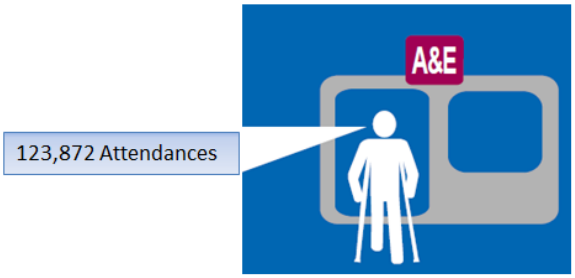
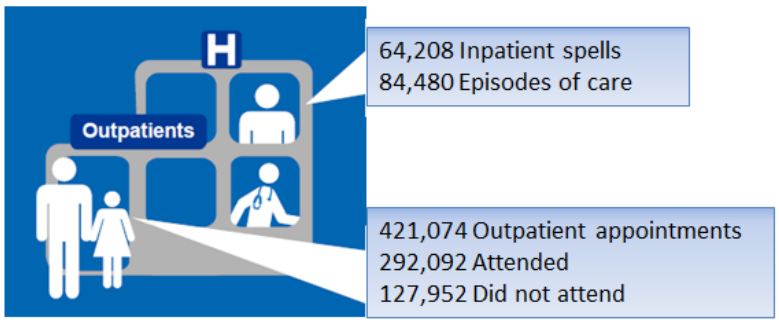
Gateshead Health
NHS Foundation Trust

Quality Account

Gateshead Health NHS Foundation Trust 2018/19

Gateshead Health NHS Foundation Trust at a glance…





Contents

Part 1

1. Statement on Quality from the Chief Executive

I am delighted to introduce the Quality Account for Gateshead Health NHS Foundation Trust for 2018/19. This provides details of some of our work over the past 12 months on improving the care we deliver in line with our organisational 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 agreed financial envelope.

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 2018/19, some of the key highlights are as follows:

Clinical Effectiveness

- Developed a programme of work to implement the recommendations within the National Confidential Enquiry into Patient Outcome and Death "Treat as One – Bridging the gap between mental and physical healthcare in general hospitals". This included introducing Mental Health Champions across the organisation and commissioning external expertise to deliver Suicide Awareness Training.
- Fully engaged with the Getting it Right First Time (GIRFT) national programme.

Patient Safety

- Undertook a patient safety culture assessment, engaged with the National Safer Maternity Care Strategy and reviewed the process for investigating patient safety incidents that occur within the organisation.
- Introduction of separate Serious Incident Panels to review all inpatient falls and pressure damage of moderate and above harm. Development and publication of a Serious Incident (including Never Events) Reporting and Management Policy.

Patient Experience

- Successfully implemented an 'Always Event' within our inpatient functioning mental health ward.
- Adapted our Friends and Family Test card to ensure it was fit for purpose for use within the mental health setting. Established patient and carer forums within our two mental health inpatient wards.

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:

- Our Friends and Family Test feedback identifies that the Trust provides a positive patient experience, with 96.5% of patients indicating that they would definitely recommend our services to friends and family.
- 88% of patients who completed the 2018 NHS Inpatient Survey rated the care we provided at 7/10 or above (Picker Institute, 2018).
- Patients who have used our cancer services rated the care received as an average of 9.1/10.
- Our incident reporting rate has shown an increase from 33.79 in October 2017 to March 2018 to 38.27 in April 2018 – September 2018 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 2019/21. To this end, our Quality Account Priorities for 2019/21 are set out below:

Clinical Effectiveness

- Ensure robust processes are in place to set and deliver on the National Commissioning for Quality and Innovation (CQUIN) to ensure that our patients receive the best high quality and innovative service possible
- Research will be undertaken to ensure that we are providing the most beneficial and cost-effective care and treatment for our patients
- Improve Clinical Audit: best practice and compliance to improve patient care and outcomes through systematic review of care and the implementation of changes and review alignment against Healthcare Quality Improvement Partnership (HQIP) Best Practice in Clinical Audit
- Enabling women to access their care records to improve outcomes for mother and baby
- Build a culture and environment that supports continuous health improvement through the contact we have with individuals using the Making Every Contact Count platform

Patient Safety

- We will reduce avoidable harms in the Trust, by making our organisation more resilient to risks and acting on feedback from patients.
- We will promote a just, open and supportive learning culture across the organisation.
- Improve mortality reviews and embed the new medical examiner process, providing families, carers and staff with opportunities to both raise concerns and highlight examples of good practice and excellent care.
- To support the National ambition to halve the rates of still births, maternal deaths, neonatal deaths and brain injuries.

Patient Experience

- We will ensure that patients, carers and the public have the best experience possible when they are receiving our care
- We will ensure that patients, carers and the public are engaged in our Quality Improvement work and that patient, carer and public involvement is embedded as business as usual across the organisation
- Improved Experience for our Mothers, babies and their families

I hope you enjoy reading this report which identifies the excellent progress made in providing high quality clinical care in 2018/19 and also identifies the continuous quality improvement we strive to make for the coming years. 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 on behalf of the Board of Gateshead Health NHS Foundation Trust that to the best of my knowledge the information presented in the Quality Account is accurate.

Signed

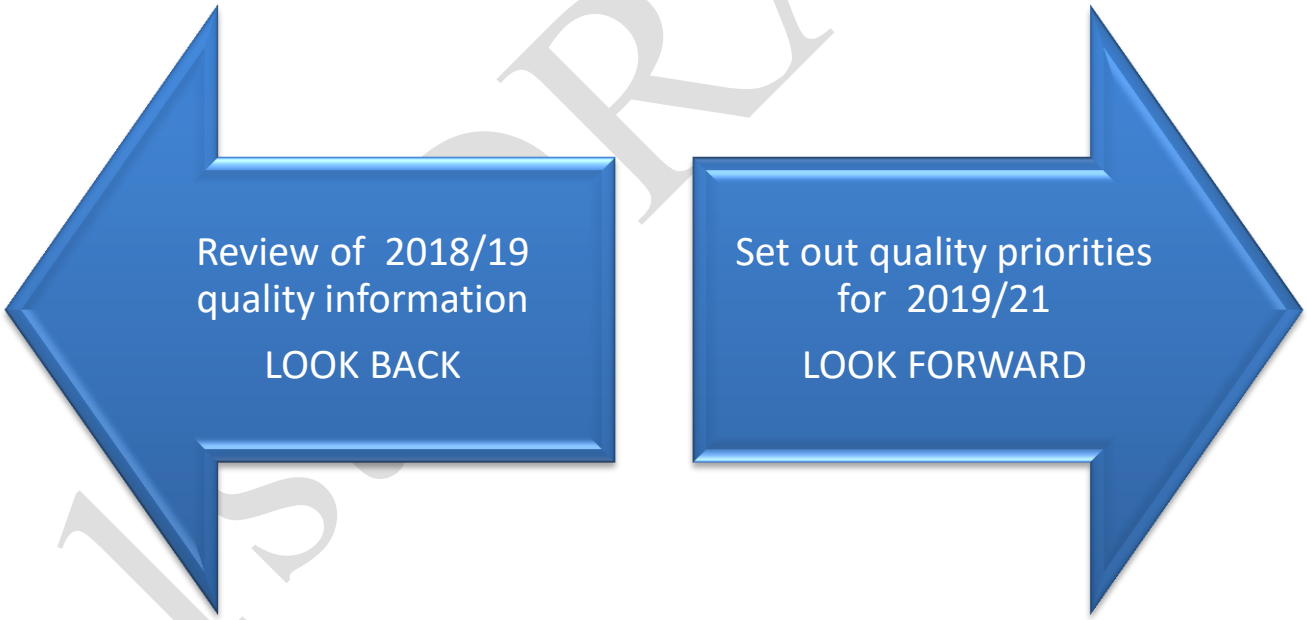
Mr J Maddison, Acting Chief Executive Date: 22nd May 2019

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. As part of this process all NHS hospitals are required to 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 2018/19.
- Outline the quality priorities and objectives we set ourselves going forward for 2019/21.



Part 2

2. Priorities for Improvement

2.1 Reporting back on our progress in 2018/19

In our 2017/18 Quality Account we identified six quality improvement priorities that we would focus on in 2018/19. This section presents the progress we have made against these.

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"

What did we say we would do?

- We will ensure that the recommendations within 'Treat as One – Bridging the gap between mental and physical healthcare in general hospitals' are implemented within the Trust.
- All staff should have basic mental health awareness, frontline staff should have additional training and mental health champions should be available across the acute Trust and Community.
- Patients who present with known co-existing mental health conditions should have them documented and assessed along with any other clinical conditions that have brought them to hospital. These should be documented: a. in referral letters to hospital b. in any emergency department assessment c. in the documentation on admission to the hospital. Existing guidance in these areas for specific groups should be followed which includes but is not limited to National Institute for Health and Care Excellence (NICE) Clinical Guideline 16 and Clinical Guideline G113.
- Patients who have been admitted to hospital and have been referred to liaison psychiatry should have a named liaison psychiatry consultant documented in the general hospital case notes and recorded centrally wherever possible.
- In order to overcome the divide between mental and physical healthcare, liaison psychiatry services should be fully integrated into general hospitals. The structure and staffing of the liaison psychiatry service should be based on the clinical demand both within working hours and out-of-hours so that they can participate as part of the multidisciplinary team.
- Liaison psychiatry consultants and associated mental health staff should be actively integrated into all relevant general hospital governance structures and committees. This should include issues around audit, risk management, education and training, serious/adverse incident investigations and senior director level meetings.
- Liaison psychiatry review should provide clear and concise documented plans in the general hospital notes at the time of assessment. As a minimum the review should cover: a. What the problem is (diagnosis or formulation) b. The legal status of the patient and their mental capacity for any decision needing to be made if relevant c. A clear documentation of the mental health risk assessment – immediate and medium term d. Whether the patient requires any further risk management e.g. observation level e. A management plan including medication or therapeutic intervention f. Advice regarding contingencies with an explicit plan and g. A clear discharge plan in terms of mental health follow-up.

- All healthcare professionals must work together to eradicate terms such as 'medically fit' or 'medical clearance'. The terms 'fit for assessment', 'fit for review' or 'fit for discharge' should be used instead to ensure parallel working (All Healthcare Professionals).
- Patients with mental health conditions should be supported in overcoming/managing alcohol and/or substance abuse.
- Smoking cessation services and brief interventions must be offered to all patients who would benefit (All Healthcare Professionals).
- All general hospital pharmacy departments should be able to undertake medicines reconciliation of medications for mental health conditions within the first 24 hours of admission. Communication between general hospital and mental health hospital pharmacists should be encouraged.
- General hospitals must have a robust centralised hospital system for the management of mental health legislation processes whether by themselves or with their local mental healthcare providers. This should be audited regularly to ensure that the law is complied with.
- Record sharing (paper or electronic) between mental health hospitals and general hospitals needs to be improved. As a minimum patients should not be transferred between the different hospitals without copies of all relevant notes accompanying the patient.
- Diagnostic coding of mental health conditions must be improved. Liaison psychiatrists should enter the diagnosis in the general hospital notes so that they can be coded appropriately and included in discharge summaries made by general hospital doctors. This will help with local and national audit.

Did we achieve this?

Yes we achieved this.

How we achieved it:

- A task and finish group was established with key stakeholders, meeting monthly with a targeted action plan.
- Training needs analysis was completed to inform the training requirements across the organisations.
- Training package introduced including e learning, simulation training, suicide awareness training, mental health champion training day and four half day training sessions throughout the year
- Development of 64 mental health champions throughout the organisation, who have access to a mental health resource file.
- Making Every Contact Count (MECC) quarterly audits to establish compliance with brief advice and referral process.
- Access for Emergency Care Centre staff to the RIO, electronic patient administration system in January 2019
- Application of funding for simulation training has been completed and a decision is currently awaited.
- The development of screening questions for all to use, embedded within the assessment documentation. Training for front line staff to ask the questions, and development of a pathway of referral.
- Patients who have been admitted to hospital and have been referred to liaison psychiatry have a named liaison psychiatry consultant documented in the general hospital case notes and recorded centrally on Medway.
- Liaison psychiatry services are fully integrated into general hospitals. The structure and staffing of the liaison psychiatry service is based on the clinical demand both within working hours and out-

of-hours so that they can participate as part of the multidisciplinary team we have cover 24 hours a day seven days a week.

- Liaison psychiatry consultants and associated mental health staff are actively integrated into all relevant general hospital governance structures and committees. This includes audit, risk management, education and training, serious/adverse incident investigations and senior director level meetings.
- The Mental Health Admin Office ensures that the relevant information goes with the patient when discharged/transferred and audited for compliance.
- The observation of patients within the Acute Trust is included in the Care Programme Approach Policy and Enhanced Care and Supportive Engagement Policy and encompasses patients across the organisation.
- SafeCare Good Practice bulletin has been circulated regarding wording to ensure the correct terms are used in medical documentation.
- Task and finish group set up with coding and objectives achieved with regard to documentation within the patient record and discharge record.

Evidence of achievement:

- Treat as One launch in September 2018
- Mental Health Triage Tool Plan Do Study Act (PDSA) two cycles complete and continues to be refined
- Introduction of screening questions within the assessment process in Emergency Care Centre in April 2019
- Audit of notes to ensure concise documented plans in the general hospital notes at the time of assessment demonstrates compliance
- Treat as One Champions Day March 2019 with 64 champions completing initial training
- Suicide awareness training with Washington Mind
- Successful trial of simulation training for four scenarios. (Intoxicated patient lacking capacity, patient admitted with a delirium, patient with suicidal ideation, patient with escalating challenging behaviour)

Next steps:

- Further work to incorporate the mental capacity assessments into Medway, electronic patient administration system.
- Medicine reconciliation on weekends remains an issue further work corporately across the acute Trust.
- Mental Health Champions training for community and medical staff in November 2019.
- Mental health first aid kit training for 40 members of staff applications currently being processed.
- Process for supervision for the Mental Health Champions to be agreed. Four half day training workshops have been arranged over the next 12 months.
- Further training for the Emergency Care Centre staff on RIO.
- Roll out of the simulation training for preceptors and F1 rotation staff.
- Launch of Intranet site with resources, tools, signposting to services and referral pathway to talking therapies.

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

What did we say we would 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 that the Trust acts on any feedback we receive as a consequence.
- The learning from these reports will be shared with the Departments and Business Units and we will develop a plan for how to address any areas for improvement.

Did we achieve this?

Yes, the Trust and the clinical teams who received requests for data have fully engaged with the GIRFT team and all information was provided in a timely way. All learning was shared with the clinical teams and plans produced for those areas that have received their data and visits from the GIRFT team. The specialist areas identified have included Trauma and Orthopaedics, Obstetrics and Gynaecology, General Surgery, Emergency Care, Diabetes, Radiology, Outpatients and Managing Frailty and Delayed Transfers of Care.

How we achieved it:

The Trust and the clinical teams worked closely with the GIRFT Regional and National teams to ensure that the data requests were responded to and engaged in the process of feedback meetings held with the GIRFT clinical lead to ensure that actions were produced to reduce variation and produce quality improvement plans.

Evidence of achievement:

Over 2018/19 the Trust have received and returned 10 requests for data from the GIRFT team. Once the GIRFT team have analysed the information they return to visit the clinical teams to share the information and work with the teams to ensure improvement plans are put in place. Over 2018/19 three visits were arranged to review the data packs and produce the improvement plans and four revisits also took place to review and update the improvement plans. The Trust has also worked with the GIRFT teams to identify best practice improvements which are being shared nationally with other NHS Trusts, one of which related to improving the information provided to GP's following discharge.

Next steps:

The Trust will continue to work with the GIRFT team and is awaiting eight feedback meetings to be arranged by GIRFT where information will be shared and improvements identified. The Trust and clinical teams have wholeheartedly embraced this programme for the benefit of all patients who come through its services.

Patient Safety:

Priority 3: Continue work on improving patient safety culture with focus on: Manchester Patient Safety Framework (MaPSaF), Maternal and Neonatal safety and Trust investigation training

What did we say we would do?

3a. MaPSaF

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

3b. Maternal and Neonatal Safety

- As part of the National Safer Maternity Care Strategy we will focus on improving the continuity of care 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 care pathway with a personalised care plan by the end of March 2019.

3c. Trust patient safety and complaints/PALS investigation training

- 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.

Did we achieve this?

3a. MaPSaF

A Safety Culture Survey was undertaken throughout the Trust in June and July 2018 using the MaPSaF tool, which had been used previously. This enabled us to obtain an overview of staff opinion on safety culture across the Trust, as well as providing a comparison to prior results.

An overview of the results was presented to Risk and Safety Council at the September 2018 meeting, with a Trust-wide report subsequently being received at Risk and Safety Council and Quality Governance Committee.

Business Unit/Directorate level reports were also produced, providing further analysis and breakdown in each area, and subsequent local actions were identified and summarised within the Trust-wide report.

3b. Maternal and Neonatal Safety

Statistics have been collated from Badger from 1st March 2019 however bookings only went live to Community Midwives from 25th March 2019.

Projections for Continuity statistics submitted last month included all women at risk of developing Gestational Diabetes Mellitis (GDM). This was included as there was uncertainty as to what stage in pregnancy women could be booked onto a Continuity Pathway.

In March 2019 the Local Maternity System (LMS) subgroup took place in Leeds. The Maternity Transformation Programme confirmed that women could be added to a Continuity Pathway up to 28 weeks gestation.

The figures for this month reflect that only women who have been diagnosed with GDM up to 28 weeks in the month of March have been included in the figures. Bookings for March were down compared to February with 191 bookings compared to 232 in February. Therefore our Continuity of care pathway figure for March total is 17.85%, down 3% from an expected 20% achievement.

3c. Trust patient safety and complaints/PALS investigation training

The Human Factors approach for investigating and learning from incidents is replacing the traditional Root Cause Analysis (RCA) method across the Trust as current evidence advocates that NHS organisations move away from a culture of blame, to an investigative approach which focuses on the context in which clinicians are working, rather than the actions of individual staff.

How we achieved it:

3a. MaPSaF

The MaPSaF was used in the development of a Safety Culture Survey which was run throughout the Trust in June and July 2018. All staff received an individual email with a link to the survey, and a response rate of 27% (1169 staff responses) was achieved.

Detailed analysis was undertaken on the results and detailed Business Unit and Directorate level reports were produced. These were distributed to Directors/Associate Directors as applicable for the area and subsequent meetings held with them or presentations given at Operational Board/SafeCare meetings as requested to provide an overview and discuss their results and any areas that may require further scrutiny.

Trust-wide results were published in QE Weekly, and a Trust-wide report produced summarising overall results and actions identified from different areas.

3b. Maternal and Neonatal Safety

Our project midwives have focused on three core groups of women to pilot and test the model. The three groups for continuity of care pathways are:

1. Women who have had a previous Caesarean Section

   We are also considering whether to add women who are advised to have an Elective Lower Segment Caesarean Section.

2. Women < 20 years of age

3. Diabetic mothers including GDM

We are also considering adding women at increased risk of premature labour onto the Continuity of Care pathway. Proforma adapted within our Badger clinical system to enable quicker auditing of women booked onto Continuity pathway. Personalised care plans developed in badger/access to mothers and midwives. Potential family hub sites visited and considerations taking place as to suitability for community teams to work from.

3c. Trust patient safety and complaints/PALS investigation training
The Trust began the roll out of the Human Factors approach to investigate Serious Incidents at the beginning of 2019.

From October 2018, the Trust have trained Family Liaison Officers (FLOs) to support patients and their families following the occurrence of Serious Incidents, to ensure they are fully involved in the process and given the opportunity to ask questions and make suggestions for improvements. So far, we have deployed FLOs to support the investigation of 11 Serious Incidents.

Evidence of achievement:

3a. MaPSaF
Full survey results are available in the reports produced, of which final copies are held centrally within the Risk and Patient Safety Team.
QE Weekly publication in October 2018
Local Business Unit Operational Board/SafeCare meeting Minutes and papers where report was received through the meeting and actions identified. Actions were to be incorporated within local quality action plans or similar (as already in place), or separate action plans established and these were to be monitored via these meetings.

3b. Maternal and Neonatal Safety
Mothers just booked on pathways now. Achievement of continuity of care will be measured during the pathway and after delivery.

3c. Trust patient safety and complaints/PALS investigation training
Since October 2018, we have deployed FLOs to support the investigation of 11 Serious Incidents. Training sessions for using this approach have begun and the Patient Safety team is supporting Business Units to manage this new process.

We have undertaken a Human Factors approach to investigating Serious Incidents in five cases since January 2019. Early feedback suggests that staff find this alternative method to undertaking investigations very helpful, in that weaknesses and gaps in systems and processes are investigated and addressed rather than the practice of individuals.

As a result of these initiatives, there is noticeable improvement in the quality of investigations, which will hopefully result in the organisation's ability to learn from incidents.

Next steps:

3a. MaPSaF

In quarter 3 of 2019 feedback from each Business Unit/Directorate will be collated on the actions delivered and any improvements identified. These will be reported to Risk and Safety and Quality Governance Committee.

The survey had previously been run every three years, and therefore would be re-run in 2021. The Trust will consider the benefits of this in early 2021, and seek to consider any new evaluation tools at that time.

3b. Maternal and Neonatal Safety

- Confirm Continuity of Care team
- Develop and finalise Continuity of Care pathways
- Contact mothers on Continuity pathway to update on pathway development and what to expect re: care during pregnancy
- Continue to develop plans around Family hubs
- Continue to develop Maternity Voices Partnership to promote at International Day of Midwife events on 3rd & 7th May, focussed input from Communications team to develop stock photos, online presence and targeted questionnaires.

3c. Trust patient safety and complaints/PALS investigation training

In April 2019, a Complaints Review Panel will be established to ensure there is a robust process in place for the Trust to respond to and learn from complaints. This will be a similar process to how Serious Incidents are managed within the organisation.

During 2019, there will be a training package developed and implemented for staff as to how to respond to and investigate complaints. This will be based on current guidance and best practice.

A review of the governance process for complaints management will take place in early 2019/20.

During 2019, there will be a move for all incident investigations to be undertaken using a Human Factors approach. Therefore there will be an increased focus on providing training for this approach. There will also be two further cohorts of FLOs trained during 2019, to increase our capacity to support patients following incidents or complex complaints.

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

What did we say we would do?

- We will ensure that the new guidance for Serious Incidents and Never Events 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.

Did we achieve this?

Yes we achieved this.

How we achieved it:

A revised framework and list of Never Events was published by NHSI in 2018, and a SafeCare Good Practice Bulletin was disseminated across the Trust in April 2018 to highlight key changes.

In April 2018, separate panels were introduced to review all inpatient falls and pressure damage of moderate and above harm. These are in addition to the Serious Incident Review Panel, chaired by the Medical Director. These changes have enabled the Trust to ensure that all possible learning is identified through the investigation process. The Inpatient Falls and Pressure Damage Panels report themed learning to the Serious Incident Review Panel on a quarterly basis and key lessons are shared within the Quality and Learning Report, which is presented to the Board and circulated for review and discussion across the Trust.

A review of the Terms of Reference and current membership of the Serious Incident Panel has also been undertaken, in order to ensure that the Panel has an appropriate range of clinical expertise available as necessary, to facilitate adequate scrutiny of incidents. Clinicians and senior staff from a range of clinical and non-clinical backgrounds are now attending Serious Incident Review Panel, and their contributions are ensuring enhanced scrutiny and challenge, and additional opportunities to learn from the incidents.

There has been a separate Serious Incident (including Never Events) Reporting and Management Policy developed, which was ratified at Risk and Safety Council in September 2018.

The policy advocates the need for robust 'patient centred' investigation following a Serious Incident, whilst also recognising the importance of supporting staff who have been involved in a Serious Incident in order to reduce the 'Second Victim' phenomenon.

Two cohorts of Family Liaison Officer training took place in October and November 2018. Each training programme lasted five days and is facilitated by Northumbria Police, NEAS, Ward Hadaway Solicitors and Independent Clinical Initiative Psychology Services. The Trust has trained 18 FLOs (from existing staff who have volunteered for the role) in the two cohorts.

Evidence of achievement:

- Separate Serious Incident Panels set up to review all inpatients falls and pressure damage of moderate and above harm
- Serious Incident (including Never Events) Reporting and Managing Policy developed and implemented
- 18 FLO's trained and have supported 11 patients and their families who have been involved in serious incidents

Next steps:

A Supporting Staff Policy will be developed and ratified by the Risk and Safety Council in May 2019, which will support the implementation of a 'Just culture' approach across the Trust, to support a consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents.

In order to ensure there is sufficient capacity of FLOs across the Trust, two further training dates have been arranged during 2019.

Patient Experience:

Priority 5: Develop our patient and public involvement activities

What did we say we would 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.

Did we achieve this?

Yes we achieved this.

How we achieved it:

- We developed and published a Patient and Public Involvement Toolkit for staff to provide guidance on how to effectively involve patients and the public in healthcare planning and delivery.
- The toolkit was launched in August 2018. The launch included an article in the staff newsletter – QE weekly, screensavers and presentations at various staff meetings and forums throughout September and October 2018.
- A baseline of current Patient and Public Involvement activity within the Trust was established via discussions with Service Line Managers to ascertain what patients are currently involved in and how this could be improved. Monthly communication via email has also been established as a prompt for services and departments to inform the Quality Team of any patient involvement activity undertaken.
- A database has been developed to ensure all activity is captured centrally. From March 2019, this has been reported through the Patient, Public & Carer Involvement & Experience Group.

Four key priorities areas of involvement activity were identified for 2018/19. The progress against those key areas is as follows:

- Work with our patients, carers and clinicians in Elderly Mental Health Services to identify an 'Always Experience' (Always Event).
    - The Trust took part in a collaborative with NHS England and NHS Improvement to implement Always Events. The pilot site for this work was the Sunniside Unit (Elderly Mental Health Services). A Point of Care Team (project team) was established including nursing staff, Occupational Therapist, activities co-ordinator, consultant psychiatrist and patients/carers. During the project the team met on a fortnightly basis.
    - Consultation with patients and/or their families and carers on what is so important to them that should always happen was undertaken throughout June 2018. All inpatients on the ward in June were consulted. In order to ensure that as wide a view as possible was

obtained, patients discharged from the Sunniside Unit between January and June 2018 were also consulted.

- The Always Event was co-designed as:
  - Vision Statement - 'I will always have the opportunity to ask questions or raise concerns.'
  - Aim Statement - 'By the end of March 2019, 90% of patients on the Sunniside unit will have the opportunity to ask questions or raise concerns.'
- An information board was developed to keep staff in the area up to date on progress.
- The national team visited the Trust on Wednesday 1st August 2018. The Point of Care Team gave an overview of progress and showcased our work to date. The visit was very successful and feedback was very positive.
- The Point of Care Team also showcased the Trust's 'Always Events' journey at the NHS England Regional Event on 2nd October 2018.
- Two members of the Point of Care Team were chosen to be 'Always Events Buddy's', to support other organisations to implement 'Always Events'. Training for this took place in January 2019.
- Key interventions have been implemented in order to ensure patients have the opportunity to raise concerns and ask questions. They include – staff sharing mealtimes with patients, co-designing a patient information leaflet, question and answer session at the beginning of every Patient Forum meeting and awareness raising with staff.
- In order to measure whether patients have had the opportunity to ask questions or raise concerns, patients and/or their family and carers are asked the following on discharge:
  - 'Did you have the opportunity to ask questions or raise concerns while on the Sunniside Unit?'
  - 'Was the question or concern resolved?'
  - 'How did it make your experience better?'
- Baseline before initiatives were introduced = 69% of patients felt they had the opportunity to ask questions or raise concerns.
- In January, February and March 100% reported that they had the opportunity to ask questions or raise concerns, the question or concern was resolved and it made their experience better.

- Involve an appropriate group of patients in the procurement of a new Interpreting Service.
  - The Deaf Community and the Regional Refugee Forum North East were approached to provide their views on what makes a good interpreting service. The Deaf Community took up this invitation and provided their views which were incorporated into the procurement process.

- Determine a programme of involvement work for our Governors and Members to include a focus on hard to reach groups to understand their experiences.
  - Medicine for Member Events have continued throughout 2018/19 when we held four events at which 164 people attended. Governors also attended six community meetings in 2018 engaging with Members and communicating news from the Trust. Governors are also regular visitors at QE Out-Patients where they engage and recruit new members to the Trust. In conjunction with our Governors we arranged and facilitated the Trust's Open Event, inviting members and young people to visit the Quenellies, the Trust's dining room, where staff manned stands covering careers and all services within the Trust. This proved

to be a very successful event with over 150 attendees many of whom were students who subsequently signed up to be Members of the Trust.

- 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 tool and agree how to implement this within the Trust.
    - It was agreed as part of the patient involvement strategy that during community events Governors would invite members to take part in the Equality Monitoring Questionnaire. Unfortunately this proved unsuccessful as the monitoring form was felt to contain too many questions on top of the usual information required when completing membership applications. Discussions are to take place between the Human Resources Department and Patient Experience Team to develop a process to collect this information from patients.

Evidence of achievement:

- Patient and Public Involvement Toolkit developed and available to all staff.
- There have been 19 pieces of work involving patients and/or their families and carers. With the topics ranging from a Radiology Patient Access Survey, Liver Service Patient Involvement Event, establishment of forums for Young Onset of Dementia for carers and patients, review of the Palliative Care Day Care Services provided by the Trust, Intensive Care Unit Steps – a forum where previous patients who have been in Intensive Care meet and support existing patients, the formation of a Stoma Support Group and involvement in the Gestational Diabetes Pathway Redesign.
- Within the Always Events project, the aim of 'By the end of March 2019, 90% of patients on the Sunniside unit will have the opportunity to ask questions or raise concerns' was exceeded with 100% of patients in January, February and March reporting they had the opportunity.

Next steps:

- Establish a Patient Involvement and Engagement Group.
- Steering Groups and Workstreams set up to ensure necessary work is undertaken to meet the requirements of the Accessible Information Standard.

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

What did we say we would 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.

Did we achieve this?

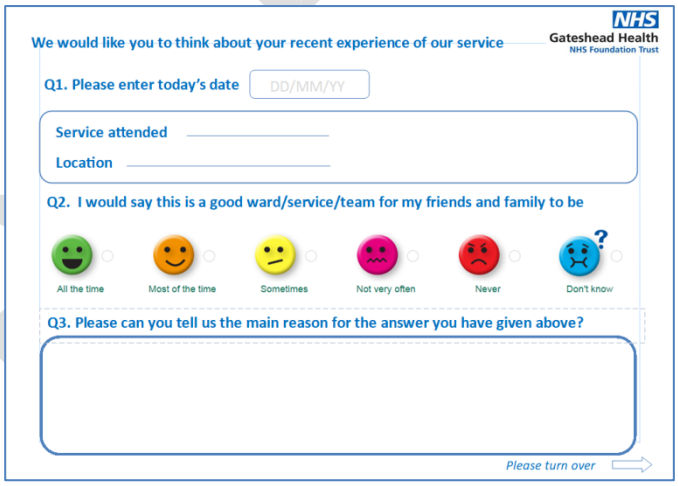
Yes, we have achieved this. However, this work has highlighted there are a number of strategies and initiatives that we would like to implement over the next two years.

How we achieved it:

- The Friends and Family Test card was adapted for use in the mental health setting. This was bespoke to the client group within the setting, using visuals instead of words to allow the patients to feedback their experience. This was a pilot initially for three months, and now is embedded.
- Patient Community Forums were established within both inpatient areas – the Sunniside Unit and Cragside. The forums provide patients, carers and families with an opportunity to ask questions, receive updates and give their own feedback on their experience.
- As part of the Falls Collaborative on Cragside, staff engaged with patients, families and carers to find out what they thought we should be doing to reduce falls. From this, feedback was displayed within the family hub room in a 'you said, we did' format.

Evidence of achievement:

- Feedback from Friends & Family Test on the Sunniside Unit and new Friends & Family Test card embedded within all Mental Health areas.



Next steps:

- A strategy 2019-21 has been developed by the Mental Health Patient Experience Group for patient experience and engagement within older persons inpatient mental health services. This has been developed as a plan on a page and encompasses detailed work streams within the following key areas: feedback, communication, workforce, patient/carer involvement, recruitment and selection, training and leadership. We have already implemented the use of an adapted version of the friends and family test to make it more accessible to our inpatient group to encourage their feedback. Current focus includes development of a bespoke volunteer profile, review of patient/ carer information leaflets, and collaborative working with Northumberland Tyne and Wear NHS Foundation Trust to deliver carers awareness training.

2.2 Our Quality Priorities for Improvement 2019/21

We have set 12 key priorities for quality improvement; these are aligned to our Quality Improvement Strategy – Driving Excellence through Quality Improvement 2019/21. These are two year priorities and progress after year one will be reported in our Quality Account 2019/20.

The Quality Improvement Strategy was developed using a collaborative and iterative approach, key national, regional and local reports, documents and intelligence were considered to build our strategic intent and guide the direction for our continuous improvement journey. We engaged with key internal and external stakeholders, and our patients, this has been instrumental in developing the two year strategy.

Patient Experience

Priority 1:
We will ensure that patients, carers and the public have the best experience possible when they are receiving our care

What will we do?

- We will reinvigorate our Volunteers Service in order to release time to care for staff across the Trust acute and community.
- Following the success of the NHS England 'Always Events®' collaboration in one pilot site, we will spread the use of the methodology as a tool to understand what is important to patients, to ensure that it should always happen when patients are under our care

How will we do it?

- Increase the number of volunteers by 100 by March 2021
- Ensure that our volunteers are highly trained through a newly development training programme.
- Introduce two specific role profiles:
    - Falls volunteers in areas where there is a high prevalence of falls
    - 'Bleep volunteers' - a pool of hospital volunteers are on stand-by to help patients and staff with a wide variety of tasks – from collecting a prescription to helping transfer a patient to X-ray.
- Identify 4 wards and departments to complete an 'Always Events®' project by March 2021.
- Using the 'Always Events®' toolkit and trained 'Always Events®' Mentors, develop a training programme to build capacity for 'Always Events®' to be undertaken by individuals in their own areas
    - Begin roll out of 'Always Events®' methodology across the organisation

How will it be measured?

- Numbers of volunteers recruited per month will be monitored
- New training programme will be in place
- Volunteers will be recruited into new roles
- A reduction in the number of falls
- Undertake an audit and staff survey to evaluate the impact of the 'bleep volunteers' service
- Wards identified will complete the 'Always Events®' project

- Training programme in place and 20 staff members trained
- A reduction in the number of complaints in the areas where 'Always Events®' have been implemented
- Existing metrics for patient experience to be positive – Friends & Family Test and Real Time Survey programme

How will we monitor and report it?

A six monthly continuous improvement review will be undertaken by the key leads and reported to the Quality Governance Committee (a sub-committee of the Board) to provide assurance to our Trust, our people and our stakeholders.

Priority 2:

We will ensure that patients, carers and the public are engaged in our Quality Improvement work and that patient, carer and public involvement is embedded as business as usual across the organisation

What will we do?

- Build on our patient, carer and public involvement work to ensure their voice and contribution is included in all aspects of quality improvement and delivery of care

How will we do it?

- Establish a Patient Involvement Forum by Summer 2019
- Recruit patients to initiatives across the organisation including:
    - The Ward Accreditation Programme
    - Patient Safety Collaboratives for Falls, Pressure Damage and Hydration & Nutrition
    - Recruit a patient representative to the Complaints Review Panel
    - Explore the involvement of patients and carers in a revised values based recruitment process
- Strengthen our links with our local Healthwatch to assist us to further understand the needs of our community including the Equality and Inclusion Delivery System
- Link with NHS Improvement to understand the national perspective and requirements in relation to the patient, carer and public involvement
- Support Business Units to include patient representatives in specific service redesign projects
- Understand our patient demographics and ensure patients of all sexual orientations have a voice

How will it be measured?

- The Patient Involvement Forum will be established
- Work plan agreed and monitored through Patient Public & Carer Involvement & Experience Group
- Maintain a list of patients who are involved in all initiatives
- Undertake joint projects with Healthwatch and involve them in our EDS grading in 2019
- Complete a gap analysis against national guidance to understand where the areas of focus should be
- Maintain a database of all Business Unit projects
- Baseline assessment and implementation of the sexual orientation monitoring standard

How will we monitor and report it?

A six monthly continuous improvement review will be undertaken by the key leads and reported to the Quality Governance Committee (a sub-committee of the Board) to provide assurance to our trust, our people and our stakeholders.

Priority 3:
Improved Experience for our Mothers, babies and their families

What will we do?

- Focus on the improvement of continuity of care implementation for pilot group of mothers
- Offer access to the patient portal 'Your care in your hands' to all mothers who book with us

How will we do it?

- Identify a core group of mothers to develop the pathway of care with us
- Develop the personalised care plan on the portal with our mothers
- Lead project midwife appointed for this work
- Lead project midwife for digital work to work with continuity of care team

How will it be measured?

- 20% of pilot group to be commenced on Continuity of care pathway by March 2019
- Measure percentage of mothers who actually deliver with continuity of care package by March 2020
- Personalised care plan maternal satisfaction survey

How will we monitor and report it?

A six monthly continuous improvement review will be undertaken by the key leads and reported to the Quality Governance Committee (a sub-committee of the Board) to provide assurance to our trust, our people and our stakeholders.

Patient Safety:

Priority 4:
We will reduce avoidable harms in the Trust, by making our organisation more resilient to risks and acting on feedback from patients.

What will we do?

- Continue to raise awareness across the organisation of how Human Factors impacts upon patient safety
- Develop a patient safety investigation training programme to ensure that we keep the patient at the centre of everything we do
- Develop innovative ways to involve staff, patients and families in patient safety
- Work with NHS Improvement on patient safety collaboratives to ensure our work is effective and that we are implementing best practice, using a structured quality improvement approach

How will we do it?

- Staff will learn Human Factors skills, thus improving their own performance and that of their teams
- Human Factors will form the basis of how we undertake patient safety investigations within the Trust
- Deliver rolling program over a two year period incorporating a range of training packages based on the needs of specific staff groups
- Establish a patient safety forum for patients, carers and staff to share and learn from experiences that will proactively support quality improvement initiatives to reduce and prevent future harm
- Develop a network of Patient Safety Champions and Ambassadors ensuring patients and staff have access to advice, guidance and support
- Staff, patients and their families will be actively encouraged to identify potential patient safety issues and risks they perceive to their care
- Provide Family Liaison Officer (FLO) training to existing staff, to ensure FLOs are available in every case where they are needed
- Undertake a yearly programme of collaboratives for falls and pressure damage in specific clinical areas, in relation to the prevention and reduction of falls and pressure damage

How will it be measured?

- Number of staff who have undertaken Human Factors training
- Revised template for undertaking patient safety investigations
- Number of staff trained and competent in undertaking robust Patient Safety investigations
- Reduction in incidents, complaints and claims
- Increase in incident reporting rate and a reduction in level of harm as the organisation cultural safety ethos reaches a degree of maturity
- Number of staff trained in the Family Liaison Officer role
- Reduction in the number of patient falls resulting in harm

- Reduction in the number of avoidable hospital acquired pressure ulcers
- Improved outcomes for our patients

How will we monitor and report it?

A six monthly continuous improvement review will be undertaken by the key leads and reported to the Quality Governance Committee (a sub-committee of the Board) to provide assurance to our trust, our people and our stakeholders.

Priority 5:

We will promote a just, open and supportive learning culture across the organisation.

What will we do?

- Implement and embed all principles of a just culture across the organisation
- Adopt a Safety II approach to patient safety within the organisation
- Align this work to Freedom to speak up guardian role to ensure
    - Staff have a range of mechanisms to voice their concerns and ideas
    - Leaders within the organisation listen to feedback and take appropriate steps
    - All staff feel safe to share information in the knowledge it will be used for learning, change and improvement

How will we do it?

- Provide a just culture workshop to the Trust Board, focusing on transparency, fairness and accountability
- Revise Trust policies to ensure all policies promote a just culture
- Work with the Trust Executive lead for Freedom To Speak Up (FTSU) and our Trust's FTSU Guardians/champions
- Develop a Trust policy for supporting staff, to ensure there is adequate provision for any staff involved in a Serious Incident
- Implement Appreciate Enquiry within patient safety work, building on the existing 'Greatix' system; identifying and learning from those who demonstrate exceptional performance

How will it be measured?

- Improvements in specific areas of NHS staff survey, e.g. '*My organisation treats staff who are involved in an error, near miss or incident fairly'*
- Provide a report to the board on a yearly basis aligned to staff feedback, patient feedback, FTSU enquiries, Greatix and Staff Advice and Liaison (SALS) for triangulation of data
- Through a Freedom to Speak Up survey
- Action taken to address any concerns raised

How will we monitor and report it?

A six monthly continuous improvement review will be undertaken by the key leads and reported to the Quality Governance Committee (a sub-committee of the Board) to provide assurance to our trust, our people and our stakeholders.

Priority 6:
Improve mortality reviews and embed the new medical examiner process, providing families, carers and staff with opportunities to both raise concerns and highlight examples of good practice and excellent care.

What will we do?

- The Trust will use the learning from mortality reviews to identify improvement opportunities to ensure high standards of patient care
- By March 2021, 80% of deaths will have received a Level 1 review within 60 days of death
- By March 2021, 100% of deaths identified within the National Quality Board Learning from Deaths guidance receive a Level 2 review will be reviewed by Mortality Council
- By March 2021, random quality assurance check will be undertaken on 5% of cases already reviewed
- Share any lessons learned, good practice or areas for improvements, and actions identified throughout the Trust
- Investigate any national alerts and implement any corresponding recommendations for improvement if required
- By June 2019, we will implement a Medical Examiner Service within the Trust

How will we do it?

- Clinical Leads to support departments to embed mortality review process into all departments
- Cases identified and added to Mortality Council agenda
- Lessons learned to be shared via the Trusts Integrated Quality and Learning report
- Monitor data monthly at Mortality & Morbidity Steering Group
- In April 2019, we will hold a rapid improvement event to design the process for our Medical Examiner Service

How will it be measured?

- Monthly performance report to Mortality & Morbidity Steering group
- Monthly performance report to Mortality & Morbidity Steering group
- Monthly report produced with learning identified. Shared via the Communication Department
- HSMR and SHMI to be in the expected range and numerically fewer deaths than expected observed. (HSMR<100 and SHMI<1)
- Medical Examiner Service in place and fully utilised across the Trust

How will we monitor and report it?

A six monthly continuous improvement review will be undertaken by the key leads and reported to the Quality Governance Committee (a sub-committee of the Board) to provide assurance to our trust, our people and our stakeholders.

Priority 7:

To support the National ambition to halve the rates of still births, maternal deaths, neonatal deaths and brain injuries.

What will we do?

- Our Safety improvements will focus around key areas:
    - Implementation and development of Saving babies lives Care bundle
    - Reduction of term infants admitted to SCBU
    - Ensure compliance with Clinical Negligence Scheme for Trusts (CNST)10 safety actions

How will we do it?

- Incorporate PreCept elements to care bundle. (Treatment of pre-term infants with Magnesium sulphate)
- Participate in regional SBL care bundle improvement programme
- Ensure all staff trained annually in the elements and application of the care bundle
- Participation in the Maternity and Neonatal Safety Collaborative

How will it be measured?

- Compliance with 10 safety actions
- Monitor maternity dashboard
- Reduction in term admissions to SCBU by 10%
- Quarterly small for gestational age audits and missed SGA audits
- Reduction of avoidable term stillbirths
- Reduction in mothers smoking at delivery

How will we monitor and report it?

A six monthly continuous improvement review will be undertaken by the key leads and reported to the Quality Governance Committee (a sub-committee of the Board) to provide assurance to our trust, our people and our stakeholders.

Clinical Effectiveness:

Priority 8:
Ensure robust processes are in place to set and deliver on the National Commissioning for Quality and Innovation (CQUIN) to ensure that our patients receive the best high quality and innovative service possible

What will we do?
- Ensure robust processes in place to set and deliver on the National Commissioning for Quality and Innovation (CQUIN) to ensure that our patients receive the best high quality and innovative service possible.

How will we do it?
- Support departments to achieve the two year National and Specialised CQUINs
- Produce monthly reports for the Integrated Quality & Learning Report
- Work with the CCG to identify early any areas of concern

How will it be measured?
- Reconciliation of quality indicators with the CCG

How will we monitor and report it?
A six monthly continuous improvement review will be undertaken by the key leads and reported to the Quality Governance Committee (a sub-committee of the Board) to provide assurance to our Trust, our people and our stakeholders.

Priority 9:
Research will be undertaken to ensure that we are providing the most beneficial and cost-effective care and treatment for our patients

What will we do?
Increase our commitment to taking part in high quality research

How will we do it?
- Increase the number of research projects
- Research projects will be clinically led (National Institute for Health Research (NIHR) portfolio commercial & non-commercial) in line with the North East & North Cumbria Clinical Research Network by 33%
- The increase will come from identifying clinical areas previously untapped, offering support to the multi-disciplinary teams with the research process and subsequent recruitment
- Principal investigator and Research Nurses within the Trust will be tasked with horizon scanning for new Local and National studies coming through onto the Portfolio and checking for eligibility

How will it be measured?

- Produce a Research & Development Annual Report and also through the Trust Quality Account 2020/21
- As part of the reports identified above review the patient outcomes from previous research
- An increase in recruitment of patients for research studies

How will we monitor and report it?

A six monthly continuous improvement review will be undertaken by the key leads and reported to the Quality Governance Committee (a sub-committee of the Board) to provide assurance to our Trust, our people and our stakeholders.

Priority 10:

Improve Clinical Audit: best practice and compliance to improve patient care and outcomes through systematic review of care and the implementation of changes and review alignment against Healthcare Quality Improvement Partnership (HQIP) Best Practice in Clinical Audit

What will we do?

- Achieve a '*significant assurance'* outcome from next internal audit on clinical audit processes

How will we do it?

- Undertake a gap analysis against HQIP Best Practice in Clinical Audit standards; produce a plan for improvement
- Strong clinical engagement in leading programmes of work
- Develop an effective communication strategy and align with the Trust policy
- Building capability and capacity with staff in the audit processes and delivery

How will it be measured?

- Improvement plan developed and all actions will be complete
- Produce a Clinical Audit Annual Report 2019/20 which will include improved experiences of care, outcomes and resources
- Clinical Audit Annual Report 2019/20 – will highlight and identify audits where patients have been involved
- Training package with face to face training in place which covers audit process from initial idea to report and presentation

How will we monitor and report it?

A six monthly continuous improvement review will be undertaken by the key leads and reported to the Quality Governance Committee (a sub-committee of the Board) to provide assurance to our Trust, our people and our stakeholders.

Priority 11:
Enabling women to access their care records to improve outcomes for mother and baby

What will we do?
- Develop and implement a transitional care model of care
- Develop our electronic records work stream for maternity and neonatal care

How will we do it?
- Digital project midwife appointed to lead this
- GDE project will support development of neonatal Badger system
- 4G upgrade to community teams IPads
- Transitional care MDT appointed and model of care developed

How will it be measured?
- Co-production with service users via satisfaction surveys
- Feedback to Trust groups
- Model of Transitional care implemented by Oct 2019
- Phased implementation of electronic clinical records to begin in SCBU by September 2019

How will we monitor and report it?
A six monthly continuous improvement review will be undertaken by the key leads and reported to the Quality Governance Committee (a sub-committee of the Board) to provide assurance to our trust, our people and our stakeholders.

Priority 12:
Build a culture and environment that supports continuous health improvement through the contact we have with individuals using the Making Every Contact Count platform

What will we do?
Review pathways to ensure we support individuals with brief interventions and enable access to services for reducing smoking, alcohol intake and eat well, move more, live longer programmes.

How will we do it?
- Review the current programmes in the trust
- Bring all groups that are undertaking programmes together under one Making Every Contact Count Group to enable a full overview
- Review training opportunities for staff and support with access to this training
- Use the Global digital exemplar programme to support new innovative ways of working so that individuals can access the support via digital support
- Work with local authority to ensure all support programmes are available and provide cohesive access to these programmes for all Gateshead residents.

How will it be measured?

- Increased uptake in support services
- Report identifying how many individuals have been asked about their smoking/alcohol/weight status and how many brief interventions have been undertaken
- Longer term:
    - Impact on health and wellbeing

How will we monitor and report it?

A six monthly continuous improvement review will be undertaken by the key leads and reported to the Quality Governance Committee (a sub-committee of the Board) to provide assurance to our Trust, our people and our stakeholders.

2.3 Statements of Assurance from the Board

During 2018/19 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 2018/19 represents 100% of the total income generated from the provision of relevant health services by Gateshead Health NHS Foundation Trust for 2018/19.

Participation in national clinical audits 2018/19

During 2018/19, 35 national clinical audits and 12 national confidential enquiries covered relevant health services that Gateshead Health NHS Foundation Trust provides.

During that period Gateshead Health NHS Foundation Trust participated in 91% 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 2018/19 are listed below.

The national clinical audits and national confidential enquiries that Gateshead Health NHS Foundation Trust participated in during 2018/19 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 2018/19, 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 2018/19

Audit title	Participation	% of cases submitted/number of cases submitted
Adult Community Acquired Pneumonia	No	Did not participate as had no capacity to complete the audit
Cardiac Rhythm Management (CRM)	Yes	Data still awaited
Case Mix Programme (CMP)	Yes	769 submissions to December 2018 – no minimum requirement
Elective Surgery (National PROMs Programme)	Yes	Hips – 277 no minimum requirement Knees – 325 no minimum requirement
Falls and Fragility Fractures Audit Programme (FFFAP)* National Hip Fracture Database (NHFD) National In-patient Falls Audit (NAIF)	 Yes Yes	 90.4% submission rate No data collected during 2018/19

Feverish Children (care in emergency departments)	Yes	128 cases submitted - no minimum requirement
Inflammatory Bowel Disease programme / IBD Registry	Yes	98 cases submitted - no minimum requirement
Major Trauma Audit	Yes	60%
Myocardial Ischaemia National Audit Project (MINAP)	Yes	234 submissions to March 2019 – 95% requirement
National Asthma and COPD Audit Programme (NACAP adult asthma)	Yes	460 cases submitted - no minimum requirement
National Audit of Anxiety and Depression	No	Did not participate as had no capacity to complete the audit
National Audit of Breast Cancer in Older People	Yes	Data still awaited
National Audit of Cardiac Rehabilitation	No	Currently don't have the staff to extrapolate the information to allow data to be uploaded.
National Audit of Care at the End of Life (NACEL)	Yes	80 cases submitted – 80 is the maximum submission limit
National Audit of Dementia	Yes	66 cases submitted – no minimum requirement
National Audit of Seizures and Epilepsies in Children and Young People	Yes	This audit is currently still in progress : Apr 19
National Bowel Cancer Audit (NBOCA)	Yes	235 cases submitted– no minimum requirement
National Cardiac Arrest Audit (NCAA)	Yes	53 – no minimum requirement
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Yes	155 cases submitted – no minimum requirement
National Comparative Audit of Blood Transfusion programme Major Haemorrhage audit Tri-regional survey of blood use in Obstetrics	 Yes Yes	 3 cases submitted – All cases required 5 cases submitted – All cases required
National Diabetes Audit – Adults*	No	The Trust did not have the appropriate IT system to support participation in this audit. Switched the diabetes database from protos to medway in April 2018 and will participate in 2019/20.
National Emergency Laparotomy Audit (NELA)	Yes	71%
National Heart Failure Audit	Yes	248 cases submitted – no minimum requirement
National Joint Registry (NJR)	Yes	100%
National Lung Cancer Audit (NLCA)	Yes	216 cases submitted – no minimum requirement

National Maternity and Perinatal Audit (NMPA)	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	223 cases submitted – no minimum requirement
National Oesophago-gastric Cancer (NAOGC)	Yes	60 patients submitted – no minimum requirement
National Paediatric Diabetes Audit (NPDA)	Yes 67	114 cases submitted – no minimum requirement
National Prostate Cancer Audit	Yes	164 patients submitted – no minimum requirement
National Vascular Registry	Yes	12 cases submitted – no minimum requirement
Non-Invasive Ventilation - Adults	Yes	Data collection remains open until June 2019
Sentinel Stroke National Audit programme (SSNAP)	Yes	186 cases submitted – no minimum requirement. Data available to 31.12.18
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	5 – no minimum requirement
Vital Signs in Adults (care in emergency departments)	Yes	135 cases submitted – no minimum requirement

Participation in National Confidential Enquiries 2018/19

Enquiry	Participation	% of cases submitted
Child Health Clinical Outcome Review Programme	Yes	Data still awaited
Mental Health Clinical Outcome Review Programme (NCISH)	Yes	Data still awaited
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%
National Confidential Enquiry into Patient Outcome and Death - Acute Heart Failure	Yes	Organisational questionnaire returned 50% clinical questionnaires returned

		33% case notes returned
National Confidential Enquiry into Patient Outcome and Death - Perioperative Diabetes	Yes	Organisation questionnaire returned 50% surgical questionnaires returned 66% anaesthetic questionnaires returned 16% case notes returned
National Confidential Enquiry into Patient Outcome and Death - Pulmonary Embolism	TBC	Organisation questionnaire returned 66% clinical questionnaires returned 16% case notes returned
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 TBC national clinical audits were reviewed by Gateshead Health NHS Foundation Trust in 2018/19 and Gateshead Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

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.

We receive a Quarterly Quality Report which contains information on our Unit's performance compared to other Critical Care Units and also identifies trends over time. In addition to the Quarterly report there is also an Annual Report summarising performance for the year and which is available to the general public. A Network report is also produced allowing comparison of Units within the North of England Critical Care Network.

For the year 2018/19 there were 1015 entered into the Case Mix Programme from our Critical Care Unit.

The most recent Annual Quality Report (2017/18) demonstrates that the Critical Care Unit is performing around the national average in most areas. This included in the areas of high risk admissions and high risk sepsis admissions from the ward (suggesting that patients are being admitted to Critical Care in a timely manner). Performance was better than the national average on rates of non-clinical transfers to other units, and readmissions to Critical Care within 48 hours of discharge.

The number of delayed discharges (as evidenced by the number of bed days occupied by patients

with a delay of more than 8 and 24 hours) were reduced compared to the previous year and in line with the national average.
Standardised mortality rates were as predicted for all admissions. Risk-adjusted mortality for patients with a predicted mortality of less than 20% was higher than expected (although within two standard deviations). Investigation into this has revealed issues with the quality of data entry into WardWatcher resulting in the predicted mortality for patients being lower than it should have been. This was addressed by education of staff on the correct input of data into WardWatcher and making the entering of history and diagnosis data a consultant-only task.
The data from the first three quarters of 2018/19 show an improvement in risk-adjusted mortality, down to below what would be expected.

Action plan:

- Continue to collect and submit data to Intensive Care National Audit and Research Centre (ICNARC)/CMP.
- Maintain accuracy of data collection within WardWatcher, with ongoing education of ward clerks and nursing staff, and the requirement for Consultants to complete all history and diagnosis data. Explore the possibility of a data entry clerk role.
- Continue work on prioritising discharges from Critical Care. There has been a significant amount of work across the Trust to raise the profile of Critical Care discharges and to help prioritise them with the patient flow team. Recording and Datixing of mixed sex breaches has been established and will be monitored going forwards.
- Review quarterly reports regularly to identify new areas where action is required.

Elective Surgery (National PROMs Programme)

The latest published data covers the period 2017-18. This data shows an improvement in patient reported outcomes for elective hip and knee replacement, bringing the Trust less than two standard deviations from the national average. We continue to make improvements to the pathway for patients having hip and knee replacement. All hip and knee patients are now given weekly physiotherapy appointments for six weeks after discharge from hospital. These appointments have become more structured and continue until the patient has been followed up by their consultant. Provision of additional staff within Occupational Therapy has provided improved work around patient function prior to discharge from hospital.
An agreed surgery site infection bundle is being implemented within the patient pathway. This aims to reduce risk of surgical wound infection in hip and knee replacement patients.

Action Plan:

- Continue to analyse data and identify patients who have lower than expected outcomes to surgery. We will use this data to assist in improving our patient outcomes.
- The latest published data reports that we have a lower than 50% participation for this period. We are confident that this will improve with the work we are currently implementing around compliance.

Falls and Fragility Fractures Audit Programme (FFFAP)*

National Hip Fracture Database (NHFD)

We continue to contribute to this national audit. Nearly all hip fracture patients over 60yrs are included. Data is collected on a wide range of parameters regarding demographics and clinical care. In 2018 the Trust was one of the top performing hospitals in the country, and top in the region, in terms of achieving the Best Practice Tariff (BPT) for hip fracture care at a level of 90.4%. This was an

improvement from 79% the year before and compares to a national average of 58% this year. For most audit parameters the Trust are in the upper middle or top quartile nationally. Length of stay has continued to decrease from 17.7 days in 2017 to 16.7 days in 2018. Year on year, the Trust continues to improve in terms of reduction in levels of avoidable harm from hospital acquired pressure damage. The percentage of patients having a nerve block in theatre has dropped considerably this year despite no obvious change in clinical practice therefore it is suspected this may relate to a change in the way the data is collected. The number of patients treated with a sliding hip screw has increased compared to 2017 but still remains in the lower middle quartile nationally.
The Trust is still in the lowest quartile for hip fractures sustained as an in-patient. The higher rate could be reflective of the population at the Trust, in terms of having a higher percentage of patients with mental health conditions and increased levels of confusion which are known risks for falling.

Action Plan:

- Improvement work will continue through the Trust Falls Strategic Group, as part of the wider Gateshead Falls Group.

Inflammatory Bowel Disease (IBD) programme /Registry

The IBD Registry is a not-for-profit company set up by three member organisations: The British Society of Gastroenterology, The Royal College of Physicians and Crohn's and Colitis UK. The IBD Registry seeks to transform outcomes for patients, clinicians and health organisations through better IBD information enabling greater understanding, treatment and care of people with IBD. The IBD Registry seeks to transform outcomes for patients, clinicians and health organisations through better IBD information enabling greater understanding, treatment and care of people with IBD.

The quarterly report issued by the registry for the period ending September 2018 and aims to provide local data /information to participating teams to support planning of services and to improve the services provided to the patients.
In the various graphs that registry have provided us , we can see that Gateshead IBD team falls within the median range of data set when we compare to the national standards.
The initial part of the report provides the comparison of basic demographic data between local and national statistics.
The Trust is at par with national figures in recording the demographics, however we need to improve recording the smoking status of the patient. Other points for action in light of this report includes
Recording the consent of the patient for their data to be included in the registry (currently optional for registry participants)

Action Plan:

- Probably we are recruiting less patients as compared to national data (QEH registered 31 patient on biologicals as compared to median number of 59 nationwide.)
- We should also encourage more patients to take part in future researches.
- We do not have adequate data on follow up of patients on biologics at three and six months interval which we should strive to improve.
- On these follow up visits we should also record the activity indices of IBD.

Major Trauma Audit

The Trauma Audit & Research Network (TARN) is a collaboration of hospitals from all over England, Wales, Ireland and other parts of Europe based at the University of Manchester, Hope Hospital,

Salford. The Trauma Network has been operating since 1989 and in 1997 became self-funding. The TARN database is the largest trauma database in Europe with more than 200,000 cases including over 22,000 paediatric patients.
Results from the March 2019 Tarn report looked at cases inputted between 1st April 2018 and 30th November 2018. Data ascertainment (% submission rate) was 60-71% (151 cases form estimated 213-253 according to HES). 60% of patients were aged 75 years or older whilst 21% patients were severely injured (ISS > 15). 13 of the 151 patients were transferred out of the QE meaning that 138 patients had their in-patient episode completed within the QE.
For the time period 1st April 2017 – 30th Nov 2018 the Ws score was 1.5 (CI -0.87 – 3.87). This means there were 1.5 excess survivors per 100 patients than expected. Given less than 80% data ascertainment this needs to be viewed with caution however it is a positive result.
Over the next few months our primary aim has to be to try and increase the data ascertainment figure to over 80% in order to increase the reliability of the results.

Action Plan:

- We need to look at the hospital episode statistics (HES) data set to identify which patients we missed and why, and also inform TARN about patients that were contained within the HES figure that were actually not suitable for inclusion in the audit. This will hopefully enable us to identify more cases for input (thus increase the numerator) and reduce the expected HES case number (thus reducing the denominator) which will raise the data ascertainment percentage.

National Audit of Care at the End of Life (NACEL)

The Trust's overall results are very good and show the continuous emphasis on embedding the five priorities of care for the dying patient. Also over the last year there has been a significant piece of work undertaken to embed the regional caring for the dying patient document. This document helps to bring together all of the elements of documentation regarding the five priorities of care. This piece of work has been underpinned by a greater presence of the Specialist Palliative Care Team across the Trust in conjunction with staff continuing to access palliative and end of life care education sessions.

Action Plan:

- One area that requires further investing in is our specialist palliative care workforce. We currently provide out of hours telephone advice for professionals via the regional palliative care advice line. 24/7 Specialist Palliative Care support is currently being scoped to enhance our own services by initially providing local telephone and face to face support by our specialist nursing team at the weekends.
- We are also continuing to network with specialist palliative care colleagues across the region to enhance services.

National Cardiac Arrest Audit (NCAA)

The NCAA is the national clinical comparative audit for in-hospital cardiac arrest. The purpose of the NCAA is to promote local performance through the provision of timely validated comparative data in participating hospitals. NCAA is a joint initiative between the Resuscitation Council and Intensive Care National Audit and Research Centre (ICNARC).
The results from 1st April to 31st December 2019 show return of spontaneous circulation of 43.3%, with survival to hospital discharge of 8.1% this is lower than the national trend but is not statistically significant. In addition the trust had fewer patients in ventricular fibrillation (VF) and pulseless electric activity (PEA) than the national trend and more in pulseless ventricular tachycardia (pVT) and

asystole.

Action plan:

- We have identified that more of our patients are older and have significant co-morbidities than the national trend. This has prompted a conversation with the consultant staff via the training sessions to consider whether certain patients may benefit from a Do Not Resuscitation decision. We are an active member of the regional Deciding Right group, which seeks to promote appropriate early end of life decision making.
- We have refocussed the direction of our basic life support training to include, and emphasise the importance of recognition and management of the deteriorating patient. This includes a focus on National Early Warning Score (NEWS) 2.
- We have the capacity to download data from the memory card within all of the defibrillators. This provides data regarding the quality of cardiac compressions, time off the chest and number of shocks delivered. We intend to download this data and provide feedback to the clinical areas and medical staff regarding the quality of the above during a cardiac arrest. It will allow us to identify areas of good practice as well as any requiring improvement.

National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)

The Trust performed better compared to the last audit in 2014-2015 with much better recruitment, 160 patients to date. The average waiting times for patients to be seen within three weeks (quality standard 2) is 48% as opposed to the target of 80%. This is due to an increase in number of referrals especially out of area & reduced capacity. However the average wait in the last six months has been 22-28 days which is consistently below the national 25th centile. The average waiting times to start Disease-Modifying Anti-rheumatic Drugs (DMARDs) within six weeks (quality standard 3) is 48.6% as opposed to target of 80% again. However the average wait has improved in the last three months has improved to below three weeks. There were a couple of outlying months (September and November) that we need to review as we have seen issues with data quality.

Action Plan:

- There is a Kaizen event (an improvement workshop) planned to review our processes for new DMARD starts.

National Emergency Laparotomy Audit (NELA)

The National Emergency Laparotomy Audit is an ongoing national clinical audit of patients having emergency bowel surgery, which is associated with high mortality. The quality of care and outcomes for patients can be improved through planning and delivering care based upon a comprehensive assessment of each patient's risk of death. The Trust reported 156 cases, with case ascertainment of 93%. The audit reports on nine key standards that are subject to RAG rating (vs standard of 80% or more). The Trust are rated green (G) for five of these, amber (A) for three and red (R) for one.
For most areas we sit around the national average, but could improve documentation of pre-op consultant assessment, and look into post- critical care discharge deaths. An area which merits some more input is the role of Care of the Elderly physicians. Our case numbers entered into NELA have increased (Latest figures 156 per annum), better than average consultant surgeon and anaesthetist input pre-op. High POSSUM scores in the Trust's patients (ie sicker patient population than average), Possible variations in practice (in terms of case identification etc) between.

Action Plan:

- Worse than average rate of input by Care Of The Elderly physicians, this will be picked to improve

participation.

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 and achieved 100% compliance for the 2017/18 NJR Data Quality audit. The Trust has also been awarded as an NJR Quality Data Provider for 2017/18.

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.

National Paediatric Diabetes Audit (NPDA)

The Children and Young People (CYP) Diabetes Service has looked after 127 patients (123 with Type 1 Diabetes and four with Type 2 Diabetes) over the last year, this includes 13 patients who were transferred and 10 new patients. We have submitted to the NPDA annually. Our outcomes continue to improve and we benchmark ourselves regionally and nationally to ensure ongoing improvement in outcomes and to ensure good practice. Our current annual median HbA1C is 63mmol/mol and mean is 67.5 mmol/mol. All our new patients are started on intensive multi dose insulin injection regimes and are taught to carbohydrate count from diagnosis. We have 41% patients on insulin pump therapy and 53% on either Libre Flash Glucose Scanning (FGS) or continuous Glucose Monitoring (CGM). We have embraced new technology including downloading meters and pumps in clinic and have facilitated home downloading. Our service meets the Borderline Personality Therapy (BPT) criteria with 92.1% of our patients having had over eight contacts per year in addition to at least four Multidisciplinary Team (MDT) clinics per year.
We have significantly improved the uptake and provision of care processes in particular retinal screening.

Action Plan:

- To continue to work across multi agencies to support the significant number of CYP requiring local authority support, mental health/MDT psychology services and / or safeguarding which is an ongoing challenge.
- To continue to improve education for CYP and their carers/ families and school staff to enable them to embrace new technology and ensure CYP with diabetes are fully included in all aspects of school life and achieve their full potential.
- To address the need for increased admin support to improve data entry including accurate documentation of Physical Disability and Sensory Needs (PDSN) activity for Best practice Tariff (BPT) , National Paediatric Diabetes Audit (NPDA) and Regional Diabetes registry, to support the new Value Based Commissioning (VBC) pathway & other funding requests, to improve efficiency of communication with CYP and their families.
- To work with the trust, primary care and the adult service to provide a dedicated young person (19-25yrs) clinic within adult service with adult dietetic provision; a dedicated Young Persons

Adolescent Development Support Nurse (ADSN); psychology provision for 19-25yrs; to facilitate access to education (accessing the new Clinical Commissioning Group education pathway for those with Type 1 & Type 2 Diabetes); to improve engagement - as complex needs prevent regular clinic attendance results in Did Not Attends (DNA's) & effectively early discharge from the adult service.
National Prostate Cancer Audit – data still awaited
Non-Invasive Ventilation - Adults– data still awaited
Sentinel Stroke National Audit programme (SSNAP) – data still awaited
Cardiac Rhythm Management (CRM) – data still awaited
National Neonatal Audit Programme (NNAP) – data still awaited
National Oesophago-gastric Cancer (NAOGC) – data still awaited
Myocardial Ischaemia National Audit Project (MINAP) – data still awaited
National Audit of Breast Cancer in Older People– data still awaited
National Bowel Cancer Audit (NBOCA) – data still awaited

The reports of 13 local clinical audits were reviewed by Gateshead Health NHS Foundation Trust in 2018/19 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
Clinical Support & Screening	Breast Screening	Annual Treatment Rate (TR) Audit - Although Gateshead Breast Screening Unit is currently meeting the standard set by the NHS Breast Screening Programme (NHSBSP) and is close to the target there are a number of staff members who are outliers. Two mammographers have been identified as having a TR rate which is consistent with statistical significance and these members of staff will be offered help to improve as appropriate. Part time staff and those with other responsibilities have a naturally lower workload leading to a higher TR rate. Technical Recall rate has proven to be acceptable within this audit. Staff will be supported with additional training if required to lower recall rate.
Clinical Support & Screening	Abdominal Aortic Aneurysm (AAA) Screening	Improving uptake and reducing variation in uptake in AAA screening Recommended areas for improvement are to carry out service promotion on a local level, source new clinics in suitable locations, and look at extending some clinic times. We will look to source

		more suitable clinics within the geographical areas, trial more accessible clinic times, complete service promotion locally through community awareness sessions and the Trust Communications Team.
Clinical Support & Screening	Diagnostic Imaging	Reporting Radiographer Audit - Accuracy was in excess of 95% reference standard. No trends identified to suggest any specific areas of weakness within the team that would require additional targeted training sessions. Standards will need to be maintained over the next 12 months. Reporting standards were met however there was a minimal drop in accuracy from the year before and there is still room for improvement. Repeat audit is needed to make sure standards are maintained this will be undertaken in 2019/20.
Clinical Support & Screening	Bowel Screening	Audit Report Adverse Event - Changes will be made to current practice as a result of this audit. Recommendations would be to use patient identifiers on the system to facilitate easier review, ensure all concerned keep up to date with common practice and being aware of any changes made to the way adverse events are recorded within the Bowel Cancer Screening Programme guidelines. If incident occurs, report straight away. Inform appropriate people. Discuss at Team Meeting – in order for analysis and learning. Make changes to practice if appropriate. Update work instructions. Audit was difficult and lengthy due to the lack of patient identifiers, changes recommended are the use of patient identifiers on the system.
Medical Services	Palliative Care	Audit to review transfer of patients to St. Bede's Unit from other hospital wards within the QE Hospital - The audit has continued to show problems with transfers. The increase in issues detected in the second audit may partly reflect the smaller amount of data collected. Also more people are starting to use the checklist, so issues are more obvious. To further improve the service we have: offered teaching to all St. Bede's staff on how to make best use of the checklist. Made the checklist available on the Trust Intranet for staff to complete before a transfer is arranged. Trust staff including, Macmillan nurses, Junior Doctors and ward staff will be educated on the existence and use of the checklist when they identify a patient for transfer. This project will be re-audited in the next audit programme.
Medical Services	Mental Health	Audit of incidents of Rapid Tranquilisation (RT) against case notes to ensure appropriate use and monitoring following RT. There is some duplication, the printed out incident report is the only record and all relevant details are within this report, which are then added to patient notes on the Cragside Unit. The Sunniside Unit have duplication of where the information within this report is documented. The report highlighted that the policy was not being adhered to; there were no recorded post incident reviews and there were no records of a patient being given the opportunity to document their own account of the intervention in their medical notes. Ward managers to ensure compliance with policy and

		standard operating procedure. Training for the qualified nurses in RT. Repeat audit six months' time.
Medical Services	Ward 23	Venous Thromboembolism (VTE) thromboprophylaxis prescription on Ward 23. Monitoring of weight and renal function should be continued. More input is needed in regard to patients who are independently mobile. It has been recommended that mobility status is added to the nursing handover, the Medway whiteboard system is monitored in order to identify when a patient is independently mobile. This will prevent a potential subcutaneous injection in a patient population frequently with agitation and/or dementia. The audit found we were compliant with patient's prescription of Tinzaparin in regard to weight and renal function. However with regards to patient's mobility, three out of four patients who were deemed independently mobile by physiotherapy were still on prophylactic, preventative, Tinzaparin. Re-audit in 2019/20.
Medical Services	Care of the Elderly	An audit of prescribing of Osteoporosis drugs to ensure compliance with local and national guidance, safe and effective practice as a non-medical prescriber. The audit shows that prescribing is safe and in line with local and national guidance. Consultant to undertake a further audit on another 10 patients for quality assurance purposes.
Medical Services	Rheumatology	Medications on the Medical Interoperability Gateway (MIG), the system that provides access to real time information about patients. The audit identified areas for improvement in relation to the recording of hospital prescribed medications on the MIG. If these prescriptions were issued by General Practitioner (GP), then the rate would be much nearer to 100%. The Trust is in ongoing discussion with the Clinical Commissioning Group and GP surgeries regarding long-term prescriptions of hospital commenced medications.
Nursing & Midwifery	Safeguarding	Measuring the quality of Looked After Children (LAC) Health Assessments for Unaccompanied Asylum Seeking Children (UASC), As the UASC had only recently arrived in the UK there were no child health records available. There were also gaps in the information about the health care some of them had received prior to being moved to Gateshead. Height and weight were recorded in all of the young people who accepted the health assessment (100%). However weight and height percentile / Body Mass Index (BMI) were only calculated for 62%. Named Nurse for LAC and Young People to share findings of audit with Paediatricians and Clinical Commissioning Group. Practitioners carrying out health assessments for young people need to ensure that consent is sought at the time of the health assessment for all young people who have the capacity to consent. Weight and height percentile / Body Mass Index (BMI) should be recorded as standard on all health assessments. Junior clinicians carrying out health assessment for UASC, need to be supervised and action taken to ensure that they have completed referrals as per guidance.
Surgical	Ward 14	To what extent do our Trauma and Orthopaedic operation notes

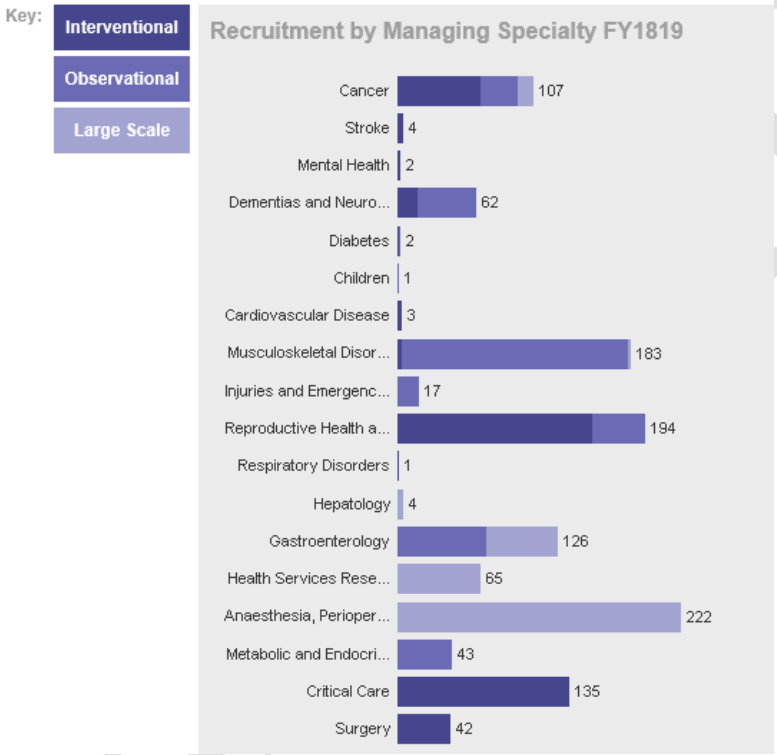
Services		comply with Royal College of Surgeons' guidelines (Re-audit)? This audit found that there are several areas not routinely documented in operation notes, including indication, blood loss and time. This audit found no significant change from previous audit and as such it is imperative to re-audit the issue to ensure result from planned interventions. Plan to edit current operation note templates to include titles for these areas to prompt inclusion in documentation that is then transferred to ward. Plan for re-audit in one years' time, this project has been placed on the audit programme for 2019/20.
Surgical Services	Paediatrics	Safeguarding supervision audit of Community Midwives safeguarding cases. The findings from this audit provide the Trust with significant assurance that the community midwifery teams are complying with Safeguarding Children Supervision processes as documented in the Safeguarding Children Policy. The Safeguarding supervision is positively assisting the Community Midwives ability to reflect around safeguarding children issues leading to an increased confidence, critical analysis of cases and enhanced ability to work collaboratively with other agencies. Only 72% of forms returned felt that the child's voice is incorporated in to Safeguarding Supervision. The Safeguarding Supervision paperwork has a section where it specifically asks about 'the child's voice'. As a recommendation from this audit, with assistance from the Named Midwife, further attempts will be made to incorporate the supervision documentation on to the maternity system. Issues regarding time allocated for supervision and extra time required for actions raised following supervision will be raised with the Named Midwife and Head of Maternity. The audit form will be revised for the next audit and be more specific as to what is meant by capturing the child's voice within supervision. This audit will be repeated in one year and will remain part of the Safeguarding Children Annual Audit Programme.
Surgical Services	Theatres	Scrub Count Audit - Audit showed that staff had concerns about the lack of continuity when different members of the team were involved in the same count. A full handover has been suggested if different team members are to undertake any part of the count that they were not initially involved in. Handover needed between staff if change during the procedure for breaks. New standard of practice implemented this will require further audit to make sure standard operating procedure is adhered to.

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Gateshead Health NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by the Health Research Authority (HRA) was 1,213. This was a decrease of 160 participants from last year (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 (NE & NC CRN), the Trust has focused on building the recruitment for both Portfolio and Industry studies.

Gateshead Health NHS Foundation Trust is currently involved in 234 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 2018-2019 were The GCA Study (Rheumatology - 162 participants), DALES (Anesthesia - 142 participants), PEPTIQ Study (Critical Care -135 participants), PREP (MS-E-CIG) (Maternity - 127 participants) and The PQIP Study (Critical Care - 80 participants). The Recruitment by Managing Specialty can be seen below -



Over the last year, researchers from the Trust have published over 54 publications, two posters and one presentation which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

There were 88 members of staff participating in research at Gateshead Health NHS Foundation Trust during 2018/2019. These staff participated in research covering 18 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 2018/2019. This element of the scheme focused on completion of specific Pharmacy data fields within the Local Portfolio Management System (LPMS) related to the NE & NC CRN High Level Objectives

with a 90% target for data field completion for Pharmacy Set-Up. The Trust achieved a 100% completion on the target and was awarded £6,000. The initiative took place over quarters four and one 2018/2019.

- The MAMMO-50 - Mammographic Surveillance in breast cancer patients aged 50 years or older research team were congratulated on being one of the highest recruiting Trusts in May 2018.
- The PREP (MS-E-CIG) – Helping pregnant smokers quit: Multicentre RCT of electronic cigarettes vs usual care - research team were congratulated for their strong recruiting performance and for being the highest recruiting Trust in the whole of the UK from January through to September 2018.
- The MROC – The impact of multiparametric MRI on the staging and management of patients with suspected or confirmed ovarian cancer - research study team were congratulated for being one of the highest recruiting Trusts between August and November 2018.
- The QUIDS – Quantitative Fibronectin to help Decision-making in women with symptoms of pre-term labour - research team were congratulated for having the highest number of clinician consents for interview (12). 30 consents were obtained in total across 10 Trusts.
- The Endometrial Scratch Trial team were congratulated on recruiting 62 participants – well above their target of 46.

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

A proportion of Gateshead Health NHS Foundation Trust income in 2018/19 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 2018/19 and for the following 12 month period are available electronically at http://www.qegateshead.nhs.uk/cquin

A monetary total of £4,945,070 of the Trust's income in 2018/19 was conditional upon achieving quality improvement and innovation goals. The Trust were paid a total of £4,981,173 for achieving the quality improvement and innovation goals for 2017/18.

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 2018/19.

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

Following on from the unannounced focused CQC inspection of Older Person's Inpatient Mental Health Services which took place in December 2016, the CQC returned to re-inspect the wards for older people with mental health problems in November 2018. Following the 2016 inspection there were 22 must do actions across 8 areas of Regulated activity (covering both Inpatients and Community). It is positive that this latest inspection has identified a significantly reduced number,

down to five, 'must do' actions; four that were across three areas of Regulation. There was also one 'should do' improvement action.

A Mental Health Improvement Steering Group supports with the actions required to improve the services. The overall 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.

The four actions across three areas of Regulation include:

- New blanket restrictions in place without evidence of review
- Some individual risk assessments not carried out or mitigation in place to protect the privacy and dignity of patients using dormitories
- One ward did not comply with guidance on eliminating mixed-sex accommodation which compromised patients' privacy and dignity
- Data on the use of tranquilisation by oral administration was not being recorded, monitored or documented through incident reports

The CQC has recently carried out two Mental Health Act 1983 Monitoring visits in December 2018 and February 2019. 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 2018/19 to the Secondary Uses Service (SUS) 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	99.8%	99.6%
Percentage for accident and emergency care	99.0%	97.6%

Which included the patient's valid General Medical Practice Code was:	Trust %*	National %*
Percentage for admitted patient care	99.7%	99.9%
Percentage for outpatient care	99.8%	99.8%
Percentage for accident and emergency care	99.7%	99.3%

* SUS Data Quality Dashboard - Based on the April 18 to February 19 - SUS data at the Month 11 inclusion date

Information Governance Toolkit

Gateshead Health NHS Foundation Trust's Information Governance Assessment Report overall score for 2018/19 was 98/100 and graded as 'Standards not fully met (plan agreed)"

Standards of Clinical Coding

Gateshead Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.

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

- A full review of the Data Quality Strategy Group, to ensure it 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 aligned 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.
- A project is underway with Global Digital Excellence programme to deliver an integrated Patient Demographic Search (PDS) to the national spine which validate patient demographic details and allocate real time NHS Nos to patient records improving and updating the quality of patient information.
- Circulate weekly patient level reports to allow the clinical services to fully validate 18 week and cancer pathways.
- A real time dashboard for 18 weeks validation has been developed with the services which no longer require them to wait until reports are circulated. They have at a glance their waiting time position with the ability to drill down to patient level information for validation purposes.
- 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.
- Continue to work with Commissioners to ensure commissioning datasets are accurate, completing data challenges within five days.
- Monthly Data Quality Information Governance (DQIG) meetings 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 2018/19, 1,060 of Gateshead Health NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 269 in the first quarter;
- 247 in the second quarter;
- 272 in the third quarter;
- 272 in the fourth quarter.

* Seasonal increases in mortality are seen each winter in England and Wales.

By 4th April 2019, 817 case record reviews and 71 investigations have been carried out in relation to 1,060 of the deaths included above.

In 64 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:

- 229 in the first quarter;
- 209 in the second quarter;
- 225 in the third quarter;
- 154 in the fourth quarter.

One death representing 0.12% 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;
- 0 representing 0.% for the second quarter;
- 1 representing 0.12% for the third quarter;
- 0 representing 0% for the fourth quarter;

These numbers have been estimated using the Trust's 'Reviewing and Learning from Deaths' policy. Reviewed cases are graded using the Hogan preventability score and National Confidential Enquiry into Patient Outcome and Death (NCEPOD) overall care score following case note review by the consultant led team that was responsible for the patient at the time of death.

Summary of learning:

The Mortality Council has highlighted areas of improvement in practice. These include the following:

1. GP Notification of Deaths
2. Palliative and End of Life care
3. Education around Resuscitation and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
4. Education around anticoagulation
5. Place of Death at home rather than hospital as laid out in the patient's Emergency Health Care Plan (EHCP)
6. Communication with families

Description of Actions:

- Medway training has been instituted for all senior clinicians in order to educate them on how to complete the GP Notification of Deaths form and pass the information on to juniors. This is already done for the junior doctors at the time of their induction but will be reinforced.
- Palliative care teaching sessions now take place regularly for medical and nursing staff.
- Resuscitation and DNACPR training for senior staff is now being carried out by Resuscitation Team. This is level 2 training focused at senior staff who may not have undergone any update. Level 1 training is mandatory and is already in place. This is already in place for junior staff.

- Education around management of anticoagulation has taken place in the respective business units where the incidents have occurred.
- EHCP pathways are being made more robust in order to reduce inappropriate number of hospital admissions where clear plans have been made for management at home.
- There are several areas of poor communication which has been fed back to the staff involved.

Assessment of the Impact:

- Mortality review has highlighted areas of excellent team working between staff and families and examples of excellent documentation.
- Level 1 and Level 2 reviews have identified some clear areas where improvement is required and appropriate actions have been implemented.
- The Trust has further developed its bereavement service to make this more accessible to families and carers.
- We strive to continue to improve our service on the result of mortality review.

190 case record reviews and 75 investigations completed after 1st April 2018 which related to deaths which took place before the start of the reporting period. 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 2017/18 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 standards five (access to diagnostics) and six (access to consultant directed interventions) from the 10 clinical standards as identified via the seven day hospital services NHS England recommendations.

For clinical standard eight (ongoing review) we have 100% compliance for those requiring twice daily review. We have increased our consultant cover on Care of the Elderly wards at the weekends and were above 90% compliance for once daily review for patients in during weekdays (96%) but below 90% for weekends (83-87%). (April 2018 Seven Day Self-Assessment Tool). Current workforce resources make increasing weekend consultant ward cover further not viable and we will need to look at other ways such as improving flow and defining more clearly patients who require consultant review at weekends.

For clinical standard two (speciality consultant review within 14 hours) we are 76% compliant (April 2018) across all seven days. We have identified arrival of patients between 4-8pm as a problem area. We have introduced an extra twilight registrar shift to improve flow (August 2018) and held a week long improvement event in March 2019 to look at flow in the Emergency Admissions area. Improvements in documentation (e.g. noting the time seen/identity of doctor) may also help to make survey results more accurate. We have introduced a seven day frailty front of house assessment to

reduce admission and plan discharge. There is ongoing system work within Gateshead to look at frailty across all parts of the health and social care sector with which we are fully engaged.

We have moved to the Board assurance approach for assessing compliance with the seven days standards and presented the first (test) template to Board in January 2019. We have incorporated aspects of the seven day audit work (standards two & eight) into our ongoing regular notes audit (from February 2019) and will assess if this gives us the required data to give assurance around performance.

2.6 Freedom to Speak Up

Gateshead Health NHS Foundation Trust is committed to achieving the highest possible standards/duty of care and the highest possible ethical standards in public life and in all of its practices. We are committed to promoting an open and transparent culture to ensure that all members of staff feel safe and confident to speak up. Our Freedom to Speak Up (FTSU) Guardian supports the delivery of the Trust's corporate strategy and vision as encapsulated in our ICORE values. As well, as the FTSU Guardian, staff may also raise concerns with their trade union or professional organisations as per our Freedom to Speak Up Policy. When concerns are raised via the FTSU Guardian, the Guardian commissions an investigation and feeds back outcomes and learning to the person who has spoken up.

2.7 NHS Doctors and dentists in training – annual report on rota gaps and the plan for improvement to reduce these gaps

The Trust Board via the Human Resources Committee receives quarterly reports from the Guardian of Safe Working summarising identified issues, themes and trends. The exception report data are scrutinised by the Medical Workforce Group with representation from all business units and actions to support areas and reduce risk/incident levels identified on a quarterly basis. These actions are escalated to the Human Resources Committee by exception when it is deemed necessary due to difficulty to reach local resolution.

The Trust Board via the Human Resources Committee receives an annual report from the Guardian of Safe Working which includes a consolidated report on rota gaps and actions taken by the Medical Workforce Group. This report is provided to the Local Negotiating Committee (LNC) by the Guardian of Safe Working and the LNC representation at the Medical Workforce Group.

2.6 Mandated Core Quality Indicators

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

SHMI	Jul-16 - Jun 17	Oct-16 - Sep-17	Jan-17 - Dec 17	Apr-17 Mar-18	Jul-17 - Jun 18	Oct-17 - Sep-18
Gateshead Health NHS Foundation Trust	1.01	1.00	1.02	1.03	1.05	1.04
England highest	1.23	1.25	1.22	1.23	1.26	1.27
England lowest	0.73	0.73	0.72	0.70	0.70	0.69
Banding	2	2	2	2	2	2

Source: www.digital.nhs.uk/SHMI

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

% Deaths with palliative coding	Jul-16 - Jun 17	Oct-16 - Sep-17	Jan-17 - Dec 17	Apr-17 Mar-18	Jul-17 - Jun 18	Oct-17 - Sep-18
Gateshead Health NHS Foundation Trust	16.7%	18.9%	19.9%	22.1%	22.7%	24.9%
England highest	58.6%	59.8%	60.3%	59.0%	58.7%	59.5%
England lowest	11.2%	11.5%	11.7%	12.6%	13.4%	14.3%
England	31.1%	31.5%	32.2%	32.5%	33.1%	33.6%

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 death rates (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, mortality for the Trust is described as being 'as expected'.
- The Clinical Coding Department receive information on a monthly basis from the palliative care team that identifies those patients under their care. The Clinical Coding Team verifies this information against the coded admissions to ensure that Palliative Care coding is captured accurately.

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:

- Continuing to review the Trust's mortality review process and standardising it 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
- The Trusts Mortality Council continues 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 Trust's 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 reviewing the existing 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

Proportion of patients on Care Programme Approach (CPA) who were followed up within 7 days	2016-17				2017-18				2018-19			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Gateshead Health Foundation Trust	100.0%	90.0%	80.0%	84.6%*	71.4%†	87.5%††	90.9%†††	100%	100%	100.0%	100.0%	100.0%
England	96.2%	96.8%	96.7%	96.8%	96.7%	96.7%	95.4%	95.5%	95.8%	95.7%	95.5%	-
England Highest	100.0%	100.0%	100.0%	99.4%	100.0%	100.0%	100.0%	100%	100%	100.0%	100.0%	-
England Lowest	28.6%	76.9%	73.3%	84.6%	71.4%	87.5%	69.2%	68.8%	73.4%	83.0%	81.6%	-

* 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 in for the following reasons:

- We recognise that our number of patients on a Care Programme Approach is relatively small; however we pride ourselves on taking a person centred approach and caring well for our patients.

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

- The Trust has high standards of practice related to the communication from our community services in supporting discharge from hospital for all of our patients, this includes involvement in the discharge planning process and including a date/time and venue for a post-discharge appointment as mandatory.
- The Trust has learned lessons from previous years, which include having a community Nurse at ward multidisciplinary teams to support discharge planning.

PROMs (Patient Reported Outcome Measures) for Hip Replacement and Knee Replacement:

Hip Replacement Adjusted average health gain EQ-5D index	2015-16 Final	2016-17 Final	2017-18 Final
Gateshead Health Foundation Trust	0.403	0.401	0.463
England	0.438	0.445	0.468
England Highest	0.512	0.537	0.566
England Lowest	0.320	0.310	0.376

Knee Replacement Adjusted average health gain EQ-5D index	2015-16 Final	2016-17 Final	2017-18 Final
Gateshead Health Foundation Trust	0.284	0.282	0.339
England	0.320	0.325	0.338
England Highest	0.398	0.404	0.417
England Lowest	0.198	0.242	0.234

Source: https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms

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

Hip

- The Trust has invested significantly in a PROMS improvement project to improve previous scores which were below national average over the last two years. The Trust is delighted to report a huge improvement and the results show we are in line with national average.

Knee

- The Trust has invested significantly in a PROMS improvement project to improve previous scores which were below national average over the last two years. The Trust is delighted to report a huge improvement and the results show we are 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:

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 the North East Quality Observatory Service (NEQOS) to further analyse the information recorded and identify trends.

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.

Emergency Readmissions within 28 Days

- Aged 0 – 15yrs

Child 0-15 Years	2015-16	2016-17	2017-18	2018-19 to Sep-18
Emergency Readmission Rate	8.95%	8.54%	7.19%	7.81%
Number of Spells	4,772	4,849	4,563	2,241
Number of Readmissions	427	414	328	175

Source: Healthcare Evaluation Data (HED)

- Aged 16 years or over

Adult 16+ Years	2015-16	2016-17	2017-18	2018-19 to Sep
Emergency Readmission Rate	9.34%	8.73%	8.50%	8.23%
Number of Spells	62,451	59,000	57,830	28,910
Number of Readmissions	5,832	5,150	4,916	2,378

Source: Healthcare Evaluation Data (HED)

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

- The rate of our emergency admissions is a valued quality metric that helps us measure the quality of care and it can also provide us with an indicator of the quality of discharge. It will never be zero as patients will, and do, deteriorate, and they also may be admitted for a different reason or condition. We monitor this metric closely to ensure there is no adverse impact on the quality of our discharge practice as we continually make changes to improve discharge co-ordination.

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

- This year there has been a significant amount of work undertaken as part of the Trust's Just Try It… SAFER Programme. This has included:
  - Launch of the 'Just Try It… SAFER Programme: Safe, Timely and Effective Transfers of Care.
  - Launch of the Transfer of Care Policy – an overhaul of the Trust's former Discharge Policy.
  - A SAFER baseline audit on all wards and development of local improvement action plans.
  - A Rapid Process Improvement Workshop (RPIW) on Ward 22 focusing on the effectiveness of the Board Round.

- Development of electronic white boards to improve the visibility and tracking of patient discharge plans.
- A long stay patient audit to identify any delay themes.
- Establishment of a Transfer of Care forum.
- Discharge Improvement Workshop and a refresh of all supporting training material.
- A website and resource file made available for all staff.

This is a long term programme of work that will continue into 2019/20.

Trust's responsiveness to the personal needs of its patients

Inpatients - Overall Patient Experience Score	2014-15	2015-16	2016-17	2016-17*	2017-18
Gateshead Health NHS Foundation Trust	81.8	79.2	79.1	80.4	81.9
England Average	76.6	77.3	76.7	78.0	78.4
England Highest	87.4	88.0	88.0	89.0	88.9
England Lowest	67.4	70.6	70.7	72.0	71.8

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

*Adjusted to allow comparison to 2017-18 data

A&E - Overall Patient Experience Score	2014-15	2015-16	2016-17	2017-18
Gateshead Health NHS Foundation Trust	79.8	*	83.6	*
England Average	77.1	*	78.2	*
England Highest	83.5	*	83.6	*
England Lowest	67.2	*	71.1	*

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

* national survey not undertaken

Outpatients - Overall Patient Experience Score	2009/10	2011/12	2017/18
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

* national survey not undertaken since 2011/12

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

- Our inpatient score remains stable for 2017/18 and we remain above the national average for our overall patient experience score. We continually listen to what our patients tell us and recognise the importance of their feedback. We act upon this to improve the care we deliver to patients.

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

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

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	2016	2017	2018
Gateshead Health NHS Foundation Trust	81.1%	80.9%	81.2%
England highest - Combined Acute & Community Trusts	84.8%*	89.3%	90.3%
England Lowest - Combined Acute & Community Trusts	48.9%*	48.1%	49.2%
England - Combined Acute and Community Trusts	69.8%*	68.4%	69.9%

Source:www.nhsstaffsurveys.com

*Acute Trusts

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

- Gateshead Health NHS Foundation Trust is consistently well regarded by our staff as a place for their family/friends to receive care, and this has continued in 2018. We believe this is because of multiple factors, and not least because we have a loyal, compassionate and proud workforce who continuously live our values of innovation, care, openness, respect and engagement.

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

- Continue 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 recruitment, induction, training and appraisals, to ensure all staff, regardless of their role contribute directly or indirectly to patient care.
- Embed the use of LEAN and continuous improvement techniques to support our workforce to develop outstanding services.
- Recognise the high standards of care delivered by staff through our 'You're a Star' programme and Star Awards ceremony.

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%	100.0%	67.0%	95.2%
2018-19	Q1	99.5%	100.0%	75.8%	95.6%
	Q2	99.2%	100.0%	68.7%	95.4%
	Q3	99.1%	100.0%	54.9%	95.6%
	Q4	98.5%			

https://improvement.nhs.uk/resources/vte/

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

- Gateshead Health NHS Foundation 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 risk assessment continues to be recorded on the electronic prescribing management system.

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 Root Cause Analysis (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,
- 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 CDI per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	2015/16	2016/17	2017/18	2018/19
Gateshead Health NHS Foundation Trust	26.7	11.1	17.4	11.2†
England highest	66	82.7	91.0	-
England lowest*	1.1	1.2	1.4	-
England	14.9	13.2	13.7	-

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

*Where cases reported

†During 2018/19 the Trust reported twenty (20) Hospital-onset CDI cases against its annual objective of 18 cases and an annual rate of 11.2 against its annual objective rate 10.1 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 high quality of patient care we deliver. The Trust has reported 20 cases for 2018/19 exceeding its objective by two cases and reporting a rate of 11.24 per 100k bed days reporting our lowest case numbers to date. However following review and successful appeals the Trust reports only three cases against the quality premium. 2018/19 has proved to be a successful year for improving patient safety and reducing CDI. A focused and zero tolerance approach continue 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. A more efficient localised process has been implemented in partnership with the CCG to review all CDI cases, root cause and lessons learned in a timely fashion
- 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 stools
- 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 Trust guidelines are developed to reflect the national 5 year AMR strategy
- 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 Hospital-onset positive CDI cases is arranged with the *Clostridium difficile* Ribotyping Network (CDRN) to determine if cross infection has taken place within clinical areas and to identify the specific organism type. This confirmed there was no cross infection with any of the 20 cases reported.

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	Apr 17 – Sep 17	Oct 17 – Mar 18	Apr 18 – Sep 18

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	3001	705,564	3472	730,151	3308	731,348
Rate of all incidents per 1,000 bed days	34.19	N/A	33.79	N/A	38.27	N/A
Number of incidents resulting in Severe harm or Death	21	2,482	32	2,522	29	2,477
Percentage of total incidents that resulted in Severe harm or Death	0.70%	0.35%	0.92%	0.35%	0.88%	0.34%

Source: www.improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-data/

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

To be added

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:

To be added

Part 3

3. Review of quality performance

2018/19 has been a successful year in relation to the three domains of quality:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

3.1 Patient Safety

Safeguarding Adults and Children

The safeguarding agenda is immense and the responsibilities are broad and far reaching. The Trust has effective partnership working arrangements in place and systems, processes and policies are constantly reviewed to ensure compliance with local and national guidance. Safeguarding for adults and children has clear lines of accountability, well defined structures and clarity about roles and responsibilities. A dynamic work plan is in place to support the realisation of the safeguarding agenda which is monitored through strong governance arrangements. There is recognition by our organisation that safeguarding all our patients is everybody's business.

Within the Trust, the Safeguarding team continue to work towards the training standards set by the Intercollegiate Documents for Safeguarding Children and Adults. A safeguarding training strategy is in place and is regularly monitored by the Safeguarding Committee. Risks, when identified, are being managed effectively and audits carried out to monitor effectiveness and identify areas for improvement.

<u>Key Achievements for 2018</u>

- The Safeguarding Children Team have been instrumental in facilitating the implementation of the Child Protection Information Sharing System (CP-IS) throughout the maternity settings within GHNFT. CP-IS went live throughout the urgent care settings within the Trust in June 2017, followed by implementation of CP-IS throughout the Trust's maternity settings in March 2018.
- The Children's Cause for concerns forms are now completed by staff electronically via the Datix system, rather than by paper forms. This system has been embedded well throughout 2018.
- The Safeguarding Children team historically shared a safeguarding database with South Tyneside Foundation Trust. Due to the changes in commissioning of the 0-19 Service, the database was de-commissioned in June 2018 and the Safeguarding Children Team have implemented a Trust safeguarding database.
- A briefing paper was provided to the Trust Board in September 2018 to provide assurance to the Board that the Trust has a planned response to the Newcastle Joint Serious Case Review Recommendations. This response includes the Named Nurse for Safeguarding Children and the Strategic Lead for Adults being involved in the Gateshead Action Plan and also implementation of a Sexual Exploitation and Grooming Risk Identification Checklist within the Emergency Care Settings.
- In response to Recommendation 10 from Newcastle Joint Serious Case Review a 'Sexual Exploitation and Grooming Risk Identification Checklist' was launched throughout the urgent care settings in November 2018. The aim of this tool is to be used by practitioners that have 'time limited' contact with patients (*Emergency Care/Walk in Centre Staff)*, to help them quickly

identify risk of sexual exploitation and grooming. Girls are Proud, Men are Proud (GAP MAP) provided some bespoke training sessions to staff in the emergency care settings prior to the implementation of the new Sexual Exploitation and Grooming Risk Identifier tool.

- The Government Agenda for PREVENT has continued to be highlighted with Workshops to Raise Awareness of Prevent (WRAP) training transferred to e learning as mandatory training for identified staff.
- Mental Capacity Act (MCA) has been identified as a priority area for awareness in light of the changing legislation and a new post for MCA and Deprivation of Liberty (DoLs) Lead has been approved for appointment in 2019.
- The safeguarding adult team appointed a Domestic Abuse (DA) advisor in April 2018, a post funded by Police and Crimes Commissioner, to provide support and training to the staff of the trust with identification of adults and children at risk. The DA advisor works with community partners and attends Multi Agency Risk Assessment Conference (MARAC) meetings for individual case discussions. A training programme was commenced in October 2018 and identified champions will be recruited for 2019.
- The Safeguarding Children and Adult Teams launched a Quarterly Safeguarding Newsletter in July 2018. The aim of the newsletter is to keep staff updated quarterly with key safeguarding information and support staff with their safeguarding responsibilities.
- The Safeguarding Children and Adult teams hosted a Joint Safeguarding Conference at the Trust's Education Centre in September 2018. The Conference was organised by the Children and Adult Safeguarding Teams as a collaborative project to raise the awareness of the diverse range of areas covered by Safeguarding and that Safeguarding is 'Everyone's Responsibility'. 102 delegates attended the conference from a wide variety of disciplines within the Trust along with colleagues from the Local Authority Safeguarding and Housing, Police and Probation services.

Early recognition and prompt treatment for patients with Sepsis

Early recognition and prompt treatment for patients with sepsis remains a high priority for the trust. Sepsis is the body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure, and death. The Trust continue to reach targets for Commissioning for Quality and Innovation (CQUIN). The key achievements this year include:

- Sepsis Steering group meetings
- Mortality & Morbidity Meetings - reporting to the group
- Representation at regional Deteriorating Patient group
- Review of data from North East Quality Observatory Service and National SOS dashboard
- Collaboration with Sepsis team at regional and national platforms
- Electronic Sepsis pathway

Training and Education

- Development of competency based assessment for qualified nurses and midwifes with accompanying work book
- Sessions for junior doctors at induction and at various levels within their teaching programme.
- Sessions at corporate induction
- Preceptorship training
- Maternity teaching monthly

- Three half day teaching sessions
- Ward based training
- Each ward and department has identified Sepsis Champions to provide support and promote best practice within their areas.
- Critical care event 56 staff trained within one week

Sepsis trolley teaching

Due to increasing pressures on ward staff we wanted to develop a series of educational tasks/games that could be delivered quickly and within ward areas that did not require staff to be released from the clinical area. A trolley was purchased which has all its own resources. The sessions take 25 minutes and also incorporate information on National Early Warning Score 2 and delirium. So far over 200 staff have been trained using the teaching trolley.

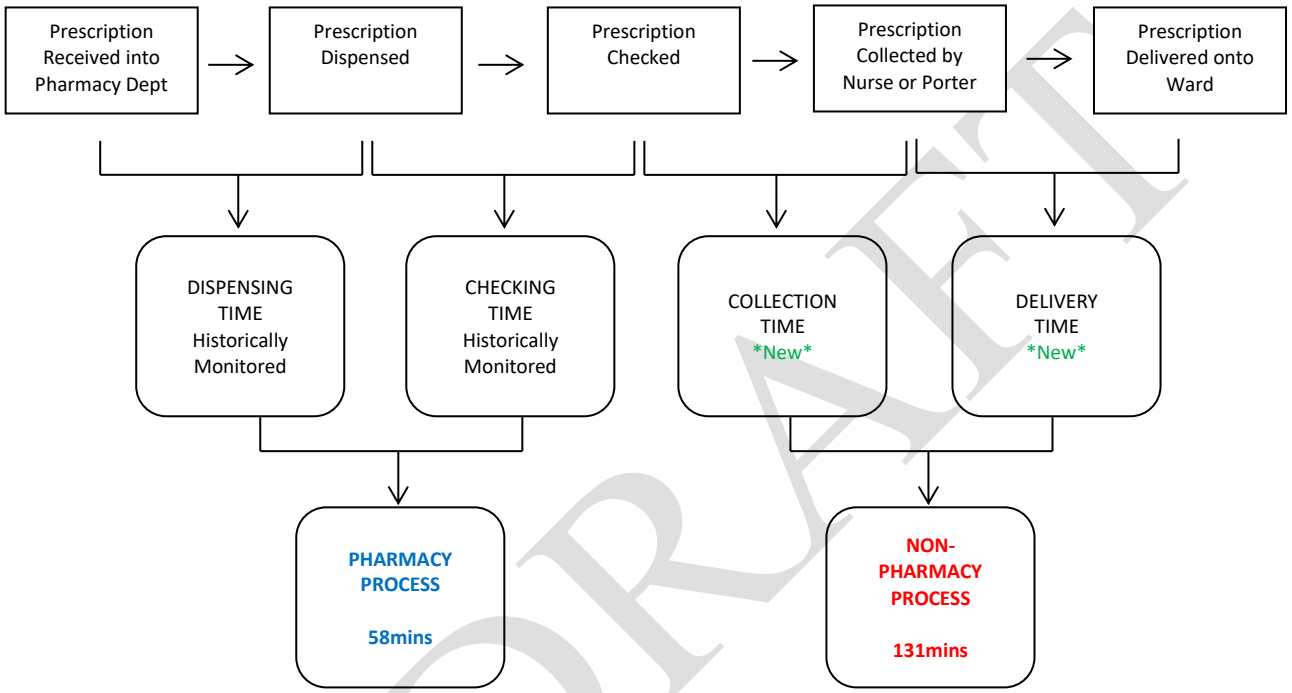
Sepsis celebration day

60 staff attended and session evaluated very well comments included, good networking excellent presenters

Medicines Management - Improving Discharge Medicines Delivery to Wards

Introduction

The Pharmacy has been for many years actively tracking the dispensing and checking of discharge prescriptions in the department, which has enabled wards and clinical areas to remotely view progress with individual items. Recently, as part of a broader piece of work we have been progressing extending our tracking system to allow visibility of discharge prescription collection and delivery (see diagram below for process map).



Problem

This data highlighted that the Non-Pharmacy Process was taking in excess of the value-added Pharmacy Process. Further data analysis demonstrated that this prolonged wait was largely due to the lack of a Porter delivery at a key point in the afternoon.

Solution

In response to this data, we liaised with the Portering Service to introduce an additional delivery each day.

Outcome

A re-audit post-implementation of this additional delivery has shown that the Non-Pharmacy process time has dropped on average to 57 minutes.

This represents a **57% reduction** in the delay in Discharge Prescriptions being delivered to the wards after the Pharmacy Process is completed.

This additional Delivery Time is now embedded in the normal Portering Schedule ensuring that there is minimal delay in the discharge of patients from the hospital due to waiting for medicines.

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 associated urinary tract infections (CAUTIs)
- Venous Thromboembolism (VTE)

The results from the audit 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-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sample	866	703	775	747	744	785	690	714	715	690	758	667
Surveys	32	31	30	31	32	31	30	30	30	31	30	31
Harm free	97.0%	93.3%	97.3%	96.4%	95.7%	96.2%	96.5%	96.4%	96.4%	96.8%	96.4%	95.7%
Pressure Ulcers - All	2.1%	2.4%	1.4%	2.3%	3.2%	2.7%	2.9%	2.7%	2.2%	2.3%	2.5%	3.2%
Pressure Ulcers - New	0.5%	0.6%	0.1%	0.5%	0.3%	0.6%	0.1%	0.8%	0.3%	0.7%	0.4%	0.9%
Falls with Harm	0.6%	0.7%	0.3%	0.5%	0.4%	0.3%	0.3%	0.4%	0.7%	0.6%	0.7%	0.5%
Catheters and UTIs	0.6%	0.4%	1.0%	0.8%	0.7%	0.5%	0.3%	0.7%	0.7%	0.4%	0.5%	0.8%
Catheters and New UTIs	0.4%	0.4%	0.9%	0.5%	0.4%	0.5%	0.3%	0.6%	0.7%	0.3%	0.5%	0.5%
New VTEs	0.1%	0.1%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
All Harms	3.0%	3.7%	2.7%	3.6%	4.3%	3.8%	3.5%	3.6%	3.6%	3.2%	3.6%	4.4%
New Harms	1.5%	1.9%	1.3%	1.6%	1.1%	1.8%	0.7%	1.8%	1.7%	1.6%	1.6%	1.8%

- **Pressure Damage**

The NHS Safety Thermometer asks the organisation to record the patient's worst old pressure ulcer and worst new pressure ulcer. An 'old' pressure ulcer is defined as being a pressure ulcer that was present when the patient came under our care, or developed within 72 hours of admission to our organisation. A 'new' pressure ulcer is defined as being a pressure ulcer that developed 72 hours or more after the patient was admitted to our organisation.

Over the last 12 months we have consistently achieved a prevalence rate of 0.8% or less for new pressure ulcers that have developed whilst the patient has been under our care. This has been achieved due to the tremendous work that has been undertaken 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 incorporate Community Services. 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**

The Safety Thermometer asks the organisation to record the severity of any fall that the patient has experienced within the previous 72 hours in a care setting (including home if the patient is on a district nursing caseload). A fall is defined as an unplanned or unintentional descent to the floor, with or without injury, regardless of cause (slip, trip, fall from a bed or chair, whether assisted or unassisted). Patients 'found on the floor' should be assumed as having fallen, unless confirmed as an intentional act.

Over the past 12 months we have achieved a prevalence rate of 0.7% or less for those patients who have suffered harm as a result of a fall. Staff are committed to reducing patient falls and are supported by the Practice Development and Falls Team to actively take ownership of improving patient falls risk assessments and monitoring processes.

Falls Prevention week continues to be held annually. The initiative has been well received by staff which has also included a public engagement event in which visitors, patients and staff were asked for their opinions on how the Trust could reduce the incidence of in-patient falls. Improvement methodologies are currently being introduced in two in patient areas as a structured Falls Collaborative.

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

The Safety Thermometer asks the organisation to record whether the treatment started before the patient was admitted to our organisation (old) or after the patient was admitted to your organisation (new).

Over the last 12 months we have achieved a prevalence rate of 0.9% 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 utilizing 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. Daily surveillance continues for those patients' who have grown an organisms and a review of both the patient and documentation at the bedside.

- **Venous Thromboembolism (VTE)**

The NHS Safety Thermometer asks the organisation to record whether or not a patient is being clinically treated for VTE of any type. A patient may be defined as having a new VTE if they are being treated for a deep vein thrombosis (DVT), pulmonary embolism (PE) or any other recognised type of VTE with appropriate therapy such as anticoagulants. If treatment for the VTE was started after the patient was admitted to our organisation, it is counted for this measure as a new VTE

Over the last 12 months we have consistently seen a very low prevalence rate of less than 0.3 % and eight months when we have seen no VTE'S to declare. This 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.

- **Monitoring our results**

As an organisation we will continue to capture data across the four areas of harm, using the NHS Safety Thermometer as a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. The Trust is performing well above the national average for harm free care in comparison to other organisations achieving 96.4% in February 2019 in comparison to the national average of 93.9%. It is possible to take assurance from the safety thermometer data that reduction in overall harm is declining.

3.2 Clinical Effectiveness

Health Records Audit

The aim of this multidisciplinary audit undertaken on a monthly basis is to assess the compliance with basic record keeping standards, identify areas of good practice and highlight and address areas for improvement. Every professional member of staff is required to audit one set of case notes each month (real time) using an electronic audit tool (available to everybody on the intranet). The core standards are displayed in a dashboard across all disciplines to make comparison as easy as possible.

Uptake of this year's audit has been steady throughout the year with a total of 2,315 individuals participating. Examples of positive results for 2018 include:

- Legibility of every entry record
- Documents filed within the record in the correct location
- Documentation assist with patient care all achieved consistently high 98% or higher throughout the year for each discipline.
- "Consent" results for this year – only 31 of the 313 (10%) cases audited by medical staff had the need for consent, which were 100% complaint with the consent process, the patient was offered a copy of the consent form in 63% of cases.
- The continuing significant area for concern across the disciplines relates to errors, all aspects of this element were poor across seven of the eight disciplines.

In addition to the criteria for this audit, the Clinical Effectiveness Team undertake a visual inspection of the cases notes we hold within the organisation. 95 case notes are inspected per month, five sets of notes from each ward for the physical state of the patient's record.

Nutrition – Improvement Collaborative

The Trust joined the second NHS Improvement (NHSI) Nutrition Collaboration in September 2018. Allied Health Professionals (AHPs), nurses, house keepers and catering were able to work together towards achieving the three main goals as detailed below:

Goal One:
On two wards:
a) Improve the Malnutrition Universal Screening Tool (MUST) scores by 20% before June 2019.
b) Provide assurance the MUST care plans are implemented fully according to level of malnutrition risk

Goal Two:
a) To implement the International Dysphagia Diet Standardisation Initiative (IDDSI) across Trust by April 2019
b) Implementation of Risk Feeding across hospital and community, with new policy and patient information leaflet by June 2019

Goal Three:
Reformat of the Nutrition Steering Group to provide the Governance and Assurance required for Regulation 14 to the SafeCare Council and the Trust Board by June 2019

Goal 1 has been achieved fully, with extra benefits of 'making nutrition fun', streamlining activities on Ward 4 to enhance mealtimes for our patients.

Goal 2 is fully implemented across the Hospital, Community with 2a in Care Homes.

An addition to goals one and two, has been the continued work of education and training across the care homes of Gateshead. This was started in 2017 by Vanguard commissioned by Clinical Commissioning Group.

Goal 3, work has commenced but requires further meetings to be completed by June 2019.

This work has been showcased to the NHSI and celebrated with the NHSI Nutrition Collaborative in London. The biggest celebration of this work was the collaborative working of AHPs, ward staff and Catering with the constant help from NHSI that has shown an improvement to patient care and safety.

The improvements in care and quality will continue on three wards at a time over the next two years to ensure sustainability.

3.3 Patient Experience

‡Friends and Family Test

We continue to apply the Friends and Family Test (F&FT) within the inpatient wards, outpatient 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	2016-17	2017-18	2018-19	National 2018-19*
A&E	95.1%	95.1%	94.1%	86.7%
Inpatients & Day cases	97.2%	97.8%	98.4%	95.8%
Maternity - Antenatal	98.8%	98.1%	99.5%	95.3%
Maternity - Delivery	98.6%	98.5%	98.8%	96.9%
Maternity - Postnatal Ward	97.8%	98.0%	99.1%	95.0%
Maternity - Postnatal Community	100.0%	100.0%	100.0%	97.7%
Outpatients	96.2%	97.4%	97.6%	93.9%
Mental Health	99.7%	99.1%	99.4%	89.4%
Community	-	98.3%	96.4%	95.5%

Friends and Family Test Response Rate	2016-17	2017-18	2018-19	National 2018-19*
A&E	35.4%	24.0%	21.0%	12.3%
Inpatients & Day cases	28.5%	27.1%	24.3%	24.7%
Maternity - Antenatal	3.8%	6.0%	11.4%	N/A
Maternity - Delivery	44.0%	32.8%	46.2%	21.1%
Maternity - Postnatal Ward	45.3%	30.0%	42.4%	N/A
Maternity - Postnatal Community	7.8%	5.4%	5.4%	N/A

* published data Apr-18 to Feb-19

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

The National Patient Survey Programme

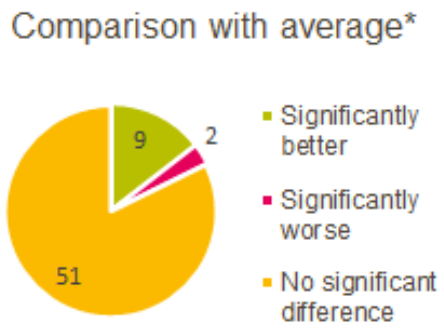
The National Patient Survey Programme comprises the annual adult inpatient survey and maternity survey and in rotation the community mental health survey, A&E survey, children & young people survey and the outpatient survey. These national surveys are valuable sources of information on various aspects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

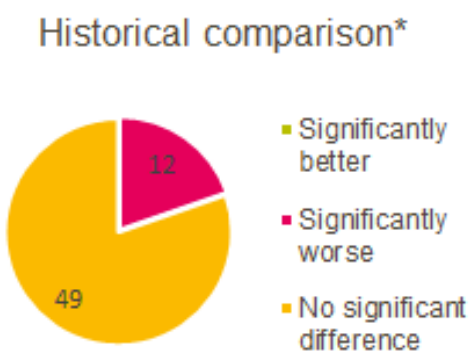
Adult Inpatient Survey 2018

There were 77 Trusts commissioned to undertake the 'Picker' inpatient survey in 2018. 1,250 patients from our Trust were sent a questionnaire of which 593 were returned. This gave us a response rate of 49%; this is above the average response rate of 43% of the other 76 Trusts taking part in the Picker survey.

In relation to overall positive score, we are ranked number 19 out of 77 trusts who took part in the Picker survey.

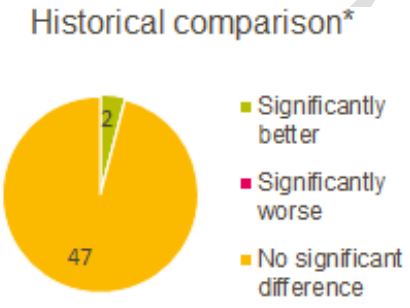
Historical comparison

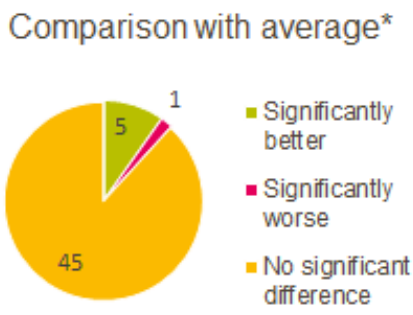




Maternity Survey 2018

There were 69 trusts commissioned to undertake the 'Picker' Maternity Survey in 2018. 115 eligible patients responded. This gave us a response rate of 39% this is slightly above the average response rate of 36% of the other 68 trusts taking part in the survey.





Good results:

- 83% were given a choice of where to have their baby
- 100% said that the midwives listened to them during their antenatal care
- 96% felt that their partner was involved in their care during labour and birth
- 99% said that they were treated with respect and dignity.

In relation to overall positive score, we are ranked number 14 out of 69 trusts who took part in the Picker survey.

National Cancer Patient Experience Survey 2018

The National Cancer Patient Experience Survey was first undertaken in 2010. It was designed to monitor national and local progress on cancer care, providing information to drive quality improvements. This is the 7th National Cancer Patient Experience Survey that has been published.

Since the 2016 survey the CQC standard of reporting comparative performance, based on calculations of 'expected ranges' have been adopted. This means that the Trust would be flagged as an outlier if their scores deviate from the range of scores that would be expected from a Trust of the same size.

As a Trust we scored within the expected range in all of the questions asked. We scored on or above the expected upper range in 22 of the 52 questions and above the national average in 49 of the 52 questions. Importantly when our patients were asked to rate their care on a scale of zero to 10, respondents gave an average rating of 9.1, this is a slight increase on last year.

The key achievements are as follows:

- 90% - of respondents said that there were seen as soon as necessary
- 98%- of respondents said that they received all of the information they needed about their test
- 97% - of respondents said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment
- 89% - of respondents said that it had been 'quite easy' or 'very easy' to contact their Clinical Nurse Specialist
- 94% - of respondents said that, overall, they were always treated with dignity and respect while they were in hospital
- 97% - of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital

The following actions will be taken as a result of the survey findings:

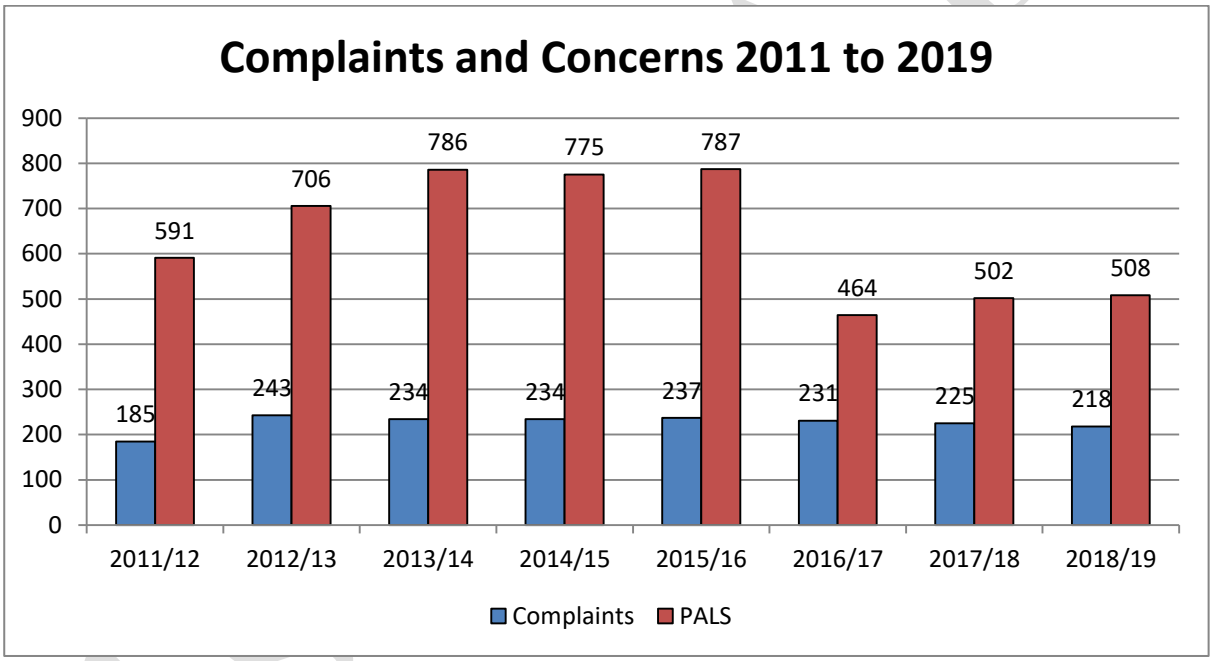
- Share National Patient Survey results through cancer leads group
- Share patient comments to site specific tumour groups / MDT leads and Service level managers for reflection of good practice and learning
- Ensure patient information book (green pocket folder) is actively used by the cancer nurse specialists to all new diagnosis and contains appropriate general information
- Continue discussion with Macmillan Cancer support and CCG Cancer Group regarding access to financial advice & support for cancer patients and explore models to implement improvements.
- Continue to participate in national audit annually

Listening to Concerns and Complaints, Compliments

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 2018/19 we received a total of 218 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 2018/19 the top five main reasons to raise a formal complaint were in relation to:

- Communications (46 complaints).
- Clinical Treatment – Surgical Group (43 complaints).
- Clinical Treatment – General Medical Group (42 complaints).
- Clinical Treatment – Accident & Emergency (29 complaints).
- Values & Behaviours (Staff) (13 complaints).

Complaints Performance Indicators	Total 2018/19
Complaints received	218
Acknowledged within three working days	218
Complaints closed	199
Closed within agreed timescale (eight weeks)	82
Number of complaints upheld	159
Concerns received by PALS	508

Complaints Indicators	Total 2018/19
Number of closed complaints reopened	42*
Number of closed complaints referred to Health Service Ombudsman	7

Outcome of complaints referred to Health Service Ombudsman (HSO)	Total 2018/19
Awaiting decision	2 (1 referred 17/18)
Complaints upheld	0
Part upheld	3 (referred 17/18)
Declined to be investigated	6

***Number of closed complaints reopened.**

In the year 2018/19 there were 42 closed complaints which were reopened. This compares to 46 in 2017/18. The number had been under-reported for a number of years previously. Reasons for reopening cases include where the complainant has additional questions/concerns. They may request a meeting or the meeting may have been offered in the response. Of the 42:

Two were complaints initially raised in 16/17
11 were complaints initially raised in 17/18
The remaining 29 were raised in 18/19.

The 42 included seven meeting requests.

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

- The Endoscopy Department made changes to the format of their appointments as a result of complainant feedback. Patients will be asked about surgically placed metal work i.e. pins, plates, joint replacement in their body at the beginning of the procedure and again if they identify any polyps and plan to remove them. Patients will be asked prior to entering the room if they would like music played during procedure.

- In relation to missed fractures, individual cases have been used within teaching sessions with the Emergency Department Junior Doctors.

- In response to issues identified around patients being discharged inappropriately, particularly around the attire that they are dressed in, a number of initiatives have been implemented.

Firstly, the trialing of foil blankets to be used under normal blankets to assist keeping patients warm. The discharge checklist has been updated to include a step to check that the patient is wearing suitable attire for discharge and lastly these issues have been raised with the Trust's internal ambulance service to ensure they are transporting patients in appropriate attire.

- In one complaint there were concerns surrounding diagnosis of melanoma not followed through to treatment within given time. As a result of this case, work has commenced with the Lead for Cancer working across all the cancer specialties at the Trust to identify different pathways for patients having to move to different organisations due to their provisional diagnosis and need for treatment.

- As a result of a number of issues with the interpreting service, the Trust is shortly to move to a different language and translation service.

- As a direct result of the investigation into a patients laparoscopic cholecystectomy, the Consultant will insist that the standard practice for patients undergoing laparoscopic cholecystectomy under his care will be removal of the gallbladder via the epigastric port site, which will mean that the port site can be inspected from within the abdomen after the laparoscopic port has been removed, and then should bleeding occur, steps to control this will be able to be taken. Consultant will ensure this reflection and learning is shared with his colleagues.

- As a result of concerns raised about the shower on ward 4 being used as a storage facility for a number of chairs, the Chief Matron carried out an inspection of Ward 4 and provided assurances that all equipment and chairs are stored in appropriate storage areas and the showers are free of inappropriate equipment.

- As a result of concerns raised regarding the attitude of a nurse practitioner at Blaydon Walk in Centre, all members of the team at Blaydon were reminded of the importance of caring communication and to be aware of how they present themselves and how manner and tone can be perceived by patients and relatives using the service.

- A complaint was raised around incorrect dosage of medication given resulting in patient having to be cared for in the Critical Care department. As a result the Sister reflected on her actions and acknowledged she did not follow the Trust policy, which would have been to check the dosage on the medication label. As part of her own reflection she spoke to the staff at the Ward meeting to address her mistake. She has also initiated teaching sessions for qualified staff and student nurses, addressing her own error so they can learn from this as well as the need to follow policy at all times. Of her own volition, she also attended one of the Trust's SafeCare meetings to take the error to the wider teams within the hospital such as medical staff and other Ward managers, to promote shared learning and support service improvement. The ward now has a designated nurse on duty each shift who receive all deliveries from Pharmacy and places them into the appropriate allocated slot in the Omnicell cabinet.

During 2018/19 the Patient Advice and Liaison Service (PALS) received 854 compliments.

Business Unit	Number of Compliments
Medical Business Unit	302
Surgical Business Unit	161
Clinical Support and Screening Business Unit	211
Community Based Services	180
Total	**854**

"*I would like to take this opportunity to acknowledge the care and treatment I received as an inpatient on treatment centre level 2. As a member of staff I was able to appreciate the service from the perspective of a patient and can confidently say I have absolute reverence in the provision provided by QE Gateshead. The Sister and her entire team went above and beyond to promote my comfort. I was always made to feel at ease and nothing was too much trouble. I would also like to extend my gratitude to the theatre/recovery staff and anaesthetist; whose reassurance made a world of difference*".

"*I am writing to say what an excellent service your minor injuries clinic provides. I popped in on Thursday evening at around 5.30pm after what I thought was a sprained ankle didn't seem to be healing three and a half weeks after the injury. I had prepared myself for a lengthy wait but was happy to do so – better to wait a long time with a minor injury than have something so serious as to warrant immediate treatment*".
"*Within about five minutes of booking in I was called into see the triage nurse. She took my details and advised that I would be seeing the minor injuries nurse practitioner and that it was only a short wait. She wasn't exaggerating. I was called into the nurse practitioner within ten minutes. She was lovely (I'm afraid I've forgotten her name), examined my injury and sent me along for an x-ray again. Again I only waited five to ten minutes to be seen*".

"*Once out of x-ray it was the longest wait of my visit – about 15 minutes to see the nurse practitioner again who advised that there was an abnormality on the x-ray and she would ask the on call orthopaedic registrar to check it over. The online system meant that they didn't even have to leave the ward where they were working. Another ten minutes or so and the fracture was confirmed. I was speedily fitted with a support boot and discharged with a virtual appointment in the fracture clinic*".

"*I had a double knee osteotomy under the care of Mr E at the end of January 2018. From the beginning the care and communication was fantastic. Big thanks to Mr E, his secretary S, the pre-op staff, Peter Smith Surgery Centre staff, Dr K and his team. The care on Ward T26 and physiotherapy was amazing. The food was not bad at all. I'm going for a six week appointment next week, where hopefully I can start to put my foot down and subsequently walk again. Keep up the good work*".

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.

Staff Engagement

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, encouraging staff to share ideas and concerns through a range of mechanisms including the Freedom to Speak Up Guardian, using the Friends and Family Test, as well as professional forums, away days and annual conferences.

Formally, the Trust has a Joint Consultative Committee (JCC), which is the key mechanism for consulting with our employees across the organisation. 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. In addition we have held a Partnership Away Day in 2018 to bring together trade union and employer representatives in a more informal setting, with a focus on learning together.

The JCC is 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.

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.

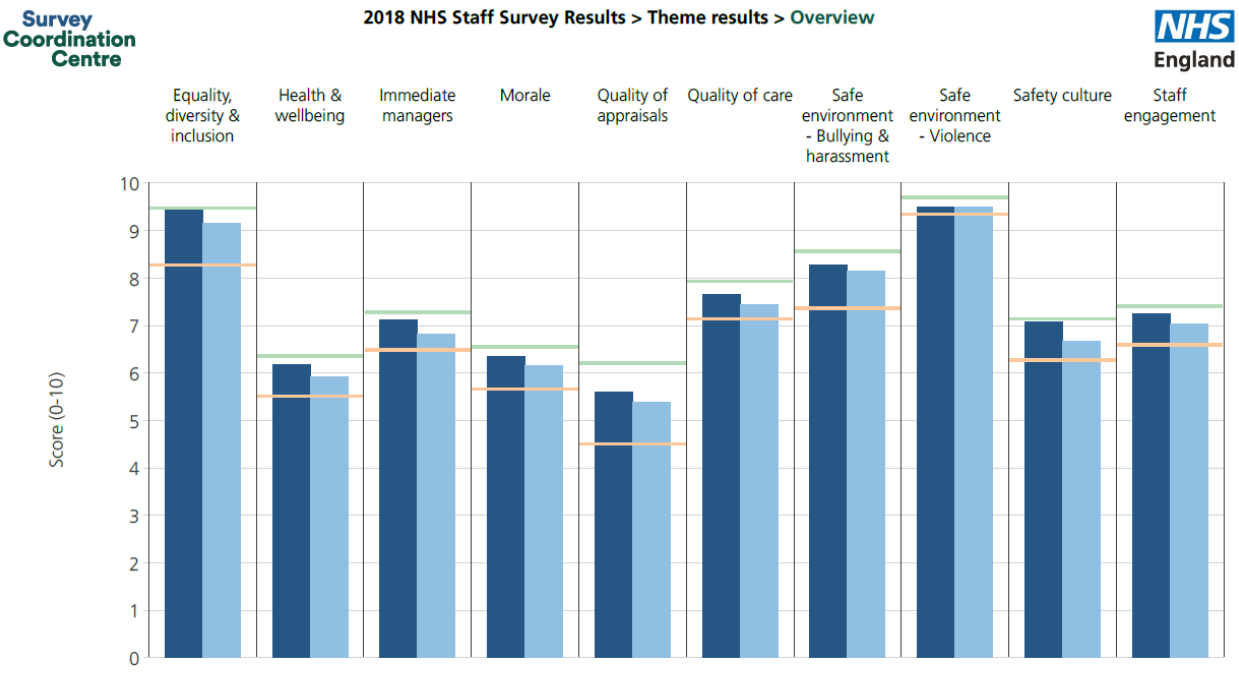
The arrival of over 600 community staff into the Trust has resulted in a shift in the profile of the Trust in line with the national survey co-ordination centre for the last 2 years. The Trust is now classified as a 'Combined Acute and Community Trust', rather than an 'Acute Trust'.

This year the Trust chose to include all staff in the Staff Survey for the fourth consecutive year (not using a sample) to give everyone the opportunity to provide feedback. Additionally, this year staff surveys were delivered to staff electronically rather than a mixture of paper-based and electronic. Our response rate is illustrated in the table below.

	2016/17		2017/18		2018/19		Trust comparison to previous year
Response rate	**Trust**	**National average**	**Trust**	**National average**	**Trust**	**National average**	
	39%	43%	44%	43%	40%	41%	4% decrease

The slight decline in the response rate, whilst reflective of the national trend could be due to all staff receiving their surveys electronically for the first time. Work is planned for the 2019 survey in order to provide support for staff that may be less confident with IT and looking at innovative ways to enable and encourage staff to complete surveys.

Previously staff surveys were organised against 32 key indicators. This year, driven nationally, the results are organised into 10 key themes. The Trust performed very well scoring above average in 9 out of the 10 key themes. Gateshead was the best Acute and Community Trust for equality, diversity and inclusion and for safety culture. The full results are below:



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.5	6.4	7.3	6.5	6.2	7.9	8.6	9.7	7.1	7.4
Your org	9.5	6.2	7.1	6.3	5.6	7.6	8.3	9.5	7.1	7.3
Average	9.2	5.9	6.8	6.2	5.4	7.4	8.1	9.5	6.7	7.0
Worst	8.3	5.5	6.5	5.7	4.5	7.1	7.4	9.3	6.3	6.6
No. responses	1,396	1,400	1,406	1,395	1,200	1,249	1,398	1,393	1,397	1,413

Following the publication of the 2017 survey results, the Trust set two-year objectives to give us sufficient time to make changes and demonstrate progress. They were to:

1. Improve staff motivation
2. Improve reporting (of bullying and/or violence)
3. Aim for all staff to agree that their role makes a difference to patients

At this 1-year stocktake, there has been a slight increase in staff feeling motivated in going to work and static reporting of staff understanding the impact their role has on patients/service users at 90.8%. There has been a deterioration in the percentage of staff/colleagues reporting experiences of violence or harassment/bullying therefore we will continue to work to improve this in pursuit of a culture of openness.

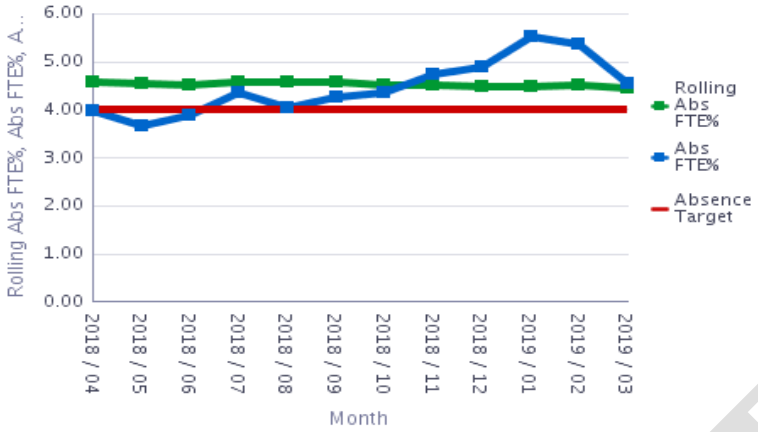
The Trust achieved very positive scores on two key questions focused on by the CQC:

Question Number	Question	Comparison to 2017 Trust score	Comparison to average
21c	I would recommend my organisation as a place to work	0.9% increase	10.9% above average
21d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	0.6% increase	11.4% above average

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, such as a fun pedometer team challenge to encourage staff to be more active.

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 2018/19 we have seen sickness absence plateau just over 4.5%, which, whilst above our target of 4% has not increased. We continue to focus on a multi-factoral approach to prevention as well as absence management, particularly in relation to mental wellbeing, our highest reason of sickness absence.



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 2018 – 31st March 2019 we have provided 5778 appointments for staff which can be broken down as follows:

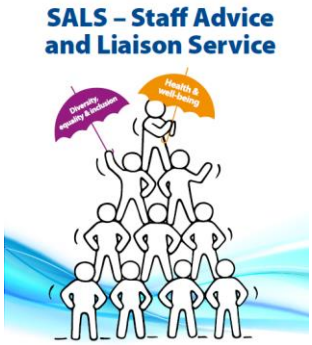
- ✓ 517 counselling appointments
- ✓ 1285 pre-employment screening appointments
- ✓ 1688 vaccination/immunisation screenings
- ✓ 320 ergonomic and workplace assessments
- ✓ 1204 sickness absence management appointments
- ✓ 201 other consultations
- ✓ 121 appointments associated with sharps injuries
- ✓ 380 physiotherapy referrals
- ✓ 62 health Surveillance appointments

In 2018/19 we were also delighted to see that 80% of our staff chose to have their flu vaccination, to protect themselves, their family and our patients and visitors.

During 2018 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 training session for line managers which aims to enable managers to feel confident in supporting the mental well-being of the people in their teams.

In 2018 we trained a number of employees to act as 'diffusers' within various departments across the Trust. In the event of a traumatic incident on a ward or in a department, a 'diffuser' can provide an immediate de-brief to members of staff who are affected. The support which is provided, aims to ensure that staff feel supported in the period immediately following an incident.

During 2018 we have introduced the Staff Advice and Liaison Service (SALS) which brings together a range of support services which are available to staff. The Trust is committed to making sure that staff can access the support they need, when they need it, and complements our goal of improving communication, and living our values of openness and



engagement. SALS will be further promoted and embedded through 2018/19.

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.

Living Our Values

NHS
Gateshead Health
NHS Foundation Trust

Remember the acronym ICORE

– Innovation, Care, Openness, Respect and Engagement

I INNOVATION

- Look for better ways to do things
- Embrace new ways of working
- Continually develop ourselves
- Uphold a service ethos

C CARE

- Put ourselves in other people's shoes
- Be approachable
- Be sensitive and considerate
- Listen, respond and support

O OPENNESS

- Be honest
- Be courageous
- Admit mistakes
- Share information
- Do the right thing

R RESPECT

- Value the skill and contribution of others
- Treat each other fairly and reasonably
- Appreciate and embrace difference
- Be polite and helpful
- Maintain dignity of others

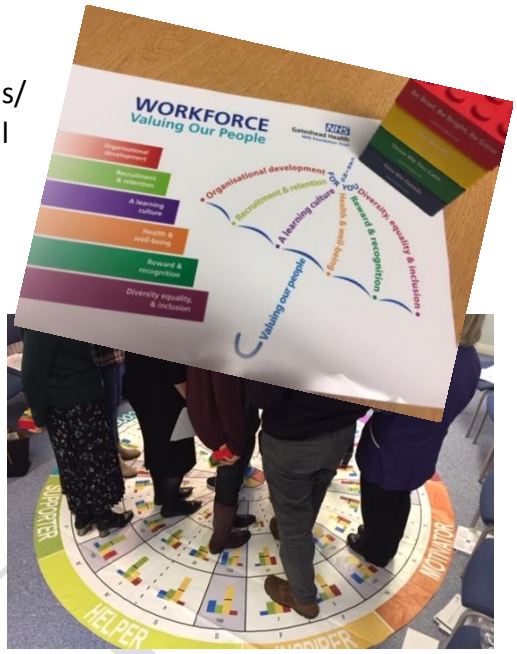
E ENGAGEMENT

- Involve others
- Listen
- Work together
- Share information and resources

(* 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, as well as the wider Gateshead System
- Engaging over 100 staff from multiple professions within Mental Health Services to improve the delivery of quality services
- Encouraging and embedding the use of Insights Discovery Model as a way 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
- Redesigning the Appraisal process and roll out of new training for staff and managers



Recruitment and Retention

At the end of 2018/19 we employed 4533 people. The number is broken down as follows:

PROFESSION	
Additional Professional, Scientific and Technical	184
Additional Clinical Services	828
Administrative and Clerical	934
Allied Health Professionals	298
Estates and Ancillary	521
Healthcare Scientists	168
Medical and Dental	321
Nursing and Midwifery Registered	1276
Students	3
Total	**4533**

As at 31st of March 2019 our Board of Directors was 57.2% male and 42.8% female. There are two senior managers within the Group who are not included in the above Board statistics who are both male.

A comparison of our workforce is provided below:

	2017/18	%	2018/19	%
AGE				
17-21	107	2.44	111	2.45
22+	4279	97.56	4422	97.55
ETHNICITY				
White	4126	94.07	4223	93.16
Mixed	19	0.43	20	0.44
Asian or Asian British	120	2.74	137	3.02
Black or Black British	40	0.91	40	0.88
Other	24	0.55	29	0.64
Not Stated	57	1.30	84	1.85
GENDER				
Male	831	21.23	952	21.00
Female	3455	78.77	3581	79.00
RECORDED DISABILITY				
	167	3.81	242	5.34

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 2018/19 the Trust hosted 134 placements, 36% for the medical shadowing programme. We also hosted a Careers Event for one local school in 2018 inviting over 100 students from Year 12 into the Trust to showcase a range of careers within the NHS.

Policies and Practices to support diverse groups

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. During 2018/19 we have hosted over 10 Project Choice work experience placements in a number of different areas including Screening Services, Health Records and Bensham Café. Following a successful and positive placement, one individual has subsequently been offered a post with within our Booking and Referrals Centre.

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. Our recruitment 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. In 2018 the Trust started working with the Access to Work Mental Health Support Service. This confidential service delivered by two specialist support providers - Remploy and Able Futures, and funded by the Department for Work and Pensions - is available at no charge to any employees with depression, anxiety, stress or other mental health issues (diagnosed or undiagnosed) affecting their work and provides support to help individuals remain in work.

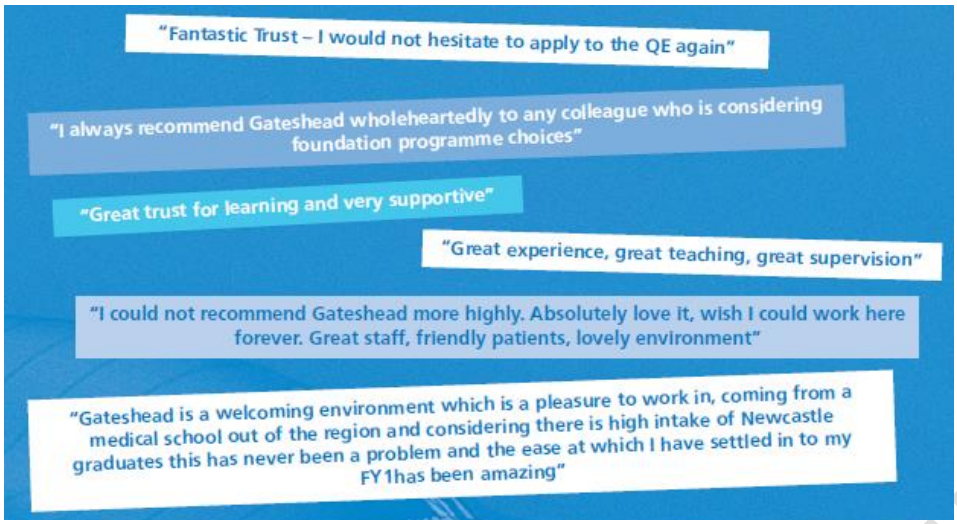
In 2018 the Trust had its status as a Disability Confident Employer confirmed for another two years. The status is awarded by the Jobcentre Plus to employers who have agreed to make certain positive commitments regarding the employment, retention, training and career development of disabled people. In continuing to hold the Disability Confident Employer status, the Trust is ensuring that disabled people and those with long term health conditions have the opportunities to fulfil their potential and realise their aspirations.

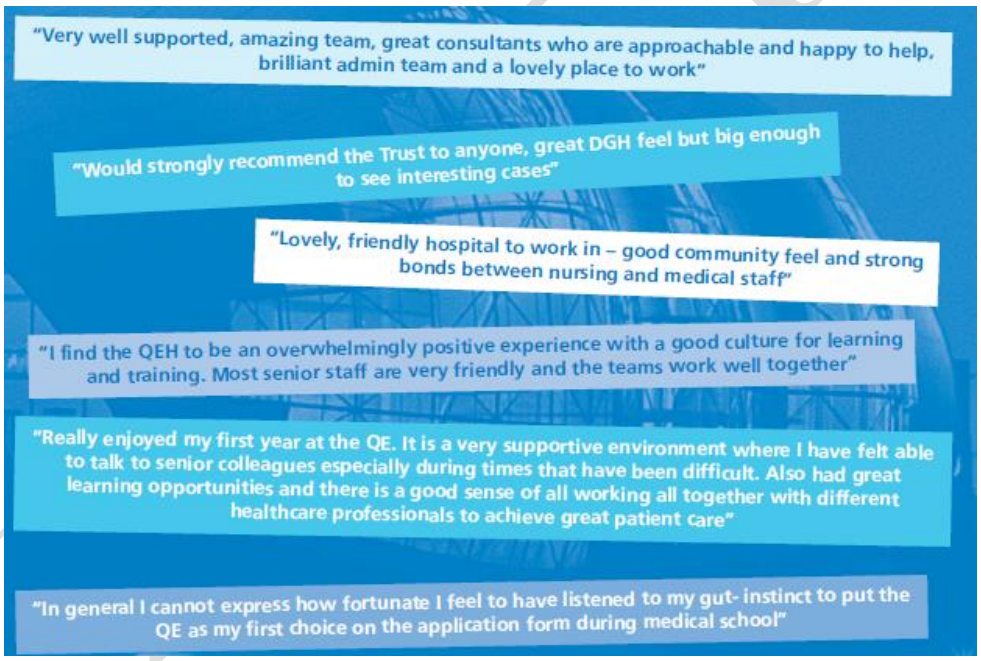
We are a Mindful Employer, which demonstrates our commitment to supporting staff who experience stress, anxiety, depression or other mental health conditions. As part of this charter, we raise awareness and share information to support both existing and prospective employees.

A Learning Culture

Library and Knowledge Services maintained a score of 97% compliance in the Library Quality Assurance Framework (LQAF) assessment, resulting in a green quality assurance status. Access to resources and support for study, research and professional development from hospital, community or home has been improved through redevelopment of the library website, introduction of a Discovery search tool, and expansion of print and digital collections.

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 the 'Your School Your Say' survey in 2018, 92.5% of our foundation trainees would recommend the Trust to a friend who was thinking about becoming a doctor, based on our educational opportunities and experiences.





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 this is now integral to our behaviour statements in line with the Trust's values, and our Appraisal process.

We continue to work with our partners in Gateshead College to deliver Leadership Programmes aimed at first time managers and developing leaders. Our first cohort of Team Leader Apprentices will complete later this year. The programme has evaluated well and as a result, we have recruited a new cohort of 13 to start on the Team Leader / Supervisor Apprenticeship in April 2019.

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 October 2018 the Trust recruited 10 Business & Administration apprentices, 7 Healthcare and 4 Therapy apprentices. The Nurse Associate Apprenticeship continues to grow, the first cohort are due to complete this year and we have just recruited a further 10 to start in March/April 2019. In addition to the above, we have supported members of our current workforce in developing via Apprenticeships in a range of specialisms such as; Theatre Assistant Practitioners, Senior Leadership MBAs and Project Management skills. The Trust has also this year supported 5 members of staff to progress onto the Registered Nurse BSc Apprenticeship which is an 18 month programme which allows those with prior qualifications and experience to upskill into the nursing profession.

Reward and Recognition

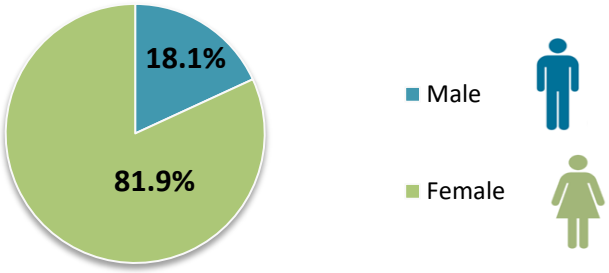
We continue to look for innovative ways to recognise our staff. We continue to run a media campaign to get our public and patients to nominate their "QE Angel" recognising the importance of our patients' voices.

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 2018 Trophy.

In 2018 we introduced "You're a Star" which runs alongside and in addition to the annual Star Awards. Sometimes, people do something for us which might be small, but can really make our day. We wanted to enable people to say a public 'thank you' to their colleagues for those small gestures, and to be able to tell them "You're a Star"! When someone tells us about a colleague who is in their eyes, a star, the recipient is acknowledged by the Chief Executive with a personally signed card and a place in the 'You're a Star Hall of Fame'. The top three "You're a Star" recipients are also invited to attend the annual Star Awards ceremony, where the ultimate winner is announced.

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 - total number of employees 3849



Pay and Bonus pay gap	Mean 2018	Mean 2017	Median 2018	Median 2017
Ordinary Pay	**29.84%**	30.80%	**14.32%**	17.46%
Bonus	**45.05%**	50.48%	**51.25%**	50.94%

(* does not cover QE Facilities Limited)

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 2018/19, 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 continues to invest 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 2018/19:

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 fourth WRES information in 2018 (* does not cover QE Facilities Limited) and moving forward the Operational Workforce Forum and Your Voice Staff Forum 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.

A staff diversity forum 'Your Voice' was set up in 2017 and continues to champion diversity and inclusion in the workplace. The membership of the forum continued to grow steadily through 2018 and members of the forum actively contribute to internal engagement events, hold informal lunch & learn sessions, publish regular articles in the staff newsletter and represent the Trust at external events. In 2018 the forum was nominated for a QE Star Award and described as a truly committed forum living the values through their innovative, caring and engaging approach to Diversity and Inclusion, recognising the commitment to work in partnership with the Trust and helping drive the very important agenda for the benefit of all our staff and patients.

The Workforce Disability Equality Standard (WDES) is mandated by the NHS Standard Contract and will apply to all NHS Trusts from April 2019. The WDES is a set of specific measures that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used to develop a local action plan, and enable organisations to demonstrate progress against the indicators of disability equality. The Trust will be publishing its first WDES report by 1 August 2019.

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 Sponsors.

During 2018/19 the Trust was selected to be part of the "NHS Employer Diversity and Inclusion Partner" programme for the second year running. This programme supports organisations to develop their equality performance over a period of 12 months, and is closely aligned to EDS2.

In May 2018 the Trust celebrated the annual NHS Employers Equality, Diversity and Human Rights Week. With the lead from the Your Voice forum, fact sheets and various leaflets on the protected characteristics including gender reassignment, disability, sexual orientation, age and religion were shared, staff were encouraged to complete a Diversity & Inclusion quiz and Hijab lessons took place to encourage cultural awareness.

The Trust now has a well-established workplace mediation service available to all staff. Workplace Mediation is an informal, voluntary process which aims to help people in disagreement or dispute to resolve their conflict and find a way to re-establish a professional working relationship. Mediation is available for all employees and can involve two or more parties.

Gateshead Health NHS Foundation Trust is positively encouraging the recruitment of Reservists from amongst our staff to join the four reservists we currently employee. We held a Reservist stand in the Queen Elizabeth Hospital on Reserves Day in 2018 and also supported a Navy Reservists stand in March 2019. The Trust signed its own Armed Forces Covenant in March 2018 and was successful in achieving the Silver award. The Trust

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 are 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:*

2013/2014	2015/2016	2016/2017	2017/2018	2018/19
Pro-Active	No Assessment Due	No Assessment Due	No Assessment Due	Pro-Active

2) Team Effectiveness / Efficient / Innovative

Team Effectiveness	2015-16	2016-17	2017-18	2018-19	Target
Core Skills Training Compliance	74.56%	73.37%	79.75%	87.27%	85%
Appraisal Compliance (Staff with a current appraisal)	71.93%	81.82%	67.81%	73.34%	85%
Staff Sickness Absence (12 month rolling percentage)	4.82%	4.49%	4.62%	4.47%	4.00%
Staff Turnover (Labour turnover based on Full Time Equivalent)	24.63%**	12.92%*	11.48%	12.87%	N/A

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

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

3) Safe Reliable Care / No Harm

A) Reducing Harm from Deterioration:

Safe Reliable care	2016-17	2017-18	2018-19	Target
HSMR	104.0	107.9	109.4*	<100
SHMI Period	Apr-17 to Mar-18	Jul-17 to Jun-18	Oct-17 to Sep-18	
SHMI	1.03	1.05	1.04	<=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)	22.1%	22.7%	24.9%	N/A
Crude mortality rate taken from CDS	1.67%	1.81%	1.62%	<1.99%
Number of calls to the CRASH team	177	156	118	N/A
Of the calls to the arrest team what percentage were actual cardiac arrests	53.1%	43.6%	45.8%	N/A
Cardiac arrest rate (number of cardiac arrests per 1000 bed days)	0.52	0.37	0.31	N/A
Hospital Acquired Pressure Damage (grade 2 and above)	104	92	130	Year on year Reduction
Community Acquired Pressure Damage (grade 2 and above)	1214†	1346	1312	N/A
Number of Patient Slips, Trips and Falls	1668	1505	1656	N/A
Rate of Falls per 1000 bed days	9.18	9.02	9.38	Reduction (<8.5)
Number of Patient Slips, Trips and Falls Resulting in Harm	407	347	385	N/A
Rate of Harm Falls per 1000 bed days	2.24	2.08	2.18	Reduction (Less than <2.25)
Falls Change	13.8% reduction	7.1% reduction	4.8% Increase	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)	24.4%	22.7%	23.2%	Year on Year reduction

*HSMR figures are April 2018 to December 2018

† Community services transferred from South Tyneside in October 2016

B) Reducing Avoidable Harm:

Reducing Avoidable Harm		2015-16	2016-17	2017-18	2018-19	Target
Medication Errors	No Harm	366	413	454	562	N/A
	Minimal Harm	51	45	54	73	N/A
	Moderate Harm	5	3	10	7	<8
	Severe	1	0	0	0	0
	Total	423	461	518	642	N/A
Never Events		2	3	3	4	0
Patient Incidents per 1,000 bed days		34.72	37.33	43.93	45.60	N/A
Rate of patient safety incidents resulting in severe harm or death per 100 admissions		0.16	0.18	0.21	0.17	N/A

Source: Trust incident reporting system Datix

C) Infection Prevention and Control:

Infection Prevention & Control	2016-17	2017-18	2018-19	2018-19 Objective
MRSA bacteraemia apportioned to acute trust post 48hrs	0	0	2*	0
MRSA bacteraemia rate per 100,000 bed days	0	**0**	**1.12***	**0**
NB: *Clostridium difficile* Infections (CDI) post 72hr cases	**20^**	**31†**	**20††**	**<=18**
Clostridium difficile Infections (CDI) rate per 100,000 bed days	**11.59^**	**17.97 †**	**11.24††**	**<=10.1**

*During 2018/19 the Trust reported two (2) MRSA bacteraemia.
The Trust had successfully achieved 1,016 Hospital-onset MRSA BSI free days up to October 2018 and celebrated continuing to maintain the national aspiration until November when two hospital-onset positive blood culture samples were reported. All Investigations were implemented in line with revised guidance followed by a post infection review (PIR). Both cases were allocated to the Trust however upheld as unavoidable with appropriate lessons learned and shared.

††During 2018/19 the Trust has reported twenty (20) CDI cases; exceeding its objective by two (2) cases and reporting a rate of 11.24 per 100k bed days. However following review and successful appeals the Trust reports only three (3) cases against the quality premium and seventeen (17) cases with no lapses in care. 2018/19 has proved to be a successful year for improving patient safety by reducing CDI, reporting our lowest case numbers to date A focused and zero tolerance approach continues to support a reduction in CDI for patient safety in line with national guidance.

†During 2017-18 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.

^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).

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.

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 (KI) scores. The methodology aims to take into account guideline recommendations and clinical consensus. The SSNAP Summary Report, including scores and levels is available in the public domain.

‡Team Centred Key Indicators	Dec-Mar 17	Apr-Jul 17	Aug-Nov 17	Dec-Mar 18	Apr-Jun-18	Jul-Sep-18
1) Scanning*						
2) Stroke unit	B	A	B	A	A	A
3) Thrombolysis*						
4) Specialist Assessments*						
5) Occupational therapy	A	A	C	B	A	A
6) Physiotherapy	A	A	A	A	A	A
7) Speech and Language therapy	C	C	D	D	C	B
8) MDT working*						
9) Standards by discharge	C	C	B	C	C	C
10) Discharge processes	A	A	A	D	D	C
Team-centred Total KI level	A	A	B	B	B	A
Team-centred Total KI score	83	87	77	70	77	83
Team-centred SSNAP level (after adjustments)	C	B	B	C	B	B
Team-centred SSNAP score	67	74	73	63	73	79

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

* These indicators are no longer relevant to the Trust as patients are now transferred to the Newcastle Upon Tyne Hospitals NHS Foundation Trust's Stroke Unit for these services.

Other Indicators:

Other Indicators	2016-17	2017-18	2018-19	Target	Benchmark
Percentage of Cancelled Operations from FFCE's†	0.70%	0.68%	0.60%	0.80%	1.0%**
Percentage of Patients who return to Theatre within 30 days (Unplanned / Planned / Unrelated)	4.80%	5.48%	5.28%	Improve Year on Year	N/A
Fragility Fracture Neck of Femur operated on within 48hrs of admission / diagnosis	91.8%	94.7%	95.3%	90%	N/A
Proportion of patients who are readmitted within 28 days across the Trust*	8.63%	8.32%	8.29%	Improve year on year	N/A
Proportion of patients undergoing knee replacement who are readmitted within 30 days*	4.41% 20 patients readmitted	5.90% 24 patients readmitted	6.00% 18 Patients readmitted	Improve Year on Year	N/A

Proportion of patients undergoing hip replacement who are readmitted within 30 days*	7.46% 34 patients readmitted	7.43% 31 patients readmitted	6.09% 19 patients readmitted	Improve Year on Year	N/A

* Figures taken from Healthcare Evaluation data (HED) and provide full financial years for 2016-17 and 2017-18, and April to December 2018

** NHS England Statistics - NHS Cancelled Elective Operations Quarter Ending December 2018

† 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 NHS Inpatient Survey 2018 Positive Scores	2014	2015	2016	2017	2018	5 year average All Inpatient Organisations	Average for similar organisations
Was the patient as involved as they wanted to be in decisions about their care and treatment?	93%	91%	90%	92%	89%	69%	69%
Did the patient find someone to talk to about their worries and fears?	81%	82%	76%	82%	73%	73%	73%
Was the patient told about medication side effects to watch out for?	67%	65%	59%	64%	57%	57%	57%
Was the patient told who to contact if they were worried?	80%	84%	80%	82%	77%	77%	77%
Was the patient given enough privacy when discussing their condition or treatment?	96%	94%	95%	96%	95%	94%	96%

Source: Picker Institute Inpatient Survey 2018 Gateshead Health NHS Foundation Trust Management Report February 2019

6) Safe, Effective Environment, Appropriate Equipment & Supplies

Patient-Led Assessments of the Care Environment (PLACE)		2016	2017	2018
Cleanliness	Gateshead Health NHS Foundation Trust	99.9%	99.9%	99.9%
	National Average	98.1%	98.4%	98.5%
Food	Gateshead Health NHS Foundation Trust	91.5%	93.9%	93.4%
	National Average	88.2%	89.7%	90.2%
Environment	Gateshead Health NHS Foundation Trust	96.5%	97.1%	99.0%
	National Average	93.4%	94.0%	94.3%
Privacy, Dignity and Wellbeing	Gateshead Health NHS Foundation Trust	84.7%	85.3%	87.0%
	National Average	84.2%	83.7%	84.2%
Dementia	Gateshead Health NHS Foundation Trust	75.8%	78.3%	86.6%
	National Average	75.3%	76.7%	78.9%

Disability	Gateshead Health NHS Foundation Trust	81.6%	86.7%	93.4%
	National Average	78.8%	82.6%	84.2%

Source: https://digital.nhs.uk/data-and-information/publications/statistical/patient-led-assessments-of-the-care-environment-place

Maximiser results – data still awaited

3.6 National targets and regulatory requirements

‡ The following indicators are all governed by standard national definitions

Data for 2018/19 is not yet available

No	Indicator		2016/17	2017/18	2018/19	Target	National Average
1	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted		83.7%	81.5%	TBC	90.0%	74.4%**
2	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted**		91.4%	91.4%	TBC	95.0%	89.2%**
3	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway**		93.4%	94.3%	TBC	92.0%	87.9%**
4	A&E – maximum waiting time of four hours from arrival to admission / transfer / discharge		96.1%	94.6%	TBC	95.0%	88.4%
5	All cancers: 62 day wait for first treatment from: urgent GP referral for suspected cancer /		86.7%	88.4%	TBC	85.0%	82.3%†
	NHS Cancer Screening Service referral		94.5%	96.3%	TBC	90.0%	91.6%†
6	All cancers: 31 day wait for second or subsequent treatment, comprising:	Surgery	100.0%	98.9%	TBC	94.0%	95.8%†
		Anti-cancer drug treatments	99.7%	99.9%	TBC	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		99.9%	99.7%	TBC	96.0%	97.6%†
8	Cancer: two week wait from referral to date first seen, comprising:	All urgent referrals (cancer suspected)	96.80%	95.78%	TBC	93.0%	94.1%†
		Symptomatic breast patients (cancer not initially suspected)	96.50%	96.57%	TBC	93.0%	93.0%†

9	Maximum 6-week wait for diagnostic procedures		99.4%	99.1%	99.5%	99%	TBC
10	Care Programme Approach (CPA) patients, comprising:	Receiving follow up contact within seven days of discharge	84.60%	87.10%	TBC	95.0%	96.3%††
		Having formal review within 12 months	nil return*	nil return*	TBC	nil return*	N/A
11	Minimising mental health delayed transfers of care		0.0%	3.0%	TBC	< 7.5%	N/A
12	Mental health data completeness: identifiers		99.70%	99.73%	TBC	97.0%	N/A
13	Mental health data completeness: outcomes for patients on CPA		85.4%	83.3%	TBC	50.0%	N/A
14	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
15	Data completeness: community services, comprising:	Referral to treatment information	98.1%	96.3%	TBC	50.0%	N/A
		Referral information	100.0%	100.0%	TBC	50.0%	N/A
		Treatment activity information	100.0%	95.3%	TBC	50.0%	N/A
16	C. difficile – meeting the C. difficile objective	No. of Post 72hr Clostridium Difficile cases	20	31	TBC	19	N/A
		No. of Post 72hr Clostridium Difficile cases following appeal	11	25	TBC	N/A	N/A
		Clostridium Difficile - infection rate (per 100,000 bed days	11.6	17.97	TBC	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 2018/19 Quality Account

4.1 Gateshead Overview and Scrutiny Committee – to be added

4.2 Gateshead Clinical Commissioning Group – to be added

4.3 Healthwatch – to be added

4.4 Council of Governors – to be added

Annex 2: Statement of directors' responsibilities in respect of the quality account

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 2018 to March 2019
    - papers relating to quality reported to the board over the period April 2018 to March 2019
    - feedback from commissioners dated - TBC
    - feedback from governors dated - TBC
    - feedback from local Healthwatch organisations dated - TBC
    - feedback from Overview and Scrutiny Committee dated - TBC
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated - TBC
    - the 2018 national patient survey February 2019
    - the 2018 national staff survey February 2019
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated - TBC
    - CQC inspection report dated CQC Inspections and rating of 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

Date:
22nd May 2019

Chairman:

Date:
22nd May 2019

Acting 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
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.

Anaphylaxis
Anaphylaxis is a serious allergic reaction that is rapid in onset and may cause death. It typically causes more than one of the following: an itchy rash, throat or tongue swelling, shortness of breath, vomiting, light-headedness, and low blood pressure

Aspiration pneumonia
Aspiration pneumonia occurs when food, saliva, liquids, or vomit is breathed into the lungs or airways leading to the lungs, instead of being swallowed into the oesophagus and stomach.

Care Quality Commission (CQC)
The CQC is the independent regulator of all health and adult social care in England. The CQC aim is 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
Commissioners are responsible for ensuring that adequate services are available for their local population by assessing need and purchasing services.

Continuity of Care
Care where the midwife is the lead professional in the planning, organisation, and delivery of care throughout pregnancy, birth, and the postpartum period.

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.

Deprivation of Liberty (DoLS)
The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

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.

Dysphagia
Is the medical term for swallowing difficulties. Some people with dysphagia have problems swallowing certain foods or liquids, while others can't swallow at all.

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.

Fragility Fracture
A fragility fracture is any fall from a standing height or less, that results in a fracture.

Friends and Family Test (F&FT)
The friend and family test is an important feedback tool that supports the 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 Hospital Episode Statistics (HES) national inpatient and outpatient and Office of National Statistics (ONS) Mortality data sets.

Hospital Episode Statistics (HES)
HES 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.

Intentional Rounding
Intentional rounding is a structured process where nurses on wards in acute and community hospitals and care home staff carry out regular checks with individual patients at set intervals, typically hourly. During these checks, they carry out scheduled or required tasks.

Invasive
A medical procedure that invades (enters) the body, usually by cutting or puncturing the skin or by inserting instruments into the body.

Joint Consultative Committee (JCC)
JCC 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.

Lasting Power of Attorney (LPA)
A lasting power of attorney is a legal document that lets the 'donor' appoint one or more people (known as 'attorneys') to help make decisions or to make decisions on their behalf. There are two types of LPA: health and welfare and property and financial affairs.

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. 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.

Multidisciplinary Team
A multidisciplinary team is a group of health care workers who are members of different disciplines (professions e.g. Psychiatrists, Social Workers, etc.), each providing specific services to the patient.

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 is a central database of all patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted.

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

Overview and Scrutiny Committee
The 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.

Pandora
The Trust's electronic document management system.

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.

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.

Prevent

Prevent is part of the UK's Counter Terrorism Strategy.

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.

Ribotyping
Is a technique for bacterial identification and characterisation. It is a rapid and specific method widely used in clinical diagnostics and analysis of microbial communities in food, water, and beverages.

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 (RCA)
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.

Safety Cross
The safety cross is a visual tool used to collect data for improvement. It is displayed in care settings to encourage the communication of goals and results to the team. It can also help to empower ownership of the data locally.

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 e.g. blood pressure, pulse, and temperature 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 on completion