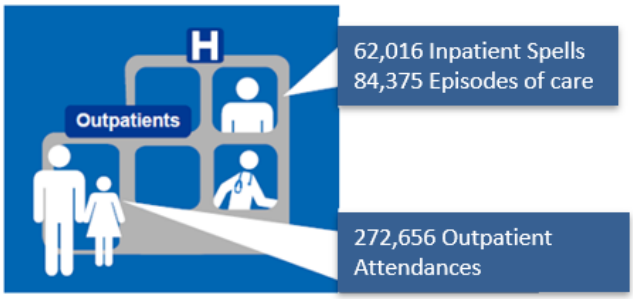
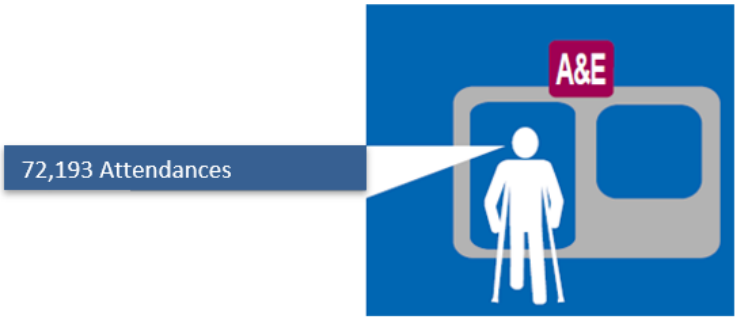
Gateshead Health
NHS Foundation Trust

Quality Account

Gateshead Health NHS Foundation Trust 2021/22

Gateshead Health NHS Foundation Trust at a glance…





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Part 1

Quality Account – Chief Executive's Statement

Statement on Quality from the Chief Executive

On behalf of the Trust Board and staff working at Gateshead Health NHS Foundation Trust, I am delighted to introduce you to our Quality Account for the year 2021/22, which highlights our continued dedication to improving all aspects of quality for patients and staff.

The last 12 months have been difficult, however the importance that colleagues have placed on ensuring we continue deliver safe, compassionate, effective care and improved patient experience has been clear throughout. We cannot get away from the fact that Covid-19 has had a very significant impact on the NHS here in Gateshead and across the country and we have seen how it has stretched services and people to near breaking point. As a Board we have been continually impressed and humbled by the strength and resilience of our brilliant staff and volunteers, their commitment, creativity, and determination despite the challenges they have faced. I am so proud of how they have responded and continue to keep themselves, our patients, and the community safe. It is a remarkable achievement for this organisation that in a year of so much change and difficulty, our people have continued to improve the services that we provide and have taken great strides forward. The contents of this report should be considered against the background of the continuing pandemic; however, we recognise there are still some areas where improvement is ongoing and will continue working to fully achieve these.

During the year, because of Covid-19, many of our targets were halted. For example, the CQUINs we traditionally need to achieve to receive funding have been paused temporarily and the Care Quality Commission (CQC) continued its pause on inspections. However, within the Trust, we have not taken the focus away from our own quality targets, even when we have not been required to report on them. Now more than ever, the quality of the services that we provide to our local community is of paramount importance to me and to the whole organisation.

As we look back on the past year and ahead to the future, we need to take stock of what we learned during the pandemic, how this will influence what we do in the future, and how we can keep on track with implementing all the things we have set out to achieve. We are currently developing our new Trust Vision and Strategy and at its heart will be people - both our people within the Trust and the people we serve.

Our Quality Account Priorities for 2022/23 include for the first time a section on our people where we have identified areas where our staff have told us we need to enhance their experiences when working within the Trust. Alongside this, we continue to include priorities that encompass patient experience, patient safety and clinical effectiveness so that together we can support safe, high quality patient focused care as we continue to develop services which provide for the communities we serve, both now and in the future. To the best of my knowledge the information presented in this report is accurate and represents a balanced view of the quality of services that the Trust provides. I sincerely hope that you find it informative and that you enjoy reading about our quality achievements in what has been an extraordinary year.

Signed Date: 6 June 2022

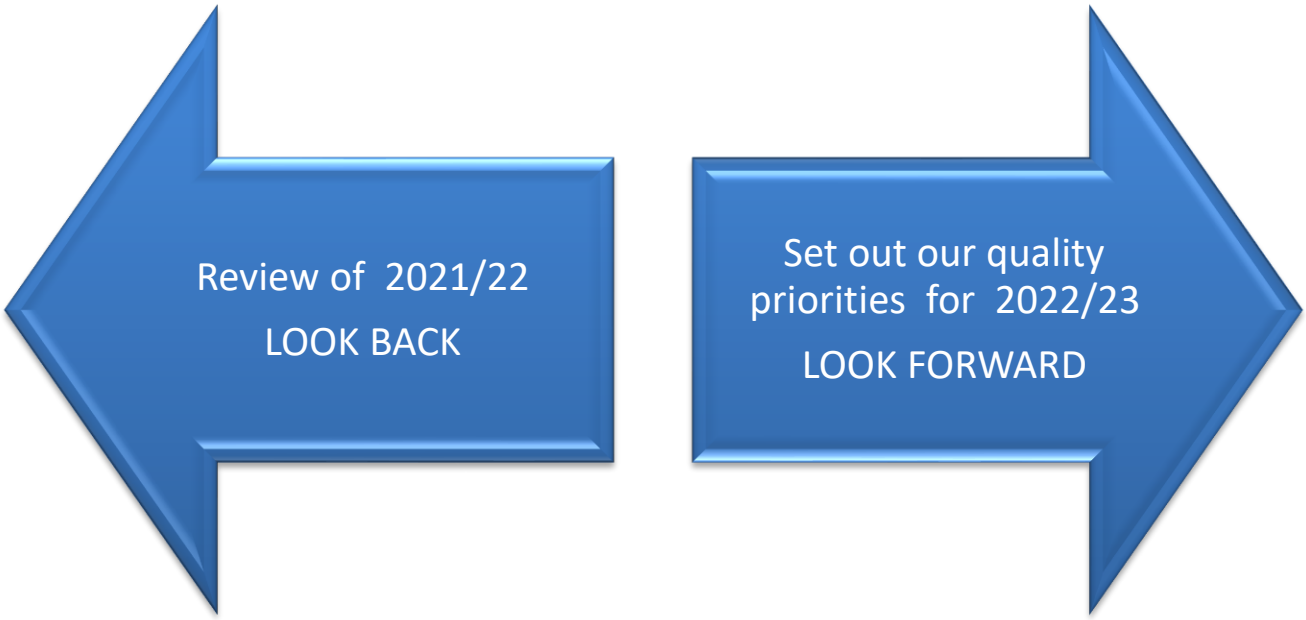
Mrs Yvonne Ormston MBE
Chief Executive

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 2021/22.
- Outline the quality priorities and objectives we set ourselves going forward for 2022/23.



Part 2

Quality Priorities

2. Priorities for Improvement

2.1 Reporting back on our progress in 2021/22

In our 2020/21 Quality Account we identified nine quality priorities that we would focus on. This section presents the progress we have made against these.

PATIENT EXPERIENCE:

Priority 1: **We will ensure that we have effective ways of receiving feedback from our patients, their relatives and carers which will lead to demonstrable improvements in practice.**

➢ What did we say we would do?

- We will review and revise the Patient Advice and Liaison Service (PALS) and complaints processes.
- We will re-establish a programme for collecting real-time patient feedback in clinical areas.

➢ Did we achieve this?

- We achieved this Quality Account priority.

➢ Progress made:

- The initial stages of a Rapid Process Improvement Workshop (RPIW) commenced in Quarter 1 with the aim of revising the PALS and complaints processes. This included Process Mapping and demonstrated a clear alignment between PALS and formal complaints. The use of a RPIW was discussed and a decision was made that it was not the most effective model to use as the core requirement was collaborative working when a complaint was also a patient safety incident. A revised Complaints and Concerns Policy was ratified in September 2021.
- There was a need to consider wider processes when looking to revise the PALS and complaints process such as patient safety incidents. A team away day was held in November 2021, and this highlighted areas which need to be included to ensure that there is an effective complaints process in place that is aligned to that of incident investigations. In Quarter 4, a Patient Safety Triangulation Meeting was initiated and as part of this, complaints that may also be patient safety incidents are discussed as a multidisciplinary team.
- Volunteers have been supporting the Practice Development Team completing questionnaires with patients on the wards as part of the Care Quality Assurance Framework (CQAF). This is an ongoing real-time programme of work. Any comments or concerns on the questionnaires are placed on Datix and shared with the relevant team/s.
- Each day (except weekends) the Patient Experience Volunteers visit the wards and spend time talking to patients. This enhances patient experience. If a patient raises any concerns, the volunteers will feedback to the Ward Sister and/or patient experience team and concerns are logged, or comments forwarded to the team/department for early resolution. In terms of volunteers supporting patient experience, the response volunteers have assisted with the delivery and collection of patients notes, to wards and departments. They have collected and delivered personal property to patients when visiting was restricted and they have also collected and delivered Chemotherapy medication to the Chemotherapy Day Unit, which enabled this to be administered in a timely manner.

- The electronic Friends and Family Test (FFT) went live across the Trust (across inpatients, outpatients, and the Accident & Emergency) except for the Community and Maternity. The FFT is now an automated telephone text service system, this is an 'opt out' process – there is a tick box on patient administration system with the patient contact details for this to be amended should the patient not want to take part in test message FFT. Where patients do not have access to a smart phone, they still can provide real-time feedback on wards using Friends and Family cards, which is by exception only. The cards are collected from each ward/area's FFT box at the end of each month.

- During the Hidden Disabilities Week, the volunteers asked patients (with their consent) to record what their hidden disabilities were to give us as an organisation an understanding of those patients who would require support. Sunflower lanyards and pin badges were also available.

Next steps:

- We are currently looking at how we can triangulate Patient Experience data such as PALS, formal complaints and the FFT, with patient safety data such as incidents and staffing data for wards and departments.
- The Patient Experience team are working collaboratively with both the Community Business Unit and Maternity and are looking to implement a digital FFT option in 2022/23.

Priority 2: We will ensure that patients, relatives, and carers have the best experience possible when they are receiving our care

What did we say we would do?

- Following the success of the NHS England 'Always Events®' collaboration in one pilot, we will spread the use of the methodology as a tool to understand what is important to patients.

Did we achieve this?

We partially achieved this Quality Account priority.

Progress made:

- In-house training on Always Events® had previously been facilitated across the Trust. This was stood down due to COVID-19. The first stage of Always Events® is the capture of patient experience feedback and data. Multiple projects have been facilitated by the Patient Experience team which have generated a large amount of patient feedback and data through other means excluding Always Events®.
- Co-design workshops are discussed in Priority Three, and these demonstrate collaborative working to make improvements to ensure that patients, relatives, and carers have the best experience possible when they are receiving our care.

➢ Next steps:

- The in-house training package around Always Events® will be considered alongside the Trust's wider improvement and transformation plans. An improvement handbook is anticipated to be developed.

Priority 3: We will ensure that patients, relatives, and carers are engaged in our Quality Improvement work and that patient, relative and carer involvement is embedded as business as usual across the organisation.

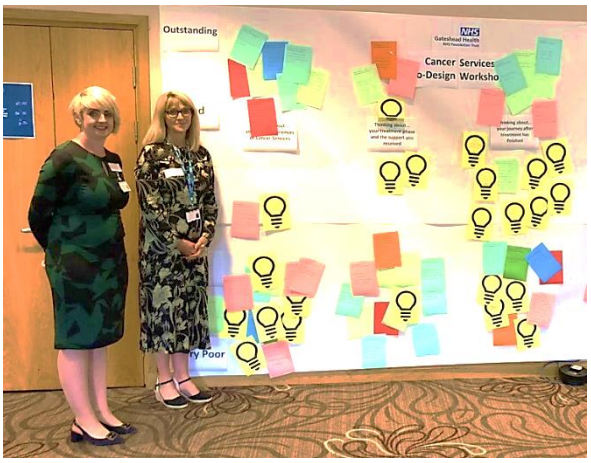
➢ What did we say we would do?

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

➢ Did we achieve this?

We partially achieved this Quality Account priority.

➢ Progress made:



- Co-design workshops have been facilitated by the Patient Experience team. An example of the impact of this was one held with cancer services which resulted in over 50 patient stories and over 25 improvement ideas being generated between patients and staff at the point of care. Measuring, understanding, and improving patients' experiences is of central importance to the Trust, and rather than doing things 'to' or 'for' patients, we aim to work with them as equal partners. This cannot be considered as an optional extra but must be considered a core component in everything we do. This co-design workshop provided:
    - a focus on designing experiences, not just improving performance, or increasing safety
    - put patient experiences at the heart of the service improvement effort - but not forgetting staff
    - a space where staff and patients do the designing together (co-design rather than re-design)
    - and, in the process, improving day-to-day experiences of giving and receiving the care, and the way they feel about those experiences.

- Recent evidence also suggests positive associations between patient experience, patient safety and clinical effectiveness for a wide range of disease areas, and positive associations between patient experience and self-rated and objectively measured health outcomes.
- The Head of Quality and Patient Experience has worked with the Trust's Deputy Director Corporate Services and Transformation to consider how co-design workshops and wider methods to ensure that patient voice and contribution is included in all aspects of quality improvement and delivery of care and how it can be built into the Trust's strategy around quality improvement and ultimately, business as usual.

➢ Next steps:

- Further areas have expressed an interest in holding a co-design workshop. These workshops will be facilitated by the Patient Experience team as required and workshops are planned within maternity services and in gynae-oncology in Quarter 1 of 2022/23.
- The Head of Quality and Patient Experience and Deputy Director Corporate Services and Transformation will continue to work collaboratively to discuss collaborative working across portfolios and how patient voice and contribution is included and will be delivered across the Trust.

PATIENT SAFETY:

Priority 4: **We will ensure there is a positive safety culture within the organisation in which openness, fairness, accountability and learning from high levels of incident reporting is the norm**

➢ What did we say we would do?

- We will implement the Patient Safety Incident Response Framework (PSIRF).

➢ Did we achieve this?

- The National Patient Safety team has not yet implemented the PSIRF as full evaluation from early adopter sites is underway and Trusts were advised not to change over any of their processes. It is anticipated that the new framework will be implemented gradually from Summer 2022.

➢ Progress made:

- The National Patient Safety team have advised that the revised PSIRF is expected to be published in June 2022 and that Trusts are not to introduce any changes before then. Following the publication of the revised framework, Trusts will be asked to begin to prepare for the transition from the Serious Incident Framework to PSIRF. This is anticipated to be a gradual process. The national team have advised that all tools, templates, and guides will be revised based upon the feedback given from early adopter sites.
- The Trust's Patient Safety Team has introduced thematic analysis of low and no harm incidents to reports which are shared with the Trust. The table below demonstrates the top ten categories of low and no harm incidents currently open within the Datix system as of April 2022.

	Clinical Support & Screening	Surgical Services	Medical Services	Community Services	Nursing, Midwifery & Quality	QE Facilities	Digital	People and OD	Chief Operating Officer	Total
Patient falls	3	24	200	11	0	0	0	0	0	238
Infection prevention & control	1	0	115	3	10	0	0	0	1	130
Delay / failure to treat / monitor	9	58	30	10	2	0	0	0	0	109
Medication	23	18	39	11	1	0	0	0	0	92
Discharge or transfer issue	5	19	40	2	2	2	0	0	1	71
Communication failure	7	19	12	3	3	4	4	2	0	54
Pressure damage	0	3	20	28	0	0	0	0	0	51
Staffing / resource issue	1	2	27	0	1	2	0	2	1	36
Appointment issues	14	11	5	1	3	0	0	0	0	34
Patient information (inc patient records)	3	7	6	2	0	0	3	0	0	21

- Datix also has the capability to provide further information regarding each of these patient safety incidents. This detail will inform focused quality improvement work in specific areas where these incident categories are most prevalent.
- The monthly learning bulletin is now implemented into practice and captures the learning from serious incidents. This is distributed across the Trust via the Comms team through QE Weekly.
- All staff can access the national eLearning courses for patient safety via their 'My Learning' page on ESR, however this is not currently mandated. There are two levels and one specifically for the Trust Board and senior leadership teams.

Next steps:

- To develop a process for sharing the thematic analysis of low and no harm incidents across the organisation.
- To ensure that the electronic Learning Library is established during the first quarter of 2022/23 to ensure a repository of information pertaining to learning from incidents is available for all staff to access.
- Promotion of the eLearning packages for patient safety through Comms, preceptorship sessions and local patient safety meetings.
- To explore the capacity of mandatory training to incorporate patient safety training within these sessions.

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

What did we say we would do?

- We will implement and embed all principles of a just culture across the organisation.

Did we achieve this?

- We partially achieved this priority.

Progress made:

- We have recently established a Culture Programme Board, which will report directly through to the Transformation Board, with the aim of driving this agenda forward and provide Board assurance on progress. The embedding of a just and restorative culture will form one of the primary workstreams and planning is currently underway to establish the lead for this work and determine our approach.

Next steps:

- The current cohort attending the training delivered by Northumbria University is almost through the programme and we are currently reviewing funding options to ensure a range of leaders are able to attend. The timeline for this work will extend into 2023 and beyond.

Priority 6: We will ensure that our patient discharge processes are safe and effective.

What did we say we would do?

- We will ensure that the principles and requirements of the recently published national discharge requirements are realised.

Did we achieve this?

- Yes, our discharge processes follow the national discharge requirements, and this is reflected in our improvement plan. Work is ongoing to continuously improve our discharge processes.

Progress made:

- An Improving the Patient Journey Task and Finish Group was established to focus on hospital discharge, reporting into the Unscheduled Care Programme Board. The programme has several workstreams including ward ways of working, 7 day working/discharge and operational site management as phase 1 priorities with discharge to assess as a phase 2 priority.
- A standardised board round process has been developed to support timely discharge and a pilot is underway across two medical wards to support the ward ways of working workstream. This will be extended to focus on the development of standardised ward processes in line with guidance from the Royal College of Physicians.
- Implementation of whiteboards across all ward areas to support the ward ways of working workstream is currently underway.
- A review of the Discharge Lounge model and pathways is underway to understand any potential opportunities for expansion.
- Currently scoping the 7-day working/discharge workstream which includes criteria led discharge.
- Developed whiteboards for operational site management both front and back of house.
- Business Continuity plans developed to support site management as well as an operational site resilience policy.
- Business Case for Discharge Coordinators approved and recruitment to these posts is nearing completion.
- We have worked closely with the Emergency Care Improvement Support Team (ECIST) to review patient pathways and discharge across the organisation. ECIST have provided recommendations which we have incorporated into our transformation plans.

NHS
Emergency Care Improvement Support Team
Safer, faster, better care for patients

Next steps:

- To continue progressing the defined workstreams as part of the Improving the Patient Journey Task and Finish Group.

CLINICAL EFFECTIVENESS:

Priority 7: **We will ensure the care that we provide to our patients is consistent with recognised best practice, leading to improved outcomes for patients (falls)**

➢ What did we say we would do?

- We will reinstate the Falls Collaborative to ensure falls can be prevented wherever possible.

➢ Did we achieve this?

- Whilst the data does show a small reduction in the rate of harmful falls, this is not a significant change. It is difficult to assess given the influence of the pandemic in terms of beds occupancy and patient acuity compared to 2020/21.

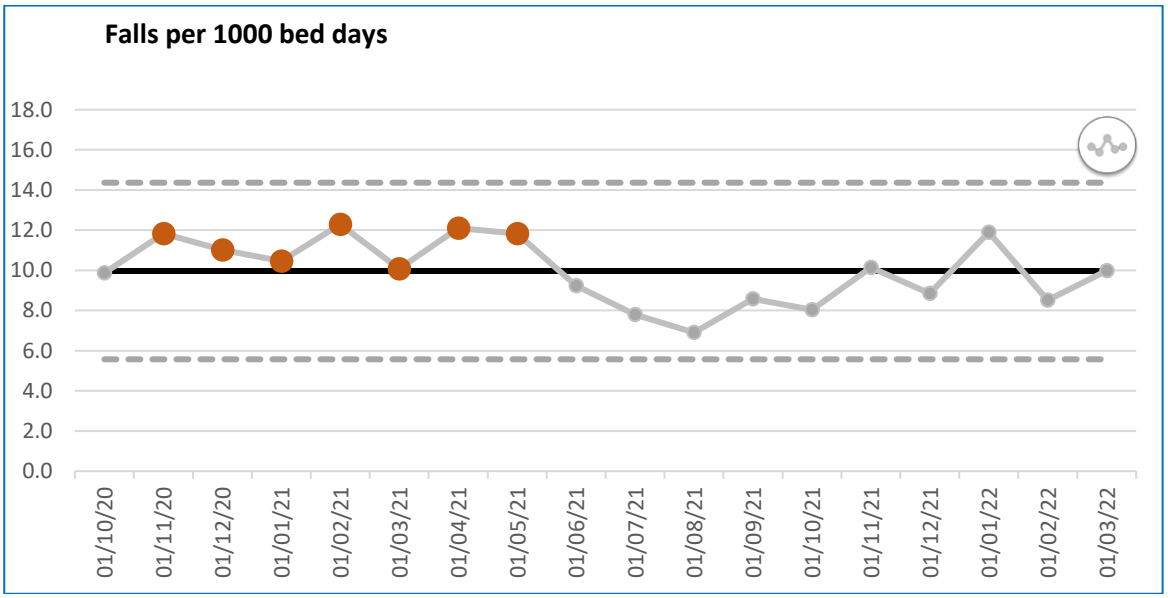
➢ Progress in 2021/22:

- Prevention of falls improvement initiatives have commenced within one area of the Trust so far (Cragside).
- Our Practice Development Nurses have supported the reduction of falls. In analysing data and working in collaboration with all staff on the unit, a quality improvement initiative was developed to support improvement in clinical practice, which included the following pieces of work:
    - One of the key drivers was education for staff, patients, and visitors. Due to visiting restrictions and suspension of family forums, it has been difficult to provide education to visitors. However, information on falls prevention is given verbally and has been introduced into welcome packs.
    - Liaison with family members on the most appropriate footwear for patients to use, as research has highlighted this will support with the reduction of the incidence of falls.
    - Staff have received formal education from the Falls Team as well as informal training specifically for patients who have fallen or have recurring falls.
    - Patient's falls risks are discussed in the Safety Huddle by the multidisciplinary team and subsequent actions are agreed and cascaded to the whole team.
    - The pathway for staff referrals to the Physiotherapy team has been agreed and shared.
    - When developing the education programme, it was highlighted that the patient's cognition and medication will have an impact and increase their falls risk. Therefore, the programme had input from the Specialist Dementia Nurses and the Ward Pharmacist, which was well received and evaluated positively.
    - The quality of the completion of appropriate falls documents i.e., risk assessment, post falls checklist, was inconsistent. Therefore, this was addressed in the education programme, along with a reminder that all patients require a lying and standing blood pressure to be

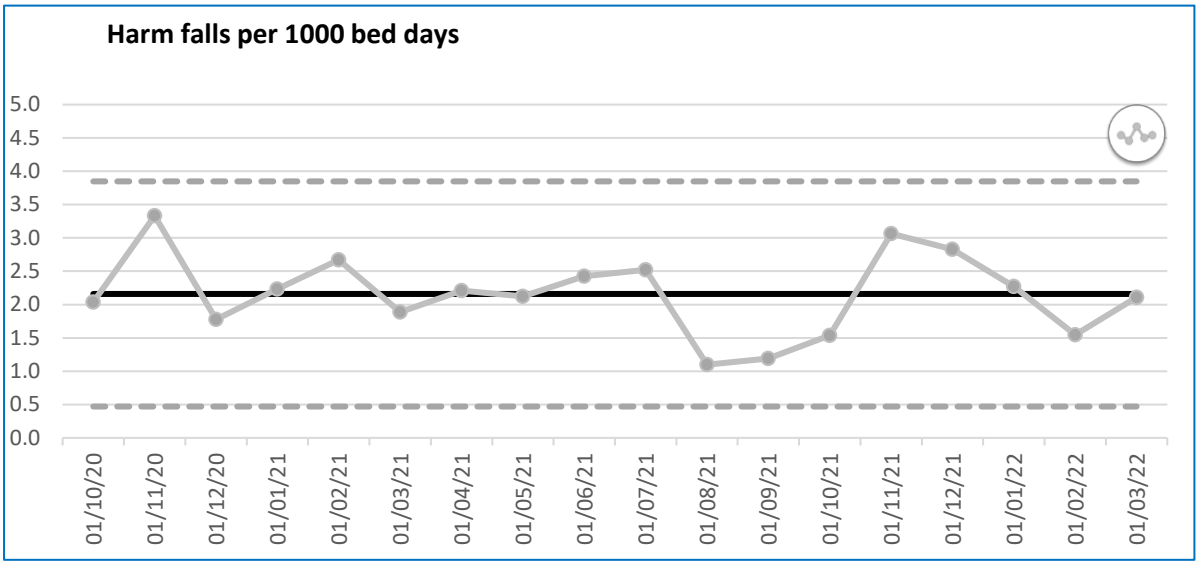
undertaken. A focus on documentation features within the Trust's Quality Account Priorities for 2022-23 within this document.

- There have been no significant harms reported since the quality initiatives commenced however the opportunity has been taken to do a review of patients who had multiple falls.
- In terms of Trust-wide improvement work, this is ongoing to convert the post fall protocol from a paper-based capture to an electronic data capture on Nervecentre.
- Lying and standing blood pressure is now captured on Nervecentre and this now includes patients where this is recorded in the Accident and Emergency department.
- A clinical audit was undertaken to see if there was a correlation between those patients who were predicted at the front door to be at a higher falls risk (and therefore measures would be put in place in a timelier fashion with the ultimate goal of preventing in-patient falls) and those patients who were not deemed to be at a higher risk of a fall based on the initial assessment. The results of the audit conclude that there is some data which suggests that low and no harm falls should form part of the Trust's toolkit to prevent further in-patient falls. This will be taken forward into 2022/23.

Falls data for 2021/22:



	2020-21	2021-22	Change
Falls	1415	1525	+7.8%
Falls rate per 1000 bed days	10.36	9.51	-8.2%



	20-21	21-22	Change
Harm Falls	318	335	+5.3%
Harm falls per 1000 bed days	2.33	2.09	-10.3%

A reduction of 10.3% was observed in the Harm falls rate per 1000 bed days. Common cause variation observed in the harm falls rate over the previous 18 months.

➢ Next steps:

- The Trust Falls Prevention Group will be reinstated in 2022/23 to ensure a collaborative approach to falls prevention.
- Rapid reviews/debrief to be explored in relation to harmful falls to allow learning to be identified in real time and improvements implemented straight away.
- Explore options for mandatory training for all clinical staff in falls prevention.

Priority 8: We will ensure the care that we provide to our patients is consistent with recognised best practice, leading to improved outcomes for patients – pressure damage

➢ What did we say we would do?

- We will reduce the number of Trust (hospital and community) acquired pressure damage by 10%.

Did we achieve this?

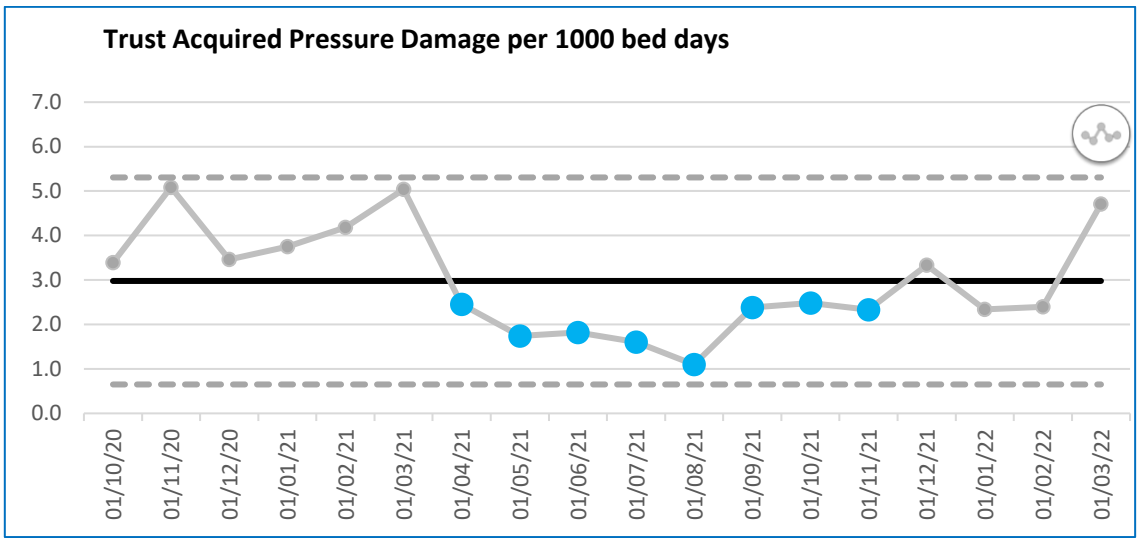
- Yes, we achieved this priority.

Progress in 2021/22:

- Implementation of the Surface, Skin inspection, Keep moving, Incontinence, and Nutrition (SSKIN) bundle in the community.
- Guideline devised to assist staff in nursing patients who are reluctant to comply with pressure ulcer prevention and management techniques.

- Pocket guides provided regarding the classification of pressure damage.
- All community dressings are provided via a Dressings Platform instead of individual pharmacies.
- Additional training has been delivered to complement our in-housing training sessions.
- A Pressure Ulcer Safety Huddle Rapid Review Tool (Push Tool) has been devised to identify any omissions in care concerning all Trust related Deep Tissue Injuries / Unstageable damage and Category 3 and Category 4 damage and implemented within the hospital setting a Rapid Review meeting will take place within 72 hours of the injury being validated. Any omissions in care that are not related to themes and trends will be escalated to Serious Incident Panel.
- A baseline assessment of the SSKIN Bundle audit has been undertaken across the Trust highlighting inconsistencies with the recording wound assessments and positional changes.
- Weekly SSKIN bundle audits have been re-establishment across the ward areas using paper-based format. This is now in the final stage to move towards electronic capture and will be implemented during Quarter 1 of 2022/23.
- The Digital Transformation Team and the Tissue Viability Service have been developing an electronic solution to the Wound Management Booklet which will be available on Nerve Centre. The Wound Management Booklet will also be redesigned so it can be used on EMIS in the Community. Development of this is within the final stages and will be implemented within Quarter 1 of 2022/23.
- Safety Cross Boards across the hospital site have been re-established incorporating the number of harm free days. Ward 1 / Ward 11 / Ward 22 have achieved over 365 days of harm free care.
- The Pressure Ulcer Collaborative has been re-established on Ward 14A and preliminary work has started on Critical Care (Red and Yellow Zone) using the Model of Improvement Methodology. The collaborative will continue to be rolled out in areas with the highest incidence of harm.

➢ Evidence of achievement:

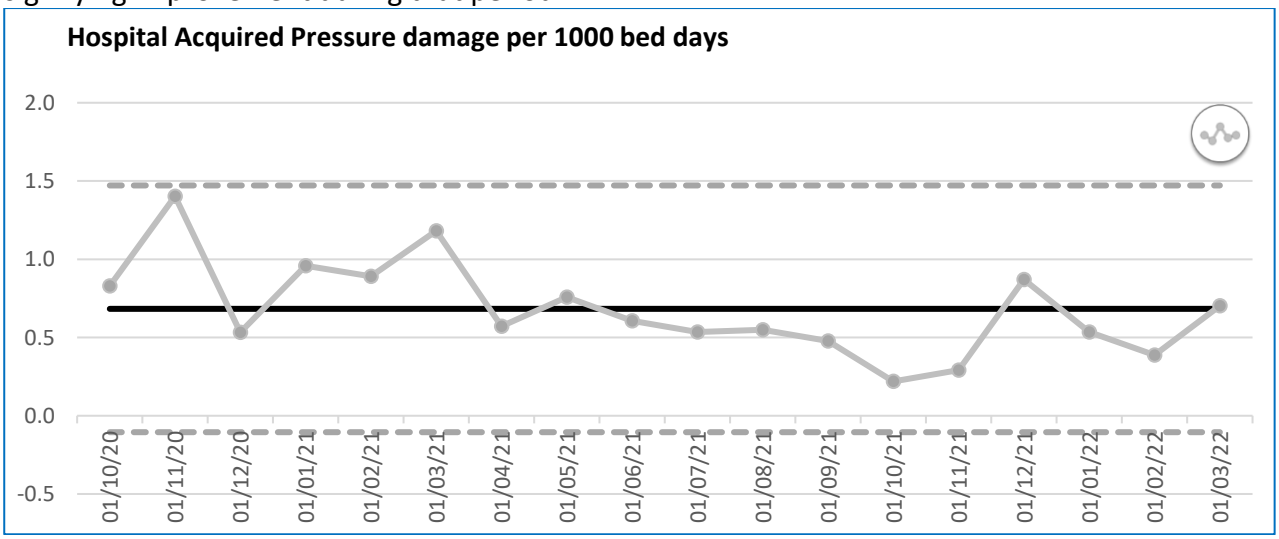


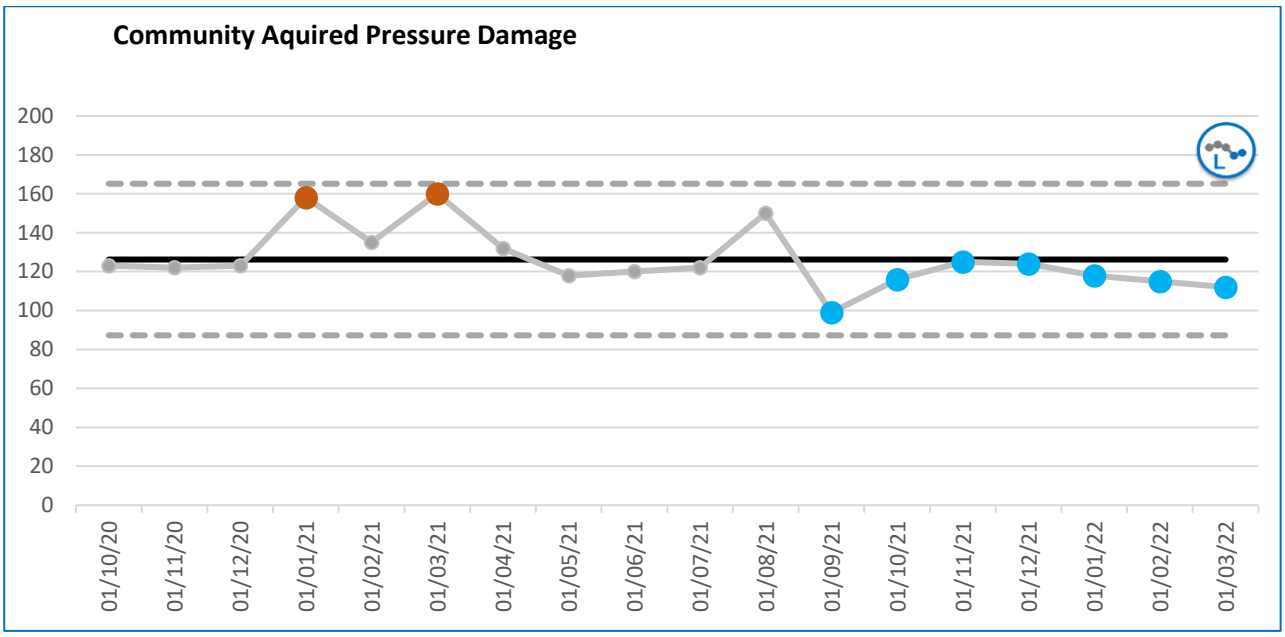
Comparing 2020-21 to 2021-22, Trust acquired pressure damage rate for 2021-22 is 2.41 per 1000 bed days compared 3.81 per 1000 bed days for the equivalent previous period, demonstrating a 37% reduction in the rate.

The was a significant reduction in Trust acquired pressure damage between April and November 2021 identified by eight consecutive months below the 18-month mean.

	2020-21	2021-22	Change
Trust acquired pressure damage rate per 1000 bed days	3.81	2.41	-37%
Hospital acquired pressure damage per 1000 bed days	0.84	0.54	-36%
Community acquired pressure damage (monthly average)	130	121	-7%

A 7% reduction was observed in the monthly average number of grade 2 and above pressure damage incidents. Special cause variation (low) identified in the number of community acquired pressure damage incidents (Grade 2 and above) with seven consecutive months below the 18 months mean signifying improvement during that period.





Next steps:

- SSKIN bundle to move to electronic capture by Quarter 1 of 2022/23.
- Wound Management Booklet to be available on Nervecentre by Quarter 1 of 2022/23.
- Intentional Rounding chart to be available on Nervecentre to capture positional changes for patients by the end of Quarter 2 2022/23.
- Pressure Damage Collaborate to continue to be rolled out to the areas where the is the highest incidence of pressure damage.

Priority 9: We will review and revise our level 1 mortality review process, providing families, carers, and staff the opportunity to identify themes for improvement and to highlight areas of good practice and excellent care

What did we say we would do?

- We will ensure that at least 80% of patient deaths will have received a level 1 review within 60 days.

Did we achieve this?

- The waves of the Covid-19 pandemic impacted on the number of mortality reviews taking place, therefore we did not achieve our aim of 80% of deaths being reviewed within 60 days of death.

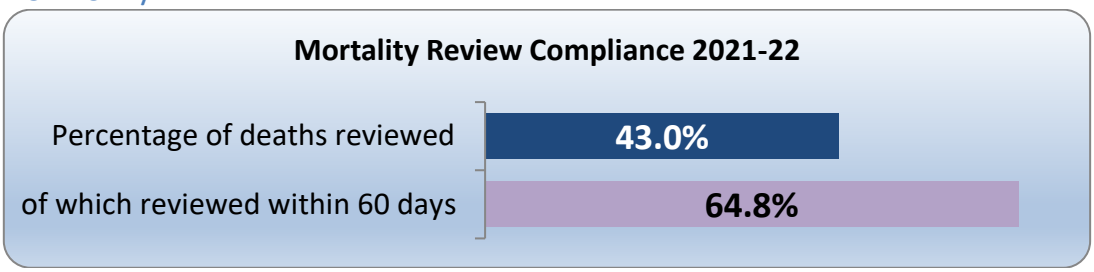
Progress in 2021/22

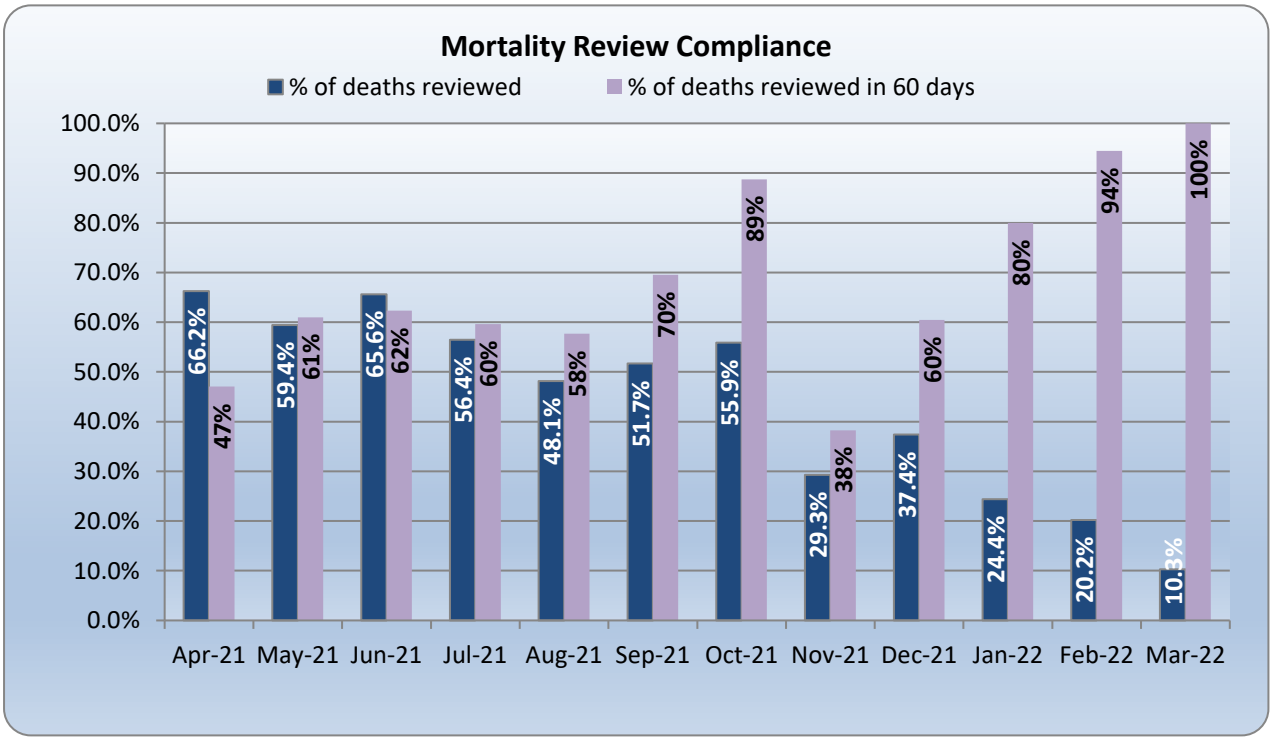
- The number of level 1 reviews carried out by the ward teams has significantly decreased since the onset of the pandemic in March 2020. The Medical Examiner Service was implemented within the Trust in September 2020, and since then the team have been working towards reviewing all deaths. The Medical Examiner team flag cases where they deem there may be issues with the quality and safety of patient care to the Mortality Council for the appropriate scrutiny and escalation for a patient safety investigation should it be necessary. Therefore, going forward, the Medical Examiner review will become the 'level 1' review and in addition to their existing review, the Hogan and NCEPOD scores will be added. Ward teams will still have the opportunity to review deaths in their

areas to ensure all good practice, learning and any improvement required is captured and disseminated to the ward team.

- Audit One carried out an audit of the Mortality Review process in late 2021, the outcome was 'reasonable' assurance. This external audit recognised the duplication of the level 1 review undertaken by the ward teams and the Medical Examiner. An action plan has been developed to take forward the recommendations from the audit, and a Mortality Review Task and Finish Group convened with representation from key stakeholders across the Trust. The remit of the group is to implement the actions arising from the Audit One recommendation which will encompass: revising the Learning from deaths policy, ensuring the process align with other functions such as patient safety investigation and complaints and finally, reviewing the various electronic systems that are currently in use.
- In terms of sharing learning from mortality reviews, this is carried out via a number of routes namely, annual/quarterly learning bulletins triangulated with patient safety investigations and complaints, a six-monthly overview report to the Trust Board, a monthly Mortality Council learning bulletin and speciality level learning presented annually at the Mortality and Morbidity Steering Group.

Data for 2021/22





Next steps:

- Continue to work through the recommendations from the Audit One report, with a view to launching a new Learning from Deaths policy by the end of Quarter 1 2022/23.

2.2 Our Quality Priorities for Improvement 2022/23

PATIENT EXPERIENCE				
Quality Priority	**What will we do?**	**How will we do it?**	**Expected Outcome?**	**How will it be measured?**
Reinvigorate the Volunteers Service	Increase volunteer number by 100	New recruitment drive Develop new volunteer's communications materials	Volunteer numbers will increase by 100	ESR data
	Full evaluation of the 'Response Volunteer Programme' and 'Patient Experience Volunteer Programme'	Volunteer and staff engagement events and surveys Patient feedback	Evaluation report for both programmes and associated action plan (as needed)	Monitor via bi-annual reports
	Develop a contingency plan for the recruitment and mobilisation of external volunteers	Work collaboratively with external stakeholders to develop an external volunteer staff base as needed e.g., further Covid-19 wave	Contingency plan will be in place	Contingency plan will be in place (and this will be evaluated if it is utilised)
Understand and improve the experiences of service users with Learning Disabilities and Mental Health needs	Ensure we identify service users	Review flagging and alert system to identify patients	Increase in the number of service users with flag and alert	Medway and EMIS BI reports
	Understand the experiences of service users with Learning Disabilities and Mental Health needs and look at where improvements can be made	Co design work with service users to identify and implement where improvement can be made	Evidence that improvements have been made based on feedback from service users with Learning Disabilities and Mental Health needs	A minimum of one co-design workshop or improvement event will be held with this cohort of patients and point of care staff across 2022/23

	Review patient information leaflets to identify core areas where easy read leaflets are needed	Mechanism to be implemented to enable staff to request a leaflet in easy read format	Increase the number of easy read leaflets	Patient Information Leaflet database and Trust website leaflet data
		Explore the procurement of a software license with NHS approved images for easy read leaflets		
		Develop a section on the Trust website where easy read leaflets are accessible for service users	Trust website will have a section where leaflets are held	
	Provide easy read appointment letters	Develop template for use by Bookings and Referral team	Easy read appointment letter template will be implemented	Audit of the use of easy read appointment letters
		Review flagging system of AIS on Medway and EMIS to ensure that easy read is an available option for communication	Easy read will be an option for communication recorded and flagged on Medway and EMIS	Medway and EMIS BI reports
	Increasing biopsychosocial assessments to a minimum of 60%	Staff will be reminded of the biopsychosocial assessments that should be completed/under what circumstances	The number of biopsychosocial assessments will increase to meet or exceed the target	This will be monitored via the CQUIN
		Review NICE guidance CG133	A multidisciplinary team will review the NICE guideline	Nice Guidance Compliance Monitoring
Working with patients as partners in improvement	Demonstrate that we value to contribution of our patient partners	Consider developing a Trust policy and process aligning with NHS policy 'Reimbursing expenses and paying involvement payments'	New policy developed	Implementation of the policy

	Ensure the patient partner voice is heard	Inviting patients to sit on operational sub-groups and participation in ward accreditation visits	Patient will be within the core membership of a minimum of 5 operational sub-groups across the Trust	Number of patients on operational sub-groups
	To provide a forum for staff to seek feedback, engagement, and involvement from patient partners	Work collaboratively at an ICS level with the Gateshead PLACE team and reinvigorate the existing patient panels	The Trust will be a core member of all patient panels and Trust staff will be invited to join the appropriate panels to seek feedback, engagement, and involvement from patient partners	Number of forums attended by the Trust
				Number of projects taken to patient forums by Trust staff for patient feedback, engagement, and involvement
STAFF EXPERIENCE				
Quality Priority	**What will we do?**	**How will we do it?**	**Expected Outcome?**	**How will it be measured?**
We will focus on the health and wellbeing (HWB) of our staff	Being responsive to staff feedback	HBW check ins	Number of HBW check ins will have increased, and this will reflect in staff feedback	Monitored through the People and OD Committee
		Review of Occupational Health and resolve key issues around progressing the appointment of staff into posts	A review will have been undertaken and action plan implemented as deemed appropriate	Monitored through the People and OD Committee
		Increase the uptake of Flu vaccination amongst point of care healthcare staff to 70%	Increase in the number of point of care healthcare staff vaccinated against Flu	This will be monitored via the CQUIN

		HWB Initiatives will be rolled out across the Trust e.g., Out of Hours catering	Evidence that HWB Initiatives have been rolled out across the Trust in response to staff feedback	Monitored through the HWB Programme Board
		Seek feedback e.g., bi-annually that health and wellbeing initiatives meet the needs of staff, can progress at pace, can be sustained into the future, and are evaluated	Evidence of staff engagement events with staff feedback generated	Monitored through the HWB Programme Board
		Develop and publish a HBW Strategy	A HBW Strategy will have been published	Progress updates against the Health and Wellbeing Strategy will be provided on minimum of a bi-annual basis
We will advocate for equality, diversity, and inclusion for all of our staff	Demonstrate progress in meeting the Workforce Disability Equality Standard (WDES) recommendations	Adopt a program of review and development to include recommendations for change across all of the ten WDES indicators	Progress will be demonstrated in working towards achieving the WDES recommendation	WDES recommendations monitored through the People and Organisational Development Committee
		Incorporate data from the WDES outcomes and develop a specific WDES action plan indicating all areas that need improvement	WDES action plan will be implemented	
	Demonstrate progress in meeting Workforce Race Equality Standard	Adopt a program of review and development to include recommendations	Progress will be demonstrated in working towards achieving the	WRES recommendations monitored through the People and OD Committee

	(WRES) recommendations	for change across all of the nine WRES indicators	WRES recommendation	
		Review and refresh the policy around Recruitment and Selection	A revised policy will be implemented around Recruitment and Selection	
		Undertake a Race Disparity Audit	A Race Disparity Audit will have been undertaken and action plan implemented as deemed appropriate	
		Engage with external development programmes	Evidence that Black, Asian and minority ethnic (BAME) staff members have had opportunities to engage with external development programmes	
		Work towards a Zero Tolerance policy	A Zero Tolerance Policy will be in place	
	Staff inclusion and ensuring all professional voices are heard (e.g., Allied Health Professionals (AHP), pharmacy, community, staff networks)	Hold a Nursing, Midwifery and AHP Conference	Nursing, Midwifery and AHP Conference will go ahead in 2022/23	Diversity of attendees at the conference and conference evaluation
		As part of the Trust's strategic workforce plan, complete a self-assessment around AHP workforce including a review of Electronic Staff Record (ESR) AHP data	Implement an action plan as deemed appropriate	Monitoring of Trust action plan
		Take part in the National Workforce Supply project	We will have taken part in the National Workforce Supply project and	Participation in the National Workforce Supply project

			identified any relevant learning for the Trust	
		Establish an AHP Leads Forum	Forums will be established	Number of forums that take place and assurance reports/annual review
		Establish a minimum of five Subject Area Forums or Task and Finish Groups		
		Hold awareness raising events covering a broad range of professions e.g. 'A day in the life of' and take part in National AHP Day	Awareness raising events will go ahead	Number of awareness raising events and diversity of professions featured
	Increase the number of professional development opportunities	Development and implementation of a Fellowship Scheme including AHP Fellows, Nursing Fellows and Midwifery Fellows, led by the Trust's Chief Nurse and Professional Lead for Midwifery and AHPs	5-10 staff members (who are within 5 years of professional registration and AFC Band 5-7) will take part in the fellowship scheme	Number of staff members taking part in the Fellowship Scheme from a diverse range of professions
We will promote a just, open, and restorative culture across the organisation (priority carried over)	We will implement and embed all principles of a just culture across the organisation	Board Development Sessions around just culture	Staff will be empowered to speak up and identify risks to safety without fear of punitive response which will facilitate better outcomes for patients	Monitoring of staff survey results and any other safety culture assessment tools through the SafeCare/Risk and Safety Council and the People and OD Committee
		As part of the People Portfolio Board, we will establish a Leadership and OD Programme of which Just Culture will be a core strand of work		
		The Trust's Patient Safety Specialists will work with the People and OD team to ensure a Just Culture guide		

		(or equivalent) is developed and formally adopted and built into the Trust's Human Resource (HR) and patient safety policies		
		We will ensure the safety sections of our recently published NHS Staff Survey results are reviewed and discussed, and triangulated with patient experience data and patient safety data in order to identify actions needed to improve patient safety culture		

Staffing resource is a Quality Account priority within the next section.

PATIENT SAFETY				
Quality Priority	**What will we do?**	**How will we do it?**	**Expected Outcome?**	**How will it be measured?**
To maximise safety in maternity services through the implementation of the Ockenden Recommendations	To fully implement all immediate and essential actions	We will comply with the Ockenden Recommendations	We will comply with the Ockenden Recommendations	Self-assessment against the Ockenden Recommendations
Staffing	We will calculate clinical staffing requirements based on patients' needs (acuity and dependency) which, together with professional judgement, will guide us in our safe staffing decisions	Implementation of the Safer Nursing Care Tool (SNCT) Implement standardised Trust branded staffing display boards across all wards We will implement safe staffing reviews in other areas as suitable tools become available to us	Understanding of the link between patient acuity and dependency, workload, staffing and quality and demonstrating improvements over 2022/23	Organisational Nurse Sensitive Indicators (NSI) to monitor the impact of staffing on the quality of patient care and outcomes through triangulated staffing reports
	Recruit 50 Nurses within 12 months	International Recruitment Staffing Task and Finish Group	50 Nurses will be in post at Gateshead Health NHS Foundation Trust	Number of vacancies filled
Undertake improvement work to agree a safe method of processing clinical results	By March 2023 we will use recognised improvement methodology to design and agree a process for the safe management of clinical results across the organisation	Audit One to undertake audit of current processes and identify areas for improvements Commission a Rapid Process Improvement Workshop by end of Q2 to understand current processes and define which types of results should be reviewed, by	New policy agreed and ready to be launched on 1st April 2023	Key Performance Indicators (KPIs) identified for various types of results and who will review and in which timescales

		who and define timescales		
		Consultation with key stakeholders		
		Using change methodology (Plan Do Study Act cycles) test proposed concept on key areas		
		Develop Trust Wide Policy outlining expectations for all staff reviewing results, with KPIs identified for various types of results		
CLINICAL EFFECTIVENESS				
Quality Priority	**What will we do?**	**How will we do it?**	**Expected Outcome?**	**How will it be measured?**
We will revisit the core fundamental standards of care	We will revisit the core fundamental standards of care	Band 7 and Matron Development	Band 7's and Matron's feel confident in the promotion/ management and escalation around core fundamental standards of care	Number of Band 7 and Matrons who have taken part in development opportunities
				Evaluation of development programmes
			Improvements to the core fundamental standards of care	Trust CQC Compliance Tracker Document
		A revised programme of Environmental Audits will be implemented	Revised programme of Environmental Audits will have been implemented and an associated action plan for improvement will be made and monitored	Monitoring paper to the SafeCare/Risk and Safety Council
				Trust CQC Compliance Tracker Document

		Implementation of the Trust's CQC Monitoring approach	Assurance of compliance with the Fundamental Standards and CQC Regulations	Trust CQC Compliance Tracker Document
We will encourage, help, and support all staff to engage with research	We will embed research into our ways of working	Review how we notify staff of research projects that can be accessed	Increase in the number of staff actively involved in research	Number of staff actively involved in research
		To develop a research newsletter and web-based resource for staff		
		To ensure that support is available in staff that are interested in undertaking research		
We will support the continual improvement of clinical record keeping (both paper and electronic) throughout the Trust	Review and reinstate a revised programme of documentation audits	Review documentation audit criteria/ methodology	Documentation audit will be reimplemented and improvements will be identified and actioned	Monitoring via the SafeCare/Risk and Safety Council
		Review audit policy/Standard Operating Procedure (SOP)		
		Review monitoring approach		
		Consider triangulation of this data		

2.3 Statements of Assurance from the Board

During 2021/22 the Gateshead Health NHS Foundation Trust provided and/or sub-contracted 31 relevant health services. The Gateshead Health NHS Foundation Trust has reviewed all the data available to them on the quality of care in 100% of these relevant health services. The income generated by the relevant health services reviewed in 2021/22 represents 100% of the total income generated from the provision of relevant health services by Gateshead Health NHS Foundation Trust for 2021/22.

Participation in National Clinical Audits 2021/22

During 2021/22, 40 National Clinical Audits and four National Confidential Enquiries covered relevant health services provided by Gateshead Health NHS Foundation Trust.

During that period Gateshead Health NHS Foundation Trust participated in 90% of National Clinical Audits and 100% of National Confidential Enquiries which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that Gateshead Health NHS Foundation Trust participated in, and for which data collection was completed during 2021/22, 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.

Audit title	Participation	% of cases submitted/number of cases submitted
Case Mix Programme	Yes	784 cases submitted no minimum requirement
Elective Surgery (National PROMs Programme)	Yes	441 cases submitted no minimum requirement
Pain in Children (care in Emergency Departments)	Yes	5 cases submitted no minimum requirement
National Audit of Inpatient Falls	Yes	23 cases submitted no minimum requirement
National Hip Fracture Database	Yes	334 cases submitted no minimum requirement
Learning Disabilities Mortality Review Programme NHS England	Yes	6 cases submitted no minimum requirement
National Pregnancy in Diabetes Audit	Yes	50 cases submitted no minimum requirement
National Diabetes Footcare Audit	Yes	106 cases submitted no minimum requirement
Adult Asthma Secondary Care	Yes	Data submission remains open until 30/05/2022
Chronic Obstructive Pulmonary Disease Secondary Care	Yes	Data submission remains open until 30/05/2022

Pulmonary Rehabilitation-Organisational and Clinical Audit	Yes	466 cases submitted no minimum requirement
National Audit of Cardiac Rehabilitation	Yes	220 cases submitted no minimum requirement
National Audit of Care at the End of Life	Yes	100% (40/40)
National Audit of Dementia	Yes	Data collection was suspended due to the pandemic
National Cardiac Arrest Audit	Yes	66 cases submitted
National Audit of Cardiac Rhythm Management	Yes	Data not yet available
Myocardial Ischaemia National Audit Project	Yes	251 cases submitted no minimum requirement
National Heart Failure Audit	Yes	163 – no minimum requirement
Audit of Patient Blood Management & NICE Guidelines	Yes	100%
National Emergency Laparotomy Audit	Yes	100%
National Oesophago-gastric Cancer	Yes	60 – no minimum requirement
National Bowel Cancer Audit	Yes	224 – no minimum requirement
National Joint Registry	Yes	506 cases submitted no minimum requirement
National Lung Cancer Audit	Yes	247 cases submitted no minimum requirement
National Maternity and Perinatal Audit	Yes	100%
National Neonatal Audit Programme	Yes	100%
National Paediatric Diabetes Audit	Yes	127 cases submitted no minimum requirement
National Prostate Cancer Audit	Yes	156 cases submitted no minimum requirement
National Vascular Registry	Yes	50 cases submitted no minimum requirement
National Outpatient Management of Pulmonary Embolism	Yes	100%
National Smoking Cessation	Yes	100 cases submitted no minimum requirement
Sentinel Stroke National Audit Programme	Yes	286 cases submitted no minimum requirement

Serious Hazards of Transfusion Serious Hazards of Transfusion	Yes	9 cases submitted no minimum requirement
Trauma Audit & Research Network	Yes	80% (250 cases submitted)
National Inpatient Diabetes Audit	Yes	Data collection was suspended due to the pandemic
National Audit of Breast Cancer in Older Patients	Yes	593 cases submitted no minimum requirement
National Audit of Seizures and Epilepsies in Children and Young People	No	Capacity within the specialty and too resource intensive
Inflammatory Bowel Disease Audit IBD Registry	No	Resources required out way benefits of taking part
National Diabetes Core Audit	No	Medway extraction impossible and too resource intensive
National Early Inflammatory Arthritis Audit	No	Capacity within the specialty and too resource intensive

Participation in National Confidential Enquiries 2021/22

Enquiry	Participation	% of cases submitted
Child Health Clinical Outcome Review Programme National	Yes	Data not yet available
Confidential Enquiry into Patient Outcome and Death	Yes	Data not yet available
Learning Disabilities Mortality Review Programme NHS England	Yes	100%
National Confidential Inquiry into Suicide and Safety in Mental Health	Yes	Data not yet available

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 11 national clinical audits were reviewed by Gateshead Health NHS Foundation Trust in 2021/22 and Gateshead Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National Cardiac Arrest Audit (NCAA)

During this time, a total of 162 calls were raised and this includes cardiac arrest, respiratory arrest, calls for urgent help, false calls, and unknown events. 66 of these calls were for cardiac arrest and related to 63 individuals – three patients having had cardiac arrests twice. These patients still met

the criteria for inclusion within the NCAA database and any reports relating to this time frame will have referred to 66 episodes.

Our report trends relating to patient profiles changed during Covid-19 in that we were noticing younger patients having cardiac arrest. Our outcomes are still poor when compared to other participating Trusts however we are being compared to other Trusts who maybe cardiac centres or include Accident & Emergency cardiac arrest events. These are excluded from our audit and generally have better outcomes than ward based deteriorating patients.

Actions:

- We have carried out detailed forensic audits on patients who have raised concerns and two in particular were presented at the Mortality and Morbidity Steering Group.
- Fluid balance has been included within Nerve Centre this issue will improve.
- Continue with participation in the national audit

National Audit of Inpatient Falls (NAIF)

From January 2019, NAIF changed to become a continuous audit of in-patient falls resulting in in-patient hip fractures, one of the most severe harm events occurring as a result of falling. The records are cross linked with the National Hip Fracture Database (NHFD) which is part of the same audit programme. The National NAIF report 2021 (data from January 2020 to December 2020) was released in Autumn 2021. This year more focus was placed on immediate post fall checks, in line with NICE Quality Standard 86. Key post fall findings included two thirds of patients were checked for signs of injury before being moved from floor and 62% were assessed by a medical professional or equivalent with 30 mins of a suspected severe harm fall. However, it took an average of two hours for a patient with a suspected fractured neck of femur to receive analgesia. Nationally there were low rates of transfer of patient from the floor with flat lifting equipment (26%).

In terms of the local trust level report (released July 2021) the output from the facilities section of the audit was as follows: Positives: access to flat lifting equipment, reporting all inpatient fractured neck of femurs as severe harm, regular reporting of falls rates and falls per 1000 bed days, MDT led falls working group and written information for patients about falls.

Areas to improve: no mandatory falls training for all clinical staff (in 50% trusts this is the case), no walking aid policy for seven-day access to walking aids, no bed rail audit carried out in the past 12 months, not clear who the is the designated executive and non -executive director for falls in the trust. Latest trust Key Performance Indicators (based on 21 cases over the past 12 months to the end of November 2021): Checked for signs of injury before moved from the floor – 90% (NAIF overall 76%). Used a safe manual handling method to move the patient from the floor – 86% (NAIF overall 86%). Medical assessment within 30 minutes of a fall – 33% (NAIF overall 68%) – need to understand why this is lower than expected

Actions

- Falls risk assessment and post falls assessment to be moved from paper copy to Nervecentre
- Ensure Enhanced Care assessment is effective at identifying those at high risk of falling
- Aim to have rapid review/ hot debriefs post an inpatient fractured neck of femur to help provide real time feedback and learning and the inform the Datix/patient safety investigation process
- Business case for inpatient falls nursing team (currently not in place)
- Look at mandatory training of all clinical staff in falls prevention and assessment

The Case Mix Programme (CMP) 2021/22

The Case Mix Programme 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. In addition to the well-established CMP audit, ICNARC have more recently introduced a Process Audit for Covid-19 patients, which examines the therapies given to Covid-19 patients before and during their Critical Care admission. In the past 12 months the Critical Care Unit have uploaded data on 784 patients to the CMP and have continued to contribute data to the Covid-19 Process Audit. The increased frequency of data submission requested by ICNARC in response to the Covid-19 pandemic has continued with data uploads required daily at times of high Covid-19 activity. CMP/ICNARC continue to publish Quarterly Quality Reports (QQR) for each individual critical care unit. Our most recent QQR, including data up to the end of Q3 21/22 shows strong performance in admission and discharge from Critical Care with a reduction in the number of delayed discharges. Our overall standardised mortality rate was at the higher end of the normal range, but the reports advise caution in interpreting mortality rates due to the impact of Covid-19. Mortality for patients with a predicted mortality of <20% was in the middle of the normal range.

Plan for the next 12 months:

- The software used to collect patient data and produce data exports for CMP is changing to a web-based database system from 1st July 22. There is training planned to provide the required knowledge and familiarise staff with the system prior to its go-live date.
- Continue to collect and submit data to Intensive Care National Audit and Research Centre (ICNARC)/CMP.
- Continue to collect and submit data to the Covid-19 Process Audit.
- Ongoing education of ward clerks and Nursing/Medical staff regarding the correct entry of data, assisted by the ICNARC data clerk.
- Use the QQR to ensure timely identification of any areas of deterioration in performance and address these when they occur.
- Continue to share QQR and other CMP/ICNARC data with relevant teams within the Trust.

- **National Heart Failure Audit**

The number of cases submitted for 2021/22 is reduced compared to pre-Covid-19 data input. This is due to a variety of issues due to the Covid-19 pandemic. Specialist heart failure input for patients admitted with heart failure has been proven to improve outcomes in reducing in-hospital and post hospital mortality and reducing re-admission with heart failure. However, a surge in outpatient referrals and reduced workforce due to redeployment to ward areas during staffing crisis has led to many in patients with heart failure not being picked up or reviewed by the heart failure nursing team. Therefore, the number of cases submitted will not reflect Hospital Episodes Submitted data. Specialist follow up within two weeks of discharge is a measure that has been difficult to meet due to the backlog from Covid-19 and staffing shortage within the team. Heart failure input also needs to be stepped up front of house in order to avoid unnecessary admission to hospital.

Actions:

- Specialist Heart Failure pharmacist successfully appointed
- Plans to establish heart failure Specialist Nurse input into Same Day Emergency Care programme
- Plan to re-establish heart failure day unit providing ambulatory heart failure management
- Increase in-patient services in order to reduce the number of patients with heart failure being missed

- **National Audit of Care at the End of Life**

This is a comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals, community hospitals and mental health inpatient providers in England, Wales, and Northern Ireland. The Trust's overall result is excellent, with summary scores exceeding the national average in 10 out of 12 domains. This is in line with our previous results in 2018 and 2019, though scores cannot be directly compared due to changes made to the data collection domains. The below-average score for of 7.5 (compared with 8.1 nationally) reflects the fact that we were amongst a minority of 40% of Trusts that do not have a face-to-face Specialist Palliative Care advice service (doctor and/or nurse) available eight hours a day, seven days a week. Our End-of-Life Education program (including induction, mandatory training, and communication skills) was, however a strength in this area. Though not captured in the summary scores, the case note review demonstrated that the possibility of dying was recognised promptly, with time from admission to recognition less than 48 hours in 54% of Gateshead's submission, compared with 32% nationally. In 62.2% of Gateshead's submission, recognition occurred at least 48 hours prior to death, compared with 47.6% nationally.

Actions

- The audit report will be shared with the Trust End of Life Steering Group and Mortality and Morbidity Steering Group and will contribute to ongoing evaluation of strategic, clinical, and training priorities.
- The Specialist Palliative Care Team is embarking on a piece of work with the Transformation team, to explore options for seven day working.
- The Specialist Palliative Care education team is promoting palliative and end of life care training and education opportunities, via its bespoke prospectus of local events and study days.
- Training in the use of the Caring for the Dying Patient Document will continue, with plans for a full re-launch later this year when it becomes digitalized.
- The Specialist Palliative Care team will maintain visibility and accessibility on the hospital wards, utilizing systems such as Nerve Centre to proactively identify patients who may be dying. It will also participate in the Seeking Excellence in End-of-Life Care (SEECare) Audit to assess whether further work is required to support generalist provision of end-of-life care.
- The Trust will continue to participate in the National Audit on Care at the End of Life

- **Audit of Patient Blood Management (PBM) & NICE Guidelines**

PBM is a multidisciplinary, evidence-based approach to optimising the care of patients who might need a blood transfusion. The deployment of PBM initiatives reduces inappropriate transfusion, which improves patient safety, reduces hospital costs, and helps to ensure the availability of blood

components when there is no alternative. Audit of PBM practice is vital to help us to understand the quality of care and to indicate where corrective measures are needed. The standards for this audit were adapted from those issued in NICE QS138: Quality Statement 1: People with iron deficiency anaemia are treated with iron supplementation before surgery. National 665/1131 (59%) (Trust 77.8%) of the patients who were known to have iron deficiency anaemia prior to being admitted for surgery were treated with iron before surgery. The precise reasons for not treating the remainder of the patients were not captured in this audit.

Actions

- The audit shows a solid foundation for good practice and suggests hospitals need to understand what barriers may exist to improving practice and revise their procedures to implement the four Quality Statements for blood transfusion
- Continue to participate in the national audit programme.

- **Trauma Audit & Research Network (TARN)**

The latest TARN report for Queen Elizabeth Hospital Gateshead was published in August 2021 which includes data up to 31/01/2021. Case ascertainment was 40.3% in 2021 compared with 56% in 2020. Unfortunately, the data required for the most recent two quarters has not been submitted on time. As a result, a report could not be published.

Actions

- TARN has completed a review of our coding data for a fixed period and compared the list of potentially eligible patients with the output of our business intelligence report. There were significant discrepancies. Therefore, we are in the process of establishing additional methods to help identify TARN eligible patients. These include paperless documentation with relevant prompts and check boxes suitable for audit through the electronic patient administration system.
- We are currently developing business cases for a trauma coordinator and administrative support for the TARN submission process.
- We are also developing an action plan to catch up with the backlog of TARN submission data.

- **National Joint Registry (NJR)**

The Trust continues to contribute to the NJR. 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. For 2020/21 the data quality audit was extended to include ankle, elbow and shoulder cases. The Trust continues to contribute to these audits and achieved 100% compliance for the 2020/21 NJR Data Quality audit.

Actions

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

- **Elective Surgery (National PROMs Programme)**

Actions

- Data continues to be shared and discussed in the regional Orthopaedic Alliance group as part of a Getting it Right First Time (GIRFT) review across all regional providers.
- The trust is an integral part of the newly formed Northeast and North Cumbria orthopaedic alliance as part of the pandemic recovery programme and is working within this group to achieve a centrally agreed shared data set for the group to develop shared learning and reductions in unwarranted variation.

- **National Paediatric Diabetes Audit**

Real time data is collected and reviewed locally three monthly by the diabetes team and six monthly by the North East and North Cumbria Regional Children and Young People's (CYP) Diabetes Network. We have submitted data on 127 patients 122 of these patients had Type 1 diabetes.

Over the last year the CYP Diabetes team has:

- developed our service for CYP (children and young people) living with Type 2 diabetes in line with NICE and the National Guidelines including dietetic and psychology led support and education clinics in addition to their routine three monthly MDT clinics.
- offered and collected the NPDA PREM (patient reported experience measures) the outcomes have not yet been reported. We had a high completion rate with 64 CYP and 64 parents/carers completing the survey.
- participated in a Poverty Proofing Project (ongoing) with Children North East and Type 1 Kidz patient support group to increase awareness of HCPs and the trust of the difficulties those CYP and families living with T1D face and to enable strategies to be put in place to facilitate equitable access to health care and diabetes technologies. This is particularly important as 69.7% of CYP in our clinic live within the 2 most deprived quintiles which is significantly higher than the regional and national average and a greater proportion of those living in the least deprived quintile had access to insulin pump therapy compared to those in the other 4 quintiles
- had team education on delivering flipped learning and embedded DEAPP a standardised new patient education programme from diagnosis and are also using this for re-education and education of staff and students.

Actions

- To continue to support CYP and their families and carers to improve or maintain optimal glucose levels measured by HbA1C and Time in Range to ensure CYP have the best possible health outcomes and life chances.
- A new dietitian was appointed by the trust to the diabetes team in Sept 2021 and is being supported with specialist training for paediatric diabetes
- We are proactively encouraging and facilitating retinal screening in all our eligible young people with diabetes. An audit of local retinal screening outcomes is planned.
- To ensure that diabetes MDT members are supported to access the appropriate training to enable safe and expert support for patients using diabetes technology in particular the roll out of CGM for all CYP living with Type 1 Diabetes as recommended by NICE and the increased use of licensed hybrid closed loops for CYP and the need for pump therapy to be commenced from diagnosis where multiple daily injections are practical and inappropriate.

- 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.
- Ongoing review of the transition pathway and working with the adult service, primary care and young people to develop 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 age appropriate education programmes 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.
- There is a need for the MDT to re-focus on timely and complete data entry into the dendrite clinical data base and the trust to invest in increased admin time in particular dedicated data analysis and diabetes technology administration plus IT support to ensure sustainable processes to ensure good quality data in the long term and access to technology for CYP living with diabetes.

- **National Smoking Cessation**

NHS England and Public Health England jointly called for all NHS Trusts to become Smokefree as stated in the Tobacco Control Plan for England (2017). The Trust has committed to achieving Smokefree status and has signed the NHS Smokefree Pledge. All NHS trusts must implement NICE Guidance PH48 Smoking Cessation in secondary care, acute, maternity, and mental health services to qualify as Smokefree. The enhanced emphasis on this provision as detailed in the Long-Term Plan contains detailed pathways outlining the expected provision, pathways for patient management and a funding stream to support this. Implementation will be overseen at ICS level, by NHS England LTP regional teams and is likely to be subject to external research through ARC – assessing trust level markers of success.

- Smokers make up 16% of acute adult admissions
- Our patients are more likely to suffer complications, medical and surgical, and have more severe forms of chronic diseases.
- One person dies in Gateshead every 16 hours from a smoking related disease.
- Patients with Mental Health problems have >15years reduced life expectancy because of the correlation with tobacco dependence – their premature deaths are caused by smoking related diseases.
- Smoking remains is the single most important modifiable risk factor in reducing still birth rates.
- The Covid19 pandemic has widened health inequalities vastly and tackling smoking is an achievable way of working to reduce these and needs to be tackled urgently, e.g., there has been a 70% regional reduction in referral to stop smoking services from maternity since Covid.

Actions

Gateshead have looked to the CURE project model that has been adopted in the Greater Manchester area: Each admission is a 'teachable moment' – the point at which we are most likely to be successful at prompting a quit attempt.

- Early and adequate prescription of appropriate Nicotine replacement therapy (NRT)/ other pharmacotherapy is vital to support them with their acute tobacco dependency.
- Enhanced input from someone with the clinical knowledge to translate the effects of their smoking onto their current health conditions.
- Enhanced support in the form of behaviour modification strategies and psychological support to be able to engage with a quit attempt.

The reports of six local clinical audits were reviewed by Gateshead Health NHS Foundation Trust in 2021/22 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
General Surgery	Trauma and Orthopaedics	Completion of the Nottingham Hip Fracture Score (NHFS) in the Trauma and Orthopaedic Department The audit showed 12% of high-risk patients had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) discussion by the Surgical team (36% had a pre-existing DNACPR, 20% by medical team and remaining 32% did not have a DNAR on discharge). 60% of high-risk patients had their surgery discussed with the family. Higher NHFS in patients who died versus patients who survived. Need to improve compliance of NHFS completion. Room for Surgical team to increase engagement in DNACPR discussions and escalation planning for high-risk patients. The Trust needs to ensure all patients with a consent form 4 are discussed with family and that patients that are high risk, and patients with consent form 1 have this offered to them. Actions: • Clerking booklet required updating with NHFS information included this has now been completed. • An electronic application on Nervecentre needed to be created, this has now been achieved and is currently awaiting implementation. • Re-audit in 2022
Medicine	Care of the Elderly	Auditing the accurateness of fluid balance documentation, appropriate escalation and thereafter management of negative fluid balance. The audit showed that 37% did not have accurate fluid balance documented. 36% of patient with a poor fluid balance were not escalated as such incorrect fluid prescribing for clinical/individual need in 25% of cases. Areas for improvement to be made are accuracy and

		uniformity of paper fluid charts, incorporation of Intravenous Therapy IVT) and Nasogastric (NG) feeds onto all fluid charting and an escalation system in nerve centre for fluid balance problems with patients. Actions: • A new uniform paper chart is currently in development to be trialled to improve the recording of fluid balance. • A re-audit will be undertaken once the new electronic tool has been developed.
Surgery	General Surgery	Compliance with Antimicrobial Guidance in Surgical Patients Results showed 28 surgical inpatients in total, 16 of which were prescribed antibiotics. Only 3/16 patients prescribed antibiotics had an appropriate end date. Less than 20% concordance with trust guidelines. Majority of patients had no defined course length prescribed on the system, room for significant improvement, less than 20% concordance with trust guidelines. Actions: • Staff require a teaching session on antimicrobial stewardship and should include these audit results in a presentation, this was undertaken in November 2021. • Posters have been developed in the doctors' offices as a visual prompt.
General Surgery	Trauma & Orthopaedics	NEON* Regional Audit: Audit of mortality following inpatient falls and fractured neck of femur (NOF) (*Northeast Orthogeriatric Network) Compliance with national standards was 100% however, compliance with local standards required improvement. Previous inpatient fall is common in those with inpatient neck of femur (NOF) fracture (52%). Previous fragility are predictors of increased rate of inpatient NOF fracture (35%). Toilet / bathroom are common sites of inpatient NOF fracture (34%). Majority of NOF fractures occur between 5pm and 8am when less staff around. Majority of these patients were frailer and more cognitively impaired. Staff need to be reminded of the guidelines on falls. Need to understand the importance of previous falls and use as an opportunity to address and risk factors Actions: • Audit findings have been presented to Trust Falls Group, NEON and Care of the Elderly SafeCare meeting. • Update the Trust Guideline for falls - this has been done and is awaiting final ratification.
Surgery	Critical Care	Emergency drug bag and airway bag checks on critical care This audit has shown that relatively simple changes have improved our practice. The emergency airway and drug bags are now being regularly checked and re-stocked if needed. This allows us to have confidence that all the necessary equipment is there and in-date for a potential emergency. Discussion with the senior team whether the contents of the bags should be amended as there are

		as an example three different muscle relaxants including atracurium which rarely gets used. Actions: • Update the bag contents once agreed • Re-audit in six months to ensure practices are upheld and the process continues to improve
Clinical Support & Screening	Diagnostic Imaging	Audit of yield and complications of ultrasound-guided neck biopsy (non-thyroid) Ultrasound guided neck lesion sampling is considered as a low-risk out-patient procedure without any special preparation or precautions. Investigation of one case of severe bleeding prompted this audit to confirm risk: benefit ratio and help produce a patient information leaflet. 18/94 (19%) of the adequate samples were benign. Some (e.g., salivary lesions) were confirmed benign at resection and some (e.g., presumed reactive nodes) had no further relevant "events" on ICE/OpenNet and thus presumed benign. Two cases with fluorodeoxyglucose (FDG) positive nodes on positron emission tomography (PET) in context of proven primary malignancy were still regarded with suspicion for clinical management. Two cases went on to develop lymphoma in axillary nodes. This gives a crude feel for the predictive value of a benign biopsy. Actions: • Finalise patient information leaflet • Reinforce preference for core biopsy of nodes rather than fine needle aspiration (FNA) if possible and appropriate • Re-audit

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Gateshead Health NHS Foundation Trust in 2021/22 that were recruited during that period to participate in research approved by the Health Research Authority (HRA) was 2,571.

Recruitment by Managing Specialty	Total
Ageing	11
Anaesthesia, Perioperative Medicine and Pain Management	49
Cancer	55
Cardiovascular Disease	2
Critical Care	53
Dementias and Neurodegeneration	190
Diabetes	2
Gastroenterology	4
Haematology	1
Health Services Research	28
Hepatology	36
Infection	554
Mental Health	90
Metabolic and Endocrine Disorders	40
Musculoskeletal Disorders	13

Public Health	33
Reproductive Health and Childbirth	1,251
Respiratory Disorders	117
Stroke	12
Surgery	6
Trauma and Emergency Care	24
Total	**2,571**

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 National Institute for Health and Care Research (NIHR) Restart Framework, here are the 3 key aims:

1. The restart of paused NIHR research that was underway in the healthcare system prior to the COVID-19 'surge'
2. The Commencement of 'new' NIHR research, and
3. The prioritisation of resources in the NIHR Clinical Research Network (CRN) and NIHR infrastructure more broadly

The Trust restarted the paused and commenced new research following the guiding principles, preconditions, study prioritisation and local and national roles set out in the framework.

However, running alongside the Restart Framework, the Trust also worked tirelessly on the Covid-19 Urgent Public Health (UPH) studies to gather the necessary clinical evidence to inform national policy and enable new diagnostic tests, treatments, and vaccines to be developed and tested for Covid-19. The Trust ran the following studies: RECOVERY, PANCOVID, GenOMICC, MERMAIDS, The Psychological Impact of Covid-19 Pandemic, PIM-COVID and ISARIC.

The ISARIC / CCP-UK Study (formerly the Novel Coronavirus Study) is a data collection study (Protocol Tier 0) to accelerate the collective understanding of Covid-19 to help improve patient care and inform public health policy.

ISARIC would go on to recruit over 280,000 participants across the Nation. By March 2022 Gateshead had recruited **2,017** participants.

The RECOVERY trial is the world's largest clinical trial into treatments for COVID-19, with more than 45,800 participants across 205 trial sites in the UK. The RECOVERY Trial is one of the new "Platform Trials" a trial comparing multiple treatments at the same time using a single protocol. This allows new treatments to be added and ineffective treatments to be dropped throughout the course of the trial.

The RECOVERY Trial (led by Oxford University) found one of the world's first COVID-19 treatments, Dexamethasone. This cheap, readily available steroid was shown to reduce deaths of hospitalised COVID-19 patients by one third.

The press releases and publications about the results for each drug tested on the RECOVERY Trial can be found at: https://www.recoverytrial.net/results . By March 2022, Gateshead had recruited **207** participants.

GenOMICC is an, open, collaborative, global community of doctors and scientists trying to understand and treat critical illness with the aim of identifying the specific genes that cause some people to be susceptible to specific infections and consequences of severe injury. Identifying these genes will help use existing treatments better and assist with the design of new treatments to help people survive critical illness.

GenOMICC is the largest study of its kind anywhere in the world and Gateshead Health NHS Foundation Trust has consistently been the highest recruiting sites in the United Kingdom.
GenOMICC has gone on to recruit over 18,000 participants. By March 2022, Gateshead had recruited **99** participants.

PAN-COVID is a global registry of women affected by COVID-19 in pregnancy and their babies, to guide treatment and prevention.

COVID-19 outbreak will affect thousands of pregnant women globally and evidence is limited on its impact on pregnancy and neonates. There is a need to collect clinical experience of COVID in pregnancy and the neonates to inform the global community about the natural history of the disease and guide improvements in clinical care and public health.

It is hoped that the research will help scientists gain a better understanding of how coronavirus affects early pregnancy, fetal growth, prematurity, and virus transmission to the baby.

MERMAIDS
Multi-centre EuRopean study of MAjor Infectious Disease Syndromes

The aim of this European study is to find out why some people become sicker than others when they have an acute respiratory infection. More information about how different people respond to the agents that cause respiratory disease will allow better prediction on how bad the infection is likely to be and to develop treatments specific to that particular patient. This could reduce disease severity and the risk of complications and also reduce the need for hospital admission.

Blood samples will be analysed to observe individual gene activity (the process by which the instructions in our genes are converted into a product, such as a protein) and compared with samples from people with different risk factors. This will provide detailed information on how the body responds to infection and the effects of different risk factors.

MERMAIDS has gone on to recruit over 1,100 participants across 36 sites. By March 2022, Gateshead had recruited **92** participants.

The Psychological Impact of COVID-19 Pandemic: An International Survey

The Psychological Impact of COVID-19 Study aimed to explore the outbreak and the resultant restrictions in terms of behavioural, emotional, and social factors.

The general public including Health Professionals and those with pre-existing mental health conditions were invited to complete an online survey in the hope that this would enable the identification of vulnerable groups who may experience more extreme or differing impacts to the rest of the population.
The study has recruited over 188,000 participants across 400 sites. By March 2022, Gateshead had recruited **238** participants.

The aim of the PIM-Covid study is to assess the short- and long-term psychological impact on patients who have survived an admission to intensive care due to COVID-19, and identify possible predictors of anxiety, depression, and trauma symptoms in this patient group.

By March 2022 Gateshead had recruited **12** participants.

The Chief Nursing Officer (CNO) for England, launched the Strategic Plan for Research in November 2021 in conjunction with NHS England and NHS Improvement. The plan is for all nurses working in health and social care, (whether they are already or thinking about getting involved in research), colleagues in academia and the third sector and all those who support research. It has been developed in partnership with stakeholders across the health and care system including the Innovation, Research and Life Sciences Group within NHS England and NHS Improvement.
It sets out the CNO's ambition to "create a people-centred research environment that empowers nurses to lead, participate in, and deliver research, where research is fully embedded in practice and professional decision-making, for public benefit". This plan complements the ambitions set out in

Saving and improving lives: the future of UK clinical research delivery and will form part of NHS England and NHS Improvement's contribution to the delivery of this vision.

Fulfilling this ambition will strengthen and expand nurses' contribution to health and care research of global significance. This provides the scientific basis for: the care of people across the lifespan, during illness and through to recovery and at the end of life, preventing illness, protecting health, and promoting wellbeing.

The Research Team also delivered training to the Foundation Doctors to highlight why research is important within the NHS, why it is important to ask the new questions and why we need evidence-based practice. The training session proved extremely popular and will continue to be delivered to subsequent Foundation Doctors.

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

A proportion of Gateshead Health NHS Foundation Trust income in 2021/22 was not 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. A monetary total of £0 of the Trust's income in 2021/22 was conditional upon achieving quality improvement and innovation goals due to their suspension as part of the NHS Covid-19 funding regime.

Registration with the Care Quality Commission (CQC)

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 2021/22.

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 in 2021/22, there was one Mental Health Act (1983) Monitoring visit to Cragside in September 2021.

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 2021/22 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data is shown in the table below:

Which included the patient's valid NHS Number was:	Trust %	National %
Percentage for admitted patient care*	99.9%	99.7%
Percentage for outpatient care*	99.8%	99.8%
Percentage for accident and emergency care†	99.1%	96.0%

Which included the patient's valid General Medical Practice Code was:	Trust %	National %
Percentage for admitted patient care*	99.8%	99.7%
Percentage for outpatient care*	99.8%	99.6%
Percentage for accident and emergency care†	99.8%	98.6%

* SUS+ Data Quality Dashboard - Based on the April-21 to March-22 - SUS+ data at the Month 11 inclusion date extracted on the 17th of March 2022

†ECDS DQ Dashboard from Thursday 1st April 2021 up to and including Thursday 31st March extracted on Monday 4th April

Key

	The Trust % is equal or greater than the National % valid
	The Trust is up to 0.5% below the National % valid
	The Trust % valid is more than 0.5% below the National % valid

Information Governance Toolkit

Gateshead Health NHS Foundation Trust's Information Governance Assessment Report overall score for 2021/22 graded as – submission deadline is 30th June 2022 – therefore results are not available for this publication.

Standards of Clinical Coding

Gateshead Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2021/22 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 was completed on the Performance, Planning, Analytics and Information department away day and new weekly, monthly and quarterly meetings are to be organised and held to align good data quality with accurate reporting and performance
- 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.
- Robotic automation software has been implemented and now has a number of live automations which focus on ensuring quality of data across all of our systems
- 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. Insource reviewed our 18 weeks process and positive feedback was provided on both data quality and the ability to report live dashboards.

- 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.
- Work with NHSI and NHSE to continue provide accurate, complete and good quality data sets with the aim of reducing some of the duplicated reporting requirements that the Trust are asked to submit.

2.4 Learning from Deaths

During 2021/22, there were 1169 patient deaths within Gateshead Health NHS Foundation Trust. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 239 in the first quarter;
- 298 in the second quarter;
- 342 in the third quarter;
- 290 in the fourth quarter.

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

In early April 2022, 503 case record reviews and 59 investigations have been carried out in relation to 1169 of the deaths included above.

In 34 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:

- 166 in the first quarter;
- 165 in the second quarter;
- 141 in the third quarter;
- 56 in the fourth quarter.

Zero deaths representing 0% of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter;
- 0 representing 0% for the second quarter;
- 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/Description of Actions:

Patient pathways

Patients with known specialist conditions to be taken to the most appropriate Accident & Emergency for treatment where there are the specialist teams with the relevant training to provide the best treatment. This was shared with the ambulance trust who are reviewing their current vascular surgery pathway to ensure that were a patient is already under the care of a service for AAA should be taken directly to that Trust to avoid delay of urgent treatment

Clinical Care

A number of reviews have demonstrated issues related to nutrition in patients who were kept nil by mouth due to medical issues and did not receive adequate nutrition. It was highlighted that patients determined to be obese still require appropriate nutrition and that these patients can be protein deficient. Individual cases are fed back to Nutrition and Dietetics team. The Nutrition and Dietetics team are now represented on the Mortality Council and are able to provide specialist input into the discussions at the meeting.

Communication

Good practice noted within this theme

Evidence of advanced care planning documents, regular palliative care review, discussions with family, recognition of end of life and communication with the Palliative Care Team. Issues have been highlighted with the process for the use of Do Not Attempt Cardiopulmonary Resuscitation (DNACPRs) is not being followed appropriately for patients with a learning disability as has the timeliness of carrying out Mental Capacity Acts and Deprivation of Liberty (DoLs) assessments. The role of the Lead Nurse for Learning Disabilities and the support that can be provided will be promoted. An audit of all learning disability deaths that occurred between June and December 2021 to determine level of compliance with DNACPR process will be carried out. Amendments have been made to the DNACPR policy

Visiting restrictions

There have been several cases where families were unable to see their loved ones due to Covid-19 restrictions. There was evidence of poor communication with family members who should have been contacted on a regular basis by telephone calls or limited visits. Some areas have expressed concerns about poor Wi-Fi signal at times. Patient experience volunteers were introduced not only to support patients keep in touch with their loved ones via iPads, emails etc., but also to provide company and a listening ear for patients. Further initiatives to support patients and their families with Letters to a loved one, letters to a friend were introduced.

Discharge

Issues were highlighted in terms of discharge processes. Review planning and timing of discharges, to prevent inappropriate discharges late at night. Ensure that discharges to nursing homes are appropriate in terms of the nursing home having the appropriate set up to care for patients at end of life. Ensure good communication and handover to care homes and discharge of elderly patients, particularly around medication

Documentation

Issues highlighted around the quality of documentation. Ensure the sensitive recording of decision making by patient's when they do not wish to undergo treatment options offered. Ensure that when

undertaking a review for another specialty, the time of the review is documented in the patient record. All conversations had with and about patients should be clearly documented in the patient records.

Heart Failure Deaths
In response to national data, a sample of heart failure deaths were reviewed; themes identified were use of telemetry, need to expand heart failure team and heart failure pathways. Actions will include more widespread use of telemetry both in cardiology ward and other areas in medicine. A business case being formulated by the heart failure specialist clinical lead to expand their services. Availability of ECHO within 24 hours of admission. Early review by Cardiologists or Care of the Elderly Consultants with specialised interest in heart failure. Clear guidelines for juniors when some of these patients are approaching end of life and do not need aggressive fluid and diuretic management. Involvement of palliative teams in the care of this group of patients. Admit or transfer patients with heart failure to the cardiology wards whenever possible.

Assessment of the Impact:

140 case record reviews and 86 investigations were completed after 1st April 2021 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.

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 ten clinical standards as identified via the seven-day hospital services NHS England recommendations.

For clinical standard eight (ongoing review), at the time of last review we had 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).

For clinical standard two (Specialty Consultant review within 14 hours) we were 76% compliant (April 2018) across all seven days. We have identified arrival of patients between 4-8pm as a problem area. We introduced an extra twilight Registrar shift to improve flow (August 2018) and held a weeklong improvement event in March 2019 to look at flow in the Emergency Admissions area. 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.

The Covid-19 pandemic delayed further work around this agenda and we had to temporarily adapt our ways of working considerably during this time. As we come out of the pandemic, we are looking at our

model of care, especially around non-elective care, and this may affect compliance with the standards as set in the original NHSE recommendations.

We had 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. This audit work has also been suspended during the Covid-19 pandemic and will be reassessed as we recover from the pandemic and revise our model of care.

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 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 Board and the People and Organisational Development Committee twice per year, as well as continuing to report 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 FTSU 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 in profile raising and education in relation to this role. The FTSUG now reports directly to the Chief Executive and has regular meetings with the Director of People and OD and the Non-Executive Director (NED) responsible for FTSU.

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 People and Organisational Development 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 People and Organisational Development by exception when it is deemed necessary due to difficulty in reaching local resolution.

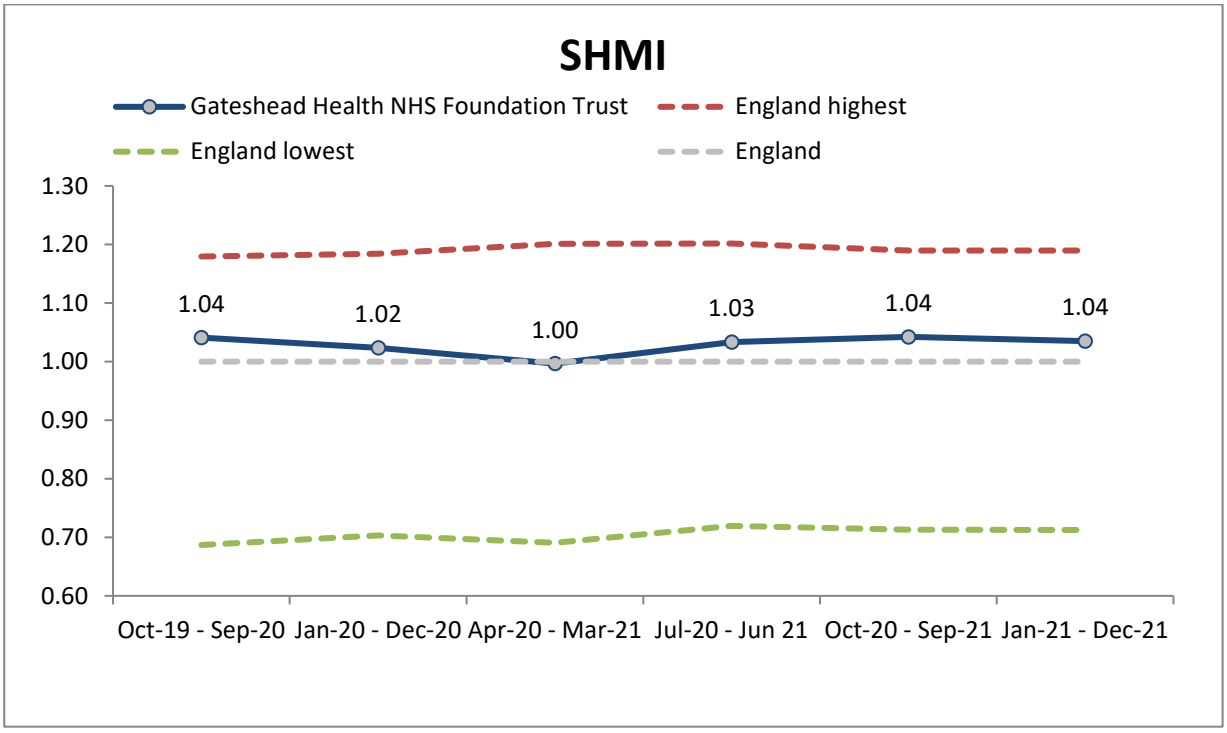
The Trust Board via the People and Organisational Development receives an annual report from the Guardian of Safe Working which includes a consolidated report on rota gaps and actions taken by the Medical Workforce Group. This report is provided to the Local Negotiating Committee (LNC) by the Guardian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

2.8 Mandated Core Quality Indicators

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

SHMI	Oct-19 - Sep-20	Jan-20 - Dec-20	Apr-20 - Mar-21	Jul-20 - Jun 21	Oct-20 - Sep-21	Jan-21 - Dec-21
Gateshead Health NHS Foundation Trust	1.04	1.02	1.00	1.03	1.04	1.04
England highest	1.18	1.18	1.20	1.20	1.19	1.19
England lowest	0.69	0.70	0.69	0.72	0.71	0.71
Banding	2	2	2	2	2	2

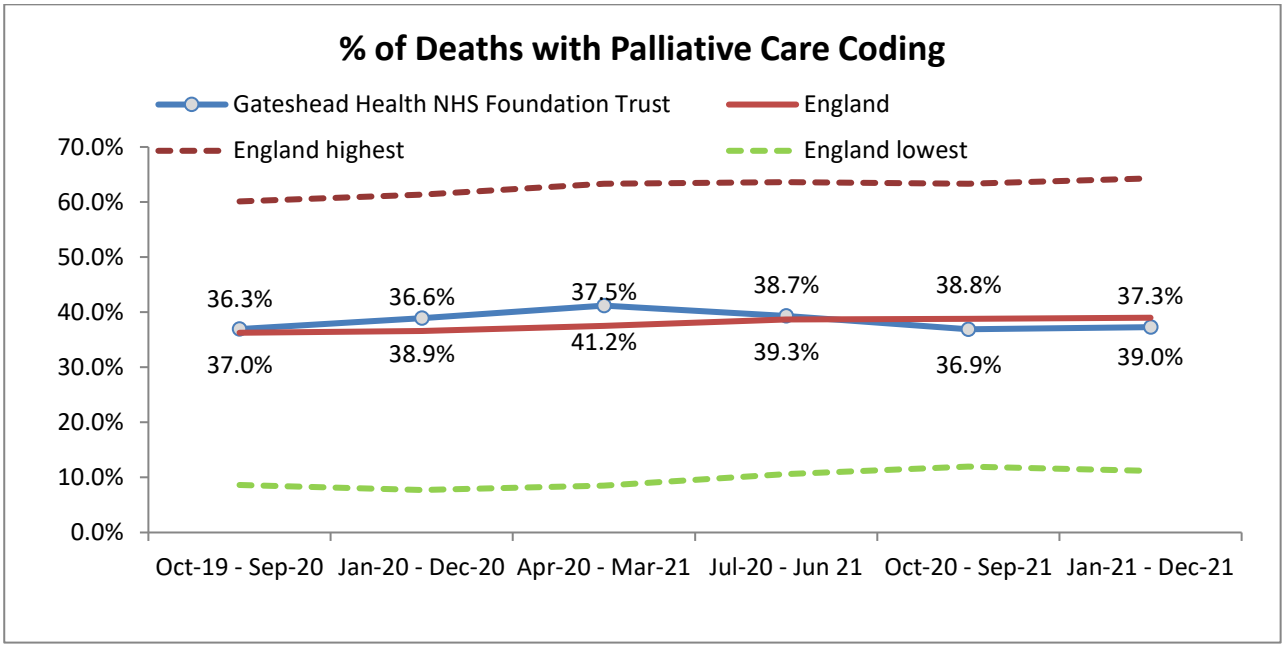
Source: www.digital.nhs.uk/SHMI



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

% Deaths with palliative coding	Oct-19 - Sep-20	Jan-20 - Dec-20	Apr-20 - Mar-21	Jul-20 - Jun 21	Oct-20 - Sep-21	Jan-21 - Dec-21
Gateshead Health NHS Foundation Trust	37.0%	38.9%	41.2%	39.3%	36.9%	37.3%
England highest	60.1%	61.4%	63.3%	63.6%	63.3%	64.3%
England lowest	8.6%	7.7%	8.5%	10.6%	12.0%	11.2%
England	36.3%	36.6%	37.5%	38.7%	38.8%	39.0%

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 SHMI calculations since October 2011, mortality for the Trust is banded '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 Trust continues to review cases for individual diagnosis groups where the SHMI & HSMR demonstrates more deaths than expected or an alert is triggered for a diagnosis group. The Trusts mortality review process can be used to review the Hogan preventability score & NCEPOD quality of care score and interrogate the narrative from the review to identify specific learning or learning themes.
- In response to a national alert, an extraordinary Mortality Councils have been set up to review a sample of heart failures deaths.
- The Trust reviews the clinical coding for alerting diagnosis groups to determine whether the appropriate diagnosis was assigned and to refine the coding where appropriate.
- The Trust continues to review palliative care coding and to ensure palliative care is recorded for all cases where this is appropriate and has seen the level of palliative care increase over the last 12 months

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

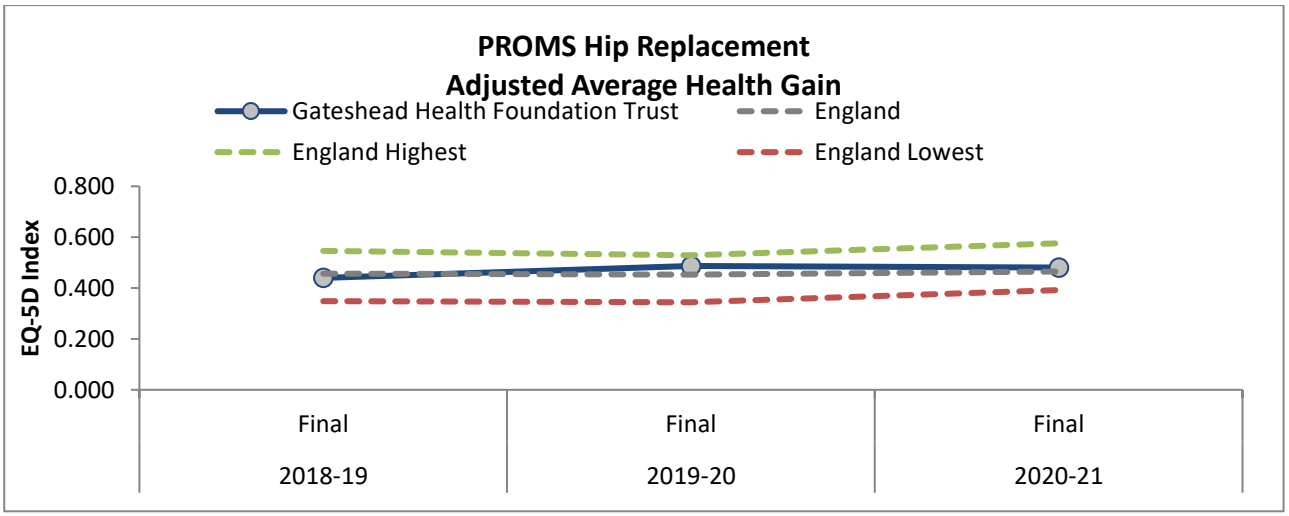
In March 2020, the collection was suspended due to the coronavirus illness (COVID-19) and the need to release capacity across the NHS to support the response. This indicator is not included because of the suspension and has not yet been reinstated.

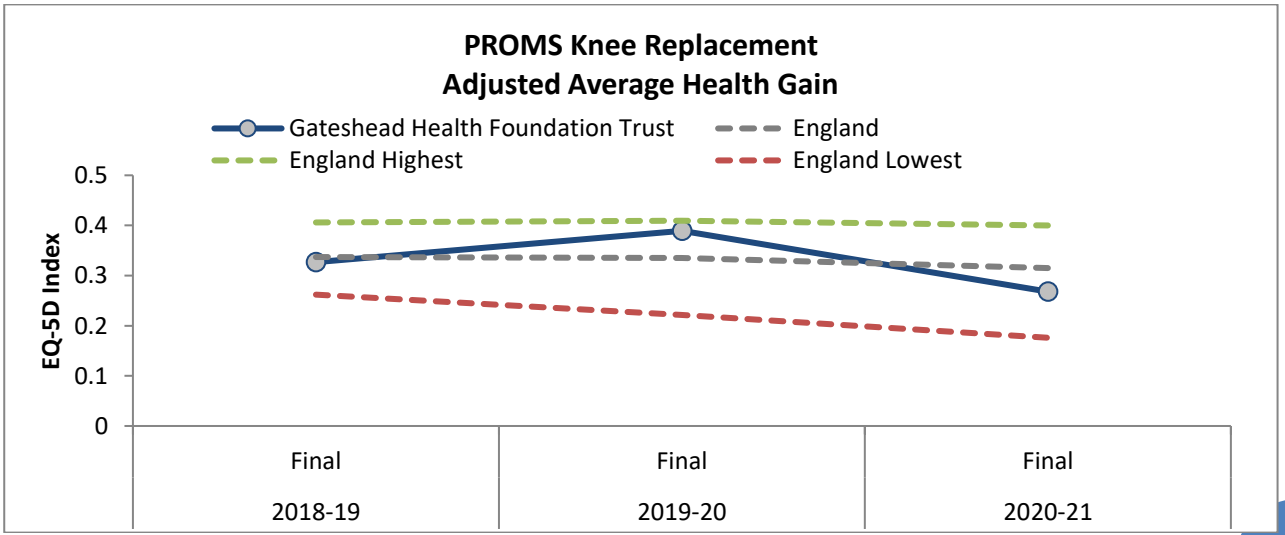
PROMs (Patient Reported Outcome Measures) for Hip Replacement and Knee Replacement:

Hip Replacement Adjusted average health gain EQ-5D index	2018-19 Final	2019-20 Final	2020-21 Final
Gateshead Health Foundation Trust	0.440	0.487	0.481
England	0.457	0.453	0.465
England Highest	0.546	0.529	0.576
England Lowest	0.348	0.344	0.392

Knee Replacement Adjusted average health gain EQ-5D index	2018-19 Final	2019-20 Final	2020-21 Final
Gateshead Health Foundation Trust	0.327	0.389	0.268
England	0.337	0.335	0.315
England Highest	0.406	0.409	0.400
England Lowest	0.262	0.221	0.176

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 performance for PROMS score in 2020-21 has decreased for both hips and knees. The Trust scores are within common cause variation from the England average therefore neither statistically better nor worse.
- Procedure volumes were reduced due to Covid, any outliers are likely to skew data negatively. For patients who were waiting longer, it is likely that more complexity to their case contributed to their outcomes.

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

- Data continues to be shared and discussed in the regional Orthopaedic Alliance group as part of a Getting it Right First Time (GIRFT) review across all regional providers.
- The trust is an integral part of the newly formed North East and North Cumbria orthopaedic alliance as part of the pandemic recovery programme and is working within this group to achieve a centrally agreed shared data set for the group to develop shared learning and reductions in unwarranted variation.

Emergency Readmissions within 30 Days

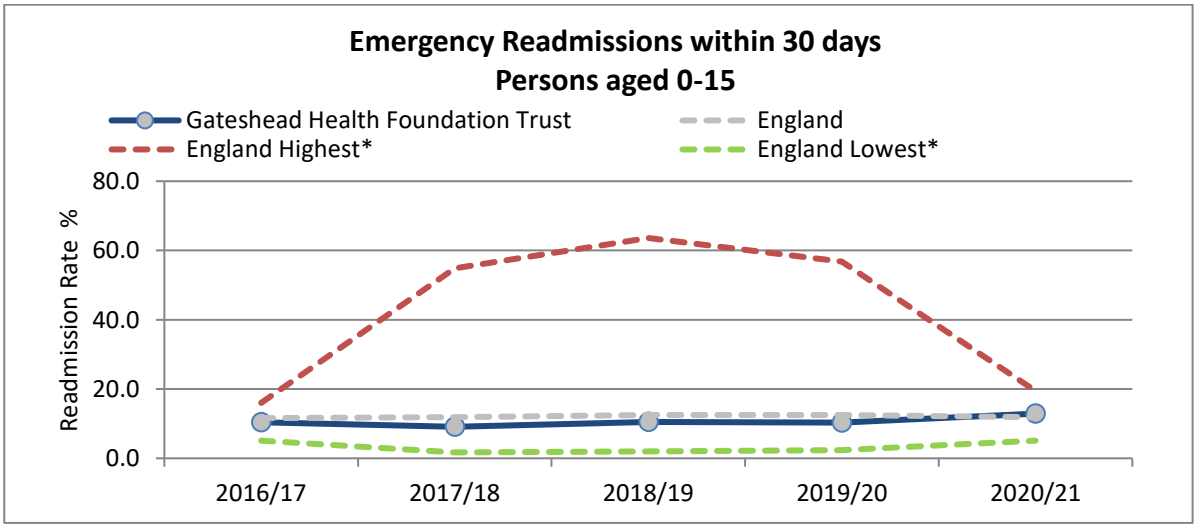
- Aged 0 – 15yrs

Emergency readmissions within 30 days of discharge from hospital Persons aged 0-15	2016/17	2017/18	2018/19	2019/20	2020/21
Gateshead Health Foundation Trust	10.4	9.1	10.5	10.3	12.9
Banding	W	B1	B5	B5	W
England	11.6	11.9	12.5	12.5	11.9
England Highest*	16	54.9	63.6	56.8	19.5
England Lowest*	5.1	1.7	2.0	2.4	5.1

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

B5 = Significantly lower 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)
*Excluding caution in interpretation of data records. Numbers of patients discharged too small for meaningful comparisons (i.e., below 200).



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

- Whilst Emergency readmission rates have increased slightly in 2020/21, they have broadly remained static over the last five years, tracking 'Significantly lower' or within than the national average in each of the last six years. The increase this year remains within the expected variation from the national average.

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

- The Trust will continue to monitor performance and undertake further investigations/actions should the increase in rates continue.

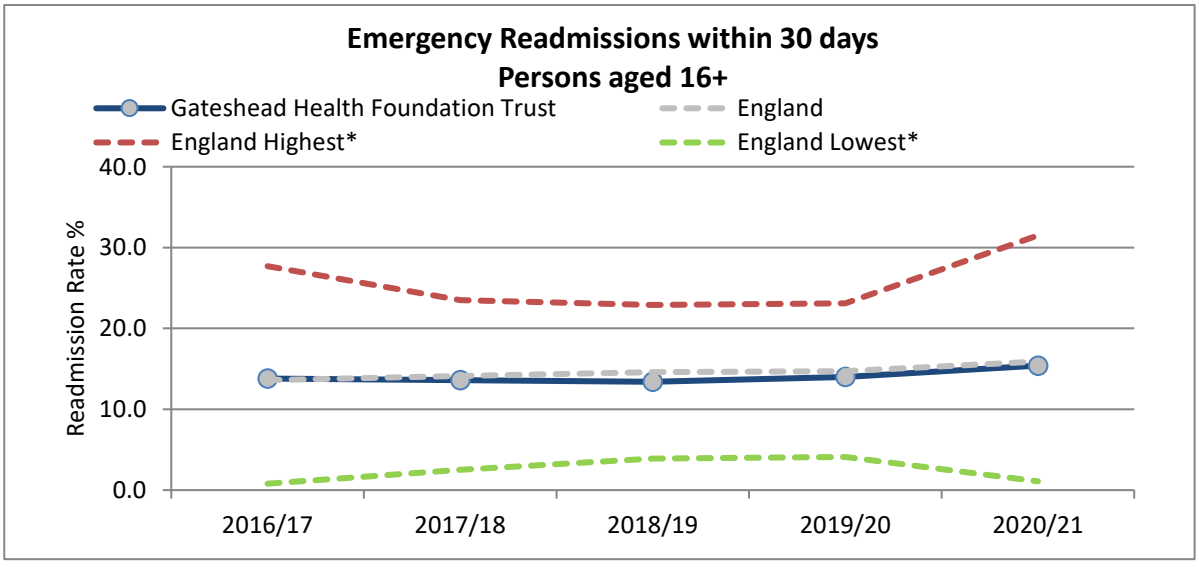
- Aged 16 years or over

Emergency readmissions within 30 days of discharge from hospital Persons aged 16+	2016/17	2017/18	2018/19	2019/20	2020/21
Gateshead Health Foundation Trust	13.8	13.6	13.4	14.0	15.4
Banding	W	W	B1	B5	W
England	13.6	14.1	14.6	14.7	15.9
England Highest*	27.7	23.5	22.9	23.1	31.5
England Lowest*	0.8	2.5	3.9	4.1	1.1

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

B5 = Significantly lower 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)
*excluding caution in interpretation of data records. Numbers of patients discharged too small for meaningful comparisons (i.e., below 200).



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

- Emergency readmission rates have risen slightly in 2020/21 however remain in line with the national average. We continue to work on our transformation agenda and believe current levels reflect the various actions taken and initiatives listed below.

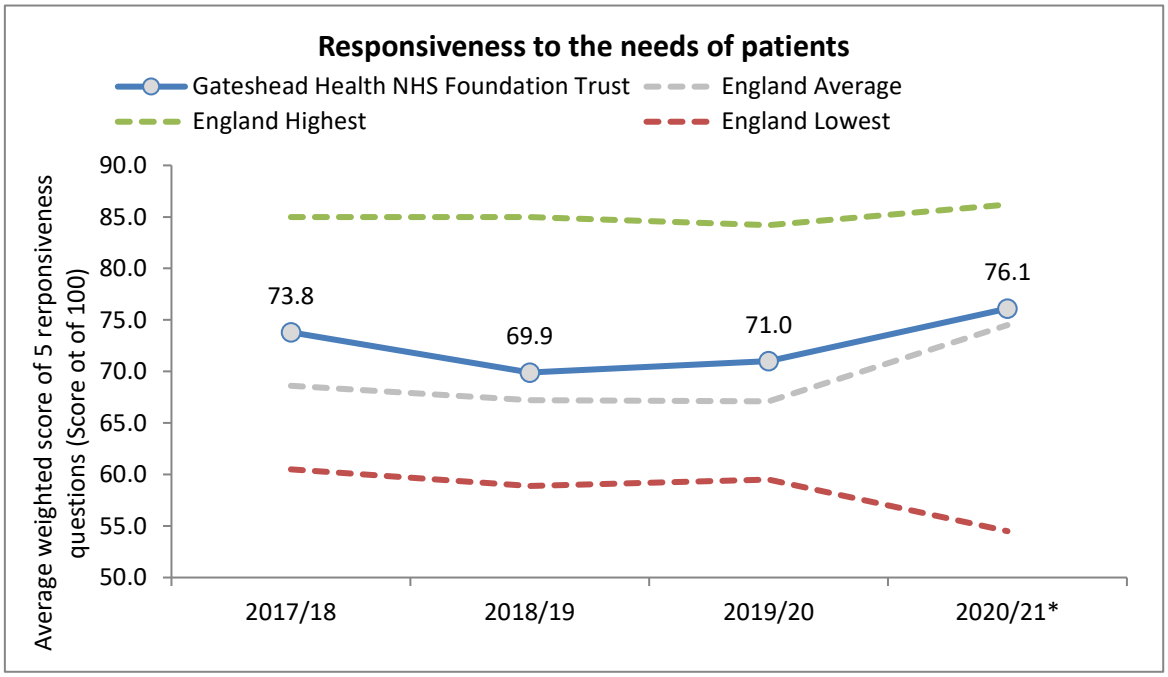
Gateshead Health NHS Foundation Trust has taken the following actions to improve these outcomes, and the quality of its services, by:

- Local monitoring of readmissions by ward and speciality to ensure that there is oversight of outlying areas.
- Reviews of readmissions that highlight failed / inappropriate discharges to better understand where practices can be improved and help ensure lessoned are learned.
- Successfully appointed a number of Discharge Coordinators across the Trust to improve discharge arrangements for patients and more robustly ensure patients' needs are met on discharge.
- Established a new Same Day Emergency Care (SDEC) Unit, which focuses on reducing patient admissions into hospital. We are looking to expand this service to include additional pathways of care and are working closely with colleagues in Primary Care to improve our services for patients.

Trust's responsiveness to the personal needs of its patients

Responsiveness to the personal needs of patients	2017/18	2018/19	2019/20	2020/21*
Gateshead Health NHS Foundation Trust	73.8	69.9	71.0	76.1
England Average	68.6	67.2	67.1	74.5
England Highest	85.0	85.0	84.2	86.2
England Lowest	60.5	58.9	59.5	54.5

*March 2022 - As of the 2020-21 survey, changes have been made to the wording of the 5 questions, as well as the corresponding scoring regime, which underpin the indicator. As a result, 2020-21 results are not comparable with those of previous years.
The indicator value is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to NHS hospitals. (Score out of 100) Patient experience measured by scoring the results of a selection of questions from the National Inpatient Survey focusing on the responsiveness to personal needs



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 which has recently been enhanced through a digital text messaging option for patient feedback in addition to Friends and Family Test cards, service level patient experience questionnaires as well as a through the collection of patient stories and co-design workshops by the Patient Experience Team which has led to service level action plans for improvement.
- The Patient Involvement Forum has been stood down during Covid-19, but this has utilised email and post to ensure service developments are responsive to patient needs.
- We continue to closely monitor our patient experience reporting and provide updates through the Patient Public Carer Involvement and Experience Group (PPCIEG) and the SafeCare/Risk and Patient Safety Council.
- Within the Patient Experience Team, a Rapid Process Improvement Workshop (RPIW) has commenced in response to complainant feedback and the new Parliamentary and Health Service Ombudsman (PHSO) which are being piloted in sites across the UK. The aim is to provide a quicker, simpler, and more streamlined complaint handling service, with a strong focus on early resolution by empowered and well-trained staff. There will also be a strong emphasis on senior leaders regularly reviewing what learning can be taken from complaints, and how this learning should be used to improve services.
- Implementing a series of Business Unit level improvements following patient engagement and involvement demonstrating our responsiveness to individual needs. This includes an initiative launched by our Safeguarding team with the introduction of grab bags which will include essential items for people who have fled domestic abuse situations and following PALs and Complaints feedback, introducing a 'Give and Go' service at the main entrance of the Queen Elizabeth Hospital, allowing friends and family members to deliver essential belongings to the main entrance for patients while they are in our hospital.

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

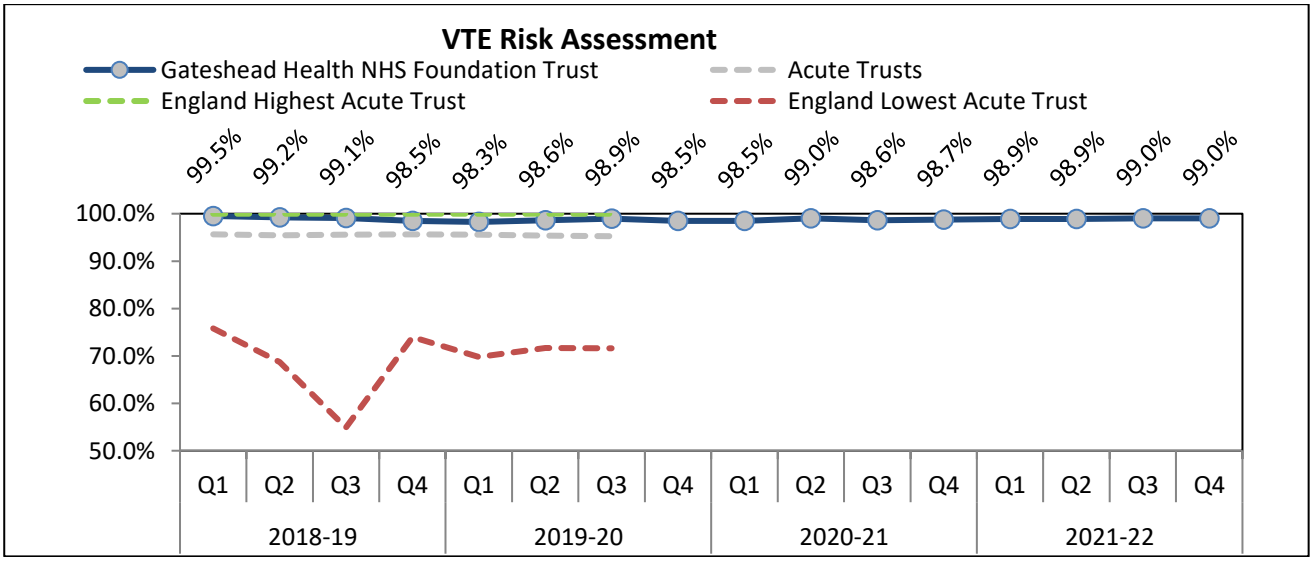
The Gateshead Health NHS Foundation Trust considers that these percentages are as described for the following reasons:

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

No longer collecting this data – replaced by People's Pulse

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
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	98.5%	Collection suspended to release capacity to manage COVID-19 and yet to be reinstated		
2020-21	Q1	98.5%			
	Q2	99.0%			
	Q3	98.6%			
	Q4	98.7%			
2021-22	Q1	98.9%			
	Q2	98.9%			
	Q3	99.0%			
	Q4	99.0%			



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

- Gateshead Health NHS Foundation Trust Compliance with DVT risk assessment has reached 95% in all areas of the hospital which use the JAC prescribing site and reassurance have been gained regarding robust assessment in Critical Care which use a paper documentation. A customised area has been set up on Datix in order to report cases of Hospital Acquired Thrombosis

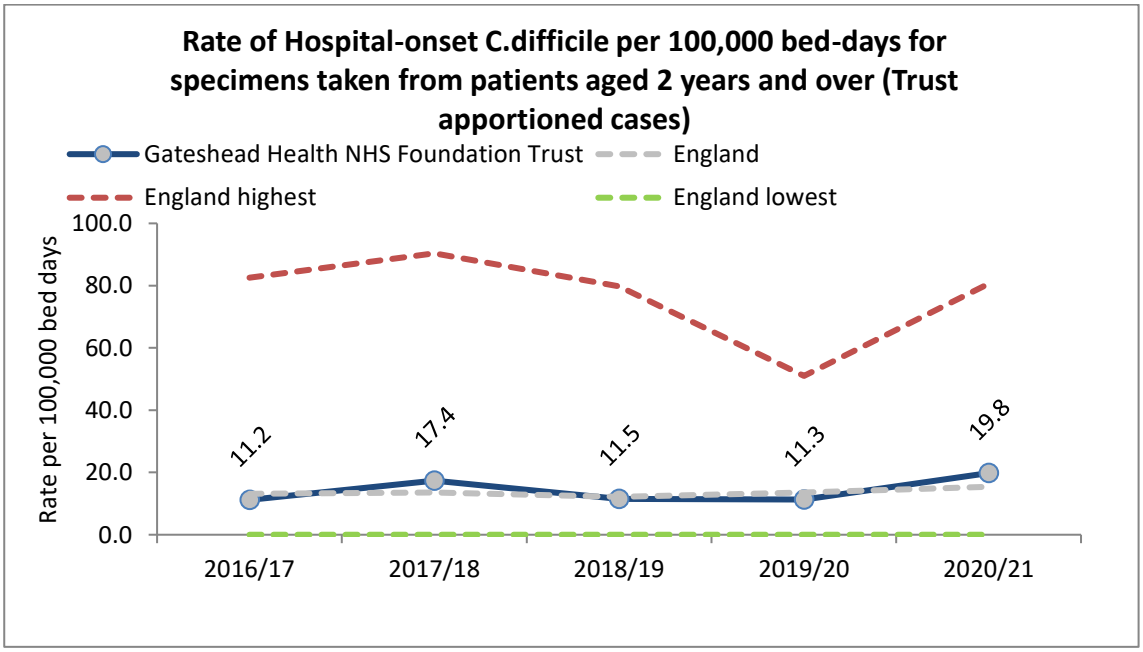
The Gateshead Health NHS Foundation Trust intends to take the following actions to improve these percentages, and so the quality of its services, by:

- A Venous Thromboembolism Committee meet regularly to update all guidelines and raise awareness of deep vein thrombosis and pulmonary embolism and the impact on health. Education of junior doctors and nursing staff have been commenced with regular sessions in the Clinical Leads Nursing meeting and SafeCare meetings. The intranet has been updated with these guidelines and an e-learning module for this has been set up with the help of the Practice and Development Team.
- All new NICE guidelines are monitored on a monthly basis and the relevant updates sent to the respective teams

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 Hospital-onset C. difficile per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	2016/17	2017/18	2018/19	2019/20	2020/21
Gateshead Health NHS Foundation Trust	11.2	17.4	11.5	11.3	19.8
England highest	82.6	90.4	79.8	51.0	80.6
England lowest	0.0	0.0	0.0	0.0	0.0
England	13.1	13.6	12.2	13.6	15.4

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



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

- 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.
- The Trust reports Healthcare associated CDI cases to PHE via the national data capture system against the following categories:
    - Hospital onset healthcare associated (HOHA): cases that are detected in the hospital 2 or more days after admission (where day of admission is day 1)
    - Community onset healthcare associated (COHA): cases that occur in the community (or within 2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks.
- Nationally the financial sanctions for CDI have been removed and the 'appeals' process no longer in use, and the expectation that organisations will perform local review of cases.
- The Trust is required under the NHS Standard Contract 2021/22 to minimise rates of Clostridioides difficile (C. difficile) so that it is no higher than the threshold level set by NHS England and Improvement.
- For 2021/22 we reported thirty-two (32) cases of healthcare associated CDI against the threshold of forty-two (42). Twenty-two (22) hospital onset healthcare associated, and ten (10) community onset healthcare associated cases.
- The Trust has reported a yearly reduction in CDI cases following the introduction of the revised categories. In 2019/20 the Trust reported forty-five (45) healthcare associated CDI and in 2020/21 reported forty (40) healthcare associated CDI, a reduction of five (5) cases and demonstrating an 11% improvement. In 2021/22 the Trust reported thirty-two (32) healthcare associated CDI, a reduction of eight (8) cases from the previous year and as such a 20% improvement. From the introduction of the revised reporting classifications for CDI, the Trust has demonstrated an 29% reduced incidence of healthcare associated CDI.

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:

- An internal review is held for all healthcare associated CDI cases, supported by root cause/human factors review as necessary, where good practice and 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. The good practice and lessons learnt are then cascaded back to through the internal safe care mechanisms.
- 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.
- When there is an increased incidence of CDI cases associated with a particular clinical area Ribotyping is arranged with the Clostridium difficile Ribotyping Network (CDRN) to determine if cross infection has taken place.
- The Diarrhoea Assessment Management Pathway (DAMP) tool provides guidance for clinical staff managing those patients experiencing loose stools, and has been 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 antimicrobial resistance strategy.

Patient Safety Incidents per 1,000 bed days	Apr 19 – Sep 19		Oct 19 - Mar 20		Apr 20 – Mar 21*	
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	3,111	815,852	2,929	838,722	4,638	1,550,306
Rate of all incidents per 1,000 bed days	37.0	N/A	34.8	N/A	35.3	N/A
Number of incidents resulting in Severe harm or Death	27	2,524	19	2,536	75	6,828
Percentage of total incidents that resulted in Severe harm or Death	0.87%	0.31%	0.23%	0.30%	1.62%	0.44%

Source:www.england.nhs.uk/patient-safety/organisation-patient-safety-incident-reports/
*NRLS Organisational workbooks now published annually whereas previously these were six-monthly

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

** NB previous figures relate to 6-month time periods and the latest data covers a 12 month period.

- The table above demonstrates a decrease in the overall reporting of patient safety incidents to the NRLS in 2020-2021. This is felt to be related to peaks and troughs in demand throughout this full year of pandemic activity. Dips in reporting during period of high pressure were responded to by shortening the reporting form to ensure data capture was simplified.
- During periods of high demand and pressure to enable delivery of optimised front-line care, members of the patient safety team were redeployed to support front line and Covid specific services. One output from these redeployments was and inability to maintain incident review functions at the same levels as previously. Subsequent analysis of incident in the system highlighted the need to implement processes for early review of incidents to assess if the reported level of harm was correct, and to determine the correct proportionate onward investigation. This process is now in place in the form of a weekly MDT. Subsequent review of incidents remaining as severe harm and death shows that after robust review for this time period, there are 58 incidents currently reported in these categories for the year 2020-2021, and whilst this is higher than twice the previous six months but is congruent with the numbers for twice the reported incidents in April-October 2019, which covers the increased demands seen during the winter months

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

- Training is to be offered in a variety of mediums to meet the needs of a wide variety of learners within the Trust. This will include going forward face to face interactive sessions, sessions via TEAMS and an e-learning package are currently under development.

- Current systems for reporting and investigation are being maintained as the new launch post COVID-19 of the Patient Safety Incident Response Framework (PSIRF) is anticipated to for June 2022. The outputs from early adopter sites is that this launch will include a range of templates for investigations that are nationally standardised and local amendments will not be allowed. This will enable national standards for investigations and data collection and is anticipated to incorporate the pillars on which the strategy is based including patient and family involvement, a systems and processes approach to investigations and just and restorative culture principles for staff and patients.
- A GAP analysis will be undertaken following the launch with an action plan agreed to meet the expected implementation date of June 2023.
- Scoping and implementation of thematic analysis of no harm, low harm and near miss incidents is being undertaken to enable identification of themes and trends that will enable corrective systems actions to prevent incidents with greater patient harms.
- Re-invigoration and strengthening of the falls work within the Trust to enable the digitisation of risk assessments and improve analysis of falls data for local systems actions.

Part 3

Review of Quality Performance

Review of quality performance

2021/22 has been a successful year in relation to the three domains of quality:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

The Council of Governors has a key role in our assurance processes – both representing the interests of members, the public, staff and stakeholders, as well as holding our Non-Executive Directors to account for the performance of the Board. As part of the Council of Governors' meetings, our Chief Executive delivers an overview of our performance against key quality metrics, with opportunities to question our Board Members on this. Two Governors are also nominated observers of our Quality Governance Committee and we have put in place new structures to support representatives to share feedback on the quality of debate and contributions with the rest of the Council. Our Council agendas now also include presentations from the chairs of each Board committee, and the chair of the Quality Governance Committee presented to the Council in February 2022. This provides further opportunities for Governors to seek assurance and hold our Non-Executive Directors to account in respect of quality.

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.

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

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

3.1 PATIENT SAFETY

Reducing Harm from Deterioration:

Safe Reliable care	2019-20	2020-21	2021-22	Target
HSMR	115.0	107.0	118.3*	<100
SHMI Period	Apr-19 to Mar-20	Apr-20 to Mar-21	Jan-21 to Dec-21	
SHMI	1.06	1.00	1.04	<=1

SHMI Banding	As Expected	As Expected	As Expected	As expected or lower than expected
SHMI - Percentage of provider spells with palliative care coding (contextual indicator)	2.3%	2.7%	2.2%	N/A
Crude mortality rate taken from CDS	1.73%	2.32%	1.83%	<1.99%
Number of calls to the CRASH team	143	113	164	N/A
Of the calls to the arrest team what percentage were actual cardiac arrests	45.5%	38.1%	40.2%	N/A
Cardiac arrest rate (number of cardiac arrests per 1000 bed days)	0.52	0.83	0.41	N/A
Hospital Acquired Pressure Damage (grade 2 and above)	105	115	87	Year on year Reduction
Community Acquired Pressure Damage (grade 2 and above)	1462	1565	1451	N/A
Number of Patient Slips, Trips and Falls	1519	1415	1525	N/A
Rate of Falls per 1000 bed days	8.70	10.36	9.51	Reduction (<8.5)
Number of Patient Slips, Trips and Falls Resulting in Harm	329	318	335	N/A
Rate of Harm Falls per 1000 bed days	1.89	2.33	2.09	Reduction (Less than <2.25)
Harm Falls Rate Change	13.5% reduction	23.6% Increase	10.3% 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)	21.7%	22.5%	22.0%	Year on Year reduction

*HSMR figures are April 2021 to January 2022

Reducing Avoidable Harm:

Reducing Avoidable Harm		2019-20	2020-21	2021-22	Target
Medication Errors	No Harm	440	529	620	N/A
	Minimal Harm	63	75	84	N/A
	Moderate Harm	5	4	4	<8
	Severe	1	2	1	0
	Death	0	1	0	0
	Total	509	611	709	N/A
Never Events		4	2	0	0
Patient Incidents per 1,000 bed days		44.66	46.52	38.92	N/A
Rate of patient safety incidents resulting in severe harm or death per 100 admissions		0.11	0.19	0.15	N/A

Infection Prevention and Control:

Infection Prevention & Control	2019-20	2020-21	2021-22	2021-22 Objective
MRSA bacteraemia apportioned to acute trust post 48hrs	1	0	0	0

MRSA bacteraemia rate per 100,000 bed days	0.57	0	0	0
NB: *Clostridium difficile* Infections (CDI) post 72hr cases	45	40	32	<=42
Clostridium difficile Infections (CDI) rate per 100,000 bed days	25.65	29.28	20.58	-

Infection Prevention & Control	2019-20	2020-21	2021-22
Hospital Onset Healthcare Associated C.difficile per 100,000 occupied overnight beds	12.54	17.72	14.15

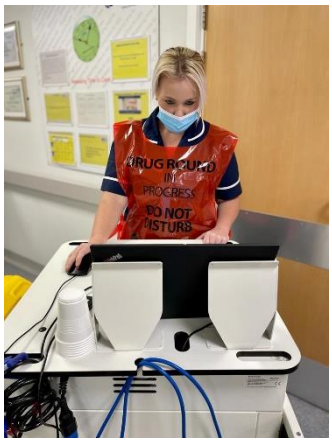
Other Indicators:

Other Indicators	2019-20	2020-21	2021-22	Target	Benchmark
Percentage of Cancelled Operations from FFCE's†	0.54%	0.24%	0.55%	0.80%	1.00%**
Percentage of Patients who return to Theatre within 30 days (Unplanned / Planned / Unrelated)	3.85%	4.40%	4.89%	Improve Year on Year	N/A
Fragility Fracture Neck of Femur operated on within 48hrs of admission / diagnosis	96.3%	93.9%	92.7%	90%	N/A
Proportion of patients who are readmitted within 28 days across the Trust*	9.13%	10.43%	11.20%	Improve year on year	N/A
Proportion of patients undergoing knee replacement who are readmitted within 30 days*	6.55% 15 Patients readmitted	5.66% 6 Patients readmitted	6.21% 10 Patients readmitted	Improve Year on Year	N/A
Proportion of patients undergoing hip replacement who are readmitted within 30 days*	6.00% 15 patients readmitted	7.34% 8 patients readmitted	9.83% 17 patients readmitted	Improve Year on Year	N/A

* Figures taken from Healthcare Evaluation data (HED) and provide full financial years for 2018-19, 2019-20, 2020-21 and April 2021 to December 2021
† FFCE's refer to First Finished Consultant Episodes. A patient's treatment or care is classed as a spell of care. Within this spell there 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.
** Q3 2021-22 national position www.england.nhs.uk/statistics/statistical-work-areas/cancelled-elective-operations/

Medication Safety:

Medicines Safety Roadshow



A roadshow was held by the Surgical Business Unit in March 2022. Information displayed to encourage learning from common error themes, short quizzes, infusion pumps, charts for PCAs/epidurals etc. Flip charts were used to allow visitors to highlight their reflections around medicine safety issues. There were around 60 visitors to stand, including Nurses, Students, Junior Doctors, Consultants, Anaesthetists, ODPs, Pharmacists, Pharmacy Technicians and Managers.

Biodegradable red tabards were launched at the roadshow. This was identified as a learning point from a medication error whereby the nurse was distracted whilst administering a high-risk medication.

Distractions whilst carrying out safety critical tasks such as administering medicines increases the risk of things going wrong and is a common problem cited in incident reporting. We all come to work to do a great job for our patients and we hope that the red tabards will be a visual reminder to all members of the MDT that disturbances should be avoided during such tasks and to support our safety culture.

Safeguarding Children and Adults

The Safeguarding of children and vulnerable adults has remained a priority throughout the Covid-19 pandemic. There has been a national picture of increased safeguarding in particular mental health issues for children and adults and an increase in incidents of domestic violence. These figures are reflected in the numbers of cause for concerns and referrals coming through to the safeguarding teams and in response to this we have undertaking various pieces of work.

- We continue to provide monthly updates within the QE Weekly providing valuable updates on current safeguarding issues and promotes training opportunities.
- The Adult and Children Safeguarding teams provide monthly safeguarding link meetings where up to date safeguarding information can be shared with the safeguarding link representatives from each ward or practice area within the trust.
- Within the quarterly Safeguarding Committee, we bring the lived experiences of service users by sharing patient stories at every meeting.
- Safeguarding during Covid-19 has created additional pressures for staff, and we have Health and Wellbeing ambassadors within the teams. There are also guidance and links available on the safeguarding staff zone pages for staff who have experienced any challenging or distressing safeguarding cases.
- During Covid-19 access to face-to-face safeguarding training was limited so several onsite training days have been made available for staff within the trust. These have been well received by staff and have focused on domestic abuse, county lines and knife crime which have all been very contemporary during the pandemic.
- The Adult Safeguarding team have worked with Community Services, including infection control and tissue viability services to support the care homes during the pandemic.

- With the increase in domestic abuse, it was identified that there was a gap in service support so the safeguarding teams and charitable funds team are working together to provided grab bags which will include essential items for people who have fled domestic abuse situations.
- The children and adult teams have worked together to update trusts Safeguarding Exploitation Grooming and Risk Identifier tool (SEGRI) to include both vulnerable adults and children at risk sexual exploitation, criminal exploitation, and modern-day slavery.
- Young people who are care experienced have an increased likelihood of an unplanned teenage pregnancy therefore, the Looked After Children's team have linked up with Gateshead sexual health service to look at ways of improving access to sexual health services for young people.
- The Adults team are continuing to roll out training on capacity assessments in line with Mental Capacity Act legislation and in preparation for the change in legislation in relation to deprivation of Liberties planned for later this year.
- As part of safeguarding week, the children's' and adult's team have created a resource file for all wards and departments, and they are being distributed throughout the organisation.

3.2 CLINICAL EFFECTIVENESS

Getting it Right First Time (GIRFT)

GIRFT is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change. The programme undertakes clinically led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.

During 2021/22 there have been five 'deep dive' visits:

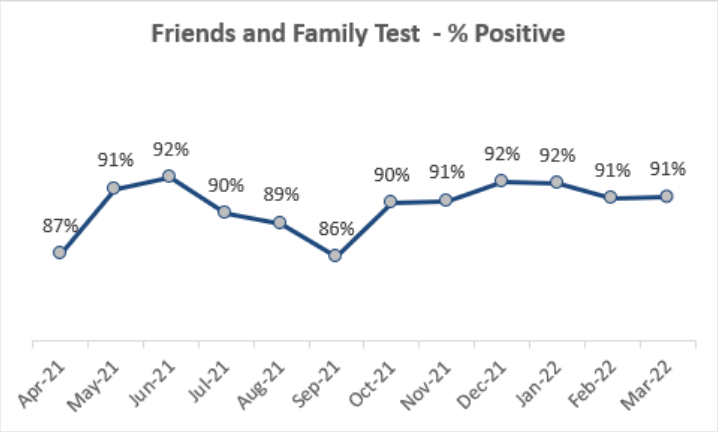
Speciality	Good practice/opportunities for improvement identified
Pathology Deep Dive	• Useful that labs are not culturing all urines. There has been significant work between microbiology and geriatricians in supporting this work since before covid. • Significant investment in transport services with temperature control and timely transport runs. • More work has occurred in supporting ED to improved quality of phlebotomy; seen as important across the teams. • More than 95% of tests are received electronically. **Opportunities for improvement have been identified in the following themes** • Review process for Test Profiles and blood cultures
Emergency Medicine Deep Dive	**Good practice** • Overall, the Accident & Emergency delivers excellent patient flow and outcomes with a fairly limited capacity to address the demand from its catchment population. • NHS Digital's Emergency Care Dataset (ECDS) data quality website shows that the Trust is in the top 40% of providers for completeness and validity and timeliness of data submission. **Opportunities for improvement have been identified in the following themes** • Flow and time metrics • Outcomes
Neurology Deep Dive	**Opportunities for improvement have been identified in the following themes** • Establishment of Acute Neurology Clinic • Liaison neurology (Ward referrals) • Management of inpatients with neurological disorders • Access to Neurophysiology/Neuroradiology • Opportunities to increase Research activity • Actively engage with the developing Integrated Care System (ICS) to promote the development of neurology services. The introduction of the ICS should reduce barriers that exist for collaborative

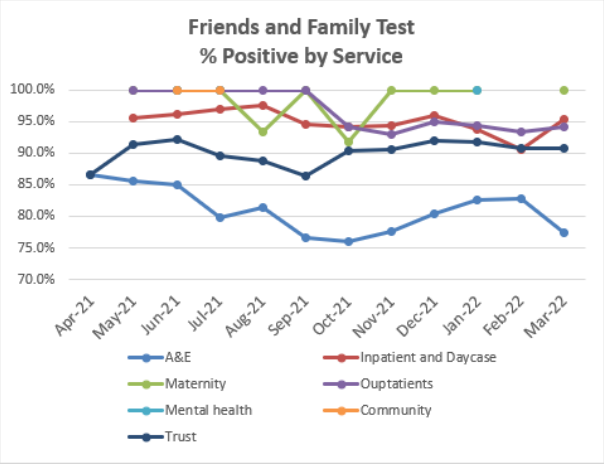
	working between trusts. The development of a neurology service at the Trust in collaboration with the regional service at RVI would be exactly the type of collaboration to benefit from the population-based approach within the ICS.
Paediatric Trauma & Orthopaedic Deep Dive	**Good practice** • Good networking with Newcastle and good referral pathways • Good day case recorded for elective and trauma • 100% Developmental dysplasia of the hip data recorded on Newborn and Infant Physical Examination database • Virtual fracture clinic in place **Opportunities for improvement** • Improve the general quality of coding and case capture • Audit the numbers of elbow and tibial fractures from the GIRFT data period • Review pathway for forearm and wrist manipulations. • Review the litigation claims and ensure the wider team are aware of them and that the learning is disseminated and embedded into practice
Lung Cancer	**Awaiting recommendations to be formally provided**

3.3 PATIENT EXPERIENCE

Friends and Family Test

Following a successful pilot of the Friends and Family Test (FFT) within A&E role out continued to all inpatient areas and outpatient areas. Electronic capture of the FFT has been partially rolled out within Maternity Services. Patients are able to be excluded from the electronic data capture by informing a staff member who can opt them out within Care Flow. Review confirms that more qualitative data is being shared than was previously collected by cards.





Additionally, the three protected characteristics data is being collected using the electronic method to ensure we are meeting our responsibility under the Accessible Information Standard. Respondents are asked –

Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last at least 12 months? (include any issues related to age)
[ ] Yes – limited a lot
[ ] Yes – limited a little
[ ] No
[ ] Prefer not to say

Which of the following options best describes how you think of yourself?
[ ] Heterosexual or straight
[ ] Gay or lesbian
[ ] Bisexual
[ ] Other sexual orientation not listed
[ ] Does not know or not sure
[ ] Prefer not to say

How would you describe your ethnic group?
[ ] White
[ ] Mixed/Multiple Ethnic Group
[ ] Asian/British Asian
[ ] Black/African/Caribbean/Black British
[ ] Jewish
[ ] Other Ethnic Group
[ ] Prefer not to say

Feedback has continued to be reviewed monthly and provided to the relevant departments which ensures we are providing the best possible service to our patients.

The National Patient Survey Programme

The National Patient Survey Programme comprises the annual Adult Inpatient Survey, Maternity Survey and Urgent and Emergency Care 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.

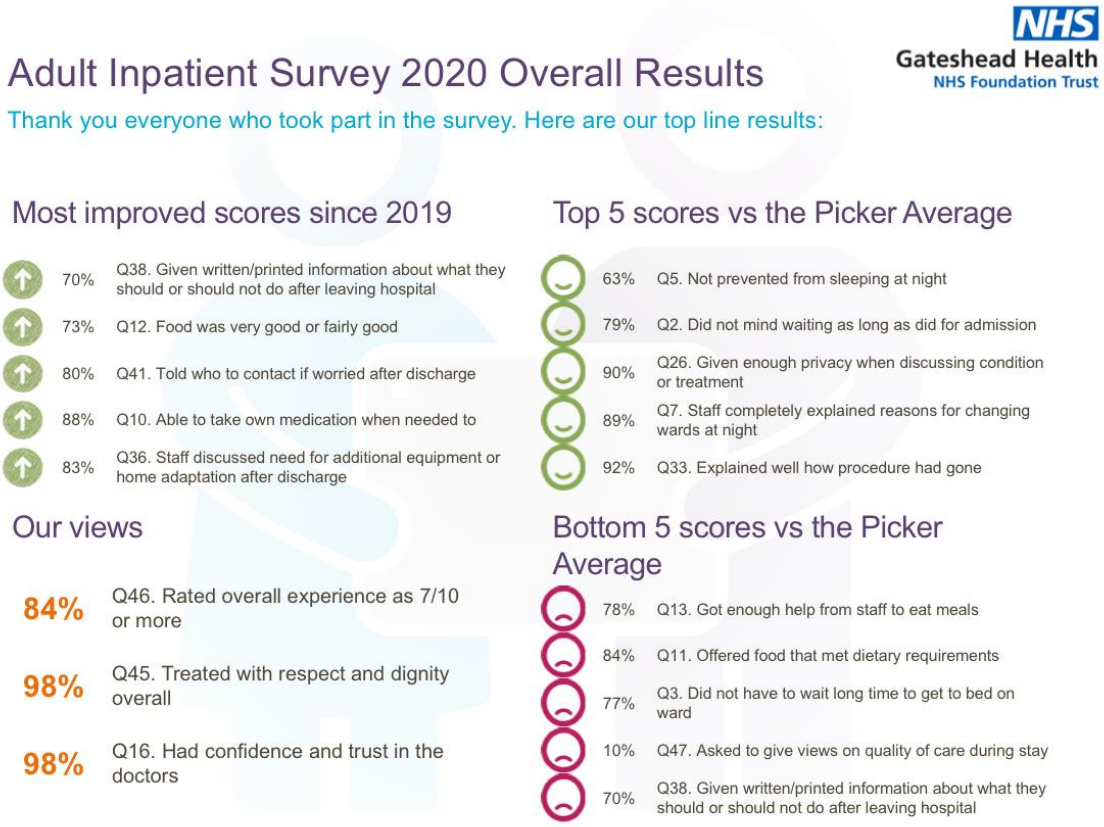
Adult Inpatient Survey 2020

The National Inpatient Survey is undertaken every year. All eligible Trusts in England are required by the Care Quality 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 75 other NHS Trusts (known as the "Picker Average" score). A total of 57 questions were asked in the 2020 survey. Our results include every question where our Trust received at least 30 responses (the minimum required). It is noteworthy that the survey data relates to care between January and July 2020 and improvements have already begun to be implemented since the survey took place.

1250 service users were invited to complete the survey and we received a response rate of 46%. This was slightly below our previous response rate from the National Inpatient Survey 2019 of 48% yet still above the national average of 45% for 2020.

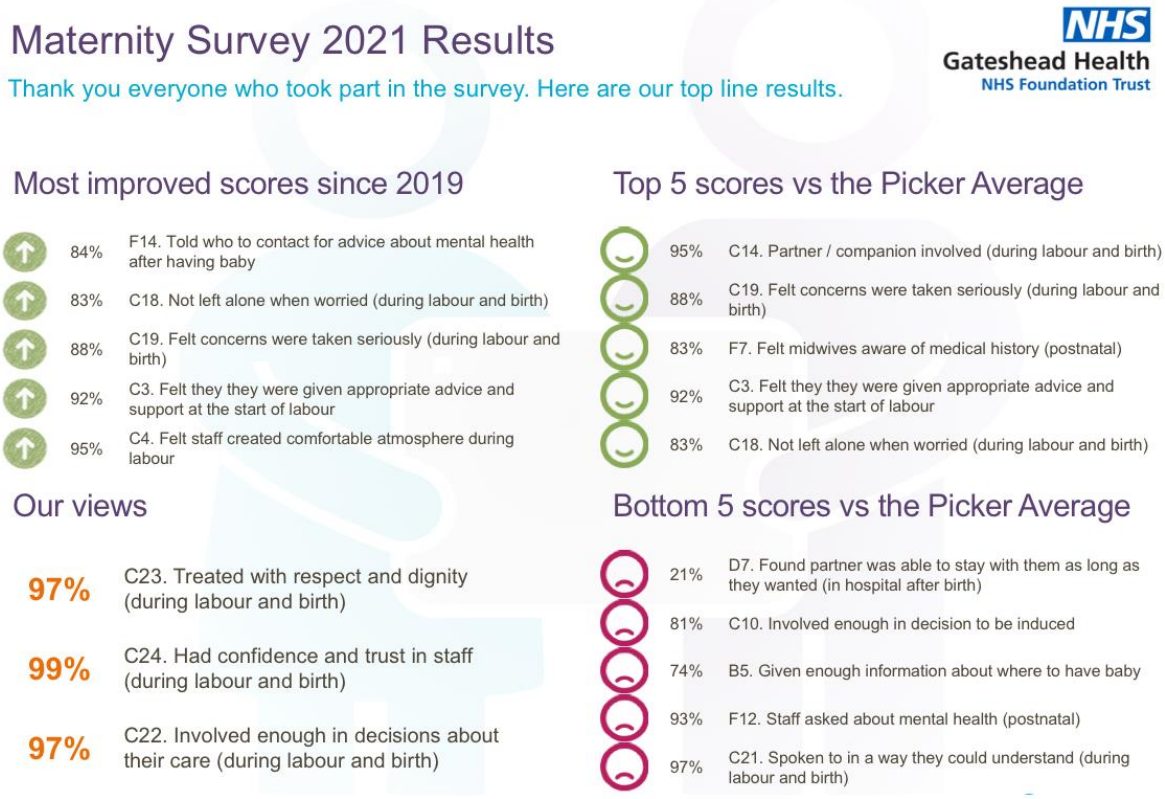
Compared to the national average, the Trust has received excellent results with six questions being better than other Trusts and 33 questions being about the same. A summary of our top line results is displayed on the following charts:



Maternity Survey 2021

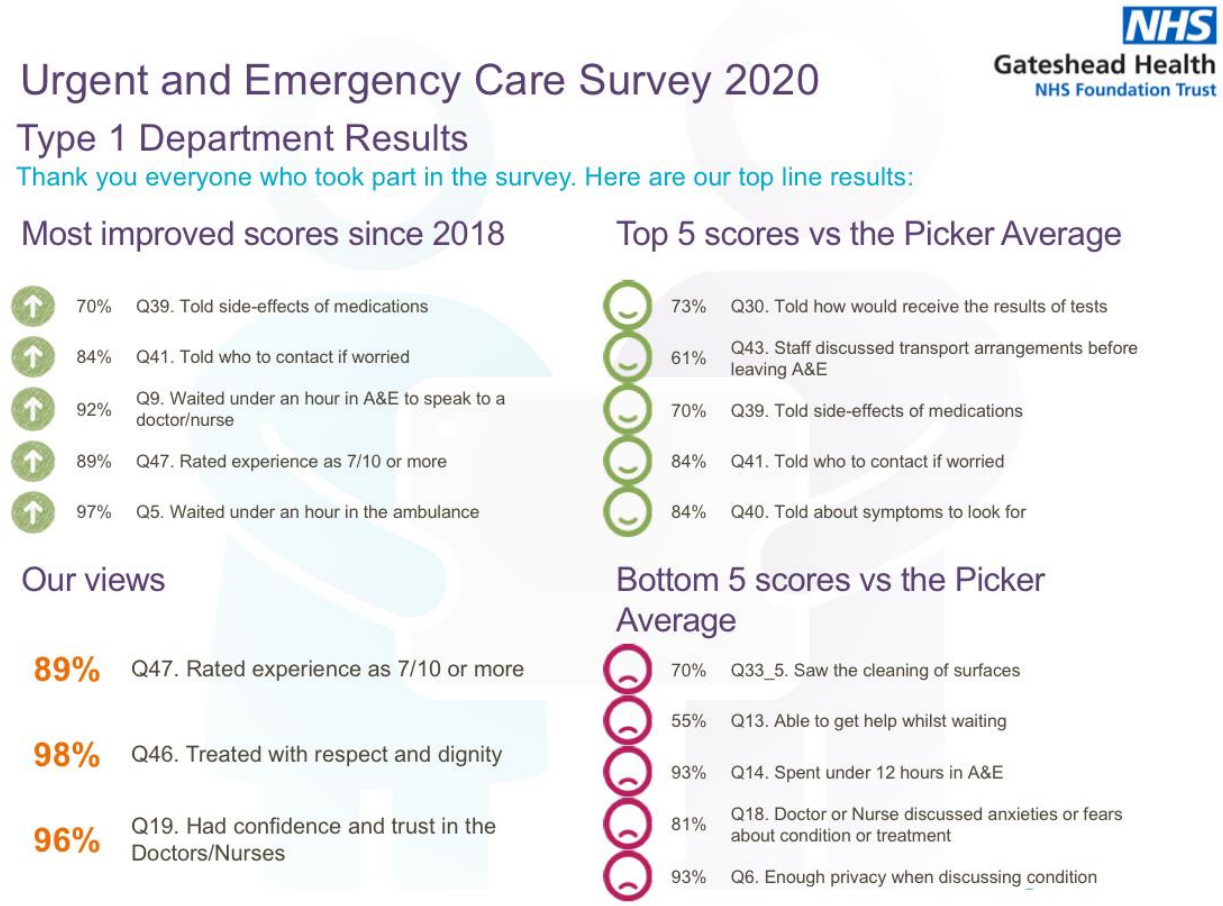
All eligible Trusts in England are required by the CQC to conduct the Maternity Survey. 155 eligible patients responded to the survey in 2021. This gave us a response rate of 60% and this is above the average response rate of 54% of the other 66 trusts taking part in the survey and is significantly higher than our previous surveys response rate of 38%.

A total of 87 questions were asked in the 2021 survey, of these 52 can be positively scored. A summary of our top line results is displayed on the following charts:



Urgent and Emergency Care Survey 2020

All eligible Trusts in England are required by the CQC to conduct the Urgent and Emergency Care Survey. The Trust use an approved survey contractor called Picker. A total 65 questions were asked in the 2020 survey, of these 44 can be positively scored, with 32 of these which can be historically compared. For questions that can be compared across organisations, it is noteworthy that there are no areas where we scored significantly worse when compared with the national average. The North East Quality Observatory Service (NEQOS) provided benchmark results for the Trust on how we performed compared to other Trusts across the region. This showed that the Trust has scored the highest in the region for our Urgent and Emergency Care services. A summary of our top line results is displayed on the following charts:



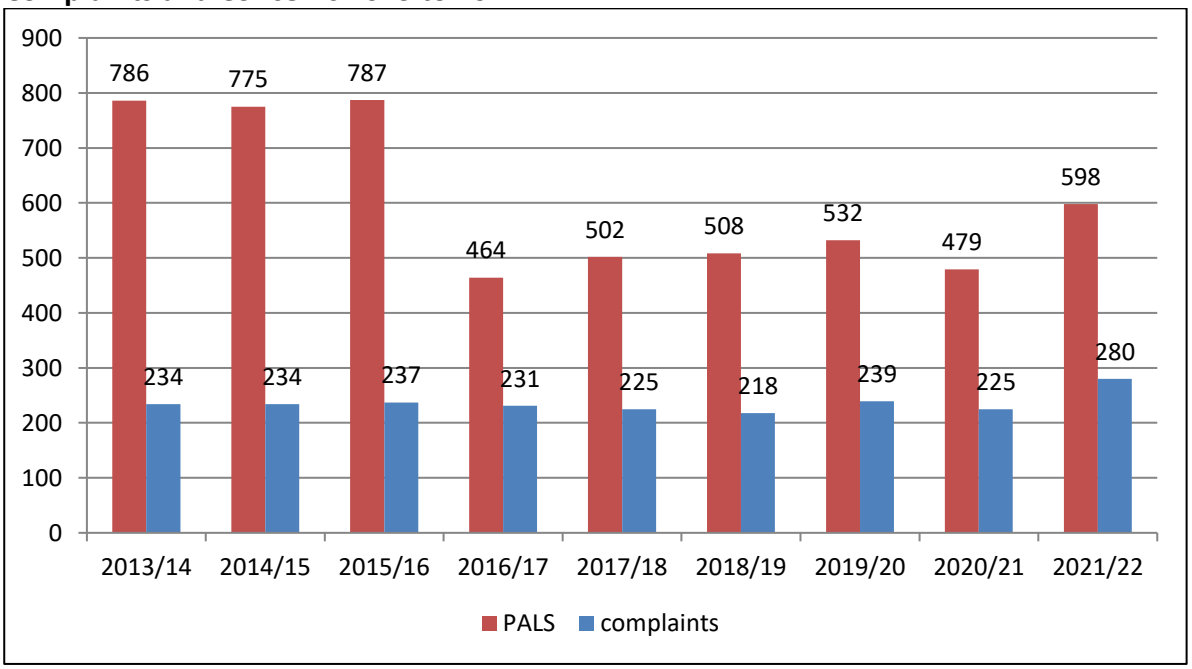
Listening to Concerns and Complaints, Compliments

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 2021/22 we received a total of 280 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 because 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.

Complaints and Concerns 2013 to 2022



During 2021/22 the top five main reasons to raise a formal complaint were in relation to:

- Communications - (54 complaints)
- Clinical treatment – Surgical Group (48 complaints)
- Clinical treatment – General Medical Group (47 complaints)
- Values and behaviours - (Staff) (35 complaints)
- Clinical treatment – Accident & Emergency (30 complaints)

Complaints Performance Indicators	Total 2021/22
Complaints received	280
Acknowledged within three working days	280
Complaints closed	279
Closed within agreed timescale (eight weeks)	89
Number of complaints upheld	217
Concerns received by PALS	598

Complaints Indicators	Total 2021/22
Number of closed complaints reopened	40*
Number of closed complaints referred to Parliamentary & Health Service Ombudsman	8

Outcome of complaints referred to Parliamentary & Health Service Ombudsman (PHSO)	Total 2021/22
Currently investigating	5
Complaints upheld	0
Part upheld	0
Declined to be investigated	2
Agreed actions with Trust (because of learning)	1

***Number of closed complaints reopened.**
In the year 2021/22 40 closed complaints were reopened. This compares to 25 in 2020/21. Reasons for reopening cases include where the complainant has additional questions/concerns.

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

In response to a complaint about post-natal care, including pressure sores, there will be focused improvement on the ward to raise awareness and standards within the maternity department relating to the formal assessment and prevention of developing skin trauma. The team are developing some clear assessment tools on their electronic records to support all staff in remembering to complete and record basic tasks. They are implementing a robust training and awareness programme around risk assessments with all the staff.

The maternity team will be making focused improvements to ensure mothers who have had epidurals have regular postnatal checks and pressure sore assessments. The team have now added this to morning safety huddles to raise awareness and ensure learning. The care of a mother with an epidural will also be highlighted within staff mandatory training when the planned pathways have been reviewed.

In response to a complaint regarding interaction with security at Accident and Emergency, QE Facilities have mandated that all security staff attending the site to carry out the greeting role should attend a customer service and disability awareness course to ensure they can assist service users going forward.

Following a complaint in which a patient was upset that she attended the Gynaecology Rapid Access Clinic (RAC) with a full bladder to enable an ultrasound scan (as per the instructions on the invite letter), however no scan was provided, and she had to return later for this. After receiving the complaint, the department reviewed their clinic letters and implemented a new triage process so that women who are attending a clinic appointment without a same day scan slot receive a separate letter that does not have any details about scans or instruct them to arrive with a full bladder. This triage should also help to ensure that the most appropriate patients are prioritised for the same day scan slots. The department is trying to provide as many additional scan slots as possible, but this is challenging with such a rise in demand. The department is also working with GPs to ask them to arrange blood tests before patients are referred to RAC. They hope to implement this later in the year.

As a result of concerns raised regarding how hot it was in the scanning room in Women's Health, a total cost for the work has been provided and a funding stream has been identified by the department. The order for air conditioning equipment has now been placed and this should mitigate the ongoing issue when the warm weather arrives.

Following a concern raised regarding care received on Ward 8 - the Staff Nurse who attempted to administer further IV antibiotics was not aware that a decision had been made a few days prior to dilute the patient's antibiotics. To avoid this occurring again, specific details regarding patient's medication and their treatment plan will be digitally recorded and will be verbally handed over at each shift change.

3.4 Good News Stories

Trust staff participated in a number of promotional, awareness raising and celebration events throughout the year.

Teams recognised with national awards

Team celebrating after being recognised as a top provider of clinical data for the fourth year in a row for the National Joint Registry Audit –providing information that helps support improvements in patient safety and standards of care.

A big well done to the Community Mental Health Teams based at Bensham who were awarded an Accreditation from the Royal College of Psychiatry.

New wards and facilities opened along with new initiatives

Our new stroke unit was officially opened in 2021/22.

Well done to all the team on the unit and staff across the Trust who worked hard to open this fabulous new facility - that will help stroke patients get better, quicker.

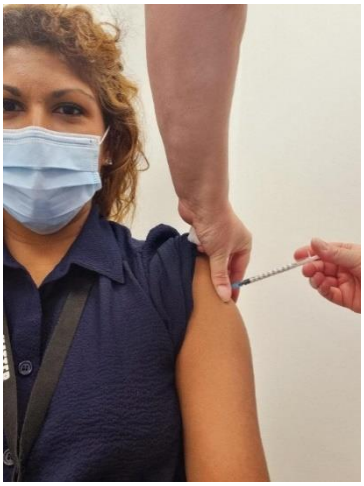
Our new Sunniside Unit was designed with the help of patients and their carers in the hope of revolutionising how they are looked after during mental health crises.

A new Resuscitation training facility was opened.

Breast screening unit launched contrast enhanced mammography

Vaccination Programme

We pulled together and vaccinated thousands of staff



Giving the gift of life

In 2021/22, from 5 consented donors the Trust facilitated 5 organ donors resulting in 12 patients receiving a lifesaving or life-changing transplant. We are so grateful for this immense gift from patients and their families at such a sad time.

3.5 Focus on staff

Health and Wellbeing

Gateshead Health NHS Foundation Trust delivers high quality care to our patients and service users from within the Gateshead community and further afield. We achieve this in no small part, thanks to the compassion, knowledge, commitment, and skills of our workforce.

The last two years have been extremely challenging for all NHS services nationwide, and our own organisation is no exception. We have faced a rapidly changing health landscape, worked at pace to implement innovative solutions to difficult challenges, and have done so with a workforce which is exhausted and depleted.

The people who make up our workforce have been nothing short of amazing during our pandemic response, stepping up in a way that no-one could have planned for. They have worked in ways and in roles that have stretched and challenged teams and individuals. They have done so in a way that has been supportive, collaborative and has shown real care for each other.

We know that where NHS organisations prioritise staff health and wellbeing, and actively include staff in developing work in this area, levels of engagement increase along with morale, loyalty, innovation and productivity.

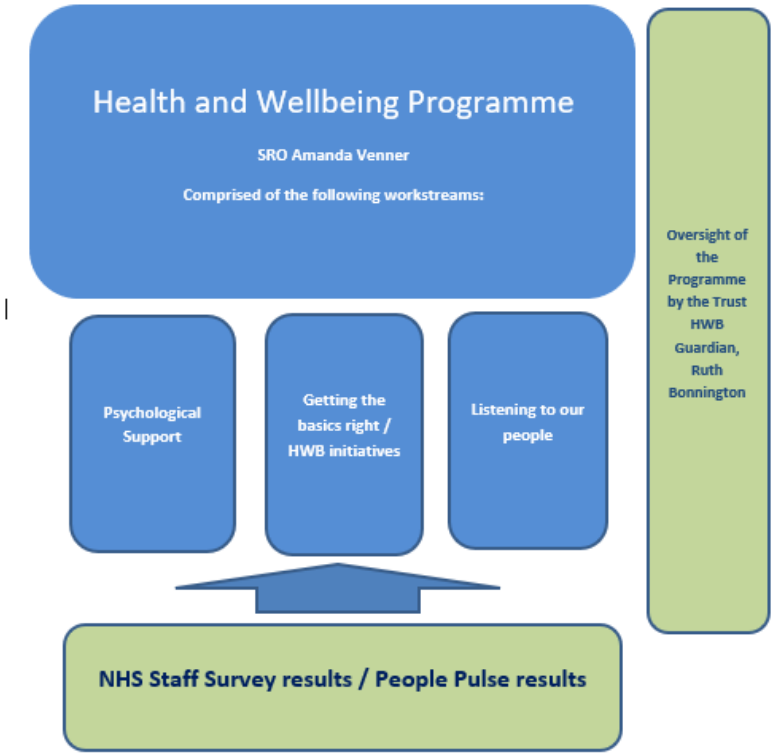
Our aim is to make Gateshead Health a happy and healthy place to work for everyone who works here. We want Gateshead to be a place where people want to come and work, and then choose to stay. If we can attract and retain high quality staff, it follows that patient care will be positively impacted.

As we hopefully move out of the worst stages of the Covid-19 pandemic we need to find a way to ensure the care and compassion our staff have shown to their patients and each other, continues to be shown to them.

In Spring 2021 a Health and Wellbeing Programme Board was established, reporting directly to the People and OD Portfolio Board. This Board aims to provide focus and a contextual understanding of the HWB challenges within the organisation, as well as drive forward specific work streams of activity. These work streams will evolve as we move throughout the period of this strategy, although the main focus will remain the health, safety and ability of our people to thrive at work.

In early 2022, a review of the work streams within the HWB programme plan was undertaken. Much of the initial work of the HWB Programme Board had focussed on supporting our people during the pandemic, and much of the output of those initial work streams has become 'business as usual'. At this stage in the pandemic recovery, it is right that the focus shifts to sustainability – how do we continue with the good work which has already happened to ensure that HWB support continues in a sustainable way throughout the organisation, and how do we ensure that we are focussed on the things which matter to our people.

This has then informed the new workstreams which sit within the HWB Programme Plan from April 2022 onwards:



To structure our aims and objective we have looked at the 7 areas of focus in the NHS England HWB framework

1. **Environment**

"*Workers need a work environment in which there is not only an absence of harmful conditions that can cause injury and illness, but one that supports healthy choices and offers resources to actively encourage healthy behaviour*" NHS Health and Wellbeing Strategic Overview, 2021

It has become apparent during the course of the pandemic response that some of our estate is not being utilised effectively. It is also acknowledged that there has been a significant impact on estate usage due to a large proportion of the workforce working from home.

Patients have high expectations of the environment in which they receive their care, and talented recruits know that they can choose to work in organisations where the environment supports their wellbeing.

For all of these reasons and more, a wide-ranging estates strategy is currently being developed which will address all of these areas.

What have we already done?	We else will we do?
Installed a range of outside seating areas at both QEH and BGH sites, in areas which are shielded from visitors to both sites.	Open a Listening Space on site at QEH, offering a quiet reflective space for staff to use which is away from the work place. It will also offer a range of HWB activities for

	staff to access throughout the week, both during the day and early evening.
Improved the menu choices within the catering establishments at QEH, including healthier options such as vegetarian, vegan as well as specific dietary requirements e.g., halal, kosher.	Provide an innovative 24/7 catering offer on site at QEH, to enable staff who work out of hours to access hot food during all shifts.
Widened the range of menu options available at BGH to include more hot food options.	Improve the catering experience – both the environment and the menu choices – at BGH
	Improve the information we give to staff about healthy eating, allowing them to make healthy choices at work, but also to inform their choices at home.

2. Professional Wellbeing Support

The teams which support the wellbeing of the workforce are not simply limited to the Occupational Health and Wellbeing Team. However, these professional teams and services should be robust and effectively resourced, to enable appropriate expertise and involvement in the development of an integrated health and wellbeing strategy.

What have we already done?	We else will we do?
Undergone a full review of the Occupational Health Service, to expand to the Occupational Health and Wellbeing Service, ensuring a more holistic approach to support.	Introduce focussed psychology support, with the planned recruitment of a Clinical Psychologist for staff referrals, as well as supporting other areas with appropriate supervision e.g., Mental Health First Aiders. Additionally, review the support that Talkworks have provided since July 2020, which has been critical in supporting the psychological needs of our staff.
Consolidated the testing and vaccination services into their permanent 'homes'; vaccinations within Occupational Health and Wellbeing; testing within Pathology.	Reinvigorate the physiotherapy support for staff, with the recruitment of a Physiotherapist who will be focussed on staff referrals, and who will maintain

	string links with the Trust Physiotherapy service.
Maintained the PCAS service in a form that keeps our staff safe and offers the best advice and up to date guidance and PPE.	Ensure that on-site vaccinations for staff, including for Covid-19, remain available, or that suitable alternative options are provided as appropriate (for example, when demand for Covid-19 vaccination falls.)
Reviewed and improved the manager referral process into Occupational Health and Wellbeing, with full stakeholder involvement.	Agree the longer-term sustainability of the Health and Wellbeing Team, which is currently employed on a fixed term basis.

3. Data Insights

"*Good data and robust analysis are fundamental to knowing where to focus your health and wellbeing interventions…(and) enables you to measure whether they are having the desired impact or not*." NHS Health and Wellbeing Strategic Overview, 2021

We will continuously improve our understanding of the health and wellbeing needs of our people by the use of data and feedback. Historically we have had limited feedback in relation to HWB and have had limited engagement with the Staff Survey and Pulse surveys.

However, the most recent quarterly and annual staff surveys have both had highest ever response rates, following dedicated and focussed work to improve participation. This is a trend which we hope to continue as we ensure that the feedback loop is closed quickly, leading to an understanding amongst our people that taking the time to give us their views can make a difference to their employee experience.

What have we already done?	**We else will we do?**
Completed a local health needs assessment as part of our successful accreditation for the North East Better Health at Work Award.	Improve the participation rate of the quarterly Pulse Survey, acknowledging that 'survey fatigue' is a real thing, but understanding that this real time feedback is extremely valuable in determining local focus of effort.

Added a number of local HWB specific questions to the annual NHS Staff Survey.	Implement an effective feedback mechanism for emerging themes from the HWB Check-ins
Developed a HWB early Warning Dashboard, highlighting key areas of staff absence, including type specific absence, starters and leavers, and Occupational Health data.	Complete the NHS England HWB Framework self-assessment
Launched HWB Check-ins for all staff	Engage with staff networks and staff side directly to ensure that anecdotal evidence is heard and triangulated with more formal data.
Participated in the monthly (now quarterly) Pulse Survey	

4. Managers and Leaders

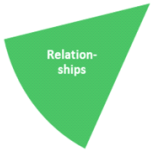
"Our managers and leaders are fundamental to creating positive and healthy working environments for our diverse NHS people. This includes the responsibilities of senior leaders, what healthy behaviours look like for the leaders across our organisations and the importance of skilled and supported managers in helping to build and sustain cultures of health and wellbeing." NHS Health and Wellbeing Strategic Overview, 2021

Often, the experience of an employee depends wholly on their relationship with their line manager. An organisation can have the best policies, procedures, health and wellbeing initiatives imaginable, but if the line manager does not lead from a position of compassion, then often those supportive policies cannot do the things they were intended to do.

There is an oft-quoted saying that 'people don't leave organisations, they leave poor managers. Whilst the reality of that can be argued to be true or otherwise, it is widely agreed that when employees don't feel valued by the managers in their organisation, engagement is lower, morale is lower, productivity suffers, sickness absence increases and staff turnover rates increase.

The wider leadership and management development work within Gateshead is being led by a newly formed OD Team, who will align to specific business units, and who will support Trust-wide development to develop our leaders and managers. It's important to note that this work will be a result of collaborative working throughout the People and OD Team, as well as with operational colleagues.

What have we already done?	We else will we do?
HWB Check-ins	Launch the 'Leading Well at Gateshead' Programme for all managers and leaders, with the golden threads of compassion and inclusivity woven through each element.
Delivered compassionate HWB conversation training to managers.	Encourage managers to role model behaviours such as planning and taking annual leave, not working excessive hours regularly and thus making it 'the norm' and taking regular breaks – acknowledging the importance of doing so.
Launched the new 'Managing Well at Gateshead' programme for managers, with the golden thread of HWB and ED&I woven through each element.	As part of the wider recruitment and retention work, aim to build capacity into rotas to enable staff to attend activities outside of the normal job role, such as training and HWB activities.
Started our Compassionate Leadership work, led by the OD Team, and encompassing work around a Just and Restorative Culture.	Aim to enable all Health and Wellbeing Ambassadors to have one hour each week of protected time, in order for them to carry out HWB activity.
Engaged our Chief Nurse as a Health and Wellbeing Ambassador for the Executive Team, as well providing leadership and 'permission' for this work amongst other teams.	Working with POD Leads, ask all business units to include HWB as a regular agenda item at Business Unit, Departmental and Team meetings.
	Ensure that as part of the Leading Well at Gateshead programme that managers understand that they have 'permission to act' in terms of supporting people in their teams.



5. Relationships

"Extensive evidence shows that having good-quality relationships can help us to live longer and happier lives with fewer mental health problems. Having close, positive relationships can give us a purpose and sense of belonging". NHS Health and Wellbeing Strategic Overview, 2021.

Just as supportive managers are vital to the overall employee experience, the relationships we have with our managers, our immediate colleagues, and with people from the wider organisation can all impact upon how happy we feel at work.

If relationships are strained, dis-trustful, antagonistic and unfriendly, then work becomes a place where we don't want to be. Conversely, if we feel supported by our colleagues, if we feel that we can be vulnerable and open to new ideas and ways of working, if we feel that we can be our true self at work, then it becomes a place where we can thrive.

Often, we are told that Gateshead is like a family – but even the closest families have difficulties, and so when those difficulties arrive, we need to be able to support our people to resolve differences in a mature and 'just' way.

What have we already done?	We else will we do?
Implemented our Trust ICORE values; Innovation, Care, Openness, Respect, Engagement; along with the associated desired behaviours	Review the Bullying and Harassment (B&H) support that we offer, including the B&H advisors. Ensure that if the service is useful and effective, that the advisors reflect the diversity of our workforce.
Continued to provide a bespoke internal mediation service, to provide support when relationships break down	Launch the 'Leading Well at Gateshead' programme, focussing on compassionate and inclusive leadership.
Launched the 'Managing Well at Gateshead' programme, with sessions focussed on areas such as behaviours, engagement, team development, and communication	Review the internal mediation service to understand the impact of that work, and whether it will be beneficial to train more staff to carry out this role.
Trained a number of cultural ambassadors who are available to support colleagues from our diverse workforce in areas such as disciplinary hearings.	Develop a 'Just & Restorative Culture' at Gateshead, to ensure that a culture of fairness, openness and learning is felt by all staff.
Continued to support the work of the Freedom to Speak Up Guardian and promoted the service widely.	Develop a network of Freedom to Speak Up Champions who will be a touchpoint for staff to get signposting and support.

6. Improving personal health and wellbeing

"This section thinks about the proactive interventions and services that empower our NHS people to manage their own health and wellbeing. Personal health is more than the absence of dysfunction and disease. Mental and emotional health, physical health and a healthy lifestyle all contribute to an individual's health and wellbeing". NHS Health and Wellbeing Strategic Overview, 2021

The development of a small but active HWB Team, has resulted in a range of activities becoming part of the day to day offering. There are regular engagement events (always covid dependent) and activities which our people are able to access as and when they have a specific need. This day-to-day activity enables our people to be proactive about their own wellbeing and allows the organisation to respond in a timely way to the changing needs of our workforce.

Routes into self-help are promoted regularly, including from the regional ICS Staff Wellbeing Hub. A newly developed website will enable staff to access this signposting away from the workplace, enabling those staff who may find it difficult to access time at a PC during work time – or who simply prefer to access support in their own time.

This is about more than simply reducing sickness absence – an active HWB events calendar and routes into support will promote a healthy environment at work.

What have we already done?	We else will we do?
Focussed attention on Menopause support, including regular menopause peer support drop in sessions (the Menopause Café); offered training to staff and managers; developed guidance for staff and managers.	A number of staff will be trained as Menopause Champions, to be a point of contact for staff who may need to be signposted to further support. Develop a Menopause Policy, to ensure fair and consistent support across the Trust.
Worked with Citizen's Advice Gateshead to develop a direct access route into support, advice and guidance. This service enables staff to 'queue jump' and speak to an advisor within 24 hours of an enquiry.	Provide timely and responsive support to themes that emerge as the wider data collection work – from health needs assessments; from HWB Check-in themes; from Pulse survey results; from annual staff survey results.
Offered convenient, on-site access to vaccinations, not just for Covid-19, but flu and other relevant vaccines.	Develop a Working Carers Support Group, using the same model as the Menopause support group, to enable working carers to come together and

	offer peer support, as well as access professional support.
Partnered with Salary Finance to offer financial education, simple savings, and affordable loans, including short term loans – helping staff to avoid high interest 'pay day loans'.	The HWB Programme Board will explore whether it would be beneficial for all staff to have a personal HWB objective within their appraisal - linked to the HWB check-in.
Developed a comprehensive range of routes into self-help which is promoted on the HWB pages of StaffZone, as well as being produced as a resource for managers as part of the HWB Check-in Materials.	

7. Fulfilment at work

"Fulfilment at work encompasses not only the work we do on a day-to-day basis but a range of themes and activities that together form a critical component of an individual's health and wellbeing. This includes enabling the diversity of our NHS people to bring their whole self to work, enabling life balance, and helping our talented people reach their full potential". NHS Health and Wellbeing Strategic Overview, 2021.

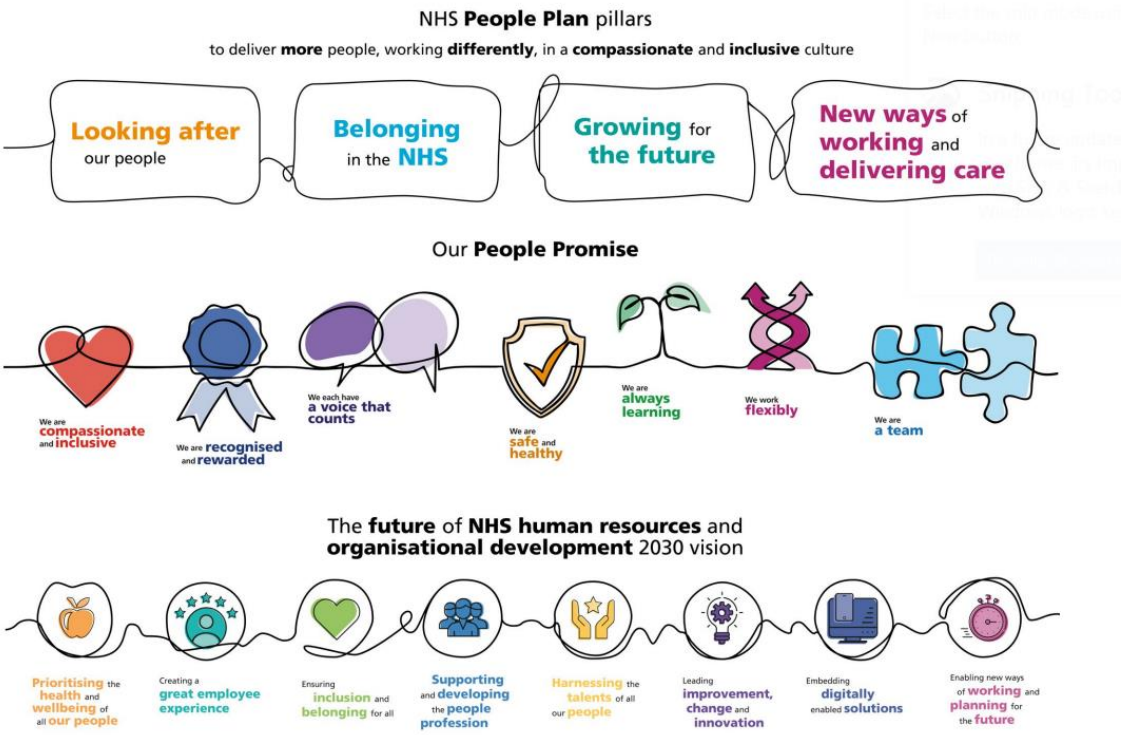
The health and wellbeing of our people is not a linear, one dimensional state. A holistic approach to health and wellbeing – as demonstrated by this framework – will ensure that we are supporting the whole person. An essential component of being able to thrive at work, and in life in general, is the feeling of being accepted as we are – so we must ensure that we have the processes in place which allow our people to thrive no matter their background. Our diverse workforce should each equally have opportunities to grow and develop at work, bringing with them the richness of their experiences.

What have we already done?	**We else will we do?**
Three staff networks are now well established within the Trust, with a fourth in its infancy. Representatives from the networks support not only network specific work, but also have	Review our flexible working practices and enable our people to think differently about how they work.

influence and stakeholder involvement with Trust-wide pieces of work.	
Delivered a number of 'Thank you' events and gestures such as the free ice cream van, festive hampers, free drinks and snacks, and a £250 HWB bonus payment for every member of staff.	Design jobs which reflect the way in which a modern organisation works, embracing digital technology to enable more agile ways of working.
Recognise outstanding achievements in an annual award ceremony – The Star Awards – as well as smaller acts of behaviour or achievements which demonstrate people living our ICORE values day to day, with the monthly You're a Star process.	Continue to offer a range of activities to support staff morale including physical activities, support groups, and a range of other activities depending on staff interests. For example: Weekly choir; annual walking challenge; annual 5-a-side football tournament.
Launched Schwartz Rounds and Team Time, as a way for individuals and teams to examine the emotional impact of working in healthcare.	

The Future of NHS human resources and Organisational Development

In November 2021 the future of NHS human resources and Organisational Development report was published. Outlining a vision and actions that support the delivery of the four pillars of We are NHS: People Plan for 2020/2021 – action for us all and embeds the seven elements of our People Promise.



The report was co-created by those most impacted by our work: NHS staff and their representatives, leaders and members of the people profession itself. It sets out the vision for how the people profession will continue to maximise our collective contribution to the NHS and meet the needs of staff, patients and local communities over the coming decade and beyond – building a brighter future for all. The immediate priorities for organisations and systems are provided on the following page:

Supporting and developing the people profession Actions 2 and 3	• Develop professional development plans for their teams, optimising use of apprenticeship levy
Leading improvement, change and innovation Action 6	• Review allocation and distribution of people function resources to ensure alignment with the People Plan, NHS Long Term Plan and local system priorities • Create plans for system-level consolidated and simplified transactional people services
Embedding digitally enabled solutions Action 8	• Optimise the adoption of current people digital solutions • Create plans and commence action to align and harmonise digital strategies and solutions, across providers wherever possible, to enable more joined-up
Prioritising the health and wellbeing of all our people Actions 13 and 15	• Build health and wellbeing metrics into performance dashboards and consider them with the same scrutiny as operational and financial performance • Review and baseline the current health and wellbeing offer, including identifying which areas to enhance or evolve
Ensuring inclusion and belonging for all Actions 17 and 18	• Embed the overhauled recruitment processes to take account of EDI considerations • Ensure that all individuals, teams and organisations have measurable objectives on equality, diversity and inclusion, including all board members
Creating a great employee experience Actions 21 and 24	• Build employee experience metrics into performance dashboards • Develop strategies to make health and care the first choice for local employment
Harnessing the talents of all our people Action 29	• Proactively set the direction for talent management and start embedding the approach
Enabling new ways of working and planning for the future Actions 31 and 35	• Develop system workforce plans that align with local service and financial planning, HEE plans and the responsibilities set out in the guidance on the ICS people function • Lead action to address local supply issues, using the benefit of scale wherever possible and innovative approaches that broaden access to roles for the local community

The Executive Director and Deputy Director of People and OD were appointed in 2020/2021. As part of their appointment work begun to understand the current service offer within the Directorate, national, regional and local expectations on our teams moving forward and our capacity to deliver. Late 2021 saw 'Delivering Excellence in People Practice' consultation introducing a new operating model, placing customer facing POD teams at the heart of our Directorate, served by a core number of corporate specialist teams, together with additional investment for key elements of our portfolio, all within the lens of a united, customer focused service offer. We developed our new operating model taking account of Futures themes and as we move through 2022/23, we will work across our networks and internally to deliver the ambitions of 2030.

3.6 National targets and regulatory requirements

The following indicators are all governed by standard national definitions

Indicator		2019/20	2020/21	2021/22	Target	National Average
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway		91.1%	69.0%	78.6%	92.0%	65.4%
A&E – maximum waiting time of four hours from arrival to admission / transfer / discharge		89.6%	91.4%	81.6%	95.0%	76.7%
All cancers: 62 day wait for first treatment from: urgent GP referral for suspected cancer		76.7%	68.1%	64.4%	85.0%	Cancer Waiting Times Report for 2021/22 not yet published
NHS Cancer Screening Service referral		93.9%	76.4%	85.9%	90.0%	
All cancers: 31 day wait for second or subsequent treatment, comprising:	Surgery	97.7%	95.8%	86.5%	94.0%	
	Anti-cancer drug treatments	99.5%	98.9%	96.9%	98.0%	
All cancers: 31 day wait from diagnosis to first treatment		99.3%	97.9%	96.3%	96.0%	
Cancer: two week wait from referral to date first seen, comprising:	All urgent referrals (cancer suspected)	91.2%	67.3%	83.2%	93.0%	
	Symptomatic breast patients (cancer not initially suspected)	95.9%	91.8%	96.2%	93.0%	
Maximum 6-week wait for diagnostic procedures		98.8%	55.8%	70.6%	99.0%	75.2%

Annex 1: Feedback on our 2021/22 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 2021-22 we feel able to comment as follows:-

Quality Priorities for 2022-23
OSC is supportive of the Trust's proposed Quality Priorities for Improvement.

Progress Against Quality Priorities for 2021-22
OSC expressed its thanks to all the Trust's staff and volunteers for its excellent work in continuing to make some real improvements in quality and safety whilst still facing significant operational challenges as the Trust recovers from the impact of the Covid 19 pandemic eg End of Life Care where the results of the national audit were excellent and the Trust is exceeding the national average in 10 out of the 12 domains being audited; Responsiveness to the needs of patients – where the trust is above the national average in this area; a 29% reduction in C Difficile cases since 2019-20 and reductions in both Hospital Acquired Pressure Damage and Community Acquired Pressure Damage and introduction of biodegradable red tabards to help avoid medication errors.

Workforce
OSC noted that workforce challenges meant that Trusts were having to rely on agency staff in some areas and sought to understand how the Trust was ensuring continuity of care for patients, particularly those in vulnerable groups, such as the elderly, where this was the case. OSC was informed that agency staff are seen as a key part of the workforce in times of pressure and are block booked so they get to know wards/patients and staff and become part of the team and this supports continuity and quality of care.

OSC also noted that some staff are on short contracts and then pick up agency work and sought to understand whether there was scope for such staff to be on longer contracts. OSC was informed that some staff prefer to have the flexibility of shorter contracts to fit in with other outside responsibilities. The Trust is also, through its workforce strategy, carrying out investment with a view to reducing the Trust's reliance on casual staff and last year had managed to achieve zero vacancy rates for healthcare support workers.

Patient Engagement
OSC noted that non-attendance in outpatients was an issue and queried what work was taking place to address this. OSC was advised that it was considered that non- attendance at outpatients had been exacerbated as a result of the Covid 19 pandemic and there had been a great deal of work carried out via social media to reassure patients that outpatients provides a safe environment for appointments.

Quality of Care
OSC sought to understand the work the Trust was progressing to ensure that patients from minority ethnic groups were not receiving a lesser standard / quality of care. OSC was reassured to note that the Trust was consulting on improvements arising from the national Ockendon Review of Maternity Services and would be using the Maternity Voices Partnership to involve patients from all backgrounds to assist in the co-design of services and ensure care is delivered to meet the specific needs of all patients. In addition, the Trust was building in all equality metrics into its Friends and Family Test and this was just starting to be

evaluated and it was anticipated that the learning would be identified in the Trust's Quality Account for 2022-23.

CQC Inspection Outcomes
OSC noted that the Care Quality Commission has not taken enforcement action against Gateshead Health NHS Foundation Trust during 2021-22.

4.2 Gateshead Clinical Commissioning Group

NHS
Newcastle Gateshead
Clinical Commissioning Group

NHS Newcastle Gateshead Clinical Commissioning Group statement for Gateshead Health NHS Foundation Trust Quality Accounts 2021/22

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 2021/22 and would like to offer the following commentary:

As commissioner, the CCG is committed to commissioning high quality services from Gateshead Health NHS Foundation Trust. They take 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 2021/22 has again been an extremely challenging time for the Trust and the entire NHS due to the unprecedented challenges of the ongoing pandemic. The CCG would like to extend its sincere thanks to the Trust and all their staff for the excellent commitment shown in responding to the pandemic, and for rapidly transforming services to deliver new ways of working, whilst ensuing that patient care continued to be delivered to a high standard.

It is acknowledged that COVID-19 has unfortunately had a significant impact on the backlog of work and has consequently increased waiting times, which inevitably will have had an impact on patient experience and outcomes. The commissioners will continue to work collaboratively with the Trust to support and ensure delivery of the elective recovery programme as the NHS learns to live with COVID-19. We fully recognise the important work the Trust has undertaken, working in collaboration with other NHS organisations, CCGs and partner agencies to deliver a system wide approach to maintain the quality of commissioned services and improve the health outcomes for the local population.

The CCG has remained sighted on the Trust's priorities for improving the quality of services for its patients and have continued to provide robust challenge and scrutiny through the Quality Review Group (QRG) meetings. Due to social distancing restrictions, these meetings continued to be held on a virtual basis during 2021/22 which created significant efficiencies in terms of staff time and continued the improved attendance at meetings seen in 2020/21. QRG meetings are a helpful and constructive forum for discussing and reviewing quality issues and it is hoped this collaborative working relationship will continue as an integral part of the new North East and Cumbria Integrated Care Board (ICB) arrangements.

The quality account provides a comprehensive description of the progress the Trust has made during 2021/22 against the nine quality priorities identified for the year. There is a transparent account of where improvements have been made and a rationale provided where these have not been fully achieved. It is fully acknowledged that a great deal of work has taken place over the past year but unfortunately, as a consequence of the pandemic, a number of the quality priorities were only partially achieved.

The CCG acknowledges that although the Trust did not achieve all the aims in relation to the three patient experience quality priorities, there has been significant progress made. The CCG recognises that it was not possible to establish an in-house *'Always Events'* training programme due to the pressures of the pandemic. It is however positive to note that there have been multiple projects undertaken, facilitated by the Patient Experience Team, which generated a large amount of patient feedback and data. The CCG notes that the inhouse training package around 'Always Events' will be considered alongside the wider improvement and transformation plans, together with plans for the development of an improvement handbook.

The CCG congratulates the Trust on the successful review and improvement of the Patient Advice and Liaison Service and complaints processes, with a focus on the alignment to patient safety and incident investigation processes. The triangulation of patient safety data sources, the real-time patient feedback gathered by patient experience volunteers and the work to actively co-design and collaborate with patients as partners demonstrates the Trust's commitment to hearing the voices of patients. The CCG notes the next steps outlined in the report to further progress this important work and fully supports the three patient experience priorities for 2022/23.

The CCG recognises that it has not been possible for the Trust to fully progress the three quality priorities within the patient safety domain. It is positive to see that the patient safety team has introduced thematic analysis of low and no harm incidents and a monthly learning bulletin has been implemented to capture the learning from serious incidents. The national delay on the implementation of the new Patient Safety Incident Response Framework was outside the Trust's control however the CCG is satisfied that patient safety incidents are managed effectively under current processes. The commissioners look forward to working in partnership with the Trust on the implementation of the Patient Safety Incident Response Framework when this is launched later in 2022, noting that this is a quality priority for 2022/23.

It is noted that the Trust partially achieved the quality priority to promote a just, open and restorative culture across the organisation. It is positive to see that a Culture Programme Board was recently established, with the aim of driving this agenda forward and providing the Board with assurance on progress. The CCG fully supports that this is carried forward as a quality priority into 2022/23.

The CCG congratulates the Trust for the excellent progress made with the ensuring patient discharge processes are safe and effective quality priority. It is positive to note the extensive work which has been undertaken to improve discharge processes and ensure these meet the national requirements. As stated in the report, this is an area in which continuous improvement is key and the commissioners look forward to receiving updates from task and finish group and the progress of the workstreams.

It is noted that there has been a small reduction in the rate of harmful falls occurring within the Trust. However, it is acknowledged that it has been difficult for the Trust to accurately assess the falls data due to the influence the pandemic placed on bed occupancy and patient acuity. The CCG congratulate the Trust for the excellent fall's prevention work undertaken in Cragside Court, which included a practice development nurse working in collaboration with staff on a quality improvement initiative to improve clinical practice. It is encouraging to see the breadth of work that has taken place and it is positive to note that no significant harm has been reported since the quality initiative started. The CCG notes the ongoing Trust-wide improvement work and the plans

to capture data electronically on Nervecentre, including the post fall protocol and standing and lying blood pressure. The CCG supports the next steps to build further on this important work in 2022/23.

The CCG congratulates the Trust on the achievement of their harm reduction work with regards to pressure damage, with a 37% reduction in the overall rate per 1000 bed days. The progress made with the implementation of the Surface, Skin Inspection, Keep moving, Incontinence and Nutrition (SSKIN) bundle and the supporting training, guidance, tools and weekly audits have enabled the Trust to make real improvements in this area, which will hopefully be sustained in the coming year. It is positive to see the plans in 2022/23 to move towards the electronic capturing of data on Nervecentre, including the SSKIN bundle, wound management booklet and intentional rounding chart.

It is acknowledged that the Trust unfortunately did not achieve their aim of ensuring at least 80% of patient deaths received a level 1 review within 60 days in 2021/22. It is noted only 43% of patient deaths received a level 1 review, 64.8% of which were undertaken within 60 days of death. This is a further significant decrease on the 2020/21 position and the CCG recognises that the pandemic limited the Trust's ability to undertake mortality reviews. It is noted that Audit One carried out an audit of the mortality review process in late 2021 and *'reasonable'* assurance was provided. It is reassuring to note that an action plan has been developed to take forward the recommendations arising from the audit, and this will be overseen by a task and finish group. 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 118.3 continued to be above the national average of 100, with more deaths than expected. The CCG is assured that there are no concerns regarding the quality of care provided by the Trust following a detailed mortality review undertaken by the North East Quality Observatory Service. The CCG supports the Trust's approach to monitoring mortality using a range of different sources of data, including the outcome of mortality reviews, medical examiner reviews and serious incident patient safety investigations. The commissioners will continue to receive regular updates at the QRG meetings on the mortality reviews undertaken, including lessons learned, good practice, areas for improvement and resulting actions.

The emphasis the Trust gives to national clinical audits and confidential enquiries demonstrates that they are focussed on delivering evidence-based best practice. The CCG commends the Trust for their continued commitment to clinical research, particularly with regards to their invaluable contribution to the COVID-19 urgent public health studies which supported the development of new diagnostic tests, treatments and vaccines. It is also positive to note the training on the importance of research proved extremely popular and this will continue to be delivered to foundation doctors. The CCG fully supports the Trust's quality priority for 2022/23 to encourage, help and support all staff to engage with research.

The CCG acknowledges that the pandemic has had a significant impact on safeguarding activities, with a national rise in mental health issues for children and adults and an increase in incidents of domestic violence. The CCG recognises that the safeguarding teams have continued to provide a comprehensive service, and this is evidenced by the wide range of work they have undertaken over the past year. The introduction of grab bags with essential items for people who have fled domestic abuse situations is an excellent initiative. It is also reassuring to note that health and wellbeing ambassadors are now within teams and staff have access to a range of appropriate support when dealing with distressing safeguarding cases.

The CCG would like to commend the Trust for their strong performance in the National Patient Surveys and for the positive results they received, in particular the Urgent and Emergency Care Survey which showed the Trust scored the highest in the region for their urgent and emergency care services.

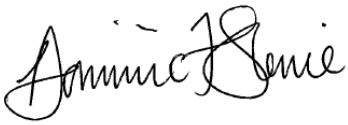
It is acknowledged that the pandemic has had a significant effect on staff and the CCG commends the Trust for their excellent and comprehensive approach to supporting staff and promoting their health and wellbeing. The CCG was impressed by the wide range of work undertaken across the seven areas of focus in the NHS England Health and Wellbeing framework. As highlighted in the Chief Executive statement the Trust wish to build on this further and is it very positive to see a dedicated section on staff experience included for the first time in their quality priorities for 2022/23.

The CCGs were impressed by the good news stories and quality improvements initiatives the Trust has implemented over the past year, as set out in the report. These are all fantastic achievements, and the CCG would again like to thank the Trust and all its staff for their continued hard work and commitment in delivering high quality, effective and compassionate care to patients.

The CCG welcomes the specific quality priorities for 2022/23 highlighted in the Quality Account. These are appropriate areas to target for continued evidence-based quality improvement and link well with the commissioning priorities, which will be transferred to the new ICB. In the light of the publication of the Ockenden Report, the CCG also welcomes that a quality priority has been included to maximise safety in maternity services and ensure there is full compliance with the Ockenden recommendations.

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 2021/22. It is clearly presented in the format required and contains information that accurately represents the Trust's quality profile; the document is reflective of quality activity and aspirations across the organisation for the forthcoming year.

The commissioners look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned in 2022/23.



Julia Young
Executive Director of Nursing, Patient Safety & Quality

Dr Dominic Slowie
Medical Director

May 2022

4.3 Healthwatch

Healthwatch Gateshead statement for the Gateshead Health NHS Foundation Trust (GHFT) Quality Account 2021/22

We are pleased to see that the Trust has been rated 'Good with Outstanding for Caring' by the Care Quality Commission and we would like to thank GHFT for the opportunity to respond to their quality account for 2021/22.
We recognise the challenges GHFT has faced during the Covid 19 pandemic and the impact on services due to increased demand and would like to thank all the staff for their hard work during these unprecedented times.

Given the extra pressures of a pandemic, it is understandable that many additional factors compounded to affect the outcomes of priorities. While we see that of the nine priorities, two priorities were not met, it is reassuring to see that four were still fully met and three partially met. It is welcoming to see next steps already are in place to help build on the partial success of 2021/22.

Progress on the Trust's priorities for 2021/22
Healthwatch Gateshead comments

Patient experience

Priority 1: We will ensure that we have effective ways of receiving feedback from our patients, their relatives and carers which will lead to demonstrable improvements in practice.

We commend the Trust for the progress it has made reviewing and revising the PALS and complaints processes. More efficient systems are always welcome to see, especially as this can be a frustrating experience during times of heightened individual frustrations. While the move away from the Friends and family cards is understandable it begins to contribute to the barriers faced by individuals, especially when they are "exception only".

We are disappointed to see in the next steps that there is no written intention to seek or share information from other sources or to collaborate with other user experienced focussed organisations in Gateshead.

Priority 2: We will ensure that patients, relatives, and carers have the best experience possible when they are receiving our care

We congratulate the patient experience team who "have generated a large amount of patient feedback and data". While we understand that this priority was largely impacted by COVID, the drive to engage with people is warmly welcomed. The development of an improvement handbook sounds beneficial, and we would recommend exploring baking the Always events and Just Culture training into all of the customer facing role induction processes, to ensure patient experience from the start of employment with the Trust.

Priority 3: We will ensure that patients, relatives, and carers are engaged in our Quality Improvement work and that patient, relative and carer involvement is embedded as business as usual across the organisation.

We congratulate the Trust on engaging very well with patients, relatives and carers. We would welcome and value, if possible, an analysis of the demographics of those engaged with to ensure the design is reflective of

the needs of the whole community. However, we commend the Trust on implementing the co-design approach and welcome the interest to expand these workshops into other areas.

Patient safety

Priority 4: We will ensure there is a positive safety culture within the organisation in which openness, fairness, accountability and learning from high levels of incident reporting is the norm

We look forward to the implementation of the PSIRF and resulting evaluations.
We welcome the new approach to previous years and the monthly learning bulletin. We look forward to seeing how this thematic approach develops.

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

We recognise most of these objectives have been met by the Trust and welcome the Trust's approach to introducing Culture Programme Board. We are encouraged that this continues to be a priority and that there are next steps in place to continue this work into 2023 and beyond.

Priority 6: We will ensure that our patient discharge processes are safe and effective.

We are encouraged to see that the Trust has met the national discharge requirements. It is obvious some significant work has taken place and much progress has been made.

Priority 7: We will ensure the care that we provide to our patients is consistent with recognised best practice, leading to improved outcomes for patients (falls)

It is clear some progress has been made in the period and the reinstation of the falls prevention group will aid the collaborative approach required throughout departments. While it is difficult to draw direct comparisons due to the pandemic, we feel this should be a key area of focus for the Trust and would encourage the trust to look at successful initiatives happening elsewhere such as other trusts and community settings.

Clinical Effectiveness

Priority 8: We will ensure the care that we provide to our patients is consistent with recognised best practice, leading to improved outcomes for patients - pressure damage

We congratulate the achievement of an ambitious 10% reduction. We look forward to learning more about the Pressure Damage Collaborate roll out across other areas and the growth of accessibility of the service.

Priority 9: We will review and revise our level 1 mortality review process, providing families, carers, and staff the opportunity to identify themes for improvement and to highlight areas of good practice and excellent care

We support the Trust's plans to continue its commitments to recommendations from the Audit One report.

Healthwatch Gateshead

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 2021/22. 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 2021/22, 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:

Comments received regarding future process to be considered going forward.

Comment received regarding Staff and Response Volunteers incorporated into the report.

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 2021/22 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 2021 to March 2022
    - papers relating to quality reported to the board over the period April 2021 to March 2022
    - feedback from commissioners dated – 26/05/2022
    - feedback from governors dated – 11/05/2022
    - feedback from local Healthwatch organisations dated – 12/05/2022
    - feedback from Overview and Scrutiny Committee dated – 19/05/2022
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 – 19/05/2022
    - the 2021 national patient survey – May 2021
    - the 2021 national staff survey – March 2022
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated – 22/06/2022
    - 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

- 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: 6 June 2022 Chairman: 

Date: 6 June 2022 Chief Executive: 

Glossary of Terms

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

Care Quality Assurance Framework (CQAF)
CQAF provides wards and departments with a coordinated set of standards that will provide information in relation to quality and safety.

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.

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.

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.

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)

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.

Just Culture

The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated.

Methicillin 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 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.

Nervecentre

Nervecentre is an electronic clinical application used to record a variety of patient observations and assessments.

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.

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.

Pressure Ulcers

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

Research

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

Risk

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

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.