Appendix 1

Gateshead Health
NHS Foundation Trust

Quality Account 2017/18

Contents

1. Statement on Quality from the Chief Executive

I am delighted to introduce the Quality Account for Gateshead Health NHS Foundation Trust for 2017/18. This provides details of some of our work over the past 12 months on improving the care we deliver in line with our strategic aims to:

- provide high quality, sustainable clinical services to our local population in new and innovative ways.
- develop new effective partnerships with organisations in health and social care to offer high quality, seamless care.
- optimise opportunities to extend our business reach in the delivery of high quality clinical care.
- deliver the proposed portfolio of services and quality of care within the resources available.

The Trust monitors all of its improvement plans from ward to board through its Quality Governance structure. In terms of our Quality Account priorities for 2017/18, some of the key highlights are as follows:

Clinical Effectiveness

- Development of an improvement plan in relation to our Patient Reported Outcome Measures (PROMS) score for Hip and Knee replacements, which included working with North East Quality Observatory Service (NEQOS) which supported the Trust with its Musculoskeletal Services bid.
- Increased level of mortality reviews and the production of a policy in relation to Reviewing and learning from deaths. These reviews are now supported by a database which has been developed in-house.

Patient Safety

- Commissioned external expertise for the development of in-house Root Cause Analysis (RCA) training.
- Promotion of Datix incident reporting throughout the trust.
- Worked with the clinical teams produce 32 Local Safety Standards for Invasive Procedures (LocSSIPs).

Patient Experience

- Patient Experience is now a standing agenda of the ward managers meeting to feedback any issues, concerns and compliments to staff.
- The complaints manager is working with her regional colleagues to share good practice and learn from each other.

Further detail is provided within the body of the Quality Account itself.

In addition to these priorities, our work to promote quality and safety in the care we provide has been further supported and reflected through a variety of routes and sources:

- In March 2018 the Trust hosted its first Quality Summit, with 110 delegates in attendance. The theme was Patient Safety with inspirational and motivational presentations from external and internal speakers. Both Sir Robert Francis QC, Chaired the two Mid-Staffordshire NHS enquiries and the NHS Freedom to Speak up Review and Dr Umesh Prabhu, retired Medical Director from

Wigan and Leigh NHS Trust, provided keynote speeches with further topics covered including Sepsis, Medicines Management and Duty of Candour.

- 2017/18 has seen the further integration of Community Services to ensure that the care we provide is of high quality across the patient pathway, whether hospital or community based.
- Our Friends and Family feedback identifies that the Trust provides a positive patient experience, with 97% of patients indicating that they would definitely recommend our services to friends and family.
- 90% of patients that completed the 2017 NHS Inpatient Survey rated the care we provided at 7/10 or above (Picker Institute, 2017).
- In cancer services the patients who have used our services rated their care received as an average of 9 out of 10 (an increase on last year's figures), with 98% of patients also saying that received all of the information they required before investigations and also before their operation.
- Our incident reporting rate has shown an increase from April 2017 of 32.12 to December 2017 37.46 per 1,000 bed days.

Whilst we have made significant progress in these key areas over the past year, we know that we can always do better. Our focus will not waver from providing high quality improvements and innovation for all our patients, carers and staff, which will be planned and implemented as part of our Quality Improvement Strategy 2018/21. To this end, our Quality Account Priorities for 2018/19 are set out below:

Clinical Effectiveness

- Implementation of the National Confidential Enquiry into Patient Outcome and Death "Treat as One – Bridging the gap between mental and physical healthcare in general hospitals".
- Reducing Variation in Clinical Practice – Getting it Right First Time.

Patient Safety

- Continue the work to improve patient safety culture with focus on: Manchester Patient Safety Framework (MaPSaF), Maternal and Neonatal safety and Trust investigation training.
- Ensure that all patients are kept safe by embedding the new national guidance for Serious Incidents and Never Events.

Patient Experience

- As part of the Patient Public & Carer Involvement & Experience Strategy develop work around patient involvement activities.
- Develop a range of approaches to understand the experiences of patients and carers who use our mental health services.

I hope you enjoy reading this report which identifies the excellent progress made in providing high quality clinical care for 2017/18 and also identifying the continuous quality improvement we strive to make for the coming year. Our aim is that the Trust will provide high quality, sustainable clinical services to our local population in new and innovative ways and provide an organisation that the local population and our staff will have pride in being a part of.

Finally, none of this is possible without the commitment, passion and dedication of our staff to improve the care and experience we deliver to our patients and their families and carers, and I would like to take this opportunity to thank them for their continued efforts to improve the care we provide. I can confirm that on behalf of the Board of Gateshead NHS Foundation Trust that to the best of my knowledge the information presented in the Quality Account in accurate.

Signed

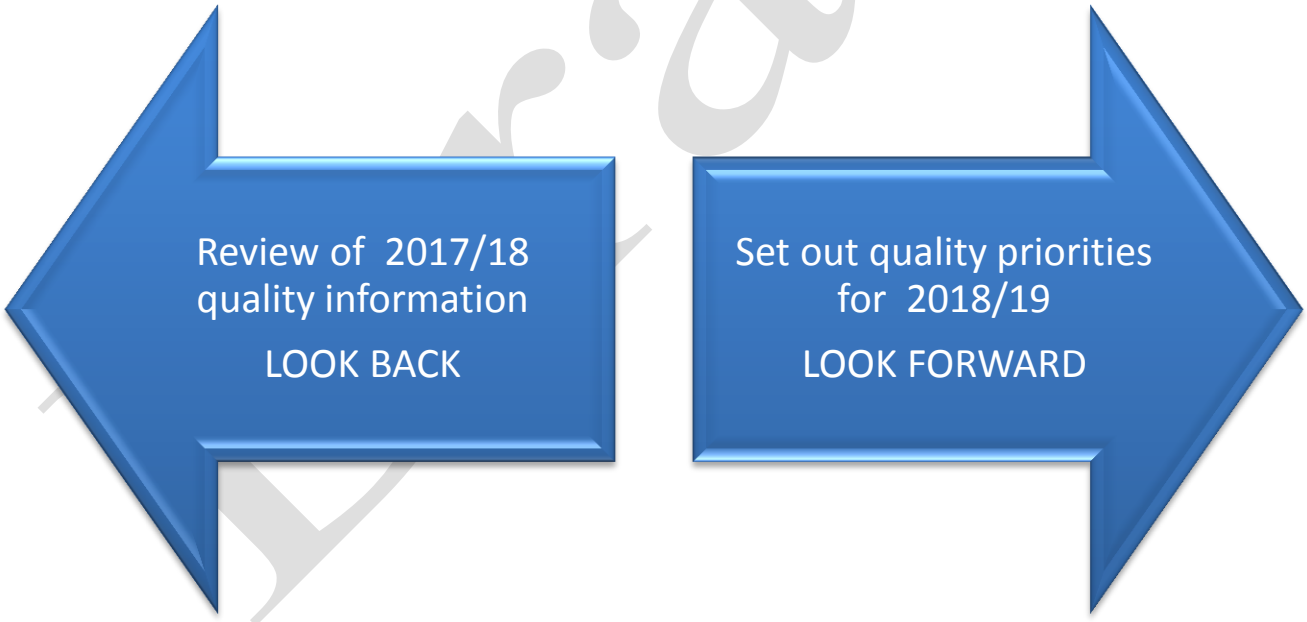
Mr I D Renwick, Chief Executive Date:

What is a Quality Account?

Since 2009 the NHS has been required to be open and transparent about the quality of services provided to the public, all NHS hospitals must publish a Quality Account (The Health Act 2009). Staff at the Trust can use the Quality Account to assess the quality of the care we provide. 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 2017/18.
- Outline the quality priorities and objectives we set ourselves going forward for 2018/19.



2. Priorities for Improvement

2.1 Reporting back on our progress in 2017/18

In our 2016/17 Quality Account we identified five quality improvement priorities that we would focus on in 2017/18. This section presents the progress we have made against these.

Clinical Effectiveness:

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

What did we say we would 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

Did we achieve this?

Unknown. We are pleased with the progress we have made in relation to our improvement plan. However due to the time delay in the publication of the PROMS data we are unable to determine whether our improvement work has had an impact on our PROMS performance.

How we planned to achieve it:

- A task and finish group was set up to map and redesign the patient pathway and to undertake a gap analysis to compare our pathway against high performing trusts.
- NEQOS provided bespoke work looking at individual consultant measurements which was presented to the Trauma and Orthopaedic team.
- A Surgical Business Unit proposal was produced, working with the Trauma and Orthopaedic team and NEQOS which provided standardised ways of working amongst the surgical team.
- The Trust successfully bid for a new contract to deliver MSK services. Developments associated with new clinical pathways are an integral part of the new MSK Service. The procurement was stalled and the process restarted in January 2018. This delay has clearly impacted on the implementation of the new clinical pathways across Gateshead and Newcastle.

Latest PROMS data:

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	E2	**PROMs: Groin Hernia Surgery EQ-5D score (16-17) - Provisional (finalised Aug 2018)** Information Centre for Health & Social Care (IC) - Patient reported outcome measures (PROMS) (01 Mar 2018)		NA	Lower 95% Apr 16 - Mar 17	NA	
	E2	**PROMs: Primary Hip Replacement EQ-5D score (15-16) - Final** Information Centre for Health & Social Care (IC) - Patient reported outcome measures (PROMS) (17 Aug 2017)		NA	Lower 95% Apr 15 - Mar 16	NA	
	E2	**PROMs: Primary Hip Replacement EQ-5D score (16-17) - Provisional (finalised Aug 2018)** Information Centre for Health & Social Care (IC) - Patient reported outcome measures (PROMS) (01 Mar 2018)		NA	Lower 95% Apr 16 - Mar 17	NA	
	E2	**PROMs: Primary Hip Replacement Oxford score (15-16) - Final** Information Centre for Health & Social Care (IC) - Patient reported outcome measures (PROMS) (17 Aug 2017)		NA	Lower 99.8% Apr 15 - Mar 16	NA	
	E2	**PROMs: Primary Hip Replacement Oxford score (16-17) - Provisional (finalised Aug 2018)** Information Centre for Health & Social Care (IC) - Patient reported outcome measures (PROMS) (01 Mar 2018)		NA	Lower 95% Apr 16 - Mar 17	NA	
	E2	**PROMs: Primary Knee Replacement EQ-5D score (15-16) - Final** Information Centre for Health & Social Care (IC) - Patient reported outcome measures (PROMS) (17 Aug 2017)		NA	Lower 95% Apr 15 - Mar 16	NA	
	E2	**PROMs: Primary Knee Replacement EQ-5D score (16-17) - Provisional (finalised Aug 2018)** Information Centre for Health & Social Care (IC) - Patient reported outcome measures (PROMS) (01 Mar 2018)		NA	Lower 95% Apr 16 - Mar 17	NA	
	E2	**PROMs: Primary Knee Replacement Oxford score (15-16) - Final** Information Centre for Health & Social Care (IC) - Patient reported outcome measures (PROMS) (17 Aug 2017)		NA	Lower 99.8% Apr 15 - Mar 16	NA	
	E2	**PROMs: Primary Knee Replacement Oxford score (16-17) - Provisional (finalised Aug 2018)** Information Centre for Health & Social Care (IC) - Patient reported outcome measures (PROMS) (01 Mar 2018)		NA	Lower 99.8% Apr 16 - Mar 17	NA	

Next steps:

- The new clinical pathways identified in the MSK bid incorporate a prehabilitation phase for patients who progress to surgery in addition to a post-surgical rehabilitation programme. These changes to the pathway will improve patient selection and preparation for surgery as well as providing a comprehensive programme to increase functional independence post-surgery.
- Recruitment is underway for a Physiotherapy Consultant Lower Limb, with an agreed two sessions per week dedicated to PROMs and improving patient outcomes.

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

What did we say we would 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 and Morbidity steering group, Business Unit SafeCare meetings and Service Line SafeCare meetings.
- In line with National Quality Board (NQB) 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.

Did we achieve this?

Yes

How we achieved it:

- A Rapid Process Improvement Workshop (RPIW) was held in March 2017 with the objective of improving and standardising our processes for mortality reviews for all inpatient deaths and those that occur within the Emergency Department. During the RPIW we:
    - Agreed the use of a standardised tool for undertaking 'level 1' mortality reviews.
    - Agreed the use of a single database for data from mortality reviews to be captured.

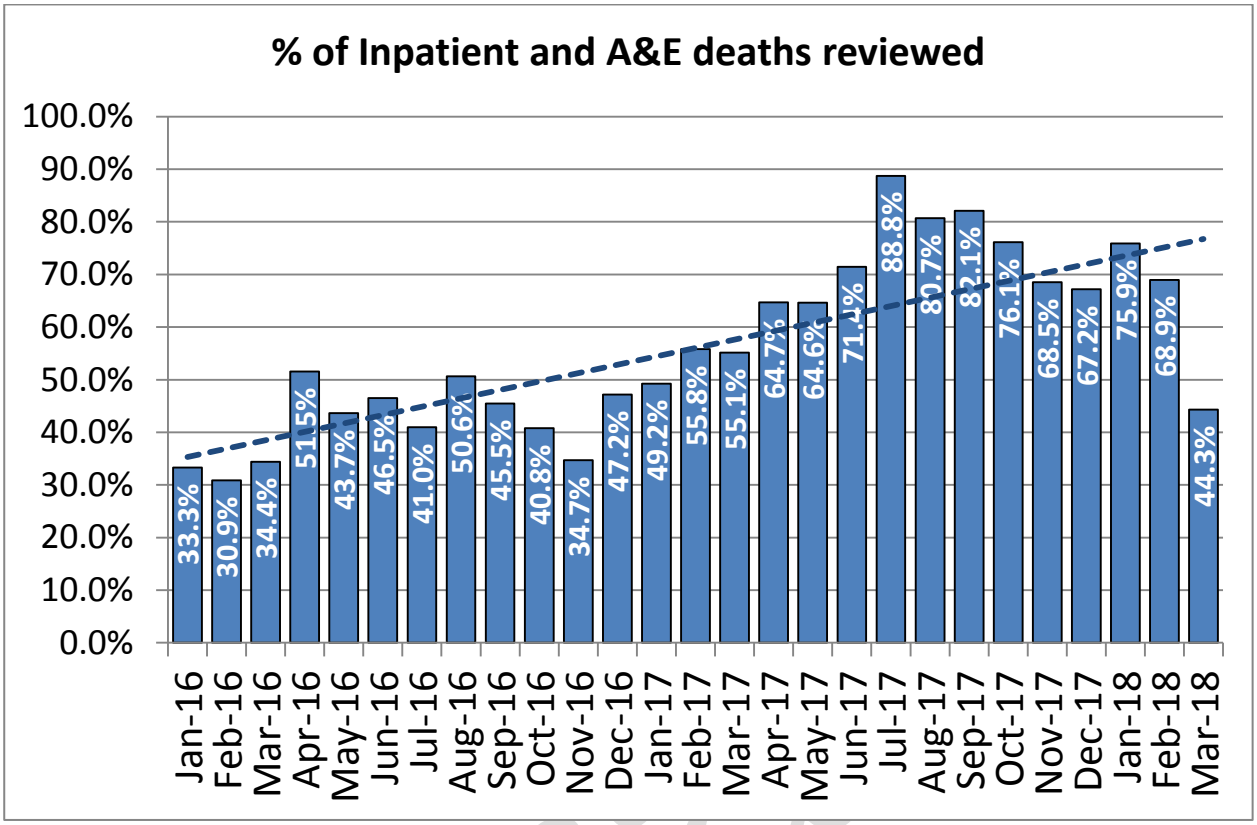
- Following the RPIW, the new process was launched on 1st April 2017, this involved:-
    - Promoting the use of the standardised tool and database to all clinicians, wards and specialties via a programme of training. This included attending ward sister's meetings, departmental SafeCare meetings and one to one sessions. This is ongoing.
    - Developing and implementing a new Trust policy 'Reviewing and Learning from Deaths' to formalise and outline the agreed processes for mortality review. The policy was implemented with the support of a communications strategy and included articles in the QE Weekly staff newsletter, a screensaver and a promotional stand within Quenellies, the Trust Restaurant. A standard operating procedure is included within the policy to ensure that all staff are undertaking mortality reviews in the same way.
    - Developing a dashboard from the Mortality Review Database in order to monitor the number of mortality reviews undertaken each month.
    - Implementing all actions identified within the RPIW which were captured on the RPIW Newsletter, which is a form of action plan.
    - Introducing colour coded visible containers to all wards to hold notes awaiting review, which is identifiable across the Trust.

- Setup of a Mortality Council to undertake a 'level 2' review of deaths that meet a specific criteria including – bereaved families and carers, or staff, who have raised a significant concern, all patients who died in our care who have a diagnosed learning disability or severe mental illness, all deaths in a service or specialty where an alert has been raised via the CQC or any other regulator, all deaths in areas where patients are not expected to die i.e. elective cases, Hogan score 2 or above, all deaths linked to an inquest and have been issued a Regulation 28 report on Action to Prevent Future Deaths, all patients who died in our care who were detained under the Mental Health Act, and also a random sample of up to 5% of deaths reviewed at level 1.

- Enabling reporting and learning themes to be available from the home screen within the Mortality Database.

- Tailoring the Trusts mortality database to allow for the entry of the findings from coroners cases and inquests. This information also links to the bereavement office section of the database so that information can be shared.

Evidence of achievement:



The Trust policy recommends that review meetings should be carried out at intervals appropriate to the number of deaths. Review of care leading up to a death should normally be performed within six weeks of death, in order that memory of events is fresh. Performance of the percentage of deaths reviewed will therefore lag; the low review rate observed in March 2018 will increase as deaths are reviewed in line with the policy.

Next steps:

- Develop a timetable for specialties to attend the Mortality and Morbidity steering Group to share learning and action from Mortality Reviews.
- Develop a process of capturing the responses/feedback from bereavement questionnaire – 'Evaluation of Care in the Last Few Days of Life' in order for this to be stored electronically and reports produced easily.
- Review whether deaths within 30 days of surgery should be included and how this can be introduced along with deaths where we are notified that a patient has died and recently attended as an inpatient, outpatient or via Emergency department.
- Review how to include deaths which occur within 30 days of discharge and how this can be incorporated into the Mortality Review process.

Priority 3: Improve Patient Safety Culture

What did we say we would 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 incidents.
- Implement investigator training to further improve the quality and consistency of root cause analysis (RCAs) investigations.

Did we achieve this?

Yes.

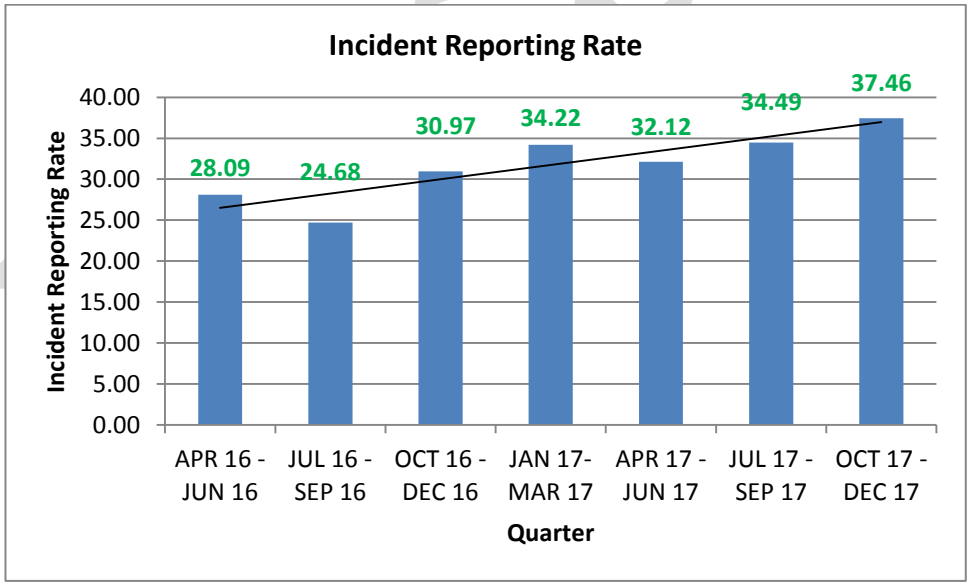
How we achieved it:

The Trust patient safety facilitators have worked collaboratively across the Business Unit attending SafeCare sessions and have supported the RCA process. This has helped to ensure all incidents are in investigated in a more timely manner. This process has been advantageous in identifying areas of learning and where actions can be taken to improve processes of care.

The Trust commissioned a company to provide expertise in training on RCA theory to 75 members of staff. Following this, in January 2018, the first of our new internal root cause analysis training was carried out, covering incident reporting, investigations, and RCA methodology.

Evidence of achievement:

There has been a continuous rise in our incident reported rate which is monitored by the National Reporting and Learning Service (NRLS). Whilst we expected the incident rate to rise following the transfer of Community Services, this has continued to rise throughout the last two financial years, see the chart below.



Next steps:

- Continue supporting the Business Units with reporting and investigating.
- The MapSAF work will continue as a priority within 2018/18.

Priority 4: Implement National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs)

What did we say we would do?

- Produce LocSSIPs for all invasive procedures carried out in the Trust, in line with guidelines used for NatSSIPs. NatSSIPs support the NHS to provide safer care and reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events can occur. They bring together national and local learning from the analysis of Never Events, Serious Incidents and near misses in a set of recommendations that will help provide safer care for patients undergoing invasive procedures. The NatSSIPs enable trusts to review their current local processes for invasive procedures (LocSSIPs) and ensure that they comply with the new national standards.

Did we achieve this?

- Partially, a great deal of progress has made, however work is ongoing to ensure all LocSSIPs are finalised.

How we partially achieved it:

- A LocSSIPs Implementation Group was set up to oversee the production of LocSSIPs across the Trust.
- A Trust wide standard LocSSIPs template was produced.
- Where a procedure is undertaken in more than one department we have a standardised LocSSIP so the process is consistent wherever the procedure is undertaken.
- As the LocSSIPs are ratified they are added to the Trust Ulysses system and review dates added to ensure these LocSSIPs are reviewed on a yearly basis.
- All LocSSIPs have been incorporated into the annual Business Unit Clinical Audit Programme for 2018/19.

Evidence of achievement:

We currently have 32 LocSSIP ratified and in use, and audits plans are in place for them.

Next steps:

To continue to work with all departments to identify invasive procedures which require the production of a LocSSIP.

Patient Experience:

Priority 5: Review of complaints investigations and actions

What did we say we would do?

Following a North East Quality Observatory Service (NEQOS) report, July 2016, we will reflect on its findings and implement the recommendations to enhance our complaints process. The recommendations were based around the following themes:

- Communication
- Sharing learning

- Investigation
- Complaints System
- Independent assessments

Did we achieve this?

Yes.

How we achieved it:

- The Complaints manager completed an RCA training course.
- The Trust made a decision to manage all complaints via the electronic Datix system that has a specific module that allows us to manage complaints more robustly. This enables staff within the Trust to have access to complaints information including the production of reports.
- Following the change to the Datix, issues were identified with the flow of information. In response to this, a working group consisting of matrons, service line managers and members of the complaints team was set up to. The remit of this group was to look at the complaints process with a view to simplifying and coming to a consensus around what works for everyone.
- The Patient Experience team have a standing agenda item on the Ward Sisters monthly meetings – there is a rolling timetable in place for members of the Patient Advice and Liaison Service (PALS), Complaints and Patient Experience Team to attend this to engage with staff.
- A flow chart to detail the expectation of a complaints investigating officer was developed in consultation with the Complaints Working Group and shared with all Investigating Officers.
- Learning from complaints was included in all Complaints, Litigation, Incidents, Patient Advice and Liaison Service (CLIP) Reports.
- The complaints service questionnaire, which is sent to all complainants following investigation and response of their complaint has been reviewed and updated. The first of which was sent out to complainants in July 2017.
- Monthly training sessions have continued to be provided to staff around the use of the Datix system in relation to complaints management.
- The Complaints Manager met with counterparts from Newcastle upon Tyne Hospitals NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust and there are plans to hold regional meetings to share good practice.

Evidence of achievement:

- 100% of complaints received in 2017/18 have been managed through the Datix System.
- 92% of complainants found it easy to find out how to complaint.
- 69% of complainants found the information on how to make a complaint easy to understand.

Next steps:

- To continue to work with services across the Trust to ensure that the process for managing complaints is efficient and effective as possible. Ensure that responses to complaints are in a standard format and measured.
- Present results from complaints service questionnaire to SafeCare Council in June 2018.

2.2 Our Quality Priorities for Improvement in 2018/19

We have set six key priorities for quality improvement for 2018/19 and these are linked to patient safety, effectiveness of care and patient experience.

We have established our priorities for improvement in 2018/19 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 Quality Improvement 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

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

Priority 1: **Implementation of the National Confidential Enquiry into Patient Outcome and Death "Treat as One – Bridging the gap between mental and physical healthcare in general hospitals"**

Priority 2: **Reducing variation in Clinical Practice – Getting it Right First Time**

Priority 3: **Continue the work around improving patient safety culture with focus on: MaPSaF, Maternal and Neonatal safety and Trust investigation training**

Priority 4: **Ensure that all patients are kept safe by using the new national guidance for Serious Incidents and Never Events**

Priority 5: **Develop our patient and public involvement activities**

Priority 6: **Develop a range of approaches to understand the experiences of patients and carers who use our mental health services**

Clinical Effectiveness:

Priority 1: Implementation of the National Confidential Enquiry into Patient Outcome and Death "Treat as One – Bridging the gap between mental and physical healthcare in general hospitals"

The Treat as One – Bridging the gap between mental and physical healthcare in general hospitals' study was undertaken by the National Confidential Enquiry into Patient Outcome and Death throughout 2015-16 with the final report published in January 2017. The aim of the study was to

identify and explore remediable factors in the overall quality of mental health and physical healthcare provided to patients with significant mental health conditions who were admitted to a general hospital. The report included 21 recommendations including patient care, legislation, training and organisational.

What will we do?

- We will ensure that the recommendations within 'Treat as One – Bridging the gap between mental and physical healthcare in general hospitals' are implemented with the Trust.

How will we do it?

- Set up a "Treat as One" Task and Finish Group to lead on this piece of work.
- We will undertake a gap analysis of our current processes against the recommendations.
- Following the gap analysis we will identify actions to address the areas that we are not fully compliant with.
- From an initial review of the recommendations, the focus of our work in the next 12 months will be to:-
    - Develop and introduce a screening tool for all admissions to hospital to ascertain if there is any history of mental illness and ensure that this is assessed along with their clinical condition.
    - Develop a pathway for those patients with a positive mental health condition following screening.
    - Develop a local guideline outlining the expectations of staff in the management of mental health conditions.
    - Undertake an audit to measure whether mental liaison assessments are made in an appropriate timeframe and by a mental health professional of appropriate seniority to meet the needs of the patient.
    - Develop and launch a training programme in order to raise staff awareness.
    - Review the process for wards referring to alcohol and substance abuse services.
    - Review coding in relation to mental health conditions.

How will it be measured?

- Screening tool will be developed and introduced. An audit will be undertaken to measure the use of the screening tool.
- Pathway and local guidelines will be developed, published and communicated to staff.
- Training programme developed and launched.
- Audit will be undertaken, results presented and any actions developed in relation to the appropriateness of mental liaison assessments.
- Process for wards referring to alcohol and substance abuse services will be reviewed and improved if necessary.
- Coding will be reviewed.

How will we monitor and report it?

- Monthly at the Treat as One Task & Finish Group.
- Quarterly at the Mortality & Morbidity Steering Group.
- Quarterly paper to the Quality Governance Committee.
- Quarterly paper to the Trust Board.
- Annual report to the Commissioners via the Quality Review Group.

Priority 2: Reducing variation in Clinical Practice – Getting it Right First Time (GIRFT)

Getting it Right First Time is a national programme to improve care within the NHS by ensuring no difference in the standard of care provided irrespective of which hospital you would receive the treatment. This programme is led by frontline doctors who are expert in the areas they are reviewing which means that the data is being reviewed by the people who lead and understand these services. The national programme is made up of 30 projects with a lead doctor who heads up a project to compile a report, which looks at a wide range of factors, from length of stay to patient mortality, and individual service costs through to overall budgets.

What will we do?

- We will ensure that the Trust fully engages with the national GIRFT Programme by ensuring that any data requests are acted upon in a timely way and act on any feedback we receive as a consequence.
- The learning from these reports will be shared with the Departments and Business Units and will develop a plan for how to address any areas for improvement.

How will we do it?

As the different specialties national reports are produced we will:

- Supply any data required for the development of speciality data packs.
- Engage with GIRFT deep-dive speciality visits and identify improvement work.
- Receive the National GIRFT speciality reports and act on the recommendation relevant to us and the areas of best practice identified in the reports.

How will it be measured?

- Each national report will be presented to the SafeCare Council and any outstanding actions to ensure high standard care is provided. Over 2018/19 at least four reports will have been to the SafeCare Council with any actions identified and reported on a six monthly basis.

How will we monitor and report it?

- Co-ordination of GIRFT work via Quality Department.
- Six monthly assurance that action plans being developed and progressed. Report via SafeCare Council.
- Quarterly paper to the Quality Governance Committee.
- Quarterly paper to the Trust Board.
- Annual report to the Commissioners via the Quality Review Group.

Patient Safety:

Priority 3: Continue the work around improving patient safety culture with focus on: MaPSaF, Maternal and Neonatal safety and Trust investigation training

Owing the importance that the Trust places on patient safety, the Trust will undertake three separate initiatives within this priority. Please see below:

3a. MaPSaF

What will we do?

- Initiate the MaPSaF process throughout the Trust which is a tool to help trusts reflect and improve the patient safety.

How will we do it?

- The Quality Team will work with departments across the Trust to review and measure patient safety.

How will it be measured?

- Once the review has been undertaken we will analyse the findings, present to the Risk and Safety Council and work with departments to produce an action plan identifying any areas for improvement.

How will we monitor and report it?

- Bi-monthly at Risk & Safety Council
- Quarterly paper to the Quality Governance Committee
- Quarterly paper to the Trust Board
- Annual report to the Commissioners via the Quality Review Group

3b. Maternal and Neonatal Safety

What will we do?

As part of the National Safer Maternity Care Strategy we will focus on improving the continuity of carer of pregnant women (known team of midwives). Initially we will focus on women with Diabetes improving continuity of care across the maternity care pathway. We will initially aim for 20% of these mothers to be on a continuity of carer pathway with personalised care plan by end of March 2019.

How will we do it?

- We will participate in Wave 2 of the National Maternal and Neonatal Safety Collaborative which utilises service improvement methodology to assist us in meeting our aim.
- We will identify a core group of staff from a range of disciplines to take part in this initiative. They will be supported by designated improvement managers from NHS Improvement who will provide improvement coaching and help build local capability in quality improvement
- We will participate in regular coaching calls, national learning sets and peer support meetings

- We will design and implement a new care pathway that will ensure continuity of carer for Diabetic women.
- We will work with maternity units across the country to develop this initiative, share best practice, guidelines and learning.
- We will second a midwife to support the current multi-disciplinary Diabetic team.

How will it be measured?

- We will undertake a baseline audit to understand our current provision of continuity of carer for diabetic mothers. This will be benchmarked regionally with other units.
- We will re-audit in six months.
- We will undertake a patient satisfaction survey at key point of the project.
- We will Identify and utilise key quality outcome and patient satisfaction measures to measure and monitor our progress.

How will we monitor and report it?

- Monthly to Maternity SafeCare meetings
- Quarterly to Business Unit SafeCare meetings
- Quarterly to SafeCare Council
- Quality Governance Committee and Trust Board
- Bi monthly to Neonatal and Maternity Regional Networks / Local Maternity System
- Monthly to National Safety Collaborative team

3c. Trust investigation training

What will we do?

- The Trust is committed to using one method for investigation across patient safety and patient experience. We will work together to facilitate RCA as being the method that we use. This quality improvement process will increase the number of trained investigators and ensure all investigators use a standardised process.

How will we do it?

- The Trust will provide bi-monthly full day training sessions for staff from all disciplines within the Trust.
- Review investigation documentation with a view to developing a standardised format.

How will it be measured?

- The Trust will work with NEQOS to review and analyse the quality and standard of our incident RCA's.
- Standard documentation to be produced.

How will we monitor and report it?

- Bi-monthly at Risk & Safety Council
- Quarterly paper to the Quality Governance Committee
- Quarterly paper to the Trust Board
- Annual report to the Commissioners via the Quality Review Group

Priority 4: Ensure that all patients are kept safe by using the new national guidance for Serious Incidents and Never Events

What will we do?

- We will ensure that the new guidance is fully implemented within the Trust, and that the governance process for the monitoring of Serious Incidents is robust and all opportunities for effective learning are fully realised.

How will we do it?

- When the new guidance is released, we will undertake a gap analysis against our current processes.
- We will publish a Never Event SafeCare Bulletin to highlight key changes to staff.
- We will undertake a full review of effectiveness of our current Serious Incident Panel.
- We will develop and publish a separate Never Event Trust policy, so that our staff are fully supported to recognise and effectively manage such incidents.
- We will develop and implement the role of Family Liaison Officer (FLO) across the Trust to support patients and their families following an adverse incident within the Trust, to ensure their voices and opinions are heard throughout the investigation process.
- We will develop and publish a Trust Supporting Staff Policy to ensure that the Trust has in place adequate provision for any staff involved in a Serious Incident.

How will it be measured?

- Presentation of gap analysis to Risk & Safety Council, and associated action plan to address any gaps identified.
- The SafeCare Bulletin will be circulated across the Trust.
- The revised Terms of Reference for Serious Incident Panel will reflect the review and revisions to the Serious Incident Panel process.
- The Never Event Policy will be published and available to staff via the intranet.
- Relevant staff within the Trust will receive externally provided FLO training and will be deployed by the end of 2018.
- The Supporting Staff Policy will be published and available to staff via the intranet.

How will we monitor and report it?

- Quarterly learning reports from Serious Incident Panel presented at Risk & Safety Council, in addition to providing assurance that all identified actions from Serious Incidents have been completed.
- Quarterly paper to the Quality Governance Committee.
- Quarterly paper to the Trust Board.
- Annual report to the Commissioners via the Quality Review Group.

Patient Experience:

Priority 5: Develop our patient and public involvement activities

Patient and public involvement is the active participation of patients, users, carers, community representatives and the public in the development of health services and as partners in their own health care. It is broader and deeper than traditional consultation. It is giving local people a say in how services are planned, delivered and evaluated, by developing good communication with them, providing the information to make informed choices about their care and working in partnership to make decision about Quality Improvement.

What will we do?

- The Trust is truly committed to patient and public involvement by ensuring that all decisions around service design and delivery will explicitly take into account the views of patients and the general public in Gateshead. We recognise that this will improve the quality of our decision making and lead to services based around the needs of patients. Throughout 2018/19 we will develop our activity of involving patients and the public to ensure we are doing this to the best of our ability.

How will we do it?

- Develop and publish a Patient and Public Involvement Toolkit for staff to provide guidance on how to effectively involve patients and the public in health care planning and delivery.
- Launch a Patient and Public Involvement Toolkit via a robust communication strategy including articles in staff newsletters, screensavers and presentations at meetings.
- Establish a baseline of current Patient and Public Involvement activity within the Trust and ensure all activity is reported through the Patient Public & Carer Involvement & Experience Group.
- Identify key priority areas for involvement activity for 2018/19. We will:-
    - Work with our patients, carers and clinicians in Elderly Mental Health Services to identify an 'Always Experience' (Always Event). 'Always Events' are aspects of the patient experience that are so important to patients and family members that health care providers must aim to perform them consistently for every individual, every time. These can only be developed with the patient firmly being a partner in the development of the event, and the co-production is key to ensuring organisations meet the patients' needs and what matters to them. We will co-design and implement reliable processes of care that will achieve this.
    - Involve an appropriate group of patients in the procurement of a new Interpreting Service.
    - Determine a programme of involvement work for our Governors and Members to include a focus on hard to reach groups to understand their experiences.
    - Develop robust monitoring to understand the patient experience and the impact of service delivery on different communities. The focus of this will be to design an Equality Monitoring and agree how to implement within the Trust.

How will it be measured?

- Patient and Public Involvement Toolkit developed and published.
- Database of current Patient and Public Involvement activity developed.
- Successful identification of 'Always Experience'.
- Successful procurement of new Interpreting Service.

- Governors and Members work programme produced.

How will we monitored and report it?

- Bi-monthly at the Patient, Public & Carer Involvement & Engagement Group.
- Quarterly paper to the Quality Governance Committee.
- Quarterly paper to the Trust Board.
- Annual report to the Commissioners via the Quality Review Group.

Priority 6: Develop a range of approaches to understand the experiences of patients and carers who use our mental health services

Patients and carers lie at the heart of everything we do. Their experience and perceptions of the Trust are our measures of success. Accessing and understanding the care experiences of those living with a mental health condition can be a challenging process, which often means such experiences go unheard and under-represented.

What will we do?

- Develop a range of approaches to seek patient, family and carer feedback to help better understand the unique experiences of people who use our elderly mental health services.

How will we do it?

- We will ask patients, families and carers how they would like to give feedback on their experiences.
- Based on feedback from patients, families and carers, we will develop and test a number of methods of obtaining feedback from them.
- We will evaluate these methods and implement a new programme based on the feedback.

How will it be measured?

- The volume of feedback from people who use our elderly mental health services will increase.
- Actions taken and improvements made directly as a result of feedback will be demonstrated.

How will we monitor and report it?

- Bi-monthly at the Patient, Public & Carer Involvement & Engagement Group.
- Quarterly paper to the Quality Governance Committee.
- Quarterly paper to the Trust Board.
- Annual report to the Commissioners via the Quality Review Group.

2.3 Statements of Assurance from the Board

During 2017/18 the Gateshead Health NHS Foundation Trust provided and/or sub-contracted 31 relevant health services. The Gateshead Health NHS Foundation Trust has reviewed all the data available to them on the quality of care in 100% of these relevant health services. The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by Gateshead Health NHS Foundation Trust for 2017/18.

Participation in clinical audit

During 2017/18, 37 national clinical audits and nine national confidential enquiries covered relevant health services that Gateshead Health NHS Foundation Trust provides.

During that period Gateshead Health NHS Foundation Trust participated in 97% 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 2017/18 are listed below.

The national clinical audits and national confidential enquiries that Gateshead Health NHS Foundation Trust participated in during 2017/18 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 2017/18, 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 2017/18

Audit title	Participation	% of cases submitted/number of cases submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	286 as of end Jan 18 – 95% requirement
Bowel Cancer (NBOCAP)	Yes	179 – no minimum requirement
Cardiac Rhythm Management (CRM)	Yes	146 – no minimum requirement
Case Mix Programme (CMP)	Yes	818 submitted as at end of December 2017. Data for January to March 2018 is not yet available
Diabetes (Paediatric) (NPDA)	Yes	124 – no minimum requirement
Elective Surgery (National PROMs Programme)	Yes	Hips – 192 no minimum requirement Knees – 288 no minimum requirement
Falls and Fragility Fractures Audit programme (FFFAP) Inpatient Falls National Hip Fracture Database	 Yes Yes	 21 – no minimum requirement 303 – no minimum requirement
Fractured Neck of Femur (CEM)	Yes	100%
Inflammatory Bowel Disease (IBD) programme	Yes	6 cases submitted – no minimum requirement
Major Trauma Audit	Yes	43%

National Audit of Anxiety and Depression	-	This audit was not conducted by the national team during 2017/18, therefore data submission was not required
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	595 cases submitted
National Audit of Dementia	Yes	49 cases submitted
National Audit of Intermediate Care (NAIC)	Yes	Only organisational data required
National Audit of Rheumatoid and Early Inflammatory Arthritis	-	This audit was not conducted by the national team during 2017/18, therefore data submission was not required
National Audit of Seizures and Epilepsies in Children and Young People	-	This audit was not conducted by the national team during 2017/18, therefore data submission was not required
National Cardiac Arrest Audit (NCAA)	Yes	67 – no minimum requirement
National Chronic Obstructive Pulmonary Disease Audit programme (COPD)	Yes	Registered and participated in the organisational side - We plan to start submitting data in April 2018.
National Comparative Audit of Blood Transfusion programme	Yes	34%
National Diabetes Audit - Adults	No	The Trust does not have the appropriate IT system to support the participation in this audit. Progress is being made to address this and it hoped we will participate in 2018/19.
National Diabetes Foot Care Audit	Yes	67 submitted - no minimum requirement
National Emergency Laparotomy Audit (NELA)	Yes	60%
National End of Life care audit	-	This audit was not conducted by the national team during 2017/18, therefore data submission was not required
National Heart Failure Audit	Yes	292 – no minimum requirement
National Joint Registry (NJR)	Yes	1377 – no minimum requirement
National Lung Cancer Audit (NLCA)	Yes	246 – no minimum requirement
National Maternity and Perinatal Audit	Yes	1874 – required for all admissions

National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Yes	100%
National Vascular Registry	Yes	167 – no minimum requirement
Oesophago-gastric Cancer (NAOGC)	Yes	49 – no minimum requirement
Pain in Children (CEM)	Yes	100%
Procedural Sedation in Adults (CEM)	Yes	100%
Prostate Cancer	Yes	135 – no minimum requirement
Sentinel Stroke National Audit programme (SSNAP)	Yes	470%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	7 – no minimum requirement
UK Parkinson's Audit	Yes	100%

Participation in National Confidential Enquiries 2017/18

Enquiry	Participation	% of cases submitted
Child Health Clinical Outcome Review Programme	Yes	No eligible cases during 2017/18
Mental Health Clinical Outcome Review Programme (NCISH)	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme • Confidential Enquiry into stillbirths, neonatal deaths and serious neonatal morbidity • Perinatal Mortality Surveillance • Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths) • Confidential enquiry into serious maternal morbidity • Maternal mortality surveillance • Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)	Yes	100%
Cancer in Children, Teens and Young Adults	Yes	100%
Acute Heart Failure	Yes	50%
Perioperative Diabetes	Yes	Study remains open, figures have not been finalised

Chronic Neurodisability	Yes	0%
Young Peoples Mental Health	Yes	100%
Learning Disability Mortality Review Programme (LeDeR)	Yes	100%

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.

The reports of 15 national clinical audits were reviewed by Gateshead Health NHS Foundation Trust in 2017/18 and Gateshead Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Case Mix Programme (CMP)

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 using the WardWatcher system and is submitted to the CMP who process the data. Data on various outcomes and process measures are then compared with the outcomes from other Critical Care Units in the UK.

The most recent Quarterly Quality Report from CMP (Apr-Sep 2017) has shown a reduction in delayed discharges from Critical Care and ongoing low rates of non-clinical transfers and readmissions to Critical Care. The most recent report does show an increase in standardised in-hospital mortality rates, both overall, and for patients with a predicted mortality of <20%. Preliminary investigation into this has highlighted an issue with data entry into WardWatcher resulting in inaccurate predicted mortality rates (lower rates of mortality were predicted than should have been had data entry been correct).

Action plan:

- Continue to collect and submit data to Intensive Care National Audit and Research Centre (ICNARC)/CMP.
- Continue work on delayed discharges from Critical Care. There has been work to increase awareness of delayed discharges within the Trust and to highlight the issue at bed meetings. Going forward, mixed-sex breaches resulting from delayed discharges will be uploaded to Datix and reported, and the rates of delayed discharge are to be added to the Business Unit performance dashboard.
- Improve accuracy of data entry on WardWatcher to ensure correct predicted mortality rates. We are exploring the possibility of introducing a "Data Entry Clerk" role on the unit to help with management of WardWatcher and ICNARC data.
- Review quarterly reports regularly to identify new areas where action is required.

Falls and Fragility Fractures Audit Programme (FFFAP)

This clinical audit, run by the Royal College of Physicians (RCP) is designed to audit the care that patients with fragility fractures and inpatient falls receive in hospital and to facilitate quality improvement initiatives. It has four overarching aims:

- To improve outcomes and efficiency of care after hip fracture.
- To improve services in acute and primary care to respond to first fracture and prevent second fracture.
- To improve early intervention to restore independence.

- To work in partnership to prevent frailty, preserve bone health and prevent accidents in older people.

The Trust performed better in all of the key clinical indicators (with the exception of continence assessment) compared to its 2015 results. Call bell in reach, mobility aid in reach and bedside visual assessment were all above 90% compliance. Good improvement was also made in falls risk medication review, 59% of cases had a review compared to 20% of cases in the 2015 audit. Although improvement was made in measuring lying and standing blood pressure and delirium assessment compared to 2015, the numbers still fell below the national average. Continence assessed had dipped from 88% in 2015 to 52% in 2017; the cause for this is unclear

Action Plan

- A walking aid policy is to be developed to ensure seven day access to walking aids for all newly admitted in-patients who require them.
- Further embed the Royal College of Physicians clinical practice tool to improve rates of lying and standing blood pressure. Consider the role of electronic observation recording systems to record postural blood pressure.
- To work with pharmacy colleagues to improve review of falls risk medications in those over 65 years old on admission to hospital.
- A delirium strategy to be developed and the identification of a recognised delirium screening tool for use throughout the trust. Delirium care standards and policy need to be cross referenced with falls policies.
- Repeat a spot continence assessment audit to see if results are replicated.
- Recommendations will form part of the trust's Fall Prevention Strategy for 2018/19.

Inflammatory Bowel Disease (IBD) programme

The inflammatory Bowel Disease (IBD) programme was established over 10 years ago with the aim of improving the quality and safety of care for people with IBD throughout the UK. The initial emphasis was to audit quality and care to show variation, but through four rounds of audit the programme has steadily evolved to encompass a wider range of quality improvement measures, and has supported the development of national standards for IBD care and helped establish quality IBD care as a key component of local healthcare delivery.

Action Plan:

- UK IBD Registry.
  - This is a portal of IBD patient registry which is nationwide, we have registered for it and we are using it to enter our patients details
- Acute care pathways are being developed for IBD patients.
- Streamlining the IBD multidisciplinary team which happens on the first Friday of each month.
- Incorporating new drugs in treating patients of IBD
- Taking part in research for IBD

National Cardiac Arrest Audit (NCAA)

We have been members of the national cardiac arrest audit since 2010. The dataset includes all patients over the age of 28 days who have received Cardiopulmonary Resuscitation (CPR) and/or defibrillation. Information following all emergency (2222 on the internal telephone system) calls is collected on a local data collection form, the fields of which duplicate the information required for the national audit. We are provided with quarterly and annual reports from the NCAA which allows us to benchmark our Organisation against other Trusts and identify cardiac arrest trends within our trust Survival to Discharge rates are consistently below the national average. This is due to the profile of the patients who have cardiac arrests in our Trust. The audit recognises that we have more elderly patients and less younger patients in cardiac arrest. In addition, the types of cardiac arrest rhythms

that patients have are consistent with less favourable outcomes. However, our cardiac arrest numbers per 1,000 admissions are more positive. We are unable to change the profile of the patients admitted to our hospital and recognise that cardiac arrest prevention is preferable to managing a patient in arrest.

Action Plan:

- We will continue to deliver courses focusing on cardiac arrest prevention.
- Our Basic Life Support (BLS) sessions have been extended to include recognition of the deteriorating patient (using early warning systems), anaphylaxis and management of the choking adult/ child.
- Quarterly and Annual reports are summarised and reported to the Resuscitation and deteriorating patient committee meetings. The information from the report is provided in addition to the separate data we collect which identifies areas of good practice and areas for improvement in our Trust. Going forward we will share this information with ward teams, in particular cardiology and Acute Response Team (ART) who work hard to complete local audit forms at the time of the event.

National Comparative Audit of Blood Transfusion programme

The National Comparative Audit of Blood Transfusion (NCABT) is a programme of clinical audits which looks at the use and administration of blood and blood components in NHS and independent hospitals in England and North Wales.

The objective of the audit programme is to provide evidence that blood is being prescribed and used appropriately and administered safely, and to highlight where practice is deviating from the guidelines to the possible detriment of patient care.

We now have a single point of submitting data for the Medicines and Healthcare Products Regulatory Agency (MHRA) and Serious Hazards of Transfusion (SHOT) via Serious Adverse Blood Reactions and Events (SABRE). We have submitted seven incidents. We report all transfusion incidents as we can exclude them later if evidence suggests transfusion was not the cause of the incident. We would also always report incidents late if we found about an incident late.

No incidents were classed as Serious Adverse Reaction (SAR)/Serious Adverse Event (SAE) and all seven incidents have been excluded by the MHRA from their report.

Previously these incidents would only have been reported directly to SHOT and not to the MHRA.

The SHOT reports have all been completed for the seven incidents.

Action Plan:

- All transfusion incidents to be reported within two days, previously we had seven days to report.

National Diabetes Audit – Foot Care Adults (NDFA)

National audit collecting information about the care that people with diabetes receive for their foot ulcers. This audit looks at consent, data collection and reporting. Data will be used to generate reports on how we are doing locally and comparison data with other areas.

Action Plan:

- Ensure whole podiatry department involvement in audit to increase numbers of patients recruited
- Re-iterate the importance of prompt referral to diabetic foot clinic via training .Patients presenting early leads to ulcers healing quickly.
- Discuss whether we can arrange for Newcastle/Gateshead Clinical Commissioning Group (CCG) amputation rates to be reported separately (Public health amputation rates 7.0 per 10,000 for Newcastle Gateshead CCG – in line with national average of 8.0 per 10,000). The NDFA reported the Trust's amputation rate at 3.9% per 10,000 bed days.

- Meet with senior managers /hospital managers to develop inpatient pathways / Multidisciplinary Team foot clinic in line with NICE guidance where we can look at other factors that would prevent wound healing.

National Hip Fracture Database

We continue to contribute to this national audit which has just celebrated its 10 year anniversary. 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 virtually every area, both when compared both regionally and nationally, e.g. time to theatre, length of stay and mortality.

Action Plan:

- We have continued to be an outlier in terms of recorded hospital acquired pressure damage. A great deal of work has been done in this area in terms of recording pressure damage correctly and our figures for 2017 now suggest an improvement from 10-12% pressure damage to around 4%, compared to a national average of around 3%. This represents a considerable improvement and we intend to continue our performance in this area. It appears that the discrepancy has come from the way the figures are recorded rather than the actual clinical care given, which is reassuring.
- We remain a marginal outlier in terms of hip fractures sustained as an inpatient. This has been raised with SafeCare meetings and the falls team and a programme of work is underway to improve this. We will continue to monitor this situation.

National Joint Registry (NJR)

The Trust continues to contribute to the National Joint Registry. Data is entered regarding all hip, knee, ankle, elbow and shoulder replacement operations, enabling the monitoring of the performance of joint replacement implants and the effectiveness of different types of surgery.
In 2014 the NJR introduced annual data completeness and quality audits for hip and knee cases, with the aim of improving data quality. The Trust continues to contribute to these audits.

Action Plan:

- Continue to ensure that robust systems are in place to guarantee that a Minimum Dataset form is generated for all eligible NJR procedures
- Consider displaying NJR Data Collection posters in Theatres
- Further investigate the small number of records with incorrect Clinical Coding

National Maternity and Perinatal Audit

Using timely, high quality data, the National Maternity and Perinatal Audit (NMPA) aims to improve the treatment of mothers and babies during their stay in a maternity unit by evaluating a range of care processes and outcomes in order to identify good practice and areas for improvement in the care of women and babies looked after by NHS maternity services. The audit also includes information about all mothers as well as the child.

Action Plan:

- Review 16/17 data relating to the same indicator. Identify key themes.
- The audit has been registered and all eligible mothers' data provided via the Information Department.
- Collect real time data in relation to the above indicator. Cases will be reviewed 3 monthly to assess if we are in line with best practice
- Apgar score training has been incorporated into clinical skills training alongside Neonatal Life Support (NLS) update for this year. Share with Paediatric doctors to ensure learning across teams
- Review all unexpected term admissions to the Special Care Baby Unit (SCBU). Monitor via

Perinatal Multidisciplinary Team (MDT).

Sentinel Stroke National Audit Programme (SSNAP)

The Stroke Sentinel National Audit Programme (SSNAP) considers nine domains for stroke care, from hyper acute assessment and treatment, through to rehabilitation and discharge planning. Services are given an overall rating on a scale from A to E. Historically the Trust has scored a category D. Results are published three times a year, each covering a four month period. The most recent results are available for the period to August 2017.

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 hyper acute care (the first 72 hours) at the Royal Victoria Infirmary 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 was that the average score would improve. Overall the SSNAP score for April to July 2017 has now improved to a category B. Further work is required with Speech and Language Therapy resources and Standards by Discharge. The report for August to November is currently embargoed. However we are expecting to demonstrate a slight improvement. The hyper-acute service provided by Newcastle Hospitals is now within the top 10% in the country.

Action Plan:

- We are exploring a joint management structure / to oversee developments and share risks with Newcastle upon Tyne Hospitals NHS Foundation Trust going forwards.

UK Parkinson's Audit

The UK-wide clinical audit was developed to address the concerns of professionals, patients and their representatives about the quality of care provided to people with Parkinson's. The audit uses evidence-based clinical guidelines as the basis for measuring the quality of care.

The design of the audit has changed from year to year. Reflecting a shift in focus from early diagnosis and intervention for people newly diagnosed with Parkinson's to the effective continuous management of patients within a multidisciplinary team. This report therefore draws on separate service audits and care available to people with Parkinson's from doctors, Parkinson's nurses, occupational therapists, physiotherapists, and speech and language therapists. Where relevant, the results are compared with those from previous audits.

This year the Parkinson's disease team contributed to the 2017 audit. 20 anonymised returns were made representing approximately 4.4% patient caseload.

Action Plan:

- Side effects of medications. Although side effects of medications are discussed in consultations, patients would value additional written information, consistent with that available on the Parkinson's UK website. We plan to develop Patient information leaflets to address this need.
- End of life preferences should be considered in all patients, throughout all phases of the disease.
- A discussion regarding Lasting power of attorney during assessments would be helpful.
- Assessing fracture risk as a consequence of associated Osteoporosis. A nominated Consultant will be taking a lead on developing this aspect.

National Vascular Registry

The National Vascular Registry is a national clinical audit commissioned by the Health Quality Improvement Partnership (HQIP) to measure the quality of care for patients who undergo vascular procedures in NHS hospitals. We continue to enter all our data for major vascular procedures in the

national vascular data base.
The results for our unit in the previous year 2016-2017 showed very good results regarding mortality and morbidity in all index vascular procedures. The only criterion that the unit didn't fulfil was performing Carotid endarterectomy within two weeks of start of symptoms.

Action Plan:

- We have audited the carotid endarterectomies at the TRUST and identified the cause of delay in performing surgery and we now admit patients directly to the surgical ward instead of the stroke ward to expedite investigations and surgery. The early results are encouraging and the figures for the timing of carotid endarterectomy for this year 2017-2018 will show marked improvement and will be in line with the national figures.
- We will continue to admit patients to expedite their carotid endarterectomy and to audit the timing of carotid endarterectomies.

National Paediatric Diabetes Audit

The 2016-17 NPDA report highlights the demographic challenges in the Gateshead population with higher deprivation scores than the rest of the region and nationally and a higher proportion of young people in the transition age group (15-19 years) which impacts on our data.
Despite this there has been a continued improvement in our median HbA1C over the last five years which now is comparable to the rest of the region and England and Wales.

Action plan:

- Continue to deliver a best practice service to children and young people (CYP) 0-19yrs
- Continue to support CYP and their families/carers to self-manage their diabetes
- Ensure all CYP have an individualised education plan.
- Provide education to CYP and their families/carers to ensure technology (pumps and flash/continuous glucose monitoring) are being used safely and optimally to both improve quality of life, reduce acute admissions and improve long term health outcomes.
- Improve long term health outcomes for CYP by continuing to use the high HbA1C pathway and involvement of our psychologist, social services and safe guarding teams when necessary.
- Continue to improve and optimise data collection via the clinical data base (there is a new national data set for 2017-18 NPDA)
- Continue to actively support the local patient support group
- Continue to develop the transition service to improve quality of life and health outcomes for these young people.
- Continue to monitor blood pressures in an ambulatory setting to ensure accuracy of readings and ensure appropriate management for CYP with persistently elevated blood pressures.
- Raise awareness and facilitate/optimise uptake of the annual appointments offered to CYP over 12 years by the National Retinal screening programme.

National Audit of Dementia

The National Audit of Dementia (care in general hospitals) measures the performance of general hospitals against criteria relating to care delivery which are known to impact upon people with dementia while in hospital. The National audit of Dementia (NAD) takes place every two years. The last audit took place in 2016 with the results being published in 2017. The audit was in three parts; a case note audit, a staff questionnaire and a carer questionnaire. Areas of good practice and carer/staff experience. Personal preferences regarding likes/dislikes regarding food and drinks. Staff and carers felt that there was support regarding personal care and aids to communication. Carers overall rated us as good about care received. Staff felt supported most of the time with specialist services.

Action Plan:

- Delirium screening has been added into the EAU admission document.
- An improvement workshop is being considered with regards to Delirium to add information onto discharge summary.
- Out of hours dementia support - when two dementia nurses are in post they will be covering six day week. Dementia advocates now on most wards and departments who are the first point of contact. All advocates have undertaken appropriate Dementia training.
- Carers needing support to discuss their concerns – dementia advocates are the first point of contact, or alternatively specialist dementia nurses are available to support ward teams.

Cardiac Rhythm Management

The National Audit of Cardiac Rhythm Management (CRM) collects information about all implanted cardiac devices and all patients receiving interventional procedures for management of cardiac rhythm disorders in the UK.

The audit aims to improve the care of patients who undergo pacemaker, Implantable cardioverter defibrillators (ICD), Cardiac Resynchronization Therapy (CRT) and cardiac ablation procedures in the UK, through the collection, analysis and dissemination of data relating to centres across the UK

The total number of implants was 122 new devices, and 24 generator changes (146 device procedures in total). The minimum number of new device implants according to the British Heart Rhythm Society (BHRS) consensus statement is 80, placing the Trust above that target. Although implant rate per head of population regionally is not presented, the national pacemaker implantation rate is reported to be 621 per million. Assuming a local population of 200,000 people our implant rate in 2016-2017 was 415 per million i.e. around two thirds the national rate. In the year 2017-2018 this has increased to 610 per million. The reasons for this improvement may include appointment of another pacing operator, measures to improve cardiac cath lab efficiency, increasing awareness of pacing indications following education sessions, or a combination of these factors.

Action Plan:

- The Cardiology team hopes to maintain these improvements over following year, and ongoing efforts to increase awareness and encourage appropriate referrals will be made.
- The next financial year will require full reporting of complication rates to National Institute for Cardiovascular Outcomes Research (NICOR); strategies are already in place within the department to ensure this is delivered.

The reports of 14 local clinical audits were reviewed by Gateshead Health NHS Foundation Trust in 2017/18 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** Improvements since previous audit has been the revision of the Ligature Audit Tool, and processes. There has been a standardising of placing patients on Care Programme Approach (CPA), the change

		in practice being that all patients admitted to the Sunniside Ward are placed on CPA at point of admission. Changes in documentation evidence this practice improvement. The care plans held for patient's receiving care in the Sunniside Unit have been revised, and information is easy to audit, evidencing positive practice. The follow up for patients on discharge matches the identified standard, recognising the high risk period for these patients being within the first three days of discharge. Critical incidents have been investigated, and lessons shared. ○ Alternate electronic system being addressed, RIO (electronic system) being considered as an option. ○ A Nurse Consultant has been appointed to support Mental Health training for all staff. CPA training is to be provided in-house. ○ Ligature audit- Tool and processes have been revised. ○ Additional pharmacy cover for wards is being reviewed by senior management.
	Accident & Emergency	**Pathway audit for ambulance admissions to the Emergency Department** Comparison audit on patients who are successfully referred to alternative providers by ambulance clinicians. Explore further the reasons why referrals are rejected by providers. Explore further why ambulance clinicians are not referring appropriate patients. Re-circulate Patient Care Updates (PCU's) to all ambulance clinicians. Development of a system to allow ambulance clinicians to access PCU's during actual incidents. Further encouragement for the use of alternative pathways during staff appraisals/review. Distribution of patient care updates to ambulance staff is required.
	Emergency Admissions Unit	**Audit of Management of Acute Kidney Injury (AKI)** The audit has identified that we need to increase our adherence to local and national guidelines when requesting ultrasound exam for patients with AKI. We learnt from this audit that it is vital to adhere to NICE guidelines in each and every step during the management of patients with AKI. There are several essential areas which need to be improved in order to reach the best possible management of patients with AKI. Staff should be kept well-informed by all the essential guidelines and updates. This can be achieved by frequent education approaches, including regular scientific meetings, reviews, journal clubs and regular discussions during grand rounds.
	Stroke	**Prevention and treatment of aspiration pneumonia in stroke patients** Ensure that all stroke staff are trained in performing a swallow screen. Ensure appropriate documentation of all assessments. Multidisciplinary Team goal sheet to include postural changes required to aid swallowing. Potential need for greater use of instrumental assessments of swallowing. Inclusion of mouth care needs on MDT goal sheet. The audit identified that no physio assessments of new stroke

		patients were done within 24 hours, no documentation of initial swallow screening seen in notes. We need to improve on using compensatory strategies used in patients with unsafe swallow.
Clinical Support & Screening	Endoscopy	**Decontamination process audit: Scope Journey** 59% compliance of manual leak test prior to manual clean in decontamination. Increased compliance needed. 71% compliance in Personal Protective Equipment (PPE) being changed after manual clean prior to connection to endoscope washer- disinfector (EWD). Remind staff at endoscopy SafeCare meeting to place scopes in trays carefully without twists to help prevent damage. Discussed with staff at endoscopy SafeCare meeting.
	Endoscopy	**Audit of Endoscopy Global Rating Scale Standards for Oesophageal stent insertion** The cancer Multidisciplinary Team uses a system (Dendrite) that does not link with Medway, it remains difficult to record dysphagia (difficulty in swallowing) scores and note symptomatic improvement (or otherwise) in a consistent way. This has been exacerbated in the most recent cycle as we did not have an upper Gastro-Intestinal cancer nurse in post for part of the time. Mortality, morbidity and process standards for upper Gastro-Intestinal stent insertion need to be regularly audited. To present audit findings at the next upper Gastro-Intestinal Annual General Meeting and discuss future assessment of symptomatic response to stenting - including how and where to record this (currently dysphagia score is on the MDT input on dendrite, but the patient does not come back through the MDT to discuss symptomatic response unless further treatment is proposed).
	Diagnostic Imaging	**Re-audit - Musculoskeletal (MSK) Ultrasound Audit** Deletion of incorrectly labelled images at time of scan is suggested. However these changes would have no impact on the accuracy of the diagnostic report, only on the quality of the saved images (electronic record). The partial-thickness tendon tear discrepancy identified through *Magnetic resonance imaging* (MRI) imaging will be discussed at the next departmental discrepancy meeting as a means to inform practice. We need to save images where compression is applied to soft tissue lumps to provide further evidence to its nature.
	Diagnostic Imaging	**An audit of Compliance with the ionising Radiation (Medical Exposure) Regulations with relation to Optimisation of exposure - Regulation 7(8) in respect to mini c arm (a small mobile scanner) procedures** All clinicians / staff would benefit from being reminded of the Ionising Radiation (Medical Exposure) Regulations (IRMER) regulations and their responsibility to record the radiation dose in a permanent format. It may also be helpful if the manufacturer of the mini c arm could be contacted to see if anything could be done with regards to the radiation dose being automatically stored on the machine and therefore transferred onto picture archiving and communication system (PACS) alongside relevant imaging. From the

		audit results all clinicians / staff would benefit from being reminded of the IRMER regulations and their responsibility to record the radiation dose in a permanent format. To contact Mini c arm manufacturer to see if there was any modification that could be made to the equipment so that the radiation dose is automatically sent to the hospitals PACs system - This was completed and there is no modification that can be made to the mini c arm so that radiation doses are automatically sent to PACS
Surgery	General Surgery	**Prospective audit of completion of outpatient 'clinic instruction slips'** No consistent documentation standard for instruction slips. Inter clinic variability; no improvement after presentation highlighting issues at SafeCare meeting; likely lack of clinician engagement in slip completion; fortunately other specialties exist to identify patients who require follow up who have unclear forms. (6/37 requiring follow up had ambiguous Clinic Instruction Slip (CIS) or required Follow Up to be booked at time of completion). Clinic instruction slips with the patients outcome recorded varies from clinic to clinic.
	Paediatrics	**Audit of Child Protection Referral forms** The audit identified that 23.05% of referral forms were incomplete. The audit identified that 19.6% of referrals had been sent without parental consent. The audit identified that 17.6% of referrals did not evidence the voice of the child. Safeguarding Children Team to design a pro-forma to guide and assist staff in completion of Child Protection Referral Form. Child Protection Referral Feedback form to be initiated and completed on receipt of referral form and returned to staff member. Safeguarding Children Team to review training to include documenting the 'voice of the child' when completing a referral form. Safeguarding Children Team to explore possibility of a letter template for circumstances whereby parents have left the department prior to being told of form completion
	Fertility	**The identification and prevention of women at risk of moderate and severe ovarian hyper stimulation syndrome** During this audit we ascertained that the department comply with National Institute for Clinical Excellence (NICE) guidelines. For the future audit we should include day 10 monitoring USS results for number of follicles greater than 12-14mm.
	Theatres	**Critical analysis of the operative notes in the surgical services** From the results obtained – it seems there is a room for improvement in some of the major categories such as Deep vein thrombosis (DVT) prophylaxis which was better in the elective group. Antibiotics prophylaxis was better documented in the emergency post op group. Antibiotic type should be mentioned. Anticipated blood loss needs documentation. The operative finding/diagnosis (equal in elective and emergency), staff names (slightly better documented in elective notes) and incision (better in elective notes) were documented very well. Extra procedures and

		complications were documented poorly and it needs to be specifically mentioned whether there were or were not any complications. Inadequate detail on the post op notes may increase the risks of litigations, difficulties in deciding choice of antibiotics and general post-operative care. No clear pattern or difference to the quality of documentation in between the two categories. The audit indicated that there is detailed guidelines regarding post-operative documentation to help handover and provide concise information regarding the patients operation legibly. This is important to allow safe handover of patients.
Nursing & Midwifery	Clinical Effectiveness	**Trust wide Record Keeping Audit** The results are shared monthly within all the Business Units. 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. The figures for participation have significantly increased during 2017/18. Medical Staff have increased by 176%, Nursing Staff have increased by 725% and Allied Health Professionals have increased by 383% overall giving a more accurate picture of the status of our record keeping standards.
	Clinical Effectiveness	**World Health Organisation (WHO) checklist audit** The results of this monthly audit are shared and displayed within the main theatre area on a monthly basis and discussed at the Business Units SafeCare Meeting. All staff are reminded to fully participate in the WHO checklist. The number of participants has increased in 2017/18. Medical Director to speak to senior medical staff regarding the importance of attending briefing sessions both before and after surgery.

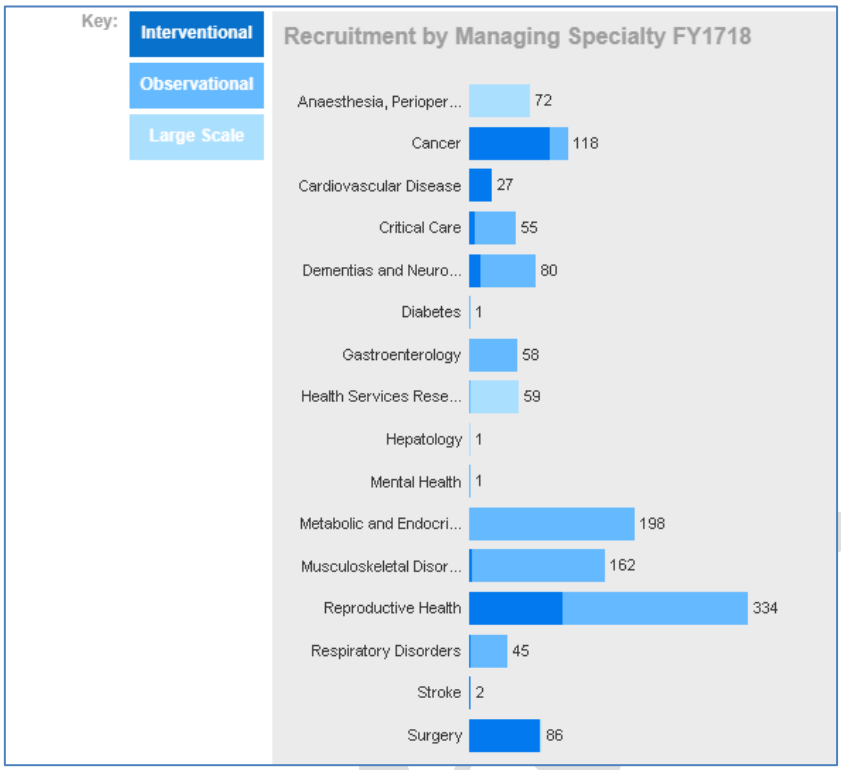
Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Gateshead Health NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee (the Health Research Authority (HRA)) was 1,299. This was an increase of 266 additional patients recruited into research within the Trust for 2017/2018.

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 191 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. The top 5 recruiting studies for 2017 - 2018 were The GCA Study (Rheumatology - 155 participants), The Spire Study (Obstetrics - 149 participants), The PETS Study (Endocrinology -124 participants), The KREBS

Study (Surgery - 85 participants) and The PQUIP Study (Critical Care - 72 participants). The Recruitment by Managing Specialty can be seen below -



Over the last year, researchers from the Trust have published over **(awaiting figures)** publications, and delivered **(awaiting figures)** 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 112 members of staff participating in research at Gateshead Health NHS Foundation Trust during 2017/18. 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.

Good News!

- The Trust was successful in meeting the Quality Improvement Incentive Criteria for 2017/18. The scheme focused on completion of data fields within the Local Portfolio Management System (LPMS) related to the NE & NC CRN High Level Objectives with a 90% target for fields completed for Study Set-Up and Recruitment to Time and Target. The Trust achieved a 100% completion on the target and was awarded £15,000. The initiative took place over quarters one and two of 2017/2018. The NE & NC CRN extended the initiative into quarter 3 and the Trust achieved a continued 100% completion on all data fields. A further £5,000 was awarded to the Trust. Totalling £20,000 for 2017/18.

- The R&D Director stood down from his role as R&D Director at the end of December 2017. He had been the R&D Director for the last 10 years and had worked tirelessly within Research & Development and the North East & North Cumbria Clinical Research Network. He will now take up

a National Post within Dementia and continue to be an active researcher within the Trust and continue to bring his knowledge and experience to the R&D Council Meetings.

- A new Assistant Medical Director for Research & Development has been appointed. They commenced in post at the beginning of January 2018.

- The VESPA Study – as previously highlighted as an excellent example of collaborative working and Best Practice between the Research Nurses, Research Midwives, Clinical Trials Officers and Data Managers, the Research Midwives have submitted an entry into The Nursing Times Awards for 2018 – fingers crossed! The VESPA Study was also presented at the Trust's Nursing & Midwifery Conference in May 2017 by both Research Midwives.

- The R&D Team were invited to attend an event organised by the Academic Health Science Network (AHSN) at the Great North Museum, Newcastle, to develop a Regional Research Strategy for the North East and North Cumbria. Those invited were asked to give a small presentation on setting the scene regarding their own organisation and how they could contribute to the overall regional development of research.

- The Giant Cell Arteritis (GCA) Study (Ear Involvement in Giant Cell Arteritis) – this study is the biggest recruiter for Gateshead Health NHS Foundation Trust for 2017/18.

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

A proportion of Gateshead Health NHS Foundation Trust income in 2017/18 was conditional on 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 2017/18 and for the following 12 month period are available electronically at http://www.qegateshead.nhs.uk/cquin

A monetary total of £4,981,173 of the Trust's income in 2017/18 was conditional upon achieving quality improvement and innovation goals. The Trust were paid a total of £4,552,491 for achieving the quality improvement and innovation goals for 2016/17.

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 2017/18.

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

An unannounced focused CQC inspection of Older Person's Inpatient Mental Health Services took place in December 2016. The report was published in June 2017 and rated the Community-based

mental health services for older people as 'Requires Improvement' and Wards for Older People with Mental Health problems as 'Inadequate'.

Actions were identified prior to and following the publication of the report, in which 22 breaches, encapsulated within eight requirement notices, were identified, and a copy of the action plan was sent to the CQC. A Mental Health Improvement Steering Group and Task and Finish group was set up to support the Business Unit with the actions and improvements required to improve the services. The overall improvement plan contributes to improving patient safety and the quality of care through the provision of staff training, introduction of improved care planning and structured documentation, more robust risk assessment processes and increased therapeutic activity. There are three outstanding breaches (of the 22) which relate to:

- Limited access to psychological therapies – there is ongoing recruitment into these posts.
- Rapid restraint – there is Immediate Life Support training currently being rolled out.
- Implementation of Electronic Patient Record across Mental Health Services.

The CQC carried out two Mental Health Act 1983 Monitoring visits in July and November 2017. Actions were identified from both and these were incorporated into the overall action plan.

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 2017/18 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	99.8%	99.4%
Percentage for outpatient care	99.7%	99.6%
Percentage for accident and emergency care	98.9%	97.4%

Which included the patient's valid General Medical Practice Code was:	Trust %*	National %*
Percentage for admitted patient care	99.9%	99.9%
Percentage for outpatient care	99.9%	99.8%
Percentage for accident and emergency care	99.9%	99.3%

* SUS Data Quality Dashboard - Based on provisional April 17 to February 18 - SUS data at the Month 11 inclusion Date

Information Governance Toolkit

Gateshead Health NHS Foundation Trust's Information Governance Assessment Report overall score for 2017/18 was 85% and graded satisfactory (green).

Standards of Clinical Coding

Gateshead Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017/18 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.

2.4 Learning from Deaths

During 2017/18 1,192 of Gateshead Health NHS Foundation Trust patients died. This compromised the following number of deaths which occurred in each quarter of that reporting period:

- 251 in the first quarter;
- 258 in the second quarter;
- 329 in the third quarter;
- 354 in the fourth quarter.

By 18th April 2018, 829 case record reviews and 76 investigations have been carried out in relation to 1192 of the deaths included above.

In 75 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 168 in the first quarter;
- 215 in the second quarter;
- 230 in the third quarter;
- 216 in the fourth quarter.

One death representing 0.08% of the patient deaths during the reporting period is judged to be more likely than not to have been due to problems in the care provided to the patient.
In relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter;
- 1 representing 0.08% for the second quarter;
- 0 representing 0% for the third quarter;
- 0 representing 0% for the fourth quarter;

These numbers have been estimated using the Trusts 'Reviewing and Learning from Deaths' policy. Reviewed cases are graded using the Hogan preventability score and NCEPOD overall care score following case note review by the consultant led team that was responsible for the patient at the time of death.

The Trust has learnt the following from case record reviews and investigations conducted in relation to the deaths judged to be more likely than not to have been due to problems in the care provided to the patient.

The root cause analysis (RCA) for this case identified the following learning.

- Inadequate senior review by specialty team.
- Delay in receiving antibiotics.
- Initial glucose test not carried out.
- Regular monitoring of urea and electrolytes not done (difficult access).
- Sharp rise in sodium levels not monitored.

The Trust has taken the following in consequence of what has been learnt during the reporting period.

Following the RCA the following actions were identified as part of the action plan.

- Surgical team to review practice around initial assessment and to ensure that all emergency admissions are reviewed by a senior team member in a timely fashion.
- Set up ECC admission profile to ensure standardized blood sampling for all patients which will include glucose levels. Additional tests will still be requested which are patient specific. All patients having IVT will have daily U&E / glucose.
- Educate nursing and junior medical team re fluid and electrolyte balance & implementation of the AKI bundle.
- Dissemination of NICE guidelines update on intravenous fluid and electrolyte treatment published in January 2018 via deteriorating patients committee.

The Trust will assess the impact of these actions during 2018-19.

0 representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Trusts 'Reviewing and Learning from Deaths' policy. Reviewed cases are graded using the Hogan preventability score and NCEPOD overall care score following case note review by the consultant led team that was responsible for the patient at the time of death.

0 representing the 0% of the patient deaths during 2016-17 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.5 Seven Day Hospital Services

The Trust has fully implemented priority standard five (access to diagnostics) and standard eight (access to consultant directed intervention).

For clinical standard eight (ongoing review) we have 100% compliance for those requiring twice daily review. We have increased our base ward consultant cover on Care of the Elderly wards at the weekends and were at 98% compliance for once daily review in the March 2017 Seven Day Self-Assessment Tool.

We have introduced a seven day frailty front of house assessment to reduce admission and plan discharge.

For standard two (speciality consultant review within 14 hours) we are 74% compliant (Sept 2017) across all seven days. We have identified arrival between 4-8pm as a problem area and are considering options around transfer to base ward earlier or staggering consultant shifts (without compromising care elsewhere). Some improvements in documentation (e.g. annotating time seen/identity of doctor) may also help to make survey results more accurate.

2.6 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 NHS Digital.

(a) SHMI (Summary Hospital-level Mortality Indicator)

SHMI	Oct 15 – Sept 16	Jan-16 - Dec 16	Apr 16 - Mar 17	Jul-16 - Jun 17	Oct-16 - Sep-17
SHMI	0.99	1.00	1.00	1.01	1.00
England highest	1.16	1.19	1.21	1.23	1.25
England lowest	0.69	0.69	0.71	0.73	0.73
Banding	2	2	2	2	2

Source: www.digital.nhs.uk/SHMI
SHMI Banding 2 indicates that the Trusts mortality rate is 'As Expected'

(b) The percentage of patient deaths with Palliative Care coded at either diagnosis or specialty level

% Deaths with palliative coding	Oct 15 – Sept 16	Jan-16 - Dec 16	Apr-16 Mar-17	Jul-16 - Jun 17	Oct-16 - Sep-17
% Deaths with palliative coding	15.0%	15.2%	15.4%	16.7%	18.9%
England highest	56.3%	55.9%	56.9%	58.6%	59.8%
England lowest	0.4%	7.3%	11.1%	11.2%	11.5%
England	29.7%	30.1%	30.7%	31.1%	31.5%

Source: www.digital.nhs.uk/SHMI

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:

- Reviewing the Trusts mortality review process and standardising the mortality review process across the Trust.
- Production and Implementation of a new Learning from Deaths Policy.
- Increasing the proportion of cases receiving a mortality review following the release of the CQC 'Learning Candour and Accountability' (December 2016) publication and subsequent guidance on learning from deaths.
- Introducing a Mortality Council to review cases outlined in the learning from deaths requirements, or cases where carers, relatives, or staff have expressed concerns.

- Regularly reviewing a variety of mortality indicators at the Trusts Mortality and Morbidity Steering Group. Conducting further review where appropriate.
- Regular review of learning themes, identifying actions, and sharing of learning across the Trust.
- Developing a bereavement letter and questionnaire to capture valuable feedback from relatives and carers.

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

Patients on Care Programme Approach (CPA) Followed up within 7 days	2015-16				2016-17				2017-18			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Gateshead Health Foundation Trust	89.0 %	100.0 %	50%*	80%**	100.0 %	90.0%	80.0%	84.6%***	71.4% †	87.5%††	90.9%†††	100.0 %
England	97.0 %	97.0%	97.0%	97.2%	96.2%	96.8%	96.7%	96.8%	96.7%	96.7%	95.4%	
England Highest	100 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	99.4%	100.0 %	100.0%	100.0%	
England Lowest	89.0 %	83.0%	50.0%	80.0%	28.6%	76.9%	73.3%	84.6%	71.4%	87.5%	69.2%	

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
*** 13 of 11 patients followed up within 7 days after discharge from psychiatric inpatient care
† 5 of 7 patients followed up within 7 days after discharge from psychiatric inpatient care
†† 7 of 8 patients followed up within 7 days after discharge from psychiatric inpatient care
††† 10 of 11patients 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 had a follow up arranged but moved out of the area (1 patient Q3)
- Two patients received a follow up on day eight for one patient this was the first available appointment due to staff leave.

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 will be made 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	2013-14 Final	2014-15 Final	2015-16 Final	2016-17 Final	Apr-17 to Sep-17 Final
Gateshead Health Foundation Trust	0.064	0.084	0.045	0.05	*
England	0.085	0.084	0.088	0.086	0.089
England Highest	0.139	0.154	0.157	0.135	0.140
England Lowest	0.008	0.000	0.021	0.006	0.000

Varicose Vein Adjusted average health gain	2013-14 Final	2014-15 Final	2015-16 Final	2016-17 Final	Apr-17 to Sep-17 Final
Gateshead Health Foundation Trust	0.125	0.067	0.107	0.054	*
England	0.093	0.094	0.096	0.092	0.096
England Highest	0.150	0.154	0.150	0.155	0.134
England Lowest	0.022	-0.009	0.018	0.010	0.000

Hip Replacement Adjusted average health gain	2013-14 Final	2014-15 Final	2015-16 Final	2016-17 Provisional	Apr-17 to Sep-17 Provisional
Gateshead Health Foundation Trust	0.391	0.420	0.403	0.401	**
England	0.436	0.436	0.438	0.445	**
England Highest	0.544	0.524	0.512	0.537	**
England Lowest	0.311	0.331	0.320	0.310	**

Knee Replacement Adjusted average health gain	2013-14 Final	2014-15 Final	2015-16 Final	2016-17 Provisional	Apr-17 to Sep-17 Provisional
Gateshead Health Foundation Trust	0.291	0.310	0.284	0.282	**
England	0.323	0.315	0.320	0.324	**
England Highest	0.425	0.418	0.398	0.404	**
England Lowest	0.215	0.204	0.198	0.242	**

Source: http://content.digital.nhs.uk/proms
* Figure not calculated. Average case mix 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.
** Insufficient data to allow calculation.

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

Groin

- The Trust recognises that our provisional reported outcomes are below the national normal distribution using this measure.
- We will remain committed to providing patients with high quality care, and as such we will continue to work towards improving our scores to a level equal to or greater than the national norm distribution.
- We will continue to share data with clinical teams and commissioners to ensure that health gains can be maximised from future procedures. We will also discuss with patients considering surgery

the range of outcomes that can be expected to ensure they have an informed choice of treatment, including alternatives to surgery where appropriate.

Veins

- The provisional data would suggest that our reported outcomes are above the national normal distribution for April 2015 to March 2016
- This recognises the efforts of the speciality team to address the performance previously reported, not least the agreed actions regards patient education to ensure patients are suitably informed when they are considering surgery about the range of outcomes that can be expected, including alternatives to surgery where appropriate.
- We will continue to share this data with the relevant clinical teams to strive for further improvements

Hip

- The Trust recognises its outcomes are below recommended parameters based on health gain scores and are below the average scores in England. We are continuing to work toward improving our score in line with national average.

Knee

- The Trust recognises its outcomes are below recommended parameters based on health gain scores and are below the average scores in England. We are continuing to work toward improving our score in line with national average.

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

Groin

- To strive towards improved reported outcomes, we will ensure this data is shared with the clinical teams and used to support discussion as to how to improve our service and deliver quality improvements.
- This will include a range of initiatives including exploring the potential role of a "PROMs champion" (from within the existing nursing teams); internal case study/audit reviews to identify any potential trends in this performance data; review of existing patient education in order to ensure appropriate patient expectations of this procedure including education regarding alternative management options to surgery.
- The potential impact that introduction of alternative follow-up pathways will have on data capture and thus our future compliance, also requires consideration.

Veins

- Despite decreasing numbers of these procedures, we remain committed to improving our service to patient. The PROMS data along with other performance data, will continue to be reviewed to ensure continued focus on delivering quality patient care.
- It should be noted that with the introduction of value based commissioning (VBC), GP referrals dipped whilst practitioners adjusted to the new system and there was some uncertainty regards the referral process. This was addressed through further education to GPs, following which referrals increased back to a level higher than that prior to VBC introduction.
- We will remain committed to our work to ensure we share with patients sufficient information and support to ensure they have an informed choice of treatment, including alternatives to surgery where appropriate.

- This commitment to improved service delivery, also includes consideration of alternative follow-up pathways for patients, perhaps by telephone, but still ensuring adequate support and clinical safety.

As from mid-2017, the PROMS data for Varicose Veins and Groin has not been collected, due the termination of the national programme.

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 recently signed a new agreement with NEQOS to break this down to Consultant level data.
- We established a dedicated PROMS Group to review and implement improvements to the current pathway and outcomes for patients. The group have identified specific action points that we are progressing.

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 recently signed a new agreement with NEQOS to break this down to Consultant level data.
- We established a dedicated PROMS Group to review and implement improvements to the current pathway and outcomes for patients. The group have identified specific action points that we are progressing.

Emergency Readmissions within 28 Days

- Aged 0 – 14yrs

Child 0-14 Years	2013-14	2014-15	2015-16	2016-17	2017-18 to Dec 17
Emergency Readmission Rate	8.91%	11.51%	8.94%	8.54%	6.66%
Number of Spells	4,970	5,154	3,936	4,849	3,301
Number of Readmissions	443	593	352	414	220

- Aged 15 years or over

Adult 15+ Years	2013-14	2014-15	2015-16	2016-17	2017-18 to Dec 17
Emergency Readmission Rate	8.69%	9.48%	9.50%	8.72%	8.00%
Number of Spells	54,234	58,712	51,871	59,000	43,964
Number of Readmissions	4,714	5,565	4,929	5,143	3,515

Source: Dr Foster Quality Investigator 2013-14 to 2014-15
Source: Healthcare Evaluation Data (HED) 2015-16 to 2017-18

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

- Outcomes are sustained to the levels through safe discharge practice, coordinated discharges and transfers of care achieved through working in a multi-disciplinary way.

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

- Holding multi-agency partnership meetings and timely surge meetings to address any concerns or delays associated with discharge.
- Encouraging early discharge planning.
- Completion of a Comprehensive Geriatric Assessment on or pre admission by the Frailty Team which is now working across seven days and is based in the A&E Department.
- Introduction of the Transfer Bag (Black bag) scheme (from January onwards) to help co-ordinate safe transfers back to care homes.
- Enhancement of the Urgent Care Team over winter pressure to help manage any deterioration of patients and enable them to safely remain at home.

Trust's responsiveness to the personal needs of its patients

Inpatients - Overall Patient Experience Score	2013/14	2014/15	2015/16	2016/17
Gateshead Health NHS Foundation Trust	81.5	81.8	79.2	79.1
England Average	76.9	76.6	77.3	76.7
England Highest	87.0	87.4	88.0	88.0
England Lowest	67.1	67.4	70.6	70.7

A&E - Overall Patient Experience Score	2012/13	2014/15	2015/16	2016/17
Gateshead Health NHS Foundation Trust	79.5	79.8	*	83.6
England Average	75.4	77.1	*	78.2
England Highest	82.2	83.5	*	83.6
England Lowest	67.1	67.2	*	71.1

* National survey not undertaken in 2015-16

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:

- Our inpatient score remains stable for 2016/17 and we remain 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.
- We have seen an increase in our score for A&E in 2016/17.

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.
- Launching the new Patient Public & Carer Involvement & Experience Strategy – Your Care, Your Voice in 2018 which sets out the Trust's vision for ensuring that patients remain at the heart of everything we do, and for our patients to be empowered and influence the care we deliver.

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	2017
Gateshead Health NHS Foundation Trust	74.7%	76.2%	81.1%	80.9%
England highest - Acute Trusts	89.3%	85.4%	84.8%	89.3%*
England Lowest - Acute Trusts	38.2%	46.0%	48.9%	48.1%*
Acute Trusts	64.7%	69.2%	69.8%	68.4%*

Source:www.nhsstaffsurveys.com

*Combined Acute and Community Trusts

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

- The Trust continues to perform positively as being a place our staff would recommend as a provider of care. This is underpinned by the Trust's Vision and Values which puts the patient and 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.
- Raising staff awareness during induction, core 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
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%	100.0%	63.0%	95.5%
2017-18	Q1	98.3%	100.0%	51.4%	95.1%
	Q2	99.2%	100.0%	71.9%	95.2%
	Q3	99.3%	100.0%	76.1%	95.3%
	Q4	99.1%	N/A	N/A	N/A

Source https://www.england.nhs.uk/statistics/statistical-work-areas/vte/
Source: https://improvement.nhs.uk/resources/venous-thromboembolism-vte-risk-assessment-201718/

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

- The Trust continues 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 continues to be recorded by the risk assessment on the electronic prescribing management 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 to all relevant clinical and support staff.

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)	2013/14	2014/15	2015/16	2016/17	2017/18
Gateshead Health NHS Foundation Trust	12.3	15.1	26.7	11.1	17.9
England highest	37.1	62.2	66	82.7	-
England lowest*	1.2	2.8	1.1	1.2	-
England	14.7	15	14.9	13.2	-

Source: www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data
*Where cases reported

*** During 2017/18 the Trust reported thirty one (31) post 72hr CDI cases against its annual objective of 19 cases and annual rate of 17.9 against its annual rate 11.6 per 100,000 bed days as reported by Public Health England data capture site.

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. Comparatively six of the eight regional Foundation Trusts, including Gateshead, have demonstrated an increase in post 72hr CDI cases against 2016/17 and also exceeded their annual objective. NHS Improvement (NHSI) contacted the Trust during November as an informal response to the Trust being outside of its monthly objective to review possible causes, the Trust approach to CDI, the reaction to increasing cases and to ascertain if there was any support NHSI could offer.
- NHSI recognised that the IPC team had implemented a comprehensive process review and identification of key themes based on sampling delays, prescribing, documentation, patient management and review, human factors, feedback and education. NHSI agreed there were no clear reasons for the recent gradual increase in cases however offered a level of external support if the Trust recognised the need. A focused and zero tolerance approach continues to support a reduction in CDI for patient safety in line with national guidance.

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 Newcastle Gateshead Clinical Commissioning Group and other regional Foundation Trusts to review lessons learned and share good practice in reviewing CDI cases.
- Lessons learned are shared with clinical staff and Business Units including key themes based on sampling delays, prescribing, documentation, patient management and review, human factors, feedback and education.
- Enhanced education support has been provided to both secondary and primary care sectors across Gateshead.

- The Diarrhoea Assessment Management Pathway (DAMP) tool 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.
- To enhance antimicrobial stewardship, the Trust antimicrobial guidelines have been redeveloped with inclusion of an electronic smartphone/device application.
- Polymerase chain reaction (PCR) testing continues to be used 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 15 – Mar 16		Apr 16 – Sep 16		Oct 16 – Mar 17	
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	2785	655,193	2399	673,865	3036	696,643
Rate of all incidents per 1,000 bed days	30.93	N/A	27.48	N/A	33.25	N/A
Number of incidents resulting in Severe harm or Death	17	2642	13	2516	15	2,623
Percentage of total incidents that resulted in Severe harm or Death	0.60%	0.40%	0.54%	0.37%	0.49	0.38%

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

- The Trust has seen an overall 26.6% increase from 2399 to 3036 in the amount of incidents reported from April – September 2016 to October 2016-March 2017. This evidences the work that the Trust has undertaken to improve the culture of reporting incidents. The Trust has recorded a rise in the reporting rate ratio per 1000 bed days, this has been influenced by the

Community Services moving across to the Trust in October 2016, however this does not equate to all of the increase. Work will continue to improve the Trust patient safety culture and raise awareness on sharing learning from incidents.

- Whilst the Trust has seen a rise in the amount of incidents reported and the reporting rate per 1000 bed days rise, there has also been a slight increase from 13 to 15 incidents severe harm or death that were reported October 2016 to March 2017. Whilst the Trust would expect a potential rise in the winter months as winter pressures are upon us there has been a reduction in October 2016 – March 2017, 15 compared with October 2015-March 2016 were there was 17 reported.

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:

- In 2017 the Trust invited an external trainer to carry out Root Cause Analysis (RCA) training. The Trust now has an accredited RCA trainer who can roll out Investigator Training to its staff. This in house training began in January 2018 and is now carried out on a bi-monthly basis. There has been an improved compliance with the policy to investigate incidents in a timely manner to ensure that learning can be shared to help us mitigate the risk of reoccurrence.
- 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 an Integrated Quality Report
- A Patient Safety Culture Review will be initiated throughout 2018. The Trust will 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 pressure damages incidents and to proactively respond to ongoing information analysis to identify measures that will positively impact on reducing harm.

3. Review of quality performance

2017/18 has been a successful year in relation to the three domains of quality:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

‡ denotes indicators governed by standard national definitions

Quality Summit

The first Gateshead Health NHS Foundation Trust Quality Summit on patient safety took place on Friday 23rd March 2018 with inspirational and motivational talks from leading healthcare figures. Sir Robert Francis QC gave the keynote speech and shared lessons learned from the Mid Staffordshire report, the inquiry he chaired. The other key speaker was Dr Umesh Prabhu, a paediatric consultant and former Medical Director at Wigan and Leigh NHS Trust. There were further sessions throughout the day on topics such as Sepsis, medicines management, Duty of Candour, supporting staff through an investigation and reviewing and learning from deaths.

L to R: Dr R Garkhoti, Sir Robert Francis, Dr C Kalluri Ms A Forrester, Mrs J Flinn

L to R: Mrs J Hickey, Sir Robert Francis, Mr V Bhattacharya

3.1 Patient Safety

As identified in priority three in 2017/18, the Trust has seen an increase in the incident reporting rate from all staff which improves the patient safety culture and ensures that we learn from all incidents to assist with prevention of reoccurrence.

To further improve the quality and the patient journey, we have introduced two audits to review how well we perform following an incident, firstly in being 'open and honest', informing the patient (via the Duty of Candour process) as soon as possible as to what has gone wrong, and secondly ensuring a thorough investigation is undertaken to identify what happened, in order to identify where we can make changes to prevent similar incidents occurring in the future.

The audits will look at;

- Duty of Candour - Where the duty of candour has been initiated with the patient or family as a result of the incident, we will ensure that written notification to the patient and any correspondence advising the patient of our investigations findings, and all actions and evidence of completion are uploaded to our incident management system (Datix).
- Investigation – We will also check that a full investigation (Root Cause Analysis) has been carried out, documentation completed, and all actions and evidence of completion are uploaded to our incident management system (Datix).

Once the first audits are carried out, we will look at the results to see how well we do, and identify areas for action. For example where documentation or evidence is missing the patient safety team will work with the Business Units to ensure these are identified and all the relevant assurance is received. Once all the actions have been completed a re-audit will be carried out to give assurance we have 100% compliance.

Initial audits have been very positive and the team have been able to gather the relevant documentation/evidence to confirm 100% compliance. Once there is a full quarter a quarterly report will be presented to Risk and Safety Council for Trust assurance.

Safeguarding Adults and Children

The Trust continues to maintain effective partnership working with key organisations. Systems, processes and policies are constantly reviewed to ensure compliance with local and national guidance. Safeguarding as core business is foremost in new ways of working and this is reflected in the training and support programmes developed and rolled out. One focused area of support is around Mental Capacity Act (MCA) assessments to improve the confidence of staff to support patients with reduced capacity who may be at risk.

A safeguarding training strategy is in place and is monitored by the Trust's Safeguarding Committee and formal training sessions were delivered to staff throughout 2017. Safeguarding training is now aligned with the core skills framework and training has been updated to reflect the recommended changes to the core competences (to include issues such as modern slavery, sexual exploitation, female genital mutilation (FGM) and radicalisation).

The Training Needs Analysis was revised to include the new staff groups requiring safeguarding adults training in addition to providing the in-house Mental Capacity Act training for all clinical staff groups and as part of the induction training for new members of the Trust. Additional Workshop to Raise the Awareness of the Prevent (WRAP) training has been given to meet targets set by the Home office to deliver training to 85% of the frontline staff by March 31st 2018.

Following the introduction of the Homelessness Reduction Act (April 2018) NHS Trusts will be among the organisations that have a duty to help those at risk of becoming homeless and refer them to a housing authority, therefore additional policies and procedures will be implemented to ensure compliance with the legislation.

Key achievements for 2017

- Policies and procedures for Safeguarding adults have been revised to highlight the need for the Trust to ensure all actions have been carried out to safeguard a vulnerable adult before a concern is shared with the local authority.
- Continued close partnership working between the Trust and Gateshead Local Authority has proven to be a good model of successful health/social care interagency working in a challenging environment.
- The addition of community services has enabled parity of processes across hospital acute settings and community to ensure continuity.
- The MCA/DOLS lead is continuing to forge close links with MCA leads from other trusts and local authorities to share good practice.
- Close links are established with the Security Manager to promote awareness of protection of vulnerable adults and the protection of staff members.
- The Trust has continued to fulfil its obligation of highlighting the Governments PREVENT agenda, via mandatory WRAP sessions. These sessions are to be transferred to online Mandatory training.
- Audits were carried out to ensure the Trust adheres to the responsibilities under the Care Act. This includes sharing concerns with the Local Authority where this is deemed necessary, and Trust staff and teams fulfilling their duties to safeguard vulnerable patients.
- A full time Emergency Care Domestic Violence and Safeguarding Advisor has been appointed.
- The implemented a robust process for reviewing deaths and the Safeguarding team played an important role in ensuring patients who require a second level review as part of The Learning Disability Mortality Review (LeDeR) process and that relatives are given the opportunity to engage and feedback. This has been recognised nationally by NHS Improvement and case studies have been presented to the Secretary of State for Health.
- The Safeguarding Children Team have been instrumental in facilitating the implementation of the Child Protection Information Sharing System (CP-IS) throughout the urgent care settings within GHNFT. CP-IS went live throughout the Trust in June 2017, followed by Gateshead Local Authority in September 2017. CP-IS roll out was completed with GHNFT maternity settings going live in March 2018.
- The Safeguarding Children Team have facilitated the move from paper based children's cause for concern forms to the electronic Datix system. This will allow timely sharing of information and more accurate data collection and recording of information.
- The Safeguarding Children Team now includes the Looked After Children's Team.

Sepsis Awareness

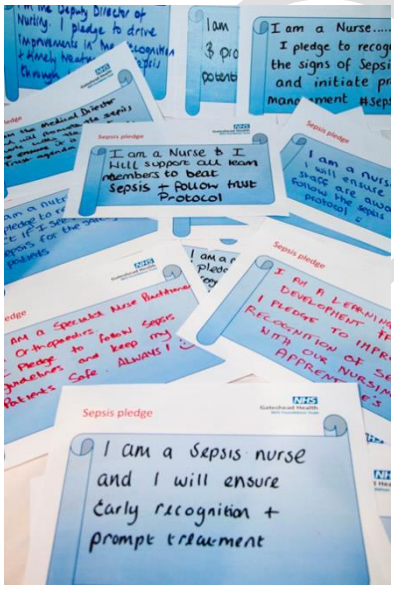
Sepsis is the body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure, and death. A number of initiatives to raise awareness of Sepsis with the Trust have been undertaken throughout 2017/18. A programme of work is in place for Sepsis management. The key achievements this year include:

Training and Education

- Development and introduction of a competency based assessment for qualified nurses.
- Sessions for junior doctors at induction and at various levels within the foundation teaching programme. Ward based training.
- An intranet page has been created dedicated to Sepsis.
- Each ward and department has identified Sepsis Champions to provide support and promote best practice within their areas.

Sepsis Awareness Day

- Held in June 2017 with the aim to :
  - develop a resource that can be used for all wards/units
  - assess the need for Sepsis boxes
  - deliver the message of early recognition and prompt treatment



Cycle for Sepsis

- Held on World Sepsis Day on 13th September 2017 we worked in collaboration with Gateshead Leisure services and hospital staff to raise awareness around early recognition and prompt treatment of Sepsis and encourage staff to commit a pledge.

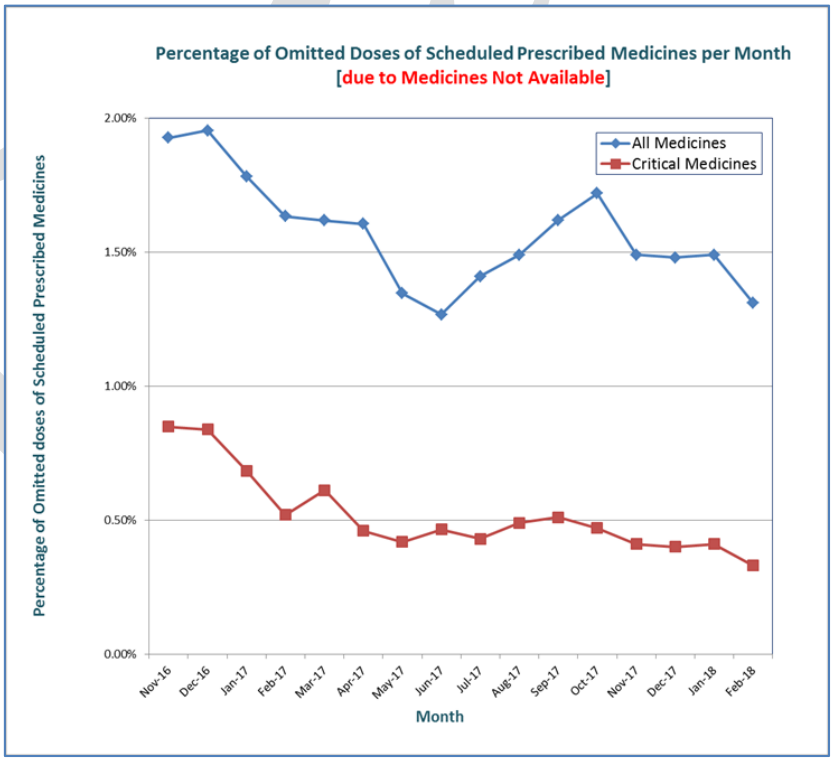
Medicines Management
Omitted and delayed medicines

A NPSA Rapid Response Report (RRR009): **Reducing harm from omitted and delayed medicines in hospital**, published in 2010, highlighted the importance of medicines to a patients care, the potential serious outcomes if these were omitted or delayed, and the actions to be taken to start to address the problem.

Medicine doses are often omitted or delayed in hospital for a variety of reasons. Whilst these events may not seem serious, for some critical medicines or conditions, such as patients with sepsis or those with pulmonary embolisms, delays or omissions can cause serious harm or death. Patients going into hospital with chronic conditions are particularly at risk. For example, patients with Parkinson's disease who do not receive their medicines on time may recover slowly or lose function, such as ability to walk.

The percentage of omitted doses of scheduled prescribed critical and non-critical medicines [due to medicines not available] are monitored closely on a monthly basis as key Medicines Management KPIs for the organisation. Both KPIs have reduced significantly since November 2016:

Omitted doses of ALL medicines; ↓32%, Omitted doses of CRITICAL medicines; ↓1%



There have been three key enablers of this quality improvement work:

- Timely accurate data on omitted doses via JAC® EPMA.
- Partnership working between Pharmacy and frontline Nursing staff.

- Robust medicines management by the Pharmacy Medicines System Team utilising Omnicell® Automated Drug Cabinets.

We are also confident that we will see further improvements in these indicators in the forthcoming months.

Omnicell® Automated Drug Cabinets

During the latter half of 2016, the organisation replaced virtually all traditional medicines cupboards with **Omnicell® Automated Drug Cabinets.**

These electronic cabinets have distinct advantages for the organisation:

- No keys - accessed via fingerprint.
- Directional lighting to aid locating Medicines.
- Automatic ordering of medicines with low stock.
- Analysis of usage to support stock management.

We are using the information gathered from these cabinets to adjust medicines stock lists (and levels) to most closely match the usage in each individual clinical area in the hospital.

For example, data from these cabinets has enabled us to identify critical medicines that require more widespread stockholding. In addition, careful management of non-moving medicines lines has significantly reducing potential medicines waste. This continuous dynamic stock adjustment means that clinical areas are far more likely to have **the right drug, in the right place, at the right time** reducing the potential of patients missing doses of medicines due to a medicine not being available.

Pressure Damage

Preventing pressure ulcers remains one of the greatest healthcare challenges today in terms of reducing patient harm. Despite progress being made in the management of pressure ulcers since 2012, they remain a significant healthcare problem affecting 700,000 people per year. Estimates on pressure ulcer incidence and prevalence from hospital-based studies vary widely according to the definition and category of ulcer, the patient population and care setting. Reported prevalence rates range from 4.7% to 32.1% in hospital populations in comparison to 22% in nursing home populations (AHSN 2015).

The key successes in 2017/18 are:-

- National Finalist in the 'Nursing Times Awards 2017' in the Category of Patient Safety.
- Project title: 'React to Red: How Vigilance At The Bedside Can Drive Excellence In Reducing Harm from Pressure Damage'
- Trust Finalist in the 'Star Awards' in the Category of 'Innovation and Improvement' for reducing the incidence of pressure damage across the organisation.
- Building upon the tremendous success of participating in the 'Regional Pressure Ulcer Collaborative' which was funded by the Academic Health Science Network: Ward teams continue

to be supported to actively take ownership for improving their care processes. The programme continues to be rolled out to those wards still experiencing incidents of pressure damage by using a variety of improvement methodologies / Plan Do Study Act cycles.

- The SSKIN Bundle which is a five steps reliable care process to prevent pressure damage from occurring has been incorporated into our Intentional Rounding Chart and embedded in to clinical practice (**S** = Support surface **S** = Skin inspection **K** = Keep moving **I**= Incontinence **N** = Nutrition).
- The Safety Cross is displayed at ward level which graphically shows how many days since the last incident of pressure damage which helps to generate a sense of pride and achievement whilst also proving a constant reminder of our 'Pressure Ulcer Prevention and Management Strategy'.
- The Prevention and Management of Pressure Ulcer Policy has been rewritten to incorporate Community using a variety of pictorial tools and guides to aid the appropriate classification of damage and selection of preventative equipment.
- An extensive training package has been devised for the Prevention and Management of Pressure Ulcer which can be accessed by all Trust staff and also those staff from Residential and Nursing Homes.
- Developed a Joint Wound Formulary and Wound Management Booklet following successful participation in NHS England's Improving Wound Care Project for Community Services to increase the number of wounds that have failed to heal after four weeks to receive a full wound assessment.

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.

‡Safety Thermometer	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Sample	801	733	800	727	796	793	749	761	771	802	825	781
Surveys	30	29	29	29	29	29	29	29	29	30	30	30
Harm free	95.5%	95.8%	97.3%	97.1%	97.0%	97.5%	96.7%	96.1%	96.1%	96.8%	97.3%	96.5%
Pressure Ulcers - All	3.0%	3.0%	2.4%	2.1%	2.1%	1.9%	2.5%	3.0%	3.5%	2.9%	1.7%	2.4%
Pressure Ulcers - New	0.4%	0.7%	0.5%	0.3%	0.8%	0.4%	0.3%	0.8%	0.4%	0.4%	0.2%	0.6%
Falls with Harm	0.4%	0.4%	0.1%	0.7%	0.5%	0.5%	0.3%	0.5%	0.3%	0.3%	0.5%	0.1%
Catheters and UTIs	1.1%	0.8%	0.1%	0.1%	0.3%	0.3%	0.4%	0.4%	0.3%	0.3%	0.6%	0.6%
Catheters and New UTIs	0.3%	0.4%	0.1%	0.1%	0.1%	0.3%	0.4%	0.4%	0.1%	0.3%	0.4%	0.6%
New VTEs	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.4%	0.1%	0.0%	0.0%	0.0%	0.3%
All Harms	4.5%	4.2%	2.8%	2.9%	3.0%	2.5%	3.3%	3.9%	3.9%	3.2%	2.7%	3.5%
New Harms	1.1%	1.6%	0.9%	1.2%	1.5%	1.1%	1.3%	1.7%	0.8%	0.9%	1.1%	1.7%

- **Pressure Damage**

  We have a dedicated workforce who are committed to continue to reduce the number of pressure damage incidents on a year on year basis. Over the last 12 months we have consistently achieved a prevalence rate of 0.5% or less on 8 separate occasions for new pressure ulcer that have developed whilst the patient has been under our care. This has been achieved due to the tremendous work across the Trust, building upon the success of participating in the Northern Regional Pressure Ulcer Collaborative. Teams have been supported to actively take ownership for improving their care process using a variety of improvement methodologies by testing small changes in practice and monitoring closely their effectiveness. The Safety Cross is displayed at ward level which graphically shows how many days since the last incident of pressure damage which helps to generate a sense of pride and achievement whilst also providing a constant reminder of our 'Pressure Ulcer Prevention Strategy'.

  As part of our Strategy, the 'Pressure Ulcer Prevention Policy' has been amended to reflect changes in clinical practice and our provision of services in the Community. A number of pictorial guides and aids have been incorporated to aid staff to appropriately classify pressure damage and select products to aid the redistribution of pressure. An extensive training package has also been formulated which can be accessed by all Trust staff and also staff from the local community who work in Residential and Nursing Homes.

- **Falls**

  Over the last 12 months we achieved a prevalence rate of 0.5% or less for those patients who have suffered harm as a result of a fall.

- **Catheter Associated Urinary Tract Infections (CAUTI)**

  Over the last 12 months we have achieved a prevalence rate of 0.6% or less for those patients who have developed a CAUTI whilst in our care.

  The Infection Control Team continues to undertake targeted work on a daily basis using utilising the 'High Impact Interventions' from the NHS Improvement Infection and Prevention Society to prevent catheter associated urinary tract infections from occurring.

  Two main areas of practice are being targeted: the insertion phase and also routine maintenance and assessment. Risks can be greatly reduced by complying with all parts of the process for safe catheterisation which incorporates the removal of the catheter as soon as it is no longer required.

- **Venous Thromboembolism (VTE)**

  Over the last 12 months we have had no VTE's on four separate occasions and had a 0.1% prevalence rate on a further 6 occasions to report.

  This fantastic achievement has been achieved as a direct result of introducing an electronic prescribing and dispensing system into the organisation known collectively as Jac. This has provided reassurance that all patients' are assessed by a Doctor according to their individual risk of developing a VTE whilst they are in hospital and if they require treatment as a preventative measure this is prescribed and the necessary medication given. If any missed doses occur this can be quickly highlighted to the nursing staff during their drug round and investigated immediately.

3.2 Clinical Effectiveness

Record Keeping Audit

The Record Keeping Audit is the vehicle used to measure compliance with the Trust's documentation standards. However, participation in this audit was limited to specific members of staff, which did not give all staff the opportunity to reflect on their own record keeping standards. The audit tool had been systematically added to over the course of its existence to provide evidence and assurance for multiple initiatives. The focus was taken away from measuring compliance with basic record keeping standards. This process did not give the Trust adequate assurance and participation in the audit has continued to decrease year on year.

In December 2016, following consultation with various staff groups, a new Record Keeping Audit was launched. The new process requires every professional member of staff to audit one set of case notes each month (real time), using an electronic audit tool. The audit tool was scaled back to only the core standards for good record keeping (mapped against each professional body e.g. Royal College of Physicians, Nursing & Midwifery Council and Health & Care Professions Council). With the option to add service specific requirements if required. This gives all professional staff the opportunity to reflect on their own record keeping and drive improvements.

Results are shared via a monthly dashboard. The dashboard includes performance against each of the core standards and participation from each staff group. This will enable direct comparisons between each staff discipline.

The success of the project this year can be seen by the outstanding improvement in the numbers of staff participation since the relaunch.

Medical Staff	Nursing Staff	Allied Health Professional
176% increase	725% increase	383% increase

Areas of Good practice:

- "Is all the documentation filed within the record, in the correct locations" achieved between 67% and 100%.
- "Can you read all the written entries (is it legible)" achieved the highest compliance across the board 86% and 100%.
- "Do the notes that are written assist with patient care" ranged between 96% and 100%.
- "Black ink used throughout" ranged between 88% and 100%.

Areas for improvement

The area for improvement across all disciplines relates to errors, all aspects of this element were poor across the year, the numbers of errors made is very small but the results show that when an error is made it is not correctly amended.

Action taken

- The production of a screensaver for all Trust computers to raise awareness of the new process.
- Publication of a Good Practice Bulletin to remind all clinical staff of what to do when an error has been made.
- Circulate monthly results to all areas, email all staff weekly as a prompt to participate in the audit.

Clinical Audit Training Programme

Specialised external Clinical Audit Training has enabled us to develop our own accredited in-house two tier training programme.

The beginners and advanced sessions, cater for healthcare professionals of differing backgrounds, abilities and experience. The beginners training session covers the basic things you need to know about clinical audit in order to be fully capable of completing a project on your own.

The advanced training session covers everything you need to know about clinical audit. The session explains the clinical audit process in detail and attendees leave with a full appreciation of clinical audit and will be able to deliver their own clinical audit projects. It also covers challenging issues that professionals face, e.g. overcoming typical barriers to successful audit and the process for formatting your information and results into a successful report. The programme was launched in April 2017 with sessions available monthly.

Local Clinical Guidelines

Over the past 15 months the Trust Clinical Guidelines have been migrated over to Pandora. This process took four weeks and involved building the pages to replicate how they were organised on the Intranet. The Clinical Effectiveness team have taken control over the Pandora page to allow the quick update of guidelines.

There are currently 441 active Trust Clinical Guidelines, 173 of which have been added in the past 15 months. 159 of the guidelines have been updated in the past 15 months. 53 guidelines have been closed either due to being obsolete or being incorporated into other guidelines or Trust policies. At present there are 123 guidelines which require an update. The Clinical Effectiveness Team has also taken control of the Emergency Department (ED) Guideline page on Pandora. This has ensured we have access to all guidelines which weren't previously available to the rest of the Trust and reduces the admin burden on the ED consultants.

3.3 Patient Experience

Patient Public & Carer Involvement & Experience Strategy 2018-21 – 'Your Care, Your Voice'

This new strategy was developed and launched in January 2018; it sets out the Trust's vision for ensuring our patients remain at the heart of everything we do, and for our patients to be empowered to influence the care we deliver. The strategy was developed through consultation with patients, carers and the public and continues to utilise the 5 steps to Excellent Care Framework which is described below:

1. Planning for a visit either to our hospital facilities or services in your own home.
2. While you are in our care, whether this be in our hospital facilities or in your own home.
3. Moving on from our care.
4. Shaping our services for the future.
5. Overall patient care/experience excellence in care.

The strategy is at the heart of what we do as a Trust, and we intend to implement it with energy and commitment. To ensure delver of the strategy progress against our identified priorities will be monitored through the Patient, Public & Carer Involvement & Experience Group.

ǂFriends and Family Test

We continue to apply the Friends and Family Test (F&FT) within the inpatient, outpatients areas and Community Services. 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.

Friends and Family Test Recommend Rate	2015-16	2016-17	2017-18	National 2017-18*
A&E	91.0%	95.1%	95.1%	86.6%
Inpatients & Day cases	97.7%	97.2%	97.8%	95.9%
Maternity - Antenatal	98.5%	98.8%	98.1%	96.3%
Maternity - Delivery	97.4%	98.6%	98.5%	96.5%
Maternity - Postnatal Ward	97.9%	97.8%	98.0%	94.6%
Maternity - Postnatal Community	100.0%	100.0%	100.0%	97.9%
Outpatients	94.9%	96.2%	97.4%	93.8%
Mental Health	100.0%	99.7%	99.1%	88.2%
Community	-	-	98.3%	95.4%

Friends and Family Test Response Rate	2015-16	2016-17	2017-18	National 2017-18*
A&E	32.9%	35.4%	24.0%	12.7%
Inpatients & Day cases	19.8%	28.5%	27.1%	25.2%
Maternity - Antenatal	9.9%	3.8%	6.0%	N/A
Maternity - Delivery	43.7%	44.0%	32.8%	22.9%
Maternity - Postnatal Ward	43.2%	45.3%	30.0%	N/A
Maternity - Postnatal Community	10.5%	7.8%	5.4%	N/A

* published data Apr-17 to Feb-18

source: https://www.england.nhs.uk/fft/friends-and-family-test-data/

The National Patient Survey Programme

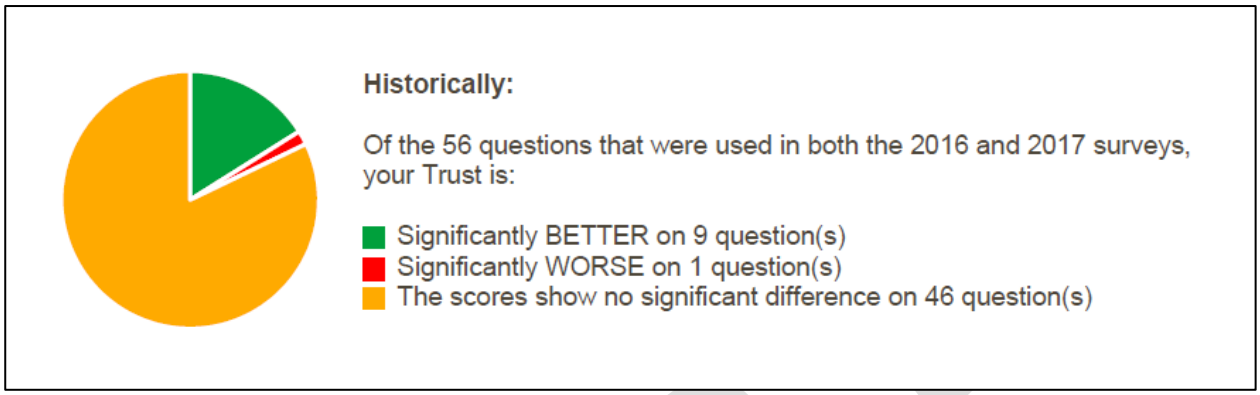
The National Patient Survey Programme comprises the annual adult inpatient survey and maternity survey and in rotation the community mental health survey, A&E survey; children & young people survey and the outpatient survey. These national surveys are valuable sources of information on various aspects of our service and are used to measure and monitor our performance against Trusts locally and nationally.

Adult Inpatient Survey 2017

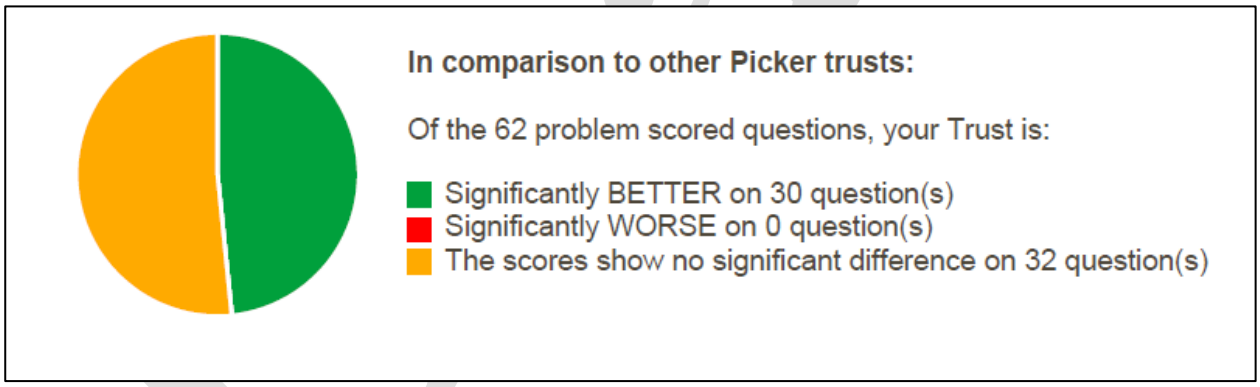
There were 81 Trusts commissioned to undertake the 'Picker' inpatient survey in 2017. 1,222 patients from our Trust were sent a questionnaire of which 534 were returned. This gave us a response rate of 43.7%; this is above the average response rate of 38.3% of the other 80 Trusts taking part in the Picker survey.

A total of 56 questions were used in both 2016 and 2017 surveys.

Historic comparisons



Compared to other Trusts



We are ranked no. 10 out of 81 trusts and no. 14 most improved trust with 3.1% fewer patients on average reporting a problem.

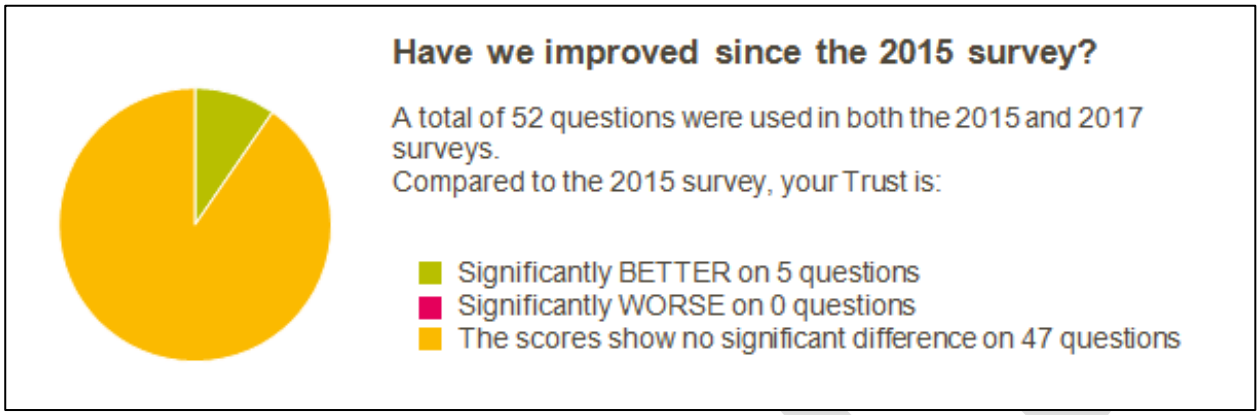
An improvement map has been developed to look at the importance of each question in relation to the overall patient experience as an inpatient. This allows us to channel our resources into what matters to patients and how we can improve our service to meet patient needs.

Maternity Survey 2017

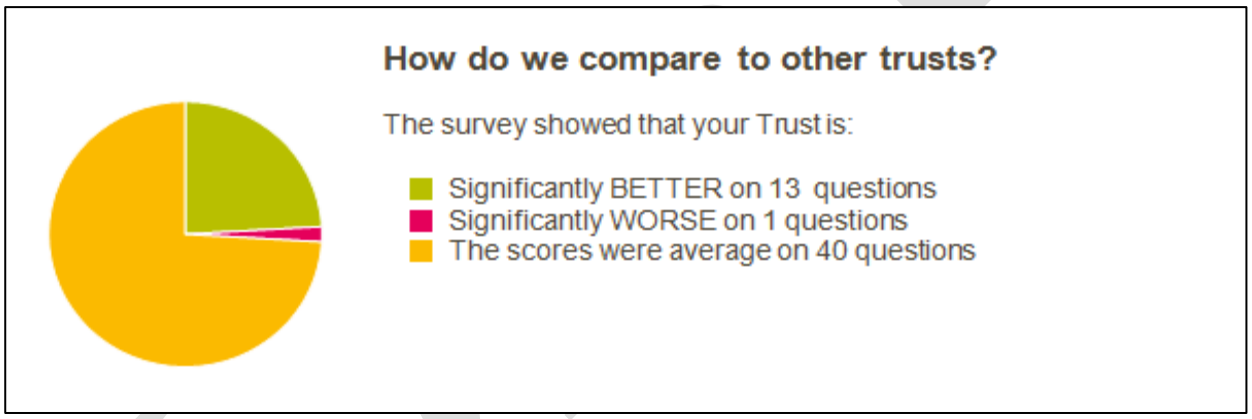
There were 68 trusts commissioned to undertake the 'Picker' Maternity Survey in 2017. 236 mothers from our Trust were sent a questionnaire of which 86 were returned. This gave us a response rate of 36.4%; this is slightly above the average response rate of 35.8% of the other 67 trusts taking part in the survey.

The Maternity Survey has historically been repeated every other year, however from 2018 this will move to annually. Looking at trends over a time helps to focus attention on improvements required. A total of 52 questions were used in both 2015 and 2017 surveys.

Historic Comparisons



Compared to other Trusts



We are ranked no. 5 out of 68 trusts taking part in the Picker survey, as a best performer and no. 16 most improved trust with 3.0% fewer mothers on average reporting a problem

'PJ Paralysis' Campaign

In April 2017, the Trust signed up to the national 'PJ Paralysis' Campaign.

'PJ Paralysis' is a really simple idea, but it has a big benefit for patients. The campaign encourages patients to get dressed into their own day clothes as early as possible, instead of remaining in pyjamas or night wear while in hospital. It also drives us to put the patient at the centre of everything we do.

We know that if patients stay in their pyjamas or gowns for longer than they need to they have a higher risk of infection, decreased mobility, fitness and strength, and can stay in hospital longer. If we can help patients get back to their normal routine as quickly as possible, including getting dressed, we can support a quicker recovery to help patients maintain their independence and help to get them home sooner.

Led by the Practice Development Team a number of initiatives have been undertaken:

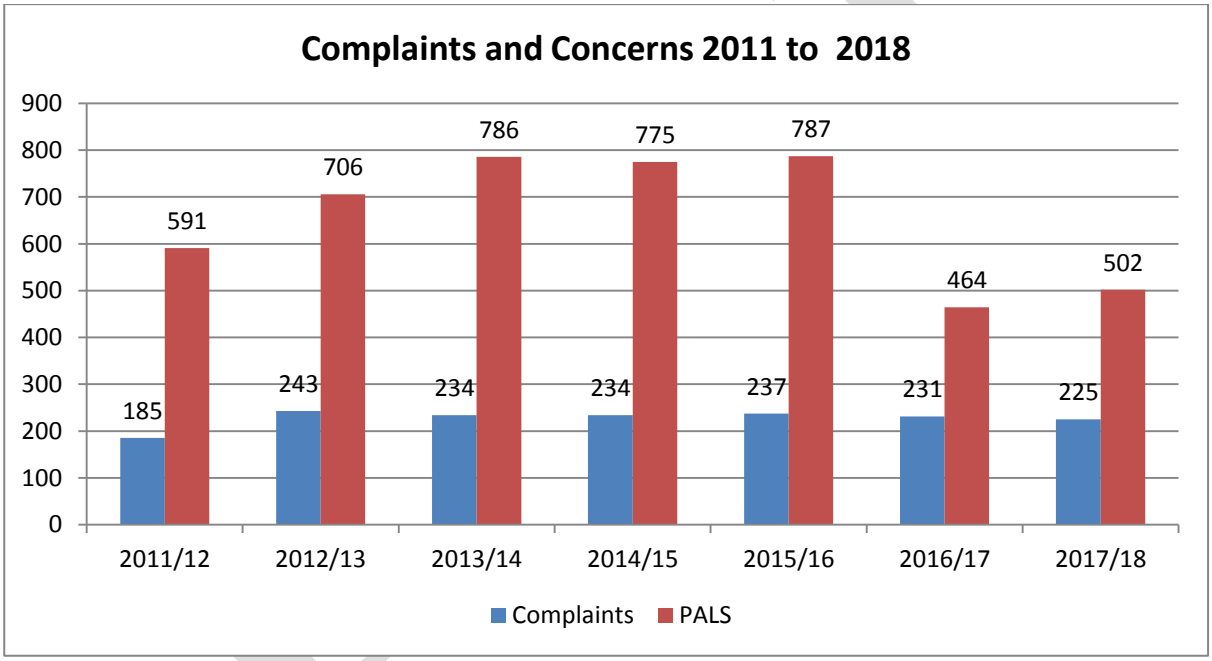
- Met with patients and relatives to raise awareness of the campaign.
- Engaged with staff around the campaign via various methods: screensavers, articles in staff newsletter and presentations at staff meetings.
- Worked with patients and families to develop a Trust logo and notices for ward areas.
- Working with staff in the community to promote awareness before patients are admitted to hospital.

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 2017/18 we received a total of 225 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 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 2017/18 the top five main reasons to raise a formal complaint were in relation to:

- Clinical Treatment – General Medical Group (52 complaints).
- Clinical Treatment – Surgical Group (45 complaints).
- Communications (26 complaints).
- Values & Behaviours (Staff) (25 complaints).
- Clinical Treatment – Accident & Emergency (18 complaints).

Complaints Performance Indicators	Total 2017/18
Complaints received	225
Acknowledged within three working days	225
Complaints closed	195
Closed within agreed timescale (eight weeks)	116
Number of complaints upheld	132
Concerns received by PALS	502

Complaints Indicators	Total 2017/18
Number of closed complaints reopened	46*
Number of closed complaints referred to Health Service Ombudsman	12

*although this number has increased from 12 last year, this includes cases opened from previous years as well as better reporting by the complaints staff.

Outcome of complaints referred to Health Service Ombudsman (HSO)	Total 2017/18
Awaiting decision	9
Complaints upheld	0
Part upheld	0
Declined to be investigated	2

3.4 Focus on Staff - Valuing Our People

The Trust's goal is to have an engaged and motivated workforce living the values and behaviours of the organisation, and who are responsive and adaptive to the changing needs of our environment. Throughout the year we have worked towards this through recognising, involving and developing our staff, in order 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.

Listening to our Staff through the NHS Staff Survey (* does not cover QE Facilities Limited)

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 and we've seen an improvement this year in terms of response rate.

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, as well as professional forums, away days and annual conferences.

Formally, 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.

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

	2016/17		2017/18		Trust improvement/ deterioration on previous year
Response rate	**Trust**	**National average**	**Trust**	**National average**	
	39%	43%	44%	43%	5% increase

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

	2016/17		2017/18		Trust improvement/ deterioration on previous year
Top 5 ranking scores	**Trust**	**National average**	**Trust**	**National average**	
Percentage of staff experiencing physical violence from staff in last 12 months	1%	2%	1%	2%	No Change
Staff confidence and security in reporting unsafe clinical practice	3.79	3.65	3.84	3.67	0.05 improvement
Organisation and management interest in action on health and wellbeing	3.69	3.61	3.82	3.63	0.13 improvement
Staff satisfaction in resourcing and support	3.43	3.33	3.46	3.27	0.03 improvement
Percentage of staff felling unwell due to work related stress in the last 12 months	33%	35%	31%	38%	2% improvement

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

	2016/17		2017/18		Trust improvement/ deterioration on previous year
Bottom 4 ranking scores	**Trust**	**National average**	**Trust**	**National average**	
Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	40%	45%	42%	47%	2% improvement
Percentage of staff/colleagues reporting most recent experience of violence	63%	67%	59%	67%	4% deterioration
Percentage of staff agreeing their role makes a difference to patients/service users	92%	90%	91%	90%	1% deterioration
Staff motivation at work	3.93	3.94	3.92	3.91	0.01 deterioration

Our ratings show that we are:

- Better than average in twenty eight key scores (24 in 2016/17).
- Average in two key scores (4 in 2016/17).
- Below average in two key scores (4 in 2016/17).

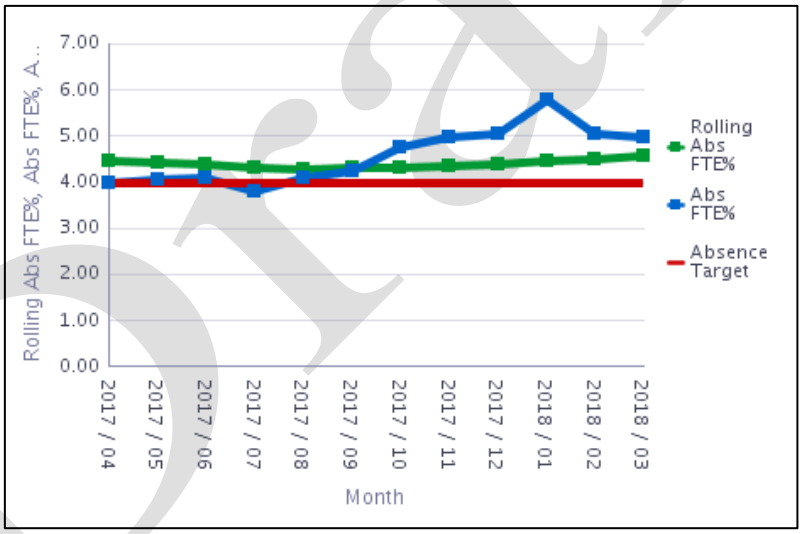
The arrival of over 600 community staff into the Trust since the last staff survey has resulted in a shift in the profile of the Trust in line with the national survey co-ordination centre. The Trust has now been classified as a 'Combined Acute and Community Trust', rather than an 'Acute Trust'.

Following the publication of the 2015 survey results, the Trust set two-year objectives to give us sufficient time to make changes and demonstrate progress. As a result of listening to staff feedback, the 2017 results show progress in all three areas, including Health and Well-being of staff and reduction of stress, the eradication of violence between colleagues taking a zero tolerance approach, and to redesign our appraisal framework based on our values and behaviours. However, there has been a deterioration in the percentage of staff/colleagues reporting most recent experience of violence therefore we will continue to work to improve this in pursuit of a culture of openness.

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 events to increase healthier lives throughout the year.

The Trust continues to support staff to be able to attend and sustain attendance at work. Robust monitoring of sickness absence enables early intervention and support. In 2017/18 we have seen more staff with long-term absences compared to short-term absences, potentially reflective of our population's increasing complex health needs.



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 1st April 2017 – 31st March 2018 we have provided 4806 appointments for staff which can be broken down as follows:

- ✓ 513 counselling appointments.
- ✓ 1196 pre-employment screening appointments.
- ✓ 1525 vaccination/immunisation screenings.
- ✓ 330 ergonomic and workplace assessments.
- ✓ 982 sickness absence management appointments.
- ✓ 106 other consultations.

- ✓ 111 appointments associated with sharps injuries.
- ✓ 350 physiotherapy referrals.
- ✓ 35 health Surveillance appointments.

In 2017/18 we were also delighted to see that 76% of our staff chose to have their flu vaccination, to protect themselves, their family and our patients and visitors. This allowed us to achieve the national Commissioning for Quality and Innovation (CQUIN) goal and is testament to the continued commitment of our staff in this area.

Organisational Development (OD)

Ensuring that each and every patient has a great experience does not only depend on **what** we do, but also **how** we do it. At the centre of this are our Trust values and in the last year our staff have spent time refreshing those values and developing a behaviours framework around them. This is designed to run alongside our new appraisal process and future values-based recruitment plans.

(* does not cover QE Facilities Limited)

The Trust has focused this year on supporting our staff and the Trust to be ready for, and respond to the challenges it faces. This has included:

- Continuing support of the Community Service Teams/Gateshead Care Partnership transformation plans.
- Engaging staff within Mental Health Services to improve the delivery of quality services.
- Encouraging and embedding the use of Insights Discovery Model and the Healthcare 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.
- Refreshing of the Trust's Values and creation of a behaviours framework.
- Redesigning the Appraisal process and roll out of new training for staff and managers.

Recruitment and Retention

At the end of 2017/18 we employed 4386 people. The number is broken down as follows:

PROFESSION	
Additional Professional, Scientific and Technical	167
Additional Clinical Services	806
Administrative and Clerical	890
Allied Health Professionals	296
Estates and Ancillary	504
Healthcare Scientists	162
Medical and Dental	297
Nursing and Midwifery Registered	1261
Students	3
Total	**4386**

A comparison of our workforce is provided below:

	2016/17	%	2017/18	%
AGE				
17-21	106	2.53	107	2.44
22+	4086	97.47	4279	97.56
ETHNICITY				
White	3987	95.11	4126	94.07
Mixed	19	0.45	19	0.43
Asian or Asian British	107	2.55	120	2.74
Black or Black British	32	0.76	40	0.91
Other	21	0.50	24	0.55
Not Stated	26	0.62	57	1.30
GENDER				
Male	841	20.06	931	21.23
Female	3351	79.94	3455	78.77
RECORDED DISABILITY				
	91	2.17	167	3.81

As at 31st of March 2018 our Board of Directors was 57.2% male and 42.8% 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 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 2017/18 the Trust hosted 125 placements, 63% for the medical shadowing programme. We also hosted a Careers Event for local schools in 2017 inviting over 60 students from neighbouring schools into the Trust to showcase a range of careers within the NHS.

Policies and Practices to support Disabled Staff

The Trust supports Project Choice, 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 Health Records. We continue to work with a number of charitable organisations working on pre-employment programmes including Shawe Trust, Azure and the Wise Group.

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 Policy in 2017 and this policy encourages the use of reasonable adjustments as a means of removing any disadvantage for disabled persons. The Supporting and Managing Sickness Absence Policy provides 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 Confident Employer. This scheme replaced the "Disability Two Ticks Employer" status, which was 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.

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.

During 2017/18 we have developed new guidance which provides line managers with a toolkit to support staff who may be experiencing poor mental well-being. This "Well-being at Work" guidance has been launched in conjunction with a bitesize session for line managers (Mental Well-being in the

Workplace) which aims to enable managers to feel confident in supporting the mental well-being of the people in their teams.

A Learning Culture

One of the initiatives we are proud of again this year is continued improvement and scores in the Library Quality Assurance Framework (LQAF) awarding the library service a score of 97% compliance. This is an increase of 1% from 2016. 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. In a recent visit the Dean commented that we could well be "the jewel in the crown of the Foundation Programme".

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 and as such we've been developing our behaviour statements in line with the Trust's values.

Which is why this year we've worked with our partners in Gateshead College to design two new Leadership Programmes aligned to the apprentice standards and aimed at first time managers and developing leaders.

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 people at all levels to gain valuable experience and a vocational qualification with the ultimate aim of securing employment within the NHS. In September 2017 the Trust recruited 14 Business & Administration apprentices and 12 Healthcare apprentices. We have also been part of the new pilot of Nursing Associates total number (10) which has been extended and amended to be an apprentice programme from next year.

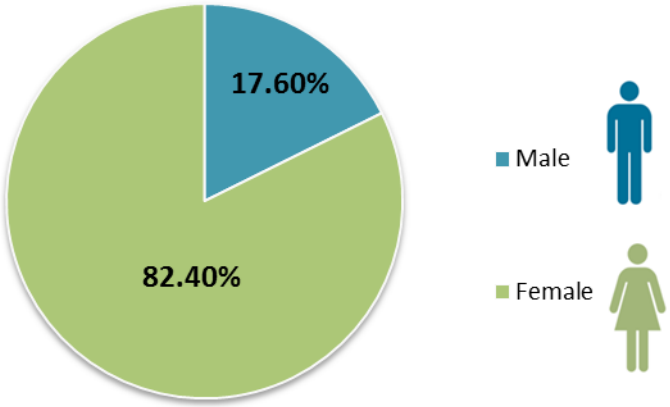
Reward and Recognition

We continue to look for innovative ways to recognise our staff. We continue to run a media campaign to get our public and patients to nominate their "QE Angel" recognising the importance of our patients' voices.

We also held our annual Star Awards event; a humbling and proud evening where around 200 guests (staff, patients and partners from the local community) came together to celebrate the amazing work that members of our workforce 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, as well as a QE Gateshead Star pin badge to wear. The winners in each category were presented with a coveted QE Gateshead 2017 Trophy.

New legislation means that all large employers across the UK with more than 250 employees are required to show the difference between the average earnings of all men and women as a percentage and publish their results. This helps us understand the gender pay gap which we must analyse and take appropriate action to address any imbalance or inequality.

Gender split



Pay and Bonus pay gap	Mean	Median
Ordinary Pay	30.80%	17.46%
Bonus	50.48%	50.94%

(* does not cover QE Facilities Limited)

82.4% of our workforce is female and there are more male employees in certain occupations that fall into the higher paid quartile, for example consultants. The gender split across the national landscape of the NHS is 77% female and 23% males and amongst medical staff the ratio is 2:1 with a male dominated workforce. Gateshead is not dissimilar to the national picture.

Further information on our findings is published here - https://www.qegateshead.nhs.uk/edhrreports

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 openness, respect and engagement. 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 2017/18, the Trust's Executive Sponsors of our Equality Objectives have met a number of times to drive activity from a Trust Board level. This has included around Gender Pay Gap Reporting, Accessible Information Standard and Sexual Orientation Monitoring Standard.
- 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 2017/18:

The Workforce Race Equality Standard (WRES) aims to ensure all NHS organisations 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 third WRES information in 2017 (* does not cover QE Facilities Limited) and moving forward the Operational Workforce Forum and Your Voice Staff Forum (see below) will consider this information and use it to inform appropriate actions to ensure the treatment of our staff is not unfairly affected by their ethnicity.

The new "Your Voice Staff Forum" was established in 2017. This forum draws its membership from a wide range of staff from across the organisation, and aims to support the Trust by driving change and challenging future priorities, ensuring the different values and needs of our workforce, patients and local communities are represented. The forum has elected its own chair, and works in partnership with members of the Workforce Team.

The Trust continues to progress work in relation to our three Equality Objectives which underpin our Public Sector Equality Duty.

Equality Objectives

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.

Progress continues to be monitored through bi-monthly meetings with our three Executive Leads.

During 2017/18 the Trust became an "NHS Employer Diversity and Inclusion Partner". This programme supports organisations to develop their equality performance over a period of 12 months, and is closely aligned to Equality Delivery System 2.

As part of the NHS Employers Equality Diversity and Human Rights week in May 2017 the Trust launched a 'STOP Bullying and Harassment' campaign. We also participated in a national 'Call to Action' from the Social Partnership Forum to raise awareness of how to stop bullying in the workplace. As part of this campaign we also launched a workplace Mediation Service with 12 accredited mediators to support positive informal resolution to workplace issues.

3.5 Quality overview - performance of Trust against selected indicators

The following sections provide details on the Trust's performance on a range of quality indicators. 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 tool 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.

‡ denotes indicators governed by standard national definitions

1) Visible Leadership for Safety and Culture

‡*Outcomes of Trust Wide MaPSaF Patient Safety Culture Assessment:*
An assessment will be undertaken in 2018/19. Following this a Trust wide action plan will be developed to address any areas for improvement.

Executive Quality and Safety Walkabouts (implemented from February 2010):
All Board members undertake walkabouts within their own teams and across the wider organisation. The Chairman and Chief Executive undertake regular walkabouts and the Director and Deputy Director of Nursing, Midwifery & Quality attend the clinical areas on a weekly basis.

2) Team Effectiveness / Efficient / Innovative

Team Effectiveness	2015-16	2016-17	2017-18	Target
Core Skills Training Compliance	74.56%	73.37%	79.75%	90%
Appraisal Compliance (Staff with a current appraisal)	71.93%	81.82%	67.81%	90%
Staff Sickness Absence (12 month rolling percentage)	4.82%	4.49%	4.62%	4.00%
Staff Turnover (Labour turnover based on Full Time Equivalent)	24.63%**	12.92%*	11.48%	N/A

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

*the turnover figures is affected significantly by the transfer in of Community Services.

From September 2017 the Trust has been part of a Regional Streamlining Programme which is aimed at reducing the variation in Core Skills Training between NHS organisations (aligning to the National NHS Core Skills Framework) and thus enabling portability.

3) Safe Reliable Care / No Harm

A) Reducing Harm from Deterioration:

Safe Reliable care	2015-16	2016-17	2017-18	Target
‡HSMR*	100.2	104.0	108.0**	<100
‡SHMI Period	Apr 16 to Mar 17	Jul 16 to Jun 17	Oct 16 to Sep 17	
‡SHMI	1.0	1.01	1.0	<=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)	15.4%	16.7%	18.9%	N/A
Crude mortality rate taken from CDS	1.71%	1.67%	1.81%	<1.99%
Number of calls to the CRASH team	224	177	177	N/A
Of the calls to the arrest team what percentage were actual cardiac arrests	48.7%	53.1%	38.4%	N/A
Cardiac arrest rate (number of cardiac arrests per 1000 bed days)	0.58	0.52	0.37	N/A
‡Hospital Acquired Pressure Damage (grade 2 and above)	108	104	92	Year on year Reduction
‡Community Acquired Pressure Damage (grade 2 and above)	854	1214†	1346	N/A
Number of Patient Slips, Trips and Falls	1902	1668	1505	N/A
Rate of Falls per 1000 bed days	10.21	9.18	9.02	Reduction (<8.5)
Number of Patient Slips, Trips and Falls Resulting in Harm**	484	407	347	N/A
Rate of Harm Falls per 1000 bed days	2.60	2.24	2.08	Reduction (Less than <2.25)
Falls Change	1.2% Increase	13.8% reduction	7.1% 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)**	25.45%	24.40%	23.10%	Year on Year reduction

* HSMR figure taken from HED April 2018

**HSMR figures are April 2017 to January 2018

† Community services transferred from South Tyneside in October 2016

B) Reducing Avoidable Harm:

Reducing Avoidable Harm		2015-16	2016-17	2017-18	Target
Medication Errors	No Harm	366	413	454	N/A
	Minimal Harm	51	45	54	N/A
	Moderate Harm	5	3	10	<8
	Severe	1	0	0	0
	Total	423	461	518	N/A
‡Never Events		2	3	3*	0
Patient Incidents per 1,000 bed days		34.72	37.33	43.93	N/A
Rate of patient safety incidents resulting in severe harm or death per 100 admissions		0.16	0.18	0.21	N/A

*2 never events reported in March relate to recently discovered incidents of Wrong implant/prosthesis. One in 2011 and One in 2016.

C) Infection Prevention and Control:

Infection Prevention & Control	2015-16	2016-17	2017-18	2016-18 Objective	2018-19 Objective
‡MRSA bacteraemia apportioned to acute trust post 48hrs	1^	0	0	0	0
‡MRSA bacteraemia rate per 100,000 bed days	0.005	0	**0**	**0**	**0**
‡*Clostridium difficile* Infections (CDI) post 72hr cases	**48^**	**20^^**	**31**	**<=19**	**<=18**
‡*Clostridium difficile* Infections (CDI) rate per 100,000 bed days	**27.17^**	**11.59^^**	**17.97**	**11.6**	**<=10.1**

During the 2017/18 period the Trust reported zero (0) post 72hr MRSA bacteraemia.

The Trust reported thirty one (31) cases of post 72hr CDI overall however six (6) cases were deemed unavoidable with twenty five (25) cases against the Trust objective of nineteen (19). NHS Improvement (NHSI) contacted the Trust during November as an informal response to the Trust being outside of its monthly objective to review possible causes, the Trust approach to CDI, the reaction to increasing cases and to ascertain if there was any support NHSI could offer.

NHSI recognised that the IPC Team had implemented a comprehensive process review and identification of key themes based on sampling delays, prescribing, documentation, patient management and review, human factors, feedback and education. NHSI agreed there were no clear reasons for the recent gradual increase in cases however offered a level of external support if the Trust recognised the need.

^^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).

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.

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.

‡Team Centred Key Indicators	Oct-Dec 15	Jan-Mar 16	Apr-Jul 16	Aug-Nov 16	Dec-Mar 17	Apr-Jul 17
1) Scanning	D	C	B	B	N/A	N/A
2) Stroke unit	D	D	C	C	B	A
3) Thrombolysis	D	C	D	C	N/A	N/A
4) Specialist Assessments	D	D	B	C	N/A	N/A
5) Occupational therapy	A	A	A	B	A	A
6) Physiotherapy	A	A	A	A	A	A
7) Speech and Language therapy	D	E	E	D	C	C
8) MDT working	D	D	D	D	N/A	N/A
9) Standards by discharge	B	D	B	B	C	C
10) Discharge processes	A	C	A	A	A	A
Team-centred Total KI level	C	D	B	B	A	A
Team-centred Total KI score	62	56	70	70	83	87
Team-centred SSNAP level (after adjustments)	D	D	C	D	C	B
Team-centred SSNAP score	56	53	63	60	67	74

Other Indicators:

Other Indicators	2015-16	2016-17	2017-18	Target	Benchmark
Percentage of Cancelled Operations from FFCE's††	0.97%	0.70%	0.68%	0.80%	1.1%**
Percentage of Patients who return to Theatre within 30 days (Unplanned / Planned / Unrelated)	5.31%	4.80%	5.48%	Improve Year on Year	N/A
Fragility Fracture Neck of Femur operated on within 48hrs of admission / diagnosis	91.16%	91.81%	94.72%	90%	N/A
Proportion of patients who are readmitted within 28 days across the Trust*	9.23%	8.62%	7.90%	Improve year on year	N/A
Proportion of patients undergoing knee replacement who are readmitted within 30 days*	6.97% 35 patients readmitted	4.41% 20 patients readmitted†	5.64% 18 patients readmitted	Improve Year on Year	N/A
Proportion of patients undergoing hip	8.90%	7.46%	7.67%		N/A

replacement who are readmitted within 30 days*	39 patients readmitted	34 patients readmitted†	26 patients readmitted	Improve Year on Year

* Figures taken from Healthcare Evaluation data (HED) and provide a full year for 2015-16, 2016-17 and Apr to Dec 2017

** NHS England Statistics - NHS Cancelled Elective Operations Quarter Ending December 2017

†† 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.

5) Positive Patient Experience

Responsiveness to Inpatients' personal needs Question	2015	2016	2017	Average†
Was the patient as involved as they wanted to be in decisions about their care and treatment?	62%	57%	59%	57%
Did the patient find someone to talk to about their worries and fears?	50%*	42%	52%*	39%
Was the patient told about medication side effects to watch out for?	48%*	46%	43%	39%
Was the patient told who to contact if they were worried?	85%*	82%	83%	80%
Was the patient given enough privacy when discussing their condition or treatment?	80%*	82%	84%*	77%
Overall Composite Score	65%	63%	64%	58%

*Scores significantly better than average

†Average score for all 'Picker' Participating Trusts

Source: Picker Institute Inpatient Survey 2017 Gateshead Health NHS Foundation Trust Final Report January 2018

6) Safe, Effective Environment, Appropriate Equipment & Supplies

Patient-Led Assessments of the Care Environment (PLACE)		2015	2016	2017
Cleanliness	Gateshead Health NHS Foundation Trust	99.78%	99.94%	99.94%
	National Average	97.57%	98.06%	98.38%
Food	Gateshead Health NHS Foundation Trust	93.47%	91.53%	93.89%
	National Average	87.21%	88.24%	89.68%
Environment	Gateshead Health NHS Foundation Trust	93.13%	96.52%	97.05%
	National Average	90.11%	93.37%	94.02%
Privacy, Dignity and Wellbeing	Gateshead Health NHS Foundation Trust	84.61%	84.65%	85.30%
	National Average	86.03%	84.16%	83.68%
Dementia	Gateshead Health NHS Foundation Trust	64.93%	75.76%	78.27%
	National Average	74.51%	75.28%	76.71%

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
https://digital.nhs.uk/catalogue/PUB30055

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	2015-16	2016-17	2017-18
Gateshead Health NHS Foundation Trust	98.00%	98.31%	98.60%	98.54%

3.6 National targets and regulatory requirements

‡ The following indicators are all governed by standard national definitions

No	Indicator		2015/16	2016/17	2017/18	Target	National Average
1	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted		86.5%	83.7%	81.5%	90.0%	74.4%**
2	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted**		94.4%	91.4%	91.4%	95.0%	89.2%**
3	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway**		93.1%	93.4%	94.3%	92.0%	87.9%**
4	A&E – maximum waiting time of four hours from arrival to admission / transfer / discharge		93.7%	96.1%	94.6%	95.0%	88.4%
5	All cancers: 62 day wait for first treatment from: urgent GP referral for suspected cancer /		86.1%	86.7%	88.4%	85.0%	82.3%†
	NHS Cancer Screening Service referral		95.3%	94.5%	96.3%	90.0%	91.6%†
6	All cancers: 31 day wait for second or subsequent treatment, comprising:	Surgery	99.3%	100.0%	98.9%	94.0%	95.8%†
		Anti-cancer drug treatments	99.7%	99.7%	99.9%	98.0%	99.4%†
		Radiotherapy	N/A	N/A	N/A	94.0%	97.1%†
7	All cancers: 31 day wait from diagnosis to first treatment		99.4%	99.9%	99.7%	96.0%	97.6%†
8	Cancer: two week wait from referral to date first seen, comprising:	All urgent referrals (cancer suspected)	93.9%	96.80%	95.78%	93.0%	94.1%†
		Symptomatic breast patients (cancer not initially suspected)	94.9%	96.50%	96.57%	93.0%	93.0%†
9	Care Programme Approach (CPA) patients,	Receiving follow up contact within seven days of discharge	82.8%	84.60%	87.10%	95.0%	96.3%††

	comprising:	Having formal review within 12 months	nil return*	nil return*	nil return*	nil return*	N/A
10	Minimising mental health delayed transfers of care		0.0%	0.0%	3.0%	< 7.5%	N/A
11	Mental health data completeness: identifiers		99.8%	99.70%	99.73%	97.0%	N/A
12	Mental health data completeness: outcomes for patients on CPA		73.5%	85.4%	83.3%	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	92.5%	98.1%	96.3%	50.0%	N/A
		Referral information	100.0%	100.0%	100.0%	50.0%	N/A
		Treatment activity information	100.0%	100.0%	95.3%	50.0%	N/A
15	C. difficile – meeting the C. difficile objective	No. of Post 72hr Clostridium Difficile cases	48	20	31	19	N/A
		No. of Post 72hr Clostridium Difficile cases following appeal	18	11	25	N/A	N/A
		Clostridium Difficile - infection rate (per 100,000 bed days	26.8	11.6	17.97	11.6	N/A

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

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

* There were no qualifying patients for this period

**Benchmarking Data for 18 weeks relate to 2017-18 data up to and including February 2018

†Cancer waiting times Benchmarking figures are 2017-18 to Dec-17

††CPA Patients Q1-Q3 2017-18

Annex 1: Feedback on our 2017/18 Quality Account – **to be inserted 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**

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 2017/18 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 2017 to March 2018
    - papers relating to quality reported to the board over the period April 2017 to March 2018
    - feedback from commissioners dated xxxx
    - feedback from governors dated xxxx
    - feedback from local Healthwatch organisations dated xxxx
    - feedback from Overview and Scrutiny Committee dated xxxx
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated xxxx
    - the 2017 national patient survey February 2018
    - the 2017 national staff survey February 2018
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated xxxx
    - CQC inspection report dated 24/02/2016
    - CQC Inspections and rating or specific services dated 28/06/2017

- 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

23rd May 2018	Date	Chairman
23rd May 2018	Date	Chief Executive

Glossary of Terms

Always Events
'Always Events' are aspects of the patient experience that are so important to patients and family members that health care providers must aim to perform them consistently for every individual, every time. These can only be developed with the patient firmly being a partner in the development of the event, and the co-production is key to ensuring organisations meet the patients' needs and what matters to them.

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.

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 infection* (CDI)**
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.

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.

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.

Elective Cases
Elective cases or elective procedure is surgery that is scheduled in advance because it does not involve a medical emergency.

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.

Friends and Family Test (F&FT)
Is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses.

Healthcare Quality Improvement Partnership (HQIP)
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.

Hogan Score
A standard scale to determine whether a death was avoidable.

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.

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.

Manchester Patient Safety Framework

The Manchester Patient Safety Framework (MaPSaF) is a tool to help NHS organisations and healthcare teams assess their progress in developing a safety culture.

MaPSaF uses critical dimensions of patient safety and for each of these describes five levels of increasingly mature organisational safety culture. The dimensions relate to areas where attitudes, values and behaviours about patient safety are likely to be reflected in the organisation's working practices. For example, how patient safety incidents are investigated, staff education, and training in risk management.

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 Reporting and Learning System (NRLS)

The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted.

NATSSIPS/LOCSSIPS

The NatSSIPs support the NHS to provide safer care and reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events can occur. They bring together national and local learning from the analysis of Never Events, Serious Incidents and near misses in a set of recommendations that will help provide safer care for patients undergoing invasive procedures. They do not replace the existing World Health Organisation (WHO) Surgical Checklist, but enhance it by looking at extra factors such as the need for education and training. The NatSSIPs enable trusts to review their current local processes for invasive procedures (LocSSIPs) and ensure that they comply with the new national standards.

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.

North East Quality Observatory System

The North East Quality Observatory Service (NEQOS) provides quality measurement for NHS organisations (both providers and commissioners)

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.

Rapid Process Improvement Workshop (RPIW)
An RPIW is an improvement workshop that brings together staff from the organisation or health and care system improve a process.

Regulation 28
The Coroner has a legal power and duty to write a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. This is known as a 'report under regulation 28' or a Preventing Future Deaths report because the power comes from regulation 28 of the Coroners (Inquests) Regulations 2013.

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 that was not expected. The learning is then shared with staff across the hospital to inform our practice and help prevent further recurrence.

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.

Standard Operating Procedure
A Standard Operating Procedure is a set of step-by-step instructions compiled to help workers carry out complex routine processes.

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.

Ulysses System

Ulysses Safeguard is an electronic system. The Trust use two modules Ulysses Alerts module is used to track alerts issued from external agencies, as well as disseminating internal policies and documents. The audit module is used to register and monitor all clinical audit activity within the organisation, including all National Audits.

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