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CARE, HEALTH AND WELLBEING OVERVIEW AND SCRUTINY COMMITTEE AGENDA

Thursday, 12 May 2016 at 10.30 am in the Blaydon Room - Civic Centre

From the Chief Executive, Jane Robinson

Item	Business
1.	**Apologies for absence**
2.	**Quality Accounts 2015-2016 - Gateshead Health NHS Foundation Trust, Northumberland, Tyne and Wear NHS Foundation Trust and South Tyneside NHS Foundation Trust** (Pages 3 - 224) Report of the Interim Strategic Director, Care, Wellbeing and Learning

Contact: Helen Conway, email helenconway@gateshead.gov.uk, Tel: 0191 433 3993,
Date: Wednesday, 4 May 2016

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Gateshead Council

Care, Health and Wellbeing Overview and Scrutiny Committee
12 May 2016

TITLE OF REPORT: **Quality Accounts**

REPORT OF: **Alison Elliott, Interim Strategic Director, Care, Wellbeing and Learning**

Summary
The OSC is invited to comment on the Quality Accounts for Gateshead Health NHS Foundation Trust, Northumberland Tyne and Wear NHS Foundation Trust and NHS South of Tyneside NHS Foundation Trust.

Background

High Quality Care for All, published in June 2008, proposed that all providers of NHS Care should produce Quality Accounts to provide the public with information on the quality of care they provide with a view to enhancing public accountability and ensuring a focus on improving quality.

Subsequently, the Department of Health produced legislation which places a legal duty on providers of NHS Services to publish Quality Accounts as part of a new Quality Framework which was brought into force in April 2010.

The accounts are to be published annually in June and they cover healthcare services for the previous financial year. The accounts outline:-

- What an organisation is doing well
- Where improvements in service quality are required
- What an organisation's priorities for improvement are for the coming year
- What actions an organisation intends to take to secure these improvements
- how the organisation has involved people who use their services, staff and others with an interest in their organisation in determining their priorities for improvement

The requirement to produce Quality Accounts initially only applied to those NHS providers who deliver acute, mental health, learning disability and ambulance services. It did not apply to primary care services and community healthcare services. Providers of primary care and community services were brought into the process during 2011.

Commissioners are required to provide a corroborative statement in provider Quality Accounts as to whether or not they consider the document contains accurate information. The CCG is expected to check accuracy of data in so far as it relates to information supplied to it as part of its contractual obligations – but not any other data.

Role of OSCs and Healthwatch

As part of the Quality Accounts process, providers are required through regulations to send a draft of their Quality Account to the appropriate Overview and Scrutiny Committee. Regulations currently specify that the "appropriate" Overview and Scrutiny Committee means the Overview and Scrutiny Committee of the local authority in whose area the provider has its registered or principle office located.

Overview and Scrutiny Committees, along with Healthwatch, are invited, on a voluntary basis, to review the Quality Accounts of relevant providers and supply a statement commenting on the Account– based on the knowledge they have of the provider.

Draft Quality Accounts for Gateshead Hospitals NHS Foundation Trust and Northumberland Tyne and Wear NHS Foundation Trust and South Tyneside NHS Foundation Trust are attached at Appendices 1,2 and 3.

Taking account of the OSC's work during the previous year the OSC may wish to comment on the following for each respective account:-

- the Quality Account
- whether they believe that the Account is representative
- whether it gives comprehensive coverage of the provider services
- whether they believe that there are significant omissions of issues of concern that had previously been discussed with providers in relation to Quality Accounts.

Providers are required to include any statement supplied in their published Quality Account and any narrative provided should be published verbatim (up to a maximum of 500 words). Providers are required to give OSCs at least 30 working days to prepare their comments on the Quality Account and send back to the provider, prior to publication.

The OSC is asked to note that Northumberland Tyne and Wear NHS Foundation Trust is currently only obliged statutorily to consult with Newcastle Health Overview and Scrutiny Committee as its head office is based in Newcastle. However, the Trust is adopting a partnership approach to this issue and has widened its consultation process to other local authority Overview and Scrutiny Committees in areas which receive the Trust's services.

A representative of Healthwatch Gateshead will attend the meeting and provide verbal comments on the respective Quality Accounts.

Recommendations
The Committee is asked to comment on the respective Quality accounts of Northumberland Tyne and Wear NHS Foundation Trust and Gateshead NHS Hospitals Trust and South Tyneside NHS Foundation Trust.

Contact: Angela Frisby **Ext**: 2138

Gateshead Health NHS Foundation Trust
Quality Account
2015/16

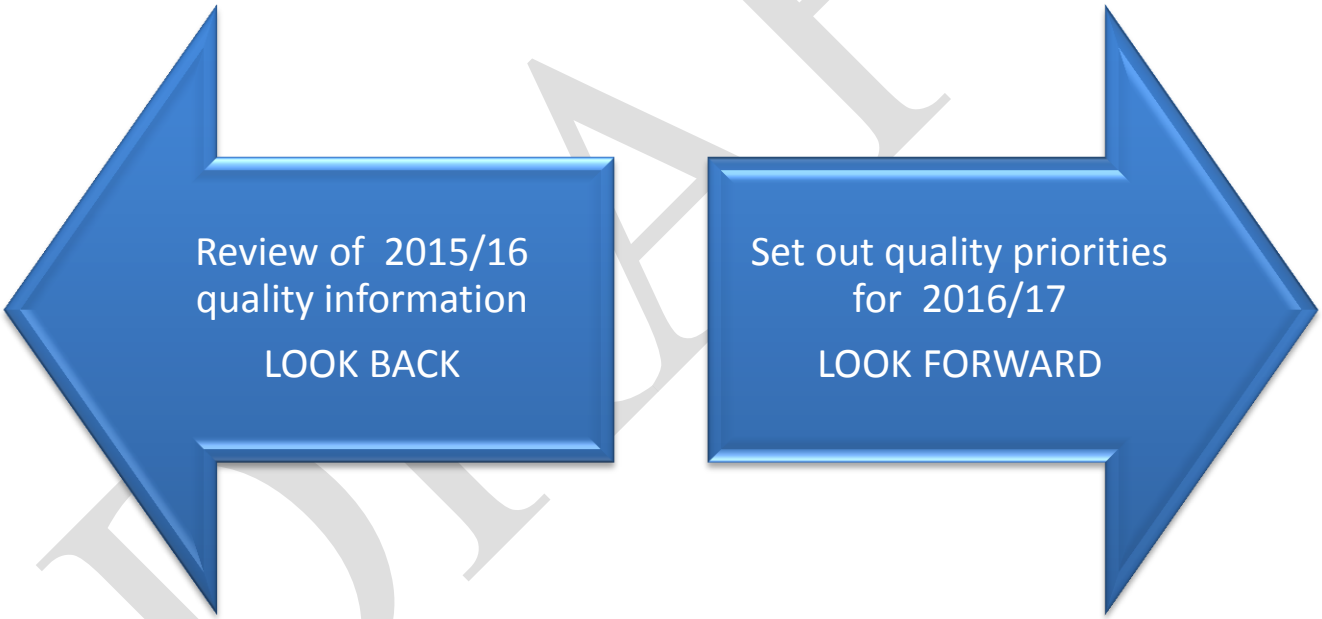
Contents

What is a Quality Account?

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

The dual functions of a Quality Account are to:

- Summarise our performance and improvements against the quality priorities and objectives we set ourselves for 2015/16.
- Outline the quality priorities and objectives we set ourselves going forward for 2016/17.



1. Achievements in Quality in 2015/16

Rated by CQC as 'Good' overall with 'Outstanding' care

Maternity Services rated by CQC as 'Outstanding'

Nominated for Patient Experience Network National Award for implementation of the 'ThinkSAFE' project

Ambulatory Care Team was presented with an award for 'Project Team Resilience' at the National Ambulatory Emergency Care Network (AEC) conference

We became the first NHS Trust in the country to achieve the new Investors in People Health and Wellbeing Good Practice Award

A&E care has been highlighted among the very best in the country after being named as one of the top three units in a major national awards scheme

Statement on Quality from the Chief Executive

This is the seventh Quality Account to be published by Gateshead Health NHS Foundation Trust. Against the backdrop of the many challenges facing health and social care, both nationally and at a local level, sustaining high quality and safe care remains central to our values and our approach to service delivery on a daily basis.

I am therefore delighted to report that the Quality Account for 2015/16 once again reflects another excellent year for the Trust in our pursuit of high quality and safe care for everyone that uses our services. Our staff are to be commended for their continuing dedication, commitment and passion to provide and continuously improve the care we deliver to patients and their families. This can be seen from the recent CQC inspection to the Trust in which where we were graded as 'GOOD' overall with 'OUTSTANDING' for caring.

Our Maternity Unit at QE Gateshead was also rated as 'OUTSTANDING' by the CQC which places among the very best in the country. New and expectant mothers across the region will be delighted to hear the maternity team described as a "highly committed, enthusiastic team, each sharing a passion and responsibility for delivery high-quality service" by the inspectors.

A&E care at QE Gateshead has also been highlighted among the very best in the country after being named as one of the top three units in a major national awards scheme. The team at the Queen Elizabeth Hospital was one of the top three in the 'Excellence in Accident and Emergency Care Award, part of the CHKS annual Top Hospitals programme awards in 2015. The awards celebrate the success of healthcare providers across the UK and are awarded to healthcare organisations for their achievements in quality and improvement. The QE made the national finals following a visit by judges and an analysis of 28 key measures covering clinical outcomes and patient experience across the NHS.

Feedback from our patients show us that the Trust continues to provide a positive patient experience with an average of 97% of inpatients saying that they would definitely recommend the hospital to friends and family. 83% of patients that completed the 2015 NHS inpatient survey would rate the care provided at 7/10 or above (Picker Institute, 2015) and 97% of inpatients in our local Trust survey say that our staff are caring and compassionate.

The new Patient Experience and Information Centre opened this year. Staff working in the centre will be able to give "on the spot" help and advice to patients, relatives, carers and staff.

We have regularly monitored our improvement plans during 2015/16 through our Patient, Quality, Risk and Safety Committee and the Trust Board. In addition to the examples detailed above, the Quality Account for 2015/16 reflects the excellent progress we have made against our priorities for the year:

- Increased numbers of patients using their own drugs;
- 50% reduction in the number of stillbirths and neonatal deaths;
- Implementation of the 'ThinkSAFE' project; and
- Reductions in reported Mortality rates.

Whilst we have made significant progress in key areas over the past year we are not complacent and recognise that we can always do better. We will therefore continue to develop our focus on improved quality through the implementation of our SafeCare Strategy 2014/17 that sets out how we will continue to deliver improvements over the next year, alongside our six key priorities reflected in our Quality Account for 2016/17:

Clinical Effectiveness

- Continue to reduce avoidable hospital deaths focusing on the timely recognition and management of sepsis;
- Continue to review and embed learning from the Saving Babies Lives Campaign

Patient Safety

- Improve patient safety by reducing medication errors;
- To continue to implement the 'ThinkSAFE' project within the Trust;
- Continue to reduce harm from falls occurring in hospital.

Patient Experience

- Using information from complaints to improve the patient (and family and carers) experience of our services.

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

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

Signed:

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

2. Priorities for Improvement

2.1 Reporting back on our progress in 2015/16

In our 2014/15 Quality Account we identified six quality improvement priorities that we would concentrate on in 2015/16. This section focuses on the progress we have made against these.

KEY:

We achieved our aims

We partially achieved our aims or significantly improved our processes to enable future improvement

We did not achieve our aims

Clinical Effectiveness:

Priority 1: Reduce avoidable hospital deaths, including focusing on recognition and management of Sepsis.

The UK Sepsis Trust 2013 defined Sepsis as "A life threatening condition that arises when the body's response to an infection injures its own tissues and organs. Sepsis leads to shock, multiple organ failure and death especially if not recognised early and treated promptly".

What did we say we would do?

We will continue to implement our mortality reduction strategy and programme of work over 2015/16.

We will continue to aim to achieve a year on year reduction in mortality utilising the crude mortality rate, the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI). Our aim is to achieve a lower than expected or as expected SHMI banding.

In 2015/16 a key focus will be improving our performance in relation to the recognition and timely treatment of patients presenting with Sepsis.

Explanation of how mortality is measured:

Like many other Trusts, the Trust uses an independent organisation called Dr Foster to monitor its Hospital Standardised Mortality Ratio. The Hospital Standardised Mortality Ratio (HSMR) compares the expected rate of death in a hospital with the actual rate of death and allows us to assess the Trust's performance on a range of clinical conditions, such as patients with conditions which most commonly result in death, for example heart attacks and strokes.

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

Table illustrating how the risk adjusted scores are interpreted:

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

Crude mortality rate is a measure of the number of deaths which does not include an adjustment for risk factors as in the HSMR. The crude rate is the percentage of deaths that have occurred out of all hospital spells (stays).

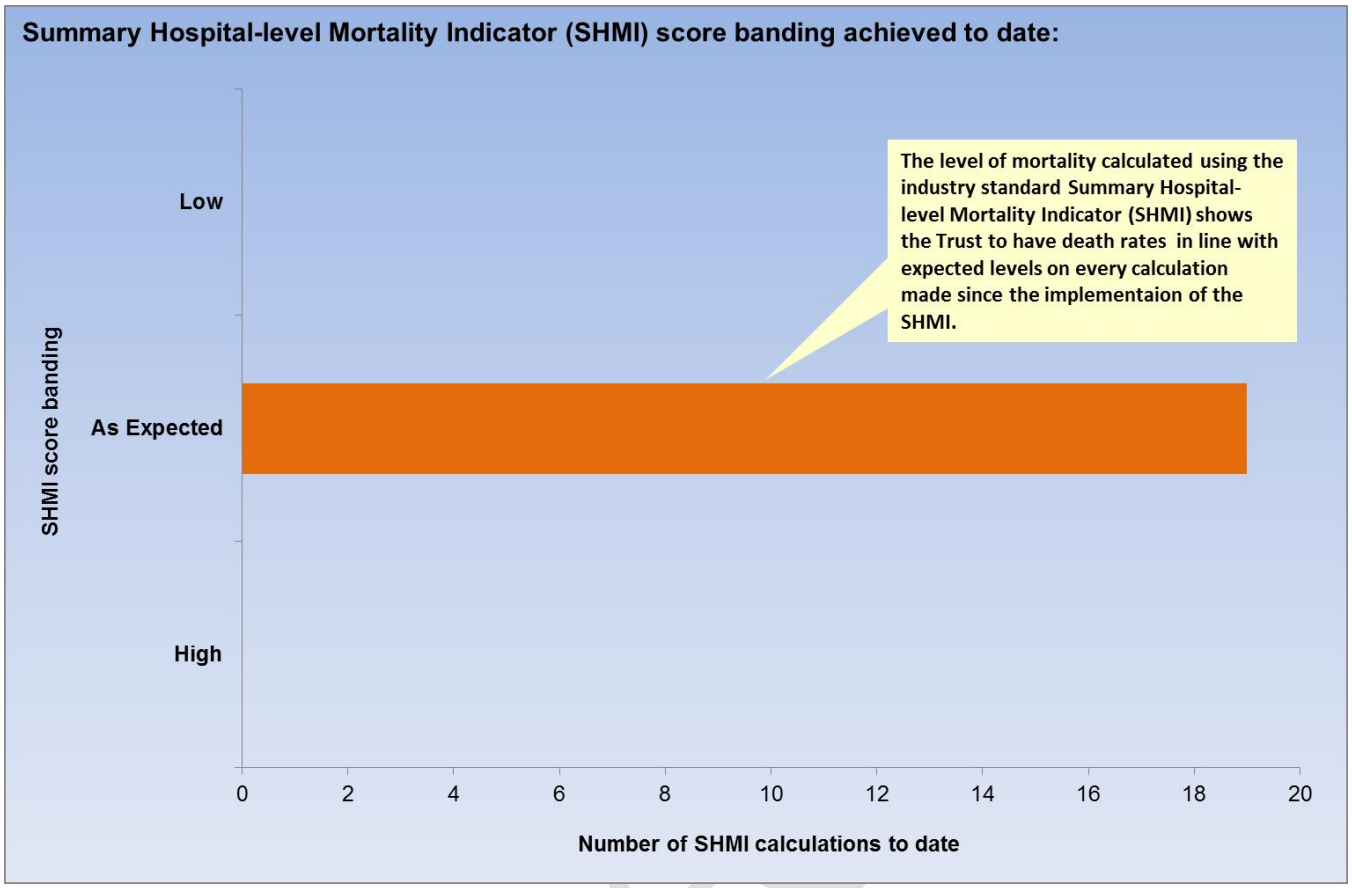
Did we achieve this?

Yes we did.

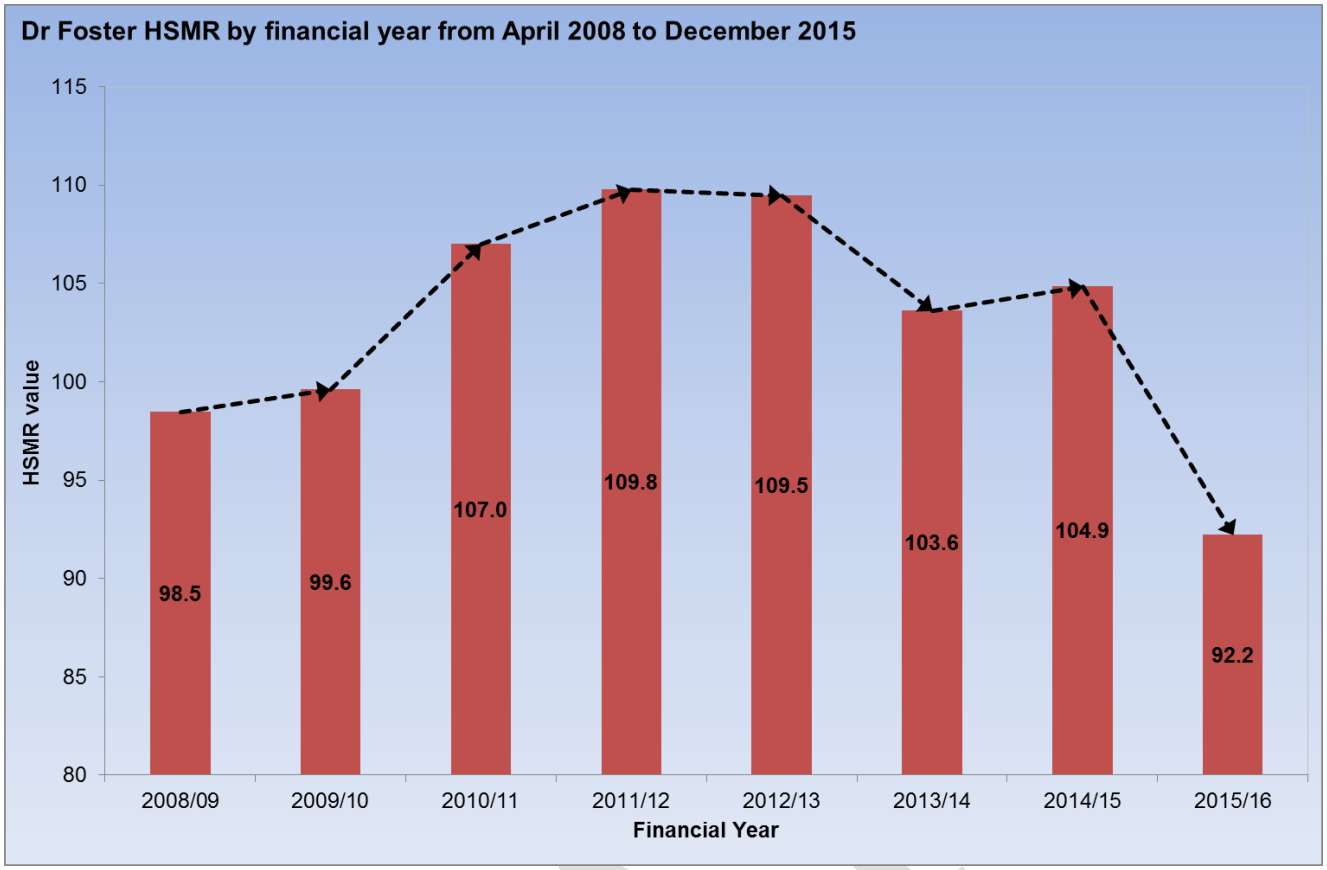
How we achieved it:

- We undertook a baseline assessment of clinical knowledge of Sepsis and practice during April to June 2015.
- We provided a programme of Sepsis education sessions for front line clinical staff.
- We developed a communication strategy to raise staff awareness of our improvement campaign.
- We promoted the use of national screening tools to enable us to better recognise patients with Sepsis and measure our performance through case review.
- We worked to improve our performance in relation to the timely implementation of the 'Sepsis six' care bundle and measure this through case review.
- We took part in a regional patient safety collaborative where we worked with other Trusts to share knowledge and learning that will drive improvements in patient care.
- We shared our performance and any learning from 'Ward to Board' and with external partners.
- We continued to implement the Mortality Reduction Strategy, with particular focus on rolling out VitalPAC as well as the development of a database to capture details of all of the mortality reviews undertaken to enable us to share learning across the Trust.

Evidence of achievement:

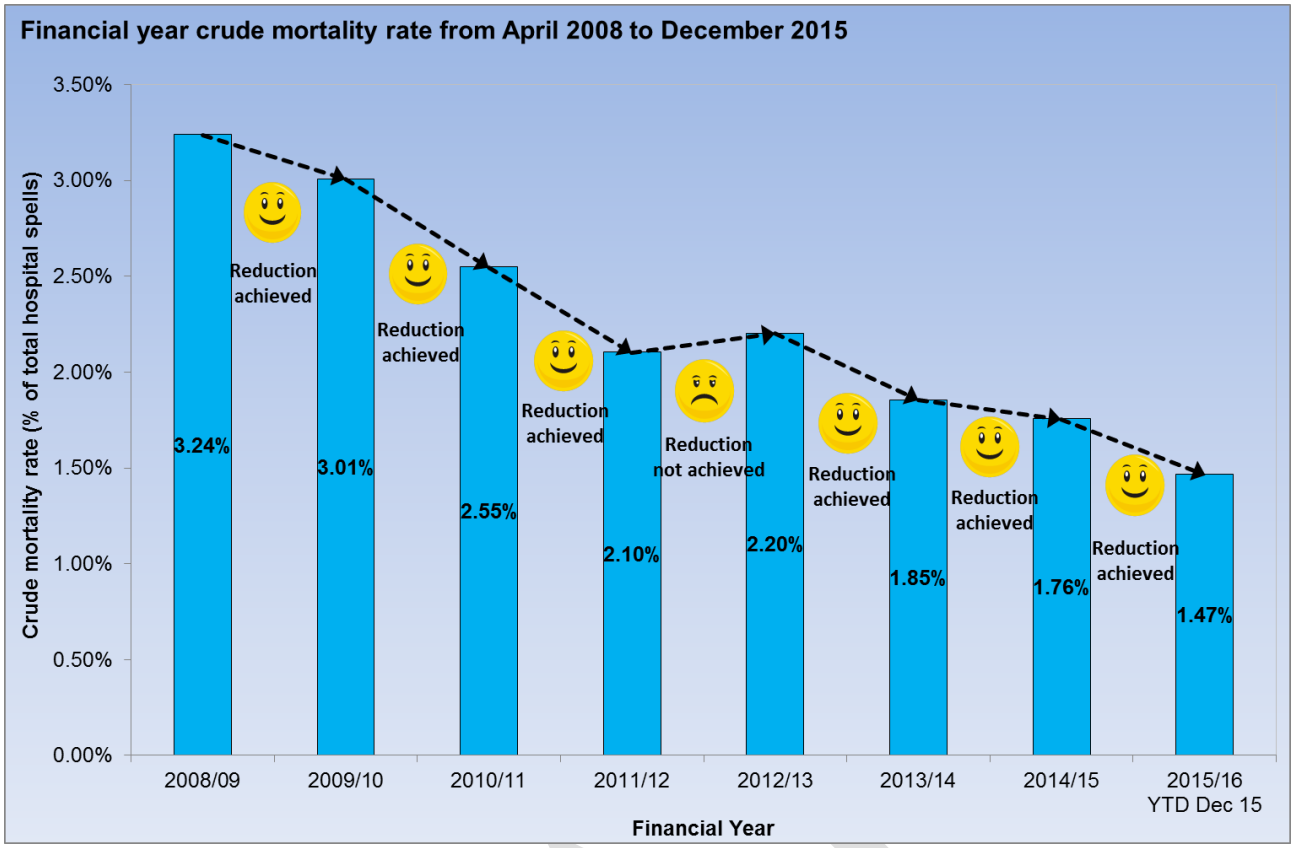


The Summary Hospital-level Mortality Indicator (SHMI) reports mortality at a Trust level across the NHS in England and is regarded as the national standard for monitoring of mortality. The main development in measuring mortality, that the SHMI takes into account, is patient deaths outside of hospital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

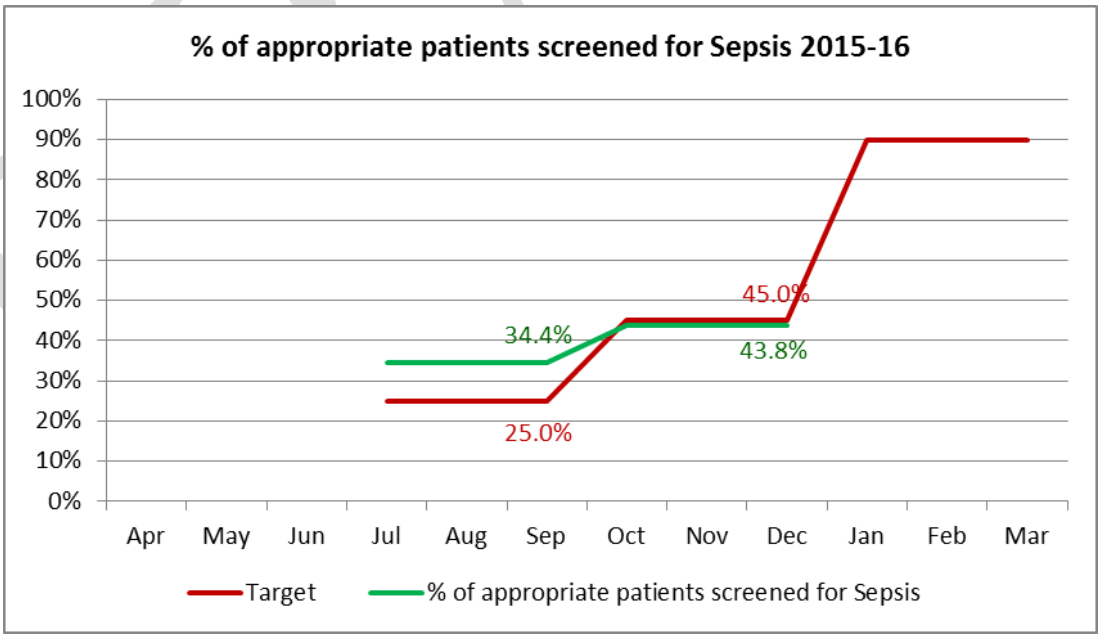


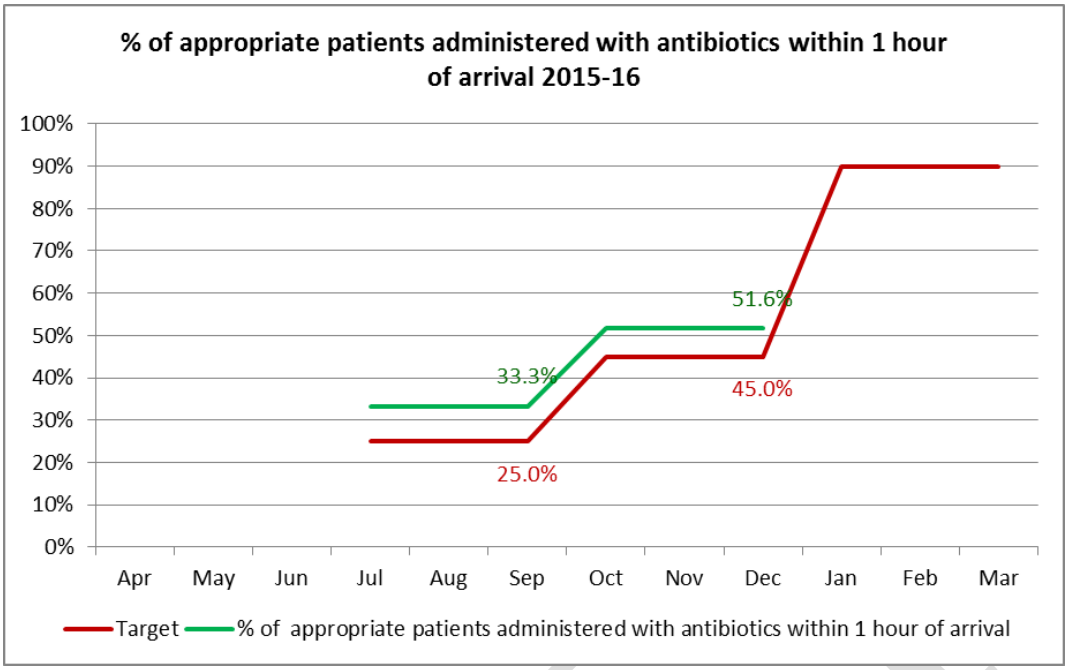
One of the key advantages to using Dr Foster is the in-depth information around mortality and the ability to see the data that underpins many of the publications related to hospital death rates, allowing the Trust to realise opportunities for learning and improve patient care.

The latest 2015/16 position available as at December 2015 is showing the HSMR at Gateshead as being considerably lower than the previous year. The Trust's target of achieving a year on year reduction at this stage is being achieved. This can only be confirmed once the data is processed by Dr Foster for the full year, however the signs are extremely encouraging.



A reduction in crude mortality was observed again in 2015/16 from the previous year. The pattern demonstrated for crude death rates shows a downward trend with the exception of a slight increase in 2012/13. The Crude mortality rate has reduced from 3.24% in 2008/09 to 1.47% in 2015/16 (December 2015) representing a 54.6% reduction overall.





The performance against the National Sepsis CQUIN is shown above.

Improvements have been observered in both the screening of appropriate patients for Sepsis and administration of antibiotics for those identified with suspected severe Sepsis, Red Flag Sepsis or septic shock.

Quarter 1 was utilised to set up the screening tool and collect baseline data. Local targets were set for Quarter 2 and Quarter 3 of 25% and 45% respectively. The Quarter 4 national target of 90% for both Sepsis indicators has been identified as challenging by many Trusts. The Trust will endeavour to achieve the best result possible against this target. Quarter 4 results will be available mid May 2016.

Next steps:

This will remain a priority for 2016/17. We will continue to reduce avoidable hospital deaths including the recognition and timely management of Sepsis by ongoing development of the Sepsis screening process (within the Accident & Emergency Department and Inpatient Wards) and further development of training and education. We anticipate that this will also remain as a national NHS England CQUIN indicator for 2016/17.

Priority 2: Implement the 'Saving Babies' Lives' Campaign

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

What did we say we would do?

We will implement the NHS England care bundle initiative which will run alongside the Royal College of Obstetricians & Gynaecologists (RCOG) 'Each Baby Counts' project to reduce the number of stillbirths, early neonatal deaths and brain injuries in the UK as a result of incidents occurring during labour. We set ourselves an ambitious target to reduce still births by 50% annually and to reduce the number of infants born with birth related injuries by 69%.

Did we achieve this?

Yes we reduced our stillbirths and neonatal deaths by 50% during 2015/16.

The target set by which to reduce the number of birth related injuries during 2015/16 was 69%. This was challenging as it was initially deemed a local target but was in fact a national target. 'Birth related injuries' were classed as 'Severe brain injury diagnosed in the first seven days of life' using the following definition:

- Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE); or
- Was therapeutically cooled (active cooling only); or
- Had decreased central tone AND was comatose AND had seizures of any kind

Therefore we have not reported against this target during 2015/16. However we recognise the importance of measuring this within the service. During 2015/16 there were two babies who required active cooling (preventative treatment at tertiary units to prevent long term brain injury). During 2014/15 there was one baby who required active cooling.

How we achieved it:

We implemented the NHS England care bundle. Which comprises of:

- Detection of fetal growth restriction (FGR) (FGR is a condition in which a baby's growth slows or stops when they are in the womb)
  - The detection and prevention of fetal growth restriction plays a major role in preventing still birth and early neonatal deaths. Cases where fetuses who are small for gestational age (SGA) go undetected are viewed as 'avoidable' deaths. Prior to implementation of the care bundle our detection rate for this group was 6%. Following implementation of the care bundle, specifically the customised growth charts and serial growth scans for those at risk, the SGA detection rate increased to over 50% (national average is 35%).

- Smoking cessation - Reducing smoking in pregnancy
  - During 2015/16 the percentage of women smoking during pregnancy was 14.5%, with a reduction to 12.7% smoking at the time of delivery. All women now have a carbon monoxide (CO) (raised in smokers) reading completed at the time of the pregnancy booking appointment and women with high readings are referred for high impact smoking cessation support.

- Fetal movements (movement of a baby in the womb)
  - The service has introduced a patient information leaflet which is provided to all women during the antenatal period to inform them of the importance of closely monitoring their baby's movement and when to contact the hospital.
  - Improved triage and assessment has been achieved by the implementation of a reduced fetal movement assessment sheet.
  - In the last quarter of 2015/16 312 women attended the pregnancy assessment unit with concerns over fetal movements, an increase of 46% on the same quarter in the previous year.

- Intrapartum fetal monitoring (monitoring of a baby during labour)
  - The service has recently implemented the new NICE guidance on intrapartum monitoring and has invested in the K2 Cardiotocography (CTG) training package in order to improve staff interpretation of fetal heart monitoring during labour.

Evidence of achievement:

Year	Number of stillbirths and early neonatal deaths
2014/15	8
2015/16	4
	= 50% reduction

Year	Number of 'Birth related injuries' (who required active cooling)
2014/15	1
2015/16	2

Next steps:

This will remain a priority for 2016/17 and we will continue to embed the NHS England care bundle initiative which will run alongside the Royal College of Obstetricians & Gynaecologists' (RCOG) 'Each Baby Counts'.

Priority 3: Continue to reduce harmful 'in hospital' falls

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

What did we say we would do?

- We will continue to implement our three year falls reduction strategy and aim to reduce the rate of harmful falls to 2.25 per 1,000 bed days or less, the target we were unable to achieve in 2014/15.
- We will review our performance collected via the incident reporting system over the last 12 months to identify any areas for focused education or targeted improvement work.
- We will focus on the effective and safe handover of patients at nursing staff shift changes to ensure patients with falls prevention needs and treatment plans are clear.
- We will continue our education programme and awareness sessions for staff, patients and visitors about falls prevention strategies. We will commence this with a falls out and about Trust-wide SafeCare session on 1st April 2015 called April 'Falls' Day.

Did we achieve this?

Our rate of harmful falls this year is 2.60 per 1,000 bed days. We are very disappointed that we were not able to meet our target of 2.25 per 1,000 bed days despite a number of improvement initiatives that have been ongoing throughout the year.

Improvements undertaken in 2015/16:

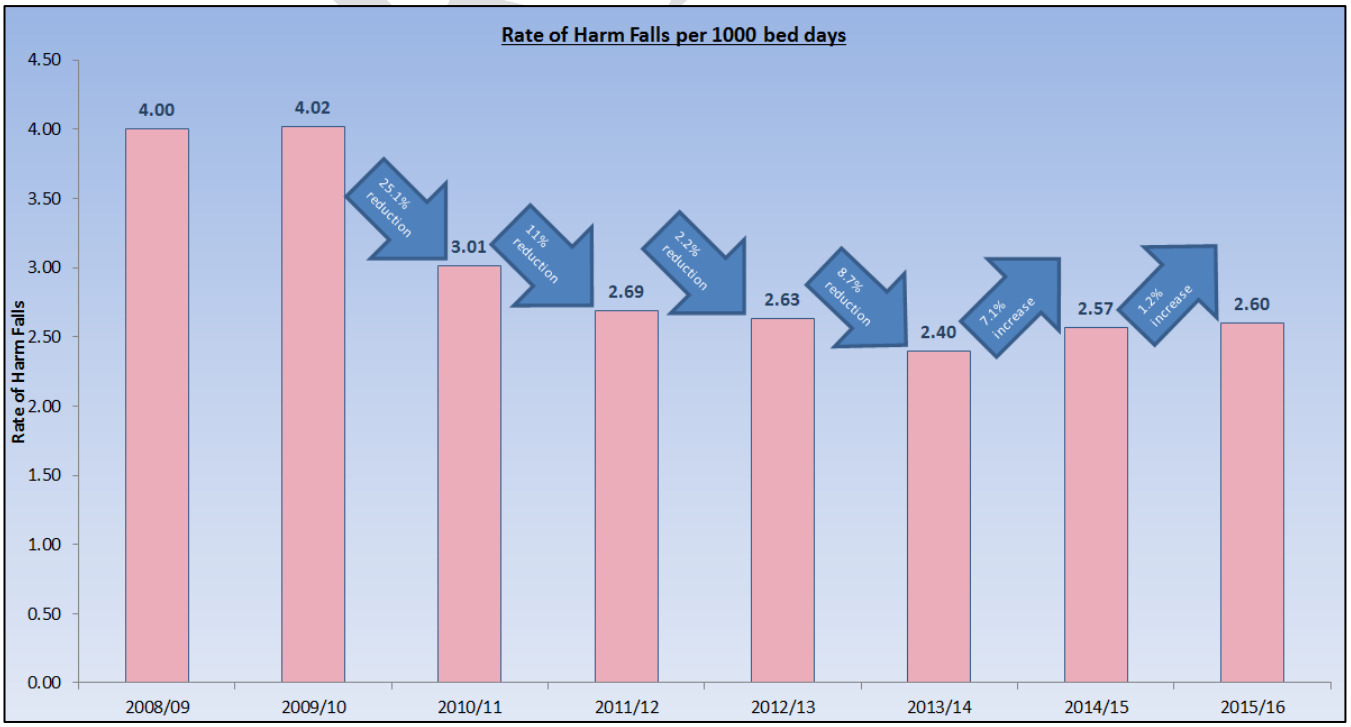
There have been a number of improvement initiatives ongoing throughout the year. These include:

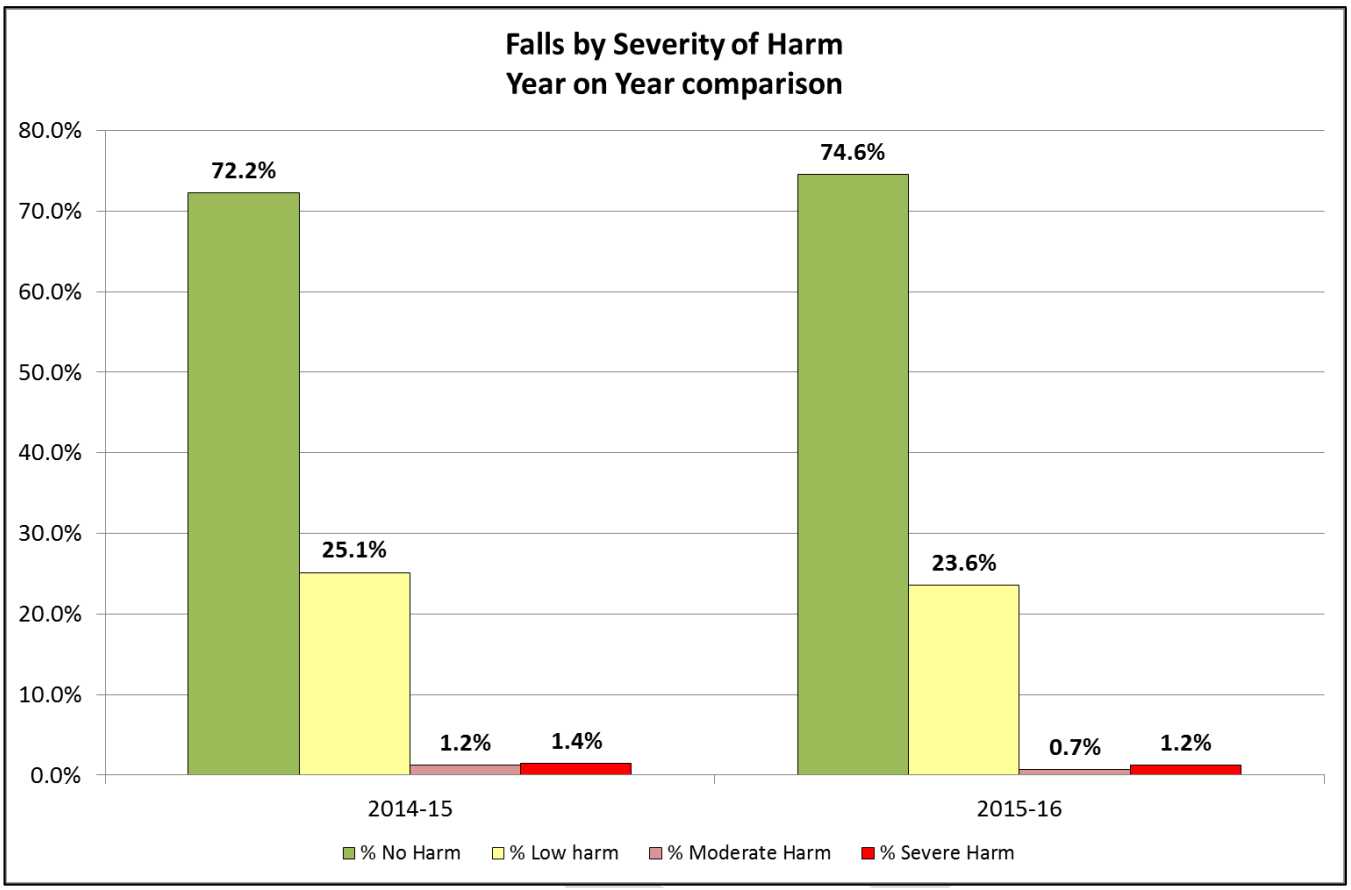
- Appointing a new strategic falls lead in January 2016 to re-energise implementation of the inpatient falls strategy 2014/17.
- Reviewing and refreshing our falls reduction strategy to help steer us to reduce harmful 'in hospital'

falls.

- Reviewing the membership of the Strategic Falls Reduction Group to ensure it is multidisciplinary and that all key stakeholders are involved this will drive the improvement work required to reduce harmful 'in hospital' falls.
- Splitting the operational and strategic falls meetings to allow a clear focus on delivery of the strategy.
- Holding a Trust Wide SafeCare session on 1st April 2015 called April 'Falls' Day. This day was an opportunity to offer support and education to front line staff about falls prevention strategies, promote the new falls multifactorial assessment and falls pathway document, share information on medication that may have an effect on patients falling and remind staff to use previously implemented tools such as falling stars and slip resistant socks.
- Continuing to provide education and awareness sessions for staff (ward specific), patients and visitors have continued throughout the year. These are currently being reviewed/updated.
- Completing Root Cause Analysis (RCA) for all falls of moderate harm and above.
- Reviewing and updating the documentation for RCAs to ensure we receive standardised key information to enable us to identify good practice and areas for organisational learning.
- Fully implementing a multifactorial assessment tool to identify patient's individual risk of falling as recommended by the National Institute for Health and Care Excellence (NICE).
- Testing a shortened multifactorial assessment tool in our emergency care assessment unit.
- Purchasing bed and chair sensors and developing guidance for the use of these.
- Testing an intentional rounding chart to incorporate falls – Footwear, Orientation, Continence, Understanding the patient, Safe environment (FOCUS). This has evaluated well and will be rolled out Trust wide.
- Participating in the National Audit of Inpatient Falls (NAIF).
- Reviewing the results of the NAIF to identify areas of good practice and assist us to develop an action plan to improve our practice where necessary. This has been incorporated into the refreshed falls strategy.

Evidence:





The chart above demonstrates that the proportion of patients suffering harm as a result of falling reduced from 2014/15 to 2015/16. A reduction was observed in all severities.

Next steps:

Reducing the rate of inpatient harmful falls will remain a Trust priority for 2016/17. We will continue to review and monitor delivery against the refreshed inpatient falls reduction strategy 2014/17 at our strategic falls meetings. The improvement work programmes will be driven by the newly developed Strategic Falls Reduction Group.

Priority 4: Continue to improve medication safety

Medicines remain the most common therapeutic intervention in healthcare and therefore it is essential that individual patients and society as a whole gets as much value out of them as possible, that they are used safely and resources are used wisely and effectively. The increased use of patient's owns drugs within the hospital have many advantages for the patient, the Trust and the wider health economy:

- Improved drug history
- Decreased missed doses
- More rapid discharge
- Discharge with familiar medicines
- Less waste
- Decreased costs

We carried out a baseline assessment in December 2014 which showed that 31% of patients used their

own medications whilst in hospital and were discharged back home with them where appropriate.

What did we say we would do?

We will increase the usage of patient's own drugs within the hospital from 31% to at least 50% by the end of March 2016.

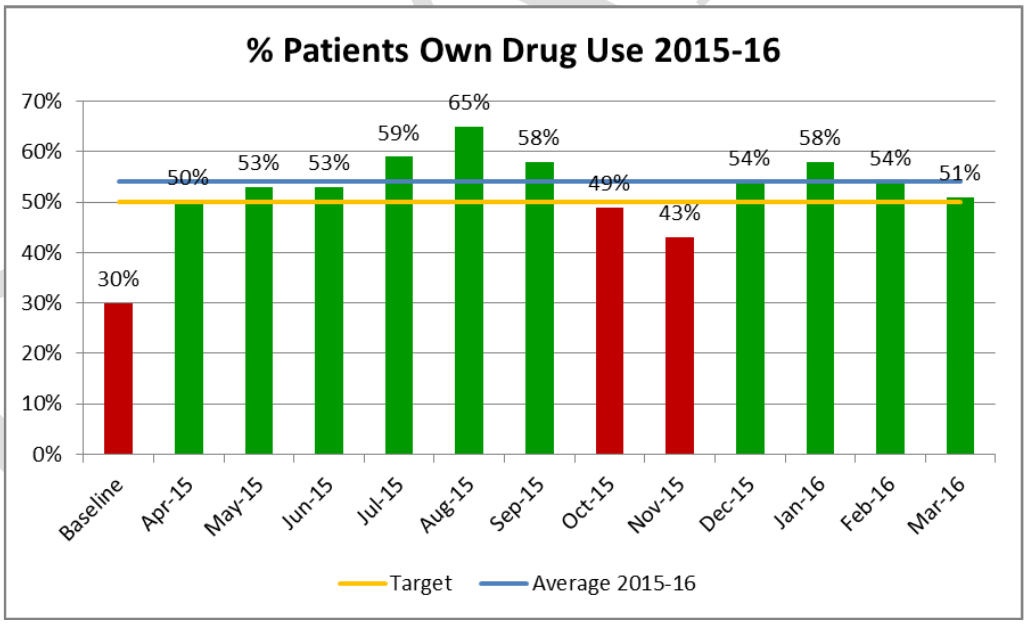
Did we achieve this?

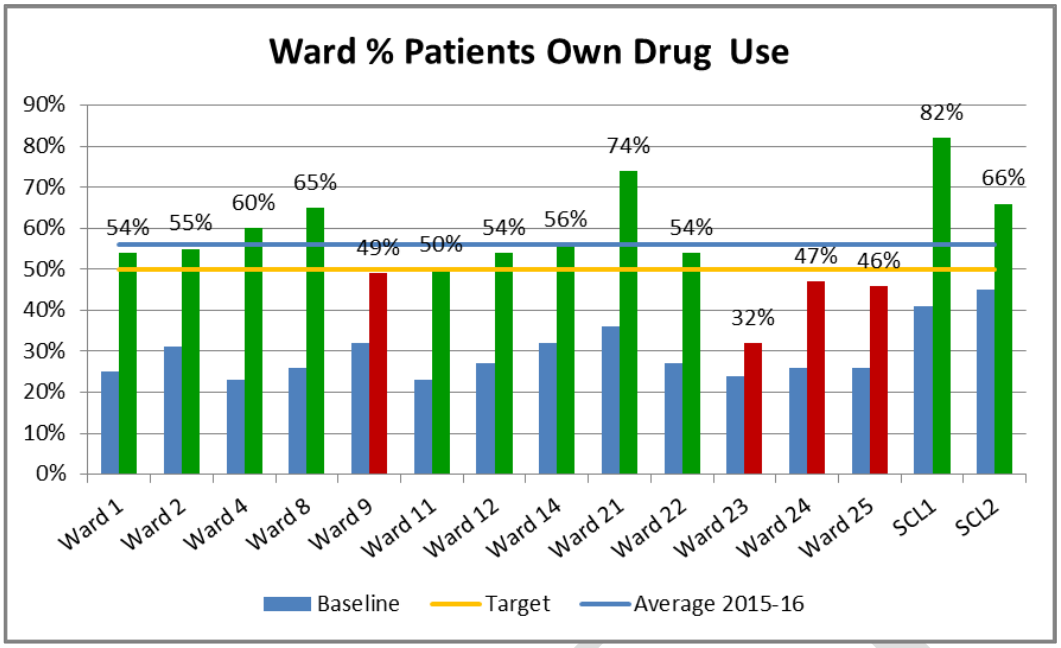
We increased the usage of patient's own drugs within the hospital to an average of 54% across 2015/16.

How we achieved it:

- We carried out an advertisement campaign to raise awareness via a number of methods; screensavers, article in QE weekly staff publication, promotional stand in Quenellies and Emergency Care Centre, meetings with the ambulance service and ward staff who were reminded to encourage patients and/or their relatives and carers to bring in their own drugs.
- We reviewed the facilities available to store patient's own drugs which resulted in new lockers with transparent fronts, new locks and moving lockers to ensure that they were located in the most accessible place for patients.
- We undertook monthly audits to monitor performance within ward areas.
- We provided regular feedback to ward areas on their numbers of patients using their own drugs and assistance provided for areas with low performance.

Evidence of achievement:





Next steps:

We will continue our programme of work around improving medication safety via the implementation of the e-prescribing system which is a priority for 2016/17.

Priority 5: Implement the 'ThinkSAFE' project

In the UK active involvement of patients and families for safer healthcare is a key recommendation of a number of national publications such as the Francis, Keogh and Berwick reports. Both staff and patients recognise patient safety benefits from having patients routinely involved in their care. 'ThinkSAFE' is a user informed robust approach to supporting patient and family involvement in improving patient safety while in hospital.

What did we say we would do?

We will join the second phase of this research project along with four other Trusts in the region to develop an implementation package. The approach comprises four interlinked components: a patient safety video, a patient-held Logbook containing a number of tools to facilitate patient/professional interactions and the sharing of information; 'Talk Time' – dedicated time to discuss queries and concerns with staff; and a training session for staff. This will ultimately become freely accessible to other NHS Trusts and patients.

Did we achieve this?

Yes we did.

How we achieved it:

- We identified a patient group to implement 'ThinkSAFE'– patients undergoing elective orthopaedic procedures.
- We identified a project team to implement the project along with the development of an action plan with the national programme manager.
- Using professional and patient feedback, we contributed to the development of monitoring tools, a dedicated website and refinement of existing tools and resources from the first stage of the research

project.

- We set up and delivered training sessions for all staff and patients involved in the project.
- We developed an action plan for commencing the test phase.
- We amended implementation package and resources with final feedback from staff and patients.

Evidence of achievement:

The project was nominated for a Patient Experience Network National Award. Newcastle University invited us to attend the awards ceremony due to how well the project was implemented within the Trust. The standard of entries was high and the award was won by Cambridgeshire and Peterborough NHS Foundation Trust for 'PROMISE: PROactive Management of Integrated Services and Environments'. The experience of attending the award ceremony has renewed our enthusiasm for improving the patient experience.

Next steps:

This will remain a priority for 2016/17 and we will expand the use of this tool to patients who have Inflammatory Bowel Disease (IBD) and are increasing their treatment to a group of drugs known as biological therapies, as well as patients who undergo planned gynaecological surgery.

Patient Experience:

Priority 6: Implement the 'Family Voices' project at end of life

Communication in the last hours and days of life can be very difficult in hospital. A 'Family Voices' diary to help families communicate with healthcare staff at this crucial and sensitive time was tested through a research project.

What did we say we would do?

We will implement this initiative in St Bede's, our palliative care ward, and ward 11, gastroenterology ward with the aim of:

- Improving communication between family/friends of a patient and the ward team.
- Give friends/family a 'voice' on behalf of the patient.
- Providing feedback to all staff every time they review the patient.

Did we achieve this?

Yes we did.

How we achieved it:

- We delivered awareness and education sessions to staff participating in the project.
- We used the project information booklet to obtain consent from families to participate in the project.
- We communicated with families to ensure they were aware that participation was not compulsory. We asked those who did want to participate to complete the diary once per day or as often as they wished.
- We reviewed the diaries regularly to identify and resolve any highlighted issues.
- At the end of the episode of care diaries were forwarded to a researcher for analysis.

Evidence of achievement:

Six diaries were completed within St Bedes during May to September 2015 and we have been awaiting the final results of the national research study from North Tees. Provisional results show that this low number has been mirrored in other Trusts regionally, however all areas have found the diaries very useful and a good tool to complement caring for patients and relatives when they are recognised as entering the last days of life. Our results showed that relative's satisfaction with the quality of care and communication with them was documented as excellent.

Next steps:

Reflecting on key lessons learned and developing a mechanism for taking this learning forward in future practice.

2.2 Our Quality Priorities for Improvement in 2016/17

Our SafeCare Strategy 2014/17 aims to deliver a programme of work that will reduce harm and avoidable mortality, improve our patients' experience and make the care that we give to our patients reliable and grounded in the foundations of evidence based care. We have set six key priorities for quality improvement for 2016/17 and these are linked to patient safety, effectiveness of care and patient experience.

We have established our priorities for improvement in 2016/17 through the following:

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

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

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

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

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

Priority 4: Continue to implement the 'ThinkSAFE' project within the Trust

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

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

Clinical Effectiveness:

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

What will we do?

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

How will we do it?

We will develop a positive Sepsis culture for identifying, treating, reporting, learning and educating including;

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

We will bring together a number of work streams including the Sepsis National Confidential Enquiry into Patient Outcome and Death (NCEPOD), regional development work and the national CQUIN in order to maximise our improvement efforts and ensure a well-co-ordinated approach.

How will it be measured?

Improvement will be measured via the CQUIN quarterly targets. These are currently being negotiated with the Clinical Commissioning Group. The targets will set an improvement goal to be achieved quarterly with the overarching goal of compliance not to fall below 50%.

Specific audits as detailed by the CQUIN for 2016/17 will also be undertaken on a monthly basis and utilised to inform progress and measure compliance.

Progress against the improvement plan will be measured monthly.

How will we monitor and report it?

- A Sepsis improvement plan will be developed detailing key milestones during the year.
- This will be monitored via the SafeCare Council and linked to the Trust's Mortality and Morbidity Steering Group and Resuscitation and Deteriorating Patient Committee.

- Quarterly to the Quality Governance Committee.

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

What will we do?

Funding for this project 2015/16 was provided by an NHS Litigation Authority (NHSLA) Sign up to Safety bid. This funding has been utilised. Last year we achieved a 50% reduction in stillbirths and early neonatal deaths. To make further improvements, we have set ourselves an ambitious target of no **avoidable** stillbirths, neonatal deaths or birth related injuries during 2016/2017.

How will we do it?

Continuing to use the NHS England Care Bundle and ensure that this is embedded into practice by:

- Continuing to carry out a carbon monoxide (CO) testing at booking to identify smokers and refer to stop smoking services.
- Continuing to provide annual staff training for Customised Growth Charts-identification and surveillance of vulnerable babies.
- Continuing to provide patient information leaflets regarding fetal movements. This is a very important intervention to ensure that we 'Ask, Assess, Act, Advise'.
- Ensuring sufficient capacity for ultrasound scanning and staffing for increased surveillance. Service Line Manager/Head of Midwifery have identified these requirements in a business case.
- Continuing to provide Cardiotocography (CTG) Assessment and training programme for all relevant clinical staff.
- Continuing to undertake peer review of all stillbirths and neonatal deaths.
- Continuing to review each case internally and will be peer reviewed. This is already undertaken by Regional Maternity Survey Office but will report to the Royal College of Obstetricians and Gynaecologists (RCOG) with 'Each baby counts' reporting framework. The Perinatal Institute will audit all customised growth charts and produce reports.
- Reporting cases and results of local serious incident investigation to the RCOG 'Each Baby Counts' project. A dedicated team at RCOG will analyse the data sent in by all Trusts in order to identify avoidable factors in the cases and share lessons learned and develop action plans for local implementation.

How will it be measured?

- Compliance with each component of the bundle will be audited monthly to assess outcome indicators.
- Work with the Perinatal Institute to benchmark and measure performance and provide quarterly audit of detection rates.
- Audit compliance with RCOG and local Small for Gestational Age (SGA) guidelines.
- Report missed cases of SGA to RCOG.
- Audit all stillbirth and neonatal deaths as part of maternity risk and governance and report on the maternity dashboard.
- The numbers of stillbirths, neonatal deaths and birth related injuries will be reviewed monthly.
- National audit data provided via MBRACE and RCOG data base.
- Benchmark with other Trusts via strategic clinical network.

How will we monitor and report it?

- Monthly at the Maternity SafeCare Meeting

- Quarterly to the Quality Governance Committee
- Yearly to the Trust Board
- Yearly to the Commissioners via Quality Review Group

Patient Safety:

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

Medicines remain the most common therapeutic intervention in healthcare, and while they may deliver significant benefits to patients they are not without potential risks.

Medication-related clinical incidents within the Trust are relatively common and their repeated analysis has demonstrated that there are some recurring types of medication errors which could result in significant patient morbidity or mortality. Historically interventions to prevent some of these errors have either been ineffectual or, at best, only partially successful.

The three types of recurring medication errors are those involving:

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

This priority is targeted at reducing the incidence of these types of errors and by doing so making patient care in the organisation safer.

What will we do?

We will fully deploy an Electronic Prescribing and Medicines Administration (EPMA) system across all acute wards in the hospital.

How will we do it?

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

How will it be measured?

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

How will we monitor and report it?

- Quarterly to the Medicines Governance Group
- Quarterly to the Quality Governance Committee
- Yearly to the Trust Board

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

What will we do?

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

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

We will continue to seek other clinical areas to adopt the project.

How will we do it?

Alongside the identified project lead for each area, develop a project plan with key milestones. The project plan will include:

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

The gastroenterology nurse specialist will introduce the approach to the patient during the consultation about the change in treatment as well as a patient networking session in May 2016.

Patients undergoing gynaecological surgery will be introduced to the approach at the pre-assessment clinic.

How will it be measured?

We will monitor patient safety/experience data within the participating areas, such as information from our incident reporting system (DATIX) and contact with the patient advice and liaison service. The key milestones identified in the project plans will be used to measure progress.

How will we monitor and report it?

- Bi-monthly at board to board performance meeting
- Quarterly to the Quality Governance Committee
- Yearly to the Trust Board

Priority 5: To continue to reduce harmful 'in hospital' falls

What will we do?

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

How will we do it?

- The Strategic Falls Reduction Group will drive the improvement work required to reduce harmful 'in hospital' falls via the following four work streams:

- Leadership and Governance
  - Undertake full review of the Falls Team to understand role and capacity.
  - Review and refresh Falls Strategy.
  - Review RCA data and findings to identify themes and actionable organisational learning.
  - Review current falls policies and protocols to ensure that they are linked to the care of patients with Dementia, Delirium and Osteoporosis.
  - Set a programme of clinical audits.
  - Develop a dedicated Falls Serious Incident Review Panel to discuss RCA findings.

- Staff Awareness, Education and Training
  - Review education and training to ensure staff are able to maintain basic professional competence in falls assessment and prevention.
  - Work with education leads to ensure nursing staff have access to and receive education and appropriate records are maintained.
  - Work with clinical leads as falls champions to ensure staff are appropriately informed of developments in falls prevention work.
  - Network with other Trusts to identify and share good practice.
  - Develop website for falls prevention.
  - Align Dementia, Delirium and falls work.
  - Evaluate impact of multifactorial assessment tool.
  - Ensure the findings from the National Audit of Inpatient Falls 2015 that relate to clinical practice are addressed.

- Review of reporting, analysis and learning systems
  - Review Datix reporting system to ensure timely, meaningful data.
  - Develop suite of reports to ensure falls reports provide timely and useful information from ward to board level.
  - Review format of RCA tool to ensure timely, good quality information is captured to enable us to learn from falls.

- Availability and use of appropriate equipment from admission
  - Undertake a full review of equipment used for mobility across inpatient service and current storage provision.
  - Undertake a review of training needs associated with the provision of basic mobility aids.
  - Develop a community strategy in relation to mobility aids.

How will it be measured?

- We will continue to use data collected on DATIX to monitor the incidence of falls on a monthly basis.
- We will ensure learning is shared and practice developed or changed where appropriate.
- We will also use the findings from our programme of audit to celebrate good practice and make improvements where necessary.

How will we monitor and report it?

- Bi-monthly to the Strategic Falls Reduction Group
- Quarterly to the Quality Governance Committee
- Yearly to the Trust Board

Patient Experience

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

What will we do?

In December 2015, the Parliamentary and Health Services Ombudsmen published a review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged. They found that:

1. The process of investigating is not consistent, reliable or good enough.
2. Staff do not feel adequately supported in their investigatory role.
3. There are missed opportunities for learning.

In April 2016, a new Independent Patient Safety Investigation Service (IPSIS) will be established. Through a combination of exemplary practice and structured support to others, IPSIS has the opportunity to make a decisive difference to how the NHS improves the way it investigates in the future.

We are seeking to take a proactive approach to prepare for working with IPSIS and is also aspiring to be a recognised champion for adopting the broad principals of a good investigation and demonstrating that learning from complaints is systematically embedded into this process.

This piece of work aims to provide us with a robust evaluation of the current process for complaints and to make recommendations about what actions need to be considered for improving the quality of this process. It is envisaged that this work will help to not only improve the process of complaints handling but also gather insight into the quality of the responses themselves and how we can better learn from our complaints. This piece of work will inform future service improvement including investigator training and improved experience for our complainants navigating our service.

How will we do it?

The work will utilise a thematic qualitative analysis and review of a 12 month sample of complaints drawn from the Datix system. This information from the Datix system will be reviewed including complaint letters, Trust responses, meeting notes and associated action plans.

Review of the reporting mechanisms alongside cascade of lessons learned will be undertaken, to produce recommendations for improvement.

Findings from the review will be used to support a more consistent and streamlined process of dealing with complaints and improve complainant satisfaction with both the process and outcome. The Trust will gather a better appreciation of the nature of the complaints received and a deeper understanding of the issues being raised (including trends and themes).

How will it be measured?

A detailed plan of work will be used to monitor and measure progress linked to the areas described above. Successful completion will be assumed once a project report with recommendations and

action plan are approved.

How will we monitor and report it?

- The work plan will be monitored and reported bi-monthly via the Patient, Public and Carer Involvement and Experience Group.
- The final report will be approved at the Quality Governance Committee.
- Quarterly to the Quality Governance Committee.

2.3 Implementing the Duty of Candour

The Trust's Duty of Candour and Being Open policy (RM49) was ratified in August 2015 by the PQRS Committee. Updates to the policy provide detailed guidance to staff to ensure compliance with statutory requirements.

Training has been rolled out throughout the Trust and includes induction for new starters and mandatory training sessions for all other staff. Additional detailed training has been provided at individual departmental sessions targeting appropriate clinical staff. Training sessions cover all aspects of the policy (RM49), and good practice in the Duty of Candour is explained and examples are discussed with the group.

The Duty of Candour verbal notification should be carried out with the 'relevant person' within 10 days of becoming aware of a patient safety incident that has, or may have resulted in moderate harm, severe harm or death. Ongoing monitoring of compliance with the Duty of Candour shows that there has been 100% compliance with carrying out stage one (verbal explanation and apology) within 10 days. Reports on compliance are received by the Trust Board every six months. See chart below for compliance in quarter three.

Month 2015	Total Duty of Candour Incidents	Severe Harm	Moderate Harm	Death	Duty of Candour carried out on time	% Compliance
October	13	2	11	0	13	100%
November	2	1	1	0	2	100%
December	8	4	3	1	8	100%

Further detailed monitoring of the Duty of Candour is ongoing to ensure that all letters of notification and letters of findings are produced, shared with the 'relevant person' and stored appropriately. Each incident is currently followed up on an individual basis to ensure these standards are met appropriately. Full compliance is expected to be reached for ensuring documentation is produced and stored in the incident management system (Datix) following the implementation of planned updates to the administrative system and formal review of all documentation at the Serious Incident Panel.

2.4 Sign up to Safety – Patient Safety Improvement Plan

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

Area/Workstream 1: Reduce omitted doses of critical medicines (focusing on regular intravenous antimicrobial medication and medicines for Parkinson's disease)

We will:

- Continue to measure the number of missed doses of intravenous antimicrobials and Parkinson's medication to ensure we sustain and better the improvements made in 2013/14. In addition we will focus on improving missed doses of Tinzaparin.
- Work with staff to better understand why doses of critical medicines are not being given to patients.
- Review our systems related to the accessibility of critical medicines across the organisation.
- Introduce a robust communication strategy to ensure all staff are aware that 'critical medicines' are always available and accessible in the Trust 24 hours a day seven days a week.
- Hold a Trust Wide SafeCare Event to promote good practice around medicines management.

Measures:

- Undertake a programme of monthly clinical audits to measure the percentage of missed prescribed doses or critical medicines that have not been administered across the organisation

Area/Workstream 2: Reducing harm from inpatient falls

We will:

- Follow up patients who have fallen to ensure patients who fall receive all elements of the post falls care bundle.
- Prioritise falls prevention work on patients with a diagnosis of Dementia, Parkinson's disease and impaired mobility.
- Launch a multi-disciplinary falls awareness campaign that involves using a variety of approaches. This will commence with a SafeCare Out & About awareness session.
- Undertake a Training Needs Analysis to identify staff requirements in prevention, reporting and management of falls and further develop a training programme.
- Review and update falls Competency Based Assessment.
- Ensure all staff within their clinical area have completed falls Competency Assessment via the education lead.
- Ask clinical leads to champion falls prevention work within their clinical area.
- Use ward Situation Background Assessment Recommendation (SBAR) handover to identify patients at risk of falls.

Measures:

A baseline assessment was undertaken and showed that no patients were receiving all 11 elements of the bundle. This result was due, in some cases, to the way in which the care was recorded onto and extracted from the Datix, incident management system, rather than a reflection of the care that was actually provided. We will undertake a programme of clinical audits monthly to measure the percentage of patients who have received all elements of the post fall care bundle.

Area/Worksteam 3: Implementation of the Sepsis Six care bundle

We will:

- Establish a robust governance framework.
- Undertake baseline assessments of clinical knowledge and practice.
- Develop a communication strategy.
- Develop staff education and awareness.
- Aspire to real time measurement of compliance.

Measures:

A baseline assessment to show compliance of the implementation of the Sepsis Six care bundle has been undertaken on 10 patients by reviewing patient records. The baseline showed that there was variation on the number and the time frame of the Sepsis Six elements being implemented. This resulted in no patients having all six elements implemented within eight hours from recognition of Sepsis. We will continue to review 10-15 cases monthly to audit compliance with the Sepsis Six bundle. We will use Plan Do Study Act (PDSA) cycles to drive improvement.

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

We will:

Implement the NHS England care bundle via;

- Implementation of robust Smoking interventions – Baby Clear initiative
- Implementation and staff training for Customised Growth Charts-identification and surveillance of vulnerable babies
- Patient information leaflets regarding fetal movements implemented and improved. This is a potentially high impact intervention to ensure that we 'Ask, Assess, Act, Advise'
- RCOG SGA guidelines to be integrated into practice and guidelines
- Review capacity for ultrasound scanning in view of increased surveillance
- Standardised and assessed measurement of fundal height for all clinical staff
- CTG Assessment and training programme implemented for all clinical staff
- Peer review of all stillbirths and neonatal deaths
- Gateshead Maternity Services nominated as 'Early Implementer' of care bundle by NHS England
- Audit all stillbirth and neonatal deaths
- Each case reviewed internally and be peer audited-work with RMSO/SCN
- Report to RCOG 'Each Baby Counts' project

Measures:

- Smoking Cessation implementation-Lead Midwife in Antenatal Care - measured via number of women who quit or are referred for further interventions, continuous audit. CQUIN targets and commissioner surveillance-Working with Regional Improvement team for quarterly surveillance.
- Management of Reduced Fetal Movements-Work with regional strategic clinic network to standardise guidelines and patient information. – Northern Clinical Network Steering Group. Patient Information sheet utilised with roll out of Customised Growth Charts
- Implementation of standardised, regional Small for Gestational Age guideline-Northern Clinical Network clinical group.

Area/Workstream 5: Implementation of a programme to empower patients in relation to their own safety whilst in our care. Participate in the Academic Health Science Network 'ThinkSAFE' project by being a test site. A project to develop a package to support and promote dissemination and implementation of the 'ThinkSAFE' concept across the Trust, North East region and beyond.

We will:

- Develop a local implementation team.
- Establish and agree area to be initial pilot site in the Trust.
- Set up and roll out of project plan.
- Delivery of 'ThinkSAFE' training sessions.
- Develop/ utilise ward/ staff support networks'
- Development of monitoring tools, refinement/ tailoring of existing 'ThinkSAFE' materials'
- Develop a dedicated ThinkSAFE website.
- Implementation of ThinkSAFE into pilot areas.

• Monitor implementation and feedback considering amendments to materials to be made for introduction to other clinical areas. • Further roll out to other areas in the organisation.
Measures: • Project plan set for implementation by the Institute of Health & Society, Newcastle University.

2.5 NHS Staff Survey results – indicators KF19 and KF27

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	2013	2014	2015
Gateshead Health NHS Foundation Trust	18.8%	23.0%	22.4%
England highest - Acute Trusts	34.0%	41.3%	42.0%
England Lowest - Acute Trusts	17.6%	17.40%	16.5%
Acute Trusts	24.1%	24.1%	25.8%

Source:www.nhsstaffsurveys.com

The results compared to 2013 have deteriorated, as has the national average. The Trust remains below the national average (lower is better) for this measure and has done for each of the three years. The Trust's results were improved compared to 2014.

Percentage believing that the Trust provides equal opportunities for career progression or promotion	2013	2014	2015
Gateshead Health NHS Foundation Trust	94.3%	91.4%	90.4%
England highest - Acute Trusts	96.3%	96.2%	95.6%
England Lowest - Acute Trusts	72.1%	70.4%	75.8%
Acute Trusts	87.5%	86.7%	86.8%

Source:www.nhsstaffsurveys.com

The results compared to 2013 have deteriorated. The Trust remains above the national average (higher is better) for this measure and has done for each of the three years. The Trust will continue to monitor this trend.

2.6 Care Quality Commission (CQC) Ratings Grid

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

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

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

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

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

An action plan has been developed to address any areas that require improvement.

2.7 Statements of Assurance from the Board

During 2015/16 the Gateshead Health NHS Foundation Trust provided and/or sub-contracted 32 relevant health services. The Gateshead Health NHS Foundation Trust has reviewed all the data available to them on the quality of care in 32 of these relevant health services. The income generated by the relevant health services reviewed in 2015/16 represents 100% of the total income generated from the provision of relevant health services by Gateshead Health NHS Foundation Trust for 2015/16.

Participation in clinical audit

During 2015/16, 39 national clinical audits and seven national confidential enquiries covered relevant health services that Gateshead Health NHS Foundation Trust provides.

During that period Gateshead Health NHS Foundation Trust participated in 90% 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 2015/16 are listed below.

The national clinical audits and national confidential enquiries that Gateshead Health NHS Foundation Trust participated in during 2015/16 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 2015/16, 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 2015/16

Audit title	Participation	% of cases submitted
Acute		
Adult Critical Care (Case Mix Programme – ICNARC)	Yes	1220 – no minimum requirement
National Emergency Laparotomy Audit (NELA)	Yes	93%
Joint Registry (NCAPOP)	Yes	100%
Severe Trauma (TARN)	Yes	77%
Non Invasive Ventilation	Yes	Not taking place during 15/16
Emergency use of Oxygen	Yes	1 – no minimum requirement
Procedural sedation in adults (care in emergency departments)	Yes	100%
Vital signs in children (care in emergency departments)	Yes	100%
VTE risk in lower limb immobilisation	No	-
Blood and Transplant		
National Comparative Audit of Red Cell & Platelet Transfusion in Adult Haematology Patients	Yes	100%
National Comparative Audit of Patient Blood Management in Adults undergoing Scheduled Surgery	Yes	100%
Cancer		
Bowel Cancer (NCAPOP)	Yes	176 – no minimum requirement
Lung Cancer (NCAPOP)	Yes	231 – no minimum requirement
Oesophago-gastric Cancer (NCAPOP)	Yes	52 – no minimum requirement
National Prostate Cancer Audit	Yes	131 – no minimum requirement
Heart		
Acute myocardial infarction and Acute Coronary Syndrome (MINAP) (NCAPOP)	Yes	91%
Cardiac Rhythm Management	Yes	136 – no minimum requirement

Heart Failure (NCAPOP)	Yes	Data not available until 30.06.16
National Cardiac Arrest Audit (NCAA)	Yes	108 – no minimum requirement
National Vascular Registry	Yes	143 – no minimum requirement
Long term conditions		
National Diabetes Inpatient Audit – Adult (NADIA)	Yes	60 - No minimum requirement
National Audit of Diabetes	No	-
National Diabetes Footcare Audit	Yes	94%
National Pregnancy in Diabetes Audit	Yes	2 – no minimum requirement
Diabetes audit – Paediatric	Yes	104 – no minimum requirement
Inflammatory Bowel Disease (IBD)	Yes	17 – no minimum requirement
National Chronic Obstructive Pulmonary Disease (COPD) (secondary care)	Yes	Not taking place during 15/16
Rheumatoid and early inflammatory arthritis	Yes	138 – no minimum requirement
Adult Asthma	Yes	Not taking place during 15/16
National Complicated Diverticulitis Audit (CAD)	Yes	140% (21 submitted against a minimum of 15)
UK Parkinson's Audit	No	-
Older people		
Falls and Fragility Fractures Audit Programme – National Audit of Inpatient Falls	Yes	30 – no minimum requirement
Falls and Fragility Fractures Audit Programme – National Hip Fracture Database	Yes	307 – no minimum requirement
Sentinel Stroke National Audit Programme (SSNAP)	Yes	291 (up to Dec 2015 – Jan-Mar16 not yet published)
Other		
Elective Surgery (PROMS)	Yes	67%
National Audit of Intermediate Care	No	-
Women & Children's		
Neonatal intensive & special care (NCAPOP)	Yes	232 – no minimum requirement
Paediatric Asthma	Yes	27 – no minimum requirement
Paediatric Pneumonia	Yes	Not taking place during 15/16

Participation in National Confidential Enquiries 2015/16

Enquiry	Participation	% of cases submitted
NCEPOD – Acute Pancreatitis Study	Yes	60% (3/5)
NCEPOD – Mental Health in General Hospitals	Yes	80% (4/5)*
NCEPOD – Sepsis	Yes	60% (3/5)
NCEPOD – Gastrointestinal Haemorrhage	Yes	100% (4/4)
MMBRACE - Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK	Yes	100% (6/6)
Mental Health Clinical Outcome Review Programme:		
• Suicide and Homicide	Yes	No eligible patients met the criteria during the reporting period
• Sudden explained death	Yes	No eligible patients met the criteria during the reporting period

*this study is still open and figures have still to be finalised

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

The reports of TBC national clinical audits were reviewed by the provider in 2015/16 and Gateshead Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National Cardiac Arrest Audit:	Myocardial Ischaemia National Audit Programme (MINAP):
The numbers of cardiac arrests per 1,000 hospital admissions has remained stable and compares favourably with national statistics. The annual total hospital admissions for 2015 were 9332 more than the previous year. Overall calls were more (209 compared to 184). The numbers of actual cardiac arrests were actually slightly increased. We continue to have older (75+) and more elderly (85+) patients in cardiac arrest than the national average. We also have more non shockable rhythm cardiac arrests and less shockable types which have an impact on our overall survival rates. Nationally, survival to discharge is approximately 17% however our survival rates for 2015 were 10.71% which is an improvement on the previous year.	This national audit measures the quality of management of patients suffering heart attacks (myocardial infarction) and angina (acute coronary syndrome) in hospitals in England and Wales. The audit enables the Trust to measure its performance against targets in the National Service Frameworks, which in turn enables the Trust to improve the care and treatment of these patients. The Trust continues to maintain a high level of performance in patient management across key standards. Over the last year Secondary Prevention Medications has been consistently 100% in patients who are eligible to receive these medications on discharge (especially ACE inhibitors – medicines used to treat high blood pressure). We continue to

The following actions have been recommended. Actions: • Continue to promote early anticipatory decisions relating to resuscitation for all acute admissions by consultant review. • Monitor the implementation of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms against numbers of cardiac arrests. • Continue to identify factors contributing to cardiac arrests in hospital by performing retrospective reviews on a proportion of cardiac arrests identifying events in the previous 48 hours. • Continue to support clinical areas where patients are more likely to suffer cardiac arrest with Immediate Life Support (ILS) and Advanced Life Support (ALS) Courses. • Ensure areas of concern and progress are discussed at regular Resuscitation & Deteriorating Patient meetings.	provide a high standard of care and more importantly personalised care. The following actions have been identified to further improve care: • Continue to ensure consistency of input of information into the cardiology database by weekly review of data via electronic patient administration system in collaboration with the Information Technology department. • Chest pain nurses to continue with data input and high standard of review within A&E Department to ensure smooth flow of patients appropriately. These nurses to be utilised as a cardiology resource in other areas. • To ensure that all of the cardiology team are aware of the value of MINAP data and its value to the general public.
National Care of the Dying Audit:	**National Comparative Audit – 2015 Audit of Patient Blood Management in Adults undergoing scheduled surgery**
The organisational audit results were very positive and encouragingly we had improved from last year as a Trust. We have ongoing audit procedures, clear policies and guidance, an end of life care facilitator in post and a lay member responsible for end of life care on the board. As well as a robust education programme for all grades of health care professionals including communication training. The gaps identified were a lack of access to 24/7 specialist palliative care services which was epidemic to most Trusts and secondly that we are not using Electronic Palliative Care Co-ordination Systems (EPaCCS) which is a record sharing system that has been suggested nationally as best practice. Actions: • This is identified as a key priority work stream action for the End of Life Steering Group, further discussions with the commissioners regarding face to face 24/7 access to palliative care are also reflected on the CCG work plan (only 11% of Trusts offered this access). • EPaCCS work with CCG to develop next steps to implement this.	This was a National Comparative Audit to review patient blood management for adults undergoing scheduled surgery. Patient Blood Management (PBM) is an emerging concept whereby factors that may predispose patients to needing allogeneic (donor) transfusions are addressed before transfusion is considered. PBM has been described as a “three-pillar approach” aimed at optimising the patient’s red cell mass, reducing surgical blood loss and harnessing the patient’s physiological reserve including the restrictive use of blood transfusion. Although red cell usage in surgical patients has decreased over recent years, surgery still accounts for a quarter (450,000 units) of total UK red cell use. There is a need to assess the current role of PBM in surgical practice to establish a benchmark and set audit standards in the UK. For the audit the patients were audited against 11 patient blood management criteria. 55% patients had pre-operative anaemia management. This compares to 46% nationally. Intra-operatively, cell salvage was not used; however cell salvage would not have been appropriate for these patients. 100% patients

The clinical case note review results were better than last year and were encouraging in most aspects, taking into consideration that the Liverpool Care Pathway had been withdrawn. We again scored better than last year, but did fall below the national average on documentation that patients were dying. Actions: • Implementation throughout the Trust of the caring for the dying document. • When the document is not deemed to be appropriate, medical and nursing staff should be encouraged to document using the five priorities of care. • Ongoing training and education will incorporate all of the above action points, particularly for staff to use skills of good communication and the recognition of dying.	had at least one PBM measure attempted, although only 29% had all measures met. Post operatively all patients had at least 1 PBM measure attempted. 73% of the transfusions were given within the first seven post-operative days. The audit highlighted a difference in practice across the country and suggested developing a standard of practice to promote appropriate use of transfusion in surgery. The following actions have been identified following this audit: • Discuss the report at the Hospital Transfusion Committee. • Circulate results of the audit to all relevant staff. • Discuss audit results with relevant staff during training sessions. • The use of cell salvage is currently being reviewed. • Promote the use of single unit transfusions during training sessions and by transfusion staff at the initial blood request.
National Emergency Laparotomy Audit (NELA):	**Patient Reported Outcome Measures (PROMS)**
This national audit measures the quality of care for patients undergoing emergency laparotomy through the provision of high quality comparative data from all providers of emergency laparotomy. The results highlighted very good performance with regards to consultant intra-operative involvement (85% cases had consultant and consultant anaesthetist (national average 65%), goal directed fluid therapy (85% v 52% nationally) and post-op critical care admission (85% v 60% nationally). There were some areas where performance was below national average and these included consultant surgeon review within 12 hours of admission (39% v 48% nationally), and use of CT scanning pre-op (70% v 80% nationally). The following actions are recommended for moving forwards: • Continued promotion of emergency laparotomy care with Anaesthetics/Critical Care and Surgical teams, with ongoing monitoring of NELA data collection. • Enhance NELA data collection through improved data collection forms.	The Trust scored slightly higher than the national average for participation (patients completing the questionnaire) for primary total hip replacement and primary knee replacement. We are however below the national average for the outcomes for both primary hip and knee replacements. We have taken the following action to improve outcomes in primary hip and knee replacement: Actions: • Staff reminding patients during follow up telephone conversations and appointments, of the importance to complete the six month post-operative questionnaire. • Maintaining a robust system using nursing and admin staff for collection of questionnaires. • Ensuring content of patient information leaflets reflect current practice. • Regular multidisciplinary group meetings to review joint care pathways highlighting PROMS. • Reducing the length of time patients follow hip precautions. • Holding quarterly focus groups with patients

• Continued monitoring of performance against standards set by research trial, utilising graphs etc and sharing results with team members. Providing case by case feedback to the clinicians involved regarding their performance at meeting certain criteria. • Use of NELA data to inform other quality improvement such as post op pneumonia prevention study. • Use SafeCare sessions to provide regular updates and opportunities for discussions of areas of concern or improvement.	to hear their views. • Consulting with other Trusts whose outcomes are above the national average to see if we can learn to improve our outcomes. • Consultants undertaking an audit using PROMS data to identify patterns and draw further conclusions. • Reviewing how the Trust promotes shared decision making for patients before surgery.
National Audit of Inpatient Falls 2015	**Neonatal Intensive and Special Care**
The Trust scored well in terms of having an appropriate falls risk assessment tool with which to assess an individual's risk of falling when they are admitted into the Trust. We also performed well in some of the other aspects of good falls prevention care. 88% of patients had a continence assessment and 96% had the call bell in reach. However there are areas for improvement and by implementing the following actions the quality of care will improve: Actions: • A walking aid policy is to be developed to ensure seven day access to walking aids for all newly admitted in-patients who require them. • An education programme is to be developed to improve compliance with measuring lying and standing blood pressures in those over 65 years old on admission to hospital. • To work with pharmacy and medical staff to improve review of falls risk medications in those over 65 years old on admission to hospital. • Trust falls documentation is to be reviewed to include screening for delirium (acute confusion) as this is a significant risk factor for falling.	Awaiting data
National Diabetes Audit – Paediatrics:	**Severe Trauma Audit & Research Network (TARN):**
Awaiting data	Awaiting data
National Bowel Cancer Audit (NBCA):	**Lung Cancer:**
Awaiting data	Awaiting data
National Complicated Diverticulitis Audit:	**Sentinel Stroke National Audit Programme:**
Awaiting data	Awaiting data
Rheumatoid and early inflammatory arthritis national audit:	
Awaiting data	

The reports of 24 local clinical audits were reviewed by the provider in 2015/16 and Gateshead Health NHS Foundation Trust intends to take the following 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
Surgery	Trauma & Orthopaedics	The Trauma & Orthopaedic team developed education sessions for staff in relation to the removal of catheters within the 48 hours following surgery for fractured neck of femur.
	Trauma & Orthopaedics	The Trauma & Orthopaedic team have improved the post-operative review processes as the nurse practitioner is now aiding in the review and discharge planning for elective patients and the Orthogeriatrician provides input for trauma patients.
	General Surgery	The Vascular Team have made changes to the clinical guideline relating to making the best effort to sample artery - instructing surgeons to sample adequate length of the artery.
	Maternity	The maternity department are reviewing the methodology for their Maternity Record Keeping Audit. In order to improve the timeliness and efficiency of the audit, the department have developed an electronic tool which will support the development of the audit methodology, collection progress and enable direct population of results to a report.
Medicine	Haematology	In order to improve some areas of the process for Chronic Lymphocytic Leukaemia (CLL) practice, the team have reviewed and improved the content of the Chronic Lymphocytic Leukaemia GP information leaflet. They have also added a tick box to chemotherapy prescriptions to act as a reminder for staff to check human immunodeficiency virus (HIV)/hepatitis B virus (HBV)/hepatitis C virus (HCV) status.
	Gastroenterology	The team responsible for looking after patients with Decompensated Cirrhosis (the liver is not able to perform all its functions adequately) has amended its processes including ensuring the care bundle is made available on the Trust intranet and in paper copy in the Emergency Admissions Unit/Accident & Emergency. Addition of the decompensated cirrhosis investigation bundle to the ICE request system. Further education sessions for medical staff around the use of care bundle.
	Old Age Psychiatry	The team are developing a training package for relevant staff in suicide prevention and risk management. Complexities around the electronic system for recording patient information, assessments and care plans continue to cause issues, a meeting has been set up to discuss ways to improve this.
	Respiratory	The respiratory team reviewed practice against NICE guidance for Asthma. They plan to improve the quality of the service by; asthma management flow chart to be displayed in the Emergency Care Centre, Emergency Care Centre Assessment Unit and the intranet. Personalised action plans to be developed on Medway (patient

		administration system) for asthma admissions. Peak expiratory flow rate charts/devices to be more widely available in Emergency Care Centre. Education sessions to be developed for junior doctors for start of next placement.
	Accident & Emergency	The Computed Tomography (CT) team plan to carry out further research to identify the reasons why 50% of patients did not have a scan completed and reported on within one hour. Training and awareness sessions will be carried out for staff around timely CT requests and the importance of telephoning radiology to advise of the urgency of the requests.
Clinical Support & Screening	Pathology	The Pathology Service will use the dissemination of the results of the audit to promote and raise awareness of positive patient identification and hold training sessions with relevant staff where more in depth knowledge is required.
	Diagnostic Imaging	The team will liaise with managers/senior staff within the Emergency Care Centre and Emergency Assessment Unit to develop a standard operating procedure to define how patients should be transferred to diagnostic imaging. The standard operating procedure will then be audited to assess compliance/effectiveness.
	Breast Screening	A programme of training and awareness raising has been developed to support staff to complete handover following a visit from engineers working on x-ray equipment in line with Ionising Radiation Regulations (IRR).
	Bowel Screening	In order to improve the delays occurring at key points in the pathway highlighted by the results of the audit, the team are planning to; place a flag on the computer system to clearly identify Bowel Cancer Screening Programme (BCSP) patients. Pathway to be reviewed to allow BSCP radiology lead to provide facility for nurse-led referral for Computed Tomographic Colonography.
	Outpatient Department	Although the audit results identified a low rate for Did Not Attend (DNA), some further work is planned by the team in order to identify avoidable reasons for patient DNA. A questionnaire is to be designed to send to patients with previous DNA who subsequently attend.
	Outpatient Department	Via a series of staff training, clinical supervision and re-audit, the nursing staff within the outpatient department plan to improve the standard of their documentation within the patient's notes.
	AAA Screening	The team will continue their programme of audit to sustain the low levels of incidence of incorrectly recorded longitudinal section (LS) and transverse section (TS) (diameter of the aorta (main artery in the human body) in two planes). The NHS Abdominal Aortic Aneurysm Screening Programme (NAAASP) Screener reports will continue to be reviewed in conjunction with Quality Assurance reports from the Screening Management and Referrals Tracking (SMaRT) system by the management team for incorrect data and inaccuracies will be rectified immediately. In addition reports will be produced from the SMaRT system by the nurse practitioners on a monthly basis to check the correct screener and role are documented in all screening records.
	Pharmacy	In order to improve the prescribing of strong opioids, the Pharmacy Team have developed a programme of education for prescribers through good practice guidance/medicines optimisation newsletter.

		Pharmacist independent prescribers will be encouraged to amend inappropriate prescriptions and a training programme has been developed for junior medical staff.
Nursing Directorate	Acute Response Team	The Acute Response Team have developed a programme of work to improve privacy and dignity for patients at night. The work programme will look at improving the following areas; bottle stands to be available and stored appropriately in ward areas, catheterised patient's night bags to be emptied more regularly, most appropriate storage for commodes and the main cause of noise overnight.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Gateshead Health NHS Foundation Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 800. Although a slight drop in recruitment from last year, it has been another successful period for Research & Development within the Trust.

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

Gateshead Health NHS Foundation Trust has continued to be involved in 181 clinical research studies in a variety of areas including cancer, dementia & neurodegenerative disease, diabetes, endocrinology, medicines for children, mental health, stroke, rheumatology, gynaecological oncology, obstetrics and various specialty groups between 2015/16.

Over the last year, researchers from the Trust have published over 85 publications, submitted 19 abstracts and delivered 37 presentations to a variety of audiences, the majority of which are as a result of our involvement in National Institute for Health Research (NIHR), which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

There were 121 members of staff participating in research approved by a research ethics committee at Gateshead Health NHS Foundation Trust during 2015/2016. These staff participated in research covering 10 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.

Gateshead Health NHS Foundation Trust remains one of the top 100 performing Trusts (ranked 74th overall in the Guardian League Table). In comparison to other Trusts in the region the Trust did very well, only three other Trusts had higher recruitment: - Newcastle (ranked 8th), South Tees (ranked 51st) and Northumbria (ranked 53rd).

Good News!

Research Study – PARAGON (Phase III study for patients with symptomatic heart failure) the Trust was the first site nationally to recruit the first patient into the study and the Trust remains the top recruiting site for the UK. The Trust continues to be a green light site by one particular pharmaceutical company.

Dr Ray Meleady, Consultant Cardiologist, has been nominated and recognised for his personal contribution by the NIHR CRN and by Professor Chris Whitty, Chief Scientific Advisor, in the First Commercial Study Delivered Successfully category.

The Research & Development Team continues to grow with the dual appointment of two, Band 5 Intern Research Nurses. The Intern Research Nurses will have a varied role which includes - the promotion of research activity within their specialties, develop initiatives to increase the visibility of research, contribute to the development of clinical practice and work as part of the research team to positively impact on current and future activity. The Trust is keen to 'grow its own' Research Nurses and will hopefully continue with the Intern Programme in the future.

Use of the Commissioning for Quality and Innovation Framework

A proportion of Gateshead Health NHS Foundation Trust income in 2015/16 was conditional upon achieving quality improvement and innovation goals agreed between Gateshead Health NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically at http://www.qegateshead.nhs.uk/cquin

A monetary total of £4,393,179 of the Trust's income in 2015/16 was conditional upon achieving quality improvement and innovation goals. The Trust were paid a total of £4,107,871 for achieving the quality improvement and innovation goals for 2014/15.

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 2015/16.

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

The Care Quality Commission made two unannounced visits during 2015/16. The visits were to carry out routine Mental Health Act monitoring visits of detention in hospitals. This visits were carried out in May and June 2015 and covered Sunnside and Ward 23.

There were no compliance issues identified in either of the visits.

However, Gateshead Health NHS Foundation Trust was routinely inspected by the CQC during 2015/16 and was given an overall rating of Good with 'Outstanding' for caring. Further information can be found at pages 31-32.

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 is essential if improvements in quality of care are to be made.

Gateshead Health NHS Foundation Trust submitted records during 2015/16 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data is shown in the table below:

Which included the patient's valid NHS Number was:	Trust %*	National %*
Percentage for admitted patient care	99.7%	99.2%
Percentage for outpatient care	99.8%	99.4%
Percentage for accident and emergency care	98.2%	95.6%

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

* SUS Data Quality Dashboard - Based on provisional April 15 to February 16 SUS data at the Month 11 inclusion Date

Information Governance Toolkit

Gateshead Health NHS Foundation Trust's Information Governance Assessment Report overall score for 2015/16 was 91% and was graded satisfactory.

Standards of Clinical Coding

Gateshead Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission.

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

- Data Quality Strategy Group which includes key staff from all specialities to highlight and drive continual improvement.
- Continual development of our Data Quality Metrics to ensure all appropriate indicators are covered and align to national and local quality indicators.
- Continue with daily batch tracing to ensure the patient demographic data held on our Patient Administration System (PAS) matches the data held nationally.
- Circulate weekly patient level reports to allow the clinical services to fully validate 18 week and cancer pathways.
- Spot check audits to randomly select patients and correlate their health record information with that held on electronic systems.
- Continue to work the data quality leads throughout the Trust to promote and implement data quality policies and procedures to ensure that data quality becomes an integral part of the Trust's operational processes.

- Clinical Coding Quality Assurance Programme to provide assurance on the quality of coding within the Trust.
- Working with Commissioners to ensure commissioning datasets are accurate, completing data challenges with five days.
- Monthly data meetings Data Quality Information Governance (DQIG) are held with the CCG to discuss any data concerns and data challenges.
- Review Internal Audit Department plans to include data quality processes.

2.8 Mandated Core Quality Indicators

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

SHMI (Summary Hospital-level Mortality Indicator)

(a) SHMI	Oct 13 – Sep 14	Jan 14 - Dec 14	Apr-14 Mar-15	Jun 14 - Jul 15	Oct 14 – Sept 15
SHMI	1.01	1.01	1.00	0.98	0.95
England highest	1.19	1.24	1.21	1.21	1.12
England lowest	0.59	0.66	0.67	0.66	0.65
Banding	2	2	2	2	2

Source: www.HSCIC.gov.uk

SHMI Banding 2 indicates that the Trusts mortality rate is 'As Expected'

(b) % Deaths with palliative coding	Oct 13 – Sep 14	Jan 14 - Dec 14	Apr-14 Mar-15	Jun 14 - Jul 15	Oct 14 – Sept 15
% Deaths with palliative coding	14.9%	15.2%	14.5%	15.0%	16.6%
England highest	49.4%	48.3%	50.9%	52.9%	53.5%
England lowest	7.5%	7.7%	10.1%	12.4%	0.2%
England	25.3%	25.9%	25.8%	25.9%	26.6%

Source: www.HSCIC.gov.uk

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

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

Gateshead Health NHS Foundation Trust has taken the following actions to improve the indicator and percentage in (a) and (b), and so the quality of its services, by [please see pages 8-12].

Gateshead Health NHS Foundation Trust intends to take the following actions to improve the indicator and percentage in (a) and (b), and so the quality of its services, by [please see page 21].

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

Proportion of patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric inpatient care	2013-14				2014-15				2015-16			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Gateshead Health Foundation Trust	100%	100%	Nil*	100%	100%	100%	90%	100%	89%	100%	50% **	80 %
England	97%	98%	97%	97%	97%	97%	97%	97%	97%	97%	97%	NA
England Highest	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100 %	NA
England Lowest			77%	93%	93%	92%	90%	93%	89%	83%	50%	NA

Source:https://www.england.nhs.uk/statistics/statistical-work-areas
* There were no qualifying patients for this period.
**3 of 6 patients followed up within seven days after discharge from psychiatric inpatient care

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

- One patient was seen while on home leave from a hospital stay, they were discharged without returning to the inpatient unit then seen again the first available date after discharge (day8).
- One patient was seen on the first available date (day12).

Gateshead Health NHS Foundation Trust has taken the following actions to improve these outcome scores, and so the quality of its services, by:
As part of the the discharge planning process for all patients:

- A named Care Co-ordinator will be allocated to the patient where ever possible.
- An appointment with the patient within seven days after they have been discharged from hospital.

PROMs (Patient Reported Outcome Measures) for

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

Groin Hernia Adjusted average health gain	2011-12 Final	2012-13 Final	2013-14 Final	2014-15 Provisional	Apr 15 to Sep 15 Provisional
Gateshead Health Foundation Trust	0.054	0.081	0.064	0.084	0.008
England	0.087	0.085	0.085	0.084	0.088
England Highest	-	-	0.139	0.154	0.135
England Lowest	-	-	0.008	0.000	0.010

Varicose Vein Adjusted average health gain	2011-12 Final	2012-13 Final	2013-14 Final	2014-15 Provisional	Apr 15 to Sep 15 Provisional
Gateshead Health Foundation Trust	0.079	0.053	0.125	0.067	*
England	0.095	0.093	0.093	0.095	0.104
England Highest	-	-	0.150	0.154	0.130
England Lowest	-	-	0.022	-0.004	0.037

Hip Replacement Adjusted average health gain	2011-12 Final	2012-13 Final	2013-14 Final	2014-15 Provisional	Apr 15 to Sep 15 Provisional
Gateshead Health Foundation Trust	0.393	0.424	0.391	0.428	*
England	0.416	0.438	0.436	0.437	0.454
England Highest	-	-	0.544	0.524	0.520
England Lowest	-	-	0.311	0.322	0.000

Knee Replacement Adjusted average health gain	2011-12 Final	2012-13 Final	2013-14 Final	2014-15 Provisional	Apr 15 to Sep 15 Provisional
Gateshead Health Foundation Trust	0.285	0.331	0.291	0.310	0.278
England	0.302	0.318	0.323	0.315	0.334
England Highest	-	-	0.425	0.42	0.142
England Lowest	-	-	0.215	0.202	0.207

Source: www.HSCIC.gov.uk

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

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

Groin

- Our outcomes are in line with the national normal distribution using the EQ-5D measure.
- We will continue to share data with clinical teams and commissioners to ensure that health gains can be maximised from future procedures. We will also discuss with patients considering surgery the range of outcomes that can be expected to ensure they have an informed choice of treatment, including alternatives to surgery where appropriate.

Veins

- Our outcomes are in line with the national normal distribution using the EQ-5D measure. Planned procedures on an OP basis are also predicted in 2016/17.
- We will continue to share data with clinical teams and commissioners to ensure that health gains can be maximised from future procedures. We will also discuss with patients considering surgery the range of outcomes that can be expected to ensure they have an informed choice of treatment, including alternatives to surgery where appropriate.

Hip

- Our outcomes are below recommended parameters using the EQ-5D and Oxford hip score.
- We will continue to share data with clinical teams and commissioners to ensure that health gains can be maximised from future procedures.
- See below for other actions taken to improve our outcome scores.

Knee

- Our outcomes are below recommended parameters for the Oxford knee score.
- We will continue to share data with clinical teams and commissioners to ensure that health gains can be maximised from future procedures.
- See below for other actions taken to improve our outcome scores.

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

- Asking patients via planned focus groups.
- Analysing data at patient level.
- Consultant level data feedback to review individual practices.
- Following consultation with North East Quality Observatory (NEQOS), plan to implement strategies to move the whole population score higher rather than concentrating on detail behind low scores.
- Regular MDT that reviews pathway and highlights PROMS.
- Reviewed patient literature.
- Promoting PROMS – contact patients M4/5.
- Shared decision making – relaunch in Outpatients.

Emergency Readmissions within 28 Days

- Aged 0 – 15yrs
- Aged 16yrs or over

Child 0-15 Years	2012-13	2013-14	2014-15	Apr 15 to Dec 15
Emergency Readmission Rate	10.19%	8.91%	11.49%	8.79%
Number of Superspells	6,489	4,970	5,154	2,264
Number of Readmissions	661	443	592	199

Adult 16+ Years	2012-13	2013-14	2014-15	Apr 15 to Dec 15
Emergency Readmission Rate	9.44%	8.69%	9.42%	10.11%
Number of Superspells	50,820	54,234	58,712	32,310
Number of Readmissions	4,795	4,714	5,532	3,267

Source: Dr Foster Quality Investigator
11th April 2016

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

- Improvements in alternatives to admission- for example through Ambulatory Emergency Care which means that the patients that are being admitted are very ill and are more likely to be re-admitted.
- Increasing elderly frail population with several co-morbidities
- Being able to successfully treat patients experiencing an exacerbation of their chronic disease and getting them home whereas previously these would have been fatal much earlier in the disease process. Patients nearing end of life have frequent exacerbations of their disease often requiring hospital admission.

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

- Several Nursing teams are working to ensure that patients are not admitted unnecessarily and being cared for in their own homes. Their interventions will help to reduce the risk of re- admission and will spot patients who have early signs of deterioration so that these can be treated in a timely way. For example the Respiratory Nursing team who have an early supported discharge service.
- Heart Failure Nurses visit recently discharged patients in the community to monitor their signs and symptoms to ensure any deterioration is treated in a timely way.
- Parkinson's disease Nurse Specialists visit patients at home to monitor their signs and symptoms to ensure any deterioration is treated in a timely way.
- The above all work very closely with the patients' General Practitioner (GP) and Community staff.
- Establishing a frail elderly team who perform rapid front of house assessments, support transfer back to home where appropriate and ensure support at home is optimised. This is a Multidisciplinary Team (MDT) approach involving physiotherapy, occupational therapy and nursing input.
- Agreeing a Rapid Response service with Social Services to the Accident and Emergency Department so that appropriate patients can be placed in the community with the right support and not turn into an admission/re-admission.
- Inviting the Community Matrons to the Ward Sister sessions at the Trust to promote role and ensure contact details are widely known and used to improve communication on discharge.
- Re-invigorating discharge planning work and developing action plans jointly with Community Services and the Local Authority.
- Supporting and working to the Emergency Health Care plans that have been put in place by the GPs.

Trust's responsiveness to the personal needs of its patients

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

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

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

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

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

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

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

- We are continually listening to what patients tell us in their feedback through a variety of media sources and 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:

- Implementing our strategy through the Patient, Public and Carer Involvement and Experience Group that includes key internal an external stakeholders such as the Local Authority, HealthWatch and Voluntary Groups and Organisations.
- 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	2013	2014	2015
Gateshead Health NHS Foundation Trust	69.7%	74.7%	76.2%
England highest - Acute Trusts	88.5%	89.3%	85.4%
England Lowest - Acute Trusts	39.6%	38.2%	46.0%
Acute Trusts	64.5%	64.7%	69.2%

Source:www.nhsstaffsurveys.com

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

- Gateshead Health NHS Foundation Trust has scored consistently above the national average for staff recommending their organisation as a place to receive care.
- This rating has improved year on year for the last three years.

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

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

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

Year	Quarter	Gateshead Health NHS Foundation Trust	England Highest Acute Trust	England Lowest Acute Trust	Acute Trusts
2012-13	Q1	92.8%	100.0%	80.8%	93.4%
	Q2	91.9%	100.0%	80.9%	93.9%
	Q3	91.1%	100.0%	84.6%	94.1%
	Q4	91.9%	100.0%	87.9%	94.2%
2013-14	Q1	91.0%	100.0%	78.8%	95.4%
	Q2	95.2%	100.0%	81.7%	95.8%
	Q3	95.1%	100.0%	74.1%	95.7%
	Q4	95.8%	100.0%	78.9%	95.9%
2014-15	Q1	95.3%	100.0%	87.2%	96.1%
	Q2	95.3%	100.0%	90.5%	96.2%
	Q3	95.1%	100.0%	81.2%	95.9%
	Q4	95.3%	100.0%	79.2%	95.9%
2015-16	Q1	95.6%	100.0%	86.1%	96.0%
	Q2	95.1%	100.0%	75.0%	95.8%
	Q3	95.0%	100.0%	61.5%	95.4%
	Q4	95.3%*	N/A	N/A	N/A

*Q4 Indicative Position as at 11th April – Submission due on 28th April

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

- We are continually monitoring our performance and compliance through the VTE committee to maintain over 95%.

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

- Continuing the implementation of the electronic system for undertaking and recording of VTE risk assessment.
- Continuing to perform Root Cause Analysis (RCA) on all patients with a possible hospital associated thrombosis where they are readmitted to hospital within 90 days of discharge with a diagnosis of Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) or they are discharged from a hospital stay with a diagnosis or DVT or PE.
- Identifying learning as a result of these RCA's and ensure it is shared with our clinical teams.
- Continuing to promote education and training of all relevant clinical and support staff.

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

Rate of C. difficile per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	2012-13	2013-14	2014-15	2015-16
Gateshead Health NHS Foundation Trust	17.5	12.2	15.3	13.4*
England highest	31.2	37.1	62.2	
England lowest	1.2	1.2	1.2	
England	17.4	14.7	15.1	

Source:www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data
15/16 number based on 25 post 72hr figure

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

- *Clostridium difficile* infection (CDI) continues to present a key risk to patient safety therefore ensuring preventative measures and reducing infection is very important to the quality of patient care we deliver. A focused and zero tolerance approach to support a reduction in CDI for patient safety was implemented in line with the Infection Prevention Strategy.

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:

- A number of infection prevention initiatives and developments have been implemented within the Trust to ensure complacency does not exist with regard to CDI and also to provide assurance that the Trust is delivering the best evidence based care for patient safety.
- Multidisciplinary CDI RCA meetings are arranged and reviewed to ensure lessons learned are shared.
- The diarrhoea assessment management pathway (DAMP) provides both qualitative and quantitative data against the level of compliance for frontline staff managing those patients experiencing loose stools.
- Personal protective equipment and long sleeved protective gowns are worn following isolation of the patient with suspected infective diarrhoea.
- Due to the limited number of isolation rooms available in the Trust the prioritisation of patients requiring isolation always requires an individual patient risk assessment.
- Isolation/cubicle audits are completed by the IPC team on a daily basis to ensure a comprehensive review contributing to the risk assessment of effective patient safety.
- Environmental surveillance provides an ongoing assurance against contamination of the general environment highlighting areas where cleaning and general adherence to policy can be improved. Infection prevention strategies and regular environmental screening of clinical areas are proving

valuable in identifying areas of high risk in clinical areas providing an evidence base for enhanced/deep cleaning, and targeted education.

- NICE recommendations issued in March 2015 support existing evidence that some antibiotics carry with them a greater risk of developing CDI than others. Audits have shown that as evidence of risk has become apparent, changes have been made to the Gateshead Health NHS Foundation Trust antimicrobial guidelines and action taken to ensure the changes are implemented.
- A weekly CDI MDT meeting takes place and antimicrobial prescribing is reviewed along with all aspects of CDI care.
- Ribotyping of CDI cases is arranged with the *Clostridium difficile* Ribotyping Network (CDRN) to determine if cross infection has taken place within specific clinical areas.
- An overarching IPC Strategy was developed setting out a clear objective for the Trust in ensuring that patient safety in respect of IPC is delivered. It provides a framework for the management of Healthcare-associated Infection (HCAI) and establishes Trust priorities for IPC for the population of Gateshead and its surrounding area.

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

Patient Safety Incidents per 1,000 bed days	Oct 14 – Mar 15		Apr 14 – Sep 14		Oct 13 – Mar 14	
Organisation	Gateshead Health NHS Foundation Trust	Acute (non -specialist) Organisations	Gateshead Health NHS Foundation Trust	Acute (non-specialist) Organisations	Gateshead Health NHS Foundation Trust	Acute (non- specialist) Organisations
Total number of incidents occurring	2,496	621,776	2,532	587,483	2,256	N/A
Rate of all incidents per 1,000 bed days	27.94	N/A	30.46	N/A	26.92	N/A
Number of incidents resulting in Severe harm or Death	14	3,089	19	2,168	20	N/A
Percentage of total incidents that resulted in Severe harm or Death	0.56%	0.49%	0.75%	0.36%	0.89%	N/A

Source: www.nrls.npsa.nhs.uk

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

- The incident reporting rate has fluctuated since the period October 2013- March 2014, with an overall increase from 26.92 to 27.94. Work is ongoing to ensure that the electronic incident reporting system (Datix) is efficient and user friendly. Staff receive training to report incidents appropriately at induction and mandatory training.
- The percentage of total incidents resulting in severe harm or death has reduced from 0.89% to 0.56%, which is comparable to the national rate for acute non-specialist organisations (0.49%). This represents a reduction from 20 incidents occurring during the six month period from Oct 2013-

March 2014 to 14 incidents in October 2014 – March 2015. Ongoing work to prevent serious harm from fractures as a result of falls and a reduction in the number of incidents of severe harm from pressure damage has had a positive impact on this number.

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

- Registering staff as account holders to Datix to make it easier to report incidents.
- Improvements made to sharing lessons learned using SafeCare Alerts and Good Practice Bulletins.
- Improving the efficiency of the serious incident review process to ensure that lessons are learned in a more timely way.
- Improving the process to ensure that all incidents of pressure damage are investigated thoroughly, lessons are learned and shared to prevent a recurrence.

3. Review of quality performance

2015/16 has been a successful year in relation to the three domains of quality:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

3.1 Patient Safety

Harm free care - measured by the NHS Safety Thermometer

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

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

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

Safety Thermometer	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Sample	517	516	481	474	458	465	482	490	499	515	541	512
Surveys	27	27	26	25	25	24	25	26	26	26	25	26
Harm free	95.4%	96.7%	95.0%	96.6%	93.0%	94.8%	95.4%	94.1%	96.2%	92.8%	96.9%	95.7%
Pressure Ulcers - All	3.1%	2.3%	3.3%	1.9%	3.3%	3.0%	2.5%	3.7%	2.0%	5.2%	2.0%	2.0%
Pressure Ulcers - New	1.2%	1.0%	1.3%	0.2%	0.9%	0.4%	1.2%	1.2%	0.8%	1.4%	0.6%	0.2%
Falls with Harm	0.4%	0.2%	0.4%	0.2%	1.8%	0.9%	0.8%	0.4%	1.2%	0.6%	0.7%	0.8%
Catheters and UTIs	1.4%	0.6%	1.0%	0.8%	1.3%	1.3%	1.2%	1.4%	0.6%	1.2%	0.2%	1.0%
Catheters and New UTIs	1.2%	0.6%	0.4%	0.8%	0.9%	1.3%	1.0%	1.4%	0.6%	0.6%	0.2%	0.6%
New VTEs	0.0%	0.2%	0.4%	0.4%	0.7%	0.2%	0.2%	0.6%	0.0%	0.2%	0.2%	0.6%
All Harms	4.6%	3.3%	5.0%	3.4%	7.0%	5.2%	4.6%	5.9%	3.8%	7.2%	3.1%	4.3%
New Harms	2.7%	1.9%	2.5%	1.7%	4.2%	2.8%	3.1%	3.7%	2.6%	2.7%	1.7%	2.2%

- Pressure Damage

As part of our ongoing commitment to the reduction of pressure ulcers the Trust is taking an active role in the "North East Pressure Ulcer Collaborative" which commenced in June 2015. The initiative is a quality improvement initiative funded by the Academic Health Science Network covering the Northeast and Cumbria. We have three pilot wards using a variety of quality improvement methods to test small changes. This includes the use of the SSKIN bundle, a five step model to prevent pressure ulcers. The Trust had a 13.5% reduction in pressure ulcers in 2015/16.

- Falls

Information of our action plan to reduce harmfull falls may be found on pages 24-25.

- Catheter Associated Urinary Tract Infections (CAUTI)

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

- Venous Thromboembolism (VTE)

The VTE Committee meets every quarter and continues to oversee the implementation of guidelines for the prevention and management of thromboembolism within the Trust in line with National Institute for Health and Care Excellence (NICE) and other national guidance. Please see page 50 for interventions.

Safeguarding adults and children

The following are the key achievements within the Safeguarding adults and children's teams during 2015/16:

- In accordance with the Strategic Audit Plan 2015/2016, a high level review was undertaken of the Trust's arrangements for safeguarding children and adults in August 2015. Based on the work undertaken by the Internal Auditors, the Trust has significant assurance with issues of note that there is a generally sound system of control designed to meet the organisation's objectives. The findings within the action plan are low risk in nature and remedial action was agreed with staff during the course of the audit.
- The 'Think Family' agenda promoted across the organisation has been strengthened through the recognition that children and adults do not exist in isolation of each other. The A&E Department documentation for adult patients has been amended to ask for information regarding any children in the household, which is particularly important during adult high risk presentations to the Emergency Department (e.g. domestic abuse, deliberate self-harm, adult substance misuse etc).
- There was a Safeguarding Children Inspection of Gateshead Local Authority by Ofsted during October/November 2015. The findings were released on 20th January 2016, and feedback was positive in terms or partnership working regarding Child Sexual Exploitation and joint child protection enquiries (section 47 enquiries, in which there is significant Trust safeguarding children team participation).
- There has been a rigorous programme of Safeguarding audits undertaken throughout 2015, to monitor practice across the organisation and between GHNFT and other health organisations.
- Following a recommendation from the Serious Case Review of Baby T (2013), the issue relating to the use of Medical Photography in cases of child protection has been resolved with a contract established with Medical Photography Department at Newcastle Hospitals. The Safeguarding Children Policy was amended to reflect this development.
- There are now concrete plans to enable the filling of the Designated Doctor for Safeguarding Children role, which has been vacant since 2012. Once the new Consultant is in post, the current Named Doctor will move into the Designated Doctor role.
- A Trust-wide Domestic Violence and Abuse Policy has been developed and implemented.
- As a result of recommendations made during the CQC inspection in August 2014, a number of improvements have been made to the information sharing process between Community Midwives and GPs. The Named Nurse and Midwife developed information sharing proformas to be completed by the Community Midwives on a monthly basis, detailing the high risk safeguarding cases within

their caseloads. This is now shared with GPs, and the Community Midwives are encouraged to attend the GPs multi-disciplinary safeguarding meetings to ensure robust sharing of information.

- Following a Supreme Court Judgement in 2015, the application of deprivation of liberties for patients who lack capacity has more than doubled. This was highlighted in the CQC report and staff demonstrated good knowledge of the policy and the process in the application of deprivation of liberties.
- From November 2015 a learning disabilities nurse has joined the team. The focus for this role is to ensure high quality patient centred care is delivered to patients with learning disabilities who require our services. The scope involves ensuring care pathways are in place, appropriate reasonable adjustments are made and recorded and that staff delivering the care are appropriately informed and supported.
- The Counter-Terrorism and Security Act 2015 contains a duty on specified authorities to have due regard to the need to prevent people from being drawn into terrorism. This is also know as the Prevent duty. The Safeguarding Adult Lead Nurse initially is the Prevent Lead in the Trust and radicalisation was added into the Trust's Safeguarding Adults policy. Awareness of this issue continues to be raised via the Trust Mandatory Training Day, Corporate Induction and initial awareness sessions were delivered to staff in A&E and Mental Health services.
- The Care Act 2015 came into force from the 1st of April 2015 and the adult policy was amended accordingly and processes were put in place to work collaboratively with the local authority in relation to section 42 enquiries.
- All adult cause for concerns from the 1st of April are reported using the Datix system allowing a robust audit trail and also the creation of a dashboard for reporting incidents.
- The safeguarding team have provided information for two domestic homicides and one serious case review which will be published later in 2016.

Infection, Prevention and Control

Culture and Practice driving excellence in patient safety

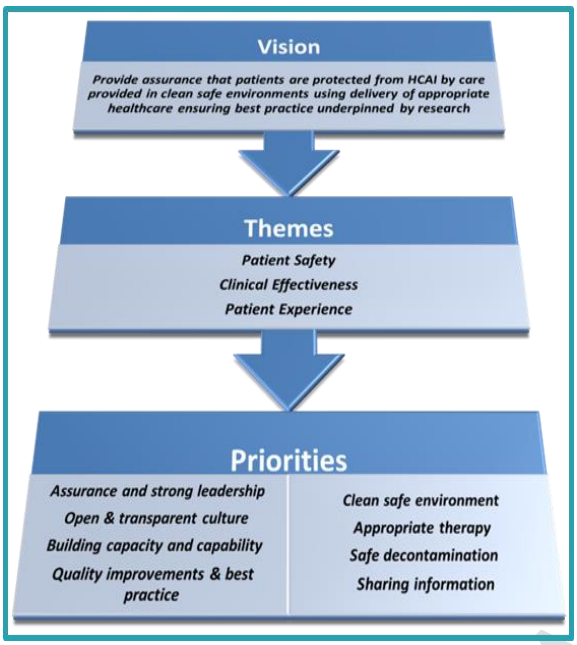
Nurses and Midwives are at the centre of effective prevention and control of infection.

All our staff understand that the culture and practice of driving excellence for patient with a zero tolerance approach to avoidable infection is essential to ensure provision of safe and effective care for all our patients.

A five year overarching Infection prevention and control (IPC) strategy sets out clear objectives for the Trust in ensuring that patient safety in respect of IPC is delivered.

The strategy is based upon three strategic themes:

- Patient safety
- Clinical effectiveness
- Patient experience



The strategy intends to lead, direct and ensure quality and safety where patient safety is paramount; prevention and control of infection is key and a positive patient experience is at the heart of everything we do as a leading healthcare provider in delivering a compassionate and caring patient experience.

IPC quality and performance reports are submitted to the annual Trust Quality Account and the 'Open and Honest Care: Driving Improvements' programme.

HCAI performance data is submitted so that patients and the public can see how the Trust is performing in these areas. This data is also published as part of the annual report and monthly HCAI performance reports to the Board.

The IPC forward programme for April 2016 – March 2017 will identify priorities by which the Trust and its Business Units are measured against.

The CQC undertook a comprehensive inspection of the Trust from 29th September to 2nd October 2015 providing the Trust with a 'good' rating. IPC rated highly throughout the CQC report which acknowledged the level of cleanliness and the robust processes in place for the prevention and control of infection and patient safety. The report acknowledged the Trust had:-

- arrangements in place to manage and monitor the prevention and control of infection.
- rates of infection were within an expected range for the size of the Trust.
- scored higher than the England average in the 'Patient Led Assessments of the Care Environment' (PLACE) for cleanliness.

The Trust has IPC nursing and medical representation at:-

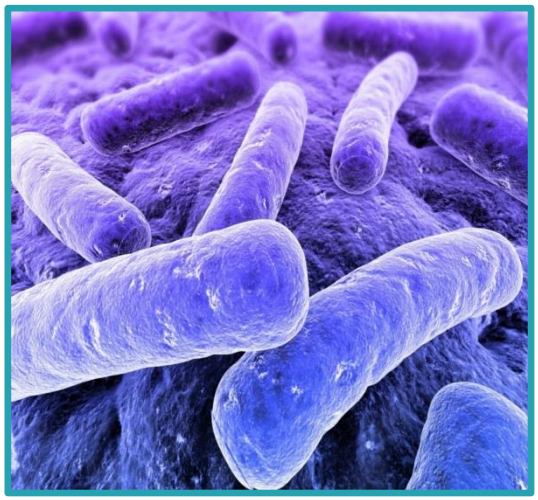
- Newcastle Gateshead Alliance HCAI Reduction Partnership
- Cumbria and North East HCAI Steering Group
- North & South of Tyne Area Health Protection Group

Membership allows partnership working and sharing of lessons learned to enable better ways of working and reduce infections.

The IPC education and learning delivered within the Trust is reviewed annually and also as an ongoing development when new guidance and/or regulation is issued. Education and learning continues to be a key area of development ensuring all Trust staff are provided with appropriate mandatory education and training as well as opportunities for further development.

The IPC team provide bespoke training and education to departments on request.

Ensuring preventative measures to reduce infection is very important to the quality of patient care. Key indicators such as Meticillin resistant *Staphylococcus aureus* (MRSA) blood stream infections (BSI) and *Clostridium difficile* Infection (CDI), Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia, *Escherichia coli* (E. coli) bacteraemia are used nationally to benchmark and measure performance. The Trust remains one of the best performing Trusts in the North East region with regards to mandatory HCAI reporting, demonstrating robust systems are in place and providing assurance for patient safety as assessed and reported by the CQC.



The Trust has remained focused to ensure that prevention of HCAI performance is maintained, however it presents a constant challenge in an ever changing and complex healthcare environment. Good effective IPC culture and practice are what are required to drive forward excellence in patient safety, quality and the patient experience. This approach will continue to ensure that as a leading provider of healthcare the Trust will be compliant with regulatory requirements meeting contractual obligations for IPC safeguarding thereby patient safety.

All IPC activity has been successfully achieved through the combined efforts of all Trust staff with the IPC team through what has been a challenging year for the Trust and NHS however this approach must continue to strengthen our focus on maintaining prevention of infection. Whilst the responsibility for continuously improving the quality of care lies with all healthcare professionals, nurses as direct caregivers have a key role in identifying potential problems, leading change and innovation for IPC, patient safety and quality.

3.2 Clinical Effectiveness

Improvements to corporate function for managing clinical effectiveness

Throughout the year there have been a number of improvements to the corporate function for clinical effectiveness, as follows:

- Implementation of Clinical Audit Action Plan developed outlining the steps that need to be undertaken in order to improve the Trust's audit position and strengthen the mechanisms by which we govern and provide assurance against the audit process.
- Purchase of a fully integrated clinical effectiveness system 'Ulysses Safeguard' which provides modules for clinical audit, NICE guidelines, clinical guidelines and safety alerts. This will reduce the unnecessary administration from Business Units and corporate perspective and provide significant assurance for the above.

- SafeCare Team members have undertaken accredited Advanced Clinical Audit Training as well as Train the Trainer in Clinical Audit. This will enable a clinical audit training programme to be developed for the organisation.
- Clinical Audit Leads have been identified within each Business Unit to improve reporting and accountability within the Business Units.
- We will continue our improvement work throughout 2016/17 concentrating on implementing the 'Ulysses Safeguard' system and refreshing our processes for measuring standards of record keeping.

Quality Improvements in Gateshead Endoscopy Unit

The endoscopy unit identified a need to improve their processes with regard to requesting to reporting the results back to the practitioner who made the initial referral. Thus ensuring there are no delays in the patient pathway. A team of clinicians and nurses collaborated with software companies to design, build and implement the world's first end to end referral, vetting, scheduling and reporting system. The system took two years to develop and is now live and being used. It has made the flow of referrals into the endoscopy unit easier to manage, audit and schedule in a timely manner. Referrers can see the details and results of the procedure on their computer instantly, even remotely in the community.

The Liver Services Department

The liver service was visited by assessors from the Royal College of Physicians in October 2015. This was the first step towards the service receiving official accreditation. Prior to the visit the service completed a self-assessment against the Liver Quest (Quality Enhancement Service Tool) Standards. These standards have been developed by the Royal College of College of Physicians of London supported by the British Society of Gastroenterologists and the British Association for the Liver.

The report singled out the nursing team for being "passionate, committed and faithful to the care of liver patients."

The team was highly commended for:

- Doing an "amazing job" delivering and developing the liver service
- Achieving so much with such limited resources and time

The Trust is the only hospital in the region where every patient is screened with a risk assessment on admission, which includes an alcohol assessment. If the patient is found to be consuming excessive amounts of alcohol, a nurse from the liver unit will visit the patient and give advice and signposts to other sources of help.

This screening service was described as

- "Outstanding" by the assessors, while the alcohol liaison nurses were singled out as an "excellent team."

The liver services department will now work towards official accreditation from the RCP, where clinical services are assessed in relation to established Liver Quest Standards. The service will develop and continually audit and improve quality of services.

New Pharmacy

The new pharmacy opened on the 25th January 2016 located on Level 2 in the main entrance of the Emergency Care Centre. The purpose-built pharmacy will provide a focused and dedicated Outpatient dispensing service to patients from the Trust.

They will be dispensing all Outpatient and Accident and Emergency prescriptions, as well as offering 'Over the Counter' medicines and products for sale. The pharmacy is owned by QE Facilities Ltd however they work to a Pharmacy contract with the Trust and commission the same clinical governance standards as staff employed by the Trust. The contract also ensures the pharmacy has robust key performance indicators which control waiting times, medicine owing's, medication errors and complaints.

3.3 Patient Experience

Improvements to corporate function for managing patient experience

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

- Establishment of a dedicated patient experience team including PALS.
- Implementation of new Friends and Family Test cards as detailed below.
- Work has commenced revising and refreshing the Friends and Family Test card for children to ensure we continue to meet their needs.
- Collection of data regarding how many observational visits take place on the wards, such as 15 Steps Challenge and PLACE visits. This has enabled the patient experience team to utilise their time in direct patient contact more effectively and gain richer qualitative data.
- New patient experience and information hub has been created, opening in April 2016.
- Improved links with the wards to promote patient experience tools and develop strategies for wards to increase response rates for tools such as the Friends and Family Test.

Friends and Family Test

We continue to apply the Friends and Family Test (F&FT) within inpatient and outpatient areas in line with national requirements. This patient experience survey is called the F&FT because it is based on asking all patients a standard question:

"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 patient responses are reviewed and used to ensure we are providing the best possible services to our patients.

Changes to the F&FT

A pilot of new F&FT cards is to commence in May 2016, the new cards will contain the same F&FT data as previously but the cards will also include questions about patient experience. The questions are selected from the real time surveys which are conducted by SafeCare staff on inpatient wards. The original questions for these surveys were developed from the 6 C's Nursing Strategy in the three domains of Communication, Care and Compassion. All areas will be given envelopes for patients to

continue to return their survey by post if they wish. The new cards will be piloted for six months at which juncture they will be evaluated to review the quality of the extra information derived from the changes. Children's services during May/June 2016 will also have a new child friendly F&FT card introduced which will also be evaluated at the end of six months.

The response rate for the test has fallen in the inpatient areas, on further investigation one of the reasons for this is due to the increased bed pressures the Trust has endured in the last quarter of the year. The SafeCare team have attended various meeting within the Trust to increase the awareness of the response rate reduction and requested suggestions to increase the response rate.

Inpatients

The acute inpatients results for both response rate and overall score have been pleasing. Due to unprecedented pressures over the winter period our response rate has fallen, however our percentage would recommend scores have remained good throughout. Results for our inpatient F&FT from April 2015 to March 2016 are in the table below.

Month	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**National***
Inpatient % would recommend	96.5	96.9	97.0	97.1	97.5	98.0	97.8	97.9	97.6	96.4	96.7	98.1	96.0
% would not recommend	1.8	1.2	1.3	0.6	1.5	0.8	1.1	0.5	0.9	1.3	1.5	0.7	2.0
Inpatient Response Rate %	36.4	32.7	41.3	42.4	40.5	35.1	33.0	33.0	28.8	25.0	25.4	34.5	24.9

Through this process patients have left many comments about their care which are fed back to the individual areas.

A&E Department

On April 1st 2015 NHS England abolished the token system in A&E. Comments cards were developed to enable patients to respond and also to leave additional feedback about the service. The results for the A&E Friends and Family Test for the year April 2015 to March 2016 are displayed in the table below.

Month	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**National***
A&E % would recommend	86.7	93.7	92.7	91.0	91.6	94.8	93.8	92.9	96.9	85.1	86.3	85.8	85.0
% would not recommend	4.4	3.2	3.3	3.8	2.6	2.5	2.9	4.0	1.6	4.2	1.8	5.4	8.0
A&E Response Rate %	8.5	34.6	38.6	43.5	40.5	35.4	28.8	27.9	16.0	26.0	40.6	41.2	13.3

In October 2015 Blaydon walk in centre began using the Friends and Family Test cards following ongoing issues with the iPad. Each month the response rate has increased.

Maternity

The friends and Family test for maternity is measured at four touchpoints. The results are shown below for each touchpoint.

Q1 – Antenatal
Q2 – Delivery
Q3 – PostNatal Ward
Q4 – Postnatal Community

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**National***
Q1 % would recommend	95.2	100	100	94.7	100	100	100	100	100	100	100	95.2	95
Q1 % would not recommend	0	0	0	0	0	0	0	0	0	0	0	4.8	2
Q2 % would recommend	95.7	91.5	95.2	94.4	96.3	100	98.4	98.6	98.5	98.6	98.9	100	96
Q2 % would not recommend	0	1.7	1.6	2.8	0	0	0	0	0	0	1.1	0	1
Q3 % would recommend	95.7	96.7	95.2	97.2	94.4	97.3	100	98.5	98.5	100	100	99.0	94
Q3 % would not recommend	1.7	3.3	0	0	0	0	0	0	0	0	0	0	2
Q4 % would recommend	100	100	100	100	100	100	100	100	100	100	100	100	98
Q4 % would not recommend	0	0	0	0	0	0	0	0	0	0	0	0	1

Outpatients

Results for the total outpatient services scores are outlined in the table below. Response rates are not collected for this F&FT.

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**National***
% would recommend	95.0	95.0	95.4	96.6	94.1	95.1	94.7	95.8	93.9	93.6	93.7	95.0	93
% would not recommend	1.3	1.4	1.2	0.8	1.1	1.5	1.8	1.2	1.8	1.7	1.7	1.3	3

Mental Health

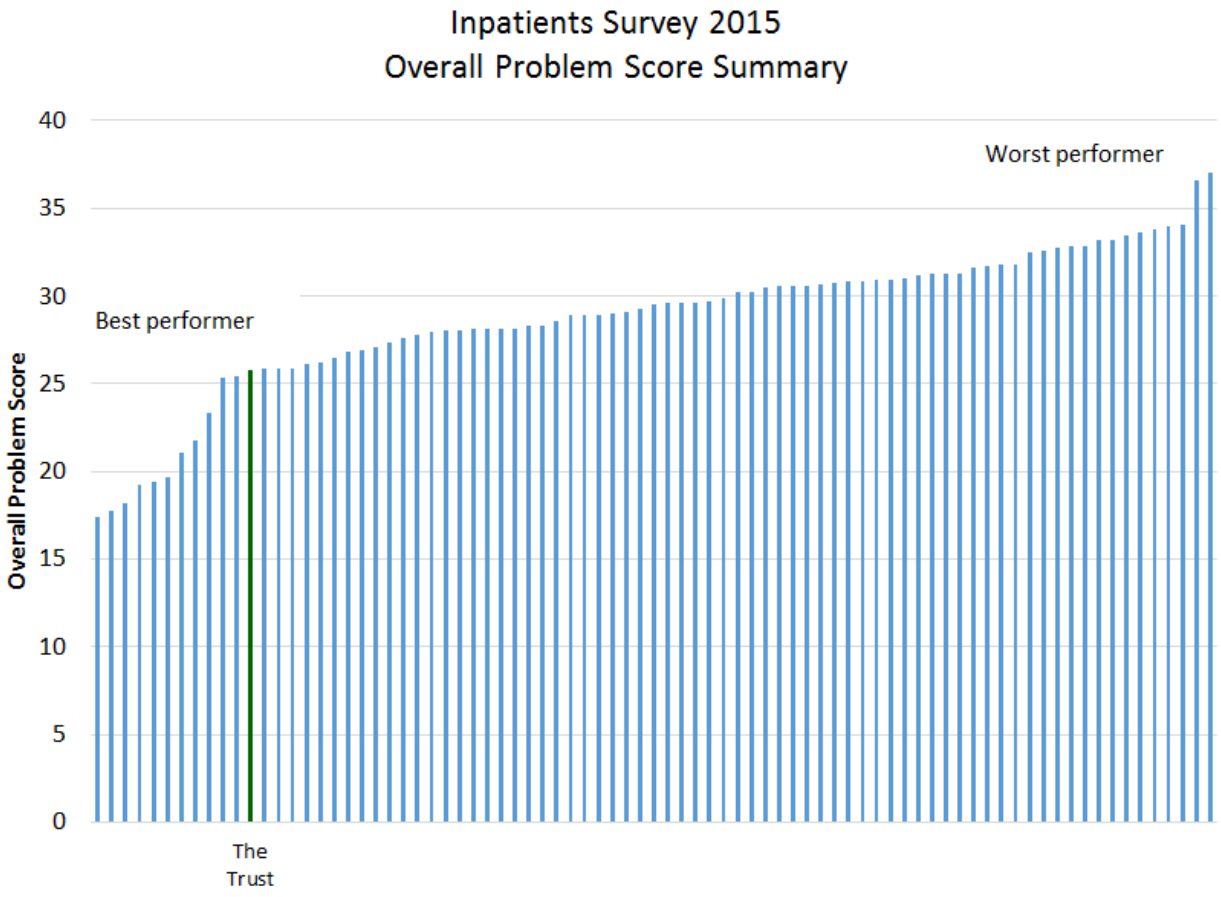
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**National***
% would recommend	100	100	100	100	100	100	100	100	100	100	100	100	87
% would not recommend	0	0	0	0	0	0	0	0	0	0	0	0	5

*National figures based on February 2016 (YTD) publication data. Next data available on May 12th 2016.

The National Patient Survey Programme

The National Patient Survey Programme of annual surveys includes: Adult Inpatient; Mental Health; Outpatients; Maternity Services and Emergency Departments. These national surveys are valuable as they provide information on various aspects of service and are used to measure and monitor our performance against Trusts locally and nationally. In 2015 the Trust enrolled in the adult inpatient and maternity services surveys.

81 Trusts enrolled in the Adult inpatient survey, our results are therefore compared against 80 other Trusts. We were ranked 12th in the league table of the 81 Trusts which enrolled. In the following table the red line indicates the Trust.



This survey demonstrated many positive aspects in the patient's experience.

- Overall: 83% rated care 7+ out of 10
- Overall: treated with respect and dignity 82%
- Doctors: always had confidence and Trust 87%
- Hospital: room or ward was very/fairly clean 98%
- Hospital: toilets and bathrooms were very/fairly clean 97%
- Care: always enough privacy when being examined or treated 93%

However we scored significantly worse internally from last year's survey on the following question:

- Discharge: staff did not discuss need for further health or social care services

Overall as a Trust we did not score significantly worse than the "Picker average" on any questions.

As a Trust we have recognised from other sources that discharge is an area requiring further improvement. This will be reviewed later in this section.

Maternity Services

64 Trusts enrolled in the maternity services survey, our Trust results are therefore compared against 63 other Trusts.

This survey demonstrated many positive aspects of the patient's experience.

- 89% of respondents were given a choice of where to have their baby
- 82% of respondents said that the midwife listened to them during their antenatal check –ups
- 82% of respondents felt that they were involved enough in decisions about their antenatal care
- 94% of respondents felt that their partner was involved in their care during labour and birth
- 91% of respondents said they were treated with respect and dignity
- 72% of respondents said that the hospital room or ward they were in was very clean
- 96% of respondents were visited at home by a midwife
- 77% of respondents had confidence and Trust in the midwives they saw after going home

However it is evident from these scores we still have scope for improvement. We have on one question scored significantly worse that the "Picker average:

- Postnatal Hospital Care: Patient not having anyone close to be able to stay as long as they wanted.

Maternity services were one of the areas highlighted in the recent CQC report as outstanding for caring.

Bespoke Patient Experience Improvement Project: "Understanding Pain from a Patient's Perspective."

Following the 2014 "Picker" inpatient survey it was emphasised that the Trust had significantly worsened on the following question:

- Care: staff did not do everything to help control pain

The Trust therefore commissioned "Picker" to undertake a bespoke patient experience project about pain. The project utilises a unique mixed methods approach using broad surveys that have been cognitively tested, and in depth interviews with patients. The survey has now been validated and will be sent to patients in the early summer and followed up with a telephone interview post receipt of the paper based survey.

In the interim the practice development team worked with the pain specialist nurses and attended the clinical leads away day on the 14th September 2015 to give an update on treatment options for acute and chronic pain. On the day the clinical leads were given posters to display further training days on acute and chronic pain. The clinical leads were also requested to disseminate their learning from the day to their clinical areas.

The pain specialist nurse also attended the Health Care Assistants clinical days on a monthly basis.

A pain assessment chart was developed and is displayed on all blood pressure machines to aid staff to score the levels of pain on VitalPAC.

Safe Discharge

The Trust has recognised that discharges are becoming more complex and cause pressure on bed management when discharges are delayed. Delayed discharge also reduces the positive experience for patients, as identified in the inpatient survey as detailed above and in the Gateshead Healthwatch discharge survey. The survey by HealthWatch was conducted between August and October 2015. This survey highlighted several areas where discharge was delayed, such as waiting times for discharge medication. In addition to the work being conducted as detailed in the bullet points below, it is anticipated that the opening of the new outpatient pharmacy will relieve pressure on the inpatient pharmacy. Also with the implementation of electronic prescribing, discharge prescriptions are sent directly to pharmacy therefore this process is no longer reliant on a person taking the prescription to pharmacy. Patients also informed us when the discharge lounge was utilised the discharge was a more pleasurable experience than waiting on the ward. Unfortunately we are aware the discharge lounge is underutilised and in response to this a new leaflet for the wards to present to patients about the discharge lounge has been produced.

In addition to the above, there are currently discharge workstreams operating to improve and streamline discharges from the Trust into a seamless activity. Examples of the work already completed:

- The commencement of discharge planning workshops for newly qualified nurses.
- Several wards have implemented discharge co-ordinators; qualified staff are assigned on a rotational basis therefore enabling all staff to experience and learn from planning discharges in a timely manner.
- Audits were completed in the autumn of 2015 to identify bottle necks in the system.
- Trial deployment of a Care of the Elderly Consultant to the front of house to aid with streaming to the right parts of the service in conjunction with the Frailty team.
- Trial deployment of a social worker based in the Emergency Care Centre to aid with early identification and services required.

Flexible Visiting

In September 2015 the Trust signed up to John's Campaign, which was led by Nicci Gerarrd following the death of her father in 2014 and Julia Jones whose mother has Alzheimer's disease and who expressed a wish for her daughter to be able to stay with her if she was hospitalised. Research supported by the Alzheimer's Society emphasises the importance of the fact that patients with dementia respond better to treatment if their carers are present. This is reminiscent of the campaign work undertaken over 50 years ago by the campaign group "Mother Care for Children in Hospital" following the work carried out by James Robertson demonstrating the effects on children who are separated from their mothers when hospitalised. It is now unthinkable that parents were only allowed to visit their child during short visiting hours.

Posters are in place at the entrance to many of the wards to show that "carers are welcome here", and to show the value that the Trust places on links with carers. A "Carer's Passport" enables carers to access wards outside of normal visiting hours.

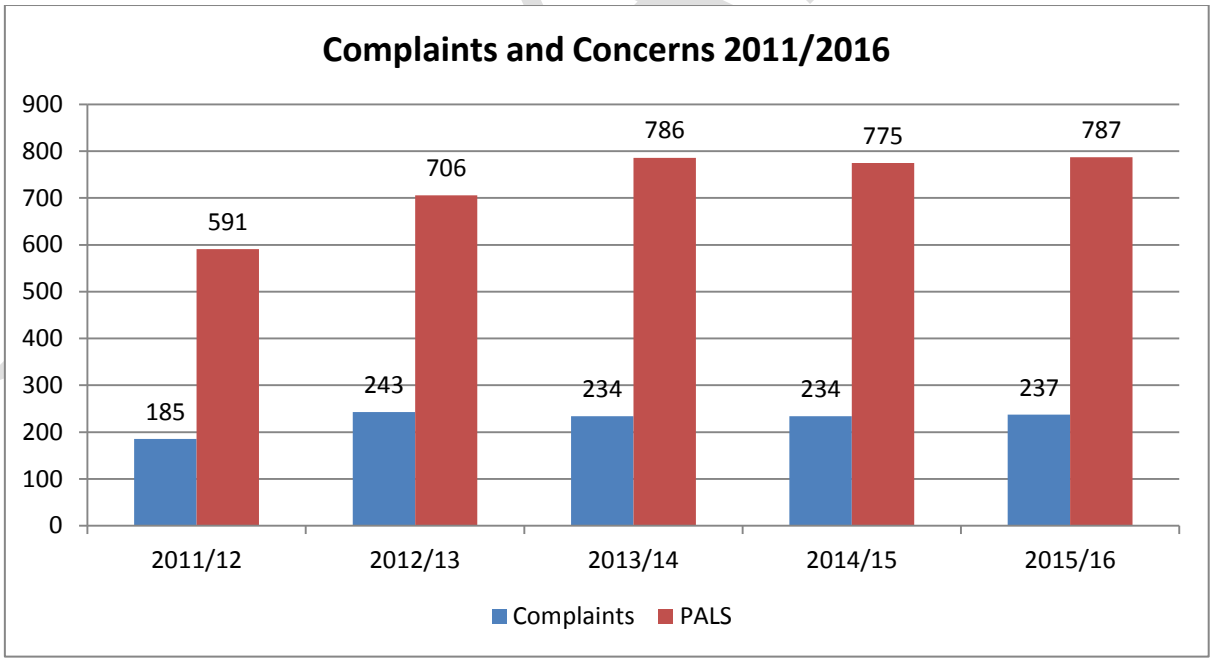
Listening to Concerns and Complaints

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

For the year 2015/16 we received a total of 237 formal complaints. Promoting a culture of openness and truthfulness is a prerequisite to improving the safety of patients, staff and visitors as well as the quality of healthcare systems. It involves apologising and explaining what happened to patients who have been harmed as a result of their healthcare treatment or when in-patients 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 culture of "Being open" should be fundamental in relationships with and between patients, the public, staff and other healthcare organisations. The Duty of Candour introduced from 1st April 2013 is the contractual requirement to ensure that the Being Open process is followed when a patient safety incident results in moderate harm, severe harm or death.

The introduction of the Duty of Candour process has not resulted in an increase in the numbers of complaints and concerns received.



During 2015/16 the top five main reasons to raise a formal complaint were in relation to;

- Clinical Assessment (A&E & Outpatient) (57)
- Clinical Assessment (Inpatient) (54)
- Communication (33)
- Attitude (22)
- Discharge/Transfer Issues (19)

Complaints Performance Indicators	Outturn 2015/16
Complaints received	237
Acknowledged within 3 working days	237
Complaints closed	210
Closed within agreed timescale (25 working days)	95
Number of complaints well founded#	61
Concerns received by PALS	787

 # Complaints well founded = complaints either fully or significant part upheld.

Complaints Indicators	Outturn 2015/16
Number of closed complaints reopened	12
Number of closed complaints referred to parliamentary ombudsman	11

Outcome of complaints referred to parliamentary ombudsman	Outturn 2015/16
Awaiting decision	5
Complaints upheld	1
Complaint referred back for local resolution	1
Declined to be investigated	0
Intervention	0
Outstanding from previous year – upheld	2
Outstanding from previous year - declined	2

As a result of complaints and concerns raised over the past year a number of initiatives have been implemented, some examples of these are provided below:

- To improve communication with people attending the new Emergency Care Centre, television screens have been placed to guide patients through the triage process, and to remind attendees that patients are reviewed in the order of urgency.
- As discharges become more complex a number of wards are piloting a "Discharge Co-ordinator" role. To ensure communication with the relevant community/social services are in place prior to discharge and that the patients carer's / relatives are aware of the pending discharge and are involved in the planning of this.
- Discharge Planning workshops have been commenced to increase awareness of the discharge planning process for newly qualified staff nurses.
- A quiet room is planned for A&E so that bereaved relatives may spend time with their loved ones following their death in the department. Staff may also converse with the relatives in a private environment despite the background of a busy A&E department.

3.4 Focus on Staff

Investors in People

Investors in People (IiP) is an international award which recognises excellent people practices which directly contribute to a high performing organisation. The Trust has held the Standard for almost 20 years and attained "gold" level in 2012, which was then the highest level of attainment. The award is viewed as a mark of distinction to organisations that can meet the criteria set out in the framework.

Despite the financial pressures facing all NHS organisations, we are still committed to training, developing and supporting staff to reach their full potential and to attract and retain the best calibre of people to provide our services.

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 a good deal of time and effort into making sure that the right conditions and support are in place to create a healthy workforce.

In August this year, the organisation became a pilot site for the latest version of the Investors in People Health and Well-being Good Practice Award and successfully attained "advanced" status. The Trust is recognised nationally as well as regionally as an exemplary organisation which recognises the importance of keeping staff well and emotionally resilient in order to provide better quality care to patients and service users.

In the past twelve months activities and events have included:

- Provision of a "Stress Awareness" orange file for wards which may have limited intranet access;
- A stress awareness event, to let staff know about the support that is available for the prevention and treatment of stress;
- Promotion of "Stoptober" campaign and No Smoking Day in March 2016;
- Annual "Celebrating our Staff" awards ceremony at the Hilton Newcastle/Gateshead;
- Provision of internal "Building your personal resilience" workshops for staff and one-to-one resilience coaching;
- Development of a new "Creating resilient teams" workshop, aimed at managers to help them to create the right conditions for a resilient environment;
- Access to on-site holistic therapies for staff and seasonal special offers;
- Promotion of Men's Health Day in June 2015;
- Promotion of Dry January, encouraging zero alcohol intake for the whole month;
- Continuation of GO! Gateshead scheme offering staff subsidised membership of Gateshead Council fitness and leisure facilities;
- "Movember" moustache competition to raise awareness of male cancers;
- Provision of a June Carer's event, including staff who are carers;
- Promotion of e-publications on health, safety and well-being for staff to access on-line;
- Supporting Christmas activities – the annual quiz and carol service, and the first Christmas fayre;
- Achievement of the bronze award in the Ministry of Defence employer recognition scheme.

Developing our leaders

The Trust has a Leadership Strategy, which is designed to develop and grow effective leaders who can take on the challenge of leading teams through change and engage staff in finding new and innovative ways of designing and delivering services.

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.

The organisation delivers a number of high profile internal programmes to fulfil this ambition. There is a clear leadership development pathway for managers and leaders as they progress through their career.

Chrysalis is a two-day programme for team leaders and supervisors which provides an introduction to leadership and management and forms the foundation for further development.

Kaleidoscope is a programme spanning almost twelve months, designed for front-line managers, and comprising ten modules of learning and culminates in the achievement of an Institute of Leadership and Management (ILM) qualification at Level 5.

This year we have showcased our **Leadership and Transformation** programme, which we developed in partnership with the University of Sunderland, at the Health Education England North East (HEENE) conference as an example of innovative partnership working and learning. This programme provides more experienced leaders with new insights and extra stretch to plan and implement improvements to services to benefit both the organisation, and patients and service users. Participants emerge from this programme with a University Certificate of Post Graduate study which holds 40 Post Graduate credits.

PRISM is our most recent addition to this suite of programmes and is designed to provide senior medical staff with a sound introduction to leadership and transformation as a basis for further development into key clinical leadership roles within the Trust. This four day programme is augmented by one-to-one executive coaching support.

Listening to our staff through the NHS Staff Survey

All NHS Trusts in England are required to take part in the annual National NHS Staff Survey. The survey enables each organisation to benchmark itself against other similar NHS organisations and the NHS as a whole, on a range of measures of staff satisfaction and opinion.

The Trust has an open and transparent approach to publicising Trust-wide and departmental results and acting upon them to improve staff satisfaction and well-being at work.

This year the Trust conducted a census of all staff, giving every member of staff (as at the 1st September 2015) the opportunity to feedback on the Trust. Our response rate is illustrated in the table below.

	2014/15		2015/16		Trust improvement/ deterioration
Response rate	Trust	National average	Trust	National average	
	50%	42%	40%	41%	10% Decrease

Measured against 32 Care Quality Commission key indicators, we came out most favourably compared to other acute Trusts in the UK in the following areas:

	2014/15		2015/16		Trust improvement/ deterioration
Top 4 ranking scores	Trust	National average	Trust	National average	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	25%	29%	22%	28%	3% Improvement
Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.62	3.54	3.81	3.70	0.19 Improvement
Percentage of staff appraised in last 12 months	88%	85%	91%	86%	3% Improvement
Percentage of staff suffering work related stress in last 12 months	36%	37%	31%	36%	5% Improvement

The Trust's lowest four ranked scores were:

	2014/15		2015/16		Trust improvement/ deterioration
Bottom 4 ranking scores	Trust	National average	Trust	National average	
Percentage of staff experiencing physical violence from staff in last 12 months	2%	3%	3%	2%	1% Deterioration
Staff motivation at work	3.75	3.86	3.87	3.94	0.12 Improvement
Quality of non-mandatory training, learning or development	-	-	3.99	4.03	Not a KF in 14/15
Percentage of staff agreeing that their role makes a difference to patients / service users	89%	91%	89%	90%	No Change

Italics indicate a lower score is better for that Key Finding

Our ratings show that we are:

- In the top 20% of acute Trusts for eleven key scores (7 in 2014/15)
- Better than average in eight key scores (8 in 2014/15)
- Average in seven key scores (6 in 2014/15)
- Below average in four key scores (7 in 2014/15)
- Worst 20% in two key scores (1 in 2014/15)

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

- Percentage of staff recommending the organisation as a place to work or receive treatment
- Staff Motivation at work
- Percentage Reporting good communication between senior management and staff
- Staff satisfaction with level of responsibility and involvement
- Support from immediate managers
- Percentage suffering from work related stress in the last 12 months
- Percentage witnessing potentially harmful errors, near misses or incidents in the last month

There has been no significant deterioration in any area.

Key priorities for the coming year:

- Present the results to a range of meetings and committees across the Trust.
- HR team will work with Business Units/Directorates to further analyse data.
- Business Units/Directorates to use an appropriate process to develop SMART actions relevant to their specific results.
- Plans to be monitored through the Human Resources Committee.
- A maximum of three Trust-wide objectives will be identified to address key findings - led by the workforce teams.

The chart below shows the percentage of staff that have completed the national staff survey in 2015 who said they would be happy with the standard of care provided by the Trust compared to other Trusts within the region.

Trust	2014/15	2015/16
Gateshead NHS Foundation Trust	75%	76%
Newcastle	85%	89%
Northumbria	81%	85%
South Tyneside	63%	62%
Sunderland	63%	70%

3.5 Quality overview - performance of Trust against selected indicators

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

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

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

1) Visible Leadership for Safety and Culture

Outcomes of Trust Wide MaPSaF Patient Safety Culture Assessment:

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

MaPSaF Assessment undertaken in May – September 2013 as part of a three year cycle.

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

Executive Walkabouts	2013/14	2014/15	2015/16	Target
Quality and Safety Walkabouts Undertaken	24	23	N/A	48
Executive walkabouts Undertaken	N/A	N/A	11	12
Average Walkabouts Undertaken per month	2	1.9	0.9	1
Cumulative Actions Identified	49	35	39	N/A
Cumulative Actions Implemented	34	27	39	N/A
Outstanding Actions (more than 60 days old)	0	0	0	90% less than 60 days old

Source: Trust Quality & Safety Dashboard

In December 2014, the Corporate Management Team approved a proposal to combine both the Executive Walkabout and Night Visit schedules into one schedule of monthly visits. The visits now entail visiting a number of defined areas between 2.00pm-5.00pm, alternating the following month with a night visit between 8.30pm-11.30pm. This new process allows us to work more efficiently within current resources and to work within a framework that facilitates a discussion focussing on quality and safety. This new system has already demonstrated improved attendance for visits.

2) Team Effectiveness / Efficient / Innovative

Team Effectiveness	2013-14	2014-15	2015-16	Target	National Benchmark
Mandatory Training Compliance (Percentage take up on allocated places)	82.40%	78.55%	74.56%	90%	N/A
Personal Development Plan (PDP) Compliance (Staff with a timely completed PDP)	77.40%	66.15%	71.93%	90%	N/A
Staff Sickness Absence (As reported from HR)	5.06%	5.00%	4.82%	3.40%	4.03%* (Apr 15 – Nov 15)
Staff Turnover (Labour turnover based of Full Time Equivalent)	10.62%	15.92%	24.63%**	10%	N/A

*The National Benchmark is calculated using the average of the months April to November 2015 and is available from http://www.hscic.gov.uk/catalogue/PUB16383 - "NHS Sickness Absence Rates April 2015-November 2015 Quarterly Tables"

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

3) Safe Reliable Care / No Harm

A) Reducing Harm from Deterioration:

Safe Reliable care	2013-14	2014-15	2015-16	Target
HSMR	103.8	104.46	92.2*	<100
SHMI Period	Apr 13 - Mar 14	Apr 14 - Mar 15	Oct 14- Sep 15	
SHMI	0.98	1.00	0.95	<=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	14.0%	14.5%	16.6%	N/A
Crude mortality rate taken from CDS	1.76%	1.72%	1.68%	<1.99%
Number of calls to the CRASH team	200	192	224	N/A
Of the calls to the arrest team what percentage were actual cardiac arrests	37.0%	44.8%	48.7%	N/A
Cardiac arrest rate (number of cardiac arrests per 1000 bed days)	0.40	0.46	0.59	N/A
Hospital Acquired Pressure Damage (grade 2 and above)**	188	161	108	Year on year Reduction
Community Acquired Pressure Damage (grade 2 and above)**	845	772	854	N/A
Number of Patient Slips, Trips and Falls**	1541	1687	1902	N/A
Rate of Falls per 1000 bed days**	8.71	9.26	10.21	Reduction (<8.5)
Number of Patient Slips, Trips and Falls Resulting in Harm**	424	468	484	N/A
Rate of Harm Falls per 1000 bed days**	2.4	2.57	2.60	Reduction (Less than <2.25)
Falls Change**	8.7% reduction	7.1% Increase	1.2% 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)**	27.50%	27.74%	25.45%	Year on Year reduction

* HSMR to end December 2015
** Datix Figures for 15/16 taken from April 10th 2016

B) Reducing Avoidable Harm:

Reducing Avoidable Harm		2013-14	2014-15	2015-16	Target
Medication Errors	No Harm	311	307	366	N/A
	Minimal Harm	28	21	51	N/A
	Moderate Harm	5	8	5	<8
	Severe	0	2	1	0
	Total	344	338	423	N/A
Never Events		0	2	1	0
Patient Incidents per 1,000 bed days		33.86	32.59	34.72	N/A
Rate of patient safety incidents resulting in severe harm or death per 100 admissions		0.19	0.16	0.16	N/A

Source: Trust incident reporting system Datix – 1516 taken on 11th April 2016

C) Infection Prevention and Control:

Infection Prevention & Control	2012-13	2013-14	2014-15	2015-16	2015-16 Target
MRSA Bacteraemia apportioned to Acute Trust post 48hrs	1	1*	1†	1^^^	0
MRSA Bacteraemia per 1,000 bed days	0.006	0.006	0.005	0.005	Year on year Reduction
Clostridium Difficile Infections post 72hrs	22**	16***	14††	25^	<26
Clostridium Difficile Infections per 10,000 bed days	1.30	1.23	1.43	1.34^	Year on year Reduction
Uniform Policy	98.7%	99.6%	99.0%	98.7%^^	100%
Hand Hygiene	98.4%	99.6%	98.8%	98.2%^^	100%
Intravenous Cannula	94.9%	96.8%	96.4%	94.4%^^	100%
Indwelling Catheter	95.9%	97.8%	97.4%	94.6%^^	100%
Equipment Clean and Records Up To Date	98.0%	98.6%	97.8%	97.8%^^	100%

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

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

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

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

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

^ In 2015/16 the Trust had 48 cases of CDI; 23 cases of CDI were deemed as being unavoidable by an expert appeal panel. This meant that the Trust had a total of 25 avoidable cases of CDI against a trajectory of 26. March data still to be reviewed.

^^ Indicative figures as at April 12th 2016.

^^^ In 2015/16 the Trust had one case of MRSA bacteraemia however; this was as the result of a contaminated specimen not an infection.

4) Right Care, Right Place, Right Time

Care of patients following a Stroke:

		2013/14	2014/15	2015/16*	National Target	National Benchmark
Percentage of patients who spend >90% of time within a dedicated stroke unit		87.27%	90.50%	88.2%	90%	81.9%††
Stroke Bundle of 12, percentage of patients who receive bundle of 12 key elements of care		27.13%	54.65%	52.3%	N/A	N/A
Stroke bundle of 12 indicators	1. Number of patients scanned within 1 hour of arrival at hospital	90.40%	94.89%	74.3%	50%	44.1%††
	2. Number of patients scanned within 24 hours of arrival at hospital	91.50%	94.59%	90.7%	N/A	N/A
	3. Number of patients who arrived on stroke bed within 4 hours of hospital arrival (when hospital arrival was out of hours)	81.10%	78.68%	79.9%	N/A	57.3%††
	4. Number of patients seen by stroke consultant or associate specialist within 24h	81.90%	83.18%	85.1%	95%	75.7%††
	5. Number of patients with a known time of onset for stroke symptoms	48.90%	89.49%	90.1%	N/A	N/A
	6. *Number of patients for whom their prognosis /diagnosis was discussed with relative/carer within 72h where applicable	97.30%	98.50%	95.4%	N/A	N/A
	7. Number of patients who had continence plan drawn up within 72h where applicable	97.90%	98.80%	90.1%	N/A	N/A
	8. Number of potentially eligible patients thrombolysed	98.10%	99.40%	95.0%	90%	80.7%††
	9. *Bundle 1: Seen by nurse and one therapist within 24h and all relevant therapists within 72h (proxy for NICE QS 5)	64.20%	76.88%	81.7%	60%	51.4%††
	10.Bundle 2: Nutrition screening and formal swallow assessment within 72 hours where appropriate	93.60%	96.10%	91.3%	N/A	N/A
	11.Bundle 3: Patient's first ward of admission was stroke unit and they arrived there within four hours of hospital arrival	74.90%	72.73%	66.6%	90%	56.8%††
	12.*Bundle 4: Patient given anti-platelet within 72h where appropriate and had adequate fluid and nutrition in all 24h periods	87.00%	95.20%	93.8%	N/A	N/A

†† Source:https://www.strokeaudit.org/results/Clinical-audit/National-Results.aspx - 201415.

Other Indicators:

Other Indicators	2013-14	2014-15	2015-16	Target	Benchmark
Percentage of Cancelled Operations from FFCE's††	0.68%	0.97%	0.97%	0.80%	1.1%**
Percentage of Patients who return to Theatre within 30 days (Unplanned / Planned / Unrelated)†	4.53%	5.43%	5.31%	Improve Year on Year	N/A
Fragility Fracture Neck of Femur operated on within 48hrs of admission / diagnosis	91.72%	91.15%	91.22%***	90%	N/A
Proportion of patients who are readmitted within 28 days across the Trust	9.18%*	9.48*	9.9%+	Improve year on year	N/A
Proportion of patients undergoing knee replacement who are readmitted within 30 days	4.34% 17 patients readmitted	4.35% 20 patients readmitted	7.5% 23 patients readmitted+	Improve Year on Year	N/A
Proportion of patients undergoing hip replacement who are readmitted within 30 days	6.96% 24 patients readmitted	7.91% 28 patients readmitted	12.3% 29 patients readmitted+	Improve Year on Year	N/A

* Figures taken from Dr Foster and provide a full year for 2013-14, and year to date December for 2014-15.

** NHS England Statistics - NHS Cancelled Elective Operations Quarter Ending March 2015

†† 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.

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

+Figures taken from Dr Foster for period April – December 2015.

5) Positive Patient Experience

Positive Patient Experience	Nov 2013-March 2014	2014-15	2015-16	Target / Benchmark
Communication	5.76	5.86	5.77	5.4
Care	5.85	5.91	5.86	5.4
Compassion	5.90	5.96	5.95	5.4
Overall composite Score	5.84	5.91	5.86	5.4

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

	Question	Nov 13 to Mar 14	2014-15	2015-16	Target / Benchmark
Communication	When you reached the ward, did you get enough information about ward routines e.g. mealtimes, visiting, doctors ward rounds?	5.35	5.61	5.48	5.4
	When you had important questions to ask a member of staff did you get answers that you could understand?	5.84	5.93	5.84	5.4
	If your family or anyone else close to you wanted to talk to a doctor did they get the opportunity to do so?	5.89	5.94	5.89	5.4
	Have you been involved as much as you wanted to be in decisions about your care and treatment?	5.81	5.91	5.83	5.4
	Have you found someone to talk to about your worries and fears?	5.9	5.94	5.79	5.4
Care	Do you get enough help from staff to eat your meals?	5.97	5.97	5.96	5.4
	Do you get enough help from staff with washing and dressing?	5.95	5.97	5.95	5.4
	If you pressed the call bell, did staff respond promptly?	5.75	5.82	5.72	5.4
	Did the staff do everything they could do to help control any pain you were experiencing?	5.89	5.92	5.91	5.4
Compassion	Do the staff looking after you have a caring and compassionate attitude?	5.89	5.95	5.94	5.4
	Do you feel you are treated with respect?	5.92	5.96	5.97	5.4
	Do you feel you are treated in a friendly manner?	5.92	5.97	5.97	5.4
	Are you given enough privacy and treated with dignity when discussing your condition or treatment?	5.93	5.98	5.94	5.4

Responsiveness to Inpatients' personal needs					
Question	2012	2013	2014	2015	Average†
Was the patient as involved as they wanted to be in decisions about their care and treatment?	60%	58%	61%	62%	59%
Did the patient find someone to talk to about their worries and fears?	47%	47%	45%	**50%***	41%
Was the patient told about medication side effects to watch out for?	45%	53%	49%	**48%***	41%
Was the patient told who to contact if they were worried?	82%	82%	82%	**85%***	80%
Was the patient given enough privacy when discussing their condition or treatment?	78%	75%	81%	**80%***	77%
Overall Composite Score	62%	63%	64%	65%	60%

* **Scores significantly better than average**
†Average score for all 'Picker' Participating Trusts
Source: Picker Institute Inpatient Survey 2015 Gateshead Health NHS Foundation Trust Final Report January 2016

6) Safe, Effective Environment, Appropriate Equipment & Supplies

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

Sources
www.hscic.gov.uk/catalogue/PUB18042
www.hscic.gov.uk/catalogue/PUB14780
www.hscic.gov.uk/catalogue/PUB11575

Maximiser	Target	2012-13	2013-14	2014-15	2015-16
Gateshead Health NHS Foundation Trust	98.00%	98.50%	98.80%	98.64%	98.31%

3.6 National targets and regulatory requirements – data to be updated

No	Indicator		2012/13	2013/14	2014/15	2015/16	Target	National Average
1	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted		96.9%	94.3%	91.6%	86.9%*	90.0%	86.2%**
2	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted		98.5%	97.4%	96.9%	94.5%*	95.0%	95.4%**
3	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway		96.3%	94.3%	94.7%	93.0%*	92.0%	93.1%**
4	A&E – maximum waiting time of four hours from arrival to admission / transfer / discharge		95.6%	95.2%	95.5%	93.7%	95.0%	93.6%
5	All cancers: 62 day wait for first treatment from: urgent GP referral for suspected cancer /		88.6%	85.0%	86.0%	86.1%	85.0%	83.4%
	NHS Cancer Screening Service referral		98.1%	97.4%	96.1%	95.7%	90.0%	93.2%
6	All cancers: 31 day wait for second or subsequent treatment, comprising:	Surgery	98.0%	98.0%	99.2%	98.6%	94.0%	95.7%
		Anti-cancer drug treatments	100.0%	99.8%	99.7%	99.7%	98.0%	99.6%
		Radiotherapy	N/A	N/A	N/A	N/A	94.0%	97.5%
7	All cancers: 31 day wait from diagnosis to first treatment		99.8%	98.8%	99.4%	99.4%	96.0%	97.7%
8	Cancer: two week wait from referral to date first seen, comprising:	All urgent referrals (cancer suspected)	94.0%	92.6%	93.5%	93.9%	93.0%	94.2%
		Symptomatic breast patients (cancer not initially suspected)	95.3%	95.7%	92.9%	94.9%	93.0%	93.3%
9	Care Programme Approach (CPA)	Receiving follow up contact within seven	N/A	100.0%	95.0%	82.8%	95.0%	97.2%

	patients, comprising:	days of discharge						
		Having formal review within 12 months	nil return*	nil return*	nil return*	nil return*	95.0%	N/A
16	Minimising mental health delayed transfers of care		0.0%	0.0%	0.0%	0.0%	< 7.5%	N/A
17	Mental health data completeness: identifiers		99.5%	99.2%	99.2%	99.8%	97.0%	N/A
18	Mental health data completeness: outcomes for patients on CPA		100.0%	85.2%	93.5%	73.5%	50.0%	N/A
19	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	N/A
20	Data completeness: community services, comprising:	Referral to treatment information	92.7%	91.8%	92.4%	92.5%	50.0%	N/A
		Referral information	95.7%	100.0%	100.0%	100.0%	50.0%	N/A
		Treatment activity information	92.9%	100.0%	100.0%	100.0%	50.0%	N/A

Source: http://www.england.nhs.uk/statistics/statistical-work-areas
Indicators 10-14 are not applicable. Indicator number 15 (MRSA) of the Compliance Framework 2013/14 was removed on publication of the Risk Assessment Framework August 2013.
* There were no qualifying patients for this period
**Figures relate to data published for 12 months of 2014-15 to the end of March 15.
† 1516 Cancer figures are indicative - March submission not due until Friday 8th May.
*Figures for Trust's 18 weeks relate to data up to and including February 2016
Cancer Benchmarking figures are 1415 Annual National Average.

Annex 1: Feedback on our 2015/16 Quality Account

4.1 Gateshead Overview and Scrutiny Committee

To be inserted

4.2 Gateshead Clinical Commissioning Group

To be inserted

4.3 Healthwatch

To be inserted

4.4 Council of Governors Representative

To be inserted

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

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

Monitor 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 2015/16 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 - March 2015 – April 2016
    - papers relating to Quality reported to the board over the period - March 2015 – April 2016
    - feedback from commissioners dated xxx
    - feedback from governors dated xxx
    - feedback from local Healthwatch organisations dated xxx
    - feedback from Overview and Scrutiny Committee dated xxx
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated xxx
    - the 2015 national patient survey 2016
    - the 2015 national staff survey 2016
    - the Head of Internal Audit's annual opinion over the Trust's control environment dated xxx
    - CQC Intelligent Monitoring Report dated xxx

- 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 Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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

NB: sign and date in any colour ink except black

Date: Signed

Chairman

Chief Executive

Glossary of Terms

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

Trust Board
A Trust Board is a body of elected or appointed members who jointly oversee the activities of an organisation.

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

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

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

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

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

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.

Department of Health (DOH)
The Department of Health is a department of the UK government with responsibility for government policy in England on health, social care and the NHS.

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

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

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

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

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

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

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

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

HealthWatch
Healthwatch are local like-minded individuals and organisations who share a commitment to improvement and learning and a desire to improve services for local people local.

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

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

Meticillin- Resistant Staphylococcus Aureus (MRSA)

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

Monitor

Monitor is the independent regulator of NHS Foundation Trusts. Established in January 2004 to authorise and regulate NHS Foundation Trusts it is independent of central government and directly accountable to parliament.

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 and generally making available 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 heath 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 Patient Safety Agency (NPSA)

The National Patient Safety Agency promotes improved, safe patient care by informing, supporting and influencing the health sector. It is an arm's length body of the Department of Health, established in 2001 with a mandate to identify patient safety issues and find appropriate solutions.

National Health Service Litigation Authority (NHSLA)

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

Overview and Scrutiny Committee

Overview and Scrutiny Committees in local authorities have statutory roles and powers to review local health services. They have been instrumental in helping to plan services and bring about change. They

bring democratic accountability into healthcare decision-making and make the NHS more responsive to local communities.

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

Plan, Do, Study, Act (PDSA) cycles
Plan, do, study, act (PDSA) cycles are used to test an idea by temporarily trialling a change and assessing its impact. The four stages of the PDSA cycle are:
Plan - the change to be tested or implemented
Do - carry out the test or change
Study - data before and after the change and reflect on what was learned
Act - plan the next change cycle or full implementation

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

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

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

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

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

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

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

Special Review
A special review is carried out by the Care Quality Commission. Each special review looks at themes in health and social care. They focus on services, pathways and care groups of people. A review will usually

result in assessments by the CQC of local health and social care organisations as well as supporting the identification of national findings.

Trust Board

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

Appendix A: Independent Auditor's Report to the Board of Governors of Gateshead Health NHS Foundation Trust on the Quality Report

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Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Quality Account 2015-16

Draft V1.3 (14/04/2016)

Please note that in this draft version of the report, text highlighted yellow is still subject to review and may refer to the previous year.

Northumberland, Tyne and Wear NHS Foundation Trust 2015-16 at a glance…

81% of service users would recommend the Trust in 2016

Employs more than 6,000 members of staff

98.6% of inpatients were followed up within 7 days of discharge

NTW

42,000 Mental Health contacts

NTW

Serves a population of 1.4 million people

89% of staff felt their role makes a difference to service users

2% reduction in delayed transfers of care year on year

Contents

Part 3

Other Information

Appendices

Part 1

Welcome and Introduction to the Quality Account

Northumberland, Tyne and Wear NHS Foundation Trust is one of the largest mental health and disability organisations in the country with an income of more than £300 million.

About our Trust

Northumberland, Tyne and Wear NHS Foundation Trust provides a wide range of mental health, learning disability and neuro-rehabilitation services to a population of 1.4 million people in the North East of England. We employ over 6,000 staff, operate from over 60 sites and provide a range of comprehensive services including some regional and national services.

We support people in the communities of Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland working with a range of partners to deliver care and support to people in their own homes and from community and hospital based premises. Our main hospital sites are:

- Walkergate Park, Newcastle upon Tyne
- St. Nicholas Hospital, Newcastle upon Tyne
- St. George's Park, Morpeth
- Northgate Hospital, Morpeth
- Hopewood Park, Sunderland
- Monkwearmouth Hospital, Sunderland
- Ferndene, Prudhoe

What is the Quality Account?

All NHS healthcare providers are required to produce an annual Quality Account, to provide information on the quality of services they deliver.

Northumberland, Tyne and Wear NHS Foundation Trust welcomes the opportunity to describe how well we have performed over the course of

2015-16, taking into account the views of service users, carers, staff and the public, and comparing ourselves with other Mental Health and Disability Trusts. This Quality Report outlines the good work that has been undertaken, the progression made in improving the quality of patient services and identifies areas for improvement.

To help with the reading of this document we have provided explanation boxes alongside the text.

This is an "explanation" box

It explains or describes a term or abbreviation found in the report.

This is a 'news' box

It reports news stories from 2015-16

This is a 'quote' box

It quotes statements from staff, patients and their families.

Statement of Quality from the Chief Executive

Thank you for taking the time to read our Quality Account. As Chief Executive, I am committed to ensuring that everything we do strives to meet the highest quality standards. We aim to provide services that have our service users and carers at the centre, and which are both easy and quick to access and also focussed on recovery.

Over the past year our staff have endeavoured to ensure that our services meet the highest standards, and our achievements, as well as areas where we have more work to do are set out in this document. Our aim is to tell the story of our journey to develop excellent services, led by our quality priorities which were developed in partnership with our stakeholders.

I feel honoured to be Chief Executive of this organisation, and I am very proud of our staff, and the services we provide. Equally, I know that we have more to do before every service user and family feels that they are getting the best care.

I hope you will find the information in the document useful.

To the best of my knowledge, the information in this document is accurate.

John Lawlor

Chief Executive

The Northumberland, Tyne and Wear NHS Foundation Trust is often referred to as “NTW” or “NTWFT”.

Operations Statement from Interim Executive Medical Director and Executive Director of Nursing

This Quality Account includes information which demonstrates to our service users, carers, commissioners and the public that we provide high quality Mental Health, Learning Disability and Neurological services.

TBC

We have set out in this Quality Account how well we have performed against local and national priorities - including how we have progressed with those areas we highlighted as our quality improvement priorities for 2015-16, and setting out our quality priorities for 2016-17.

Dr Rajesh Nadkarni, Interim Executive Medical Director

Gary O'Hare, Executive Director of Nursing & Operations

People receiving treatment from NTW are often referred to as "patients", "service users" or "clients". To be consistent, we will use the term "service users" throughout this document.

Statement on Quality from Council of Governors Quality Scrutiny Group

The Council of Governors considers the quality of services provided by Northumberland, Tyne and Wear NHS Foundation Trust via a Quality Scrutiny Group who meet every two months. The group has a comprehensive workplan in place, ensuring that all aspects of quality are considered, including environmental issues, safety, complaints, safer staffing, service user & carer feedback and other quality indicators.

During 2015-16 the group has received a number of presentations from the Trust during the year on varied topics such as clinical audit, values based recruitment, transformation of services and serious incident reporting processes, providing Governors with a valuable opportunity to discuss quality issues with a wide range of Trust staff.

Alongside this ongoing work, Governors have also attended the Trust Quality and Performance Board sub-committee, they have participated in mock CQC inspection visits to a number of clinical services and they have also contributed towards the development of the 2016-17 Trust Quality Priorities.

The Quality Scrutiny Group is planning to further develop their quality remit in 2016-17, by identifying specific areas of focus and also increasing the level of involvement in the Trust's Quality Priorities.

Margaret Adams

Chair, Northumberland, Tyne and Wear NHS Foundation Trust Council of Governors Quality Scrutiny Group

Vision, Mission & Values

Northumberland, Tyne and Wear NHS Foundation Trust aim at all times to work in accordance with our visions, mission and values.

Figure 1: Northumberland, Tyne and Wear NHS Foundation Trust Vision, Mission and Values

Part 2a

Looking ahead – Our Priorities for Quality Improvement in 2016-17

This section of the report outlines the annual key quality priorities identified by the Trust to improve the quality of our services in 2016-17. We have developed our quality improvement priorities in line with our long term quality goals (shown below), which are based on patient safety, patient experience and clinical effectiveness.

Quality Goal One - Patient Safety: Reduce incidents of harm to patients.

Quality Goal Two - Patient Experience: Improve the way we relate to patients and carers.

Quality Goal Three - Clinical Effectiveness: Ensure the right services are in the right place at the right time for the right person.

Each year we set new quality priorities to help us to achieve our quality goals. The Trust has identified these priorities in partnership with staff, service users, carers and partners from their feedback, as well as information gained from incidents, complaints and other quality reports.

As in previous years, we remain committed to taking any Quality Priorities that are not fully achieved during 2015-16, or priorities which we feel should continue, forward to 2016-17 to ensure we meet and maintain targets that were set in these important areas.

Quality Engagement

An engagement exercise with stakeholders (including Trust staff, service users, carers, governors and commissioners) took place in late 2015 to gather suggestions for new quality priorities to be developed for 2016-17.

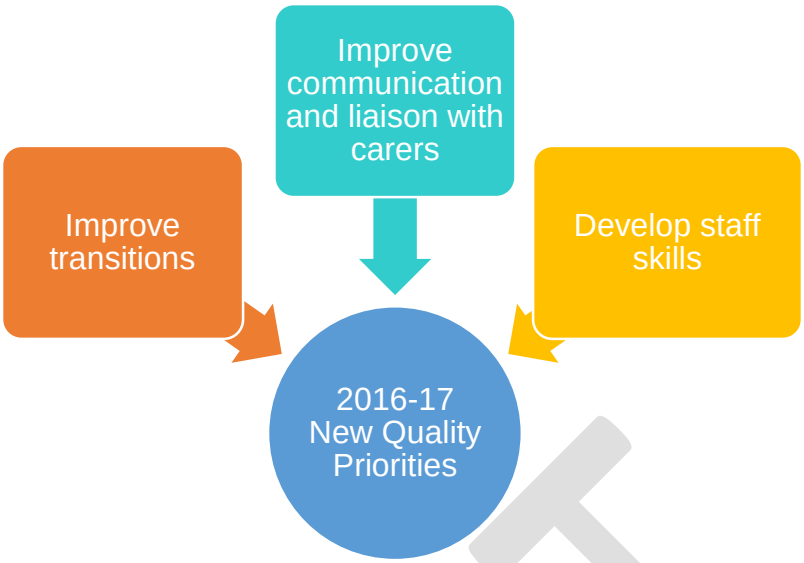
Over fifty people attended a series of workshops and many people contributed their ideas via an online survey.

As part of this exercise, we asked stakeholders the question *"what does "quality" mean to you?"* and the diagram below summarises the results:

Figure 2: Prevalent themes about "What does quality mean to you?"

We were delighted to receive more than 150 ideas for quality improvement, and these were summarised into a list of themes, alongside themes arising from serious incidents, complaints, Mental Health Act Review visits and service user/carer feedback received in 2015.

We then again approached stakeholders once again to understand better which of the quality improvement themes identified were considered the most important. The Trust reviewed this valuable feedback and the ideas identified as most suitable were approved by the Trust Board for implementation in 2016-17 as new quality priorities as follows:



Any Quality Priorities from 2016-16 that were not fully achieved in the year will also continue into 2016-17 and progress will be monitored regularly at the Trust Quality and Performance Committee.

The full list of quality priorities to be progressed during 2016-17, consisting of those continuing from 2015-16 plus the new quality priorities identified, are:

Quality Goal One – Patient Safety		
Quality Priority One	To embed suicide risk training	Continues from 2015-16
Quality Priority Two	To improve transitions between young people's services and adult services	New
Quality Priority Three	To improve transitions between inpatient and community mainstream services	New

Quality Goal Two – Patient Experience		
Quality Priority Four	To improve the referral process and the waiting times for referrals to multidisciplinary teams	Continues from 2015-16
Quality Priority Five	Implement principles of the Triangle of Care	New

Quality Goal Two – Clinical Effectiveness		
Quality Priority Six	To improve the recording and use of Outcome Measures by improving suppression rates of patient rated outcome measurement (PROMs)	Continues from 2015-16
Quality Priority Seven	To develop staff to prevent and respond to violence and aggression, through implementing the Positive and Safe Strategy.	New

Part 2b

Looking back – Review of Quality Goals and Priorities in 2015-16

In this section we will review our progress and performance against our 2015-16 Quality Goals and Quality Priorities.

Taking each Quality Goal in turn, we will look back on the last year to assess progress against the Quality Priorities we set in 2015-16, and we will reflect on how these actions have affected progress against the overarching Quality Goal.

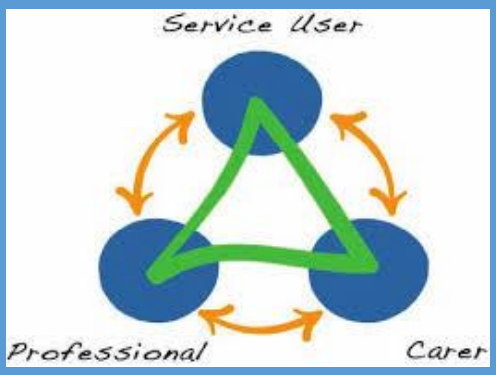
The Trust is currently providing care for just under 42,000 people. Table 1 below shows the number of current service users as at 31st March 2016, split by locality, with a comparison of the same figures from the previous 3 years:

Table 1: Service Users by locality 2013/14 to 2015/16

Clinical Commissioning Group (CCG)	2013-14	2014-15	2015-16
Durham Dales Easington & Sedgefield CCG	388	371	375
North Durham CCG	561	557	578
Darlington CCG	89	86	111
Hartlepool & Stockton CCG	115	131	137
Newcastle	8986	8913	8741
Gateshead	3706	3868	4138
Newcastle & Gateshead CCG (Total)	12692	12781	12879
North Tyneside CCG	3778	4031	3996
Northumberland CCG	10739	10345	10361
South Tees CCG	175	189	198
South Tyneside CCG	4599	4336	3990
Sunderland CCG	9084	8786	9020
Other areas	413	171	310
Total	**42530**	**41784**	**41955**

Table 1 above shows that the number of service users as at 31st March 2016 has increased by 171 when compared with 31st March 2015.

What is the Triangle of Care?



The Triangle of Care guide was developed by the Carers Trust and the National Mental Health Development Unit, emphasising the need for better involvement of carers and families in the care planning and treatment of people with mental ill-health.

Quality Goal One - Patient Safety: Reduce incidents of harm to patients

We will demonstrate success against this goal by reducing the severity of incidents and the number of serious incidents across the trust.

2015-16 Quality Priority: To improve the assessment and management of risk

Target

In 2015-16 our aim was for 85% of qualified clinical staff to have completed the enhanced suicide risk training, develop a Risk of Harm training package and review the FACE risk assessment tool, implementing any recommended changes and training staff on those changes.

Progress

Partially Met

As of 31st March 2016, 69% of the applicable 2,600 staff had completed the enhanced suicide risk training, which represented an increase from 31% one year before. This will element of the quality priority will continue into 2016-17 until 85% of applicable staff have completed the suicide risk training.

The risk of harm training package has been developed as planned. The FACE risk assessment tool has been evaluated, updated and the clinical risk training package has been amended to reflect the changes made.

What is the FACE risk tool?

Functional Analysis of Care Environments (FACE) – The FACE assessment tool is nationally accredited by the Department of Health, and used to assess risks for people with mental health problems, learning disabilities, substance misuse problems, young and older people, and in perinatal services.

How have the Quality Priorities in 2015-16 helped support this Quality Goal?

The aim of this Quality Goal is to reduce the impact and severity of patient safety incidents. Table 2 below shows the total number of patient safety incidents reported by the Trust over the past 6 years:

Table 2: Number of reported patient safety incidents 2013-14 to 2015-16

Patient Safety Incidents reported:	2013-14	2014-15	2015-16
Patient Safety Incidents	12,725	11,067	10,775

(Data is as at 5/4/16)

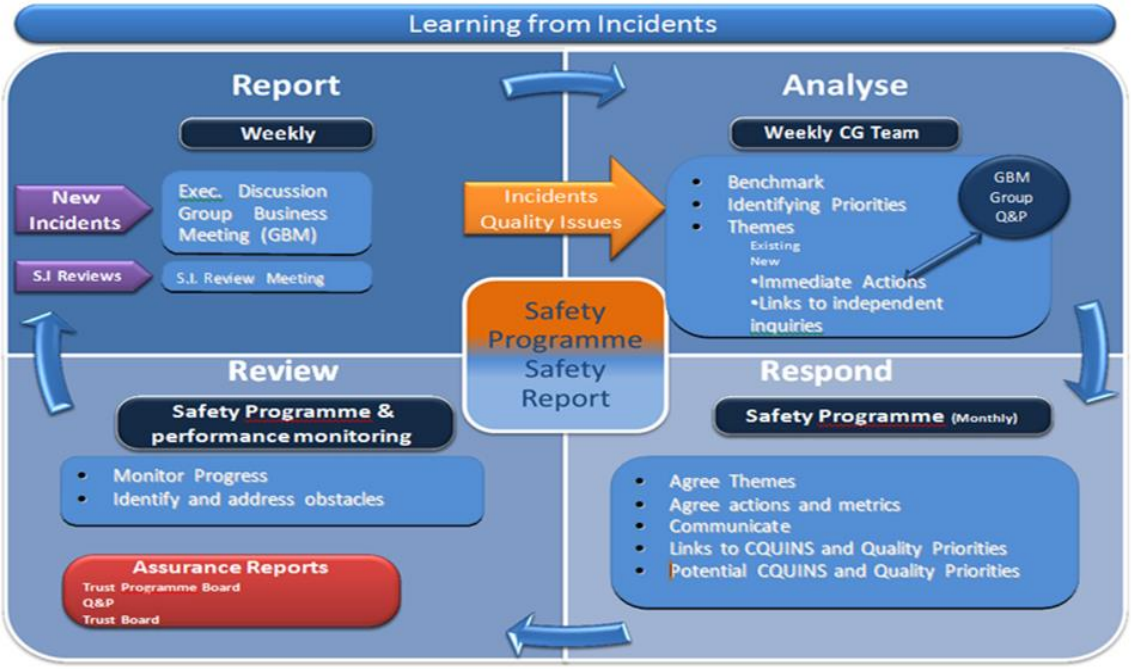
A patient safety incident is defined as 'Any unintended or unexpected incident, which could have or did lead to harm for one or more patients receiving NHS funded healthcare. This is also referred to as an adverse event/incident or clinical error and includes near misses.'

Throughout 2015-16 the Trust fully implemented a web based incident reporting system, allowing immediate incident reporting to managers as and relevant specialists within the Trust, facilitating enhanced support for both clinical and operational teams. This has resulted in improved quality and more timely reporting of patient safety incident data into the National Reporting and Learning System.

Most serious incidents reported are unexpected deaths in mainstream community services or substance misuse services. The Trust has continued to develop investigation and learning processes, reporting themes from serious incidents to the Board of Directors on a quarterly basis throughout 2015-16 and further thematic analysis is planned for 2016-17.

The Trust's Incident Policy was recently updated to reflect the NHS England Serious Incident Framework and the new internal incident reporting system. Figure 2 shows how information reported from incidents is considered, analysed and responded to so that the Trust continuously learns from the process.

Figure 3: Incident Policy Process



Patient Safety Incidents by impact

Table 3: Number of Patient Safety Incidents by impact 2013-14 to 2015-16:

Number of Patient Safety Incidents reported, by impact:	2013-14		2014-15		2015-16	
No Harm	3401	27%	4215	38%	5129	48%
Minor Harm	8355	66%	6093	55%	4940	46%
Moderate Harm	771	6%	587	5%	603	6%
Major Harm	65	1%	55	0%	22	0%
Catastrophic, Death	133	1%	117	1%	81	1%
Total patient safety incidents reported*	12,725	100%	11,067	100%	10,775	100%

(NB Annual totals for previous years may differ from previously reported data due to on-going data quality improvement work and to reflect coroner's conclusions when known. Data is as at 5/4/16).

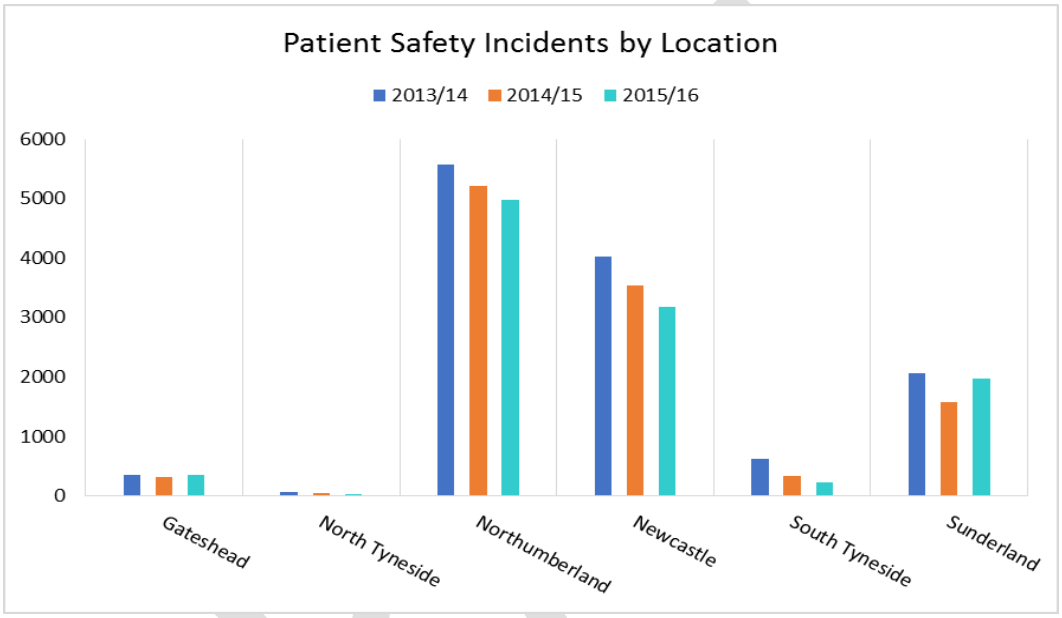
As demonstrated in Table 3, above during 2015-16, both the total numbers and the proportion of "major" and "catastrophic harm" patient safety incidents continue to reduce from previous years while the number and proportion of "no harm" incidents have increased. The impact of quality priorities, combined with enhancements in recording and

categorisation of patient safety incidents have contributed to the reduction in severity of incidents reported.

Patient Safety Incidents by locality

Figure 4 below shows patient safety incidents which have been reported over the past 2 years split by location of the incident (i.e. where the incident took place):

Figure 4: Patient Incidents by location 2013-14 to 2015-16



Services based in Newcastle and Northumberland continue to report more patient safety incidents than others areas, which reflects the volume and types of inpatient services located in those areas – for example, these areas include a number of specialist inpatient services treating service users with complex needs, often resulting in higher numbers of incidents reported. Table 4 below shows patient safety incidents by both location and the severity of harm caused. The information has been divided into patient safety incidents which happen in community based services and those in inpatient units.

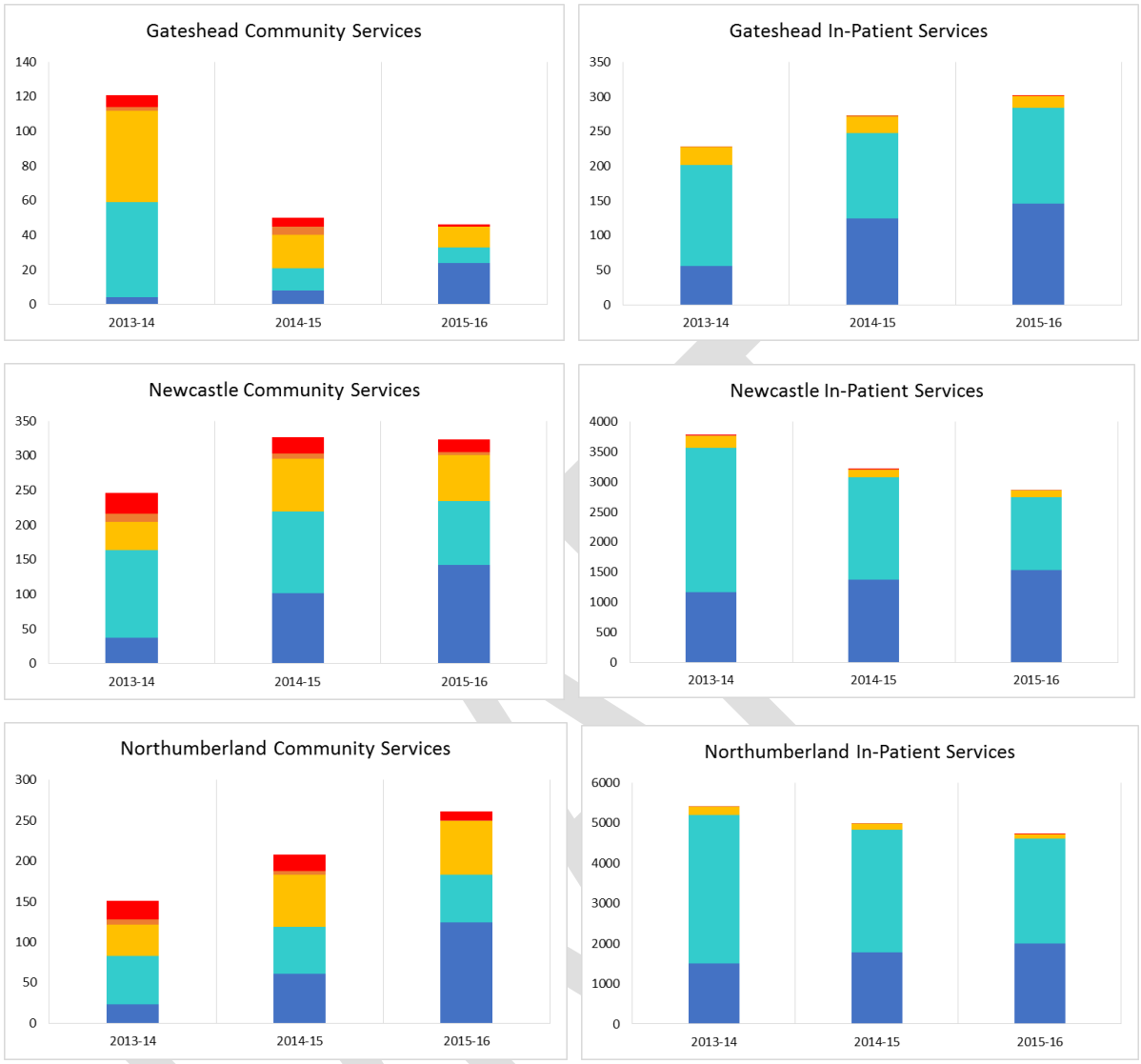
Table 4: Number of Patient Safety Incidents in Community and Inpatient Services 2013-14 to 2015-16

Number of Patient Safety Incidents reported	2013-14	2014-15	2015-16
Community	844	818	887
Inpatient	11,881	10,249	9,888
Total patient safety incidents	12,725	11,067	10,775

(Data is as at 5/4/16)

Patient Safety Incidents by Location and Level of Harm

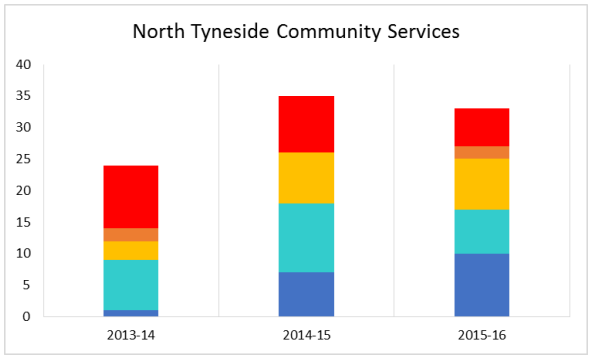
Figure 5: Patient Safety Incidents by Location and Level of Harm

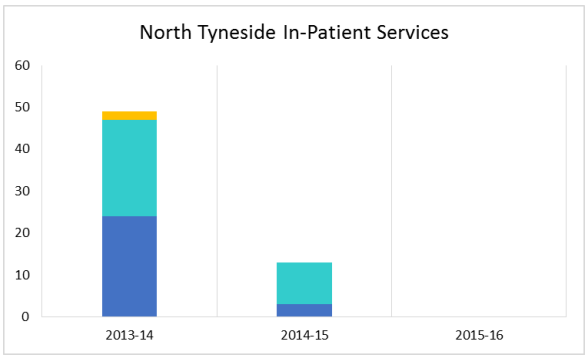


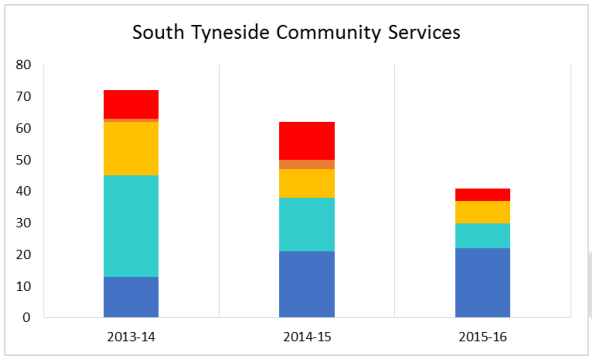
Patient Safety Incident Category
Catastrophic, Death
Major, permanent harm
Moderate, semi-permanent harm
Minor, non-permanent harm
No harm

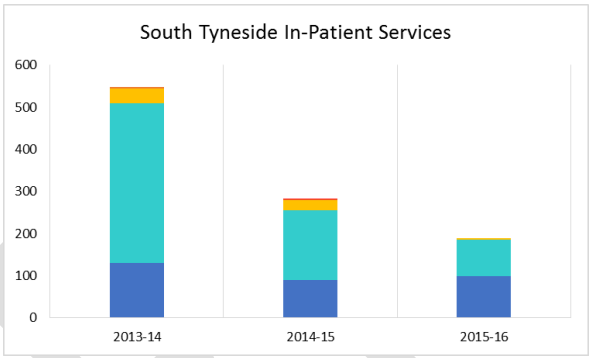
NB The numbers shown relate to where the services are located. For example, Trust sites in Newcastle and Northumberland include a number of specialist inpatient services treating service users with complex needs, often resulting in higher numbers of incidents reported.

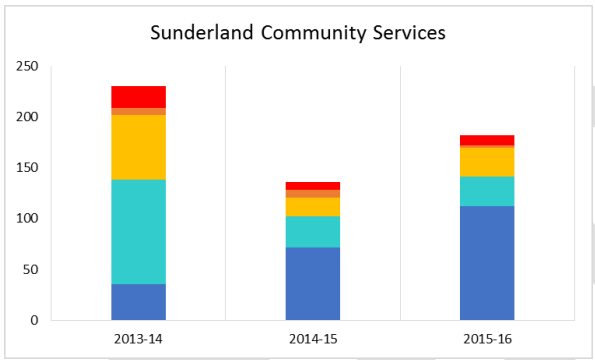
Note that the vertical scales on each graph differ to reflect variation by location.

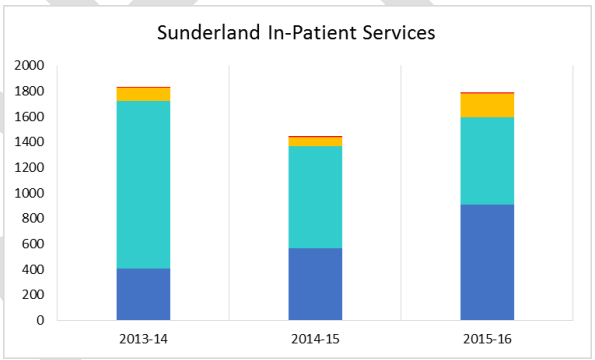












Patient Safety Incident Category
Catastrophic, Death
Major, permanent harm
Moderate, semi-permanent harm
Minor, non-permanent harm
No harm

NB The numbers shown relate to where the services are located. For example, Trust sites in Newcastle and Northumberland include a number of specialist inpatient services treating service users with complex needs, often resulting in higher numbers of incidents reported.

Note that the vertical scales on each graph differ to reflect variation by location.

National benchmarking information on our serious incident reporting can be found on page 48-49 of this report.

For further updates on patient safety incident information please access the Trust Board patient safety reports – these are published quarterly and can be found at http://www.ntw.nhs.uk/section.php?l=2&p=26.

News from 2015-16

NHS providers have been publically ranked on their openness and transparency under a new 'Learning from Mistakes League' launched by Monitor and the NHS Trust Development Authority in March 2016.

Data for 2015-16, drawn from the 2015 NHS staff survey and from the National Reporting and Learning System, ranked Northumberland, Tyne and Wear NHS Foundation Trust as "Good".

The league table scores providers on the fairness and effectiveness of procedures for reporting errors, near misses and incidents; staff confidence and security in reporting unsafe clinical practice and the percentage of staff who feel able to contribute towards improvements at their trust.

Quality Goal 2 - Patient Experience: Improve the way we relate to patients and carers

We will demonstrate success by improving the overall score achieved in the patient survey and by reducing the number of complaints received.

2015-16 Quality Priority: Greater choice, quality of food and timing of meals to inpatient areas

Target We aimed to roll out our meal ordering system, introduce nutritionally adequate menu options, update the pictorial menus, advise Trust café's and shops on appropriate portion sizes and nutritional information.

Progress Met

While no longer continuing as quality priority, The Trust aims for continuous improvement of food and nutrition issues, ensuring that feedback from service users is reflected upon. This will be monitored through the Trust wide Food and Nutrition Group.

2015-16 Quality Priority: To improve the referral process and the waiting times for referrals for multi-disciplinary teams

Target To meet waiting times targets for Children's and Young Peoples' services, reduce waiting times for the Gender Dysphoria service and ensure that 100% of service users in all other services will wait no longer than 18 weeks for their first contact with a service by March 2016.

Progress Partially Met

NB waiting times information will be further developed in draft 2

Children's and Young Peoples' community services had locality specific targets in relation to service users waiting less than 9 or 12 weeks as at 31st March 2016. Continuous improvement was expected to be demonstrated each quarter and this has been achieved. All of the nine weeks targets were

NB waiting times information will be further developed in draft 2

achieved, and the 12 weeks target was achieved in Northumberland and South Tyneside.

The Gender Dysphoria service is subject to specific development needs in line with similar services nationally. Additional investment, a recruitment strategy and service model redesign has been implemented during 2015-16, however difficulties in recruiting highly specialist staff into the service along with continuing increases in demand has resulting in continued long waits to access the service. It is anticipated that the waiting times will decrease in 2016-17 as new staff are recruited.

Autism Spectrum Disorders & ADHD Service: It is intended that this service will meet the 18 week maximum wait by September 2016, followed by transition of the service into mainstream adult community teams.

All other services: on 31st March 2016, 99.5% of service users on a waiting list for all other multi-disciplinary teams had waited less than 18 weeks.

What is a multi-disciplinary team?

A multi-disciplinary team is composed of staff members from different healthcare professions with specialised skills and expertise. The members collaborate together to make treatment recommendations to ensure improved patient care.

2015-16 Quality Priority: To improve communication to, and involvement of carers and families (focus on young carers)

Target To map current provision of support for young carers, developing plans to address any gaps identified and provide guidance to Trust staff to help them identify, support and work with young carers.

Progress Met

The focus on issues affecting carers will continue into 2016-17 with a quality priority to develop the use of the Triangle of Care across the organisation (see page 13).

"Consistently happy with the care and the support and communication provided to my daughter and I over the last 9 months."

(Fraser House)

"Everything that was explained to me, that they were just a phone call away if I was experiencing some difficulty and I am very appreciative of all their help. Thank you."

(Sunderland CRHT)

How have the 2015-16 Quality Priorities helped support this Quality Goal?

We aim to continue to ensure that service users and carers have a positive experience of care and treatment when accessing our services and we use national surveys to find out about peoples experiences of the Trust. The annual CQC Community Mental Health Patient Survey was completed in 2015 by 227 community service users (27% of those asked). There are 10 sections of the survey and the table below reports the NTW patient response score per section, along with a comparison with other Mental Health Trusts. (NB scores are out of 10).

Table 5: National Mental Health Community Patient Survey Results 2014 - 2015

Section	2015 NTW Score	2015 NTW Lowest – Highest Score	Position relative to other Mental Health Trusts	2014 NTW Score
1.Health or Social Care Workers	**7.6**	6.8 – 8.2	About the Same	8.1
2. Organising your Care	**8.7**	7.9 – 9.1	About the Same	8.9
3. Planning your Care	**7.3**	6.1 – 7.6	Best Performing Trust	7.5
4. Reviewing your Care	**7.5**	6.8 – 8.2	About the Same	8.0
5. Changes in who you see	**6.3**	4.7 – 7.5	About the Same	7.0
6. Crisis Care	**6.5**	5.1 – 7.2	About the Same	6.9
7. Treatments	**7.3**	6.3 – 7.9	About the Same	7.4
8. Other Areas of Life	**5.2**	3.9 – 5.8	About the Same	5.2
9. Overall View of Care and Services	**7.3**	6.4 – 7.7	About the Same	7.5
10. Overall Experience	**7.0**			7.2

The Trust emerged as a 'best performing trust', in comparison to other providers in one section – Section 3: Planning your Care. Our services did not receive any scores where performance was judged to be lower than the majority of other providers.

Comparison to previous year's scores:

Previous surveys of community mental health services were carried out between 2004-08 and 2010-14. The questionnaire for the 2014 survey was substantially redeveloped and updated in order to reflect changes in policy, best practice and patterns of service, therefore the detailed results

from the 2014 and 2015 surveys are not comparable with the results from previous national community mental health surveys.

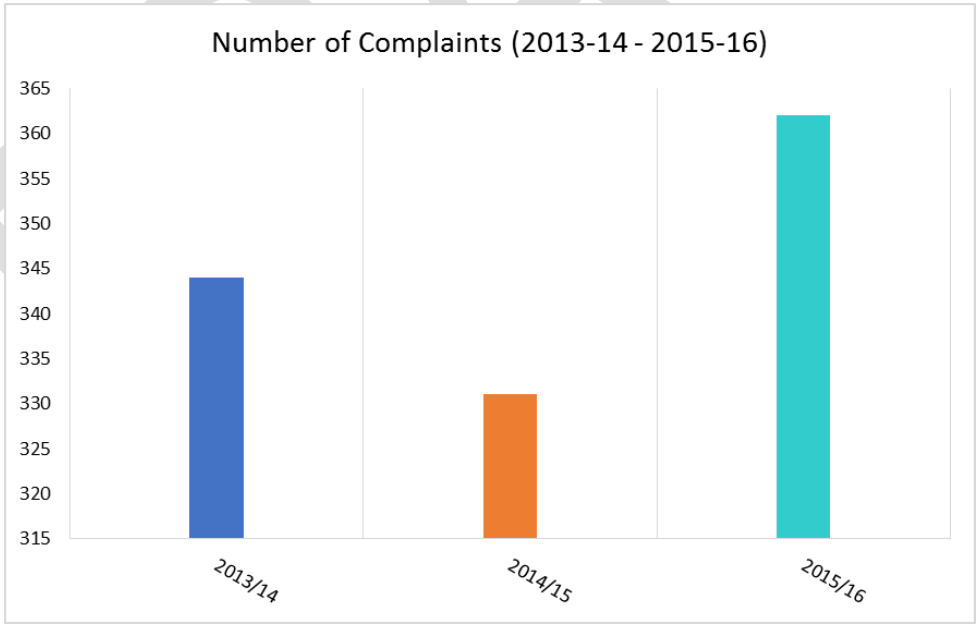
When compared with the 2014 survey, 2015 scores have deteriorated in nine out of ten sections and remained static in one section (Section 8 – Other Areas of Life). Analysis of published data shows that patient experience of community mental health service decreased nationally between 2014 and 2015.

Complaints

NTW welcomes the valuable information gathered from our complaints process as this is used to inform our service improvements to ensure we provide the best possible care to our patients and carers.

Complaints have increased during 2015-16 with a total of 362 received during the year. This is an increase of 32 complaints (or 10%) from 2014-15.

Figure 6: Number of complaints received 2013-14-2015-16



Complaints received 2015-16 (using new nationally defined categories)

Table 6: 2015-16 Number of complaints and new national categories types

Category Type	2015-16
Patient Care	76
Communications	72
Values and Behaviours	58
Admissions and Discharges	24
Prescribing	24
Appointments	22
Clinical Treatment	15
Other	15
Trust Admin/Policies/Procedures	11
Waiting Times	10
Access to Treatment or Drugs	9
Privacy, Dignity and Wellbeing	9
Restraint	9
Facilities	6
Consent	1
Integrated Care	1
Total	**362**

Outcomes of complaints

Within the Trust there is continuing reflection on the complaints we receive, not just on the subject of the complaint but also on the complaint outcome. Table 7 indicates the numbers of complaints and the associated outcomes for the 6 year reporting period:

Table 7: Number of complaints and outcomes 2013-14 to 2015-16

Outcome	2013-14	2014-15	2015-16
Closed – Not Upheld	90	88	90
Closed – Partially Upheld	109	99	88
Closed - Upheld	95	75	72
Complaint withdrawn	34	47	28
Decision not to investigate	2	1	3
Still awaiting completion	0	0	63
Unable to investigate*	15	20	18
Total	**345**	**330**	**362**

*category relates to complaints received which are not about our services, or the Trust was unable to contact the complainant.

Complaints referred to the Parliamentary and Health Service Ombudsman

If a complainant is dissatisfied with the outcome of a complaint investigation they are given the option to contact the Trust again to explore issues further. However if they choose not to do so, or remain unhappy with responses provided, they are able to refer their complaint to the Parliamentary and Health Service Ombudsman (PHSO).

The role of the PHSO is to investigate complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England.

There were 10 NTW complaints referred to the PHSO during 2015-16 and the status is recorded at the time of writing this report.

The following table provides the PHSO outcome for those that were completed at the time of writing this report. The Trust has been fully compliant with the timescales for response to PHSO requests and the results demonstrate an improvement on 2014-15, with a reduction to zero of PHSO complaints upheld or partially upheld

Table 8: Outcome of complaints considered by the Parliamentary and Health Service Ombudsman

Closed - Upheld	0
Closed - Partially Upheld	0
Closed - Not Upheld	6
Decision Not To Investigate	1
Still Awaiting Completion	3

NB as at 31.03.16 there were 5 cases still ongoing, including two from previous years.

Friends and Family Test – Service Users

The NHS Service User Friends and Family Test was implemented nationally in January 2015 and has become an important part of the Trust's patient experience feedback programme.

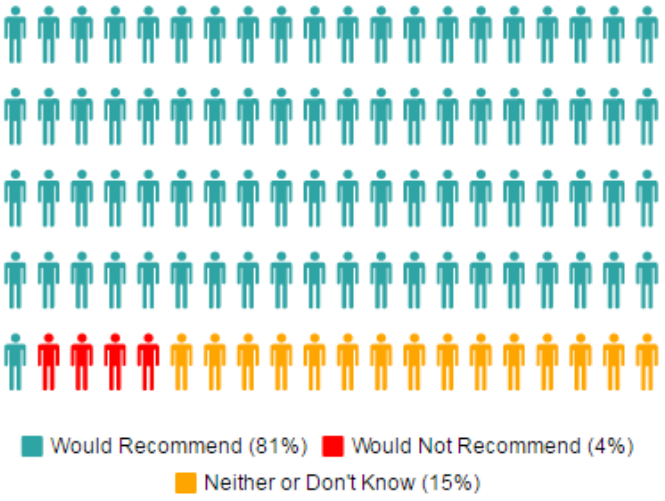
The Service User Friend and Family Test enables service users to have the opportunity to give feedback at any point in time. It is a single question survey that asks patients the following question:

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

Scores range from extremely likely (positive response) to extremely unlikely (negative response).

The Friends and Family Test has increasingly become embedded into practice. During 2015/16, 2,001 Friends and Family Test responses were received.

Figure 7: Percentage of respondents who would/not recommend the service they received to their friends and family



81% of respondents indicated they would recommend the service they received to their friends and family (rating of extremely likely or likely); whereas 4% indicated that they would not (ratings of extremely unlikely or unlikely).

Many other patient feedback measures are in use across the organisation such as “Points of You”, “How’s It Going” (often used in learning disability services) and “Experience of Service Questionnaire” (ESQ - used in community Children and Young People’s Services).

The Trust regularly considers themes arising from all service user feedback mechanisms, including compliments, thank you letters and comments made on websites such as NHS Choices and Patient Opinion.

Example comments received during 2015/16:

“After being discharged from hospital to early, my GP referred myself to the crisis team. Within less than half an hour they were on the phone offering to come out and assess me. They were a great support to my family who were also at the end of their tether. I will always be grateful for their help.”

Quality Goal 3 - Clinical Effectiveness: Ensure the right services are in the right place at the right time for the right person

We will demonstrate success by delivering demonstrable improvements in service delivery.

2015-16 Quality Priority: To continue to embed the Recovery Model

What is ImROC?

The Implementing Recovery through Organisational Change (ImROC) programme is a new approach to helping people with mental health problems. In mental health, 'recovery' means the process through which people find ways to live meaningful lives, with or without the on-going symptoms of their condition.

Target To introduce Peer Support Workers into all localities, ensuring an appropriate recruitment and induction process, develop the ImROC strategy and continue to progress Recovery Colleges.

Progress Met

The specific aims of the above quality priority have been achieved and this will no longer be a quality priority into 2016-17, however this work will continue and will be overseen by clinical groups.

2015-16 Quality Priority: To ensure comprehensive diagnosis information is available in relation to community service users

Target To increase recording of ICD10 diagnosis codes in community Early Intervention in Psychosis, Older People's and Memory Protection teams to 30% by quarter four.

Progress Met

This important work will continue and be monitored in 2016-17 as part of the Trust's Data Quality Improvement Plan.

2015-16 Quality Priority: To improve the recording and use of outcome measures by improving suppression rates of patient rated outcome measures (PROM)

What is our Patient Rated Outcome Measurement (PROM)?

The Trust uses the Short Warwick and Edinburgh Mental wellbeing Scale (SWEMWBS) to provide service users with an opportunity to feedback their views on their clinical outcomes.

Target To increase the rates of SWEMWBS forms being sent to service users to 45% by quarter four.

Progress Met

This will continue as a quality priority into 2016-17 to increase the rates further.

How have the 2015-16 Quality Priorities helped support this Quality Goal?

Service Improvement and Developments throughout 2015-16

These are some of the key service developments that the Trust has made during 2015-16:

Community Transformation Programme

The Community Transformation Programme aims to deliver new community evidence based care pathways with improved access to services, improved quality outcomes and improved experience for service users and carers. The programme is focusing on the redesign of Psychosis; Non-psychosis; Cognitive Disorders and Learning Disability services.

The programme started in 2013-14 in Sunderland and South Tyneside, testing interventions focused on recovery and effective support for people to live and work in their own communities with the aim of reducing reliance on hospital beds. During 2014-15 the Trust commenced the roll out of the

redesigned Community Pathways across Sunderland and South Tyneside and this work continued through 2015-16, while engagement on the principles and design of improved community pathways in north of Tyne resulted in the launch of the Northumberland Initial Response Team in December 2015. This 24/7 service, based at St. George's Park, provides a single point of access for urgent requests including signposting to relevant services within and outside the organisation. New Community Pathways are to be fully introduced into Northumberland, North Tyneside, Newcastle and Gateshead during 2016-17.

Last year also saw the introduction of Street Triage Teams both North and South of Tyne, with the police and mental health nurses jointly dealing with incidents involving people experiencing a mental health crisis. This ensures the best and most appropriate care at that time, resulting in a reduction in individuals detained by the police.

Developing New Models for Inpatient Care Programme

Since 2013, the Trust, in collaboration with partners, has considered a range of options to determine the most appropriate future configuration of services and hospital sites for people with serious mental health conditions in the light of the roll out of the improved Community Pathways and the anticipated reduction in demand for inpatient services, ensuring that services remain clinically appropriate, safe and affordable.

This work led to the agreed closure of the Bede Unit in South Tyneside. In Newcastle and Gateshead, partners have together looked carefully at the services for people living in Newcastle and Gateshead. Newcastle and Gateshead CCG led a listening and engagement process from November 2014 to February 2015 called "Deciding Together" with the aim of collecting views and experiences about specialist mental health services. The feedback from this process informed the development of scenarios for change which were the subject to a formal consultation during 2015-16. The public consultation has sought views on three possible locations for adult acute assessment and treatment and rehabilitation services and two possible locations for older people's services.

A full Case for Change document is scheduled to be completed in May 2016, reflecting on the outcome of the public consultation. Alongside the CCG we will begin to plan the implementation of the agreed changes during 2016-17.

Specialist Care Services Programme

The Specialist Care Services Programme is responsible for ensuring the Trust continues to provide sustainable specialist services.

Significant progress in this programme of work has been achieved during 2016-16, including:

- Development of the Mitford Unit at Northgate Hospital commenced and is due to be completed mid-2016. This new autism assessment and treatment facility will meet the very specific needs of service users with highly complex needs.
- Ongoing review of both Neurological Services and Secure Services long term sustainability.
- With the support of commissioners, the development of an integrated Attention Deficit Hyperactivity Disorder service providing a service across children and young people's services into adult services.

Social and Residential Services

During 2015-16 the Trust continued to review Northumberland Mental Health Day Services in partnership with stakeholders, and agreed a redesign of services strategy. It has been agreed that the Trust will provide health focused activities, integrated into the overall model of the Community Mental Health team, enabling service users access to a wide range of recovery focused and evidenced based interventions around psycho-education, self-management and physical wellbeing services.

Learning Disability Services

The Trust provides a wide range of services for people with learning disabilities and/or autism spectrum disorder including those with a mental illness and whose behaviour challenges services, including community services, inpatient assessment and treatment services and secure services.

"Transforming Care for People with Learning Disabilities – Next Steps (2015)" reaffirmed the Government's and leading organisations across health and social care commitment to transforming care for people with

learning disabilities and / or autism spectrum disorder who have a mental health condition or whose behaviour challenges services. In 2015 NHS England publicly committed to a programme of closing inappropriate and outmoded inpatient facilities and establishing stronger support in the community. Six "Fast Track" areas were identified and included the North East and Cumbria, working towards reallocating resources from inpatient services into new community services and reducing usage of inpatient provision by approximately 50% over the coming three years. A highly skilled, confident and value driven community workforce delivering early intervention and effective crisis support will support the closure of some assessment and treatment beds and secure beds provided by the Trust.

The development of integrated and "place based services"

The Trust's Strategic 5 Year Plan 2014-19 supported the development of integrated services designed around the needs of the population, replacing any remaining institutional based models of care. Overall progress across the Trust's six localities during 2015-16 has been positive with differing approaches and priorities and we are fully committed to working with partners to develop integrated models of care, designed around the needs of local populations delivering significant benefits in aligning the approach to physical and mental health long term conditions, and in aligning delivery of support and care across health and social services.

New Services

During 2015-16 the Trust successfully tendered for a number of new services and service improvements, including

- The implementation of evidenced based IAPT interventions in Children and Young People's services in Northumberland and North Tyneside in partnership with Northumbria Healthcare NHS Foundation Trust.
- Sunderland Integrated Substance Misuse and Harm Reduction Service in partnership with DISC and Changing Lives, to commence on the 1st July 2016.

- Inclusion on a framework to provide mental health inpatient services to Sussex Clinical Commissioning Groups (CCGs) out of area placements.
- Inclusion on a framework to provide Cognitive Behavioural Therapy for Psychosis training for Early Intervention in Psychosis.

Partnerships

The Trust continues to work in partnership with NHS organisations, the community, voluntary and independent sectors which we highly value.

NTW Clinical Effectiveness Strategy

The Trust's Clinical Effectiveness Strategy forms an overarching framework aligning with other relevant strategies and programmes. This collaborative approach will optimise the benefits for all service users by rapidly implementing evidence-based practice and measuring, as well as learning from, the outcomes of the care provided by the Trust. The mission for the Clinical Effectiveness Strategy is for the Trust to provide safer, better quality care that enables service users to live better for longer. The three year strategy is in the context of a ten-year aim to demonstrate a significant measurable improvement in the extent to which service users are living better for longer.

The Trust already has a wide range of policies, processes and programmes that are addressing clinical effectiveness, for example Transformation, Physical Health and Informatics programmes. In 2016-17, NTW will be refreshing the Clinical Effectiveness Strategy implementation plan to ensure delivery of the following objectives:

1. All service users (and carers where relevant) will have the outcomes that are important to them measured, reported and tracked over time;
2. There is evidence that the culture of the organisation is supporting staff in delivering clinically effective care;
3. Routine measurements demonstrate that evidence-based guidelines, including but not limited to NICE quality standards, will inform care that is given to all service users;
4. There is evidence that the infrastructure of the Trust will support staff to deliver clinically effective care;
5. Routine measurements demonstrate that the physical health care needs of our service users are consistently recognised, monitored and managed.

Part 2c

Mandatory Statements relating to the Quality of NHS Services Provided

Review of Services

During 2015-16 the Northumberland, Tyne and Wear NHS Foundation Trust provided and/or sub-contracted 181 NHS Services.

The Northumberland, Tyne and Wear NHS Foundation Trust have reviewed all the data available to them on the quality of care in all 181 of these relevant health services.

The income generated by the relevant health services reviewed in 2015/16 represents 100 per cent of the total income generated from the provision of relevant health services by the Northumberland, Tyne and Wear NHS Foundation Trust for 2015/16.

Participation in clinical audits

During 2015-16, 8 national clinical audits and ? national confidential enquiries covered relevant health services that Northumberland, Tyne and Wear NHS Foundation Trust provides.

During that period Northumberland, Tyne and Wear NHS Foundation Trust participated in 100% national clinical audits and ?% national confidential enquiries of the national clinical audits and national confidential enquires which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Northumberland, Tyne and Wear NHS Trust was eligible to participate in during 2015-16 are as follows:

Table 9: National Clinical Audits 2015-16 and National Confidential Enquiries 2015-16

National Clinical Audits 2015-16	
1	National Audit of Schizophrenia (Royal College of Psychiatrists)
2	Prescribing for Substance Misuse: Alcohol Detoxification (POMH-UK Topic 14a)
3	Prescribing for People with a Personality Disorder (POMH-UK Topic 12b)
4	Use of Anti-Psychotic Medicine in CAMHS (POMH-UK Topic 10c)
5	Assessment of Side Effects of Depot Anti-Psychotic Medication (POMH-UK Topic 6d)

6	Use of Anti-Psychotic Medication in People with Learning Disabilities (POMH-UK Topic 9c)
7	Prescribing for ADHD in Children, Adolescents and Adults (POMH-UK Topic 13b)
8	Early Intervention in Psychosis Audit
National Confidential Enquiries 2015-16	
1	National Confidential Enquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)
2	National Confidential Enquiry (NCI) into Inpatient Suicide whilst Under Non Routine Observation

The national clinical audits and national confidential enquiries that Northumberland, Tyne and Wear NHS Foundation Trust participated in, and for which data collection was completed during 2015-16, are shown in Table 10 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.

Table 10: National Clinical Audits 2015-16 and National Confidential Enquiries 2015-16

National Clinical Audits 2015-16	Cases submitted	Cases required	%
National Audit of Schizophrenia (Royal College of Psychiatrists)	89 cases submitted. Trust action plan was submitted in May 2015. Quarterly monitoring is on-going – latest update of action plan is February 2016.	75	100%
Prescribing for Substance Misuse: Alcohol Detoxification (POMH-UK Topic 14a)	21 cases submitted. Trust action Plan reported as complete in July 2015.	No minimum requirement.	-
Prescribing for People with a Personality Disorder (POMH-UK Topic 12b)	50 cases submitted. Trust action plan reported as complete in August 2015.	No minimum requirement.	-
Use of Anti-Psychotic Medicine in CAMHS (POMH-UK Topic 10c)	83 cases submitted. Trust action plan reported as complete in September 2015	No minimum requirement.	-
Assessment of Side Effects of Depot Anti-Psychotic Medication (POMH-UK Topic 6d)	Postponed indefinitely at a National level	n/a	n/a

Use of Anti-Psychotic Medication in People with Learning Disabilities (POMH-UK Topic 9c)	90 cases submitted in 2015. Trust Action Plan reported as complete in February 2016	No minimum requirement.	-
Prescribing for ADHD (POMH-UK Topic 13b)	80 cases submitted. Report complete October 2015 and Trust action plan reported as complete in January 2016	No minimum requirement.	-
Early Intervention in Psychosis Audit	48 cases submitted. Data analysis currently underway and proposed completion date is April 2016	No minimum requirement.	-
National Confidential Enquiries 2014/2015	**Cases submitted**	**Cases required**	**%**
National Confidential Enquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)	Reported directly to NCI	n/a	n/a
National Confidential Enquiry (NCI) into Inpatient Suicide whilst Under Non Routine Observation	Reported directly to NCI	n/a	n/a

The reports of 6 national clinical audits were reviewed by the provider in 2015/2016, and Northumberland, Tyne and Wear NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Table 11: Actions to be taken in response to national clinical audits

Project	Actions
National Audit of Schizophrenia (Royal College of Psychiatrists)	A Trust action plan was developed and is monitored at the Clinical Effectiveness Committee. While the findings for NTW were generally average for the audit, the report authors commented that national performance was generally below what should be provided. Individual team action plans are in place to improve practice in physical health, psychological therapies and prescribing practices.
Prescribing for Substance Misuse: Alcohol Detoxification (POMH-UK Topic 14a)	The Medicines Management Committee developed actions from the audit recommendations: • Development of an evidence-based guideline and approval for use in NTW • Key card developed and circulated to all clinical staff to raise awareness of the guideline

	• Increase compliance with baseline bloods being taken • POMH-UK will request a re-audit of this topic in 2016
Prescribing for People with a Personality Disorder (POMH-UK Topic 12b)	The Medicines Management Committee developed actions from the audit recommendations: • Share the learning from the audit widely and agree local action plans where appropriate • Review prescribing in community Emerging Unstable Personality Disorder patients
Use of Anti-Psychotic Medicine in CAMHS (POMH-UK Topic 10c)	The Medicines Management Committee developed actions from the audit recommendations: • Ensure medication reviews are undertaken and recorded every 6 months • Standardise where information is recorded on the electronic record • Ensure side effects are assessed and recorded as part of the medication review
Use of Anti-Psychotic Medication in People with Learning Disabilities (POMH-UK Topic 9c)	The Medicines Management Committee developed actions from the audit recommendations: • The actions have been added as a CPA review agenda point • Sharing of physical health monitoring results. • A separate action plan from an audit of NICE NG 11 standards has been used to record indication and review of antipsychotics in line with NICE guidance
Prescribing for ADHD (POMH-UK Topic 13b)	A Trust-level report was provided for this audit and appropriate actions taken from the audit recommendations: • Discuss results with Specialist Care Safe group • Circulate and discuss results with CYPS managers & consultants • Discuss results at CYPS Prescribers • Discuss Results with CYPS ADHD Team Leads and standardise information recording:

The reports of 74 local clinical audits were reviewed by the provider in 2015-16 and the details can be found at Appendix 3 of this report.

Research

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Northumberland, Tyne and Wear NHS Foundation Trust in 2015-16 that were recruited during that period to participate in research approved by a research ethics committee was 1226.

Increased participation in clinical research demonstrates Northumberland, Tyne and Wear NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. The Trust was involved in 94 clinical research studies in mental health, learning disability and neuro-rehabilitation related topics during 2015-16, 45 of which were large-scale nationally-funded studies, and was ranked as the second most research active mental health trust in England by The National Institute for Health Research (NIHR).

Staff participation in research increased during 2015-16 with 60 clinical staff participating in ethics committee approved research employed by the Trust. We have continued to work closely with the NIHR Clinical Research Networks North East and North Cumbria Local Clinical Research Network to support national portfolio research and have achieved continued success with applications for large-scale research funding in collaboration with Newcastle and Northumbria Universities.

Goals agreed with commissioners

Use of the CQUIN payment framework

The CQUIN framework aims to embed quality improvement and innovation at the heart of service provision and commissioner-provider discussions. It also ensures that local quality improvement priorities are discussed and agreed at board level in all organisations. It enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

A proportion of Northumberland, Tyne and Wear NHS Foundation Trust income in 2015-16 was conditional on achieving quality improvement and innovation goals agreed between Northumberland, Tyne and Wear 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.

For 2015-16, £6.4m of Northumberland, Tyne and Wear NHS Foundation Trust's contracted income was conditional on the achievement of these CQUIN indicators (£6.4m in 2015-16).

CQUIN Indicators

At the time of writing this Quality Account the majority of CQUIN indicators were fully achieved although there are ongoing challenges in relation to some of the physical health requirements and also waiting times for Children and Young People's in some locality areas.

A summary of the agreed CQUIN indicators for 2015-16 and the new indicators for 2016-17 is shown in Tables 12 to 14 below. The tick marks show which financial year the indicator applies to:

Table 12: CQUIN Indicators to improve Safety

CQUIN Indicators to improve Safety	2015-16	2016-17
Collaborative Risk Assessment in Secure Services	✓	
Reducing Restrictive Practices within adult low and medium secure inpatient services		✓
Reducing avoidable repeat detentions under the Mental Health Act		✓

Table 13: CQUIN Indicators to improve Patient Experience

CQUIN Indicators to improve Patient Experience	2015-16	2016-17
Reduce waiting times for Children and Young Peoples services (CYPS)	✓	
Involvement & engagement with service users and carers: -support for young carers -support for service users & carers accessing crisis services	✓	✓
Perinatal inpatient services involvement and support for partners/ significant others	✓	✓
Liaison Services North Tyneside - Improving diagnoses and re-attendance rates of service users with mental health needs at A&E	✓	
Improving inpatient CAMHS Care Pathway Journeys by enhancing the experience of the family/carer		✓

Table 14: CQUIN Indicators to improve Clinical Effectiveness

CQUIN Indicators to improve Clinical Effectiveness	2015-16	2016-17
To increase the percentage of people with mental health illness who receive appropriate physical health care.	✓	
Mental Health & Deafness recovery and outcomes	✓	✓
Development of Recovery Colleges for adult medium and low secure inpatients		✓
Embedding Clinical Outcomes: - Adult mental health community teams - People with learning disabilities - Community Children and Young Peoples' services		 ✓ ✓ ✓

Statements from the Care Quality Commission (CQC)

Northumberland, Tyne and Wear NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions and therefore licensed to provide services. The Care Quality Commission has not taken enforcement action against Northumberland, Tyne and Wear NHS Foundation Trust during 2015-16. Northumberland, Tyne and Wear NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC registers and licenses Northumberland, Tyne and Wear NHS Foundation Trust as a provider of care services as long as we meet the fundamental standards of quality and safety. The CQC monitors us to make sure that we continue to meet these standards.

CQC Intelligent Monitoring Report

The Intelligent Monitoring Report, published by the Care Quality Commission (CQC) is a useful tool to help us to continually monitor the quality of our services. It allows us to identify any areas of lower than average performance and take action to address them if necessary.

The report gathers together a range of key indicators about the Trust in relation to the CQC's five key questions - is the Trust safe, effective, caring, responsive and well-led. These indicators are used by the CQC to highlight potential risks about the quality of care provided by the Trust.

The most recent Intelligent Monitoring Report was published by the CQC in February 2016 and it identifies the Trust as having an overall risk score of 6 out of a possible maximum score of 142. The report can be found on the CQC website here.

Benchmarking of the CQC national mental health intelligent monitoring information conducted in 2015 highlighted xxxxxxx to be inserted

CQC Registration Activity 2015-16

During 2015/16, the Care Quality Commission did not undertake any compliance visits to the Trust, a full inspection is due to take place in June 2016.

External Accreditations

The Trust has gained national accreditation for the quality of services provided in many wards and teams.

- Nearly xx% of adult and older people's mental health wards have achieved the AIMS Accreditation for Inpatient Mental Health Services; the remainder are seeking to gain accreditation within the next 12-18 months.
- xx% of the adult forensic medium and low secure wards have been accredited by the Quality Network for Forensic Mental Health Services.
- xx% of the children's wards in the Ferndene unit have been accredited by the Quality Network for Inpatient CAMHS

Table 15 below provides a breakdown of current clinical accreditations as at March 2016.

Table 15: Current clinical external accreditations (March 2016)

External Accreditation	Ward/Department	Location
Accreditation for Inpatient Mental Health Services (AIMS)	Beckfield (PICU)	Hopewood Park
	Collingwood Court	Campus for Ageing and Vitality
	Embleton	St George's Park
	Fellside Ward	Queen Elizabeth Hospital
	Gainsborough Ward	Campus for Ageing and Vitality
	Lamesley Ward	Queen Elizabeth Hospital
	Lowry Ward	Campus for Ageing and Vitality
	Warkworth Ward	St George's Park
	Rosewood	Hopewood Park
	Longview	Hopewood Park
	Shoredrift	Hopewood Park
	Springrise	Hopewood Park
	Akenside (OP)	Centre for Ageing and Vitality

External Accreditation	Ward/Department	Location
	Hauxley (OP)	St George's Park
	Castleside Ward (OP)	Campus for Ageing and Vitality
	Cresswell (OP)	St George's Park
	Mowbray Ward (OP)	Monkwearmouth Hospital
	Roker Ward (OP)	Monkwearmouth Hospital
	Bluebell Court (Rehab)	St George's Park
	Clearbrook (Rehab)	Hopewood Park
Quality Network for Forensic Mental Health Services	Bamburgh Clinic	St Nicholas Hospital
	Bede Ward	St Nicholas Hospital
	Kenneth Day Unit	Northgate Hospital
Quality Network for Inpatient CAMHS	Stephenson	Ferndene
	Fraser	Ferndene
	Riding	Ferndene
	Redburn	Ferndene
	Alnwood	St Nicholas Hospital
Quality Network for Community CAMHS	Northumberland CYPS	Villa 9, Northgate Hospital
	Newcastle & Gateshead CYPS	Benton House
	South of Tyne CYPS	Sunderland and South Tyneside
ECT Accreditation Service	Hadrian Clinic	Campus for Ageing and Vitality
	Treatment Centre	St George's Park
Psychiatric Liaison Accreditation Network	Psychiatric Liaison Team Sunderland Royal Hospital	Sunderland
	Northumberland Liaison Psychiatry and Self Harm Team	Northumberland
	Newcastle Integrated Liaison Psychiatric Service, RVI	Newcastle
Memory Service National Accreditation Programme	Newcastle Memory Assessment and Management Service	Newcastle
	Monkwearmouth Memory Protection Services	South Tyneside
Quality Network for Perinatal Mental Health Services	Beadnell Mother and Baby Unit	St George's Park
	Newcastle & North Tyneside Perinatal Community Team	Northumberland (based alongside the inpatient unit)
Home Treatment Accreditation Scheme	Crisis Assessment & Home Based Treatment Service Newcastle	Newcastle

Data Quality

Northumberland, Tyne and Wear NHS Foundation NHS Trust will be continuing to take the following actions to improve data quality:

Table 16: Actions to be taken to improve data quality

Clinical Record Keeping	We will continue to provide training in the use of the RIO clinical record system and raise awareness of the linkages to quality dashboards, measuring adherence to the Clinical Records Keeping Guidance, highlighting the impact of good practice on data quality and on quality assurance recording. This work will link clinical record keeping, data quality and quality assurance reporting, highlighting the importance of CPA status recording and supporting the planned upgrade of the RIO clinical record system.
Business Intelligence and NTW Dashboard development	We will continue to further refine the NTW dashboards, providing greater analysis of complex metrics, developing metric definitions and implementing service line reporting. We will implement a new business intelligence system, providing greater availability and transparency of management information to clinical services.
Data Quality Kite Marks	We will develop and implement a policy for measuring the data quality of all reported information using a recognised methodology.
Mental Health Services Dataset (MHSDS)	We will continue to implement this new national dataset, understanding data quality issues and improving the use of national benchmarking data. Improving demographic recording eg NHS number, ethnicity, gender etc. We will continue to use the MHSDS Clinical Reference Group to improve data quality, raise awareness of data quality issues and focus on specific improvements (e.g. enhancing discharge information recording and sharing with GPs).
Consent recording	We will redesign the consent recording process in line with national guidance and increase the recorded consent status rates.
CQC Intelligent Monitoring reports	We will ensure that we have a good understanding of the data used by the CQC in their Mental Health Intelligent Monitoring Reports.
ICD10 Diagnosis Recording	Building upon the 2015-16 quality priority, we will increase the level of ICD10 diagnosis recording across community services.
Mental Health Clustering	We will increase the numbers of clinicians trained in the use of the Mental Health Clustering Tool and improve data quality and data completeness, focusing on issues such as cluster waiting times analysis, casemix analysis, national benchmarking and four factor analysis to support the implementation of outcomes contracting in mental health.

Contract and national information requirements	We will continue to develop quality assurance reporting to commissioners and national bodies in line with their requirements.
Outcome Measures	We will enhance the current analysis of outcome measures in line with the 2016-17 CQUIN requirements, focusing on implementing a system for reporting information back to clinical teams.
Principal Community Pathways	We will further develop the availability of management information for clinicians and benefits realisation analysis.

Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made. The Trust has already made extensive improvements in data quality. During 2016-17 the Trust will build upon the actions taken to ensure that we continually improve the quality of information we provide.

North East Quality Observatory (NEQOS) Benchmarking of 2014-15 Quality Account Indicators

The North East Quality Observatory System (NEQOS) provides expert clinical quality measurement services to most NHS organisations in the north east.

During 2015 NTW once again commissioned NEQOS to undertake a benchmarking exercise, comparing the Trust's Quality Account 2014/15 with those of 56 other NHS Mental Health organisations. A summary of the top 10 indicators found in all Quality Accounts has been provided in Table 17 below.

Table 17: Top 10 Quality Account Indicators

	Top 11 Quality Account Indicators	Target	Average	Peer*	NTW	Number of Trusts
1	National Clinical Audit participation (%)	100%	93.4	81.9	**100.0**	56
2	National Confidential Enquiry participation (%)	100%	96.4	100.0	**100.0**	56
3	Admissions to adult urgent care wards gatekept by CRT (%)	95%	98.2	97.9	**100.0**	56

4	Inpatients receiving follow up contact within 7 days of discharge (%)	95%	97.5	97.6	**97.4**	56
5	Incidents for severe harm/death (%)	-	1.3	1.0	**1.3**	56
6	Patient experience of community MH services	-	7.8	7.9	**8.1**	45
7	Inpatients classed as delayed transfers of care (%)	< 7.5%	3.4	2.8	**2.6**	45
8	CPA formal review within 12 months (%)	95%	96.6	96.5	**95.6**	43
9	Proportion of inpatients readmitted	-	7.9	8.8	**6.2**	37
10	Staff who would recommend the trust to their family/friends (%)	-	3.51	3.46	**3.64**	18

*Peer includes data for (C&W, Lancashire, Norfolk, North Essex, Oxford, Southern, Sussex, TEWV)

The Trust scored equal to or higher than average on 6 of the 10 indicators. Likewise, when compared to the peer cohort the Trust scored equally or higher on 6 of the 10 indicators.

NHS Number and General Medical Practice Code Validity

Northumberland, Tyne and Wear NHS Foundation Trust submitted records during 2015-16 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

99.5% for admitted patient care; and

99% for out patient care."

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

99.9% for admitted patient care; and

99.9% for out patient care."

Information Governance Toolkit attainment

The Northumberland, Tyne and Wear NHS Foundation Trust Information Governance Assessment Report overall score for 2015-16 was 74% and was graded green.

Clinical Coding error rate

Northumberland, Tyne and Wear NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2015-16 by the Audit Commission.

Performance against mandated core indicators

The mandated indicators applicable to Northumberland, Tyne and Wear NHS Foundation Trust are as follows:

1. The percentage of patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period (data governed by a national definition)

The Northumberland, Tyne and Wear NHS Foundation Trust considers that this data is as described for the following reason - we have established, robust reporting systems in place through our electronic patient record system (RiO) and adopt a systematic approach to data quality improvement.

The Northumberland, Tyne and Wear NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services by ensuring clinicians are aware of their responsibilities to complete these reviews.

Table 18: 7 day follow up data 2013-14 to 2015-16

7 day follow up	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15
NTW %	**95.8%**	**97.5%**	**97.6%**	**97.0%**	**98.3%**	**95.8%**	**98.2%**
National Average %	97.4%	98.8%	96.7%	97.4%	97.0%	97.3%	97.3%
Highest national %	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Lowest national %	94.1%	90.7%	77.2%	93.3%	95.0%	91.5%	90.0%

(higher scores are better)

2. The percentage of admissions to acute wards for which the Crisis Home Treatment Team acted as a gatekeeper during the reporting period (data governed by a national definition)

The Northumberland, Tyne and Wear NHS Foundation Trust considers that this data is as described for the following reasons - we have established, robust reporting systems in place through our electronic patient record system (RiO) and adopt a systematic approach to data quality improvement.

The Northumberland, Tyne and Wear NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services by closely monitoring this requirement and quickly alerting professionals to any deterioration in performance.

Table 19: Gatekeeping data 2013/14-2014/15

Gatekeeping	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15
NTW %	**99.6%**	**99.6%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.7%**
National Average %	97.7%	98.7%	98.6%	98.2%	98.0%	98.5%	97.8%
Highest national %	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Lowest national %	74.5%	89.8%	85.5%	75.2%	33.3%	93.0%	73.0%

(higher scores are better)

3. The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends

The Northumberland, Tyne and Wear NHS Foundation Trust consider that this data is as described for the following reasons – this is an externally commissioned survey.

The Northumberland, Tyne and Wear NHS Foundation Trust has taken the following actions to improve this number, and so the quality of its services by continuing to hold multidisciplinary staff engagement sessions regarding the results of the staff survey and identifying actions for improvement.

Table 20: Staff recommendations data 2013 to 2015

Staff recommendation of the organisation as a place to work or receive treatment	2013 Staff Survey	2014 Staff Survey	2015 Staff Survey
NTW	**3.61**	**3.64**	**3.71**
National Average	3.54	3.57	3.66

Table 20 shows that NTW scored above (better than) the national average.

4. 'Patient experience of community mental health services' indicator score with regard to a patients experience of contact with a health or social care worker during the reporting period

The Northumberland, Tyne and Wear NHS Foundation Trust considers that this data is as described for the following reasons – this is an externally commissioned survey.

The Northumberland, Tyne and Wear NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services by constantly engaging with service users and carers to ensure we are responsive to their needs and continually improve our services.

Table 21: Patient experience of community mental health indicator scores 2013 to 2015

Patient experience of community mental health indicator scores	2013	2014	2015
NTW	**87.4**	In 2014 the national survey was substantially redeveloped and updated in order to reflect changes in policy, best practice and patterns of service. The removal of the question regarding patients' experience of contact with a health or social care worker during the reporting period prevents comparative data to be determined and reported on during 2014 and 2015.	
National Average	85.8		
Highest national	91.8		
Lowest national	80.9		

(higher scores are better)

Please see page 26-27 for the results from the National Community Mental Health Patient Survey for 2014 and 2015.

5. The number and , where available the rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death (data governed by a national definition)

The Northumberland, Tyne and Wear NHS Foundation Trust considers that this data is as described for the following reasons – this is data we have uploaded to the National Learning and Reporting System (NRLS).

The Northumberland, Tyne and Wear NHS Foundation Trust has taken the following actions to improve this rate/number/percentage, and so the quality of its services by ensuring all serious Patient Safety Incidents are robustly investigated and lessons shared throughout the organisation (including the early identification of any themes or trends).

TBC

Table 22: Patient Safety Incident (PSI) data April 2013 – March 2015

	NTW	National average	Highest national	Lowest national*
Apr 13 - Sept 13				
Number of PSI reported (per 1000 obd)	33.9	28.0	67.1	0
Number of 'Severe' PSI(% of incidents reported)	0.4%	0.4%	1.6%	0
Number of 'Death' PSI(% of incidents reported)	1.0%	0.9%	4.7%	0
Oct 13 - Mar 14				
Number of PSI reported (per 1000 obd)	38.5	28.0	58.7	0
Number of 'Severe' PSI(% of incidents reported)	0.6%	0.4%	2.9%	0
Number of 'Death' PSI(% of incidents reported)	0.9%	0.7%	3.5%	0
Apr 14 - Sept 14				
Number of PSI reported (per 1000 obd)	39.3	35.6	90.4	0
Number of 'Severe' PSI(% of incidents reported)	0.5%	0.3%	2.9%	0
Number of 'Death' PSI(% of incidents reported)	1.0%	0.7%	3.0%	0
Oct 14 - Mar 15				
Number of PSI reported (per 1000 obd)	36.3	31.1		
Number of 'Severe' PSI(% of incidents reported)	0.6%	0.4%		
Number of 'Death' PSI(% of incidents reported)	1.2%	0.7%		

(lower scores are better)

obd = occupied bed days

*nb some organisations report zero patient safety incidents

Part 3

Review of Quality Performance

In this section we will report on the quality of the services we provide, by reviewing progress against indicators for quality improvement, and feedback from sources such as patient and staff surveys.

We will report separately on each of the quality domains (safety, patient experience and clinical effectiveness). Some of the indicators from our 2014/15 report are no longer included and we have added some new indicators this year as we feel this gives a more appropriate balance of our performance measures. For indicators which relate to our CQUIN goals no comparator information is included as the milestones change from year to year.

The information included in this section has been developed in conjunction with staff, our Council of Governors, commissioners and partners, to ensure that we include relevant, meaningful information about the quality of services we provide.

Review of Quality Performance – Patient Safety

Table 23: Patient Safety Quality Indicators Performance 2015-16

Quality Indicator	Why did we choose this measure?	Performance in 2015-16 (2014-15 comparison in brackets)
*Same Sex Accommodation Requirements	Reducing mixed sex accommodation is a national priority and Department of Heath requirement Data source: Safeguard	There have been no breaches of same sex accommodation requirements during 2015/16(also none in 2014/15)
*Patients on CPA have a formal review every 12 months	Monitor Compliance Framework requirement Data source: RiO	As at the end of March 2016, **97.2%** of applicable service users had a CPA review in the last 12 months, meeting the Monitor target of 95% (95.6% March 2015)
2015 Staff Survey - The percentage of	The annual staff survey is a	The 2015 staff survey showed that our staff scored the question regarding recommending

staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends	valuable tool for understanding how our staff think the Trust is performing against the four pledges to staff in the NHS constitution Data source: CQC NHS Staff Survey 2015	the trust as a place to work or receive treatment as 3.71 out of 5 (2014 3.64 out of 5). The average score for mental health trusts for this question is 3.66. The survey is available via the following link: http://www.nhsstaffsurveys.com/Page/1053/Latest-Results/Mental-Health-Learning-Disability-Trusts/
Safeguarding Awareness Training	The Safeguarding Adults and Children courses are essential training for all staff and must be completed every three years Data source: ESR	By the end of March 2016: The number of staff trained in Safeguarding Adults was **93.1%** (95.0% in March 2015) The number of staff trained in Safeguarding Children was **94.4%** (96.2% in March 2015)

*data for this indicator governed by a national definition

Review of Quality Performance – Patient Experience

Table 24: Patient Experience Quality Indicators Performance 2015-16

Quality Indicator	Why did we choose this measure?	Performance in 2015-16 (2014-15 comparison in brackets)
*Delayed transfers of care	Monitor and CQC requirement to minimise the number of patients in hospital who are ready for discharge Data source: RiO	During March 2015, 2.4% of total inpatient bed days were classed as delayed transfers of care, thus meeting the target to have no more than 7.5% of inpatient bed days delayed (4.3% in March 2015).
TBC		
TBC		

*data for this indicator governed by a national definition

Review of Quality Performance – Clinical Effectiveness

Table 25: Clinical Effectiveness Quality Indicators Performance 2015-16

Quality Indicator	Why did we choose this measure?	Performance in 2015-16 (2014-15 comparison in brackets)
*CRHT Gate kept Admissions	Both Monitor and CQC require us to	A Crisis Resolution Home Treatment Team provides intensive support for people in mental health crisis in

	demonstrate that certain inpatients have been assessed by a CHRT prior to admission Data source: RiO	their own home. It is designed to prevent hospital admissions. In the last two financial years, **100%** of the North East CCG admissions to adult urgent care wards were gatekept by a CRHT prior to admission, thus exceeding the target of 95%.
*7 Day Follow Up contacts	Seven day follow up is the requirement to visit or contact a service user within seven days of their discharge from inpatient care, to reduce the overall rate of death by suicide. This is a Monitor and CQC requirement Data source: RiO	During 2015-16, 1,654 service users (98.6% of those discharged from inpatient care in the year) were followed up within seven days of discharge. In 2014/15, 1,702 service users (97.4**%** of those discharged from inpatient care in the year) were followed up within seven days of discharge. Note: the target for this indicator is 95% and applies to adult service users on CPA. Further analysis by locality is as follows: Newcastle Gateshead CCG: 96.7% North Tyneside CCG: 98.2% Northumberland CCG: 98.3% South Tyneside CCG: 98.1% Sunderland CCG: 97.1%
Emergency re-admission rates	Emergency readmission rates are an important tool in the planning of mental health services and the reviewing of quality of those services Data source: RiO	In 2015/16, 181 mental health inpatients (7.3%) were readmitted within 28 days of discharge and 10 learning disability patients (12.3%) were readmitted within 90 days of discharge. In 2014/15, 172 mental health inpatients (6.2%) were readmitted within 28 days of discharge and 10 learning disability patients (8.1%) were readmitted within 90 days of discharge. During 2013/14, 236 mental health inpatients (7.9%) were readmitted within 28 days of discharge and 11 learning disability inpatients (9.7%) were readmitted within 90 days of discharge.
*Patient outcomes – numbers of patients in settled accommodation	This is an outcome measure Data source: RiO	At the end of March 2016, the number of English service users recorded as living in settled accommodation was **76.8%** (76.8% in 2014-15).

<table>
<tr>
<td>Improving Physical Healthcare for mental health patients</td>
<td>To improve premature mortality for people with severe mental illness which is currently estimated at 15 to 20 years.

2015/16 National CQUIN.

Data source: RiO</td>
<td>The national CQUIN was in 2 parts.

Part A concentrated on an audit undertaken by the Royal College of Psychiatrists to establish if inpatients had been appropriately screened in line with NICE guidance using the Lester Tool. A similar internal audit was required for service users receiving treatment within Early Intervention in Psychosis teams; the outcome of which was reported to local CCGs.

Part B related to improving communication between ourselves and GP’s at certain key points in a service users pathway.

NTW has fully participated in the CQUIN during 2015-16 which has resulted in significant improvements to service user physical health screening and interventions.</td>
</tr>
<tr>
<td>Staff Survey results 2015</td>
<td>The annual staff survey is a valuable tool for understanding how our staff think the Trust is performing against the NHS constitution
Data source: NHS Staff Survey 2015 (KF3)</td>
<td>The 2015 staff survey showed that 89% of staff who responded agreed that their role makes a difference to service users (89% in 2014).

The survey is available via the following link: http://www.nhsstaffsurveys.com/Page/1053/Latest-Results/Mental-Health-Learning-Disability-Trusts/</td>
</tr>
<tr>
<td>Staff absence through sickness</td>
<td>High levels of staff sickness impact on patient care: therefore the Trust monitors sickness absence levels carefully
Data source: ESR

Inclusion of benchmarking info TB</td>
<td>The 12 month rolling average staff sickness absence figures have decreased when compared to 2015, the decrease is largely attributed to the implementation of the new sickness absence policy during 2015.

<table>
<tr><th></th><th>Short term sickness</th><th>Long term sickness</th><th>Total average sickness</th></tr>
<tr><td>31.03.2010</td><td>2.23%</td><td>4.01%</td><td>6.24%</td></tr>
<tr><td>31.03.2011</td><td>1.76%</td><td>3.75%</td><td>5.51%</td></tr>
<tr><td>31.03.2012</td><td>1.57%</td><td>4.19%</td><td>5.76%</td></tr>
<tr><td>31.03.2013</td><td>1.81%</td><td>4.42%</td><td>6.23%</td></tr>
<tr><td>31.03.2014</td><td>1.53%</td><td>4.33%</td><td>5.86%</td></tr>
<tr><td>31.03.2015</td><td>1.72%</td><td>4.17%</td><td>5.88%</td></tr>
<tr><td>31.03.2016</td><td>1.31%</td><td>4.11%</td><td>5.42%</td></tr>
</table>
</td>
</tr>
</table>

*data for this indicator governed by a national definition

Performance against contracts with local commissioners

During 2015-16 the Trust had a number of contractual targets to meet with local commissioners (CCG's). Table 26 below highlights the targets and the performance of each CCG against them, as at 31st March 2016.

Table 26: Contract Performance Targets as at 31st March 2016

Contract performance targets quarter 4 2015-16 (target in brackets)	**Newcastle Gateshead CCG**	**Northumberland CCG**	**North Tyneside CCG**	**Sunderland CCG**	**South Tyneside CCG**
CPA Service Users reviewed in the last 12 months (95%)					
CPA Service Users with a risk assessment undertaken/reviewed in the last 12 months (95%)					
CPA Service Users with identified risks who have at least a 12 monthly crisis and contingency plan (95%)					
Number of inpatient discharges from adult mental health illness specialties followed up within 7 days (95%)					
Current delayed transfers of care -including social care (<7.5%)					
RTT percentage of incomplete (unseen) referrals waiting less than 18 weeks (92%)					
Current service users aged 18 and over with a valid NHS Number (99%)					
Current service users aged 18 and over with valid Ethnicity completed (90%)					
The number of people who have completed IAPT treatment during the reporting period (50%)					

*N/A = those services are not commissioned in the CCG areas

The Trust also has specific contractual targets for specialised services with NHS England for which the majority of targets were met by the 31/3/2016.

Staff Survey 2015

The NHS Staff Survey ensures that the views of staff working in the NHS inform local improvements and input in to local and national assessments of quality, safety, and delivery of the NHS Constitution. The 2015 staff survey questions were structured around the following issues:

• Personal development	• Staff health
• Job roles	• Staff well-being and safety at work
• How staff feel about managers	• Background (demographic) information
• How staff feel about their organisation	

2015 Agreed Trust Wide Actions in response to the Staff Survey

Issue	Proposed Action
Last experience of harassment/bullying/abuse not reported	Coordinated campaign of action, relaunching a number of initiatives under one banner, including induction, training and the importance of communications and review of policy
Appraisals: needs not identified	Targeted work on training needs identification and analysis
Violence and aggression	Implementation of Trust's Positive and Safe Strategy

Staff Survey ongoing themes:

Violence and Aggression. This remains a high priority for the organisation and a range of measures are in place to address this issue, including the implementation of the Positive and Safe Strategy in 2016-17.

Harassment and Bullying. Whilst our reported levels of harassment and bullying are lower than other comparable trusts, we aim to reduce instances of harassment and bullying while also increasing staff confidence in reporting these issues. Alongside local programmes of work being developed in areas of concern in this area, the Trust is reviewing the content of all training programmes, reviewing provision of support to affected staff and continuing staff engagement and involvement activities.

Appendix 1

Monitor Compliance Framework

TBC

Appendix 2

CQC Registered locations

The following table outlines the Trust's primary locations for healthcare services as at 31st March 2016.

Locations	Regulated Activities			Service Types							
	Treatment of Disease, Disorder or Injury	Diagnostic and Screening Procedures	Assessment or medical treatment for persons	CHC	LDC	LTC	MHC	MLS	PHS	RHS	SMC
Brooke House	●	●	●							●	
Craigavon Short Break Respite Unit	●	●	●					●			
Elm House	●	●	●					●			
Ferndene	●	●	●			●		●		●	
Heppell House	●	●	●			●				●	
Hopewood Park	●	●	●			●		●		●	
Monkwearmouth Hospital	●	●	●			●		●		●	
Campus for Ageing and Vitality	●	●	●					●		●	
Northgate Hospital	●	●	●			●		●		●	
Queen Elizabeth Hospital	●	●	●					●			
Rose Lodge	●	●	●					●			
Royal Victoria Infirmary	●	●	●					●			
St George's Park	●	●	●			●		●		●	
St Nicholas Hospital	●	●	●	●	●	●	●	●	●	●	●
Walkergate Park	●	●	●					●		●	

Key

CHC – Community health care services
LDC – Community based services for people with a learning disability
LTC – Long-term conditions services
MHC – Community based services for people with mental health needs
MLS – Hospital services for people with mental health needs, and/or learning disabilities, and/or problems with substance misuse

PHS – Prison healthcare services
RHS – Rehabilitation services
SMC – Community based services for people who misuse substances

CQC Registered Locations, Regulated Activities and Service Types – Social and Residential

Registered Home/Service	Regulated Activity	Service Type
	Accommodation for persons who require nursing or personal care	Care home service without nursing
Easterfield Court	●	●

Appendix 3

Local Clinical Audits

Project (Local Clinical Audits)	
Board Assurance Framework	
CA-15-0020	Care Co-ordination Audit – IAPT
CA-15-0021	Care Co-ordination Audit – Specialist Care
Trust Programme	
CA-15-0045	Audit of Transition Between Inpatient & Community Services
Inpatient Care Group (Urgent Care) Programme	
CA-15-0011	Audit of Mental State Examination Recording in Admission Documentation (Core Assessment Document)
CA-15-0013	Quality Improvement Audit: Prescribing Practice in Old Age Psychiatry
CA-15-0014	Improving the information given to patients admitted to Rosewood, Hopewood Park, about purpose and possible side-effects of Psychotropic Medication
CA-15-0028	An analysis of whether current rapid tranquilisation monitoring is meeting policy requirements
CA-15-0060	Cardio-Metabolic Monitoring of Inpatients at Rose Lodge
Medicines Management Programme	
CA-15-0026	Medical Gas Storage
Community Services Group Programme	
CA-15-0005	Audit of anti-psychotic monitoring in a Crisis Team setting
CA-15-0035	Physical monitoring of patients prescribed anti-psychotics
CA-15-0047	Advance Statements / Advance Directives Record Keeping
CA-15-0056	Physical health monitoring in anti-psychotic medication according to Trust Guidelines
CA-15-0066	Audit of dementia diagnosis recording across secondary and primary care
CA-15-0101	Use of CRHT prescription chart within the Sunderland Crisis Team – does it comply with Trust Policies?
Specialist Care Group Programme	
CA-15-0086	Urine drug screening for newly admitted patients to Redburn Ward (Re-audit)
CA-15-0006	Audit of departmental Clinical Professional Development (CPD) Activities 2015
CA-15-0008	Clinical audit on prescription of psychotropic medications for referred patients for admission to Learning Disability Child & Adolescent Services at Ferndene, comparing practice against standards like NICE Guidelines
CA-15-0009	Record Keeping Audit
CA-15-0010	Assessing the quality of smoking cessation provision and documentation in a Forensic Inpatient Unit

CA-15-0016	5-A-Day – Are young people with a learning disability supported to meet this target?
CA-15-0039	Audit to ensure compliance with the legislation relating to Capacity & Consent, Codes of Practice relating to the legislation and the Trust's Electronic Record (RiO) Systems with regards to CT012 Forms
CA-15-0074	Re-audit of referrals process for Bamburgh Clinic
CA-15-0082	Audit of letter quality at the Regional Affective Disorder Service
CA-15-0083	Audit on physical health monitoring baseline checks for patients accepted by Adolescent Bipolar Services (ABS)
CA-15-0085	Time of assessment by a doctor when admitted to NTW Mother & Baby Unit, St George's Park Hospital
CA-15-0111	Benzodiazepine prescribing: if patient are above the BNF guided dose of Benzodiazepines and z-drugs is there a reduction plan in pace and is it followed?

Appendix 4

Statement of Directors' Responsibilities in respect of the Quality Report

TBC

Appendix 5

Limited Assurance Report on the content of the Quality Report

TBC

Appendix 6

Glossary of Terms

AIMS	Accreditation for inpatient mental health services
Care Co-ordinator	A named person to co-ordinate the services a patient receives where their needs are numerous or complex, or where someone needs a range of different services.
Care Packages and Pathways	A project to redesign care pathways that truly focus on value and quality for the patient.
Commissioners	Members of Primary Care Trusts (PCT's), regional and national commissioning groups responsible for purchasing health and social care services from NHS Trusts.
CQUIN	Commissioning for Quality and Innovation – a scheme whereby part of our income is dependant upon improving quality
CMHT	Community Mental Health Team
CRHT	Crisis Resolution Home Treatment – a service provided to service users in crisis.
Clinician	A clinician is a health professional. Clinicians come from a number of different healthcare professions such as psychiatrists, psychologists, nurses, occupational therapists etc.
Clusters	Clusters are used to describe groups of service users with similar types of characteristics.
CQC	Care Quality Commission – the independent regulator of health and adult social care in England. The CQC registers (licenses) providers of care services if they meet essential standards of quality and safety and monitor them to make sure they continue to meet those standards.
CPA	Care Programme Approach. CPA is a term for describing the process of how mental health services service users' needs, plan ways to meet them and check that they are being met.
CYPS	Children and Young Peoples Services – also known as CAMHS
Dashboard	An electronic system that presents relevant information to staff, service users and the public
Dual Diagnosis	Service users who have a mental health need combined with alcohol or drug usage

Forensic	Forensic teams provide services to service users who have committed serious offences or who may be at risk of doing so
HoNOS/HoNOS 4 factor model	Health of the Nation Outcome Scales. A clinical outcome measuring tool.
IAPT	Improving Access to Psychological Therapies – a national programme to implement National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders.
LD	Learning Disabilities
Lead Professional	A named person to co-ordinate the service a patient receives if their needs are not complex.
Leave	A planned period of absence from an inpatient unit which can range from 30 minutes to several days
MHA	Mental Health Act
MHMDS	Mental Health minimum data set – a standard set of information sent from mental health providers to the Information Centre
Monitor	The independent regulator of NHS Foundation Trusts, ensuring they are well led and financially robust.
Monitor Compliance Framework	Monitor asks Foundation Trusts to assess their own compliance with the terms of their authorisation. NHS foundation Trusts submit an annual plan, quarterly and ad hoc reports to Monitor.
Multi- Disciplinary Team	Multi-disciplinary teams are groups of professionals from diverse disciplines who come together to provide care – i.e. Psychiatrists, Clinical Psychologists, Community Psychiatric Nurses, Occupational Therapists etc.
Next Steps	A group of projects to ensure that the organisation is fit for the future and provides services that match the best in the world.
NEQOS	North East Quality Observatory System – an organisation that helps NHS Trusts to improve quality through data measurement

NHS Performance Framework	An assessment of the performance of NHS Trusts against minimum standards. As a Foundation Trust we are not required to report against these standards however we have decided to utilise the framework to strengthen our performance management function.
NHS Safety Thermometer	The NHS Safety Thermometer provides a quick and simple method of surveying patients harms and analysing results so that you can measure and monitor local improvement
NICE	National Institute for Health and Clinical Excellence – a group who produce best practice guidance for clinicians
NIHR	National Institute of Health Research – an NHS organisation undertaking healthcare related research
NPSA	National Patient Safety Agency
NTW	Northumberland, Tyne and Wear NHS Foundation Trust
Out of area placements	Service users who are cared for out of the North East area or service users from outside of the North East area being cared for in the North East.
Pathways of care	Service user journey through the Trust – may come into contact with many different services
PCT	Primary Care Trust – a type of NHS Trust that commissions primary, community and secondary care from providers
Points of You/How's it Going	NTW service user/carer feedback processes allowing us to evaluate the quality of services provided
Productive Ward	The Productive Ward focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency
QRP	Quality and Risk Profile – produced by the Care Quality Commission, this document gathers together key information about Northumberland, Tyne and Wear NHS Foundation Trust to support CQC's role in monitoring our compliance with the essential standards of quality and safety.
RIO	Electronic patient record
Shared Care	A partnership between two different healthcare organisations involved in an individual's care, i.e. between the Trust and the patient's GP.

SMART	Specific, Measurable, Achievable, Realistic, Timely – a way of setting objectives to make sure they are achievable
Serious Incident	Serious incident - an incident resulting in death, serious injury or harm to service users, staff or the public, significant loss or damage to property or the environment, or otherwise likely to be of significant public concern. This includes 'near misses' or low impact incidents which have the potential to cause serious harm.
SWEMWEBS	Warwick-Edinburgh Mental Wellbeing Scale – a clinical outcome measuring tool.
Transition	When a service user moves from one service to another i.e. from an inpatient unit to being cared for by a community team at home.

South Tyneside NHS Foundation Trust

“Choose High Quality Care”

Our Quality Report

2015/16

Contents

1: Statement from the Chief Executive

QUALITY REPORT

Part 1 – Chief Executive's Statement

2015/16 was a year of great challenge for the NHS nationally, and for South Tyneside NHS Foundation Trust locally. Emergency demand and financial pressures combined to create significant challenges for providers of health services across the NHS. Throughout this time our Trust maintained a clear focus on the quality of the essential services and support we provide to our patients, their carer's, and their families.

We received our first of the new style comprehensive Care Quality Commission (CQC) inspections in May 2015. This was a wide raging inspection of the vast majority of hospital and community health services that we provide. The inspection team identified a number of areas for improvement and provided an overall assessment of 'Requires Improvement' for our Trust. Since that inspection our Board and our clinical teams have been focussed on quickly addressing those areas for improvement and this focus will continue going forward into 2016/17. Within the overall assessment, the CQC also judged that the quality of the care and compassion that we offer to patients across our hospital and community services was 'outstanding'; I believe this is a great reflection of the dedication and compassion of staff across our organisation, and provides a fantastic basis on which to deliver further improvements across our Trust.

Our control of hospital acquired infection has continued to be excellent with no cases of MRSA throughout the last 12 months and only 6 cases of Clostridium Difficile. Performance for both of these areas is amongst the best in the country and also an improvement on our excellent performance in the previous year. Emergency demand facing the NHS across the country has been exceptional this year and our Trust was no exception to this. Consequently our A&E performance, like much of the NHS, was below the expected 95% target, particularly over the very challenging winter period. Since then we have worked hard with partners in South Tyneside, to put in place actions to further integrate aspects of our health and care system to help reduce avoidable emergency admissions, and help to reduce unnecessary delays in discharging patients back to their homes with the right support. These actions will help us to improve our A&E performance over the coming year. Our cancer performance and our elective waiting time performance for the year continued to be very good, providing excellent access to these important elective and urgent services.

This year has also seen building work commence on Haven Court, our new state of the art Integrated Care Services Hub, which will be a centre of excellence and support for elderly residents of South Tyneside, particularly those with dementia. Haven Court will bring together services from South Tyneside Council, Mental Health services, Community Health services, Primary Care and our voluntary sector to provide exceptional integrated care and support for some of our vulnerable elderly

residents. A significant focus of our work ovet he last 12 months has been in preparing for this excellent new service which we will open in the summer of 2016.

We have also put in place the basis for a strategic alliance with City Hospitals Sunderland NHS Foundation Trust which will enable the two Trusts to work more closely together in delivering some of our clinical services in order that we can collectively improve outcomes and secure the future sustainability of quality health services across South Tyneside and Sunderland. This partnership will be developed in 2016/17 and will be an important part of our plans for quality, performance, and financial improvement.

Looking ahead to 2016/17, there are clearly unprecedented challenges facing the NHS. However with the passion for care and compassion that I see every day in staff across our Trust, I am confident that we will continue to deliver exceptional levels of support and care to our patients and those who use our services.

To the best of my knowledge, the information in the Quality report and Account is accurate.

Steve Williamson

Chief Executive

2: Priorities for Improvement and Statements of Assurance from the Board

Foundation Trusts are required to publish quality accounts each year, as set out in National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Accounts) Amendment Regulations 2012. The quality report must be included as part of the Trust's annual report. In addition the report must be prepared in accordance with annual reporting guidance provided by Monitor and the Department of Health. Much of the text in the report is therefore both prescribed and mandatory.

In our 2015-16 Quality Report we explained the areas where we would focus attention on quality improvements during 2016-17. Part 2 of this report highlights our performance against the indicators we selected and sets out our priorities for 2017-18. We will also provide statements of assurance from our Board of Directors and commentary from a range of stakeholders.

2.1 Progress Made Since Publication of the 2014/15 Quality Report

In our last Quality Report we identified four key priority areas that we intended to develop during 2015/16. Our progress since then is described in this section.

Our Patient Safety Priorities for 2015-16

Priority 1	**Clinical Effectiveness: To develop and publish a three year Safety Improvement Plan (SIP) as part of a 5-year Quality Strategy**
Rationale for Inclusion:	
The Trust has 'Signed Up To Safety', a national campaign to reduce avoidable harm by half and save 6000 lives over the next three years. Each participating organisation is required to publish a Safety Improvement Plan	
Target 2015/16:	
Publish Safety Improvement Plan by June 2015 and 2020 Quality Strategy by December 2015 and deliver Year 1 objectives by March 2016.	
Our Progress:	

We published our Safety Improvement Plan in June 2015 with the following objectives:

1. Roll out use of the Medication Safety Thermometer and report through a Dashboard approach – Completed October 2015
2. Lead the regional Pressure Ulcer Collaborative, funded by the North East and North Cumbria Academic Health Science Network, aiming to achieve 50% reduction in unavoidable pressure ulcers by June 2016 – Progressing to time
3. Review how we learn lessons from incidents, complaints and harms and establish a Patient Participation Panel to share and embed learning – Completed March 2016.

Our Quality Strategy will now be published until June 2016.

Priority 2	Clinical Effectiveness: To create and roll out quality Improvement training that will equip front-line teams to utilise improvement methods in their everyday practice

Rationale for Inclusion:

Building capability and capacity to undertake continuous quality improvement (CQI) activities is a national priority (Berwick Report, 2013)

Target 2015/16:

Design and test a quality improvement training programme between October 2015 and March 2016.

Our Progress:

Between September 2015 and March 2016 we tested a programme aimed at enabling team leaders, specialist nurses and ward managers to develop skills in continuous quality improvement and the development of a caring culture in their areas. This has been positively evaluated and will be rolled out during 2016/17.

Priority 3	Patient Experience: To further develop our culture of learning from experience

Rationale for Inclusion:

New regulations such as the Duty of Candour further emphasise the importance of open and honest reporting, learning lessons and demonstrating accountability in assurance around actions.

Target 2015/16:

To fully implement Duty of Candour requirements, put into place a Patient and Public Involvement Panel and demonstrate confidence in our approach to system-wide learning and improvement.

Our Progress:

We have implemented Duty of Candour regulations through ensuring training has been provided to all newly appointed staff at induction, also as a training programme for current staff. We have embedded the Duty of Candour policy and monitor compliance through monthly reporting to a sub-committee of the Board of Directors. Compliance is improving and we will continue to develop our approach to learning lessons during 2016/17.

Priority 4	**Patient Safety:** To provide assurance to the Board and patients that we are continually focused on demonstrating safe staffing levels

Rationale for Inclusion:

Safe Staffing is a National Quality Board, NHS England and CQC priority. There is an increasing evidence-base that demonstrates the link between the number, skills and mix of staff and the quality of care patients receive.

Target 2015/16:

We will implement NICE Guidance for Safe Staffing in hospitals and participate in the development of guidance for nursing in the community.

Our Progress:

NHS England has unexpectedly not mandated the use of NICE Safe Staffing guidance, focusing now on the national Lord Carter of Cole programme, one element of which has produced nurse staffing indicators around 'Care Hours per Patient Day' (CHPPD). It is anticipated that Trusts will be required to report CHPPD monthly, from a point in time when National Quality Board guidance is issued during 2016.

The Trust has followed NQB guidance by reporting nurse staffing numbers and skill mix to the Board of Directors on a monthly basis throughout 2015/16 and further developed this through reporting 'Safer Nursing Care' analysis, which sets out nursing numbers and skill mix compared with set versus actual budget spend and patient dependency/acuity.

2.2 Our Priorities for 2016-17

The following list of priorities for improvement for 2016/17 has been developed following wide consultation. Key areas are identified by our patients and their carers through surveys, questionnaires and complaints. To gain the contribution of the wider public we discuss priorities with local Healthwatch organisations, and the three local authority health oversight committees, and particularly with the public members of our Council of Governors. Staff engagement in developing priorities continues to come through the staff side representatives, but increasingly we benefit from staff responses in Choose Safer Care Sub-Committee and through quality improvement activities.

In South Tyneside NHS Foundation Trust we recognise that it is absolutely right to focus on the importance of having the right organisational culture to deliver high quality, compassionate care; engaging all staff in a patient centred culture and being open and honest with our patients and their families.

Priority 1	**To deliver the CQC Quality Improvement plan of actions by March 2017, and facilitate every service to be working at a level that would merit a rating of good or outstanding by March 2018.**
Rationale for Inclusion:	
One of our top organisational priorities is to deliver the CQC Improvement plan, a post inspection programme of 52 actions (23 of which are required regulatory actions) by March 2017.	
Target 2016-17:	
To deliver all 52 actions by March 2017	
Baseline:	
In April 2016, 50% of the required actions has been completed	

Priority 2	**To finalise and publish (in June 2016) the five year Quality Strategy, and objectives for year two of the 'Sign up to Safety' improvement programme.**

Rationale for Inclusion:

Building on the work from 2015/16, we will continue to follow the 'Sign Up To Safety' campaign to reduce avoidable harm by half and save 6000 lives over the next three years.

Target 2016-17:

Publish the Year 2 Safety Improvement Plan and the 2020 Quality Strategy by June 2016 and deliver Year 1 objectives by March 2017.

Baseline:

Our baseline is the safety and quality targets achieved in the 201/16 year:

- Reducing by 50% the number of avoidable pressure ulcers
- Medicines Safety Dashboard across every clinical team
- Evidence of embedding learning from experience

Our objectives for 2016/17 will build on the above.

Priority 3	**To commence delivery (in September 2016) of the 'Safety, Quality, Experience' (SQE) programme that will provide teams with a training and quality improvement curriculum that will develop workforce capability in the application of improvement methods.**

Rationale for Inclusion:

Building capability and capacity to undertake continuous quality improvement (CQI) activities is a national priority (Berwick Report, 2013)

Target 2016-17:

We will train a minimum of ten frontline teams in quality improvement methods through providing access to the SQE programme between September 2016 and March 2017.

Baseline:

We are working from a baseline of a pilot programme during 2015/16 involving 30 practitioners.

Priority 4	**To implement (from July 2016) a revised Integrated Governance Framework that aligns with the redesign of operational structures and the Trust transformation programme**.

Rationale for Inclusion:
One of the CQC improvement actions is around strengthening our clinical governance to include ensuring there is a robust process for learning from incidents and embedding the learning organisation-wide.

Target 2016-17:
In line with a revised Operation's and Professional Practice structure due in place from July 2016, we will implement and evaluate the governance framework.

Baseline:
The corporate and operational governance model that we are currently using is the baseline, but has been under review and subject to change.

NHS Staff Survey Results

In 2015, the thirteenth annual national survey of NHS staff was undertaken, involving 297 organisations in England and over 741,000 staff being invited to participate. We have been asked to provide information in this Quality Report on 2 of the questions that were put to our staff:

- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months?

  On this key finding the Trust scored 23% which was better than the national performance for all trusts (24%).

- Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion?

  On this key finding, the Trust scored 86% equal to the national performance for all trusts.

Duty of Candour

The Duty of Candour ("the Duty") process begins with the recognition that a patient has suffered moderate harm (including any prolonged psychological harm for 28 days or longer), severe harm or has died as a result of a patient safety incident whilst in our care. In order to ensure that we comply with the process we have implemented a monitoring system that:

- Identifies when the Duty should be implemented
- Identifies who is responsible for applying the Duty in each case (the "responsible person")
- Provides guidance and support to the responsible person to ensure the procedure is followed correctly
- Ensures that the responsible person fully understands their role and responsibilities
- Provides tools and resources for recording and reporting candid discussions
- Monitors and audits each case to ensure that all aspects of the process are adhered to including the correct filing of all related documentation
- Reports performance quarterly to the Choose Safer Care Committee

The latest audit results show that whilst the process is completed in the majority of cases, it is not always completed within the 10 day deadline. Work is on-going to identify the reasons for such delays or failure to comply with and actions taken accordingly.

Care Quality Commission Inspection

During May 2015 the Care Quality Commission undertook a comprehensive inspection of South Tyneside NHS Foundation Trust, which covered our acute hospital services in South Tyneside, and our community services across South Tyneside, Sunderland and Gateshead. Overall, the Trust was rated "Requires Improvement" with the ratings for each service area against the 5 key areas shown on the next page. Full details of the inspection report can be found on the CQC website using the following link:

http://www.cqc.org.uk/sites/default/files/new_reports/AAAD4436.pdf

Following publication of the inspection report, a comprehensive action plan was agreed with the CQC, and as of 31st March 2016, our performance against that action plan shown below.

The report contained 23 "Must Do's", 20 "Should Do's" and 9 "Recommendations". The status as of 13th April 2016 is:

	Complete	Progressing On Time	Risk of Not Delivering On Time
Must Do's	**13**	**9**	**1**
Should Do's	**10**	**9**	**1**
Recommendations	**5**	**4**	

Care Quality Commission Inspection May 2015

	Hospital Urgent and emergency services	Community health services for adults	Hospital Medical Care	Maternity and Gynaecology	Community health services for children	Hospital services for children and young people	Hospital end of life care	Community end of life care	Surgery	Outpatients and diagnostic imaging	Critical Care	Community dental services	Overall
Safe	Requires Improvement	Good	Requires Improvement	Good	Good	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement
Effective	Good	Good	Requires Improvement	Good	Good	Requires Improvement	Good	Good	Good	Not rated	Requires Improvement	Good	Requires Improvement
Caring	Good	Good	Good	Good	Outstanding	Good	Outstanding	Outstanding	Good	Good	Good	Good	Outstanding
Responsive	Requires Improvement	Good	Requires Improvement	Good	Good	Good	Good	Good	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement
Well-led	Requires Improvement	Good	Requires Improvement	Requires Improvement	Good	Requires Improvement	Good	Good	Inadequate	Good	Requires Improvement	Outstanding	Requires Improvement
Overall	Requires Improvement	Good	Requires Improvement	Good	Good	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement

2.3 Statements of Assurance from the Board

During 2015-16 South Tyneside NHS Foundation Trust provided and sub-contracted 130 relevant health services. The South Tyneside NHS Foundation Trust has reviewed all the data available to it on the quality of care 130 of these relevant health services.

The income generated by the relevant health services reviewed in 2015-16 represents 100 per cent of the total income generated from the provision of relevant health services by South Tyneside NHS Foundation Trust for 2015-16.

The safety, effectiveness and patient experience of all of our clinical services is reviewed on an on-going basis through a process of Board of Director and Executive Board oversight. Performance against national and local contractual targets is reported regularly to the Board of Directors. Patient safety and patient experience reports are also scrutinised at the Choose Safer Care Subcommittee which is a Board delegated committee chaired by a Non-Executive Director.

2.4 Clinical Audit and Research

Clinical Audit

Participation in audits and clinical research programmes helps us to review our performance and standards across a wide range of areas. We participate in national and local audits and implement a range of developments and changes as a result.

This Clinical Audit Quality Account covers the period from 1st April 2015 to 29th February 2016.

During 2015/16 35 national clinical audits and 7 national confidential enquiries covered relevant health services that South Tyneside NHS Foundation Trust provides.

During 2015/16 South Tyneside NHS Foundation Trust participated in 94% (n=31) national clinical audits and 100% (n=7) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to take part in.

Of the 35 national clinical audits that the Trust was eligible to take part in, participation was not applicable to 2 audits for the following reasons:

- National Non-Invasive Ventilation Audit (BTS) was postponed by BTS
- National Audit of Intermediate Care

The national clinical audits and national confidential enquiries that South Tyneside NHS Foundation Trust was eligible to participate in during 2015/16 are as follows: See table below.
The national clinical audits and national confidential enquiries that South Tyneside NHS Foundation Trust participated in during 2015/16 are as follows: See table below.
The national clinical audits and national confidential enquiries that South Tyneside NHS Foundation Trust participated in and for which data collection was completed during 2015/16 are listed in the table 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.

The reports of 48 national clinical audits were reviewed by the Clinical Audit Committee and South Tyneside NHS Foundation Trust intends to take the following actions to improve the quality of health care provided:

The reports of 50 local clinical audits were reviewed by the Clinical Audit Committee and South Tyneside NHS Foundation Trust intends to take the following actions to improve the quality of health care provided:

- Ensuring the lead clinician produces an action plan
- The action plan is signed off by the appropriate strategic group or committee
- Progress is monitored through the appropriate committee.

Due to the much varied submission/reporting deadlines for on-going/continuous national audits, the figures for such audits have been based upon the number of cases actually submitted out of the number of identified cases from 1st April 2015 to 29th February 2016.

National Clinical Audits and Confidential Enquiries for inclusion in Quality Accounts Report 2015/2016

	Eligible	Participated	% submitted to audit
Acute Care			
Adult critical care (ICNARC CMP)	Yes	Yes	Unable to ascertain
CONFIDENTIAL ENQUIRY (NCEPOD) Acute Pancreatitis	Yes	Yes	**100%**
CONFIDENTIAL ENQUIRY (NCEPOD) Gastrointestinal Haemorrhage Study	Yes	Yes	**80%**
CONFIDENTIAL ENQUIRY (NCEPOD) Sepsis Study	Yes	Yes	**100%**
National Emergency Laparotomy Audit (NELA)	Yes	Yes	**98%**
National Joint Registry (NJR)	Yes	Yes	Data collection on-going
National Non-Invasive Ventilation Audit (BTS) Note: Audit postponed by BTS. Awaiting revised timelines	Yes	No	**N/A** .
Trauma (TARN)	Yes	Yes	**66%** Data collection on-going
Procedural Sedation in Adults	Yes	Yes	**100%**
Blood and Transplant			
National Comparative Audit of Blood Transfusion: Medical Use of Blood	Yes	Yes	**100%**
Audit of patient blood management in scheduled surgery	Yes	Yes	**100%**
Cancer			
Bowel Cancer - National Bowel Cancer Audit Programme (NBOCAP)	Yes	Yes	**100%**

	Eligible	Participated	% submitted to audit
Lung Cancer - National Lung Cancer Audit (NLCA)	Yes	Yes	**100%**
Oesophago-gastric cancer (NAOGC)	Yes	Yes	Unable to ascertain
Heart			
Acute coronary syndrome or acute myocardial infarction (MINAP)	Yes	Yes	**82%**
Adult Cardiac Surgery (ACS)	No	N/A	**N/A**
Cardiac arrest (NCAA)	Yes	Yes	**100%**
Cardiac arrhythmia (Cardiac Rhythm Management Audit) HRM	Yes	Yes	**100%**
Congenital Heart Disease – Paediatric Cardiac Surgery (CHD)	No	N/A	**N/A**
Coronary Angioplasty	No	N/A	**N/A**
Heart Failure (HF)	Yes	Yes	**100%**
Pulmonary Hypertension	No	N/A	**N/A**
Vascular Surgery Registry – VSGBI Vascular Surgery Database (NVD)	No	N/A	**N/A**
Long Term Conditions			
Chronic Kidney Disease in primary care	No	N/A	**N/A**
Pulmonary Rehabilitation Audit	Yes	Yes	Unable to ascertain
COPD audit - Secondary Care Snapshot	Yes	Yes	**93%**
Diabetes - Paediatric (NPDA)	Yes	Yes	**100%**
National Diabetic Inpatient Audit (NaDIA) Note: Not collecting data 2015/2016. Provisional date to commence data collection September 2016	Yes	Yes	
National Pregnancy in Diabetes Audit (NPID)	Yes	Yes	**100%**
National Diabetes Footcare Audit	Yes	Yes	**91%**

	Eligible	Participated	% submitted to audit
Inflammatory Bowel Disease Programme: Biologics Audit	Yes	Yes	**100%**
Adult Asthma Audit Note: Not collecting data 2015/2016. Provisional date to commence data collection September 2016	Yes	Yes	
Renal Replacement Therapy	No	N/A	**N/A**
Rheumatoid and early inflammatory arthritis	No	N/A	**N/A**
Mental Health			
NATIONAL CONFIDENTIAL INQUIRY Suicide and homicide in people with mental illness (NCISH)	Yes	Yes	**100%**
Prescribing Observatory for Mental Health (OMH-UK)	No	N/A	**N/A**

	Eligible	Participated	% submitted to audit
Older People			
Sentinel Stroke National Audit Programme (SSNAP) SSNAP Acute Organisational Audit	Yes	Yes	**100%**
Falls and Fragility Fractures Audit Programme: National Hip Fracture Database	Yes	Yes	**100%**
Falls and Fragility Fractures Audit Programme: Inpatient Falls	Yes	Yes	**100%**
Falls and Fragility Fractures Audit Programme: Fracture Liaison Service Facilities Audit	Yes	Yes	Unable to ascertain
Older People: Care in Emergency Departments (College of Emergency Medicine)	Yes	Yes	Unable to ascertain
Other			
Elective Surgery (National PROMS programme) – Hernia	Yes	Yes	Data handled by external agency
Elective Surgery (National PROMS programme) – Hips	Yes	Yes	Data handled by external agency
Elective Surgery (National PROMS programme) – Knees	Yes	Yes	Data handled by external agency
Elective Surgery (National PROMS programme) – Varicose Veins	No	N/A	**N/A**
National Audit of Intermediate Care	Yes	No	**N/A**
National Ophthalmology Audit	No	N/A	**N/A**
Women's & Children's Health			
Child Health Programme (CHR-UK)	Yes	Yes	Data handled by external agency
Perinatal Mortality Surveillance Report (MBRRACE-UK)	Yes	Yes	Unable to ascertain

	Eligible	Participated	% submitted to audit
Perinatal Confidential Enquiry (MBRRACE-UK)	Yes	Yes	100%
Confidential Enquiry into Maternal Death (MBRRACE-UK)	Yes	Yes	100%
Neonatal intensive and special care (NNAP)	Yes	Yes	100%
Vital signs in children	Yes	Yes	96%
Paediatric Intensive Care (PICANet)	No	N/A	N/A

2.4 RESEARCH

South Tyneside NHS Foundation Trust recognises the numerous benefits of Research to the organisation and more importantly for our patients. According to a consumer poll conducted in 2013 commissioned by the National Institute for Health Research (NIHR), 87% of people would prefer to be treated in a hospital that does clinical research. Being a research active Trust demonstrates a commitment to high quality patient care and embeds a culture of quality and innovation across the organisation.

South Tyneside NHS Foundation Trust is committed to the promotion and conduct of research. As a partner organisation of the North East and North Cumbria Local Clinical Research Network (NENC CRN) South Tyneside NHS Foundation Trust was awarded approximately £475K to support and deliver NIHR Portfolio studies.

Research is underway in a number of clinical specialities, 905 patients have been recruited to 32 NIHR Portfolio studies. The Trust had a target to recruit to 4 industry trials in 2015/16 and have exceeded this target recruiting to 5 industry trials recruiting a total of 52* patients to industry trials.

The table below outlines our recruitment by study to portfolio studies (recruitment data from the NIHR open data platform as at 20th March 2016.

Topic/ Specialty Group	Study Title	Total Number of Patients Recruited 2015/16
Mental Health	SIPs Jr RCT	57
Gastroenterology	Adenoma Trial	437
	A Feasibility Study of Patient Navigation in Bowel Screening	153
	Scope Me – PREM Development	48
	Advanced Endoscopic Imaging Strategies for Colitis Surveillance	9
	PANTS	8
	A randomised controlled trial of eicosapentaenoic acid (EPA) and/or aspirin for colorectal adenoma (or polyp) prevention during colonoscopic surveillance in the NHS Bowel Cancer Screening Programme: The seAFOod (Systematic Evaluation of Aspirin and Fish Oil) polyp prevention trial	1
Cancer	Lungcast	2
	MARS 2	2
	Stampede	1
Cardiovascular	GLORIA - AF: Global Registry on Long-Term Oral Anti-thrombotic TReatment In Patients with Atrial Fibrillation (Phase II/III – EU/EEA Member States)	41
	AFGEN – long term registry of atrial fibrillation patients	12
	Paradigm Follow Up Study	2
Dermatology	Pressure 2	10
Diabetes	ADDRESS 2	2
	TrialNet	1
Health Services Research	Modelling BSL IAPT and standard IAPT accessed by deaf people	3
	Early Evaluation of the Integrated Care and Support Pioneers	1
Injuries and Emergencies	Tranexamic Acid for the Treatment of Gastrointestinal Haemorrhage: An International Randomised, Double Blind Placebo Controlled Trial	9

Topic/ Specialty Group	Study Title	Total Number of Patients Recruited 2015/16
Primary Care	PCRN2761 COPD	2
Reproductive Health	Effect of folic acid supplementation in pregnancy on preeclampsia -Folic Acid Clinical Trial (FACT) A randomized, double-blind, placebo-controlled, Phase III, international multi-centre study of 4.0 mg of Folic Acid supplementation in pregnancy for the prevention of preeclampsia	19
	Supporting Parents Through Stillbirth	18
	Creative Interventions for Post Natal Depression	12
	DAPPA	9
	Neurodevelopment of babies born to mothers born to mothers with epilepsy	8
Respiratory	A randomised, double-blind placebo controlled trial of the effectiveness of low dose oral theophylline as an adjunct to inhaled corticosteroids in preventing exacerbations of chronic obstructive pulmonary disease (TWICS)	20
	A multicentre non-blinded randomised controlled trial to assess the impact of Regular Early SPEcialist symptom Control Treatment on quality of life in malignant Mesothelioma " - RESPECT-Meso"	5
	CCRN2593	5
	CCRN3069	3
	Admission and discharge care bundles for COPD	1
	RESP3821 (Asthma)	1
Stroke	Extras	3

The number of patient receiving relevant health services provided or subcontracted by South Tyneside NHS Foundation Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee 905.

Research Performance Metrics

In the 2011 ‘Plan for Growth’ the Government outlined the need for a dramatic and sustained improvement in the performance of providers of NHS Services in initiating and delivering clinical research and outlined two benchmarks against which all NHS providers would be measured

Research Management and Governance (approval targets)

The Research & Development Team have approved 25 portfolio studies in 2015/16 consistently achieving the 15 day approval target.

Performance in Initiating Clinical Trials

The performance in initiating clinical trials benchmark monitors 70 days from receipt of a valid research application to recruitment of the first participant in the trial. This data has to be submitted to the NIHR on a quarterly basis. The data outlined in the table below outlines our performance in the first three quarters of 2015/16.

Name of Trial	Date of Receipt of Valid Research Application	Date of NHS Permission	First Patient Recruited?	Date of First Patient Recruited	Duration between VRA and NHS Permission	Duration between NHS Permission and First Patient	Duration between VRA and First Patient	Benchmark Met
DYNAGITO - A randomised, double blind, active controlled parallel group study to evaluate the effect of 52 weeks of once daily treatment of orally inhaled tiotropium + olodaterol fixed dose combination compared with tiotropium on Chronic Obstructive Pulmonary Disease (COPD_ exacerbation in patients with severe to very sever COPD	16/02/2015	18/02/2015	yes	19/03/2015	2	29	31	yes
	Comments:							
FOCUS4 - Molecular selection of therapy in colorectal cancer: a molecularly stratified randomised controlled trials programme	19/02/2015	03/03/2015	yes	23/09/2015	12	204	216	no
	Comments: Two patients consented to registration but failed to attend							
MARS 2 - A study to determine if it is feasible to recruit into a randomised trial comparing (extended) plurectomy decortication versus no plurectomy decortication in the multimodaility management of patients with malignant pleural mesothelioma	11/06/2015	11/06/2015	yes	26/10/2015	0	137	137	no
	Comments: Patients required to travel to Sheffield for surgery prior to chemo at STFT. One patient approached but decided against taking part. Two patients now recruited.							
A multicenter study to evaluate safety and tolerability in patients with chronic heart failure and reduced ejections fraction from PARADIGM-HF receiving open label LCZ696	25/08/2015	25/08/2015	yes	21/09/2015	0	27	27	Yes
	Comments: Recruitment target achieved							

Name of Trial	Date of Receipt of Valid Research Application	Date of NHS Permission	First Patient Recruited?	Date of First Patient Recruited	Duration between VRA and NHS Permission	Duration between NHS Permission and First Patient	Duration between VRA and First Patient	Benchmark Met
LIBERTY ASTHMA QUEST - A randomised, double blind, placebo-controlled, parallel group study to evaluate the efficacy and safety of dupilumab in patients with persistent asthma	16/09/2015	30/09/2015	yes	04/01/2016	14	96	110	
	Comments: SIV 30/9/15. Green light not given till 21/10/15 due to issues with sponsor accepting GCP and delay in fridge delivery. Patient consented on 28/10/2015 however later failed screening							
ADD-Apirin - A phase 111 double-blind placebo-controlled randomised trial assessing the effects of aspirin on disease recurrence and survival after primary therapy in common on metastatic solid tumours	13/10/2015	21/10/2015	no		8			
	Comments: Study delays due to local pathology issues. (Path Lab provided by NHS South of Tyne and Wear Pathology Services)							
GORD - A multicenter randomised double blind two arm parallel group place-bo controlled study to assess the effect of Sodium Alginate Chewable Tablets on symptoms of gastro-oesophageal reflux disease	27/11/2015	29/12/2015	Yes	04/02/16	32			
	Comments: Green light from sponsor not given until 20/01/2016							

Performance in Delivering Industry Trials

The performance in delivering clinical trials benchmark measures recruitment of the target number of patients within the agreed time (recruitment to time and target) for all industry studies. South Tyneside recruited to 6 industry studies, 5 of which were new industry studies. All trials are still actively recruiting so it is not yet possible to say if time and target was achieved. The data outlined in the table below outlines our performance in the first three quarters of 2015/16

Name of Trial	Target number of patients available	Target Number of patients	Date Agreed to recruit target number of patients available	Date Agreed to recruit target number of patients	Trial Status	Target met within the agreed time	Comments
CRYSTAL - A prospective, multi-centre, 12-week, randomised open-label study toe vaulate the efficacy and safety of glycopyrronium (50 mg od) or indacterol and glycopyrronium bromide fixed-dose combination (110/50 mg od) regarding symptoms and health sattus in patients with moderate chronic obstructive pulmonary disease (COPD) switching from treatment with any standard COPD programme	Yes	8	Yes	10/12/2015	closed in follow up		Target achieved
ORBIT 3 - A multi-centre, randomised, double-blind, placebo-controlled study to evaluate the safety and efficacy of Pulmaquin® in the management of chronic lung infections with pseudomonas aeruginosa in subjects with non-cystic fibrosis bronchiectasis, including 28 day open-label extension and pharmacokinetic sub-study	Yes	3	Yes	31/05/2015	closed follow up complete	yes	Target achieved
DYNAGITO - A randomised, double blind, active controlled parallel group study to evaluate the effect of 52 weeks of once daily treatment of orally inhaled tiotropium + olodaterol fixed dose combination compared with tiotropium on Chronic Obstructive Pulmonary Disease (COPD_ exacerbation in patients with severe to very sever COPD	Yes	7	Yes	28/02/2016	Open	Yes	Target achieved

Name of Trial	Target number of patients available	Target Number of patients	Date Agreed to recruit target number of patients available	Date Agreed to recruit target number of patients	Trial Status	Target met within the agreed time	Comments
A multicenter study to evaluate safety and tolerability in patients with chronic heart failure and reduced ejections fraction from PARADIGM-HF receiving open label LCZ696	Yes	2	Yes	27/01/2016	Open	yes	Target achieved
LIBERTY ASTHMA QUEST - A randomised double blind, placebo-controlled, parallel group study to evaluate the efficacy and safety of dupilumab in patients with persistent asthma	Yes	3	Yes	30/06/2016	Open		2 patients randomised to date
GORD - A multicenter randomised double blind two arm parallel group place-bo controlled study to assess the effect of Sodium Alginate Chewable Tablets on symptoms of gastro-oesophageal reflux disease	Yes	4		30/11/2016	Open		2 patients randomised to date

2.5 Commissioning for Quality and Innovation (CQUIN) Payment Framework

A proportion of South Tyneside NHS Foundation Trust's income in 2015-16 was conditional upon achieving quality improvement and innovation goals agreed between South Tyneside NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) Payment Framework.

Further details of the agreed goals for 2015-16 and for the following 12 month period are available at: foi@stft.nhs.uk

The monetary total for the amount of income in 2015-16 conditional upon achieving quality improvement and innovation goals is £XX. The monetary total for the associated payment in 2014/15 was £3,486,317.

Final reconciliation does not occur until after preparation of this report, however the indicative position shows that for the full year we will have achieved over 90% for the scheme.

Indicative Achievement of the Nationally Mandated CQUINs

No	Goal	Indicator	Status
1	**Acute Kidney Injury**	This focused on AKI diagnosis and treatment in hospital and the plan of care to monitor kidney function after discharge	**Partial**
2a	**Sepsis Screening**	This focused on the screening of a specified group of adult and child patients in emergency departments and other units that directly admit emergencies	**Full**
2b	**Sepsis Antibiotic Administration**	To rapidly initiate intravenous antibiotics, within 1 hour of presentation, for those patients who have suspected severe sepsis, Red Flag Sepsis or septic shock	**Partial**
3a	**Dementia & Delirium(FAIRI)**	Aimed to improve care for patients with dementia or delirium during episodes of emergency unplanned care	**Full**
3b	**Staff Training**	Ensures that appropriate dementia training is available to staff through a locally determined training programme	**Full**
3c	**Supporting Carers**	Ensures carers of people with dementia and delirium feel adequately supported	**Full**
4	**Reducing the Proportion of Avoidable Emergency Admissions**	Ensures that patients with ambulatory care sensitive conditions and similar conditions that do not normally require admission to a hospital bed receive highly responsive urgent care services outside of hospital.	**Partial**

Indicative Achievement of the Locally Agreed CQUINs

No	Goal	Indicator	Status
5	**HbA1C and Lipid Levels**	To check Hb1AC and lipid levels in diabetic patients admitted with a diagnosis of diabetes to hospital or seen in A&E, if these tests have not been done in the past 3 months as part of diabetic review.	**Full**
6	**End of Life Care**	Actions to be taken to ensure excellence in End of Life care during the withdrawal of the Liverpool Care Pathway	**Full**
7	**Learning Disability Coding, Flagging and Care pathways**	Early flagging of patients in health care settings to support the implementation of learning disability care pathways	**Full**
8	**High Impact Interventions / Actions**	Development and implementation of jointly agreed projects or service developments to meet the requirements of the relevant 'High Impact Actions' as identified by NHS England	**Full**
9	**Integrated Community Teams**	To support the CCG ambition of better joined up care delivered via integrated community teams	**Full**
10	**Increased number of conditions that have access to an ambulatory care pathway**	To support the CCG ambition of reducing emergency admissions by 15% over 5 years by identifying and implementing (where appropriate) opportunities for increasing the number of conditions managed through ambulatory care pathways.	**Full**
11	**Enhancing quality of life for people with long term conditions – Telehealth**	To support improved quality of life by the rollout of Telehealth technology	**Partial**
12	**Enhancing quality of life for people with long term conditions - COPD**	To support the CCG ambition of showing a marked improvement over 5 years in the quality of life for patients with LTCs	**Partial**
13	**Improving Pulmonary Rehabilitation Access for Patients With COPD**	To support the CCG ambition of a 3.2% improvement in 2014/15 in the years lost due to premature death by improving care for patients with COPD	**Full**
14	**Community IM&T Integration**	To implement EMIS Community Web and Mobile working for nursing teams in Sunderland	**Full**

No	Goal	Indicator	Status
15	**Continuing Healthcare**	Supporting the achievement of the 28 day pathway is vital as delays in providing outcomes to claimants causes distress and potential financial hardship to them.	**Full**
16	**Smoking at Time of Delivery**	To support the CCG and South Tyneside Council initiatives to reduce the impact of smoking on the population	**Full**
17	**Health Visiting**	To support the transfer of commissioning responsibility to local authorities from NHS England	**Full**
18	**Retinal Screening**	Improving the experience for patients with a Learning Disability	**Full**
18	**Delayed Discharge from Intensive Care**	To reduce the delays in patient transfer to hospital general wards once they are medically fit	**Full**
20	**Community Pulmonary Rehabilitation**	Improving access to the Gateshead service	**Full**
21	**St Benedicts**	Improving patient experience for Durham patients in St Benedicts Hospice	**Full**

2.6 Information on Care Quality Commission (CQC) Registration

South Tyneside NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registration in full, with no conditions. The Care Quality Commission has not taken any enforcement action against South Tyneside NHS Foundation Trust during 2015-16.

Activities that the trust is registered to carry out:

- Accommodation for persons who require nursing or personal care
- Diagnostic and screening procedures
- Family planning services
- Maternity and midwifery services
- Nursing care
- Personal care
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury

The South Tyneside NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2015-16.

- Comprehensive inspection of all services in May 2015. This inspection included all acute and community services, and the Trust was rated “requires improvement” overall.

South Tyneside NHS Foundation trust intends to take the following action to address the conclusions or requirements reported by CQC:

- A comprehensive action plan was developed as part of the Quality Summit following publication of the inspection report

South Tyneside NHS Foundation trust has made the following progress by 31st March 2016 in taking such action:

- The action plan is now in place.

Further information about our registration status can be found at www.cqc.org.uk

2.7 Customer Services

In 2015-16 a total of 190 people raised formal complaints with us as indicated below:

	2015-16	2014-15	2013-14	2012-13	2011-12	2010-11	2009-10
Q1	42	52	60	71	64	72	70
Q2	55	65	73	71	57	55	77
Q3	51	35	42	68	55	60	60
Q4	42	58	46	71	71	48	70
Total	**190**	**210**	**221**	**281**	**247**	**235**	**277**

During 2015-16 a total of 8 complainants referred their complaints to the Parliamentary and Health Services Ombudsman.

To date, 8 reviews have been concluded by the Ombudsman, 4 with no case to answer and 3 with actions for the Trust to take forward. 1 complaint was withdrawn by the complainant.

2.8 Information on Data Quality

Good quality information underpins sound decision making at every level in the NHS and contributes to the improvement of health care.

South Tyneside NHS Foundation Trust submitted records during 2015/16 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data (from months April 2015 to January 2016):

- which included the patient's valid NHS number was:
    - 99.7% for admitted patient care;
    - 99.9% for outpatient care and
    - 98.7% for accident and emergency care
- Which included the patient's valid General Medical Practice Code Valid General Practitioner Registration Code was:
    - 99.3% for admitted patient care;
    - 100% for outpatient care and
    - 100% for accident and emergency care

2.9 Information Governance Assessment Report

South Tyneside NHS Foundation Trust Information Governance Assessment Report overall score for 2015/16 was 78% and was graded green.

To facilitate our commitment to the better sharing of patient information, we will continue with two programmes of work which will run for a further two years. These programmes are developed in collaboration with our commissioners, and in partnership with South Tyneside Council and will:

- Deploy a new Electronic Patient Record (EPR) into community healthcare, based on EMIS Web and including mobile working for staff such that Community and GP data will be shared, and the quality of data captured will be driven up capture occurs at point of treatment. Several services have already moved over to EMIS (community nursing and MSK in Sunderland), with a further group to transition during 2016-17 including Podiatry, Child Health Records, Speech and Language Therapy, Occupational Therapy.

- Deliver application integration across Health and Social Care in South Tyneside to facilitate integrated ways of working with Council staff, as well as other HealthCare organisations such as Northumberland Tyne and Wear NHS Foundation Trust. We are leading on the development of the Health and Social Care Integration Engine, which will link the major systems across providers.

In addition the Trust has continued to invest in delivering its Information Technology Strategy, continuing to extend the use of electronic whiteboards and electronic discharge solution.

In progressing actions against the data quality plan we particularly expect to see further progress from:

- Extending the digital referral and reporting system to cover new services currently requested on paper. This will have both an increase in the quality of service delivery and in the quality of data gathered and recorded. We have already developed this system to cover referrals in social care, district nursing and cardiology.

- The Trust will invest in mobile technology for community nursing services, which in conjunction with the community electronic patient record will allow patient care to be recorded at time of the event even in the patient's home. We have started the trial of mobile devices in Sunderland and have procurements in place to roll out the technology to a wider group of staff.

2.10 Information on Clinical Coding

South Tyneside NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission.

Audits conducted during 2015/16 have been undertaken in accordance with the HSCIC Clinical Classifications Service Clinical Coding Audit Methodology 2015/16 Version 9.0. During the reporting period the error rates reported in the latest audit report for that period for diagnoses and treatments coding (clinical coding) were:

- Primary Diagnoses Incorrect 9.50%
- Secondary Diagnoses Incorrect 9.10%
- Primary Procedures Incorrect 3.52%
- Secondary Procedures Incorrect 8.18%

All episodes within the audit sample were identified from:

- General Medicine specialty;
- General Surgery specialty;
- Gynaecology specialty; and
- Trauma and Orthopaedics specialty

The results of the coding audits should not be extrapolated further than the actual sample audited.

South Tyneside NHS Foundation Trust will be taking the following actions to improve data quality. We have developed an action plan on the basis of the recommendations made in the audit report. Our plan supports continuous improvement in the accuracy of our coding. We have begun work to improve the coding of patients in the St Benedict's Hospice in Sunderland; this has been identified as a contributory factor to our "SHMI" mortality rate, and we will mirror the assurance processes that are used in the coding within the acute hospital.

2.11 Reporting Against Core Quality Indicators

This section of the Quality Report covers our performance against a core set of mandated indicators, using a standardised format that includes our performance alongside the performance of other trusts or the NHS nationally.

The value and banding of the Summary Hospital-level Mortality Indicator (SHMI) for the Trust

Period	Dec14 – Nov15	Oct14 – Sep15	Jul14 – Jun15	Apr14 – Mar15	Jan14 – Dec14
STFT Value	114.7	114.0	114.8	117.7	117.5
STFT without Hospice	99.1		99.9		
STFT Band (Target "2")	1	1	1	1	1
Highest National	NA	117.7	120.9	121.0	124.3
Lowest National	NA	65.2	66.1	67.0	65.5
Data Source	https://indicators.ic.nhs.uk/webview/				

SHMI is a ratio of the observed number of deaths to the expected number of deaths for a provider. The observed number of deaths is the total number of patient admissions to the hospital which resulted in a death either in hospital or within 30 days post discharge from the hospital.

South Tyneside NHS Foundation Trust considers that this data is as described for the following reasons. The table above demonstrates our SHMI values and bandings over several reporting periods. We have identified that the SHMI value for STFT is affected by the management of St Benedict's Hospice in Sunderland. If the data concerning those hospice patients was removed from the SHMI calculation, the most recent data suggests that the Trust SHMI value is '99.9'. The deterioration to a band 1 ("higher than expected") has been discussed with commissioners and NHS England, and can again be linked to St Benedict's, specifically the increase in the number of beds in a newly built facility, and the reduction in admissions to the acute hospital.

South Tyneside NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by continuing to develop our mortality review processes. Our Mortality Review Group is responsible for scrutinising mortality and the work of individual departmental mortality measures. Patient deaths are reviewed to identify any concerns or areas where care could be improved in the future. The Mortality Review Group also regularly audits the main mortality types included with the SHMI calculation. These

audits provide assurance and form the basis for further investigations during the year by consultants in each area.

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

	Oct13 – Sep14	Jul13 – Jun14	Apr13 – Mar14	Jan12 – Dec12
STFT Value		**26.1**	**27.4**	**26.6**
Highest National		**49**	**48.5**	**46.9**
Lowest National		**0.0**	**0.0**	**1.3**
Data Source	• CHKS • https://indicators.ic.nhs.uk/webview/			

South Tyneside NHS Foundation Trust considers that this data is as described for the following reasons. Some acute Trusts including ours provide specialist palliative care inpatient services within designated wards, or within the community. This potentially affects the SHMI value and means that it may be difficult to compare one Trust with another.

The South Tyneside NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its service, by

Our Mortality Review Group is responsible for scrutinising mortality and the work of individual departmental mortality measures. Patient deaths are reviewed by the group to identify any concerns or areas where care could be improved in the future.

Our mortality data and SHMI rating is affected by the fact that our trust provides specialist palliative care to the people of Sunderland and the surrounding areas at St Benedict's Hospice.

Patient Reported Outcome Measures (PROMS) - % of Patients Reporting Improvements

	Value = EQ-5D	2015/16 (Apr – Sep Provisional)	2014/15
Varicose Vein Surgery	Trust Score:	N/A	N/A
	National Average:	39.6	52.1
Hip Replacement Surgery	Trust Score:	80.0*	90.9
	National Average:	89.7	89.6
Knee Replacement Surgery	Trust Score:	100*	63.2
	National Average:	82.8	81.0
Groin Hernia Surgery	Trust Score:	61.3	45.0
	National Average:	51.1	50.7
Data Source	HSCIC: http://www.hscic.gov.uk/proms		

South Tyneside NHS Foundation Trust considers that this data is as described for the following reasons. Varicose vein procedures is not a routine operation at STFT and none were carried out during this reporting period.

*The performance for Knee Replacement Surgery and Hip Replacement Surgery in 2015/16 is based on a low number of patient responses and therefore should be interpreted with caution.

South Tyneside NHS Foundation Trust intends to take the following actions to improve PROMs performance, and so the quality of its services, by continuing to look specifically at the actual health gains from a pre-operative to post-operative position. We will continue to encourage patients to complete the PROMS survey to ensure we receive valid data.

The percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust

		2015/16	2014/15	2013/14
Age 0 to 15	Readmission Rate	5.7%	5.8%	5.8%
	Peer Readmission Rate	10.8%	8.3%	8.4%
Age 16+	Readmission Rate	5.7%	5.5%	5.7%
	Peer Readmission Rate	7.0%	6.9%	7.0%
Data Source	In the absence of data from the Health & Social Care Information Centre, data from CHKS has been used			

South Tyneside NHS Foundation Trust considers that this data is as described for the following reasons. In order to demonstrate our performance for 28 day readmissions against the national context, we have provided a comparison with data extracted from the CHKS database. CHKS is a healthcare intelligence provider with whom a large number of Trusts are registered nationally. The peer group shown in the table above includes all registered CHKS Trusts.

South Tyneside NHS Foundation Trust has taken the following actions to improve this readmission rate, and so the quality of its services, by showing that the data has been provided for the last two reporting periods and demonstrates that our Trust compares favourably with the peer group readmission rates in both age groups.

We continue to work with partner organisations in improving the resilience of the systems across South Tyneside to reduce readmissions to hospital. A number of new projects were implemented over the winter period, including enhancing rehabilitation services. We continue to develop Haven Court (the Integrated Care Hub) which will open in 2016-17 and offer further options that should reduce readmissions.

Measure	**Responsiveness to Patient Need**
Survey of Adult Inpatients 2015 versus 2014	
The South Tyneside NHS Foundation Trust considers that this data is as described for the following reasons. XXXX The South Tyneside NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by XXXXX	
Data Source	http://www.cqc.org.uk/provider/RE9/survey/3

The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends

	2015**		2014*		2013*	
	% Agree	% Strongly Agree	% Agree	% Strongly Agree	% Agree	% Strongly Agree
Trust	44	17	46	17	47	17
National Average	48	20	47	20	47	20
National Highest	54	46	58	44	58	47
National Lowest	37	8	32	6	33	7
Data Source	http://www.nhsstaffsurveys.com/ Note: *Acute Trusts **Combined Acute and Community Trusts					

The South Tyneside NHS Foundation Trust considers that this data is as described for the following reasons. The 2015 results are consistent with earlier years, however the satisfaction rate when these questions are asked through the national surveys is always lower than the locally organised quarterly surveys, which average 70% satisfaction Though response rates are low).

The South Tyneside NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by refreshing the Board of Directors approved targeted action plan.

Friends and Family Test - Patient

		Feb 2016		Jan 2016		Dec 2015	
		% Response Rate	% Recommended	% Response Rate	%Recommended	% Response Rate	% Recommended
A&E	Trust	6	92	13	83	5.4	88
	National	13.3	85	12.9	86	12.7	87
Community	Trust		98		98		99
	National		95		95		95
Inpatient	Trust	29.0	93	27.5	95	27.8	96
	National	24.1	95	23.5	95	22.6	95
Maternity	Trust		89		93		97
	National		95		96		95
Outpatient	Trust		96		95		98
	National		92		92		92
Data Source		https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/					

The South Tyneside NHS Foundation Trust considers that this data is as described for the following reasons. From April 2015, the national CQUIN targets for Friends and Family Test have been relaxed with a shift of emphasis from response rate targets and financial rewards to broader use of the question and expectations of service improvement as a result. The Trust's Carer and Patient Involvement Team have revised their process in order to accommodate this whilst building on the good will and success of the previous process.

The South Tyneside NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by the Carer and Patient Involvement making progress on identifying and mapping indicators of patient feedback across the Trust. This triangulation will provide a more holistic picture of patient experience resulting in a single approach by clinical services to take action and make improvement.

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

	2015/16				2014/15
	Q1	Q2	Q3	Q4	
Trust Score	97.1%	96.4%	95.6%	96.5%	97.6%
National Average	96.0%	95.9%	95.5%	N/A	96%
Data Source	https://www.england.nhs.uk/statistics/statistical-work-areas/vte/vte-risk-assessment-2015-16/				

South Tyneside NHS Foundation Trust considers that this data is as described for the following reasons. All Trusts are required to report the proportion of documented VTE risk assessments being conducted as a percentage of all admitted patients. The national target requires that at least 90% of all admitted patients should receive a VTE risk assessment. In 2015-16 we exceeded the national average.

The South Tyneside NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by continuing to monitor performance as part of our quality dashboard at the Choose Safer Care Committee.

The rate per 100,000 bed days of cases of C. Difficile infection reported within the Trust amongst patients aged 2 or over

Value	2015/16	2014/15	2013/14
Trust Score	6.2	7.8	12.2
National Average	Not Available	15.1	14.7
Highest National	Not Available	62.2	37.1
Lowest National	Not Available	0	0
Data Source	https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data		

South Tyneside NHS Foundation Trust considers that this data is as described for the following reasons. In 2015/16 we had 7 cases of *Clostridium Difficile* infection against a target of 8. To set this in context, the rate of infection reported at South Tyneside NHS Foundation Trust compares extremely favourably with the national average. The data

demonstrates that we have consistently reported below the national average of reported cases whilst also ranking amongst the most effective healthcare providers for this indicator.

The South Tyneside NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by Our Infection Prevention and Control Team will continue to work alongside our hospital and community teams to provide and monitor good practice in order to achieve the targets set in all local patches. We will continue to be a proactive partner in the local infection control network alongside commissioners.

The number, and where available, rate of patient safety incidents reported within the Trust

Period	Oct 15 - Mar 16 Number (Rate / 1,000 Bed Days)	Apr 15 - Sep 15 Number (Rate / 1,000 Bed Days)	Oct 14 – Mar 15 Number (Rate / 1,000 Bed Days)	Apr 14 – Sep 14 Number (Rate / 1,000 Bed Days)
Trust	1,846 (Not Available)*	1,891 (Not Available)*	2,271 (39.2)	2,253 (38.52)
National Average	Not Available	Not Available	4539 (37.1)	4,196 (35.9)
National Highest	Not Available	Not Available	12,784 (82.2)	12,020 (74.96)
National Lowest	Not Available	Not Available	443 (3.6)	35 (0.24)
Data Source	http://www.nrls.npsa.nhs.uk/resources n.b. Reported against Acute non-specialist hospitals			

The number and percentage of such patient safety incidents that resulted in severe harm or death

Period	Oct 15 - Mar 16 Number (%)	Apr 15 - Sep 15 Number (%)	Oct 14 – Mar 15 Number (%)	Apr 14 – Sep 14 Number (%)
Trust	5 (0.2%)	4 (0.2%)	10 (0.2%)	10 (0.4%)
National Average	Not Available	Not Available	11.3 (0.3%)	10.18 (0.6%)
National Highest	Not Available	Not Available	128 (5.2%)	74 (74.3%)

National Lowest	**Not Available**	**Not Available**	**0 (0%)**	**0 (0%)**
Data Source	http://www.nrls.npsa.nhs.uk/resources n.b. Reported against Acute non-specialist hospitals			

South Tyneside NHS Foundation Trust considers that this data is as described for the following reasons. The Trust actively promotes a culture in which the reporting of incidents, errors and near misses is encouraged and used as a mechanism towards improving the safety of our patients. We have robust internal review processes including Medical Director leadership of the Clinical Incident Review Group, and we work closely with commissioners on reviewing performance in the bi-monthly Quality Review Group.

The South Tyneside NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by the Board of Directors agreeing a new Quality Strategy in May 2016, and completing the “Getting to Good” improvement actions required as a result of the CQC Inspection in May 2015.

3 An Overview of the Quality of Care

The data set below is included in our monthly performance report to the Trust Board. The indicators have been selected by our board and key stakeholders on the basis that any non-compliance would adversely affect patient safety, clinical effectiveness and patient experience. Many of these indicators are also either operational standards, or national or local quality requirements of the NHS Standard Contract. Part three contains performance against national key priorities that have not already been reported in part two.

3.1 Quality of Care Data

Patient Safety Indicator 1	Data Source	Data Standard	Average 2013-14	Average 2014-15	Average 2015-16	National Contract Target
Fractured Neck of Femur- Patients Operated on Within 36 Hours of Admission	Internal Integrated Performance Dashboard	NHS Standard Contract	**75.6%**	**78.1%**	**74.5%**	**75%**
	National Data	National Hip Fracture Database	**Average 71.7%**	**Average 72.1%**	**N/A**	

Reason For Selection:

This is a quality requirement within the NHS Standard Contract. Fracture neck of femur (NOF) is associated with significant morbidity and an estimated one-year mortality of 30%.

Patient Safety Indicator 2	Data Source	Data Standard	Average 2013-14	Average 2014-15	Average 2015-16	National Contract Target
Ambulance Handover Time in A&E (% recorded using handover screens)	Internal Integrated Performance Dashboard	NHS Standard Contract	**76%**	**70.1%**	**64.0%**	**90%**

Reason For Selection:

Handover start time is defined as the time of arrival of the ambulance at the accident and emergency department, with the end time defined as the time of handover of the patient to the care of accident and emergency staff. The performance of the Trust has been validated by the commissioners, and it is recognised that the number of non-NEAS ambulances used to transport patients to our A&E department affects the maximum possible performance. We continue to work with commissioners to understand where performance can be improved.

Patient Safety Indicator 3	Data Source	Data Standard	Average 2013-14	Average 2014-15	Average 2015-16	Target
Staff Turnover **Stability of Turnover Relating to Staff with >1 year of Service.**	Internal Workforce Performance Dashboard	Local HR Strategy	**90.3%**	**89.8%**	**90.0%**	**90%**

Reason For Selection:

There is a nationally accepted and growing body of evidence that patient outcomes are linked to whether or not organisations have the right people, with the right skills, in the right place at the right time. Staff turnover has a direct impact on staffing levels.

'Turnover' includes statistics on joiners to and leavers from the Trust within a specific time period based on headcount. There has again been a significant number of staff leave the Trust under TUPE legislation following the loss of contracts to other providers.

Clinical Effectiveness Indicator 1	Data Source	Data Standard	Average 2013-14	Average 2014-15	Average 2015-16	Target
Breastfeeding Initiation	Internal Integrated Performance Dashboard		**55.4%**	**50.7%**	**50.4%**	**>56.8%**
	NHS England Statistical Work Areas - Maternity & Breastfeeding	Average	**74.0%**	**74.3%**	**73.8% (Q1)**	

Reason For Selection:

This is a local quality requirement within the NHS Standard Contract. Breastfeeding has many health benefits for both the mother and infant. To reduce infant mortality and ill health, WHO recommends that mothers first provide breast milk to their infants within one hour of birth – referred to as "early initiation of breastfeeding". We continue to work with mothers in both Maternity services and Health Visiting to improve initiation and maintenance of breast feeding rates. South Tyneside Council have continued the funding of a Public Health Midwife into 2015/16 and this will again contribute to identifying opportunities to improve practice.

Clinical Effectiveness Indicator 2	Data Source	Data Standard	Average 2013-14	Average 2014-15	Average 2015-16	National contract Target
Improving Access to Psychological Therapies – Moving to Recovery	Internal Integrated Performance Dashboard	http://www.hscic.gov.uk/iapt	**52%**	**54.6%**	**53.3%**	**50%**
	National Data				**45.7% (Q1 – Q3)**	

Reason For Selection:

Improving Access to Psychological Therapies (IAPT) is an NHS programme rolling out services across England offering interventions for treating people with depression and anxiety disorders. Performance in both of our services - Gateshead and South Tyneside - has exceeded national targets in 2015/16 and seen both recognised nationally. Targets for waiting times and access numbers has also exceeded their respective national targets.

Clinical Effectiveness Indicator 3	Data Source	Data Standard	Average 2013-14	Average 2014-15	Average 2015-16	National Contract Target
Proportion of Patients Who Spend More than 90% of Their In-patient Stay on a Stroke Unit	Internal Integrated Performance Dashboard	National Stroke Strategy	**85%**	**69%**	**71.1%**	**80%**
	Strokeaudit.org	National Average			**84.0% (Q1 – Q3)**	

Reason For Selection:

In the UK, the National Sentinel Stroke Audits have documented changes in secondary care provision over the last 10 years, with increasing numbers of patients being treated in stroke units, more evidence-based practice, and reduced mortality and length of hospital stay. In addition to other measures, Trusts are assessed by the proportion of stroke patients who spend more than 90% of their in-patient stay on a stroke unit. Performance was particularly affected by pressures on bed availability across the wider hospital. This restricted the ability to ensure stroke patients moved directly to the unit from A&E.

Patient Experience Indicator 1	Data Source	Data Standard	Total 2013-14	Total 2014-15	Total 2015-16	Target
Cancellation of Elective Operations	Internal Integrated Performance Dashboard	National Standard	**81**	**196**	**68**	**0**
	NHS England Statistical Work Area – Cancelled Elective Operations	Average		**123**	**102**	

Reason For Selection:

Cancelled operations are distressing and inconvenient for patients. Understanding the reasons for cancellations and then tackling them appropriately, improves the throughput of patients along the patient pathway. Performance in quarter 3 was affected by emergency admission pressures on beds; this restricted the number of beds available for elective operations. We will continue to work to improve our winter resilience, in partnership with all other stakeholders in the urgent care pathways, and to improve our emergency planning for winter.

Patient Experience Indicator 2	Data Source	Data Standard	Total 2013-14	Total 2014-15	Total 2015-16	Target
Percentage of Women who have Seen a Midwife by 12 Weeks and 6 Days of Pregnancy	Internal Integrated Performance Dashboard /	National Standard	**90.1%**	**90.7%**	**91.2%**	**90%**
	https://indicators.ic.nhs.uk/webview/	Average	**94.2%**	**N/A**	**N/A**	

Reason for Selection:

This is a local quality requirement within the NHS Standard contract. All women should access maternity services for a full health and social care assessment of needs, risks and choices by 12 weeks and 6 days of their pregnancy to give them the full benefit of personalised maternity care and improve outcomes and experience for mother and baby. Reducing the percentage of women who access maternity services late through targeted outreach work for vulnerable and socially excluded groups will provide a focus on reducing the health inequalities these groups face whilst also guaranteeing choice to all pregnant women.

Patient Experience Indicator 3	Data Source	Data Standard	Average 2013-14	Average 2014-15	Average 2015-16	Target
Choose and Book Slot Utilisation Issues	Internal Integrated Performance Dashboard / Choose and Book National System and Reports	Choose and Book Best Practice Guidance	**5.2%**	**13.7%**	**6.6% (Apr – Dec)**	**<4%**

Reason for Selection:

This is a quality requirement within the NHS Standard Contract with a target of < 4%. Patients should always be able to book an appointment at their chosen provider using the Choose and Book system when the service is a directly bookable service. In order to support this the Trust has a target to ensure sufficient appointment slots available on choose & book at least 96% of the time. Performance is measured through data collection relating to slot utilisation issues against a 4% or less target. The Choose & Book national system was re-launched in 2015-16, with system issues restricting availability of data.

3.2 Key National Priorities 2015/16

The Risk Assessment Framework from Monitor includes key national targets and thresholds for achievement. The Trust's performance in 2015-16 against those not covered elsewhere in this Quality Report is shown below.

Risk Assessment Framework Indicator	Target	Actual 2015/16
A&E: maximum waiting time of 4 hours from arrival to admission/discharge/transfer	**95%**	**93.4%**
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	**92%**	**96.5%**
Cancer:62-day wait for first treatment from NHS Cancer Screening service referral	**90%**	Not Applicable
Cancer: 62-day wait for treatment from urgent GP referral	**85%**	**85.6%**
Cancer:31-day wait for second or subsequent treatment, comprising surgery	**94%**	**99.6%**
Cancer:31-day wait for second or subsequent treatment, comprising anti-cancer drug treatments	**98%**	**99.6%**
Cancer:31-day wait for second or subsequent treatment, comprising radiotherapy	**94%**	Not Applicable
Cancer:31-day wait from diagnosis to first treatment	**96%**	**100%**
Cancer: two week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	**93%**	**97%**
Cancer: two week wait from referral to date first seen – for symptomatic breast patients (cancer not initially suspected)	**93%**	Not Applicable
Improving access to psychological therapies (IAPT): People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	**75%**	**71.8%**
Improving access to psychological therapies (IAPT): People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	**95%**	**99.3%**
Certification against compliance with requirements regarding access to health care for people with a learning disability	**N/A**	**Compliant**
Data completeness: community services – referral to treatment information	**50%**	**60.8%**
Data completeness: community services – referral information	**50%**	**75.9%**
Data completeness: community services – treatment activity information	**50%**	**65.0%**

Annex 1: Statements from commissioners, local Healthwatch organisations and Oversight and Scrutiny Committees

Where 50% or more of the relevant health services that the NHS foundation trust directly provides or sub-contracts during the reporting period are provided under contracts, agreements or arrangements with NHS England, the trust must provide a draft copy of its quality accounts/report to NHS England for comment prior to publication

Where this is not the case, a copy must be provided to the clinical commissioning group (CCG) which has responsibility for the largest number of people to whom the trust has provided relevant health services during the reporting period for comment prior to publication and should include any comments made in its published report.

NHS foundation trusts must also send draft copies of their quality accounts/report to their local Healthwatch organisation and oversight and scrutiny committee for comment prior to publication.

The commissioners have a legal obligation to review and comment, while local Healthwatch organisations and OSCs are offered the opportunity on a voluntary basis.

South Tyneside NHS Foundation Trust made copies of its draft quality account report available to South Tyneside CCG (as lead commissioner for local CCGs), and to the OSCs and Healthwatch organisations in South Tyneside, Sunderland and Gateshead.

Feedback on Our 2015/16 Quality Report

Statement from the Commissioners: South Tyneside Clinical Commissioning Group, Sunderland Clinical Commissioning Group and Gateshead Clinical Commissioning Group.

Response from Healthwatch South Tyneside

Response from South Tyneside Council Oversight & Scrutiny Committee

Response from Sunderland City Council Oversight & Scrutiny Committee

Response from Governors

Annex 2: Statement of directors responsibilities for the quality report

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.

Monitor 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 2015/16 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 2015 to May 2016
    - papers relating to Quality reported to the the board over the period April 2015 to May 2016
    - feedback from commissioners dated XX/05/2016
    - feedback from governors dated XX/05/2016
    - feedback from local Healthwatch organisations dated XX/05/2016
    - Feedback from Overview and Scrutiny Committee dated XX/05/2016
    - The trusts complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/06/2016
    - The 2015 national patient survey XX/05/2015
    - The 2015 national staff survey XX/04/2016
    - The Head of Internal Audit's annual opinion over the trust's control environment dated XX/05/2015
    - CQC Intelligent Monitoring Report dated XX/XX/2015
    - 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 Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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

By order of the board

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

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

Glossary of Terms

Board of Directors

A board of directors is a body of elected or appointed members who jointly oversee the activities of an organisation.

Care Quality Commission (CQC)

The CQC is the independent regulator of all health and adult social care in England. The primary role of the CQC is to ensure that hospitals, care homes and care services are meeting national standards.

Commissioning for Quality and Innovation (CQUIN)

The CQUIN framework is an incentive scheme which enables commissioners to reward excellence by linking a proportion of English healthcare provider's income to achievement of local quality improvement goals.

Commissioners / Clinical Commissioning Groups (CCGs)

Clinical Commissioning Groups (CCGs) in each local area are made up of doctors, nurses and other professionals coming together to use their knowledge of local health needs to commission the best available services for patients. They have the freedom to innovate and commission services for their local community from any service provider which meets NHS standards and costs – these could be NHS hospitals, social enterprises, voluntary organisations or private sector providers.

Clinical Audit

Clinical audit is a process that aims to improve patient care and outcomes through systematic review of care against agreed standards implementation of identified improvements.

Clostridium Difficile (C.Diff)

Clostridium Difficile is is a species of Gram-positive bacteria that occurs naturally in the gut. Approximately two-thirds of children and 3% of adults test positive for C Diff. The bacteria are harmless in healthy people but can cause severe diarrhoea and other intestinal disease when competing bacteria in the gut flora have been wiped out by antibiotics.

Datix

Datix is an electronic risk management software system which allows incident forms to be completed electronically by all staff. The use of this technology allows greater transparency and trend analysis in addition to improving access to the reporting system

Department of Health (DH)

The Department of Health is a department of the UK government with responsibility for government policy in England on health, social care and the NHS.

Foundation Trust (FT)

A Foundation Trust is a type of NHS organisation which have a significant amount of managerial and financial freedom when compared to NHS hospital trusts. Although still part of the wider NHS, they have greater level of autonomy in setting strategic goals. Similar to the concept of 'co-operatives' local people, patients and staff can become members and governors and hold the Trust to account.

Healthcare- acquired infection (HCAI)

This is an infection that occurs as a result of the healthcare that a person receives.

Meticillin- Resistant Staphylococcus Aureus (MRSA)

MRSA is a bacterium which has developed resistance to a range of antibiotics including penicillin. MRSA is therefore responsible for several difficult to treat infections in humans. MRSA is often associated with clinical care as patients with invasive devices such as central lines, open wounds and reduced immunity are more at risk of infection than the general public.

Monitor

Monitor is the independent regulator of NHS Foundation Trusts. It is independent of central government and directly accountable to parliament.

National Institute for Health and Care Excellence (NICE)

Previously known as the National Institute for Health and Clinical Excellence, following the Health and Social Care Act 2012, NICE was renamed the National Institute for Health and Care Excellence on 1 April 2013 and changed from a special health authority to a non-departmental public body. The primary role if NICE is to provide guidance and quality standards. NICE makes recommendations to the NHS on clinical treatments and medicines and also makes recommendations to the NHS, local authorities and other organisations involved in healthcare 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 Patient Safety Agency (NPSA)

The National Patient Safety Agency is an arm's length body of the Department of Health which promotes improved, safe patient care by informing, supporting and influencing the health sector.

Overview and Scrutiny Committee

Overview and Scrutiny Committees are local authority bodies with statutory roles and powers to review local health services. They help to plan services and implement change to make the NHS more responsive to local communities.

Pressure Ulcers / Pressure Sores

Pressure ulcers are also known bed sores. They occur when the skin and underlying tissue becomes damaged as a result of reduced mobility combined with pressure applied to soft tissue so that blood flow to the soft tissue is completely or partially obstructed. Most commonly pressure ulcers occur to the sacrum, coccyx, heels or the hips, but other sites such as the elbows, knees, ankles or the back of the cranium can also be affected.

Risk Assessment

This is a methodology used to protect patients and staff from harm. It is a systematic examination of what could cause harm to allow us to weigh up if we have taken enough precautions or should do more to prevent harm.

Root Cause Analysis (RCA)

RCA is a method used to solve problems by attempting to identify and correct the root causes of events, as opposed to simply addressing their symptoms. RCA is generally used in a learning culture to drive continuous improvement. By focusing correction on root causes, problem recurrence can be prevented. Following RCA we share learning with staff across the hospital to inform our practice and help prevent further reoccurrence.

Safety Thermometer

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The tool provides a quick and simple method for surveying patient harms and analysing results so that we can measure and monitor local improvement and harm free care over time.

Venous Thromboembolism (VTE)

A venous thrombosis is a blood clot (thrombus) that forms within a vein. *Thrombosis* is a term for a blood clot occurring inside a blood vessel. A typical venous thrombosis is deep vein thrombosis (DVT), which can break off (or embolise), and become a life-threatening pulmonary embolism (PE).