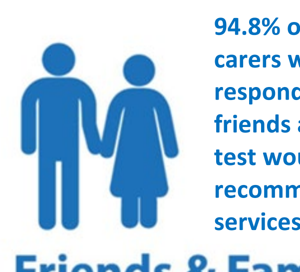
Quality Account

Gateshead Health NHS Foundation Trust 2019/20

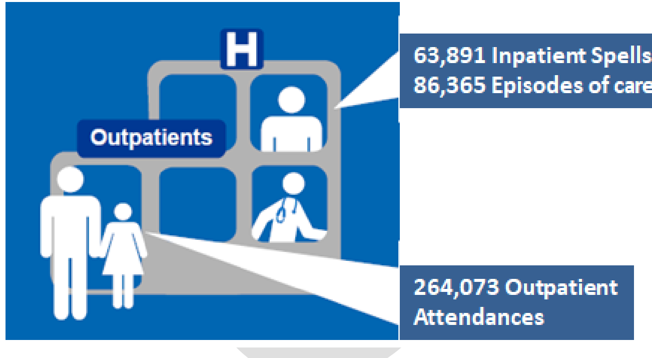
Gateshead Health NHS Foundation Trust at a glance...

Good with
Outstanding for Caring



94.8% of patients and carers who responded to the friends and family test would recommend our services

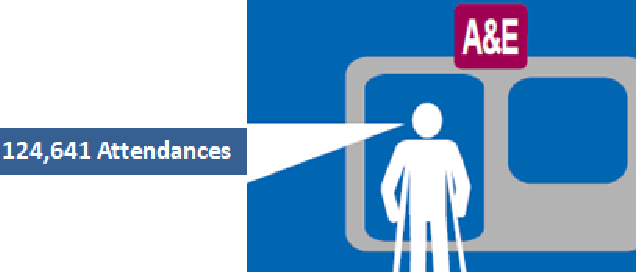
Friends & Family Test



63,891 Inpatient Spells
86,365 Episodes of care

264,073 Outpatient Attendances

1,888 births



124,641 Attendances

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Part 1

Quality Account – Chief Executive's Statement

1.Statement on Quality from the Chief Executive

Our approach to Quality: An introduction to this Annual Quality Account from the Chief Executive

I am delighted to introduce the Gateshead Health NHS Foundation Trust Quality Account for 2019/20, which is an excellent demonstration of the Trust's continuing commitment to provide high quality, patient focused care. Our ambitious two year Quality Improvement Strategy was launched in 2019, which set out our quality objectives for 2019/21, enabling us to deliver the highest standard of care possible, within a strong safety culture and an ethos of shared learning. Feedback from our patients over the last 12 months shows that 94.8% of our inpatients would recommend our care to their family and friends and 88% of our inpatients rated the care we provided to them at 7/10 or above.

The Quality Account details the progress we have made against our priorities over the last year, in addition to outlining our plans to achieve these during 2020/21, and aims to build on what we have achieved so far within a culture of continuous improvement.

It goes without saying that the Covid-19 pandemic has posed profound and unprecedented challenge to the NHS as a whole, and has had an extraordinary impact on the way health services were and will be delivered in the future. Due to the professionalism, hard work and unfaltering dedication of our staff, the emphasis has remained on providing high quality care to our patients throughout the response and recovery phases of the pandemic. We are committed to hearing the views of staff and patients as to what their experiences are of the innovative changes in care and treatment pathways we have implemented, to ensure that these are inclusive and accessible to all who need them.

With regards to the quality priorities we set ourselves for 2019/20, we performed very well in our priority around improving mortality reviews and implementing the medical examiner system. 79.9% of patient deaths received a level 1 review in 2019/20, with 67.2% of these being undertaken within 60 days of the patient's death. This is against a target of 80% in 60 days by March 2021. Processes and pathways have been scoped and developed in relation to the Medical Examiner System and all of the personnel successfully recruited, and I am delighted to confirm that the system will go live in September 2020.

One of our patient safety priorities was to involve patients and families in patient safety, and the deployment of Family Liaison Officers to patients and/or their families involved in patient safety incidents and complex complaints has been another key success this year. The Trust has trained 27 members of staff as Family Liaison Officers, and they have supported 25 families during 2019/20.

Another of our quality priorities is 'making every contact count', which is about making the most of each interaction we have with our patients, ensuring the care we deliver is linked to wider public health issues and taking every opportunity to improve the health and wellbeing of the population of Gateshead.

It is with pride that I note we received an award in October 2019 for our commitment to making sure that staff are able to speak up when things go wrong. We were commended after achieving the highest Freedom to Speak up Index score in the Combined Acute and Community Trust category. It is vital that our people feel able to speak up without fear of reprisal. Not only does this show that we value and trust our staff, it will ultimately make all NHS services safer for patients.

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I would like to end by thanking and commending all of our staff. Without their skill, loyalty and commitment we would not be able to achieve such high quality services. Their dedication and focus remains firmly on ensuring the very best outcomes for our patients.

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

Signed

Mrs Y Ormston, MBE
Chief Executive Date:

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What is a Quality Account?

The NHS is required to be open and transparent about the quality of services provided to the public. As part of this process all NHS hospitals are required to publish a Quality Account (The Health Act 2009). Staff at the Trust can use the Quality Account to assess the quality of the care we provide. The public and patients can also view quality across NHS organisations by viewing the Quality Accounts on the NHS Choices website: www.nhs.uk.

The dual functions of a Quality Account are to:

- Summarise our performance and improvements against the quality priorities and objectives we set ourselves for 2019/20.
- Outline the quality priorities and objectives we set ourselves going forward for 2020/21.

Review of 2019/20 quality information

LOOK BACK

Set out quality priorities for 2020/21

LOOK FORWARD

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Part 2

Quality Priorities

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2. Priorities for Improvement

2.1 Reporting back on our progress in 2019/20

In our 2018/19 Quality Account we identified 12 quality improvement priorities that we would focus on in 2019/21. This section presents the progress we have made against these in the first year.

PATIENT EXPERIENCE:

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

- What did we say we would do?

In 2019/20 we planned to reinvigorate our volunteer's service in order to release time to care for staff across the Trust acute and community. In 2020/21 we will spread the use of the NHS England 'Always Events® methodology as a tool to understand what is important to patients, to ensure that it should always happen when patients are under our care

- Did we achieve this?

During 2019/20 we achieved the majority of our aims to reinvigorate the volunteer's service.

- Progress during 2019/20:

Response Volunteers

The Trust secured £25k funding from NHSI and launched a 'Response Volunteers' programme with the aim of helping to alleviate winter pressures. We have taken a modular approach to developing the Response Volunteering programme – identifying particular volunteer roles that could have maximum impact first and adding to responsibilities over time. These Response Volunteers hold a mobile device to be contacted upon and are made available to the Senior Nurse on call. Volunteer tasks could include transporting patients between appointments, making beds, supporting discharge and collecting medication from pharmacy to enable patients to be discharged quicker. Plans are being developed for response volunteers to receive training from the Pharmacy team with regards to supporting discharge medication.

The programme aims to:

- Save clinical staff time by delivering take home prescriptions
- Enable patients to be discharged faster
- Create additional, flexible, support to staff on wards and in the emergency department
- Improve patient flow
- Support frontline staff

Volunteer Recruitment and Training

Advertisements for various volunteer roles within the Trust (including the 'Response Volunteers') are on the NHS Jobs website. Thirty new volunteers have joined the Trust in the first six months. A streamline volunteer recruitment process has been implemented which includes a revised shorter application form. The Workforce Department now manage the entire process for volunteer recruitment.

All volunteers including chaplaincy volunteers now attend the Corporate Induction programme. In addition, a bespoke volunteer training programme is under development. This will include dementia awareness, conflict resolution, infection control awareness and nutrition awareness.

Partnership working with NHS Business Authority

An innovative use of the 'Clinical Passport Scheme' (a form that allows employees from other NHS organisations to work elsewhere within the NHS) has been initiated between the Trust and NHS Business Authority (NHSBA) Newcastle. This provides the Trust with a significant opportunity to increase the number of volunteer hours facilitated to ensure that they are working in a purposeful way.

The Patient Experience and Volunteer Manager has attended NHSBA and held a welcome session prior to the first cohort of volunteers attending the Trust. The first cohort dedicated their time to gardening in St. Bedes courtyard over one week, enhancing the outside space that patients, families and carers are able to access throughout their care. Volunteering from NHSBA was anticipated to be facilitated on a bi-monthly basis initially, however due to Covid-19 there is a hold on welcoming the next cohort of NHSBA volunteers back on-site.

Impact of Covid-19 on volunteer's service

Covid-19 has impacted on the number of volunteers who are attending the Trust. This is due to the volunteer's personal preference as well as based on Trust Risk Assessments which have been completed by all volunteers. This has resulted in a significantly lower number of volunteers who are regularly on-site. The Trust remains in regular contact with those volunteers who are currently not on-site in the form of well-being telephone calls.

Evidence of achievement:

- £25k funding secured from NHSI
- 30 new volunteers have joined the Trust between October 2019 and March 2020
- Partnership working with NHSBA has resulted in a cohort of NHSBA staff volunteering at the Trust on rotational basis

Next steps:

- Continue with volunteer recruitment to increase volunteer numbers to reach our target of 100 by March 2021.

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- Evaluate the Response Volunteer Programme once fully embedded to demonstrate its effectiveness.
- Develop further volunteer training based on individual role profiles.
- Roll out of in-house Always Events® Training Programme to a second cohort.
- Work with the ward team to progress their Always Event® based on their co-design data.
- Look to develop an Always Event® with the community Speech and Language Team based on the data from their in depth patient experience work.

Priority 2: We will ensure that patients, carers and the public are engaged in our Quality Improvement work and that patient, carer and public involvement is embedded as business as usual across the organisation

What did we say we would do?

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

Did we achieve this?

These objectives were to be achieved by March 2021.

Progress in 2019/20:

- A monthly Patient Involvement Forum has been established and this has been advertised on social media and within the Trust Members bulletin. The first meeting took place in September 2019 with attendance from patients/volunteers with staff providing information about their initiatives.

- Specific projects which may benefit from having a patient representative as a key stakeholder have been identified. These will be discussed at the Patient Involvement Forum over the coming months.

Evidence of achievement:

Patient representatives have been recruited to a number of initiatives including the Patient Information Review Panel (looking at leaflets and printed information), a Nutrition work stream and steering group, an audit group, the Complaints Review Panel as well as two representatives to the Values Based Recruitment working group and two joining the wider work surrounding Outpatients Transformation.

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- Next steps:
  - Continue to advertise the Patient Involvement Forum internally and externally and facilitate these meetings.
  - Continue to embed engagement and involvement with patients, carers and the public to ensure that this way of working is business as usual across the organisation.

Priority 3: Improved experience for our mothers, babies and their families

- What did we say we would do?

In 2019/20 we planned to offer access to the patient portal 'your care in our hands' to all mothers who book with us and begin the implementation of the Continuity of Carer model for a group of mothers. In 2020/21 we will continue to embed the model into practice.

- Did we achieve this?

Our priorities are over two years, therefore full achievement by March 2021.

- Progress in 2019/20:
  - Successful recruitment enabled us to appoint six midwives for Continuity of Carer team and areas identified where our poorest outcomes originate.
  - To support identification of the most vulnerable women and to measure their outcomes we made changes to the existing booking process for women being added into Continuity of Carer model.
  - The Patient Portal 'your care in your hands' was offered to all mothers who book with the Trust, with 84% of women accessing their maternity records digitally.
  - We significantly improved our engagement via two routes; development of the Maternity Voices Partnership (MVP) and continued work to develop our social media impact.
  - Community Hubs were agreed and we successfully secured funding for the refurbishment of rooms to facilitate clinical duties. However, this work has been paused during Covid-19.

- Evidence of achievement:
  - Due to successful recruitment we have a staff in place for continuity of carer caseloads.
  - Our development of the MVP has resulted in increase in social media use, evidenced through our growing Facebook page which now has 294 members.
  - Quarterly reports from MVP are provided to the Head of Midwifery.
  - Funding for the project has been extended and secured until 2021.
  - The MVP group has had its first meeting and virtual meetings are planned in coming months.
  - Patient information - Smart leaflets now on maternity badger patient portal.

- Next steps:
  - Further plans with staffing and the community teams to begin to include intrapartum care by March 2021.
  - Work to be completed on Community Hubs to enable these to be ready for use by the teams.
  - To continue to develop collaboration between the Trust and the MVP group.

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- Continue to offer access to the patient portal 'your care in your hands' to all mothers who book with us.

PATIENT SAFETY:

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

and

Priority 5: We will promote a just, open and supportive learning culture across the organisation

What did we say we would do?

- During 2019/20 we planned to focus on the objectives within Priority 4 by raising awareness of human factors within the organisation, developing a patient safety investigation training programme, developing innovative ways to involve staff, patients and families in patient safety and to work with NHSI on patient safety collaboratives.
- In 2020/21 we will focus on Priority 5 by implementing and embedding the principles of a just and restorative culture across the organisation, adopting a Safety II (a learning from when things go well) approach to patient safety within the organisation and aligning this work to Freedom to Speak Up Guardian role

Did we achieve this?

- We have achieved the majority of the objectives with Priority 4; however Covid-19 caused disruption and postponement to some of the planned activities. Priority 5 is to be achieved by March 2021.

How we achieved it:

- Human Factors awareness has been raised initially through providing staff with updates in QE Weekly and the Medical Director Bulletin. The Patient Safety Team collaborated with the Clinical

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Business Units to support them in moving away from the traditional Root Cause Analysis approach to investigating incidents resulting in moderate harm and above towards adopting the Human Factors approach through attending a range of departmental meetings. The Clinical Commissioning Group (CCG) was advised of this change in approach through a presentation which was shared during a Quality Review Group meeting.

- The Patient Safety Team, in collaboration with the Medical Education Programme Manager, developed a Human Factors training session for those staff with responsibility for undertaking patient safety incident investigations; this training is aimed at staff who investigate incidents resulting in moderate harm and above.
- The Human Factors report template for investigating serious incidents was introduced initially for incidents excluding falls and pressure damage; however this has since been evaluated and amended based on users feedback.
- In December 2019, the Trust Falls Group adapted the template to ensure that information relevant to investigating patient falls is captured whilst ensuring the investigation has a systems-based focus.
- In September 2019, the Trust hosted its second Patient Safety Conference at the Newcastle Gateshead Marriot Hotel which was attended by 105 delegates from the Trust. This included a breakout session for delegates which focused on the theory underpinning Human Factors and their relevance to patient safety incident investigations.
- Invitations to the Patient Safety Conference in September were directed towards frontline staff to provide patient-facing colleagues with the theory underpinning the contemporary theories linked to improving patient safety.
- The first World Patient Safety Day took place in September 2019 and the Trust used this as an opportunity to showcase a number of patient safety initiatives taking place throughout the organisation through poster displays and stalls. The human factor approach in investigations for patient safety incidents was promoted and we also provided an example of how Human Factors have been introduced into a number of national safety campaigns relating to theatre safety.
- The Trust is represented at a regional level at each of the following groups/committees - the Faculty of Patient Safety; the Human Factors Network Steering group and the Simulation Steering group to participate in region-wide sharing of best practice in these areas.
- In order to promote transparency and shared learning and also to provide an element of objectivity and challenge to decision-making within the Serious Incident Review panel process, clinicians from the Business Units are encouraged to attend panel meetings. The Terms of Reference for this panel have been amended to reflect this requirement.
- Additional Family Liaison Officer (FLO) training has been provided to staff from across the Trust during September and October 2019.
- The Patient Safety Team introduced the role of the Patient Safety Partner in August 2019 to a group of volunteers, to gauge interest and explore what this may look like in practice.
- To enable staff to undertake safety collaboratives in their workplace, the first 'Introduction to Quality Improvement' programme was launched in April 2019, using NHS QI tools: participants from both clinical and non-clinical backgrounds were involved. The aim of this programme was to provide staff with the ability to critically appraise current processes and pathways, identify areas that required improvement and then apply the most appropriate methodology to implement and evaluate changes.

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- The Trust has been part of NHSI Nutrition and Hydration Collaborative and Wave 2 of the Maternity and Neonatal Safety Collaborative. Both collaboratives have seen improvements for patients and the work continues to ensure a sustainable improvement journey.
- A Falls Collaborative was introduced onto a number of clinical areas identified as having a high number of falls: the Senior Clinical Improvement Leads team worked with ward staff to develop training and raise awareness of a number of factors designed to prevent inpatient falls.

Evidence of achievement:

- Independent feedback from Newcastle/Gateshead CCG regarding the Human Factors approach taken by the Trust has also been very positive, and the improved quality of completed investigation reports and subsequent learning from these has also been recognised.
- Formal training records of Human Factors Investigation training sessions which have taken place on a bi-monthly basis to members of the multidisciplinary team until the beginning of 2020 which were then disrupted by the Covid-19 pandemic.
- The Human Factors template has been well received by staff and the CCG as it guides the investigating team towards making recommendations and identifying learning based upon the systems and processes involved in a patient safety incident and not on the individual. This template has also been shared regionally with the Human Factors Network Steering Group to assist with the development of a system-based approach to incident review.
- A number of Trust staff have attended external Human Factors programme provided by the Patient Safety Faculty and Oxford University which has further developed the knowledge and skillset within the organisation.
- The Trust participated in a regional Quality and Safety Conference in November 2019 to showcase the learning which was identified by using a Human Factors investigation approach following a Never Event.
- The Serious Incident Review Panel has been strengthened by the attendance of a wide range of clinical staff including Rheumatology, Accident and Emergency Medicine, Anaesthetics, Care of the Elderly, Gynae-oncology, Trauma and Orthopaedics, General Surgery, Palliative Care, Old Age Psychiatry and Paediatrics.
- A second cohort of staff have been trained to work as Family Liaison Officers, with 27 staff now being able to fulfil the role; they have supported 25 families through both serious incident and complex complaint investigations.
- The deployment of Family Liaison Officers is now fully embedded within the patient safety investigation process: FLOs also attend the Serious Incident Review panel to ensure discussion and decision-making is focused towards recommendations being patient-centred.
- 19 staff successfully completed the Trust's QI programme, presenting their quality improvement projects to an audience of Trust staff in July 2019.

Next steps:

- Develop the reporting template to ensure its suitability for pressure damage investigations and also collaborate with Pharmacy and Infection Prevention and Control to ensure investigations follow a standardised process.
- To deliver shorter but more frequent human factors training – incorporating the reporting requirements / timescales of the Strategic Executive Information System (StEIS) and the role of the Family Liaison Officer with serious incidents.
- To ensure all patients involved in serious incidents are supported by FLOs, further training will take place during 2020.

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- Collaboration between with the Patient Safety and Patient Experience teams is required to progress the Patient Safety Partnership initiative, working with volunteers and patient representatives.
- Identify Falls Champions within the inpatient environment.
- Deliver falls prevention training to staff delivering enhanced care to patients.

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

What did we say we would do?

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

We will do this by:

- March 2021:
  - 80% of patient deaths will have received a Level 1 review within 60 days of death
  - 100% of patient deaths identified within the National Quality Board Learning from Deaths guidance receive a Level 2 review by the Mortality Council
  - A random quality assurance check will be undertaken on 5% of cases reviewed at Level 1
  - Share lessons learned, good practice or areas for improvement and actions identified throughout the Trust
  - Investigate any national alerts and implement any corresponding recommendations for improvement
  - We will implement a Medical Examiner Service within the Trust.

Did we achieve this?

These objectives were to be achieved by March 2021.

Progress in 2019/20:

- 79.9% of patient deaths received a level 1 review in 2019/20; of these 67.3% were undertaken within 60 days of death. This has since decreased significantly due to Covid-19 and resources being deployed into clinical areas.
- Of the 128 patient deaths which were identified for a Level 2 review, there has been a review of 122 (95.3%). 113 (88.2%) cases have been fully reviewed and had their final mortality score, and nine cases required further action before their review can be complete. Six cases remain on the case list for review. It was identified in 2019 only mental health patients who had been detained under the Mental Health Act had received a review. A process to ensure that we capture and review all deaths is currently underway.
- 94% of random quality assurance checks have been undertaken on cases reviewed at Level 1
- Lessons learned and actions have been shared throughout the Trust – see section 2.4. Specific lessons learned are shared within the monthly Integrated Quality & Learning Report.
- No national alerts relating to mortality were received by the Trust in 2019/20.
- In April 2019, an improvement event was held to design and develop processes for the Medical Examiner Service. Medical Examiners are NHS doctors, who have undertaken specialist training, and part of their role is to give independent advice into causes of death; they offer families and

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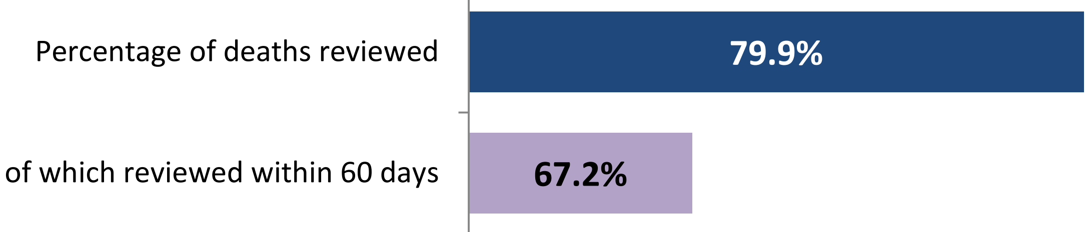
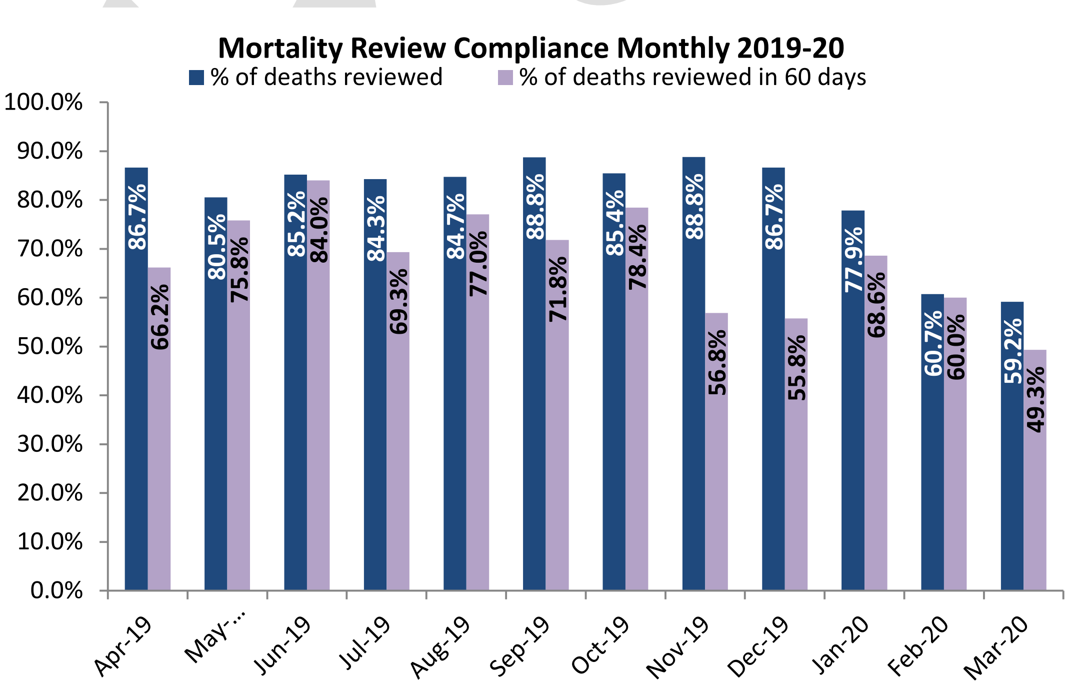
carers an opportunity to raise questions or concerns about the cause of death of a loved one or about the care they received beforehand. Medical Examiners can help explain medical language to make it easier to understand and will look at the relevant medical records and discuss the cause of death with the doctor who has completed the Medical Certificate of Cause of Death.
The Lead Medical Examiner, Medical Examiner and Medical Examiner Officer roles have now been successfully appointed to. The roll out of the service was interrupted and delayed by Covid-19. Therefore the service will be rolled out incrementally across the Trust from September 2020, to ensure sufficient opportunities for learning and refinement of the process.

Evidence of achievement:

Mortality Review Compliance 2019-20





Deaths reviewed – Hogan and NCEPOD Scores:

Deaths reviewed
79.9%

Hogan 1 - Definitely Not Preventable	Hogan 2 - Slight Evidence of Preventabiliy	Hogan 3 - Possibly Preventable (Less than 50:50)	Hogan 4 - Probably preventable (more than 50:50)	Hogan 5 - Strong Evidence Preventable	Hogan 6 - Definitely Preventable	Potentially avoidable deaths
98.1%	1.3%	0.5%	0.11%	0.0%	0.0%	0.1%

NCEPOD Score 1 Good Practice	NCEPOD Score 2 Room for improvement - Clinical Care	NCEPOD Score 3 Room for Improvement - Organisational Care	NCEPOD Score 4 Room for Improvement Clinical and Organisational Care	NCEPOD Score 5 Less Than Satisfactory	NCEPOD score 6 Insuficient data	No Score Allocated
82.7%	4.2%	8.8%	1.6%	0.0%	1.4%	1.4%

The Hogan score is used to determine the likelihood that a patient's death was preventable. The key determinant is to identify patients where the possibility that the death was preventable is more than 50/50.
The NCEPOD (National Confidential Enquiry into Patient Outcome and Death) grading system is used by case reviewers to grade the overall care each patient received; it is used at Mortality reviews to aid the assessment of quality of care provided by the Trust.

Next steps:

- The Covid-19 pandemic has resulted in a decrease in the number of level 1 mortality reviews undertaken, impacting on the opportunities to learn from deaths and improving patient safety. Communications have been circulated via the Medical Directors Office and a meeting held to discuss ways to support the Business Units to increase compliance. Ward level data has been shared in SafeCare Meetings to highlight the current position and facilitate discussion for improvement. Wards within the Trust identified as having low compliance are those who responded to the Covid-19 pandemic, function and staffing changed multiple times creating difficulties in identifying the team to undertake the level 1 review. Multidisciplinary review panels will be set up where a team cannot be identified.
- Agree process for reviewing deaths of patients with severe mental illness and monitor compliance.
- Evaluate success of the implementation of the Medical Examiner service, by providing quarterly updates to the Mortality & Morbidity Steering Group.

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Priority 7: To support the national ambition to halve the rates of still births, maternal deaths, neonatal deaths and brain injuries

What did we say we would do?

During 2019/20 we planned to implement and develop the Saving Babies Lives Care Bundle, and ensure compliance with the 10 CNST (Clinical Negligence Scheme for Trusts) Safety Actions. This is a scheme run by NHS Resolution (our Indemnifiers) that incentivises Trusts to improve the safety of maternity care. If Trusts can demonstrate they are compliant with 10 maternity safety actions, they will be eligible for a 10% discount of their maternity premium.

Did we achieve this?

These objectives were to be achieved by March 2021.

Progress in 2019/20

- We fully implemented Saving Babies Lives (SBL) care bundle version 1 and are fully compliant with all elements of this. The Care Bundle brought together four key elements of care that are recognised as evidence based and/or key practice, which are reducing smoking in pregnancy, risk assessment for fetal growth restriction, raising awareness of reduced fetal movements and effective fetal monitoring during labour.
  - This includes the development and updating of guidelines and practice to reflect the necessary changes to frequency of ultrasound scans and antenatal appointments.
  - Updated staff training in Sonography has been delivered.
  - The revised CNST guidance was received in January 2020, however due to covid-19 the scheme was paused in March 2020 and we are awaiting confirmation of new timescales and evidence.

Evidence of achievement:

- Lead midwife for Quality, Risk and Safety was appointed in May 2020.
- All sonographers have completed specialist training in measuring the blood flow between the mother and the baby during pregnancy, in compliance with Saving Babies Lives care bundle version 2, which in addition to the four elements of care in version 1, also focuses on fetal growth restriction.
- Smoking cessation referrals continue within the current restrictions. National guidance has paused carbon monoxide monitoring due to Covid-19.
- 700 licenses were made available for pregnant women and their partners to enable them to provide 9 months of premium access to the Smoke Free app, featuring 24/7 access to National Centre for Smoking Cessation and Training (NCSCT) advisors.
- We achieved 100% compliance with the 10 CNST safety actions in 2019.

Next steps:

- To await the revised timescales for submitting evidence to NHS Resolution regarding the 2020 CNST safety standards. In the meantime we will continue working towards the achievement of these.

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CLINICAL EFFECTIVENESS:

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

What did we say we would do?

We will ensure robust processes are in place to set and deliver on the National Commissioning for Quality and Innovation (CQUIN) to ensure that our patients receive the best high quality and innovative service as possible.

Did we achieve this?

We achieved eight of the ten CQUIN indicators as at the end of quarter 3 2019/20. The Clinical Commissioning Group (CCG) have confirmed that the CQUIN scheme is on hold due to Covid-19, submissions were not required for quarter 3 and quarter 4 and there will be no financial loss to the Trust. Data collection ceased at the end of quarter 3 due to Covid-19.

Progress in 2019/20:

Leads were identified for each indicator and work plans were agreed. Progress against the work plans was monitored on a regularly basis with the leads to ensure that any issues were highlighted and increased support and resources were provided where necessary. A quarterly monitoring paper was developed to provide assurance to both the Quality Governance Committee and the CCG.

Evidence of achievement:

CQUIN 2019-20 Performance	Payment Levels	Q1	Q2	Q3	Q4	Total
CCG1a - Antimicrobial Resistance - Lower Urinary Tract Infections in Older People	60%-90%	37%	50%	37%		41%
CCG1b - Antimicrobial Resistance - Antibiotic Prophylaxis in Colorectal Surgery	60%-90%	96%	89%	92%		92%
CCG2 - Staff Flu Vaccinations	60%-80%				81%	81%
CCG3a - Alcohol and Tobacco - Screening	40%-80%	77%	79%	87%		82%
CCG3b - Alcohol and Tobacco - Tobacco Brief advice	50%-90%	91%	82%	94%		89%
CCG3c - Alcohol and Tobacco - Alcohol Brief advice	50%-90%	63%	59%	90%		73%
CCG7 - Three high Impact actions to prevent falls	25%-80%	29%	4%	3%		12%
CCG11a - SDEC - Pulmonary Embolus	50%-75%	87%	96%	98%		95%
CCG11b - SDEC Tachycardia with Atrial Fibrillation	50%-75%	88%	97%	99%		95%
CCG11c - SDEC Community Acquired Pneumonia	50%-75%	96%	100%	88%		92%

Further detail on the two CQUINs that were not achieved is provided below:

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CCG1a - Antimicrobial Resistance - Lower Urinary Tract Infections (UTI) in Older People
Compliance relied on achieving 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE diagnosis of UTI guidance in terms of diagnosis and treatment:

1. Diagnosis of lower UTI based on documented clinical signs or symptoms
2. Diagnosis excludes use of urine dip stick
3. Empirical antibiotic prescribed following NICE guideline (NG109)
4. Urine sample sent to Microbiology

The Trust achieved compliance with some of the individual elements, however not overall compliance. An extensive programme of work was undertaken in relation this CQUIN:

- Teaching sessions in a number of forums including the FY1, FY2 and care of the elderly.
- The Trust antimicrobial policy document and app were updated.
- Ongoing ward based education / publicity / feedback on performance.
- Central focus around 'world antibiotic awareness week and European antibiotic awareness day', Nov 2019. Posters and 'educational aids' developed by pharmacy and delivered to all ward areas.

The overall compliance in the first two quarters was higher than the national average. However compliance in Q3 declined as an increase in the number of urine dips was used to diagnose UTIs and a fall in the number of urine samples sent for culture and sensitivities was observed (from 100%).

CCG7 – Three high Impact actions to prevent falls
Compliance relied on achieving 80% of older inpatients receiving all 3 key falls prevention actions:

1. Lying and standing blood pressure recorded at least once.
2. No hypnotics or antipsychotics anxiolytics given during stay OR rationale for giving hypnotics or antipsychotics anxiolytics documented.
3. Mobility assessment documented with 24 hours of admission to inpatient unit stating walking aid not required OR walking aid provided within 24 hours admission to inpatient unit.

The Trust was compliant with actions 2 and 3; extensive work has been identified and undertaken in relation to action 1, as follows:

- Lying and standing blood pressure protocol circulated to all clinical leads for dissemination.
- Lanyard cards, posters and a screensaver have been developed.
- Include written section for recording of lying and standing blood pressure in falls risk assessment pathway and also within new falls risk assessment on Nervecentre/EMIS – electronic patient observation system – this has not yet been incorporated in to Nervecentre.
- Refresher training on correct technique
- Link in with ward managers/teams to engage for their own ideas in how to achieve compliance
- Monthly spot checks of compliance and production of dashboard.
- Session on clinical days dedicated to Falls prevention was scheduled for April 2020, unfortunately due to Covid-19 this was unable to go ahead.

Next steps:

- The CCG have confirmed that the CQUIN scheme for 2020/21 is suspended due to Covid-19. No data submissions required to allow Trusts to focus on recovery and reinstatement of services.
- Identify Falls Champions within the inpatient environment.
- Continue with the development of the electronic falls assessment for inpatients.
- Deliver falls prevention training to staff undertaking enhanced care.

draft

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

➢ What did we say we would do?

In 2019/20 we planned to increase our commitments to taking part in high quality research, by increasing the number of research projects by 33%, projects being led in with North East and North Cumbria Clinical Research Network, identifying clinical areas previously untapped and offering support with the processes and finally horizon scanning for new local and national studies.

➢ Did we achieve this?

These objectives were to be achieved by March 2021.

➢ Progress in 2019/20:

The number of participants recruited across all specialities was 1,030 compared to 1,255 in 2018/2019. The Trust opened 48 new research studies (6 less than 2018/2019).

Further information on the Trust's research activity can be found on page 57.

➢ Evidence of achievement:

We have not yet achieved our objective of increasing the number of research projects during 2019; this is similar to other Trusts within the region and some of the reasons for this are beyond the Trust's control. This includes large recruiting studies closing at the same time across the region, and no similar big recruiting studies taking their place. There was also a lack of studies available for different specialities, which was a national problem and therefore this remains an area for improvement during 2020/21.

- The PREP (MS-E-CIG) was congratulated for their excellent research activity for the year 2019/20 and for being the highest recruiting Trust in the whole of the UK with 229 participants.
- The Big Baby Trial Research Team were joint highest recruiting Trust in February 2020.
- The SYMBAD Research Team was congratulated for being the highest recruiting Trust at the end of the recruitment period (March 2020) with 36 participants.

➢ Next steps:

March 2020 was the beginning of the Covid-19 Pandemic and the R&D Team were preparing to set up and take part in the National Urgent Public Health Studies. All 'normal' research was placed on hold.

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Priority 10: Improve Clinical Audit: best practice and compliance to improve patient care and outcomes through systematic review of care and the implementation of changes and review alignment against Healthcare Quality Improvement Partnership (HQIP) Best Practice in Clinical Audit

What did we say we would do?

- Achieve a 'significant assurance' outcome from next internal audit on clinical audit processes.
- Fully engage with the Getting It Right First Time (GIRFT) Programme.

Did we achieve this?

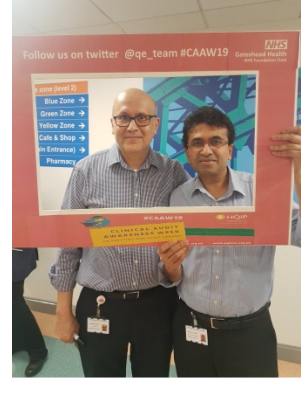
- These objectives were to be achieved by March 2021. The next internal audit on clinical audit processes has not yet been scheduled.

Progress in 2019/20

- The gap analysis against HQIP's Best Practice in Clinical Audit identified that 'Partnership with other health and social care providers and commissioners' and 'Patients, patient representatives, stakeholders and Healthwatch involvement' were areas for improvement.
- The Clinical Audit Manager attended the established Patient Involvement Group in October 2019 and recruited two patients which were willing to give up their time to participate in audit activity within the organisation.
- 'Clinical Audit Awareness Week' took place in November 2019. In the week there was a display stand, multiple drop-in sessions for advice and training and competitions. The aim was to raise awareness of clinical audit and its benefits. The event was a great success with a large amount of interest from all levels of staff throughout the Trust from porters to the Chief Executive. 24 pledges were made by staff to state why they felt clinical audit was beneficial.
- Clinical Audit training sessions are available on a monthly basis and ad hoc for individuals and departments. 35 members of staff have undertaken Clinical Audit training during 2019/20.
- The GIRFT visits went ahead as planned with appropriate presentation at local committees to feedback the details of each visit. Action plans have been developed to implement recommendations made from the visiting teams and monitored by the SafeCare Council.

Evidence of achievement:

Clinical Audit Awareness Week



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GIRFT activity:

Four 'Deep Dive' visits took place during 2019/20 – Geriatric Medicine, Breast Surgery, Rheumatology, Radiology. Four surveys were completed – Pathology, Lung Cancer, Neonatal and Paediatric Workforce, Neonatal Service and Surgical Site Infection Audit. At the onset of the Covid-19 pandemic all GIRFT activity was suspended. This is now gradually being reinstated with the first virtual 'Deep Dive' visit taking place in September 2020.

Next steps:

In 2019/20 participation in national clinical audits reduced to 84% from 91% in 2018/19. To ensure robust governance processes are in place for the participation in National Clinical Audits, the Clinical Audit Manager now meets on a quarterly basis with the local national audit leads to discuss progress within the audits and ensure that data submissions is going as expected and to offer assistance with any problems which may be expected during the year. This new process enables the team to deal with any unexpected issues as they arise rather than retrospectively at the end of the year. The process also includes challenge and scrutiny of the decisions made and agreed in relation to non-participation in National Clinical Audit being made at the Business Unit Level forum.

Priority 11: Implement a transitional care model and enable women to access their care records to improve outcomes for mother and baby

What did we say we would do?

- During 2019/20 we planned to develop and implement a transitional care model, to support mothers to remain beside her baby as the primary care giver, supported by healthcare professionals to provide care for her baby who has additional care requirements but not requiring admission to the Special Care Baby Unit.
- We also planned to develop our electronic records work stream for maternity and neonatal care.

Did we achieve this?

- Yes, the transitional care model was launched in September 2019 and is now fully implemented and forms part of the CNST safety actions.

How we achieved it:

- We identified the teams from Special Care Baby Unit and Postnatal Ward to provide care and to implement the transitional care model. We trained the Advanced Neonatal Practitioners to lead the service and support the Paediatric team. We have trained 5 maternity support workers to support the model of care. Wherever possible infants now remain with their mother.

Evidence of achievement:

- Development and implementation of the Transitional Care Model.
- Reduction in term admissions to SCBU is monitored and audited monthly within the clinical dashboard.
- We have had excellent feedback from our mothers and families via our maternity voices partnership around the quality aspect of this change.
- Patient information - Smart leaflets now on maternity badger patient portal (objective 3)

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- Next steps:
- Develop our electronic records work stream for maternity.
- We will continue to evaluate, refine and monitor clinical improvement indicators for our transitional care model. The impact will be that we will have a reduction of term infants admitted for conditions where they can be treated with their mothers on the postnatal ward and not separated.

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

- What did we say we would do?
- Using the 'make every contact count' brief interventions approach our aim was to advocate behaviour changes for better lifestyles simply by using the millions of day-to-day interactions that organisations and individuals have with other people, therefore we would promote choices for making positive changes to their physical and mental health and wellbeing and to introduce easier access to services for reducing smoking, alcohol in-take eat well, move more and live longer programme.

- Did we achieve this?
- Yes recognising that MECC is everyone's business and that our staff are uniquely placed to give health promotion information we developed the MECC Strategic Group with key stakeholders to oversee the approach across the organisation. The National Institute for Clinical and Health Excellence (NICE) Guidance and resources for MECC are incorporated into a trust action plan.

- How we achieved it:
- We identified a lead for MECC to plan, promote and coordinate plans for increasing this activity across the organisation.
- A MECC training programme was developed and is accessed via the Trust staff development prospectus; to date we have 675 staff who have completed MECC training, covering a 'how to' conversation about smoking, alcohol intake and weight management.
- A further 754 staff have had the 'brief advice smoking cessation' training which is a further hours training specifically around supporting and using Nicotine replacement therapy for inpatients and outpatients.
- We now have 47 stop smoking advisors across the organisation including community, midwives, ward staff, physiotherapists, occupational health, occupational therapists, pharmacy and outpatient staff.
- We have secured 45 carbon monoxide monitors which are now in use as part of the assessment process for referral for nicotine replacement therapy. To maintain our efforts in continuous healthy messages a text messaging service implemented for patients to support stopping smoking has won national recognition with the Health Service Journal and over 600,000 texts have been sent to patients.
- Further support and action has been achieved through the new development and introduction of the QE Facilities Pharmacy Stop Smoking Service available for both patients and staff. We have launched a selection of health promotion apps available for Trust accessible via IPad and smartphones.

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Evidence of achievement:

- Implementation of MECC was a CQUIN indicator for 2019/20; the Trust's performance is displayed in the table below:

CQUIN 2019-20 Performance	Q1	Q2	Q3	Q4
CCG3a - Alcohol and Tobacco - Screening	77%	79%	87%	
CCG3b - Alcohol and Tobacco - Tobacco Brief advice	91%	82%	94%	
CCG3c - Alcohol and Tobacco - Alcohol Brief advice	63%	59%	90%	
Increasing Uptake of Screening Programmes through MECC	100%	100%	100%	

To maintain momentum and share MECC messages Trust wide there is a calendar of health promotion events, they are coordinated by and reported via the MECC strategic group to monitor all activities and record and report attendance and support.

Next steps:

- We are currently developing virtual training with the MECC Gateshead team with the aim that this will be functional by late summer.
- We are also working with the health and wellbeing team to ensure an integrated approach to ensure psychological wellbeing is addressed and also to support our mental health first aiders and mental health champions, in recognition of the impact of Covid-19 on the mental health of our patients as well as our staff.
- MECC is key to ensuring we have staff confident to have conversations and sign post on both physical and mental health concerns with everyone across the organisation ensuring the people of Gateshead thrive.

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2.2 Our Quality Priorities for Improvement 2019/21

We have set 12 key priorities for quality improvement; these are aligned to our Quality Improvement Strategy – Driving Excellence through Quality Improvement 2019/21. These are two year priorities and progress after year one progress is reported in section 2.1.

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

We are also mindful that the Covid-19 pandemic may impact on the Trust's ability to achieve some aspects of the Quality Priorities that were previously set in 2019. We have therefore amended the Quality Priorities to ensure they remain ambitious but are also realistic, in the current circumstances.

PATIENT EXPERIENCE:

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

What will we do?

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

How will we do it?

- Increase the number of volunteers by March 2021
- Identify four wards and departments to complete an 'Always Events®' project by March 2021.
- Using the 'Always Events®' toolkit and trained 'Always Events®' Mentors, develop a training programme to build capacity for 'Always Events®' to be undertaken by staff in their own areas
- Begin roll out of 'Always Events®' methodology across the organisation

How will it be measured?

- Numbers of volunteers recruited per month will be monitored
- Undertake an audit and staff survey to evaluate the impact of the 'bleep volunteers' service
- Wards identified will complete the 'Always Events®' project
- Training programme in place for 'Always Events®' and number of staff members to be trained
- Reduction in complaints in the areas where 'Always Events®' have been implemented
- Positive patient experience metrics – Friends & Family Test and real time survey programme

How will we monitor and report it?

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

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Priority 2: We will ensure that patients, carers and the public are engaged in our quality improvement work and that patient, carer and public involvement is embedded as business as usual across the organisation

What will we do?

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

How will we do it?

- Recruit patients to initiatives across the organisation including:
  - The Ward Accreditation Programme
  - Patient safety collaboratives for falls, pressure damage and hydration & nutrition
  - Explore involvement of patients and carers in a revised values based recruitment process
- Strengthen our links with our local Healthwatch to assist us to further understand the needs of our community including the Equality Delivery System
- Understand the national requirements in relation to patient, carer and public involvement
- Support Business Units to include patient representatives in specific service redesign projects
- Understand our patient demographics and ensure patients of all sexual orientations have a voice.

How will it be measured?

- Work plan agreed and monitored through Patient Public & Carer Involvement & Experience Group
- Maintain a list of patients who are involved in all initiatives
- Complete a gap analysis against national guidance to understand the areas of focus
- Maintain a database of all Business Unit projects
- Baseline assessment and implementation of the sexual orientation monitoring standard.

How will we monitor and report it?

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

Priority 3: Improved experience for our mothers, babies and their families

What will we do?

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

How will we do it?

- Develop the personalised care plan on the portal with our mothers

How will it be measured?

- Personalised care plan maternal satisfaction survey

How will we monitor and report it?

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

PATIENT SAFETY:

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

What will we do?

- Continue to raise awareness across the Trust of how Human Factors impacts upon patient safety
- Develop a patient safety investigation training programme keeping the patient at the centre of everything we do
- Develop innovative ways to involve staff, patients and families in patient safety.

How will we do it?

- Continue to deliver rolling program over the next year incorporating a range of training packages based on the needs of specific staff groups
- Develop a network of Patient Safety Champions (subject to guidance published by NHSE/I) and Ambassadors ensuring patients and staff have access to advice, guidance and support
- Staff, patients and their families will be actively encouraged to identify potential patient safety issues and risks they perceive to their care.

How will it be measured?

- Number of staff who have undertaken Human Factors training
- Number of staff trained and competent in undertaking robust Patient Safety investigations
- Reduction in preventable harmful incidents, complaints and claims
- Increase in incident reporting rate and a reduction in level of harm as the organisation cultural safety ethos reaches a degree of maturity.

How will we monitor and report it?

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

Priority 5: We will promote a just, open and supportive learning culture across the organisation.

What will we do?

- Implement and embed all principles of a just culture across the organisation
- Adopt a Safety II approach to patient safety within the organisation
- Align this work to Freedom To Speak Up (FTSU) guardian role to ensure
    - Staff have a range of mechanisms to voice their concerns and ideas

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- Leaders within the organisation listen to feedback and take appropriate steps
- All staff feel safe to share information in the knowledge it will be used for learning, change and improvement

How will we do it?

- Provide a just culture workshop to the Trust Board, focusing on transparency, fairness and accountability
- Revise Trust policies to ensure all policies promote a just culture
- Work with the Trust Executive lead for FTSU and our Trust's FTSU Guardian/champions
- Develop a Trust policy for supporting staff, to ensure there is adequate provision for any staff involved in a serious incident
- Implement appreciative enquiry within patient safety work, building on the existing 'Greatix' system; identifying and learning from those who demonstrate exceptional performance

How will it be measured?

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

How will we monitor and report it?

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

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

What will we do?

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

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How will we do it?

- Clinical Leads to support departments to embed mortality review process into all departments
- Cases identified and added to Mortality Council agenda
- Lessons learned to be shared via the Trust's Integrated Quality and Learning report
- Monitor data monthly at Mortality & Morbidity Steering Group

How will it be measured?

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

How will we monitor and report it?

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

Priority 7: To support the national ambition to halve the rates of still births, maternal deaths, neonatal deaths and brain injuries

What will we do?

- Our Safety improvements will focus around key areas:
    - Implementation and development of Saving Babies Lives (SBL) Care bundle v2
    - Reduction of term infants admitted to Special Care Baby Unit (SCBU)
    - Ensure compliance with Clinical Negligence Scheme for Trusts (CNST)10 safety actions

How will we do it?

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

How will it be measured?

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

How will we monitor and report it?

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

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CLINICAL EFFECTIVENESS:

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

Due to the suspension of the CQUIN scheme as a result of Covid-19, this priority will be suspended for 2020/21.

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

What will we do?

Increase our commitment to taking part in high quality research

How will we do it?

- Increase the number of research projects subject to the availability of recruiting studies
- Research projects will be clinically led (National Institute for Health Research (NIHR) portfolio commercial & non-commercial) in line with the North East & North Cumbria Clinical Research Network
- The increase will come from identifying clinical areas previously untapped, offering support to the multi-disciplinary teams with the research process and subsequent recruitment
- Principal investigator and research nurses within the Trust will be tasked with horizon scanning for new local and national studies coming through onto the portfolio and checking for eligibility

How will it be measured?

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

How will we monitor and report it?

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

Priority 10: Improve clinical audit: best practice and compliance to improve patient care and outcomes through systematic review of care and the implementation of changes and review alignment against Healthcare Quality Improvement Partnership (HQIP) Best Practice in Clinical Audit

What will we do?

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

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How will we do it?

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

How will it be measured?

- Improvement plan developed and all actions will be complete
- Produce a Clinical Audit Annual Report 2020/21 which will include improved experiences of care, outcomes and resources
- Clinical Audit Annual Report 2020/21 will highlight and identify audits where patients have been involved
- Training package with face to face training in place which covers audit process from initial idea to report and presentation

How will we monitor and report it?

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

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

What will we do?

- Continue to embed the transitional care model of care

How will we do it?

- Develop our electronic records work stream for maternity.
- Progression of Neonatal badger project which is currently on hold.
- We will continue to evaluate, refine and monitor clinical improvement indicators our transitional care model. The impact will be that we will have a reduction of term infants admitted for conditions where they can be treated with their mothers on the postnatal ward and not separated.

How will it be measured?

- Co-production with service users via satisfaction surveys
- Feedback to Maternity SafeCare Meetings
- Monitor clinical improvement indicators

How will we monitor and report it?

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

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

What will we do?

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

How will we do it?

- Review the current programmes in the trust
- Bring all groups that are undertaking programmes together under one MECC Group to enable a full overview
- Review training opportunities for staff and support with access to this training
- Use the GDE programme to support new innovative ways of working so that individuals can access the support via digital support
- Work with the local authority to ensure all support programmes are available and provide cohesive access to these programmes for all Gateshead residents.

How will it be measured?

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

How will we monitor and report it?

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

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2.3 Statements of Assurance from the Board

During 2019/20 the Gateshead Health NHS Foundation Trust provided and/or sub-contracted 30 relevant health services. The Gateshead Health NHS Foundation Trust has reviewed all the data available to them on the quality of care in 100% of these relevant health services. The income generated by the relevant health services reviewed in 2019/20 represents 100% of the total income generated from the provision of relevant health services by Gateshead Health NHS Foundation Trust for 2019/20.

Participation in national clinical audits 2019/20

During 2019/20, 37 national clinical audits and 6 national confidential enquiries covered relevant health services that Gateshead Health NHS Foundation Trust provides.

During that period Gateshead Health NHS Foundation Trust participated in 84% 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 2019/20 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 2019/20, 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 2019/20

Audit title	Participation	% of cases submitted/number of cases submitted
Care of Children in Emergency Departments	Yes	100 Cases submitted – no minimum requirement
Case Mix Programme (CMP)	Yes	946 Cases submitted – no minimum requirement
Elective Surgery (National PROMs Programme) Hips Knees	Yes	225 Cases, 78% submitted 50% required 278 Cases, 71% submitted 50% required
Falls & Fragility Fractures Audit Programme Hip Fracture Database Inpatient Falls Audit	Yes	350 Cases submitted – no minimum requirement 21 Cases submitted – no minimum requirement
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	No	Did not participate – due to the cost implications.
Major Trauma Audit	Yes	73 % Submission rate – 80% requirement

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Mental Health - Care in Emergency Departments	Yes	133 Cases submitted – no minimum requirement
National Asthma Audit (NACAP Audit Programme)	Yes	263 Cases submitted – no minimum requirement
National Audit of Breast Cancer in Older People (NABCOP)	Yes	489 Cases submitted – no minimum requirement
National Audit of Cardiac Rehabilitation (NACR)	No	Did not participate as we do not have the IT infrastructure to allow easy extraction of data in the format required.
National Audit of Care at the End of Life (NACEL)	Yes	40 Cases submitted – 40 maximum submission limit
National Audit of Dementia (Care in general hospitals)	Yes	56 Cases submitted – 50 minimum requirement
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	We are participating but did not upload any new cases during 2019
National Cardiac Arrest Audit (NCAA)	Yes	53 Cases submitted – no minimum requirement
National Cardiac Audit Programme (NCAP) Heart Failure Audit Cardiac Rhythm Management (CRM)	Yes Yes	339 Cases submitted – no minimum requirement 152 Cases submitted – no minimum requirement
National Clinical Audit of Anxiety and Depression	No	Did not participate, due to lack of resources
Diabetes Audit Programme National Diabetes Inpatient Audit Diabetes Foot Care National Diabetes Audit – Adults	Yes Yes No	100% 63 Cases submitted – no minimum requirement Did not have the capacity to participate
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	77 Cases submitted – no minimum requirement
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Gastro-intestinal Cancer Programme Oesophago-gastric	 Yes	 59 Cases submitted – no minimum requirement

cancer (NAOGC) Bowel Cancer (NBOCAP)	Yes	226 Cases submitted – no minimum requirement
National Joint Registry (NJR)	Yes	100%
National Lung Cancer Audit (NLCA)	Yes	239 Cases submitted – no minimum requirement
National Maternity and Perinatal Audit (NMPA)	Yes	100%
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	195 cases submitted – no minimum requirement
National Paediatric Diabetes Audit (NPDA)	Yes	121 Cases submitted – no minimum requirement
National Prostate Cancer Audit	Yes	142 Cases submitted – no minimum requirement
National Smoking Cessation Audit	No	Unfortunately we had insufficient data to complete the audit, and also our in house stop smoking service did not commence until September 2019 which meant we would have been unable to complete that section of the audit
Prescribing Observatory for Mental Health (POMH-UK)	No	Not participating as there is a £5000 cost implication
Sentinel Stroke National Audit programme (SSNAP)	Yes	263 Cases submitted – no minimum requirement
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Yes	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	100%
Surgical Site Infection Surveillance Service	Yes	100%
UK Parkinson's Audit	No	Did not have the capacity to submit data on time. Plan to participate in the next cohort in 2021/22.

Participation in National Confidential Enquiries 2019/20

Enquiry	Participation	% of cases submitted
Maternal, Newborn and Infant Clinical Outcome Review Programme • Confidential Enquiry into stillbirths, neonatal deaths and serious neonatal morbidity • Perinatal Mortality Surveillance • Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths) • Confidential enquiry into serious maternal morbidity • Maternal mortality surveillance • Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)	Yes	100%
National Confidential Enquiry into Patient Outcome and Death – Out of Hospital Cardiac Arrest	Yes	Organisational questionnaire returned – still open for submissions 33% clinical questionnaires returned 100% case notes returned
National Confidential Enquiry into Patient Outcome and Death – Dysphagia	Yes	Organisation questionnaire returned Study still open figures have not been finalised
National Confidential Enquiry into Patient Outcome and Death – Acute Bowel Obstruction	Yes	Study still open figures have not been finalised
National Confidential Enquiry into Patient Outcome and Death – Long Term Ventilation	Yes	Study still open figures have not been finalised
Learning Disability Mortality Review Programme (LeDeR)	Yes	100%

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

The reports of 17 national clinical audits were reviewed by Gateshead Health NHS Foundation Trust in 2019/20 and Gateshead Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

The Case Mix Programme (CMP) is an audit of patient outcomes from adult and general critical care units (intensive care and combined intensive care/high dependency units) covering England, Wales and Northern Ireland. It is run by the Intensive Care Audit and Research Centre (ICNARC). Data is collected on all patients admitted to the Critical Care Unit. Data on various outcomes and process measures are then compared with the outcomes from other Critical Care Units in the UK.
The most recent annual quality report (2018/19) demonstrates that the Critical Care Unit continues

to perform in line with expectations and better than the national average in most areas. This includes areas of high risk admissions and high risk sepsis admissions from the ward (suggesting that patients are being admitted to Critical Care in a timely manner). Performance continues to be better than the national average on rates of non-clinical transfers to other units, and readmissions to Critical Care within 48 hours of discharge.
Standardised mortality rates were as predicted for all admissions, at just below 1.0. Risk-adjusted mortality for patients with a predicted mortality of less than 20% was better than last year and below 1.0.

Action points:

- Continue to collect and submit data to Intensive Care National Audit and Research Centre (ICNARC)/CMP.
- Appointment of an ICNARC data clerk to improve the quality of data entry and timeliness of submissions to the CMP.
- Ongoing education of ward clerks and nursing/medical staff regarding the correct entry of data, assisted by the ICNARC data clerk.
- Use the Quarterly Quality Reports to ensure timely identification of any areas of deterioration in performance and address these when they occur.

Elective Surgery (National Patient Reported Outcome Measures (PROMS) Programme)

To meet the criteria for Best Practice Tariff (BPT) the provider should have a participation rate of 50% in PROMS. For this period Gateshead had 78% participation in patients having total hip replacement and 71% participation in patients having total knee replacement. To meet the criteria for Best Practice Tariff, the average health gain a patient reports to have after surgery must not be significantly lower than the national average. For both total knee replacement and total hip replacement Gateshead data showed that their patients reported an average of less than one standard deviation from the national average, therefore the BPT criteria was met.
We continue our contract with North East Quality Observatory Service (NEQOS) who analyse our PROMS data and send us twice yearly reports. We use this data to identify trends and improve the quality of our patient's pathway and outcomes to their surgery. We identify patients who have the highest health gain and the lowest health gain and use this data to help us improve our patient pathway.

Action points:

- Continue to optimise patient health before surgery using an agreed research based pathway.

Falls & Fragility Fractures Audit Programme
National Hip Fracture Database

The data supplied by the Trust for the 2018-19 year showed that we perform well in all areas, notably in the top quartile nationally for timely admission to the Orthopaedic ward, perioperative medical assessment, efficient assessment by the physiotherapy, nutrition and mental health teams, timely surgery and efficient discharge practice. We have significantly improved our performance in terms of the frequency of perioperative pressure damage and now lie within the middle quartiles for this area. The only area in which we perform below-average is in terms of fractures sustained by existing inpatients and this is being addressed by an extensive audit and action plan carried out by the falls team.
The Trust was very proud in 2019 to become the third highest performing trauma unit in the entire UK in terms of the overall 'best practice' care given to hip fracture patients.

Action Points:

We meet regularly to review all hip fracture cases who fail to meet Best Practice Criteria for any reason. Any learning points are recorded and fed back, with a Datix completed in each case. This practice will continue. Further work is planned to further review our situation regarding inpatient fractures and will look to instigate the actions of the falls team audit. These include better awareness

of falls risk in vulnerable patients and optimising the availability of nursing and healthcare staff for this patient group.

Inpatient Falls Audit

From January 2019 National Audit Inpatient Falls (NAIF) changed to become a continuous audit of in-patient falls resulting in in-patient hip fractures. No bed rail audit has been undertaken in the past 12 months (only 43% trusts reported to have done this). 14 in-patient hip fractures occurred in the trust (data linked from NHFD). The majority of these occurred on medical and older person's wards (in line with national data). However the Trust also had a relatively high proportion of in-patient hip fractures on mental health wards (14% versus 3.8% nationally). The Trust is an outlier in terms of length of stay (median) prior to in-patient hip fracture: 17 days in the Trust versus 7 days nationally. In terms of post fall care, the Trust performed very similarly to other trusts.

In summary, the NAIF concludes that older people who sustain a hip fracture after a fall in hospital face obstacles including a longer wait for surgery, longer periods in bed after surgery and a greater risk of post -operative delirium. They also have significantly poorer outcomes, including a two-fold increase risk of dying compared to those who fracture outside hospital.

Action Points:

- The Trust look to resource an inpatient falls prevention lead to provide a coordinated and effective approach to falls prevention and post falls reviews.

Major Trauma Audit

The latest Trauma Audit & Research Network (TARN) report was published in April 2020 which includes data up to 31/12/2019. Case ascertainment was 66 – 78% in 2019 compared with 62 – 74% in 2018.

Action points:

- We need to make great efforts to achieve a case ascertainment percentage of above 80% in order to improve the reliability and thus the interpretability of the results. This will require a review of how patients are identified for inclusion and how patient records are analysed. We are currently looking into tweaking the system so we can get a more accurate list of patients to include.
- It will also likely require an increase in the number of hours of paid TARN data input time. Once this is achieved it will be easier to see where we need to focus our attention to improve specific aspects of patient care. Currently planning a business case to achieve this.

Mental Health - Care in Emergency Departments

This was the first review audit for mental health patients presenting aged 18- 65 years old with an episode of self-harm and who were discharged from the Emergency Department. 133 patients included of which 98.3% were primarily self-poisoning vs 1.6% self-injury only. Overall the use of the triage tool is near to the national levels. The tool has only been in use since Feb 2019 and ongoing work is underway to embed the use in further. The time to triage, (when done, was good compared to national numbers. The need for observations is part of the tool but its use, as shown by this audit, is still limited. Mental health review documentation by ED staff is low.

Action Plan:

- Continue nurse education re the triage tool completion and use Royal College of Emergency Medicine (RCEM) audit platform to monitor improvement.
- Embed the need to document mental health observations as per the tool, review any barriers to this.
- Discuss at Emergency Department Mortality & Morbidity Meeting to the juniors about the importance/ need for initial psychiatric mental health review and documentation and how to do this, and review with them barriers to undertaking this.
- Discuss findings with consultant colleagues around the best way to capture the medical assessment information. (E.g. use of a specific mental health assessment proforma and consider

electronic options to aid this information capture.
- Continue to use RCEM Quality Improvement/ audit tool to monitor outcomes post changes.

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

The Trust's overall result is excellent with all scores exceeding the national average. This is in line with our previous results in 2018 where we rated higher than national averages and rated highest in the North East. Scores cannot be directly compared due to changed made. The results of this audit provide assurance that the five priorities of care are being met for patients in the last few days of life. The results of this audit are also triangulated with information gathered from the Trust's bereavement survey. Areas which require extra input are identified and made a priority.

Action Points:

- Ongoing training and education for all staff focusing on good communication skills and supportive care for patients and their families ensuring excellent end of life care is everyone's business.
- Continue to offer a highly visible and proactive specialist palliative care service.
- 24/7 Access to Palliative Care: - Further discussions with the commissioners regarding face to face 24/7 access to palliative care are also reflected on the CCG work plan
- Access to an Electronic Palliative Care Coordination Systems: - This is an ongoing piece of work with the regional end of life network.
- Initiatives to support last days of life: Continue to facilitate the implementation throughout the trust of the Caring for the Dying Patient Document and the Family's Voice Diary.

National Audit of Dementia (Care in general hospitals)

The Royal College of Psychiatrists (RCPSYCH) National Audit of Dementia (NAD) takes place every two years. This case note audit was last completed in 2018, with results being published in 2019 (Round 4). A survey of carer experience of quality of care (including carer rating of communication and patient care). A staff questionnaire on providing care and support to people with dementia (including staff rating of communication).

Action points:

- The delirium screening tool (4AT) has been introduced which forms part of the dementia patient assessment, this is now available electronically via Nervecentre – an electronic patient observation system. Whilst this was introduced in March 2020, education with junior medical staff and senior ward based staff regarding assessment and discharge remains ongoing.
- Dementia education remains a fundamental part of patient facing staff's core requirements. The dementia nursing team with the support of the Older Person's Mental Health Liaison service continues to provide ward based and formal education on both dementia and delirium.

National Cardiac Arrest Audit (NCAA)

The National Cardiac Arrest Audit (NCAA) is the national, clinical, comparative audit for in-hospital cardiac arrest. The purpose of NCAA is to promote local performance management though the provision of timely, validated comparative data to participating hospitals. Overall there were 45 cardiac arrest calls during this period, of which data was submitted for 44. Whilst the data indicates that the outcomes are within the expected confidence intervals and standard deviations we are consistently towards the outer limits of these.

Action points:

- Continue to collect and submit data to the NCAA
- Continue to share information from the reports at Rescuing the Deteriorating Patient Committee and via training sessions
- Interrogate defibrillator post cardiac arrest to see if there were any opportunities for learning (quality of Cardiopulmonary resuscitation (CPR), time off of the chest and time taken for rhythm recognition), where appropriate feedback to relevant staff

National Diabetes Audits

Diabetes Foot Care

The number of new diabetic foot ulcers seen at Queen Elizabeth-Trinity increase year by year. The evidence suggests that in decompensated diabetic foot, early vascular opinion and possible intervention is associated with better outcomes. Therefore, there has been a lot of discussion around the vascular element of the multidisciplinary approach. Identified areas with room for improvement include: Referral Pathway to Vascular Services, Referral Pathway to MDT, Communication between Podiatry Team and MDT team or members, Communication between MDT teams and an inpatient Podiatry Service.

Action points:

- Active dialogue between stakeholders including Newcastle and Gateshead CCG (ongoing)
- Business case for inpatient Podiatry Service
- Continue participating in the NDFA

National Joint Registry (NJR)

The Trust continues to contribute to the National Joint Registry. Data is entered regarding all hip, knee, ankle, elbow and shoulder replacement operations, enabling the monitoring of the performance of joint replacement implants and the effectiveness of different types of surgery.

In 2014 the NJR introduced annual data completeness and quality audits for hip and knee cases, with the aim of improving data quality. The Trust continues to contribute to these audits and achieved 100% compliance for the 2018/19 NJR Data Quality audit. The Trust has also been awarded as an NJR Quality Data Provider for 2018/19.

Action Points:

- Continue to ensure that robust systems are in place to guarantee that a Minimum Dataset form is generated for all eligible NJR procedures.

National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)

The National Neonatal Audit Programme (NNAP) is a national clinical audit of NHS-funded care for babies admitted to neonatal services in England, Scotland, Wales and the Isle of Man. The Study shows good data presentation as compared to National Data, regarding administering steroids to mothers. Excellent data with Caring of babies on the Special Care Baby Unit and management with regards to temperature, Communication with parents and review of babies

Action Points:

- Encourage parental presence and improve senior review within 24 hrs and improving documentation regarding this.
- Better data collection with regards to magnesium sulphate and follow up of babies up to two years of age.
- Neonatal Notes Audit undertaken in May 2020 to review notes and documentation regarding daily review of babies, communication with parents and documentation by Senior Staff.

National Paediatric Diabetes Audit (NPDA)

The Trust's continuous support to this audit has demonstrated improvements through the ability to benchmark ourselves regionally against good practice. Our service meets the Best Practice Tariff (BPT) criteria with 86.1% of our patients having had over eight contacts per year in addition to at least four multidisciplinary team (MDT) clinics being offered per year to all patients. We have significantly improved the uptake and provision of care processes, in particular retinal screening although the 19-20 data and care process uptake has been impacted by the Covid-19 epidemic.

Action Points:

- To continue to support CYP and their families and carers to improve or maintain optimal glucose levels measured by HbA1C or Time in Range to ensure CYP have the best possible health outcomes and life chances. The multidisciplinary team have enrolled on the RCPCH Paediatric Diabetes national QI Collaborative and are initially focusing on the optimal use of technology.

- To continue to work across multi agencies to support the significant number of CYP requiring local authority support, mental health/MDT psychology services and /or safeguarding.
- To continue to improve education for CYP and their carers/ families and school staff to enable them to use new technology and ensure CYP with diabetes are fully included in all aspects of school life and achieve their full potential. To review administration support in relation to data entry to include accurate documentation of Paediatric Diabetes Specialist Nurse (PDSN) activity for Best Practice Tariff (BPT), National Paediatric Diabetes Audit (NPDA) and Regional Diabetes registry, to support the new Value Based Commissioning (VBC) pathway for both CGM and insulin pump therapy & other funding requests, to improve efficiency of communication with CYP and their families.
- Review the pathway and consider implementation of a dedicated young person (19-25 years) clinic within adult services with adult dietetic provision; a dedicated Young Person's Adolescent Diabetes Support Nurse (ADSN); psychology provision; to facilitate access to education (accessing the new Clinical Commissioning Group education pathway for those with Type 1 & Type 2 Diabetes); to improve engagement - as complex needs prevent regular clinic attendance and potentially results in Did Not Attends (DNAs) and effectively early discharge from the adult service.

Sentinel Stroke National Audit programme (SSNAP)

The Sentinel Stroke National Audit Programme (SSNAP) considers ten domains for stroke care, from hyper acute assessment and treatment, through to rehabilitation and discharge planning. Services are given an overall rating on a scale from category A (highest) to category E (lowest). Historically prior to the joint pathway with Newcastle-upon-Tyne Hospitals, the Trust scored a category D. Since the pathway merger, the outcomes for Gateshead patients have generally improved. The most recent results available are for the period January to March 2020. Overall the SSNAP score for that period was B for patient centred care which rates the overall service received by patients and considers the service provided at the Royal Victoria Infirmary (RVI) and the Trust presented an aggregate score. This has been a downgrading from the A rating that we received in the previous two quarters. The key indicator that has changed has been Speech and Language Therapy input. A lack of Speech and Language therapy resource is a known risk that was highlighted to the Trust in the recent Stroke Service review. Another key domain with potential for improvement is Discharge Processes. The service consistently receives a C rating for this, despite scoring 100% in most indicators, due to the fact that we do not have an Early Supported Discharge team.

Action points:

- The Trust carried out a pilot earlier this year, as well as an audit jointly with the RVI, in order to gather evidence to make the case for this to be commissioned.
- During March-May 2020 provision of stroke care was severely disrupted, due to the Covid-19 pandemic, by: Closure of the Acute Stroke & Rehabilitation Unit and relocation of patients to an area with few rehabilitation facilities
- Reassignment of key MDT members (including physiotherapists and stroke nurses) to Covid-19 areas
- Restriction in the ability of other MDT members (including clinical psychology and community stroke therapists) to review patients face-to-face
- Significant delays in patients presenting with their stroke, due to concerns about attending hospital during the pandemic, such that many have presented directly to the Trust rather than being admitted via the RVI.
- Delay in inputting data due to staff being reassigned, unwell or self-isolating which will affect audit compliance
- Continue to participate in this national project.

Serious Hazards of Transfusion: UK National Haemovigilance Scheme This audit looked at the way in which major haemorrhage was managed in adults and collected information about the presentation of the bleed, the products used and the following of key timelines. There was a short organisational audit tool and a clinical audit tool. The clinical part of the audit was completed in retrospect. The information from the audit will be compared to existing guidelines and recommendations for change will be given as necessary. **Action points:** • Clinical areas to be reminded of the importance of informing transfusion that major haemorrhage episode is over and that no further blood products are expected at this time (Laboratory stand down). Standing the laboratory down as soon as possible will help reduce wastage and provide better service to non-urgent requests.
Surgical Site Infection (SSI) Surveillance Service The second GIRFT SSI survey was launched in May 2019 covering six months. Data on SSI (mostly deep SSI) diagnosed between May 2019 and October 2019 was entered onto an online portal from over 100 NHS Trusts and over 50 independent sector sites. We are therefore in the first quartile in the rate of infections reported. Other Trusts with higher volumes have been placed higher up in the first quartile. **Action points:** • We will continue to participate in the GIRFT audit and continue to ensure that all protocols are followed to maintain a low rate of infections
Care of Children in Emergency Departments This national Quality Improvement Programme recognises the important role Emergency Departments play in safeguarding infants, children and adolescents, and examines the performance of Emergency Departments (ED) in relation to certain key safeguarding standards outlined in national guidance by the Royal College of Paediatrics and Child Health. **Action plan:** • Continue good practice of senior clinicians reviewing patients aged 12 months and under presenting with injuries – this should be emphasised during departmental induction to ensure awareness amongst all clinicians • All staff should be educated regarding the need to involve senior clinicians in case note reviews of children who leave the department without being seen – strategies to implement this could include department induction, email broadcast and reminder posters in clinical/triage areas. The self-discharge form could also be modified to include a senior review section/tick box.

The reports of 11 local clinical audits were reviewed by Gateshead Health NHS Foundation Trust in 2019/20 and Gateshead Health NHS Foundation Trust intends to take actions to improve the quality of healthcare provided. Below are examples from across the Trust that demonstrate some of the actions taken to improve the quality of our services:

Business Unit	Speciality	Actions identified
Nursing & Midwifery	Safeguarding	Audit of Child Protection Referral forms - as a recommendation from this audit the Safeguarding Children Team will continue to monitor the receipt of Safeguarding Children Referral Forms. Safeguarding Children Team will continue to educate and train staff in documenting 'The Voice of the Child' in order to acknowledge and

		implement within practice that all children's views can be documented.. The Safeguarding Children team will also promote the importance of advising parents of safeguarding children concerns prior to completion of the safeguarding referral form, unless this poses a further risk of harm to the child, and documenting a rationale if unable to obtain consent for referral.
Surgery	Maternity	Audit of Female Genital Mutilation (FGM) Proforma's completed by maternity staff and received by the safeguarding team - To check EMIS, electronic patient management system, before booking appointment to see if there is any information to suggest FGM has been carried out. A professional interpreter should be used if English is not the patient's first language and not rely upon a relative. A proforma should be completed in all cases where FGM is disclosed and sent to the safeguarding admin team and attached to badger, maternity electronic patient management system.
Surgery	General Surgery	Breast implant loss audit - Working together as a breast team to devise a standardised pathway for use of breast implants in theatre, Biopatch disk. Protective disk with chlorhexidine gluconate. Shown to reduce the risk of hospital-acquired bloodstream infections. Trialled in haematology, oncology, intensive care and trauma settings and shown to reduce number of infection requiring treatment and in turn improved patient outcomes and cost-effective.
Surgery	Paediatrics	Does inpatient and discharge documentation meet national guidance for management of suspected neonatal sepsis? - Consistency of documentation by member of paediatric team when a neonate is started/stopped on antibiotics for suspected neonatal sepsis. Number of neonates who have been started on antibiotics for suspected neonatal sepsis receiving discharge letters.
Clinical Support	MRI	Magnetic resonance imaging (MRI) Department Contrast Administration Record - The purpose of this audit was to assess the accuracy of completed MRI Contrast Administration forms, for patients requiring contrast enhanced examinations. While some forms were completed very accurately others were not. However, the main questions for patient safety regarding eGFR levels and type and quantity used, all achieved above the bench mark standard.
Clinical Support	Radiology	Radiology inpatient wristband audit - The specialist transfusion nurses confirm results are similar to the Trust wide audit the specialist blood transfusion nurses complete on an annual basis. The presentation and results have been passed to the specialist transfusion nurses as further evidence for their audit.
Clinical Support	Outpatient Department	Missing Clinic Outcome Slips Monitor Compliance - Areas for room of improvement, nursing staff and consultants should be giving patient the clinic instruction at the end of their consultation, to bring back to reception, however day to day this does not always happen. Audit has demonstrated that we are still having issues with missing clinics slips. Reception staff have been asked to ask all patients for the slips upon leaving the consultation room.

Medicine	Accident & Emergency	National Audit Feverish Children (care in emergency departments) - We need to ensure that all documentation related to the patient's attendance is scanned to windip, electronic filing system - including Paediatric Early Warning System (PEWS) and SEPSIS charts. These charts should also be used as screening tools - not just when we know there is a positive finding. Good discharge information given - above national average.
Nursing & Midwifery	Resus Team	Audit to assess communication of DNACPR decisions amongst ward teams - Handover to allied healthcare professionals and bank staff on wards needs to be improved. To consider if handover sheets have a designated section to record DNACPR decisions. Current date needs to be marked on handover sheets.
Medicine	Care of the Elderly	Audit of Post Falls Assessment for Inpatient Falls within Care of the Elderly - Are we meeting Trust and NICE guidelines? - Documentation was fair however there was no one area of a post falls assessment completed 100% of the time. A standardised assessment protocol or proforma's could help achieve compliance with Trust guidelines. A draft proforma has been developed which is to be discussed and modified, with the aim to pilot this year followed by a re-audit to complete the cycle.
Medicine	Mental Health	Audit of MDT meeting documentation. - A form needs to be created each week for every patient (some patients had forms missing). Each section of the form needs completing. The form needs amending to remove unnecessary boxes and to streamline the remaining sections/avoiding repetition, The team needs training on completion of the form and who is responsible for its completion. The forms need to be improved to reflect the different nature of the patients on the two different wards. An acceptable way of updating the form throughout the week needs to be developed and each member of the MDT to play a role in adding to it.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Gateshead Health NHS Foundation Trust in 2019/20 that were recruited during that period to participate in research approved by the Health Research Authority (HRA) was 1,030. This was a decrease of 183 participants from last year (2018/2019).

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 the North East and North Cumbria Clinical Research Network, the Trust has focused on building the recruitment for both Portfolio and Industry studies. However, this focus changed with the onset of the Covid-19 Pandemic. By the end of March 2020 the majority of normal research projects had been put on hold for the duration of the Pandemic and the Trust was expected to participate in Covid-19 Urgent Public Health research.

Gateshead Health NHS Foundation Trust is currently involved in 135 clinical research studies with 14 in setup. This research is in a variety of areas including – cancer, dementia & neurodegenerative

disease, diabetes, critical care, cardiology, endocrinology, medicines for children, mental health, stroke, rheumatology, gynecological oncology, obstetrics and various specialty groups.

The top 5 recruiting studies for 2019-2020 were:-
The Whickham Thyroid Function Study (Endocrinology - 166 participants)
PREP (MS-E-CIG) (Maternity - 122)
DETERMIND (Dementia's & Neurodegeneration - 120)
The Big Baby Trial (Maternity - 100)
PQIP (Anaesthesia - 80)

Over the last year, researchers from the Trust have published 44 publications, and two presentations, which demonstrate our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

There were 66 members of staff participating in research at Gateshead Health NHS Foundation Trust during 2019/2020. These staff participated in research covering 18 medical specialties.

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

The Trust was successful in meeting the two separate Quality Improvement Incentive Criteria for 2019/2020 and received a total of £9,500.00 for this achievement. These were:

Participation in Digital PRES (Participant in Research Experience Survey)
The incentive criteria for PRES was for POs to achieve a 100% of their target number of questionnaires. The Target for Gateshead Health NHS FT was 27 - 105 questionnaires were completed (388.89%) For this achievement the Trust was awarded £5,000.

Recording Year of Birth (YoB) for participants into NIHR CRN Portfolio studies in LPMS
The YoB was collected to produce age profiles for study participants by disease area, in order to assess the extent to which study recruitment age profiles match the age demographics of the incidence/prevalence of diseases in the following specialties:

Ageing | Dementias & Neurodegeneration | Cancer
Mental Health | Children | Neurological Disorders

The incentive criteria for YoB was for POs to achieve 80% of participants recruited into NIHR CRN Portfolio studies in LPMS for each of the above six specialties between 1st January 2020 and 31st March 2020.

	Ageing	Cancer	Children	DeNDRoN	Mental Health	Neurological Disorders
Gateshead Health NHS Foundation Trust	100%	100%	N/A	97.37%	N/A	N/A

For this achievement the Trust was awarded £4,500.

The PREP (MS-E-CIG) research team were congratulated for their excellent research activity for the year 2019/20 and for being the highest recruiting Trust in the whole of the UK with 229 participants.

The Big Baby Trial research team was congratulated for being the highest recruiting Trust for the months of May, June, August, and October 2019 and joint highest recruiting Trust in February 2020.

The SYMBAD research team was congratulated for being the highest recruiting Trust at the end of the recruitment period (March 2020) with 36 participants.

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

A proportion of Gateshead Health NHS Foundation Trust income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between Gateshead Health NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2019/20 and for the following 12 month period are available electronically at http://www.qegateshead.nhs.uk/cquin

A monetary total of £2,682,964 of the Trust’s income in 2019/20 was conditional upon achieving quality improvement and innovation goals. The Trust was paid a total of £4,933,642 for achieving the quality improvement and innovation goals for 2018/19.

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 2019/20.

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

There were no unannounced inspections by the CQC and no Mental Health Act (1983) Monitoring visits throughout 2019/20.

Data Quality

Gateshead Health NHS Foundation Trust recognises that it is essential for an organisation to have good quality information to facilitate effective delivery of patient care and this is essential if improvements in the quality of care are to be made.

Gateshead Health NHS Foundation Trust submitted records during 2019/20 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data is shown in the table below:

draft

Which included the patient's valid NHS Number was:	Trust %	National %
Percentage for admitted patient care	99.8%	99.4%
Percentage for outpatient care	99.9%	99.7%
Percentage for accident and emergency care	98.9%	97.7%

Which included the patient's valid General Medical Practice Code was:	Trust %	National %
Percentage for admitted patient care	99.1%	99.7%
Percentage for outpatient care	99.3%	99.6%
Percentage for accident and emergency care	99.2%	97.9%

* SUS+ Data Quality Dashboard - Based on the April-19 to March-20 - SUS+ data at the Month 12 inclusion date

Information Governance Toolkit

Gateshead Health NHS Foundation Trust's Information Governance Assessment Report overall score for 2019/20 graded as "standard met"*

*Toolkit submission date for 2019/20 has been extended to September 2020; therefore scores are for 2018/19.

Standards of Clinical Coding

Gateshead Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2019/20 by the Audit Commission.

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

- A full review of the Data Quality Strategy Group, to ensure it includes key staff from all specialities, to highlight and drive continual improvement.
- Continual development of our Data Quality Metrics to ensure all appropriate indicators are covered and aligned to national and local quality indicators.
- Continue with daily batch tracing to ensure the patient demographic data held on our Patient Administration System (PAS) matches the data held nationally.
- A project is underway with the Global Digital Exemplar programme to deliver an integrated Patient Demographic Search (PDS) to the national spine which validates patient demographic details and allocates real time NHS numbers to patient records, improving and updating the quality of patient information. This has been taken out of the GDE programme
- Robotic automation software has been purchased which will automate and validate where appropriate manual processes which will increase data quality and
- Circulate weekly patient level reports to allow the clinical services to fully validate 18 week and cancer pathways.
- A real time dashboard for 18 weeks validation has been developed with the services which no longer require them to wait until reports are circulated. They have at a glance their waiting time position with the ability to drill down to patient level information for validation purposes.
- Spot check audits to randomly select patients and correlate their health record information with that held on electronic systems.
- Continue to work with the admin 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.

Draft

- Clinical Coding Quality Assurance Programme to provide assurance on the quality of coding within the Trust.
- Continue to work with Commissioners to ensure commissioning datasets are accurate, completing data challenges within five days.
- Monthly Data Quality Information Governance (DQIG) meetings are held with the CCG to discuss any data concerns and data challenges. This isn't happening at present as there is a block contract and they have reinstated since Covid-19.
- Review Internal Audit Department plans to include data quality processes.

2.4 Learning from Deaths

During 2019/20, 1169 of Gateshead Health NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 240 in the first quarter;
- 241 in the second quarter;
- 330 in the third quarter;
- 358 in the fourth quarter.

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

By 1st September 2020, 934 case record reviews and 87 investigations have been carried out in relation to 1169 of the deaths included above.

In 79 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 202 in the first quarter;
- 207 in the second quarter;
- 287 in the third quarter;
- 238 in the fourth quarter.

One death representing 0.12% of the patient deaths during the reporting period is judged to be more likely than not to have been due to problems in the care provided to the patient.
In relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter;
- 1 representing 0.49% for the second quarter;
- 0 representing 0% for the third quarter;
- 0 representing 0% for the fourth quarter;

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

Summary of learning: -

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

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

Description of Actions:

- Medway training has been instituted for all senior clinicians in order to educate them on how to complete the GP Notification of Deaths form and pass the information on to juniors. This is already done for the junior doctors at the time of their induction but will be reinforced.
- Palliative care teaching sessions now take place regularly for medical and nursing staff.
- Resuscitation and DNACPR training for senior staff is now being carried out by Resuscitation Team. This is level 2 training focused at senior staff that may not have undergone any update. Level 1 training is mandatory and is already in place for junior staff.
- Education around management of anticoagulation has taken place in the respective business units where the incidents have occurred.
- EHCP pathways are being made more robust in order to reduce inappropriate number of hospital admissions where clear plans have been made for management at home.
- There are several areas of poor communication which has been fed back to the staff involved.

Assessment of the Impact:

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

141 case record reviews and 56 investigations were completed after 1st April 2019 which related to deaths which took place before the start of the reporting period. 0 representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

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

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2.5 Seven Day Hospital Services

The Trust has fully implemented priority standards five (access to diagnostics) and six (access to consultant directed interventions) from the 10 clinical standards as identified via the seven day hospital services NHS England recommendations.

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

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

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

The Covid-19 pandemic meant that specific work around the priority standards and assessing compliance was suspended. There were many temporary changes in consultant staffing and ways of working during the Covid-19 pandemic and we are currently developing our way of working going forward (our new normal) as we come out of the first wave of the pandemic.

2.6 Freedom to Speak Up

As a result of Sir Robert Francis QC's follow up report to his Mid Staffs Report, all NHS Trusts are required to have a Freedom to Speak Up Guardian (FTSUG). Gateshead Health NHS Foundation Trust is committed to achieving the highest possible standards/duty of care and the highest possible ethical standards in public life and in all of its practices. We are committed to promoting an open and transparent culture to ensure that all members of staff feel safe and confident to speak up. The FTSUG is employed by the Trust but is independent and works alongside Trust leadership teams to support this goal. The FTSUG reports to the Human Resource Committee twice a year and to the National Guardian Office on a quarterly basis. Our FTSUG supports the delivery of the Trust's corporate strategy and vision as encapsulated in our ICORE values. As well as via the FTSUG, staff may also raise concerns with their trade union or professional organisations as per our Freedom to Speak Up Policy. When concerns are raised via the FTSUG, the Guardian commissions an investigation and feeds back outcomes and learning to the person who has spoken up. The FTSUG is actively engaged

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in profile raising and education in relation to this role. The FTSUG now reports directly to the Chief Executive.

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

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

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

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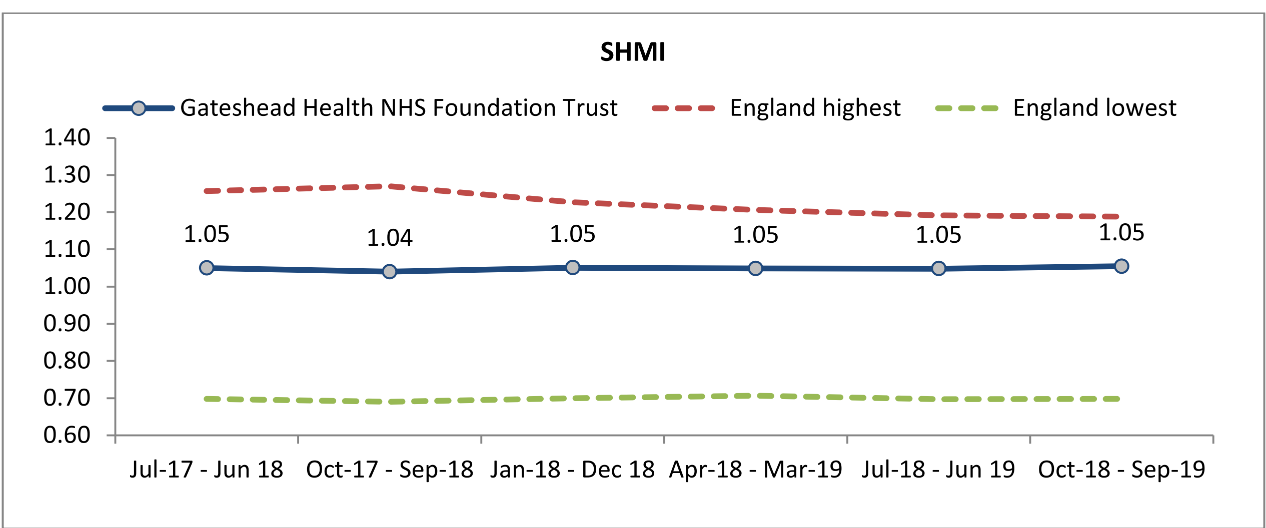
2.8 Mandated Core Quality Indicators

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

SHMI	Jul-17 - Jun 18	Oct-17 - Sep-18	Jan-18 - Dec 18	Apr-18 - Mar-19	Jul-18 - Jun 19	Oct-18 - Sep-19
Gateshead Health NHS Foundation Trust	1.05	1.04	1.05	1.05	1.05	1.05
England highest	1.26	1.27	1.23	1.21	1.19	1.19
England lowest	0.70	0.69	0.70	0.71	0.70	0.70
Banding	2	2	2	2	2	2

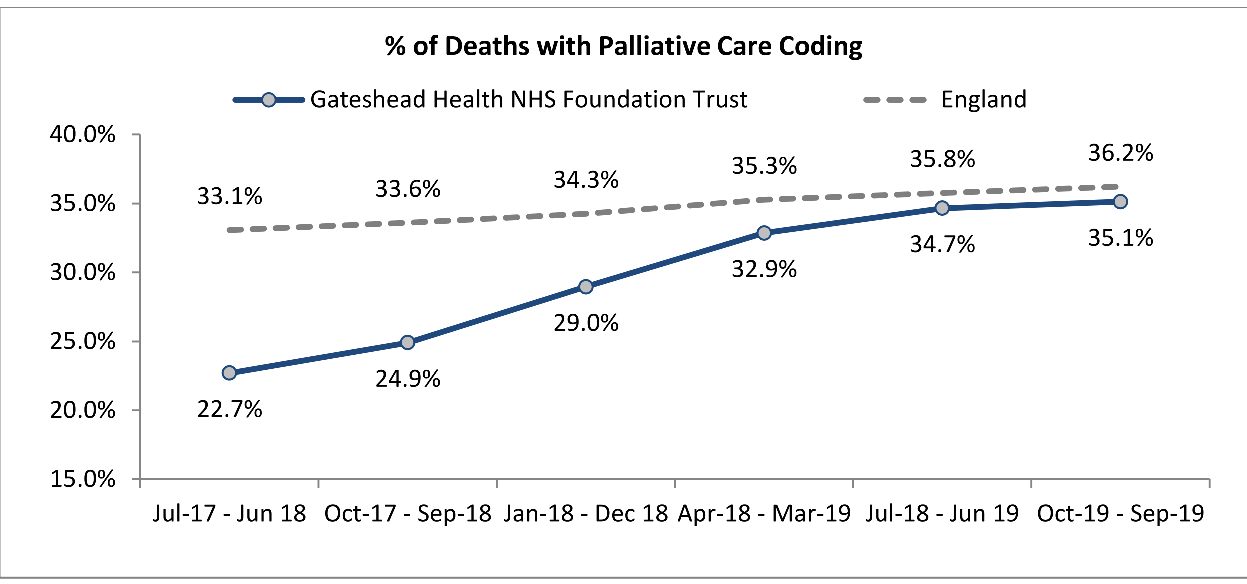
Source: www.digital.nhs.uk/SHMI



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

% Deaths with palliative coding	Jul-17 - Jun 18	Oct-17 - Sep-18	Jan-18 - Dec 18	Apr-18 - Mar-19	Jul-18 - Jun 19	Oct-19 - Sep-19
Gateshead Health NHS Foundation Trust	22.7%	24.9%	29.0%	32.9%	34.7%	35.1%
England highest	58.7%	59.5%	59.7%	60.0%	59.6%	58.7%
England lowest	13.4%	14.3%	15.1%	12.3%	14.6%	12.0%
England	33.1%	33.6%	34.3%	35.3%	35.8%	36.2%

Source: www.digital.nhs.uk/SHMI



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

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

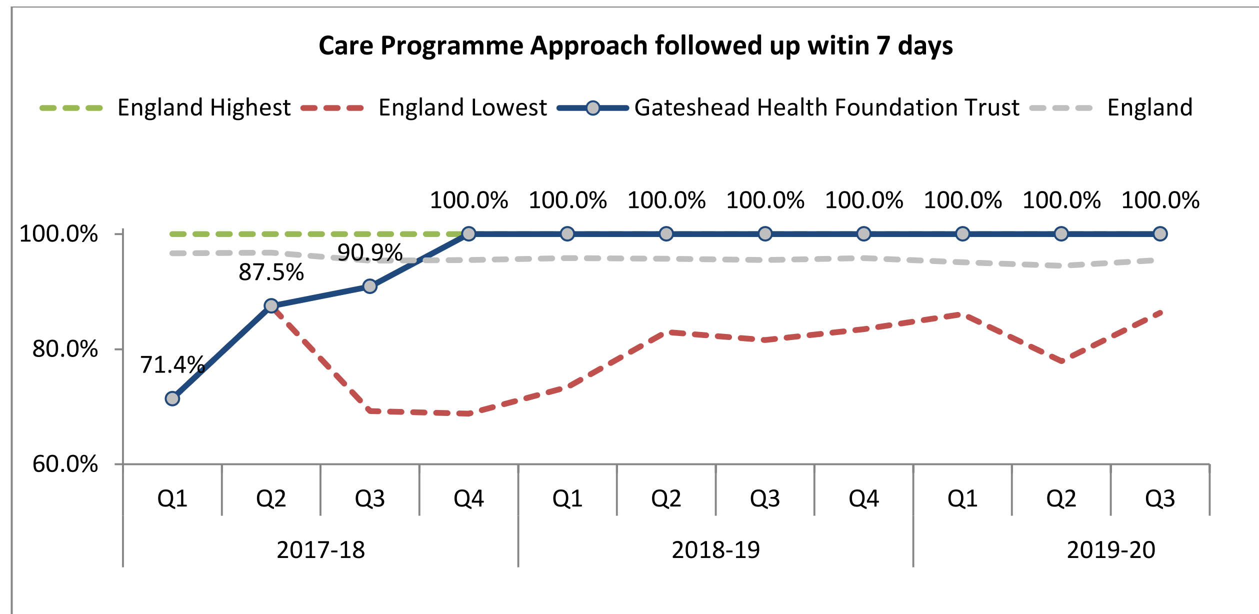
Gateshead Health NHS Foundation Trust has taken the following actions to improve the indicator and percentage in (a) and (b), and so the quality of its services, by:

- The Assistant Director of Quality has recently met with NHSI to discuss and review this further analysis.
- A review of the palliative care coding across the region was discussed and again highlighted that Gateshead is often lower than other surrounding Trust, however, NHSI did acknowledge confidence in our analysis and mortality report. Further actions taken have been to meet with coding managers and the consultants in palliative care to review our data and discuss any potential options for improvement in practice. The specialist team currently use sticker identification for coding if they have been involved in patient care at a specialist level. However the following actions were agreed with aim of improvement and consistency for coding;
    - Raise importance within team of using colour coded sticker identification.
    - Record all intervention/advice given by SPC team (tel. call advice received from St Bedes, ad-hoc ward request for advice when visiting a different patient).
    - Recording of intervention into specialist areas such as chemotherapy day unit, (gynae-oncology and A&E- team advised currently capture this in their data).
    - The percentage of deaths with palliative care coding has increased over recent quarters and is close to being in line with the levels observed nationally.

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

	2017-18				2018-19				2019-20			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Gateshead Health Foundation Trust	71.4†	87.5††	90.9%†††	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
England	96.7%	96.7%	95.4%	95.5%	95.8%	95.7%	95.5%	95.8%	95.1%	94.5%	95.5%	-
England Highest	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-
England Lowest	71.4%	87.5%	69.2%	68.8%	73.4%	83.0%	81.6%	83.5%	86.1%	77.9%	86.3%	-

Source:https://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/ Q4 2019-20 collection cancelled due to the coronavirus illness (COVID-19) and the need to release capacity across the NHS,
† 5 of 7 patients followed up within 7 days after discharge from psychiatric inpatient care
†† 7 of 8 patients followed up within 7 days after discharge from psychiatric inpatient care
††† 10 of 11 patients followed up within 7 days after discharge from psychiatric inpatient care



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

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

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

- The use of EMIS as our electronic Patient Record system which is used across both inpatient and community has enabled a more streamlined pathway and enabled consistent reporting

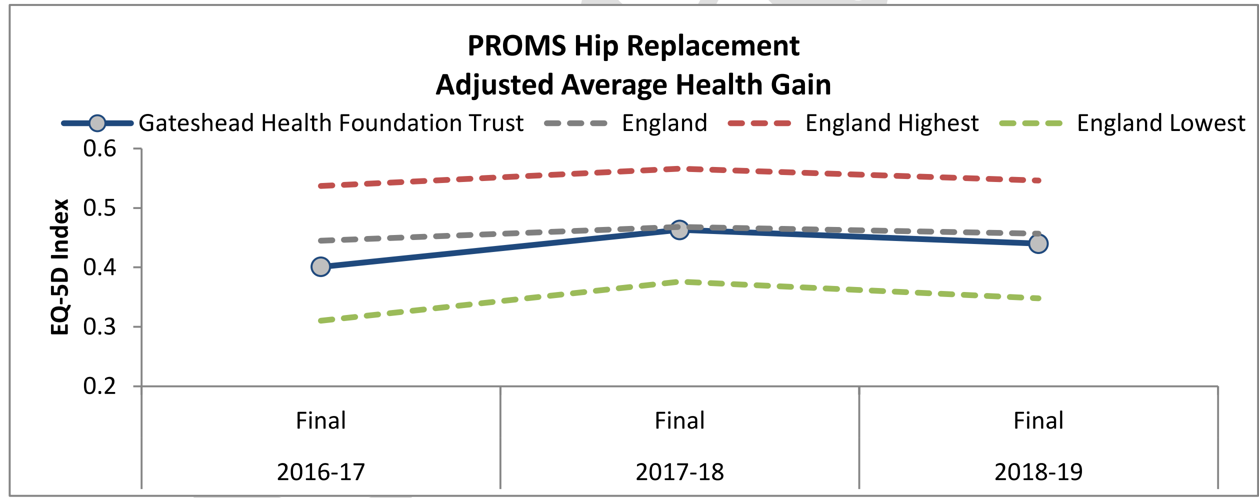
- The service regularly audits the CPA compliance as part of its monthly document records audit and produces a report for its Older Persons' Mental Health Performance and Quality meetings.

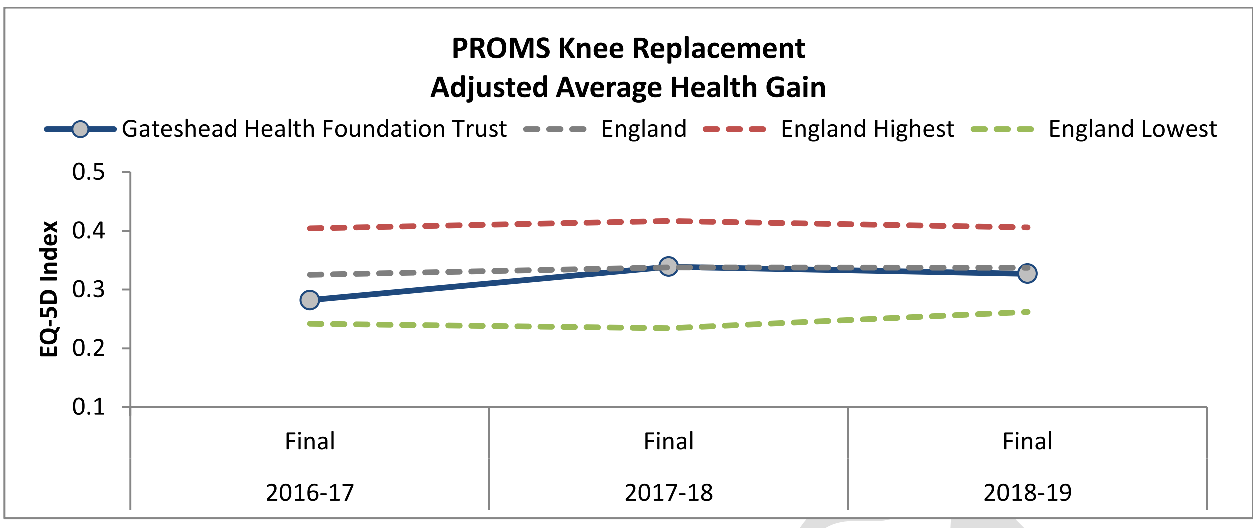
PROMs (Patient Reported Outcome Measures) for Hip Replacement and Knee Replacement:

Hip Replacement Adjusted average health gain EQ-5D index	2016-17 Final	2017-18 Final	2018-19 Final
Gateshead Health Foundation Trust	0.401	0.463	0.440
England	0.445	0.468	0.457
England Highest	0.537	0.566	0.546
England Lowest	0.310	0.376	0.348

Knee Replacement Adjusted average health gain EQ-5D index	2016-17 Final	2017-18 Final	2018-19 Final
Gateshead Health Foundation Trust	0.282	0.339	0.327
England	0.325	0.338	0.337
England Highest	0.404	0.417	0.406
England Lowest	0.242	0.234	0.262

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





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

- The Trust was previously a negative outlier for Hip and Knee PROMS prior to 2017-18. Although the overall position has demonstrated a slight reduction from 2018/19 for both hip and knee scores, this mirrors the national trend, and GHNT continues to perform in line with the England average.

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

- The Trust has invested significantly in a PROMS improvement project to improve previous scores, including utilisation of a data collection and reporting software package, and local reporting of lowest PROMS scores for MDT review.

Hip

- We will continue to share data with clinical teams and commissioners to ensure that health gains can be maximised from future procedures.
- We are continuing to work in conjunction with NEQOS to further analyse the information recorded and identify trends.
- Data has been shared and discussed in the regional Orthopaedic Alliance group as part of a Getting it Right First Time (GIRFT) review across all regional providers.

Knee

- We will continue to share data with clinical teams and commissioners to ensure that health gains can be maximised from future procedures.
- We are continuing to work in conjunction with NEQOS to further analyse the information recorded and identify trends.
- Data has been shared and discussed in the regional Orthopaedic Alliance group as part of a Getting it Right First Time (GIRFT) review across all regional providers.

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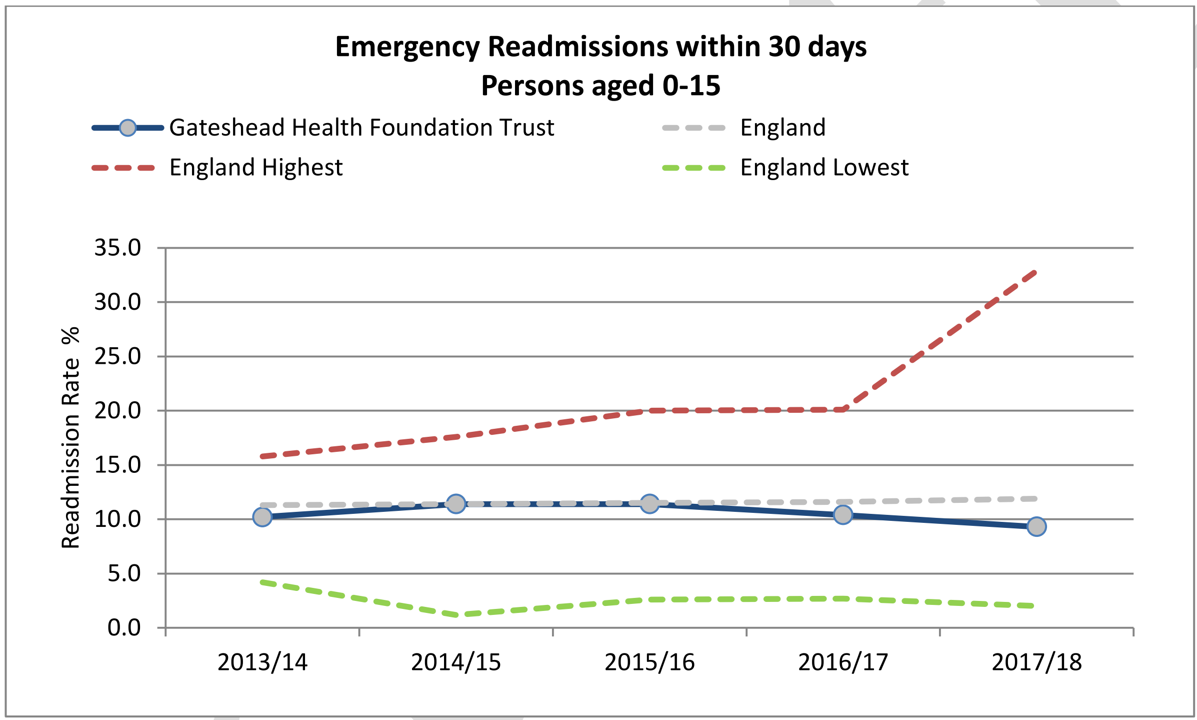
Emergency Readmissions within 30 Days

- Aged 0 – 15yrs

Emergency readmissions within 30 days of discharge from hospital Persons aged 0-15	2013/14	2014/15	2015/16	2016/17	2017/18
Gateshead Health Foundation Trust	10.2	11.4	11.4	10.4	9.3
Banding	W	W	W	W	B1
England	11.3	11.4	11.5	11.6	11.9
England Highest	15.8	17.6	20	20.1	32.9
England Lowest	4.2	1.2	2.6	2.7	2.0

B1 = Significantly lower than the national average at the 99.8% level

W = National average lies within expected variation (95% confidence interval)



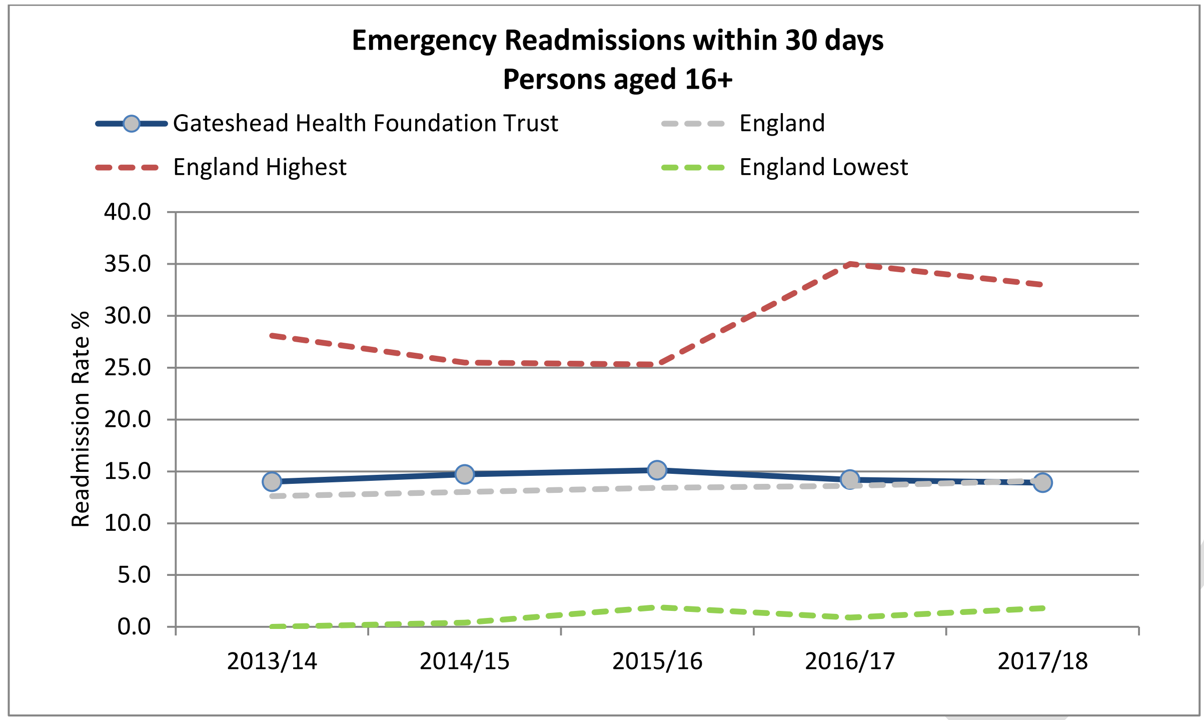
- Aged 16 years or over

Emergency readmissions within 30 days of discharge from hospital Persons aged 16+	2013/14	2014/15	2015/16	2016/17	2017/18
Gateshead Health Foundation Trust	14.0	14.7	15.1	14.2	13.9
Banding	A1	A1	A1	A5	W
England	12.6	13	13.4	13.6	14.1
England Highest	28.1	25.5	25.3	35	33
England Lowest	0.0	0.4	1.9	0.9	1.8

A1 = Significantly higher than the national average at the 99.8% level.

A5 = Significantly higher than the national average at the 95% level but not at the 99.8% level

W = National average lies within expected variation (95% confidence interval)



Source: https://digital.nhs.uk/data-and-information/publications/ci-hub/compendium-indicators

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

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

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

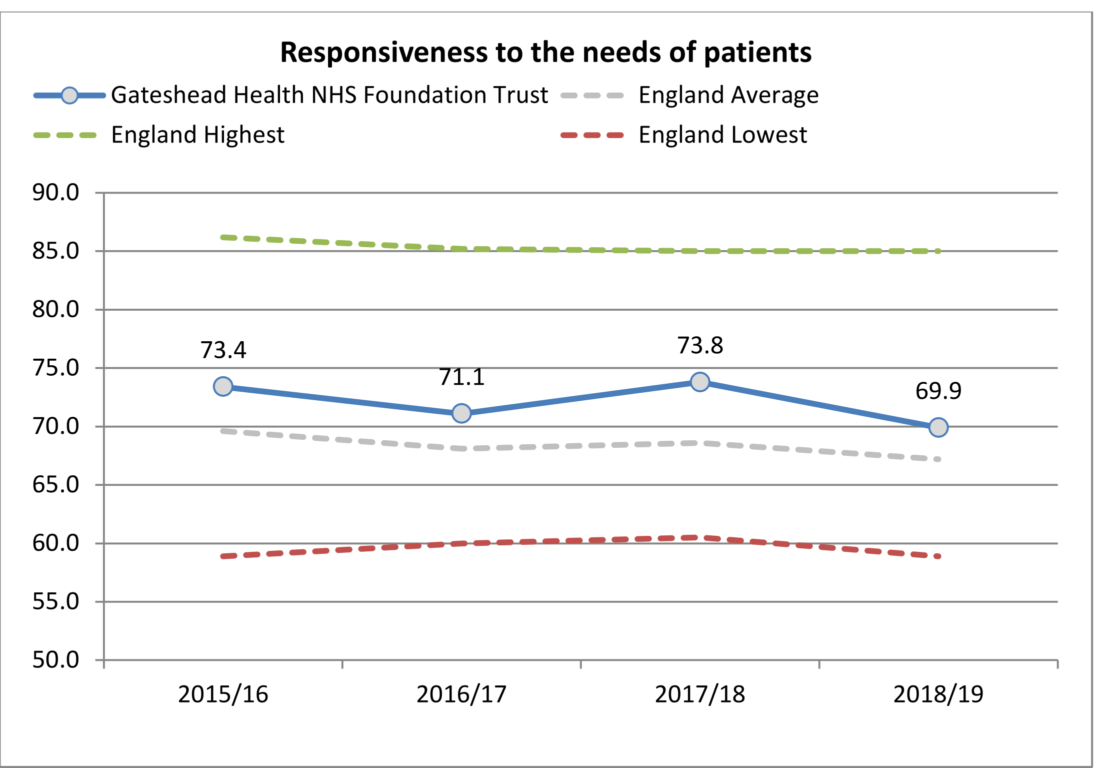
- Throughout 2019 there was a significant amount of work undertaken as part of the Trust's newly established Transformation Board. A key programme of work related to 'patient flow' in which a number of projects targeting reducing unnecessary long length of stays, improving discharge planning/transfers of care and re-admissions were progressed, as follows:
  - Weekly reviews of long-stay patients in all areas to optimise care and identify opportunities for streamlining services were rolled out from July 2019. A substantial reduction in long stay patients was seen initially but in line with the national trend, could not be sustained over the winter period. A drill down into the ECIST codes identified the most common codes being used for patients staying >21 days which allowed improvement opportunities affecting flow to identified and addressed.
  - A pilot of Clinical Criteria for Discharge (CCD) to enable other groups of staff (junior medical staff, Allied Health professionals etc.) to undertake the discharge of patients within agreed parameters. Once the pilot is complete any learning will be used to formulate a wider roll out plan across more medical inpatient wards.

- The Trust also participated in the Getting It Right First Time (GIRFT) Geriatric Medicine programme within NHS Improvement, and NHS Benchmarking Network 'Managing Frailty and Delayed Transfers of Care in the Acute Setting' data collection in 2018/19. Whilst the Trust had one of the lowest % emergency readmission rates within 7 days for 75years+ patients, our % emergency readmissions within 30 days for frail 75years+ patients was a slight outlier, being higher than national average. A case review of a sample of readmissions was commenced to understand the environment, the pathway the patient follows and the potential reasons behind readmissions. Some initial emerging themes were identified early on in the audit with the intention of a more detailed review once the audit was complete. Findings from the audit were to be shared with the relevant services to identify what improvement measures were needed.
- The QEH frailty transformation programme was also established outlining a hospital wide programme of work reporting into the Trust Transformation Board and the Gateshead System Group. Key components to this programme are (i) identification of frailty and (ii) timely intervention for people at risk with complex care needs and (iii) creating transparency by sharing & standardising care planning throughout the journey.

Understandably many of the work streams outlined above were put on hold whilst resources were diverted to support the Covid-19 pandemic. However work is underway once again and this long term programme of work will continue throughout the remainder of 2020/21.

Trust's responsiveness to the personal needs of its patients

Responsiveness to the personal needs of patients	2015/16	2016/17	2017/18	2018/19
Gateshead Health NHS Foundation Trust	73.4	71.1	73.8	69.9
England Average	69.6	68.1	68.6	67.2
England Highest	86.2	85.2	85.0	85.0
England Lowest	58.9	60.0	60.5	58.9



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

- The data supplied by NHS digital and is consistent with internal data reviewed on a monthly basis of patient feedback of their experience.

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 encourage patients and carers in taking part in robust multi-disciplinary care discussions where the patient can discuss their individual needs as an inpatient.
- Continuing to collect feedback from patients, carers and relatives through a variety of different sources including the Friends and Family Test, service level patient experience questionnaires as well as a new programme of collecting patient stories initiated in community settings.
- A Patient Involvement Forum has been established to ensure service developments are responsive to patient needs.
- We continue to closely monitor our patient experience reporting and include these measures as part of the compliance monitoring again the Trust's Quality Improvement Strategy and the Patient, Public and Carer Involvement and Experience Strategy 2018-2021 and these are monitored through the Patient Public Carer Involvement and Experience Group and the SafeCare Council.
- A series of existing initiatives have been revised to ensure that patient experience and responsiveness to individual needs is at the heart of what we do. This includes the Ward Accreditation Programme whereby volunteers facilitate real-time surveys with patients on wards and departments as well as implementing a revised Well Led Walk About and 15 Steps Challenge. Following the results of the National Inpatient Survey, we intend to continue work around patient discharge, including the information given to patients.

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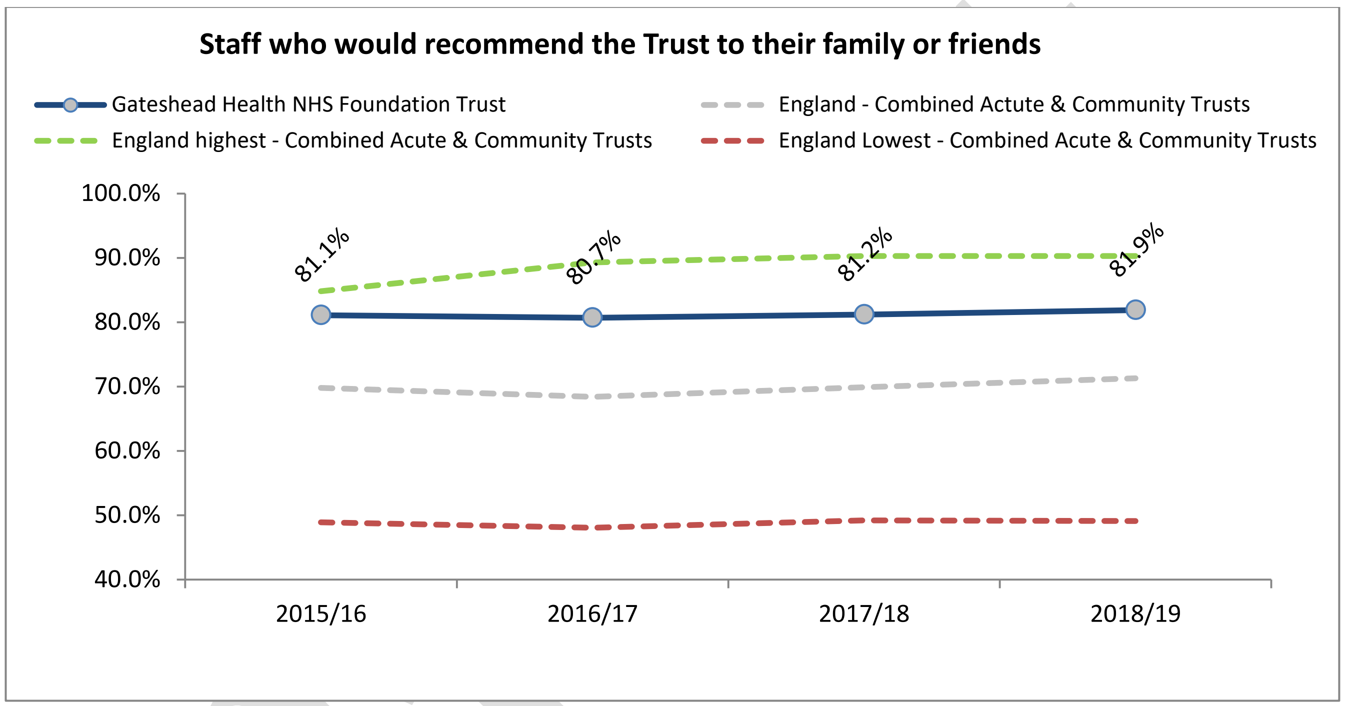
Percentage of staff employed by, or under contract to the Trust who would recommend the Trust as a provider of care to their family or friends

Staff who would recommend the Trust to their family or friends	2016*	2017	2018	2019
Gateshead Health NHS Foundation Trust	81.1%	80.7%	81.2%	81.9%
England highest - Combined Acute & Community Trusts	84.8%	89.3%	90.3%	90.3%
England Lowest - Combined Acute & Community Trusts	48.9%	48.1%	49.2%	49.1%
England - Combined Acute & Community Trusts	69.8%	68.4%	69.9%	71.3%

Source:www.nhsstaffsurveys.com

*Acute Trusts



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

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

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

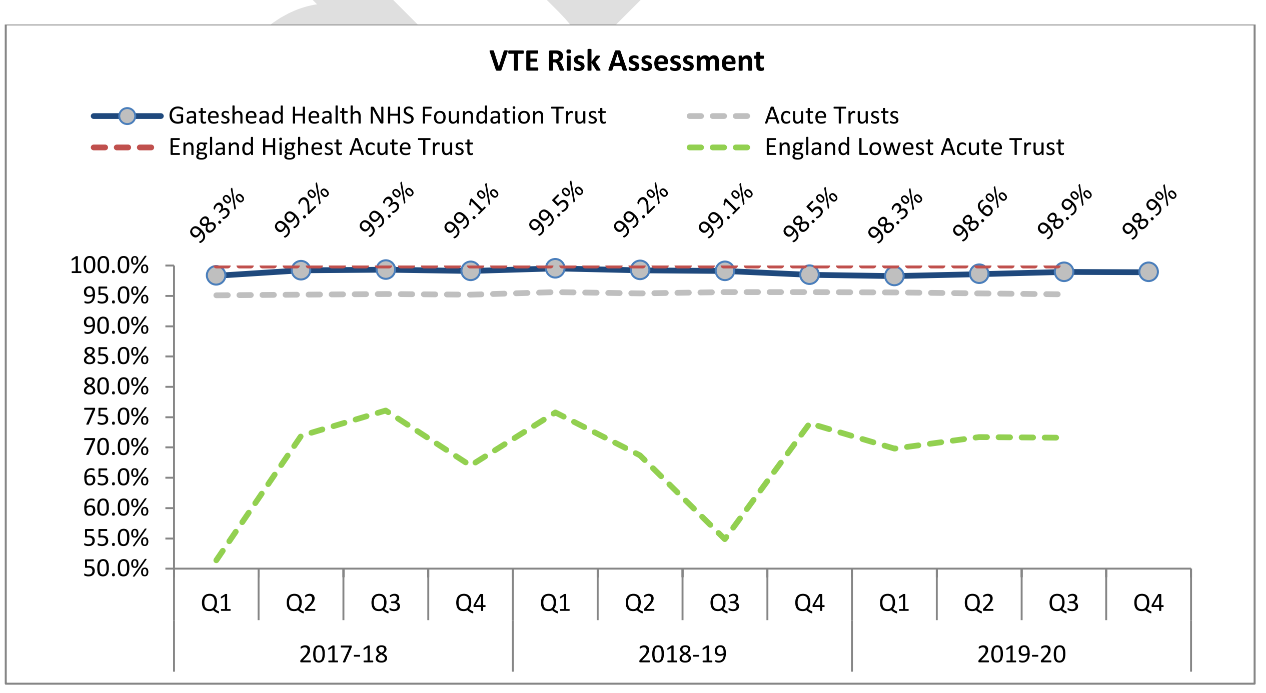
Continuing to promote the Trust's Vision and Values, which place the patient at the centre of everything we do.

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

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

Year	Quarter	Gateshead Health NHS Foundation Trust	England Highest Acute Trust	England Lowest Acute Trust	Acute Trusts
2015-16	Q1	95.6%	100.0%	86.1%	96.0%
	Q2	95.1%	100.0%	75.0%	95.8%
	Q3	95.0%	100.0%	78.5%	95.5%
	Q4	95.3%	100.0%	78.1%	95.5%
2016-17	Q1	97.8%	100.0%	80.6%	95.6%
	Q2	97.9%	100.0%	72.1%	95.5%
	Q3	98.5%	100.0%	76.5%	95.6%
	Q4	98.8%	100.0%	63.0%	95.5%
2017-18	Q1	98.3%	100.0%	51.4%	95.1%
	Q2	99.2%	100.0%	71.9%	95.2%
	Q3	99.3%	100.0%	76.1%	95.3%
	Q4	99.1%	100.0%	67.0%	95.2%
2018-19	Q1	99.5%	100.0%	75.8%	95.6%
	Q2	99.2%	100.0%	68.7%	95.4%
	Q3	99.1%	100.0%	54.9%	95.6%
	Q4	98.5%	100.0%	74.0%	95.6%
2019-20	Q1	98.3%	100.0%	69.8%	95.6%
	Q2	98.6%	100.0%	71.7%	95.4%
	Q3	98.9%	100.0%	71.6%	95.3%
	Q4	98.9%	Not published		

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



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

- Gateshead Health NHS Foundation Trust continues to have a high compliance with the NICE guidance regarding patient risk assessment for VTE on admission to hospital, and this is documented as being above 98% for the last year. The audit process has been facilitated and risk assessment continues to be recorded on the electronic prescribing management system.

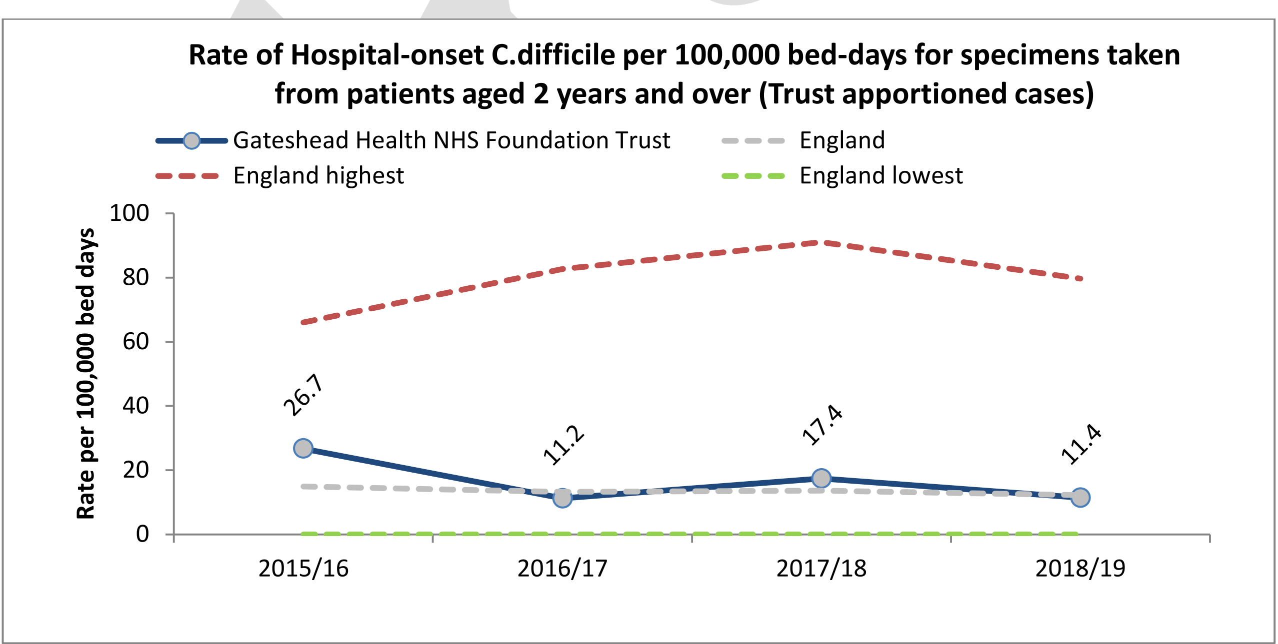
The Gateshead Health NHS Foundation Trust intends to take the following actions to improve these percentages, and so the quality of its services, by:

- A VTE Steering Group was established during 2019, the purpose of Group is to set the strategic direction for the management of VTE across the Trust. The Group will develop and oversee the implementation of guidelines for the prevention and management of venous thromboembolism within the trust as well as ensuring staff have access to the appropriate education and training.

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

Rate of CDI per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust associated cases)	2015/16	2016/17	2017/18	2018/19	2019/20
Gateshead Health NHS Foundation Trust	26.7	11.2	17.4	11.4	?
England highest	66.0	82.7	91.0	79.7	
England lowest	0.0	0.0	0.0	0.0	
England Average	14.9	13.2	13.7	12.2	

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



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

- Clostridium difficile infection (CDI) remains an unpleasant, and potentially severe or even fatal, infection that occurs mainly in elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment. Reduction of CDI continues to present a key challenge to patient safety across the Trust, therefore ensuring preventative measures and reducing infection is very important to the high quality of patient care we deliver.
- For the financial year 2019/20 NHS improvement changed the CDI reporting algorithm by
- adding a prior healthcare exposure element for community onset cases reducing the number of days to apportion hospital-onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission.
- The Gateshead Health NHS Foundation Trust was set a CDI case objective for 2019/20 of forty (40) cases and a CDI rate objective for 2019/20 of 23.6 per 100,000 bed days using the two categories:
- Hospital onset healthcare associated: cases that are detected in the hospital two or more days after admission
- Community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks
- The Trust reported forty five (45) healthcare associated CDI. Twenty two (22) hospital onset healthcare associated (HOHA) and twenty three (23) community onset healthcare associated (COHA). Forty five (45) cases were reviewed and thirty five (35), where no lapses in care identified, were successfully presented for appeal. Therefore, the Trust reported ten (10) CDI positive samples against the objective of forty (40) for 2019/20.
- A focused and zero tolerance approach to all avoidable healthcare-associated infections continue to support reduction of CDI in line with national guidance.

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

- Local multidisciplinary CDI Root Cause Analysis meetings are arranged for all healthcare associated cases. Cases are reviewed and good practice/lessons learnt can be identified. The learning is then linked, if appropriate, to the key themes of sample submission, antimicrobial prescribing, documentation, patient management and human factors.
- Where there is an increased incidence of CDI associated with a particular clinical area, a multidisciplinary meeting will review all the cases collectively, consider if any cross infection may have occurred then formulate and enable an action plan to address any shortcomings identified.
- Ribotyping of Hospital-onset positive CDI cases is arranged with the *Clostridium difficile* Ribotyping Network (CDRN) to determine if cross infection has taken place within clinical areas when there is an increase in incidence of CDI.
- The Trust works closely in partnership with the Newcastle Gateshead Clinical Commissioning Group, and other regional Foundation Trusts, to review lessons learned and share good practice from CDI cases.
- Bespoke CDI education support has been provided to both secondary and primary care sectors across Gateshead.
- The Diarrhoea Assessment Management Pathway (DAMP) tool provides guidance for clinical staff managing those patients experiencing loose stools, and will be assimilated into the suite of electronic documents available on Nerve Centre
- Enhanced personal protective equipment is worn when caring for patients with suspected infective diarrhoea.

- Patients are risk assessed and prioritised, ensuring those patients requiring a level of isolation are identified.
- To enhance antimicrobial stewardship Trust guidelines are developed to reflect the national five year AMR strategy.
- Polymerase chain reaction (PCR) testing continues to be used to enhance the testing regimen of samples.
- A weekly CDI MDT meeting takes place and antimicrobial prescribing is reviewed along with all aspects of CDI care.

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

Patient Safety Incidents per 1,000 bed days	Apr 18 – Sep 18		Oct 18 – Mar 19		Apr 19 – Sep 19	
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	3,308	731,348	3,366	765,221	3,111	815,852
Rate of all incidents per 1,000 bed days	38.3	N/A	38.8	N/A	37.0	N/A
Number of incidents resulting in Severe harm or Death	29	2,477	41	2,458	27	2,524
Percentage of total incidents that resulted in Severe harm or Death	0.88%	0.34%	1.22%	0.32%	0.87%	0.31%

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

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

- Analysis of the categories of incidents graded as severe harm has demonstrated a significant decrease in the number of reported incidents relating to Grade 3 and 4 pressure damage within the specified timeframe.
- This corresponds with the implementation of revised guidance in April 2019 (issued by NHS Improvement) regarding the definition and measurement of pressure ulcers which advises that damage is recorded as 'unstageable' or 'deep tissue' until staff are able to visualise the wound bed.
- This damage would previously have been categorised as either Grade 3 or 4 and as such would have been reported as severe harm to Strategic Executive Information System (StEIS).
- Unstageable damage is managed by the Tissue Viability Team who monitors the wound until categorisation is possible and is graded as low harm until then.

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

- To maximise the learning from investigating incidents graded as moderate and above, the Trust has amended the investigation report template for severe harm falls to incorporate Human Factors which ensures this is in keeping with the Trust's approach to investigating patient safety incidents.
- Work is underway to amend the investigation report for pressure damage to ensure that all StEIS reported incidents are presented in the same format and that learning identified is systems-based.
- Family Liaison Officers continue to be deployed to support patients and families involved in severe harm incidents and further staff have been identified to train as FLOs which will ensure all families who require FLO support can be offered this.

Part 3

Review of Quality Performance

3. Review of quality performance

‡ denotes that this indicator is governed by standard national definitions

2019/20 has been a successful year in relation to the three domains of quality:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

The following sections provide details on the Trust's performance on a range of quality indicators. The indicators themselves have been extracted from NHS nationally mandated indicators, 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.

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

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

3.1 PATIENT SAFETY

‡*Outcomes of Trust Wide MaPSaF Patient Safety Culture Assessment:*

2015/2016	2016/2017	2017/2018	2018/19	2019/20
No Assessment Due	No Assessment Due	No Assessment Due	Pro-Active	No Assessment Due

Reducing Harm from Deterioration:

Safe Reliable care	2017-18	2018-19	2019-20	Target
HSMR	107.9	107.7	113.3*	<100
SHMI Period	Jul-18 to Jun-19	Oct-18 to Sep-19	Jan-19 to Dec-19	
SHMI	1.05	1.05	1.05	<=1
SHMI Banding	As Expected	As Expected	As Expected	As expected or lower than expected

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SHMI - Percentage of provider spells with palliative care coding (contextual indicator)	1.5%	2.0%	2.3%	N/A
Crude mortality rate taken from CDS	1.81%	1.62%	1.73%	<1.99%
Number of calls to the CRASH team	156	118	143	N/A
Of the calls to the arrest team what percentage were actual cardiac arrests	43.6%	45.8%	45.5%	N/A
Cardiac arrest rate (number of cardiac arrests per 1000 bed days)	0.37	0.31	0.52	N/A
Hospital Acquired Pressure Damage (grade 2 and above)	92	130	105	Year on year Reduction
Community Acquired Pressure Damage (grade 2 and above)	1346	1312	1462	N/A
Number of Patient Slips, Trips and Falls	1505	1656	1519	N/A
Rate of Falls per 1000 bed days	9.02	9.38	8.70	Reduction (<8.5)
Number of Patient Slips, Trips and Falls Resulting in Harm	347	385	329	N/A
Rate of Harm Falls per 1000 bed days	2.08	2.18	1.89	Reduction (Less than <2.25)
Falls Change	7.1% reduction	4.8% Increase	13.8% reduction	Reduction (Less than <2.25)
Ratio of Harm to No Harm Falls (i.e. what percentage of falls resulted in Harm being caused to the patient)	22.7%	23.2%	21.7%	Year on Year reduction

*HSMR figures are April 2019 to December 2019

Reducing Avoidable Harm:

Reducing Avoidable Harm		2016-17	2017-18	2018-19	2019-20	Target
Medication Errors	No Harm	413	454	562	440	N/A
	Minimal Harm	45	54	73	63	N/A
	Moderate Harm	3	10	7	5	<8
	Severe	0	0	0	1	0
	Total	461	518	642	509	N/A
Never Events		3	3	4	4	0
Patient Incidents per 1,000 bed days		37.33	43.93	45.60	44.66	N/A
Rate of patient safety incidents resulting in severe harm or death per 100 admissions		0.18	0.21	0.17	0.11	N/A

Source: Trust incident reporting system Datix

Infection Prevention and Control:

Infection Prevention & Control	2017-18	2018-19	2019-20	2019-20 Objective
MRSA bacteraemia apportioned to acute trust post 48hrs	0	2	1	0
MRSA bacteraemia rate per 100,000 bed days	**0**	**1.14***	**0.57**	**0**
NB: *Clostridium difficile* Infections (CDI) post 72hr cases	**31†**	**20††**	**45**	**<=40**
Clostridium difficile Infections (CDI) rate per 100,000 bed days	**17.97 †**	**11.24††**	**25.65**	**<=23.60**

During 2019/20, 28 Clostridium difficile cases have been successfully presented for appeal with 9 cases currently awaiting joint review meetings; therefore the Trust currently has 17 cases held against the identified ambition of 40 cases.

During 2018/19 the Trust reported two (2) MRSA bacteraemia.

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

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

Safeguarding Adults and Children

Safeguarding children and adults is recognised by the Trust as being everybody's business.

Working with our community partnerships, the safeguarding teams provide an efficient and effective advisory and support service to protect vulnerable people to live a life free from abuse in an ever expanding area of concern with multiple complex situations requiring interventions. The teams review and update policy and procedure in line with local and national guidance and have clear lines of responsibility. Work plans address the constantly changing and expanding safeguarding agenda and there is strong governance in place to monitor process.

Training is key to high standards of safeguarding support and the training strategy aims to provide the appropriate level of training to each area in line with the Intercollegiate Document guidance. Risks are effectively managed and monitored to improve the safeguarding service and audits carried out to inform and develop the work plans.

Key achievements for 2019:

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- In response to local and national guidance around children and young people at risk of child sexual exploitation the safeguarding children team have developed and implemented the Sexual Exploitation and Grooming Risk Identification (SEGRI) tool. The tool has been promoted throughout 2019 alongside training updates and an audit plan is in place to evaluate its use.

- Following an audit of Female Genital Mutilation (FGM) cases it was discovered that paper FGM proformas were not always completed by midwives. Named Safeguarding Midwife introduced an electronic pro forma which is now routinely sent at the time of the booking appointment bringing compliance rates to the expected standard.

- In order to promote better outcomes for children during the "Critical 1001 Days", the Named Safeguarding Midwife has developed monthly Multidisciplinary Team (MDT) meetings with the Gateshead recovery partnership to provide a multi-agency approach to support vulnerable pregnant women to.

- The Looked After Children (LAC) team have been supporting the transition of Young people from child to adult services by completing a Leaving Care Health Passport for 17year olds prior to leaving care. There has been a 100% uptake from service users and a subsequent audit evaluated well, the majority of feedback was positive and indicated that engagement with the Health Passport is valued by young people.

- The LAC Health Team were able to offer initial health assessment appointments to 100% of children within 20 working days of consents being received and achieved 87.29% compliance which was an increase from 62.26% the previous year. A challenge in meeting the overall time frame was the delay in obtaining parental consent from social workers and there is ongoing work with the Local Authority to continue to improve this.

- The appointment of a Mental Capacity Act & Deprivation of Liberty (DoLs) lead has seen an improvement in the quantity and quality of DoLs applications made. Training is being rolled out at both basic and complex levels. The outcome of a recent audit by Audit One was good.

- Prevent Level 3 training was transferred to e learning in an effort to reach the compliance standard required of 85% and this has been achieved. This continues to be monitored and quarterly returns submitted to NHS England.

- A comprehensive training package is delivered by the Domestic Abuse advisor as concerns regarding domestic abuse continue to escalate. Key areas including Accident and Emergency, Maternity and Gynaecology were prioritised in the roll out and Domestic Abuse champions trained to support the service.

- The adult Safeguarding team participated in a Challenge Event hosted by the Safeguarding Adults Board where partner agencies defined their areas of good practice and areas for improvement. Members of the organisations were challenged to discuss their achievements and methods of improvement, to share good practice and promote improved partnership working.

- Members of the teams attended an Adverse Childhood Experience (ACE) conference organised by Gateshead Safeguarding Adult Board (SAB) and Local Safeguarding Children's Board in partnership with Public Health. This was attended by over 200 delegates, many of which from partnership organisations. Work has commenced to consider how the SAB can champion the

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importance of understanding and responding to the impact of Adverse Childhood Experiences and Adult attachment theories and has been included in the 2019/2024 Strategic Plan.

Harm Free Care – measured by the NHS Safety Thermometer

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

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

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

Safety Thermometer	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Sample	715	685	727	705	649	670	759	674	767	766	739	450
Surveys	30	29	29	31	30	29	30	29	31	29	31	27
Harm free	95.8%	95.3%	95.2%	95.7%	95.5%	96.1%	95.5%	96.1%	97.7%	95.7%	96.9%	96.2%
Pressure Ulcers - All	2.9%	3.2%	3.0%	3.0%	3.1%	3.1%	3.0%	2.8%	1.3%	3.1%	2.0%	2.9%
Pressure Ulcers - New	1.0%	0.4%	0.7%	0.4%	0.6%	0.8%	0.7%	0.5%	0.1%	0.4%	0.1%	0.0%
Falls with Harm	0.3%	0.9%	0.6%	0.3%	0.5%	0.0%	0.9%	0.5%	0.4%	0.4%	0.3%	0.0%
Catheters and UTIs	1.1%	0.6%	1.2%	1.3%	0.9%	0.8%	0.7%	0.6%	0.5%	1.0%	0.8%	0.7%
Catheters and New UTIs	0.8%	0.4%	0.8%	1.0%	0.8%	0.8%	0.4%	0.6%	0.5%	0.5%	0.1%	0.4%
New VTEs	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.2%
All Harms	4.2%	4.7%	4.8%	4.3%	4.5%	3.9%	4.5%	3.9%	2.4%	4.3%	3.1%	3.8%
New Harms	2.1%	1.8%	2.1%	1.6%	1.9%	1.5%	2.0%	1.5%	1.2%	1.2%	0.8%	0.7%

3.2 CLINICAL EFFECTIVENESS

Right Care, Right Place, Right Time

Care of patients following a Stroke:
Results from the Sentinel Stroke National Audit Programme (SSNAP) are provided below.

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

‡Team Centred Key Indicators	Apr-Jun-18	Jul-Sep-18	Oct-Dec 18	Jan -Mar 19	Apr-Jun 19	Jul-Sep 19
1) Scanning*						
2) Stroke unit	A	A	B	A	A	A
3) Thrombolysis*						
4) Specialist Assessments*						
5) Occupational therapy	A	A	C	B	C	A
6) Physiotherapy	A	A	A	A	B	A
7) Speech and Language therapy	C	B	C	E	D	E
8) MDT working*						
9) Standards by discharge	C	C	C	B	B	A
10) Discharge processes	D	C	C	D	C	C
Team-centred Total KI level	B	A	B	B	B	B
Team-centred Total KI score	77	83	70	70	70	80
Team-centred SSNAP level (after adjustments)	B	B	C	C	C	B
Team-centred SSNAP score	73	79	67	67	67	76

Source: https://www.strokeaudit.org/results/Clinical-audit/National-Results.aspx
* These indicators are no longer relevant to the Trust as patients are now transferred to the Newcastle Upon Tyne Hospitals NHS Foundation Trust's Stroke Unit for these services.

Other Indicators:

Other Indicators	2017-18	2018-19	2019-20	Target	Benchmark
Percentage of Cancelled Operations from FFCE's†	0.68%	0.60%	0.54%	0.80%	1.1%** update
Percentage of Patients who return to Theatre within 30 days (Unplanned / Planned / Unrelated)	5.48%	5.28%	3.85%	Improve Year on Year	N/A
Fragility Fracture Neck of Femur operated on within 48hrs of admission / diagnosis	94.7%	95.3%	96.3%	90%	N/A
Proportion of patients who are readmitted within 28 days across the Trust*	8.32%	8.34%	8.81%	Improve year on year	N/A
Proportion of patients undergoing knee replacement who are readmitted within 30 days*	5.90% 24 patients readmitted	5.50% 21 Patients readmitted	6.55% 15 Patients readmitted	Improve Year on Year	N/A
Proportion of patients undergoing hip replacement who are readmitted within 30 days*	7.43% 31 patients readmitted	6.08% 23 patients readmitted	6.00% 15 patients readmitted	Improve Year on Year	N/A

* Figures taken from Healthcare Evaluation data (HED) and provide full financial years for 2016-17, 2018-19, and April to November 2019

** NHS England Statistics - NHS Cancelled Elective Operations Quarter Ending December 2019

† 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

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3.3 PATIENT EXPERIENCE

Responsiveness to Inpatients' personal needs NHS Inpatient Survey Positive Scores	2015	2016	2017	2018	2019	Average for similar organisations
Was the patient as involved as they wanted to be in decisions about their care and treatment?	91%	90%	92%	89%	92%	90%
Did the patient find someone to talk to about their worries and fears?	82%	76%	82%	73%	73%	72%
Was the patient told about medication side effects to watch out for?	65%	59%	64%	57%	59%	57%
Was the patient told who to contact if they were worried?	84%	80%	82%	77%	74%	76%
Was the patient given enough privacy when discussing their condition or treatment?	94%	95%	96%	95%	97%	94%

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

Red cells show a significantly worse score

Green cells indicate a significantly improved score

Safe, Effective Environment, Appropriate Equipment & Supplies

Patient-Led Assessments of the Care Environment (PLACE)		2016	2017	2018	2019*
Cleanliness	Gateshead Health NHS Foundation Trust	99.9%	99.9%	99.9%	100.0%
	National Average	98.1%	98.4%	98.5%	98.6%
Food	Gateshead Health NHS Foundation Trust	91.5%	93.9%	93.4%	99.6%
	National Average	88.2%	89.7%	90.2%	92.2%
Environment	Gateshead Health NHS Foundation Trust	96.5%	97.1%	99.0%	99.7%
	National Average	93.4%	94.0%	94.3%	96.4%
Privacy, Dignity and Wellbeing	Gateshead Health NHS Foundation Trust	84.7%	85.3%	87.0%	98.4%
	National Average	84.2%	83.7%	84.2%	86.1%
Dementia	Gateshead Health NHS Foundation Trust	75.8%	78.3%	86.6%	97.6%
	National Average	75.3%	76.7%	78.9%	80.7%
Disability	Gateshead Health NHS Foundation Trust	81.6%	86.7%	93.4%	96.8%
	National Average	78.8%	82.6%	84.2%	82.5%

*As a result of extensive changes to the survey it is important to note that the results of the 2019 assessments will not be comparable to earlier collections.

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

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‡Friends and Family Test

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

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

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

Friends and Family Test Recommend Rate	2017-18	2018-19	2019-20	National 2019-20*
A&E	95.1%	94.1%	91.3%	85.1%
Inpatients & Day cases	97.8%	98.4%	98.2%	95.9%
Maternity - Antenatal	98.1%	99.5%	78.9%	95.0%
Maternity - Delivery	98.5%	98.8%	99.3%	96.7%
Maternity - Postnatal Ward	98.0%	99.1%	99.2%	95.0%
Maternity - Postnatal Community	100.0%	100.0%	100.0%	97.8%
Outpatients	97.4%	97.6%	98.1%	93.8%
Mental Health	99.1%	99.4%	99.7%	89.2%
Community	98.3%	96.4%	98.2%	95.4%

Friends and Family Test Response Rate	2017-18	2018-19	2019-20	National 2019-20*
A&E	24.0%	21.0%	20.1%	21.1%
Inpatients & Day cases	27.1%	24.3%	22.5%	24.7%
Maternity - Antenatal	6.0%	11.4%	1.0%	N/A
Maternity - Delivery	32.8%	46.2%	32.6%	20.1%
Maternity - Postnatal Ward	30.0%	42.4%	31.1%	N/A
Maternity - Postnatal Community	5.4%	5.4%	0.7%	N/A

* published data Apr-19 to Feb-20

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

The National Patient Survey Programme

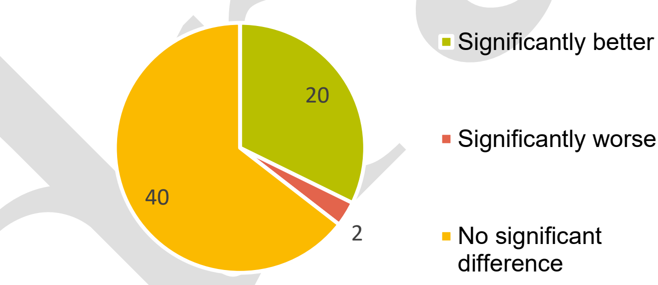
The National Patient Survey Programme comprises the annual adult inpatient survey and maternity survey and in rotation the community mental health survey, urgent and emergency care survey, children & young people survey and the outpatient survey. These national surveys are valuable sources of information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

Adult Inpatient Survey 2019

The National Inpatient Survey is undertaken every year. All eligible Trusts in England are required by the Quality Care Commission (CQC) to conduct the Survey. The Trust use an approved survey contractor called Picker and their comprehensive results report shows our results in comparison to the average of 74 other NHS Trusts (known as the "Picker Average" score). A total of 62 questions were asked in the 2018 and 2019 surveys and these have been used for historical and overall comparisons. The Trusts results include every question where our organisation had the minimum required 30 respondents.

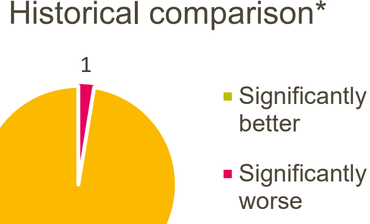
1250 service users were invited to complete the survey and we received a response rate of 48%. This was slightly below our previous response rate from the National Inpatient Survey 2018 of 49% yet still above the national average of 44% for 2019.

Compared to the national average, the Trust has received excellent results with 20 questions being significantly better than other Trusts and 40 questions being about the same. This is demonstrated in the graph below.



Maternity Survey 2019

69 Trusts took part in the survey, 104 eligible patients responded to the survey in 2019. This gave us a response rate of 39% this is slightly above the average response rate of 36% of the other 68 trusts taking part in the survey.



National Cancer Patient Experience Survey 2019

The National Cancer Patient Experience Survey 2019 is the ninth iteration of the survey having run annually since 2010. It was designed to monitor national and local progress on cancer care, providing information to drive quality improvements. There are 61 questions within the comprehensive survey which are designed to reflect different elements of the patient pathway from seeing a General Practitioner, diagnostics, decisions on treatment, hospital care, home care and support.

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

As a Trust we scored within or above the expected range in all of the questions asked. Importantly, when our patients were asked to rate their care on a scale of zero to 10, respondents gave an average rating of 9.1.

The key achievements are as follows:
89% of respondents said they were seen in a timely manner
95% of respondents said that they received all of the information they needed about their test
92% of respondents said they were told sensitively that they had cancer
98% of respondents said they had all of the information regarding their operation prior to their surgery
95% of respondents said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment
89% of respondents said they had confidence and trust in the doctors treating them
89% of respondents said that, overall, they were always treated with dignity and respect while they were in hospital
95% of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital

The following actions will be taken as a result of the survey findings:
Share the National Patient Survey results through cancer leads group
Share patient comments to site specific tumour groups / MDT leads and Service level managers for reflection of good practice and learning
Liaise with regional Lead Cancer Nurses to share good practice and support with improvements across Trusts
Liaise with Cancer Patient Advisory group in relation to ongoing service design

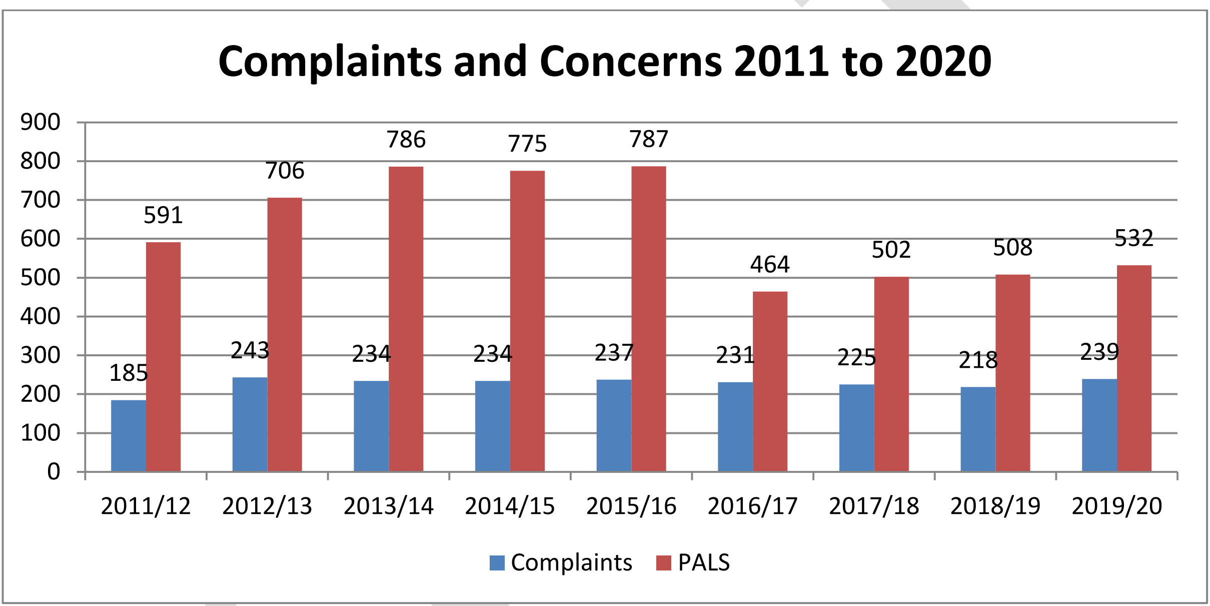
Unfortunately due to the Covid-19 pandemic there will be no 2020 survey.

Listening to Concerns and Complaints, Compliments

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

For the year 2019/20 we received a total of 239 formal complaints. Promoting a culture of openness and truthfulness is a prerequisite to improving the safety of patients, staff and visitors as well as the quality of healthcare systems. It involves apologising and explaining what happened to patients who have been harmed as a result of their healthcare treatment when inpatients or outpatients of the Trust. It also involves apologising and explaining what happened to staff or visitors who have suffered harm. It encompasses communication between healthcare organisations, healthcare teams and patients and/or their carers, staff and visitors and makes sure that openness, honesty and timeliness underpins responses to such incidents.

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



During 2019/20 the top five main reasons to raise a formal complaint were in relation to:

- Clinical Treatment – Surgical Group (59 complaints).
- Clinical Treatment – General Medical Group (41 complaints).
- Clinical Treatment – Accident & Emergency (34 complaints).
- Communications (42 complaints).
- Values & Behaviours (Staff) (17 complaints).

Complaints Performance Indicators	Total 2019/20
Complaints received	239
Acknowledged within three working days	239
Complaints closed	239
Closed within agreed timescale (eight weeks)	99
Number of complaints upheld	184
Concerns received by PALS	532

Complaints Indicators	Total 2019/20
Number of closed complaints reopened	32*
Number of closed complaints referred to Health Service Ombudsman	7

Outcome of complaints referred to Health Service Ombudsman (HSO)	Total 2019/20
Currently investigating	1
Complaints upheld	1 (referred in 2018/19)
Part upheld	2 (1 referred 18/19 & 1 referred in 19/20)
Declined to be investigated	5

***Number of closed complaints reopened.**
In the year 2019/20 32 closed complaints were reopened. This compares to 42 in 2018/19. Reasons for reopening cases include where the complainant has additional questions/concerns. Of the 32; six were complaints initially raised in 18/19. The remaining 26 were raised in 19/20.

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

- As a result of concerns relating to a breast screening appointment, the Matron for out-patient areas immediately arranged for signage to be posted on the doors to patient clinic areas, reminding all staff of the need to ensure that they enter the clinic rooms with the required level of professionalism so as to ensure a positive patient experience. A reminder to all staff working in the clinics was also shared by the Breast Care Nurse Consultant to ensure that the privacy curtains within the clinic rooms are also used to provide patients with an additional level of privacy should the door be opened.
- In response to concerns raised by a patient prepped for surgery (Trauma & Orthopaedics) before being told the surgeon was not at work; the department have introduced a system where the theatre schedule states "Middle-grade to perform" next to any surgical list scheduled without the consultant present. This allows all medical and theatre personnel, as well as administrative staff to see the theatre list has no consultant present. This has been developed in conjunction with the orthopaedic administration team.
- In response to issued raised regarding communication on Ward 6, work was undertaken to include patients and their family in discussions about their care, in the first 48 hours of admission. Rehabilitation goals are discussed as well as the plan for discharge. The importance of this was reinforced within the team.

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- In response to concerns that an appointment letter did not clearly state that the Main Outpatients Department is situated in the Queen Elizabeth Hospital, (a different hospital to the patient's previous appointment at Bensham) the standard letter format was changed so that all appointment letters clarify which hospital site the department is based at. For example "Location: Main Outpatients Department (Orange Zone) in the Queen Elizabeth Hospital".
- In response to feedback provided following attendance to A&E and the hospital information provided on the screens, the screens have been updated to make use of revolving news headlines from the BBC, Sky News and local news from the Chronicle. This meant that patients will no longer see relentless advertising for cancer screening programs.

3.4 Focus on Staff - Valuing Our People

The Trust's goal is to have an engaged and motivated workforce living the values and behaviours of the organisation, and who are responsive and adaptive to the changing needs of our environment. Throughout the year we have worked towards this through recognising, involving and developing our staff, in order to ensure we are a high quality, patient-focused organisation. Despite the financial pressures facing all NHS organisations, we are still committed to training and supporting staff to reach their full potential, and to attracting and retaining the best calibre of people to provide our services.

Staff Engagement

Highlighted by the Trust's values of openness and honesty, we have a multi-faceted approach to staff engagement which includes partnership working with staff representatives, involving staff in service transformation work, regular communications via QE Weekly, encouraging staff to share ideas and concerns through a range of mechanisms including the Freedom to Speak Up Guardian, using the Friends and Family Test, as well as professional forums, away days and annual conferences.

Formally, the Trust has a Joint Consultative Committee (JCC), which is the key mechanism for consulting with our employees across the organisation. Meetings are held regularly with representatives from trade union organisations and employee representatives to seek their views before decisions are made. This has been on matters ranging from policies and procedures to new systems or initiatives, and future plans of the Trust. In addition we have held a Partnership Away Day in 2018 to bring together trade union and employer representatives in a more informal setting, with a focus on learning together.

The JCC is supplemented by professional groups; business unit events, service line meetings and any organisational change processes include staff in matters relating to the financial, operational and quality performance of the Trust.

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

The annual NHS Staff Survey is a critical tool in enabling the Trust to benchmark itself against similar NHS organisations and the NHS as a whole, on a range of measures of staff engagement and satisfaction.

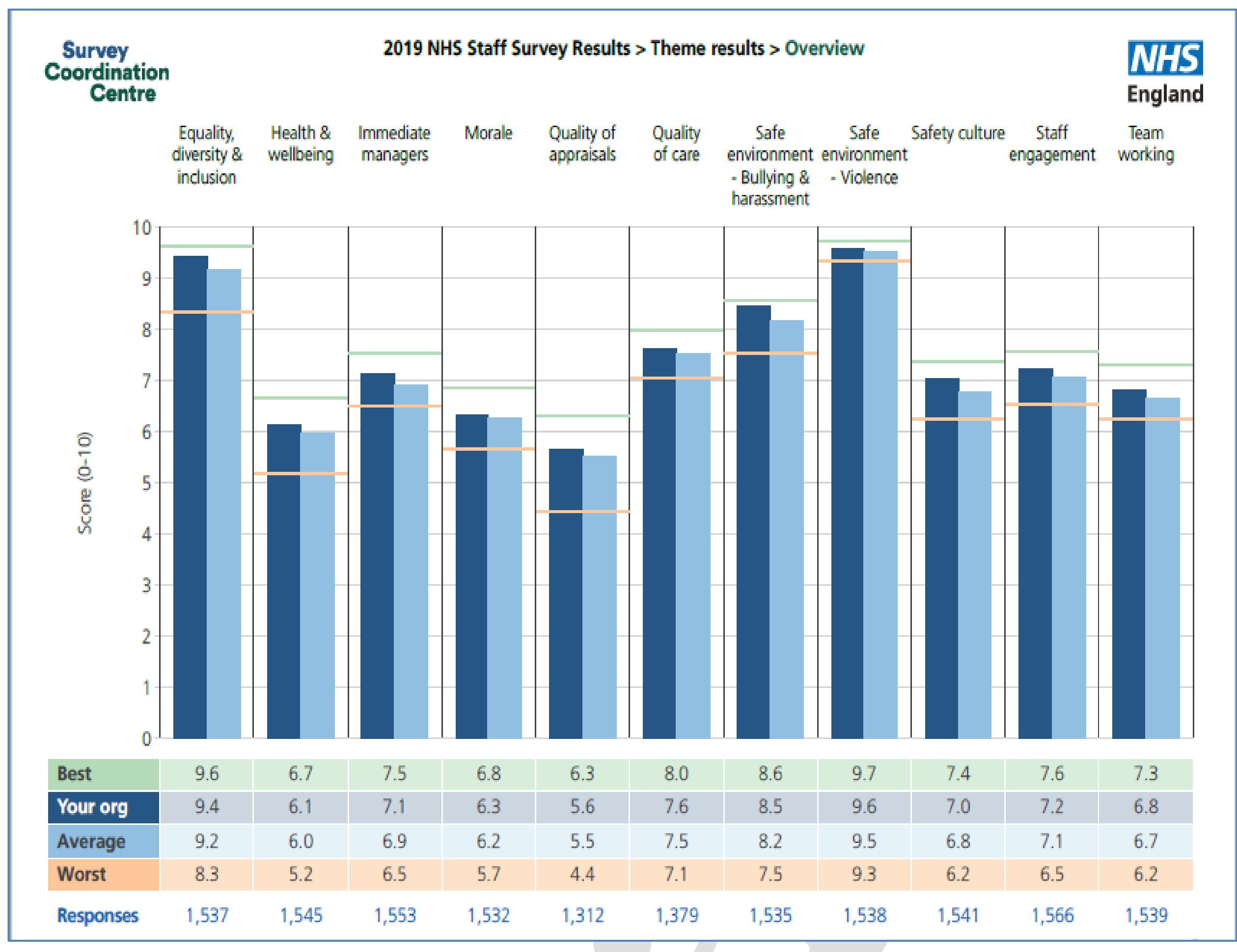
The arrival of over 600 community staff into the Trust has resulted in a shift in the profile of the Trust in line with the national survey co-ordination centre for the last 2 years. The Trust is now classified as a 'Combined Acute and Community Trust', rather than an 'Acute Trust'.

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

	2016/17		**2017/18**		**2018/19**		**2019/20**		**Trust comparison to previous year**
Response rate	**Trust**	**National average**	**Trust**	**National average**	**Trust**	**National average**	**Trust**	**National average**	
	39%	43%	44%	43%	40%	41%	42%	46%	2% increase

The slight increase in the response rate could be attributed to the planned work discussed in 2018 to provide support for staff who may find it difficult to take the time to fill the survey in. The workforce team organised a two month plan during which team members visited different areas of the Trust with iPads, specifically targeting those that had the lowest response rates in 2018 in conjunction with a targeted communications plan. This approach will be revisited in future years.

The results are organised into 10 key themes. The Trust performed very well scoring above average in 9 out of the 10 key themes. Gateshead was rated one of the highest Acute and Community Trust for equality, diversity and inclusion and for safety culture. The full results are below:



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.6	6.7	7.5	6.8	6.3	8.0	8.6	9.7	7.4	7.6	7.3
Your org	9.4	6.1	7.1	6.3	5.6	7.6	8.5	9.6	7.0	7.2	6.8
Average	9.2	6.0	6.9	6.2	5.5	7.5	8.2	9.5	6.8	7.1	6.7
Worst	8.3	5.2	6.5	5.7	4.4	7.1	7.5	9.3	6.2	6.5	6.2
Responses	1,537	1,545	1,553	1,532	1,312	1,379	1,535	1,538	1,541	1,566	1,539

Key Theme	2017	2018	2019
Equality, Diversity and Inclusion	9.5	9.5	9.4
Health and Wellbeing	6.4	6.2	6.1
Immediate Managers	7.1	7.1	7.1
Morale	N/A	6.3	6.3
Quality of Appraisals	5.5	5.6	5.6
Quality of Care	7.7	7.6	7.6
Safe Environment – Bullying and Harassment	8.5	8.3	8.5
Safe Environment – Violence	9.6	9.5	9.6
Safety Culture	7	7.1	7.2
Staff Engagement	7.3	7.3	6.8

Notes

- 2018 is the first year morale has been calculated so can't be compared to previous years
- 2016 data cannot be provided by the survey co-ordination centre due to moving benchmarking groups, this data is not comparable.

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

1. Improve staff motivation

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

At the 1-year stocktake, there was a slight increase in staff feeling motivated in going to work and static reporting of staff understanding the impact their role has on patients/service users at 90.8%. There was deterioration in the percentage of staff/colleagues reporting experiences of violence or harassment/bullying. .
We are now at the stage to review the Trusts strategic.

Since the previous year there have been no significant changes to staff feeling motivated to come to work and this remains in line with other Trusts in the region.

Reporting has increased for harassment and bullying from 32% in 2018 to 41% in 2019, which reflects the level of reporting in 2017. Reporting has decreased for physical violence; this is in line with the decrease in staff reporting experiencing physical violence at work.

Ensuring staff agree that their role makes a difference as also stayed static in the 90% range.

Overall, the average rates for the Trust have seen no significant changes, increased or decreased.

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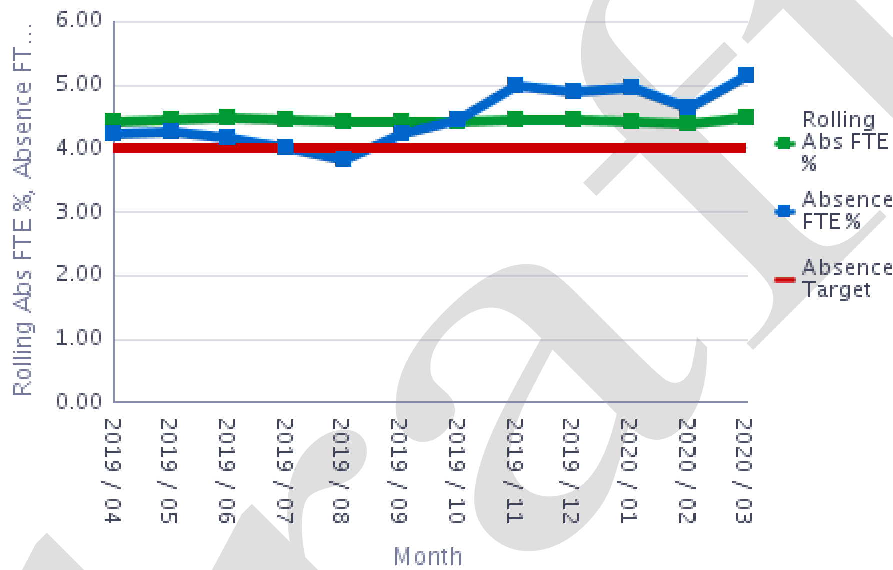
Health and Well-being

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

The Trust continues to support staff to be able to attend and sustain attendance at work. Robust monitoring of sickness absence enables early intervention and support. In 2018/19 we have seen sickness absence plateau just over 4.5%, which, whilst above our target of 4% has not increased. We continue to focus on a multi-factoral approach to prevention as well as absence management, particularly in relation to mental wellbeing, our highest reason of sickness absence.



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

Throughout 1st April 2019– March 2020 we have provided 6252 appointments for staff which can be broken down as follows:

- ✓ 936 counselling appointments
- ✓ 1200 pre-employment screening appointments
- ✓ 1316 vaccination/immunisation screenings
- ✓ 321 ergonomic and workplace assessments
- ✓ 1245 sickness absence management appointments
- ✓ 607 other consultations/Advice
- ✓ 118 appointments associated with sharps injuries
- ✓ 393 physiotherapy Appointments
- ✓ 86 Management referrals (Physio)
- ✓ 30 health Surveillance appointments

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In 2019/2020 we were also delighted to see that 80.5% of our front line staff chose to have their flu vaccination, to protect themselves, their family and our patients and visitors.

During 2019 we have continued to deliver a bitesize training session for managers to support "Mental Well-being at Work". This training session for line managers aims to enable managers to feel confident in supporting the mental well-being of the people in their teams. The session has been extended following feedback from participants that they wanted to ensure that they were equipped with the best information and tools to support the people in their teams to remain well at work.

During 2019 the Health and Wellbeing Steering Group supported a bid to invest in the training of Mental Health First Aiders. A total of 48 trained first aiders work closely with the Mental Health Champions across the Trust. These Mental Health First Aiders and Mental Health Champions are a first port of call for staff who may have concerns about their own or someone else's mental health. They can signpost staff to sources of help and encourage them to have open and honest conversations with line managers for example, but also with family members to ensure that they are receiving the right level of support. In addition the steering group support the Trusts 'Treat as one' ethos by supporting key messages, for example promoting the self-help apps that have been approved.

Importantly, both the Mental Health First Aiders and the Mental Health Champions have access to regular supervision and CPD to ensure that they are protecting their own mental well-being.

Organisational Development (OD)

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

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Living Our Values

Remember the acronym ICORE

– Innovation, Care, Openness, Respect and Engagement

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

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

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

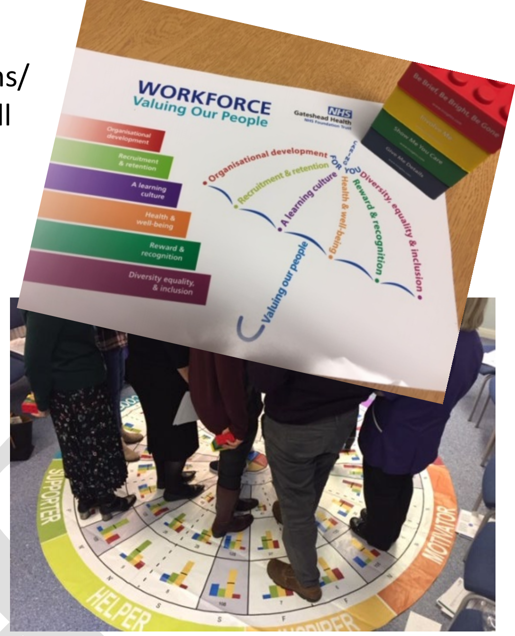
R RESPECT
- Value the skill and contribution of others
- Treat each other fairly and reasonably
- Appreciate and embrace difference
- Be polite and helpful
- Maintain dignity of others

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

(* does not cover QE Facilities Limited)

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

- Continuing support of the Community Service Teams/ Gateshead Care Partnership transformation plans, as well as the wider Gateshead System
- Engaging over 100 staff from multiple professions within Mental Health Services to improve the delivery of quality services
- Encouraging and embedding the use of Insights Discovery Model as a way to improve individual behaviours and team working
- Work has begun to be able to identify the talent in the Trust, and how this will help us have succession pathways to support our future workforce needs
- Redesigning the Appraisal process and roll out of new training for staff and managers



Recruitment and Retention

At the end of 2019/20 we employed 4658 people. The number is broken down as follows:

PROFESSION	
Additional Professional, Scientific and Technical	190
Additional Clinical Services	873
Administrative and Clerical	949
Allied Health Professionals	292
Estates and Ancillary	563
Healthcare Scientists	181
Medical and Dental	308
Nursing and Midwifery Registered	1299
Students	3
Total	**4658**

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

A comparison of our workforce is provided below:

	2018/19	%	2018/19	%
AGE				
17-21	111	2.45	102	2.19
22+	4422	97.55	4556	97.81
ETHNICITY				
White	4223	93.16	4312	92.57
Mixed	20	0.44	26	0.56
Asian or Asian British	137	3.02	1378	2.96
Black or Black British	40	0.88	42	0.90
Other	29	0.64	36	0.77
Not Stated	84	1.85	104	2.23
GENDER				
Male	952	21.00	997	21.40
Female	3581	79.00	3661	78.60
RECORDED DISABILITY				
	242	5.34	245	5.26

Work Experience

The Trust offers an extensive work experience programme enabling us to build invaluable links with the surrounding community through working with local schools and colleges. By providing work experience for 14 -19 year old students we are aiming to build and grow our workforce for the future. Work placements are offered in a number of different areas across the Trust including medicine, midwifery, nursing and physiotherapy to help local young people to gain a broader understanding in these areas. In 2019/2020 the Trust hosted 120 placements, 38% for the medical shadowing programme. We also hosted a school visit from neighbouring school Kingsmeadow Secondary School in July 2019. We invited over 100 students from Year 11 into the Trust to showcase a range of careers within the NHS.

Policies and Practices to support diverse groups

The Trust supports Project Choice, which provides young people who have learning difficulties/disabilities with support and access to work experience placements and employment opportunities. During 2019/20 we have hosted over 14 Project Choice work experience placements in a number of different areas including Screening Services, Health Records and Bensham Café. Following a successful and positive placement, one individual has subsequently been offered a post with within our Booking and Referrals Centre.

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we treat staff reflects their individual needs and does not unlawfully discriminate against individuals or groups on the grounds of any protected characteristic (Equality Act 2010). Our key employment policies promote the right of all staff to be treated fairly and consistently in accordance with equality and human rights requirements. Our recruitment Policy encourages the use of reasonable adjustments

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as a means of removing any disadvantage for disabled persons. The Supporting and Managing Sickness Absence Policy provides a supportive framework to help employees return to work where possible.

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

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

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

A Learning Culture

Library and Knowledge Services provide access to a range of evidence-based print and online research resources to support teaching, learning, research and professional development. Professional support services help clinicians answer clinical questions which directly impact patient care. Extensive collection development work has been carried out to ensure that the print and online portfolios continue to provide best access to research and best value for money to the Trust. Collaboration between the Library and Senior Clinical Improvement Leads has developed the number and quality of Induction opportunities. Regional working by the library team has contributed to a Patient Information project to widen patient and public access to quality health information and develop health literacy skills. The GMC survey of trainee satisfaction with online resources places Gateshead in the top performing North East Trusts.

We have also had positive feedback from a General Medical Council (GMC) Survey in relation to our Doctors in Training and an Annual Deans Quality Meeting from Health Education England (HEE) commending our commitment to providing a positive learning environment for all. In the 'Your School Your Say' survey in 2018, 92.5% of our foundation trainees would recommend the Trust to a friend who was thinking about becoming a doctor, based on our educational opportunities and experiences.

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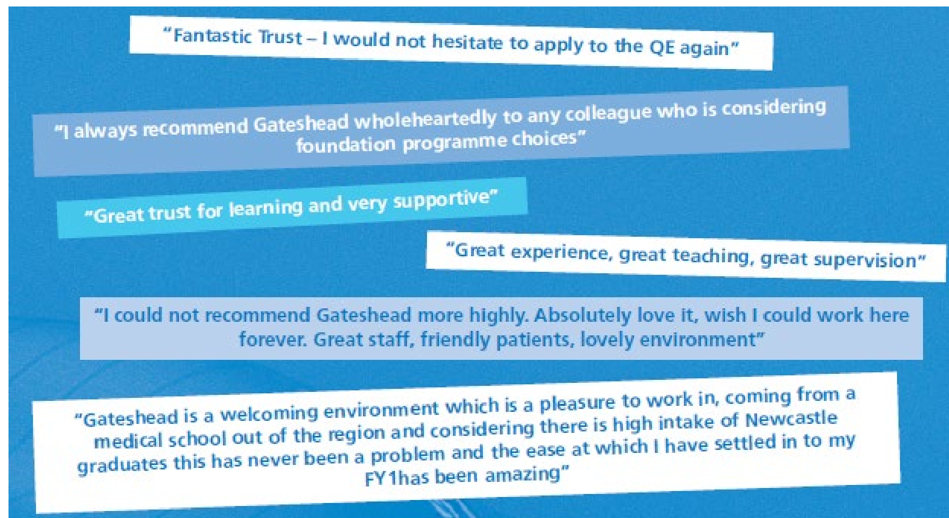

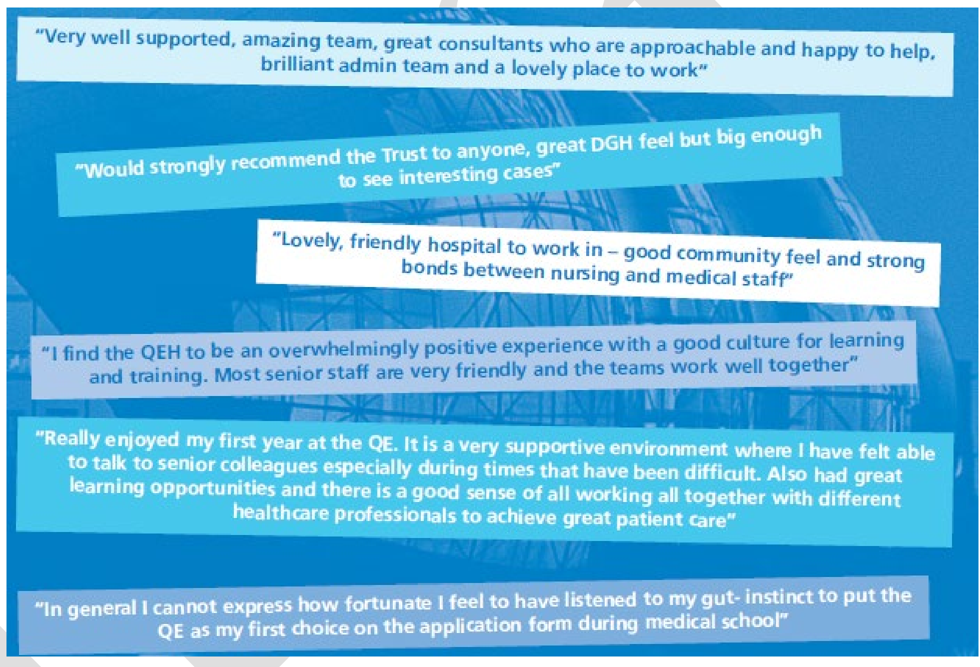

We believe that effective leadership means not only having the right knowledge and skills, but demonstrating the right behaviours and values to ensure patient safety and quality. Our strategy has embraced the Healthcare Leadership Model as a means of ensuring that consistent messages are given around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

In addition to our in house leadership and management programme we continue to work with our partners in Gateshead College to deliver Leadership Programmes aimed at first time managers and developing leaders. Our first cohort of Team Leader and Organisation Manager Apprentices have completed the apprenticeship and achieved the embedded CMI Diploma. The programme has evaluated well and as a result, we recruited a new cohort of 13 who started on the Apprenticeships in April 2019. Demand remains high and we are about to recruit another cohort for both programmes.

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

The Trust continues to provide apprenticeship opportunities to support people at all levels to gain valuable experience and a vocational qualification with the ultimate aim of securing employment within the NHS. We currently have 6 Level 2 Business & Administration apprentices and 5 Level 2 Healthcare apprentices. The Nurse Associate Apprenticeship continues to grow. In addition to the above, we have supported members of our current workforce in developing via Apprenticeships in a range of specialisms such as; Theatre Assistant Practitioners, Senior Leadership MBAs and Project Management skills. The Trust has also continues to support 5 members of staff to progress onto the Registered Nurse BSc Apprenticeship which is an 18 month programme which allows those with prior qualifications and experience to upskill into the nursing profession.

Reward and Recognition

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

We also held our annual Star Awards event; a humbling and proud evening where around 200 guests (including partners from the local community) came together to celebrate the amazing work that members of our workforce do each and every day. Those who were nominated as a ‘Star’ of the organisation received a personal note from the Chief Executive letting them know that their contribution counts, as well as a QE Gateshead Star pin badge to wear. The winners in each category were presented with a coveted QE Gateshead 2019 Trophy.

During 2019 we continued to recognise the great “everyday” things which our colleagues do with the “You’re a Star” programme. This runs alongside and in addition to the annual Star Awards. Sometimes, people do something for us which might be small, but can really make our day. We want to enable people to say a public ‘thank you’ to their colleagues for those small gestures, and to be able to tell them “You’re a Star”! When someone tells us about a colleague who is in their eyes, a star, the recipient is acknowledged by the Chief Executive with a personally signed card and a place in the ‘You’re a Star Hall of Fame’. The top three “You’re a Star” recipients are also invited to attend the annual Star Awards ceremony, where the ultimate winner is announced.

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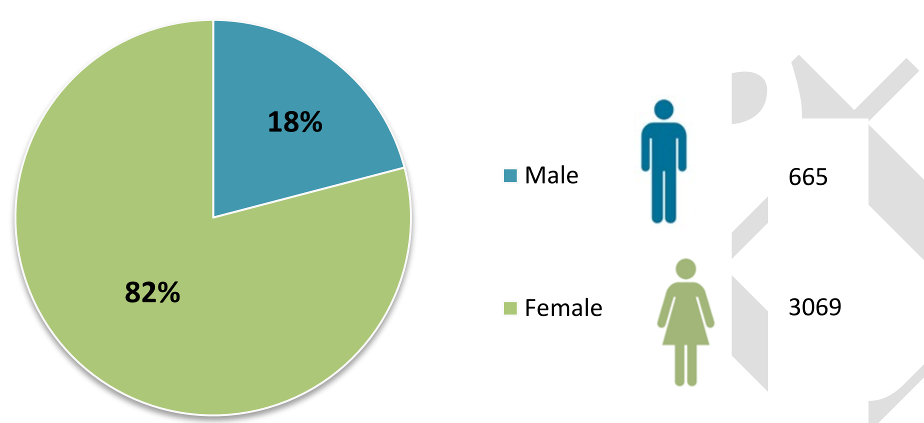
Gender Pay Gap report

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



Pay and Bonus pay gap	Mean 2019	Mean 2018	Mean 2017	Median 2019	Median 2018	Median 2017
Ordinary Pay	29.83%	29.84%	30.8%	16.26%	14.32%	17.46%
Bonus	44.5%	45.05%	50.48%	53.9%	51.25%	50.94%

(* does not cover QE Facilities Limited)

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

Diversity and Inclusion

The Trust has operated a human rights based approach to promoting equality, diversity and human rights for many years. This is reflected in the 'Vision for Gateshead', which promotes the core values of openness, respect and engagement. The aim is to ensure services are accessible, culturally appropriate and equitably delivered to all parts of the community, by a workforce which is valued and respected, and whose diversity reflects the community it serves. To support accountability, there is a well-established infrastructure in place which has provided leadership, governance and continuity, for example:

- The Trust Board has appointed Governors from diverse backgrounds, including Gateshead Youth Council, the Jewish Council and the Diversity Forum for Gateshead. Many Governors are active members of groups and committees.

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- We publish a separate annual report relating to diversity and inclusion, on a dedicated part of the QE Gateshead website. Information about diversity and inclusion can be accessed using the following link: http://www.qegateshead.nhs.uk/edhr
- During 2018/19, the Trust's Executive Sponsors of our Equality Objectives have met a number of times to drive activity from a Trust Board level. This has included around Gender Pay Gap Reporting, Accessible Information Standard and Sexual Orientation Monitoring Standard.
- The Trust continues to invest in corporate membership of the Employers Network for Equality & Inclusion, which is a leading employer network covering all aspects of equality and inclusion issues in the workplace. We aim to develop a programme of work in partnership with other NHS organisations in the North East region to support an inclusive and diverse workplace. We will use this work to help build staff networks, to offer support and the opportunity for feedback in the future.

In addition, the following important areas of work were undertaken in 2019:

- Ongoing promotion of the Trust's internal mediation service, including team mediation and also supporting regional colleagues by handling mediation cases for their organisation.
- Publication of the third Workforce Race Equality Standard (WRES) report in August 2019 and the first Workforce Disability Equality Standard (WDES) in August 2019 – this data and benchmarking allowed us to target specific activities such as:
    - Training colleagues from BAME backgrounds, via the RCN cultural ambassadors programme, to act as advocates for employees from BAME backgrounds during formal HR processes.
    - Participation in a regional BAME recruitment event to attract new people into the NHS. The event had over 400 visitors and was a real success.
    - Re-shaping the 'Your Voice' forum by creating three distinct staff networks; LGBTQ+, Disability and BAME. Each network has a chair who forms the Your Voice Steering group together with representatives from the Executive Team and Board.
    - The D-Ability network held a launch event on 12 December 2019 which attracted new network members and they are currently promoting the "Not every disability is visible campaign" by displaying signs around the Trust.

- The LGBTQ+ staff network will launch as part of LGBTQ+ awareness month in February 2020
- Participated in Equality, Diversity and Human Rights week in May 2019 by successfully launching the 'rainbow badge pledge' where employees from across the Trust were invited to sign a charter committing to being advocates for and supporting colleagues from diverse backgrounds. The event was led by the Your Voice Forum and was supported by a local transgender charity as well as representatives from our local Muslim community who provided the opportunity to try Henna tatoos and participate in Hijab lessons.
- Implementation of Mental Health First Aider training, resulting in over forty trained first aiders across the Trust. These volunteers link closely with our mental health champions and work is currently underway to measure the impact of these roles.
- An awareness raising session with the Trust Board in March 2019 exploring personal views and unconscious bias.

disability confident EMPLOYER

- We successfully re-applied for Mindful Employer status.
- We have retained our ‘Disability Confident’ employer status.

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

Equality Objectives

1. All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers.
2. The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments.
3. Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve.

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

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

Team Effectiveness / Efficient / Innovative

Team Effectiveness	2016-17	2017-18	2018-19	2019-20	Target
Core Skills Training Compliance	73.37%	79.75%	87.27%	80.06%	85%
Appraisal Compliance (Staff with a current appraisal)	81.82%	67.81%	73.34%	70.19%	85%
Staff Sickness Absence (12 month rolling percentage)	4.49%	4.62%	4.47%	4.49%	4.00%
Staff Turnover (Labour turnover based on Full Time Equivalent)	12.92%*	11.48%	12.87%	13.44%	N/A

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

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3.5 National targets and regulatory requirements

‡ The following indicators are all governed by standard national definitions

Indicator		2016/17	2017/18	2018/19	2019/20	Target	National Average
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway		93.4%	94.3%	92.6%	91.1%	92.0%	85.0%††
A&E – maximum waiting time of four hours from arrival to admission / transfer / discharge		96.1%	94.6%	94.0%	89.6%	95.0%	84.2%
All cancers: 62 day wait for first treatment from: urgent GP referral for suspected cancer /		86.7%	88.4%	83.6%	76.2%	85.0%	75.6%‡
NHS Cancer Screening Service referral		94.5%	96.3%	92.8%	93.9%	90.0%	80.5%‡
All cancers: 31 day wait for second or subsequent treatment, comprising:	Surgery	100.0%	98.9%	99.0%	97.7%	94.0%	90.9%‡
	Anti-cancer drug treatments	99.7%	99.9%	99.9%	99.5%	98.0%	98.7%‡
	Radiotherapy	N/A	N/A	N/A	N/A	94.0%	96.0%‡
All cancers: 31 day wait from diagnosis to first treatment		99.9%	99.7%	99.5%	99.3%	96.0%	95.9%‡
Cancer: two week wait from referral to date first seen, comprising:	All urgent referrals (cancer suspected)	96.8%	95.8%	95.6%	91.2%	93.0%	91.6%‡
	Symptomatic breast patients (cancer not initially suspected)	96.5%	96.6%	95.1%	95.9%	93.0%	85.6%‡
Maximum 6-week wait for diagnostic procedures		99.4%	99.1%	99.5%	98.8%	99.0%	97.2%†
Care Programme Approach (CPA) patients, comprising:	Receiving follow up contact within seven days of discharge	84.60%	87.10%	100.00%	100.0%	95.0%	95.0%*

*Q1 to Q3 2019-20

** figures relate to April to November prior to CIDS transfer to Newcastle

† Feb 20 position

††Apr-19 to Feb-20

‡ Q4 2019-20

Annex 1: Feedback on our 2019/20 Quality Account

4.1 Gateshead Overview and Scrutiny Committee

Based on Gateshead Care, Health and Wellbeing OSC's knowledge of the work of the Trust during 2019-20 we feel able to comment as follows:-

Quality Priorities for 2019 - 21
OSC has expressed its continued support for the Trust's 12 proposed Quality Priorities for Improvement, and in particular priorities 2,4 and 12.

Progress Against Quality Priorities for 2019 -20

Patient Safety
In 2018-19 OSC expressed concern that earlier improvements in reducing incidents of pressure damage and the percentage of falls resulting in harm had not been sustained and the Trust had not met its targets in these areas. However, OSC is pleased to note that analysis of the number of incidents graded as severe harm has demonstrated a significant decrease in the number of reported incidents of grade 3 and 4 pressure damage and the number of falls resulting in harm has reduced and the Trust has achieved its target in reducing the rate of harm per 1000 bed days. OSC was also pleased to note that a Falls Collaborative has been introduced onto a number of Clinical Lead areas and the Trust is looking to introduce a Falls Champion.

Infection Control
OSC has previously asked the Trust to explore the feasibility of installing additional containers for hand washing near to points of entry into the hospital and understands that there are now a number of hand sanitising stations at main entrances and departmental/ward entrances and throughout the hospital, corridors etc.

Inpatient Readmissions
OSC noted that the proportion of patients being readmitted within 28 days was rising and seek reassurance that reducing such re-admissions is a priority. OSC also request that they are provided with data and clarity on the discharge pathways of the people who were being readmitted.

Supporting Transition of Young People to Adult Services
OSC was pleased to note the 100% take up of the Leaving Care Passport and that feedback indicated that this is valued by young people.

Trust Achievements
The OSC would like to congratulate the Trust on becoming the third highest performing trauma unit in the UK for best practice care given to hip fracture patients in 2019 and on the excellent results it has achieved in its adult inpatient survey and the Friends and Family test.

CQC Inspection Outcomes
OSC noted that the Care Quality Commission has not taken enforcement action against Gateshead Health NHS Foundation Trust during 2019/20.

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4.2 Gateshead Clinical Commissioning Group

NHS Newcastle Gateshead Clinical Commissioning Group statement for Gateshead Health NHS Foundation Trust Quality Accounts 2019/20

Newcastle Gateshead Clinical Commissioning Group (CCG) welcomes the opportunity to review and comment on the Annual Quality Account for Gateshead Health NHS Foundation Trust for 2019/20 and would like to offer the following commentary:

As commissioners, the CCG is committed to commissioning high quality services from Gateshead Health NHS Foundation Trust and takes seriously their responsibility to ensure that patients' needs are met by the provision of safe, high quality services and that the views and expectations of patients and the public are listened to and acted upon.

Firstly, the CCG acknowledges that this year has been, and continues to be, an extremely challenging time for the NHS due to the COVID-19 pandemic. The CCG would like to thank the Trust and all their staff for the excellent commitment shown in responding to the pandemic and for transforming services to deliver new ways of working to ensure patient care continues to be delivered to a high standard. The CCG will continue to work closely with the Trust and primary care colleagues to support and ensure delivery of the Restart, Reset and Recovery Plan.

Throughout 2019/20 the CCG has continued to hold regular quality review group meetings with the Trust which were well attended and provided positive engagement for the monitoring, review and discussion of quality issues. The CCG also conducted a programme of assurance visits to a number of Trust sites to gain assurances and a valuable insight into the quality of care being delivered to patients. This has resulted in valuable partnership working with the Trust and provided the CCG with an opportunity to make recommendations on suggested areas of improvement. Due to the COVID-19 pandemic commissioner assurance visiting arrangements for 2020/21 are currently paused.

In 2018/19 the Trust set 12 key priorities for quality improvement which covered a two year period, 2019/21, which are aligned to their *'Quality Improvement Strategy – Driving Excellence through Quality Improvement*'. The report provides a comprehensive description of the progress the Trust has made during the first 12 months and an open account of where improvements have been made. It is acknowledged that a lot of work has been undertaken to deliver the Trust's ambitions in a number of key areas and the Trust is to be commended on their achievements.

It is acknowledged that the pandemic may impact on the Trust's ability to achieve some aspects of the quality priorities previously set in 2019 and these have been amended to reflect this; whilst ensuring they remain ambitious and achievable. The CCG fully supports this approach and agree with the next steps for 2020/21 outlined in the report for each of the 12 agreed quality priorities.

The CCG recognises that the Trust achieved the majority of its aims in relation to ensuring patients, carers and the public have the best experience possible when receiving care priority. This included successfully securing funding from NHS Improvement to launch a Response Volunteers Programme to help alleviate winter pressures and recruiting 30 new volunteers. The Trust also worked in partnership with NHS Business Authority (NHSBA) using the 'Clinical Passport Scheme' and this resulted in a cohort of staff volunteering at the Trust. It is noted that COVID-19 impacted on the number of volunteers attending the Trust and further cohorts from NHSBA are on hold. It is positive to see that in 2020/21 the Trust will continue to reinvigorate the volunteer service in order to release time to care and plans are in place to spread the use of NHS England's 'Always Events' methodology.

The CCG acknowledges the progress made in ensuring patients, carers and the public are engaged in quality improvement work. It is positive to see that a number of patient representatives have been successfully recruited to participate in a number of initiatives and specific projects have been identified where patient representation may be beneficial. The CCG supports the Trusts plans to build on patient, care and public involvement work in

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2020/21 to ensure their voice and contribution is included in all aspects of care delivery and quality improvement.
The CCG commends the Trust for the excellent progress made in improving experience for mothers, babies and their families' priority which has been achieved through a number of initiatives. It is positive to note the successful recruitment of staff to the continuity of carer caseloads and the significant improvement in patient engagement with the development of the Maternity Voices Partnership and a social media Facebook page. It is impressive to see that the patient portal *'Your Care in Your Hands'* was offered to all mothers and this resulted in 84% of women accessing their maternity records digitally. It is noted that community hubs were agreed and funding secured for the refurbishment of rooms, however this work was unfortunately paused due to the pandemic.
The CCG recognises that the Trust achieved the majority of objectives for reducing harm by making the organisation more resilient to risk and acting on feedback from patient's priority; although it is noted that some planned activities were postponed due to the pandemic. The CCG commends the Trust for the excellent work they have undertaken in implementing human factors as this offers an integrated, evidence based and coherent approach to patient safety, quality improvement and clinical excellence. It is also positive to see that a second cohort of staff have been trained as Family Liaison Officers and these roles are now fully embedded within the investigation process. The CCG is pleased to see that the Trust is to build further on this work in 2020/21.
It is also acknowledged that promoting a just, open and supportive learning culture priority is due to be achieved by March 2021. It is positive to note the Trust's plans to implement and embed all principles of a just culture and adopt a Safety II approach to patient safety aligning this work to the Freedom to Speak Up Guardian role.
The CCG commends the Trust for the excellent progress made in improving mortality reviews and embedding the medical examiner process. It is acknowledged that there has been a decrease in the number of level 1 reviews taking place due to the impact of COVID-19 however plans are in place to increase compliance. It is positive to note that there have been a number of successful appointments to the Medical Examiner Service and this is being rolled out across the Trust from September 2020. The CCG will continue to receive regular updates at the quality review group meetings on the mortality reviews undertaken by the Trust including lessons learned, good practice, areas for improvement and resulting actions.
The CCG notes the progress the Trust has made in supporting the national ambition to halve the rates of still birth, neonatal deaths and brain injuries priority. This included implementing and being fully compliant with the Saving Babies Lives care bundle (version 1) and achieving 100% compliance with the Clinical Negligence Scheme for Trusts (CNST) ten safety actions in 2019. It is acknowledged that the CNST scheme for 2020 has been paused due to the pandemic and the Trust is waiting for confirmation of the revised timescales for submitting the required evidence to NHS Resolution.
It is noted that at the end of quarter 3 2019/20 the Trust had made good progress against the Commissioning for Quality and Innovation (CQUIN) scheme; achieving eight of the ten indicators. The CCG acknowledges that extensive work has been undertaken by the Trust to improve compliance for the two indicators (Antimicrobial Resistance – Lower Urinary Tract Infections in Older People and Three High Impact Actions to Prevent Falls) which were not fully achieved. Due to the pandemic the CQUIN scheme has been suspended for all NHS providers until March 2021 to allow Trusts to focus on recovery and reinstatement of services. The CCG acknowledges the Trust is continuing with key areas of falls prevention work, which includes identifying falls champions within inpatient areas, developing an electronic falls assessment and delivering falls prevention training to staff undertaking enhanced care.
It is acknowledged that the Trust did not achieve their objective of increasing the number of research projects undertaken in 2019/20. It is however positive to see that three research teams received congratulations for recruiting the highest number of participants and one team also received praise for their excellent research activity. It is noted that the majority of normal research projects were put on hold due to the pandemic with Trusts expected to participate in

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COVID-19 Urgent Public Health Research. The CCG notes the Trust's plans in 2020/21 to increase their commitment to participate in high quality research.

The CCG acknowledges that some progress has been made against the improving clinical audit priority and it is positive to see that two patient representatives have been recruited to participate in clinical audit activity. It is noted that there has been a decrease in the participation of national clinical audits in 2019/20 and a new process has been implemented to address this. It is acknowledged that the Get It Right First Time (GIRFT) visits went ahead as planned and action plans arising from the recommendations made by the visiting teams were developed and monitored via the SafeCare Council. It is noted that all GIRFT activity was suspended due to the pandemic however this is gradually being reinstated. The CCG supports the plans in place for the Trust to achieve a 'significant assurance' outcome from the next internal audit on clinical audit processes.

The Trust has made excellent progress in developing and implementing a transitional care model to improve outcomes for mother and baby; which was launched in September 2019. This included training advanced neonatal practitioners to lead the service and training five maternity support workers to support the model of care. It is very positive to note that the Trust has received excellent feedback from mothers and families around the quality aspect of this change. The CCG notes the plans in 2020/21 to develop the electronic records work stream for maternity, the progression of the Neonatal Badger Project and the continued evaluation and monitoring of the clinical indicators for the transitional care model.

The Trust has made excellent progress with Making Every Contact Count (MECC) priority which has been achieved through a variety of different initiatives and innovations. This included identifying a lead to plan, promote and co-ordinate plans to increase activity and develop a MECC training programme covering how to have a conversation with patients about smoking, alcohol intake and weight management. It is impressive to note that 675 staff have completed this training and a further 754 staff have undertaken additional smoking cessation training. The CCG commends the Trust for implementing the text messaging service to support patients stopping smoking and it is noted that over 600,000 texts have been sent to patients. This is an excellent initiative and it is well deserved that the Trust won national recognition from the Health Service Journal. The CCG acknowledges the Trust's commitment to this priority in 2020/21 and is particularly impressed to see the plans to work with the local authority to ensure all support programmes are available and that there is cohesive access to these, for all Gateshead residents.

In 2019/20 the Trust reported 4 never events, which is consistent with the number reported in 2018/19. All never events are managed through the serious incident process and the CCG will continue to work with the Trust to identify learning and appropriate actions; gaining assurance through the CCG SI Panels and Quality Review Group meetings.

The CCG notes the decreased performance across a number of national cancer targets and other performance measures due to the impact of the pandemic. The CCG supports the ongoing work and initiatives in place to improve performance and will continue to work in partnership with the Trust to ensure these measures improve.

The Trust's Summary Hospital Mortality Indicator (SHMI) banding remains *'as expected'* however it is noted that the Hospital Standardised Mortality Ratio (HSMR) score of 113.3 is above the national average of 100, with more deaths than expected. The CCG receives regular mortality updates at the quality review group and acknowledges that the Trust has robust processes in place to monitor and investigate any concerns with coding or with the quality of care provided.

The CCG notes the positive results from the various national patient surveys and where improvements are required; action plans are in place to achieve these. In particular the CCG was impressed to see in the cancer survey patients rated their overall care 9.1 out of 10 and reported a positive experience in many areas. The results from the 2019 PLACE assessments are also pleasing as the Trust scored higher than the national average across all of the domains.

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The CCG welcomes the specific quality priorities for 2020/21 highlighted in the Quality Account. These are appropriate areas to target for continued improvement and link well with CCGs commissioning priorities. The CCG can confirm that to the best of their ability the information provided within the Annual Quality Account is an accurate and fair reflection of the Trust's performance for 2019/20. It is clearly presented in the format required and contains information that accurately represents the Trust's quality profile and is reflective of quality activity and aspirations across the organisation for the forthcoming year.

The CCG looks forward to continuing to work in partnership with the Trust to assure the quality of services commissioned in 2020/21.

Chris Piercy
Executive Director of Nursing, Patient Safety & Quality
November 2020

Dr Dominic Slowie
Interim Medical Director

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4.3 Healthwatch

Healthwatch Gateshead statement for the Gateshead Health NHS Foundation Trust Quality Account 2019/20

Thank you for giving Healthwatch Gateshead the opportunity to respond to the Gateshead Health NHS Foundation Trust (GHFT) Quality Account for 2019/20.

Firstly, we would like to thank all the staff at GHFT for all the hard work that has been put in to keeping services running as normally as possible during the COVID-19 pandemic. It is evident that the Trust has worked hard making improvements based on progress against the priorities from last year, particularly during this challenging, unprecedented period.

We have attended various system wide meetings where the Q.E.staff have kept us all informed on their work and how they have been able to meet the COVID-19 challenges for their patients. It is also to be commended that key decision makers within the Trust have ensured staff as well as patients and their families are kept safe and well informed.

We are pleased to see the following identified within the report:

☐The Trust has been rated ‘Good’ with ‘Outstanding’ for caring by the Care Quality Commission

☐ The Trust has achieved the highest Freedom to Speak up Index score in the Combined Acute and Community Trust category

☐ That 88% of patients who completed the Inpatient Survey rated the care provided at 7/10 or above

☐ That 94.8% of people who completed the Friends and Family test said the Trust provided a positive patient experience indicating they would definitely recommend these services to friends and family.

We are also pleased that the Trust celebrates its staff via the QE Gateshead Star Awards.

The Trust’s priorities for 2019/20
Patient experience

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

We commend the Trust for the progress it has made with reinvigorating its volunteer service to release time to care more for patients.
We are pleased to see that the Trust secured £25k to invest into the ‘Response Volunteers’ programme, that 30 new volunteers have joined and that a partnership arrangement with NHS Business Services Authority has been agreed and has led to an increase in voluntary hours completed.
It is a shame, but also understandable, that COVID-19 has had an impact on volunteers

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attending the Trust to do voluntary work. For this reason, we are pleased to see that the Trust is still in contact with volunteers who are not able to attend at the moment.

Priority 2: We will ensure that patients, carers and the public are engaged in our Quality Improvement work and that patient, carer and public involvement is embedded as business as usual across the organisation
We fully support the Trust in its commitment to involving patients and the public in its quality improvement work. We are pleased to see that the Trust has been successful in setting up a monthly Patient Involvement Forum and that some patient representatives have been recruited to quality improvement initiatives.
We welcome the Trust's interest in strengthening its links with Healthwatch Gateshead to further understand the needs of the community. We do collect patient experience data which will be of interest to the Trust, and we would be happy to explore how we can work together to ensure the patient voice is heard.
With further work on this priority over the coming year, we hope to see that this fully embeds engagement and involvement of patients and carers in the quality improvement work of the Trust.

Priority 3: Improved experience for our mothers, babies and their families
We are pleased to see that the patient portal 'your care in our hands' was offered to all mothers who booked into the Trust's maternity services and that 84% of women accessed their maternity records digitally as a result of this. We are also pleased that the Trust has managed to successfully recruit midwives to the Continuity of Carer team.
The Maternity Voices Partnership appears to have made good progress, with an improved social media presence and future meetings planned.
We are pleased to see that further work will continue, with a focus on improving the implementation of the Continuity of Care model. By March 2021, we would hope to see that the new model has been fully embedded and that the Maternity Voices Partnership is even more active and having an impact.

Patient safety
Priority 4: We will reduce avoidable harms in the Trust, by making our organisation more resilient to risks and acting on feedback from patients
Priority 5: We will promote a just, open and supportive learning culture across the Organisation

We welcome the Trust's approach to reducing avoidable harms through implementing a human factors approach to patient safety investigations. A lot of work has been done to work towards achieving the objectives that were set out.
We also welcome the Trust's commitment to promoting a just, open and supportive culture, and its plans to align this work with the Freedom to Speak Up Guardian role.
As this work progresses, we would like to see more evidence of how the Trust has developed innovative ways to involve staff, patients, and families in patient safety. We also hope to see that the Safety II approach has been successfully adopted, and work effectively aligned to the Freedom to Speak Up Guardian role.

Priority 6: Improve mortality reviews and embed the new medical examiner process, providing families, carers and staff with opportunities to both raise concerns and highlight examples of good practice and excellent care
Despite the COVID-19 pandemic, it appears that good progress has been made. We

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congratulate the Trust on reviewing 79.9% of patient deaths, and that 67.3% of these were reviewed within 60 days of death. Level 2 review completions also seem to be going in the right direction.
The Hogan and NCEPOD scores from the death reviews are reassuring, both highlighting that most deaths that occurred were not preventable or a result of ineffective clinical or organisational care.
We note that there has been a reduction in the number of reviews because of the pandemic, but that the Trust is taking action to mitigate this.
We wish the Trust success in achieving its goals despite the pandemic, and look forward to reading more about the implementation of the Medical Examiner Service.

Priority 7: To support the national ambition to halve the rates of still births, maternal deaths, neonatal deaths and brain injuries
We congratulate the Trust on successfully implementing and being fully compliant with the Saving Babies Lives care bundle version 1. We also note the Trust's success in training all sonographers on some elements of the Saving Babies Lives care bundle version 2, and achieving 100% compliance with the 10 'Clinical Negligence Scheme for Trusts' safety actions in 2019.
We hope that the Trust manages to successfully implement the Saving Babies Lives Care bundle version 2 in the coming year.

Clinical Effectiveness
Priority 8: Ensure robust processes are in place to set and deliver on the National Commissioning for Quality and Innovation (CQUIN) to ensure that our patients receive the best high quality and innovative service as possible
We are pleased to see that most of the CQUIN targets were achieved this year. For the two targets that were not achieved, it is good to see that the Trust has plans to investigate the problems and act appropriately.
We hope the Trust continues to achieve its CQUIN targets once the scheme starts up again post COVID-19.

Priority 9: Research will be undertaken to ensure that we are providing the most beneficial and cost-effective care and treatment for our patients
We support the Trust's plans to increase its commitments to taking part in high quality research.

Priority 10: Improve Clinical Audit: best practice and compliance to improve patient care and outcomes through systematic review of care and the implementation of changes and review alignment against Healthcare Quality Improvement Partnership (HQIP) Best Practice in Clinical Audit

We note that the gap analysis against the HQIP's Best Practice in Clinical Audit identified that 'Partnership with other health and social care providers and commissioners' and 'Patients, patient representatives, stakeholders and Healthwatch involvement' were noted as areas for improvement. We hope to see that reflected in the plan for improvement going forward and would be happy to discuss ways forward with the Trust.

Priority 11: Implement a transitional care model and enable women to access their care records to improve outcomes for mother and baby

We would like to congratulate the Trust on its successful implementation of the Transitional Care Model. We look forward to learning more about the impact of the

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Transitional Care Model as it becomes embedded, along with any developments with respects to electronic maternity records.

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

We support the ongoing work to ensure the Making Every Contact Count programme continues by supporting and enabling patients' to access services to reduce alcohol and/or smoking, improve eating, and being more active as part of the live long programmes.
Plenty has been achieved and the CQUIN indicator results give a good indication of the success. We hope to see continued success in 2020/21.

Healthwatch Gateshead aims to run various projects to support providers in Gateshead to meet their statutory obligation of consulting/engaging with patients and the public. We like to ensure that Trusts are using public and patient feedback to:

☐ inform changes to services

☐ improve the quality of services

☐ understand inequality in access to services and health outcomes

We would welcome the opportunity to explore how we can support with the quality priorities in the year ahead.

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4.4 Council of Governors

The Governors of Gateshead Health NHS Foundation Trust have been consulted on and been involved in the formation of the Trust's Quality Account in 2019/20. Governors have been continuously involved in refreshing the Trust's strategic plans with their involvement at various Trust committees and the Council of Governors meetings throughout the year. At each of the Council of Governors meeting during 2018/19, a range of reports have been presented, which enable Governors to receive and discuss quality and patient safety matters and progress against our quality priorities.

Overall the Quality Account clearly demonstrates the Trust's ongoing commitment to delivering high quality and safe patient care and improved health outcomes.

Comments received from Governor's:

"1. I'm very impressed with the quality of the information and what's been achieved over the year.
2.I'm pleased to read about a new appraisal system as this has long been an issue for the trust.
3. It's unfortunate and disappointing, given all the time and effort that's been spent by staff, that three of the national targets were missed by such small amounts.
4. It's good to read about the enhanced commitment to inclusivity and the personal commitment of the CEO in this area.
5. I think the report could be enhanced by the inclusion of more specific detail on the role of individual governors throughout the Trust. To recognise the hard work but also to consider the positive effect this has."

"I am happy with the document."

"The Report is good at identifying responses to particular complaints / issues raised, but there are responses recorded which appear as a one-off reaction, not that a message is subsequently reinforced."

"It was a very complete and informative paper. Thanks to all involved in the preparation."

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

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/20 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2019 to March 2020
    - papers relating to quality reported to the board over the period April 2019 to March 2020
    - feedback from commissioners dated – November 2020
    - feedback from governors dated – November 2020
    - feedback from local Healthwatch organisations dated – November 2020
    - feedback from Overview and Scrutiny Committee dated –November 2020
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 – Q4 was suspended due to Covid-19, this was submitted on 9th October 2020.
    - the 2019 national patient survey March 2020
    - the 2019 national staff survey March 2020
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated – xxx
    - CQC inspection report dated CQC Inspections and rating of specific services dated 14/08/2019

- 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

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

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

By order of the board

Date: Chairman:

Date: Chief Executive:

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Glossary of Terms

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

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

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

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

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

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

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

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

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

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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.

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

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

Getting It Right First Time (GIRFT)
Getting It Right First Time is a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

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

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

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

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

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

Joint Consultative Committee (JCC)

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

Lasting Power of Attorney (LPA)

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

Making Every Contact Count (MECC)

Making Every Contact Count (MECC) is an approach to behaviour change that uses the millions of day-to-day interactions that organisations and people have with other people to support them in making positive changes to their physical and mental health and wellbeing.

Meticillin Resistant *Staphylococcus aureus* (MRSA)

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

National Confidential Enquiries

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

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

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

National Institute for Health and Clinical Excellence (NICE)

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

National Patient Survey

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

National Reporting and Learning System (NRLS)

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

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

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

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

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

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

Picker Institute
Picker Institute is a non-profit organisation that works with patients, professionals and policy makers to promote a patient centred approach to care. It uses surveys, focus groups and other methods to gain a greater understanding of patients' needs.

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

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

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

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

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

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Risk assessment

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

Root Cause Analysis (RCA)

This is a technique that helps us to understand why something has occurred that was not expected. The learning is then shared with staff across the hospital to inform our practice and help prevent further recurrence.

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.

Staff Advice and Liaison Service

Brings together a range of support services that are available to staff.

Standard Operating Procedure

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

Trust Board

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

Ulysses System

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

Disclaimer: All photographic images within this document were taken prior to the pandemic, and therefore social distancing measures were not required.

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