yet identified
British Association of Urological Surgeons Nephrostomy	British Association of Urological Surgeons	To collect data on the management and outcomes of patients undergoing primary insertion of nephrostomy for an infected, obstructed, kidney in the emergency setting and identify variation in the nephrostomy pathway and its effect on the patient outcome.	✓	Data collection February 2023 – February 2024	Published report expected June 2024
Breast and Cosmetic Implant Registry	NHS Digital	Captures the details of all breast implant procedures completed by both the NHS and private providers.	✓	Continuous data collection	No publication date yet identified
British Hernia Society Registry	British Hernia Society	The registry will, permit large-scale, cost-effective embedded research, guide product development, track outcomes across a lifetime and, therefore improve patient safety.	The Trust did not participate in the programme.		

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/24	Percentage Data completion	Outcome
Case Mix Programme	Intensive Care National Audit & Research Centre	This audit looks at patient outcomes from adult, general critical care units in England, Wales and Northern Ireland.	The Trust did not participate in the programme.		
Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	The audit aims to assess the quality of healthcare and stimulate improvement in safety and effectiveness.	✓	Cohort 1st April 2021 to 31st March 2022	Report awaiting baseline assessment
Cleft Registry and Audit Network Database	Royal College of Surgeons of England	The CRANE Database collects information about all children born with cleft lip and/or cleft palate in England, Wales and Northern Ireland.	✓	Continuous data collection	Report awaiting baseline assessment
Elective Surgery (National Patient Reported Outcome Measures (PROMs) Programme)	NHS Digital	This audit looks at patient reported outcome measures in NHS funded patients eligible for hip or knee replacement.	✓	Continuous data collection	No publication date yet identified
Emergency Medicine Quality Improvement Project : Care of Older People	Royal College of Emergency Medicine	The purpose of this audit is to assess and improve the quality of care given to older and frail patients and to ensure that recommended interventions that can make a meaningful difference to mortality, morbidity and quality of life are implemented where feasible.	✓	Data collection October 2022 – October 2024	No publication date yet identified
Emergency Medicine Quality Improvement Project : Mental Health (Self-Harm)	Royal College of Emergency Medicine	The purpose of this QIP is to improve patient safety and quality of care as well as workspace safety by collecting sufficient data to track change but with a rigorous focus on actions to improve.	✓	Data collection October 2022 – October 2024	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/24	Percentage Data completion	Outcome
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Royal College of Paediatrics and Child Health	The audit aims to address the care of children and young people with suspected epilepsy who receive a first paediatric assessment within acute, community and tertiary paediatric services.	✓	Continuous data collection	Published report expected July 2024
Falls and Fragility Fracture Audit Programme: Fracture Liaison Service Database	Royal College of Physicians	Fracture Liaison Services are the key secondary prevention service model to identify and prevent primary and secondary hip fractures. The audit has developed the Fracture Liaison Service Database to benchmark services and drive quality improvement.	The Trust did not participate in this audit.		
Falls and Fragility Fracture Audit Programme: National Audit of Inpatient Falls	Royal College of Physicians	The audit provides the first comprehensive data sets on the quality of falls prevention practice in acute hospitals.	✓	Continuous data collection	Report awaiting baseline assessment
Falls and Fragility Fracture Audit Programme: National Hip Fracture Database	Royal College of Physicians	The audit measures quality of care for hip fracture patients and has developed into a clinical governance and quality improvement platform.	✓	Continuous data collection	Published expected September 2024
Improving Quality in Crohn's and Colitis	Inflammatory Bowel Disease	The audit aims to improve the quality and safety of care for Inflammatory Bowel Disease patients throughout the UK.	The Trust did not participate in this audit.		
Learning from lives and deaths of people with a learning disability and autistic people	NHS England	The audit aims to improve the health of people with a learning disability and reduce health inequalities.	✓	Continuous data collection	Published report expected July 2024

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/24	Percentage Data completion	Outcome
Maternal, Newborn and Infant Clinical Outcome Review Programme	University of Oxford / MBRRACE UK	The aim of the audit is to provide robust national information to support the delivery of safe, equitable, high quality, patient-centred maternal, new-born and infant health services.	✓	Continuous data collection	Trust not fully compliant. Action plan developed
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	The audit aims to assess the quality of healthcare and stimulate improvement in safety and effectiveness.	✓	1st April 2023 to 31st March 2024	Report awaiting baseline assessment
Mental Health Clinical Outcome Review Programme	The University of Manchester / National Confidential Inquiry into Suicide and Safety in Mental Health	The audit aims to decrease suicide rates, particularly in people under mental health care and in patient subgroups.	The Trust does not provide this service.		
National Adult Diabetes Audit: Diabetes Footcare	NHS Digital	Patients referred to specialist diabetes foot care services for an expert assessment on a new diabetic foot ulcer.	✓	Continuous data collection	Publication date yet to be identified
National Adult Diabetes Audit: Inpatient Safety Audit	NHS Digital	The National Diabetes Inpatient Audit is an annual snapshot audit of diabetes inpatient care in England and Wales and is open to participation from hospitals with medical and surgical wards. The audit allows hospitals to benchmark hospital diabetes care and to prioritise improvements in service provision that will make a real difference to patients' experiences and outcomes.	✓	Continuous data collection	Publication date yet to be identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/24	Percentage Data completion	Outcome
National Adult Diabetes Audit: Pregnancy in Diabetes Audit	NHS Digital	The audit aims to support clinical teams to deliver better care and outcomes for women with diabetes who become pregnant.	✓	Continuous data collection	Publication date yet to be identified
National Adult Diabetes Audit: Core Audit	NHS Digital	National Diabetes Audit collects information on people with diabetes and whether they have received their annual care checks and achieved their treatment targets as set out by NICE guidelines.	✓	Continuous data collection	Publication date yet to be identified
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: Chronic Obstructive Pulmonary Disease Secondary Care	Royal College of Physicians	The aim of the audit is to drive improvements in the quality of care and services provided for Chronic Obstructive Pulmonary Disease patients.	✓	Continuous data collection	Report awaiting baseline assessment
National Asthma and Chronic Obstructive Pulmonary Disease Chronic Obstructive Pulmonary Disease Audit Programme: Pulmonary Rehabilitation	Royal College of Physicians	This audit looks at the care people with Chronic Obstructive Pulmonary Disease get in pulmonary rehabilitation services.	✓	Continuous data collection	Report awaiting baseline assessment
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: Adult Asthma Secondary Care	Royal College of Physicians	The audit looks at the care of people admitted to hospital adult services with asthma attacks.	✓	Continuous data collection	Report awaiting baseline assessment

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/24	Percentage Data completion	Outcome
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: Children and Young People's Secondary Care	Royal College of Physicians	The audit looks at the care children and young people with asthma receive when they are admitted to hospital because of an asthma attack.	The Trust did not participate in this audit		
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.	The Trust did not participate in this audit		
National Audit of Cardiovascular Disease Prevention in Primary Care	NHS Benchmarking Network	Analysis and reporting of the suit is designed to support systematic quality improvement using the findings from annual audit reports and the associated Data & Improvement Tool, to reduce health inequalities and improve outcomes for individuals and populations.	The Trust does not provide this service		
National Audit of Care at the End of Life	NHS Benchmarking Network	The National Audit of Care at the End of Life is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals, community hospitals and mental health inpatient providers in England, Wales and Northern Ireland.	✓	Data collection 1st January 2024 to 31st December 2024	No publication date identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/24	Percentage Data completion	Outcome
National Audit of Dementia	Royal College of Psychiatrists	The National Audit of Dementia looks at quality of care received by people with dementia in general hospitals.	✓	Data collection September 2023 – March 2024	Published report expected July 2024
National Audit of Pulmonary Hypertension	NHS Digital	The audit measures the quality of care provided to people referred to pulmonary hypertension services.	✓	Continuous data collection	Report awaiting baseline assessment
National Bariatric Surgery Registry	British Obesity & Metabolic Surgery Society		The Trust does not provide this service		
National Cancer Audit Collaborating Centre: National Audit of Metastatic Breast Cancer	Royal College of Surgeons of England	Aims to report on all patients diagnosed with metastatic breast cancer (MBC; also known as secondary, advanced or stage 4 breast cancer) in NHS hospitals in England and Wales.	✓	Continuous data collection	No publication date yet identified
National Cancer Audit Collaborating centre: National Audit of Primary Breast Cancer	Royal College of Surgeons of England	The NAoPri will report on all patients newly diagnosed with primary breast cancer (stages 0 to 3) in NHS hospitals in England and Wales.	✓	Continuous data collection	No publication date yet identified
National Cardiac Arrest Audit	Intensive Care National Audit & Research Centre	Intensive Care National Audit and Research Centre / Resuscitation Council UK.	✓	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme: Adult Cardiac Surgery	National Institute for Cardio-vascular Outcomes Research	This audit looks at heart operations. Details of who undertakes the operations, the general health of the patients, the nature and outcome of the operation, particularly mortality rates in relation to preoperative risk and major complications.	✓	Continuous data collection	Published report expected April 2026
National Cardiac Audit Programme: Congenital Heart Disease	National Institute for Cardio-vascular Outcomes Research	The congenital heart disease website profiles every congenital heart disease centre in the UK, including the number and range of procedures they carry out and survival rates for the most common types of treatment.	✓	Continuous data collection	Published report expected April 2024

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/24	Percentage Data completion	Outcome
National Cardiac Audit Programme: Heart Failure	National Institute for Cardio-vascular Outcomes Research	The aim of this project is to improve the quality of care for patients with heart failure through continual audit and to support the implementation of the national service framework for coronary heart disease.	✓	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme: Cardiac Rhythm Management	National Institute for Cardio- vascular Outcomes Research	The audit aims to monitor the use of implantable devices and interventional procedures for management of cardiac rhythm disorders in UK hospitals.	✓	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme: Myocardial Ischaemia	National Institute for Cardio- vascular Outcomes Research	The Myocardial Ischaemia National Audit Project was established in 1999 in response to the National Service Framework for Coronary Heart Disease, to examine the quality of management of heart attacks (Myocardial Infarction) in hospitals in England and Wales.	✓	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme: Percutaneous Coronary Intervention	National Institute for Cardio- vascular Outcomes Research	The audit collects and analyses data on the nature and outcome of Percutaneous Coronary Intervention procedures, who performs them and the general health of patients. The audit utilises the Central Cardiac Audit Database, which has developed secure data collection, analysis and monitoring tools and provides a common infrastructure for all the coronary heart disease audits.	✓	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme: Mitral Valve Leaflet Repairs	National Institute for Cardio-vascular Outcomes Research	The aim of the audit is to collect clinical and outcome data on structural heart intervention services carried out in the UK.	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/24	Percentage Data completion	Outcome
National Cardiac Audit Programme: UK Transcatheter Aortic Valve Implantation Registry	National Institute for Cardio-vascular Outcomes Research	The project aims to capture detailed information on how TAVI is used to treat patients with severe aortic stenosis and significant comorbidities; improving the care of patients and benchmarking TAVI units to learn best practice.	✓	Continuous data collection	Published report expected January 2025
National Child Mortality Database	University of Bristol	The National Child Mortality Database collates information nationally to ensure that deaths are learned from, that learning is widely shared and that actions are taken, locally and nationally, to reduce the number of children who die.	✓	Continuous data collection	No publication date yet identified
National Clinical Audit of Psychosis	Royal College of Psychiatrists		The Trust does not provide this service		
National Comparative Audit of Blood Transfusion: 2023 Audit of Blood Transfusion against National Institute for Health and Care Excellence Quality Standard 138	NHS Blood and Transplant	The National Comparative Audit of Blood Transfusion is a programme of clinical audits which looks at the use and administration of blood and blood components in NHS and independent hospitals in England.	✓	Data 1st January 2023 to 31st March 2023	Report awaiting baseline assessment
National Comparative audit of Blood Transfusion: 2023 Bedside Transfusions	NHS Blood and Transplant	The National Comparative Audit of Blood Transfusion is a programme of clinical audits which looks at the use and administration of blood and blood components in NHS and independent hospitals in England.	✓	1st March 2024 to 31st April 2024	No publication date yet identified
National Early Inflammatory Arthritis Audit	British Society for Rheum-atology	The audit aims to improve the quality of care for people living with inflammatory arthritis.	✓	Continuous data collection	Published report expected October 2024

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/24	Percentage Data completion	Outcome
National Emergency Laparotomy Audit	Royal College of Anaesthetists	National Emergency Laparotomy Audit aims to look at structure, process, and outcome measures for the quality of care received by patients undergoing emergency laparotomy.	✓	Continuous data collection	No publication date yet identified
National Gastro-Intestinal Cancer Audit Programme: Bowel Cancer Audit	Royal College of Surgeons of England	The National Bowel Cancer Audit collects data on items that have been identified and accepted as good measures of clinical care. It compares regional variation in outcomes between English cancer alliances and Wales as a nation. It also compares local variation between English NHS trusts or hospitals, and Welsh Multidisciplinary Teams.	✓	Continuous data collection	No publication date yet identified
National Gastro-Intestinal Cancer Audit Programme: Oesophago-Gastric Cancer Audit	Royal College of Surgeons of England	The audit aims to evaluate the quality of care received by patients with oesophago-gastric cancer in England and Wales.	✓	Continuous data collection	Data has been paused nationally
National Joint Registry	Healthcare Quality Improvement Partnership	The audit covers clinical audit during the previous calendar year and outcomes including survivorship, mortality, and length of stay.	✓	Continuous data collection	Published report expected September 2024
National Lung Cancer Audit	Royal College of Surgeons of England)	The audit was set up to monitor the introduction and effectiveness of cancer services.	✓	Continuous data collection	No publication date yet identified
National Maternity and Perinatal Audit	Royal College of Obstetricians and Gynae-cologists	A large-scale audit of NHS maternity services across England, Scotland and Wales, collecting data on all registrable births delivered under NHS care.	✓	Continuous data collection	No publication date yet identified
National Neonatal Audit Programme	Royal College of Paediatrics and Child Health	To assess whether babies requiring specialist neonatal care receive consistent high-quality care and identify areas for improvement in relation to service delivery and the outcomes of care.	✓	Continuous data collection	Published report expected October 2024

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/24	Percentage Data completion	Outcome
National Obesity Audit	NHS Digital	It will bring together comparable data from the different types of adult and children's weight management services across England in order to drive improvement for the benefit of those living with overweight and obesity.	✓	Continuous data collection	Report awaiting baseline assessment
National Ophthalmology Database Audit: Cataract Audit	Royal College of Ophthalmol-ogists	The Royal College of Ophthalmol-ogists runs the National Ophthalmology Database Cataract audit which measures the outcomes of Cataract surgery.	✓	Continuous data collection	Published report expected June 2025
National Paediatric Diabetes Audit	Royal College of Surgeons of England	The audit covers registrations, complications, care process and treatment targets.	✓	Continuous data collection	Published report expected April 2024 and January 2025
National Prostate Cancer Audit	Royal College of Surgeons of England	The National Prostate Cancer Audit is the first national clinical audit of the care that men receive following a diagnosis of prostate cancer.	✓	Continuous data collection	Published report expected August 2024
National Vascular Registry	Royal College of Surgeons of England	The National Vascular Registry collects data on all patients undergoing major vascular surgery in NHS hospitals in the UK.	✓	Continuous data collection	Trust not fully compliant. Action plan developed
Out-of-Hospital Cardiac Arrest Outcomes	University of Warwick		The Trust does not provide this service		
Paediatric Intensive Care Audit Network	University of Leeds / University of Leicester	Paediatric Intensive Care Audit Network aims to continually support the improvement of paediatric intensive care provision throughout the UK by providing detailed information on paediatric intensive care activity and outcomes.	✓	Continuous data collection	No publication date yet identified
Perinatal Mortality Review Tool	University of Oxford / Mothers and Babies :Reducing Risk through Audits and Confidential Enquiries UK Collaborative	The aim of this programme is introduce the Perinatal Mortality Review Tool to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland, and Wales.	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/24	Percentage Data completion	Outcome
Perioperative Quality Improvement Programme	Royal College of Anaesthetists	The Perioperative Quality Improvement Programme measures complications, mortality and patient reported outcomes from major non-cardiac surgery.	✓	Continuous data collection	No publication date yet identified
Prescribing Observatory for Mental Health: Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	Royal College of Psychiatrists		The Trust does not provide this service		
Prescribing Observatory for Mental Health: Monitoring of patients prescribed lithium	Royal College of Psychiatrists		The Trust does not provide this service		
Sentinel Stroke National Audit Programme	King's College London	The audit collects data on all patients with a primary diagnosis of stroke, including any patients not on a stroke ward. Each incidence of new stroke is collected.	✓	Continuous data collection	Published report expected November 2024
Serious Hazards of Transfusion UK National Haemovigilance Scheme	Serious Hazards of Transfusion	The scheme collects and analyses anonymised information on adverse events and reactions in blood transfusion from all healthcare organisations that are involved in the transfusion of blood and blood components in the United Kingdom.	✓	Continuous data collection	Published report expected June 2024
Society for Acute Medicine Benchmarking Audit	Society for Acute Medicine	This 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.	✓	1st June 2023 to 30th June 2023	Trust is compliant with report

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/24	Percentage Data completion	Outcome
The Trauma Audit & Research Network	Trauma Audit & Research Network	The audit aims to highlight areas where improvements could be made in either the prevention of injury or the process of care for injured patients.	✓	Continuous data collection	Published report expected September 2024
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	This audit looks at the care of people with a diagnosis of cystic fibrosis under the care of the NHS in the UK.	✓	Continuous data collection	Published report expected September 2024
UK Renal Registry Chronic Kidney Disease Audit	UK Kidney Association	The UK Renal Registry (UKRR) annual reports contain analyses about the care provided to patients with Chronic Kidney Disease (CKD) (including people pre-Kidney Replacement Therapy (KRT) and on KRT) at each of the UK's adult and paediatric kidney centres against the UK Kidney Association's guidelines.	✓	Continuous data collection	No publication date yet identified
UK Renal Registry National Acute Kidney Injury Audit	UK Kidney Association	The UKRR annual reports contain analyses about the care provided to patients with CKD (including people pre-KRT and on KRT) at each of the UK's adult and paediatric kidney centres against the UK Kidney Association's guidelines.	✓	Continuous data collection	No publication date yet identified

An additional twenty-four new audits have been added to the list for inclusion in 2024/2025 Quality Account. The audits include:

- British Association of Urological Surgeons Data and Audit Programme – Baus Penile Fracture Audit, BAUS I-DUNC (Impact of diagnostic ureteroscopy on radical nephroureterectomy and compliance with standard of care practice and environmental lessons Learnt and Applied to the Bladder Cancer Care pathway Audit.
- Emergency Medicine Quality Improvement Project – Adolescent Mental Health and Time Critical Medications.
- National Adult Diabetes Audit – Diabetes Prevention Programme, Transition (Adolescents and Young Adults) and Young Type 2 Audit and Gestational Diabetes Audit.
- National Cancer Audit Collaborating Centre – National Kidney Cancer Audit, National Non-Hodgkin Lymphoma Audit, National Ovarian Cancer Audit, Pancreatic Cancer.

- National Cardiac Audit Programme – Left Atrial Appendage Occlusion Registry, Patent Foramen Ovale Closure Registry, Transcatheter Mitral and Tricuspid Valve Registry.
- National Major Trauma Registry.
- National Ophthalmology Database – Age-Related Macular Degeneration Audit.
- Prescribing Observatory for Mental Health – Rapid Tranquillisation in the context of the pharmacological management of acutely disturbed behaviour, The use of melatonin and The Use of Opioids in Mental Health Services.
- Quality and Outcomes in Oral and Maxillofacial Surgery - Oncology and Reconstruction, Trauma, Orthognathic Surgery, Non-Melanoma Skin cancers, Oral and Dentoalveolar Surgery.

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.
- Each national clinical audit report is reviewed by an identified lead clinician who completes a baseline assessment indicating areas of good practice and recommendations related to the trust's performance in the respective audit.
- The Clinical Governance and Risk Department will provide the Clinical Boards with monthly profiles of outstanding baseline assessments and non-compliant report recommendations. The profiles will be reviewed at the monthly Clinical Board Quality Oversight Group meetings and any issues of significant non-compliance will be escalated to the Clinical Audit and Guidelines Group.
- In addition, each Clinical Board 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.
- 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 414 local audits were reviewed by the provider in 2023/2024 and the Newcastle Hospitals intends to take the following action to improve the quality of health care provided:

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

Information on Participation in Clinical Research

In the last year over 14,131 participants were recruited to clinical trials provided or hosted by Newcastle Hospitals, of which 13,315 enrolled onto the National Institute for Health and Care Research Clinical Research Network portfolio studies.

A wide range of clinical trials take place, ranging from complex and rare disease to common conditions that affect many of our patients. One such trial is the ADVANCE liver study, which aims to better understand how cirrhosis develops over time with a view to finding treatments for patients with the condition.

The Trust continues to be one of the top research trusts in the country for the number of individuals participating in research and for the number of studies open.

Information on the use of the Commissioning for Quality and Innovation (CQUIN) Framework

A proportion of the Trusts income in 2023/2024 was conditional upon achieving Quality Innovation and innovation goals agreed between Newcastle Hospitals and any person or body they entered a contract, agreement, or arrangement with for the provision of relevant health services, through Commissioning for Quality and Innovation payment framework. The monetary value totals from achievement of the specialised Commissioning for Quality and Innovation was £5.132m however achievement of the local Commissioning for Quality and Innovation (acute and community) was not explicit in the contract and was therefore estimated at 1.25% of total contract value.

Information on the use of the CQUIN framework

CQUIN Indicators - Acute Hospital – (CCG/Integrated Care Board)

CQUIN01: Flu vaccinations for frontline healthcare workers

CQUIN04: Compliance with timed diagnostic pathways for cancer services

CQUIN05: Identification and response to frailty in emergency departments

CQUIN06: Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service

CQUIN07: Recording of and response to National Early Warning Score 2 score for unplanned critical care admissions

CQUIN Indicators - Community – (CCG/ Integrated Care Board)

CQUIN01: Flu vaccinations for frontline healthcare workers.

CQUIN13: Assessment, diagnosis, and treatment of lower leg wounds.

CQUIN Indicators - Specialised Commissioning

CQUIN01: Flu vaccinations for frontline healthcare workers

CQUIN08: Achievement of revascularisation standards for lower limb ischaemia

CQUIN09: Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres

CQUIN10: Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway

CQUIN11: Achieving high quality Shared Decision Making conversations in specific specialised pathways to support recovery

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

Information relating to Registration with the Care Quality Commission

Newcastle Hospitals is required to register with the Care Quality Commission and its current registration status is fully registered. Newcastle Hospitals currently has conditions imposed on its registration.

We are registered with the Care Quality Commission to deliver care from eight separate locations and for ten regulated activities.

During 2023/2024 the Care Quality Commission visited the Trust on a number of dates between June and September 2023. They looked at how the organisation was led and assessed some services at the Royal Victoria Infirmary and Freeman Hospital, which included urgent and emergency care, medicine, surgery, maternity, children and young people, as well as NECTAR, the regional patient transport service. They also spent some time in the cardiothoracic surgery department.

The inspectors found that overall Newcastle Hospitals' 'requires improvement'. They also highlighted areas for improvement with the way some services are run and that changes are required to ensure that learning always takes place when things don't go as planned.

The Care Quality Commission also highlighted some positive findings from their inspection, including staff who treated 'patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers'.

In response to the inspection findings the Trust has acted quickly to implement a rapid and focused programme of improvement to address the report recommendations which will continue until the issues raised have been addressed. This includes regular meetings with the CQC to demonstrate progress.

The Care Quality Commission did not inspect critical care, diagnostic and imaging, outpatients, end of life or community services during 2023/2024.

Overview

	Safe	Effective	Caring	Responsive	Well-led	**Overall**
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Inadequate	Requires Improvement

Information on the Quality of Data

The Newcastle upon Tyne Hospitals NHS Foundation Trust submitted records during 2023/2024 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

Which included the patient's valid NHS number was:

- 99.7% for admitted patient care.
- 99.9% for outpatient care.
- 99.0% for accident and emergency care.

Which included the patients valid General Medical Practice Code was:

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

Clinical Coding Information

Score for 2023/2024 for Information Quality and Records Management, assessed using the Data Security and Protection Toolkit.

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

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

- Breast Surgery
- Colorectal Surgery
- Plastic Surgery

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

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

Table shows the levels of attainment of coding of inpatient activity:

	Levels of Attainment		
	Standards Met	Standards Exceeded	NUTH Level
Primary diagnosis	>=90%	>=95%	97.5%
Secondary diagnosis	>=80%	>=90%	96.2%
Primary procedure	>=90%	>=95%	96.3%
Secondary procedure	>=80%	>=90%	93.8%

Comments from the external Data Security and Protection audit:

Clinical coding accuracy overall was found to be at standards that exceeded level for all areas, the Trust should be commended on this excellent result. This is the most advanced level that can be achieved.

Compelling evidence suggests the local validation strategy has a positive impact on the data quality. The results are comparative to the previous year's outcomes. Effective management and support of motivated staff is a significant factor in this. The Team Leader's set a positive example through their actions, fostering constructive collaboration to achieve this accomplishment.

There is a well-established training unit that instils confidence for coders to develop to accredited levels, the Clinical Coders are up to date with their required training and demonstrate a sound grasp of national clinical coding rules and standards.

Key National Priorities 2023/2024

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 Care Quality Commission Intelligent Monitoring Report. A wide range of measures are included and the Trust's performance against the key national priorities for 2023/24 are detailed in the table below.

Operating and Compliance Framework Target	Target	Annual Performance 2023/2024	Annual Performance 2022/2023
Incidence of Clostridium (*C .difficile*: variance from plan)	National Threshold ≤165	144 cases	172 cases
Incidence of Methicillin Resistant Staphylococcus Aureus Bacteraemia	Zero tolerance	4 cases	2 cases
28 Day Faster Diagnosis Standard - Wait from Urgent Referral to Patient Told they have Cancer (or Cancer is Definitively Excluded)	75%	75.1% (Apr-Jan)	75.2%
31 Day (Decision to Treat to Treatment) - Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	96%	85.9% (Apr-Jan)	87.7%
62 Day (Referral to Treatment) - Wait from an Urgent Suspected Cancer or Breast Symptomatic Referral, or Urgent Screening Referral, or Consultant Upgrade to a First Definitive Treatment for Cancer	85%	55.5%(Apr-Jan)	53.4%
Referral to Treatment - Admitted Compliance	90%	65.9%	61.3%
Referral to Treatment - Non-Admitted Compliance	95%	76.7%	77.6%
Referral to Treatment - Incomplete Compliance	92%	67.1%	69.2%
Maximum 6-week wait for diagnostic procedures	95%	71.2%	80.7%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	76%	75.65%	77.72% (target in 2022/2023 95%)
Cancelled operations – those not admitted within 28 days	Operations not arranged within 28 days of the day cancelled.	561	555
Maternity bookings within 12 weeks and 6 days	Not Defined	86%	86.5%

Details on Hospital-level Mortality Indicator please refer to page 58.

Rationale for any failed targets Infection Prevention and Control:

Increase in the number of Methicillin-resistant Staphylococcus aureus bacteraemia cases – there are a number of reasons for this:

- A national increase in the number of hospital acquired Methicillin-resistant Staphylococcus aureus bacteraemia in 2023/24; this is being reviewed nationally.
- Themes from cases included intravenous drug use for immunocompromised patients; poor compliance with Trust screening; community transmission of Methicillin-resistant Staphylococcus aureus; patient's non-compliance with skin washes; complex patients; difficult intravascular access.

Mitigations to address:

- Initiative on patient focused hygiene to prevent infection, includes washing patients, oral health, urinary catheter care and IV device management.
- Methicillin-resistant Staphylococcus aureus screening compliance audit undertaken and finalised result will be shared through various forums.
- Relaunch of Aseptic Non-Touch Technique, now part of mandatory training.

Cancer Wait times:

Please note that there has been a change in the national cancer standards this year, with the previous nine being consolidated into three overall standards. These are what we are now required to report against nationally and as such we have provided compliance levels for these new targets. The 2022/2023 position is taken from NHSE statistics as a retrospective production of what our compliance would have been against these standards had they been in place for 2022/2023.

Please also note that we only have 10 months of official performance data available to us for 2023/2024 against these standards (April-January). As such final year compliance levels are subject to change but will not be formally finalised until later in the year.

Underlying issues preventing the Trust from achieving the 31 and 62 day cancer standards this year have included limited theatre capacity with additional provision not keeping pace with increases in demand, as well as some capacity throughout the year being lost due to estate updates and refurbishments. A significant shortfall in capacity for the provision of Radiofrequency ablation also exists with this treatment method becoming an increasingly popular option.

Theatre Capacity Mitigation:

- Implementation of 6:4:2 theatre scheduling (a model of theatre scheduling, named after the number of weeks in advance that plans should be finalised. E.g. at six weeks, surgical staff should have their annual leave approved. At four weeks, surgeons should have scheduled their theatre lists etc. The 6-4-2 model supports theatre teams to work more effectively together; to improve the quality of patient experience, the safety and outcomes of surgical services, the effective use of theatre time and overall staff experience).
- Continued role out of Care Coordination Solution to ensure theatre efficiency.
- Development of robust escalation plans by Clinical Board e.g. development of weekly theatre prioritisation meetings.
- Continued use of the independent sector for routine patients, freeing up capacity on site for cancer patients.
- Engagement in mutual aid processes.
- Various service improvement initiatives e.g. redesign of regional pathways to ensure the patients are seen in the most appropriate place e.g. Urology Alliance work.
- Maximisation of Day Treatment Centre utilisation.

Radiofrequency ablation Mitigation:

- Use of Community Diagnostic Centres to free up Computed Tomography capacity.
- Flagged the need for an additional Interventional Computed Tomography to the Executive team.
- There is a plan to do more procedures under General Anaesthetic as this will reduce the number of re-do procedures and improve patient experience.
- Re-prioritisation of capacity to dedicate more time to ablation procedures, they aim to use other resources as far as possible but anticipate some impact on routine scanning times to accommodate the ablation treatments.

Other contributing factors include the ongoing late receipt of a substantial number of tertiary referrals, as well as significant workforce gaps at times across numerous different tumour groups. Delays to the diagnostic element of the patient pathway have also contributed to lower levels of performance.

Late referrals mitigation:

- Working with the Northern Cancer Alliance through the pathway boards to monitor and reduce late referrals.
- Streamlining existing pathways to ensure that treatment can occur within 24 days of referral reducing the number of shared breaches we receive.
- Working towards implementation of the Best Practice Timed Pathways internally and across the region.

Workforce gaps mitigation:

- Looking at skill mix reviews e.g. the use of Advanced Clinical Practitioners and Physician Associates to implement the premenstrual bleed pathway in Gynaecology instead of consultants.
- The Trust has supported investment in teams where demand has outstripped capacity e.g. Dermatology business case approved in 2023 and once staff are fully trained this will increase capacity within the team.
- Reviewing induction and competency packages of staff (Multidisciplinary Team Co-ordinators, Care Co-ordinators, Navigators, Clinical Nurse Specialists) to ensure increase recruitment and retention rates.

Our skin cancer service has experienced unprecedented demand throughout 2023/2024, both in terms of peaks in the volume of referrals and the extent to which this has continued throughout the year – a summer peak is always anticipated, but above average demand continued much later into the year than usual. As the tumour group that already receives more referrals, and delivers more treatments, than any other across Newcastle Hospitals, any impact on performance within Skin will disproportionately affect the overall Trust position relative to other tumour groups.

Dermatology Mitigation:

- Implementation of tele dermatology – working with the Northern Cancer Alliance to complete a review of the tele dermatology pathway and implement best practice.
- Exploring the use of Artificial Intelligence in the pathway.
- Increased capacity through the Dermatology business case approved in 2023.
- Additional capacity through surgical lists with Plastics.
- Reducing inappropriate referrals through General Practitioner education.

- Work underway to reduce new to review ratio in line with peers.
- Implementation of Patient Initiated Follow-Up throughout the specialty increasing clinical buy in to create additional capacity.
- Maintaining cancer competency in those that don't routinely work in cancer by holding a monthly joint clinic – this will increase the number of staff that are able to cover capacity demand.

Referral to Treatment Targets:

Over the last year, the overall Referral to Treatment Targets performance has remained circa 67%. There has been an unrelenting focus on treating the longest waiters and a significant achievement for the Trust has been to treat all patients over 104 weeks wait by January 2024. This position has been maintained, whilst addressing 78 and 65 week waiters. Patients on the waiting list continue to be prioritised by clinical need and longest waits.

The overall size of Referral to Treatment Targets waiting list increased over the year to circa 108,000 and this position has now been reduced back down to 99066 patient waiting for first treatment in February 2024.

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

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

Core Set of Quality Indicators

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

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

Measure	Data Source	Target	Value	2023/24		2022/23				2021/22			
1. The value and banding of the summary hospital-level mortality indicator for the Trust	NHS Digital Indicator Portal https://digital.nhs.uk/data-and-information/publications/statistical/shmi	Band 2 "as expected"		Oct22 – Sept 23 NUTH Value: 0.9095	Jul22 - Jun 23 NUTH Value: 1.0095	Apr22 - Mar 23 NUTH Value: 0.9170	Jan21 - Dec 21 NUTH Value: 0.9167	Oct21 – Sept 22 NUTH Value: 0.9105	Jul21 - Jun 22 NUTH Value: 0.9148	Apr21 - Mar 22 NUTH Value: 0.9180	Jan21 - Dec 21 NUTH Value: 0.9804	Oct20 – Sept 21 NUTH Value: 0.9606	Jul20 - Jun 21 NUTH Value: 0.9369
				NUTH Band 2	NUTH Band 2	NUTH Band 2	NUTH Band 2	NUTH Band 2	NUTH Band 2	NUTH Band 2	NUTH Band 2	NUTH Band 2	NUTH Band 2
			National Average	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
			Highest National	1.2293	1.2129	1.2074	1.2186	1.2340	1.2112	1.1942	1.1897	1.1909	1.2017
			Lowest National	0.6770	0.7097	0.7191	0.7117	0.6454	0.7047	0.6964	0.7127	0.7132	0.7195

The 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. The 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 meetings within each speciality of all clinical boards.

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

Measure	Data Source	Target	Value	2023/24		2022/23				2021/22			
2. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust	NHS Digital Indicator Portal https://digital.nhs.uk/data-and-information/publications/statistical/shmi	N/A	Trust	41%	29%	39%	40%	41%	41%	42%	42%	44%	44%
			National Average	42%	41%	40%	40%	40%	40%	40%	39%	39%	39%
			Highest National	66%	66%	66%	65%	65%	65%	66%	64%	63%	64%
			Lowest National	15%	14%	14%	12%	12%	12%	11%	11%	12%	11%

The 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. The 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 3. The Patient Reported Outcome Measures scores for groin hernia surgery.

Collection of groin procedure scores ceased on 1 October 2017.

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

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

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

Measure	Value	2021/22	2020/21	2019/20	2018/19	2017/18	2016/17
5. The patient reported outcome measures scores (PROMS) for primary hip replacement surgery (adjusted average health gain – EQ5D)	Trust Score	**0.46**	**0.52**	**0.46**	**0.50**	**0.48**	**0.44**
	National Average:	0.46	0.47	0.46	0.47	0.47	0.45
	Highest National:	0.53	0.57	0.54	0.56	0.54	0.54
	Lowest National:	0.37	0.39	0.35	0.35	0.39	0.31

The Newcastle Hospitals considers that this data is as described for the following reasons:

The Newcastle Hospitals Patient Reported Outcome Measures scores 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.

Data for 2021/2022 has been populated, but no other data is currently available.

The North East Quality Observatory Service are in touch with the team at NHS England who work on the data but currently know the timetable for producing the final 2022/23 data – the provisional version of this has major issues with the data quality.

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

Measure	Value	2021/22	2020/21	2019/20	2018/19	2017/18	2016/17
6. The patient reported outcome measures scores (PROMS) for primary knee replacement surgery (adjusted average health gain – EQ5D)	Trust Score	*	**0.35**	**0.36**	**0.31**	**0.33**	**0.33**
	National Average:	0.32	0.32	0.34	0.34	0.34	0.33
	Highest National:	0.42	0.40	0.42	0.41	0.42	0.40
	Lowest National:	0.25	0.18	0.22	0.28	0.25	0.25

The Newcastle Hospitals considers that this data is as described for the following reasons:

The Newcastle Hospitals Patient Reported Outcome Measures scores 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.

Data for 2021/2022 has not yet been released, and no other data is currently available.

The North East Quality Observatory Service are in touch with the team at NHS England who work on this data but currently know the timetable for producing the final 2022/23 data – the provisional version of this has major issues with the data quality.

Please note that finalised Patient Reported Outcome Measures scores data is only available for 2021/2022. The North East Quality Observatory Service have reviewed the provisional data for 2022/2023 but data quality issues mean that this cannot currently be used to give a comparison between us and the national average. The North East Quality Observatory Service are in contact with NHS Digital to try to get an update on when the next Patient Reported Outcome Measures scores publication will be.

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

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

The Newcastle 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.

7a. Emergency readmissions to hospital within 28 days of discharge from hospital: Children of ages 0-15.

Year	Total number of admissions/spells	Number of readmissions (all)	Emergency readmission rate (all)
2012/2013	31,841	2,454	7.7
2013/2014	32,242	2,648	8.2
2014/2015	34,561	3,570	10.3
2015/2016	38,769	2,875	7.4
2016/2017	35,259	1,983	5.6
2017/2018	35,009	2,077	5.9
2018/2019	36,387	2,003	5.5
2019/2020	42,238	4,609	10.9
2020/2021	29,319	2,643	9.0
2021/2022	34,112	3,080	9.0
2022/2023	33,945	2,859	8.4
2023/2024	33,865	2,637	7.8

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

Year	Total number of admissions/spells	Number of readmissions (all)	Emergency readmission rate (all)
2012/2013	173,270	8,788	5.1
2013/2014	177,867	9,052	5.1
2014/2015	180,380	9,446	5.2
2015/2016	182,668	10,076	5.5
2016/2017	186,999	10,219	5.5
2017/2018	182,535	10,157	5.6
2018/2019	185,967	10,461	5.6
2019/2020	192,365	12,648	6.6
2020/2021	142,629	10,730	7.5
2021/2022	185,434	12,104	6.5
2022/2023	193,003	13,575	7.0
2023/2024	203,143	15,065	7.4

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

Measure	Data Source	Value	2022/23	2021/22	2020/21	2019/20	2018/19	2017/18
8. The Trust's responsiveness to the personal needs of its patients	NHS Information Centre Portal https://indicators.ic.nhs.uk/	Trust percentage	Ceased Publication August 2020	Ceased Publication August 2020	77.7%	72.6%	73.1%	74.9%
		National Average:			74.5%	67.1%	67.2%	68.6%
		Highest National:			85.4%	84.2%	85.0%	85.0%
		Lowest National:			67.3%	59.5%	58.9%	60.5%

This data used in the table above ceased to be published in August 2020.To assign a score to indicate the patient experience, the table below uses the Care Quality Commission benchmark data from the National Adult Inpatient Survey. The data shows that the Trust scores above the national average in this indicator. The results of the Inpatient 2023 survey are due to be published in August 2024.

Measure	Data Source	Value (out of 10)	2022 (Published Sept 2023)	2021 (Published August 2022)
8. Overall rating of experience	CQC Benchmark results for National Adult Inpatient Survey https://www.cqc.org.uk/publications/surveys/adult-inpatient-survey	Trust score	8.4	8.6
		National Average score:	8.1	8.1
		Highest National:	9.3	9.4
		Lowest National:	7.4	7.4

Measure 9. The percentage of staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends changed to "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation" in 2021/2022 survey and has continued to be the same for the 2023/2024 survey. It has also changed from question ID 23d to 25d.

Measure	Data Source	Value	2023/24	2022/23	2021/22	2020/21	2019/20	2018/19
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	https://www.cqc.org.uk/publications/surveys/adult-inpatient-survey	Trust percentage	77.4%	82.6%	85.4%	91.3%	90%	90%
		National Average:	63.3%	61.9%	66.9%	74.3%	71%	70%
		Highest National:	88.9%	86.4%	89.5%	91.7%	95%	95%
		Lowest National:	44.3%	39.2%	43.6%	49.7%	36%	33%

The Newcastle Hospitals considers that this data is as described for the following reasons:

The Trust continues to score well above the National average in relation to staff survey Q25d. By ensuring all colleagues have a voice and continuing to listen and act on all sources of staff feedback, The Newcastle Hospitals is committed to maintaining the highest quality of services for both patients/service users and its staff.

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

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

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

Measure	Data Source	Target	2023/24	2022/23	2021/22	2020/21
11. The number of cases of Clostridioides difficile infections reported within the Trust amongst patients aged two or over	PHE Data Capture System	Trust number of cases	144 HOHA* = 114 COHA* = 30	172 HOHA* = 138 COHA* = 34	169 HOHA* = 135 COHA* = 34	111 HOHA* = 85 COHA* = 26
		National Average number of cases	HOHA* = 54 COHA* = 20	HOHA* = 52 COHA* = 19	HOHA* = 44 COHA* = 18	HOHA* = 35 COHA* = 16
		Highest National number of cases	HOHA* = 227 COHA* = 82	HOHA* = 212 COHA* = 76	HOHA* = 189 COHA* = 76	HOHA* = 151 COHA* = 60
		Lowest National number of cases	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0

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

The Newcastle Hospitals considers that this data is as described for the following reasons:

The Trust has a robust reporting system in place and adopts a systematic approach to data quality improvement.

The Newcastle Hospitals has taken the following actions to improve this rate, and so the quality of its services by having a robust strategy; Quarterly Health Care Associated Infection Report to share lessons learned and best practice from Clinical Board Oversight Groups.

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

Measure	Data Source	Target	2023/2024	2022/2023	2021/2022	2020/2021
12. The number and rate per 1000 admissions of patient safety incidents reported	NHS Information Centre Portal https://www.england.nhs.uk/patient-safety/national-patient-safety-incident-reports/	Trust no.	April 2023 – March 2024 20909	April 2022 – March 2023 20464	April 2021 – March 2022 18440	April 2020 – March 202 17915
		Trust Rate	39.3	38.7	37.5	50.3
		National Average	Not available	50.0	57.5	58.4
		Highest National	Not available	224.6	205.5	118.7
		Lowest National	Not available	14.9	23.7	27.2

The Newcastle Hospitals considers that this data is as described for the following reasons:

Over the previous 12 months the trust has introduced two significant changes to patient safety incidents and their management.

In November 2023 Learning from Patient Safety Events was introduced. This changed the way incidents were graded with the introduction of psychological harm categories and moved the trust from reporting externally via the National Reporting and Learning System to real time updates via the Learning from Patient Safety Events database.

In January 2024 the Trust introduced the Patient Safety Incident Response Framework which resulted in new processes for review and escalation of incidents.

Incident data, themes and organisational learning is reported annually through the Trusts governance structures to Quality Committee and Trust Board.

In September 2023 NHS England paused the annual publishing of incident data while they consider future publications in line with the introduction of the Learning from Patient Safety Events service in replacement of National Reporting and Learning System.

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

Measure	Data Source	Target	2023/2024		2022/2023		2021/2022	
13. The number and percentage of patient safety incidents that resulted in severe harm or death	NHS Information Centre Portal https://www.england.nhs.uk/patient-safety/national-patient-safety-incident-reports/	Trust no.	April 2023 - March 2024 **Severe Harm** 115	April 2023 - March 2024 **Death** 50	April 2022 - March 2023 **Severe Harm** 88	April 2022 - March 2023 **Death** 53	April 2021 - March 2022 **Severe Harm** 85	April 2021- March 2022 **Death** 50
		Trust Rate	0.6%	0.2%	0.4%	0.2%	0.5%	0.3%
		National Average	Not available	Not available	Not available	Not available	Not available	Not available
		Highest National	Not available	Not available	Not available	Not available	Not available	Not available
		Lowest National	Not available	Not available	Not available	Not available	Not available	Not available

The 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. Incident reporting rates have remained stable, but the trust has seen a small increase in incidents of severe harm.

The introduction of Patient Safety Incident Response Framework has introduced new ways in which the Trust investigates and learns from incidents with significant harm.

In September 2023 NHS England paused the annual publishing of incident data while they consider future publications in line with the introduction of the Learning from Patient Safety Events service in replacement to National Reporting and Learning System.

Workforce Factors

The tables below provide data on the loss of work days. The table directly below reports on the Trust and Regional position rate (data taken from the NHS Information Centre).

This table shows the loss of work days (rate).

	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23
The Newcastle Upon Tyne Hospitals	6.54	5.79	5.12	5.15	4.72	4.58	4.66	4.88	4.85	4.98	5.64	5.73
South Tyneside and Sunderland	7.47	6.64	5.73	5.26	4.99	5.24	5.58	5.68	5.64	5.68	5.85	5.68
County Durham and Darlington	6.90	6.07	5.31	5.09	5.04	4.85	4.83	5.20	5.00	5.49	5.59	5.80
Gateshead Health	6.66	6.10	5.24	5.51	4.96	5.02	5.11	5.37	5.76	6.04	6.11	6.02
North Tees and Hartlepool	7.06	5.93	5.79	5.65	5.10	4.98	5.10	5.60	5.46	5.52	5.77	5.80
Northumbria Healthcare	6.82	6.18	5.30	5.19	4.89	4.85	5.20	5.53	5.41	5.41	5.86	6.11
South Tees Hospitals	7.58	6.35	6.01	5.72	5.40	5.22	5.16	5.46	5.59	5.84	6.12	6.01
England	**6.30**	**5.34**	**5.01**	**4.95**	**4.52**	**4.47**	**4.52**	**4.77**	**4.89**	**4.99**	**5.33**	**5.30**

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
2012/13 no. of days	154	138	174	209	675
2013/14 no. of days	489	331	785	147	1752
2014/15 no. of days	333	284	178	206	1001
2015/16 no. of days	360	194	365	219	1138
2016/17 no. of days	230	387	136	84	837
2017/18 no. of days	137	90	51	122	400
2018/19 no. of days	214	131	188	326	859
2019/20 no. of days	249	172	67	123	611
2020/21 no. of days	65	61	335	212	673
2021/22 no. of days	318	475	618	409	1820
2022/23 no. of days	319	119	139	321	898
2023/24 no. of days	368	454	263	168	1253

2023 NHS Staff Survey Results Summary

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

A full census survey was sent via email to all eligible employees of the Trust (via external post for those on maternity leave and employees under the Estates directorate), giving all members of our staff a voice with 6,457 staff participating in the survey, equalling a response rate of 42%. This is 3% lower than the sector average and was a 2% decrease on the 2022 response rate of 44%.

Providing the highest standard of care has always been our priority and we know how important this is to all our staff.

The NHS Staff Survey looks at staff experience in these areas, described as the people promise:

- We are compassionate and inclusive.
- We are recognised and rewarded.
- We each have a voice that counts.
- We are safe and healthy.
- We are always learning.
- We work flexibly.
- We are a team.

Alongside the NHS People Promise are two main themes:

- Staff Engagement.
- Morale.

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

- Advocacy: 6.99 out of 10, measured by Q23a, Q23c and Q23d (Staff recommendation of the trust as a place to work or receive treatment).
- Motivation: 6.76 out of 10, measured by Q2a, Q2b and Q2c (Staff motivation at work).
- Involvement: 6.86 out of 10, measured by Q3c, Q3h and Q3i (Staff ability to contribute towards improvement at work).

At Newcastle Hospitals this score was:

Overall: rating of staff engagement 6.76 (out of possible 10).

This score was 0.52 **below** top position and 0.42 **above** worst position in the sector (Combined Acute & Community Trusts). It sits **below** sector average by 0.15.

Including Staff engagement, the Trust scored slightly **lower** than average on all of the nine people promises / themes when compared with 126 other Combined Acute and Acute & Community Trusts in England. These are:

We are compassionate and inclusive

Newcastle Hospitals Score: 7.09 out of 10
Sector Score: 7.24 out of 10
Difference: -0.15

We are recognised and rewarded

Newcastle Hospitals Score: 5.60 out of 10
Sector Score: 5.94 out of 10
Difference: -0.34

We each have a voice that counts

Newcastle Hospitals Score: 6.49 out of 10
Sector Score: 6.70 out of 10
Difference: -0.21

We are safe and healthy

Newcastle Hospitals Score: 5.96 out of 10
Sector Score: 6.06 out of 10
Difference: -0.10

We are always learning

Newcastle Hospitals Score: 5.31 out of 10
Sector Score: 5.61 out of 10
Difference: -0.30

We work flexibly

Newcastle Hospitals Score: 5.72 out of 10
Sector Score: 6.20 out of 10
Difference: -0.48

We are a team

Newcastle Hospitals Score: 6.35 out of 10
Sector Score: 6.75 out of 10
Difference: -0.40

Morale

Newcastle Hospitals Score: 5.77 out of 10
Sector Score: 5.91 out of 10
Difference: -0.14

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

- **88.94%** feel trusted to do their job.
- **87.12%** feel their role makes a difference to patients.
- **86.98%** of employees have had an appraisal in the last 12 months which is a 1.73% increase from last year's staff survey and **3.86%** higher than the sector average.
- **85.15%** know what their work responsibilities are.
- **78.48%** enjoy working with the colleagues in their teams.
- **77.48%** of staff feel care of patients is Newcastle Hospitals top priority.
- **77.41%** would be happy with the standard of care provided if a friend or family member needed treatment, meaning we are **14.09%** higher than the sector average.

The Trust demonstrated improvement in 21 questions versus its 2022 results with the majority remaining below sector average.

Trust and Sector scoring both saw improvements under the "We are safe and healthy" and "We work flexibly" People Promise themes, with the trust performing above average in the following People Promise and Sub-score areas:

People Promise	Sub-score
Morale	Thinking about leaving
Morale	Work pressure
Staff Engagement	Motivation
We are safe and healthy	Burnout
We are safe and healthy	Health and safety climate
We work flexibly	Flexible working
We work flexibly	Support for work-life balance

Ensuring that the voices of our staff continue to be heard continues to be a priority, and our survey results provide more depth to understanding of the issues affecting staff and these findings, alongside other feedback drivers such as 'What Matters to you', will be fed into the development of our new People Plan Strategy. Feedback from the Staff Survey provides intelligence and informed steer on which areas our organisation can develop, but also which areas are showing growth and progression.

There is work ongoing to further understand and break down the 2023 results, including how they differ between staff groups and directorates, to help inform the Trust's next steps in supporting staff through the People Plan Strategy.

Involvement and Engagement 2023/2024

The Trust continues to be genuinely motivated and committed to improving the experience of patients, families, carers, and visitors and are constantly learning from lived experiences. We want to truly understand what matters to people who access our services and involve them in how we evaluate and improve the care we provide to them.

In our previous quality account, we explained the focus for 2023/2024 was to work in partnership with local communities and voluntary groups to help ensure that equal opportunities were promoted and encouraged. Over the past year we are proud to have been given the opportunity to work on projects driven by local communities which will have great outcomes for people accessing our services in the future.

We have worked in close partnership with Deaflink to implement the health navigator programme to help improve access and experience of care for patients who are deaf. Skills for People have facilitated focus groups with people who have a learning disability; they are currently developing some priority quality improvement work and will lead on this for us.

The patient experience team have also worked in partnership with patient contributors, recruited from the Cumbria, Northumberland, Tyne & Wear engagement bank who have been at the forefront of involving people with lived experience of mental health and ensuring their voices are central to the co-development of the mental health strategy which is due to be launched this year.

In addition, the equality diversity and human rights group continue to meet quarterly where charities and voluntary organisations, such as HAREF, Newcastle Vision Support, Newcastle Carers, Be Trans Support, Disability North, are key members; driving and leading on the mutually agreed priorities within the equality delivery system.

This year we also aspired to design a patient and engagement toolkit to help empower and support services to actively engage and work with patients. This toolkit is in the final draft stage and is hoped to be launched by summer 2024.

In 2023, with the support of Newcastle Hospitals Charity, we also began a journey to develop a clear, cohesive, and forward-thinking patient experience strategy which was developed through meaningful engagement and listening. A communications plan was drawn up to ensure the activities planned provided wide-ranging opportunities to participate and include as many people as possible. A period of involvement was conducted between June and August 2023, which led to the co-production of the Trust's Experience of Care Strategy. The strategy has 5 key objectives with a number of commitment statements related to each:

1. We take a patient-centred approach because patients should always be at the heart of everything, we do.
2. We develop a listening culture, actively asking people what matters to them, encouraging feedback at each stage of their journey. We will demonstrate how feedback has led to change.
3. We develop patient experience opportunities that are easy to understand and access, which reflect the diverse range of people who access our services.

4. We champion innovation in patient experience and actively seek to be the best we can.
5. We use experience feedback to instil pride amongst patients, stakeholders, and staff, celebrating contributions towards our overall success.

Most recently the Trust has appointed a Chief Experience Officer within the Executive team, designed to strengthen board accountability, and provide visibility and momentum for a trust-wide patient and staff experience programme. A programme of work is currently being developed to help ensure the organisation has a systematic way of analysing patient feedback in all its forms and has dedicated analytics and intelligence support for patient experience data. We anticipate that our local communities will help us understand this data and work in co-production when any improvements or themes are identified.

In 2024/2025 the focus will be to:

- Launch and embed the patient and staff experience programme.
- Continue to work in partnership with local communities on projects and concerns which matter to them.
- Launch of the patient experience engagement toolkit to support services to involve and engage with patients when evaluating, redesigning or implanting new systems and processes.

Annex 1:

Statement on Behalf of The Newcastle Health Scrutiny Committee

Newcastle City Council

Our Reference: WT/JHa24

3 June 2024

By Email: nuth.qualityaccount@nhs.net

Ms Anne Marie Troy-Smith
Quality Development Manager
Newcastle upon Tyne Hospitals NHS Foundation Trust

Dear Anne Marie,

NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST DRAFT QUALITY ACCOUNT 2024/25

On behalf of the Health and Social Care Scrutiny Committee, I would like to thank Rob Harrison, Managing Director, and Caroline Docking, Director of Communications and Corporate Affairs, for attending the Health and Social Care Scrutiny Committee on Thursday 9 May 2024.

The committee was pleased to welcome Sir James Mackey, Chief Executive to its March meeting following the recent CQC inspection of the Trust and it was therefore appreciated and timely to be able to receive an interim update on progress the Trust is making, alongside the identified and related Quality Priorities for 2024/25.

The committee noted the following areas:

- An update on governance arrangements, the work of the eight Clinical Boards and changes to the Trust Board.
- The role of the Freedom to Speak Up Guardian and ongoing staff engagement – and that ways of doing so – continues.
- Systemic changes to gathering and understanding patient feedback to improve services.
- People Changes and a focus on strengthened clinical leadership.
- Strong focus on patient safety and care.
- 100 Days in review and the results of the internal staff survey and Trust wide scores
- The financial position and the Financial Recovery Plan. It is understood that the deficit is a major concern and we heard that there will be focus on ensuring whatever can be done to protect frontline services and direct care. The committee would welcome further information on this over the course of the year.
- Performance and some of the progress being made. It was positive to note this around elective care and further, the expectation that NHS England tiering and oversight will be de-escalated.
- 'Big Signals' and the eight key areas of focus.

The committee also reflected on the 2023/24 Quality Priorities, and it was highlighted there remains work to do. Assurances were provided, that they remain areas of focus going forward. The committee has noted the purposeful intention to identify five clear 2024/25 Quality Priorities, that embedding good governance is central and are assured that other issues won't be lost. We look forward to receiving updates over the course of the year and understanding their progress and implementation.

The presentation of the Quality Account and Priorities this year was succinct and clear. We are grateful that committee feedback on the previous year's presentation has been taken on board. This approach will support us as a committee to ensure we fulfil our scrutiny role effectively, constructively, and proportionally as the Trust moves forward with its Improvement Plan and implementation of the Quality Priorities.

The committee also reflected on the assurances received last year during the Trust's presentation of the Quality Account and Priorities for 2023/24. The committee welcome the understanding and appreciation of its concerns around this and how it can be avoided in future. As a committee we will also consider and reflect on how we as Members further engage with the Trust and identify issues and areas of concern affecting services and patients as they arise.

We also welcome the Trust's commitment to transparency and accountability. The committee will look forward to regular interim updates from the Trust on the delivery of the Improvement Plan and the Quality Priorities.

I would like to extend my thanks to Rob and Caroline for answering the wide-ranging questions of the committee. The detailed discussion that ensued also enabled the committee to identify some further issues we may to consider in more depth including the Right Care, Right Person model and its implementation, delivery and impact on patients, access to maternity care including approaches to addressing health inequalities, and patient discharge.

Finally, we have welcomed the Trust's engagement with the committee over recent months and recognise the progress to date following the CQC Inspection Report at the beginning of the year. I look forward to enjoying an ongoing constructive and supportive dialogue over the next year and beyond.

Yours sincerely

Cllr Wendy Taylor
Chair, Health and Social Care Scrutiny Committee

If you need this information in another format or language, please contact the writer.

Statement on Behalf of Northumberland County Council

Northumberland
County Council

Annemarie Troy-Smith
Quality Development Manager

By email to – Annemarie.troy-smith@nuth.uk

Our ref: CA/OSC/QA/2024/2
Enquiries to: Chris Angus
Email: democraticservices@northumberland.gov.uk
Tel direct: (01670) 622604
Date: 07 May 2024

Dear Ms Troy-Smith

NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST'S ANNUAL PLAN AND QUALITY ACCOUNT 2023/24

Statement from Northumberland County Council's Health and Wellbeing Overview and Scrutiny Committee

On behalf of the Health and Wellbeing Overview and Scrutiny Committee (OSC), I am writing to formally acknowledge receipt of the Quality Accounts for 2023/24. We appreciate the opportunity to provide commentary and feedback on this important document. The Committee always welcomes your attendance and input at their meetings and believe it is vital to effective scrutiny.

In our recent committee meetings, we have reviewed quality accounts from various local NHS trusts, which has provided us with a comprehensive understanding of healthcare services in Northumberland and their respective priorities.

We extend our gratitude to the NUTH staff who attended our overview and scrutiny committee meeting in May. Their participation underscores our shared commitment to transparency, accountability, and ongoing enhancement of health services for our residents. While the recent CQC inspection report was disappointing, we commend the Trust's candid approach in addressing challenges and outlining improvement plans for the forthcoming year.

Upon reviewing the Annual Quality Account 2023/24 and the outlined priorities for 2024/25, the Committee acknowledges and welcomes:

- The Trust's proactive engagement with partners and its eagerness to leverage insights from other organisations.
- The focused approach on a streamlined set of priorities for 2024/25, informed by feedback from the CQC, staff, and patients.
- Whilst oncology waiting times were still a concern to members, there had been reassuring progress made, resulting in the removal from the national support network due to notable improvements.

We eagerly await your written response in relation to the question about which national and local audits have taken place.

Based on the information shared with us throughout the past year, including the presentation on the

draft 2023/24 Quality Account, we believe that the contents accurately reflect the services provided by the Trust and resonate with the community's priorities.

If I can be of any further assistance regarding the Committee's response, please do not hesitate to contact me.

Yours sincerely,

Councillor Barry Flux

Chair of Health and Wellbeing Overview and Scrutiny Committee

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Statement on Behalf of the Newcastle & Gateshead Integrated Care Board

NHS
North East and
North Cumbria

Commissioner Statement from
North East and North Cumbria Integrated Care Board (NENC ICB)
Newcastle Upon Tyne Hospitals NHS Foundation Trust
Quality Account 2023/24

The North East and North Cumbria Integrated Care Board (NENC ICB) is committed to commissioning high quality services from Newcastle Upon Tyne Hospitals NHS Foundation Trust (NuTHFT). NENC ICB is responsible for ensuring that the healthcare needs of the patients that they represent are safe, effective and that the experiences of patients are reflected and acted upon. The ICB welcomes the opportunity to review and provide comment on the 2023/24 Quality Account for NuTHFT.

Firstly, the ICB recognises that 2023/24 remained a challenging year across the system due to increasing service demands and the impact of industrial action, with NuTHFT being no exception. The ICB acknowledges and appreciates the combined effort of all staff to deliver safe and effective care during this period, and their ongoing commitment to improve patient experience and drive to deliver continuous quality improvement to the services offered.

The ICB would also like to acknowledge the challenges for the Trust following the CQC's overall rating of *'requires improvement'* due to serious concerns identified during their inspection last year. The CQC also placed restrictions on the Trust's license to provide services, which was imposed through a 'Notice of Decision' in December 2023. The ICB understands how disappointing this outcome is for the Trust and its staff. However, it is reassuring that rapid improvement actions have been undertaken, with continued efforts to resolve all identified issues. The Trust has established a dedicated CQC delivery group, overseen by the Trust Board, to ensure these improvements are effectively implemented. The ICB remains committed to supporting and working collaboratively with the Trust to oversee the necessary improvements as highlighted in the CQC's inspection report and warning notice.

The ICB would like to thank the Trust for welcoming their attendance at a variety of committees and meetings to gain assurance and seek insight into the Board level oversight, challenge, safety culture and transparency within the organisation. These meetings will provide the ICB with assurance that the Trust provides safe, high quality health care and has effective internal review and governance processes in place.

The Trust's Quality Account provides an honest, comprehensive, and transparent appraisal of the quality improvements made over the past year and the aspirations for the coming twelve months. The ICB welcomes that safe and high quality-care has remained a priority and progression has been made towards achieving the 2023/24 quality priorities.

The ICB acknowledges the Trust's efforts to reduce healthcare-associated infections (HCAI). In 2023/24, the Trust reduced the incidences of C. difficile and Klebsiella spp infections, keeping them below the national thresholds. However, the Trust reported four MRSA bacteraemia cases and did not achieve the national thresholds for E. coli and P. aeruginosa infections.

Additionally, the Trust did not achieve its internal target of a 10% reduction in MSSA cases. Comprehensive quality improvement projects are in place, focusing on antimicrobial stewardship, early infection recognition and management, and device compliance monitoring. Improved diagnosis and management of sepsis, evidenced by the increase in sepsis compliance for inpatients from 66% to 81%, is a notable achievement. The ICB will continue to work collaboratively with the Trust and system partners, to improve infection control practice and reduce HCAI's across the wider healthcare economy.

The Trust has continued to make good progress with the quality priority to develop a long-term electronic solution for the management of abnormal results. The initiative to agree the list of over 1000 lead clinicians with patient responsibility demonstrates a proactive approach to ensuring appropriate oversight. The robust process implemented for new joiners to be added and leavers removed from this list, will ensure it is maintained accurately. The addition of a new mandatory field of *'lead clinician to receive report'* in the order entry forms to digitally request investigations through eRecord will help to ensure that results are appropriately directed to the message centre of the specified clinician. However, the percentage of cases where the correct clinician received the MRI scan (61.3%) and CT scan (51%) highlights further work is needed. The ICB therefore supports the Trust's plans to further enhance and optimise the current systems and processes, to facilitate the effective and timely management of abnormal results.

The Trust has made significant progress in implementing the National Patient Safety Strategy and the Patient Safety Incident Response Framework (PSIRF), with their formal transition to PSIRF in January 2024 following agreement with the ICB. Notably, the appointment of a PSIRF Implementation Lead and a Patient Safety Strategy Clinical Director has facilitated the establishment of governance mechanisms for effective patient safety incident responses within the Clinical Boards. Staff capacity and capability for systems-based investigation have been strengthened, and efforts to secure funding for patient safety partners demonstrates a proactive approach. The ICB regularly attends Trust internal meetings where proportionate learning responses are identified and learning responses agreed. The ICB looks forward to continuing to work in partnership with the Trust to promote a systematic, compassionate, and proportionate response to patient safety incidents, with the aim of learning how to reduce risk and associated harm within our health and care system.

The ICB commends the Trust for the excellent progress made with the quality priority to establish a formal triage process in the Maternity Assessment Unit (MAU) to improve recognition of the deteriorating patient or recently pregnant women. Key achievements include the development of a new maternity day-care unit to reduce elective workload on the MAU and the successful implementation of a comprehensive training package. Notably, the Birmingham Symptom Specific Obstetric Triage System (BSOTS) was integrated into BadgerNet and went live on December 18, 2023, leading to improved triage times with 90% of women triaged within fifteen minutes, nearing the 95% target. It is encouraging that 80% of women receive appropriate ongoing midwifery care based on risk, though medical review rates, currently at 50%, requires improvement. However, the ICB acknowledges that achieving the desired targets may take six to twelve months, based on the experience of sixty units using BSOTS. The BSOTS Triage Oversight and Implementation Group will continue monthly meetings to ensure compliance, assurance, and effectiveness.

The Trust has made good progress in the implementation of the Modified Early Obstetric Warning Score (MEOWS) quality priority. This includes the successful integration of a specific question into admission documentation within the Electronic Patient Record, which facilitates the efficient identification of pregnant patients or women who have been pregnant within the preceding 42 days. Furthermore, it is noteworthy that the electronic MEOWS chart has been operational in maternity areas since May 2023, with the exception of the MAU, which remains a high-risk area. This is due to the need for further IT development in the admission process in

MAU and it is reassuring to note that this request has been approved, and plans are in place for the Trust to progress this.

While recognising the significant progress made in 2023/24 with the two maternity quality priorities, the ICB acknowledges that the Trust's Maternity Service received a '*requires improvement*' CQC rating in May 2023 following an inspection in January 2023. Additionally, a subsequent CQC inspection in July 2023 resulted in the well-led domain deteriorating from good to 'requires improvement'" with the safe domain rating of 'requires improvement' remaining unchanged. The ICB acknowledges the Trust's ongoing commitment to enhancing the quality and delivery of safe and compassionate maternity care. It fully supports the new maternity quality priority for 2024/25, which focuses on establishing a staffing model for the birthing unit and an associated staff development plan, ensuring the consistent opening of the birthing centre. The ICB will continue to collaborate with the Trust to monitor and facilitate the necessary improvements within Maternity Services, as highlighted in the CQC inspections.

The Trust has made good progress with the Best Interests Decisions/Mental Capacity Assessment (MCA) and Deprivation of Liberty Safeguards (DoLS) quality priority. Notably, the significant staff training which has taken place as part of the Trust's *'Care for Me, With Me'* project, achieving 92% compliance with MCA training. It is noted that compliance audits in Quarter 3 showed an 83% completion rate for capacity assessments of patients subject to Urgent DoLS, with 72% seen as good or meeting minimal requirements. It is positive to see there has been an increase in DoLS referrals, which indicates heightened staff awareness. However, it is acknowledged that further efforts are needed to ensure clinical staff consistently understand and document MCA assessments and best interest's decisions. The ICB fully supports the quality priority for 2024/25, which focuses on making reasonable adjustments for patients with Learning Disabilities and/or Autism and ensuring appropriate use of MCA and DoLS for vulnerable patients.

The Trust made good progress with the quality priority to ensure reasonable adjustments are made for patients with a suspected or known learning disability. Key achievements include the integration of digital documentation that prompts staff to identify patients with a learning disability, if they have a passport and a flag on the system. The increased visibility of the Learning Disability Liaison team and the high staff compliance with the Diamond Standards e-learning (90%) are also commendable. Participation in the Oliver McGowan training pilot and the reintroduction of Learning Disability Champions further highlight the Trust's commitment to staff training and support. While the audit showed an increase in the documentation of learning disabilities in patient records from 25% to 53% which is positive, the consideration of reasonable adjustments has only seen a slight increase from 43% to 46%. The ICB therefore fully supports the Trust's plans to continue with this important quality priority in 2024/25.

The ICB congratulates the Trust for the excellent progress made with the quality priority to improve services in the Emergency Department for children, young people and adults with mental health issues. It is positive to note that a Clinical Manager was appointed by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust to lead on the Children and Young People's Service (CYPS) proposal, which commenced in April 2023. The "We Can Talk" training is an excellent initiative, and it is positive to note 253 staff have been trained. Additionally, the implementation of the *"We Can Talk in Private"* Quality Improvement project in the adult Emergency Department is a notable achievement, as this will foster an environment where patients can feel safe and heard.

The Trust has made good progress with the quality priority to embed a consistent approach to transitioning young people from child to adult services. Securing funding for a 23-month project team is a notable achievement, enabling the development of bespoke pathways for complex patient groups and ensuring oversight by a youth worker for patients under 18

years old in non-paediatric areas. Additionally, the recruitment of a data manager to monitor relevant metrics is commendable and will aid in evaluating the project's success. The ICB fully supports the Trust's plans to progress this important project in 2024/25.

The ICB acknowledges the Trust's continued commitment to improve the safety and experience of people and their relatives throughout their care journey. However, it is concerning that the Trust reported twelve never events in 2023/24, a significant increase from the five reported the previous year. A Never Event is defined as *"a serious largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers"*. In light of this, the ICB fully supports the quality priority for 2024/25 which aims to achieve a reduction in the incidence of surgical never events, particularly focussing on Ophthalmology. This will include sharing the learning across other surgical specialities to inform and improve practice. The ICB looks forward to receiving regular progress updates on work and anticipates a reduction in the number of never events reported.

It is noted that during 2023/24, 887 case record reviews and 54 investigations have been carried out in relation to 1,982 patient deaths within NuTHFT. The ICB commends the Trust's commitment to learning from patients' deaths and applying learning from these difficult experiences to drive future improvements in high quality care, as highlighted in the report.

The Trust's focus on national clinical audits and confidential enquiries, with participation rates of 89% and 100% respectively, highlights its commitment to evidence-based best practices. Clinical research, a key driver of innovation and essential for maintaining high standards of patient care, remains a priority for the Trust. Their ongoing dedication has earned them recognition as one of the leading research Trusts in the country.

The ICB notes the nine cancer standards have been consolidated into three overarching standards and acknowledges that the 2023/24 data provided by the Trust is based on ten months, with the year-end position pending. The Trust's performance against the 31-day target stands at 85.9%, falling short of the 96% target, while for the 62-day target, is at 55.5% against an 85% target. Challenges in meeting these targets stem from limited theatre capacity, late referrals, workforce gaps, increasing demand and capacity loss due to estate updates and refurbishments. Despite these challenges, the ICB is reassured by the extensive range of mitigations in place, which aim to enhance performance against these cancer targets.

The ICB acknowledges the difficulties in meeting the Referral to Treatment Targets, with current performance approximately 67%. However, the Trust is commended for their ongoing efforts to tackle long waiting times. Notably, all patients waiting over 104 weeks were treated by January 2024, with attention also given to those waiting 78 and 65 weeks. Despite an increase in the overall waiting list to 108,000, the Trust has managed to reduce this to 99,066 patients awaiting their first treatment by February 2024. The ICB remains cited on the ongoing initiatives to improve the referral to treatment performance targets, noting that despite the challenges such as industrial action, cancer and high clinical priority patients have continued to be appropriately treated by the Trust.

The ICB wishes to highlight the Trust's performance in the National Staff Survey published in March 2024, which showed a concerning decline compared to last year's results. The Trust ranked lowest in the country for 'we are a team' and ranked poorest nationally in the eight questions related to leadership and line management. Feedback regarding culture, concerns, civility, respect, and staff engagement mirrored the findings from CQC inspection and internal staff feedback gathered through Trust roadshows and People Plan focus group consultations. The ICB recognises the Trust's commitment to significantly improving staff experience and fostering a culture of openness and honesty, to listen, learn and innovate to deliver the highest quality and safest care to patients from skilled staff. Consequently, the ICB fully supports the two quality priorities for 2024/25 to improve patient safety by ensuring

staff feel empowered to report safety concerns, incidents, and near-misses, thereby increasing incident reporting rates and establishing a systematic way of improving from patient and staff feedback.

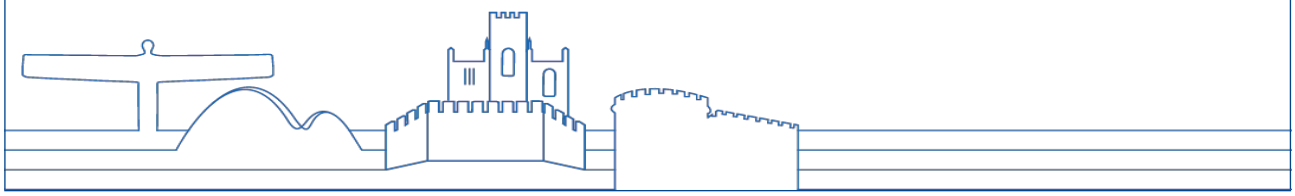
The Quality Account clearly defines the key priorities for 2024/25 which have been agreed following discussion with the Board of Directors, Council of Governors, patient representatives, staff and members of the public. These are clearly aligned to the three domains of patient safety, clinical effectiveness and patient experience and include detailed explanation of how progress will be measured to deliver safe, clinically effective services and to improve patient and staff experience. The ICB welcomes and fully supports these quality priorities as appropriate areas to target for continuous evidence-based quality improvement, which link well with the commissioning priorities.

The ICB 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 2023/24. 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 commissioners look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned in 2024/25.

Richard Scott
Director of Nursing (North)
NENC ICB

May 2024



Joint statement on behalf of Healthwatch Gateshead, Healthwatch Newcastle, Healthwatch North Tyneside and Healthwatch Northumberland for The Newcastle upon Tyne Hospitals NHS Foundation Trust's Draft Quality Account 2023/24

Joint statement from Healthwatch Gateshead, Healthwatch Newcastle, Healthwatch North Tyneside and Healthwatch Northumberland for The Newcastle upon Tyne Hospitals NHS Foundation Trust's Draft Quality Account 2023/24

Thank you for sharing the draft quality account for our comment. We would like to take this opportunity to thank your team for all their hard work during these challenging times.

We were obviously disappointed to see the findings of the Care Quality Commission (CQC) reports published during this period. At the time we welcomed the robust approach taken by the CQC and the clear expectations of NUTH set out in those reports. We were also reassured that the CQC findings around caring is rated 'good'.

We are encouraged by the Trust's open, transparent and accessible approach to addressing these findings and the new leadership team's focus on service improvement. We have offered our support to help rebuild patients' and residents confidence in NUTH. Given the issues to be addressed we feel that fewer, more focussed quality priorities for 2024-25 is appropriate.

We welcome the **priorities for 2024/5** set out in this report and the clear focus on service user experience throughout. We note the shift of approach to be more focused on users experience, something we have encouraged over the years. Alongside patient experience, we strongly encourage the trust to improve how families and carers views are heard and involved.

We have met with your new Chief Experience Officer to discuss the plans set out in Priority 4. We encourage the trust to work with partners, such as Healthwatch, to understand the experience of patients, families, carers and the wider community, in addition to the internal mechanisms you are implementing. Patients tell us that it is the holistic view of their care and support that is important to them.

We welcome the focus on patients who have been waiting longest for elective care and to start cancer treatment (over 62 days). We note the Trust has achieved sufficient progress to have been removed quickly from the National Tiering Support Mechanism.

We know timely care is a key priority for our residents and they are increasingly concerned about delays within the NHS. This applies across all services including urgent and emergency care services as well as community and clinical pathways.

Waiting times continue to be highlighted as a particular concern from our residents. A key element of this is communications with those on waiting lists so that they don't 'feel forgotten about'. This includes timely sharing of test results.

We have shared our feedback from residents about accessing audiology services in North Tyneside and Northumberland and are keen to progress the planned involvement activities to identify service improvements using co-production principles.

We have heard concerns from residents about the transition between different services and are surprised that this isn't more of a focus within your priorities. This includes handovers between ambulances to the emergency department, GP referrals and handovers to social care/community support when people are leaving hospital. Patients tell us that it is the holistic view of their care that is important to them.

Travel and transport issues remain a concern.

The identification of carers and connecting carers to appropriate support is also an issue we hear a lot about, particularly connecting carers to support in their local communities. We know that the Trust has developed plans to improve this approach and the offer of support to ensure this works well remains.

It was interesting to read the comments about involvement and engagement in 2023/4. We encourage the Trust to think about how they engage with communities across their wider footprint alongside the work established in Newcastle. For many residents of Gateshead, North Tyneside and Northumberland, Newcastle Hospitals are their local hospital and go-to service if they need support. We appreciate this is complex given the footprint your different services cover.

Notes

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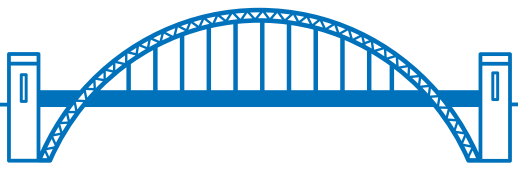

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