Gateshead Health
NHS Foundation Trust

Quality Account
2016/17

Contents

1.Statement on Quality from the Chief Executive

I am delighted to introduce the Quality Account for 2016/17, the eighth produced by Gateshead Health NHS Foundation Trust. This once again reflects another excellent year for the Trust in our pursuit of high quality and safe care for patients and their families. In 2016 our health regulator the Care Quality Commission (CQC) inspected our services in the Trust and rated us as 'GOOD' overall with 'OUTSTANDING' for caring. Our Maternity Unit at Gateshead Health NHS Foundation Trust was also rated as 'OUTSTANDING' by the CQC which places it amongst the very best in the country.

Our staff are to be commended for their continuing dedication, commitment, and passion to provide and continuously improve the care we deliver to patients and their families. Against the backdrop of the many challenges facing health and social care, both nationally and at a local level, sustaining high quality and safe care remains central to our values and our approach to service delivery on a daily basis.

In 2016 our organisation faced significant growth as we became an integrated acute and community provider, now delivering high quality community services to the population of Gateshead alongside our hospital-based services. This has enabled us to work more closely, and in partnership with our Primary Care and Local Authority colleagues through the Gateshead Care Partnership, to deliver high quality and seamless care to our most vulnerable and frail patients. I am particularly proud of the way that our workforce has embraced the mobilisation and integration of community services.

Feedback from our patients shows us that the Trust continues to provide a positive patient experience with an average of 96% of inpatients saying that they would definitely recommend the hospital to friends and family. 83% of patients that completed the 2016 NHS inpatient survey would rate the care provided at 7/10 or above (Picker Institute, 2016) and over 96% of inpatients in our local Trust survey say that our staff are caring and compassionate.

The Trust have consistently performed within the top three Emergency departments in the country for the Friends and Family Test and we have provided advice and guidance to other Trusts.

The new Patient Experience and Information Centre opened in 2016 and has gone from strength to strength as we increase our contact with the public who visit our hospital, and also our community facilities. The Centre is also supported by a growing number of volunteers who give invaluable support to patients.

We have regularly monitored our improvement plans during 2016/17 through our Quality Governance Committee and the Trust Board. In addition to the examples detailed above, the Quality Account for 2016/17 reflects the excellent progress we have made against our priorities for the year:

- Reduce avoidable hospital deaths from sepsis through timely recognition and management.
- Achieved our target of zero preventable stillbirths through the 'Saving Babies Lives' campaign.
- Improve patient safety by reducing three key common medication errors.
- Implementation of the 'ThinkSAFE' project.
- Continue to reduce harmful 'in hospital' falls.

- Qualitative analysis of complaints (including responses and actions) to improve the patient's (and family's or carer's) experience of the process. Production of an improvement plan and reinvigoration of the complaints service and processes in line with best practice

Whilst we have made significant progress in these key areas over the past year, we recognise that we can always do better. We will therefore continue to develop our focus on quality improvement through the implementation of our new Quality Strategy 2017/20 that sets out how we will continue to deliver improvements over the next three years, alongside our five key priorities reflected in our Quality Account for 2017/18:

Clinical Effectiveness

- Continue to implement the improvement plan in relation to Patient Reported Outcome Measures (PROMS) for hip and knee replacements.
- Standardise and increase the number of mortality reviews undertaken in line with national guidance.

Patient Safety

- Improve our patient safety culture.
- Implement National Safety Standards for Invasive Procedures (NatSSIPS) and Local Safety Standards for Invasive Procedures (LocSSIPS).

Patient Experience

- Review of complaints investigations and actions

I trust that you will enjoy reading about some of our examples of improvement work that teams across the organisation are pursuing and will get a sense from them of our unerring focus on the provision of excellent care which meets the high standards that our patients deserve. We want the Trust to continue to be the health care provider that patients trust to deliver those highest standards of care - and the organisation that staff have pride in and where they are willing always to give of their best.

I can confirm that on behalf of the Board of Gateshead Health NHS Foundation Trust that to the best of my knowledge the information presented in the Quality Account is accurate.

Signed:

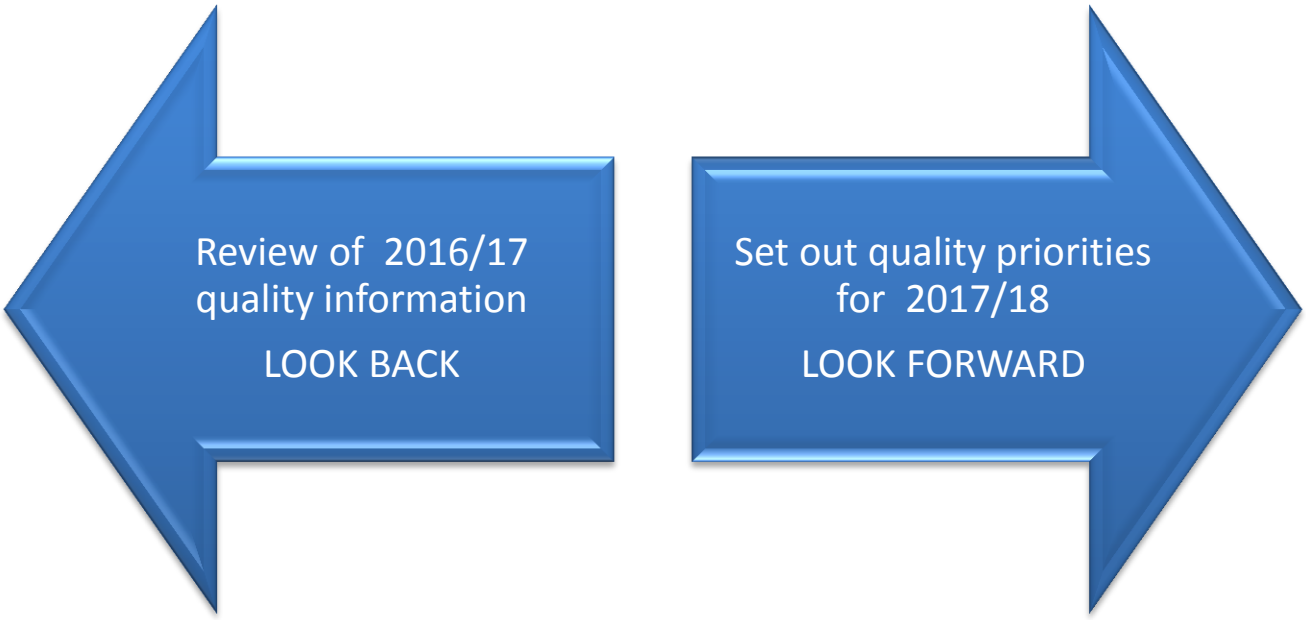
Mr I D Renwick, Chief Executive **Date:**

What is a Quality Account?

Since 2009 as part of the movement across the NHS to be open and transparent about the quality of services provided to the public, all NHS hospitals must publish a Quality Account (Health Act 2009). Staff at the hospital can use the Quality Account to assess the quality of their care. The public and patients can also view quality across NHS organisations by viewing the Quality Accounts on the NHS Choices website: www.nhs.uk.

The dual functions of a Quality Account are to:

- Summarise our performance and improvements against the quality priorities and objectives we set ourselves for 2016/17.
- Outline the quality priorities and objectives we set ourselves going forward for 2017/18.



2. Priorities for Improvement

2.1 Reporting back on our progress in 2016/17

In our 2015/16 Quality Account we identified six quality improvement priorities that we would concentrate on in 2016/17. This section focuses on the progress we have made against these.

Clinical Effectiveness:

Priority 1: Continue to reduce avoidable hospital deaths focusing on the timely recognition and management of sepsis by ongoing development of the sepsis screening process (within the Accident & Emergency Department and Inpatient Wards) and further development of training and education

What did we say we would do?

Build on the work undertaken within emergency and urgent care to recognise and treat sepsis in a timely manner and widen this piece of work to include acute inpatient areas. We will actively participate in the 2016/17 National Commissioning for Quality and Innovation (CQUIN) indicator and use this as a focus for our work. We will use sepsis improvement as a key project for reducing avoidable hospital deaths and ensure we broaden our approach from emergency care into inpatient areas. We will embed our learning and development processes in all clinical areas.

Explanation of how mortality is measured:

Like many other Trusts, the Trust uses independent organisations such as Dr Foster and Healthcare Evaluation Data (HED) to monitor its Hospital Standardised Mortality Ratio. The Hospital Standardised Mortality Ratio (HSMR) compares the expected rate of death in a hospital with the actual rate of death and allows us to assess the Trust's performance on a range of clinical conditions, such as patients with conditions which most commonly result in death, for example heart disease, respiratory conditions, stroke and cancer.

The Summary Hospital-level Mortality Indicator (SHMI) is produced by NHS Digital and similar to the HSMR but this takes into consideration deaths that have occurred within 30 days of discharge from hospital. The SHMI calculates a score which places each Trust into one of three bands for mortality rating.

Table illustrating how the risk adjusted scores are interpreted:

Interpretation of score	HSMR value	SHMI band
Deaths as predicted	100	'as expected'
More deaths than predicted	Score greater than 100	'high'
Less deaths than predicted	Score less than 100	'low'

Crude mortality rate is a measure of the number of deaths which does not include an adjustment

for risk factors as in the HSMR. The crude rate is the percentage of hospital deaths that have occurred out of all hospital spells (stays).

Did we achieve this?

Yes we did.

How we achieved it:

We have concentrated on developing a positive sepsis culture for identifying, treating, and reporting patients with sepsis. We also improved staff learning and education through:

- Developing a sepsis steering group to centralise the management of sepsis as a key priority. The group comprises of key stakeholders who have met on a monthly basis to oversee and drive our improvement work related to sepsis. The group has brought together a number of work streams including the Sepsis National Confidential Enquiry into Patient Outcome and Death (NCEPOD), regional development work and the national CQUIN in order to maximise our improvement efforts and ensure a well co-ordinated approach.
- We have developed an integrated sepsis work plan that focused upon the whole patient pathway and has remained a dynamic document to address changing priorities and challenges. We have identified sepsis champions across the Trust who support and drive the implementation of this sepsis work programme.
- We have focused upon improving early identification and treatment of sepsis to improve patient outcomes across the whole patient pathway. Key to this has been the development and implementation of a regional sepsis screening tool which has been rolled out to all inpatient wards. We have also reviewed the screening tool within the A&E department and integrated this into the documentation. We have designed and implemented a range of tools including screensavers, posters, videos, prompt cards, resource folders and sepsis 'boxes'.
- We have provided a wide range of education and training opportunities for all appropriate staff across the organisation. This range of education has included:

    - ✓ Early recognition and treatment of patients with sepsis for all clinical staff within the Trust through mandatory training, preceptorship, bespoke training for particular wards and individuals
    - ✓ Attending SafeCare meetings, ward sister away days, a range of nursing and medical staff meetings to raise awareness of sepsis
    - ✓ Specific training for junior doctors
    - ✓ Targeting community teams and GP practices
    - ✓ Utilising patient stories

- We have continued work to improve upon our target of administering appropriate antibiotics within one hour (as per the CQUIN 2016/17) to improve the number of patients who receive the appropriate treatment across both the emergency and inpatient pathways.
- We have worked to improve our processes for data capture and reporting of sepsis**.** This has been a challenging area of work as we currently rely on a manual paper based system for data capture and reporting. We are working to develop an electronic solution to capture data which will be more time efficient.
- Our lead nurse for sepsis is the Vice Chair for the Regional Sepsis Network group which meets on a two monthly basis. This has enabled sharing of good practice, development of training programmes and collaborative working.

Evidence of achievement:

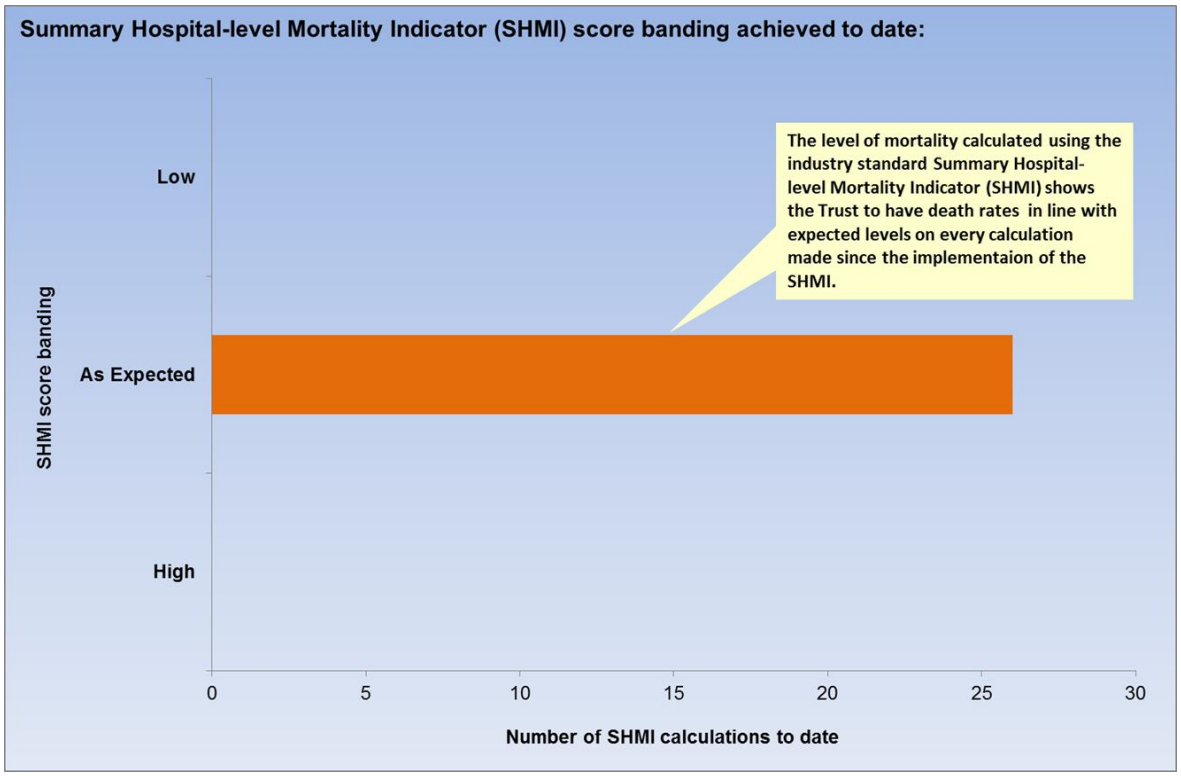
Whilst we did not achieve all of our CQUIN targets the table below demonstrates improvement we have made in relation to both screening and treating patients with sepsis. However we did see a decrease in quarter 3, this was due to winter pressures.

Accident & Emergency Department CQUIN Target	April –June 2016	July – Sept 2016	Oct- Dec 2016	Jan – March 2017
Target	90%	90%	90%	90%
Percentage of patients screened	50.8%	80%	54.4%	Not available
Target	40%	45%	50%	60%
Percentage of patients receiving antibiotics within 90 minutes and receive 72 hour antibiotic review	39%	67.2%	56.6%	Not available

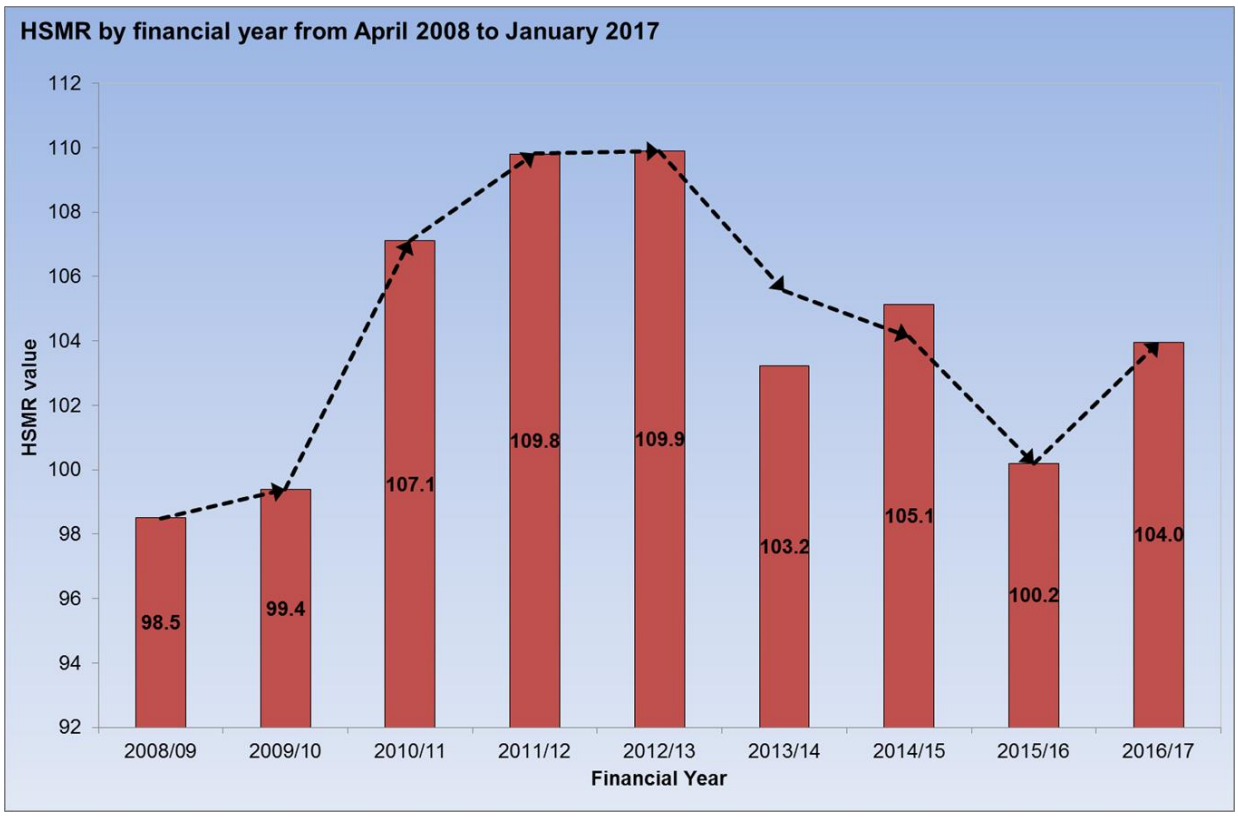
Inpatient wards CQUIN Target	April –June 2016	July – Sept 2016	Oct- Dec 2016	Jan – March 2017
Target	Screening tool in place	10%	20%	90%
Percentage of patients screened	Screening tool in place	10.7%	23%	Not available
Target	Baseline data	10%	20%	90%
Percentage of patients receiving antibiotics within 90 minutes and receive 72 hour antibiotic review	69%	79.6%	74%	Not available

Quarter 4 results for 2017 will be available mid-May.

The Summary Hospital-level Mortality Indicator (SHMI) reports mortality at a Trust level across the NHS in England and is regarded as the national standard for monitoring of mortality. The main development in measuring mortality, that the SHMI takes into account, is patient deaths outside of hospital within 30 days of discharge from hospital. The SHMI is produced quarterly with the first publication made in October 2011. The SHMI categorises Trusts into one of three groups based on the Trust SHMI calculation; low, as expected and high. For all of the SHMI calculations since October 2011, death rates (mortality) for the Trust are described as being 'as expected'.

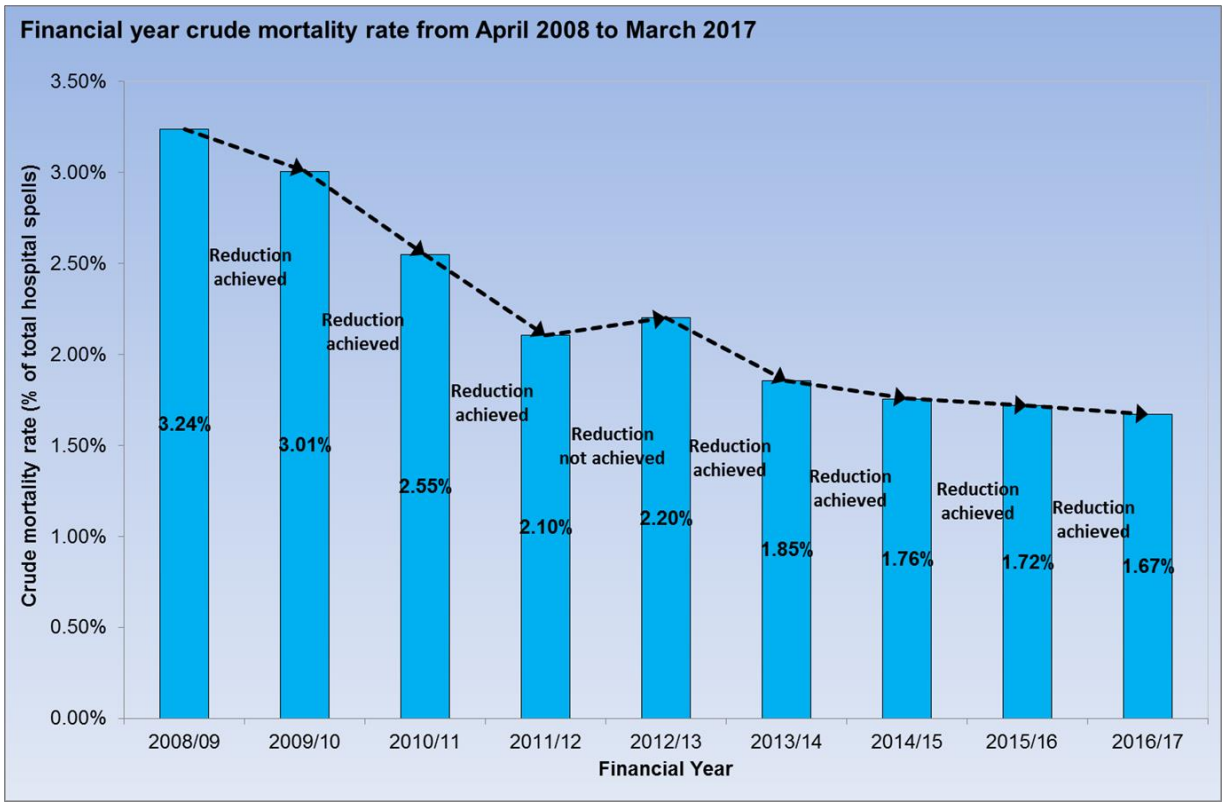


The HSMR is a calculation used to monitor death rates in a Trust and we monitor this data closely. The HSMR is based on a subset of diagnoses which give rise to around 80% of in-hospital deaths.

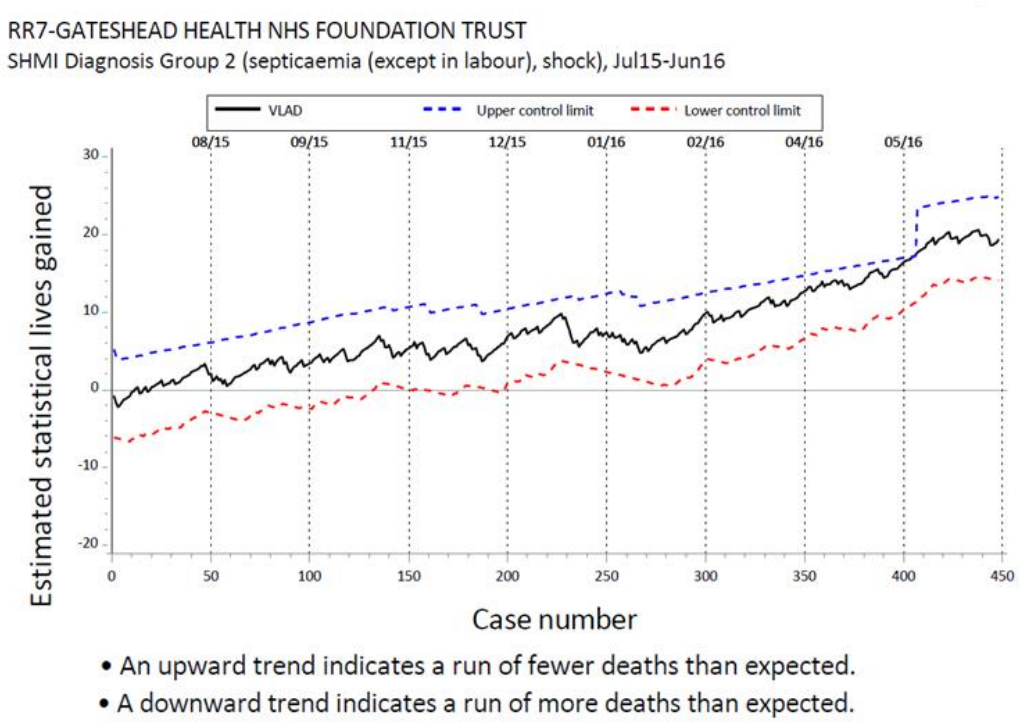


The latest 2016/17 position available to January 2017 is showing the HSMR at Gateshead as slightly higher than the previous year but still within the expected range. The Trust monitors mortality monthly at its Mortality and Morbidity Steering Group. The SHMI, HSMR and crude mortality rate are discussed and further analysis and investigation is undertaken where required.

A reduction in crude mortality was observed again in 2016/17 from the previous year. The pattern demonstrated for crude death rates shows a downward trend with the exception of a slight increase in 2012/13. The crude mortality rate has reduced from 3.24% in 2008/09 to 1.67% in 2016/17 representing a 48.5% reduction overall.



Recent SHMI data demonstrates fewer deaths than expected in relation to sepsis.



Next steps:

We will continue to drive improvements in the timely recognition and treatment of sepsis through the use of evidence based guidance to ensure our patients receive a high standard of care and the best possible outcomes.

Priority 2: Continue to review and embed learning from 'Saving Babies Lives' campaign

Stillbirth, death of a newborn baby or the birth of a baby with a brain injury are life changing events that affect women and their families for many years.

What did we say we would do?

Funding for this project in 2015/16 was provided by an NHS Litigation Authority (NHSLA) Sign up to Safety bid. This funding supported a dedicated midwife for the 'Saving Babies Lives' campaign. Last year we achieved a 50% reduction in stillbirths and early neonatal deaths. To make further improvements, we have set ourselves an ambitious target of **no avoidable** stillbirths, neonatal deaths or birth related injuries during 2016/17.

Did we achieve this?

Yes we did.

How we achieved it:

We have achieved our ambitious target of having **no avoidable** stillbirths, neonatal deaths or birth related injuries during 2016/17.

- We implemented the total care bundle which included all four elements of the 'Saving babies Lives' campaign.
- Continued to provide patient information leaflets regarding fetal movements. This is a very important intervention to ensure that we 'Ask, Assess, Act, Advise'. A new guideline was completed and ratified; this is now in use within the unit. Regional fetal movements' documentation to be implemented following regional network consultations. A draft tool has been completed. We are awaiting new Royal College of Obstetricians and Gynaecologists (RCOG) guidance to complete this work. The Trust website and online information has been updated and includes patient information regarding fetal movements.
- We have increased our ultrasound capacity and our midwifery ultrasound hours including a new midwife sonographer trainee who commenced third trimester ultrasound training in March 2017. A business case was submitted by the Associate Director of Surgical Business Unit for consideration by Central Management Team (CMT). This has not yet been agreed. Sustainability and capacity of the obstetric ultrasound service has been added to the risk register. Monthly meetings with the radiology department to proactively forward plan and deliver the service in line with 'Better Births' recommendations over the next two years.
- Continued to provide annual staff training for customised growth charts and the identification, surveillance and referral of vulnerable babies.
- We have continued to provide Cardiotocography (CTG) Assessment and training programme for all eligible clinical staff. Maternity safety fund has enabled three years of K2 training (Perinatal Institute training package for CTG) which now includes a competency based assessment for staff.
- We continue to carry out a carbon monoxide (CO) testing at booking of all women irrespective of their smoking and refer to stop smoking services. We have reviewed staff training and equipment to provide CO readings at booking which is a national recommendation.
- We are working with Public Health England to deliver 'high impact' training to pregnant women but the service is resource driven at present.

Evidence of achievement:

- Audit of compliance with CO monitoring at booking.
- Audit via new Badger clinical system is currently ongoing.
- Annual training for all staff is planned and recorded for CTG assessment, CO testing and monitoring and use of customised growth charts.
- We have seen an increase in the identification and has resulted in an increased surveillance of 'at risk' babies. We have also seen an increase in the induction of labour of high risk mothers following the detection of 'at risk' babies.
- Peer reviews via perinatal meetings and regional neonatal networks.
- Local discussion at perinatal mortality meetings within the department.
- Regional discussion via neonatal clinical network and maternity network meetings. Peer review to be organised and monitored regionally.
- From April 2017 all suspected babies will have to be reported via the Early Notification Scheme and maternity contributions. This will link to the RCOG database but requires early notification to NHS Resolution via the legal department.
- All stillbirth and neonatal deaths\maternal mortality are reviewed individually and reported to national Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) surveillance. All suspected infants with brain injury are reported to RCOG 'Each

baby counts' data base.

- Stillbirth rate monitored via local maternity dashboard and regional dashboard
- Cases are reported and the results of local serious incident investigation to the RCOG 'Each Baby Counts' project. A dedicated team at RCOG will analyse the data sent in by all Trusts in order to identify avoidable factors in the cases and share lessons learned and develop action plans for local implementation

Next steps:

- Plans in place to undertake audit in relation to 2017/18 compliance with CTG K2 training programme. Maternity safety training fund will enable three years of perinatal institute programme and audit support. This has also funded K2 CTG training package.
- A business case has been submitted to ensure sustainability of service. Future planning of the service needs against the recommendations of Better Births to ensure ultrasound capacity can meet the demand of the next two years.
- Succession plan for skills needed within workforce.
- Increased demand on the service requires planning and resource especially around the ultrasound capacity and training of skilled staff.

Priority 3: Improve patient safety by reducing three key common medication errors

What did we say we would do?

We will fully deploy an Electronic Prescribing and Medicines Administration (EPMA) system across all acute wards in the hospital to reduce three key common medication errors.

The three types of recurring medication errors are those involving:

1. Patient allergy status
2. Positive Patient Identification
3. Missed doses of critical medicines

Did we achieve this?

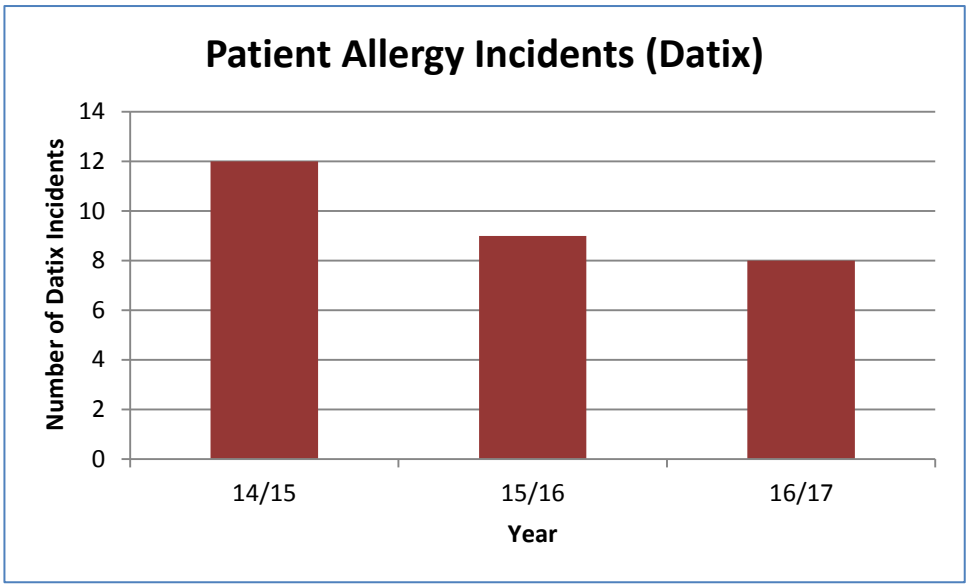
Yes we did.

How we achieved it:

The deployment of the EPMA System across acute wards in the hospital has reduced the incidence of recorded Datix incidents concerning patient allergy status and missed doses of critical medicines. There were two acute wards that were unable to have EPMA implemented and these were Special Care Baby Unit and Critical Care. The reason for this was due to the current software being incompatible with the complex dosage calculations used for patients in these areas.

Overall, EPMA has made patient care safer by reducing the two key common medication errors above. EPMA had no impact on Positive Patient Identification.

Evidence of achievement:

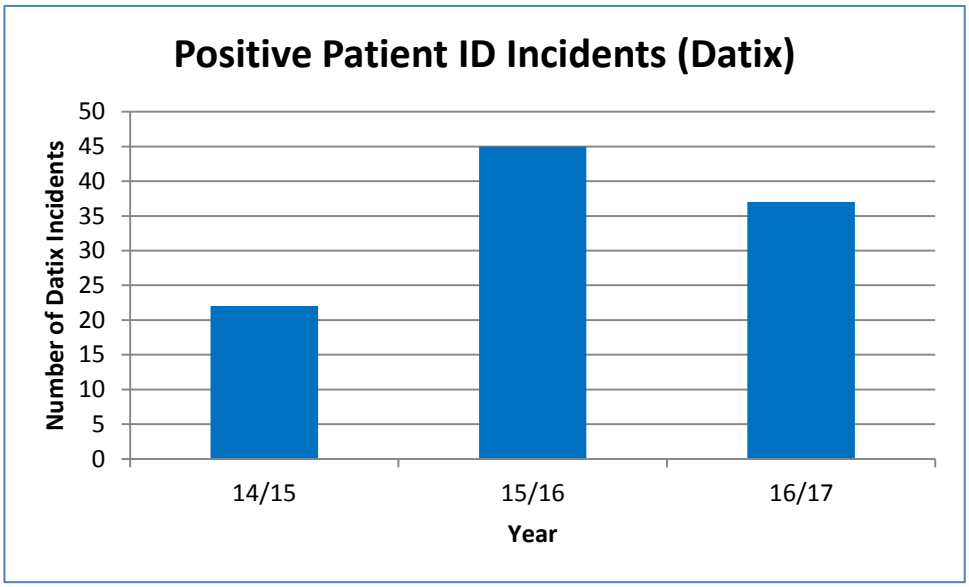


The total number of patient allergy incidents recorded Datix incidents for period April 2016 – March 2017 was eight.

This quality priority anticipated implementing EPMA would reduce allergy errors due to the inability of a practitioner (without significant effort) prescribing or administering a drug to which the patient has been recorded on the electronic prescription chart as being allergic to.

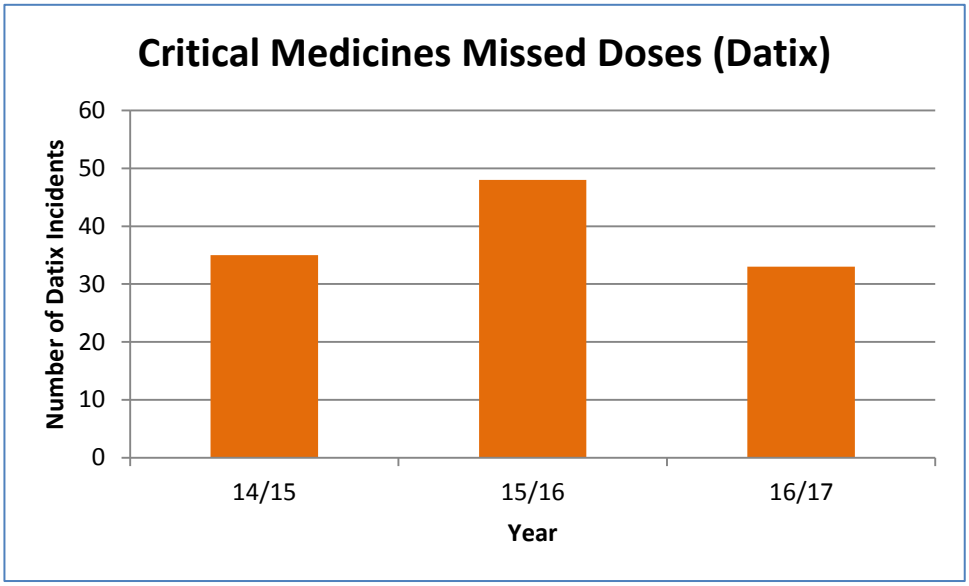
However, in 50% of the incidents recorded the patient either did not disclose a history of drug allergies or had no past history of a drug allergy. Therefore a failure to record allergies on EPMA system may result in potential incidents not being prevented.

In summary, no patient allergy incidents occurred on EPMA wards where a patient's allergy status was known and recorded.



There were 37 Datix incidents concerning failed Positive Patient Identification recorded for period April 2016 – March 2017.

While there have been fewer positive patient identification incidents across the Trust during 2016/17, the implementation of EPMA has not led to a significant improvement in this measure. The analysis of incidents when medication errors occurred were attributed to human error.



The number of recorded Datix incidents involving missed doses (critical medicines) for period April 2016 - March 2017 was 33. Of these 33 cases, only eight occurred on EPMA wards.

In summary we have reported all medication errors in this section, however we are confident that EPMA has significantly contributed towards the overall reduction.

Next steps:

We will continue to monitor incidents in relation to these three common medication errors throughout 2017/18 and develop improvement plans where appropriate.

Priority 4: To continue to implement the 'ThinkSAFE' project within the Trust

What did we say we would do?

Continue to embed the initiative for patients undergoing elective orthopaedic procedures. We will expand its use to two further clinical areas:

- Patients who have Inflammatory Bowel Disease (IBD) and are increasing their treatment to all groups of drugs known as biological therapies.
- Patients who undergo planned gynaecological cancer surgery.

Did we achieve this?

We partially achieved this.

How we partially achieved it:

We continued the initiative successfully in orthopaedics championed by the department leads.

ThinkSAFE documentation was rolled out to further patients in orthopaedics and the feedback was very positive. Patients particularly liked the process of being involved in their care and the opportunity to discuss with staff, for example bringing medications into hospital, bringing in appropriate footwear to hospital, having time to discuss any concerns with clinical staff and having all of this in a blue wallet which included a diary in which they could document their important questions about their pending hospital stay. However, the uptake in ladies with gynaecological cancer was lower than anticipated. This was partly due to winter pressures and staff sickness in the new patient clinics but also due to the amount of comprehensive information which is currently being offered in the clinic. Clinical staff felt that we were perhaps duplicating the ThinkSAFE information provided in its current format.

The initiative has not yet been implemented within the IBD services due to the lack of engagement with clinical staff.

Evidence of achievement:

The initiative is fully embedded within the orthopaedic department with good feedback from patients, and staff continue to support this initiative as being very effective within the department. All patients attending for orthopaedic surgery visit the pre-assessment and joint care clinic and watch the ThinkSAFE patient safety video. They also received patient information packs which now have the ThinkSAFE leaflets inside. Four patients were recruited with gynaecological cancer in February 2017 and we are awaiting further information and feedback.

Next steps:

In summary, our overall assessment is that the ThinkSAFE initiative is not appropriate for all clinical groups of patients. We will evaluate the appropriateness of continuing to roll out this initiative within gynaecological cancer services and explore the potential within other clinical areas. A full evaluation is required to ascertain the benefits of continuing with the initiative in its current format within the Trust.

Priority 5: Continue to reduce harmful 'in hospital' falls

Inpatient falls are common and remain a great challenge for the NHS. Falls in hospital remain the most commonly reported patient safety incident. Falls and falls related injuries can be a serious problem for older people and addressing the problem of inpatient falls is challenging. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once per year (NICE 2013).

What did we say we would do?

We will aim to maintain or reduce our harmful 'in hospital' falls rate of 2.60 per 1,000 bed days during 2016/17.

Did we achieve this?

Yes we did. We are very pleased to report that we have reduced our rate of harmful 'in-hospital' falls from 2.60 to 2.24 per 1,000 bed days.

How did we achieve this:

Delivery of the 'in hospital' falls reduction strategy has been key to achieving the reduction in harmful falls this year. The list below briefly outlines our progress made against delivery of the

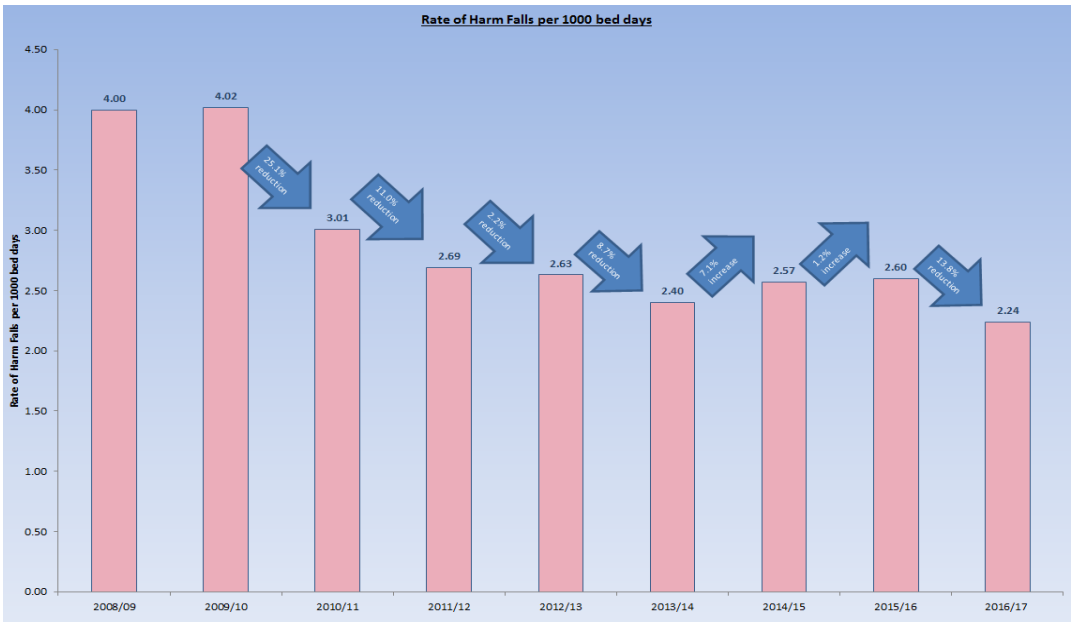
strategy and highlights some of the improvement work implemented to achieve our reduction in the rate of harmful falls.

- Training packages have been reviewed and updated to ensure staff are competent to undertake falls assessment and prevention. Two E-learning packages from the Royal College of Physicians 'FallSafe' programme are also now in place on the Trust's intranet for both medical and nursing staff. A competency based assessment was developed and has been implemented across all adult inpatient areas. All clinical teams have a 'falls champion' who attend a bi-monthly falls meeting and have responsibility for sharing good practice in falls assessment and prevention with their clinical colleagues.
- Our falls team has attended national and local networking events and share learning and good practice at the strategic falls group.
- A dedicated falls prevention site on the Trust intranet was completed in the summer and has received very positive feedback.
- The Trust's Dementia Specialist Nurse is a member of the falls action group and works closely with the falls nurses and practice development team in falls prevention programmes of work. A Trust multidisciplinary conference on dementia care was held in April 2016 and included a falls assessment and prevention workshop, as people living with dementia are often at greater risk of falls in hospital.
- The National Audit of Inpatient Falls 2015 results were shared with senior ward nursing staff and the areas highlighted for improvement were built into the Trust falls work and audit programme.
- Our incident reporting system now collects information on staffing at the time of a patient fall. It is anticipated this will inform us if there is a correlation between falls and staffing levels and skill mix. We have also ensured that recording the bed number when reporting a fall via Datix is mandatory, to enable us to identify any 'hot spot' areas within the clinical environments.
- One common theme identified through learning from falls Root Cause Analysis (RCA) data was related to the lack of availability of falls sensor alarms. A Trust wide audit was undertaken to establish stock levels available, cross referenced with the asset register which identified there were a considerable number of alarms. However, these were not suitable for all patient groups, therefore we are currently trialing new types of alarm systems which may prove to be better for those patient groups identified in the Trust.
- A new falls RCA tool was developed and has been in use since September 2016. Feedback on the tool has been extremely positive. Staff report that they find it easier to complete and the panel find they are now provided with the comprehensive information they require to ensure any gaps in practice or areas for shared learning are identified.
- Once areas were highlighted for focused falls prevention work (those with the highest rate of harmful falls) a programme of focused falls prevention interventions were developed and implemented. This programme included:
  - A weekly audit of basic falls prevention initiatives being implemented for patients at risk of fall.
  - The implementation of five simple steps in the ward area to support falls prevention interventions
    - ✓ Reviewing and updating the use of the a handover tool to identify patients at risk of falling
    - ✓ Development of a falls prevention information board aimed at patients, staff and visitors.
    - ✓ Ensuring all nursing staff have undertaken the falls competency based assessment.
    - ✓ Implementing the safety cross as a visual aid to monitor falls.

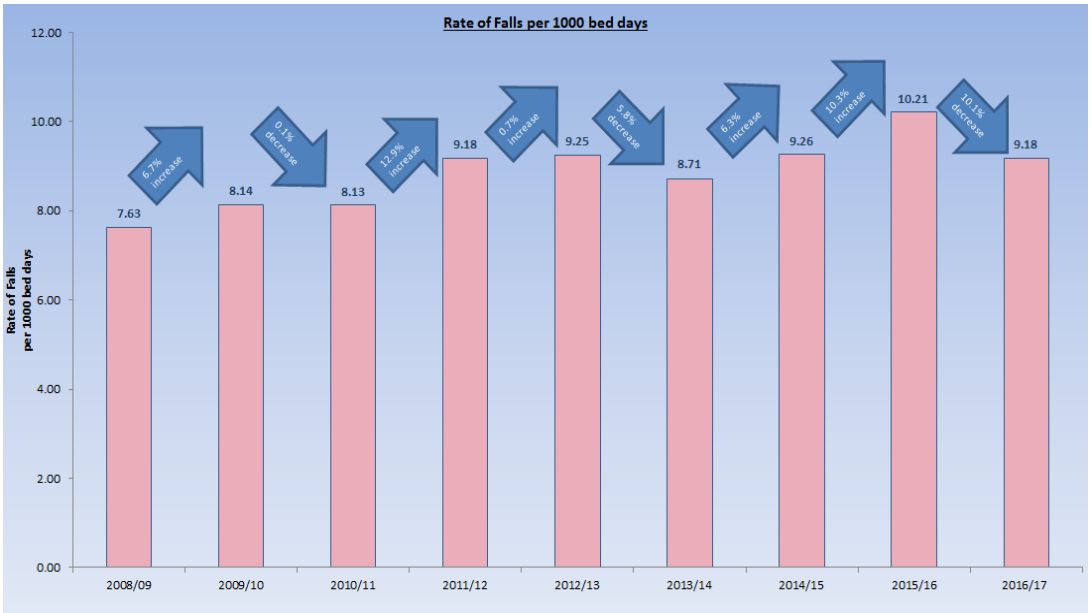
- ✓ Holding weekly huddles on the ward to monitor progress and identify issues to ensure a quick resolution.

- We carried out a full review of mobility aids across inpatient areas and our current storage provision. 150 walking frames have been purchased in 2016 to increase availability for patients during their admission to hospital. The additional equipment promotes independence, rehabilitation, reduces cross infection from the sharing of equipment and reduces the risk of falls.

Evidence of achievement:



The chart above demonstrates the reduction from 2.60 (2015/16) to 2.24 (2016/17) which equates to a 13.8% reduction. This is the lowest reported rate of harmful in-hospital falls since the introduction of the annual Trust Quality Account in 2009/10.



The chart above demonstrates the rate of **total** falls has also reduced this year from 10.21 per

1,000 bed days (2015/16) to 9.18, a reduction of 10.1%

Next steps:

Reducing the rate of inpatient harmful falls will remain a Trust quality priority for 2017/18. We will continue to review and monitor delivery against the inpatient falls reduction strategy at our strategic falls meetings.

Patient Experience:

Priority 6: Qualitative analysis of complaints (including responses and actions) to improve the patient's (and family's or carer's) experience of the process. Production of an improvement plan and re-invigoration of the complaints service and processes in line with best practice

What did we say we would do?

We were seeking to take a proactive approach to prepare for working with Independent Patient Safety Investigation Service (IPSIS) and aspire to be a recognised champion for adopting the broad principles of a good investigation. We would demonstrate that learning from complaints is systematically embedded into this process.

The North East Quality Observatory Service (NEQOS) was asked to provide a bespoke evaluation of the current process for complaints and to make recommendations about what actions the Trust needed to consider for improving the quality of the complaints process. It was envisaged that this work would help to not only improve the process of complaints handling but also gather insight into the quality of the Trust's responses and how we can better learn from our complaints. This piece of work would inform future service developments including investigator training and improved experience for our complainants navigating our service.

Did we achieve this?

Yes we did.

How we achieved it:

Evaluation research by the NEQOS commenced in May 2016 working within the complaints department. A sample of formal complaints (n=27) were thematically analysed from the 2015 calendar year. These were taken from the Datix system and included a review of the most commonly occurring complaints during this period which were communication, clinical assessment and staff issues.

The researcher who carried out the work on behalf of NEQOS was based within the Gateshead Health NHS Foundation Trust complaints office. They were able to observe the complaints staff dealing directly with complainants on the telephone and discussing complaints among the team. They also observed dealings with complaint investigators, both in person and by telephone. They were also able to meet investigators, patient safety facilitators and the patient safety manager within the Trust. Discussions also took place with the legal services manager.

The researcher had full access to all the complaint files, both paper and electronic. This included

complaint letters, Trust responses, meeting notes and action plans. A qualitative data analysis was undertaken to identify common themes and possible lessons from these complaints. The findings of the report were used to support and enable the development of an improvement plan to include the recommendations.

Evidence of achievement:

The Trust received the final report from NEQOS and accepted the findings and improvement plan in November 2016. The report was complimentary of the complaints process in Gateshead Health NHS Foundation Trust. A summary narrative stated that "*the majority of formal complaints are handled in an exemplary fashion*". This gives us assurance regarding our complaints service but also highlights areas in which we can improve.

Next steps:

A continuous review of our complaints processes will be carried out in the coming year and remains a quality priority for 2017/18. The next stage of this quality priority includes implementation of the improvement plan which includes the recommendations made by NEQOS. These include improving communication across the Trust regarding lessons learned from complaints. Embedding investigator training and undertaking independent assessment where appropriate.

2.2 Our Quality Priorities for Improvement in 2017/18

Our SafeCare Strategy 2014/17 aimed to deliver a programme of work that would reduce harm and avoidable mortality, improve our patients' experience and make the care that we give to our patients reliable and evidence based. We have set five key priorities for quality improvement for 2017/18 and these are linked to patient safety, effectiveness of care and patient experience.

We have established our priorities for improvement in 2017/18 through the following:

- ✓ Consultation with our staff through a variety of established forums and meetings
- ✓ Governor engagement
- ✓ Discussions with our Carers Group and Patient, Public & Carer Involvement & Experience Group
- ✓ Discussions with commissioners
- ✓ Clinical service SafeCare plans
- ✓ Internal and external data sources and reports including: Care Quality Commission standards, recommendations from national reviews into the quality and safety of patient care within the NHS, local and external clinical audits and analysis of complaints and incident reports
- ✓ Progress against existing quality improvement priorities
- ✓ Alignment with our SafeCare Strategy 2014/17 and Corporate Objectives

Following Trust Board consideration of our analysis, our five corporate priority areas for quality improvement are:

Priority 1: **Continue to implement the improvement plan in relation to Patient Reported Outcome Measures (PROMS) scores for hip and knee replacements**

Priority 2: **Standardise and increase the number of mortality reviews undertaken in line with national guidance**

Priority 3: **Improve Patient Safety Culture**
Priority 4: **Implement National Safety Standards for Invasive Procedures (NatSSIPS) and Local Safety Standards for Invasive (LocSSIPS)**
Priority 5: **Review of complaints investigations and actions**

Clinical Effectiveness:

Priority 1: Continue to implement the improvement plan in relation to Patient Reported Outcome Measures (PROMS) scores for hip and knee replacements

The PROMs programme is a national initiative that measures a patient's health status and quality of life prior to and following an elective hip or knee replacement. Data has been collected by all providers of NHS-funded care since April 2009. Gateshead has been identified as a negative outlier (i.e. performing below the national average) in health gains for both joint operations for more than three years now. A Task and Finish Group was created to address the problem, which included the appointment of a seconded physiotherapist in a part-time seconded role to lead on service improvements.

What will we do?

- Improve post-operative health gain in patients undergoing elective hip and knee replacements
- Cease to be an outlier with the PROMs reporting
- Promote health and wellbeing in all patients

How will we do it?

- Work with the clinical teams and Service Line Managers to map and redesign the patient pathway.
- We will undertake a gap analysis to compare our pathway against high performing Trusts.
- Reduce variation in surgical practice through developing better triage at the 'front end' of the pathway. Improve patient engagement and involvement before, during and after joint surgery.
- Support better rehabilitation services, including health and well-being.
- Use PROMs data to analyse on a more frequent basis by North East Quality Observatory (NEQOS) and the evidence base to support initiatives.
- Develop the Trust's (orthopaedic) website.

How will it be measured?

- Ongoing PROMs data
- Patient experience / involvement in project design
- Oxford hip and knee scores
- Complaints / incidents
- Reduction in failure to attend rehabilitation
- Reduction in length of stay in hospital
- Friends and Family Test feedback

How will we monitor and report it?

- Against project objectives and timeline
- Agreed data collection
- PROMs
- Quarterly at Quality Governance Committee
- Quarterly at Trust Board
- Annually with Commissioners via Quality Review Group

Priority 2: Standardise and increase the number of mortality reviews undertaken in line with national guidance

We have identified variation in practice with mortality reviews in the Trust, for example, the frequency, number of reviews undertaken and outcomes are recorded in different databases as well as a variety of mechanisms for sharing good practice and lessons learned.

There were 1,081 deaths during 2016/17 and 416 (38%) of these were reviewed.

In December 2016 the CQC published "Learning, candour and accountability: A review of the way NHS Trusts review and investigate deaths of patients in England". This publication contained seven recommendations to improve mortality reviews. Following this "National Guidance on Learning from Deaths" was published by the National Quality Board in March 2017, this document sets out clear guidance on how mortality reviews should be undertaken.

A Rapid Process Improvement Workshop (RPIW) was held in March 2017 with the objective of improving and standardising our processes for mortality reviews.

What will we do?

We will roll out our agreed standard approach for undertaking mortality reviews across the organisation. The scope for mortality reviews will be widened to include all inpatient deaths and all deaths that occur within the Emergency Department.

The learning from the reviews will be shared across the Trust via the Mortality & Morbidity Steering Group, Business Unit SafeCare Meetings and Service Line SafeCare Meetings.

In line with National Quality Board requirements, we will publish data on a quarterly basis through a Trust Board paper, the data will include the total number of inpatient deaths (including Emergency Department deaths) and those deaths that we have subjected to a case record review. Of the deaths reviewed, we will provide estimates of how many deaths were judged more likely than not to have been due to problems in care and therefore preventable.

How will we do it?

- Agree and implement standard tool for mortality reviews.
- Agree use of a single database for data from mortality reviews to be captured.
- Promote use of standardised tool and database to all clinicians, wards and specialities via a programme of training.
- Develop and implement Trust policy to formalise and outline the agreed processes for mortality review. The policy will be implemented with the support of a communications strategy that will include articles in the QE weekly staff newsletter, screensaver and a promotional stand within the staff canteen.

- Develop a standard operating procedure to ensure that all staff are undertaking mortality reviews in the same way.
- Develop a dashboard from the Mortality Review Database in order to monitor the number of mortality reviews undertaken each month.
- Implement all actions identified within the RPIW which were captured on the RPIW Newsletter which is a form of action plan.
- Colour coded visible containers to hold notes awaiting review which is identifiable across the Trust.

How will it be measured?

- We will use reports from the Mortality Review database to measure how many deaths have been reviewed each month against how many deaths have occurred each month.
- Publication of quarterly Trust Board paper.

How will we monitor and report it?

- Progress against the RPIW Newspaper will be monitored at 30, 60 and 90 days post the RPIW, which will be the end of April, May and June 2017.
- Number of deaths reviewed and any learning identified will be shared monthly at the Mortality & Morbidity Steering Group.
- Number of deaths reviewed and any learning identified will be shared monthly at Business Unit and Service Line SafeCare Meetings.
- Quarterly paper to the Quality Governance Committee.
- Quarterly paper to the Trust Board.
- Annually report to the Commissioners via Quality Review Group.

Patient Safety:

Priority 3: Improve Patient Safety Culture

Patient safety culture is where staff within an organisation have a constant and active awareness of the potential for things to go wrong. Both the staff and the organisation are able to acknowledge mistakes, learn from them, and take action to put things right.

The Patient Safety Team will make it their priority to ensure processes in place for reporting incidents and carrying out investigations are robust whilst also ensuring staff have the training and insight into what is required of them to improve the patient safety culture within the Trust. Identifying and sharing learning from incidents during the investigation process will be a key priority.

The introduction of a Human Factors Faculty, with champions of patient safety culture will be able to lead, coach and support staff to be more aware of potential risks on a daily basis. This will help prevent the occurrence of incidents and thereby reduce the potential occurrence of harm to patients.

What will we do?

- Promote teamwork between the Patient Safety team and Business Units to facilitate joined up working across the Trust to enhance learning from incidents
- Improve the incident reporting culture throughout the Trust, improving staff confidence and

competence to report
- Implement investigator training to further improve the quality and consistency of RCAs

How will we do it?

- Patient safety team will attend the Business Units' SafeCare sessions and assist with moderate and severe harm investigations.
- A monthly lessons learned bulletin will be published and we will develop a quarterly Organisational Learning Meeting.
- Continue to promote the use of Datix and use Induction and Mandatory Training sessions to share with staff examples of what should be reported as an incident.
- An external trainer will be commissioned by the Trust to deliver a session on the Theory of Investigations, a second session will be delivered to staff to cover compliance of the Trust Risk policy RM04.

How will it be measured?

- Good working relationships
- Reduction in harmful incidents and increase in no harm/low harm incidents
- Attendance at training sessions
- Incident reporting rate per 1000 bed days should increase and this will be reflected through NRLS reports

How will we monitor and report it?

- Risk and Safety Group/Council
- SafeCare Council
- CLIP report
- Quarterly paper to the Quality Governance Committee
- Quarterly paper to the Trust Board
- Annually report to the Commissioners via Quality Review Group

Priority 4: Implement National Safety Standards for Invasive Procedures (NatSSIPS) and Local Safety Standards for Invasive Procedures (LocSSIPS)

A Patient Safety Alert was received by the Trust informing organisations that they should develop LocSSIPs that include the key steps outlined in the NatSSIPs to harmonise practice across the organisation to ensure a consistent approach to the care of patients undergoing invasive procedures in any location. The Trust already has local policies and standard operating procedures that encompass many of the steps outlined in these NatSSIPs. The aim is not to replace local policies and procedures, but to benchmark them against the NatSSIP's and develop them into LocSSIPs. The development of LocSSIPs in itself cannot guarantee the safety of patients. Procedural teams must undergo regular, multidisciplinary education and training that promotes teamwork and includes clinical human factors considerations. Continuous quality improvement in the delivery of safe care for patients undergoing invasive procedures will depend upon the audit of outcomes and compliance with LocSSIPs and NatSSIPs, and upon the ongoing development and refinement of safety standards in response to audit.

A Trust wide LocSSIP's Implementation Group has been established to act as a focal point for the creation, governance, oversight, compliance, audit and review of LocSSIPs that are compatible with NatSSIP's and will meet bi-monthly. A LocSSIP has been developed for the WHO Surgical

Safety Checklist in order to standardise practice and an audit process is now in place. A list of all procedures that NatSIPP's are applicable to is currently being finalised along with related policies and standard operating procedures, to enable LocSSIP's to be drafted, ratified and circulated.

What will we do?

- Produce LocSSIPs for all invasive procedures carried out in the Trust, in line with guidelines used for NatSSIPs.

How will we do it?

- Hold monthly implementation groups with Clinical Leads within each specialty until all LocSSIPs are produced.
- Collaborative working with neighbouring Trusts when possible.

How will it be measured?

- LocSSIPs will be audited in real time, on paper and added to the patient's notes for future audits.

How will we monitor and report it?

- Risk and Safety Group/Council
- SafeCare Council
- CLIP report
- Quarterly paper to the Quality Governance Committee
- Quarterly paper to the Trust Board
- Annual report to the Commissioners via Quality Review Group

Patient Experience

Priority 5: Review of complaints investigations and actions

What will we do?

Following the North East Quality Observatory Service (NEQOS) report, we will reflect on its findings and implement the recommendations to enhance our complaints process.

How will we do it?

- Invest in training for complaint investigators to provide high quality investigations and reduce variations. This will continue to include duty of candour training and awareness for all staff.
- Improve communication with staff to raise awareness of the complaints process by visiting ward and department areas.
- Continue to include narrative information within the quarterly Complaints, Litigation, Incidents and PALS (CLIP) report.
- Update the complaint feedback questionnaire to gain better quality feedback. Complaints to be reported, investigated and actioned within the Datix system. Enabling all information to be viewable and accessible by the complaints team and investigating areas.
- Networking with other regional Trusts to share learning and good practice.

How will it be measured?

- Collate and monitor numbers of staff that have received training
- Maintain a log of wards and departments that the complaints team have engaged with over

the year
- Review CLIP report on a quarterly basis to ensure the relevant complaint information is included
- Monitor the number of feedback questionnaires sent and analyse findings
- Full implementation and training for staff of the use of DATIX to be completed within the first quarter

How will we monitor and report it?

- Quarterly paper to the Quality Governance Committee
- Quarterly paper to the Trust Board
- Annual report to the Commissioners via Quality Review Group

2.3 Implementing the Duty of Candour

The Duty of Candour is a legal duty on hospital, community and mental health Trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Duty of Candour aims to help patients receive accurate information from health providers in a timely manner.

The Trust continues to actively promote an open and honest culture. Building upon the positive feedback relating to Duty of Candour received as part of the CQC inspection in September 2015, a scoping exercise is currently being carried out to continue to improve, where possible, the procedures in place within the business units and staff training requirements.

Following completion of the scoping exercise, a plan to sustain and continue a quality improvement plan for Duty of Candour will be developed. This will contribute to the Trust's commitment to improving patient experience and putting the patient at the centre of everything we do.

Duty of Candour training continues to be provided at induction for new starters and has recently been reviewed to include a video highlighting the key principles of Duty of Candour

The Duty of Candour and Being Open Policy (RM49) is monitored for compliance and is continuously updated to reflect any changes in law and guidance. The policy is to be formally reviewed in August 2017.

Learning from Duty of Candour is included in the Trust's CLIP report and is discussed at the Risk and Safety Group. Duty of Candour is a standard agenda item at the Risk and Safety Council, with a report being provided to the Quality Governance Committee on a quarterly basis. Such incidents are also discussed at SafeCare meetings held in each Business Unit.

Individual incidents continue to be monitored on an incident by incident basis to ensure that all standards are met appropriately.

2.4 Sign up to Safety – Patient Safety Improvement Plan 2016/17

The table below provides details of the Trust's Sign up to Safety – Patient Safety Improvement Plan

Area/Workstream 1: Improve patient safety by reducing three key common medication errors

Goal:

To reduce the incidence of the three types of recurring medication errors listed below:

1. Patient allergy status
2. Positive Patient Identification
3. Missed doses of critical medicines

We will:

- An Electronic Prescribing and Medicines Administration (EPMA) will continue to be deployed across all acute wards in the hospital. This system will be configured to help facilitate a reduction in these three recurring types of medication errors by driving exemplar clinical practice in these areas. Automatic reports will also be developed in the EPMA system to support healthcare professionals target prevention of these errors.

Measures:

- All medication-related clinical incidents reported in the Trust are collated, analysed and reported on a quarterly basis. These reports will be sub-group analysed to identify those related to the three recurring themes as stated above. The incidence of these errors over 2016/17 will then be compared with their incidence over the previous two years as a baseline comparator.

Area/Workstream 2: Reducing harm from inpatient falls

Goal:

We will maintain or reduce our harmful in hospital falls during 2016/17.

The Falls Action Group will drive the improvement work required to reduce harmful in hospital falls in the following four areas:

- Leadership and Governance
  - Undertake full review of the Falls Team to understand role and capacity
  - Review and refresh Falls Strategy
  - Review RCA data and findings to identify themes and organisational learning
  - Review current falls policies and protocols to ensure that they are linked to Dementia, Delirium and Osteoporosis
  - Set programme of clinical audits
  - Develop dedicated Falls Serious Incident Panel to discuss RCA findings
- Staff Awareness, Education and Training
  - Review education and training to ensure staff are able to maintain basic professional competence in falls assessment and prevention
  - Work with education leads to ensure nursing staff have access to and receive education and appropriate records are maintained
  - Work with clinical leads as falls champions to ensure staff are appropriately informed of developments in falls prevention work
  - Network with other Trusts to identify and share good practice
  - Develop website for falls prevention
  - Align Dementia, Delirium and falls work
  - Evaluate impact of multifactorial assessment tool

- Ensure National Audit of Inpatient Falls findings 2015 that relate to clinical practice are addressed

- Review of reporting, analysis and learning systems
  - Review Datix reporting system to ensure timely, meaningful data
  - Develop suite of reports to ensure falls reports provide timely and useful information from ward to board level
  - Review format of RCA tool to ensure timely, quality information is captured to enable us to learn from falls
- Availability and use of appropriate equipment from admission
  - Undertake a full review of equipment used for mobility across inpatient service and current storage provision
  - Undertake a review of training needs associated with the provision of basic mobility aids
  - Develop a community strategy in relation to mobility aids.

Measures:

- Continue to use data collected on Datix to monitor the incidence of falls on a monthly basis.
- Ensure learning is shared and practice developed or changed where appropriate.
- Use the findings from our programme of audit to celebrate good practice and make improvements where necessary.

Area/Workstream 3: Implementation of the sepsis six care bundle

Goal:

We will build on the work undertaken to recognise and treat sepsis in a timely manner. We will actively participate in the 2016/17 National CQUIN indicator and use this as a focus for our work. We will use sepsis improvement as a key project for reducing avoidable hospital deaths. We will embed our learning and development processes.

We will:

- Develop an integrated sepsis improvement plan
- Network regionally via the Regional Network for Sepsis
- Develop simulated learning opportunities for staff in relation to sepsis
- Continue to implement a reliable and robust process for early identification of sepsis patients and treatment pathways; in both emergency and inpatient areas
- Continue to improve upon our target of administering appropriate antibiotics within one hour (as per the CQUIN 2016/17)
- Develop improved communication and patient flow processes
- Improve our processes for data capture and reporting

Measures:

- Improvement will be measured via the CQUIN quarterly targets as well as a range of other indicators. These are currently being negotiated with the Clinical Commissioning Group. The targets will set an improvement goal to be achieved quarterly with the overarching goal of compliance not to fall below 50%. Specific audits as detailed by the CQUIN for 2016/17 will also be undertaken on a monthly basis and utilised to inform progress and measure compliance.

Area/Workstream 4: Reduce harm by implementing the 'Saving Babies Lives' campaign

Goal:

Continue to use the NHS England 'Saving Babies Lives' Care Bundle and ensure that this is

embedded into practice. We have set ourselves an ambitious target of no **avoidable** stillbirths, neonatal deaths or birth related injuries during 2016/2017.

Proposed actions:

- Continue to carry out a carbon monoxide (CO) test at booking to identify smokers and refer to stop smoking services.
- Continue to provide annual staff training for Customised Growth Charts identification and surveillance of vulnerable babies.
- Continue to provide patient information leaflets regarding foetal movements. This is a very important intervention to ensure that we 'Ask, Assess, Act, Advise'.
- Ensure sufficient capacity for ultrasound scanning and staffing for increased surveillance. Service Line Manager/Head of Midwifery have identified these requirements in a business case.
- Continue to provide Cardiotocography (CTG) Assessment and training programme for all clinical staff.
- Continue to undertake peer review of all stillbirths and neonatal deaths.

Measures:

- Audit compliance with each component of the bundle monthly to assess outcome indicators.
- Work with the Perinatal Institute to benchmark and measure performance and provide quarterly audit of detection rates.
- Audit compliance with Royal College of Obstetricians and Gynaecologists and local Small for Gestational Age (SGA) guidelines.
- Report missed cases of SGA to Maternity SafeCare Sessions.
- Audit all stillbirth and neonatal deaths as part of maternity risk and governance and report on the maternity dashboard.
- Review the numbers of stillbirths, neonatal deaths and birth related injuries monthly
- Provide national audit data via Mothers and Babies Reducing Risk through audits Confidential Enquiries (MMBRACE) and Royal College of Obstetricians and Gynaecologists (RCOG) data base
- Benchmark with other Trusts via strategic clinical network

Area/Workstream 5: Implementation of a programme to empower patients in relation to their own safety whilst in our care (ThinkSAFE)

Goal:

Continue to embed the initiative for patients undergoing elective orthopaedic procedures and expand its use to two further areas:

- Patients who have Inflammatory Bowel Disease (IBD) and are stepping up their treatment to a group of drugs known as biological therapies.
- Patients who undergo planned gynaecological surgery.

Continue to seek other clinical areas to adopt the project.

We will:

- Identify project team to lead on the initiative for each area.
- Develop key metrics to measure the success of the project in each area.
- Set up and deliver training sessions for staff groups involved in project in each area.
- Monitor and evaluate implementation from staff and patients.
- Plan the next group of patients for implementation of the initiative.

Measures:

- We will monitor patient safety and experience data within the participating areas, such as information from our incident reporting system (Datix) and contact with the Patient Advice

and Liaison Service. The key milestones identified in the project plans will be used to measure progress.

2.5 NHS Staff Survey results – indicators KF21 and KF26

In relation to key finding 26 'percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months', we remain in the top 20% of Acute Trusts. For both white staff and staff from a BME background, the levels in 2016 (21% white and 27% BME) have reduced from 2015.

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	2014	2015	2016
Gateshead Health NHS Foundation Trust	23.0%	22.4%	21.4%
England highest - Acute Trusts	41.3%	42.0%	35.9%
England Lowest - Acute Trusts	17.40%	16.5%	16.5%
Acute Trusts	24.1%	25.8%	25.2%

Source:www.nhsstaffsurveys.com

Similarly in relation to key finding 21 'percentage believing that the Trust provides equal opportunities for career progression or promotion' we remain in the top 20% of Acute Trusts. However whilst for white staff this remains static (91%), staff from a Black and Minority Ethnic (BME background remains lower and has slightly decreased (74% down from 77% in 2015). We must take stock of this feedback and consider appropriate action.

Percentage believing that the Trust provides equal opportunities for career progression or promotion	2014	2015	2016
Gateshead Health NHS Foundation Trust	91.4%	90.4%	90.6%
England highest - Acute Trusts	96.2%	95.6%	94.8%
England Lowest - Acute Trusts	70.4%	75.8%	69.1%
Acute Trusts	86.7%	86.8%	86.0%

Source:www.nhsstaffsurveys.com

2.6 Care Quality Commission (CQC) Ratings Grid

The CQC inspected the Trust from 29th September to 2nd October 2015 and an unannounced inspection was undertaken on 23rd October 2015. The following core services were inspected:

- Emergency and Urgent Care
- Medical Care
- Critical Care
- Maternity and Gynaecology
- Services for Children and Young People
- End of Life Care
- Outpatients and Diagnostic Imaging

The final report was published on 24th February 2016. Our overall ratings are displayed in the table below.

Overall rating for this Trust	Good	
Are services at this Trust safe?	Good	
Are services at this Trust effectiveness?	Good	
Are services at this Trust caring?	Outstanding	
Are services at this Trust responsive?	Good	
Are services at this Trust well-led?	Good	

The Trust's Maternity and Gynaecology Services were rated as 'Outstanding'.

An action plan was developed and implemented to address any areas that required improvement.

2.7 Statements of Assurance from the Board

During 2016/17 the Gateshead Health NHS Foundation Trust provided and/or sub-contracted 32 relevant health services. The Gateshead Health NHS Foundation Trust has reviewed all the data available to them on the quality of care in 32 of these relevant health services. The income generated by the relevant health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant health services by Gateshead Health NHS Foundation Trust for 2016/17.

Participation in clinical audit

During 2016/17, 36 national clinical audits and 15 national confidential enquiries covered relevant health services that Gateshead Health NHS Foundation Trust provides.

During that period Gateshead Health NHS Foundation Trust participated in 94% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Gateshead Health NHS Foundation Trust was eligible to participate in during 2016/17 are listed below.

The national clinical audits and national confidential enquiries that Gateshead Health NHS Foundation Trust participated in during 2016/17 are listed below.

The national clinical audits and national confidential enquiries that Gateshead Health NHS Foundation Trust participated in, and for which data collection was completed during 2016/17, 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.

Participation in national clinical audits 2016/17

Audit title	Participation	% of cases submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	243 – no minimum requirement
Adult Asthma	No	Due to clinical commitments and retirement of the lead for this audit, we were unable to complete this.
Bowel Cancer (NBOCAP)	Yes	191 – no minimum requirement
Cardiac Rhythm Management	Yes	114 – no minimum requirement
Case Mix Programme	Yes	1045 – no minimum requirement
Diabetes (paediatric) (NPDA)	Yes	151 – no minimum requirement
Elective Surgery (National PROMS programme)	Yes	61%
Falls and Fragility Fractures Audit Programme (FFFAP):		
Inpatient Falls	-	Data collection did not take place in 2016/17
National Hip Fracture Database	Yes	284 – no minimum requirement
Inflammatory Bowel Disease (IBD) Programme	Yes	This audit is in a transition period, numbers will be published in Autumn 2017.
Major Trauma Audit	Yes	48%
Moderate & Acute Severe Asthma – adult and paediatric (care in emergency departments)	Yes	100%
National Audit of Dementia	Yes	98%
National Cardiac Arrest Audit (NCAA)	Yes	64 – up to quarter 3, quarter 4 not yet validated
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme:		
Pulmonary Rehabilitation	Yes	Data submission deadline 21.07.17
Secondary Care	Yes	
National Comparative Audit of Blood Transfusion:		
Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	-	Audit planned for July 2017
National Comparative Audit of Transfusion Associated Circulatory	-	Audit planned for April 2017

Overload		
Audit of patient blood management in scheduled surgery	Yes	18 – no minimum required
Audit of the use of blood in Lower GI bleeding	Yes	15 – no minimum required
National Diabetes Audit Adult:		
National Diabetes Foot Care Audit	Yes	68 – no minimum requirement
National Diabetes Inpatient Audit	Yes	100%
National Pregnancy in Diabetes Audit	Yes	12 – no minimum required
National Diabetes Transition	Yes	Data not available until Autumn 2017
National Core Diabetes Audit	No	The Trust do not have the appropriate IT system to support the participation in this audit
National Emergency Laparotomy Audit (NELA)	Yes	156 – no minimum requirement
National Heart Failure Audit	Yes	331 – no minimum requirement
National Joint Registry	Yes	1,158 – no minimum requirement
National Lung Cancer Audit (NLCA)	Yes	225 – no minimum requirement
National Neonatal Audit Programme – Neonatal Intensive and Special Care	Yes	246 – no minimum requirement
National Prostate Cancer Audit	Yes	155 – no minimum requirement
National Vascular Registry	Yes	143 – no minimum
Oesophago-gastric cancer (NAOGC)	Yes	44 – no minimum requirement
Paediatric Pneumonia	Yes	22 – no minimum requirement
Sentinel Stroke National Audit Programme (SSNAP)	Yes	104 – up to quarter 3 (deadline is 02.05.17)
Severe Sepsis and Septic Shock – care in emergency departments	Yes	100%

Participation in National Confidential Enquiries 2016/17

Enquiry	Participation	% of cases submitted
National Confidential Enquiry into Patient Outcome and Death:		
• Cancer in Children, Teens and Young Adults	Yes	Study remains open figures have not been finalised
• Acute Pancreatitis	Yes	60%
• Physical and mental health care of mental health patients in acute hospitals	Yes	20%
• Non Invasive Ventilation	Yes	100%
• Chronic Neurodisability	Yes	Study remains open figures have not been finalised
• Young People's Mental Health	Yes	Study remains open figures

		have not been finalised
Learning Disability Mortality Programme (LeDeR Programme)	Yes	100%
Maternal, Newborn Infant Clinical Outcome Review Programme:		
• Confidential Enquiry into stillbirths, neonatal deaths and serious neonatal morbidity	Yes	100%
• Perinatal Mortality Surveillance	Yes	100%
• Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Yes	100%
• Confidential enquiry into serious maternal morbidity	Yes	No cases in the reporting period
• Maternal mortality surveillance	Yes	No cases in the reporting period
• Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)	Yes	No cases in the reporting period
Mental Health Clinical Outcome Review Programme:		
• Suicide and Homicide	Yes	No eligible patients met the criteria during the reporting period.
• Sudden explained death	Yes	No eligible patients met the criteria during the reporting period.

The Trust utilises clinical audit as a process to embed clinical quality at all levels in the organisation and create a culture that is committed to learning and continuous organisational development. Learning from clinical audit activity is shared throughout the organisation from 'Ward to Board'.

The reports of 17 national clinical audits were reviewed by the provider in 2016/17 and Gateshead Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme

Although the report does not give specific points for the Trust individually, we have taken the following action:

- Increased the clinical observations to now include the recording of the patient's oxygen saturation at the same times as the temperature, pulse, respiratory rate and blood pressure.
- We already have a bedside check list on the transfusion record that we use but would consider changing to the SHOT version when the document is next reviewed. The Transfusion Associated Circulatory Overload (TACO) checklist is discussed at induction and mandatory training sessions but has not been widely introduced across the Trust as yet.

Patient Reported Outcomes Measures (PROMS) Elective Hip & Knee Replacements

The Trust scored slightly higher than the national average for participation (patients completing the questionnaire) for primary hip replacement and primary knee replacement. We are however below the national average by two to three standard deviations for health gain outcomes for both hip and knee replacement.

We are taking the following action to improve our outcomes:

- We recognised the need to involve the SafeCare Team in coordinating a task and finish group with the aim of identifying reasons for Gateshead remaining as an outlier for health gain in patients who have had elective total hip and knee replacement.
- We advertised and recruited for a secondment post as PROMS Improvement Project Lead.
- We have reviewed the hip and knee patient pathway to identify areas for improvement.
- We are exploring ways of simplifying data to enable more accurate and detailed analysis enabling us to identify trends more quickly.
- We have made improvements to our patient pre-operative education at the joint care clinic where we are linking health promotion in sustaining recovery from elective hip and knee replacement and accessing more engagement from the multidisciplinary team.
- We have reviewed and are improving our patient information booklets, again linking health promotion and involving patients who have already had hip and knee replacement. We are developing video clips with patients to use at patient education sessions and for patients to access on the QE website.
- Identifying easier access to follow up therapy and advice for patients to access at care points closer to their homes in the community.
- Strengthening our links with non NHS support groups e.g. Arthritis care.
- Improving post-operative pain by involving the pain nurse practitioner and pharmacist on the ward.

National Emergency Laparotomy Audit (NELA)

This national audit measures the quality of care for patients undergoing emergency laparotomy. It provides comparative data from all providers of emergency laparotomy. The audit publishes an annual report. The 2016 report highlighted excellent performance in many areas of emergency laparotomy care within the Trust, although some areas require improvement.

Areas of good practice included:

- Pre-operative risk assessment, performance above the 80% recommended standard and in the top 15% of Trusts nationally.
- Consultant intra-operative involvement: 83% of cases had consultant surgeon and consultant anaesthetist present for their operation (in top 30% of Trusts)
- Post-op critical care admission: we are the top-performing Trust nationally for post-operative critical care admission with 100% of patients with pre-op mortality risk of >5% being admitted to critical care.

There were some areas where performance was below national average and these included consultant surgeon review within 12 hours of admission, consultant surgeon and anaesthetist pre-op review in high risk cases, use of computerised tomography (CT) scanning pre-op, and review of appropriate patients by Care of the Elderly (all below the national average).

The following actions are recommended for moving forwards:

- Continued promotion of emergency laparotomy care with Anaesthetics/Critical Care and Surgical teams, with ongoing monitoring of NELA data collection.
- Change NELA data collection forms to include updated dataset.

- Promote data collection throughout the anaesthetics and critical care team.
- Continue to use NELA data to inform other quality improvement such as post-op pneumonia prevention study.
- Use SafeCare sessions to provide regular updates and opportunities for discussions of areas of concern or improvement.
- Highlight areas of performance below national average, particularly the use of pre-operative CT scanning.

Case Mix Programme

The Case Mix Programme (CMP) is an audit of patient outcomes from adult and general critical care units (intensive care and combined intensive care/high dependency units) covering England, Wales and Northern Ireland. Data is collected on all patients admitted to the Critical Care Unit and is submitted to the CMP who process the data. Data is compared with the outcomes from other similar patients, other similar units and all the units in the CMP. We receive a Data Analysis Report which identifies trends over time showing how we compare with others.

The most recent Annual Quality Report (2015/16) demonstrates that the Critical Care Unit is performing at or above the national average in most areas. The unit performed particularly well with the number of unit-acquired bloodstream infections. Mortality rates were as predicted and the number of non-clinical transfers to other critical care units was low.

The number of out of hour's discharges from Critical Care was higher than the national average, indicating issues with bed pressures.

The most recent Quality Report from CMP (Apr-Sep 2016) has shown low rates of high-risk, including high-risk sepsis admissions from wards (>2 standard deviations below national average) which suggests patients are being admitted to Critical Care in a timely manner, prior to development of multi-organ failure. It also showed that our standardised mortality rates are below expected. Delays in discharge from Critical Care were however above the national average (both >8 hour and >24 hour delays.

Action plan:

- Continue to collect and submit data to Intensive Care National Audit and Research Centre (ICNARC)/CMP.
- Address issues of delayed discharges and out-of-hours discharges. There is work underway looking at utilising Medway or Ward Watcher (Trust IT systems) to highlight patients ready for discharge from Critical Care Department. There has been an increased emphasis on Critical Care Department discharges at daily bed meetings.
- Continue to utilise protocols and good quality care to maintain very low rates of blood-stream infections, particularly around central venous catheter insertion.
- Review quarterly reports regularly to identify new areas where action is required.

National Comparative Audit – 2016 Audit of Red Cell and Platelet Transfusion in Adult Haematology Patients

Patients with haematological malignancies receive a significant proportion of all blood components transfused annually: 15–20% of the total red cells and 50% of platelet transfusions. An increasing body of evidence from randomised controlled trials in surgical and medical patients indicates no benefit for transfusing at higher haemoglobin or platelet count thresholds, and some evidence of harm.

A restrictive strategy reduces unnecessary transfusion of red cells, reduces adverse events from transfusion, improves outcomes and also reduces cost. The main groups of haematology patients receiving transfusions are those on chemotherapy and with bone marrow failure syndromes.

Increasing life expectancy is shifting the profile of haematology patients receiving transfusion support towards myelodysplastic syndromes (MDS). Data from earlier national audits has demonstrated the need for improvement. The 2010 National Comparative Audit of platelet transfusion in haematology reported that 27% of patients were inappropriately transfused. Our clinical staff measured haemoglobin prior to transfusion of red cells within the specified time frame in 100.0% (23/23) of haematology patients compared with 93.8% (4055/4322) nationally.

One patient was transfused above the recommended pre-transfusion haemoglobin of 80g/l for Haematological patients with additional risk factors.
No patients were given more than a single unit of platelets.
Clinical staff should identify patients with chronic irreversible bone marrow failure, to avoid routine prophylactic administration of platelets.
The majority of Trusts had written guidelines for transfusion easily accessible to the staff. Good practice was evident across a number of the standards.
Areas for improvement. There should be a clear documented transfusion plan with thresholds, targets and frequency of transfusions for those patients that justify deviation from national standards.

- Changes to the transfusion trigger, from 80g/l to 70g/l for patients with no additional risk factors are being discussed.
- Clinical staff are being asked to ensure that the patient's haemoglobin (the protein molecule in red blood cells that carries oxygen from the lungs to the body's tissues and returns carbon dioxide from the tissues back to the lungs) is measured 24 hours prior to transfusion for inpatients and 72 hours prior to transfusion for outpatients.
- Included in induction and mandatory training sessions.
- This audit is planned to be re-audited in July 2017.

Society for Acute Medicine's Benchmarking Audit (SAMBA)

SAMBA is an annual national audit of the quality of care delivered by Acute Medicine and Acute Medicine Units (AMUs) in the UK. Initially designed to focus on Society of Acute Medicine's 2011 four Clinical Quality standards which underpin the delivery of acute medical care, it has evolved to analyse other fundamental aspects of performance. For the Trust patients 80% of patients' Early Warning Score was measured upon arrival on the AMU. 98% of patients had a Consultant review within 14 hours of arrival and a full set of observations were taken on admission in 80%. However there is room for improvement around patients being seen by a clinical decision maker within four hours as this applied to 54% of patients.

The following actions have been identified:

- In order to establish the root cause of decrease in compliance with patients being reviewed within four hours a review of the raw data is to take place.
- The emergency admissions unit notice board has been altered to include patient's arrival time.
- Findings of the review of the data will be fed back to staff via the SafeCare meeting.
- Nurse co-ordinator to ensure observations are done on arrival and captured on Vitalpac (electronic system for recording patient observations) immediately.

Paediatric Diabetes

The children and young persons' (CYP) diabetes service at Gateshead Health NHS Foundation Trust has made significant progress with supporting children and young people and their families to improve the long term diabetes control and to provide and encourage engagement with the

screening processes.
We remain an outlier for adjusted mean HbA1C (is a test usually done through a fingertip blood test, this measures diabetes management over two to three months) but the median is significantly lower which would indicate that young people who have extremely high HbA1C which is more common in the teenage group of whom we have a larger proportion are misrepresenting our data. As a team we continue to strive to engage and support these individuals with a combination of frequent Multidisciplinary Team (including psychology) contacts.
Although uptake of care processes is high, there is room for improving the uptake of retinal screening and urine albumin checks. In addition to ensuring the accuracy of blood pressure results. The lack of data for thyroid and coeliac screening for new patients is a data submission issue and does not reflect what is happening in clinical practice.
The following actions have been identified:

- To continue to increase the use of intensive treatment regimens (Multiple Daily Injections and pump injections) in general in the clinic but in all CYP from diagnosis.
- Continue to support CYP and their families with carbohydrate counting from diagnosis.
- To encourage frequent home review of blood glucose testing (to measure the amount of sugar in the blood) and sensor glucose testing if using Diasend or Medtronic downloading.
- The data submission for 2016-17 has been amended to include new patient thyroid and coeliac screening data from diagnosis.
- Continue ongoing audit of retinal screening data and engagement with primary care and the retinal screening team.
- To commence ambulatory blood pressure (Bp) checks and monitoring to ensure accuracy of values and those that have raised Bps get appropriate management.
- To continue to implement and develop group structured education sessions.
- To review our High HbA1C guideline and bring it in line with regional and national recommendations with a cut-off of 69mmol/mol.

National Vascular Registry

We continue to submit our Abdominal Aortic Aneurysm and Carotid data to the National vascular registry. Our mortality and morbidity figures are at par with national figures. We continue with our joint on call emergency rota with County Durham and Darlington NHS Foundation Trust and do all major aortic surgery in Durham. The results demonstrate that improvements need to be made on the timing for carotid surgery as this is required to be done within two weeks of stroke in 100% of cases.

The following actions have been identified:

- To continue to have discussions at Multidisciplinary Disciplinary Team (MDT) meetings with the surgeons, radiologists and ultrasonographers. We have started adding the angioplasty and bypass cases in the registry as well. We also have joint MDTs with the diabetic team and podiatrists for diabetic foot care.
- Meet with the stroke physicians, radiologists and anaesthetists to allow quicker preoperative pathways as this appears to be the main cause for delays.

Severe Sepsis and Septic Shock (care in emergency departments)

The Trust performed very well in some aspects of the audit; all the patients included in this sample received antibiotics in the Emergency Department (ED). Roughly three quarters of patients, received senior review, achieved oxygen saturations greater than 94%, had blood cultures taken and lactates measured and were given an intravenous fluid bolus. However there were some standards that could be improved upon; recording of vital signs is often incomplete, this should be done in a timely manner to allow initial identification of sepsis. Capillary blood glucose is often

given verbally, and not documented unless the patient has known diabetes or requires intensive monitoring to continue. Similarly the documentation of supplemental oxygen requirement could be improved, which may also be done verbally, as could urine output measurement or fluid balance charts. However a large proportion of patients receive the first intravenous fluid bolus in the ED, these parameters should be interlinked.

The following actions have been identified:

- Share the audit results with relevant staff within the team via a teaching session.
- Staff awareness and training to be undertaken around the importance of the recording of vital signs on the nursing documentation and medical clerking and the documentation of capillary blood glucose.
- Re-audit to be undertaken following the implementation of the new sepsis screening tool as this audit was undertaken prior to the introduction of the new tool.
- Redesign the intravenous fluid prescription charts to include a fluid balance chart on the reverse and a column to record blood pressure pre and post fluid bolus. This will optimise capture of this information which for patients with sepsis should be recorded hourly.
- The Trust's antibiotic formulary was recently changed due to potentially excessive use of Piperacillin/Tazobactam (types of antibiotics). Empirical antibiotics should be tailored to the presumed source of infection as opposed to broad spectrum intravenous antibiotics. This may cause some delay in prescription and administration while waiting for initial investigations to confirm the most likely site. A new phone app has been developed with these guidelines aiming to make them more user-friendly and accessible than those found on the intranet. This means a greater variety of antibiotics will be required, especially for patients with penicillin allergies. Availability and stocking should be confirmed with pharmacy.

Vital signs in children (care in emergency departments)

During this audit there were 50 cases audited. Vital signs recorded: Temperature 49/50, Respiratory Rate 47/50, Heart Rate 50/50, Oxygen saturations 50/50, Glasgow Coma Scale 38/50, Creatinine 34/50. 14/50 cases had abnormal vital signs, In 13/14 cases with abnormal vital signs, it is clear that the clinician recognised the vital signs and they were acted upon. Repeat vital signs recorded in 17/50 cases.

39 patients were discharged home from the Emergency Department. In 36/39 of these cases, the vital signs were normal. In 29/39 of these cases, the child was reviewed by a senior clinician. All cases had vital signs recorded. Temperature, Respiratory Rate, Heart Rate, Oxygen saturations were consistently recorded. Abnormal vital signs are consistently being recognised and are being acted upon. The vast majority of cases that were discharged home had normal vital signs and most had a review from a senior clinician prior to discharge. There is scope to improve documentation of Glasgow Coma Scale and Creatinine.

The following actions were identified and undertaken:

- Recording complete sets of vital signs needed to be improved. Further education was given to nursing staff completing vital signs at triage.
- Recording of Creatinine also required improving and a Creatinine box has now been introduced into the paediatric emergency department to act as a prompt to record Creatinine.

Cardiac Rhythm Management

The total number of implants was 83 new devices, and 29 generator changes (112 in total). The minimum number of new device implants according to the British Heart Rhythm Society (BHRS) consensus statement is 80, placing the Trust in the acceptable 90-110% bracket. Although implant rate per head of population regionally is not presented, the national pacemaker implantation rate

is reported to be 621 per million. If the population of Gateshead is 200,000 our implant rate is 415 per million i.e. around two thirds the national rate. There are a variety of possible explanations for this finding including implantation of devices in other local centres, lack of referrals from general practice and elsewhere, and differing thresholds for pacing amongst operators. Physiological (atrial) pacing is recommended for patients with sinus node disease. Of 16 new implants at the Trust for this indication all 16 received physiological pacing (100%, national average 91.7%). Operator details were not given for either operator (name and general medical council (GMC) number required).

The following actions were identified:

- Present results to department (Journal club, service meeting)
- Discussion to take place between operators and Chief Physiologist to identify strategies with which improve concordance with data submission.
- Liaise with other specialties (general medicine, Care Of the Elderly, A&E) to attract more referrals for consideration of pacing.
- Consult with local tertiary centre regarding numbers of Gateshead patients implanted there.
- Identify clinical lead for pacing and data manager to ensure completeness of audit data for the coming year.

Sentinel Stroke National Audit Programme

The Stroke Sentinel National Audit Programme [SSNAP] considers nine domains for stroke care, from hyperacute assessment and treatment, through to rehabilitation and discharge planning. Services are given an overall rating on a scale from A to E. The Trust has typically scored a category D. Results are published three times a year, each covering the four month period. The most recent results are available for the period to November 2016.

The following actions have been identified:

- In November 2016 we made significant changes to the stroke pathway. A new partnership with Newcastle Hospitals NHS Foundation Trust sees stroke patients receive their hyperacute care (the first 72 hours) at the RVI hospital. Patients are then discharged directly home or repatriated to the Trust for their ongoing acute care and rehabilitation. Patients are already benefiting from more timely access to CT scanning, thrombolysis, direct access to a stroke unit and more timely assessment by the MDT, especially out of hours. These are four of the nine SSNAP domains. The Trust has historically performed better in the other five domains and so the expectation is that the average score will improve.
- Further improvement work is ongoing with regard to reallocated therapy provision to focus more on rehabilitation and closer working with the community stroke team, following their transfer to the Trust in October 2016.

National Hip Fracture Database

We continue to contribute to this national audit. All hip fracture patients are included. Data is collected on a wide range of parameters regarding demographics and clinical care. We have continued to record 'above average' performance in almost all areas, both when compared both regionally and nationally, e.g. time to theatre, length of stay, mortality.

The following actions have been identified:

- We have, for years, been an outlier in terms of recorded hospital acquired pressure damage. A great deal of work has been done on the ward to improve this. Our figures have improved considerably but we remain a marginal outlier in this area.
- Some changes will be introduced this year to the actual data collected for the database. We

now have to record a nutritional assessment for each patient and the 4-AT tool is used and recorded to screen for confusion and delirium. We have adapted to these changes and our data will continue to be thorough and complete.

Oesophago Gastric Cancer

Patients diagnosed between 01/04/2014 and 31/03/2015, All Oesophagus Patients from the Trust included in the Audit. High grade dysplasia (HGD) (refers to precancerous changes in the cells of the oesophagus) patients from the Trust were passed on to the Royal Victoria Infirmary (RVI) in Newcastle who have responsibility for entering this data. Surgery and Chemotherapy details are entered by the RVI. Only Active monitoring, Best supportive care and Stents are entered for the Trust.

The following actions have been identified:

- Review local protocols and referral processes to ensure patients diagnosed with HGD of the oesophagus have their treatment plan discussed at a specialist multidisciplinary team. Section to be included in Operational Policy document local protocol and referral process.
- Ensure the proportion of patients managed by surveillance alone with the NHS Trust / Health Board is monitored regularly. All HGD cases sent to and monitored by Royal Victoria Hospital.
- NHS Trusts / Health Boards should assess the data collection process for patients who receive an endoscopic/radiological palliative intervention and adapt the process to improve levels of data completeness. Collection of endoscopic palliative intervention was reviewed at a meeting 12/04/2016. All data items were discussed and the location where information can be found confirmed. Radiological palliative intervention information is collected by the RVI.

National Chronic Obstructive Pulmonary Disease (COPD)

There is now a national rolling COPD audit programme, with data inputted in as near real time as possible. Briefly these found that in 2016 50% of all COPD patients were under the care of a respiratory physician at the time of discharge and death rate was about 18% at 3 months for winter admissions (nasty flu year). The Trust comparison with 2014 national audit has already been presented to the audit committee.

The following actions have been identified:

- Continue to participate in the rolling programme of COPD national audit
- Continue to highlight the lack of respiratory access
- Repeat a local audit on COPD

Inflammatory Bowel Disease (IBD) Programme/registry

The last results from the IBD Audit round 4 were published in 2015. The Trust was in the national average on most of accounts.

The following actions have been identified:

- UK IBD Registry.
    - This is a portal of IBD patient registry which is nationwide, we have registered for it and we will start incorporating that in our practice
- We are going through the process of recruiting another IBD nurse
- Acute care pathways are being developed for IBD patients.
- Streamlining the IBD multidisciplinary team which happens on the first Friday of each month.

Procedural Sedation in Adults (care in emergency departments)

The results highlight that there are improvements to be made in a number of areas. . Many areas' underperformance is likely to be due to inconsistent documentation of good practice.

The following actions have been identified:

- Production of a standard sedation proforma / documentation sheet to increase accurate documentation of current practice and improve safety
- Production of a standard patient information leaflet / consent sheet
- Incorporation of audit outcomes / recommendations into in-house medical / nursing education programme
- Re-audit against Royal College of Emergency Medicine (RCEM) standards, following introduction of above

The reports of 24 local clinical audits were reviewed by the provider in 2016/17 and Gateshead Health NHS Foundation Trust intends to take actions to improve the quality of healthcare provided. Below are examples from across the Trust that demonstrate some of the actions taken to improve the quality of our services:

Business Unit	Speciality	Actions identified
Medicine	Old Age Psychiatry	**Annual Suicide Prevention** The team are developing training to support staff in having the knowledge and skills to complete the annual suicide prevention audit. Templates and frameworks are in development in order to support individual care plans and crisis plans. Awareness has been raised in team and mental health managers meetings to remind staff to report all critical events via the Datix system.
	Accident & Emergency	**NICE guidance for fast-track CT head following a head injury** The team have created a training session for medical staff highlighting the correct way in which to request scans and the importance of timely scanning for patient outcomes. This will be included in the induction programme for each new cohort of doctors.
	Gastroenterology	**NasoGastric (NG)Feeding** In order to improve the documentation around the NG feeding process, a proforma has been devised and the use of this will be mandatory for every NG tube insertion. A learning module on NG tube insertion will be included in the junior doctor's induction programme.
	Emergency Care	**Frailty Interface on Short Stay Unit** In order to improve the care for frail patients coming through Accident and Emergency a frailty screening tool is to be introduced in the department. This is to ensure a comprehensive geriatric assessment (CGA) is undertaken when patients are admitted to Emergency Assessment Unit and base wards by a member of the frailty team.
	Respiratory	**Specialist respiratory review in patients with Chronic Obstructive Pulmonary Disease (COPD)** The team have produced posters to raise awareness of the need to use the Dyspnoea, Eosinopenia, Consolidation, respiratory Acidosis and atrial Fibrillation (DECAF) score on admission to help

		predict the morbidity and mortality of patients with COPD.
	Accident & Emergency	**Management of severe pain in paediatric patients** In order to ensure children attending A&E with severe pain are appropriately managed, education and training for staff that triage children has been developed. The training includes the requirement to document severe pain scores and give supplemental simple analgesia to children, that are being given intravenous diamorphine.
Clinical Support & Screening	Endoscopy	**Internal decontamination – tracking and traceability of endoscopes** The department has raised awareness with endoscopists and all nursing staff reminding them of the importance of correct endoscope details being entered into endosoft for the purposes of audit, via emails, SafeCare meetings and daily huddles. Standard operating procedures to be developed and introduced within the department to formalise the recording of data into endosoft.
	Endoscopy	**Decontamination process – scope journey** Awareness has been raised to all staff within endoscopy of the importance of wearing full personal protective equipment for their own protection and safety and also for infection prevention and control. Training has been provided to the decontamination staff on the importance of leak testing all endoscopes before a full manual clean. Along with the importance of escalating any issues with equipment as per departmental operating procedure.
	Diagnostic Imaging	**Post procedure observations** Radiology nurse is to liaise with senior nursing staff to highlight the lack of compliance with post procedural observations and discuss ways in which this can be improved. Vitalpac has been programmed to 15 minute intervals in order to alert staff when a patient's post procedure observations are due to be undertaken.
	Diagnostic Imaging	**Re-audit of complications and accuracy of Computed Tomography (CT) guided percutaneous (a medical procedure where access to inner organs or other tissue is done via needle-puncture of the skin) chest biopsy.** In order to improve communication to patients the risks of non-diagnostic biopsy, a patient information leaflet has been developed.
	Physiotherapy	**Standards of documentation** Although the standards of documentation are satisfactory, improvements are required to be made when documenting acupuncture sessions. Acupuncture guidelines are being reviewed and will be circulated to staff once ratified and good standards of record keeping to be reiterated to staff.
	Microbiology	**Documentation and appropriate review of Intravenous (IV) antibiotic use** The audit demonstrated varying levels of compliance with documenting indication for IV antibiotics. Posters and/or stickers

		for the ward computer will be developed to remind medical staff of the requirements to document usage of antibiotics. Discussions to take place around potential upgrade of the medicines administration system to include prompts when prescribing antibiotics. Add section to the ward handover list to act as another reminder when prescribing antibiotics.
Surgery	General Surgery	**Delirium – risk factor assessment and indicators of delirium** To raise awareness of the process of risk assessing patients for delirium, clinical assessments and documentation to GPs on delirium diagnosis, a presentation has been given at a surgical SafeCare session. A poster to aid this process has been produced in consultation with the Old Age Psychiatry team.
	General Surgery	**Prospective snapshot audit of surgical venous thromboprophylaxis (VTE)** To improve the quality of surgical thromboprophylaxis the team has contacted the pharmacy department regarding an issue highlighted with compression stockings. The team is to have discussions regarding reviewing the VTE proforma. To provide further ward based education and posters detailing the need for meticulous VTE assessments. To review hospital wide practices for VTE.
	General Surgery	**Prospective audit of completion of outpatient 'clinic instruction slips'** In order to promote the importance of completing 'clinic instruction slips' the results of the audit have been shared with the team. Posters will be displayed in the Outpatient Department highlighting the areas where the 'clinical instruction slips' have not been filled in.
	Theatres	**Provision of written patient information on pain management** To ensure all patients get the relevant information regarding pain management upon discharge reiterate the need to give out information leaflets and ensure patients are signposted to the relevant section on post-operative pain management. Ensure all patients are aware that they can have access to further information should they need it.
	Paediatrics	**Management of bronchiolitis** In accordance with NICE guidance the parent information leaflet will be updated to include discharge advice with particular emphasis on the recognition of symptoms and when to seek medical help. Emphasise the importance of documentation of clinical findings and discharge advice to junior doctors as part of their induction programme.
	Trauma & Orthopaedics	**Do we follow the guidelines regarding managing Vitamin D deficiencies in at risk patients?** Further education for junior staff is required to ensure hip fracture guidelines are completed on the ward and ensure that clear guidelines for vitamin D and osteoporosis are available to all doctors.

	Gynaeoncology	**End of treatment summary** In order to improve the content of the end of treatment summary and ensure all patients receive the summary, discussions are to take place with the Information Technology Department to develop a discharge summary combining a discharge letter and end of treatment summary. Once a discharge summary is developed, it will be piloted with two consultants. Once finalised, a discharge summary will be implemented in the department.
	PODS	**Surgical Site Marking** The results of the audit highlighted that surgical site marking could be improved. A programme of staff education will be undertaken to ensure that staff are aware of the requirements and importance of surgical site marking.
	Maternity	**Response to CQC maternity outlier alert** To ensure accurate records of a patient's admissions within maternity a new system on Medway is to be developed to ensure when a baby is admitted but accompanied by the parent, the mother is not coded as an admission.
Nursing & Midwifery	SafeCare	**Trust wide audit of non-elective re-admissions within 30 days** Following this Trust wide audit, the results were shared with the Auditing Team, Clinical Commissioning Group and Central Management team. The results were fed back into the existing workstream looking at discharge and transfer of patients. Further work was undertaken to understand why the highest volume of patients were readmitted within one day of discharge.
	SafeCare	**Trust wide Record Keeping Audit** The results are shared monthly. A good practice bulletin was created and circulated to all staff regarding the correct way in which to amend any errors made within the patient record. Weekly reminders are circulated to encourage staff to participate in this audit.
	SafeCare	**World Health Organisation (WHO) checklist observational audit** The results of this quarterly observational audit are shared and displayed within the main theatre area on a monthly basis. All staff are reminded to fully participate in the WHO checklist.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Gateshead Health NHS Foundation Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 1008.

The Trust continues to demonstrate its commitment to improving the quality of care it offers and making its contribution to wider health improvement. In line with North East and North Cumbria: Clinical Research Network, the Trust has focused on building the recruitment for both Portfolio and Industry studies.

Gateshead Health NHS Foundation Trust is currently involved in 246 clinical research studies with 14 in setup. This research is in a variety of areas including, cancer, dementia & neurodegenerative disease, diabetes, critical care, cardiology, endocrinology, medicines for children, mental health, stroke, rheumatology, gynecological oncology, obstetrics and various specialty groups. New areas of research for 2016/17 include surgery, orthopedics, gastroenterology and hepatology.

Over the last year, researchers from the Trust have published over 56 publications, and delivered 14 presentations to a variety of audiences, the majority of which are as a result of our involvement in NIHR research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

There were 104 members of staff participating in research approved by a research ethics committee at Gateshead Health NHS Foundation Trust during 2016/17. These staff participated in research covering 16 medical specialties.

Our engagement with clinical research also demonstrates Gateshead Health NHS Foundation Trust's commitment to testing and offering the latest medical treatments and techniques.

Highlights of 2016/2017

- ✓ The Trust was successful in meeting five of the seven Continuous Improvement Incentive Criteria for 2016/17. The Research Team improved the commercial feasibility return rate, have a named Non-Executive Director as a Research Champion for the Trust and have a greater Research Awareness throughout the Trust, Internet, Intranet and Twitter.
- ✓ Dr Meleady, Consultant Cardiologist, was named as Chief Investigator for the OUTSTEP Study, Sponsored by Novartis Ltd. This is a highly prestigious award, based on very successful recruitment on previous Novartis studies.
- ✓ ROCKeTS , the Gynaeoncology Team were the second highest recruiting Team for the UK in February 2017.
- ✓ QUIDS, joint seventh highest recruiting Team for the UK in March 2017 - this is particularly notable because the QUIDS Team (46 novice research doctors and midwives) are helping to recruit patients around the clock seven days a week. It is a fantastic team effort and our achievements are thanks to the clinical team. The ANODE trial is using the same collaborative working approach as QUIDS and is also proving successful.
- ✓ VESPA, recruited 137 patients out of 150 patients approached consecutively - this was achieved by all of the Research Nurses working together, even though they were working across a different specialty area. The nurses were praised by the VESPA Study Team for their innovative working practice which proved to be highly successful and may lead to changes in national practice.
- ✓ The VESPA trial results will be presented at the Trust's Nursing & Midwifery Conference in May 2017.

Use of the Commissioning for Quality and Innovation Framework (CQUIN)

A proportion of Gateshead Health NHS Foundation Trust income in 2016/17 was conditional upon achieving quality improvement and innovation goals agreed between Gateshead Health NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2016/17 and for the following 12 month period are available electronically at http://www.qegateshead.nhs.uk/cquin

A monetary total of £4,432,569.88 of the Trust's income in 2016/17 was conditional upon achieving quality improvement and innovation goals. The Trust were paid a total of £4,393,179.00 for achieving the quality improvement and innovation goals for 2015/16.

Registration with the Care Quality Commission (CQC)

Gateshead Health NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against Gateshead Health NHS Foundation Trust during 2016/17.

Gateshead Health NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The Care Quality Commission made three unannounced visits during 2016/17. Two visits were to carry out routine Mental Health Act monitoring visits of detention in hospitals. These visits were carried out on 21st June 2016 to Cragside Court and 4th January 2017 to ward 23. There were no compliance issues identified in either of the visits.

The third visit was an unannounced focused inspection of older people's mental health services covering Cragside Court and Sunniside Unit between 7th and 9th December 2016 and Community Mental Health Nursing Teams (East and Central Sector) on 16th of December2016. We are currently awaiting the final reports.

Data Quality

Gateshead Health NHS Foundation Trust recognises that it is essential for an organisation to have good quality information to facilitate effective delivery of patient care and this is essential if improvements in the quality of care are to be made. Gateshead Health NHS Foundation Trust submitted records during 2016/17 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 is shown in the table below:

Which included the patient's valid NHS Number was:	Trust %*	National %*
Percentage for admitted patient care	99.5%	99.3%
Percentage for outpatient care	99.7%	99.5%
Percentage for accident and emergency care	98.3%	96.8%

Which included the patient's valid General Medical Practice Code was:	Trust %*	National %*
Percentage for admitted patient care	99.7%	99.9%
Percentage for outpatient care	99.8%	99.8%
Percentage for accident and emergency care	99.6%	99.0%

* SUS Data Quality Dashboard - Based on provisional April 16 to February 17- SUS data at the Month 11 inclusion Date

Information Governance Toolkit

Gateshead Health NHS Foundation Trust's Information Governance Assessment Report overall score for 2016/17 was 84% and was graded satisfactory.

Standards of Clinical Coding

Gateshead Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission.

Gateshead Health NHS Foundation Trust will be taking the following actions to improve data quality:

- Data Quality Strategy Group which includes key staff from all specialities to highlight and drive continual improvement.
- Continual development of our Data Quality Metrics to ensure all appropriate indicators are covered and align to national and local quality indicators.
- Continue with daily batch tracing to ensure the patient demographic data held on our Patient Administration System (PAS) matches the data held nationally.
- Circulate weekly patient level reports to allow the clinical services to fully validate 18 week and cancer pathways.
- Spot check audits to randomly select patients and correlate their health record information with that held on electronic systems.
- Continue to work with the data quality leads throughout the Trust to promote and implement data quality policies and procedures to ensure that data quality becomes an integral part of the Trust's operational processes.
- Clinical Coding Quality Assurance Programme to provide assurance on the quality of coding within the Trust.
- Working with Commissioners to ensure commissioning datasets are accurate, completing data challenges with five days.
- Monthly data meetings Data Quality Information Governance (DQIG) are held with the CCG to discuss any data concerns and data challenges.
- Review Internal Audit Department plans to include data quality processes.

2.8 Mandated Core Quality Indicators

Since 2012/13 NHS Foundation Trusts have been required to report performance against a core set of indicators using data made available to the Trust by the Health and Social Care Information Centre (HSCIC).

SHMI (Summary Hospital-level Mortality Indicator)

(a) SHMI	Oct 14 – Sept 15	Jan 15 - Dec 15	Apr-15 Mar-16	Jun 15 - Jul 16	Oct 15 – Sept 16
SHMI	0.95	0.96	0.97	0.97	0.99
England highest	1.18	1.17	1.18	1.17	1.16
England lowest	0.65	0.67	0.68	0.69	0.69
Banding	2	2	2	2	2

(b) % Deaths with palliative coding	Oct 14 – Sept 15	Jan 15 - Dec 15	Apr-15 Mar-16	Jun 15 - Jul 16	Oct 15 – Sept 16
% Deaths with palliative coding	16.6%	16.1%	16.7%	16.0%	14.95
England highest	53.5%	54.7%	54.6%	54.8%	56.3%
England lowest	0.2%	0.2%	0.6%	0.6%	0.4%
England	26.6%	27.6%	28.5%	29.2%	29.7%

Source: www.HSCIC.gov.uk

Gateshead Health NHS Foundation Trust considers that this data is as described for the following reasons:

- The Summary Hospital-level Mortality Indicator (SHMI) reports mortality at a Trust level across the NHS in England and is regarded as the national standard for monitoring of mortality. For all of the SHMI calculations since October 2011, death rates (mortality) for the Trust are described as being 'as expected'.

Gateshead Health NHS Foundation Trust has taken the following actions to improve the indicator and percentage in (a) and (b), and so the quality of its services, by [please see pages 6-11].

Gateshead Health NHS Foundation Trust intends to take the following actions to improve the indicator and percentage in (a) and (b), and so the quality of its services, by [please see pages 6-11].

Patients on Care Programme Approach (CPA) who were followed up within seven days after discharge from psychiatric inpatient care

Proportion of patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric inpatient care	2014-15				2015-16				2016-17			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Gateshead Health Foundation Trust	100 %	100 %	90 %	100 %	89 %	100 %	50 %*	80% **	100 %	90 %	80 %†	85 %
England	97 %	97 %	97 %	97 %	97 %	97 %	97 %	97%	96 %	97 %	97 %	N/A
England Highest	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	N/A
England Lowest	93 %	92 %	90 %	93 %	89 %	83 %	50 %	80%	29 %	77 %	73 %	N/A

Source:https://www.england.nhs.uk/statistics/statistical-work-areas

*3 of 6 patients followed up within 7 days after discharge from psychiatric inpatient care

**4 of 5 patients followed up within 7 days after discharge from psychiatric inpatient care

†8 of 10 patients followed up within 7 days after discharge from psychiatric inpatient care

Gateshead Health NHS Foundation Trust considers that this percentage is as described for the following reasons:

- One patient chose a later appointment than within 7 days however was made aware of crisis contact details.

- One patient was transferred to 24 hour care; was seen on 7th working day.
- Two patients were seen outside of the 7 day target due to a communication error they were seen immediately when identified

Gateshead Health NHS Foundation Trust has taken the following actions to improve these outcome scores, and so the quality of its services, by:

As part of the discharge planning process for all patients:
A named Care Co-ordinator will be allocated to the patient where ever possible.
An appointment with the patient within seven days after they have been discharged from hospital

PROMs (Patient Reported Outcome Measures) for

- Groin hernia surgery
- Varicose vein surgery
- Hip replacement surgery
- Knee replacement surgery

Groin Hernia Adjusted average health gain	2012-13 Final	2013-14 Final	2014-15 Final	Apr 15 to Mar 16 Provisional	Apr 16 to Sep 16 Provisional
Gateshead Health Foundation Trust	0.081	0.064	0.084	0.045	0.048
England	0.085	0.085	0.084	0.088	0.089
England Highest	-	0.139	0.154	0.157	0.161
England Lowest	-	0.008	0.000	0.021	0.016

Varicose Vein Adjusted average health gain	2012-13 Final	2013-14 Final	2014-15 Final	Apr 15 to Mar 16 Provisional	Apr 16 to Sep 16 Provisional
Gateshead Health Foundation Trust	0.053	0.125	0.067	0.112	*
England	0.093	0.093	0.094	0.095	0.099
England Highest	-	0.150	0.154	0.149	0.151
England Lowest	-	0.022	-0.009	0.018	0.016

Hip Replacement Adjusted average health gain	2012-13 Final	2013-14 Final	2014-15 Final	Apr 15 to Mar 16 Provisional	Apr 16 to Sep 16 Provisional
Gateshead Health Foundation Trust	0.424	0.391	0.420	0.402	*
England	0.438	0.436	0.436	0.438	0.449
England Highest	-	0.544	0.524	0.510	0.525
England Lowest	-	0.311	0.331	0.320	0.33

Knee Replacement Adjusted average health gain	2012-13 Final	2013-14 Final	2014-15 Final	Apr 15 to Mar 16 Provisional	Apr 16 to Sep 16 Provisional
Gateshead Health Foundation Trust	0.331	0.291	0.310	0.284	*

England	0.318	0.323	0.315	0.320	0.337
England Highest	-	0.425	0.418	0.398	0.430
England Lowest	-	0.215	0.204	0.198	0.261

Source: www.HSCIC.gov.uk

*Figure not calculated. Average casemix adjusted scores have been calculated where there are at least 30 modelled records, as the statistical models break down with fewer records and aggregate calculations on small numbers may return unrepresentative results.

Gateshead Health NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

Groin

- Our provisional data shows that our recurrence rate is low with stable average adjusted health gain score, although it should be noted that our response rate was low at 30% (107 of 351 records)

Veins

- Due to changes in service delivery models, there have been a lower number of records available to support this data capture.

Hip

- Unfortunately there have been a lower number of records available to support this data capture during this time period.
- Our outcomes are below recommended parameters based on health gain scores.

Knee

- Our outcomes are below recommended parameters for the Oxford knee score.

Gateshead Health NHS Foundation Trust has taken the following actions to improve these outcome scores, and so the quality of its services, by:

Groin

- We remain committed to improving our service for patients, and as such we continue to share data with clinical teams on a regular basis to promote service review and quality improvements. Currently we are exploring a range of initiatives including the potential role of a "PROMs champion"; internal case study review to identify any potential trends in performance data; methods to best manage patient expectations including alternative management options to surgery, and the potential impact that alternative follow-up models will have on data capture and compliance in future.

Veins

- Despite the low numbers, we still remain committed to improving our service to patients, and regularly review the available performance data to inform service delivery. Currently we are considering alternative follow-up arrangements, whilst continuing our work to ensure patients have sufficient information and support to ensure they have an informed choice of treatment, including alternatives to surgery where appropriate.

Hip

- We will continue to share data with clinical teams and commissioners to ensure that health gains can be maximised from future procedures.
- We are continuing to work in conjunction with NEQOS to further analyse the information recorded and identify trends.
- We have established a dedicated PROMS Group to review and implement improvements to the current pathway and outcomes for patients.
- Appointment of a dedicated PROMS Improvement Project Lead to review current practice and recommend areas for improvement.

Knee

- We will continue to share data with clinical teams and commissioners to ensure that health gains can be maximised from future procedures.
- We are continuing to work in conjunction with NEQOS to further analyse the information recorded and identify trends.
- We have established a dedicated PROMS Group to review and implement improvements to the current pathway and outcomes for patients.
- Appointment of a dedicated PROMS Improvement Project Lead to review current practice and recommend areas for improvement.

Emergency Readmissions within 28 Days

- Aged 0 – 15yrs

Child 0-15 Years	2012-13	2013-14	2014-15	2015-16	2016-17 to Dec 2016
Emergency Readmission Rate	10.19%	8.91%	11.51%	8.94%	8.86%
Number of Spells	6,489	4,970	5,154	3,936	3,353
Number of Readmissions	661	443	593	352	297

- Aged 16yrs or over

Adult 16+ Years	2012-13	2013-14	2014-15	2015-16	2016-17 to Dec 2016
Emergency Readmission Rate	9.44%	8.69%	9.48%	9.50%	8.59%
Number of Spells	50,820	54,234	58,712	51,871	39,403
Number of Readmissions	4,795	4,714	5,565	4,929	3,383

Source: Dr Foster Quality Investigator 2012-13 to 2014-15

Source: HED 2015-16 to 2016-17

Gateshead Health NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

- Continuation of many schemes introduced last year including the embedding of an effective and expanded Ambulatory Care Unit.
- Ongoing extension of services into the community; whereby our specialist nurses and teams closely monitor patients who have been recently discharged and can proactively manage any deterioration.

Gateshead Health NHS Foundation Trust has taken the following actions to improve these outcome scores, and the quality of its services, by:

- Continuing to work closely with primary care colleagues to improve the quality of discharge information we provide to them.
- We recently commenced a year-long programme of work with the Acute Frailty Network (AFN) who are helping us redesign pathways of care and develop proven interventions that help prevent avoidable admissions in the first instance.
- We have started to develop more collaborative working with our community workforce who were transferred into the organisation in October. They have supported the acute hospital during winter pressures by being involved in multi-disciplinary team meetings and ward rounds to help facilitate timely and safe discharges for patients.

Trust's responsiveness to the personal needs of its patients

Inpatients - Overall Patient Experience Score	2012/13	2013/14	2014/15	2015/16
Gateshead Health NHS Foundation Trust	78.7	81.5	81.8	79.2
England Average	76.5	76.9	76.6	77.3
England Highest	88.2	87.0	87.4	88
England Lowest	68.0	67.1	67.4	70.6

Source: www.england.nhs.uk/statistics/statistical-work-areas/pat-exp

A&E - Overall Patient Experience Score	2008/09	2012/13	2014/15
Gateshead Health NHS Foundation Trust	79.2	79.5	79.8
England Average	75.7	75.4	77.1
England Highest	82.1	82.2	83.5
England Lowest	65.7	67.1	67.2

Source: www.england.nhs.uk/statistics/statistical-work-areas/pat-exp

Outpatients - Overall Patient Experience Score	2009/10	2011/12
Gateshead Health NHS Foundation Trust	83.4	83.5
England Average	78.6	79.2
England Highest	85.1	85.8
England Lowest	72.5	73.7

Source: www.england.nhs.uk/statistics/statistical-work-areas/pat-exp

The Gateshead Health NHS Foundation Trust considers that these percentages are as described for the following reasons:

- We have seen a slight decrease in 2015-16, however we are still above the national average for our overall patient experience score. We continually listen to what are patients tell us and recognise the importance of their feedback. We act upon this to improve the care we deliver to patients.

The Gateshead Health NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

- Continually monitoring and acting upon feedback from patients, carers, the public and our staff.

- Continue to implement our strategy through the Patient, Public and Carer Involvement and Experience Group that includes key internal and external stakeholders such as the local authority, Healthwatch and Voluntary Group and Organisations.

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

Staff who would recommend the Trust to their family or friends	2014	2015	2016
Gateshead Health NHS Foundation Trust	74.7%	76.2%	81.1%
England highest - Acute Trusts	89.3%	85.4%	84.8%
England Lowest - Acute Trusts	38.2%	46.0%	48.9%
Acute Trusts	64.7%	69.2%	69.8%

Source:www.nhsstaffsurveys.com

The Gateshead Health NHS Foundation Trust considers that these percentages are as described for the following reasons:

- Gateshead Health NHS Foundation Trust continues to perform positively as being a place our staff would recommend as a provider of care. This is underpinning by the Trust's Vision and Values which puts the patient, followed closely by staff at the heart of everything we do. Our strong CQC ratings triangulate this.

The Gateshead Health NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

- Continuing to promote the Trust's vision and values, which place the patient at the centre of everything we do.
- Embedding the vision and values into training and appraisal documentation to link activities back to patient centred care.
- Promoting external feedback from patients and service users about the quality of care they have received at the Trust.
- Recognising the high standards of care delivered by staff through events such as the Star Awards Ceremony.
- Energising staff through the process of retaining Investor in People accreditation.
- Raising staff awareness during induction, mandatory training and ongoing staff development that the Trust is proud of its achievements and is constantly looking at new and better ways of working to improve the level of care we are able to offer our patients/service users.
- Increasing use of social media such as Facebook and Twitter by the Trust to get good news messages across.

Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism

Year	Quarter	Gateshead Health NHS Foundation Trust	England Highest Acute Trust	England Lowest Acute Trust	Acute Trusts
2012-13	Q1	92.8%	100.0%	80.8%	93.4%
	Q2	91.9%	100.0%	80.9%	93.9%
	Q3	91.1%	100.0%	84.6%	94.1%

	Q4	91.9%	100.0%	87.9%	94.2%
2013-14	Q1	91.0%	100.0%	78.8%	95.4%
	Q2	95.2%	100.0%	81.7%	95.8%
	Q3	95.1%	100.0%	74.1%	95.7%
	Q4	95.8%	100.0%	78.9%	95.9%
2014-15	Q1	95.3%	100.0%	87.2%	96.1%
	Q2	95.3%	100.0%	90.5%	96.2%
	Q3	95.1%	100.0%	81.2%	95.9%
	Q4	95.3%	100.0%	79.2%	95.9%
2015-16	Q1	95.6%	100.0%	86.1%	96.0%
	Q2	95.1%	100.0%	75.0%	95.8%
	Q3	95.0%	100.0%	78.5%	95.5%
	Q4	95.3%	100.0%	78.1%	95.5%
2016-17	Q1	97.8%	100.0%	80.6%	95.6%
	Q2	97.9%	100.0%	72.1%	95.5%
	Q3	98.5%	100.0%	76.5%	95.6%
	Q4	98.8%	N/A	N/A	N/A

The Gateshead Health NHS Foundation Trust considers that these percentages are as described for the following reasons:

- We continue to have a high compliance with the NICE guidance regarding patient risk assessment for VTE on admission to hospital, and this is documented as being more than 98% over the last year. The audit process has been facilitated and improved by recording the risk assessment on the electronic prescribing system. We regularly review our compliance through the VTE committee, and aim for equity across all patient groups.

The Gateshead Health NHS Foundation Trust intends to take the following actions to improve these percentages, and so the quality of its services, by:

- Ensuring we identify all patients with hospital acquired VTE through ongoing audit and data collection by the coding team. Continuing to perform RCA on all patients diagnosed with a hospital associated thrombosis.
- Identifying learning as a result of these RCAs and ensure it is shared with our clinical teams, in addition to this data being reviewed by the VTE committee to identify any learning outcomes or identify where system improvements are required.
- Continuing to promote education and training of all relevant clinical and support staff including the new e learning module which includes compression garment fitting.

The rate per 100,000 bed days of cases of *Clostridium difficile* infection (CDI) reported within the Trust amongst patients aged 2 or over

Rate of C.difficile per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	2012/13	2013/14	2014/15	2015/16
Gateshead Health NHS Foundation Trust	17.5	12.3	15.1	26.8
England highest	31.2	37.1	62.2	66
England lowest*	1.2	1.2	2.8	1.1
England	17.4	14.7	15	14.9

Source:www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data

*Where cases reported

The Gateshead Health NHS Foundation Trust considers that these percentages are as described for the following reasons:

- *Clostridium difficile* infection (CDI) is an unpleasant, and potentially severe or fatal infection that occurs mainly in elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment. Reduction of CDI continues to present a key challenge to patient safety across the Trust. Therefore ensuring preventative measures and reducing infection is very important to the quality of patient care we deliver. A focused and zero tolerance approach to support a reduction in CDI for patient safety was implemented in line with the Infection Prevention Strategy.

During 2016/17 the Trust has reported twenty (20) post 72hr CDI cases demonstrating a 58.3% performance improvement against 2015/16 and maintaining its annual rate at 11.6%.

The Gateshead Health NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services by using the following approaches:

- Local multidisciplinary CDI Root Cause Analysis meetings are arranged and reviewed to ensure lessons learned are shared within the Trust.
- The Trust works closely in partnership with the Gateshead Newcastle Clinical Commissioning Group and other regional Foundation Trusts to review lessons learned and share good practice in reviewing CDI cases.
- The Diarrhoea Assessment Management Pathway tool (DAMP) provides guidance for clinical staff managing those patients experiencing loose stool.
- Enhanced personal protective equipment is worn following isolation of the patient with suspected infective diarrhoea.
- Patients are risk assessed and prioritised ensuring those patients requiring a level of isolation are identified.
- Environmental surveillance provides an ongoing assurance against contamination of the general environment identifying areas where cleaning and general adherence to policy can be improved. These Infection Prevention Control (IPC) strategies and regular environmental screening of clinical areas are valuable in identifying areas of high risk providing an evidence base for enhanced/deep cleaning, and targeted education.
- To enhance antimicrobial stewardship, the Trust antimicrobial guidelines have been redeveloped with inclusion of an electronic smartphone/device application.
- Polymerase chain reaction (PCR) testing was implemented throughout 2016/17 to enhance the testing regimen of samples.

- A weekly CDI MDT meeting takes place and antimicrobial prescribing is reviewed along with all aspects of CDI care.
- Ribotyping of all post 72hr positive CDI cases is arranged with the *Clostridium difficile* Ribotyping Network (CDRN) to determine if cross infection has taken place within specific clinical areas and to identify the specific organism type.

The number and rate of patient safety incidents reported within the Trust and the number and percentage of such patient safety incidents that resulted in severe harm or death

Patient Safety Incidents per 1,000 bed days	Oct 14 – Mar 15		Apr 15 – Sep 15		Oct 15 – Mar 16	
Organisation	Gateshead Health NHS Foundation Trust	Acute (non specialist) Organisations	Gateshead Health NHS Foundation Trust	Acute (non specialist) Organisations	Gateshead Health NHS Foundation Trust	Acute (non specialist) Organisations
Total number of incidents occurring	2,496	621,776	2,710	632,050	2785	655,193
Rate of all incidents per 1,000 bed days	27.94	N/A	31.65	N/A	30.93	N/A
Number of incidents resulting in Severe harm or Death	14	3,089	19	2,717	17	2642
Percentage of total incidents that resulted in Severe harm or Death	0.56%	0.49%	0.70%	0.29%	0.60%	0.40%

Source: www.nrls.npsa.nhs.uk

The Gateshead Health NHS Foundation Trust considers that these percentages are as described for the following reasons:

- The incidents reported have increased steadily throughout October 2014 and March 2016 and this is very positive. It shows that work being carried out around promoting good patient safety culture is having a positive effect. Whilst the incident reporting rate shows an increase from 27.94 to 31.65 per 1000 bed days it took a dip in October 2015-March 2016 to 30.93 this was influenced by a higher amount of bed days in the Trust winter pressures. Work will continue to improve the Trust patient safety culture and raise awareness on sharing learning from incidents.
- The percentage of total incidents resulting in severe harm or death has fluctuated between 0.56% to 0.70% with a rate of 0.60% in October 2015-March 2016 compared to a national rate of between 0.29% to 0.49%. The data shows an increase from 14 incidents during the six month period from Oct 2014- March 2015 to 17 incidents in October 2015 – March 2016.

The Gateshead Health NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by the following:

- Incident investigation training has been increased to ensure that robust investigations are carried out and relevant learning is identified more effectively and shared to improve patient safety. A Human Factors faculty is being developed in the Trust, to create Human Factors

champions throughout the organisation to support the ongoing promotion of a positive patient safety culture.

- Plans are in place to share more widely and effectively lessons learned and information on measures to improve patient safety through a number of initiatives including introducing a Trust 'lessons learned bulletin' to amplify the learning identified in investigations through all areas of the Trust.
- To carry on improving the efficiency of the serious incident review process to ensure that lessons are learned in a more timely way.
- To continue to deliver the Trust strategy to reduce patient harmful falls and to proactively respond to ongoing information analysis to identify measures that will positively impact on reducing harm.

3. Review of quality performance

2016/17 has been a successful year in relation to the three domains of quality:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

3.1 Patient Safety

Incident and Complaint Investigations
Over the last six months actions have been taken to improve the quality of incident and complaint investigations throughout the Trust. The first stage was to invite an external trainer to deliver a training session to 40 members of staff who undertake RCA's; this covered the theory of root cause analysis and different methods of carrying out a root cause analysis. As part of the training five of the individuals will carry out a short piece of work that would enable them to be accredited trainers, the remaining staff that were trained will be departmental champions. This first stage was well received and a further stage has been arranged for May 2017. The second stage of the plan is to develop the investigator training package that is delivered to all relevant staff within the Trust and the accredited trainers will be able to deliver the training within the business units. The goal is to ensure all staff investigate within the parameters of the Trust Policy and the quality of the investigations are improved. This will help to maximise the lessons that are learnt through the investigation process, and reduce harmful incidents in the Trust.

Complaint Investigation Process
We have strived to ensure that the complaint process is streamlined throughout the Trust and utilise to the Datix complaint module to its capacity to reduce manual processes when complaints are made. The reason for the changes is to;

- Raise the profile of complaints and its importance
- Improve the compliance with response targets
- Bringing the process for investigating complaints in line with incident investigations

Some of the changes we have made are;

- To provide instant notification to each investigator when assigned a complaint
- A response is typed directly into Datix
- Set auditable standards
- Removed the Trust 25 day response deadline, and changed to a more achievable target of 40 days. This remains lower than the national deadline target for complaints.
- Letter of complaint made more easily accessible
- Information made available at a glance via Datix dashboard
- Easier for reporting and learning, as all information in one place

Eastwood Promoting Independence Centre
The Eastwood Promoting Independence Centre is a care home that provides respite, short break and assessment accommodation for mainly elderly people who require personal care. Some of whom have dementia. Whilst the management of this centre is with the local authority, we have

Gateshead nursing input throughout the day. In the past incidents were reported by Gateshead Health NHS Foundation Trust for information however these were not investigated as the local authority reported serious incidents to the Care Quality Commission (CQC). Whilst this process was correct we felt that there could be some learning from incidents that would help reduce harmful incidents. Meetings were held with the local authority and the Trust and it was decided to carry out a rapid review of all 'serious' incidents; generally falls causing a fractured neck of femur. Work was carried out with the community services team, patient safety team and local authority to have a joined up approach to reducing harmful incidents. The outcome was to implement a rapid review section for Eastwood within Datix, so that all the relevant information can be collated in the system and then printed into a template that can be added to the patient's record and also be shared with the CQC if this is needed. The template highlights potential contributory factors, root causes and details of all learning from this incident that can be shared at SafeCare meetings held with the multi-disciplinary team from Gateshead Health NHS Foundation Trust and the local authority. This process has now been finalised and implemented and has also given us the ability to have clear reports and benchmarks can be set to ensure harm is being reduced. Work will continue collaboratively moving forward and further improvements will be made in the coming year.

Human Factors Training

Human Factors is an established scientific discipline used in many other safety critical industries, particularly the airline industry. Human Factors approaches underpin current patient safety and quality improvement science, offering an integrated, evidenced and coherent approach to patient safety, quality improvement and clinical excellence. The principles and practices of Human Factors focuses on optimising human performance through better understanding the behaviour of individuals, their interactions with each other and with their environment. By acknowledging human limitations, Human Factors offers ways to minimise and mitigate human frailties, so reducing medical error and its consequences. The system-wide adoption of these concepts offers a unique opportunity to support cultural change and empower the NHS to put patient safety and clinical excellence at its heart.

Human Factors principles can be applied in the identification, assessment and management of patient safety risks, and in the analysis of incidents to identify learning and corrective actions.
More broadly, Human Factors understanding and techniques can be used to inform quality improvement in teams and services, support change management, and help to emphasise the importance of the design of equipment, processes and procedures. The NHS has already started to harness Human Factors approaches through the successful adoption of patient safety and quality improvement science, and in the ergonomic design of medical devices and workplaces.

As part of the Trust's plans to improve patient safety culture, the Trust has again utilised an external company to a deliver training sessions to all of our Theatre staff to share the benefits of considering human factors when incidents occur and investigations are carried out. This training has been well received and staff are embracing the Human Factors theory, when carrying out their duties. In order to incorporate Human Factors principles and practices more broadly throughout the Trust there are plans to develop a Human Factors Faculty in the Trust. This faculty will be made up from 50 people who will attend a two day training session and the attendees will then be a Faculty member. These individuals will become champions of patient safety culture; coaching and supporting colleagues and junior staff to achieve an ongoing patient safety culture change.

Safeguarding adults and children

Due to revisions with the Care Act work has been carried within the Trust to ensure the changes are reflected in Trust practice. Most of the revisions have been made for reasons of accuracy or clarity. Some however are substantial, reflecting learning through the first period of implementation and feedback from stakeholders and partners.

A summary of the main changes is provided below:

- Clarification added with regards to self-neglect. It should be noted that self-neglect may not prompt a Section 42 Enquiry (this is when a cause of concern is raised and the Trust are required to investigate). An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect them by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support.
- Updated definition on domestic violence to reflect new legislation.
- Additional information in relation to financial abuse to reflect significant increases in internet, postal and doorstop scams and crime.
- Section on reporting and responding to abuse and neglect has been amended to highlight the need for practitioners to consider the need for criminal investigations and take advice if necessary. Forensic evidence can be lost if a crime is not reported or investigated quickly enough.
- Reporting and responding to abuse and neglect amended to remind Local Authorities that they have powers even where they do not have duties, adult safeguarding is one area where this may be significant.
- The Care Act reinforces the prevention agenda (better to prevent abuse than act after the event) and reminds practitioners that it is important to identify and manage risk of abuse and neglect, even where those concerns are not the presenting issue.
- All policies and procedures have been updated to reflect the additions.

There have been some key achievements during 2016 and these have been detailed below;

- As of October 2016, a full time band 7 community safeguarding lead commenced his post supporting the community services.
- There has been a rigorous programme of safeguarding audits undertaken throughout 2016, to monitor practice across the organisation and between the Trust and other health organisations.
- A Trust-wide Domestic Violence and Abuse Policy has been developed and implemented. The Trust is represented at the Multi-Agency Risk Assessment Conference (MARAC) and Multi-Agency Tasking and Co-ordinating (MATAC) meetings.
- Internal audit of the mental capacity act showed compliance with the Mental Capacity Act and staff were meeting their responsibilities with regards capacity assessment and deprivation of liberties.
- A workshop was held and was very well attended raising awareness and highlighting issues in relation to domestic violence. There were a number of key note speakers including a victim of domestic violence who shared their story.

Harm free care - measured by the NHS Safety Thermometer

The NHS safety thermometer is an audit undertaken on all patients on one day every month, to measure, monitor and analyse patient harm and "harm free" care. The four areas of harm which are measured are:

- Pressure damage
- Falls
- Catheter related urinary tract infections (CAUTIs)
- Venous Thromboembolism (VTE)

The results from the tool are shared with clinical staff and key information is displayed on the wards. This data enables wards to address areas for improvement. The table below demonstrates: a) percentage of harm free care we have delivered each month and b) the prevalence of harm for the four key areas measured within the audit.

The sample increased from October 2016 due to the transition of Community Services with the Trust on 1st October 2016.

Safety Thermometer	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Sample	495	475	500	479	479	464	963	923	904	913	776	767
Surveys	26	25	25	25	24	25	29	29	30	30	29	30
Harm free	95.2 %	95.6 %	98.3 %	97.1 %	96.0 %	96.3 %	96.7 %	96.4 %	96.5 %	95.7 %	96.3 %	97.0 %
Pressure Ulcers - All	2.8%	2.7%	3.6%	1.5%	1.9%	2.8%	2.8%	3.1%	2.9%	3.4%	2.5%	1.8%
Pressure Ulcers - New	1.0%	0.8%	0.6%	0.2%	0.4%	0.4%	0.5%	0.2%	0.6%	1.1%	0.3%	0.7%
Falls with Harm	0.4%	0.4%	1.2%	0.8%	0.4%	0.7%	0.3%	0.3%	0.4%	0.6%	0.9%	0.5%
Catheters and UTIs	1.4%	1.3%	1.4%	0.2%	1.3%	0.4%	0.1%	0.1%	0.3%	0.2%	0.4%	0.4%
Catheters and New UTIs	1.0%	1.1%	0.6%	0.2%	0.8%	0.4%	0.1%	0.1%	0.3%	0.1%	0.4%	0.1%
New VTEs	0.2%	0.0%	0.0%	0.4%	0.4%	0.0%	0.1%	0.1%	0.0%	0.1%	0.0%	0.3%
All Harms	4.9%	4.4%	6.2%	2.9%	4.0%	3.7%	3.3%	3.6%	3.5%	4.3%	3.7%	3.0%
New Harms	2.6%	2.3%	2.4%	1.7%	2.1%	1.5%	1.0%	0.8%	1.3%	1.9%	1.6%	1.6%

- Pressure Damage

As a Trust we strive to deliver safe reliable care which is open and transparent. We have a dedicated workforce who are committed to continue to reduce the number of incidents on a year on year basis. Our Pressure Ulcer Prevention and Management Improvement Plan has been devised to build upon our previous successes and make further improvements across both the hospital and community settings.

- Falls

Information on our strategic objective to reduce harmful falls may be found on pages 16-19.

- Catheter Associated Urinary Tract Infections (CAUTI)

The Infection Control Team continues to undertake targeted work on a daily basis using the saving lives care bundle to reduce CAUTIs. As part of this surveillance patients are issued with a "Patient Catheter Care Record" to assist in a seamless transition from hospital to community.

- Venous Thromboembolism (VTE)

The VTE Committee meets every quarter and continues to oversee the implementation of guidelines for the prevention and management of thromboembolism within the Trust in line with National Institute for Health and Care Excellence (NICE) and other national guidance. Please see page 53-54 for interventions.

3.2 Clinical Effectiveness

World Health Organisation (WHO) Surgical Safety checklist
The WHO Surgical Safety checklist was relaunched in the Trust in September 2016, the objectives for the relaunch were to:

- Reinforce the message that Patient Safety is everyone's responsibility
- Reinforce that effective team work is essential to ensure a safety culture
- Introduction to the National Safety Standards for Invasive Procedures (NatSSIPs) in theatres

A 'walk the wall' visual aid was on display in the Theatres Department throughout the relaunch week.

A team off staff external to the theatre department undertook audits throughout the week across all theatres, observing the quality of the WHO checklist being undertaken. These observational audits have continued on a quarterly basis throughout the year, and results are fed back to staff working within the theatre department. Alongside the WHO checklist is a continuous monitoring of real time data through the use of an iPad within Theatres. The results of this are fed back monthly to the clinical teams.

Record Keeping Audit
High standards of record keeping are fundamental to good quality patient care. Good record keeping not only aids communication and decision making between teams regarding a patient's care and treatment, but is the point of reference when investigating incidents, complaints and legal claims.

Historically the methodology for the Health Records Review Audit (HRRA) was that it was undertaken on a quarterly basis by the relevant management across each professional discipline within the organisation. Engagement and compliance with undertaking the audit was poor and

had decreased over time. In December 2016, a new methodology was launched to include all qualified professionals to undertake the audit to encourage behavioural change.

During 2015/16 619 sets of health records were audited. The table below outlines the numbers of health records audited per month following implementation of the new methodology. This has been a huge success and very well received by clinical staff. In the first four months of implementation 1,567 health records were audited, this was 948 more records than in the whole of the previous financial year.

Month	Number of health records audited
December 2016	234
January 2017	504
February 2017	425
March 2017	404
Total	1,567

The results have demonstrated high standards of record keeping in the following areas:

Standard	Compliance
Is all documentation filed within the record, in the correct locations	98%
Can you read all the written entries (is it legible)	98%
Is the date recorded for every entry	98%
Is black ink used throughout	100%

The results of the audit have highlighted that errors made within patient records are not being dealt with appropriately across the Trust. A Good Practice Bulletin was circulated to all staff reinforcing the steps necessary once an error has been made.

Implemented Ulysses Safeguard system

In May 2016, the Trust implemented an electronic web based system 'Ulysses' to manage clinical audit and alerts (NICE guidance, clinical guidelines, national confidential enquiries, SafeCare alerts) within the organisation. A series of training sessions were held across the Trust and as part of the implementation process handouts were developed and distributed to supplement the training sessions.

As the system is web based, it has reduced the unnecessary administration required from Business Units and has given the ability to provide significant assurance for clinical audit, NICE guidance, clinical guidelines, national confidential enquiries, and SafeCare alerts.

A range of reports can be accessed at any given time by staff to aid monitoring and offer assurance within each service. Clinical Effectiveness Monitoring Reports have been developed at Trust wide and Business Unit level. These detail progress against the clinical audit annual programme and current compliance with NICE guidance. These are scheduled to automatically run on a monthly

basis and are automatically emailed from the system to Associate Directors, Service Line Managers, Matrons and Clinical Audit Leads.

3.3 Patient Experience

Improvements to corporate function for managing patient experience

Throughout the year there have been further improvements to the corporate function for patient experience as follows:

- Patient experience team established including complaints, PALS and volunteer services.
- New patient experience and information centre opened in April 2016, the centre includes an office space to enable staff to hold confidential telephone conversations with clients. The centre incorporates a meeting room which has enabled staff from the team to meet with clients to discuss their concerns in private. It has raised the profile of the PALS service and has provided a central point for patient enquiries.
- Updated Friends and Family Test card were developed for inpatient and outpatient services.
- Friends and Family Test cards developed for the addition of community services to the Trust in October.
- Work is continuing to refresh the Friends and Family cards for areas such as learning disabilities, mental health services and paediatrics.
- A workshop was held in May regarding the observational site visits which take place within the Trust. The aim of the workshop was to develop a more robust/ streamlined programme of visits.

Friends and Family Test

We continue to apply the Friends and Family Test (F&FT) within the inpatient and outpatients areas, with the addition of the Community Services from October 2016. This patient experience survey is based on asking all patients a standard question, in line with the national guidance:

"How likely are you to recommend our service to friends and family if they needed similar care or treatment?"

The F&FT provides patients with an easy way of providing us with direct feedback through asking a very simple question. All responses are reviewed monthly and feedback is provided directly to the relevant departments, this ensures we are providing the best possible service to our patients.

Changes to the F&FT

In May 2016 questions linked to the CQC key lines of enquiry were combined with questions inspired by the 6Cs of nursing in the real time surveys (questionnaires undertaken on inpatient wards) and were added to the F&FT for inpatients and outpatients. To accommodate the additional questions, amendments were made to the appearance of the card which led to the introduction of pre-paid envelopes, to enable patients to continue to return the cards by post. New F&FT cards were developed to meet the needs of the community services and included questions similar to those on the inpatient and outpatient cards. A bespoke day surgery card has also been developed and is in use.

The inpatient response rate for the F&FT has been maintained near or above the 30% target over the past year, and has also been combined with the response rate for day case patients (20% target) which was not included in last year's data. The introduction of freepost envelopes

alongside the feedback cards has seen an increase in postal returns. The patient experience team has worked with the clinical areas to implement strategies to increase the response rate in their areas and to also understand why certain areas continue to have low response rates.

Inpatients

Over the past year many departments have focused their efforts on the Friends and Family Test, consistently achieving well above the 30% response rate target, with many achieving above 60%, and one department reaching 100% response rate for several months. This has been achieved by members of the patient experience team engaging with staff and facilitating their plans, as well as the determination of the staff themselves. Several departments use multi method feedback including cards, slips and electronic tablet devices. Some departments have nominated staff 'champions' to promote patient experience feedback and passionate leadership has proven to be an effective team motivator.

The test is embedded in the Trust and staff give out the cards as part of their routine care.

The recommend rate has not been below 96% throughout the last year which gives strong assurance that the vast majority of patients would recommend the Trust's services to friends and family.

Results for our inpatient F&FT from April 2016 to March 2017 are in the table below:

Month	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Inpatient % would recommend	97.4	96.8	96.1	96.8	97.2	97.8	97.7	97.5	97.7	97.5	97.4	97.0
% would not recommend	1.1	0.8	1.2	1.1	1	1	0.8	0.5	0.6	1.4	0.9	1.2
% Inpatient Response Rate	26.7	23.9	24	32.2	26.6	27.7	27.8	26.9	30.5	25.4	29.1	28.7

*published data Apr16-Feb-17

A&E

The Trust's A&E department has been highly engaged with the F&FT. It is consistently within the top three performing A&E departments nationally. The Trust has been identified as a 'flagship' organisation for our A&E response rates, providing advice and guidance to other Trusts as requested. The patient experience team have worked closely with staff in A&E to implement various strategies to improve their response rate. This has included electronic feedback and extra boxes being placed in treatment rooms, to encourage and prompt patients to complete and return F&FT cards. Staff have been proactive in waiting areas to assure patients that their feedback is important to the Trust. These results also include paediatric emergency services and walk-in centre services. All of these services have maintained their response rate well above the 20% target for the whole year.

The results for A&E F&FT for the year April 2016 to March 2017 are displayed in the table below:

Month	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**National ***
A&E % would recommend	92.9	90	94.7	94.4	93.3	91.3	91	91.3	92.7	96.4	92.5	95.1	86.2
% would not recommend	1.7	1.5	1.8	0.7	1.4	0.8	1.9	1.4	1	0.8	1.7	1.4	7.5
% A&E Response Rate	40.7	37.8	33.8	34.4	31.8	37.1	40.9	32.5	29.9	92.7	33.5	37.3	12.7

*published data Apr16-Feb-17

Maternity

The F&FT for maternity is measured at four touch points. The majority of our responses are from the delivery suite and postnatal ward – these areas use an electronic tablet device to collect feedback. The results are displayed below for each of the touch points:

Q1- Antenatal
Q2- Delivery
Q3- Postnatal Ward
Q4- Postnatal community

The results for Maternity F&FT for the year April 2016 to March 2017 are displayed in the table below:

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**National ***
Q1 % would recommend	100	91.7	0	100	100	100	100	100	100	100	100	100	95.6
Q1 % would not recommend	0	8.3	0	0	0	0	0	0	0	0	0	0	1.5
Q1 % response rate	4	7	0	2.3	4.4	2	2.6	0.6	2	6.7	6.8	8.7	N/A
Q2 % would recommend	97.6	98.6	100	97.3	98	100	94.9	99.1	98.1	100	100	100	96.5

Q2 % would not recommend	0	0	0	1.3	2	0	0	0.9	0	0	0	0	1.2
Q2 % response rate	56.8	47.9	32.3	46.9	32.9	25.3	33.5	66.1	44.3	45.7	63.9	38.7	23.1
Q3 % would recommend	98.8	98.6	100	97.3	96.5	100	98.3	98.2	96.4	96.8	93.9	100	93.8
Q3 % would not recommend	1.2	0	0	0	1.8	0	0	0	1.8	0	0	0	1.9
Q3 % response rate	58.1	50.7	31.6	46.9	36.8	25.3	33.5	67.3	45.9	45.7	68.9	39.3	N/A
Q4 % would recommend	100	100	100	100	100	100	100	100	100	100	100	100	97.6
Q4 % would not recommend	0	0	0	0		0	0	0	0	0	0	0	0.9
Q4 % response rate	12.2	4.9	0.6	4.4	5.2	1.8	10.8	8.5	11.5	11.6	11.8	12.1	N/A

*published data Apr16-Feb-17

Community Services

The Community Services Business Unit became part of the Trust on the 1st of October 2016. The patient experience team has worked with our community colleagues to implement the F&FT as per the national guidance, with an understanding of the challenges of a diverse working and patient environment. A consistently increasing number of F&FT responses have been received each month, which is encouraging as the new Business Unit continues to embed this process. Grouped results for the Community Business Unit have been available since January 2017, as below. It is not currently possible to collect the population response rates for this F&FT.

The results for Community Services F&FT for the period January 2017 to March 2017 are displayed in the table below:

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**National***
% would recommend										98.3	97.8	98.4	95.3
% would not recommend										1	0	0	1.4

*published data Apr16-Feb-17

Outpatients

Outpatient services continue to show high patient approval with no monthly recommend rate below 93% for the last year which gives strong assurance that the vast majority of patients would recommend the Trust's services to friends and family. Results for the total outpatient service scores are outlined in the table below. It is not currently possible to collect the population response rates for this F&FT.

The results for outpatients F&FT for the year April 2016 to March 2017 are displayed in the table below:

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**National ***
% would recommend	94.9	95.1	94.3	95	94.8	93.7	96.3	97.8	97.5	96.8	97.5	97.5	92.9
% would not recommend	1.8	0.9	1.1	1.1	0.9	1.5	1	0.9	0.8	0.9	0.8	1.2	2.9

*published data Apr16-Feb-17

Mental Health Services

Mental Health inpatient and outpatient services continue to receive Friends and Family Test feedback with a consistent 100% recommend rate through the year. It is not currently possible to collect the response rates for this F&FT.

The results for Mental Health Services F&T for the year April 2016 to March 2017 are displayed in the table below:

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**National***
% would recommend	100	100	100	100	100	100	100	100	100	100	100	98	87.5
% would not recommend	0	0	0	0	0	0	0	0	0	0	0	2	4.4

*published data Apr16-Feb-17

The National Patient Survey Programme

The National Patient Survey Programme comprises of the annual adult inpatient survey, community mental health survey and in rotation every three years the A&E survey; maternity survey; children & young people survey and the outpatient survey. These national surveys are valuable sources of information on various aspects of our service and are used to measure and monitor our performance against Trusts locally and nationally. In May 2016 the Trust responded to a consultation from the CQC regarding proposed changes to the National Survey Programme. In 2016 the Trust enrolled in the adult inpatient survey, the A&E survey, paediatric emergency department and paediatric outpatient department survey.

Adult Inpatient Survey

There were 83 Trusts commissioned to undertake the 'Picker' inpatient survey in 2016. 1186 patients from our Trust were sent a questionnaire of which 551 were returned. This gave us a response rate of 46%; this is above the average response rate of 41% of the other 82 Trusts taking part in the survey.

A total of 63 questions were used in both 2015 and 2016 surveys.

In comparison to last year we were significantly better on 0 questions and significantly worse on 3 questions. The score showed no significant difference in 60 questions.

The Trust has worsened significantly on the following questions	2015	2016
Planned admission: should have been admitted sooner	12%	21%
Care: could not always find a staff member to discuss concerns with	50%	58%
Surgery: what would be done during operation not fully explained	13%	20%

An action plan and improvement map has been developed to look at the importance of each question in relation to the overall patient experience as an inpatient. This allows us to channel our resources into what matters to patients and how we can improve our service to meet patient needs.

85.2% of patients rated their care as seven or above out of ten.
86.3% of patients said they were treated with dignity and respect.
84.4% of patients said they always had confidence and Trust in the doctors treating them.
99.1% of patients said their room or ward was very or fairly clean.
95.8% of patients said the toilets and bathrooms were very or fairly clean.

A&E Survey

There were 75 Trusts commissioned to undertake the 'Picker' Emergency Department survey in 2016. 1250 patients from our Trust were sent a questionnaire of which 327 were returned. This gave us a response rate of 27%; this is slightly above the average response rate of 26% of the other 74 Trusts taking part in the survey.

The emergency department survey is currently repeated every other year. Looking at trends over a time helps to focus attention on improvements required. A total of 35 questions were used in both 2014 and 2016 surveys.

In comparison to 2014 we were significantly better on 12 questions and significantly worse on 0 questions. The score showed no significant difference in 23 questions.

Compared to other Trusts we were significantly better on 25 questions and significantly worse on 0 questions. The scores were average on 10 questions.

The Trust has improved significantly on the following questions:		
	Lower scores are better	
	2014	2016
Doctors/nurses: not enough time to discuss health or medical problems	24 %	13 %
Doctors/nurses: did not fully explain condition and treatment	28 %	21 %
Doctors/nurses: did not have complete confidence and trust	20 %	14 %
Doctors/nurses: did not have an opportunity to talk to a doctor	36 %	26 %
Care: not enough privacy when being examined or treated	15 %	7 %
Care: not always able to get help from staff when needed	37 %	27 %
Care: wanted to be more involved in decisions	36 %	26 %
Hospital: emergency department not very or not at all clean	3 %	0 %
Hospital: unable to get suitable refreshments	27 %	15 %
Leaving: not fully told when to resume normal activities	61 %	40 %
Leaving: not fully told about danger signals to look for	48 %	33 %
Overall: not treated with respect or dignity	16 %	9 %

Paediatric Emergency Department Survey

Two NHS Trusts took part in the survey; therefore our results are compared to the other Trust. However we have no historical data for comparison as this is the first year we have conducted the survey. Nonetheless the data creates a baseline for future surveys. Two surveys were carried out:

- Version 1: for parents/carers of children 0-7 years
- Version 2: for children 8-16 years

The Trust scored significantly better on 2 questions and significantly worse on 0.

- Not enough privacy when talking to doctors and nurses
- Not given enough privacy when being examined or treated

However one question was reported as room for improvement although not significantly worse than other Trusts, the department are addressing the issue urgently:

- Not enough for child's age group to do when waiting

Paediatric Outpatients Department Survey

Five NHS Trusts took part in the survey; therefore our results are compared to the other Trusts. Two surveys were carried out with the same divisions of age as the paediatric emergency department survey.

The Trust scored significantly better on 3 questions and significantly worse on 0.

- Booking in process at reception was fairly or not at all organised
- Amount of time spent with doctor was not fully acceptable
- Other healthcare professional was not always friendly and helpful

However 3 questions were reported as room for improvement although as previously they are not significantly worse.

- Parent not told there was a wait
- Parent did not fully know before appointment what was going to happen
- Child did not fully know before the appointment what was going to happen

Bespoke Picker Pain Survey

This survey was commissioned by the Trust in April 2016 to investigate the following question in the Picker adult inpatient survey 2014. The results were published in October 2016.

Trust average / Picker average	2013	2014	2015
Care: Staff did not do everything to help control my pain	22% / 29%	31% / 30%	27%/29%

- 61% of all respondents travelled to hospital by ambulance; 87% of these patients informed us they experienced pain in the ambulance. Of this group of patients 91% responded that the ambulance crew definitely did everything they could to control their pain.
- Over half of all the patients admitted via A&E reported they had experienced pain in the department. 28% of these patients reported that they did not receive pain relief quick enough. Whereas 30% reported they were offered pain relief without asking.
- 73% of all patients who experienced pain in A&E reported the staff definitely did everything they could to control their pain.
- Although the response rate was not as good as we would have wished the information gained told us that 79% of all patients who experience pain on the ward said that a staff member definitely told them what type of pain relief medication they were given.
- 52% of all respondents said that they had an operation during their hospital stay; in particular, 54% of all respondents who experienced pain on the ward reported that they had an operation or procedure.
- 92% of patients who had an operation or procedure said that they completely understood staff explanation of what would happen during the operation or procedure.

Leaving Hospital:

- 63% of all respondents said that they were given written or printed information about what to do if they experienced pain after leaving hospital.
- 74% of all patients agreed that they were told who to contact if worried after leaving hospital.
- 70% of all respondents reported that they completely understood staff explanation of the purpose of pain relief medication.

The results of the survey have provided the Trust's acute pain service with a baseline to develop their service.

Mystery Shopper

The concept of the mystery shopper, usually seen in retail has been expanded into the healthcare environment by Gateshead Health NHS Foundation Trust and Healthwatch Gateshead in partnership working. Patients are recruited to be 'mystery patients' during their surgery pre assessment appointment. The patients recruited will then be requested to evaluate their care at three points during their admission to the surgery 'PODS' at the Queen Elizabeth Hospital. Staff from Healthwatch Gateshead delivered Trust approved advertising posters and leaflets to surgical staff in January 2017 ready to commence recruitment of patients to the project in February 2017. The project is to operate for three months. Data will be analysed collaboratively for service improvement at the end of the project period.

Open and Honest Care

"*Driving improvement programme aims to support organisations to become more transparent and consistent in publishing safety, experience, an improvement data; with the overall aim of improving care, patient and culture"*

This document is reported and presented monthly for the Trust. It includes three key categories: safety, experience, and improvement. It includes information on performance related to these 3 categories including the F&FT and staff experience. The document also includes monthly patient stories and monthly service improvements within the Trust. An example of this can be seen below:

An Improvement Story

Smoothie bar is a sweet success for patients

The Trust's Nutrition and Dietetics team has pioneered a delicious new way to help patients get the nutrients they need as well as helping them to stay mobile during their hospital stay.

When patients are in hospital for prolonged periods of time, they become susceptible to something called pressure damage, sometimes known as bed sores. Malnutrition and immobility are key factors in the development of pressure damage, so the Nutrition and Dietetics team recently introduced a new initiative.

Dietitians set up a 'smoothie bar' near the nurses' station on a ward, where they make a range of nutritious fruit smoothies, such as strawberry and banana. Patients are required to collect these

from the bar which encourages them to keep mobile, while the smoothies themselves are full of nutrients and calories that cut the risk of malnutrition.

Dietitian Robyn Collery says: "*The smoothie bar initiative is off to a flying start and we are already seeing an improvement in outcomes for patients in our hospital. If a patient is well-nourished and hydrated then they tend to do so much better. Prevention is the best measure*."

Patients have commented:

"The combination of fresh fruit and a drink was a nice change and was very refreshing (very nice)."
"It would be good if they were on every day, they are very tasty."
"It gave us a little walk and we saw other staff and patients, most enjoyable."

The Nutrition and Dietetics team has also produced a range of useful recipe cards which patients and carers can take home so they're able to make their own smoothies once out of hospital.

A patient Story

This month we'd like to share the following patient story following a stay on ward 21 this January.

“I would like to say how amazing the junior sister was in handling my care from beginning to end. I was on the ward receiving treatment for a sensitive matter and I can't praise the junior sister enough.
I was looked after with so much care and compassion which is amazing and wonderful to see within the NHS. I was listened to and everything was explained. Being a nurse within the NHS myself I always expect a great standard of care from our health service and I certainly received it. The junior sister had a busy ward to run however she was never too busy to be there when I needed her, her nursing skills and people skills was second to none and she presented with a lovely attitude towards the patients on her ward.
I hope this compliment finds its way to the ward as I know how much work they put into every shift and how much pressure they are under, I would love for them to know that it doesn't go unnoticed and I express great gratitude to the junior sister and all the other staff on the ward they were a confident, reliable and empathetic bunch of professionals.
Thank you very much.”

Leaflet Amnesty

A leaflet amnesty project took place during the month of January 2017 in order to improve the quality of patient leaflets used in the Trust. This involved identifying existing leaflets which had not been approved for use by the Patient Information Review Panel, expired leaflets due for renewal, and also involved improving the professional appearance and uniformity of new and existing leaflets.

Various activities took place in this time including a new standard template which was developed to allow Trust leaflets to follow the same format. A 'top tips' guide was developed to support staff when creating new leaflets and a dedicated email address was created to receive enquiries.

The amnesty was a success with dozens of never before seen leaflets being submitted for approval, and almost one hundred new and existing leaflets brought up to date.

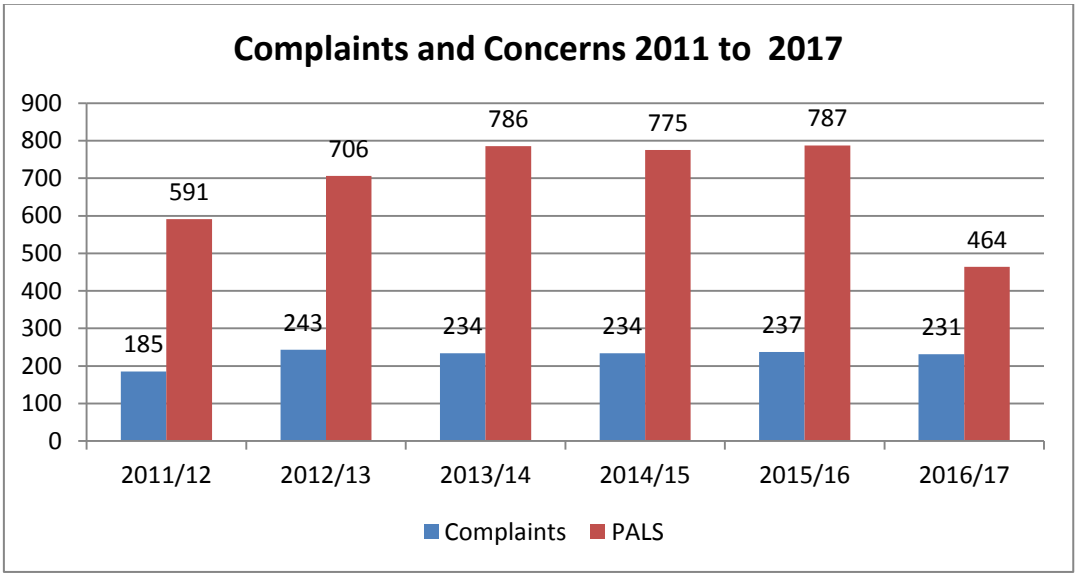
Since January a steady flow of leaflets have been reviewed monthly and future work includes leaflet projects within Radiology and the whole Community Business Unit.

Listening to Concerns and Complaints

The Trust acknowledges the value of feedback from patients and visitors and continues to encourage the sharing of personal experiences. This type of feedback is invaluable in helping us ensure that the service provided meets the expectations and needs of our patients through a constructive review.

For the year 2016/17 we received a total of 231 formal complaints. Promoting a culture of openness and truthfulness is a prerequisite to improving the safety of patients, staff and visitors as well as the quality of healthcare systems. It involves apologising and explaining what happened to patients who have been harmed as a result of their healthcare treatment or when inpatients or outpatients of the Trust. It also involves apologising and explaining what happened to staff or visitors who have suffered harm. It encompasses communication between healthcare organisations, healthcare teams and patients and/or their carers, staff and visitors and makes sure that openness, honesty and timeliness underpins responses to such incidents.

The Patient Advice and Liaison Service (PALS) offer confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and carers.



During 2016/17 the top five main reasons to raise a formal complaint were in relation to:

- Clinical Treatment – Surgical Group (50)
- Communications (39)
- Clinical Treatment – General Medical Group (38)
- Values & Behaviours (Staff) – 28
- Clinical Treatment – Accident & Emergency (27)

Complaints Performance Indicators	**Total 2016/17**
Complaints received	231
Acknowledged within three working days	231
Complaints closed	204
Closed within agreed timescale (25 working days)	95
Number of complaints upheld	97
Concerns received by PALS	464 *

** The way in which PALS cases are recorded was amended this year to reflect actual informal complaints/concerns.*

Complaints Indicators	**Total 2016/17**
Number of closed complaints reopened	12
Number of closed complaints referred to Health Service Ombudsman	7

Outcome of complaints referred to Health Service Ombudsman (HSO)	**Total 2016/17**
Awaiting decision	1 (draft report received – not upheld)
Complaints upheld	4
Part upheld	1
Declined to be investigated	1

As a result of complaints and concerns raised over the past year a number of initiatives have been implemented.

- A complainant raised an issue about a delay in performing CT guided biopsy. It has been recognised that a delay in the 1.00pm biopsy was a recurrent problem. To reduce the effect of this on patients and the consultants other clinical duties, the biopsies have subsequently been moved to a Tuesday afternoon, when the consultant has more flexibility.

- The guide for patients who are planning joint replacement surgery at the Peter Smith Surgery Centre is currently being revised. With feedback received it can now be made clear to say if a patient has not heard from the Orthopaedic Nurse Practitioner at two weeks they may have been unable to contact you, they would actively encourage patients to ring them to ensure that a conversation can still take place over the telephone to enable the patient to ask any questions, gain advice or voice any concerns.

- A review will take place of the Trust's policy relating to patients' property so that there is more clarity around the processes for non-valuable items.

- Matron in the Emergency Care Centre to organise regular audit of notes to ensure standards are maintained.

- Review of the processes at QE Metro Riverside regarding the arrangement for review/repair of hearing aids was carried out. All staff have been reminded that patients are unable to drop hearing aids off for repair and that they must be given a service and repair appointment.

- A complaint is to be used to highlight the importance of professional behaviour at the next ward away day. Concerns to be used as an anonymised example of the impressions staff make to patients, families and their carers.

- A complaint was raised regarding a patient's experience in the Maternity unit. It was agreed that more written information would have been beneficial for the patient on discharge as they were unaware a midwife should have called the next day. The unit now has written advice relating to the community midwife's visit the day following discharge, along with contact numbers for patients to ring if the midwife does not arrive. The process for discharging mothers from the Special Care Baby Unit (SCBU) has been reviewed and there is now a clear line of communication and responsibility for informing the administration team of mums who have gone home from all areas of the unit. The Maternity Administration team will inform the Community Midwifery team of that day's discharges and the new patients requiring a visit the next day.

- As a result of a complaint, the Alcohol Team has been asked to continue to raise awareness about the impact alcohol has on patients and their families and how they can be best supported.

3.4 Focus on Staff - Valuing Our People

This year has been another successful year for the Trust and the workforce. Doing everything we can to be 'the Best Employer' through recognising, involving and developing our staff within a learning culture, we want to ensure we are a high quality, patient-focused organisation. Despite the financial pressures facing all NHS organisations, we are still committed to training and supporting staff to reach their full potential, and to attracting and retaining the best calibre of people to provide our services.

Staff Involvement

The Trust has two key mechanisms for consulting with our employees across the organisation; Joint Consultative Committee for non-medical staff and Local Negotiating Committee for Medical Staff. Meetings are held regularly with representatives from trade union organisations and employee representatives to seek their views before decisions are made. This has been on matters ranging from policies and procedures to new systems or initiatives, and future plans of the Trust. These forums, supplemented by professional groups, business unit events, service line meetings and any organisational change processes include staff in matters relating to the financial, operational and quality performance of the Trust.

In 2016 the Trust worked through the Investor in People standard, being rated silver. We held a Valuing our People event to find out more about what makes our workforce feel valued following the Staff Survey results and 70 people had their say about what would make a difference to them.

Listening to our Staff through the NHS Staff Survey

The annual NHS Staff Survey is a critical tool in enabling the Trust to benchmark itself against similar NHS organisations and the NHS as a whole, on a range of measures of staff engagement and satisfaction. As demonstrated by our positive CQC rating, the staff who work at Gateshead Health NHS Foundation Trust are central to the delivery of high quality patient care, and therefore will always be a key priority.

Highlighted by the Trust's values of openness and honesty, we have a multi-faceted approach to Staff Engagement which includes partnership working with staff representatives, involving staff in service transformation work, regular communications via QE Weekly, staff briefings from the Chief Executive, using the Friends and Family Test, and our local Open and Honest surveys to regularly seek feedback from staff, using Excellence in Nursing Everyone Realising Great Innovations (ENERGI) boards in ward areas to share learning, as well as professional forums, away days and annual Senior Staff, and Nursing conferences.

This year the Trust chose to include all staff in the Staff Survey for the second consecutive year (not using a sample) to give everyone the opportunity to provide feedback. Our response rate is illustrated in the table below.

	2015/16		2016/17		Trust improvement/ Deterioration on previous year
Response rate	**Trust**	**National average**	**Trust**	**National average**	
	40%	41%	39%	43%	1% decrease

Measured against 32 CQC key indicators, the Trust performed favourably compared to other Acute Trusts in the UK in the following areas:

	2015/16		2016/17		Trust improvement/ Deterioration on previous year
Top 5 ranking scores	**Trust**	**National average**	**Trust**	**National average**	
Percentage of staff experiencing discrimination at work in the last 12 months	8%	10%	7%	11%	1% improvement
Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.81	3.70	3.89	3.72	0.08% improvement
Staff confidence and security in reporting unsafe clinical practice	3.68	3.62	3.79	3.65	0.11% improvement
Percentage of staff satisfied with the opportunities for flexible working patterns	50%	49%	56%	51%	6% improvement
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	22%	28%	23%	27%	1% deterioration

The Trust's lowest ranked scores in comparison to other Acute Trusts were:

	2015/16		2016/17		Trust improvement/ Deterioration on previous year
Bottom 5 ranking scores	**Trust**	**National average**	**Trust**	**National average**	
Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	38%	37%	40%	45%	2% deterioration
Percentage of staff/colleagues reporting most recent experience of	57%	53%	63%	67%	6% improvement

violence					
Percentage of staff appraised in the last 12 months	91%	86%	83%	87%	8% deterioration
Staff motivation at work	3.87	3.94	3.93	3.94	0.06% improvement
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	91%	90%	91%	90%	No change

Our ratings show that we are:

- In the top 20% of acute Trusts for fourteen key scores (11 in 2015/16)
- Better than average in ten key scores (8 in 2015/16)
- Average in four key scores (7 in 2015/16)
- Below average in three key scores (4 in 2015/16)
- Lowest 20% in one key score (2 in 2015/16)

We have had significant improvement on last year's results in the following areas:

- Improved support from immediate managers
- Increased contribution towards improvements at work
- Better quality of non-mandatory learning or development
- Staff more satisfied with the opportunities for flexible working patterns
- Fewer staff experiencing physical violence from other staff
- Fewer staff attending work when unwell because they felt pressure to do so
- Fairness/effectiveness of procedures for reporting errors, near misses and incidents

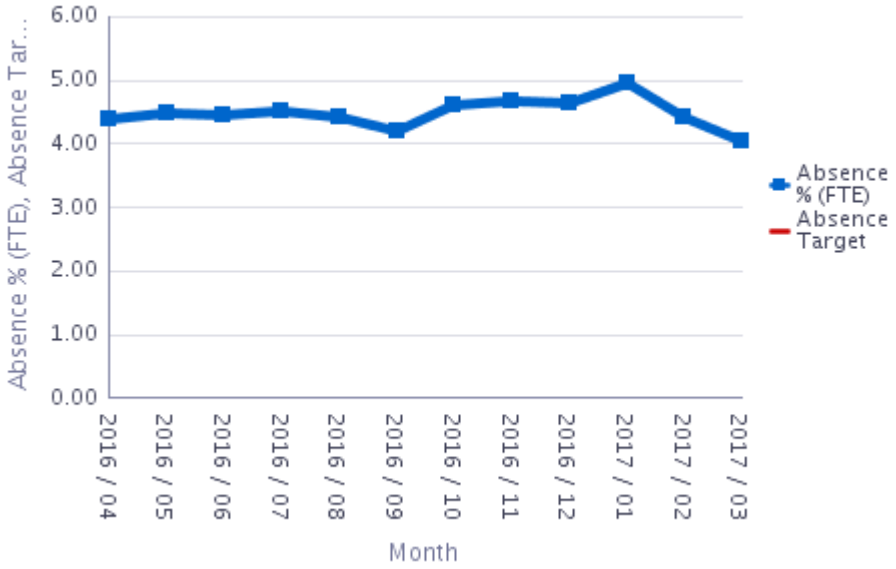
Following the publication of the 2015 survey results, the Trust set two year objectives to give us sufficient time to make changes and embed them, before the next survey. Therefore the 2016 results are a mid-point measure of progress. We have improved already against two of our goals however we will continue to work on:

Objective 1: Improving the Health & Well-being of staff and reduction of stress
Objective 2: A redesigned appraisal framework based on our values and behaviours
Objective 3: Eradication of violence between colleagues; taking a zero tolerance approach

Health and Well-being

There is a wealth of research to say that having healthy staff, both in mind and body, has a positive impact on the quality of patient experience and clinical outcomes. For this reason, the Trust invests in making sure that the right conditions and support are in place to create a healthy workforce with activities and to hold events to increase healthier lives throughout the year.

Gradually, the Trust is supporting more staff to be able to attend and sustain attendance at work, with as much support as we can provide. Sickness absence has reduced throughout the year to 4.49% (65,797 days lost) from 1 April 2016 – 31 March 2017.



We have an in-house Occupational Health Department consisting of an Occupational Health Physician, a nursing team, a multi-disciplinary ergonomics team, a physiotherapist, a counselling service; all supported by an administration team. The service holds national accreditation as a Safe Effective Quality Occupational Health Service (SEQOHS) following rigorous independent assessment against recognised industry standards across the UK.

Throughout 2016-17 we have provided 3703 appointments for staff which can be broken down as follows:

- ✓ 323 counselling appointments
- ✓ 1008 Pre-employment screening appointments
- ✓ 1222 Vaccination/immunisation screenings
- ✓ 291 Ergonomic and workplace assessments
- ✓ 691 Sickness absence management appointments
- ✓ 233 other consultations
- ✓ 89 appointments associated with sharps injuries
- ✓ 207 Physiotherapy referrals
- ✓ 29 Health Surveillance appointments

In 2016/17 we were also delighted to see that 76.1% of our staff chose to have their flu vaccination, to protect themselves, their family and our patients and visitors. This was a significant increase on previous years and the 3rd highest in the North East.

Organisational Development (OD)

The Five Year Forward View requires new and innovative ways of thinking and working. The Trust has focused this year on developing an OD plan that will support our staff and our Trust to be ready for the challenges ahead. This has included:

- ➢ Supporting the coming on board of the Community Service Teams as part of the Gateshead Care Partnership on 1st of October 2016.

- Skills Development for individuals and teams
- Looking at the introduction of Schwartz Rounds to encourage sharing and connections between services and alignment to our organisational values, particularly openness, compassion, Trust and respect.
- Encouraging and embedding the use of Insights and the Health Care Leadership models as ways to improve individual behaviours and team working.
- Work has begun to be able to identify the talent in the Trust, and how this will help us have succession pathways to support our future workforce needs.

Recruitment and Retention

At the end of 2016/17 we employed 4192 people. The number is broken down as follows:

PROFESSION	
Additional Professional, Scientific and Technical	157
Additional Clinical Services	776
Administrative and Clerical	854
Allied Health Professionals	269
Estates and Ancillary	454
Healthcare Scientists	160
Medical and Dental	277
Nursing and Midwifery Registered	1240
Students	5
Total	**4192**

A comparison of our workforce is provided below:

	2015/16	%	2016/17	%
AGE				
17-21	79	2.51	106	2.53
22+	3069	97.49	4086	97.47
ETHNICITY				
White	2979	94.64	3987	95.11
Mixed	13	0.41	19	0.45
Asian or Asian British	100	3.18	107	2.55
Black or Black British	25	0.79	32	0.76
Other	23	0.73	21	0.50
Not Stated	8	0.25	26	0.62
GENDER				
Male	585	18.58	841	20.06
Female	2563	81.42	3351	79.94
RECORDED DISABILITY				
	67	2.13	91	2.17

As at 31st of March 2017 our Board of Directors was 50% male and 50% female.

Our Senior Executives are 83.33% male and 16.66% female.

Work Experience
The Trust offers an extensive work experience programme enabling us to build invaluable links with the surrounding community through working with local schools and colleges. By providing work experience for 14 -19 year old students throughout the Trust, we are aiming to build and grow our workforce for the future. Work placements are offered in a number of different areas across the Trust including medicine, midwifery, nursing and physiotherapy to help local young people to gain a broader understanding in these areas. In 2016/2017 the Trust accommodated more than 150 placements with over half taking place on the medical shadowing programme. We also hosted a Careers Event for local schools in 2016.

Policies and Practices to support Disabled Staff
The Trust supports Project Choice in conjunction with Gateshead College, which provides young people who have learning difficulties/disabilities with support and access to work experience placements and employment opportunities. We have also offered internships in areas of the Trust such as reception, HR and administration working with Azure to support and rehabilitate individuals into the workplace.

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we treat staff reflects their individual needs and does not unlawfully discriminate against individuals or groups on the grounds of any protected characteristic (Equality Act 2010). Our key employment policies promote the right of all staff to be treated fairly and consistently in accordance with equality and human rights requirements. We reviewed our Recruitment and Selection Policy in 2017 and this policy encourages the use of reasonable adjustments as a means of removing any disadvantage for disabled persons. In 2016 we also developed a new Supporting and Managing Sickness Absence Policy to provide a supportive framework to help employees return to work where possible. We work with Access to Work, part of Jobcentre Plus, to ensure we consider the most appropriate reasonable adjustments to support our employees.

We are confirmed as a Disability 'Two Ticks' employer. This symbol is awarded by Jobcentre Plus to employers who have agreed to make certain positive commitments regarding the employment, retention, training and career development of disabled people. In December 2016, as an extension to the 'Two Tick' employer scheme, the Trust was awarded the Disability Confident Leaders award. This is awarded following a self-assessment whereby the Trust must demonstrate that it works to attract and retain disabled people.

We are a Mindful Employer, which demonstrates our commitment to supporting staff who experience stress, anxiety, depression or other mental health conditions. As part of this charter, we raise awareness and share information to support both existing and prospective employees. The Trust successfully demonstrated compliance with the charter in 2016 to retain the award for a further three years.

A Learning Culture

Some of the initiatives we are proud of this year would be our Library Quality Assurance Framework visit (LQAF) awarding the library service a score of 95% compliance. This is an increase of 3% from 2015. This gives a green quality assurance status (ranking the Trust 3rd in the North East Region with 99% being the highest scored).

We have also had positive feedback from a General Medical Council (GMC) Survey in relation to our Doctors in Training and an Annual Deans Quality Meeting from Health Education England (HEE) commending our commitment to providing a positive learning environment for all.

We believe that effective leadership means not only having the right knowledge and skills, but demonstrating the right behaviours and values to ensure patient safety and quality. Our strategy has embraced the Healthcare Leadership Model as a means of ensuring that consistent messages are given around appropriate leadership behaviours. As such we've been developing our behaviour statements in line with the Trust's values.

Our employees also have access to the many opportunities available to them via eLearning, development sessions, postgraduate support for specialist development, and Continuing Workforce Development (CWD) sessions as commissioned by HEE North East.

The Trust continues to provide apprenticeship opportunities to support young people to gain valuable experience and a vocational qualification with the ultimate aim of securing employment within the NHS. In September 2016 the Trust recruited 15 Business & Administration apprentices and 19 Healthcare apprentices.

Following the success of the Nurse Cadet programme which was commenced in 2012, we were delighted to hear that all of those students, upon completion of various University qualifications have now returned to the Trust as Adult or Children's nurses. Going forward, we have appointed our first eight student Nursing Associates in February 2017. The Nursing Associate role is a new support role that will sit alongside existing fully qualified registered nurses to deliver hands-on care. Gateshead is part of the 2nd wave of national 'test-sites' chosen to deliver training over a two- year programme.

Reward and Recognition

We continue to look for innovative ways to recognise our staff. This year we ran a media campaign to get our public and patients to nominate their "Gateshead Angel" recognising the importance of our patients' voices. 500 people took to social media in a single month to let us know their stories and nominations.

We also held our annual Star Awards event; a humbling and proud evening where over 150 staff joined patients and partners from the local community to celebrate the amazing work our staff do each and every day. Those who were nominated as a Star of the organisation received a personal note from the Chief Executive letting them know that their contribution counts.

Diversity and Inclusion

The Trust has operated a human rights based approach to promoting equality, diversity and human rights for many years. This is reflected in the 'Vision for Gateshead', which promotes the core values of equality, respect, trust, dignity and openness. The aim is to ensure services are accessible, culturally appropriate and equitably delivered to all parts of the community, by a workforce which is valued and respected, and whose diversity reflects the community it serves.

To support accountability, there is a well-established infrastructure in place which has provided leadership, governance and continuity, for example:

- The Trust Board has appointed Governors from diverse backgrounds, including Gateshead Youth Council, the Jewish Council and the Diversity Forum for Gateshead. Many Governors are active members of groups and committees.
- We publish a separate annual report relating to diversity and inclusion, on a dedicated part of the QE Gateshead website. Information about diversity and inclusion can be accessed using the following link: http://www.qegateshead.nhs.uk/edhr
- During 2016-7, the Diversity and Inclusion Steering Group was reviewed and this group now meets bi-monthly. It undertakes a range of equality work relating to both patient care and employment, and its membership includes the Chairman, Deputy Director of Workforce, Governors and Staff Side Representatives. Minutes of the group are received by the HR Committee which feeds into the Trust Board.
- The Trust has invested in corporate membership of the Employers Network for Equality & Inclusion, which is a leading employer network covering all aspects of equality and inclusion issues in the workplace. We aim to develop a programme of work in partnership with other NHS organisations in the North East region to support an inclusive and diverse workplace. We will use this work to help build staff networks, to offer support and the opportunity for feedback in the future.

In addition, the following important areas of work were undertaken in 2016-17:

The Workforce Race Equality Standard (WRES) was introduced in the NHS in 2015, with the aim of ensuring all NHS organisations could demonstrate annual progress using nine different indicators (metrics) of workforce race equality. Four of the metrics are from workforce data and four of the metrics are based on data derived from the national NHS Staff Survey. The Trust published our second WRES information in 2016, and the Diversity and Inclusion Steering Group considers this information and use it to inform appropriate actions to ensure the treatment of our staff is not unfairly affected by their ethnicity.

The Accessible Information Standard was implemented in 2016 and the Trust has a working group to improve practice in relation to how our patients' communication requirements are met. As part of this work we are currently reviewing our interpreting services and developing a ward based communications assessment tool to ensure we are able to respond to differing needs.

The Equality Delivery System (EDS) was adopted by the Trust in 2012, and refreshed with EDS2 during 2016-7. This is a framework developed by the NHS to help review and assess equality performance, to ensure there are better health outcomes for patients and communities, and better working environments for staff. It also helps to demonstrate compliance with the Equality Duty. At the heart of the EDS2 there are four goals to consider, and 18 different equality objectives. We have gathered a wide range of evidence and measured and graded our performance by consulting with patients, staff and communities. From this the Trust identified our own equality objectives for the next four years:

1. All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers.

2. The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments.
3. Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve.

This year we have appointed three Executive Directors to champion the Equality Objectives.

To promote a supportive and positive working environment, the Trust has developed a workplace Mediation Service and trained 12 accredited mediators in 2016/17 to support positive informal resolution to workplace issues. We also provided refresher training for our Bullying and Harassment Advisors.

3.5 Quality overview - performance of Trust against selected indicators

In the following sections are a range of quality indicators where the Trust performance can be seen. These further develop the three domains of quality (Patient Safety, Clinical Effectiveness and Patient Experience). The indicators themselves have been extracted from NHS nationally mandated indicators, Commissioning for Quality and Innovation (CQUIN), and locally determined measures. Trust performance is measured against a mixture of locally and nationally agreed targets. The key below provides an explanation of the colour coding used within the data tables.

	Target achieved
	Although the target was not achieved, it shows either an improvement on previous year or performance is above the national benchmark
	Target not achieved but action plans in place

Where applicable, benchmarking has been applied to the indicators using a range of data sources which are detailed in the relevant sections. The Trust recognises that benchmarking is an important attribute that allows the reader to place the Trust performance into context against national and local performance. Where benchmarking has not been possible due to timing and availability of data, the Trust will continue to work with external agencies to develop these in the coming year.

1) Visible Leadership for Safety and Culture

Outcomes of Trust Wide MaPSaF Patient Safety Culture Assessment:

2013/2014	2014/2015	2015/2016	2016/2017	Target
Pro-Active	*No Assessment Due	*No Assessment Due	*No Assessment Due	* Due

MaPSaF Assessment was undertaken in May – September 2013 as part of a three year cycle. A MaPSaF Patient Safety Culture Assessment was not undertaken this year as planned, as we feel this is now not fit for purpose and outdated. This year we have identified that a more focused piece of work needs to be undertaken to re-fresh and re-focus our efforts around all elements of the Trust patient safety culture. Improving the patient safety culture is therefore one of our Quality Priorities for 2017 – 18 and will have its own work plan.

Executive Quality and Safety Walkabouts (implemented from February 2010):

Executive Walkabouts	2014/15	2015/16	2016/17	Target
Executive walkabouts Undertaken	N/A	10	6	12
Average Walkabouts Undertaken per month	1.9	0.8	0.5	1
Cumulative Actions Identified	35	39	2	N/A
Cumulative Actions Implemented	27	39	2	N/A
Outstanding Actions (more than 60 days old)	0	0	0	90% less than 60 days old

Source:Trust Quality & Safety Dashboard

This year we have achieved only 50% of our executive quality and safety walkabouts, with planned walkabouts being cancelled due to work pressures. Going forward, we are planning a more robust approach of 'back to the floor' which is currently under discussion as the current walkabouts are not fit for purpose in today's NHS.

2) Team Effectiveness / Efficient / Innovative

Team Effectiveness	2014-15	2015-16	2016-17	Target	National Benchmark
Mandatory Training Compliance (Percentage take up on allocated places)	78.55%	74.56%	73.37%	90%	N/A
Personal Development Plan (PDP) Compliance (Staff with a timely completed PDP)	66.15%	71.93%	81.82%	90%	N/A
Staff Sickness and Absence (As reported from personnel)	5.00%	4.82%	4.49%	4.00%	3.98%* (Jul 16 – Sep 16)
Staff Turnover (Labour turnover based of Full Time Equivalent)	15.92%	24.63%**	12.92%	10%	N/A

*source: http://www.content.digital.nhs.uk/catalogue/PUB23162

**the significant shift in turnover is in relation to staff transferring to QE Facilities.

The reduction in compliance for mandatory training has been impacted since the transfer of community staff and the establishment of the community services business unit (compliance rate is currently 32.6%) and action plans are in place as part of our organisational transition.

3) Safe Reliable Care / No Harm

A) Reducing Harm from Deterioration:

Safe Reliable care	2014-15	2015-16	2016-17	Target
HSMR*	104.12	100.2	104.0**	<100
SHMI Period	Apr-15 Mar-16	Jun 15 - Jul 16	Oct 15 – Sept 16	
SHMI	1.00	0.95	0.99	<=1
SHMI Banding	As Expected	As Expected	As Expected	As expected or lower than expected
SHMI - Percentage of admitted patients whose treatment included palliative care (contextual indicator)	16.7%	16.0%	15.0%	N/A
Crude mortality rate taken from CDS	1.72%	1.71%	1.67%	<1.99%
Number of calls to the CRASH team	192	224	177	N/A
Of the calls to the arrest team what percentage were actual cardiac arrests	44.8%	48.7%	53.1%	N/A
Cardiac arrest rate (number of cardiac arrests per 1000 bed days)	0.46	0.58	0.50	N/A
Hospital Acquired Pressure Damage (grade 2 and above)	161	108	104	Year on year

				Reduction
Community Acquired Pressure Damage (grade 2 and above)	772	854	1214†	N/A
Number of Patient Slips, Trips and Falls	1687	1902		N/A
Rate of Falls per 1000 bed days	9.26	10.21	9.18	Reduction (<8.5)
Number of Patient Slips, Trips and Falls Resulting in Harm**	468	484	407	N/A
Rate of Harm Falls per 1000 bed days	2.57	2.60	2.24	Reduction (Less than <2.25)
Falls Change	7.1% Increase	1.2% Increase	13.5% reduction	Reduction (Less than <2.25)
Ratio of Harm to No Harm Falls (i.e. what percentage of falls resulted in Harm being caused to the patient)**	27.74%	25.45%	24.40%	Year on Year reduction

* HSMR figure taken from HED April 2017

**HSMR figures are April to January 2017

† Community services transferred from South Tyneside in October 2016

B) Reducing Avoidable Harm:

Reducing Avoidable Harm		2014-15	2015-16	2016-17	Target
Medication Errors	No Harm	307	366	413	N/A
	Minimal Harm	21	51	45	N/A
	Moderate Harm	8	5	3	<8
	Severe	2	1	0	0
	Total	338	423	461	N/A
Never Events		2	2	3	0
Patient Incidents per 1,000 bed days		32.59	34.72	37.33	N/A
Rate of patient safety incidents resulting in severe harm or death per 100 admissions		0.16	0.16	0.18	N/A

Source: Trust incident reporting system Datix

C) Infection Prevention and Control:

Infection Prevention & Control	2014-15	2015-16	2016-17	2016-17 Target
MRSA Bacteraemia apportioned to Acute Trust post 48hrs	1†	1^^^	0	0
MRSA Bacteraemia per 1,000 bed days	0.005	0.005	0	Year on year Reduction
NB: Clostridium Difficile Infections post 72hrs	14††	18^	11^^	<19
Clostridium Difficile Infections per 10,000 bed days	1.43	1.34^	0.605^^	Year on year Reduction

Uniform Policy	99.0%	98.7%	99.2%	100%
Hand Hygiene	98.8%	98.2%	99.1%	100%
Intravenous Cannula	96.4%	94.4%	96.3%	100%
Indwelling Catheter	97.4%	94.6%	95.8%	100%
Equipment Clean and Records Up To Date	97.8%	97.8%	97.8%	100%

^^During the 2016/17 period the Trust reported zero (0) MRSA bacteraemia. The Trust reported 20 cases of CDI overall however nine (9) cases were deemed unavoidable with eleven (11) CDI cases against the Trust objective of nineteen (19).

^During 2015/16 the Trust reported one (1) MRSA bacteraemia. A post infection review (PIR) meeting took place identifying the case result as a contaminant and not an infection. The Trust reported forty eight (48) post 72hr CDI; thirty (30) cases were deemed as being unavoidable by an expert panel, this meant the Trust had a total of eighteen (18) avoidable cases of CDI against an objective of nineteen (19).

†In 2014/15 the Trust reported 1 MRSA bacteraemia. A Post Infection Review (PIR) meeting took place in February 2015. The outcomes and lessons learned from the PIR determined a number of clinical learning opportunities and attributed responsibility to the Trust as an unavoidable healthcare associated infection in agreement with the Commissioners. The Trust demonstrated robust systems were in place providing assurance that the process of clinical learning was arranged to prevent similar cases occurring in the future.

†† In 2014/15 the Trust had 26 cases of CDI; 12 cases of CDI were deemed as being unavoidable by an expert appeal panel. This meant that the Trust had a total of 14 avoidable cases of CDI against a trajectory of 24.

*In 2013/14 the Trust had one case of MRSA bacteraemia however; this was as the result of a contaminated specimen not an infection.

**In 2012/13 the Trust had 29 cases of Clostridium Difficile infection (CDI), 7 cases of CDI were deemed as being unavoidable by an expert appeal panel. This meant that the Trust had a total of 22 avoidable cases of CDI against a trajectory of 21.

***In 2013/14 the Trust had 20 cases of CDI; 4 cases of the CDI were deemed as being unavoidable by an expert appeals panel. This meant that the Trust had a total of 16 avoidable cases of CDI against a trajectory of 17.

4) Right Care, Right Place, Right Time

Care of patients following a Stroke:

Results from the Sentinel Stroke National Audit Programme (SSNAP) are provided below. This replaces the Stroke Bundle data used in previous quality accounts to allow ongoing measuring and benchmarking.

Team Centred Key Indicators	Apr-Jun 15	Jul-Sep 15	Oct-Dec 15	Jan-Mar 16	Apr-Jul 16	Aug-Nov 16
1) Scanning	D	D	D	C	A	B
2) Stroke unit	C	D	D	D	D	C
3) Thrombolysis	D	E	D	C	B	C
4) Specialist Assessments	C	C	D	D	B	C
5) Occupational therapy	A	B	A	A	A	B
6) Physiotherapy	C	C	A	A	A	A
7) Speech and Language therapy	E	E	D	E	A	D
8) MDT working	D	D	D	D	B	D
9) Standards by discharge	E	D	B	D	B	B
10) Discharge processes	D	D	A	C	B	A
Team-centred Total KI level	D	D	C	D	A	B
Team-centred Total KI score	48	44	62	56	84	70
Team-centred SSNAP level (after adjustments)	D	E	D	D	C	D
Team-centred SSNAP score	45.6	35.5	55.8	53.2	67.8	59.8

Source: https://www.strokeaudit.org/results/Clinical-audit/National-Results.aspx

Key Stroke indicators are grouped into domains, and each domain is given a performance level (level A to E). The domain levels are then combined into a Total Key Indicator scores. The methodology aims to take into account guideline recommendations and clinical consensus. The SSNAP Summary Report, including scores and levels, will be made available in the public domain.

Other Indicators:

Other Indicators	2014-15	2015-16	2016-17	Target	Benchmark
Percentage of Cancelled Operations from FFCE's††	0.97%	0.97%	0.70%	0.80%	1.1%**
Percentage of Patients who return to Theatre within 30 days (Unplanned / Planned / Unrelated)†	5.43%	5.31%	4.80%	Improve Year on Year	N/A
Fragility Fracture Neck of Femur operated on within 48hrs of admission / diagnosis	91.15%	91.16%	91.81%	90%	N/A
Proportion of patients who are readmitted within 28 days across the Trust*	9.43*	9.23%	8.66%	Improve year on year	N/A
Proportion of patients undergoing knee replacement who are readmitted within 30 days*	5.38% 28 patients readmitted	9.78% 57 patients readmitted	5.56% 19 patients readmitted†	Improve Year on Year	N/A
Proportion of patients undergoing hip replacement who are readmitted within 30 days*	11.25% 62 patients readmitted	12.3% 29 patients readmitted	9.01% 42 patients readmitted†	Improve Year on Year	N/A

* Figures taken from Healthcare Evaluation data (HED) and provide a full year for 2014-15, 2015,16 and Apr to Dec 2017-18

** NHS England Statistics - NHS Cancelled Elective Operations Quarter Ending December 2016

***Data for FNOF April to February 15/16

†† FFCE's refer to First Finished Consultant Episodes. A patient's treatment or care is classed as a spell of care. Within this spell can be a number of episodes. An episode refers to part of the treatment or care under a specific consultant, and should the patient be referred to another consultant, this constitutes a new episode.

†Figures taken from HED for period April – December 2016.

5) Positive Patient Experience

Positive Patient Experience	2014-15	2015-16	2016-17	Target / Benchmark
Communication	5.86	5.77	5.44	5.4
Care	5.91	5.86	5.59	5.4
Compassion	5.96	5.95	5.83	5.4
Overall composite Score	5.91	5.86	5.62	5.4

Average scores taken from several questions in each domain. Scores are out of a maximum of 6.

The overall composite score is an average of all scores in the questionnaire.

	Question	2014-15	2015-16	2016-17	Target / Benchmark
Communication	When you reached the ward, did you get enough information about ward routines e.g. mealtimes, visiting, doctors ward rounds?	5.61	5.48	4.95	5.4
	When you had important questions to ask a member of staff did you get answers that you could understand?	5.93	5.84	5.52	5.4
	If your family or anyone else close to you wanted to talk to a doctor did they get the opportunity to do so?	5.94	5.89	5.69	5.4
	Have you been involved as much as you wanted to be in decisions about your care and treatment?	5.91	5.83	5.50	5.4
	Have you found someone to talk to about your worries and fears?	5.94	5.79	5.61	5.4
Care	Do you get enough help from staff to eat your meals?	5.97	5.96	5.75	5.4
	Do you get enough help from staff with washing and dressing?	5.97	5.95	5.80	5.4
	If you pressed the call bell, did staff respond promptly?	5.82	5.72	5.32	5.4
	Did the staff do everything they could do to help control any pain you were experiencing?	5.92	5.91	5.67	5.4
Compassion	Do the staff looking after you have a caring and compassionate attitude?	5.95	5.94	5.80	5.4
	Do you feel you are treated with respect?	5.96	5.97	5.86	5.4
	Do you feel you are treated in a friendly manner?	5.97	5.97	5.84	5.4
	Are you given enough privacy and treated with dignity when discussing your condition or treatment?	5.98	5.94	5.82	5.4

Responsiveness to Inpatients' personal needs Question	2014	2015	2016	Average†
Was the patient as involved as they wanted to be in decisions about their care and treatment?	61%	62%	57%	56%
Did the patient find someone to talk to about their worries and fears?	45%	50%*	42%	38%
Was the patient told about medication side effects to watch out for?	49%	48%*	46%*	39%
Was the patient told who to contact if they were worried?	82%	85%*	82%*	80%
Was the patient given enough privacy when discussing their condition or treatment?	81%	80%*	82%*	76%
Overall Composite Score	64%	65%	63%	58%

*Scores significantly better than average

†Average score for all 'Picker' Participating Trusts

Source: Picker Institute Inpatient Survey 2016 Gateshead Health NHS Foundation Trust Final Report January 2017

6) Safe, Effective Environment, Appropriate Equipment & Supplies

Patient-Led Assessments of the Care Environment (PLACE)		2013	2014	2015	2016
Cleanliness	Gateshead Health NHS Foundation Trust	98.93%	99.64%	99.78%	99.94%
	National Average	95.75%	97.25%	97.57%	98.06%
Food	Gateshead Health NHS Foundation Trust	86.10%	89.14%	93.47%	91.53%
	National Average	88.79%	86.09%	87.21%	88.24%
Environment	Gateshead Health NHS Foundation Trust	90.29%	94.33%	93.13%	96.52%
	National Average	88.78%	91.97%	90.11%	93.37%
Privacy, Dignity and Wellbeing	Gateshead Health NHS Foundation Trust	92.11%	90.79%	84.61%	84.65%
	National Average	86.98%	87.73%	86.03%	84.16%
Dementia	Gateshead Health NHS Foundation Trust	N/A	N/A	64.93%	75.76%
	National Average	N/A	N/A	74.51%	75.28%

Sources:

www.hscic.gov.uk/catalogue/PUB18042

www.hscic.gov.uk/catalogue/PUB14780

www.hscic.gov.uk/catalogue/PUB11575

http://content.digital.nhs.uk/catalogue/PUB21325

The Maximiser is an electronic auditing tool for measuring environmental cleanliness. It is a handheld device that captures audit scores (PASS /FAIL) against checklist items and calculates scores for each area. Below are the results for the Trust as a whole.

Maximiser	Target	2014-15	2015-16	2016-17
Gateshead Health NHS Foundation Trust	98.00%	98.64%	98.31%	98.60

3.6 National targets and regulatory requirements

No	Indicator		2014/15	2015/16	2016/17	Target	National Average
1	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted**		91.6%	86.5%	83.7%	90.0%	78.0%
2	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted**		96.9%	94.4%	91.4%	95.0%	90.8%
3	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway**		94.7%	93.1%	93.4%	92.0%	90.0%
4	A&E – maximum waiting time of four hours from arrival to admission / transfer / discharge		95.5%	93.7%	96.1%	95.0%	89.6%
5	All cancers: 62 day wait for first treatment from: urgent GP referral for suspected cancer /		86.0%	86.1%	86.7%	85.0%	82.3%†
	NHS Cancer Screening Service referral		96.1%	95.3%	94.5%	90.0%	92.0%†
6	All cancers: 31 day wait for second or subsequent treatment, comprising:	Surgery	99.2%	99.3%	100.0%	94.0%	95.4%†
		Anti-cancer drug treatments	99.7%	99.7%	99.7%	98.0%	99.4%†
		Radiotherapy	N/A	N/A	N/A	94.0%	97.3%†
7	All cancers: 31 day wait from diagnosis to first treatment		99.4%	99.4%	99.9%	96.0%	97.6%†
8	Cancer: two week wait from referral to date first seen, comprising:	All urgent referrals (cancer suspected)	93.5%	93.9%	96.80%	93.0%	94.3%†
		Symptomatic breast patients (cancer not initially suspected)	92.9%	94.9%	96.50%	93.0%	93.6%†
9	Care Programme Approach (CPA) patients,	Receiving follow up contact within seven days of discharge	95.0%	82.8%	84.60%	95.0%	96.6%††

	comprising:	Having formal review within 12 months	nil return*	nil return*	nil return*	95.0%	N/A
10	Minimising mental health delayed transfers of care		0.0%	0.0%	0.0%	< 7.5%	N/A
11	Mental health data completeness: identifiers		99.2%	99.8%	99.70%	97.0%	N/A
12	Mental health data completeness: outcomes for patients on CPA		93.5%	73.5%	85.4%	50.0%	N/A
13	Certification against compliance with requirements regarding access to health care for people with a learning disability		N/A	N/A	N/A	N/A	N/A
14	Data completeness: community services, comprising:	Referral to treatment information	92.4%	92.5%	98.1%	50.0%	N/A
		Referral information	100.0%	100.0%	100.0%	50.0%	N/A
		Treatment activity information	100.0%	100.0%	100.0%	50.0%	N/A

Source: http://www.england.nhs.uk/statistics/statistical-work-areas

* There were no qualifying patients for this period

**Figures for Trust's 18 weeks relate to 2016-17 data up to and including February 2017

†Cancer waiting times Benchmarking figures are 2016-17 to Dec 16

††CPA Patients Q1-Q3 2016-17

Annex 1: Feedback on our 2016/17 Quality Account – to be added once received

4.1 Gateshead Overview and Scrutiny Committee

4.2 Gateshead Clinical Commissioning Group

4.3 Healthwatch

4.4 Council of Governors Representative

Annex 2: Statement of directors' responsibilities in respect of the quality account – to be updated on final document

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the Quality Report meets the requirements set out in the NHS foundation Trust annual reporting manual 2016/17 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:

    - board minutes and papers for the period April 2016 to 24th May 2017
    - papers relating to quality reported to the board over the period April 2016 to 24th May 2017
    - feedback from commissioners dated XX/XX/2017
    - feedback from governors dated XX/XX/2017
    - feedback from local Healthwatch organisations dated XX/XX/2017
    - feedback from Overview and Scrutiny Committee dated XX/XX/2017
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31/03/2017
    - the 2016 national patient survey February 2017
    - the 2016 national staff survey March 2017
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated XX/XX/2017
    - CQC inspection report dated 24/02/2016

- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered

- the performance information reported in the Quality Report is reliable and accurate

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

.....Date.....Chairman

.....Date.....Chief Executive

Glossary of Terms

Antimicrobial
Is an agent that kills micro-organisms or inhibits their growth. Antimicrobial medicines can be grouped according to the micro-organisms they act against. For example, antibacterials are used against bacteria and antifungals are used against fungi.

Cardiotocography (CTG)
Cardiotocography (CTG) is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy.

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

Clinical Audit
Clinical audit measures the quality of care and service against agreed standards and suggests or makes improvements where necessary.

Clostridium *difficile* (C. diff)
Clostridium difficile is a bacterium that occurs naturally in the gut of two-thirds of children and 3% of adults. It does not cause any harm in healthy people, however some antibiotics can lead to an imbalance of bacteria in the gut and then the Clostridium difficile can multiply and produce toxins that may cause symptoms including diarrhoea and fever. This is most likely to happen to patients over 65 years of age. The majority of patients make a full recovery however, in rare occasions it can become life threatening.

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

Commissioners
These are responsible for ensuring that adequate services are available for their local population by assessing need and purchasing services.

Corporate Management Team (CMT)
A weekly meeting of the executive management within the Trust.

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

Dignity
Dignity is concerned with how people feel, think and behave in relation to the worth or value that they place on themselves and others. To treat someone with dignity is to respect them as a valued person, taking into account their individual views and beliefs.

Diabetic Ketoacidosis
Diabetic ketoacidosis is a dangerous complication of diabetes mellitus in which the chemical balance of the body becomes far too acidic.

Duty of Candour
Duty of candour places a legal obligation on health care providers to be open about any patient safety incident resulting in a moderate harm, severe harm or death.

Electronic Prescribing Medicines and Administration System (EPMA)
Electronic Prescribing and Medicines Administration (EPMA) is a systems to improve patient safety by reducing prescribing and administration errors that could result in medication errors and adverse drug events

Healthcare Quality Improvement Partnership
The Healthcare Quality Improvement Partnership (HQIP) was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales.

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

Foundation Doctors
A Foundation Doctor (FY1 or FY2) is a grade of medical practitioner in the United Kingdom undertaking the Foundation Programme which is a two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training. The grade of Foundation Doctor has replaced the traditional grades of Pre-registration House Officer and Senior House Officer.

Foundation Trust
A Foundation Trust is a type of NHS organisation with greater accountability and freedom to manage themselves. They remain within the NHS overall, and provide the same services as traditional Trusts, but have more freedom to set local goals. Staff and members of the public can join the board or become members.

Healthcare-associated infection
This is an avoidable infection that occurs as a result of the healthcare that a person receives.

Healthwatch
Healthwatch is an independent arm of the CQC who share a commitment to improvement and learning and a desire to improve services for local people.

Healthcare Evaluation Data (HED)

HED is an online benchmarking solution designed for healthcare organisations. It allows healthcare organisations to utilise analytics which harness HES (Hospital Episode Statistics), national inpatient and outpatient and ONS (Office of National Statistics) Mortality data sets.

Hospital Episode Statistics (HES)

This is a data warehouse containing a vast amount of information on the NHS, including details of all admissions to NHS hospitals and outpatient appointments in England. HES is an authoritative source used for healthcare analysis by the NHS, Government and many other organisations.

Joint Consultative Committee

This is a group of people who represent the management and employees of an organisation, and who meet for formal discussions before decisions are taken which affect the employees.

Meticillin- Resistant Staphylococcus aureus (MRSA)

MRSA is a bacterium responsible for several difficult to treat infections in humans. MRSA is, by definition, any strain of Staphylococcus aureus bacteria that has developed resistance to antibiotics including penicillins and cephalosporins. It is especially prevalent in hospitals, as patients with open wounds, invasive devices and weakened immune systems are at greater risk of infection than the general public.

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE)

The programme investigates the deaths of women and their babies during or after childbirth, and also cases where women and their babies survive serious illness during pregnancy or after childbirth. The aim is to identify avoidable illness and deaths so the lessons learned can be used to prevent similar cases in the future leading to improvements in maternal and newborn care for all mothers and babies.

National Confidential Enquiries

These are enquiries which seek to improve health and healthcare by collecting evidence on aspects of care, identifying any shortfalls in this, and disseminating recommendations based on these findings. Examples include Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK (MMBRACE) and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

NCEPOD's purpose is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public by reviewing the management of patients. This is done by undertaking confidential surveys and research, and by maintaining and improving the quality of patient care and by publishing the results.

National Institute for Health and Clinical Excellence (NICE)

The National Institute for Health and Clinical Excellence provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health. It makes recommendations to the NHS on new and existing medicines, treatments and procedures, and on treating and caring for people with specific diseases and conditions. It also makes recommendations to the NHS, local authorities and other organisations in the public, private, voluntary and community sectors on how to improve people's health and prevent illness.

National Patient Survey
The NHS patient survey programme systematically gathers the views of patients about the care they have recently received because listening to patients' views is essential to providing a patient-centred health service.

National Health Service Litigation Authority (NHSLA)
The NHSLA is a special health authority responsible for handling negligence claims made against NHS bodies. It also aims to raise safety standards and reduce the number of negligent or preventable incidents through its risk management programme.

NHS Improvement (NHSI)
NHS Improvement supports Foundation Trusts and NHS Trusts to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

NHS England (NHSE)
NHS England leads the National Health Service (NHS) in England. They set the priorities and direction of the NHS and encourage and inform the national debate to improve health and care.

Overview and Scrutiny Committee
Overview and Scrutiny Committees in local authorities have statutory roles and powers to review local health services. They have been instrumental in helping to plan services and bring about change. They bring democratic accountability into healthcare decision-making and make the NHS more responsive to local communities.

Patient Advice and Liaison Service (PALS)
PALS is an impartial service designed to ensure that the NHS listens to patients, their relatives, their carers and friends answering their questions and resolving their concerns as quickly as possible.

Picker Institute
Picker Institute is a non-profit organisation that works with patients, professionals and policy makers to promote a patient centred approach to care. It uses surveys, focus groups and other methods to gain a greater understanding of patients' needs. It is a world leader focusing on the measurement of the patient experience and recognised as an important source of information, advice and support.

Pressure Ulcers
Pressure ulcers are also known as pressure sores or bed sores. They occur when the skin and underlying tissue becomes damaged. In very serious cases the underlying muscle and bone can also be damaged.

Research
Clinical research and clinical trials are an everyday part of the NHS and are often conducted by medical professionals who see patients. A clinical trial is a particular type of research that tests one treatment against another. It may involve people in poor health, people in good health or both.

Risk
The potential that a chosen action or activity (including the choice of inaction) will lead to a loss or an undesirable outcome.

Risk assessment
This is an important step in protecting patients and staff. It is a careful examination of what could cause harm so that we can weigh up if we have taken enough precautions or should do more to prevent harm.

Root Cause Analysis
This is a technique that helps us to understand why something has occurred in the first place. The learning is then shared with staff across the hospital to inform our practice and help prevent further recurrence.

Royal College of Obstetricians and Gynaecologists (RCOG)
The Royal College of Obstetricians and Gynaecologists (RCOG) works to improve health care for women everywhere, by setting standards for clinical practice, providing doctors with training and lifelong learning, and advocating for women's health care worldwide.

Secondary Use Services - SUS
A system designed to provide management and clinical information based on an anonymous set of clinical data.

Special Review
A special review is carried out by the Care Quality Commission. Each special review looks at themes in health and social care. They focus on services, pathways and care groups of people. A review will usually result in assessments by the CQC of local health and social care organisations as well as supporting the identification of national findings.

Trust Board
The Trust Board is accountable for setting the strategic direction of the Trust, monitoring performance against objectives, ensuring high standards of corporate governance and helping to promote links between the Trust and the community. The Chair and Non-Executive Directors are lay people drawn from the local community and are accountable to the Secretary of State. The Chief Executive is responsible for ensuring that the Board is empowered to govern the organisation and to deliver its objectives.

Vitalpac
Vitalpac is a mobile clinical system that monitors and analyses patients' vital signs providing clinicians with accurate, real-time information for the safest possible patient care.

Appendix A: Independent Auditor's Report to the Board of Governors of Gateshead Health NHS Foundation Trust on the Quality Report **– to be added once received**