Gateshead Health NHS Foundation Trust
Quality Account
2015/16

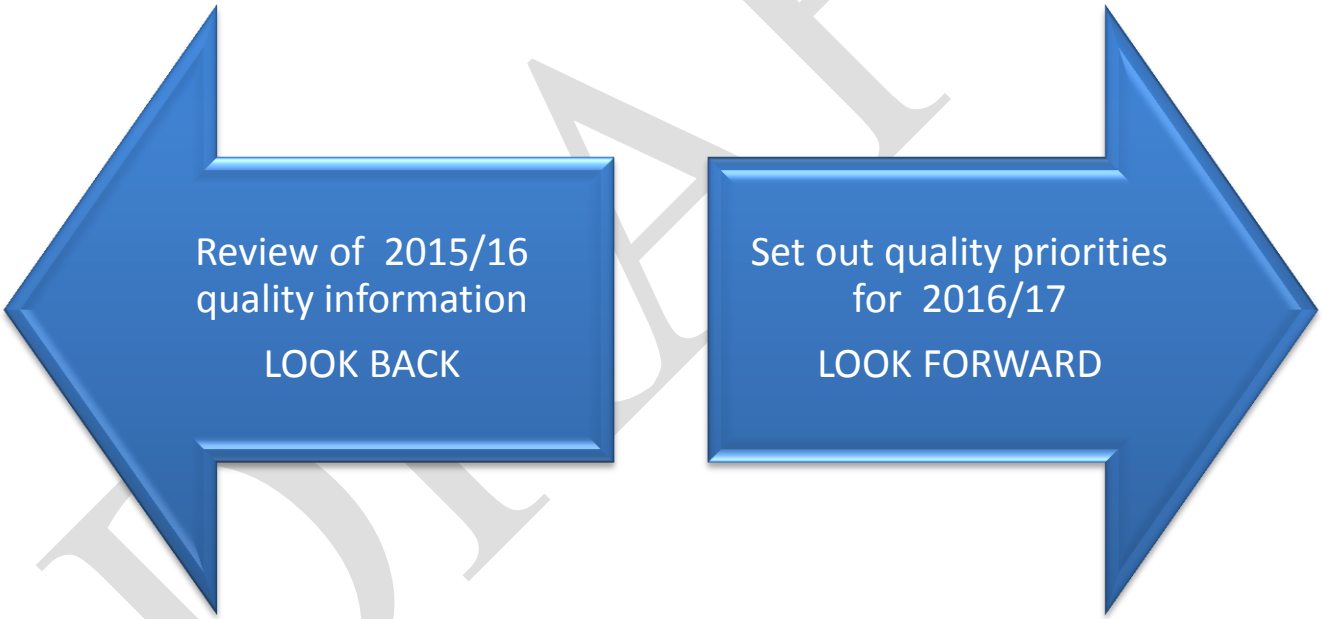
Contents

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).

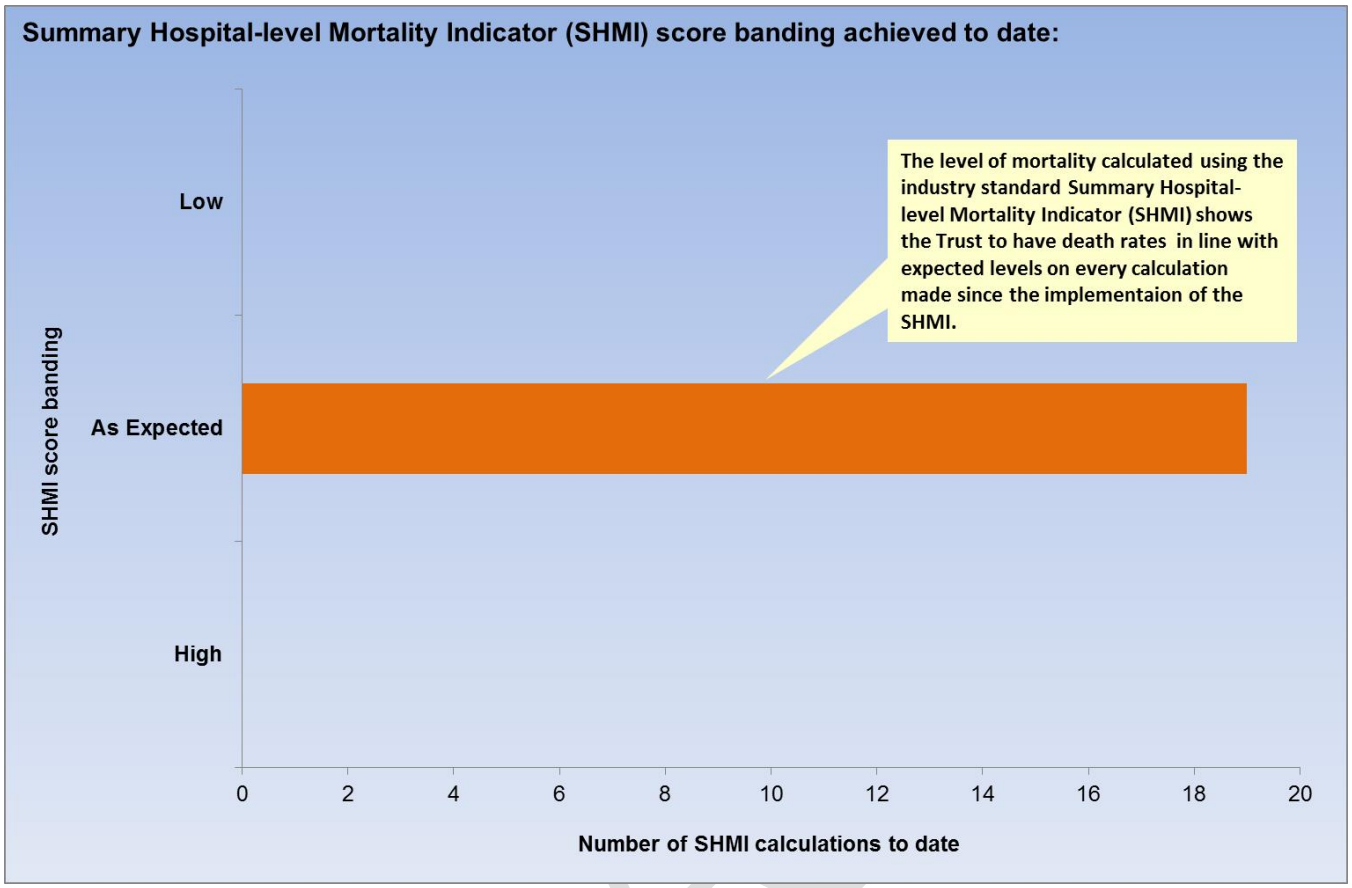
Did we achieve this?

Yes we did.

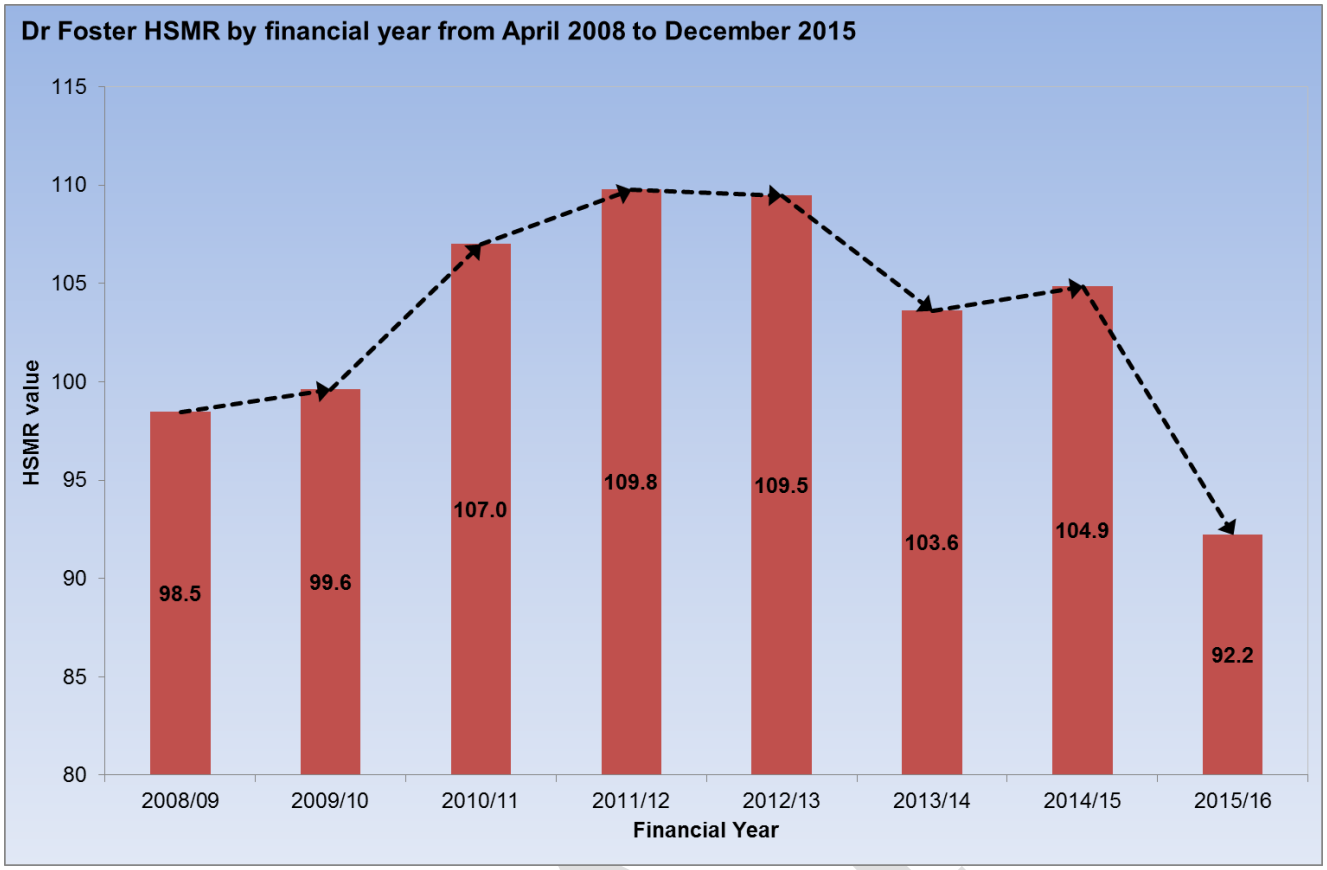
How we achieved it:

- 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:

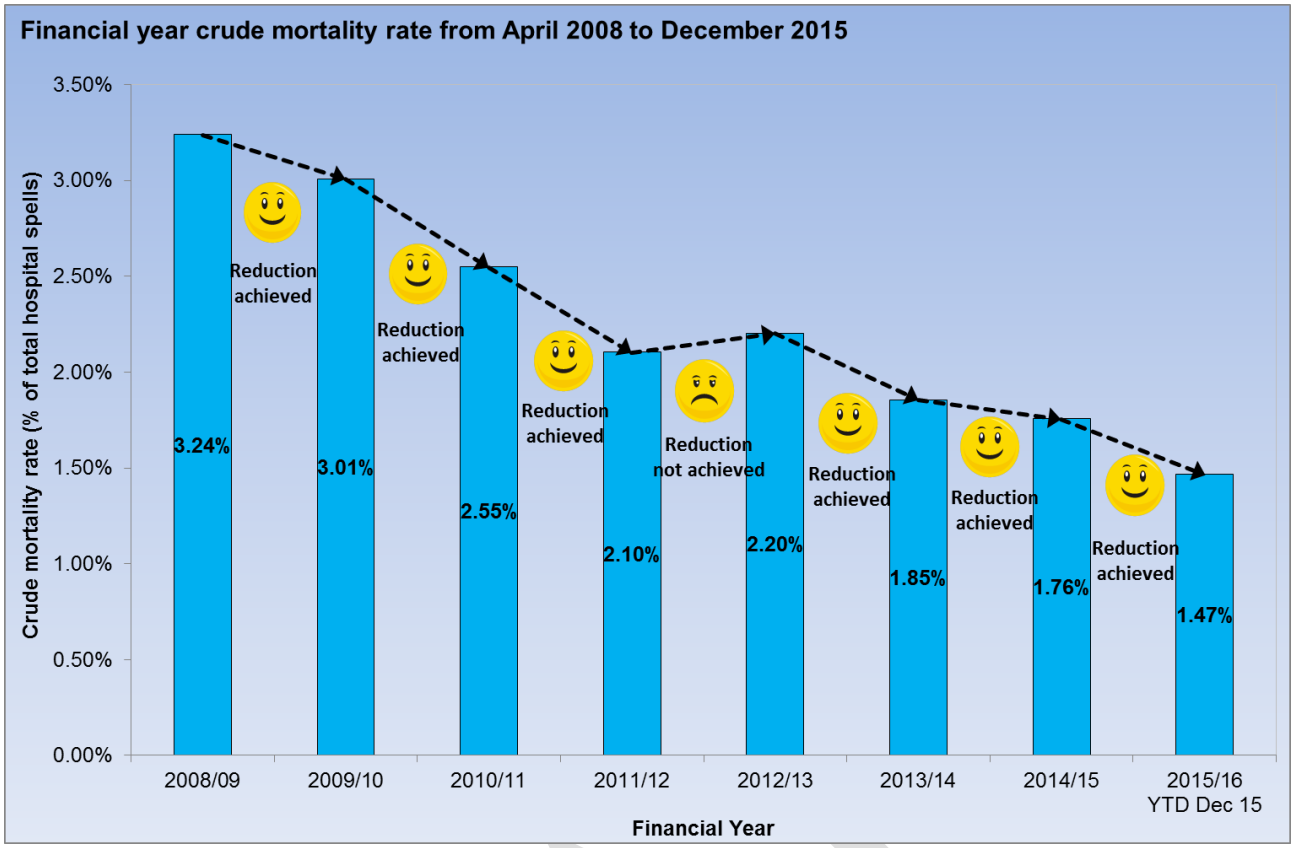


The Summary Hospital-level Mortality Indicator (SHMI) reports mortality at a Trust level across the NHS in England and is regarded as the national standard for monitoring of mortality. The main development in measuring mortality, that the SHMI takes into account, is patient deaths outside of hospital 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'.

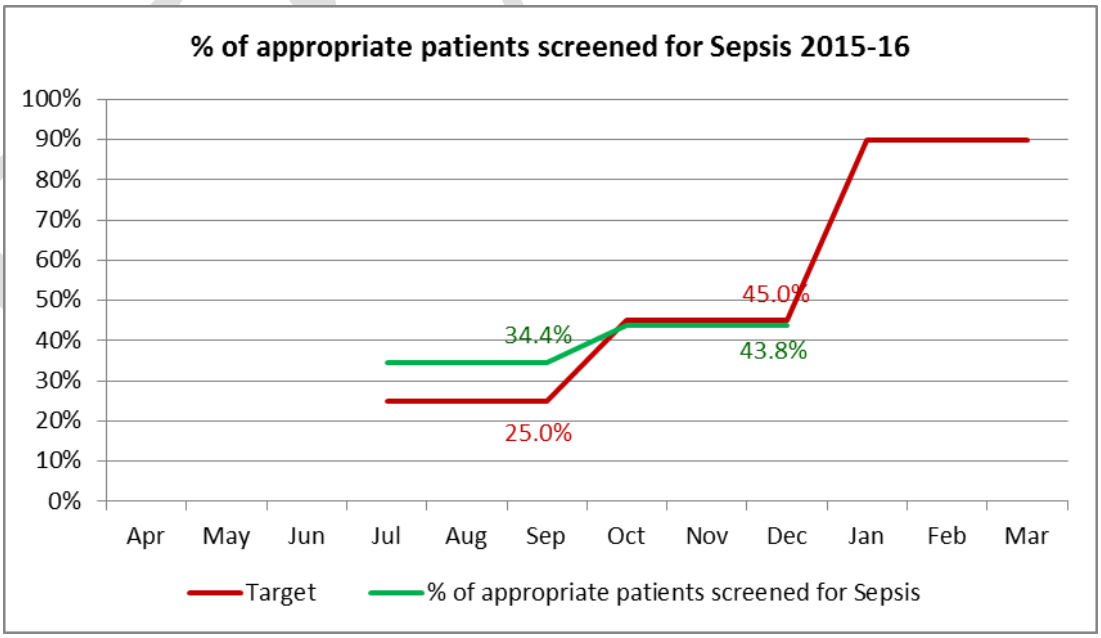


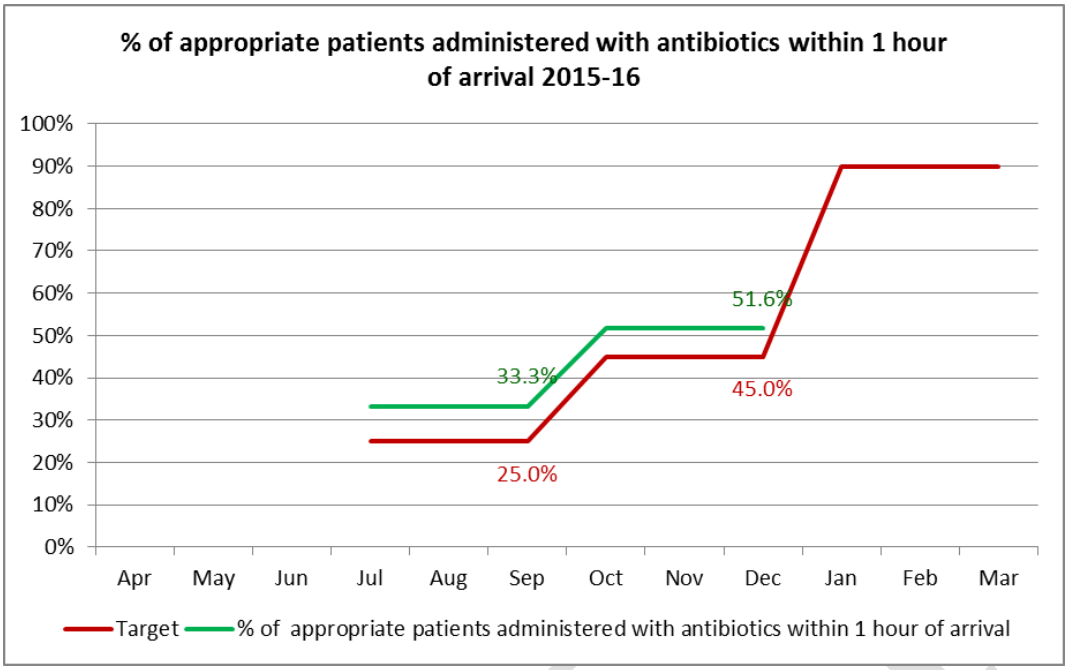
One of the key advantages to using Dr Foster is the in-depth information around mortality and the ability to see the data that underpins many of the publications related to hospital death rates, allowing the Trust to realise opportunities for learning and improve patient care.

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:

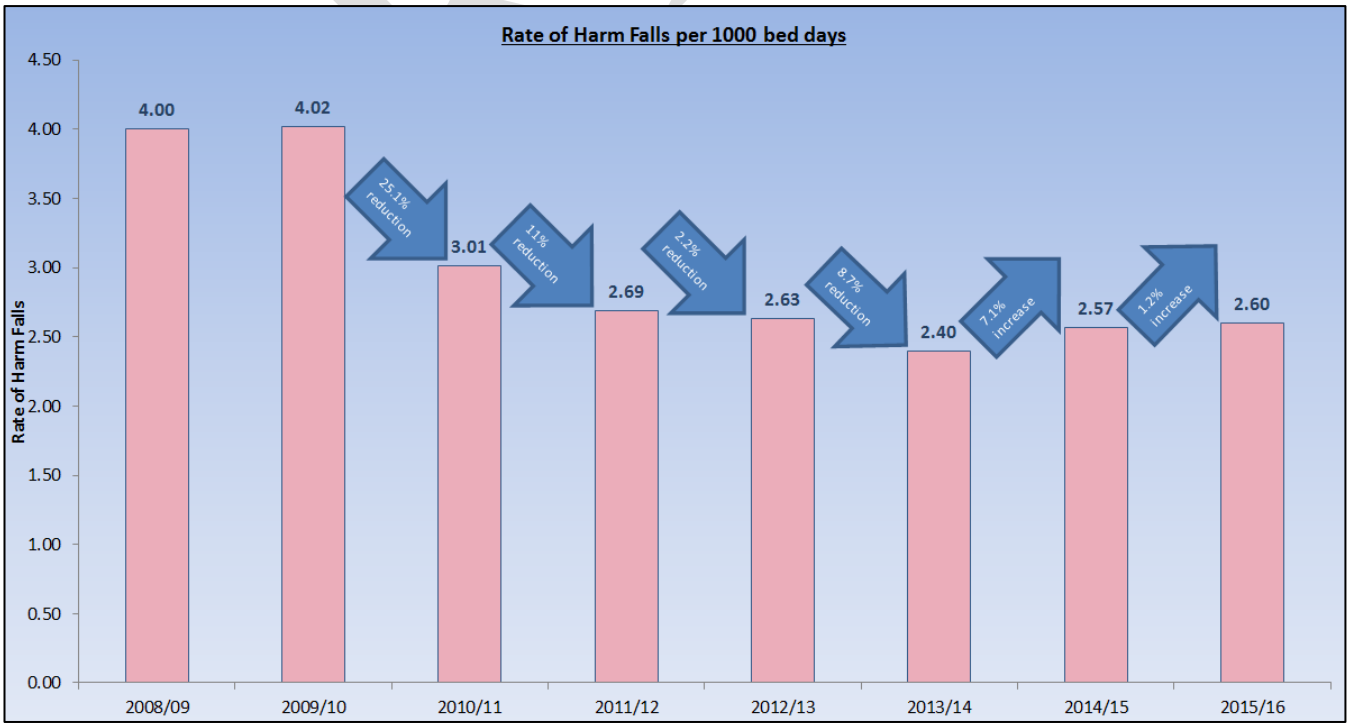
There have been a number of improvement initiatives ongoing throughout the year. These include:

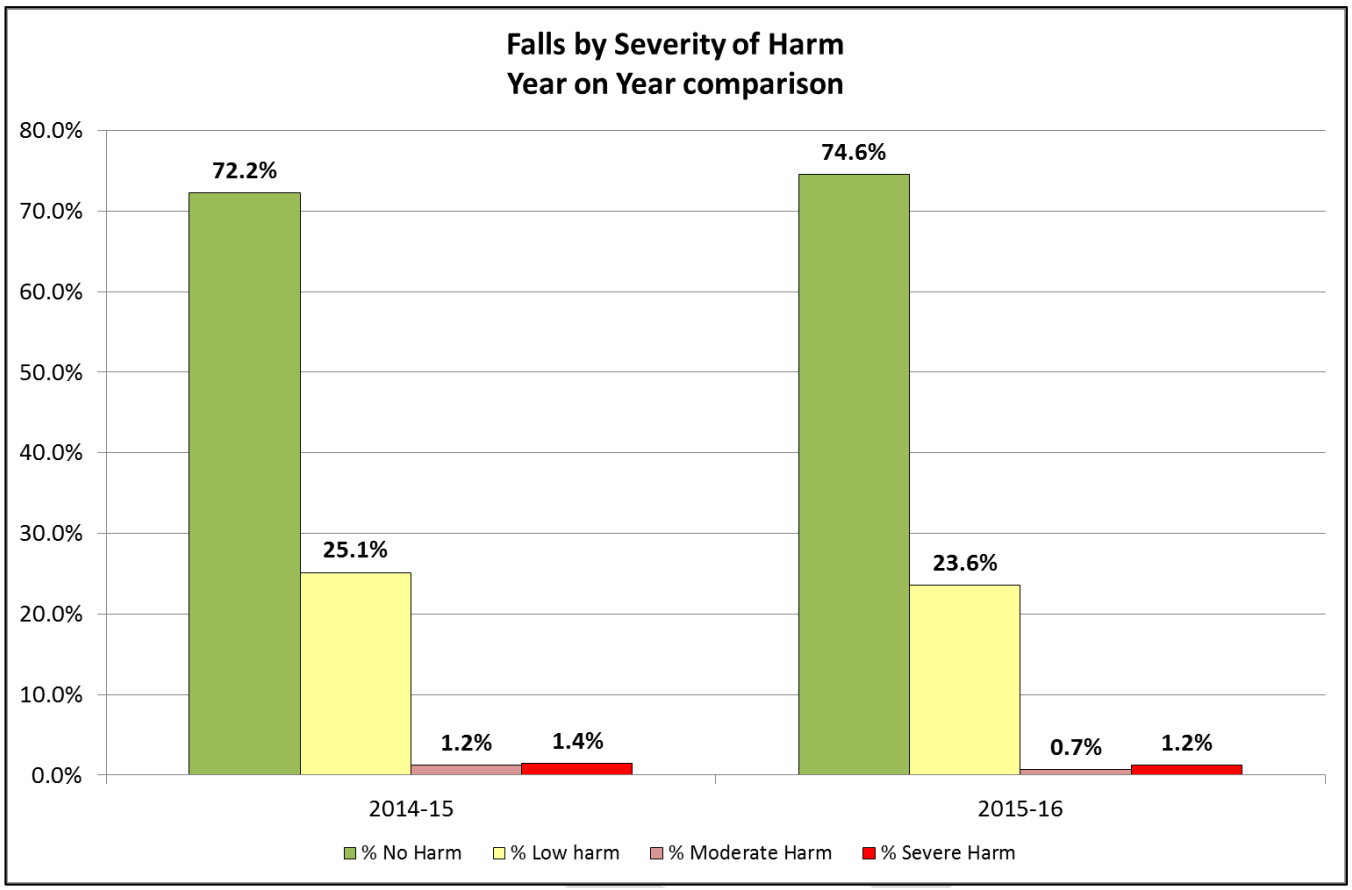
- Appointing a new strategic falls lead in January 2016 to re-energise implementation of the inpatient falls strategy 2014/17.
- Reviewing and refreshing our falls reduction strategy to help steer us to reduce harmful 'in hospital'

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.

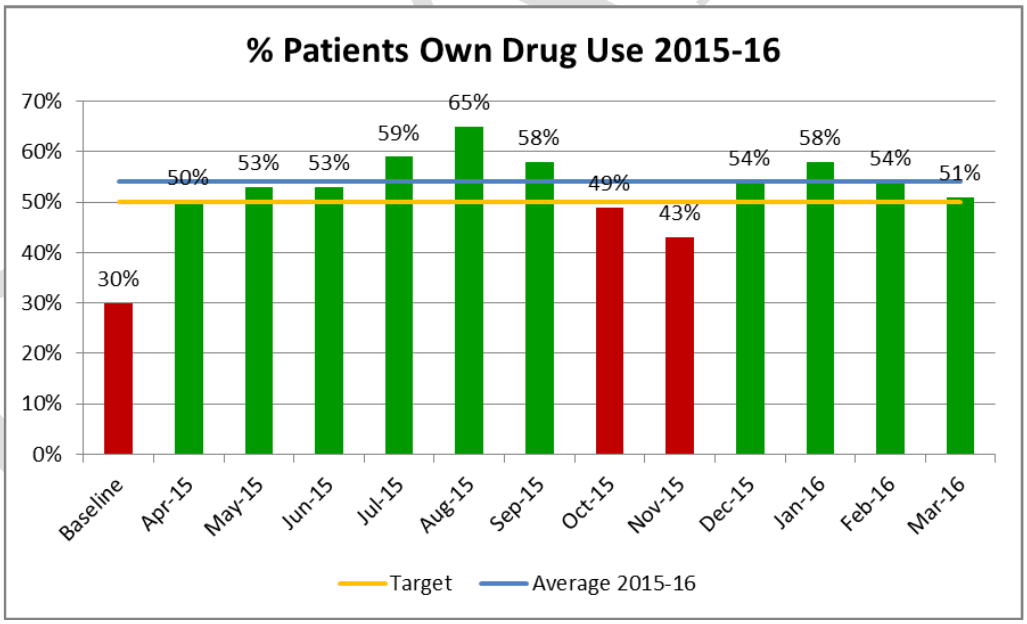
Did we achieve this?

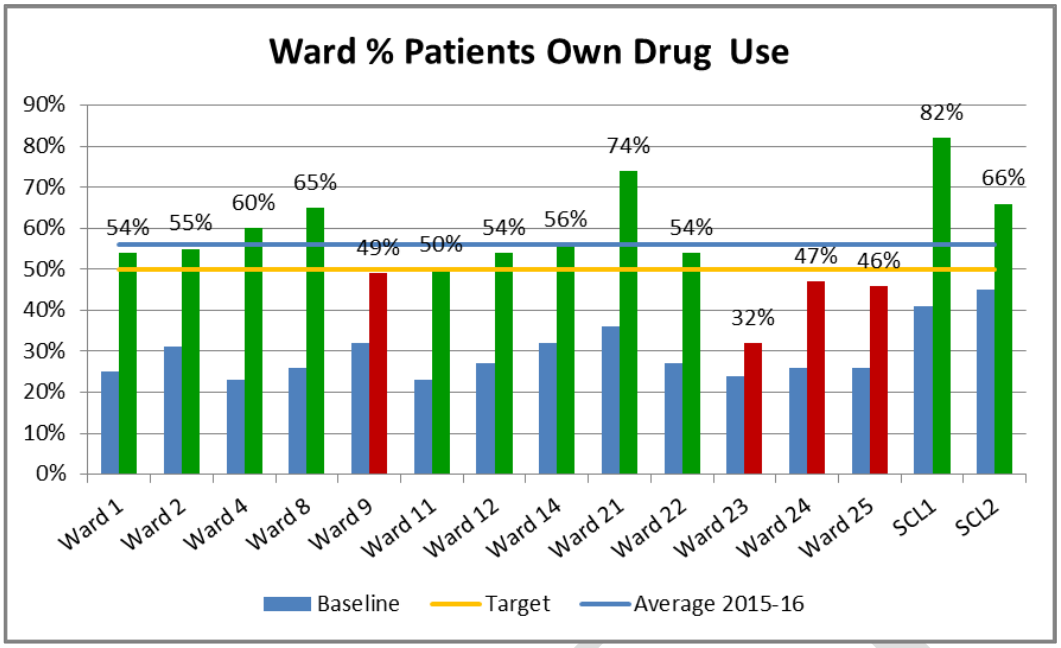
We increased the usage of patient's own drugs within the hospital to an average of 54% across 2015/16.

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):

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.

Patient Reported Outcome Measures (PROMS)

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

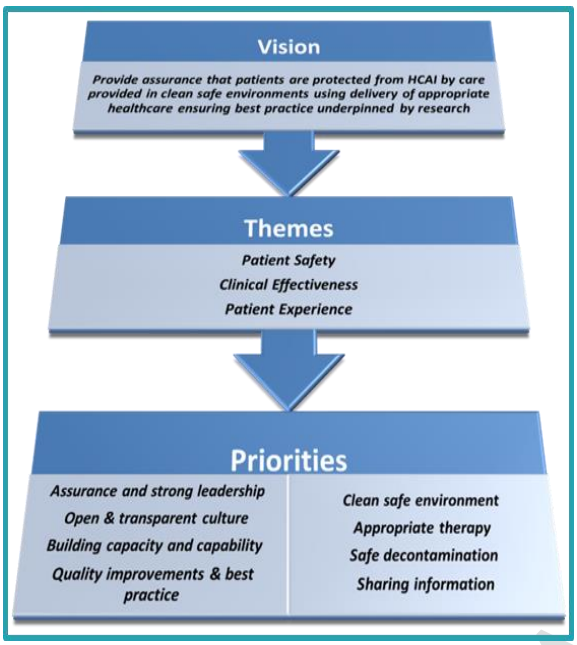
Nurses and Midwives are at the centre of effective prevention and control of infection.

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:-

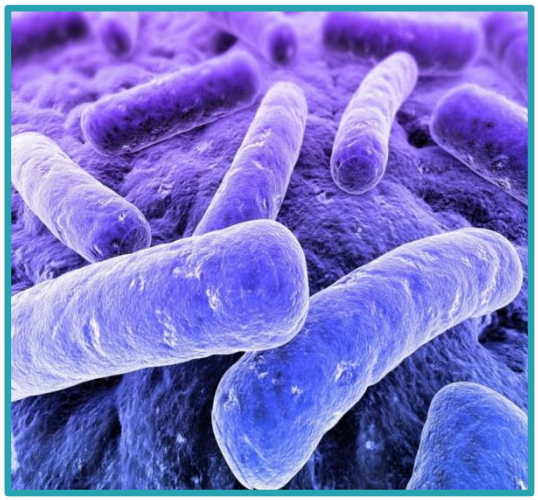
- Newcastle Gateshead Alliance HCAI Reduction Partnership
- Cumbria and North East HCAI Steering Group
- North & South of Tyne Area Health Protection Group

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

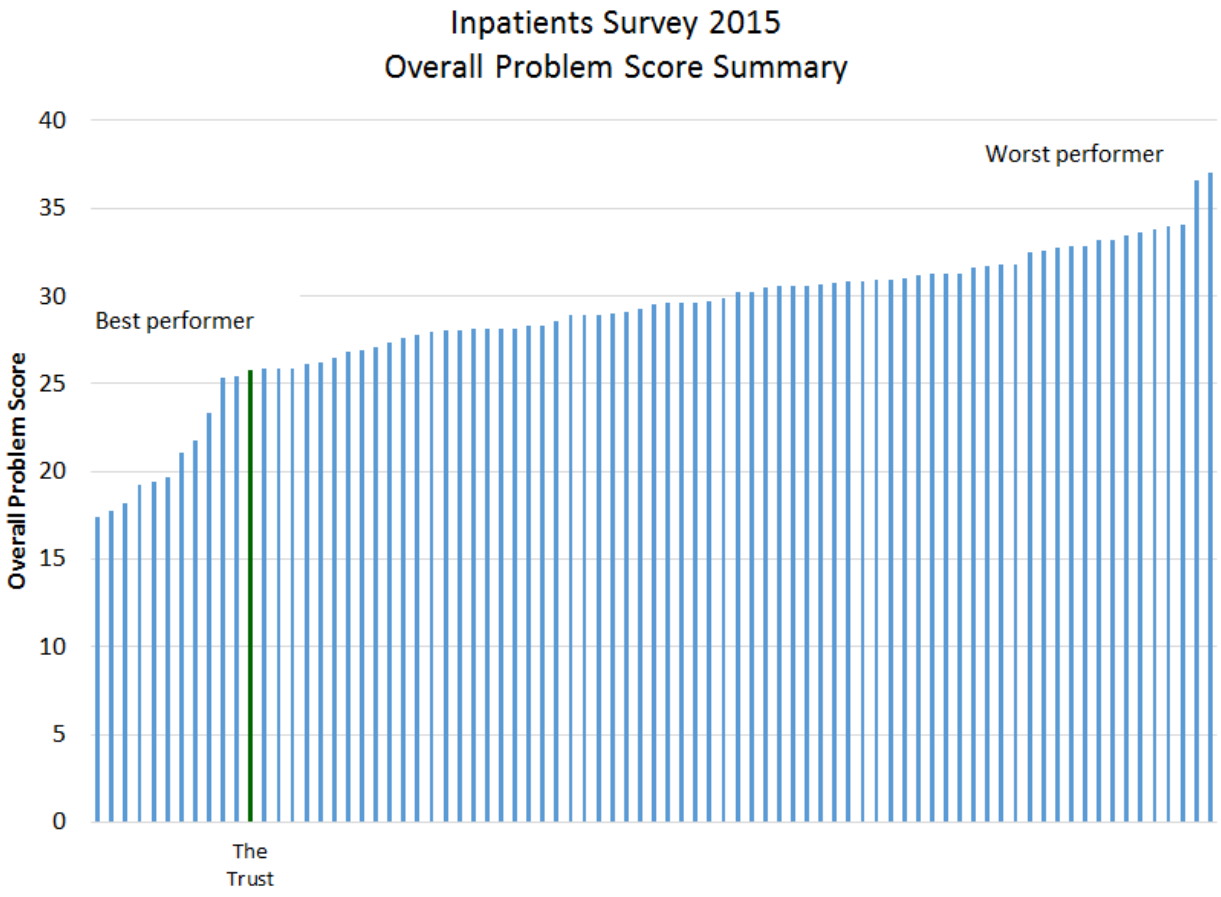
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**National***
% would recommend	100	100	100	100	100	100	100	100	100	100	100	100	87
% would not recommend	0	0	0	0	0	0	0	0	0	0	0	0	5

*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.

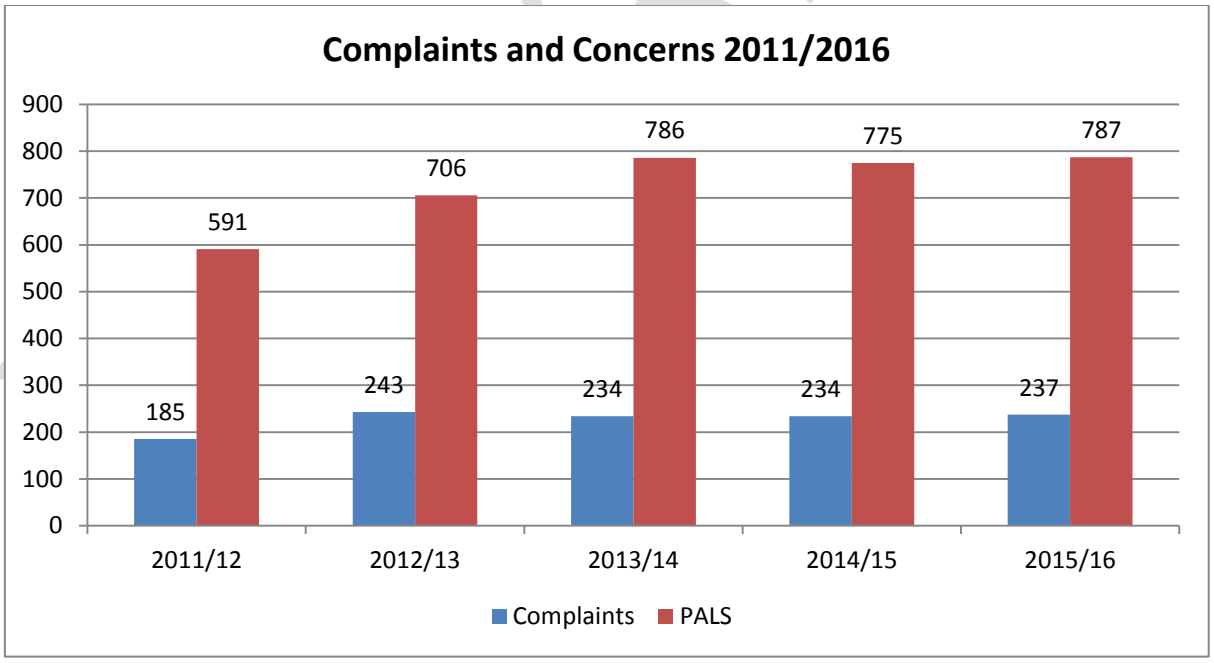
Listening to Concerns and Complaints

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